TeleMonitoring to Improve Substance Use Disorder Treatment After Detoxification

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Protocol (10/1/2014)

Sample and procedures

Patients entering one of two psychiatry units within the same health care system were included on the basis of (1) undergoing detoxification for alcohol and/or opioid dependence; and having (2) sufficient cognitive functioning to understand study procedures (i.e., able to answer the Montreal Cognitive Assessment's section on Orientation; Nasreddine et al., 2005), (3) access to a cell or land line telephone when not hospitalized, and (4) at least one person who would know of their whereabouts after discharge, for whom contact information was available. After receiving an introduction to the study, participants signed an informed consent form. All study procedures were approved by the VA Central Institutional Review Board. Patients who provided informed consent completed the baseline interview. After the baseline interview, participants were randomly assigned to condition (ETM or UC) using random numbers generated by a computer program.

Regarding follow-ups, the research assistant, blinded to patients' condition assignment, collected self-report data from patients by telephone at three months post-baseline (which was upon completion of the intervention for patients in the ETM condition) and at three months after the three-month follow-up (i.e., six months post-baseline). We used an intent-to-treat design and so followed all participants irrespective of participation in the intervention. Follow-up assessments were conducted by telephone because not all patients resided in close geographical proximity to the inpatient facility.

Conditions

Usual Care. All patients, regardless of condition, received usual inpatient detoxification which consisted of medically supervised withdrawal. The health care system had available post-detoxification addiction outpatient and residential specialty care and pharmacotherapy. Study participants, as part of usual care, were offered by detoxification staff a referral to or an appointment with addiction treatment services, if they chose to consider seeking treatment.

ETM. Patients assigned to the ETM condition received usual care plus the ETM intervention. ETM consisted of one 50-minute individual session during the inpatient stay and 12 weekly 15-minute telephone sessions from the same TeleCoach who conducted the in-person session.

The in-person session enhanced procedures in McKay, Van Horn, & Morrison's (2010a) manual for implementing telephone monitoring with addiction patients transitioning from more to less intensive treatment. It provided an orientation to the telephone monitoring protocol, which was enhanced by Motivational Interviewing and Contracting. Motivational components included the TeleCoach's empathy, conveying the patient's responsibility for change, and supporting the patient's self-efficacy to make changes, while addressing post-detoxification engagement in addiction treatment and mutual-help. Participants completed a contract containing two main elements: information that attending treatment and mutual-help increases the chances of remaining abstinent; and an intention to attend addiction treatment and/or mutual-help, with as much specificity as the patient could provide regarding these plans. Participants were informed of ETM's reinforcers for beginning and participating in treatment and mutual-help, and given *The Next Step Toward a Better Life* (SAMHSA, 2014), which tells people completing detoxification what to expect physically and psychologically post-discharge, encourages use of treatment and mutual-help, and provides tools for remaining clean and sober.

Telephone sessions also enhanced procedures in the McKay et al. (2010a) protocol. Patients were expected to complete one 15-minute telephone call per week for 12 weeks. When the patient failed to answer a call, the TeleCoach made at least two more attempts at that scheduled contact, and when successful, the initial non-response was discussed. Patients received reinforcements for completing 6 and then 12 phone calls (e.g., tote bags, key chains). During each telephone session, patients completed the Risk Assessment Worksheet (McKellar et al., 2012) about substance use and compliance with treatment and mutual-help since the last call. Telephone sessions were enhanced with prompts and reinforcements. The TeleCoach

checked whether participants had attended planned treatment sessions and mutual-help meetings, and reminded them to return even if they had missed a session or meeting. Participants received social reinforcements for attending treatment and mutual-help, i.e., a personal congratulations letter from the TeleCoach for entering treatment and attending the first post-detoxification mutual-help meeting, certificates for abstinence milestones (2, 4, and 8 weeks), and a certificate plus medallion for abstinence through 12 weeks.

2.3 Measures

At baseline, patients were asked whether they had received previous inpatient detoxification (no or yes). At follow-ups, patients were asked whether they had received inpatient detoxification since the previous interview (in the past three months; no or yes).

At baseline, patients were asked whether they had received previous outpatient treatment for alcohol and/or drugs in their lifetime and in the past 30 days. At follow-ups, patients were asked whether they had received outpatient treatment for alcohol and/or drugs since the last interview (in the past three months; no or yes). At baseline and follow-ups, patients were asked whether they had attended a 12-step meeting in the past three months and if so, how many meetings.

At baseline and follow-ups, we used the Addiction Severity Index (ASI; McLellan, Cacciola, Alterman, Rikoon, & Carise, 2006) to assess alcohol use, drug use, and psychiatric severity. In each area, items measured the number, extent, and duration of symptoms in the past 30 days. ASI composite scores were produced from sets of items that were standardized and summed to provide internally consistent evaluations of patient status in the problem areas (McLellan et al., 2006). They range from 0 to 1, with higher scores indicating poorer outcomes. In addition, to ensure the clinical utility of findings, we report responses to the ASI items referring to the past 30 days that assessed number of days drank alcohol (0-30), number of days used opioids (0-30), experienced serious thoughts of suicide (that is, seriously considered a plan for taking own life) (no or yes), and attempted suicide (no or yes).

We also used the Brief Addiction Monitor (which is required in VA for measurement based substance use disorder care) at baseline and follow-ups (Cacciola et al., 2013; CESATE, 2010), which yields two composite scores referring to the past 30 days. (1) *Substance use* is the sum of three items, i.e., number of days drank alcohol; had at least 5 drinks (if a man) or at least 4 drinks (if a woman); and used any illegal/street drugs or abused any prescription medications (for each, 0=0, to 4=16-30 days). (2) *Risk factors* for substance use is the sum of five items, e.g., physical health (0=excellent, 4=poor); number of nights having trouble falling or staying asleep (0=0, 4=16-30 days); in any situations or with any people that might increase risk for using alcohol or drugs (0=0, 4=16-30 days).

At baseline and follow-ups self-efficacy was assessed with the Brief Situational Confidence Questionnaire (Breslin, Sobell, Sobell, & Agrawal, 2000). Eight items asked patients to rate their level of confidence in resisting drinking and using drugs as a response to different types of situations (e.g., unpleasant emotions, social pressure to drink/use), and then responses were averaged such that higher scores indicate more self-efficacy (Cronbach's alpha = .91, .92, and .91 at baseline and 3 and 6 months, respectively).

2.4 Analysis Plan

We first compared patients randomly assigned to ETM or UC on baseline demographic and outcome characteristics. We then used analysis of covariance (ANCOVAs) to compare the ETM and UC groups on outcomes at the 3- and 6-month follow-ups. Covariates were the baseline value of the outcome and the inpatient detoxification unit.