



Effectiveness of Extended Telephone Monitoring for Alcohol Dependence
Telephone Monitoring and Counseling Manual

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Contents

| | |
|---------------------------------------|----|
| Orientation Session | 3 |
| Telephone Sessions | 5 |
| Support Person Role | 12 |
| Documentation | 13 |
| Maximizing Adherence | 14 |
| Risk Assessment Worksheet | 17 |
| Guidelines for Changing Level of Care | 21 |
| Face-to-Face Evaluation Session(s) | 23 |
| Adherence Checklist | 25 |

Face to Face Session: Orientation To Telephone Monitoring and Counseling

Prior to beginning telephone monitoring and counseling, the counselor will have a 45-minute face-to-face session with the client to go over the telephone protocol and explain how it works. This is also a time for the client to raise questions and identify their personalized trigger situations and recovery behaviors for ongoing monitoring.

Before the session, review the ASI and SCID diagnoses.

The session should include:

- Acknowledgement of client’s progress, in part demonstrated by completion of 3-4 weeks of IOP and commitment to ongoing monitoring and counseling.
- Explanation of telephone-based treatment, with strong emphasis on importance of the phone calls, being prepared for the phone calls, and being willing to ask for help. Fill in the dates corresponding to each time frame for “when do I call my counselor” in the client’s workbook
- Explanation of adaptive protocol that allows for flexibility depending on how the client is doing.
- Engage the client briefly in a discussion of their progress so far. Touch on the following:
 1. What has the client been doing to stay clean and sober? What are the most important things to continue, or to begin doing?
 2. If the client has had some sobriety in the past, what led to relapse? If the client has never been sober, what have been the main obstacles? What are the warning signs that a relapse might be on the way?
 3. What are the client’s most important reasons for staying clean and sober now?
 4. Follow up on any questions raised by the ASI and/or SCID (e.g., suicide attempts, psychiatric diagnoses/medications, chronic medical problems, etc.)

This discussion will help you guide the client in choosing high-risk situations and recovery activities to monitor and in selecting relevant between-session goals. Ask for permission to challenge the client to be even more proactive in managing their addiction – doing more of what has been successful, helping them catch problems in the early stages before they lead to relapse.

- Use the workbook exercise to help the client identify their top four high-risk situations for ongoing monitoring
- Use the workbook exercise to help the client identify their top four pro-recovery lifestyle activities for ongoing monitoring
- Review and complete the crisis plan with the client

- Review the Telephone Monitoring (i.e., risk assessment) Worksheet with the client during the session. Clarify with the client anything s/he does not understand and discuss any misgivings s/he may have about following through with monitoring. You can also emphasize and demonstrate for the client that it can be completed quickly, and also that spelling, complete sentences, and proper punctuation are not the important aspects of this work.
- Provide feedback based on the risk assessment worksheet, and elicit questions and concerns about feedback
- Ask the client what high-risk situations s/he anticipates facing in the interval before the first phone session. Troubleshoot briefly.
- Identify one goal for the client to work on before the first phone session. This can be related to avoiding/managing a high-risk situation or increasing/maintaining progress toward a substance-free lifestyle. The first phone session will be in just a few days so this will be an opportunity to practice identifying very specific short-term behavioral goals.
- Schedule the first phone session, ideally within the same week as the orientation, so that the second phone session will fall approximately one week after the orientation.
- Give the client the Working Alliance Inventory with a stamped envelope addressed to whoever will be following the client for research follow-up visits. Explain that it should be completed and returned after the second phone session.

Telephone Sessions: Monitoring and Counseling **Audiotape all sessions!**

Outline:

1. Acknowledge client for the call, and orient to the task at hand
2. Review Risk Assessment items
3. Provide feedback on risk level – suggest change in level of care if warranted
4. Review progress/goals from last call
5. Identify upcoming high-risk situations
6. Select target for remainder of call
7. Brief problem-solving regarding target concern(s)
8. Set goal(s) for interval before next call
9. Schedule next phone call

General Comments:

Monitoring and counseling is intended to assist clients in managing their addiction proactively over the long term. The purpose of the telephone sessions is to review client's progress, work on areas of concern, and set new goals for the coming interval.

It is the client's responsibility to initiate the counseling call. Holding the client accountable for his role in the telephone contact should not be viewed as punitive, demeaning or an infringement on her autonomy. Quite the contrary, accountability communicates the counselor's confidence in the client's capacity to follow through with the structure and improve her life situation. For effective communication of this, however, the counselor must also hold him/herself accountable for her role in monitoring. Despite the fact that this is only a 15-20 minute phone call in the midst of a very busy day, it is your responsibility to convey to the client that it is important and that you take it seriously. Be in your office to answer the phone when the client calls and attend fully to the call.

The counselor is responsible for keeping comprehensive records on each call, including a progress note and data regarding client adherence to the phone calling process.

The counselor should explain to the client why "step up care" may be recommended at some point, and how the telephone sessions will be used to make that decision. This will have been introduced in the introductory face-to-face session but will bear reviewing from time to time. The counselor should stress that a recommendation for increased level of care is not a punishment. Rather, the counselor and the client are working together to improve the client's substance abuse status, and if the current approach to treatment is not working as well as it should, another approach needs to be tried. The counselor might try saying something like:

"If you went to your doctor because of an infection and the first medication she gave you didn't seem to be doing the job, you would want your doctor to either increase the amount of the medication, add another medication to the one you

were taking, or switch medications entirely. You would expect the doctor to keep adjusting your treatment until you got better.”

Obviously, treatment for substance abuse is different from that for infections in many ways, not the least of which is that stepped-up treatment usually requires a lot more work than switching medications! However, the counselor may be able to increase the willingness of the client to go along with changes in the treatment protocol if an emphasis is placed on the message that “we’re in this together, and let’s see if making these changes will help you achieve your goals more quickly.”

The Risk Assessment items are grouped according to “risk” factors for relapse and “protective” factors against relapse, based on prior research and clinical experience. The overarching goal of the intervention is to help clients manage their addiction proactively by (a) avoiding and/or improving coping with high-risk situations (“people, places and things”) and (b) developing a lifestyle rich with rewarding activities unconnected or incompatible with substance use. Sessions are structured to include a review of the client’s progress and an opportunity to troubleshoot the week(s) ahead.

For use in counseling from a cognitive-behavioral relapse prevention perspective, it may also be helpful to think in terms of the following categories:

1. Environmental Antecedents to drinking/drug use – the external situations in which drinking is most likely. Clients need to learn to recognize high-risk situations and either avoid them or learn to cope with them without drinking. Clients will have identified their top 4 risky situations; in addition, so many clients find that being alone is a high-risk situation that it will be monitored for everyone. You can help the client identify high-risk situations by asking when and where any urges or cravings occurred.
2. Thoughts, Feelings, and Cravings - these are the link between external high-risk situations and drinking behavior. The client thinks that a drink would taste good, have a pleasant effect, or improve an unpleasant mood or problematic situation, so they pick up. Bad moods are so often associated with drinking that they will be monitored for all clients. Some situations may be so closely associated with drinking that they elicit cravings seemingly without any thoughts on the client’s part, but often clients can learn to identify and challenge their thoughts and ideas about substance use.
3. Behavior – the behavior of central interest is alcohol or drug use. However, simply “not drinking” is not enough, something must replace that behavior. If the client encountered a high-risk situation and didn’t drink, what did he/she do instead? What will he/she do to manage high-risk situations in the upcoming week? Attending treatment sessions and AA meetings and having regular contact with a sponsor are behaviors that can help clients remain sober so they will be monitored throughout the program. Furthermore, clients need to develop a range of enjoyable activities that are inconsistent with drinking.

Clients will have identified 4 sober activities they wish to participate in for monitoring.

4. Consequences – these are the results of either drinking or doing something else. Usually the short-term consequences of drinking and drug use are positive, e.g., euphoric feelings, socializing, taking a break from the work of recovery, forgetting one’s problems. It is the long-term consequences that are the problem. For pro-recovery behavior, the situation is usually the reverse, with the short-term consequences ranging from enjoyment of a sober activity (which may pale in comparison to an alcohol or drug high) to the genuine displeasure of dealing with life’s misfortunes. The true benefits of sobriety may take much longer to realize. The phone sessions will provide an opportunity for the client to recall the negative consequences of drinking and to review the benefits of maintaining sobriety and completing personal goals.

Many substance abusers view themselves as people that things “happen” to - things that they have little or no control over. One goal of cognitive-behavioral relapse prevention counseling is to help clients become more aware of the connections between the client’s behavior and what happens to him or her. A second goal is to help the client get into the habit of anticipating upcoming risky situations in order to cope with them more proactively. The counselor may need to help the client recognize these connections. From our experience, this is more difficult to do over the phone than in person. So, the counselor will have to work hard to keep pointing out when the client is being vague and omitting important details while on the telephone. Consistent use of the “behavior chain” - linking situations, thoughts/feelings, behavior, and results, will help the client to describe his behavior in a manner amenable to problem-solving.

It is very important to give the client lots of positive comments for what they are doing, including things such as calling on time, having their workbook with them, having filled out the Risk Assessment form, etc. Remember also that you want to be listening for changes in behavior patterns that might indicate cause for concern, particularly things the client has identified as ‘red flags’. The longer you and the client do this, the more the session will take on a conversational tone, but initially the phone sessions may feel quite awkward to both of you due to their newness, brevity and number of structured items to cover. To keep the telephone sessions sounding fresh and spontaneous, as opposed to overly “scripted,” it is best if counselors develop their own approach to covering the required material. What we provide here are sample scripts that might be useful in developing such an approach.

Detailed instructions and sample scripts:

1. Acknowledge client for the call, and orient to the task at hand. Since the telephone sessions are brief (15-20 minutes), the counselor should quickly get into reviewing the Risk Assessment form. Here is an example of how the call might begin:

“Thanks for calling in on time. Are there any emergencies I should know about? OK, let’s get right into your worksheet. Do you have that material with you now? Did you complete it prior to the call?”

- If client says “yes” to both, give appropriate positive feedback.
- If client didn’t call in on time, or has missed one or more scheduled call, reinforce the client for resuming calls, and mention that you will address scheduling issues later.
- If client doesn’t have materials on hand and can’t obtain them quickly, continue with Risk Assessment prompts. At end of session prompt them to locate their materials before the next call. If materials are lost, mail another copy.
- If there is an emergency, ask the client to describe it BRIEFLY. In most cases it will be enough to assure them that you will discuss it with them further after completing the risk assessment (as long as you really do follow through). If the client is very upset, it may be necessary to deal with the emergency situation before returning to the structure of the call. Even then, it may be possible to retain the “spirit” of the call by helping the client deal with the emergency without resorting to substance use.

2. Review Risk Assessment items

“Did you use any alcohol or drugs over the past week?”

- Continue through the Risk Assessment items in order, recording the client’s responses. Be alert to how the client’s responses bear on their stated goals since the last session and to longer-term treatment goals. Are they showing progress over time toward a pro-recovery lifestyle?
- Once every 3 months, review the entire list of high-risk situations and recovery-lifestyle items to determine if there have been any changes in the client’s top 4 items (to be given as a prompt in upcoming calls).
- Continually reinforce client for sticking with the process and providing complete and accurate information, even when it’s not all good news.

“Thanks for being so honest with me. That’s the only way we can tell where you are doing well and where you might need to change.”

3. Provide feedback on risk level

Based on hand or computer scoring of the Risk Assessment form, give the client feedback on relapse risk level. Place the feedback in context of the client’s goals since the last session and overall treatment goals, and include suggestions for change in level of care if warranted.

Low Risk:

“Based on what you’ve told me, you are doing a great job of keeping yourself at low risk for relapse. You are still talking with your sponsor and spending even less time alone than before.”

Moderate Risk:

“You’ve been spending a lot of time alone lately, and getting to fewer AA meetings. You’ve told me that combination has gotten you in trouble before. I am concerned that you are now at a moderate risk for relapse, and one thing we can discuss in our time today is how stepping up our phone calls can help you get back on track.”

“I’m looking over information on your progress over the past month, and it looks like your participation in AA has been steadily decreasing. Have you noticed that? What is your sense about why that is happening now? Skipping meetings is a warning sign for relapse, so I think its important that we look at this now, before you get into trouble.”

High Risk:

“Based on what you’ve told me, you are having more cravings and are very concerned about staying clean and sober. That gets me concerned too that you may be at high risk for relapse. Let’s think about having you come in for a face-to-face meeting so we have more time to address what’s going on.”

4. Review progress/goals since last call.

Ask the client how they did with respect to the issues identified in the previous call. If a high-risk situation was anticipated and planned for, how did it go? Did the client complete his/her pro-recovery goals? Engage the client in a detailed description of their successes. What did they feel good about? What was more difficult? The goals of this exercise include helping the client recognize the inherently rewarding aspects of his/her sober lifestyle and troubleshoot difficult situations or change plans that aren’t working well.

5. Identify upcoming high-risk situations

Ask the client to think ahead to the interval until the next phone call. What situations might they encounter that could increase risk for relapse?

When will it be difficult for you not to drink in the upcoming week?

You’ve had some cravings whenever you have been around your brother-in-law. Will you be seeing him in the next week?

You will be stepping down to a lower level of care at your treatment program. That’s a great milestone, but sometimes people find it is harder to stay sober when they have less support. What do you think?

The client may or may not identify anything. If the client has trouble anticipating high-risk situations, yet reports having encountered them on a regular basis or reports continued cravings,

help them to see the connection between past difficult situations and the possibility that those same situation may arise in the foreseeable future.

6. Select target(s) for the remainder of the call.

Once the Risk Assessment is completed, you will only have about 10 minutes for counseling before it is time to wrap up and schedule the next call. Together with the client, choose 1 or 2 things to focus on. These may include follow-up on client's goals from the prior session, problem-solving regarding newly identified or especially troublesome risks, and other pressing matters the client may see as having a bearing on their ability to remain clean and sober. This BRIEF process will be an exercise in prioritizing for client and counselor alike!

“Your goals were to attend AA daily and talk with doctor about problems you’ve been having with your Zoloft. You made it to AA but you’re still having trouble taking your meds, and bad moods are still a problem for you, and may be a high-risk situation for you in the upcoming week. Which of these things should be focus on? Is there something even more important for your recovery right now?”

- There is no need to repeat what you just said in the feedback step of the session if goals and concerns were already covered – just go ahead and set the agenda with the client
- If compliance with the call schedule is a problem, this is the time to get it on the agenda

7. Brief problem-solving regarding target concern(s)

Once a specific target is identified, engage the client in problem-solving. As much as possible, guide the client through the steps of problem-solving (noting that they are a step ahead of the game already, having identified the problem) rather than solving the problem for them. Encourage the client to generate a few solutions and select one for implementation. Provide information and advice as needed, but avoid telling the client what to do or getting into an unproductive back-and-forth in which the counselor offers helpful suggestions and the client rejects them. Avoid argumentation by responding reflectively to resistance and quickly getting back to the task at hand.

When motivation is flagging, this may be a signal that the client is minimizing negative consequences of substance use and benefits of abstinence. Review the information gathered in the initial face-to-face session to help identify reasons for staying clean and sober – what are client's current thoughts on the topic? How can they best remind themselves of the costs of use? Discuss the benefits of abstinence – and how the client can gain even more benefit from sober living.

There are many opportunities for the counselor to help the client integrate her various structures and supports by shaping the client's goals in a way that models such integration: connecting the client's identified interpersonal relationship goals to people at church or meetings or work, for example—“Is that something you could talk with your pastor about?” “What about asking your

brother to go with you to _____?” “When you meet with your sponsor this week, could you ask for feedback about this?” etc.

8. Set goal(s) for interval before next call.

The client should be reassured that she doesn't have to come up with lengthy or complicated tasks and goals. In fact, simple and brief is better, as long as specifics are provided. Help clients choose goals and tasks that are concrete and “do-able.” Better for the client to experience success at a modest goal than to fail at an ambitious one.

“Now let's go over what you'll be doing in the coming week, between now and our next telephone call. Given how things are going, what do you think the one or two most important goals should be for next week? The best kind of goals are ones that are stated very clearly, so next week you'll be able to see if you've made progress on them.”

“Good. Now that you picked _____ as your main goal, what are the things you will do to reach that goal? The more specific you can be, the better. For example, rather than saying 'I'll go to AA,' clarify how many meetings you plan to go to, where they are, and when they are. By doing that now, you'll have developed a good plan for the coming week.”

9. Schedule the next phone call

Schedule the next phone call. If compliance has been a problem, make sure the client agrees that the designated time will work for them. If necessary, engage in brief problem-solving regarding compliance with phone calls, including having Risk Assessment form ready. (If compliance has been a major issue, it should have been addressed earlier in the session, and can be reviewed at this point)

“OK then, we will talk again 2 weeks from today at 2:00. I'm looking forward to your call!”

Support Person Role in “Buddy” Condition

After initial randomization to either the feedback or counseling condition, patients will then undergo a second randomization regarding involvement of a support person in treatment. If they are randomized to support person involvement, they will be asked to identify someone who can play a supportive role with respect to their treatment and recovery. This does not necessarily need to be a “significant other” – it can be a spouse, friend, family member, or other associate. The patient should be encouraged to think of at least one possible support person; however, if they refuse or cannot name someone, they will not be excluded from the study. The research staff member who did the baseline interview will obtain consent to contact the support person.

Once a support person is identified, the patient should be encouraged to let him/her know that the counselor will be calling to orient him/her to the program. The counselor should call the support person as soon as possible, to obtain consent for participation and orient him/her to the role he/she will play in the program. The support person may come in for a brief (15 minute) orientation if desired but it is not necessary. Mail a copy of the consent form to the support person.

In the Feedback condition, the support person’s role is to help the counselor regain contact with the patient if the patient begins to miss phone calls and is out of contact for at least a week after a call is missed. The counselor can ask the support person to relay a message or for suggestions as to how to reach the patient. The counselor is encouraged to check in with the support person every 3 months to maintain contact and express appreciation for his/her willingness to participate, even if never called upon to take any specific action, rather than waiting for a crisis to get in touch. If the support person asks the counselor how to handle specific situations, the counselor should not provide advice but may refer them to Al-Anon or suggest that they seek counseling.

In the Counseling condition, again, the support person will help the counselor regain contact with the patient if the patient begins to miss phone calls and is out of contact for at least a week after a call is missed. The counselor can ask the support person to relay a message or for suggestions as to how to reach the patient. In addition, the support person may agree to a more active role, depending on their own comfort level. The counselor should ask the patient to identify ways the support person can be helpful, and to discuss it with them. The counselor should also ask the support person for suggestions, rather than make requests of them. Examples of the kind of support that may be offered include taking the patient to a meeting, babysitting so the patient can attend meetings or treatment, spending time with the patient, calling the patient to check in, or just offering a friendly word of encouragement from time to time. The support person’s safety is paramount, and we need to be very cautious of asking anyone to approach a patient who has been drinking/using, is in an unsafe location, or has requested that he/she be left alone.

As in the Feedback condition, the counselor in the Counseling condition is encouraged to check in with the support person every 3 months to maintain contact and express appreciation for his/her willingness to participate. The counselor may also make referrals to additional services or to Al-Anon if requested by the support person. However, the counselor should not provide advice or counseling to the support person.

Documentation

The therapist should document all contacts with the client and all attempts to reach the client. Templates have been provided for standard telephone sessions for each treatment condition and for most foreseeable additional kinds of contact. In general, if a contact doesn't fit one of the templates, a SOAP note should be used. Therapists may place handwritten notes in the chart on an ongoing basis, or may keep notes in a password-protected Word file to be printed, signed, and placed in the chart at least once every three months. If notes are maintained electronically, the project manager must have access to the therapist's computer and files in case of emergency.

Protocol-specific documentation issues

Checklists have been provided that include all elements of the orientation, telephone, and in-person sessions for ease of documentation and to help prompt protocol adherence. Please don't check anything off that you didn't actually do!

Step-up care: Note whether step-up care is recommended and whether client follows through. This information will also be collected on the online Risk Assessment Worksheet.

Referrals to outside services should be documented, along with whether you used the resource guide to identify the referral. Note whether the client followed up on the referral. This information will also be collected on the online Risk Assessment Worksheet.

Support person involvement:

1. Note whether the patient agrees to or refuses support person involvement.
2. Note whether the support person agrees or refuses to participate (i.e., gives informed consent). If you can't reach the support person to obtain consent, note that too.
3. Note all contacts with support person:
 - a. Efforts to reach patient
 - b. Quarterly check-in
4. Note whenever use of the support person is suggested in counseling sessions with patients, and whether patient follows up on this suggestion or plan.

Maximizing Adherence to Telephone Monitoring and Feedback/Counseling

It is the client's responsibility to call the counselor at the appointed time. This accountability communicates the counselor's confidence in the client's capacity to follow through with the structure and improve her life situation. However, if the client misses a phone appointment, it is the counselor's responsibility to try to reach the client, determine the reason for the missed appointment, and re-engage the client in regular phone session attendance. The counselor will make active efforts to re-engage a missing client for up to a month after a missed session, including phone calls to the client, phone calls to support people (if in the "buddy" condition), and letters to the client. After a month from the last contact, the client is considered inactive in treatment but may return at any point during the 18-month treatment period. The client is always eligible for and encouraged to participate in paid research visits regardless of session attendance.

Suggested efforts to reach a client who has missed a session:

During session time: phone call

1 day after missed call: phone call

1 week after missed call: phone call, call to support person if in buddy condition

2 weeks after missed call: letter

4 weeks after missed call: phone call; call to support person if in buddy condition

If still no response after 3 days from last round of phone calls, send 2nd letter

Additional phone calls at various times of day in an attempt to catch the client at home are strongly encouraged. The idea is to balance active, caring efforts to contact a missing client with not harassing a client who does not wish to be found or overburdening the client's support person.

Suggested outline of retention efforts:

Client does not keep her telephone appointment (i.e., hasn't called within 10 minutes of scheduled time). Call client, and if client can be reached directly, have the phone session at that time. Inquire about the missed call; if client has a plausible explanation, simply review that the calls are the client's responsibility and emphasize the importance of keeping the next appointment. Note that "plausible" need not involve the "third degree"—if client sounds "normal" to the counselor on the telephone, participates appropriately in the session and seems to be following through with what he needs to do, "I got busy and forgot" might be the absolute truth and may not be cause for concern as long as this is not one in a series of missed appointments.

Client can't be reached during the scheduled appointment time. Counselor leaves a message asking for the client to call. If the client calls back within 1 business day and has a plausible explanation for the missed appointment, have the phone session at that time if possible, including a reminder of how important it will be to keep the next phone session and problem-solving regarding compliance if necessary.

Client does not respond to counselor's message within 1 business day. If the client hasn't called back within 1 business day of counselor's first message, counselor calls client again and leaves

message stressing importance of client calling back. If client calls back within a week of the missed call with a plausible explanation for missed appointment, have the phone session at that time and review compliance issues (importance of compliance, problem-solving if necessary to increase compliance).

Client does not respond within 1 week of missed appointment. Call client. If no call back within 1 day, call support person, if applicable. If client calls back within another week (i.e., 2 weeks after missed appointment), evaluate current status according to risk assessment to determine whether a face-to-face session is desired to get counseling back on track. Review compliance issues: goals and importance of phone counseling, counseling agreements, problem-solving to maximize compliance. Evaluate whether co-occurring problems, such as psychiatric symptoms, childcare issues, other problems with children, basic needs, and so forth, are contributing to poor compliance, and provide referrals if needed.

Client does not respond within 2 weeks of missed appointment. Send letter requesting that client call back as soon as possible. Emphasize your concern for the client and let them know they are welcome back to treatment regardless of what has been going on in the meantime – and that they are welcome to continue to participate in paid research visits even if they don't continue in treatment. If client calls back within a week of sending the letter (3 weeks of missed appointment), evaluate current status according to risk assessment to determine whether a face-to-face session is desired to get counseling back on track. Review compliance issues: goals and importance of phone counseling, counseling agreements, problem-solving to maximize compliance. Evaluate whether co-occurring problems, such as psychiatric symptoms, childcare issues, other problems with children, basic needs, and so forth, are contributing to poor compliance, and provide referrals if needed. The compliance issues may be seen as a “red flag” warranting an increased level of care or an in-person evaluation session before returning to the regular phone schedule.

Client does not respond within 4 weeks of missed appointment. Call client and support person if applicable. If no call back within 3 days, send 2nd letter letting client know that you will no longer actively seek them out at this time but that they are still eligible to participate in treatment until the end of the 18-month treatment period. Make the point that they are still eligible to participate in paid research even if they drop out of treatment.

Client “disappears” – i.e., makes no contact for at least 4 weeks – then “reappears”
Counselor talks with client on the telephone about client's absence and non-response to phone messages and letters. Counselor sets up a brief (30-45 minutes) face-to-face meeting with the client to review goals, agreements, etc. and also to take a urine drug screen (UDS) and breath test. If client denies use of drugs/alcohol, but complies with biological tests, the time of next telephone appt. is reviewed with emphasis on the importance of keeping the appointment.

If client misses an in-person evaluation session: Make active efforts to reach the client by phone, calling contact people if necessary, and attempt to get them in ASAP. If client cannot be reached within a week of the missed in-person appointment, send a letter expressing concern and requesting call back and attendance ASAP. If client does not show up for evaluation session

within 4 weeks of reporting high risk or use and risk remains high, consider referral to higher level of care.

If client misses an RP session: Make active efforts to reach the client by phone, calling support person if necessary, and attempt to get them in for the next scheduled session time (i.e., within a couple of days). If no contact for a week, send a letter expressing concern and requesting a call back ASAP and attendance at a session within a week. If client is out of touch for at least 2 weeks, or repeatedly misses sessions (i.e., does not attend at least one session per week), consider referral to higher level of care.

Note about calling support people. Always thank support people for their help! Repeated calls searching for the client may be annoying or intrusive to the contact person. When trying to reach a client who has missed an appointment, ask the support person's permission to call them again after a certain interval has elapsed if the client has not called.

Risk Assessment Worksheet

| Risk Assessment Items | Scoring |
|--|---|
| Risk Factors | |
| <p>1. Alcohol and Drug Use Since we last spoke on ____, have you used alcohol or other drugs? IF YES: If not already clear, find out what substance(s) were used. Query date of last use and quantity/frequency for each substance. Record frequency as days per week. <i>Keep notes for clinical use if days/week does not adequately describe usage pattern.</i></p> | <p>Yes/No <i>Any alcohol/drug use automatically constitutes "high risk."</i></p> |
| <p>2. Medication Adherence Since we last spoke on ____, have you had any medical appointments? Have you had any changes in prescribed medications? <i>Keep notes for clinical use.</i> Have you taken your meds as prescribed this week?</p> | <p>0 = Yes OR N/A 1 = Most of the time 2 = Some of the time 3 = Rarely or never</p> |
| <p>3. Mood Since we last spoke on ____, how many days have you been in a bad mood throughout most of the day? By "bad" I mean sad, depressed, angry, worried, anxious, hopeless, etc.? How long did the bad mood last – most of the day?</p> | <p>0 = <1 day/week 1 = 1-2 days/week 2 = 3 days/week 3 = 4 or more days/week</p> |
| <p>4. Craving Since we last spoke on ____, how many days have you experienced cravings, dreams, thoughts or desires to drink or use drugs? IF ANY CRAVING: How strong were the cravings?</p> | <p>0 = Less than once per week 1 = 1-2 days/week 2 = 3 days/week 3 = 4 or more days/week 0 = very mild, just a passing thought 1 = mild</p> |

| | |
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| <p>Did you talk with anyone about the cravings?</p> | <p>2 = moderate 3 = strong If 0 or 1, no change to craving score. If 2 or 3, then increase craving score by 1 point.</p> <p>0 = Yes, always 1 = Yes, most of the time 2 = Yes, sometimes 3 = No, never If always/most of the time, then decrease craving score by 1 point. If sometimes/never, no change to craving score.</p> <p>This whole thing should lead to ONE craving score for use in overall scoring.</p> |
| <p>5. Concern How concerned are you right now about your ability to stay clean and sober for the next (interval until next phone call)?</p> | <p>0 = Not at all concerned 1 = A little concerned 2 = Somewhat concerned 3 = Very concerned – <i>automatically constitutes “high risk”</i></p> |
| <p>6. People, Places, Things Since we last spoke on ____, how many times have you spent time around situations you have identified as your “people, places, and things?” The four riskiest situations you identified at our first meeting were: <i>(orient to chosen risky situations; probe for additional risky situations; update client’s list of riskiest situations at least every 3 months)</i></p> | <p>0 = Never 1 = up to 1 time per week 2 = up to 2 times per week 3 = more than 2 times per week</p> |
| <p>7. Time Alone Since we last spoke on ____, how many days have you spent most of your day alone or in the company of strangers? (exclude work, volunteering, etc., clarify amount of time as being most of waking hours)</p> | <p>0 = Never 1 = Up to 1 day/week 2 = 2-3 days/week 3 = 4 days/week or more</p> |
| <p>Protective Factors</p> | |
| <p>8. Sober Living Since we last spoke on ____, how many times have your spent time outside of an AA/NA meeting with people who are sober or who have no alcohol/drug problem? The four</p> | <p>3 = 4 or more times per week 2 = 2-3 times per week 1 = up to 1 time per week 0 = Never</p> |

| | |
|---|---|
| <p>sober activities you chose to involve yourself in were: (orient to chosen activities, probe for additional sober activities, update client's list of sober situations at least every 3 months)</p> | |
| <p>9. Meetings Since we last spoke on ____, how many AA/NA meetings have you gone to? IF ANY MEETINGS: In how many of those meetings did you raise your hand and share? In how many of those meetings did you go early/stay late/help make coffee/set up/clean up, etc.? Score whether there was active participation in at least one meeting per week.</p> | <p>3 = 4 or more per week 2 = 2-3 per week 1 = Up to 1 per week 0 = None</p> <p>Active participation: YES/NO <i>Active participation in at least 1 meeting per week increases the meetings score by 1</i></p> |
| <p>10. Sponsor Since we last spoke on ____, how many times have you talked with your sponsor outside of meetings? IF ANY: How many times on the phone and how many times in person?</p> | <p>3 = 4 or more times per week including at least once in person 2 = 2-3 times per week 1 = Up to 1 per week 0 = Never OR NO SPONSOR</p> |
| <p>11. Treatment involvement If not known, ask whether client is in treatment. How many of your scheduled groups/individual sessions did you attend this week?</p> | <p>3 = All of them OR N/A 2 = At least 75% of them 1 = At least 50% of them 0 = Less than 50% of them</p> |

Overall Risk Levels for Relapse:

High risk:

Any alcohol/drug use reported since last phone contact

OR

“Concern” rated “3”

OR

At least 2 risk items rated “3” AND at least 2 risk items rated “2”

(i.e., frequent trigger situations)

OR

At least 1 risk item rated “3” AND at least 3 risk items rated “2” AND no protective items rated “2” or higher

(i.e., several trigger situations, coupled with minimal involvement in sober lifestyle)

Low risk:

All risk items rated 0 or 1 AND at least 1 protective item rated “2” or higher
(i.e., few trigger situations, coupled with some involvement in sober lifestyle)

Moderate risk – everything else!

Guidelines for changing level of care in Telephone Monitoring and Counseling

Levels of care:

1. Regular phone call schedule – weekly, biweekly, monthly
2. Extra phone call or 2, with expectation of returning to regular schedule
3. Increased phone call schedule in “chunks” of 2 weeks (if at weekly schedule) or 4 weeks (if at biweekly/monthly schedule)
4. 1 or 2 sessions face-to-face
5. 5 weeks Motivational Enhancement Therapy/Relapse Prevention or referral to IOP
6. Referral to IOP
7. Referral to Detox

LOW RISK

Continue regular phone schedule.

Targets of brief counseling:

- Review and reinforce client success
- Problem-solve regarding client-identified upcoming risky situations, using risk assessment as a guide
- Encourage further involvement in pro-recovery lifestyle activities

MODERATE RISK

If client moves from low to moderate risk, increase call schedule as follows:

- During 1st 8 weeks of protocol (weekly calls) – increase to 2x/wk for 2 weeks. If client is enrolled in IOP, increased call schedule may not be necessary; encourage client to make use of available treatment resources.
- During rest of protocol (biweekly/monthly calls) – increase to at least weekly calls for 2 weeks.
- In both cases, calls may be scheduled more often if requested by client or if desired to check in on a particular treatment goal
- If client complies with increased call schedule for 2 weeks, consider resuming regular call schedule if at low risk.

If risk level returns to low after 2-4 weeks, resume regular phone call schedule.

If risk level remains at moderate, continue increased call schedule and re-evaluation in 2-week intervals.

Targets of brief counseling:

- Problem-solve regarding problem areas that led to increase in risk
- Review and reinforce client success
- Encourage further involvement in pro-recovery lifestyle activities

HIGH RISK

If client moves from low/moderate risk to high risk, bring client in for 1-2 face-to-face sessions, with the first session scheduled within a week of call in which client reports high risk.

If there has been no use, and client states credible commitment to maintaining abstinence, and an acute high-risk situation is in the process of being resolved by the first face-to-face session, then return to increased call schedule for 2 weeks. If risk drops to moderate, continue increased call schedule until it drops to low. If risk remains high, schedule 2nd face-to-face session and evaluate for MET/RP or referral back to IOP. If increased level of care not indicated (i.e., client commits to plan for reducing risk), return again to increased call schedule. If risk remains high after 2nd effort at returning to increased calls, provide MET/RP or refer to IOP.

If there has been no use, but high risk situations are more problematic or client doesn't state credible commitment to maintaining abstinence, schedule 2nd face-to-face session a week after the first session – with phone call in between if needed. If risk escalates or client continues to express concern about remaining abstinent, provide MET/RP or refer to IOP. If client shows progress toward reducing risk, return to increased call schedule for at least 2 weeks and continue to evaluate progress.

If there has been any use, evaluate for need for detox. Schedule 2nd face-to-face session a week after the first session – with phone call in between if needed. If there is another episode of use during the evaluation period or client continues to express concern about remaining abstinent, provide MET/RP or refer to IOP. If client shows progress toward reducing risk, return to increased call schedule for at least 2 weeks and continue to evaluate progress.

Face-to-Face Evaluation Session(s)

The face-to-face evaluation session(s) are provided if the client reports substance use or high risk for relapse. It may also be provided if the client “reappears” after at least a month of no contact with the counselor. In most cases, a single session is scheduled within a week after the phone call in which the client reports use or relapse risk, and depending on the outcome of the first session, a second session may be scheduled about 1 week later.

By the time an in-person session is scheduled, you may have spent several phone calls “putting out fires” with a client who is experiencing one or more crises, or who is showing minimal compliance or flagging motivation. The goal of the session is to take a step back from the immediate situation and get a broader assessment of what is going on. The evaluation session will include a detailed debriefing of any relapse episodes, and will also address motivation and commitment to change in a more general sense.

When the client has a slip or becomes at high risk for relapse, despite ongoing phone intervention, it may be that the focus of sessions and between-session goals are not quite on target with respect to the client’s true relapse risk, in which case the general thrust of problem-solving efforts needs to be revised. Examples would be clients who have mis-identified their most important risky situations to follow on an ongoing basis, or clients who do not have adequate coping skills to deal with unavoidable risky situations. Clients whose case management needs are not being met would also fall in this category. Another possibility is that the client’s motivation to achieve or maintain abstinence is failing – that the benefits of recovery do not seem to be sufficiently rewarding to counteract the lure of alcohol and/or drug use. Asking the client to rate how important abstinence is to them, and how confident they are that they can achieve/maintain it, with appropriate follow-up questions, will help you to determine where to focus the rest of the session.

Basic outline (see attached Motivational Interviewing manual for details):

1. Set agenda and affirm client for taking the step of coming in to address current problems
2. Debrief any episodes of use. Frame reflective listening summaries in terms of coping/problem-solving concepts consistent with overall treatment protocol.
3. Assess current motivation for regaining/maintaining abstinence using importance/confidence scales.
4. If importance is low –
 - a. Acknowledge difficulty of following through on action plans when feeling low motivation
 - b. Use decisional balance and client’s response to “what would it take to increase importance” to find hooks for increasing motivation. Provide information and/or personal feedback if applicable – with permission!
 - c. Develop homework task to address motivation
5. If importance is high but confidence is low –
 - a. Explore past and present efforts at change. What has worked in the past? What is different now?

- b. Use client's response to "what would it take to increase confidence" to guide problem-solving efforts.
6. Use adaptive protocol to determine next course of action – return to phone calling, schedule additional session, recommend a course of RP, etc.

Extended Telephone Monitoring – Treatment Adherence Checklist

Client: ___ ___ ___ Session Date: ___ ___/___ ___/___ ___ ___ Rating Date: ___ ___/___ ___/___ ___ ___

Therapist: _____ Rater: _____

Reviewed with therapist: ___ ___/___ ___/___ ___ ___

0 = Not done
 1 = Partially done
 2 = Completely done

| Item | 0 | 1 | 2 | |
|--|---|---|---|----|
| 1. Therapist acknowledges client for call and orients to task at hand | 0 | 1 | 2 | |
| 2. Therapist reviews Risk Assessment Worksheet items with client | 0 | 1 | 2 | |
| 3. Therapist provides feedback on relapse risk level – low, moderate, high | 0 | 1 | 2 | |
| * 4. Therapist reviews client progress since last contact | 0 | 1 | 2 | |
| * 5. Therapist asks client to anticipate upcoming high-risk situations | 0 | 1 | 2 | |
| * 6. Therapist engages client in selection of topic(s) for remainder of call | 0 | 1 | 2 | |
| * 7. Therapist engages client in relapse prevention and/or pro-recovery counseling and problem-solving | 0 | 1 | 2 | |
| * 8. Therapist helps client set a goal for interval until next contact | 0 | 1 | 2 | |
| 9. Therapist schedules next contact with client | 0 | 1 | 2 | |
| * 10. Therapist suggests change in treatment protocol in response to client risk level | 0 | 1 | 2 | NA |
| * 11. Therapist offers referral to outside services in response to client needs | 0 | 1 | 2 | NA |

Notes: