

Follow-up Strategies for Tracking and Monitoring Clients

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UCLA



Overview of today's session

- Part I: Why stay-in-touch
 - Context
- Part II: How to stay-in-touch
 - First steps
 - Confidentiality
 - The locator form
 - Maintaining rapport
 - Follow up
 - Using a database to track clients
 - Reducing the cost of re-contact
 - Useful resources



Context





Background

- Substance use is a chronic disorder for many treatment clients.
- To better manage substance use disorders over time, consider shifting focus from “intensive” to “extensive” interventions.
- Relapse rates are highest in the months following treatment exit.
- Client adherence to treatment aftercare is low.
- Clients who receive “outreach” after treatment may be more likely to comply with aftercare planning and have better outcomes.



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Background (from yesterday)

- Treatment is most effective the first couple of times in care.
- More times in treatment, the poorer the prognosis.
- Staying in care predicts abstinence and recovery.
- Those in treatment (as opposed to incarceration or using in the community) are most likely to transition to recovery.



Background

- Continuing care models seek to engage clients in “flexible or adaptive treatment” that changes “in focus and intensity as symptoms wax and wane over time” (McKay et al, 2006).
- A “continuing care” model means continuing engagement, i.e., staying-in-touch with clients after treatment.
- Researchers have long utilized strategies for staying-in-touch with different types of substance abusing populations for long-term follow-up research studies.
- Others have also stayed-in-touch with clients for clinical purposes.





Why stay in touch with clients?

- Hear how clients are doing after treatment
- Learn what support services clients need after treatment
- Find out what contributes to long-term success
- Understand which clients drop out and why
- Document your success as a treatment agency
- Get client feedback on your program
- Help relapsing clients return to treatment
- Support clients in their efforts to stay clean
- Meet requirements for continued funding
- Perform outcomes monitoring



Different purpose, different strategies

	Continuing Care	Assessment
Who	Clinicians	Researchers
What	Stay in touch with clients	Actively follow-up research participants
Where	Clinic	Wherever the participant is found
When	Determined by clinical needs	Fixed time-points
Why	Ongoing engagement, assessment, service provision, intervention	Independent assessment, evaluation, research

Different purpose, different strategies

	Continuing Care	Assessment
How	Telephone, mail, aftercare services, return to treatment	Telephone, mail, in-person
How many	Determined by clinical needs and resources	≥70-80% of sample targeted for follow-up
Oversight	HIPAA, agency's institutional review board	University institutional review board, HIPAA, Certificate of Confidentiality

Different purpose, different strategies

	Continuing Care	Assessment
Incentives	Access to care, support services	Often monetary, research findings, referral to care
Adverse events	React to client behavior, provide care	Remain impartial, refer to care
Facilitators	Therapeutic alliance. Clients return to treatment.	Neutral interviewer. Follow-up expertise. Dedicated resources and staff. Confidential.
Barriers	Therapeutic alliance. Limited experience. Limited resources and staff. May not be confidential.	Interviewer is unknown to participant.

Common challenges

Most will require multiple contact attempts

Drop-out is highest at the first re-contact point

It is tough to predict who will be easy or hard to re-contact

The hard to find are hard to find!

Some don't want to stay-in-touch

Confidentiality must be protected

Staying-in-touch takes time, money, resources, and effort



Substance use behavioral patterns

- Mobile
- Nature of addiction is chronic and cyclic
 - Relapse, recovery, and treatment
- Involved with institutions
- Social withdrawal

Scott CK (2004). A replicable model for achieving over 90% follow-up rates in longitudinal studies of substance abusers. *Drug Alcohol Depend*, 9;74(1):21-36

Scott, C.K., Sonis, J., Creamer, M., & Dennis, M.L. (2006). Maximizing follow-up longitudinal studies of traumatized populations. *Journal of Traumatic Stress*, 19(6), 757-69.





How many can be found?

- 90% follow-up rate of treatment clients in Los Angeles

Kasarabada, N.D, Hser, YI, Boles, SM, & Huang, YC. (2002). Do patients' perceptions of their counselors influence outcomes of drug treatment? *Journal of Substance Abuse Treatment*, 23, 327-334.

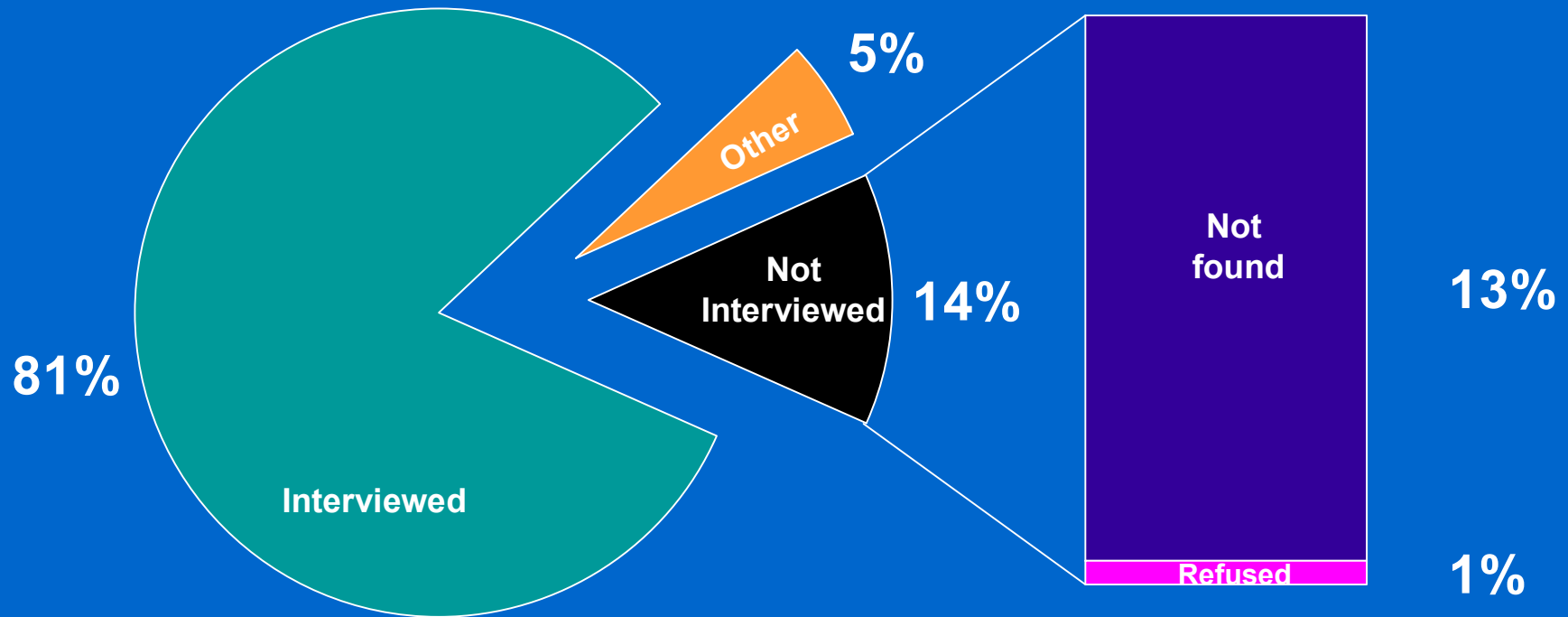
- 93% follow-up rate of men and women entering treatment in the Washington, DC area

Nemes, S, Wish, E, Wright., B, & Messina, N. (1999). *Following up drug abuse treatment cohorts: How necessary is a high response rate?* Washington, DC: National Evaluation Data and Technical Assistance Center, Center for Substance Abuse Treatment, Department of Health and Human Services.

- 85% follow-up rate of homeless mentally ill in Los Angeles

Wenzel SL, Tucker JS, Elliott MN, Hambarsoomians K, Perlman J, Becker K, Kollross C, Golinelli D. (2004). Prevalence and co-occurrence of violence, substance use and disorder, and HIV risk behavior: a comparison of sheltered and low-income housed women in Los Angeles County. *Prev Med.* 39(3):617-24.

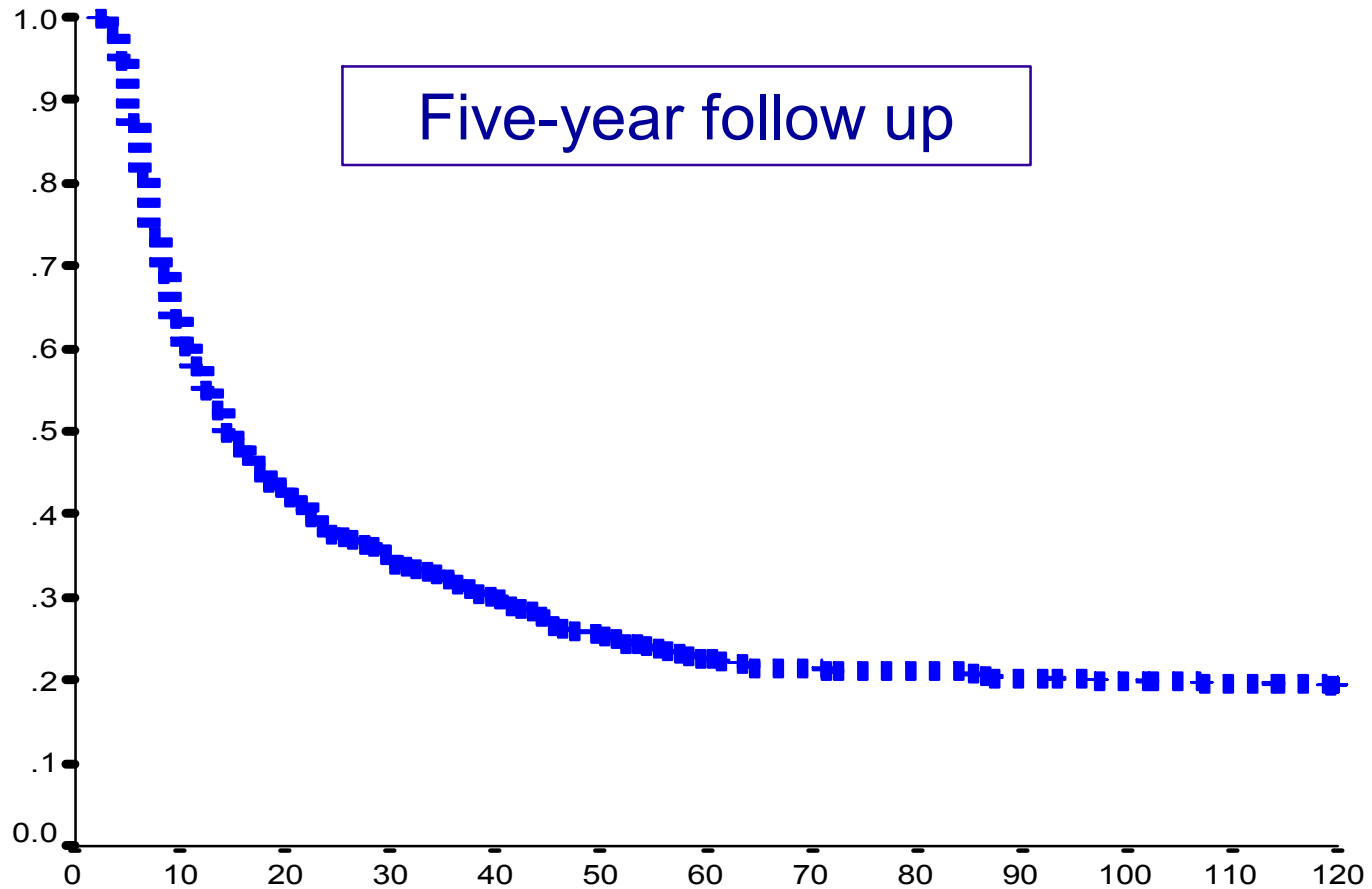
1 year follow-up of offenders in treatment



N=1,588
In CA, mostly by phone

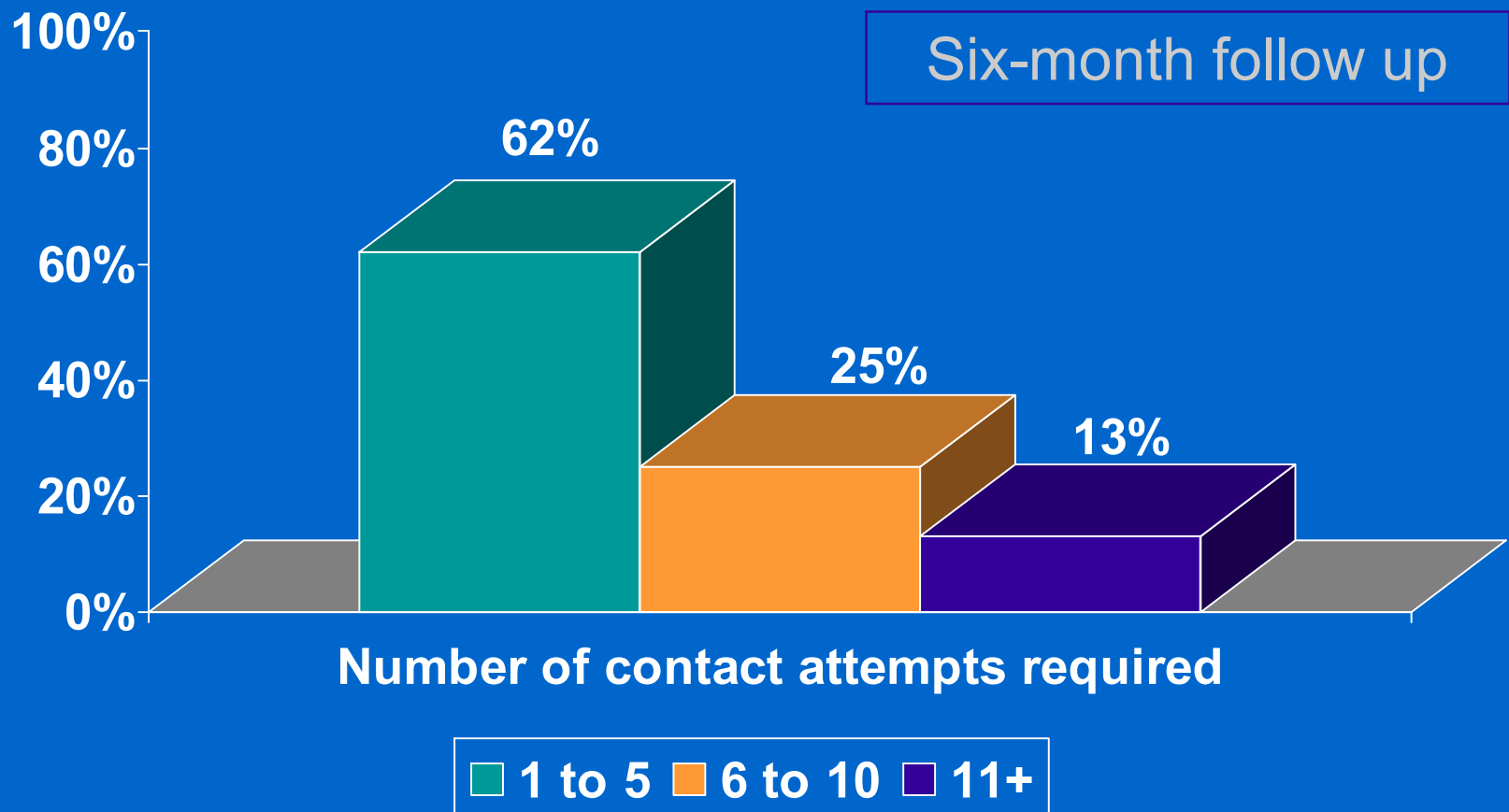
How much work does it take?

Proportion Remaining



Number of Tracking Attempts

Adolescent substance abusers

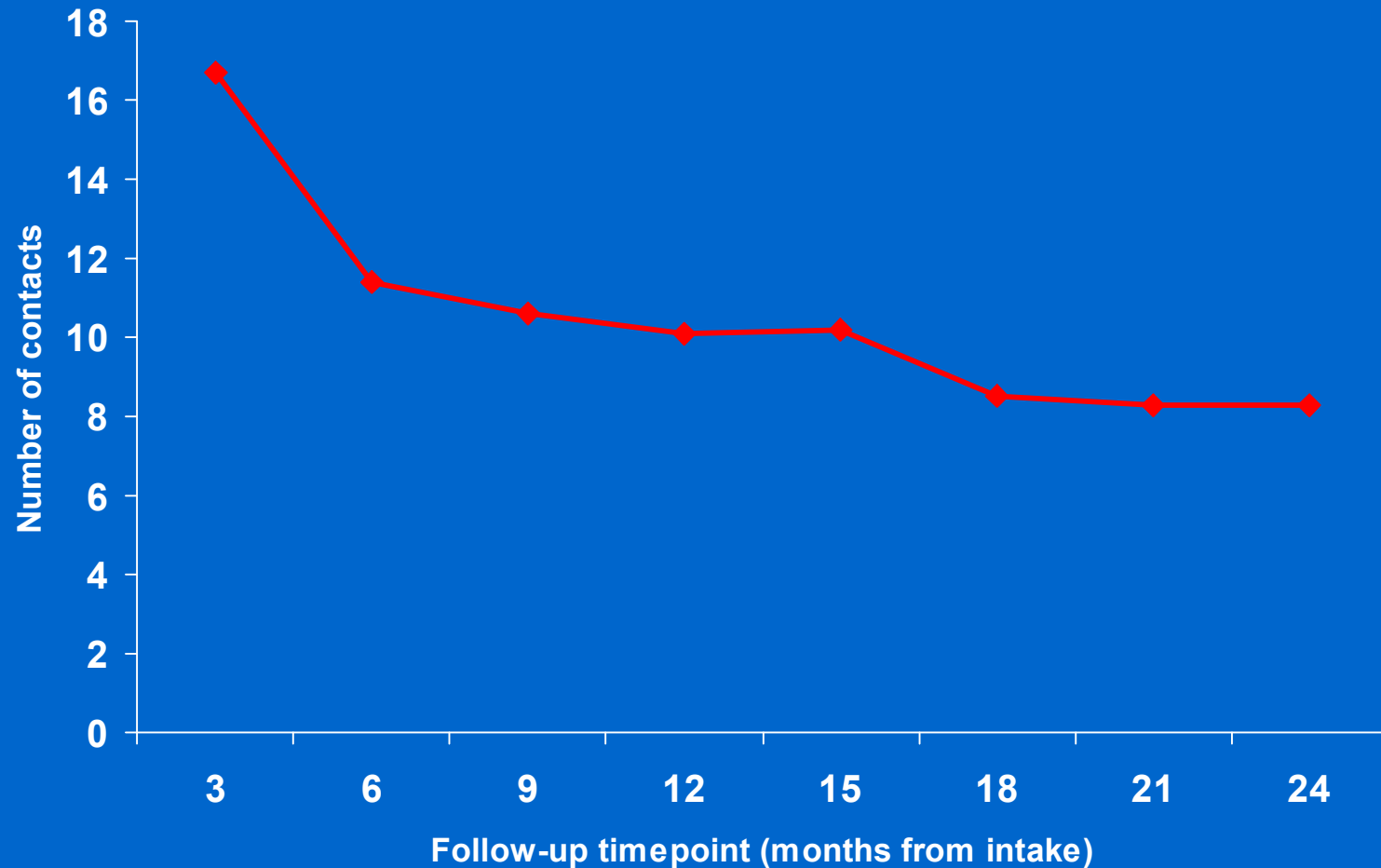


Re-contacting users treated in an ER setting

Time of follow-up (months)	Completed Interview (%)	Home visits (%)	Average contact attempts (Range)
3	77	12	9 (1-43)
6	82	6	8 (1-31)
12	80	8	8 (1-49)

Cunningham, R, Walton, MA, Tripathi, SP, Outman, R, Murray, R, Booth, BM (2008). Tracking inner city substance users from the emergency department: how many contacts does it take? *Academic Emergency Medicine*, 15 (2), 136-143.

Re-contacting traumatized users in treatment



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Re-contacting most vs. some clients

- Clients who are not re-contacted may be different
 - Basic characteristics (age, gender, race)
 - Service needs
 - Experiences with treatment
 - Mental or physical health
 - Criminal history
 - Outcomes
- How many should be re-contacted?

Finding a balance

What is feasible vs. what is ideal?

Cost of staying-in-touch depends on your goals and the strategies taken to reach those goals



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Contact difficulty

“Contact difficulty is affected by the extent of location information gathered at baseline, financial constraints that limit the amount of time spent locating participants, failure to ensure participants’ confidentiality and establish rapport, assessments occurring at inconvenient times or locations, or lack of adequate reimbursement.”

You can influence most of these elements!

Cunniff, J., and M. J. Walton, M.A., T. P. Smith, S. S. Outman, R. Murray, R. Booth, BM (2008). Tracking inner city substance users from the emergency department: how many contacts does it take? Academic Emergency Medicine, 15 (2), 106-113.

10 reasons for study drop-out

1. study intrusiveness
2. displeasure with randomization status
3. respondent burden (too many forms, questions)
4. inability to understand or answer the questions
5. perceived ineligibility for the study
6. lack of interest
7. logistical difficulties (transportation, child care)
8. being unconnected with the goals of the project
9. a desire to “forget the past”
10. feelings of distress

Reasons for continued participation

- perceived importance of the project
- desire to give back to the health team that cared
- opportunity to express experiences and emotions
- being able to interact with a “familiar face”
- opportunity to make a contribution to science
- chance to improve treatment for others
- incentives (monetary and access to care)

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What do past experiences tell us about how to re-contact clients?



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Re-contact begins at first contact

- Purpose and value of re-contact
- Trust, rapport, engagement, buy-in
- Informed consent
- Release of information
- How to stay-in-touch
- Incentives

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Staying-in-touch continues after 1st contact

- **Use several different contact strategies**
- **Combine re-contact with usual treatment visits**
- **Offer incremental rewards or incentives**
- **When these strategies don't work**
 - **Use online search engines**
 - **Access government and other public service agencies**
 - **Do fieldwork and in-person visits**

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Re-contact staff are key players

- **Culturally competent**
- **Bilingual as needed**
- **Experienced**
- **Well-trained**
- **Persistent, creative, flexible**
- **Are not necessarily counseling staff**
 - **“Linkage manager “ “engagement specialist”**

Effective continuing care models

- One year or longer
- More structured and intensive as needed
- Includes medications as needed
- Less burdensome to clients
 - Telephone

McKay JR. (2006). Continuing care in the treatment of addictive disorders. *Curr Psychiatry Rep.* (5):355-62.

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Summary

- Staying-in-touch with clients
 - Makes sense
 - Is not easy
 - Has been done many times before
- Learn from experiences of others to consider what might work best for your goals and resources

Articles

- Cottler, L.B., Compton, W.M., Ben-Abdallah, A., Horne, M., & Claverie, D. (1996). Achieving a 96.6 percent follow-up rate in a longitudinal study of drug abusers. *Drug and Alcohol Dependency*, 41(3), 209-217.
- Hansten, M.L., Downey, L., Rosengren, D.B., & Donovan, D.M. (2000). Relationship between follow-up rates and treatment outcomes in substance abuse research: More is better but when is “enough” enough? *Addiction*, 95(5), 1403-1416.
- McKay, J.R., Lynch, K.G., Shepard, D.S., Pettinati, H.M. (2005). The Effectiveness of Telephone-Based Continuing Care for Alcohol and Cocaine Dependence: 24-Month Outcomes. *Arch Gen Psychiatry*. 62 (2):199-207.
- Meyers, K., Webb, A., Frantz, J., & Randall, M. (2003). What does it take to retain substance-abusing adolescents in research protocols? Delineation of effort required, strategies undertaken, costs incurred, and 6-month post-treatment difference by retention difficulty. *Drug & Alcohol Dependency*, 69(1), 73-85.
- Ribsil, K., Walton, M.A., Mowbray, C.T., Luke, D.A., Davidson, W.I., & Bootsmiller, B.J. (1996). Minimizing participant attrition in panel studies through the use of effective retention and tracking strategies: Review and recommendations. *Evaluation Review*, 19, 1-25.
- Robinson, K.A., Dennison, C.R., Wayman, D.M., Pronovost, P.J., & Needham, D.M. (2007). Systematic review identifies number of strategies important for retaining study participants. *Journal of Clinical Epidemiology*, 60(8), 868-765.
- Scott, C.K., Sonis, J., Creamer, M., & Dennis, M.L. (2006). Maximizing follow-up in longitudinal studies of traumatized populations. *Journal of Traumatic Stress*, 19(6), 757-69.