Telephone- and Internet-Based Recovery Support Services

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Introduction

In two earlier publications, the authors outlined the varieties of addiction recovery experience as represented in the scientific and historical literature (White & Kurtz, 2006a) and outlined strategies to link individuals in addiction treatment to local communities of recovery (White & Kurtz, 2006b). In this third publication, we will:

> 1) review the ways in which communications via the telephone and the Internet can and are being utilized to deliver pre-treatment, in-treatment, and post-treatment recovery support services, and
> 2) discuss how such technologies might be utilized in the future to help people initiate, sustain, and improve the quality of recovery from severe alcohol and other drug problems.

The review will span interventions that originate from addiction treatment agencies, from free-standing, peer-based recovery advocacy and support organizations, and from recovery mutual aid groups. As such, our intended primary audiences for this paper are addiction counselors, peer-based recovery coaches (volunteer and paid), and sponsors (or their equivalent) within recovery mutual aid groups. Telephone-based services (TBS) and Internet-based services (IBS) have an enormous but currently underutilized potential to enhance addiction treatment and peer-based recovery support services. We hope that this paper will serve as an invitation to explore new service frontiers.

Telephone-based Services

Telephone-based support for the resolution of alcohol and other drug (AOD) problems has a long history in recovery mutual aid circles and to amply the effects of institution-based addiction treatment. Interest in telephone-based service technologies has increased in tandem with mounting evidence of the potential of such technologies to enhance clinical outcomes in primary medicine and in the treatment of psychiatric disorders. In this section, we will review how sponsors, recovery coaches, and addiction counselors are using the telephone as an instrument of recovery support.

Role of the Telephone in Recovery Mutual Support Affiliation and Participation

The telephone has long played a role in recovery support. The very beginnings of Alcoholics Anonymous can be traced to Bill Wilson using a pay telephone at the Mayflower Hotel in Akron, Ohio in search of another alcoholic to stave off his own craving to take a drink. Since that time, telephone support has become a routine part of the rituals of many recovery mutual aid organizations. New members are encouraged to get the phone numbers of older members and to "pick up a phone rather than a drink." The advent of cell phones has made such support much more accessible.

Telephone contact has also become an important part of the sponsorship relationship within Twelve Step programs. Many sponsors encourage their new sponsees to stay in touch daily by phone and to use the phone to help expand their network of relationships with others in recovery. Studies of AA have noted an intensity of participation effect. This means that recovery outcomes are enhanced by specific measures of participation, e.g., having a sponsor, reading program literature, participation in pre- and post-meeting rituals (White & Kurtz, 2006). However, no studies to date have specifically measured the effect of telephone-based support within recovery mutual aid societies on long-term recovery outcomes.

Telephone Support from a Treatment Site

There is wide variability in the design and delivery of telephone-based services (TBS). They span who is responsible for calling (the client or the service provider), who one reaches (from computer automated systems to one's therapist), and when in the service process TBS are utilized. All TBS are designed to enhance problem recognition and/or resolution, and most follow a 3-part structure: an opening (joining/alliance phase), a middle (the intervention phase), and a closing (summary and reference to next contact) (Kaminer & Napolitano, 2004). In this section, we will explore some of the most common forms in which TBS act as adjuncts or alternatives to face-to-face (F-2-F) contact.

Telephone Based Screening for AOD Problems: Community surveys of those experiencing AOD problems identify the following reasons for not seeking treatment: reluctance to give up the drug, reluctance to admit the need for help, perception that the problem is not severe enough to warrant treatment, perception that the problem could and should be managed by oneself without professional help, lack of knowledge about treatment, inability to afford treatment, or opinion that treatment would not be helpful (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Grant, 1997). Automated telephone screening may provide an effective strategy to overcome such resistance. Rubin and colleagues (2006) used newspaper ads and flyers to announce the availability of an automated telephone-based version of the Alcohol Use Disorders Identification Test (AUDIT) to screen callers for alcohol problems. They found the procedure to be a reliable, valid, and anonymous method of administering the AUDIT to people who would not have otherwise sought professional assistance.

The Incoming Crisis Call: There are developmental windows of crisis in all of our lives that afford opportunities for transformative change. The crisis call from a client or family member potentially affords such a developmental window of opportunity. Addiction careers are often made up of a series of such missed opportunities that precede the achievement of stable

recovery. A worthy goal of treatment and recovery support specialists is to capitalize on such crises to shorten addiction careers and extend recovery careers. Achieving that goal requires a focus on the first point of contact in such crises—the incoming crisis call. Here are several strategies for enhancing responsiveness to such calls:

- Invest considerable resources in training receptionists and other first responders in crisis management and engagement procedures.
- Monitor first responders for their ability to express calmness, empathy, warmth, optimism, and a welcoming invitation.
- Create pockets of available time of staff to provide an immediate response on the phone with arrangement for at least brief F-2-F contact either immediately or within 48 hours. (Rapid intake decreases "no shows" and enhances long-term service retention)(Ashton & Witton, 2004).
- Streamline intake procedures via triaged assessment to minimize the time between initial contact and a human (as opposed to paper and procedure) response to the crisis (Ashton & Witton, 2004).
- Offer concrete assistance for at least one presenting problem.
- Utilize trained volunteers to provide interim support and to link the caller to recovery mutual aid resources.
- Follow the initial crisis call with mailed information that relates directly to the presenting problems of the caller.
- Demonstrate responsiveness, timeliness, and thoroughness in the crisis response.

Telephone-Based Waiting List Engagement: Long waiting lists for admission to addiction treatment are not unusual in the United States, and studies have confirmed waiting list drop-out rates ranging from 25-50% (Little Hoover Commission, 2003; Stark, Campbell, & Brinkerhoff, 1990). Those on waiting lists to enter treatment are ambivalent about treatment, usually continue to use while on the waiting list, and often fail to enter treatment when the immediate crisis passes (Graham, Brett, & Bois, 1995). Some programs have been known to use the waiting list as a motivational screen, assuming that those who want treatment the most are the ones who really need it and will persist in getting admitted. Sadly, research suggests the opposite: those with the most severe AOD problems and the most disrupted lives are the least likely to make it through long waiting periods and burdensome intake procedures (Hser, Maglione, Polinsky, & Anglin, 1998). Too many things can impinge on a fleeting desire for help when that help is not quickly available—drug hunger, resumed drug use, arrest, sickness, or death.

Waiting list management strategies include 1) maintaining contact with and continually re-motivating those on waiting lists to enter treatment, 2) arranging interim recovery initiation resources (e.g., sober housing, linkage to recovery mutual aid groups), 3) providing recovery literature to those waiting to enter treatment, 4) conducting pre-treatment orientation and readiness groups, and 5) serving as an advocate to speed admission to treatment (White & Gasperin, 2006).

The telephone can be a vehicle for building a helping alliance BEFORE a person is formally admitted to treatment, a means of offering interim assistance such as assertive linkage to local recovery support groups, and a means of sustaining motivation for recovery. "Waiting is

de-motivating"; the keys are to respond as quickly as possible, to build a helping relationship, to sustain communication, and to not abandon the help seeker (Ashton & Witton, 2004). TBS offer a means of neutralizing the negative effects of delayed initiation of treatment services.

Telephone Follow-up for Missed First Appointments: Ambivalence about drug use and the prospects of sustained abstinence is common, and motivation to seek addiction treatment ebbs and flows. A strong therapeutic relationship can overcome low motivation for treatment and recovery (Ilgen, McKellar, Moos, & Finney, 2006), but can this relationship be extended early enough to reduce the inordinately high number of "no shows" for people who call to make an initial appointment at addiction treatment agencies? Dropout rates between the call for an appointment at an addiction treatment agency and the first treatment session range from 50-64% (Gottheil, Sterling, & Weinstein, 1997). Pre-treatment drop-out is particularly prevalent for people seeking outpatient treatment (Stark, 1992). Fehr and colleagues found that only 188 of 520 persons (36%) made an initially scheduled addiction treatment appointment even when most appointments were set within six days of the initial call (Fehr, Weinstein, Sterling, & Gottheil, 1991). They did note an important principle from this study: the closer the appointment time to the initial call, the greater the probability of the client making the first appointment. Gottheil, Sterling, and Weisntein used this same population of "no shows" to test whether assertive outreach could be used to re-engage these individuals. They were able to reach 46% of those who did not show or call to cancel their appointment. Of this group, 74% re-scheduled their appointments, and 46% kept this re-scheduled appointment. The importance of such assertive follow-up was further indicated by their finding that those who dropped out before starting treatment had more recent drug use and greater lifestyle instability than those who got to their first appointment and also had greater AOD problems at follow-up.

Community surveys of those experiencing AOD problems identify the following reasons cited for not seeking treatment: reluctance to give up the drug, reluctance to admit the need for help, perception that the problem is not severe enough to warrant treatment, perception that the problem could be managed by oneself without professional help, lack of knowledge about treatment, inability to afford treatment, or opinion that treatment would not be helpful (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993). If we assumed that many people calling addiction treatment agencies for an initial appointment experience ambivalence about treatment and share concerns expressed by those who do not seek treatment, then discussing such concerns at the point of initial or follow-up telephone contact might serve to increase initial engagement rates.

Another clue to lowering dropout rates comes from an early review of the research literature on dropouts by Baekeland and Lundwall (1975). Their survey suggests the utility of special engagement procedures based on client characteristics (e.g., those with the most severe substance use and collateral disorders, the most disrupted lives, and who live the greatest distance from the service site), treatment modality (with outpatient drug free modalities having the highest dropout rate), and particular events in the service process (e.g., therapist cancelling a session or missing sessions due to vacation, etc.). The essential messages are: We missed seeing you. How are you? We look forward to seeing you again. Can we set your next appointment? I'll send you a note confirming that day and time. Would you like a reminder call the day before the appointment? All conveyed with personal concern, welcoming, and warmth.

Appointment Prompts: There are two important treatment benchmarks that affect long-term recovery outcomes. The first is the actual dose of treatment received and the second is discharge status. NIDA, in its *Principles of Addiction Treatment* (1999), noted that recovery outcomes improve when the span of service across levels of care exceeds 90 days, and other studies have noted that successful treatment completion is a benchmark of post-treatment recovery status. In 2002, only 41% of clients admitted to publicly funded addiction treatment successfully completed treatment. 27% dropped out, 16% were administratively discharged by the treatment facility, 9% were referred for further treatment, and the remainder failed to complete for other reasons, e.g., incarceration (SAMHSA, 2005). More than half of clients admitted to addiction treatment do not successfully complete their course of treatment, with most studies noting 50% dropout rates in the first month following treatment admission (SAMHSA-OAS, 2002; Stark, 1992; Samantaray, Ray, & Chandiramani, 1997). Those who drop out of treatment have greater problem severity, weaker therapeutic alliances, and worse long-term recovery outcomes than those who complete treatment (Stark, 1992; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006).

Appointment prompts are a way to enhance treatment participation, reduce missed appointments and reduce the number of treatment drop-outs. They can be delivered by telephone, email, or regular mail and have been shown to increase the probability of keeping appointments. In one of the earliest and most dramatic of such studies, Panepinto and Higgins (1969) were able to reduce the percentage of alcoholics dropping out of an outpatient clinic from 51% to 28% simply by sending letters with next appointments any time a session was missed. Gariti and colleagues (1995) found that a brief phone call reminder increased appointment show rates by 15%. Telephone prompts have become a mainstream practice in primary care and dentistry, but remain underutilized in addiction treatment. We recommend that warm, motivational prompts become a routine part of engaging and sustaining the engagement of individuals and families seeking services at addiction treatment agencies.

Intermediate Contact between Face-to-Face Meetings: We found no references in the professional literature on combining face-to-face (F-2-F) counseling or recovery coaching with telephone-based support in between face-to-face meetings. Such intermediate contact might have great utility in the following circumstances:

- Providing additional support for a client going through a particularly difficult period, e.g., at risk of relapsing or just re-initiating recovery following a lapse or relapse.
- Alternating F-2-F and telephone sessions to reduce travel time and expense for clients traveling a great distance to access services.
- Offering a telephone counseling session as an alternative to a cancelled appointment due to travel problems, a babysitter cancellation, etc.
- Phasing the termination process by progressively replacing F-2-F meetings with telephone meetings as a transition to telephone-based continuing care.

Post-Treatment Monitoring and Support: There is a growing body of evidence suggesting that post-treatment monitoring and support (recovery checkups) can elevate recovery outcomes for adults (Donovan, 1998; McKay, 2001; Dennis, Scott, & Funk, 2003) and adolescents (Godley, Godley, & Dennis, 2001).   There are currently two models of recovery initiation and support. There is a short-term, high-intensity, professionally-directed treatment model and a long-term, low-intensity, peer-based recovery support model as reflected in AA and

other recovery mutual aid groups. Efforts are afoot in many quarters to bridge these two worlds. More sustained and assertive styles of monitoring and support following completion of inpatient or outpatient treatment mark a transition in thinking from *aftercare* (or *follow-up*) to *continuing care* (White & Godley, 2003) and have been conceptualized as *extended case monitoring* (Stout, Rubin, Zwick, Zywiak, & Bellino, 1999), *chronic care* or *disease management* (McLellan, Lewis, O'Brien, & Kleber, 2000), *stepped care* (Sobell & Sobell, 2000), *assertive continuing care* (Godley, Godley, Dennis, Funk, & Passetti, 2002), a shift from treatment intensity to *treatment extensity* (Humphreys & Tucker, 2002), *recovery management* (White, Boyle, & Loveland, 2003), *recovery coaching* (White, 2004a), *post-treatment recovery support services* (White, 2004b), *recovery management checkups* (Dennis, Scott, & Funk, 2003), *concurrent recovery monitoring* (McLellan, McKay, Forman, Cacciola, & Kemp, 2005), *adaptive treatment* (McKay, 2005), and *sustained care* (Flaherty, 2006). All share the re-engineering of addiction treatment from an acute care intervention to a model of sustained recovery support services for those clients with high personal vulnerability, high problem severity and complexity, and low recovery capital (Granfield & Cloud, 1999).

Early studies of telephone-based, post-treatment monitoring and support revealed that telephone-based contact was as potent in supporting continued recovery as participation in traditional aftercare groups (Fitzgerald & Mulford, 1985; Foote & Erfurt, 1991). The use of telephone-based continuing care gained greater credence after its utility was confirmed both in the primary care setting (via reductions in clinic visits, hospitalizations, and fewer total hospital days) (Wasson, Gaudette, Whaley et al., 1992) and as a post-treatment support for nicotine addiction (Rabius, McAlister, Geiger, Huang, & Todd, 2004). In one of the best designed studies of the utility of telephone-based continuing care, McKay and colleagues (2004) randomly assigned alcohol- and/or cocaine-dependent participants of an intensive outpatient treatment program to one of three conditions: telephone-based continuing care, a F-2-F relapse prevention group, or F-2-F 12-Step group counseling. They found that participants who had been dependent on cocaine or both cocaine and alcohol did as well in telephone-based continuing care as in F-2-F groups, but that those who were only dependent on alcohol actually did better in the telephone-based intervention. In follow-up reports on this same study, McKay et al. (2005a, 2005b) found that the effects of TBS did not deteriorate faster than the F-2-F interventions, but they did note that those who did not achieve significant progress in intensive outpatient treatment had better long-term outcomes in F-2-F sessions than in TBS. Brief (15 minute) but sustained telephone monitoring following primary treatment has been shown in other studies to increase abstinence rates, reduce heavy drinking (by as much as 50%), postpone and shorten relapse episodes, reduce emergency room visits, and reduce the need for further primary treatment (Stout, Zwick, Lason, & Shephard, 2001; Stout, Zywiak & Shepard, 2003; Horng & Chueh, 2004).

Stout and colleagues (1999) developed an early model of extended case monitoring with a protocol that included an initial 30 minute interview with a case manager as the client neared discharge, monthly calls for 3 months, calls every 6 weeks from 2 contacts, and calls every 2 months for another 9 months—resulting in 15 contacts over 2 years. If a client relapses, the protocol begins anew. Where available, a significant other of each client is also contacted by the case monitor on this same schedule. Coviella and colleagues (2006) utilized a telephone-based outreach program to counsel and re-engage discharged methadone patients who had returned to illicit opiate use.

Kaminer and Napolitano (2004) have developed an Individual Brief Therapeutic Phone Contact (IBTPC) protocol and have reported on its acceptability to both adolescents in treatment for a substance use disorder and to their therapists. Chong and Herman-Stahl (2003) tested the feasibility of telephone-based continuing care with American Indians returning to reservations following alcoholism treatment and found that those receiving telephone-based support were more likely to be abstinent and, if drinking, to have less drinking days and less volume of alcohol consumed than those who did not receive telephone support. Their study also confirmed the utility of telephone-based services to individuals in remote geographical areas that lacked local recovery support resources.

Typical of the new generation of TBS is the Focused Continuing Care (FCC) program at the Betty Ford Center. The FCC provides telephone-based monitoring and support of patients discharged from the Betty Ford Center, with a focus on linking graduates to 12-Step meetings. Calls begin a week after discharge and are sustained monthly. At one year, 88% of those being called report ongoing sobriety, and 78% report attending 12-Step meetings (Betty Ford, 2006). TBS are also a feature of the continuing care services offered by Hazelden and Caron Treatment Centers.

Broffman, Fisher, Gilbert, and Valentine (2006) have reported on a peer-based telephone recovery support pilot project of the Connecticut Community of Addiction Recovery (CCAR) and Community Prevention and Addiction Services, Inc (CPAS). In this model, trained CCAR volunteers met with clients graduating from treatment at CPAS and then monitored their status by phone for 90 days following treatment. Sixty-five individuals received an average of four calls per person in the pilot with 29% receiving ten or more calls. At the end of the pilot, 78% had sustained sobriety through this vulnerable period while those who had relapsed were re-linked to treatment and/or recovery mutual aid groups (Moret, 2006).

The use of TBS as a framework for post-treatment recovery support has great potential. The need for assertive approaches to such monitoring and support is confirmed by research studies noting that those most difficult to reach for follow-up are those most likely to have resumed their addiction careers and be in need of continued services (Ashton & Witton, 2004). Tracking procedures that have been successfully used in research studies to obtain 95%+ follow-up rates could be adapted to TBS to maintain contact with hard to reach clients (Scott, 2004).

Use of Interactive Voice Response Programs for Post-Treatment Relapse Prevention: One recent innovation in post-treatment support has been the use of interactive voice response (IVR) programs. IVR systems allow clients to call in daily and respond to automated voice prompts asking key questions related to their mood and activities, leave voice messages, or have a call forwarded to their counselor or case manager (Hall & Huber, 2000). Mundt, Moore, and Bean (2006) randomly assigned clients discharged from treatment to three groups: 1) daily (5-minute) IVR reporting with personal follow-up for those who did not call, 2) daily IVR without follow-up responses for non-callers, and 3) no IVR reporting. Results revealed a high dropout rate, particularly in group 1, but that those who utilized IVR were more likely to be abstinent at follow-up points than the control group members, and comparisons of those who relapsed showed the IVR group members to have fewer drinking days, fewer heavy drinking days, and fewer total drinks consumed than control group members. This study confirmed the potential utility of IVR, but also confirmed that some clients will experience the intensity of IVR as intrusive. Simpson, Kivlahan, Bush, and McFall (2005) tested daily versus weekly IVR call-in

procedures. They were able to engage most participants in the procedures, but found no significant differences in outcomes between those in the daily or weekly IVR protocol and between the IVR groups and the no-monitoring control group. IVR program participation rates can be enhanced by automated phone prompts or personal calls from counselors in response to failure to call the IVR 1-800 number (Kranzler, Abu-Hassaballah, Tennen, Feinn, & Young, 2004).

Kaminer, Litt, Burke, and Burleson (2006) piloted an IVR system for adolescents following treatment for a substance use disorder. The participants were offered financial awards for calling in during each of the 14 days following discharge from treatment using a contingency management protocol. Seventy-two percent of all possible calls were made, with data underscoring the fragility of post-treatment adolescent functioning. Of those adolescents in the study, alcohol and illicit drug consumption rates following treatment ranged from 59% (illicit drug use by males) and 90% (alcohol use by males), with more than 40% of those reporting any use also reporting driving while under the influence of alcohol or an illicit drug. Using an IVR system as a tool of post-treatment continuing care with programmed early intervention responses would seem to have great utility for the future. Both the Addiction Severity Index and the Teen-Addiction Severity Index have been recently adapted and validated for use with IVR systems (Brodey et al., 2004; Brodey et al., 2005).

The potential power of IVR may lie in the ingredient of self-monitoring—any activity that involves self-reflection and reporting. Such activities could span keeping a journal, reporting one's recovery status at a support meeting, or reviewing one's day or week via a telephone call.

The Cell Phone Safety Net: One approach that the authors have encountered in their travels but which has yet to be evaluated in the scientific literature is the use of cell phones as a post-treatment safety net for adolescents. In this procedure, each adolescent discharged from treatment is given a cell phone pre-programmed to call the treatment center (and only the treatment center). Each adolescent is encouraged to use the phone to check in with staff either on a routine basis or when a crisis arises that could threaten his or her continued recovery.

Telephone-Based Monitoring of Dropouts: We know of no study that has tested the effects of telephone follow-up as a helping intervention for those who have voluntarily disengaged from counseling, recovery support services, or mutual aid meeting attendance, or those who have been discharged from the former services for rule violations (usually AOD use). Traditional "aftercare" services have generally been limited to those who have successfully completed a particular level of care. Ironically, it may be those who have dropped out or acted their way out of treatment via disciplinary discharge who may be in greatest need of post-treatment monitoring, re-intervention, and support. We anticipate a day in the future when such monitoring will be a routine practice in addiction treatment.

Telephone-Based Counseling: In our discussion to date, we have described the telephone as an adjunct to F-2-F counseling or recovery support. There may be situations in which counseling could be provided exclusively by telephone, e.g., to individuals in remote geographical areas lacking local treatment resources. Telephone-based counseling for smoking cessation has been proven to be an effective medium of support, doubling cessation rates of young (18-25 year old) smokers compared to those who received only mailed informational materials (Rabius, McAlister, Geiger et al., 2004).

Telephone Protocol: For those interested in formal manuals or detailed descriptions of telephone-based service protocol, we would recommend the following resources:

Godley, M. (Unpublished research protocol). Outline of Telephone Protocol – 702 Study. Available upon request by email (mgodley@chestnut.org).

Morrison, R., & McKay, J.R. (1997). *Therapist manual and client workbook for telephone monitoring and brief counseling*. University of Pennsylvania. (For info, contact mckay_j@mail.trc.upenn.edu).

Napolitano, C., & Kaminer, Y. (2003). *Individual brief therapeutic phone contact*. Unpublished Manual.   (For info, contact Napolitano@psychiatry.uchc.edu Or Kaminer@psychiatry.uchc.edu).

Responses to Client Status: Those who have been directly involved in TBS know that the status of clients varies considerably when contacted. In an earlier publication, we adapted the work of Stout and colleagues (1999) to outline options based on different status conditions. It has been further refined below.

Status when Called	Intervention Options
No Problems Reported	-Expressions of regard -Identify sources (decisions, actions, people) of successful recovery maintenance -Identify positive consequences of recovery -Praise success -Maintain or reduce frequency of calls per preference of client.
Instability/distress, no alcohol/drug use but high risk of relapse (e.g. cravings, thoughts of using)	-Expressions of regard and concern -Elicit positive effects of sobriety and potential negative consequences of returning to AOD use -Intensify peer recovery supports -Enlist support from significant others -Explore option of contact with professional helper -Assertive linkage to professional help if requested -Potential linkage to sober living environment -Increase call frequency in next 30 days
Slip with return to abstinence	-Expressions of regard and concern -Evaluation of the slip (and lessons learned) -Evaluation of the strength of peer recovery supports (Re-linkage or linkage to alternative group) -Elicit positive effects of sobriety and potential negative consequences of sustained return to AOD

	use -Elicit recommitment to recovery -Increase frequency of calls for next 60 days to verify recovery stability
Alcohol/drug use without reported negative consequences	-Expressions of regard and concern -Review of past consequences of AOD use -Evaluate abstinence goal and client's commitment to continue AOD use or return to sobriety goal -Elicit positive effects of sobriety and potential negative consequences of sustained return to AOD use -Explore earliest ways client would know that AOD use was becoming a problem again -Enlist significant other in monitoring and support -Option of re-linkage to peer and professional support -Apply test of moderation ground rules, e.g., Miller & Munoz, 2005 -Increase calls for next 90 days
Alcohol/drug use with negative consequences	-Expressions of regard and concern -Elicit duration and intensity of negative consequences and future problems if use continues -Elicit how these problems would change if sobriety re-initiated -Assertive linkage to peer recovery supports -Assertive linkage to professional supports -Support to family/significant other -Increase calls to monitor response to peer & professional supports

Source: Adapted and amplified from Stout et al., 1999; Excerpted from White & Kurtz, 2006b.

Special Advantages of Telephone-Based Services: Telephone-based services (TBS) can generate outcomes comparable to F-2-F service delivery formats, but such services may also have distinct advantages. McKay and colleagues (2004) noted that TBS may foster less dependence on the service provider and are less disruptive to the life of the service recipient (e.g., no travel or childcare concerns or expense, less time demands). We would add the following advantages:

- TBS can increase the frequency of support with easy variability in duration of contact (as little as five minutes), potentially increasing the number of people being served.
- TBS can increase physical safety where F-2-F services require traversing high risk environments.
- TBS can extend services into remote areas where few services are available.

- TBS can be directed to those who have made substantial progress in primary treatment, freeing F-2-F time for those who have not made similar progress in primary treatment.
- TBS could add a potent ingredient to F-2-F contact, resulting in stronger therapeutic alliance, lower dropout rates, and better recovery outcomes.
- Data collected in TBS can also be used as a source of data to evaluate program effectiveness (See Breslin, Sobell, Sobell, Buchan, & Evans, 1996 on this final point).

General Recommendations

In reviewing the available research and current pilot studies, we would recommend the following practices related to the use of TBS as adjuncts or alternatives to traditional F-2-F treatment services.
- Provide training to all telephone first-responders to enhance empathy, respect, warmth, and welcoming (judgmental attitudes, contempt, disrespect, and distance are the enemies of engagement and retention).
- Place responsibility for sustained service contact with the helper, not the client.
- Develop TBS protocol and use a review of taped calls to monitor adherence to and refinement of service protocol.
- Provide TBS to all clients who seek services, including those who leave prior to treatment completion and those administratively discharged.
- Schedule call frequency and duration based on time of greatest vulnerability (first 90 days following discharge) and identified personal windows of vulnerability (e.g., holidays, anniversary of a traumatic event, sobriety birthday).
- Include unscheduled contact in TBS protocol, e.g., "I've been thinking about you today and thought I would call to say hi and see how things were going.") (White & Kurtz, 2006b).
- Maintain continuity of contact over time in a primary recovery support relationship (with the staff person or volunteer with the organization).
- Extend TBS (at least an annual recovery checkup) for at least five years for even the most stable of clients.

Internet-based Recovery Support Services

The History of Online Recovery Support Services

Online Recovery Support Services began when members of Alcoholics Anonymous began seeking out other online alcoholics *via* USENET as early as 1983. An article in the October 1986 issue of *The A.A. Grapevine,* "The Slopped Sysop," describes an online intervention that apparently occurred in August 1985. It took over a decade, until December 1995, for Alcoholics Anonymous itself to post a website. In the meantime, many other peer support groups came into existence for many diverse kinds of sufferers. Among the first was a site for parents of children with cancer. Also, a general Recovery BBS [bulletin board] went online from San Francisco on July 4, 1986, with an AA forum front and center.

By that time, there were as many as 15-20 AA-focused BBSs operating around the country, with another known 40-50 following over the next 2-3 years. According to one early participant: "As I recall, it was a BBS with separate message areas for A.A., N.A., Al-Anon, O.A., Smokers Anonymous and Sex & Love Addicts Anonymous." (Personal communication from Tim S., 2007).

Online recovery support for groups other than AA date from the mid 1990s. The experience of Women for Sobriety (WFS) Online services is typical. The first WFS Online presence began in 1995 with message boards and chat rooms and evolved as the site moved from AOL, to Talk City, to Yahoo to MSN in efforts to resolve problems members experienced gaining access to a site or being able to post on it. WFS Online membership grew from 10 women to currently more than 5,700 women who post more than 1,000 messages per day. The WFS Online community represented at the annual WFS conference now surpasses 50% of those attending. Online participation in WFS is the tip of the iceberg of support, as Online contact is often followed by personal email exchanges, exchange of phone numbers and direct visits between members (Cross, 2007).

Other groups also initiated Online recovery support during this period. Cocaine Anonymous created its first web site in 1995 and its first online meeting (Hope, Faith & Courage) started in early 1997 (www.ca-online,org). The earliest online Narcotics Anonymous meeting that still exists dates to October of 1998 (NAWS, 2007). Moderation Management (MM) started its first official listserv in 1996. MM Chat Rooms date to 2001 and have witnessed a significant growth in the past five years. In 2002, MM also began offering a link to ABSTAR, an online self-monitoring tool for those seeking to moderate their alcohol use (Rotgers, 2007). Secular Organization for Sobriety began an internal email list of members in 1995 which evolving into a formal list serve.   LifeRing Secular Recovery began its online chat room in 2001 ads has been supplemented by a number of Online forums and services (Marty N., 2007).

The growth of Online recovery support groups evolved in tandem with the advent of the WorldWideWeb and the dawn of the availability of the browser, Mosaic (Wired 1994). By the mid-1990s, Howard Rheingold (1993) and Sherry Turkle (1996) reported that "while chat rooms and newsgroups continue to play a role in computer mediated communication, the Web has assumed a prominent place in forging relationships among people with common interests." (Glogoff, 2001; Galegher, Sproul, & Kiesler, 1998). Storm King's 1994 "Analysis of Electronic Support Groups for Recovering Addicts" offers the best description of the earliest electronic support groups (ESGs). This study explored whether or not ESGs could be recommended by addiction treatment facilities as a way of introducing particularly shy clients to others in recovery and, it so, which clients would be most likely to benefit from this approach. King also raised the question of how much of a client's need for a peer support group could be met online. This early investigation still merits reading (see [http://webpages.charter.net/stormking/elect.html)](http://webpages.charter.net/stormking/elect.html)

King continued his research with Danielle Moreggi (1998) in a study titled, "Internet therapy and self help groups - the pros and cons." This work further highlighted the potential role of online recovery support groups:

Some people have their first contact with self-help organizations by their online presence. There are documented cases of drug addicts who became willing to give up a destructive

habit for the first time after witnessing the conversations between members of a recovery online self-help group.

This same study went on to report a dose relationship in online recovery support group participation, with improved recovery increasing in tandem with the amount of time participants spent in online recovery support meetings   VanLear and colleagues (2005) compared different formats of AA online communication with other computer-mediated support groups and noted that AA groups were charactersted by greater reciprocity of self-presentation and other-orientation.

Through the 1990s, the availability of online meetings grew dramatically for AA and other Twelve Step programs as well as for Women for Sobriety, Moderation Management, LifeRing Secular Recovery, SMART Recovery®, and a number of explicitly religious recovery support groups.

Many of the early promoters of online communication anticipated the creation of "virtual communities" (Katz, 2000). Howard Rheingold, in his book *The Virtual Community* (1993), laid out the yearning for a humanistic virtual community, rather than one purely technological or informational. Many hoped that self-help and support groups would fulfill this function (King, 1994; King, 1996). And some did (Weis et al., 2003). But in the area of addiction, the earliest reports noted that the most vibrant and helpful internet online groups were "productive" mainly to the extent that they bridged interested newcomers into actual face-to-face meetings and groups (Madara, 1997; King & Moreggi, 1998). In our interviews with the pioneers of online recovery support groups, most noted the expectation that online meetings would be a bridge to or an adjunct of face to face meetings. Many of these representatives noted their surprise at how many people would come to rely effectively and almost exclusively on online communications as their primary source of recovery support. It appears that in non-Twelve Step groups such as Moderation Management, the recent growth in membership is almost exclusively from online meetings (Kosok, 2006).

Formats

Online recovery support occurs in many formats. Individual e-mail exchanges, in the form of alternating bulletin-board postings, came first and in their more developed form remain a lively and rich means of support. These relationships often involve sponsorship. They also remain private between those who send them or those to whom they may be forwarded. Although rarer, immediate communication is also available *via* Instant Messaging, in which one's message immediately pops up on the computer or cell phone screen to which it is being sent. Awareness that unencrypted Internet communication is not sevurely private has not generally permeated the recovery community nor, indeed, the general population. Thos aware of this lack of assured privacy night wisely inform vulnerable individuals of its reality.

Newsgroups, now more often called Listservs, involve a kind of group e-mail: each message that is posted goes to all group members who receive it either individually as it is sent or on a kind of summary digest at the end of each day. Newsgroups are often moderated: each message passes through a group monitor who has responsibility for assuring that it is relevant to the concerns of the group and does not violate group standards of proper language, etc. This

modality also evolved from BBS or Bulletin Boards on which individuals could post messages inviting but not necessarily wanting response.

Chat Rooms are online locations where individuals can exchange messages in real time. These may be text-based or employing actual vocal exchanges. It is also possible to have actual visual contact at relatively minor expense as webcams have become more common, though such groups are as yet rare among alcoholics and addicts.

Advantages of Web-Based Groups

One notable advantage of web-based groups is their ability to reach special populations. Computer contact reduces barriers of time, distance, and social status, allowing persons with physical disabilites, home-bound caregivers, status-conscious professionals, and individuals in remote locations the opportunity to participate actively and on an equal basis with the more advantaged (Slatalla 1996; Cudney & Weinert, 2000; Perron, 2002; Weinert et al., 2005). Beder (2005) offers a vivid and detailed description of the importance of a variety of online resources to a professional social worker who had to become a caregiver. Similarly, shy adolescents, many of whom have not sought professional treatment (Humphreys & Klaw, 2001), and those who have sought treatment but not made substantial changes during primary treatment (McKay et al., 2005b) have made significant breakthroughs online. Those who view themselves as stigmatized are especially attracted to online resources (Cooper, 2004). As Salem and colleagues noted as early as 1997, "On-line mutual help may provide a unique form of support for persons who are not as likely to use traditional forms of helping." Also, of course, "computer-mediated social support groups may provide people with a network of individuals to whom they can turn for support when needs are not being met by traditional providers of support" (Wright & Bell, 2003).

In our review of the professional literature on telephone- and Internet-based recovery support services, we are impressed with the ability of these services to reach special populations of people who may either lack access to or face obstacles to their participation in F-2-F recovery support meetings (Kurtz, 1997). Particularly striking is the high percentage of women who utilize online support groups—a phenomenon we attribute to its accessibility, convenience, and safety, and its ability to provide gender-based services in a stigma-free format to women in communities that lack local women's recovery support group meetings. Hall and Tidwell's (2003) study of those using Internet-based recovery support services reported that women made up more than 60% of those using such services—a dramatically higher percentage than that found in treatment admissions and surveys of F-2-F recovery support groups. Other groups for whom this format could offer special advantages include status-conscious professionals (e.g., physicians, business executives, judges), adolescents (Skinner et al., 2001; Kaminer & Napolitano, 2004), persons with impairments that limit access to or usefulness of F-2-F meetings (e.g., persons with hearing loss) (Cummings, Sproull & Kiesler, 2002), individuals in remote locations (e.g., those living in rural or reservation communities) (Chong & Herman-Stahl, 2003), populations who have not sought professional treatment including non-dependent drinkers (Humphreys & Klaw, 2001), and populations who have sought treatment and made initial progress during primary treatment (McKay et al, 2005b).

Social support groups provide mutual aid and self-help for people facing chronic disease, life-threatening illness, and dependency issues (Furlong, 1989; Cline, 1999).   Benefits that accrue from use of social support groups include enhanced quality of life, improved decision making, and increased survival time (Spiegel et al., 1989; Spiegal, 1994; Cline, 1999). Social support groups offer a cooperative approach to meeting social needs, offering a sense of community that can result in genuine empowerment (Braithwaite et al., 1999; White & Dorman, 2001).   Even "lurkers", (those who observe but do not post), Nonnecke and Preece (1999) discovered, often "developed a sense of community through their lurking."

Problems with Web-Based Involvements

Web-based involvements can also, of course, lead to problems. Basic texts for anyone thinking of pursuing any kind of psychological help online can be found in the *Selfhelp Magazine* writings of M.E. Peychers and John Suler, available online at http://www.selfhelpmagazine.com/articles/internet/index.shtml. Ethical considerations in such interventions have been well covered by King (1996), Thomas (1996), and Frankel and Siang (1999).

Ambivalence about the Internet and online communication existed almost from its origin (Gilder, 1995). Early on, some hesitated to use online resources because of concerns about privacy (Agre & Rotenberg, 1997). Reasons for this concern are clear from some examples offered by Storm A. King in his 1996 study of the then-growing practice of "Researching Internet Communities." King and Moreggi (1998) noted that: "Covert access by researchers to public Internet forums where highly personal notes are posted is a growing concern. Ethical treatment of human subjects in Internet naturalistic observations requires the researcher to be keenly attuned to the nuances of such public/private spaces."

One concern has been that the availability of online communication would inhibit some individuals from seeking actual face to face contact: they would "bury themselves in their computers" (Goldberger, 1995). A reflection of the validity of this concern may be found in a December, 2005 posting to the Narcotics Anonymous Online Recovery site, reposted as recently as January, 2007.

> *We strongly urge people to consider carefully what they are doing before they share "anonymously" online and to know that things and people are not always what they may seem to be and most often are not. Please get involved in real life recovery at NA meetings in your area. Please, turn off your computers and get involved in real life in your recovery and in your community today. Life can be worth living if you go for it.*
> (http://www.narecovery.org/naonlinerecovery.html#top accessed June 2, 2007.)

This is not, of course, a sole concern of support-group members. Wellman and colleagues (1996) suggested that "Virtual communities are accelerating the ways in which people operate at the centers of partial, personal communities, switching rapidly and frequently between groups of ties. Whether working at home or at an office workstation, many workers have an enhanced ability to move between relationships. At the same time, their more individualistic behavior means the weakening of the solidarity that comes from working in large groups."

Another early concern was the disinhibition that online communication fostered. (Keisler, Siegel, & McGuire, 1984; Reid, 1994; Sproull & Kiesler, 1984; Sproull & Kiesler, 1995). As one investigator summarized: "If all computer-mediated communication systems can be said to have one single unifying effect upon human behavior, it is that usage tends to cause the user to become less inhibited." (Reid, 1994).

Others, however, saw this as an advantage. Griffiths (2005), for example, suggested that freedom from pressures for social desirability "may lead to increased levels of honesty and, therefore, higher validity in the case of self-disclosure." "The Internet may, as a consequence," Griffiths continues, "provide access to socially unskilled individuals who may not have sought help if it were not for the online nature of the self-help group."

Wider Utilization of Online Mutual Aid and Support Groups

Fewer and fewer people are without online access of some sort, but full participation in all groups may not always be available to all individuals wishing to use this resource. With the availability of g-mail and other free e-mail programs that allow private storage on the web itself, even someone who must rely on a public library terminal can participate in the many available email-based groups.   In such public venues, of course, awareness of "shoulder surfers" and library observation policies may inhibit users from effective communication.

Problems with Studying Peer Support

Barak, Grohol, and Proctor (2004) have cautioned that ". . . although clinicians and scientists strive at obtaining reliable evidence, we question whether certain types of quantitative research on Internet peer support groups are desired, needed, or even possible." They pointed out that the Eysenbach et al. article to which they were responding had admitted that "Given the abundance of unmoderated peer to peer groups on the internet, research is required to evaluate under which conditions and for whom electronic support groups are effective . . . (p.1166)." But they went on to suggest that: "research of online peer-to-peer support groups by professionals is rather paternalistic, and it completely misses the point that the Internet environment is viewed by its users as a self-empowering medium. Users do not necessarily want, or need, professional researchers present in peer-to-peer support groups, which are run by ordinary people for ordinary people. Many of these groups thrive precisely because there are no professionals in them. Moreover, we question whether researchers can truly evaluate under which conditions and for whom (p. 1170) online groups are effective given the inherent nature of these groups, characterized by minimal control, open-door approach, and unidentifiability" (e.g., Wright & Bell, 2003).

Professional Interventions

As Madara (2007) has observed, "Once professionals see the parade, they run to the front to lead it."   In the area of self-help mutual-aid, the rush to online co-optation was, if anything, greater than in the world of face-to-face meetings, particularly within the addiction treatment arena. The earliest professional involvement took place by way of information sites. A review

of electronic bulletin boards for health information together with useful definitions was published in 1985 (Peterson & Rippey, 1992). The earliest alcoholism information site was aimed at professionals, a report on "ETOH - the NIAAA data base: what it is and what to expect from it," that included "related information" (McGinn, 1989).

On the therapy side, an excellent summary may be found at the E-Therapy site, http://www.metanoia.org/imhs/history.htm, which notes that "Ivan Goldberg, M.D. began fielding questions online about medical treatment of depression at least as early as 1993. He did not solicit questions on his own popular website, Depression Central, but generously served as unofficial advisor to the online depression support group Walkers in Darkness, responding to inquiries about medications in an educational capacity." (cf. http://www.walkers.org, accessed June 2, 2007). Fee-based mental health services offered to the public began to appear on the Internet in mid-1995. The earliest was by Leonard Holmes, Ph.D. who offered "Shareware Psychological Consultation," answering questions on a "pay if it helps" basis. By the fall of 1995, two other fee-based mental health advice sites, "Help Net" and "Shrink Link" had appeared.

Screening and Assessments Research on Internet-based support groups suggests significant potential to reach many more individuals than can be physically screened in healthcare and other offline encounters. As Vinson (2001) noted in reporting on the research of Nguyen et al. (2001), computer screening for problem drinking saves precious primary care time especially when dealing with the elderly, is effective, and is generally acceptable to patients. Kypri and colleagues (2004) effectively used an Internet-based application of the Alcohol Use Disorder Identification Test (AUDIT) to reduce hazardous drinking among university students. Saitz et al. (2004) demonstrated that "[a] well-publicized, easily accessible, research-based screening and intervention Web site can attract many users, most of whom are drinking excessively, and many of whom avail themselves of referral information after receiving individualized feedback."

Several computer-based screening and problem assessment programs are available online. http://www.alcoholscreening.org/ offers a test based on the Alcohol Use Disorders Identification Test (AUDIT), developed by the World Health Organization to screen for harmful or hazardous drinking patterns. Another online alcohol screening tool can be found at http://www.alcoholscreening.org/AS/index.aspx?CID=57, a syndicated service provided by Join Together. Join Together, a project of the Boston University School of Public Health, is a national resource supporting community-based efforts to prevent and treat substance misuse and addiction. The revised Michigan Alcohol Screen Test (MAST) can be found at http://counsellingresource.com/quizzes/alcohol-mast/index.html. (All sites listed in this paragraph were accessed June 2, 2007.)

Counseling and Treatment

King and Moreggi (1998) examined the "efforts of mental health workers who offer fee based services over the internet, both by e-mail and in chat rooms," evaluating "the ethical, legal and moral implications" of these practices. Providing an "overview of the types of and nature of on-line self-help, mutual aid groups," they also described "the nature of the interpersonal relationships" in such settings and reviewed the "positive aspects of involvement in such virtual

support groups" as well as their drawbacks. Linke et al. (2004) investigated the benefits of "web-based intervention to encourage excessive drinkers to adopt a healthy pattern of drinking and reduce alcohol-associated harm." Of the 1319 registrations over the course of their six-month study, the 6% who stayed through the six-week course "provided encouraging feedback about the value of the site."

The quality of e-therapy remains an open topic. Copeland and Martin (2004) observed that although the then-largest online treatment site, e-Getgoing (http://www.egetgoing.com accessed June 7, 2007), which was accredited by the Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities in the USA and had been collecting process evaluation data for a period of time, that data remained unpublished, which is still true in 2007. As Copeland and Martin went on to note, "This approach to treatment is controversial . . . due to its unregulated nature and issues of clinical responsibility, adequacy of client/risk assessment in the absence of physical cues, therapist licensing, and treatment effectiveness" (Laszlo, Esterman, & Zabko, 1999; Manhal-Bagus, 2001; Oravec, 2000; Pomerantz, 2002).

This situation has not changed, though efforts along these lines continue. Thus, starting from the observation that "The majority of individuals with alcohol use disorders do not receive treatment," Huang and Lieberman (2006) designed an "online program . . . to increase users' motivation for change and offer treatment options." Their internet-based program "guided subjects through a series of standardized questionnaires and provided them with feedback designed to enhance their appreciation of the negative aspects of their alcohol use." Data originally collected from 1297 individuals revealed significant alcohol-related morbidity, though less than a comparison population of Project MATCH subjects. Significantly, the respondents included a greater percentage of women, and this group was also younger and more likely to be employed. The authors concluded that Alcoholcheckup.com was able to reach a hidden population with serious alcohol problems that was significantly different from the population served by traditional programs. Reaching this less motivated population may allow the program to serve as a stepping stone, moving alcohol abusers into treatment at an earlier stage of their illness. There have been no follow-up studies as of this date (April 2007). And so, as Alemi et al. note in their study of the *content* of various therapeutic exchanges with "nearly 300 clients . . . for recovery from substance abuse": "The use of electronic media in providing mental health treatment remains controversial due to concerns about confidentiality, security and legal considerations"(2007).

Despite the number of e-therapists available, lack of empirical research makes it impossible at this stage to provide an objective evaluation of the effectiveness of online therapy. In addition, the need to address central technological, legal, and ethical issues associated with efficient access, confidentiality (particularly regarding illicit drug use), and duty of care of the online therapists mean that online therapy has a only a limited role to play in treatment systems at this stage.

One difficulty with the use of such providers is that these services are not reimbursable through most public and private behavioral health care funders. Gross (2000) offered an adequate summary of both the possibilities of online counseling and the many concerns that need to be kept in mind when approaching the topic and practice of online counseling.

Computer-Mediated Addiction Counseling: E-therapy (also known as cybertherapy and online counseling) for addictive disorders is being delivered in a number of formats: an email-based question and answer format focusing primarily on information delivery, ongoing communications through live chat or extended email exchanges, online support groups that are counselor facilitated, and online video-conferencing that allows the counselor and client to see and hear each other (Griffiths, 2005).   One of the earliest of the online addiction counseling services was eGetgoing (http://www.egetgoing.com accessed June 7, 2007), which advertises itself as "anonymous, convenient, affordable". EGetgoing provides each person a PC-compatible headset and microphone that allows each client to see their therapist and speak to and hear (rather than type and read) other group members. Costs at the time this monograph was being prepared (June 2007) were $399 per month for three months of primary treatment, followed by $50 per month for participation in aftercare groups. Other addiction-focused E-therapy services include:

- www.askthetherapist.com;
- www.addictionrecoveryguide.org/treatment/online.html; and
- www.choose2change.com (Griffiths, 2005).

All of these sites are listed for illustration purposes only to convey the range of currently available E-therapy services for substance use disorders.

One of the most detailed online addiction counseling protocols published to date is provided by Farrokh Alemi and colleagues (2007). Their article acknowledges special ethical, legal, and clinical issues related to online therapy, but notes that such issues can be competently addressed by counselors and clients familiar with the potentials and limitations of Internet-based communication. Particular benefits from online therapy noted in the Alemi et al. studies are increased client retention, increased use of other recovery support resources, e.g., NA meetings, and decreased health care utilization costs. They argue that the positive effects are based not on the ready availability of the online service, but on its particular content.

The recommended format (Alemi et al., 2007) comprises a series of email exchanges sent from the counselor, which includes the client's alias (used for confidentiality purposes); Counselor's name, title, and work email; date the email was sent and time it took the client to open it (computer calculated); an opening greeting; statement of the issue (one per email); illustration of the issue; an open-ended question inviting a client response; a counselor signature; and a statement of email confidentiality. The email series occurs over what is conceptualized as 12 stages of online therapy: 1) establish contact, 2) assessment, 3) identify consequences of substance use, 4) develop a plan for recovery, 5) admit to substance abuse and mobilize support for change, 6) identify problematic interpersonal relationships, 7) adjust daily routines through group action, 8) create a sense of spirituality and community through group action, 9) identify substitute routines through group action, 10) share success with others, 11) address cycles of relapse, and 12) make amends and offer help to others. This model involves online therapy spanning 4 to 6 months that mixes counselor-client email communication, written assignments, electronic support groups, and creation of a personalized recovery team drawn from each client's natural environment.

Detailed email scripts for email-based counseling are available in the following resource:

Alemi, F., Haack, M.R., Nemes, S., Augburns, A., Sinkule, J., & Neuhauser, D. (2007). Therapeutic emails. *Substance Abuse Treatment, Prevention, and Policy, 2*(7). Retrieved February 20, 2007 from http://www.substanceabusepolicy.com/content/2/1/7.

Counselor Skills Required for Online Recovery Support

For both addiction counselors and recovery coaches, offering services online requires skills above and beyond those required for face-to-face work. Fenichel and colleagues (2002) suggest that online therapists need both technical and emotional skills. The former include the ability to type fast, knowledge of the Internet and software programs, a library of related web links, and knowledge of encryption/privacy technologies. The latter include communicating emotions in text format, ability to conduct therapeutic interventions in text, reading and managing transference via online text, ability to clarify meaning of Online communications, tolerance of occasional computer glitches, and ability to emotionally handle acting out via client projections and messages. Online counselors must also be able to navigate between online and face-to-face contact as circumstances dictate.

Client Characteristics Indicating Appropriateness of Online Recovery Support

Fenichel and colleagues (2002) have also suggested that not all clients are suitable for online counseling. Clients most suitable for online counseling are those who have a working mastery of computers and are comfortable communicating online, possess or have ready access to a computer and Internet services, can type quickly (or have voice technology), can handle occasional computer glitches, can sustain a relationship online (express themselves in writing, clarify the meaning of written messages, etc.), and have a credit card and are comfortable using it online (where service payment is done electronically).

Hall and Tidwell (2003) conducted a preliminary study of the characteristics of those using online resources for purposes of "prevention, intervention, recovery and/or aftercare." They found such consumers to be overwhelmingly white (91%), female (66%), and 21-60 years of age (86%).   Those participating in online recovery support group meetings represented a wide variety of recovery programs spanning religious, spiritual, and secular recovery support groups. 77% reported both a primary and secondary program, suggesting a high degree of co-participation in mutual aid societies. This pattern of co-participation (e.g., in AA and WFS) increased in tandem with duration of time using online recovery services. The overall mean length of time using online recovery supports was 32 months. While one would think that Internet-based recovery supports would be an attractive medium for Generation X, it is somewhat surprising that 70% of those participating in the online study of Hall and Tidwell were between ages 36 and 55.

Web-based Continuing Care

There is a growing interest in the potential for Internet-based systems of continuing care. Hazelden, for example, has recently launched a plan to offer all of its patients a web-based continuing care option. This program would combine weekly contacts with a recovery coach

with a personalized web-based home page offering learning and self-assessment modules that will guide each individual through early recovery. Unique in this system is a flagging system that alerts the recovery coach of warning signs of relapse revealed in the online self-assessment exercises (Hazelden, 2007).

Summary and Conclusions

Studies to date reveal a substantial demand for telephone- and Internet-based addiction recovery support services, and preliminary studies of the effectiveness of such studies suggest they have promise in promoting long-term recovery outcomes. Such services may offer special advantages including accessibility, convenience, flexibility, safety, and affordability. They may also offer a means of immediately capitalizing on brief windows of heightened motivation during addiction careers often marked by ambivalence related to both drug use and abstinence (Copeland & Martin, 2004). Many questions related to telephone- and Internet-based services have yet to be answered, including their degree of effectiveness, their utility with different populations, and any special risks associated with these service delivery formats. Notwithstanding these challenges, we see great potential in the use of new technologies to deliver professionally-directed treatment and continuing care services and peer-based recovery support services. Given preliminary findings that combining service ingredients (e.g., Internet screening supplemented with mailed self-help materials)(Cunningham et al., 2005) can generate additive effects, we see a future in which telephone and Internet-based services are combined and sequenced with traditional face to face services to significantly elevate long-term recovery outcomes.

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