1. Subject Area: Relapse Prevention
Relapse Prevention as a Psychosocial Treatment: A Review of Controlled Clinical Trials.

<table>
<thead>
<tr>
<th>Author/s</th>
<th>Individualized or Group Intervention?</th>
<th>Outcome/s Measures</th>
<th>Subjects Info</th>
<th>Randomized Controlled Trial?</th>
<th>Generalizable to Iowa?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carroll, K. M.</td>
<td>Both are used in various studies that are reviewed.</td>
<td>Abstinence, time to return to using, severity of using.</td>
<td>Multiple subject variations throughout 24 studies.</td>
<td>Yes. A review of 24 trials.</td>
<td>Yes, though important to consider that long-term efficacy has not been accomplished by the date of this review.</td>
</tr>
</tbody>
</table>

Citation

Abstracts/Results/Notes: Carroll provided a comprehensive review of 24 randomized controlled trials examining relapse prevention (RP), for smoking cessation, alcohol, marijuana, cocaine and other drugs. Carroll surveyed the literature and made a clear case for continued research that would move beyond the immediacy of time periods shortly after treatment into long term follow-up results in order to support any particular treatment efficacy. The majority of the studies suggested RP is effective relative to no treatment with durable results, but less consistent in effectiveness compared to discussion control group conditions or other active treatments. The evidence was strongest for smoking cessation, but the number of studies and samples within studies are small.

1. Alcohol: 1978, 88, and 89 studies produced no main effect differences for treatment type regarding abstinence or alcohol consumption. Patients who had a higher level of sociopathy had better outcomes as measured by days of abstinence or heavy drinking days and patients with lower sociopathy had better outcome when treated with an interactional counseling approach. Patients with specifically high deficits in coping skills had better outcomes. A treatment plan which added relapse prevention treatment for spouses reported more days of abstinence and better marital adjustment.

2. Marijuana: No significant treatment effects for days of marijuana use or abstinence rates were found at 12 weeks or 1 year.

3. Cocaine: More severely addicted cocaine users were significantly more likely to achieve longer continuous abstinence if they received relapse prevention treatment. RP may hold promise in reducing the severity of relapses when they occur and durability of effects after treatment ends.

Limitations:
- Study timeframes are not long enough to evaluate efficacy.
- Comparison treatments were often a conglomeration of various approaches.
- Some study treatments were manualized and others were not.
- Study samples were small.
- Pharmacological studies were promising, but again the cost of the medication prohibits direct service implementation.
## 2. Subject Area: Relapse Prevention

### Relapse Prevention Models for Substance Abuse Treatment

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<tr>
<td>Rawson, Richard</td>
<td>Both are used in the Matrix treatment package which includes outpatient relapse prevention.</td>
<td>N/A</td>
<td>N/A</td>
<td>Some models have RCT evaluations, others do not and one has extensive RCT’s in progress.</td>
<td>Yes. Possible treatment interventions for Iowa’s methamphetamine-using population.</td>
</tr>
</tbody>
</table>

**Citation**


**Abstract/Results/Notes:** Rawson presented a complete review of various models of relapse prevention (RP), many of which were poorly evaluated in 1993. Models are not necessarily manualized which poses challenges for evaluation in a controlled setting in order to determine what effects are identifiable.

Rawson discussed the foundations of relapse prevention according to Marlatt and Gordon, and provided information about Gorski’s Cenaps Model (nothing empirical), and Wallace’s RP model for Crack Cocaine Users, which had not moved from model to specific methodology. The Annis Alcoholism Model, which was a randomized controlled trial, showed no differences between the groups at 6 months. Roffman’s model for the treatment of marijuana dependence was also evaluated in a controlled study finding a greater reduction of marijuana use than a comparative social support procedure, but no significant difference in abstinence for the 30-day follow-up period.

McAuliffe’s Recovery Training and Self Help model (RTSH) was evaluated in a large randomized controlled trial for which subjects either received RTSH or were referred out to other community-based programming. Six- and 12-month follow-up points showed superior levels of opioid abstinence at the follow-up points, more employment activity and less criminal activity.

Rawson’s own Matrix neurobehavioral model provides intensive treatment contact over six months, including: Relapse Prevention; family participation; urine testing; and encouragement for 12-step program participation. Encouraging drops in usage were reported in pilot studies and both CSAT and NIDA have supported replication trials over the last few years, and CSAT results are expected soon, while the NIDA project runs until Sept. of 2004.
3. Subject Area: Relapse Prevention
Relapse Prevention: an Overview of Marlatt’s Cognitive-Behavioral Model

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<td>Larimer, Palmer, and Marlatt</td>
<td>Both types of intervention are used in the model.</td>
<td>N/A</td>
<td>N/A</td>
<td>No. This is a review of a model.</td>
<td>Yes. The article includes solid information regarding needed components for relapse prevention within treatment programs.</td>
</tr>
</tbody>
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**Citation**

**Abstract/Results/Notes:** Marlatt and Gordon’s work transformed traditional treatment approaches which conceptualized relapse prevention (RP) as a negative outcome equal to failure. By proposing a model that included immediate determinants connected to high-risk situations, coping skills, outcome expectancies and defining an “abstinence violation effect,” relapse prevention moved to a set of interventions to help identify high-risk situations, increase self-efficacy, improve coping skills for urges and cravings, and planful strategies for balancing a client’s lifestyle.

Most RP research has included treatments with the basic components of the early Marlatt and Gordon work. The components in the model are based on a cognitive-behavioral approach to treatment that is well-supported.
4. Subject Area: Relapse Prevention

Relapse Outcomes in a Randomized Trial of Residential and Day Drug Abuse Treatment

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<td>Greenwood, Woods, Guydish, and Bein</td>
<td>Yes. A TC treatment was used for both clients who stayed in residence and those who went home at night.</td>
<td>Comparing time to return to using between in-residence and not in – residence.</td>
<td>N=238 who completed at least one follow-up N=118 (72%) who completed all interview</td>
<td>This study is a re-examination of data from a randomized controlled trial by Guydish in 1998.</td>
<td>Policy decisions about budget distribution could benefit from this information.</td>
</tr>
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Citation

Abstract/Results/Notes: The data in this article are from a Guydish randomized controlled trial (Guydish et al. 1998; et al., 1999) assessing the efficacy of day versus residential treatment. A total of 534 clients seeking treatment at Walden House in San Francisco from 1992-1994 were randomly assigned to either day- or residential-treatment settings. Day and residential shared the same therapeutic community treatment with the residential clients housed at Walden House and the day clients returned home each day. Treatment analyses included 238 clients who completed at least one interview (6-, 12-, or 18- month follow-ups), and 118 clients who completed all follow-up interviews.

Results of relapse outcomes at 6-, 12-, and 18-month follow-up demonstrated a statistically significant “setting by time” interaction. Controlling for setting differences at baseline and controlling for psychosocial measures of alcohol severity, depression, psychiatric symptoms, and social support, it was three times more likely for the day-treatment-assigned clients to relapse at 6-months post-admission. Setting by time differences were not significant at the 12- and 18-month intervals.

Findings suggest that a residential- compared to day-treatment setting may reduce the risk of relapse during the initial months of treatment.
5. Subject Area: Relapse Prevention
Group Counseling versus Individualized Relapse Prevention

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<td>McKay, Alterman, Cacciola, et al.</td>
<td>A comparison of standard group counseling vs. individualized relapse prevention aftercare.</td>
<td>Time to return to use (lapse or relapse).</td>
<td>N=98 Male veterans; most African American Outpatient treatment for cocaine dependence.</td>
<td>Yes.</td>
<td>Some components of treatment for stimulants can be supported for Meth-Amphetamine users.</td>
</tr>
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**Citation**

**Abstract/Results/Notes:** McKay examined the differences between standard group counseling aftercare (12-step oriented) and individualized relapse prevention aftercare. All subjects completed a 4-week Intensive Outpatient primary treatment before recruitment and random assignment into the study.

The reported results are interesting. Standard aftercare produced substantially higher rates of continuous abstinence over the 6-month study period than the RP aftercare. Conversely, for patients who experienced some cocaine use during months 1-3, RP was more effective in limiting the extent of use during that period. The authors also bring forward the possibility that relapse prevention by its very nature brings attention to the possibility of lapse, and questions whether or not that might create some sense of permission to use in those subjects less motivated for complete abstinence. It should also be noted that the RP participation required a higher level of activity from subjects than the standard group counseling, and patients who were not strongly committed to abstinence might not have been willing to fully engage. The RP treatment shows promise for clients who continue to use during aftercare.

Baseline Self-efficacy (personal confidence about being successful) was a statistically significant predictor of cocaine use in the follow-up period.
6. Subject Area: Relapse Prevention
Article Title: Relapse Prevention for Alcohol and Drug Problems: That was Zen, This is Tao

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<td>Witkiewitz and Marlatt</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>No</td>
<td>Yes</td>
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Citation

Abstract/Results/Notes: Marlatt’s original research in 1985 placed relapse prevention (RP) as an adjunct to treatment of numerous problems, including substance abuse. This new review summarizes the basic tenets of RP and the cognitive-behavioral model of relapse. This new article also includes the 1996 randomized controlled trial reviews of relapse by Carroll (1996) that had incorporated Marlatt’s relapse components. Witkiewitz and Marlatt also re-conceptualized a relapse model which poses need for future research.

Marlatt’s early work was criticized for defining a hierarchy of risk factors leading to relapse and the new model incorporates the timing significance as well as the inter-relationships between: self-efficacy; outcome expectancy; craving; cue reactivity; motivation; coping skill level; and negative affect emotional states in an effort to explain the blended nature of what happens before relapse occurs. A good portion of the research material for outcome expectancy, cravings, and cue reactivity in particular, are evolving from smoking cessation research. Despite considerable evidence demonstrating a strong relationship between self-efficacy and treatment outcomes, the mechanism by which self-efficacy influences outcome is still unclear. Studies on cue reactivity in addiction have shown that drug-related stimuli elicit craving (self-reported) and higher physiological response, but cue reactivity is still not shown to be a good predictor of relapse. Evidence is limited for treatments that target changing expectancies to bring posttreatment usage changes forward. Motivation can be positive or negative (I want to quit, but don’t think I am strong enough to resist) and moving from that ambivalence is quite challenging.

The article is a call to begin the science research needed to test the efficacy of the newly proposed, more dynamic model.