NHS

National Treatment Agency
for Substance Misuse

Retaining clients in drug treatment

A guide for providers and commissioners

June 2005

National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harms caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000-300,000 problematic drug misusers in England who require treatment.

The NTA is responsible for meeting the Department of Health's public service agreement targets to:

- double the number of people in effective, well-managed treatment between 1998 and 2008
- increase the percentage of those successfully completing or appropriately continuing treatment year on year.

Reader information

Document purpose	To provide managers and commissioners of drug treatment services with information and advice to enable them to improve retention in treatment.
Title	Retaining clients in drug treatment: a guide for providers and commissioners.
Author	Tim Murray, policy officer, NTA
Publication date	June 2005
Target audience	Providers and commissioners of drug treatment services in England
Circulation list	Managers and commissioners of treatment services Co-ordinators and chairs of local partnership (e.g. drug action teams and crime and disorder reduction partnerships) Service user and carer groups Regional government department leads on drugs Central government department leads on drugs
Description	Information and advice to help drug treatment providers to improve retention of clients in drug treatment. Includes research and evaluated practice, and a guide to performance management of retention.
Action required	Local partnership areas to work with NTA regional teams to ensure treatment plans for 2006/07 reflect agenda outlined.
Timing	Ongoing
Contact details	National Treatment Agency for Substance Misuse Until 16 July 2005: 5th floor, Hannibal House, Elephant and Castle, London SE1 6TE. Tel 020 7972 2214. Fax 020 7972 2248. **From 18 July 2005**: 8th floor, Hercules House, Hercules Road, London SE1 7DU. Tel 020 7261 8801. Fax 020 7261 8883. Email nta.enquiries@nta-nhs.org.uk www.nta.nhs.uk
Gateway/ROCR approval	The NTA is a self-regulating agency in relation to Department of Health Gateway

Contents

Executive summary

This guide provides information to drug treatment providers about researched and evaluated practice which has been shown to improve client retention in drug treatment, with the aim of helping them to improve client retention in their services. The document will also be useful to drug action teams (DATs) and commissioners of drug treatment, who want to ensure that they are commissioning effective systems. There is also information on the 12-week retention indicator and the performance management process (local delivery plans, mental health trust star ratings and the DAT treatment planning process) which will be useful to people across the drug treatment field.

The guide is important in the context of the recent emphasis on client retention as an indicator of the effectiveness of drug treatment. In addition to numbers in drug treatment, early retention has been built into the programme management of drug treatment services, since research has shown that clients who are retained for over 12 weeks from the date of triage have better treatment outcomes. It is important to emphasise retention in the early stages of treatment, as this is when a large percentage of clients drop out. The importance of retention is also to be stressed in the context of the vast disparity between services that retain clients well and those that do not. It is expected that improvements that help to increase early retention are also likely to improve retention overall.

A selection of research on how services can improve client retention in treatment has been drawn together from a number of sources, including international research and NTA research briefings. Most of the current research on retention comes from the USA. This document is not intended to be a literature review on the subject or a comprehensive summary; rather it looks at some widely available research reports and provides a summary of some key ideas. It has been developed by the NTA to be a useful source of ideas for service providers on improving practice around engagement and retention. We expect service providers will find this a useful starting point for exploring ways of improving their own effectiveness. However, they may identify other suitable approaches locally or additional sources of evidence to assist them.

The guide sets out improving retention in drug treatment under a group of broad headings, each of which look at the important issues involved, highlight some of the research evidence base and based on this, give pointers to how services can improve client retention. The areas are outlined as follows.

Helping clients to engage with drug treatment

This section looks at the important area of a client's first contact with a drug service and considers how the initial engagement from first contact through to assessment can be improved to lead to better retention. Some of the areas highlighted that can help to improve client engagement and retention are:

- encouraging and welcoming reminders given to clients to help them to keep coming to appointments
- motivational interventions
- quicker entry into treatment, which has been shown to improve initial client engagement, but not necessarily longer-term retention
- client induction, which makes clear to the client what to expect of drug treatment.

Engaging and retaining specific client groups

This section has information on engaging and retaining two important client groups who are often under-represented in drug treatment – Black and minority ethnic (BME) groups and drug-using parents with children.

There are a large number of research papers referred to in this document, as part of looking at "what works" in retention for the above areas. Shorter, focused summaries of some of the research are available in a number of documents on the NTA website and in *Drug and alcohol findings* magazine. Full references for all relevant articles are given, as are a number of websites where further relevant documents and articles on client retention can be found.

This guide is a product of the NTA's treatment effectiveness work programme, full details of which can be found on the NTA website at www.nta.nhs.uk.

Building therapeutic alliances

This section looks at the importance of the client/practitioner relationship – the "therapeutic alliance" – and establishing it early in a client's treatment. This is often cited by clients as one of the most important aspects of successful treatment, and research has shown this to be the case. As well as exploring how to improve therapeutic alliance, the section has advice on helping to build client commitment to treatment and touches on contingency management – a system for rewarding or reinforcing positive client decisions.

Responding to the full range of service users' needs

This section considers the important issue of services being responsive to the full range of the client's needs and dealing with an individual as a whole person. This involves service flexibility and includes looking at issues such as links to education and vocational services, opening times and transport for clients.

Getting the dose right

This section focuses on getting the right therapeutic dose for clients receiving substitute prescribing treatment. Dose has been linked with retention in treatment and there is information about "flexible" doses and consultation with service users in setting dose as part of trying to improve client retention.

Involving service users in their own treatment

This section looks at how different methods of service user involvement can be used to engage clients in their own treatment and thus improve retention.

Introduction

Purpose and audience

Research evidence suggests that drug treatment services which retain their clients for longer periods of time have significantly better treatment outcomes. Drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more, with marked improvements in reducing drug use, reducing morbidity and mortality associated with misuse, reducing crime, and improving health and social functioning. Client retention is often a good measure of how well services are engaging with and treating their clients in structured drug treatment.

This guide provides drug treatment providers with information and advice to help them further improve retention of clients in drug treatment. It is also intended to be useful to DATs and commissioners of drug treatment, who want to ensure that they are commissioning effective services. It is known that the practices of individual services can have a big effect on whether clients are retained or not, and this document sets out information on programmes and initiatives that have been shown to work in retaining clients in treatment. It also sets out some of the background and policy context to the emphasis on client retention as a key quality indicator and aims to clarify the retention performance management process.

Why this guide is needed

The NTA's target is to double the number of people in effective, well-managed treatment between 1998 and 2008, and to increase the proportion of people who successfully complete or, if appropriate, continue treatment. In addition to existing indicators – reducing waiting times as an indicator for improving efficiency, and building the drug treatment workforce as an indicator for increasing capacity – the NTA is focusing on a new indicator for quality and effectiveness in structured drug treatment. Client retention in treatment is being used as an indicator of quality in structured drug treatment. Therefore, in addition to the national priority for doubling the numbers of those in drug treatment by 2008, there is a strong emphasis on retaining people across most treatment types for a minimum of three months.

Why retention is an important indicator

The National Treatment Outcome Research Study (NTORS) is the UK's biggest prospective, longitudinal, cohort study of treatment outcome for drug misusers. It monitored the progress of clients (over five years) recruited into one of four treatment modalities which were delivered in either residential or community treatment settings.

The NTORS five-year review[1] found that "length of time in treatment has been found in many studies to be one of the most consistent predictors of favourable post-treatment outcomes among drug misusers. Our more detailed analyses of the data have shown that time in both the residential treatments, and in methadone maintenance is predictive of superior outcomes." The researchers recommended that clients should be encouraged to remain in treatment of sufficient quality and intensity for it to exert positive change.

NTORS established the critical time in longer-term treatment (such as methadone maintenance and residential rehabilitation) as 90 days, and found that clients who stay in treatment for the critical time had better outcomes – five times less likely to be using heroin, three times less likely to be using stimulants, as well as substantial reductions in acquisitive crime, injecting drug use and drug selling – than those who dropped out before the 90 days[2] (the critical time for shorter-term drug treatment, such as inpatient detoxification was given as 28 days).

DATOS (Drug Abuse Treatment Outcome Studies)[3] was a 12-year collaborative national research programme for evaluating the effectiveness of drug treatment in the US. It used 96 treatment programmes in 11 large US cities to reflect typical drug treatment services available to the public. Some of the key findings from DATOS on client retention were:

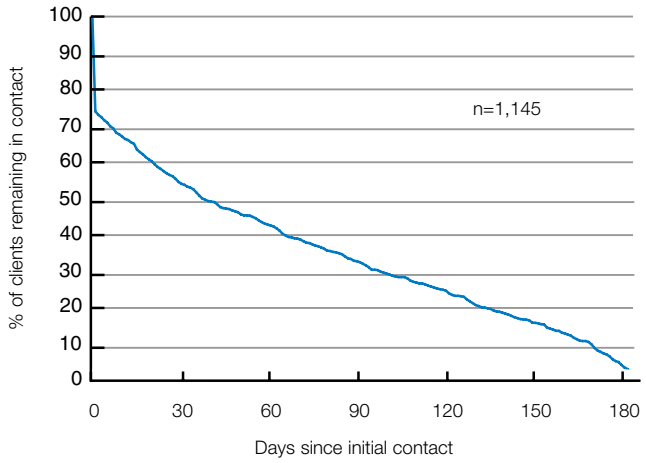
- In methadone maintenance treatment, clients who remained in treatment for a year or longer were four times less likely than early dropouts (i.e. treated under three months) to use heroin weekly during the one-year follow-up.
- In long-term residential treatment and outpatient drug-free treatment, clients who remained in treatment for three months or longer had significantly better follow-up outcomes on a variety of criteria than early dropouts (i.e. treated under three months). In both modalities, post-treatment outcomes continued to improve as treatment retention increased.
- Clients with longer stays in long-term residential treatment (three months or more) and methadone maintenance (12 months or more) had significantly better follow-up outcomes.
- Several indicators of higher quality treatment delivery – most notably better client-practitioner relationships, providing a wider range of services, and higher client satisfaction with the programme – characterised programs with longer treatment retention rates.

Data analysis carried out for the NTA by the National Drug Evidence Centre (NDEC) at the University of Manchester in 2004, looked at how a specific sample of 2,616 clients were retained in drug treatment services (49 specialist community drug services and 100 GPs) in the North West region over a six-month period (April to September 2001). The analysis looked at key factors influencing retention. A briefing on this piece of work has been published by the NTA[4] and is available from the NTA website.

Some of the key findings were:

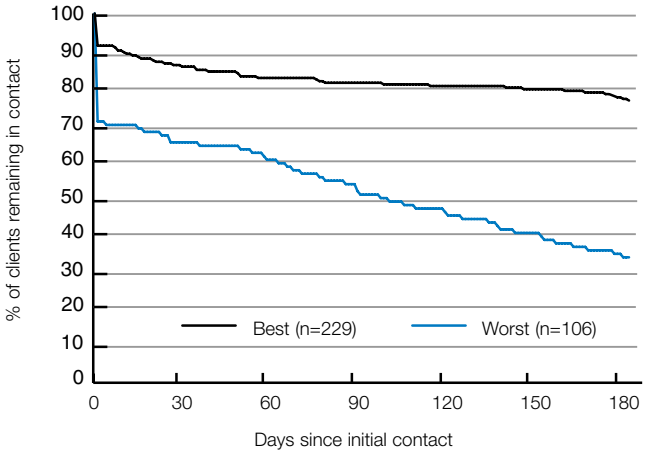
- Just under half of the total group (44 per cent) had lost contact with treatment services within six months, without completing their treatment. Of these clients, 48 per cent were known by the service to have dropped out or left, 24 per cent left for reasons not known to services and 11 per cent had been imprisoned.
- Twenty-six per cent of clients who dropped out of treatment did so immediately after initial demand for treatment. The majority of these early drop-outs (76 per cent) occurred before treatment had started.

Figure 1: Dropout rates over six months (NDEC, NTA 2004)



- Factors found not to affect retention were: ethnicity, type of drug misused, whether the client injected or not and whether the client had been using methadone at the time of presentation for treatment. Factors found to be associated with early dropout from treatment were: age (younger clients drop out earlier), gender (males are 1.5 times more likely to drop out), treatment experience (those with no experience are 1.7 times more likely to drop out), and referral route (those referred from the criminal justice system are 2.7 times more likely to drop out).
- Service factors were found to be the most important factor in client retention, as clients at the "worst performing" service were 7.1 times more likely to drop out than those at the "best performing" service. Figure 2 shows the client attrition at the "best" and "worst" service.
- At the "best performing" agency, only nine per cent of new entrants to treatment dropped out in the first two weeks, and 24 per cent dropped out in the first six months. At the "worst performing" agency, 29 per cent had dropped out in the first two weeks, and 63 per cent had dropped out in the first six months.

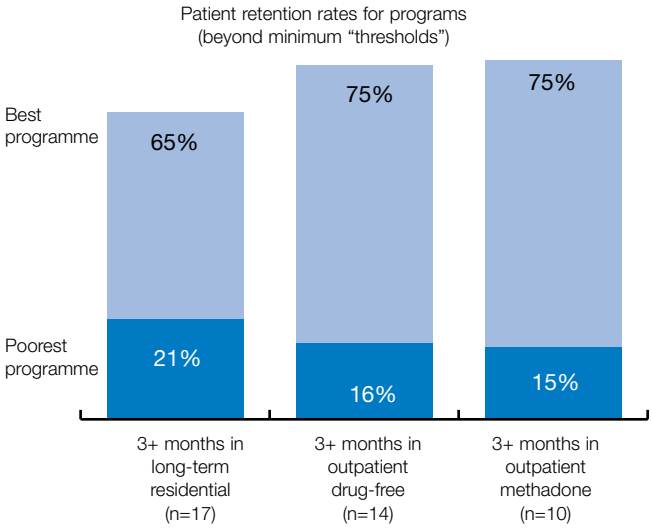
Figure 2: Client attrition at the "best" and "worst" performing services (NDEC, NTA 2004)



Although other factors affect client retention, highlighting the difference between "best" and "worst" performing services gives an indication of how much difference individual "service factors" can make in retaining clients. This guide aims to provide advice and information to help services consider how they can improve their practice and retain more clients in treatment.

Service factors were also found to be the key factor in treatment retention in American research. Research from DATOS found large differences between the "best programs" and the "poorest programs" on the key indicator of retention in three main treatment types, as figure 3 shows.

Figure 3: Retention rates from DATOS research 1997



The latest data from the National Drug Treatment Monitoring System (NDTMS) can be used to show current trends in client retention across the country. Figure 4 shows the percentage retention rates for the year end 2004/05 for each DAT in England (DAT names removed). Similarly to the data for services above, there are huge disparities between areas where services are retaining clients well and those where they are not.

Figure 4: Percentage of discharged clients retained in treatment for 12 weeks or more by DAT, 2004/05 (provisional NDTMS data)

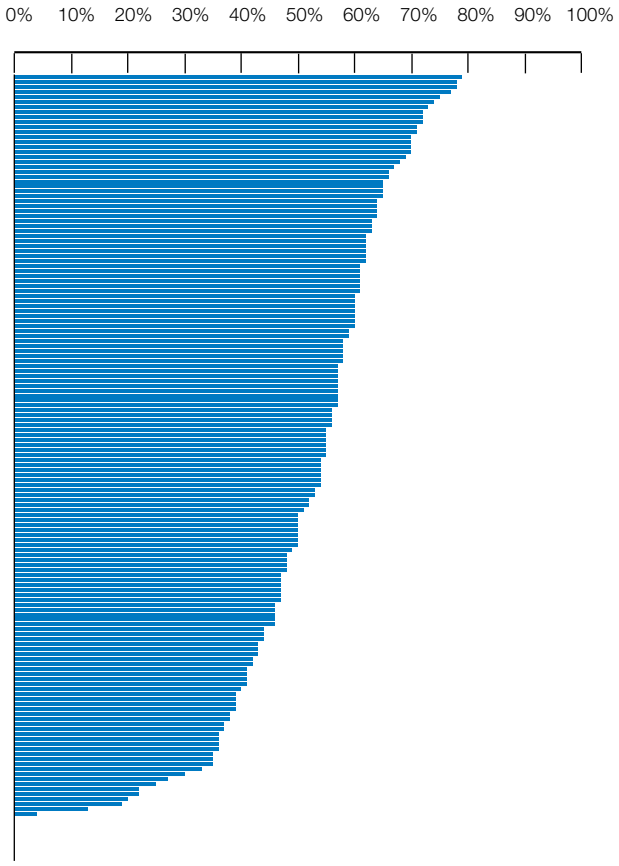
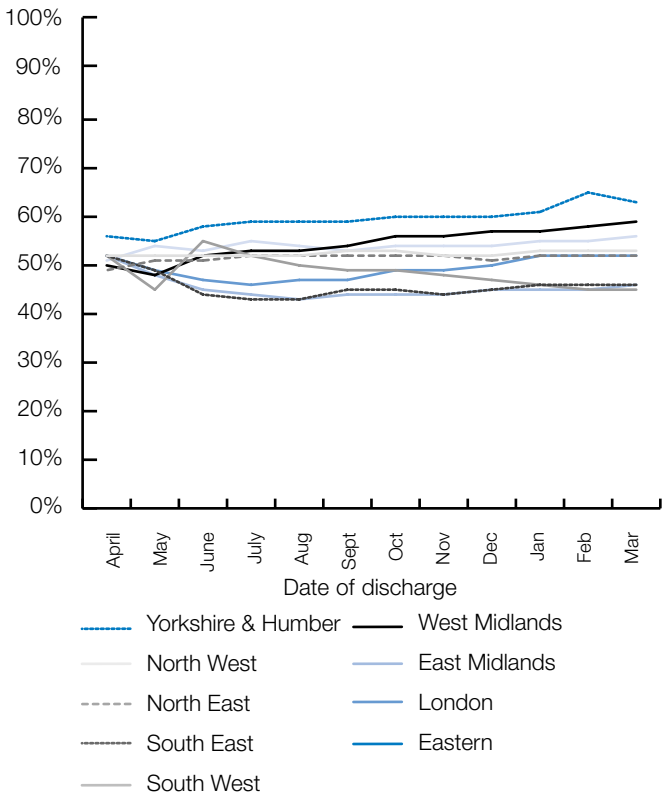


Figure 5: Retention rates by region 2004/05 (provisional NDTMS data)



The NTA's treatment effectiveness strategy

This section is a summary of the NTA's treatment effectiveness strategy, which is the basis of the NTA's business plan for 2005/2006, and was launched in June 2005.

The treatment effectiveness strategy identifies some of the critical success factors to improving drug treatment, and bases a delivery plan for 2005-08 on them. The success factors fall into two main groups:

- improving clients' journeys through treatment
- improving local drug treatment systems.

The strategy is designed to deliver a more dynamic treatment system by focusing on service users' treatment journeys, together with a focus on individuals' holistic needs (including housing and employment) to maximise the benefits of treatment.

Improving clients' journeys through treatment

Waiting times: the NTA will issue guidance setting new waiting times including three weeks for those voluntarily seeking treatment and faster access for priority groups. There will be a local investigation if service users wait longer than six weeks.

Retention: retention in structured drug treatment has been built into mainstream health performance management systems as described above.

Treatment delivery

The critical success factor in delivering improvement in clients' lifestyles is good care planning and frequent review of care plans with clients as partners in the process. The NTA wants to see all clients in treatment with an identifiable written care plan which tracks their progress and is regularly reviewed with them.

Improving treatment completion and/or community integration

For clients who wish to be drug-free, treatment systems need to be better configured to create better exits from treatment (including housing, education and employment opportunities). In addition, for clients who wish to be maintained on substitute opiate medication, drug treatment systems should also be well integrated into other systems of care and social support. They should provide them with opportunities to receive social support, education and employment where possible.

Improving commissioning

Four critical success factors that have been identified as key to improving local commissioning partnerships are:

- local commissioning partnerships linking with relevant local strategic partnership groups
- better local needs assessments
- development of local workforce strategies
- local commissioners enabled to performance manage drug treatment systems with clear routes in, through and out of drug treatment.

Improving service provision

Four critical success factors that have been identified as key for drug treatment services providing best quality drug treatment are:

- ensuring providers have a competent workforce
- ensuring service users can work with the diverse needs of their service users
- ensuring drug treatment is evidence-based and underpinned by good audit or clinical governance mechanisms
- drug treatment services are managed using real-time data provided from the NDTMS, and client satisfaction and client outcome data.

For more detail on the NTA's treatment effectiveness strategy, see the NTA website at www.nta.nhs.uk.

Key references

The section called 'Improving retention in treatment' sets out some of the key issues associated with retention in drug treatment, looks at UK and international research evidence of the effectiveness of some methods of improving retention, and gives some pointers to how services could improve their client retention. The document is not intended to be a literature review on the subject or a comprehensive summary; rather it looks at some widely available research reports and provides a summary of some key ideas.

Although all the relevant research papers are referenced in the document, it is not expected that busy treatment service managers and practitioners will necessarily have time to look at the wide range of research papers on retention in treatment. However, there are a number of easily accessible sources of summarised research evidence on the subject, in particular *Drug and alcohol findings* magazine, which has a number of articles across its issues on retaining clients in treatment. Highly recommended reading on the subject of client retention is the *Manners matter* series, in issues 11, 12 and 13 (forthcoming). Information on *Findings* back issues and subscriptions can be obtained from the *Findings* website at www.drugandalcoholfindings.org.uk

Other useful and easy to access sources of information on retention can be found in:

- NTA research briefings. Available from the NTA website at: www.nta.nhs.uk
- The NTA's treatment effectiveness briefings. Available from the NTA website at www.nta.nhs.uk
- Research summaries produced by the Institute of Behavioural Research at Texas Christian University. Available from the TCU website at www.ibr.tcu.edu
- The US Drug Abuse Treatment Outcome Study (DATOS) www.datos.org
- The National Institute on Drug Abuse (NIDA) www.nida.nih.gov
- NTORS reports available from the Department of Health website www.dh.gov.uk.

The forthcoming evidence-based review of drug misuse treatment (which will be published alongside the revised *Models of care for drug misusers*) will also be a useful resource for services looking at implementing evidence-based treatment to improve retention and client outcomes. Further information on this document will appear on the NTA website when it is published.

Full lists of references and resources are at the back of this document.

Improving retention in drug treatment

Introduction

This section gives a guide to how services can improve outcomes by improving client retention in treatment. The guide is based on research which has been drawn together from a number of sources, including international research, NTA research briefings and expert groups which were part of the treatment effectiveness project.

The recommendations are grouped into the following broad areas, which set out some of the issues involved, highlight some of the research evidence base and give some pointers on how services may improve client retention:

- helping clients to engage with drug treatment – including the first contact with treatment and engaging clients once they have made contact
- building therapeutic alliances – the importance of the client/practitioner relationship and establishing this early in a client's treatment
- responding to the full range of service users' needs – dealing with them as a whole person
- getting the dose right – for clients receiving substitute prescribing treatment
- involving service users in their own treatment.

Helping clients to engage with drug treatment

Why it is important

It is important that treatment services make the most of their first contact with clients.

The Audit Commission report *Drug misuse 2004*[5] highlights the importance of clients finding services welcoming and non-judgemental, as drug users cite attitudes of staff as a major reason for not continuing after starting treatment. The report states "It is crucial that frontline staff who have first contact with a drug user (including receptionists) are fully aware and have the skill to respond effectively to their fear, uncertainty and low self-esteem". Barriers to users entering treatment include "denial, stigma, fear of exposure, low self-esteem and peer pressure to continue". These need to be overcome by treatment services.

Feedback from service users has regularly described instances where people were motivated to enter a treatment service, but were immediately discouraged after entering the service by an unhelpful reception. As a result, the importance of receptionists and other front-line staff in service delivery should not be underestimated. It is also thought by service users that a poor physical environment in a treatment service can be a disincentive, e.g. services which are not equipped for disabled people, and where there is no discrete place for clients to give their personal details to treatment staff.

After a client has been assessed, it is important that they continue to engage with the treatment service they have been referred to. As the client will often have to wait, even if only for a short time before entering the treatment programme, the management of waiting lists is an important issue for treatment services to consider.

What works

There are a variety of initiatives that have been shown by research to assist in enabling services to make the most of first contact and stop client attrition in the first few days after contact. Little research has been done in this area in the UK, but there have been a number of studies in the US, and a number of these studies have focused on alcohol treatment. Initiatives that have been demonstrated to improve engagement and retention are set out in the following key areas:

Encouraging reminders

Research has shown that encouraging reminders (letters and telephone calls) to clients can help to improve retention, particularly before the first treatment session. If a client has to wait to enter treatment, keeping in touch with them by sending personal and encouraging reminders, has been shown to increase treatment engagement and retention. Any reminder can help, but the effectiveness of the reminder is enhanced by making it more personal, motivating and encouraging. Personal, welcoming reminders are also important in helping to keep a client engaged and has been shown to assist in encouraging clients who have dropped out back into treatment. US studies on this issue have shown positive results – examples are outlined below.

- A Massachusetts alcohol clinic saw a tenfold increase in patients returning from off-site detoxification through issuing them with a handwritten letter expressing concern and desire for the person to return.[6, 7]
- Social workers in New York halved early dropout at an outpatient alcohol clinic by persistently sending letters to people who had missed appointments. The more personal the approaches to reminding clients, the better the results have been.[8]
- A California alcohol clinic found that phone calls to people who had dropped out of treatment were more effective than letters, but also that personalised letters were more effective than standard ones.[9]
- A Florida treatment centre for young people with substance misuse problems compared phone calls to the parent and child a few days before the first and second sessions – one set of calls just provided information, the other was motivational, individualised and interactive. The information

calls improved initial attendance to 60 per cent (from 45 per cent) but the motivational calls improved initial attendance to 89 per cent. Overall attendance was improved by roughly the same degree.[10]

- Encouraging reminders have also been shown to improve attendance at aftercare services,[11] and in some instances, may be of benefit on their own.

Motivational interventions

Motivational interventions to encourage engagement with treatment have been shown to be useful for both users of heroin and cocaine. An Australian study[12] of amphetamine users showed that motivational interviews led to better outcomes (twice as many not taking amphetamines as those who did not receive the motivational intervention). A US study[13] showed that motivational interventions for cocaine users increased the completion rate for detoxification. However, it should be noted that the evidence for the effectiveness of motivational interviews is less strong for clients who are already motivated, and for people who are living in difficult circumstances.[14] For some clients, intensive case management, including advocacy, monitoring progress and helping to remove obstacles to treatment, has increased treatment uptake.[14, 15, 16]

Quicker entry into treatment

Waiting can be demotivating for people seeking drug treatment, and early initiation of treatment after first contact can mean that fewer clients drop out in the early stages of treatment. A US methadone programme[17] accelerated its assessment so clients could start on methadone within 24 hours. Only four per cent of these clients failed to make it to the first dose, compared to 26 per cent when assessments took the usual two weeks. Other US studies have had similar results.

Quick entry into talking therapies has also showed good results, for instance:

- In a US community drug service, 56 per cent of clients (mainly stimulant users) who were asked to come in for an appointment as soon as possible turned up, compared to just nine per cent of people who were given an appointment ten days later.[18]
- A US outpatient clinic for cocaine treatment found that clients offered next-day appointments after initial contact were four times more likely to turn up than those given an appointment three or seven days later.[19]

Fast entry into treatment has been found to help with initial treatment engagement, but there is not a strong link between rapid entry and retention in treatment. Research on the effects of waiting times on retention is much more equivocal. Some UK research[20] has found that shorter waiting times are linked to longer stays but this is not a consistent finding. Other UK research[21] showed that waiting times for treatment (following assessment) did not predict uptake of treatment or retention in treatment at three months and six months, and that the service itself has a greater influence on uptake and retention than waiting times. However, rapid entry into treatment rarely leads to early dropout from treatment. The main issue is how services deal with clients on their waiting lists, and encourage them to stay engaged with the treatment agency.

Client induction

In US research,[22, 23] one initiative that was successful in engaging clients in treatment was the role induction intervention to clarify what will happen in treatment and what will be expected of the client, dealing with concerns and misconceptions. Another study found that just 15 minutes clarifying client expectations from outpatient treatment resulted in a 40 per cent increase in clients returning for the first session.[24] Modified induction procedures have also been shown to be useful in residential treatment – a US therapeutic community developed an interactive readiness training course, which led to more positive client attitudes and improved retention and outcomes.[25] Another US study showed that senior staff helping to induct clients into a residential service led to an increase in retention.[26]

Client escort

Some research has shown that providing an escort can be a useful way to ensure that a client does not drop out in transition between referral and treatment or between referral sites. A US study showed that enrolment of clients moving to an aftercare service from a drug detoxification unit improved by 32 per cent by having someone to escort them.[27] Another US study at a prenatal clinic for pregnant drug users found that escorting clients to appointments was the only way to ensure initial attendance.[28]

Pointers to improve retention

- Services should keep in contact with clients while they are waiting for structured treatment, to provide information and updates on the length of the wait – this can take the form of regular phone calls or text messages. During this time, the service should also consider giving advice and information on other support services (e.g. drop-in services, induction/preparation, group support, referral to wraparound services such as housing, assistance with finances). Furthermore, as users will generally continue to use drugs whilst on waiting lists, the service could provide harm reduction services to people waiting for treatment, including needle exchange, advice on safer injecting, hepatitis B vaccination and hepatitis C screening.

- Services should contact clients before treatment appointments – particularly the first appointment – to give them an encouraging or motivating reminder to attend the treatment service. This could take the form of a letter, phone call or text message.
- Services should use motivational interventions, including motivational interviewing, to help clients engage with treatment. Motivational interventions can be provided around initial assessment sessions, particularly for clients who are reluctant to enter treatment, or who may have re-entered treatment after dropping out.
- As part of an initial engagement session, services may also wish to provide clients with information about what happens in treatment and provide safety interventions such as training on avoiding overdose.
- Effective treatment induction processes can help clients to sustain the motivation to enter and remain in treatment. Time should be set aside and specific activities or sessions arranged to induct the client into treatment, by explaining how the service operates referral and assessment processes and providing all relevant information. Induction should be done by experienced staff, or even service management.
- Services can explore the possibility of escorting clients to appointments to see if this helps engagement and retention.
- Users and carers have voiced support for a buddy system to provide a friendly face to new clients and explain how the treatment works. Buddies could be current or ex-service users who could be paid for their work. They would assist new service users, and could help to challenge any negative perceptions of treatment services they may hold.
  This system could also be linked to existing users' groups or forums.
- Services could provide training for reception staff and to other staff who act as the first point of contact in treatment services to deliver an appropriately encouraging welcome to all clients and callers. This may involve inclusion of reception staff into the work of the treatment service team (if not already included) so they understand the issues involved in accessing treatment, and are regarded as a key integral element of the treatment service.
- The physical environment of treatment services may need to be improved to help clients feel more comfortable. Services should provide information and advice (leaflets, posters etc.) to appeal to a wide range of people. Services should be aware of their responsibilities under the Disability Discrimination Act (1995) and pay particular attention to facilities for disabled clients, so that the service environment is suitable for access to all available services. If this is not physically possible, the agency must have clear policies about what alternative services should be provided – possibly in different locations.
- Services should follow up people who have failed to attend or dropped out, offering them a chance to re-engage. It may also be helpful to collate the reasons why people failed to engage or dropped out, in order to change systems if indicated.

Key references

- The power of the welcoming reminder: manners matter part 1, *Findings*, issue 11
- Can we help? Manners matter part 2, *Findings*, issue 12
- Motivational interviews as a standalone or treatment, *Findings*, issue 8
- *Outcome of waiting lists study: waiting times for drug treatment – effects on uptake and immediate outcomes*, NTA research summary, April 2005
- *Engaging and retaining clients in treatment*, NTA Research into Practice briefing 5

Drug-using parents with children

Why it is important

There is some evidence (*Drug misuse, 2004*) that some drug-using women who have children were reported to be reluctant to engage with treatment services because of fear that their children will be taken away. Services have been perceived as giving inconsistent advice on this issue and this has resulted in some women not engaging in treatment until their drug use has become very problematic.

Survey work carried out as part of producing the ACMD report, *Hidden Harm* (2003) found that 53 per cent of all specialist treatment services, social work services and maternity units offered services for clients who had dependent children. Only 31 per cent provided services for the children of drug-using parents and 30 per cent reported that they offered training to staff in working with clients with dependent children.

What works

Help with children

A major obstacle to some clients (particularly women) engaging and being retained in treatment is the provision of childcare. There have been a number of US studies in this area. One study[29] found that the provision of childcare at a counselling service helped retention to beyond five months, for women for whom childcare was important. If childcare was not provided, women left treatment a month and a half earlier. Another US study[30] in a residential rehabilitation centre found that with their children, 55 per cent of women completed treatment, but without, only 11 per cent did. Similar results have been found in other residential studies.

Pointers to improve retention

- There should be services available that cater for substance misusing parents who have children, if there is a need for them in particular areas. If no such services are available locally, this may be a commissioning issue for the DAT.
- Drug treatment staff should receive training on the issues regarding women in treatment with children. This should include a specific focus on how to assess and meet the needs of clients as parents and their children, as recommended in *Hidden harm*.
- There should be locally agreed policies (between the DAT and the area child protection committee) on when and how social services are involved, and these policies should be widely communicated with service users so they know what to expect.
- Drug treatment services should ensure that they have policies which encourage retention in treatment of clients with children, and that there is clarity with the service user on what they should expect.
- Support services for clients with children should be in place, such as facilities available for children (e.g. creches), financial assistance with childcare costs enabling the woman to attend and women-only sessions.
- Drug treatment services should have effective local inter-agency relationships, linking with agencies and groups such as family planning services, maternity services, social services and area child protection committees.
- Have support from user groups, with women with children who have been through the system.
- Services support family involvement in drug treatment – processes and resources in place to enable this.

Key references

- *Drug misuse 2004* (Audit Commission, 2004)
- *Hidden harm: responding to the needs of children of problem drug users* (ACMD, 2003)
- *Getting our priorities right: good practice for working with children and families affected by substance misuse* (Scottish Executive, 2002)
- *Supporting families and carers of drug users* (Scottish Executive, 2002)

Black and minority ethnic drug users

Why it is important

A review of the literature on drug misuse and related service provision for Black and minority ethnic (BME) communities in England, states that "it is clear that consideration of the drug service needs of BME groups is urgently required so that these services can improve delivery, retention, and outcome to all members of the communities they serve." [31]

The literature review sets out a series of perceived barriers to accessing drug treatment by BME drug users. These include lack of acknowledgement of drug use by BME communities, ethnicity of staff (the solution is more complex than just employing workers who are from the same ethnic group as their clients), lack of understanding of BME cultures by drug treatment staff and managers, language barriers (including a lack of drugs and drug treatment information in different languages, and lack of availability of translation), and lack of awareness in BME communities of drug services and their functions.

What works

Some US research[32, 33] has found that culturally-competent and culturally-responsive treatment and programme development are often associated with greater treatment retention and longer time in treatment.

It is acknowledged that there is a lack of research into the retention rates of BME clients, particularly in the UK. *Models of care* suggests that there should be research to investigate rates of retention in treatment among BME service users. The literature review supports this and better assessment of BME need of drug treatment. Some pointers however can be made which take in the broad principles of some of the evidence base available.

Pointers to improve retention

- Services need to take into account language issues when they have contact with BME clients whose first language is not English. They will need to consider providing treatment information in the appropriate language, or providing interpreters who have knowledge of drug treatment issues.
- It is important in non-ethnically or culturally specific drug services that staff are culturally competent in working with people from different ethnic groups, and understand and are sensitive to differing cultural, ethnic and religious needs. Cultural competency in staff should lead to better therapeutic alliances. This is particularly relevant in areas where there is a higher BME population. In these areas, commissioners should consider the possibility of specialised BME services.

- Engaging the community – some of the literature on BME service provision stresses the importance of involving the community in drug treatment, to raise awareness, determine need and help develop and run treatment services. This has been found to be useful in some areas in increasing numbers in treatment[34] and may also be useful in retaining clients.

Key references

- Can we help? Manners matter part 2, *Findings*, issue 12
- *Drug misuse 2004*, Audit Commission, 2004
- *Black and minority ethnic communities in England: a review of the literature on drug use and related service provision*, University of Central Lancashire/NTA (2003)

Building therapeutic alliances

Why it is important

The relationship between the client and the key worker/practitioner – usually referred to as the therapeutic alliance – is one of the most important factors in enabling the client to be retained in treatment. Research on treatment retention has consistently underlined the importance of this relationship to the extent that it is as important as the actual treatment regime delivered to the client. It is also important that therapeutic relationships are established early in the client's time in treatment. The first few weeks can be crucial as early experiences can influence confidence in treatment, even as far as three months in. It is thought that the therapeutic alliance is an important factor in the differences in retention rates between the agencies that are good at retaining clients and those that are not.

Service users have also consistently emphasised that the most important thing in treatment to them is the practitioner-client relationship. They want this relationship to be a partnership marked by honesty and respect and mutual negotiation over treatment, and not to feel that the practitioner is trying to exert control over them.

US research[35] has shown that the more commitment a client has to the treatment programme, the more confidence they will have in the treatment service and the better the relationship with their key worker will be.

What works

Therapeutic alliance

Most of the research studies in this area are from the US, and they suggest that the therapeutic alliance has a very important impact on retention and treatment outcome. This relationship is an important factor in a client's ongoing motivation to continue in treatment. It is important that the client feels that they are being understood by the practitioner, that the practitioner is knowledgeable and supportive, and that empathy exists between them.

Even in methadone treatment, where getting the dose of substitute medication right is considered to be of high importance, the keyworker/client relationship can make a significant difference to outcomes.[36] An example is a US study in a methadone clinic where it was found that regardless of dose, the choice of practitioner a client was allocated had a significant impact on retention and illegal opiate use (e.g. 11 per cent positive urinalyses for one worker compared to 60 per cent for another).[37] The DATOS study showed that motivation was affected by early relationship with the practitioner. The relationship has two elements – the quality (i.e. feeling rapport and confidence in the treatment) and the amount of opportunity the relationship has to have an effect (e.g. number of sessions, and addressing a range of client needs).[38]

A study at a Los Angeles counselling service for crack and amphetamine users found that for women, the key factor that influenced the therapeutic alliance was the feeling that the counsellor cared for them, whereas for men the important factor was how helpful they had been.[39, 40] For both men and women, a feeling of being understood was also important.

A UK study[41] at an alcohol treatment service has shown that service users are more likely to attend treatment regularly if the practitioner felt they liked the client and was optimistic about working with them, and if the client felt that the practitioner was understanding and empathetic.

Clients' commitment to treatment

Some US residential rehabilitation services found that client commitment was promoted by using resident groups as a therapeutic tool. For non-residential services, early responses to a broad range of the client's needs were found to generate their confidence in the programme.[42] Appointments that are too frequent can be a disincentive, especially if transport is a problem. Other initiatives which have been found to be useful in promoting client commitment include:

- For residential services: senior staff inducting residents into therapeutic communities; services that clearly communicate their policies to residents and involve them in running the programme; creating a supportive environment where residents feel free to express themselves; providing practical inputs such as employment training.[43]
- For non-residential (methadone) services: practical assistance (e.g. childcare); a diagram technique called node-link mapping, which depicts the client's problems and the solutions to these problems, has been shown to help when a client has difficulty in communicating with the therapist; schemes which reward engagement show improved outcomes – this also works for attendance at aftercare services.[44, 45] Also in methadone services, recognising and rewarding signs of client engagement improves outcomes.[44]

Some drug treatment agencies have found employing contingency management systems useful, even for non-responsive clients. These systems, mainly used in the USA, provide disincentives to continue drug misuse and incentives to continue in treatment and reach set outcomes. A number of methods have been tried, and both positive and negative reinforcers have been used (e.g. monetary or voucher privileges).[46, 47] Positive and negative reinforcers were found to be equally efficacious in reducing drug use, however using positive reinforcers were more likely to lead to retention in treatment for longer periods.[48] In trials, both staff and clients have found this approach useful and it has been shown to improve staff-client relationships.[49]

Pointers to improve retention

- Practitioners should focus on their initial relationship with clients (particularly poorly motivated ones) to improve outcomes. Services should be aware of the relationships between individual drugs workers and clients, and regularly monitor how effectively they are being developed. This can be done by carrying out client satisfaction surveys, or by asking the practitioner to assess the rapport with the client, or asking the client to feedback on their rapport with the practitioner. If the relationship is not working, there is a risk that the client will drop out of treatment; therefore the service should explore alternative practitioners and other measures to ensure client retention. Services can also compare retention data between practitioners within the same team as an indicator to assist in individual and service performance management and improvement.
- Service managers should ensure that their treatment service provides suitable training to develop the skills of the staff, and a good working environment for the staff to enable ongoing motivation and commitment in the team.
- Services can help clients' commitment to treatment, if in the first few weeks they take steps to build up the clients' confidence and commitment to treatment – by forging good relationships, and giving positive responses to a range of client concerns.
- Client commitment to treatment can be encouraged by the development of the client-practitioner relationship. As part of this process, services should consider: how to create an environment where the client is comfortable and can express themselves; work out how to best meet the range of client needs, and provide assistance where necessary; and arrange appointments which are suitable to the client and easily accessible.
- Services should explore a range of tools that may be available to assist with building good relationships with the clients. Depending on the type of treatment service, methods such as resident groups, client induction schemes, node-link mapping and client reward schemes can be tried to test their effectiveness in building relationships and retaining clients.
- Some services may wish to give consideration to the use of contingency management approaches. As most of the literature on the subject is from the USA, care must be given to test what contingencies work in a UK system. Monetary and voucher incentives have been used to positive effect, including use with cocaine-using clients.[50] It may be useful if the reinforcers are easy to earn earlier in treatment, so that less motivated clients can have the opportunity to benefit.[49]

Key references

- The grand design: lessons from DATOS, *Findings*, issue 7
- The power of the welcoming reminder, *Findings*, issue 11
- Treatment staff matter as much as the drug, *Findings*, issue 2
- Client-receptive treatment more important than treatment-receptive clients, *Findings*, issue 3
- Ways to promote commitment: *Findings*, issue 7
- NTA *Research into Practice briefings* 3 and 5

Being responsive to the full range of clients' needs

Why it is important

As well as the crucial relationship between the individual worker and client, the general responsiveness of the service to the full range of clients' needs is very important, including how this is embedded in their policies, procedures, monitoring and evaluation. Good assessment and care planning is key to getting this right, as the service may not be able to meet every assessed need, but should be able to refer individuals to appropriate agencies which may be able to help, where this is available.

Drug misuse 2004 (Audit Commission, 2004) found that though the range of drug treatment services has improved since 2002, more choice, greater flexibility and responsiveness to drug user needs is still required, especially for people with complex problems.

Service users have often stressed that treatment services should be more responsive to the drug user's individual needs, and meet these needs wherever possible. They would like to see treatment services adopt a more active philosophy to "meet the needs of their customers", and that they should consult with them on appropriate service provision. Service users would also like to see flexibility around appointment times and service opening times; support services as part of treatment programmes, including family support and housing support; better responses to a range of drug problems (such as crack and other stimulant use); better co-ordination and service integration with other health and support services in local areas; and a wider range of psychosocial interventions.

What works

Service responsiveness

Services that respond to the wide range of their clients' needs will have better outcomes and be more successful at retaining clients. US methadone services that responded constructively to clients' needs, provided clients with the help they required and actively involved them in care planning, did much better in helping clients stay in treatment longer and achieve abstinence.[51] Similar results have been found in non-prescribing services, e.g. in a US outpatient service where clients stayed longer when vocational, transport and childcare needs were met.[29] When comparing clients who receive a broad range of services to those who just receive standard treatment, there are clear improvements in retention for the more responsive services.[52, 53]

Service flexibility

Service opening hours have long been the subject of complaints by clients, particularly those who are in employment, and those who also find regular opening times difficult to attend. A range of studies in methadone and alcohol outpatient services in the US and UK[54] have shown the benefits of flexible opening times in engaging clients in treatment. These and other studies have shown that inflexible and prescriptive programmes are likely to experience higher treatment dropout rates.

Transport for clients

Research has found that the further clients have to travel for treatment, the less likely they are to engage. A number of US studies done on this subject have illustrated how providing transport for clients helps with engagement and retention. One of the DATOS studies showed that after taking caseload differences into account, methadone patients were three times more likely to stay for a year at the clinics which offered drivers and vehicles than when no transport assistance was provided.[55] In a study at another US methadone service, clients were given bus tokens as part of an enhanced service. The clients on this programme were half as likely to exit treatment in the first three months as those on the standard programme.[56] A US counselling programme showed that clients who had received transport services showed better engagement in the treatment programme.[57] It was generally found that direct provision of transport was the best method of sustaining engagement in treatment. Reimbursing clients' transport costs gave no real gains, but providing transport costs up front fared better.

Pointers to improve retention

There needs to be a strong emphasis on the centrality of good-quality care planning, which clearly sets out how the care plan will be delivered and who will deliver each element of the care plan. The care plan should set out the client's treatment pathway through to aftercare. The clients need to know that they have a plan and can see how it helps them to move through the system. The revised *Models of care for drug misusers* (MoCDM) will have a greater focus on the importance and centrality of care planning.

Treatment services should have close working links with a range of other services which could act to provide support for clients in treatment:

- counselling and other services providing a range of psychosocial interventions
- family support/therapy
- a range of supported housing providers
- criminal justice interventions teams.

Drug treatment services should work in partnership with specialist employability agencies (e.g. Progress 2 Work) as well as mainstream education, training and employment services to help current and ex-service users to access education, employment and training:

- links with local authority Supporting People (SP) team and SP-funded projects offering housing and housing-related support
- explore new support opportunities e.g. training family and friends in support techniques
- agencies should consider offering access to services to help clients with financial issues (including benefits advice) so that they can address these issues while accessing treatment
- agencies could engage with a basic skills training agency to assist service users who require it, with reading and writing skills whilst accessing treatment. Some drug treatment agencies have incorporated this into their day and residential programmes.

Services should explore how they can be more flexible in meeting clients' needs. This may involve opening satellite clinics, changing opening times to enable more clients to attend, or allowing them a more flexible regime for attendance, appointments or dispensing medication.

Services should also consider whether directly providing transport or providing payment for transport (e.g. paying for bus passes) would help clients to engage and continue to attend treatment appointments. This may be of particular relevance to agencies which provide services to clients in rural areas.

Key references

- Can we help? Manners matter Part 2; *Findings*, issue 12
- DATOS review, *Findings*, issue 7
- *Engaging and retaining clients in drug treatment*, NTA Research into Practice briefing 5
- *Drug misuse 2004* (Audit Commission, 2004)

Getting the dose right

Why it is important

Although methadone maintenance treatment is one of a number of treatment modalities used to treat drug misusers, it is the one that is most widely used. An important part of methadone treatment programmes is setting the methadone dose for each client. Therefore the importance of getting the right dose for clients at the start of their treatment should be emphasised, as setting appropriate dosing levels can be a critical factor in improving methadone treatment outcomes. Based on national and international evidence, the Department of Health's *Drug misuse and dependence – guidelines on clinical management*, (commonly known as the "clinical guidelines" or "the orange book") states that for methadone maintenance "there is a consistent finding of greater benefit from maintaining individuals on a daily dose of between 60mg and 120mg (and higher in exceptional cases)". This is particularly relevant as there is some evidence that many drug treatment services in Britain are not routinely providing the minimum of the dose range identified as effective.

Effective buprenorphine prescribing is also dose related. Prescribing should take place within recommended good practice guidelines from the evidence base (such the Royal College of General Practitioners' *Guidance for the use of buprenorphine for the treatment of opioid dependence in primary care*, RCGP, 2004). It has been noted that some clients drop out early in buprenorphine treatment because of difficulties with dose induction.

Feedback from service user groups has regularly stressed the importance of getting the therapeutic dose right (including titration), and have made the point that treatment services should listen to the user's opinions on what dose works for them. Service users have also emphasised their desire for a range of available prescribing options (including buprenorphine and non-opiate prescribing options) and programmes that have an element of flexibility – i.e. allowing clients different dose levels as assessed to be appropriate, or allowing for an element of client relapse without punitive measures being taken against them.

What works

There is evidence from both the UK and the US linking methadone dose with retention in treatment (e.g. from NTORS and DATOS). This evidence identifies significant improvements (reducing injecting and illicit heroin use) in treatment outcomes among clients who stay in maintenance treatment for at least a year. Australian and UK research has shown a decrease in illicit opioid use and improvements in retention from higher maintenance doses.[58, 59]

US studies have shown the benefit of flexible dosing. One of these studies showed that methadone clinics that offered flexible doses were more successful in retaining clients than those offering fixed doses.[60]

There is emerging evidence to suggest that allowing service users to have input into setting their own maintenance dose will bring about improvements in retention and reducing illicit heroin use. A recent US study reported heroin use declining and the clients generally did not seek to raise their doses to excessive levels (averaging 80mg of methadone, and 90 per cent were under 100mg) when given control over the process.[61]

Pointers to improve retention

- Drug treatment services should operate according to *Drug misuse and dependence – guidelines on clinical management*, to ensure they are prescribing consistent with the dose range found to give greater benefit.
- Drug treatment services should have greater service user consultation as part of the prescribing process, and flexibility with clients in working to determine the ideal therapeutic dose for each service user.
- Drug treatment services should have clear policies on client relapse and drug use on top, which encourage treatment retention, whilst maintaining client safety. Services may wish to consider greater flexibility with clients in the early days of treatment, when they may be more likely to relapse.
- Drug treatment services should also have clear client induction procedures, which make clients aware of what the service's expectations are of them (e.g. use on top, prescription pick-up times), and are reasonable and enforced consistently and fairly. See also the section on client induction (page 11).

Key references

- *Drug misuse and dependence – guidelines on clinical management*
- *Methadone dose and methadone maintenance treatment*, NTA Research into Practice briefing 3

Enabling service user involvement

Why it is important

Service users have stressed that user involvement should be empowering and that they should be involved in all parts of the treatment programme, including service management. It is customary in some DATs to have user representation at DAT level in order to influence local treatment. There may be a role for current and ex-users to be involved in advocacy and advisory roles, and if deployed in such a way, they should receive the training and support to do so. Some users feel that too often services have structural obstacles to user involvement.

Drug misuse 2004, a report produced by the Audit Commission, states that "to harness the potential to change behaviour, service providers must appreciate a user's own view of the future and allow informed choice and opportunity". It acknowledges the importance of advocacy services and suggests that treatment staff should proactively promote these services.

What works

How organisations are run affects how fully they engage clients in the therapeutic process, and as a result how successful their experience of treatment tends to be. US studies have focused on residential services, and have found that the best services:

- communicate the ethos and details of their programme clearly to their clients and encourage client involvement in running the programme
- adhere to a distinct therapeutic approach with structured activities
- target client development
- have a supportive social environment where residents feel free to express themselves.

As far as an individual client's treatment is concerned, the key issue is flexibility and responsiveness in pursuit of shared goals between the practitioner and the client.[43, 44, 57, 62]

Pointers to improve retention

All services should provide access to effective user involvement programmes and user groups at all levels of the service. This could include:

- ongoing client satisfaction surveys, as part of standard needs mapping, to ensure regular monitoring of user satisfaction and need
- clear complaints procedures which are accessible to clients
- client involvement at all levels of the service: care planning, service planning and involvement in the board/management of the agency if possible
- promoting user groups and advocacy services available
- training for current and ex-users who want to be involved in advisory roles.

Services should examine policies, procedures and structures to assess obstacles, and allow for greater user involvement. The focus of the involvement should be empowering the service users to have some control over their own treatment, encouraging them to remain in treatment and achieve outcomes agreed with the service user as part of the care planning process.

Key references

- *Engaging and retaining clients in treatment*, NTA Research into Practice briefing 5
- DATOS review, *Findings*, issue 7
- *Drug misuse 2004*

Performance management of treatment retention

Retention in treatment – a new effectiveness indicator

Treatment retention is a new national indicator of effectiveness in drug treatment. In 2003/04, the NTA started to measure the percentage of clients who, at the time they were discharged, had remained in structured treatment for at least 12 weeks from the date of triage. This figure is the retention rate. Evidence suggests that most drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more, by improving outcomes such as reducing drug use, reducing morbidity and mortality associated with misuse, reducing crime and improving health and social functioning. Benefits include substantial financial savings within both the criminal justice system via reduced offending and the NHS through reduction in blood-borne diseases amongst drug misusers.

Improving the retention of clients in drug treatment is now an integral part of the NTA's treatment effectiveness work programme. Drug action teams (DATs) around the country have begun ensuring that their services improve retention rates and this will be an ongoing work in progress in these initial stages. Retention has already been incorporated into targets for DATs, primary care trusts (PCTs) and strategic health authorities (SHAs), as outlined below.

Retention targets

The LDP process for PCTs and SHAs

The number of people in drug treatment already contributes to the Healthcare Commission's star rating of PCTs, in line with the public service agreement (PSA) target to double the number of people in drug treatment between 1998 and 2008. In addition to numbers in treatment, targets for retaining clients in treatment have to be set locally by each PCT, as part of the local delivery plan (LDP) process.

The LDP contains all the Government's PSA targets on health, and is the key vehicle for a local area to set its priorities for improving health, developing services and involving local people in healthcare. The LDP also ensures that there are resources to meet all the key targets.

The PCT targets on retention will be aggregated with other PCTs within an SHA area to form their overall LDP target on retention. The SHAs will account for their performance against these targets to the Department of Health. In turn, the SHAs will performance manage the PCTs to ensure they meet their targets. All SHAs have to deliver a minimum retention rate of 54 per cent by 2006, and the retention targets set by PCTs must ensure year on year increases in drug users retained in treatment for 12 weeks or more.

Setting local targets for retention

SHAs and PCTs/DATs are responsible for setting their own targets for their area(s). However, there are parameters for these targets, and DATs have been advised that their plans for increasing the percentage of discharged clients who have been retained in treatment for more than 12 weeks must achieve:

- a minimum of 45 per cent retained by 2005/06
- a year-on-year increase in retention between 2003/04 and 2004/05, and 2004/05 and 2005/06, with anticipated performance between 51 per cent and 61 per cent retained. These relatively low targets are regarded as acceptable to take into account the higher proportion of discharges of less than 12 weeks which relate to some types of treatment.

On top of these targets, DATs and the NTA will agree local "stretch targets", which are intended to better reflect local situations and need (e.g. if the retention rate is already high, more appropriate local targets can be set), and the large increase in the pooled treatment budget from 2006/07. The PCT and SHA will then include these targets in their planning.

Details of local treatment retention targets are available from the website of local SHAs and/or PCTs. Website and contact details for these can be found at the NHS website at www.nhs.uk..

The DAT treatment plan

DAT partnerships have to set out their plans for year-on-year increases in the percentage of clients retained in drug treatment for more than 12 weeks in their treatment plans. If the DAT has more than one PCT in its area, a lead PCT will work with the DAT to set an overall retention rate target for the DAT area. DATs will be performance managed on these targets by the NTA regional teams.

Star rating of mental health trusts

Targets on retention in treatment will also contribute to the star ratings for mental health trusts, from 2005. Mental health trusts will have their performance assessed by the Healthcare Commission, using a number of performance indicators which show how the trusts are doing in relation to some key targets and other performance measures set for the NHS. The performance indicator on 12-week retention in drug treatment is part of the balanced scorecard indicators which have been chosen to provide an assessment across a broad range of healthcare areas. Inpatient detoxification and other services specifically commissioned to be completed in under 12 weeks are excluded from the 12 week retention target for trusts. The construction of the indicator, which details the measurements and data required, is set out on the Healthcare Commission's website at http://ratings.healthcarecommission.org.uk/indicators_2005.

Monitoring retention targets

As for numbers in drug treatment, treatment retention will be monitored using data from the NDTMS.

The NTA, in conjunction with the Department of Health, has issued two sets of guidance on developing treatment retention trajectories, in response to queries on this subject. The guidance is available at www.nta.nhs.uk.

Treatment retention and completion for LDP purposes has changed to a single measurement that gives an indication of the effectiveness of the local treatment system to minimise early dropout, as part of ongoing work to performance manage improvements in treatment effectiveness. Measuring the percentage of drug users discharged during the financial year who were retained in treatment for 12 weeks or more from the date of triage, focuses on the effectiveness of the local treatment system in engaging drug users and minimises early dropout.

DATs/PCTs and mental health trusts will have to monitor their retention rates regularly and review the need to make improvements to the system to increase the retention rate. Information on how to improve retention rates at a service level is included in the section 'Improving retention in drug treatment'.

Treatment retention - definitions

The detailed definition in relation to retention is: drug users discharged during the financial year who were retained in treatment for 12 weeks or more from the date of triage.

This measure gives an indication of early dropout which is known to impact negatively on treatment effectiveness and is defined as the percentage of clients/patients discharged during the year 1 April to 31 March, who were retained in treatment for a continuous period of 12 weeks or more, measured from the date of triage to the date of discharge.

Further details of the definitions are found in the Appendix.

Specific retention indicator issues

Since the introduction of the 12-week retention indicator, the NTA has received a large number of queries on this subject from people in the field. This section aims to address some of these issues and make the process clearer. Some of the issues and questions that have been raised are presented under representative headings.

Retention measured by client or by service

Issue: Most of the queries received have been on this subject. The issue is that a client can be in treatment for 12 weeks or more, but may not be at the same agency all this time. If the client is transferred to another agency before 12 weeks, this could be counted as a failure, even though the client is still in treatment. It has been argued that the proposed construction may penalise agencies that have implemented whole systems approaches recommended by *Models of care*.

Response: The PCT target is not aimed at services but at systems. As discussed above, the targets have been set at a low level to reflect the significant proportion of the treatment population who will transfer or complete within 12 weeks. Services directly commissioned to last less than 12 weeks (such as inpatient detoxification) are excluded from the 12-week indicator for mental health trusts.

Issue: It has been pointed out that some non-heroin-using clients may not have to be in treatment for 12 weeks to achieve positive outcomes (e.g. retaining a chaotic crack user for eight weeks may give health gains, but would count as a failure in the current construction).

Response: While it is true that there can be benefits from being in treatment for a short time, the evidence base is clear that similarly to clients with opiate problems, clients with crack/stimulant problems have better outcomes if they are retained in treatment for three months or more.[63]

Clients not discharged who are still in treatment

Issue: The new construction measures people *discharged* from services who have been retained for 12 weeks, and there will be clients who have not been discharged and are still being retained in the treatment service. It has been contested that to be meaningful and fair, and give consideration to total numbers of people discharged, the percentage calculation should be based upon the number of people discharged as a proportion of the total caseload. This may be an issue for areas where there is a relatively low throughput of clients in drug treatment.

Response: One of the main functions of the retention indicator is to measure client *attrition* from drug services. The issue of people dropping out of drug services is the one being focused on due to the vast disparities between the services which retain clients best and those which do not retain clients well. The aim is to improve the system so that all services have high retention rates.

Creating perverse incentives

Issue: Some correspondents have claimed that the 12-week retention target may create a perverse incentive to discharge people at 13 weeks, despite NTA recommendations that this should not happen.

Response: Drug treatment services want to provide the best possible service for their clients, and would not wish to discharge them prematurely, before their planned treatment programme was completed. If there are any areas where services are routinely discharging clients at 13 weeks, this will be easily identifiable from the data and questions will be asked regarding the suitability of the discharges. Some research has shown that even longer-term (up to one year) retention has more beneficial outcomes (e.g. with methadone maintenance programmes), and this may be something to be considered in the future.

Tensions between rapid access and retention

Some people have wondered whether there may be a tension between reducing waiting lists by having quicker access to treatment, and actively engaging and keeping people in treatment for longer. This is a treatment systems and throughput issue. At present it is not known what effect the 12-week indicator will have on waiting lists. However, it is clear that the treatment system is a finite resource and there may be other ways to sustain increasing numbers in treatment (such as suitable stable clients on prescribed interventions at specialist drug services moving into a primary care/shared care service provision which meets their (non-acute) treatment needs). This reinforces the need for local drug treatment systems to be established in local areas which allow for movement between providers.

Performance vs resources

There is a view in the field that greater performance will be required of mental health trusts this year (2005/06) without the additional resources that are coming next year (2006/07). However, there will be additional resources available – there is a mean increase of 18 per cent this year (2005/06) for DATs/PCTs. The least an area will get is an inflationary increase, and some areas will get well over 18 per cent. If resources to meet retention targets are going to be a problem for any services or areas, this is an issue to take up with local commissioners. The emphasis is on *more effective* performance, rather than greater performance.

Resources/further information on retention

Drug and alcohol findings **magazine**

Sample issues, articles and subscription information available at
http://www.drugandalcoholfindings.org.uk

NTA website:

- *Research into practice* briefings
- *Treatment effectiveness* series
- *Models of care*.

www.nta.nhs.uk

Department of Health

Clinical guidelines
http://www.dh.gov.uk/assetRoot/04/07/81/98/04078198.pdf

Texas Christian University (USA)

- List of key reports
- DATOS survey
- Research summaries
- Research roundup quarterly newsletter.

All available at: www.ibr.tcu.edu

NIDA – National Institute on Drug Abuse (USA)

http://www.nida.nih.gov

Scottish Executive Effective Interventions Unit

A range of publications is available at
http://www.drugmisuse.isdscotland.org/eiu/eiu.htm

The Network for the Improvement of Addiction Treatment (NIATx) (USA)

Includes resource centre and library
http://www.niatx.net

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Appendix

Measuring retention in treatment

The detailed definition in relation to retention is: drug users discharged during the financial year who were retained in treatment for 12 weeks or more from the date of triage. This measure gives an indication of early dropout which is known to impact negatively on treatment effectiveness and is defined as:

The percentage of clients/patients discharged during the year 1 April to 31 March, who were retained in treatment for a continuous period of 12 weeks or more, measured from the date of triage to the date of discharge.

This will be measured:

- at the point of discharge
- by the partnership in which the client/patient was resident at the point of triage
- over the latest episode if there is more than one episode of treatment in the reporting period, since this will provide a better picture of treatment effectiveness. An episode is a continuous period of structured drug treatment within a single provider which begins at triage and ends at discharge.

For the purposes of NDTMS the discharge date is defined as the date that the client was discharged ending the current treatment episode. If a client has had a planned discharge then the date agreed within this plan should be used and should be the last face-to-face contact date. If a client's discharge was unplanned then the date of last face to face contact with the agency should be used.

For the purpose of this measurement, 12 weeks is defined as 84 days (inclusive of triage and discharge dates). It will include:

- clients who were triaged before 31 March as long as at the point of discharge they have been in contact with the service for 12 continuous weeks or more
- clients who were retained in treatment for 12 weeks whether they successfully completed or not.

At this point retention can only be measured by episodes in individual services. In future years, it is anticipated that treatment effectiveness will be measured as a care pathway across services.

It is noted that under this definition a client could be assumed to be successfully retained in treatment at twelve weeks from triage having only actually started treatment a few weeks earlier. However, the most significant treatment dropout occurs during the first few weeks of engagement and is affected by the ability of the service to engage with the patient/client during any waiting period. Partnerships should ensure that they are aware of the triage arrangements and waiting times management for the local drug treatment system when looking at baselines and setting trajectories.

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