

Engaging and retaining clients in drug treatment

Methadone series

There is now substantial evidence on the effectiveness of methadone maintenance treatment. Research has also identified the factors that are likely to be needed to be in place to achieve optimal methadone treatment. Three briefings for drug treatment providers and commissioners have been produced on these factors:

- Methadone dose and methadone maintenance treatment
- Enhancing outcomes of methadone maintenance treatment with counselling and other psychosocial interventions and provision of 'ancillary' services
- Engaging and retaining clients in drug treatment

Engagement of service users in treatment, as well as their retention in treatment for a sufficient period of time, are key indicators for improved outcomes for drug misusers. This includes those requiring methadone maintenance treatment as well as other forms of intervention.

Rapid intake to treatment, motivational interventions, active intensive ongoing support, as well as practical measures to encourage attendance are all approaches that research suggests can impact positively on engagement. Factors such as empathic, positive staff approaches and flexible, responsive services have been associated with more positive outcomes for clients. The attitudes of the staff and key workers can also influence engagement of drug users in services positively. Poor response to treatment can be a legitimate response to poor treatment. Much depends on the therapy and the setting. But much also depends on whether treatment is delivered quickly after presentation, and with understanding and optimism.

This research summary suggests that practitioners and services have a wide range of responses available to minimise poor engagement and retention. The research suggests that low retention figures should appropriately lead to a review of the attitudes and characteristics of the service among other factors. The simple assumption that such problems are only due to poorly motivated drug users is difficult to sustain.

This briefing paper looks at the evidence relating to these issues and at particular approaches aimed at improving engagement and retention in treatment.

Key findings

- The full engagement of clients and their retention in treatment is key to achieving more positive treatment outcomes
- Rapid treatment intake after first contact with a service can lead to fewer early dropouts and does not jeopardise longer-term retention
- Services have a crucial role in promoting the full engagement of the client. Using screening or assessment as part of a motivational process aimed at encouraging the uptake of treatment is effective where motivation is the barrier. However, intensive, ongoing help is needed to promote treatment uptake when the problems are due to instability and lack of personal resources
- Reminder telephone calls or letters before scheduled sessions improve attendance rates personal approaches incorporating motivational elements (e.g. 'we are looking forward to seeing you') have the best results
- Once clients attend for the first time, specific activities and sessions designed to clarify the treatment process and to deal with concerns and misconceptions mean clients engage more fully. An empathic and positive style works best at this stage as well as throughout the treatment process
- The service provider agency's ethos has an impact on retention and outcome. The research evidence suggests that more positive outcomes occur within services that target the overall development of clients, are responsive to their needs as rounded individuals and that show flexibility and encourage client participation within clearly communicated and coherent treatment programmes
- In addition to achieving an adequate methadone dose, the relationship between client and key worker is important to effective engagement. Service users tend to engage more fully and do better when they feel they are understood and are given helpful and positive responses to their concerns
- Organisations and key workers who prioritise engagement have been shown to retain clients in treatment and achieve positive outcomes with service users considered to have a poor prognosis (due to the severity of their problems or their lack of motivation to enter treatment).

Research into practice briefings

These briefings commissioned by the NTA are summaries of the research evidence on a particular topic to help inform providers and commissioners of services. They are not NTA guidance but are aimed at helping providers and commissioners reflect on local service provision. It is important to note that UK-based research on the issues covered by this series of briefings is currently limited and many of the studies reported here have been conducted in the USA. How such research evidence, relating to methadone maintenance treatment, is appropriately applied to clinical practice in the case of individual service users is a decision for treatment services' team members. This should be applied in discussion with the service user taking all the relevant issues in to account. Clinical teams should work within clinical governance including clear protocols and regular clinical audit to ensure good practice.

1. Introduction

This briefing paper examines evidence for effective ways to improve engagement and retention in treatment and the evidence that has shown the importance of these factors in improving treatment outcomes.

There is now substantial evidence for the effectiveness of methadone maintenance treatment programmes¹². This is particularly the case where there is provision of adequately high doses (with average doses of 60mg to 120mg being particularly identified as demonstrating benefits). Other important factors suggested by research include flexible, individualised dosing regimes and responsive treatment services. Additional factors that contribute to improved outcomes include the use of counselling and other psychosocial interventions and provision of 'ancillary' services.

2. Research and policy context

There is no doubt that drug treatment services in Britain must work to develop their ability to engage and retain clients. The English National Treatment Outcomes Research Study (NTORS), which documented outcomes for a predominantly opiate-using population, shows room for much improvement. Retention times for residential services were short of those identified to be associated with the greatest post-treatment improvements. The times associated with these greatest improvements are at least one month for inpatient treatment and short-term rehabilitation and at least three months for longer-term rehabilitation. The majority (80 per cent) of clients in inpatient treatment left before this time, as did 36 per cent and 60 per cent respectively of those in short- and long-term rehabilitation.

There is a similar picture for methadone maintenance. In this type of treatment any unplanned termination carries a high risk of return to opiate misuse, but retention for at least a year is a recognised benchmark after which benefits are more likely to be sustained. In NTORS, 38 per cent of clients in maintenance treatment had left by one year and 58 per cent by two years. At both points the treatment leavers had worse outcomes. Similar findings emerged from the national US Drug Abuse Treatment Outcome Studies (DATOS). In that study, rates of unplanned exits varied widely, even within the same type of service seeing clients with a similar range of problems. This implies that US services also varied in their ability to retain clients.

Retention is just one dimension (the most easily measured one) of engagement. Fuller engagement may actually shorten time in treatment, or retention, because clients are ready to leave sooner. However, retention is generally a sign that clients are 'working the programme or treatment' actively. They are attending counselling sessions, talking about the things that matter, forging a therapeutic relationship with their key worker and/or other clients, and are getting extra help if needed^{3 4 5 6}.

Drug treatment services in Britain are meeting new challenges. New clients are channelled increasingly into treatment via the criminal justice system. These include the so-called 'hard to reach' crack misusers or poly-drug misusers. US research shows particularly high levels of unplanned exits by cocaine- and crack cocaine-using clients. Services in this country may also face major difficulties in engaging this client group, especially at a time when treatment response to crack cocaine use remains patchy. In England, almost a quarter (24 per cent) of new or returning clients seen by specialist drug services or GPs are using cocaine (or crack cocaine), and for seven per cent it is their primary drug problem. The crack/cocaine-related service load can be expected to rise. The Audit Commission report, *Changing habits* drew attention to the paucity of response to the needs of crack users, black and minority ethnic users and women, and to the lack of systematic understanding of their needs. It is also widely acknowledged that services may be particularly poor at engaging and retaining minority ethnic service users and that this issue must be addressed, not least in line with the requirements and the spirit of the Race Relations (Amendment) Act 2000.

The need to meet the challenge of improving engagement and retention has been emphasised by a new drug strategy target, which stipulates an increase in the proportion of clients completing or retained in treatment year on year. Drug treatment services will need to take active steps to improve retention if they are to meet this target and, at the same time, meet the target of increasing the numbers in treatment.

3. Making the most of the first contact

Across a spectrum of clients and treatment types, early initiation of treatment after first contact means that fewer clients drop out in the early stages without damaging (and sometimes improving) longer-term retention⁷⁻⁹. A US methadone programme accelerated its assessment so patients could start on methadone within 24 hours. Only four per cent failed to make it to the first dose compared to 26 per cent when assessments were spread over a fortnight¹¹. Also in the USA, an outpatient cocaine clinic found that clients offered next-day appointments after initial telephone contact were four times more likely to turn up than those scheduled to return three or seven days later.

Reminder telephone calls or letters before the first scheduled session improved attendance rates across several mental health sectors, including alcohol treatment¹²; the more personal the approach, the better the results¹³. When such efforts were made with calls to both parent and child, a study in Florida³ showed that the first-session attendance rates of parents and their substance-using adolescents was improved from 60 per cent to nearly 90 per cent; overall attendance also improved to roughly the same degree¹⁴.

Work to motivate treatment entry can be beneficial. This was shown in a study of Connecticut child welfare workers who faced the challenge of motivating substance misusing parents to enter treatment¹⁵. The standard 90-minute assessment was replaced with one that gathered the same information over the same time, and did so using a motivational interviewing style. It also sought to heighten awareness of drug-related problems and to forge an empathic relationship with the parent. The proportion who attended their first treatment session doubled from approximately 30 per cent to approximately 60 per cent; 13 per cent more stayed for at least three sessions.

However, client motivation is sometimes not the key issue or problem, and motivational work is not always sufficient. Some drug misusers living in difficult circumstances can feel a keen need to enter treatment yet are unable to follow it through. Brief motivational interventions, even when allied with offers of practical help, make little difference¹⁶. However, some interventions have been found to increase treatment uptake greatly in these cases. If very rapid entry cannot be organised, intensive case management may be required. This involves assignment to a personal 'minder' who advocates for the client, monitors progress towards treatment entry, and helps him/her to remove the psychological, social and practical obstacles to treatment uptake. Such interventions have been found to greatly increase treatment uptake in a proactive way¹⁷⁻¹⁹.

Modifying client induction procedures can promote commitment to treatment. It may be possible to prevent later drop out from treatment if induction procedures are started after the first contact of the client with the service, but before s/he enters treatment. 'Role induction' interventions seek to clarify what will happen and what will be expected of the client, allaying concerns and correcting misconceptions. One study showed that this worked best when it was specific to the particular therapy the client was to enter²⁰⁻²¹. Just 15 minutes spent clarifying client expectation from the outpatient therapy resulted in a 40 per cent increase of clients returning for their first therapy session²². Modified induction procedures can have a significant impact in residential services as well. In a therapeutic community in Texas for offenders who are drug and alcohol users the service developed a readiness training course consisting of highly interactive activities, exercises and games intended to lead residents to construct their own reasons for participating in treatment. As a result, service users felt that their counsellors and the resident-led meetings were more helpful, that they and others were participating more fully in the programme and that overall the treatment was more effective. These differences have improved retention and outcomes²³. Retention was also improved in another US study when senior staff helped to

induct voluntary residents into a therapeutic community. Intakes either only underwent the normal 30-day induction by junior staff or also attended three weekly 'seminars' led by the most experienced workers and intended to elicit and address each individual's particular concerns. The proportion of clients retained for at least 30 days increased from 62 per cent to 77 per cent, largely due to the response from clients who were the least motivated at entry and most likely to leave early (the impact of senior treatment managers on treatment outcome is discussed below²⁴). All these interventions aim to improve the quality of the very first interactions between therapists and clients, or between clients where the client group is the main therapeutic agent. A few studies have observed this quality dimension directly.

A British study at an alcohol treatment service reflects the US literature on drug dependent clients²⁵. Service users were far more likely to attend treatment regularly if, at the intake interview, the therapist felt they had liked the clients and was optimistic about working with them. The clients interpreted this response as warmth and respect for them as individuals. Engagement was promoted further if the client felt the therapist was empathic and understanding, and clients were far more likely to engage with therapists who generally scored higher on these dimensions²⁶. It is probably important that the same therapist who will continue to see the client conducts the intake interview. But, whereas continuity sometimes aids retention²⁷, this is seemingly not so when the client senses that the prospects for understanding and respect are bleak.

4. Involving service users

How organisations are run affects how fully they engage clients in the therapeutic process and, as a result, how well clients do. Studies carried out in the US have looked at residential services. They found that the best services communicate their policies to clients clearly, yet permit client involvement in running the programme. They also adhere to a distinct therapeutic approach with structured activities²⁸, target client development (psychologically, in their interpersonal and vocational skills and in their lifestyles), have a lower staff-resident ratio²⁹, and have a supportive social environment in which residents feel free to express themselves³⁰. The US DATOS study showed that a climate of absenteeism from resident group sessions tends to undermine confidence in, and commitment to, the programme, even among those who do attend. In non-residential treatment, absenteeism is less visible and was found to have no significant impact. However, early responsiveness to patient needs (expressed in referral to ancillary services) did seem to foster a climate that generated confidence in the treatment over the following months³¹.

5. Service responsiveness

Responsiveness is an important variable, partly because of its possible direct impact on problems, but also because it implies that the client is being cared for as a rounded individual. Nationally in the USA, services (especially methadone services) that tend to individually match clients to the help they need and formally involve them in their care planning have a better record in achieving abstinence³². In New York, patients stayed much longer at methadone clinics that responded constructively to their problems, for example by adjusting methadone doses and offering and arranging further help³³. A similar story emerges from studies of non-prescribing services. A study showed that entrants to nonresidential treatment in Los Angeles stayed longer when the vocational, transport and childcare services they wanted before treatment were actually delivered³⁴. Generally, the more services were matched to needs, the longer clients stayed and the services achieved the desired treatment outcomes. Comparison with a similar study in the same city suggests that it is not (or not just) whether housing, employment and other problems are resolved that helps improve retention and outcome. What does help is whether the treatment agency played an effective part in this resolution³⁵. Transportation was found to be influential in improving attendance of clients in US outpatient counselling services and particularly in methadone services, which typically demand daily attendance³⁶. Clients were more likely to attend if the service provided transport, whilst services that left the client to arrange their own public transport and reimbursed them did not improve retention.

6. Embedding responsiveness to drug service procedures

All the studies mentioned above observed the practices of services rather than changing them to see what happens, making it difficult to determine if outcomes were actually caused by factors such as responsiveness. A few studies have taken this extra step. The directors of four Philadelphia drug and alcohol services were asked to provide vocational, family or psychiatric services to randomly selected clients with severe problems in these areas. Other clients with similar needs received standard treatment. The study showed that responding to need systematically improved treatment retention (outpatient only) and completion rates. It also showed improvement in six-month outcomes, as well as a reduction in arrests and in the need for further treatment. Similar results were achieved by using the same system to identify need and by going further to meet those needs through case management. Clients who had been through these enhanced programmes were less likely need further addiction treatment within six months of leaving³⁷. Similarly, a study in Illinois set out to improve access and outcomes for women with children by providing them with a greater range of family, medical and social services and transportation. As a result, 14 months later, these women were much less likely to be using alcohol or illegal drugs³⁸.

Client choice is the ultimate in responsiveness and can be an effective tactic when what the service user wants is feasible and likely to correspond to what is needed. The clearest example is methadone dosage. Studies to date indicate that patient self-regulation of dose achieves better drug use outcomes than a doctor-decided inflexible regime, or one with a bias towards minimising doses. However, client choice does not improve on flexible regimes that prioritise drug use outcomes and client functioning and comfort, rather than minimising doses. In other words, what is key is flexibility and responsiveness in pursuit of shared goals, not in whose hands the decision nominally lies. All these studies suggest the importance of a treatment service management that systematically establishes a climate of responsiveness and care within a coherent and holistic treatment philosophy. This critical leadership role has only rarely been directly investigated. An exception is a study of New York's methadone clinics, which found that illicit heroin or cocaine use was lower in clinics with more experienced directors who were more involved with the treatment process. Direct client contact with this group of professionals was particularly influential early in treatment. This group was also thought to influence outcomes by establishing a positive therapeutic tone³⁹.

7. Client/key worker relationship

Organisational factors impinge on the client largely through the interface with their key worker. Even in methadone maintenance treatment where dose is usually considered of primary importance, the individual key worker makes a big difference to treatment outcomes⁴⁰. The influence of the client/counsellor/key worker relationship was disentangled by DATOS researchers in the US⁴¹. They found that, across a range of treatment settings and with both heroin and cocaine dependent clients, the client's commitment to changing their life had a major impact on how long they stayed, itself a marker of how well they were doing. The crucial finding was that this motivation did not directly affect retention but did so via factors that lay, at least partly, within the service's own hands - the early relationship with the counsellor and, through them, with treatment. Two dimensions to the relationship were identified. One was its quality (feeling a rapport with the key worker and confidence in and commitment to the treatment). The other was the quantity of opportunities for that relationship to exert an effect (number of counselling sessions attended and how often drugs, health and other issues, such as employment and housing, were discussed). The important point is that, to a degree, all these factors can be influenced by services. Effective referral and induction processes can help clients feel more motivated to enter treatment. Also key workers can work on their initial relationship with so-called 'poorly' motivated clients and improve outcomes. Compared to these factors that can be influenced, other factors that cannot be changed by providers had no direct effect on retention - the client's race, gender and age, their prior treatment history, the drugs they were dependent on, psychological disorders or whether they had entered treatment under legal constraint.

8. Rapport, helpfulness and good communication

The influential impact of the treatment provider on client outcomes has also been suggested by other studies, including a study on counselling services in Los Angeles, which saw mainly crack and amphetamine users^{42,43}. Here too, the main factors determining treatment participation and post treatment abstinence were what happened in treatment and how clients felt about it. It was not who the client was, their pre-treatment history or their initial motivation. For women in this study, the feeling their counsellor cared about them was the most important of the factors that influences the client-counsellor relationship; for men it was how helpful they had been. For both genders, feelings of being understood ('empathy') were influential. There was no short cut to achieving these feelings, for example by attempting to improve outcomes by simply matching clients to counsellors of the same gender or race. In addition to feelings about the counsellor, the perceived helpfulness of medical services was a factor for men and women, as was how useful clients saw relapse prevention, life skills inputs and help with getting to the clinic - depending on gender. Much of what is meant by terms such as 'rapport', 'empathy' and 'therapeutic alliance' (seen from either side, as a positive relationship that is helping the client move forward⁴⁴) relates to the ease and accuracy of communication. This includes promoting the client's feelings of being understood⁴⁵, and having the trust and confidence to open up to the key worker⁴⁶. An important part of the key workers' role is to foster communication skills, and this may contribute to engagement in treatment⁴⁷. However, this is not always possible, as not all clients have the concentration required or are articulate enough to discuss problems and solutions with a professional. For these clients in particular, a technique called node-link mapping has been found to aid communication and lead to improved engagement and outcomes. This involves a visual flow chart of the client's problems and objectives and of the steps needed to reach those objectives. Studies have documented the value of this approach in group and individual settings.

9. Impact of therapeutic alliance on treatment outcome

The DATOS and Los Angeles studies mentioned above showed that it is not that age, gender, crime and drug use histories, initial client motivation and so on have no influence on outcomes. It is that this influence on outcome is realised via the interface with the treatment provider, and in particular with the counsellor or key worker. A similar finding was made by a study of buprenorphine detoxification and maintenance where the 'therapeutic alliance' between key worker and client was found to have more influence on treatment completion than factors such as dose or addiction severity, especially for people with the greatest psychiatric problems⁴⁸. Research consistently shows that service users 'buy into' the service or are engaged in treatment when they feel that they are being listened to, understood, and are being given helpful, positive responses.

10. Research, treatment and key worker limitations

Studies amongst a range of client groups and treatment settings lend confidence to the overall notion that rapport between client and key worker is highly influential. However, research findings have their limitation. For example, DATOS' methodology meant that the least motivated clients would not have made it through to the analysis stage. It is possible that even the most skilled and empathic counsellor could do little to hold on to this group of people. Moreover, the services studied differed enormously and it is therefore expected that they treated clients very differently.

11. Optimal components of methadone maintenance programmes

The research findings in this series suggest that optimal methadone maintenance treatment programmes can be achieved by taking forward developments on a number of fronts. This briefing paper has identified full engagement of clients and their retention in treatment as key to achieving more positive treatment outcomes and has discussed the evidence on effective methods to achieve this.

12. Additional information

All briefings, background papers and updates on the NTA's related work programmes are available online at www.nta.nhs.uk or from nta.enquiries@nta-nhs.org.uk, tel 020 7972 2214.

Models of care, a framework for substance misuse treatment, and the *Commissioning standards in drug and alcohol treatment and care* are available from the NTA, email: nta.enquiries@nta-nhs.org.uk, tel 020 7972 2214.

Drug and Alcohol Findings magazine provides updates on relevant research and is available from findings@alcoholconcern.org.uk, tel 020 7928 7377.

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