NHS

National Treatment Agency
for Substance Misuse

Towards successful treatment completion

A good practice guide

EFFECTIVE TREATMENT
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The 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.

The NTA works in partnership with national, regional and local agencies to:

- Ensure the efficient use of public funding to support effective, appropriate and accessible local services
- Promote evidence-based and coordinated practice, by distilling and disseminating best practice
- Improve performance by developing standards for treatment, promoting user and carer involvement, and expanding and developing the drug treatment workforce
- Monitor and develop the effectiveness of treatment.

The NTA has led the successful delivery of the Department of Health's targets to:

- Double the number of people in treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year on year.

It is now in the front-line of a cross-Government drive to reduce the harm caused by drugs and its task is to improve the quality of treatment in order to maximise the benefit to individuals, families and communities.

Going forward, the NTA will be judged against its ability to deliver better treatment and better treatment outcomes for the diverse range of people who need it.

Towards successful treatment completion – a good practice guide

Question	Answer
What is the document?	Towards successful treatment completion – a good practice guide. This is a good practice guide aimed at treatment providers to help reduce the number of unplanned discharges and increase successful treatment completions.
What is its purpose?	To describe good practice in improving engagement and retention in drug misuse treatment; improve treatment delivery, in particular for clients who are failing to benefit from treatment; and reduce the number of clients who have their treatment withdrawn.
Publisher and date	NTA, July 2009
Who is it addressing? How big/wide is the audience?	Providers of drug misuse treatment, joint commissioners, service users and service user advocacy groups.
What is it asking them to do?	To review existing practice in line with this good practice guide, which is based on a review of the current evidence base, existing national guidance and the consensus of an expert advisory group established for this purpose.
What is the business reason?	To improve engagement and retention in effective treatment and to improve the numbers of clients who complete treatment successfully and leave drug misuse treatment services in a planned way in line with the Governments' current drug strategy.
What if anything does this update, replace or complement?	Retaining clients in drug treatment – a guide for providers and commissioners, NTA, June 2005.
Disclaimer if possible	This document imposes no new demands or requirements on anyone working in the drug treatment field, but is intended to help treatment providers to meet existing commitments by providing the latest information and highlighting good practice.
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Towards successful treatment completion – a good practice guide

Contents

1 Executive summary

This document examines the reasons why clients may not complete drug treatment and examines factors involved in successful, planned discharges; reviews the research on measures designed to improve engagement and retention in treatment; and gives examples of good clinical practice aimed at improving treatment effectiveness and successful treatment outcomes. By engaging and retaining clients in effective treatment, it is anticipated that more clients will achieve their treatment goals and leave drug treatment in a planned way.

The development of this NTA guidance document was supported by an expert advisory group established for this purpose, and the document was finalised by agreement of the expert group. This group drew on a range of experts from the addictions field, including representatives from addiction psychiatry, primary care, researchers, addiction nursing, pharmacists, NHS treatment providers, the non-statutory sector, and client advocacy groups.

For the year 2007/08 202,666 individuals were recorded as being in contact with drug treatment services in England. Seventy-eight percent of individuals entering drug treatment were retained in treatment for at least 12 weeks and a further 4 per cent had a planned discharge before 12 weeks.

Whilst successfully retaining clients in treatment for 12 weeks or more is an important proxy for the delivery of effective strategies to engage and retain clients in treatment, it does not always translate into clients subsequently successfully completing their treatment and leaving treatment services in a planned way.

If a client chooses to leave treatment in an unplanned way, often before his or her goals have been fully achieved, or if the client's treatment is withdrawn, the client can be said to have had an unplanned discharge. Whilst it cannot be assumed that all do badly after an unplanned discharge, it is generally considered good practice to try to maximise planned discharges.

Unplanned discharges occur for a range of recorded reasons, the commonest being dropping out of treatment, followed by going to prison, treatment being withdrawn, the client declining the treatment offered or moving away and losing contact with the treatment service.

An unplanned discharge does not necessarily mean that treatment was a failure. For example, clients who are discharged because they have gone to prison should have their treatment continued under the Integrated Drug Treatment Systems (IDTS) that have been introduced in the prison system. Some clients who dropped out of treatment may no longer need treatment.

In 2007/08 69,642 individuals were discharged from treatment of which 51 per cent successfully completed treatment and were said to have had a planned discharge. However, 48 per cent had an unplanned discharge, with treatment drop out being the commonest reason (28 per cent).

There has been a downward trend in unplanned discharges from 71per cent of individuals leaving drug treatment in 2004/05, to 66 per cent in 2005/06, 58 per cent in 2006/07 and 48 per cent in 2007/08, which adds credence to the potential for optimising further the number of planned discharges that can be achieved.

1.1 Introduction

In the introductory section, the purpose, scope and intended audience is discussed.

1.2 The profile of unplanned discharges

In this section data are presented that identify factors predictive of whether a client will have an unplanned discharge. This draws on data from the National Drug Treatment Monitoring System

(NDTMS) and additional data are presented from the Drug Interventions Record (DIR) – a database for clients passing through the criminal justice system as part of the Drug Interventions Programme (DIP). Relevant research data are also discussed concerning service or client factors that influence whether a client leaves treatment prematurely.

There is considerable variation between partnerships in the rate of unplanned discharges. Data analysis and research suggest that 'service factors' have a much bigger impact than client characteristics; but drug(s) of misuse also has an impact, in particular combined opiate and crack use increases the risk of having an unplanned discharge. Other important themes identified by the analysis include: some stimulant users being unable to access treatment services, problems in the continuity of care for clients passing through the criminal justice system, and inpatient and residential settings having higher levels of clients having their treatment withdrawn than other treatment modalities.

1.3 Treatment engagement and retention

Most clients who drop out of treatment do so between initial assessment and the start of treatment or in the first few weeks after entry to treatment.

Research shows that a range of interventions can help to engage and retain clients in treatment. These include: the use of encouraging reminders for appointments; interventions to boost motivation to engage with treatment; quicker entry times to treatment; a more structured induction phase to treatment; accompanying clients to appointments; and, the use of elements of assertive outreach to enhance engagement.

1.4 Treatment delivery – responding to failure to benefit from treatment

Once clients have been engaged and retained for an initial period of treatment, they are still at risk of dropping out, especially when they or their clinicians feel they are no longer benefiting from treatment. For many clients treatment is a long process that can take months or even years before maximum benefits accrue. During this time there may be set backs – clients may relapse or increase their levels of illicit drug use or fail to reach the goals they have set with their keyworkers in their treatment packages. Helping clients develop strategies to deal with these challenges is an essential aspect of clinical care.

This section discusses the evidence that inflexible treatment packages, punitive responses to continued illicit drug use and a poor therapeutic alliance militate against clients staying in treatment. Clients who drop out of treatment or have their treatment withdrawn constitute a group who often have additional needs and who might benefit from receiving extended periods of treatment rather than less. Drug treatment services will want to work more effectively with this client group in line with best practice.

In most instances discharging clients for using illicit drugs or alcohol while in drug treatment is not recommended clinical practice. The UK 'Clinical Guidelines' (Drug Misuse and Dependence: UK guidelines on clinical management. DH & devolved administrations, 2007) gives guidance on responding more effectively to clients who are failing to benefit from treatment. This document revisits this subject and provides further consensus-based examples of good clinical practice for common scenarios such as on-going illicit heroin use, on-going crack use, co-existent problematic alcohol use, missed appointments, failure to collect prescribed medication and dropping out of treatment when transferred between agencies.

In addition to discussing clinical scenarios, this section stresses some important underlying components of high quality treatment. These include comprehensive assessment of need,

developing a care or treatment plan, delivering effective interventions, care plan review and outcome monitoring.

There is compelling evidence that clients who drop out of treatment are at significant risk of returning to illicit drug use, injecting, blood-borne virus transmission, committing acquisitive crime and most importantly of dying from opioid overdose. Continuous effective drug treatment can be highly protective against overdose: it can be life saving. The challenge for the clinician is to develop a treatment plan that maximises retention in effective treatment but minimises the risks to the client and the community.

By sustaining retention of clients in optimised and effective treatment there is likely to be a greater chance that they will accrue the full benefits of treatment, achieve the goals of their care plan, complete treatment in a planned way and be successfully discharged from drug treatment services.

1.5 Withdrawal of treatment

Although less than 5 per cent of clients have their drug treatment withdrawn by their service provider, it can be a controversial subject. Treatment is sometimes withdrawn when there is violence, threats of violence or other untoward incidents. Treatment may also be withdrawn when there is no sign of progress or when there is evidence of deterioration in treatment. Withdrawing treatment that involves substitute opioid prescribing puts clients at significant risk of relapse back into illicit heroin use and is associated with increased risk of drug-related overdose death – a risk 20 times higher than that of clients who stay in treatment involving prescribed opioids. Therefore, a balance needs to be struck between protecting staff who work in drug treatment services, the risks of treatment to the patient or others and minimising the risks to clients of having their treatment withdrawn.

The policy framework developed by the NHS Security Management Service is discussed and a stepped approach to responding to violent and non-violent incidents is advocated. There is also discussion of failure to progress in treatment and the clinical response to this.

1.6 Completing treatment

Leaving treatment in an unplanned way is associated with a worse outcome. Research shows that outcomes improve with time spent in drug treatment. Therefore, over time a greater proportion of clients who are retained in effective treatment should start to achieve their treatment goals and begin to leave treatment in a planned way.

Facilitating social re-integration is one of the aims of treatment and is an important element of the new drug strategy. There has been a growing interest in recovery from dependence on drugs of misuse. Further integration of the principles of recovery into the drug treatment system is likely to be the next challenge to improve treatment outcomes and increase the proportion of clients who successfully complete treatment and leave treatment services in a planned way. To facilitate more clients to complete treatment successfully, drug treatment services may need to improve their competency in enabling people to achieve their aspirations, reach treatment goals, build social and personal capital and strive for abstinence when they are ready.

2 Introduction

2.1 Purpose and audience

This document examines the reasons why clients may not complete drug treatment and have successful planned discharges, reviews the research on measures designed to improve engagement and retention in treatment and gives examples of good clinical practice aimed at improving treatment effectiveness and successful treatment outcomes.

It has been authored by the NTA but has drawn on a range of experts from the addictions field, including representatives from addiction psychiatry, primary care, researchers, addiction nursing, pharmacists, commissioners, NHS treatment providers, the non-statutory sector, residential treatment services and client advocacy groups. The document was finalised by agreement of the expert advisory group established for this purpose.

This document gives treatment providers information and advice on how to reduce unplanned discharges by enhancing strategies to improve engagement and retention, to deliver more effective interventions to clients who are failing to benefit from treatment and to reduce the risk of clients dropping out or having their treatment withdrawn. It considers evidence that the procedures and practices of individual treatment services have a significant impact on likely successful outcomes.

It is intended that this advice will also be useful to drug partnerships who want to ensure that they are commissioning effective services and to both service users and advocacy groups who wish to actively participate in service development, local policies and advocacy work.

2.2 What is an unplanned discharge?

The National Treatment Agency's Drug Treatment Effectiveness strategy (NTA, 2005) defines the client journey as having three main components:

- Treatment engagement
- Treatment delivery
- Treatment completion or community integration

The aim of treatment is to maximise positive outcomes across a range of domains including drug-related harm and dependency. For many clients the long-term goal of treatment will be to achieve stable abstinence from illicit drugs. However, for some opiate misusers social integration may be achieved while maintained on substitute opioid medication. An individual's treatment goals will be developed through the process of care planning and will be monitored by keyworkers through care plan review. Where clients have become free from their drug or drugs of dependency, they may be discharged from treatment in a planned way. If clients drop out of treatment before their remaining goals have been fully achieved or if their treatment is prematurely withdrawn, then drug treatment has not ended in a planned way and this is likely to be considered an unsuccessful ending. In these circumstances the client is said to have had an unplanned discharge.

2.3 Why this advice is needed

There is an increasing body of evidence demonstrating the effectiveness of pharmacological and psychosocial interventions for the treatment of drug misuse (NICE, 2007a, b, c, d). However, for clients to achieve most benefit from these interventions they need to be engaged and retained in effective treatment and usually to leave in a planned way having achieved the goals set out in their

care or treatment plans. Existing indicators suggest that there is significant potential to increase the number of clients who successfully complete treatment in this way. Performance across partnerships varies widely and there may be much that can be learned from those services that have already achieved low levels of unplanned discharges.

2.4 What this document covers

This document examines data from NDTMS to identify factors associated with unplanned discharges, reviews some of the literature on engagement and retention in treatment and looks at good practice and procedures to enhance engagement and retention and to ensure clients who are failing to respond to treatment have action taken to optimise their treatment.

Specific advice is given on consensus on good practice procedures to be used when consideration is being given to withdrawing treatment. A range of practice points are made.

3 The profile of unplanned discharges

3.1 Introduction

In this section, data is examined from the National Drug Treatment Monitoring System (NDTMS). Some additional data is presented from the Drug Interventions Record (DIR), where this is relevant to the issue being discussed. DIR is a data collection system similar to NDTMS but used for clients on the Drug Interventions Programme (DIP) within the criminal justice system. Research data is also presented where this provides further information on client or service factors that influence whether a client exits treatment in a planned or unplanned way.

3.2 Analysis of data from NDTMS 2006/07

NDTMS collects data from services in England that provide care planned drug treatment, primarily Tier 3 (structured drug treatment) and Tier 4 (inpatient and residential treatment) interventions. It does not collect data from private practitioners or the prison system. Data from the 2006/07 data-set were used in this analysis.

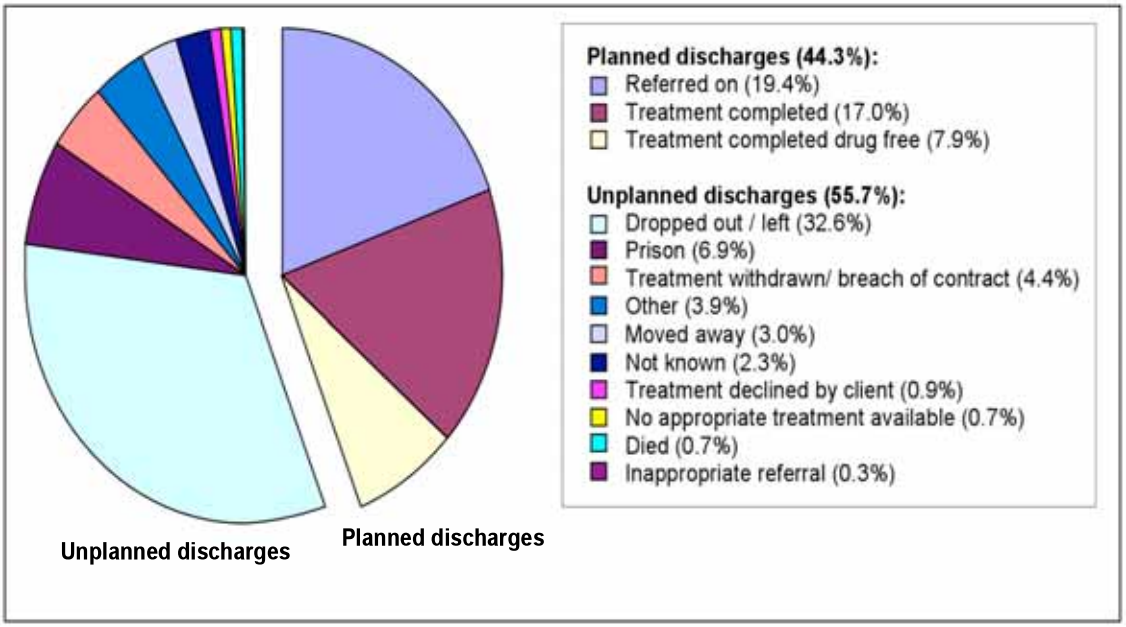
The NDTMS discharge codes used in this analysis are self explanatory, but open to some degree of interpretation. The procedures that individual services use to allocate discharge codes that best explain the reason a client exited treatment are likely to vary. The reliability of this process will be influenced by the extent to which skilled and competent clinicians who have knowledge of the client are involved in deciding which discharge code to use and how this information is then transmitted to administrative staff who input the data.

For the current analysis, for the period 2006/07, data were examined at the level of episodes of treatment, so a client exiting and re-entering treatment during the same financial year will be included more than once. There were 13 discharge codes used in this NDTMS dataset:

- Planned discharges:
    - Treatment completed drug-free
    - Treatment completed
    - Referred on
- Unplanned discharges:
    - No appropriate treatment available
    - Prison
    - Treatment withdrawn
    - Moved away
    - Died
    - Dropped out/left
    - Treatment declined
    - Inappropriate referral
    - Other
- Not known.

Figure 1 shows the frequency of each of the discharge codes for the year 2006/07.

Figure 1. NDTMS discharge codes for the year 2006/07



Unplanned discharges made up 56 per cent of all discharge episodes. There was considerable variation between partnerships in the proportion of clients discharged by each of the 13 codes. For planned discharges the biggest differences were in the proportion of treatment episodes that resulted in clients becoming drug-free (0.1 per cent to 27.2 per cent), referred on (1.9 per cent to 57.4 per cent) or treatment completed (4.5 per cent to 43.7 per cent). For unplanned discharges the biggest difference was for treatment withdrawn, which varied from 0 per cent to 31 per cent. There were also large differences in the proportion of episodes that ended with clients going to prison (0.7 per cent to 20.6 per cent), moving away (0.5 per cent to 13.9 per cent) and dropping out of treatment (11.6 per cent to 60.6 per cent). How much of this variation was due to clinical performance and how much to the reliability with which clinicians and administrative staff interpreted and allocated discharge codes is unknown. Further information on the relative performance of partnerships in relation to discharge codes is given in Appendix 1.

Previous research suggests that services factors, rather than client factors, account for most of the variation in whether clients are retained in treatment (Millar et al, 2004; Meier, 2005). Apart from treatment modality, NDTMS collects little data on the characteristics of drug treatment services, so it is not possible to elucidate what service factors are important in determining whether clients leave treatment in an unplanned way through NDTMS. In Appendix 1 further information is given on the variation in planned and unplanned discharges across the main treatment modalities.

3.3 Predicting unplanned discharges

The National Drug Evidence Centre (NDEC) study of treatment completion and retention (Millar, 2004) used statistical analysis to identify factors associated with successful and unsuccessful outcomes. The study found that younger clients were more likely to drop out of treatment as were males, those with no previous experience of treatment and those referred from the criminal justice system. However, the strongest predictor was the treatment service attended by the client, with the worst performing services having clients 7.1 times more likely to drop out earlier than the best.

In the NTA Annual Differential Impact Analysis of Drug Treatment (NTA, 2008), using NDTMS data for the period 2006/07, the service attended accounted for more difference in outcome than the individual characteristics of clients. After service variables, primary drug was the main factor influencing key indicators. Primary opioid users were better retained in treatment. Only after these factors were taken into account did ethnicity and gender have an influence. Key findings were:

- More white service users had a planned discharge
- Indian, Pakistani and African service users were more likely to complete treatment
- Bangladeshi and other Asian clients were most likely to drop out
- Women were slightly more likely to drop out of treatment
- Black service users had the lowest rate of being referred on.

Work by John Marsden and Kim Vuong (2008) has examined client and drug misuse factors to investigate predictors of unplanned discharges. Their preliminary findings show that the strongest predictor for unplanned discharges is reported use of combined opioids and crack which increased the odds of an unplanned discharge by 1.34. This means that the risk of a poor outcome increased by 13 per cent if the client was using both opiates and crack, after adjusting for the other factors in the model. This model is being used to investigate the extent to which regional variation in treatment outcome is due to differences in “case-mix”. However, their analysis did not look at the contribution of service factors.

Further analysis of NDTMS, DIR and the relevant literature reveal some common themes in relation to groups of clients who seem at greater risk of not completing treatment. These themes are presented in the next section.

3.3.1 Stimulant and cannabis users

Primary stimulant (cocaine, crack and amphetamine) users and cannabis users are more likely to be discharged because they are considered “inappropriate referrals”, “decline treatment” or because “no drug treatment is available.” This suggests that some stimulant and cannabis users are unable to access treatment at some drug services.

Penetration rates for crack users, i.e. the proportion of crack uses in a geographical area who are in treatment, are low compared to rates for opiate users. Using the Glasgow data on estimated prevalence of crack use by region of residence for the year 2004/05 (Hey, 2006), and comparing this with NDTMS data from the same year for the number of clients who state that crack is their main or secondary drug of choice, the mean penetration rate was 14.4 per cent with a range from 7.8 per cent to 19.2 per cent across the regions in England. This compares to a national average penetration rate of 54 per cent for problematic opiate users and 5.6 per cent for those with alcohol dependence (DH, 2004). It is not clear what the optimal penetration rate is for each drug of misuse.

Although pre-treatment discharges (treatment episodes where a triage assessment took place but treatment did not actually commence) are not the focus of this document, in 2006/07 crack and cocaine users were also over-represented in this group – 15.2 per cent of pre-treatment discharges were crack/cocaine users compared to 12.0 per cent of discharges where treatment started.

3.3.2 Criminal justice referrals

Using data from NDTMS, clients who left treatment because they were sentenced to prison were much more likely to have been referred from the criminal justice service compared to all discharges (51 per cent versus to 23 per cent). Analysis of all episodes ending in incarceration over the first year of treatment, suggests that this outcome is more common during the first three months and then declines over the subsequent nine months. Criminal justice referrals were also at increased risk of having their treatment withdrawn.

Home Office data for the web-based version of DIR was examined for the period December 2007 to February 2008 looking at three key outcome measures. The percentage of referrals made by DIP to specialist drug treatment that received a triage assessment averaged 41 per cent (range 14 to 82 per cent) across all drug partnerships; those receiving a triage assessment who started structured drug treatment averaged 94 per cent (range 60 to 100 per cent); while the percentage of Counselling Assessment Referral Advice and Throughcare (CARAT) referrals from prison to community-based DIP services who were picked up for treatment averaged 22 per cent (range 0 per cent to 71 per cent). These findings illustrate the challenges services face when trying to maintain continuity of care as clients move through the different components of the DIP pathway. It is important to point out that this data does not refer to unplanned discharges but whether referrals from one part of the DIP pathway were picked up by another. Whether all referrals were appropriate cannot be answered by this data. The Home Office and National Offender Management Service are currently undertaking a specific piece of work to improve the interface between services, CARATs and Criminal Justice Integrated Teams (CJITs) in order to allow criminal justice clients to be more effectively tracked as they move from custody to the community in order to improve engagement and retention in treatment. That project will look at these issues and produce further advice for CARAT and CJIT teams.

3.3.3 Inpatient and residential treatment

Although treatment episodes in inpatient services and residential rehabilitation are more likely to lead to planned discharges (drug free or treatment completed), they are also more likely to result in treatment being withdrawn – in 2006/07 10 per cent of inpatient episodes and 16 per cent of residential rehabilitation episodes ended in treatment being withdrawn compared to less than 5 per cent of all treatment modalities. This higher level of treatment withdrawal needs to be interpreted within the context of maintaining a safe and drug-free environment in which clients can complete their treatment. However, this has to be balanced against the increased risk of drug-related overdose death among clients who relapse after detoxification, having lost their tolerance to opiates.

Meier (2005) undertook a survey of retention in residential rehabilitation services in England and examined both client and self-reported service factors to see which best predicted treatment outcome. She examined three discharge outcomes: treatment completion, dropouts and disciplinary discharges and found the following:

- Treatment completion was associated with having a smaller number of beds, less house-keeping duties, higher service fees and more individual counselling

- Higher dropout rates were associated with higher numbers of beds, more housekeeping duties, the type of agency (therapeutic communities and eclectic programmes compared with 12-step) and having more shared rooms
- Disciplinary discharges were more likely to happen in services with fewer staff and counsellors and higher caseloads.

3.3.4 Time in treatment

When discharge codes were examined in relation to length of time in treatment, planned discharges became progressively more common over the first 12 months, while treatment withdrawal and drop-out became less common. This reinforces the finding that the early phase of treatment is a crucial time at which clients are at increased risk of leaving treatment. This is supported by research from the National Treatment Outcome Research Study (NTORS) and Drug Abuse Treatment Outcomes Studies (DATOS) that demonstrates that longer treatment episodes are associated with better outcomes (Gossop et al, 1999; Simpson, 1997).

3.3.5 Data entry issues

Some of the apparent variation in performance between drug partnerships may be due to data entry issues. This is illustrated by the finding that in one drug partnership 52 per cent of discharges were coded as "reason unknown", when the national average was 2.3 per cent, suggesting local problems in the process of discharge code allocation.

For episodes where treatment was declined, the average time to this event occurring was 127 days (over 4 months). It could be argued that this category should only be used for clients who decline treatment at the point at which it is offered rather than several months into treatment – clients who start treatment but subsequently discontinue might best be described as having "dropped out". A further example is for pre-treatment discharges – clients who drop out between initial assessment and the start of treatment – 8.9 per cent of this group were described as having completed treatment, even though treatment had not begun.

NDTMS discharge codes were revised in 2009. These new codes aim to better capture the clinical outcomes that drug treatment aims to achieve. The new codes have definitions to facilitate a more consistent approach to clinical interpretation (see Appendix 2). These codes have tighter definitions as to what constitutes successful treatment completion. In the new data set, only clients who are judged by the clinician not to be using heroin or crack will be considered to have completed treatment.

Practice point: *When a client exits treatment, there should be robust procedures in place to ensure that the most appropriate discharge code is allocated. Any potential internal inconsistency in discharge codes recorded would be minimised by clear agreement between practitioners and administrative staff on coding of discharges and audit of practice. Case note audits can be useful to assess the reliability of the process and identify procedures that may need improving. The new NDTMS discharge code definitions should facilitate this process.*

Practice point*: Local audits and process mapping would allow services and partnerships to identify why and where unplanned discharges are occurring; to identify why clients are dropping out of treatment; to develop more effective strategies to engage and retain clients in treatment; and to transfer clients more effectively between different providers in the treatment system.*

Example: A specialist treatment provider undertook an audit of pre-treatment discharges, using clients' case notes. The audit revealed that many of the clients who had been classified as "pre-treatment discharges" had not been discharged at all. Thirty percent were transfers between two prescribing arms within the same NHS trust and 60 per cent were referrals to another agency that

provided Tier 2 interventions (although no information was available as to whether the Tier 2 intervention actually started). New guidance was then issued so that clients transferred between the two prescribing arms within the same trust were no longer classified as discharges.

4 Treatment engagement and retention

Data from NDTMS for 2007/08 suggest that 78 per cent of clients were retained in treatment for 12 weeks or more and a further 4 per cent had a planned discharge before 12 weeks. However, there is considerable variation between the best and worst performing partnerships in relation to 12-week retention (91 per cent retained versus 49 per cent). For individuals who are discharged from treatment, the percentage that drop-out has been steadily falling from 44 per cent in 2004/05, 41 per cent in 2005/06, 36 per cent in 2006/07 to 28 per cent in 2007/08. Engagement and retention in treatment are subjects on which the NTA has already published a range of information and research papers (NTA, 2005; Donmall et al, 2005; Gossop, 2005; Millar et al, 2004 and NTAa, 2004). This section reviews some of the main findings, in particular those summarised in *Retaining clients in drug treatment* (NTA, 2005) and gives further examples of good practice.

It is important to be aware of the individual and service factors that can negatively impact on effective engagement and retention as well as the evidence of the range of initiatives and interventions that have been found to be effective in improving these particular outcomes. These individual and service factors are described first below, followed by examples of initiatives and potential actions that services will want to consider in enhancing effective care in this area.

4.1 Reasons for early exit

Research from the USA suggests that clients who drop out of treatment are characterised by lower levels of education, greater alcohol and drug problem severity, cigarette smoking, psychiatric co-morbidity, high-risk family environments, lower levels of motivation for recovery, weaker therapeutic alliances and worse long-term outcomes compared to those who complete treatment (White, 2008). Consequently, in many instances those who drop out of treatment are those with the most need.

A UK study by Stevens et al (2008) investigated clients who exited between assessment and 30 days in treatment with the aim of identifying the characteristics of those who leave treatment early. Twenty-five percent of clients dropped out of treatment before 30 days. As with previous research they found wide variation in the rates of early exits between different agencies with the proportion of clients who dropped out before 30 days varying from 0 per cent to 98 per cent. Using logistic regression analysis, the characteristics of service users with a greater likelihood of exiting early from treatment were being:

- Younger
- Homeless
- A non-injector.

Qualitative data were also collected from staff at the treatment agencies and service users through a series of meetings and focus groups. Treatment staff often used the concept of the “unmotivated” or “chaotic drug user” to explain why people leave drug treatment early. However, interviews with service users suggested that services were not responsive to the needs of clients whose work or daily activity patterns did not coincide with the nine-to-five opening times of many drug treatment services. This finding is supported by previous research (Fiorentine et al, 1999) looking into factors associated with client engagement in drug treatment which questioned the popular stereotype of “treatment-receptive” clients. This study showed that client characteristics were not strong predictors of engagement in treatment – much stronger predictors being the perceived utility of treatment, the ancillary services that were available and the client-counsellor relationship.

4.2 Service factors

A recurrent theme from research into engagement and retention is the finding that service factors have a much bigger impact than the characteristics of the clients attending treatment. The studies by Millar (2004) and Meier (2005) both showed that client factors played a relatively small role in determining treatment engagement and retention. There is little UK research to identify what these service factors are.

A group of researchers at the Texan Christian University have studied programme, staff and client factors in relation to engagement in drug misuse treatment programmes. For example, Broome et al (2007) found that engagement in drug treatment was better in those programmes that had a better organisational climate and a smaller organisational size. In a recent review, Orford (2008) summarised these organisational factors as:

- High quality therapeutic relationships
- High quality relationships with the whole treatment team
- High expectations for personal growth
- A moderate level of organisational structure
- Referral and treatment-entry procedures
- Initial assessment procedures
- Treatment environment.

4.2.1 Therapeutic alliance

Research has consistently shown that rates of client retention vary widely between therapists (Barber et al, 2001; Meier et al, 2006 and Kleinman et al, 1990). Such differences continue to exist even when client and therapist background factors are controlled for. The therapeutic alliance that develops between client and clinician is at the heart of this finding. The quality of the therapeutic alliance can be explored in clinical supervision and levels of client engagement in relation to individual clinicians can be monitored and could be a useful way to identify potential problems. Therapeutic alliance is very important for “in treatment” outcomes but once a client leaves treatment factors related to “recovery capital” become more important (White, 2008).

4.3 Helping clients to engage with and be retained in drug treatment

4.3.1 Why it is important

First contacts of the client with treatment services are an important time and present a particular opportunity to address effects of stigma and patient confidence. The Audit Commission report, Drug Misuse 2004 (Audit Commission, 2004), 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 skills 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 barriers need to be overcome by treatment services.

Feedback from service users has included instances where people were motivated to enter a treatment service, but were discouraged by an unhelpful reception immediately after entering the service. As a result, the importance of “front of house” staff, such as receptionists, pharmacy counter staff 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, where there is no discreet place for clients to give their personal details to staff, untidy and poorly maintained premises and cramped consulting rooms.

After a client has been assessed, it can be important that they continue to engage with the treatment service they have been referred to. As the client may 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 in improving engagement.

Practice point: *Training front-of-house staff to optimise their skills in responding effectively and courteously with clients' enquiries, requests and demands could improve client and staff experience and may reduce the risks of untoward incidents occurring. Conflict resolution training has the potential to improve skills in de-escalating incidents and may enable staff to seek support and back-up appropriately, further improving confidence.*

4.3.2 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 to reduce client attrition in the first few days after contact. Little research has been done in this area in the UK, but there have been several studies in the US, and a number of these have focused on alcohol treatment. Initiatives that have been demonstrated to improve engagement and early retention are described below and include:

- Encouraging reminders
- Motivational interventions
- Providing quicker entry into treatment
- Formal client induction
- Accompanying clients to appointments.

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 have been shown to assist in encouraging clients who have dropped out back into treatment. USA and some UK studies on this issue have shown positive results – examples are outlined below.

- A Massachusetts alcohol clinic saw a tenfold increase in clients returning from off-site detoxification through issuing them with a handwritten letter expressing concern and desire for the person to return (Chafetz et al, 1970; Miller, 1995).
- 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 were (Papepinto et al, 1969).

- 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 (Nirenberg et al, 1980).
- 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 (Donohue et al, 1998).
- Encouraging reminders have also been shown to improve attendance at aftercare services, and in some instances, may be of benefit on their own (Ashton and Witton, 2004). Text messaging services have been used in other areas of medicine and have been shown to improve attendance (Downer et al, 2005).

Example: Each day reception staff check to see who is due to attend for a medical appointment. They then phone the clients in the morning of the same day for afternoon appointments and in the afternoon for morning appointments on the following day.

Practice point: *Greater use could be made of electronic means of communication which are now taking the place of letters, for example, telephoning clients on their mobile phones, using text messaging services or e-mail.*

Practice point*: A culture of actively encouraging clients who are dropping out of treatment to re-engage should be the norm. The initial care plan could include a contingency plan of how best to contact and work to re-engage clients who drop out of treatment.*

Motivational interventions

Research from DATOS suggests that clients' pre-treatment problem recognition (motivation to change) and treatment readiness are important predictors of retention in treatment (Joe et al, 1998). Both these factors can be measured using standardised instruments, suggesting that clients at risk of dropping out of treatment could be identified at the point of treatment entry. Further research suggests that there is a strong relationship between motivation at intake and therapeutic involvement in the treatment programme (Joe et al, 1999).

Motivational interventions to encourage engagement with treatment have been shown to be useful for misusers of both heroin and cocaine. An Australian study (Baker et al, 2001) of amphetamine misusers 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 (Stotts et al, 2001) 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. For some clients, intensive case management, including advocacy, monitoring progress and helping to remove obstacles to treatment, has increased treatment uptake (Donovan, 2001; Bokos et al, 1992; Lidz et al, 1992).

NICE found strong evidence for brief interventions and its guidance on psychosocial interventions for drug misuse (NICE, 2007) recommended their use stating that they should be opportunistic and focused on motivation and offered to people in limited contact with drug services. These interventions should:

- Normally consist of two sessions each lasting 10-45 minutes
- Explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgemental feedback.

Contingency management (CM), using treatment incentives to reward positive behaviour change, has also been found to improve attendance and engagement with treatment. NICE has recently recommended its implementation in drug treatment services. The NTA has recently supported a series of CM demonstration projects across England, which are now complete. Advice on the implementation of CM will be issued by the NTA in 2009.

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 (Maddux et al, 1995) 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 shown 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 (Stark et al, 1990).
- 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 (Festinger et al, 2002).

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 (Addenbrooke et al, 1990) has found that shorter waiting times are linked to longer stays but this is not a consistent finding. Other UK research (Donmall et al, 2005) 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. Most services have reduced their waiting times in recent years, which will impact on the nature of any waiting list initiatives locally

Formal client induction

In US research (Stark, 1992; Marlatt et al, 1997), one initiative that was successful in engaging clients in treatment was the use of induction interventions to clarify what happens in treatment, what is expected of the client, and 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 (Higgins et al, 2002). 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 (Sia et al, 2000). Another US study showed that senior staff helping to induct clients into a residential service led to an increase in retention (De Leon et al, 2000).

Accompanying clients to appointments

Some research has shown that accompanying clients to appointments can be a useful way to ensure that a client does not drop out in transition between referral and treatment initiation 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 accompany them (Chutape et al, 2001). Another US study at a prenatal clinic for pregnant drug users found that accompanying clients to appointments was the only way to ensure initial attendance (Jones et al,

2004). Drug service staff may have a role in accompanying clients to appointments, in particular when they are being transferred from one local agency to another.

Example: One treatment service has incorporated accompanying clients to appointments into its service design. Support workers attend the first treatment appointment. This could mean driving or otherwise accompanying the client to the appointment. Workers collect clients and take them to their first appointment with local day services. Previously clients who asked for referral to these services often missed the assessment appointment. DIP workers sometimes pick up service users from prison in an attempt to intervene at a time of high vulnerability and ensure continuity of care between prison and community.

4.4 Enhanced engagement

In the area of adult mental health, considerable progress has been made in developing new models of service delivery to address poor engagement and retention in treatment. These models include early intervention psychosis services which provide additional support to clients experiencing their first episode of psychosis and who are beginning their treatment journey, and assertive outreach teams which focus resources on clients who have been identified at high risk of disengaging with treatment services.

Early intervention psychosis services, which include elements of assertive, community-based, integrated treatment systems, have been shown to reduce dropout rates (Marshall & Rathbone, 2006). Assertive community treatment for people with severe mental disorders, if targeted correctly on high users of inpatient care, can substantially reduce the costs of hospital care while improving outcome and client satisfaction (Marshall & Lockwood, 1998). These strategies have been little studied in the field of drug misuse but case management – a client centred strategy involving assessment, planning, linking to relevant services and community resources and advocacy – is effective at engaging drug misusers in treatment at different stages of the treatment process (NICE, 2007).

Example: A service has developed an enhanced engagement clinic to try to keep clients in treatment who are starting to disengage. At the weekly multidisciplinary team meeting clients are flagged up who have started to miss appointments or medication pick-ups. Where this problem persists, the client is transferred to the enhanced engagement clinic. This clinic uses a range of strategies to re-engage clients, including calling them on their mobile phones to remind them of appointments and to check where they are if they miss an appointment, leaving messages for them at the pharmacy, closer liaison with other professionals involved in their care, e.g. DIP worker, probation officer, hostel staff, social worker, street services team, etc. In some instances text messages are sent to clients from the communal work mobile phone. Clients are only discharged from treatment if all these combined measures fail to re-engage them.

5 Treatment delivery

5.1 Principles

The aim of treatment is to maximise positive outcomes across a range of domains including drug and alcohol misuse, physical and mental health, crime and social functioning and to facilitate the process of recovery. Effective treatment relies on an adequate assessment and the development of a good therapeutic relationship between client and clinician. There is evidence that the relationship is more effective where the client can be open and without fear of a punitive response but rather expects a person-centred and flexible response. It is recommended in recent guidelines that treatment should be delivered through a combination of keyworking and evidence-based psychosocial and pharmacological interventions in response to identified needs. It is clear from the available evidence that treatment reduces drug misuse and offers protection against a range of harms including the risk of contracting or spreading blood borne viruses, risk of overdose, and the likelihood of offending; and provides the basis for personal recovery and reintegration including progress to abstinence. Research confirms that clients who leave opioid maintenance treatment in a planned way are twice as likely to achieve abstinence than those who either drop out of treatment or have their treatment withdrawn (Kornor & Waal, 2005).

Progress in treatment can be monitored through on-going keyworking, care plan review and through more formal outcome monitoring with the use of dedicated outcome monitoring tools, including TOP (Treatment Outcomes Profile). Urine drug screens can be helpful to confirm compliance with prescribed medication and on-going illicit drug use. Breathalyser readings can be used to quantify levels of alcohol misuse. Where specific risks are identified these can be assessed further, for example using risk assessment schedules. These findings can be fed back to the client so that they can be reflected on and explored.

Clinical supervision and appraisal will ensure that clinicians learn from their experience and improve their skills and so improve client care. Clinicians need to be aware of their limitations and when another member of the multidisciplinary team, with different skills and competencies, is better placed to provide specific interventions.

If a client is not benefiting from treatment, in the first instance clinicians should explore the reasons why. Treatment optimisation is based on the principle of identifying unmet needs and developing a treatment or care plan to address these. Optimising treatment usually means increasing the intensity of the intervention, usually by adding discrete interventions such as psychosocial interventions to address drug misuse, psychosocial interventions to address common psychiatric disorders, increasing the dose of substitute opioid medication within evidence-based dose ranges or providing practical help with benefits, housing and employment. The timing at which the intensity of treatment is optimised may be important. Placing high demands and expectations on some clients during the initial phase of treatment may have a negative impact on their engagement.

5.2 What constitutes failure to benefit from treatment?

A number of different scenarios may constitute failure to benefit from treatment, each of which may require a different response. These are discussed separately below. It will be beneficial for clinicians to be aware of the behaviour of clients prior to starting drug misuse treatment in order to assess whether improvements, even if slow, are being made. A comprehensive assessment at the start of treatment, including a baseline TOP, will assist in this process. A good therapeutic relationship will enable continuing illicit drug use and other problems with progress to be discussed freely. If this relationship does not exist or if clinicians or services are perceived as rigid or having a

punitive response to illicit use, clients may not disclose such important information and may not be able to elicit the help they require. In all the scenarios discussed further in this section, it is assumed that the clinician's aim is to try to retain the client in effective treatment while addressing the need to balance safety and risk issues in the interest of the patient, staff and the wider community, as relevant. It is based on the assumption that continued retention in treatment is a very important element to be weighed in achieving optimum outcomes.

5.2.1 Opiate misuse in addition to an opioid prescription

While drug treatment has been shown to be effective in reducing drug misuse, clients may not cease all illicit drug use immediately on entering treatment. To illustrate this, the Harm Reduction Client Survey (NTA, 2006) of 10,070 service users asked those who were on prescribed opioid medication if they continued to use illicit drugs in addition to their prescription. The results revealed that 7 per cent of prescribed clients reported "always" using illicit drugs on top of their prescription, 12 per cent "often", 53 per cent "sometimes" and 28 per cent "never". Heroin was the drug most commonly used. Therefore, clinicians are frequently faced with this scenario and need effective responses.

However, there is evidence of some divergence in clinical practice. In the Harm Reduction Client Survey (NTA, 2006) clients were asked how services had responded to reported use of illicit drugs on top of prescribed medication. Although 41 per cent said the dose had been increased, 11 per cent said the dose had been decreased, 5 per cent reported that their prescription had been stopped and 2 per cent claimed they had been told they could no longer use the service. The independent expert group for the 2007 UK 'Clinical Guidelines' (Drug Misuse and Dependence – UK Guidelines on Clinical Management, DH & devolved administrations, 2007) issued a statement in December 2007 that "It is inappropriate for medications to be used as a reward or to be withheld or doses reduced solely as a punishment or sanction". Clearly, any service whose staff might still be using changes in medication provided to patients in a punitive way will want to review such practice in line with this advice.

There is evidence to suggest that the average dose of prescribed opioid medication has increased in recent years and is now more in line with the recommendations of the 2007 'Clinical Guidelines'. The last three Service Users Surveys conducted by the NTA (NTAa, 2007; NTAb, 2007; Gordon et al, 2008) have shown that the average self-reported methadone dose has gone up from 57.65mg in 2005, to 59.77mg in 2006 and 62.86mg in 2007, while the self-reported mean buprenorphine dose has increased from 9.6mg, to 10.56mg and 11.21mg over the same period.

The aim of methadone and buprenorphine substitution therapy is to enable clients to reduce and to stop using illicit opiates. Clients who continue to use illicit opiates may not have been titrated onto an adequate dose of a prescribed substitute or may have other unmet needs. Clients who have stopped using illicit opiates but then re-commence using them may no longer be fully compliant with prescribed medication. Monitoring use through self-report, the TOP and urine drug screens will help to quantify over time the likely on-top use. Some clients may resist having their dose of methadone increased because of negative views about the medication and there are commonly held myths about its effects (Kayman et al, 2006). These negative views should be identified and potentially exaggerated or erroneous beliefs discussed.

The risks of using illicit opiates on top of prescribed opioid medication include: overdose, return to injecting, risk of blood-borne virus (BBV) transmission, continued offending and involvement in drug misusing lifestyles. However, if the client is discharged from treatment for using "on-top", the risk of fatal drug overdose is substantially raised (Fugelstad A et al, 2007; Davoli M et al, 2007).

Table 1. Suggestions for good practice in managing opiate misuse in addition to an opioid prescription

Problem	Options
Inadequate dose	Dose re-assessment; increase dose
Non-compliance	Put client back on supervised consumption and/or more frequent pick-up
Medication unsuitable	Change medication regimen
Client on reducing regimen	Review treatment objectives; switch client to maintenance regimen
Myths about negative effects of methadone	Identify beliefs about medication and discuss potentially exaggerated or erroneous beliefs
Client using heroin and/or cocaine for “high”, to reduce craving or in response to life stresses	Increase keyworking; add psychosocial interventions (e.g. contingency management); change to supervised consumption; provide or ensure adequate injecting equipment if client an injecting drug user (IDU); address social problems such as housing if applicable

5.2.2 Cocaine/crack misuse in addition to an opioid prescription

The National Treatment Outcome Research Study (NTORS) (Gossop et al, 2002) showed that about one third of clients were using crack on entering treatment and at 4 to 5 years follow-up. However, there were different profiles during the follow-up period. For clients using crack at treatment entry their crack use more than halved at follow-up. However, among non-crack users at intake, about a quarter began using crack during follow-up, of whom about two-thirds had never used it before. Therefore, it is important that crack and cocaine use are monitored during treatment and specific psychosocial interventions are offered when use becomes problematic.

The risks of crack/cocaine misuse include: increased risk of BBV and other infections if injecting, substance misuse may become more chaotic, increase in crime and psychological problems.

Table 2. Suggestions for good practice in managing cocaine/crack misuse in addition to an opioid prescription

Problem	Options
Client using for “high”, to reduce craving or in response to life stresses	Increase keyworking; add psychosocial interventions (e.g. contingency management); provide or ensure adequate injecting equipment if an IDU
Client dependent on cocaine/crack	Increase keyworking; add psychosocial interventions (e.g. contingency management); provide or ensure adequate injecting equipment if an IDU; conduct health assessment and reflect findings back to client; consider inpatient stabilisation or residential rehabilitation

5.2.3 Illicit drug or alcohol use or non-compliance on an inpatient detoxification or residential rehabilitation unit

Inpatient and residential units represent a special environment in which clients are working towards becoming and staying abstinent from illicit drugs or alcohol. Clients who bring drugs or alcohol onto

the unit may put the abstinence of other residents at risk and create an environment that is perceived as being unsafe. Inpatient and residential units normally have policies in place to deal with such incidents. Clients who use drugs or alcohol in this setting are likely to be discharged or at least given a warning that continuation of such behaviour will lead to them being discharged. Clients may also be discharged for aggressive or threatening behaviour and for non-compliance with the treatment programme.

Measures should be taken to reduce the risks of clients being prematurely discharged from residential units. Adequate preparation of clients for inpatient or residential treatment is important so that they are clear about their rights and responsibilities and the policies that they will be expected to adhere to. When clients are admitted these issues can be discussed further. It would be good practice for the initial care plan to include a provisional discharge plan detailing how the client will get back home, and what treatment services they can access in their local area.

The risks associated with a client prematurely leaving inpatient or residential treatment, include: dropping out of treatment, relapsing on leaving the unit, returning to injecting and crime and increased risk of overdose death.

Table 3. Suggestions for good practice in managing drug or alcohol misuse or non-compliance on an inpatient or residential setting

Problem	**Options**
Client uses drugs or alcohol on inpatient or residential unit	Make policy on drug and alcohol use clear to client during pre-admission assessment and again on admission. Review progress and consider a warning, if feasible, prior to any enforced discharge. Ensure, if discharge is agreed, that any contingency plans are applied and that there is an adequate discharge care plan.
Client does not engage or participate in the programme activities	Prepare client for programme; arrange pre-admission visit to the unit; discuss timetable and programme contents at admission. Explore reasons for non-engagement; warn client of possible outcome on non-engagement
Client aggressive, violent or exhibits other unacceptable behaviour	Make policy on violence clear to client during pre-admission assessment and again at admission; train staff in conflict resolution and de-escalation. Apply appropriate responses to serious incidents consistent with service policies that address the needs of staff and other clients. Consider police involvement when appropriate, consistent with service policies, taking into account the needs of staff or other clients and involving senior staff and management.

Practice point: If a decision is made to discharge a client before treatment has been completed, a risk assessment should be performed by a competent clinician to identify any immediate or short-term risks the client may face between leaving the unit and re-engaging with local treatment services. Where clients are receiving treatment for physical or mental health problems or where significant risks have been identified, the service has a duty of care to ensure that these needs are addressed when the client leaves the unit as part of discharge care planning. Liaison with local treatment services will enable them to plan for the client's return. Care managers and probation

officers, if the client is on a residential Drug Rehabilitation Requirement (DRR), are likely to have a key role in reviewing the future care plan with the client.

5.2.4 Alcohol or benzodiazepine misuse in addition to an opioid prescription

NTORS (Gossop et al, 2001) found that at the start of treatment 24 per cent of the cohort were drinking above Department of Health recommended sensible limits and 25 per cent were doing so at the five year follow-up. Eight percent were drinking at definitely harmful levels. About one-third of clients receiving methadone have been identified as having a current drink problem and a further one-sixth have a history of a drinking problem (Senbanjo et al, 2006). Opiate dependent clients who misuse alcohol tend to have poorer treatment outcomes and are at greater risk of dropping out of treatment (Joseph & Appel, 1985). Alcohol use in addition to opiate use is associated with increased risk of fatal overdose (Darke et al, 1997).

It follows that clinicians working with drug misusers require:

- An awareness that alcohol misuse needs to be addressed alongside the management of misuse of other drugs
- Competence at detecting problem drinking
- An ability to give harm reduction and educational messages regarding misuse of alcohol
- Competence to be able to manage alcohol misuse in drug misusers, including pharmacotherapies such as substitute prescribing.

Drug misusers who are dependent on alcohol should be offered alcohol interventions. This may involve assisted withdrawal from alcohol, either in the community or as an inpatient, followed subsequently by additional psychosocial and pharmacological interventions aimed at reducing the risk of relapse. The aim is to minimise the risks of alcohol use while retaining the client in treatment, allowing the delivery of interventions to address the alcohol misuse.

Requiring alcohol dependent clients to attend in a state of withdrawal, so that their breath alcohol level is zero or below the legal driving limit, may be dangerous. Evidence suggests that repeatedly experiencing withdrawal symptoms is associated with sensitisation to these symptoms, including an increased risk of fitting and other complications such as cognitive impairment (Lingford-Hughes et al, 2004).

Where treatment services are prescribing drugs, such as methadone, the question will arise as to how to respond to clients who are under the influence of alcohol when presenting for their medication. There is little research evidence to guide the clinician as to how best to respond to this scenario. A risk assessment should be undertaken with the risks of continued alcohol consumption weighed against the benefits of continued treatment. For clients on substitute opioid treatment the stability of what is prescribed and taken is important, accidental or intended overdose is more likely when irregular high doses of a drug are consumed.

When assessing alcohol misuse among clients on substitute prescribing the following factors should be taken into account:

- The current dose of methadone or other substitute medication
- Level of alcohol dependence that can usefully be measured with a standard instrument, such as the SADQ (Stockwell et al, 1983)
- A range of breath alcohol readings with a clinical description as to the associated level of intoxication or withdrawal
- Use of other prescribed drugs
- The risk of bingeing on alcohol after medication has been taken

- The risk of taking other sedative drugs on top of prescribed medication
- Risk of using alcohol and cocaine or crack together, leading to coca-ethylene production which is cardio-toxic
- The risk of repeatedly presenting to services in a state of alcohol withdrawal, which is associated with an increased risk of withdrawal complications and cognitive impairment
- Physical complications which may impair metabolism of alcohol or methadone
- The increased risk of overdose if the client is discharged from treatment.

If a client is breathalysed and the breath alcohol level is found to be above the legal drink-drive limit, they should be advised not to drive. Further guidance on the regulations relating to driving under the influence of drugs or alcohol is available in the Driver and Vehicle Licensing Agency's (DVLA) At a Glance Guide (DVLA, 2007) and also in appendix A7 of the Drug Misuse and Dependence: UK guidelines on clinical management (Department of Health and devolved administrations, 2007).

Example: A service sought to compare its practice with other local services and performed an audit of 15 London drug treatment services. This revealed that some services use breathalysers in an attempt to quantify the level of alcohol intoxication at the time of presentation and use this as a guide in the decision making process as to whether to dispense medication or not, sometimes refusing medication when the breathalyser reading is above a pre-determined point. In the audit all services stated a level of breath alcohol concentration above which they would not usually dispense or prescribe methadone – this limit ranged from 0 to 0.4mg/L, with most quoting the drink driving limit of 0.35mg/L. Six out of 15 services said they would dispense above this level in certain clinical scenarios, such as high levels of alcohol dependence and a client presenting in a state of alcohol withdrawal despite being above the drink driving limit.

Example: A service described how alcohol dependence is flagged up after the initial comprehensive assessment. Clients found to be alcohol dependent are monitored for alcohol intoxication or withdrawal and the corresponding breathalyser readings are documented over a baseline period during the first few weeks of treatment. Once this has been established an individual breathalyser limit is set, reflecting the level at which the clients presents neither intoxicated nor in withdrawal. If the client subsequently presents with a breathalyser reading above this limit, they may be asked to return later and be re-tested or if this is not possible part or all of their opioid medication may be withheld that day. This limit is reviewed at regular intervals, e.g. at the three-monthly care plan review with the aim of bringing the level down. Clients with alcohol dependence are offered interventions specifically directed at their alcohol use as part of their care plan. These include psychosocial interventions, medically assisted withdrawal in the community, inpatient detoxification and residential rehabilitation.

As with alcohol, mixing benzodiazepines with methadone or buprenorphine increases the risk of overdose. Where benzodiazepine use is reported, a clinical assessment will establish whether the client is dependent on them. This assessment should include:

- Quantity, frequency and duration of benzodiazepine use
- Description of benzodiazepine withdrawal symptoms, including withdrawal fits
- Drug testing to confirm benzodiazepine use
- Use of other sedative drugs, such as alcohol.

Clients who are clearly dependent on benzodiazepines may benefit from a benzodiazepine reduction regimen. Prescribing benzodiazepines to clients who are dependent on them is discussed further in Drug Misuse and Dependence: UK guidelines on clinical management (DH & devolved administrations, 2007).

The risks associated with clients using alcohol and/or benzodiazepines in addition to their prescribed opioid include: respiratory depression and fatal overdose; fitting, from alcohol or benzodiazepine withdrawal; and dropping out of treatment, because of the client's instability, because of difficulties in obtaining continuity of opioid prescribing due to concerns by the service about risk, or because of a decision to discharge the patient due to lack of progress. However, the risks of intoxication from substance misuse on top of prescribed medication clearly need to be balanced with the risk of overdose if the client is discharged from treatment and takes heroin on top of alcohol and/or benzodiazepines, and hence requires careful assessment and consideration.

Table 4. Suggestions for good practice in managing alcohol or benzodiazepine misuse in addition to an opioid prescription

Problems	**Options**
Client using alcohol/benzodiazepines to get intoxicated	Risk assessment; increase keyworking; add psychosocial interventions; change to supervised consumption of opioid prescription; regular breathalyser testing
Client dependent on alcohol/benzodiazepines	Risk assessment; alcohol/benzodiazepine community or inpatient medically assisted withdrawal regimen; increased keyworking; add psychosocial interventions; change to supervised consumption of opioid prescription; regular breathalyser testing; conduct health assessment and reflect finding back to client; consider inpatient detoxification leading to residential rehabilitation

5.2.5 Client misses appointments or repeatedly arrives late

Clients may fail to benefit from treatment because they regularly miss appointments with clinicians. Missed appointments make it difficult to address clients' needs, monitor progress and review the care or treatment plan. However, specifying that a small or set number of missed appointments will automatically lead to the client being discharged from treatment is not generally considered good clinical practice as it does not reflect individual assessment of need and risk. Reasonable flexibility around appointment times and a constructive, client-focused approach to missed appointments is generally desirable and this was flagged up in the Audit Commission's review of drug treatment services in 2002 (Audit Commission, 2002).

If a client fails to attend an appointment it is important to try to find out why. Without a pro-active response there is a risk that the client will drop out of treatment altogether. It can be useful to attempt to confirm the reason for non-attendance immediately as part of an agreed response to non-attendance; not least where supply of medication may be at risk. The therapeutic alliance between client and clinician will be integral to enhancing engagement and retention in treatment. Poor attendance does not necessarily equate with poor motivation but where poor motivation is an issue this may be usefully addressed through interventions to enhance motivation to engage with treatment or contingency management (NICE, 2007).

For very stable clients and those in full-time employment a lower level of involvement and less frequent attendance may be appropriate. For more chaotic clients, minimal contact with the service is likely to mean that the client is not participating in regular keyworking or psychosocial interventions and may not be fully benefiting from treatment. However, simply increasing the intensity of the intervention and the frequency of attendance may be counterproductive if the underlying issues have not been addressed. Research confirms that adding psychosocial

interventions to methadone maintenance improves treatment effectiveness (NTA, 2004b). The important point is to tailor treatment to the individual client's needs through the process of assessment, care planning and care plan review.

For clients receiving prescribed treatment, the relationship with the dispensing pharmacist, who the client may see five or six times a week, can be crucial to the success of treatment. As highlighted by the Audit Commission's report (2002), "…research has shown that many [pharmacists] are an underused point of contact for the drug misusing population and would benefit from a closer relationship with prescribing services and improved training." When included as part of the multidisciplinary team and in regular contact with the prescriber or keyworker, pharmacists can help motivate clients, act as advocates, pass on information to and from keyworkers, support clients in their care plan and encourage them to attend appointments and remain compliant with their prescribed medication.

The opening hours of treatment services and pharmacies are particularly important for clients who are working, including sex workers. To address the needs of these clients, services could offer a range of opening times that suit clients who work during usual office hours or who may be sleeping during office hours because they work at night. Clients who are working may need to access pharmacies that stay open in the evenings.

Risks of missed appointments include: client's needs may not be adequately identified or addressed; the care plan is not developed; progress is not monitored or fed back to client; and there is an increased risk of dropping out of treatment, returning to illicit drug use, injecting and re-offending.

Table 5. Suggestions for good practice in managing missed appointment or clients repeatedly arriving late

Problems	**Options**
Involvement with multiple agencies	Coordinate appointments; liaise with other agencies; less frequent appointments; joint appointments
Mobility or physical health problems	Address health needs; organise transport; assist in application for assisted transport e.g. "freedom pass"; taxi card, etc
Mental health problems	Address mental health needs; joint appointments with community mental health team
Client is working	Offer evening or weekend appointments; if working variable shifts offer flexible appointment times; find pharmacy with later opening times
Avoidance of other service users	Coordinate appointments; see client at another service base
Ambivalence about the value of treatment	Explore ambivalence; brief interventions to enhance motivation to engage; contingency management to improve attendance
Poor therapeutic alliance with keyworker or the service	Explore problems in clinical supervision; staff training to improve therapeutic skills; consider changing keyworker; refer to other service provider

Multiple needs and conflicting priorities	Needs assessment; prioritise and address needs; flexibility around appointments; less frequent appointments; contingency management to improve attendance; coordinate appointments; joint appointments
Attends for prescription but not for keyworking appointments	Consider linking keyworking appointments to prescription due dates; or arrange with client for prescription pick-up to be on the day of keyworking appointments; contingency management may assist in encouraging a period of improved attendance
Client ill or in hospital	Contact client to check on well-being; if admitted liaise with the hospital team where appropriate to support care and to develop a discharge plan
Client may have died	Contact the GP, Coroner or Registrar of Deaths to confirm if client is deceased. In exceptional circumstances it may be appropriate to ask the police to do a welfare check if there are sufficient grounds to over-ride the duty of confidentiality
Client has moved away	Contact client by phone; write to last known address (subject to consent); liaise with other professionals involved in the client's care (subject to consent)

Example: At one partnership a protocol has been developed outlining what workers should do if a client misses an appointment. The worker uses the missed appointment time to try to contact the client and contacts other professionals involved with their care to determine the client's safety. A message may be left with the pharmacy requesting the client contact the service as soon as possible. Also the next appointment is left with the pharmacist to be passed on to the client. The level of clients dropping out of treatment is 15.3 per cent against a national average of 32.6 per cent.

Example: One service developed an audit by which the clinical lead and service manager went through each keyworker's client list to identify clients who were regularly missing appointments. Multidisciplinary team meetings were devoted to discussing these clients. Common themes were identified, for example: involvement with multiple agencies, clients in the early phase of treatment, DRR clients, those with childcare issues, clients who were working, particularly those on shifts or with irregular work patterns. A further observation was made that many of the clients who regularly missed appointments were frequently seen in the service, albeit at the "wrong" times or on the "wrong" days. Strategies were devised to offer more flexible appointment times, such as evening appointments and appointment times that could be negotiated at short notice. For some clients who were struggling to engage with treatment drop-in times were offered instead of fixed appointments, e.g. to attend between 2pm and 5pm rather than at 3pm on the dot.

5.2.6 Client misses doses or misses pick-up of medication for more than three days

After three days without taking regularly prescribed doses of opioid medication, patients may lose their tolerance and be at risk of overdose if the usual dose is then taken. In these instances, a pre-existing shared care protocol between the pharmacist and the prescribing service will be helpful. Such protocols will normally state that in cases of missed doses of more than three days, the pharmacist will be unable to dispense the usual dose unless they have confirmed with the prescriber that it is safe to do so. Usually this will trigger an urgent re-assessment by the

prescriber. If they have missed for more than five days, this re-assessment is likely to require an evaluation of the opioid tolerance of the patient.

Efforts should be made to limit the impact on the patient of being without prescribed medication, as long delays in re-accessing the medication may result in a greater risk of a more extensive relapse into illicit drug use, injecting and crime. If assertive attempts to re-engage the client are not made at this point, the client is at risk of dropping out of treatment. If delays are to be avoided and the risks to the client minimised, rapid access to assessment by the prescriber will be necessary. This will include rapid access to any new titration or re-titration that may be needed, and especially where doses have been missed for more than five days. As an early warning system pharmacists could be routinely asked about missed pick-ups and be encouraged to report problems with attendance as part of any shared care agreement.

An audit of FP10 prescriptions at an inner London drug service revealed that up to 30 per cent of clients on prescribed opioids had missed at least one pick-up in the last month (Dunn et al, in press). Missing doses of prescribed medication was associated with on-top heroin use. In a separate study, Haskew et al (2008) found that 40 per cent of clients on prescribed opioids had not fully complied with their medication. This included missing doses altogether, taking only part of the dose and splitting the dose.

Risks of missed doses of opioid medication include: loss of current level of tolerance to opiates, a return to illicit drug use and injecting, a return to crime to fund use, dropping out of treatment and drug-related overdose deaths.

Table 6. Suggestions for good practice in managing clients who miss more than 3 days of substitute opioid medication

Problems	**Options**
Client misses more than 3 days of substitute opioid medication	Develop shared care protocol with pharmacists to ensure missed pick-ups are flagged up with the treatment service; rapid access to advice from prescriber to the pharmacist in situations of missed doses; usually the offer of urgent appointment to the client for medication assessment (and for evaluation of tolerance and re-titration if needed, especially if missed for five days or more)
Client using illicit drugs	Review drug use, optimise dose; add supervised consumption; increase frequency of pick-ups; add psychosocial interventions (such as contingency management); regular liaison between pharmacist and treatment provider; if injecting ensure access to needle exchange
Client working	Find more accessible pharmacy; find pharmacy with later opening times; review need for supervised consumption; review need for daily pick-up

Example: A service has developed a procedure for re-starting clients on medication when the prescription has been stopped or interrupted for more than three days, so as to accelerate the re-entry of clients back into prescribed treatment. Previously clients had to wait for a doctor's appointment for re-titration, which could take two or three weeks. In the new system, the client is re-assessed by the duty drug worker on the day they present. The worker takes a standard drug history covering the period since the prescription stopped and does an instant urine test to confirm self-reported drug use. The case is then discussed with the on-site doctor who then develops a new re-titration prescribing plan usually starting the same day.

Example: Training of community pharmacists can lead to a reduction in the number of missed doses. A community pharmacy audit of the number of missed doses of prescribed opioid medication (Chaudhry, 2007) suggested that the number of missed doses fell as the pharmacist's knowledge and understanding of the treatment of drug misuse increased as a result of completing the Royal College of General Practitioners Part Two certificate.

5.2.7 Client drops out during transfer between agencies

Analysis of data summarised in section 3.3 identifies transfer between treatment agencies, particularly at the start of treatment, as risk points at which clients drop out. Transfer commonly occurs:

- Between assessment/outreach services and structured treatment services (Tier 2 to Tier 3 interventions)
- From Drug Interventions Programme (DIP) to structured treatment programmes
- From Counselling Assessment Referral Advice and Throughcare services (CARATs) to community-based treatment services
- From young people's to adult services
- When clients move from one area to another
- After leaving residential rehabilitation to community-based treatment programmes and aftercare services.

Research suggests that criminal justice clients enrolled in prison-based methadone maintenance programmes are more likely to engage with and be retained in post-release community-based treatment services (Magura et al, 2002). The implementation of the Integrated Drug Treatment Systems (IDTS) across the prison estate offers opportunities to improve engagement with community-based services when prisoners are released. A programme of providing FP10 and FP10 (MDA) prescriptions to released prisoners is currently being rolled out. The availability of FP10 and FP10 (MDA) prescriptions for prisoners who have been maintained on medication while in prison can enable prison healthcare services to dispense methadone or buprenorphine on the day of release and also to provide community pharmacy prescriptions to prisoners for an initial continuing supply. It will require good communication and prioritisation by prison healthcare and community drug services (including any services involved in supporting the Drug Interventions Programme) to ensure optimal continuity of care and safe and effective prescribing.

When clients are being referred from one agency to another, services should endeavour to take active steps to transfer care effectively. Such steps may include:

- A formal handover of care and care co-ordination between workers at the referring and receiving agencies
- Active liaison between services to ensure there is effective transfer of care
- Accompanying clients to their first appointment at the new service

- Having a single point of contact for those agencies that make a significant number of inter-agency referrals.
- A joint appointment with the new service so that the client can be introduced to their new worker
- A clear arrangement that the referring service will continue with provision of a prescription until the new agency has agreed to take over this responsibility.

Risks associated with clients dropping out of treatment during transfer between agencies include: relapse back into illicit drug use, increased risk of overdose, return to injecting, BBV or other infection risks, return to offending behaviour, risks to children of drug dependent parents.

Table 7. Suggestions for good practice in preventing clients dropping out of treatment when transferred between agencies

Problems	**Options**
Client detoxified in prison, becomes drug-free and is not picked up by CARAT team or referred to community-based services	Maintenance treatment in prison; referral by CARAT team and prison healthcare to community drug treatment prior to release; roll out of IDTS across prison estate; single point of contact for all inter-agency referrals; pre-discharge planning meetings; referral of drug-free clients into aftercare programmes.
Client referred by DIP to drug treatment but does not attend	Develop good liaison arrangements and consider single-point of contact; ensure DIP can offer adequate information to clients on what to expect from referral; accompany the client to first appointment or offer joint appointments (routinely or in selected cases); and DIP team to consider any appropriate advocacy concerning flexibility or addressing any identified potential barriers to access.
Client discharged from residential rehabilitation and relapses	Carry out a risk assessment prior to all discharges and develop contingency plans for the known risk of relapse; organise suitable aftercare package; plan a post discharge case conference; and if client does relapse, refer to contingency plans and provide rapid re-assessment and enable early access back into community drug treatment services.
Client moves form one area to another but drops out before engages with new treatment service	Early referral of client to new service and provision of information/reassurance to client as appropriate; continue prescribing and review until new service able to take over care; regular liaison with new treatment service until care taken over; encourage client to engage with new service, formal handover of care; joint

	initial appointment(s) or accompanying to initial appointment(s) in appropriate cases.
Stimulant misuser assessed as not requiring structured treatment but no appropriate Tier 2 treatment interventions available	Services assessing need should follow procedures for locally informing commissioners and drug partnerships of unmet needs.
Poor engagement of young people turning 18 and moving into adult services	Develop formal transitional arrangements, joint appointments and handover of care
Barriers between treatment providers due to over-structured treatment system with each Tiered intervention provided by a separate agency	Develop integrated drug treatment system and care pathways. Engage in discussion with commissioners about any specific barriers to the ability to meet substance misuse needs within a service appropriately, through direct provision, or through adequate access, to a range of interventions – in line with best practice guidance, including NICE guidance.

6 Withdrawal of treatment

At a national level “treatment withdrawal or breach of contract” accounts for less than 5 per cent of all recorded discharges from drug misuse services but in some DAT partnerships it is the recorded reasons for discharge in 30 per cent of cases. The actual reasons why treatment is completely withdrawn are not fully known, but anecdotal evidence suggests that it can happen in response to serious incidents such as threats or actual violence against staff, continuing non-compliance with the treatment regimen or certain breaches of contract with the treatment agency.

Withdrawal of pharmacological treatment can be followed in the short-term by potentially fatal overdose for the client due to readjustments in the level of tolerance to opiates occurring alongside increased illicit drug use. Any decisions about possible withdrawal of treatment, for example due to concerns about longer-term risks of prescribing to a client who is continuing to engage poorly with treatment, will need to take account of such potential risks.

There have been some reports of the withholding of treatment, short of discharging the client, such as reducing doses of prescribed medication or temporarily withholding treatment when it would be feasible to continue. For example, some clients may have their prescribed medication withheld because they are late for appointments, have missed appointments, have taken illicit drugs on top of substitute opioid treatment or have not complied with particular elements of the treatment regimen. Some instances may be due to real practical difficulties in arranging receipt of a prescription in the short term but it appears that in other cases it may be an intention to try to mould behaviour. The prevalence of intended withholding of treatment in these circumstance is not known, although 5 per cent of clients in the Harm Reduction Client Survey (NTA, 2007) reported that their prescription had been stopped because of on-top illicit drug use and 2 per cent claimed they had been told they could no longer use the treatment service. In the Audit of Prescribing Practitioners (COI, 2007) 4 per cent of prescribers said that they would discharge a client for continually declaring use of illegal drugs and 7 per cent said that they would decrease the dose of prescribed opioid as a “punishment” for on-top illicit drug use.

The ethics of using changes in medication dosage or availability solely as a sanction or “punishment” is quite clear. In December 2007, the independent expert working group that developed the UK ‘Clinical Guidelines’ (*Drug Misuse and Dependence – UK Guidelines on Clinical Management* DH and devolved administrations, 2007) issued a statement that:

> “It is inappropriate for medications to be used as a reward or to be withheld or doses reduced solely as a punishment or sanction.”

Drug Misuse and Dependence: UK guidelines on clinical management (DH & devolved administrations, 2007) make the following statement in respect of suspension and exclusion of patients from treatment:

> “It may be necessary on the basis of a careful assessment of the risks to the patient and staff to come to the conclusion that a prescription must be suspended or in rare cases withdrawn. Such decisions must involve the prescribing clinician and other members of the multidisciplinary team. Patients should be forewarned of the potential actions and consequences that the prescriber and the team may take where there is a failure to optimise treatment and be offered the opportunity to set new goals or identify contingencies that might influence their progress from this point.
>
> A decision to temporarily or permanently exclude a patient from a drug treatment service or provide coerced detoxification should not be taken lightly. Such a course of action can put the patient at an increased risk of overdose death, contracting a blood-borne virus or

offending. It may also increase the level of risk to children and vulnerable adults in the home. If at all possible, patients excluded from a service should be offered treatment at another local service or setting in a way that minimises risks and maximises opportunities for patients to be retained in treatment. Other steps in line with Good Medical Practice paragraphs 38-40 (GMC, 2006) must also be followed."

The Expert Advisory Group involved in compiling this advice considered the question of whether treatment should ever be withdrawn because of failure to progress in treatment or if the client showed evidence of deterioration in treatment. A consensus was reached that withholding treatment in such circumstances should normally be seen as a last resort and that before this situation arose other treatment strategies would have been tried. The first step would be to review the client and their care or treatment plan and identify any areas of unmet need. Thereafter, a new treatment plan should be developed which addresses the issues identified. This is the approach described in section 5 (Treatment delivery) of this advice. Any decision to withdraw treatment should only be taken after a risk assessment has been undertaken and the consequences of stopping treatment have been considered and discussed with the client.

In the case of responding to violent and other untoward incidents, there will always be a difficult balance between protecting staff from violent incidents, responding to the rights of the client to treatment and preventing the risk of a serious adverse outcome, such a drug-related overdose death, that may occur if treatment is withdrawn or in some circumstances may occur if prescribed medication is continued. Clear policies, multidisciplinary team discussions, risk assessment and clinical leadership are important components of the clinical governance structures that would usually be expected to be in place to support such decision making processes.

It is likely that the optimal management of risks and the development of optimal responses to challenging incidents will minimise the number of cases that may have to be considered for permanent or temporary withdrawal of treatment. A number of relevant issues are discussed in this section.

6.1 Preventing violent incidents and relevant good practice

The NHS Security Management Service has published a range of documents that provide national guidance on preventing and responding to violent and non-violent assaults (NHS SMS, 2007; NHS SMS, 2004; NHS SMS, 2006). These documents give detailed information on developing a pro-security culture, teaching staff conflict resolution skills and describe a range of responses to violent incidents, including verbal warnings and acknowledgement of responsibility agreements (a type of contract) and only as a last resort withdrawal of treatment. There is also an acknowledgement that some clients cannot have their treatment withdrawn, because to do so would put their life at risk. There is specific guidance on how to deal with this client group. In Appendix 3 further information is given on the NHS "zero tolerance campaign", The NHS Security Management Service and its definitions of violent and non-violent assaults.

At a local level drug treatment services often provide information leaflets that may describe the service and these may be used to outline the rights and responsibilities of both the client and the treatment service. Some services may provide this information in the form of sheets that require a signature to confirm that such policies have been read and understood. An additional approach is to ask clients, and sometimes also the staff, to sign a contract agreeing to abide by the responsibilities detailed. If the latter approach is used consideration clearly needs to be given as to the level of informed consent when clients are asked to sign such documents. At the start of treatment clients may be vulnerable and desperate for help and feel pressurised to sign a contract so that treatment can begin. The process of consent may usefully be returned to after a period of stabilisation. There appear to be genuine differences of view as to the value of general contracts and on the matter of implementing them to best effect.

Example: Some services have introduced stepped contracts with only the most basic level being signed at the start of treatment and more detailed ones being agreed once the client has engaged with the service.

The NHS Security Management Service advises Trusts to seek to engage both staff and clients in the development of local policies and procedures on withdrawing treatment. These policies and procedures should be informed by and be consistent with national guidance. Service user consultation and feedback is an essential element to developing local policies and procedures. Key documents include:

- Tackling Violence against Staff – Explanatory Notes (NHS SMS, 2007)
- Non-Physical Assault – Explanatory Notes (NHS SMS, 2004), which supersedes the zero tolerance campaign
- Prevention and Management of Violence where Withdrawal of Treatment is not an Option (NHS SMS, 2006).

The following list highlights some of the key elements from these documents:

- Making staff aware of the process and the support available to them when a violent incident takes place
- Educating staff about the importance of reporting procedures and ensuring that all incidents are recorded and appropriate measures take place
- Health and safety considerations to minimise the risk to staff from the environment in which they work
- Reporting all cases of physical assault to the police
- Sharing risk information between services involved in the care of the client where information sharing protocols exist or where other professionals may be at risk
- Training frontline staff and professionals in conflict resolution and provision of clinical supervision
- The creating and development of a pro-security culture
- Undertaking risk assessment in high-risk areas and detecting risks through clinical risk assessment protocols
- A clear outline of behaviours that are considered unacceptable as well as an outline of sanctions or action that will be taken
- Details of the entire procedure to be followed where treatment is withheld from a patient
- Legal advice on the implementation of local procedures by the health body's own solicitors, local security management specialist or the NHS Security Management Service's Legal Protection Unit
- Clear lines of accountability on the instigation of withholding of treatment, (for example, a senior clinician may provide advice, following a clinical assessment, to the Chief Executive or his deputy to issue a formal letter withholding treatment) including the role of the Security Management Director and Local Security Management Specialists. It is essential that these roles are clearly defined in order to ensure impartiality
- Information about the period for which treatment will be withheld – this should not normally exceed 12 months, as well as how the decision will be monitored and reviewed
- Information on how to arrange treatment for those patients who have a life threatening condition

- Consideration of notifying other relevant personnel within the health body, such as security, relevant local NHS services such as the ambulance service, and other agencies such as police, where appropriate, of patients who are subject to withholding of NHS treatment.

In 2004, the Government sent out a directive instructing all Primary Care Trusts (PCTs) to create a Violent Patient Scheme (VPS) – a primary care service for clients who have been excluded from treatment by their own GP because of violence or threatening behaviour. The VPS is an enhanced services contract, with a specification to provide improved staffing and security measures. Consequently, clients who have their treatment withdrawn by their GP can be transferred to the local VPS practice. However, this service is primarily only open to GPs. Clients from specialist secondary care services cannot be referred into such a scheme unless the PCT has agreed to this. Even if specialist services had access to the VPS, it would only be a useful option if the GPs working there had the skills and competencies to take on drug misuse clients and had signed an enhanced services agreement to deliver substitute prescribing. In some areas this has happened.

Example: A GP practice provides a Violent Patient Scheme through a directed enhanced services contract. It is a single practice, which covers 2 PCTs. Community drug teams from each PCT can refer clients to the VPS who have been excluded from treatment at their local service. The GPs in the practice already had some interest and experience in managing drug misuse. The VPS clinic works very much like a shared care clinic with a keyworker from each community drug team going in weekly to see clients from their service. This has not caused issues for the keyworkers as security is very much enhanced there, including bars on windows, panic alarms, CCTV and police in the consulting room.

Practice point: Partnerships could investigate the feasibility of developing services for clients who are suspended from treatment or linking in with existing Violent Patient Schemes (VPS) so that treatment does not have to be withheld. The VPS provides a model on which such services could be developed. The safety of the dispensing pharmacist will need to be considered.

6.2 Risks and risk assessment prior to withdrawing treatment

Both the 2007 UK 'Clinical Guidelines' (DH and devolved administrations, 2007) and the suite of guidance from the NHS Security Management Service on responding to physical and non-physical assaults emphasise the need for a careful assessment of the risks associated with withdrawing treatment before the clinical team make a decision to exclude or suspend a client. The risks associated with loss of treatment include:

- Changes in levels of tolerance to opiates used, with an associated risk of overdose and death
- Increased risk of returning to injecting and sharing and the associated risk of contracting or transmitting blood-borne viruses
- Increased risk of harms associated with drug use including risk to children and vulnerable adults and a return to offending behaviour.

6.2.1 Overdose

Several studies have quantified the risk of overdose death among heroin users who are not in treatment (Capelhorn JR et al, 1996; Brugal MT et al, 2005; Gibson A et al, 2008) and more specifically those who have been discharged from methadone treatment (Fugelstad A et al, 2007; Davoli M et al, 2007). Fugelstad et al (2007) examined mortality among individuals who had been in contact with the methadone programme in Stockholm between 1988 and 2000. They found that those who had been discharged from methadone treatment had a 20 times higher risk of dying from unnatural causes compared to clients who remained in treatment – the majority of deaths were due to heroin overdose. Davoli et al (2007) in the VEdeTTE study found that retention in any

specialist drug treatment was protective against overdose mortality (Hazzard Ratio 0.09, 95 per cent confidence interval 0.04 – 0.19). In a study of patients on methadone maintenance in Spain, Brugal et al (2005) found that not being in methadone treatment at the time of death was the factor most strongly associated with the risk of dying from overdose (relative risk 7.1, 95% confidence interval 3.77 – 13.45). Although it is not possible to determine conclusively a causative association between the act of discharge and subsequent overdose/mortality in those from whom treatment is withdrawn, not least because it will sometimes be the most high risk clients that are discharged, it is also clear that it may be a key factor and that substitute opioid treatment in general can be life-saving.

The risk of any significant period of enforced abstinence from opiates is illustrated by a study looking at drug-related mortality among newly released offenders (Singleton et al, 2003). In the week following release, prisoners were over 40 times more likely to die than the general population – over 90 per cent of these deaths were drug-related. At the time the study was undertaken, maintenance substitute opioid treatment had not been introduced to the prison healthcare system to any significant extent and hence most prisoners who had been dependent on heroin or prescribed opioid substitutes on entry would have been taken off substitute medication and have lost their tolerance to opiates prior to release.

6.2.2 BBVs and crime

Studies such as NTORS (Gossop et al, 2001) have shown the dramatic effect that drug misuse treatment can have on reducing injecting behaviour and acquisitive crime. Research suggests that those who drop out of treatment are at increased risk of returning to injecting drug use, sharing injecting equipment (Thiede et al, 2000) and returning to crime to fund their drug use with an increased risk of incarceration (Levaseur et al, 2002).

Clients who are discharged from treatment should be given information on access to needle exchange services and a decision will need to be made as to how they can still access BBV services, for example, complete a vaccination programme.

6.2.3 Risk to children

A further area of concern is the risk posed by a drug-using parent to their children if they return to illicit drug use following discharge from treatment. Once the client is discharged the treatment service may no longer be able to monitor the parent or the child. The 2007 UK ‘Clinical Guidelines’ give advice on the comprehensive assessment of drug-misusing parents, including:

- Effect of drug misuse on functioning, for example, intoxication, agitation
- Effect of drug-seeking behaviour, for example, leaving children unsupervised, contact with unsuitable characters
- Impact of parent’s physical and mental health on parenting.
- How drug use is funded, for example, sex working, diversion of family income
- Emotional availability to children
- Effects on family routines, for example, getting children to school on time
- Other support networks, for example, family support
- Ability to access professional support
- Storage of illicit drugs, prescribed medication and drug-using paraphernalia.

If a drug-using parent is being considered for discharge from treatment, clinicians will need to assess the risks to the child and will need to make a decision as to whether treatment currently be withheld and/or if referral to social services is required.

6.3 A stepped response to incidents

In the document Prevention and Management of Violence where Withdrawal of Treatment is not an Option (NHS SMS, 2006), staff are advised to take action when incidents occur. By tackling incidents at this early stage, risk behaviour may be identified and more serious incidents of violence prevented. Staff need to be aware of the steps that are available to them, such as verbal warnings, written warnings, acceptable behaviour agreements and criminal sanctions. For minor incidents, the stepped approach may begin with a verbal warning but for more serious incidents criminal prosecution may be the most appropriate first step. Where a criminal offence has occurred, e.g. physical assault or drug dealing on the premises, services should adhere to local policies in referring such acts to the police.

Withdrawal of treatment would only usually be considered as a last resort and may require legal advice. Some services report that a client may recognise that they do not want to participate in treatment and withdraw more by mutual agreement but in such cases, as in others, clinical assessment will help to evaluate the impact that withdrawal of treatment could have on the client's health and should take into account the views of the clinician in charge of the individual's care. The range of responses to physical and non-physical assaults includes:

- Verbal warnings
- Written warnings
- Acknowledgement of responsibility agreements
- The use of secure environments and transfer to PCT commissioned Violent Patient Schemes
- Civil injunction and Anti-Social Behaviour Orders (ASBOs)
- Criminal prosecution
- Withholding treatment.

Model examples of written warnings, final warnings and acknowledgement of responsibility agreements are given in Appendix 4.

A similar stepped response can also be applied to issues other than violence that might lead to consideration of withdrawal of treatment. This would include identifying and responding to evidence of problems at an early stage, reviewing the care plan and clarifying goals and expectations, and addressing any difficulties identified and using additional measures if the problem does not resolve or escalates.

Practice point: NHS treatment services' discharge or withholding treatment policies in response to violent incidents should be in line with national guidance issued by the NHS Security Management Service. Where private or third sector providers are commissioned to deliver Tier 3 and 4 interventions from PCTs, there is an obligation for clinical governance to be addressed, and it is likely to be useful for non-NHS providers to ensure that discharge policies are consistent with national guidance in this context.

6.4 Treatment withdrawal and pharmacological treatment

If clients in treatment with specialist drug services do have the prescribing element of their treatment withdrawn, it cannot automatically be assumed that it can be transferred to primary care. Some clients may not have a GP at the time of withdrawal of prescribing by secondary care services. Substitute prescribing to patients with opiate dependence requires suitable levels of clinical competence. The increased numbers of GPs who are involved in this work have usually undertaken additional training and are part of a commissioned service but these do not constitute a majority of GPs. Those GPs without suitable competencies, would not usually be advised to take

on the substance misuse treatment alone, and particularly not of more complex clients and it should be assumed that they may refuse. Therefore, if a clinician in a specialist prescribing service takes a decision to withdraw prescribed treatment from a client, treatment may effectively end. The clinician must take responsibility for this decision and be able to justify it. The decision making process should be documented in the client's case notes and legal advice may need to be sought either in agreeing the service withdrawal of treatment policy or on a case by case basis.

6.5 Client advocacy

Clients sometimes complain that when their treatment has been withdrawn they feel their views were not listened to.

Decisions to withdraw treatment may be taken by senior clinicians and managers or more appropriately may be taken within multidisciplinary teams. However, it is unusual for clients to be present or represented at such meetings. Clients and/or their advocates would appropriately be involved in any final review of the care plan. This ensures they have an opportunity to question staff or refute the account of events that led to the suggested suspensions from treatment and allows for optimal risk management. Clearly, where there are urgent safety concerns this cannot always be completed face-to-face at the time and other methods of communication may be needed.

Where treatment is withdrawn the only appeal process available may be to submit a complaint to the organisation, perhaps with the assistance of the local Patient Advice and Liaison Service (PALS) or one of the client advocacy organisations, such as The Alliance or Release. Some DATs have employed local advocacy workers.

Where a serious assault has taken place, immediate removal of the client from the service may be necessary but with less serious incidents clients would usually value the opportunity to present their side of the story and appeal against unfavourable decisions.

7 Effective treatment, treatment completion and planned discharge

This document highlights the evidence on the importance of effective engagement and retention in drug misuse treatment and the evidence concerning the apparent substantial variations in approaches taken to this issue across different services and partnerships.

The advice focuses on supporting the development of locally-appropriate strategies to improve engagement and retention in effective treatment and on working constructively with those clients whose behaviour has become challenging and who are at risk of discharge. The principles of comprehensive needs assessment, keyworking and care planning, delivery of optimised and evidence-based treatment, reviewing of care plans and outcome monitoring underpin the treatment process and the approaches proposed to prevent unplanned discharge.

It is likely that if the principles and strategies presented in this advice were discussed and implemented locally, where appropriate, and if this were done consistently across partnerships, some treatment providers might expect to see reductions in the number of clients leaving treatment early. Whilst this may lead to a larger number of clients staying in treatment, it may also promote the progression of others towards abstinence and recovery.

Improving engagement and retention and providing more structured approaches to those failing to benefit from treatment or who present challenging behaviours may place greater demands on existing resources but may also lead to their more effective and efficient use over time.

During 2007/08, only 52 per cent of clients leaving treatment had a planned discharge. It is expected that the proportion of clients who successfully complete treatment will continue to increase.

Although drug dependence can be a chronic and relapsing condition, evidence shows that the positive benefits of treatment accrue over time, particularly in those who remain in treatment longer (Gossop et al, 1999; Simpson, 1997). Furthermore, clients who leave opioid maintenance treatment in a planned way are twice as likely to achieve abstinence as those who either drop out of treatment or have their treatment withdrawn (Kornor & Waal, 2005). It is likely that with improved consistency of approaches, more clients will be retained in treatment and may achieve the associated benefits of treatment and so more may also become abstinent and be able to progress to completing and leaving treatment.

For clients who complete treatment an appropriate aftercare and discharge plan will need to be developed as part of the normal care planning process. Some clients who have completed treatment successfully will subsequently relapse. Therefore, it is likely to be important that rapid access back into treatment continues to be available in the aftercare period.

Some clients may achieve considerable stability and social re-integration while maintained on a dose of substitute opioid medication. Remaining in long-term treatment will be necessary for some clients and this is recognised as a treatment option in the Drug Misuse and Dependence: UK guidelines on clinical management (Department of Health and devolved administrations, 2007).

The Government's new drug strategy, Drugs: Protecting Families and Communities (HM Government, 2008), also recognises the need for continuing maintenance substitution treatment for some but also emphasises the importance of supporting recovery from addiction and progress to abstinence. The strategy makes explicit that abstinence-based treatment is recognised as appropriate for some alongside drug-replacement therapy over time for others. Use of evidence-

based effective treatments is advocated including referencing NICE recommendations on medication, contingency management, and other psychosocial interventions. It also recognises the roles of the selected use of injectable opioid medications for those who do not respond to standard oral medication.

Social re-integration is a key theme of the new drug strategy with several proposals to facilitate recovery, including developing packages of support, personalised outcome-focused treatment, greater integration of drug treatment services with wrap-around or reintegration services, and encouraging drug users into training and employment via the benefits system and Job Centre Plus.

Although this document has focused on strategies to engage and retain clients in effective treatment and prevent unplanned discharges, it is for the purpose of enabling them to fully benefit from treatment, so that they can achieve their goals, move through the treatment system, achieve recovery and leave treatment successfully and safely.

This advice is one contribution to supporting services in delivering their ambitious objectives for this client group.

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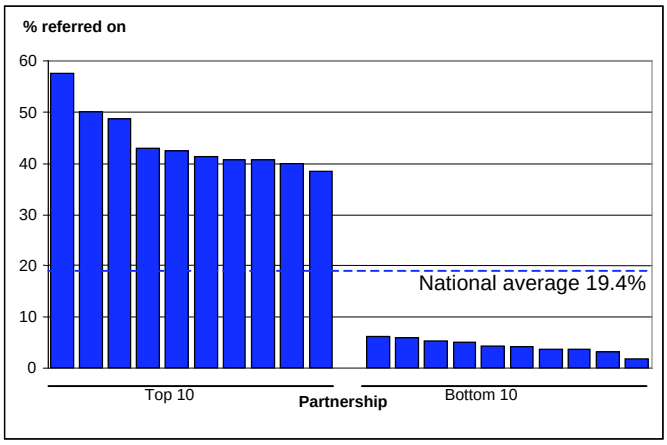
Disclaimer: While the NTA seeks to acknowledge the contributions of individuals who commented on the document while it was being developed, such acknowledgement should not imply in any way that a contributor or comments held any sort of authorship or editorial responsibility.

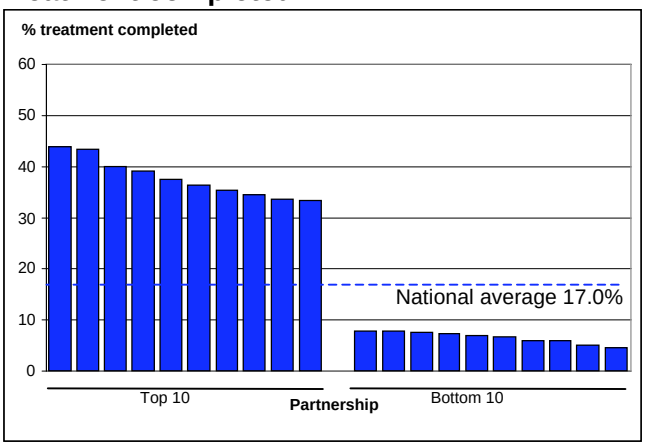
10 Appendix 1 – Performance of partnerships on main discharge outcomes

PLANNED DISCHARGES

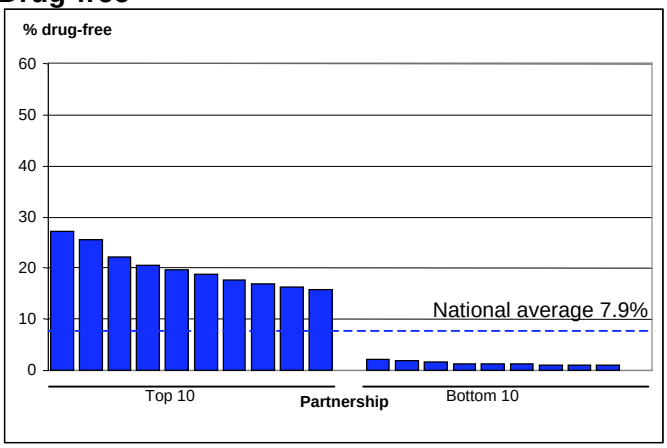
Referred on



Treatment completed

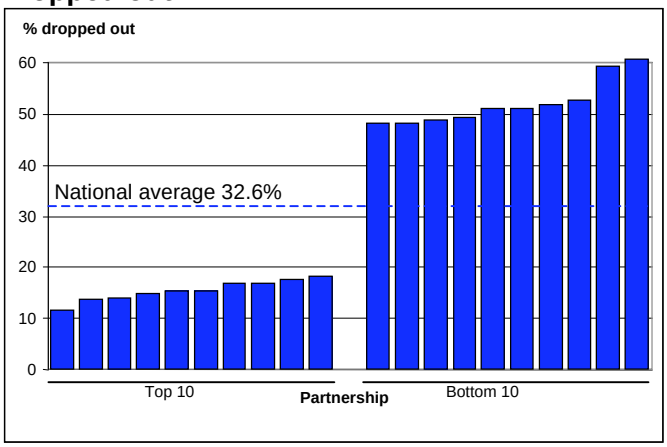


Drug-free

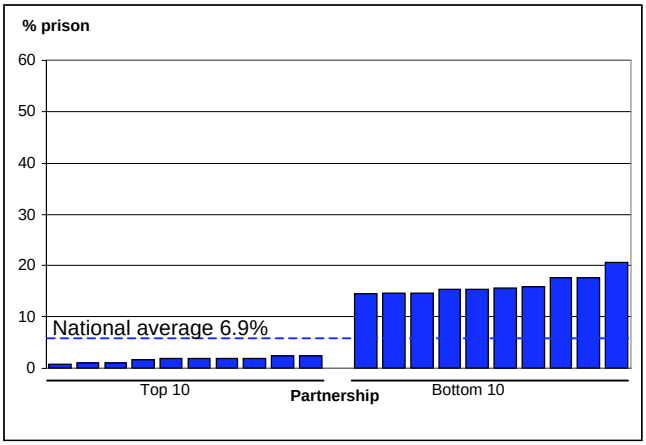


UNPLANNED DISCHARGES

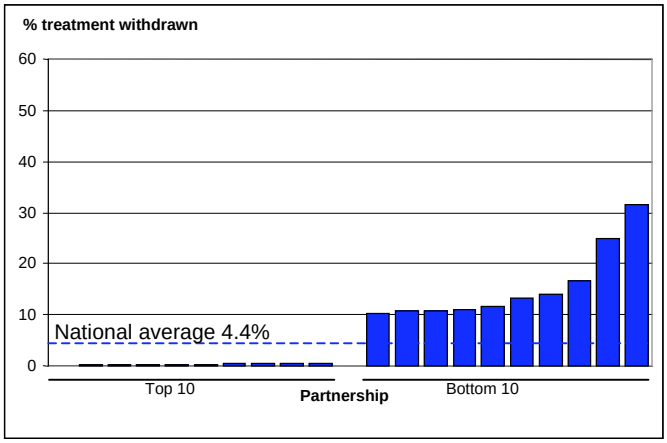
Dropped out



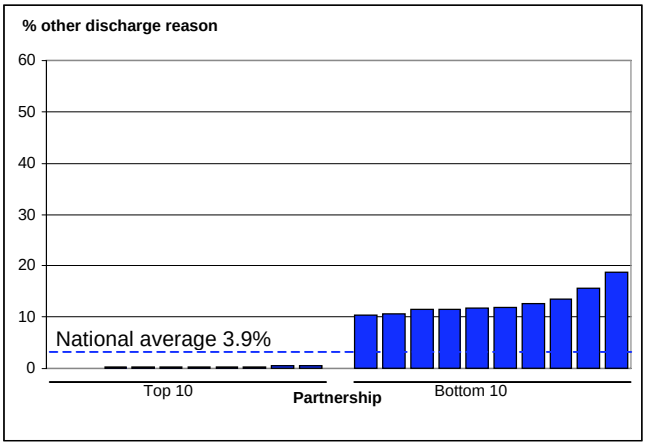
Prison



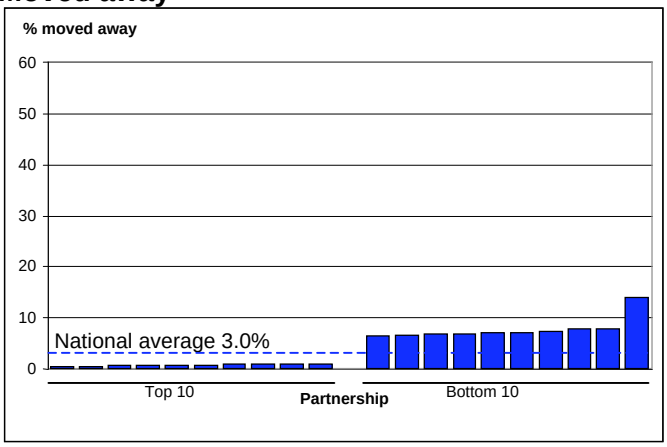
Treatment withdrawn



Other



Moved away



Not known

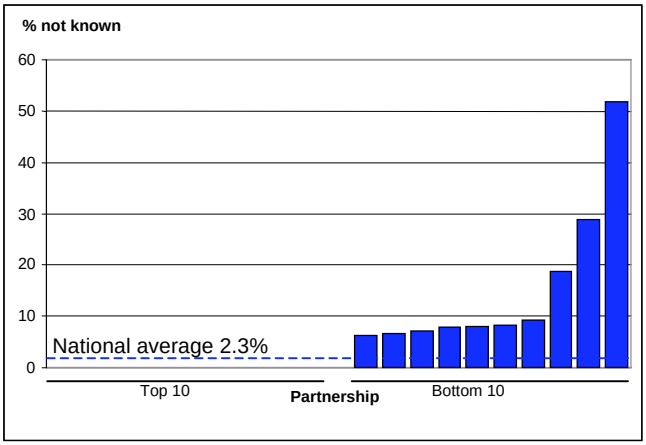


Table 17. Discharge reasons in relation to treatment modality (per cent) – NDTMS data 2006/07

Discharge reason	**Inpatient detox**	**Specialist prescribing**	**GP prescribing**	**Psychosocial**	**Day programme**	**Residential rehab**	**Young people**	**Other**	**Total**
Treatment completed drug free	12.5	6.1	7.9	8.9	9.4	26.4	9.8	7.2	7.9
Treatment completed	28.6	11.6	10.3	19.2	19.3	7.1	37.1	18.1	17.0
Treatment withdrawn	10.3	4.9	4.1	2.9	5.8	15.6	1.2	3.5	4.4
No appropriate treatment	0.1	0.3	0.3	0.5	1.0	1.2	0.5	0.9	0.7
Referred on	12.1	26.8	26.3	17.8	11.2	12.3	8.8	18.9	19.4
Dropped out	30.9	32.0	31.1	34.4	32.8	29.1	26.0	32.6	32.6
Moved away	0.5	3.0	4.3	3.1	2.1	0.7	5.1	2.8	3.0
Prison	0.5	10.4	7.3	5.6	7.0	0.9	3.5	7.0	6.9
Died	0.3	1.1	1.2	0.6	0.3	0.1	0.2	0.5	0.7
Other	1.9	2.2	3.4	3.3	6.3	2.5	5.0	5.2	3.9
Not known	1.5	1.4	3.4	3.2	3.6	2.3	1.0	1.4	2.3
Treatment declined	0.4	0.2	0.1	0.5	0.8	1.7	1.6	1.0	0.9
Inappropriate referral	0.4	0.0	0.2	0.1	0.3	0.2	0.3	0.9	0.3

11 Appendix 2 – NDTMS Dataset F – Adult discharge codes from April 1st 2009

Data item name - Treatment completed – Drug free. **Data item definition** – The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin or crack cocaine or any other illicit drug.*

Data item name – Treatment Completed - Occasional user (not heroin and crack). **Data item definition** – The client no longer requires structured drug treatment interventions and is judged by the clinician not to be using heroin or crack cocaine. There is evidence of use of other illicit drug use but this is not judged to be problematic or to require treatment.*

Data item name – Transferred – Not in custody. **Data item definition** – A client has finished treatment at this provider but still requires further structured drug treatment interventions and the individual has been referred to an alternative non-prison provider for this. This code should only be used if there is an appropriate referral path and care planned structured drug treatment pathways are available.

Data item name – Transferred – In custody. **Data item definition** – A client has received a custodial sentence or is on remand and a continuation of structured treatment has been arranged. This will consist of the appropriate onward referral of care planning information and a two-way communication between the community and prison treatment provider to confirm assessment and that care planned treatment will be provided as appropriate.

Data item name – Incomplete – Dropped Out. **Data item definition** – The treatment provider has lost contact with client without a planned discharge and activities to re-engage the client back into treatment have not been successful.

Data item name – Incomplete – Treatment withdrawn by provider. **Data item definition** – The treatment provider has withdrawn treatment provision from the client. This item could be used, for example, in cases where the client has seriously breached a contract leading to their discharge; it should not be used if the client has simply 'Dropped out'.

Data item name – Incomplete – Retained in custody. **Data item definition** – The client is no longer in contact with the treatment provider as they are in prison or another secure setting. While the treatment provider has confirmed this, there has been no formal two-way communication between the treatment provider and the criminal justice system care provider leading to continuation of the appropriate assessment and care-planned structured drug treatment.

Data item name – Incomplete – Treatment commencement declined by the client. **Data item definition** - The treatment provider has received a referral and has had a face-to-face contact with the client after which the client has chosen not to commence a recommended structured drug treatment intervention.

Data item name – Incomplete – Client died. **Data item definition** – During their time in contact with structured drug treatment the client died.

* The NTA expects that in cases where an individual has been receiving treatment for dependence on opiods and/or crack, a period of sustained abstinence, (e.g. 28 days or more), would normally occur before a discharge code denoting a planned discharge is applied. There may be scenarios where a client has used opiods or crack within the 28 days leading up to their planned discharge, when a clinician, taking all relevant circumstances into account, still judges a treatment completed code is appropriate. In every case, the decision to discharge a client in a planned way rests with the clinician and on their professional judgment.

12 Appendix 3 – NHS Security Management Service and definitions of assault

12.1 The NHS security management service

In 1999 the NHS "zero tolerance zone" campaign was launched with the aim of raising awareness with the public that violence in the NHS would be not be tolerated and to give a pledge to staff that violence was being tackled. In 2001 the Health Secretary gave the NHS the go-ahead to deny clients treatment if they attacked staff. Guidance was provided in the Health Service Circular Withholding Treatment from Violent and Abusive Patients in NHS Trusts (DH, 2001).

The Health Service Circular (DH, 2001) on withdrawing treatment to violent and abusive patients recommended that certain groups should not be excluded from treatment, including "anyone who is mentally ill or under the influence of alcohol or drugs".

In 2003 the Government created the NHS Security Management Service which has policy and operational responsibility for the management of security in the NHS. This includes tackling violent and non-physical assaults against staff. The NHS Security Management Service was required to introduce the following:

- A national definition of physical assault
- A national definition of non-physical assault
- A national incident reporting system for recording physical assaults
- A nominated security management director (SMD) at board level in all health bodies
- A network of highly trained local security management specialists (LSMS)
- Creation of a Legal Protection Unit (LPU) to increase the prosecution rate against offenders who assault staff, in particular where local police or the Crown Prosecution Service have decided not to prosecute.

12.2 The NHS definitions of physical and non-physical assault

The NHS Security Management Service has produced definitions of both physical assault and non-physical assault.

A physical assault is: "The intentional application of force to the person of another without lawful justification resulting in physical injury or personal discomfort" (NHS SMS, 2007). Examples of physical assault include:

- Spitting on/at staff
- Pushing/shoving
- Poking/jabbing
- Scratching and pinching
- Throwing objects, substance or liquids onto a person
- Punching and kicking
- Hitting and slapping
- Sexual assault

- Incidents where reckless behaviour results in physical harm to others
- Incidents where attempts are made to cause physical harm to others and fail.

A non-physical assault is: “The use of inappropriate words or behaviour causing distress and/or constituting harassment.” Examples include:

- Offensive language, verbal abuse and swearing
- Racist comments
- Loud and intrusive conversation
- Unwanted or abusive remarks
- Negative, malicious or stereotypical comments
- Invasion of personal space
- Brandishing of objects or weapons
- Near misses i.e. unsuccessful physical assaults
- Offensive gestures
- Threats or risk of serious injury to NHS staff
- Intimidation
- Stalking
- Alcohol or drug fuelled abuse
- Incitement of others and/or disruptive behaviour
- Unreasonable behaviour and non-cooperation
- Any of the above linked to destruction of or damage to property.

Within the drug misuse field other examples of non-violent incidents are familiar to staff, including: dealing drugs on or near the service premises, consuming alcohol or drugs on or near the premises, altercations between clients in the waiting room, altering prescriptions, “double scripting” (the concomitant collection of the same medication with different prescriptions, from two prescribers), selling medication to others and using deception to collect another person’s prescription from a pharmacy.

13 Appendix 4 – Examples of warning letters and contracts

In this appendix examples are given of warning letters that are taken from the NHS Security Management Service's document *Non-physical assault – explanatory notes* (NHS SMS, 2004), which at the time of writing is being updated. These letters are used as part of a process, which involves providing a verbal warning, written warning and so on. Templates similar to these might be helpful, if suitably amended, to be used for similar approaches to the management of non-violent incidents and other forms of unacceptable behaviour.

Dear

Acknowledgement of Responsibilities Agreement between <insert name of patient, visitor or member of the public> and <insert name of health body or location>

It is alleged that on the <insert date> you <insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse. This was made clear to you at the meeting you attended on <insert location and date> to acknowledge responsibility for your actions and agree a way forward.

I would urge you to consider your behaviour when attending the <insert name of trust/location> in the future and comply with the following conditions as discussed at our meeting:

<list of conditions>

If you fail to act in accordance with these conditions and continue to demonstrate what we consider to be unacceptable behaviour, I will have no choice but to take one of the following actions: (to be adjusted as appropriate):

The matter will be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.

The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.

Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.

A copy of this letter is attached. Please sign the second copy and return to me to indicate that you have read and understood the above warning and agree to abide by the conditions listed accordingly.

If you do not reply within fourteen days I shall assume tacit agreement.

Sincerely,

Signed by senior staff member

Date

I, <insert name> accept the conditions listed above and agree to abide by them accordingly.

Signed

Date

Dear

FINAL WARNING

I am writing to you concerning an incident that occurred on <insert date> at <insert name of health body or location>.

It is alleged that you <insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse. This has been made clear to you in <insert details of previous correspondence/meetings>. A copy of this health body's policy on the withholding of treatment from patients is enclosed for your attention.

If you act in accordance with what this trust considers to be acceptable behaviour, your care will not be affected. However, if there is a repetition of your unacceptable behaviour, this warning will remain on your medical records for a period of one year from the date of issue and will be taken into consideration with one or more of the following actions:

(to be adjusted as appropriate)

- The withdrawal of NHS Care and Treatment, subject to clinical advice.
- The matter will be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.
- The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.

Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.

In considering withholding treatment this trust considers cases on an individual basis to ensure that the need to protect staff is balanced against the need to provide health care to patients. An exclusion from NHS premises would mean that you would not receive care at this trust and (title, i.e. clinician) would make alternative arrangement for you to receive treatment elsewhere.

I enclose two copies of this letter for your attention, I would be grateful if you could sign one copy, acknowledging your agreement with these conditions and return it to me in the envelope provided. In the event that I receive no reply within the next fourteen days, it shall be presumed that you agree with the conditions contained herein.

I hope that you should find these conditions acceptable. However, if you do not agree with the details contained in this letter about your alleged behaviour or feel that this action is unwarranted, please contact in writing <insert details of local complaints procedure> who will review the decision in light of your account of the incident(s).

Yours faithfully

Signed by senior staff member.

I, <insert name> accept the conditions listed and agree to abide by them accordingly.

Signed	Dated

Dear

Withholding of Treatment

I am writing to you concerning an incident that occurred on <insert date> at <insert name of health body or location>.

It is alleged that you, <insert name>, used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse. A copy of this health body's policy on the withholding of treatment from patients is enclosed for your attention.

Following a number of warnings <insert details of correspondence and meetings> where this has been made clear to you, and following clinical assessment and appropriate consultation, it has been decided that you should be excluded from health body premises. The period of this exclusion is <insert number of weeks/months> and comes into effect from the date of this letter.

As part of this exclusion notice you are not to attend <health body> premises at any time except:

- in a medical emergency; or
- where you are invited to attend as a pre-arranged appointment.

Contravention of this notice will result in one or more of the following actions being taken (to be adjusted as appropriate):

- Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.
- The matter will be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service
- The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.

During the period of your exclusion the following arrangement must be followed in order for you to receive treatment <list arrangements>.

In considering withholding treatment this health body considers cases on their individual merits to ensure that the need to protect staff is balanced against the need to provide health care to individuals.

If you consider that your alleged behaviour has been misrepresented or that this action is unwarranted, please contact in writing <insert details of local complaints procedure> who will review this decision in the light of your account of the incident(s).

A copy of this letter has been issued to your GP and consultant.

Yours faithfully,

Signed by senior member of staff

Date