

Preventing unplanned discharges from drug treatment services

Introduction

The National Treatment Agency has developed guidance for service providers and commissioners on good practice in preventing unplanned discharges from drug treatment services entitled: *Towards successful treatment completion – a good practice guide*¹. This article summarises the main areas that the guidance covers.

Background

The 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 good practice guide was supported by an expert advisory group established for this purpose, and 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, National Health Service treatment providers, the non-statutory sector, and client advocacy groups.

For the year 2007/08 a total of 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treatment in an unplanned way, often before his or her goals have been fully achieved, or if the client's treatment is withdrawn, the client can be said to have had an unplanned discharge.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 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

¹ National Treatment Agency for Substance Misuse (2009) *Towards successful treatment completion – a good practice guide*. London, NTA. <http://www.nta.nhs.uk/publications/documents/completions0909.pdf>

their treatment continued under the Integrated Drug Treatment System (IDTS) that has been introduced in the prison estate. Some clients who dropped out of treatment may no longer need treatment.

In 2007/08 a total of 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 71 per 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.

The profile of unplanned discharges

There is considerable variation between partnerships in the rate of unplanned discharges. Data from the National Drug Treatment Monitoring System (NDTMS) and the Drug Interventions Record (DIR) are presented in the good practice guide. The analysis shows that 'service factors' have a much bigger impact on treatment outcome than client characteristics. However, 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 in 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.

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 treatment². 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.

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 setbacks – clients may relapse or increase their levels of illicit drug use or fail to reach the goals they have set with their keyworkers. Helping clients develop strategies to deal with these challenges is an essential aspect of clinical care.

² National Treatment Agency (2004) *Engaging and retaining clients in drug treatment*. Research to practice: 5. London, NTA.

This section of the good practice guide 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 *Drug Misuse and Dependence: UK guidelines on clinical management*³ give guidance on responding more effectively to clients who are failing to benefit from treatment. This good practice guide 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.

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 opioids⁴. 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.

³ Department of Health and devolved administrations (2007) *Drug Misuse and Dependence: UK guidelines on clinical management* London, DH.

⁴ Fugelstad A et al. (2007) Methadone maintenance treatment: the balance between life-saving treatment and fatal poisonings. *Addiction* 102 (3): 406-412.

The policy framework developed by the NHS Security Management Service, a special health authority that has the strategic lead in this area, is discussed and a stepped approach to responding to violent and non-violent incidents is advocated⁵.

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 strategy⁶. 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.

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⁵ National Health Service Security Management Service (2007) *Tackling violence against staff – explanatory notes*. London, NHS SMS.

⁶ H M Government (2008) *Drugs: Protecting Families and Communities*