CHAOTIC BEHAVIOUR & POOR CONCORDANCE

A central theme of the treatment approach with clients is to enhance the general stability of the client's life. Stabilisation may be achieved through a combination of bio-psycho-social interventions such as methadone prescription (long duration of action versus short duration of action of heroin), permanent as opposed to temporary housing, employment as opposed to acquisitive crime etc., etc.. Equally, retention in treatment has been well established as a predictor of positive outcomes, and service policies and protocols must support processes aimed at retention whilst balancing this against safe practice and demands on throughput.

In some cases, retention can be particularly difficult to achieve due to the highly chaotic nature of the client's behaviour. A lifestyle centered around a rapidly cycling pattern of intoxication, withdrawal and the need to commit acquisitive crime to continue the cycle tends to preclude reliable appointment attendance and safe use of prescribed substitute medication. High threshold programmes will thus tend to exclude such clients from treatment due to poor concordance with programme rules, and as such a perverse situation arises whereby the clients with the severest problems are also those who tend to be excluded from treatment. This section attempts to address this conflict by providing guidance in engagement of clients with treatment whilst also ensuring that practice remains safe and appropriate.

Engagement of clients who are difficult to retain is the particular task of Type 1 Units (low threshold/engaging), and such units should use all the techniques discussed below with the addition of a drop-in rationale and with the exclusion of substitute prescribing. Discharge from such units will usually only occur as a result of threatening behaviour on the part of the client. Type 2 units (high threshold) and Type 3 (low threshold/aftercare) units should apply all techniques with the exclusion of a drop-in rationale.

Services which attract clients into treatment:

- Substitute prescribing.
- Alternative therapies.
- Financial, legal and housing advice.
- Creches.
- Free transportation.
- Social care support.

Services which engage and retain clients in treatment:

- Service development:
  - the one-stop shop.
  - rapid response to need at the time of motivation.
  - flexibility with appointment times.
- Individual measures:
  - Consider reducing the intensity of treatment.
  - Form a positive alliance with the client.
  - Use motivational techniques.
  - Use a structured cognitive approach which aims primarily to reduce the risk of dropout.
- **Discharge following unsuccessful interventions should be planned together with a clear route back into treatment.**

SERVICES WHICH ATTRACT CLIENTS INTO TREATMENT

The first step is to attract clients into the service site. Several interventions are well recognised as having attractive power and are discussed below.

SUBSTITUTE PRESCRIBING

The provision of methadone or Subutex for opiate dependent clients is the commonest form of substitute prescribing. The attractive power of such interventions is evidenced by the relatively large number of opiate users in treatment, as opposed to primary amphetamine or crack cocaine users. The latter form a larger group in the general population, but are only rarely found in treatment services. Specialist services should consider the development of programmes to provide injectable opioids, dexamphetamine and benzodiazepines to selected groups of clients who are otherwise hard to engage. Equally, an on-site dispensing service can be provided for those able to access this, as opposed to prescription for community pharmacy dispensing, as the former will encourage daily as opposed to weekly or fortnightly attendance.

ALTERNATIVE THERAPIES

Although there is only limited evidence as to the therapeutic efficacy of various alternative therapies in the context of substance misuse treatment, there can be little doubt as to their power to attract clients to the site of service delivery. Auricular acupuncture and Shiatsu are the most commonly cited as well attended, and should be as widely available as possible in specialist service sites.

FINANCIAL, LEGAL AND HOUSING ADVICE

Many clients are too chaotic in their behaviour to access the various generic local services to which they have a right. Complex appointment systems and paperwork will often prevent progress with benefits and housing applications for more chaotic clients, thus placing another barrier in the way of progress towards stability. The provision of specialist advice, help with form completion and direct advocacy with statutory agencies will attract some clients into the treatment site. The client should be supported in sharing such tasks with the helper until greater stability has been attained.

CRECHES

Women are under-represented in treatment services, and one commonly sited reason for this is the difficulty of matching child-caring responsibilities with other responsibilities. The provision of a creche on-site would be highly attractive to many mothers who would otherwise fail to engage with services.

FINANCIAL INCENTIVES

All services should provide full reimbursement of travelling expenses as standard.

SOCIAL CARE SUPPORT

Helpers can be contracted through the community care budget to provide various supportive tasks such as delivering children to school.

FULL ENGAGEMENT AND RETENTION IN TREATMENT

Provision of the above services will act to increase attendance at the specialist service site. Having achieved this, clients must be engaged with treatments that are likely to improve outcomes rather than merely improve attendance.

FLEXIBILITY WITH APPOINTMENT TIMES

Services and individual workers should attempt to set appointment times that maximise the likelihood of the client attending. This will often involve making appointments in the afternoon rather than the morning for poor engagers, and sometimes making evening appointments available. If the client is to be successfully engaged, workers will often have to put the client's agenda before their own.

CONSIDER REDUCING THE INTENSITY OF TREATMENT

Some studies indicate that retention in treatment may be enhanced in some cases by reducing treatment intensity, rather than by increasing it (Moos et al, 2002). A clinician's natural response if a client is responding poorly to treatment will often be to increase the intensity of treatments provided; however, particularly for those who appear to have deteriorated since commencement of treatment, a period of reduced frequency of attendance may be beneficial. As with all of the above interventions, this will have to be balanced against service requirements regarding prescribing, risk and monitoring which will stipulate a minimum frequency of attendance for various interventions.

PSYCHOLOGICAL INTERVENTIONS AIMED AT ENHANCING ENGAGEMENT

Lack of engagement and very early dropout can be understood as representative of the pre-contemplative and contemplative stages of change (Miller, 1985). Strategies and approaches must address the lack of motivation to change, ambivalence about change, lack of a clear problem focus, and the decision-making tasks and cognitive processes that characterise the tasks and challenges of these early stages (Prochaska, 1994). The following ideals should be aimed for by individual workers in their general interactions with clients and through service design and protocols:

- **Respond quickly to requests for treatment to maximise use of whatever motivation is present at the initial request.**
- **Focus on the client's immediate concerns, not those of the programme. Such immediate concerns of the client are the entrée to whatever possibilities there are for change.**
- **Use motivational interviewing techniques to stimulate the client into seeing change as being in their best interest.**

Various factors are associated with drop-out from or failure to engage with therapy including the quality of the therapeutic alliance (Strupp et al, 1992), and the severity of the psychopathology (Sterling et al, 1994). In particular it has been demonstrated that clients with substance misuse problems are more likely than any other patients to drop out of individual therapy

(Swett & Noones, 1989). In the typical course of community treatment for drug dependence, individuals may become sceptical, believing that treatment isn't working (especially in response to strong urges, craving or lapses). This belief may lead to missed sessions and eventual drop-out from treatment. Many factors may be associated with missed sessions including continued substance misuse, extended periods of abstinence, legal problems, psychological problems, therapeutic relationship problems etc..

Possibly the most important factor associated with successful engagement is the establishment of an effective therapeutic alliance between the keyworker and client. There are various components of such an alliance as described by Newman (1994):

Establishing rapport at the outset of treatment.

- Speak directly, simply and honestly.
- Ask about the client's thoughts and feelings about being in therapy.
- Focus on the client's distress rather than the substance misuse per se.
- Acknowledge the client's ambivalence.
- Explore the purpose and goals of treatment.
- Discuss the issue of confidentiality.
- Avoid judgmental comments.
- Appeal to the patient's areas of positive self-esteem.
- Acknowledge that treatment is difficult.
- Ask open-ended questions, then be a good listener.

Maintaining a positive alliance over the course of treatment.

- Ask clients for feedback about every session.
- Be attentive. Remember details about the client from session to session.
- Use imagery and metaphors that the client will find personally relevant.
- Be consistent, dependable and available.
- Be trustworthy, even when the client is not.
- Remain calm and cool in the session, even if the client is not.
- Be confident, but be humble.
- Set limits in a respectful manner.

Having initially engaged the client, the key-worker will be offering individual sessions for care-coordination, or/and counselling of a structured or non-structured nature. Clients considered at particularly high risk of dropout should be managed with a structured cognitive approach which aims primarily to reduce the risk of dropout. The essential form of this structured approach has been outlined by Liese & Beck (1996):

Develop an accurate case formulation for each client.

Paying careful attention to factors associated with dropout - a beliefs-focused picture of the client specifically related to reasons for missed sessions should be formulated. This will include:

- Circumstances related to missed sessions and dropout (e.g. drug use, legal problems).
- Beliefs activated by missed sessions (e.g. "My therapist doesn't understand me", "I,m too busy to go to therapy").
- Associated automatic thoughts (e.g. "Why bother?", "It's hopeless", "Maybe next week").
- Associated emotions (e.g. sadness, anxiety, anger, frustration).

The therapist should recognise the cyclical nature of the thinking process and behaviour of missing appointments. Open-ended questions to elicit beliefs that potentially lead to dropout should be asked, such as:

- "When you don't feel like coming to therapy, what thoughts go through your mind?"
- "How do you respond to inevitable thoughts of not continuing with therapy?"

Use the structure of cognitive therapy to anticipate and address potential dropout - the routine structure of a session can be used to anticipate and prevent poor attendance as follows:

- Agenda setting – if the client has no immediate agenda ask: "What are your current thoughts about being in therapy?"
- Mood check – "How do you feel about being here today?"
- Bridge from the previous session – are there no perceived benefits from the last session and if so why?
- Today's agenda – prioritise items with the client so that they are heard; do not focus purely on substance misuse.
- Feedback – ask: "What are your thoughts and beliefs about therapy?". "What's motivating you to continue with therapy?"

- **Homework – assign homework that is relevant to the main problems identified; examine thoughts associated with failure to do previous week's homework.**
- **Use techniques such as an advantages-disadvantages analysis to consider the benefits of continued attendance. Educate the client about their cognitive disortions.**
- **Techniques and education must be perceived as relevant by the client, and delivered with good timing.**

DELIVERING EFFECTIVE TREATMENTS - THE ONE-STOP SHOP

Having attracted clients into the unit, and then engaged them with a treatment process, it remains to maximise the delivery of effective interventions. Specialist services should aim to provide a 'one-stop shop' where a full range of inteventions for substance misusing clients is available. These will include services often considered as ancillary such as gastroenterology, midwifery or relationship counselling, as well as more standard services such as AA and NA meetings. The guiding principle is that substance misusing clients as a group are poor attenders of all kinds of healthcare appointments, whether or not these are directly related to dealing with the substance misusing behaviour. The harm-minimisation rationale and the associated measurements of outcome dictate that the holistic needs of the client must be addressed. Overall improvements in functioning are most likely to be attained by providing a full range of services at a site which specialises in attracting clients and promoting on-going attendance.

WHEN TO DISCHARGE POORLY CONCORDANT CLIENTS FROM TREATMENT

HIGH THRESHOLD TYPE 2 UNITS AND LOW THRESHOLD TYPE 3 UNITS

There will always be a balance to be maintained between provision of a safe service which maintains an adequate throughput, and the retention of clients in treatment. In a world of limited resources, treatment spaces must continue to be made available to those that may benefit from treatment. There are several situations in which discharge due to poor compliance should occur:

- **Attendance remains erratic despite the use of the techniques described above. A reasonable cut off point might be less than 50% of appointments attended on an on-going basis.**
- **Prescribed controlled medication is sold.**
- **Prescribed controlled medication is repeatedly not used as directed, leading to direct risk to the client; for example storing of medication with subsequent consumption of large doses, regular failure to collect medication leading to potential loss of tolerance.**
- **Physical or verbal violence to staff or other clients.**
- **Use of drugs or alcohol on the premises.**

In general, clients should **not** be discharged for the continued use of illicit substances on-top of their prescribed medication. The evidence clearly demonstrates that retention is associated with the best outcomes; presumably this is related to the simple fact that major change takes time to achieve. The response to such situations is complex and will include giving advice regarding the dangers of combining prescribed and illicit substances, considering dosage increases, considering dosage decreases, tolerance testing, biological compliance monitoring, re-setting objectives, full reviews of the immediate and long-term bio-psycho-social plan. However, if after repeated attempts to address the situation it is assessed that there are no substantial gains accrued from the treatment programme such as reduced drug use, reduced injecting behaviour, improved social stability, then discharge may become inevitable.

Discharge may bring its own benefits in time, with improved concordance on re-admission to the service. This is especially likely to occur when discharge has been associated with a loss of access to the attractive elements of the service as described above.

TYPE 1 ENGAGING UNITS AND OUTREACH SERVICES

Clients who are not attracted by high threshold services may find a route into treatment through low threshold drop-in based services (Type 1 Unit) (see Section A4). Despite their potential to engage more chaotic clients into treatment, substitute prescribing interventions should not be offered in this context due to the marked medico-legal risks. The other attractive elements of service provision should be developed to the full in such units. Discharge from such units will usually only be necessary due to physical or verbal violence on the part of the client, or use of drugs or alcohol on the premises.

Outreach services are costly in terms of returns for in-put. Outreach services that focus on certain well-defined high risk groups (e.g. 'dual diagnosis') should be developed, but all specialist services should avoid developing a generic outreach-based rationale.