The power of the welcoming reminder

MANNERS MATTER • PART 1

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Doing the simple things well, and running the kind of service you yourself would like to visit, can transform treatment uptake and retention.

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THE MANNERS MATTER review is about how treatment services can encourage clients who make an initial contact to return and stay the course. Retention is a key policy target[7,8] because it is seen as the best indicator of the degree to which patients and society benefit from treatment.[1] Research broadly supports this link,[2,3,4,5,6] but retention is in turn just one indicator of 'engagement' – a sign that clients are actively 'working the programme', talking about the things that matter, forging therapeutic relationships, getting extra help if needed – the processes through which treatment makes a difference.[7,8,9,10]

Our focus is not so much on *what* services do, but *how* they do it, and how this can create a bond with the people who come to them for help. While which treatment 'technology' is delivered typically makes little difference, *how* it is done can transform the client's response. The principles are simple: the same human qualities which cement relationships outside treatment also do so within it. Part one of this review deals with some straightforward expressions of these qualities: responding quickly, keeping in touch, not too easily abandoning those who don't respond first time. Later parts deal with the client's relationships to their counsellor and to the agency. But the division is not (nor should it be) a sharp one; a reminder letter can be curt and off-putting, or warm and motivation-enhancing.

Or course, even if services know how to maximise retention, they may choose not to do so.[11] Waiting lists, deterrent intake procedures and early terminations can be used to manage workload and exclude less promising or more troublesome clients. Staff may also believe that initiating contact with clients who miss appointments erodes a necessary boundary between counsellor and client. Though acknowledging these barriers, the focus here is on what could be done with sufficient will and (usually little if any) extra resources.

Waiting is de-motivating

Having to wait is less a test of motivation than its adversary. Apart from any direct impacts, responding quickly is a clear, early token of *responsiveness*, a quality which in various manifestations emerges as an important retention-enhancer.

Forced to wait too long, even seriously ill patients awaiting emergency care give up and go home.[12,13,14] In alcohol and drug treatment too, reducing the delay between initial contact and the first scheduled treatment session generally improves attendance at this session[15,16,17,18,19,20,21] without adversely affecting longer-term retention.[19,20,22,23,24,25,26,27] Neither is there any evidence that people who give up don't really need help.[15,24,27,28,29] Some studies find the reverse: those in greatest need are excluded by treatment access barriers.[16,25]

Asked by researchers (they rarely are), patients have testified to the impact of having to wait. In two studies, substance users who contacted services were asked why they did not go on to start treatment[16] and/or dropped out early.[20] In one, a fifth cited the waiting list and in the other, 16%, but in both many more cited factors which a waiting period can create space for: a change of heart; no longer feeling in need of help; forgetting the appointment; continued or resumed substance abuse; becoming ill; being arrested.

Other studies bear witness to these processes at one remove, in their effects on treatment uptake. Most simply observed intake processes, so cannot eliminate the possibility that what looks like a causal relationship between waiting time and treatment uptake is due to something else entirely – perhaps less motivated clients delay treatment entry and eventually avoid it altogether. More weight can be placed on studies which deliberately manipulate waiting times, stripping away confounding influences to reveal the effect on treatment uptake. These are the studies on which we focus.

EVEN WHEN METHADONE IS THE INCENTIVE

Despite a powerful inducement, even prospective methadone patients are deterred by long waits. In this modality, rapid initiation must be balanced against the risks of injudicious prescribing and overdose. But within these limits, paring pre-treatment delays and 'hurdles' to the minimum increases treatment entry rates without adversely affecting retention or outcomes – exposing delays as simply a barrier to treatment, not a filter to exclude the unmotivated or unpromising.

One US service used extra funding to expand capacity, reduce the time from first contact to intake from 40 to 14 days, and to cut the intake

Norman Rockwell's *The Waiting Room* captured the resignation anticipation and frustration of being in need but having to wait

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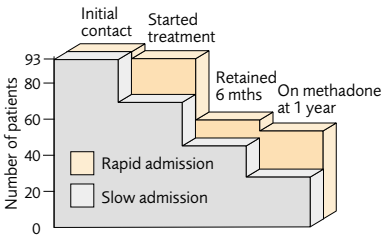

process from two weeks to two days.[25] Requests for intake appointments tripled from 35 to 100 per month yet the percentage actually kept rose from 33% to 54% without affecting longer term retention. Another effect was to open up the programme to more socially excluded and severely dependent clients, perhaps least able to hang on.

In Texas (*chart above*) a methadone programme randomly allocated 93 applicants each to its usual two-week assessment, or instead started patients on methadone within 24 hours.[28] Only 4% of these patients failed to make it to the first dose compared to 26% after extended assessment, yet over the next year just as many stayed in treatment, more (49 v 28) were still on methadone a year later,[i] and they did just as well in terms of drug use, HIV risk and social reintegration. Mexican-Americans were disproportionately represented in the pre-treatment drop-outs so benefited most from rapid admission.

The message is an old one. Over 30 years ago a methadone service in Philadelphia tried replacing its two-stage intake process (patients had to return the following day for a series of appointments) with a one-stop, walk-in procedure.[26] This completed initial assessment and the first methadone dose seamlessly on the same day. Two months after intake about 55% of one-stop patients remained in treatment but just 30% under the two-stage procedure, probably due to patients failing to return for the second stage.[ii] After this, the two sets of patients dropped out at roughly the same rate. The result was that at five months over twice as many one-stop patients were still in treatment. These gains were achieved through greater flexibility rather than greater resources.

The two previous studies are examples of 'triaged' assessment.[30] A rapid, brief assessment does enough to check whether the patient is at the right agency or should be referred on; comprehensive assessment is deferred until after treatment has started. Another approach is to establish a stripped-down methadone programme which can 'hold' applicants awaiting entry to the full programme. In New York this opened up access to treatment and reduced waiting times without adversely affecting retention.[27]

IT'S GOOD TO TALK (SOON)

Arguments for rapidly starting non-drug based therapies are given added weight by the fact that these are the main treatments for cocaine/crack users,[31] and that engaging more of these users is now a national priority.[32]

Early clues came in the 1950s from Morris Chafetz's pioneering alcohol clinic in Massachusetts *Transformation stories 1, p. 17*. Among the measures trialed there was to initiate same-day social work contact in response to a (typically crisis) call from an alcoholic or their family, if necessary visiting their home.[33] Initial attendance tripled and over the next six months 27% of patients returned at least five times compared to none sent the usual appointment.

Equally striking results have been achieved with stimulant users, who also tend to call in a crisis. At a US community drug treatment service in Portland, 60% of phone callers randomly allocated to come as soon as possible (the same day if they wished) turned up compared to just 38% given appointments for on average 10 days later.[34] Two-thirds of those who completed admission primarily used stimulants.

THE SAME HUMAN QUALITIES WHICH CEMENT RELATIONSHIPS OUTSIDE TREATMENT ALSO DO SO WITHIN IT

To similar effect, a cocaine clinic in a poor urban area of New Jersey randomly allocated phone callers to the offer of an appointment the same day, the next day, three, or seven days later.[29] Callers who couldn't make it could reschedule. The criterion for successful attendance was turning up within a week of the first time offered. 72% offered a next-day appointment did so compared to around 40% offered a later slot. Taking other factors into account, next-day appointees were over four times more likely to attend.

One issue is whether the *offer* of a prompt appointment makes a difference, even if the client has to turn it down. An earlier study at the same clinic randomly allocated patients to same-day or normal (one to seven days) appointments.[35] Almost twice as many offered a same-day appointment attended for intake irrespective of whether they could actually come at the offered time.

WAIT *less*, STAY *longer*?

Among patients who start treatment, those who had to wait less are sometimes found to stay longer. Some such studies have already been cited,[26 28 33] others are described below.

A short-term residential rehabilitation centre in England checked the records of all 2144 first admissions over 15 years.[23] About half had problems mainly with alcohol, half illicit drugs. On average those who went on to complete had waited four days less for entry. Slicing the figures another way, 56% waiting a week or less completed treatment but 44% who'd waited a month or more. Adjusting for other factors which might explain this relationship still left waiting time significantly related to completion.

Some studies have noted this trend but were unable to adjust for other factors. They add weight to the suggestion that shorter waits result in longer stays, but cannot exclude the possibility that the relationship is due to something else. Such studies have included one of a British outpatient drug and alcohol service whose caseload consisted mostly of problem drinkers,[24] an alcohol treatment unit in Manchester,[19] and a community drug team in south London.[36]

Even if shorter waits don't always result in longer stays, the reverse is rarely the case. An exception is an early study of a US alcoholism clinic.[21] Shorter delays (up to four days) between initial contact and intake appointment meant more people turned up for intake, but fewer of these returned for their first therapy session. The two effects roughly cancelled out, so that, regardless of intake delay, around a third of contacts attended their first therapy session. A possible explanation is that patients with the greatest problems (legal and employment) were fast-tracked to the intake phase but were also less able to follow through and start treatment. Another is that, for some, a rapidly arranged intake appointment was enough to quel the crisis which precipitated the original contact.

Take-home GOLDEN BULLETS *messages*

- Rapid treatment intake after first contact means more clients turn up without jeopardising longer-term retention or outcomes.
- Consider using an initial rapid, brief assessment to decide whether callers are appropriate for your service and defer the rest until treatment has started.
- Attendance at initial and later treatment sessions is improved by reminders beforehand which make the client feel wanted and which are optimistic about the treatment they are embarking on.
- Personal approaches incorporating a motivational element work best, probably because they convey active caring rather than a bureaucratic reminder-mill.
- Reminders also encourage former patients to use aftercare services; 'How are you doing?' contacts can themselves help sustain the impact of the initial treatment.
- To reach former clients most likely to be in trouble, follow-up methods need to be relatively active, intensive and persistent.
- Services which under-invest in following up former clients jeopardise the gains made in the initial treatment and risk failing ex-patients in greatest need.

Encouraging reminders improve retention …

When immediate entry cannot be arranged, measures can still be taken to increase treatment uptake. The simplest is the reminder, but its simplicity is deceptive; *how* it is done is as important as doing it. When silence or impersonal reminders are replaced by personal, motivation-enhancing, and welcoming contacts, the effect can be dramatic.[37]

In mental health services in general, reminder phone calls or letters improve attendance.[38] Especially when waits are long, the British NHS recommends a 'partial booking' system – giving the patient a rough indication, then contacting them nearer the time to agree a mutually convenient slot. Compared to fixed appointments, this reduces no-shows and cancellations on both sides.[39] The same strategy is being promoted by the English National Treatment Agency.[40] In England, the requirement to copy patients in to letters from hospital services to their GPs provides an opportunity to remind the patient of the importance of returning to the hospital or of attending aftercare.[41]

Within the substance misuse field, again Morris Chafetz's Massachusetts team were pioneers *Transformation stories 1,* p. 17.[33 37] After assessment, severely alcoholic patients who had to be sent off-site for inpatient detoxification rarely returned. A handwritten letter expressing personalised concern and desire that the individual would return increased nearly tenfold the numbers making a seamless transfer to outpatient care. A phone call had a similar impact.

Aware of Chafetz's work, in the late '60s social workers in New York tried to counter high early drop-out and erratic attendance among alcohol outpatients.[42] Letters like that in Massachusetts were sent immediately to patients who missed appointments, offering another date. The workers were persistent, continuing to send reminders until four appointments were missed, when the final letter still offered further help and expressed concern over how the patient was doing. Additionally, social workers saw any patient who made an unscheduled visit and offered crisis intervention if necessary.

The effect was to virtually halve early drop-out. In the seven weeks before these procedures, 51% of new patients dropped out within four visits, in the seven weeks after they had been established, 28%. Among patients as a whole, the proportion who missed two consecutive sessions fell from 57% to 22%. Among long-term patients, drop-out after a missed appointment fell from 33% to 8%. The letters were almost certainly the main factor, since the proportion of patients who made unscheduled crisis visits actually fell from 57% to 22%, indicative of improved stability.

MAKE IT *personal* AND WELCOMING

A personal reminder works best was the implication of a series of randomised trials at an alcohol clinic in California.[43] The aim was to retrieve the many patients who dropped out within four weeks of starting treatment. Usually no attempt was made to recontact them. First the clinic tried sending a letter to a randomly selected half and repeated it each week they remained absent. It could have seemed cold and accusatory, asking why the patient had not come back, did they still want treatment, and if not, why not. It had no impact. Just 1 in 6 of the 60 patients in each group returned for treatment within four weeks of their first missed appointment.

Next a new set of drop-outs were sent the same letter or phoned by one of the researchers.[iii] She posed similar questions, but now 10 out of 25 patients returned compared to just 2 sent the letter. Moreover, she got valuable information on why most of the rest stayed away. Clearly a phone call provided the opportunity to be more personal and interactive. In a third study, the clinic tried to incorporate these qualities in a revised letter. It more clearly expressed an interest in the client and in checklist format sought feedback on their current treatment needs. It prompted over a third to return compared to just one of the 25 sent the old-style letter, and, again, helped find out why the remainder were not coming back.

In Florida similar efforts improved attendance at a clinic for substance abusing adolescents with severely antisocial behaviour.[38] Though about half were court-mandated to treatment, usually just 45% of families who contacted the clinic attended for intake. To improve on this, calls to the parent to agree an appointment were supplemented by a preset script. It consisted less of motivational encouragement than of bureaucratic information about procedures, legal penalties (less if they cooperated), attendance requirements, and the programme's effectiveness record.

For a randomly selected half of families, this was supplemented by a phone call to parent and child a few days before the first and second sessions. These *were* motivational, individualised and interactive. They named and praised the family's therapist who was "looking forward" to meeting them, empathically addressed concerns, stressed the programme's benefits, reiterated appointment details and (if applicable) relayed how impressed their therapist had been with their punctuality at the previous session.

The 'bureaucratic' calls were not *in*effective – they improved initial attendance to 60% – but adding the motivational calls doubled it to 89%. Overall attendance also improved to 57% and 83% respectively. Before this combination, most families had not turned up, now this was the exception. The researchers believe the most influential element was involving the young person themselves in scheduling the sessions.[44]

… and aftercare attendance

Motivational reminders can also help keep former patients in contact with aftercare. This was one of the tactics which revolutionised aftercare attendance at the Salem Veterans Affairs Medical Centre, featured next issue as our *Transformation story*. Postal and phone reminders to attend and fulfil a previously signed aftercare contract improved aftercare initiation from 70% to 100%, doubled the number of sessions attended, and cut the need for hospital readmissions.[45] The letters and calls which transformed return to Morris Chafetz's alcohol clinic following off-site detoxification can be seen as another example[33] *Transformation stories 1,* p. 17.

Inspired by Chafetz, in the early '70s a short-term inpatient alcohol treatment unit in Buffalo used similar tactics to encourage use of its outpatient support services.[46] Randomly selected patients were either not contacted at all after they left or phoned six times over the next ten weeks. The calls expressed concern for the patient and successfully encouraged them to access more outpatient services, which in turn was associated with improved drinking outcomes and greater stability. Perhaps significantly, these

OFFCUT 1

Drug consumption rooms are being seen as the next step up in harm reduction to counter overdose, improve infection control, connect heavy-end drug users to treatment, and to reduce the nuisance caused by open drug 'scenes'. Common in parts of mainland Europe, these are just a distant memory in Britain and represent a step too far many UK workers. A new report from the European Monitoring Centre for Drugs and Drug Addiction has surveyed European provision and collated the evidence on its effectiveness ❶. It suggests that all the expected benefits can be realised as long as services have adequate capacity, are easy to access, and are well managed in the context of political support for their role within a wider network of services. In practice, political support is most likely to be forthcoming when the public nuisance is both large and resistant to other options. Then such services start to seem an attractive way to restore local quality of life rather than a threat to it.

❶ Hedrich D. **European report on drug consumption rooms**. EMCDDA, 2004. Copies www.emcdda.eu.int.

PROGRESS ON WAITING TIMES AND RETENTION

In England, recorded waiting times have fallen fast and some retention data (evidence is contradictory) also show big recent gains. Whether this has been achieved at the cost of quality is unclear. Similar data is not available for the rest of the UK.

Recorded waiting times down

Figures from the National Treatment Agency (NTA) show dramatic reductions in average times from referral to treatment entry, from on average nine to just over three weeks between 2001 and 2003.[81] As yet there is no way to check the times reported by services, but neither is there any reason to doubt them, and proven initiatives such as those reviewed in this article are being introduced in a programme led jointly by the NTA and the National Institute for Mental Health.[40]

The NTA plans to use treatment retention and completion statistics to assess whether targets for increased capacity[76 77 79 80 97] and rapid intake[77] are being achieved at the cost of quality. These checks may not be enough. For example, one way methadone services can (and have[82]) cut waiting times is to divert resources from maintenance to detoxification. No warning bells need sound because this could simultaneously increase treatment completion rates – in this case, detoxification. Yet the typically high relapse rate following detoxification means that it could also sacrifice health improvements, crime reductions,[83] and even lives.[84 85]

Another way to cut waiting times without more resources is to establish a 'low threshold' methadone programme which, as well as streamlining entry, provides counselling only when the client asks for it.[86] The net effect could be beneficial, but such paring down risks increasing throughput by decreasing quality[87 88] in a way which might not show up in retention statistics. Conceivably, retention could actually 'improve' because fewer patients are helped to achieve a life where they no longer feel the need for daily methadone.

Contradictory evidence on retention

The English National Treatment Outcomes Research Study (NTORS) of clients entering treatment in 1995 revealed considerable scope for improving retention. For residential services, it identified retention times associated with the greatest post-treatment gains. Most clients left before these times: 80% in inpatient programmes and 36% and 60% in short- and long-term rehabilitation.[5] For methadone maintenance, the key thing is *remaining* in treatment.[4 22 89 90] In NTORS, 38% of patients had left by one year and 58% by two years. At both points leavers had far worse outcomes.[6]

Whether things have improved since then is unclear. The NTA has said that it cannot assess retention trends until it has established a baseline for 2003/04,[78] yet also that there has been a "four-fold increase in the length of time clients stay in treatment from 57 days in September 2001, to 203 days in June 2003".[81]

This statement was based on a 15% sample of treatment services. However, routine returns from drug treatment services and GPs in England indicate that over roughly the same period, slightly *fewer* people starting treatment during a year were still there at the end.[91] Neither has England recorded the recent steep rises in the number of methadone prescriptions to be expected if services were expanding and improving retention; from 1998 to 2001, the increase levelled off to just 2–4% annually[92] and 8% from 2001 to 2002.[93] In contrast, Scotland has recently seen the expected steep increases.[94 95]

relatively light-touch procedures worked with a caseload most of whom were employed and had intact marriages.

A medical centre for ex-military veterans in California found reminders less successful.[47] However, the reminders appear to have been simply that rather than motivational in nature, and the caseload was so severely alcoholic that perhaps more was needed.

Typically patients were unemployed single men with a history of alcohol-related arrests and hospitalisations. Before inpatient detoxification they had been drinking heavily from the morning on, experiencing tremors and blackouts. On leaving, for a year they were offered at first weekly then fortnightly aftercare sessions taking a "problem-solving approach". To encourage attendance, for the first six months 96 patients were randomly allocated either to normal procedures (no active follow-up), to a phone reminder from their therapist a few days beforehand, or to instead be seen for aftercare at a place of their choosing, such as their home.

Reminders did little to increase the number of aftercare sessions attended, but did delay the point at which patients stopped coming altogether. For example, 15 weeks into the aftercare period, under 30% had dropped out compared to over 60% of normal-procedure patients. Taking aftercare to the patient had a much greater impact on its uptake, but neither reminders nor home visits improved drinking or social/emotional functioning outcomes. Possibly any such effect had been obscured by the fact that relatively few normal-procedure patients were followed up, filtering out those doing worst.[48 49 50] Possibly, too, the results raise a question mark over the appropriateness of the aftercare approach.

A face-to-face system was trialed in Chicago on people seeking treatment via a centralised intake unit.[51] This more hands-on approach may have been needed for patients who were typically dependent on crack, unemployed and with a history of homelessness and abuse. Three months later and then quarterly for two years, a randomly selected half were interviewed by unit staff who ran through a checklist to assess whether they should return to treatment. Those judged in need were transferred to another staff member to arrange the return, motivate the patient, and to give practical aid.

Over the two years, patients checked up on in this way typically returned to treatment within 376 days compared to 600 days for the remainder, 13% more returned at some stage, and they stayed longer in treatment. Perhaps as a result, by the end of the two years fewer (43% v. 56%) of the checked-up-on patients were assessed as still in need of treatment. However, the check-ups piggy-backed on visits being made anyway for research purposes. Without these how it is unclear how many of the patients would have attended.

'Hi, how are you doing?' – aftercare in itself?

'How are you doing?' contacts after patients have left do not just prompt aftercare attendance, but may themselves be therapeutic.

A recent trial used a recontact procedure similar to that in Buffalo[46] (*previous section*), but this time the benefits were not due to greater use of aftercare treatment. Two US day-hospital addiction services randomly allocated their patients to routine aftercare or to 'extended case monitoring'.[52] As in other studies where 'light-touch' interventions have worked, participants tended to have jobs, stable homes, and intact marriages.

'Case monitoring' involved specially trained staff who first met the client while they were in treatment. A week after they left the monitor initiated at first monthly phone calls, usually lasting 15 minutes. These continued for two years on a tapering schedule which could be ratcheted up in response to need. Attempts were also made to speak separately to the patient's 'significant other'. Calls adopted a motivational interviewing style, starting with a friendly enquiry about how the patient is doing and, if needed, advising further support or a return to treatment, but (unlike case management) the patient was left to take the required steps.

Interim results for the three years after discharge showed that the frequency of heavy drinking had been halved in case-monitored patients (12% v 24% of days) and that they had taken longer to resume sustained heavy drinking.[53] But this had not been achieved by encouraging a return to addiction treatment. In fact, it was the non-case monitored

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patients who tended to return. They also made many more visits to emergency departments. It seemed that the calls had reduced the need for further treatment by themselves helping to reduce drinking.

In Belfast, after six weeks' inpatient treatment alcohol patients were also routinely recontacted, but this time face-to-face during home visits by an experienced community psychiatric nurse.[54] Given the nature of the caseload, nothing less may have sufficed.

The nurse's role was to directly respond to 'slips' and to encourage attendance at AA and hospital meetings. Visits were made to 93 patients for 12 months at first weekly and then monthly, but could be increased if needed. For administrative reasons, another 54 patients were instead offered six-weekly review appointments at the clinic. In the event, these were poorly attended.

The two groups were practically identical: very heavy, highly dependent drinkers with a criminal background. Over the year of the visits and enduring for at least the next four, the nurse had a major positive impact; 36% of her patients sustained abstinence compared to 6% of the remainder and by year five two-thirds were virtually abstinent versus 40%. These results seemed due to the visits themselves rather than to these encouraging attendance at self-help groups or a return to treatment.[iv]

Outside the treatment arena there is some evidence of benefit from following up workers with substance misuse problems seen by a factory's medical/welfare service.[55] In parallel to their substance misuse treatment, a counsellor at the factory attempted to follow-up a randomly selected half of the 325 workers for a year, at first weekly then tapering to once every two months. The aim was to show concern and support, encourage their recovery, and to offer help if needed.

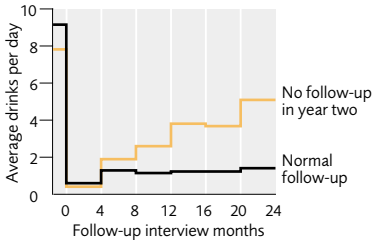
Though nearly two-thirds of the workers assigned to follow-up either refused it or dropped out, while it was in operation, company and insurance records indicated that it had reduced disability due to substance abuse and the need for substance abuse treatment. The other messages of the study lie in what went wrong: the need to gather good contact information beforehand, to integrate follow-up with the main intervention, and to create social incentives to make use of the services on offer.

JUST RE-ASSESSING CAN BE THERAPEUTIC

Mechanisms which underlie the effectiveness of therapeutic follow-up contacts may also be at work when researchers re-interview clients. As Project MATCH found,[56] clients may make little distinction between a therapist asking them how they are doing, and a researcher doing the same. Just having to regularly review your drinking may itself be a moderating influence.

Usually any such effects are hidden because all research subjects experience the same follow-up procedures, but unforeseen complications in one alcohol treatment study meant that in the second follow-up year some did not receive the intended four-monthly research interviews.[57] They were interviewed, but only after a delay of 12 or 18 months. Compared to other subjects, they did just as well in the first follow-up year, but when contact was lost their drinking deteriorated *chart right*. By the end they were drinking heavily on a fifth of days compared to under 1 in 10 for other subjects, and consuming four times more alcohol.

The same kind of effect has been suspected in the Project MATCH study of alcohol



treatment,[58] in a study of injecting drug users' HIV risk behaviour,[59 60] and in one which recruited drinkers in a bar and simply asked them to regularly record their alcohol consumption for the next two years, using an automated phone system.[61]

Benefits and costs of post-treatment follow up

Services considering whether and how much to invest in following up former clients will want to assess the benefits and the costs. Benefits can be addressed by asking what services stand to lose by *not* doing so. Evidence cited above shows that they will fail to retain patients in aftercare. Since greater access to and use of aftercare services is generally (but not always[62]) related to better outcomes,[63 64 65 66 67] they will also jeopardise progress made in the initial treatment.

Under-investing in follow-up also risks failing ex-patients in greatest need. Researchers conducting follow-up studies consistently find that former patients who are hardest to contact are the ones most likely to again be in trouble.[49 50 68 70 71 72 73] For example, in a US study primarily of crack users leaving residential rehabilitation, the harder someone was to recontact the more likely they were to have been arrested, to have resumed cocaine or crack use, and to be unemployed.[69]

WHEN TO DRAW THE LINE

To contain costs a line has to be drawn beyond which further recontact attempts are not considered the best use of resources. Treatment services could learn much from researchers about where to draw this line and how to maximise success before crossing it.

A model tailored to addicted populations has been developed by US researchers and used to successfully recontact over 90% of 5000 research subjects in seven studies.[73] The model is based on thorough preparation while the patient is in the initial treatment to ensure that they expect and hopefully welcome follow-ups, and that they have given consent to contact their nominated associates and for those associates to disclose their whereabouts. Pre-follow-up verification ensures that associate information is up to date, and can be used to prepare them for later contacts. The researchers also ensure that letters and calls to (or which might be intercepted by) third parties do not disclose the nature of the patient's condition unless this is essential and the patient has previously given consent. Without this, follow-up risks causing embarrassment or worse.[74]

Treatment services and clinical researchers have used simpler methods to good effect. A study in Leeds showed that outcome information could cost-effectively be gathered on all but a few heroin or alcohol dependent patients three months after their initial assessment.[68] The procedure was to get consent for follow up during treatment and also to ask for the name and address of an associate who could help relocate the patient. Follow-up of patients not still being seen at the clinic was entirely through letters.

Similar preparations were made at the Hazelden Centre in Minnesota before mailing questionnaires to former patient three times during the 12 months after discharge.[50] Just around half were returned but phone calls netted most of the remainder, resulting in 70–80% follow-up. When phone calls had to be resorted to, patients were much more likely to be drinking.

In Liverpool researchers started cold in their attempts to relocate alcohol patients 11 months after they had been assessed for treatment; no prior consent or associate information had been obtained.[75] Nevertheless, a three-stage process involving two letters and (if these failed) a phone call recruited 75% of the former patients. Patients for whom treatment had failed tended not to respond until the final stage of the procedure; treatment successes usually responded at the first attempt.

EFFICIENCY *and* THE HUMAN TOUCH

Though part 1 of this review has focused on relatively mundane procedures, already we can see that treating the patient as an individual, being welcoming, empathic, understanding, and demonstrating respect and active, persistent caring, are among the trademarks of services that hang on to clients.

We can also see that there is no conflict between these qualities and efficient admin-

Transformation stories 1 THE MASSACHUSETTS ALCOHOL CLINIC

Much of what we know today was prefigured in a remarkable series of studies begun in the late 1950s at the alcohol clinic of Massachusetts General Hospital.[3337] It was run by Morris Chafetz, later to become founding director of the US National Institute on Alcohol Abuse and Alcoholism.

Dr Chafetz showed that not only can a service's performance be improved, it can be transformed by the simple application of empathy and organisation. He suspected that alcoholics' notoriously poor acceptance of and response to treatment reflected the negative attitudes of those around them, including clinical staff. If these attitudes were replaced with optimism and respect, then many more patients might embrace the help they needed – exactly what happened.

Why won't they come?

Work started with the observation that virtually none of the alcoholics referred to the clinic from the hospital's emergency service actually attended. A micro-analysis of the referral process revealed that it entailed seeing perhaps a dozen individuals and numerous delays and opportunities to be baulked by the system. Staff attitudes did not engender determination to overcome the obstacles. Typically these 'Skid Row' alcoholics were in crisis (the reason for emergency admission), dirty, disturbed and disturbing, and often dragged in by the police. The effect was to evoke outright hostility and rejection on top of underlying moralistic and punitive attitudes.

Chafetz's team set out to create instead a welcoming and seamless procedure which established the emergency episode as the start of the rehabilitation process. It involved not just directly interfacing with the patient, but networking to gain the cooperation of other hospital staff and of outside welfare and housing services. Effectively Chafetz pioneered a 'case management' approach[96] intended to see that the alcoholic got coordinated, holistic and continuing care.

Because *we* are doing the wrong things

In practice they established 'treatment catalyst' teams to reach out from the clinic, consisting of a psychiatrist on 24-hour call to immediately see patients in the emergency room and a social worker who worked with the patient, their family and outside services. By being welcoming, respectful and concerned, and by caring for the patient throughout, they sought to convey that they were the patient's own personal doctor and social worker. They also tried to avoid the patient being treated poorly by other staff. Rather than the insight-oriented psychotherapy then in vogue, they focused on taking action in response to the patient's expressed needs for practical help with things such as housing, money, a meal and a shave.

Alternate male alcoholic patients were assigned either to normal emergency procedures or additionally to one of the catalyst teams, 100 in each group. Nearly two-thirds (65%) of the treatment catalyst patients made an initial visit to the alcohol clinic compared to 5% of normal procedure patients. Forty-two of the patients seen by the teams made five or more visits compared to just one of the normal procedure patients – and he was a former clinic patient. The supposedly insoluble problem of engaging these "alienated men" was exposed as due not to their intractability, but to that of an inappropriate clinical response.[v]

In a crisis, respond – *simple*

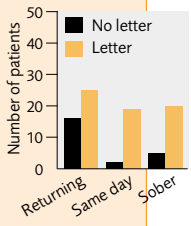
Another way the clinic came in contact with potential patients was through phone calls from the alcoholic or their family, usually during a domestic crisis. The response was typical of services then and perhaps of many now. A secretary noted basic details then mailed out an appointment for several weeks hence, by which time the moment and the motivation had passed. Instead Chafetz's team tried initiating same-day social work contact with the family, if necessary in person at the their home. After assessment, therapy and practical intervention were made immediately available. Throughout, the same social worker maintained contact.

On a quasi-random basis, callers were allocated to this approach or to normal procedures. Initial attendance tripled from 21% to 62% of patients and from 13% to 38% of their relatives. In nearly 30% of cases both came together compared to none under normal procedures. None of the usual-procedure patients returned at least five times over the next six months compared to 27% of the immediate-response patients.

Keep them coming

Patients were now coming for intake but still many failed to return, particularly those (the most inebriated and debilitated) who after assessment had first to be sent to an inpatient unit to 'dry out'. The clinic's first attempt to retrieve them was a handwritten letter sent the day after their assessment. It expressed personalised concern ("*I* am concerned about *you*.") and equally personalised desire that the individual would return, when the service would be "glad to work with you". It was sent to 50 randomly selected patients; another 50 were handled as usual.

The impact was striking: 25 returned, all but 5 sober, and 19 the day they were discharged from the unit; without the letter, 16 returned, just 2 without delay and most after having resumed drinking ◤ *chart*. Replacing the letter with a phone call to the unit had a similar impact. Within a week of discharge, 22 of the 50 called patients returned for outpatient care but just 4 of the 50 who were not called.



It's the way we say it

The next experiment was based on the belief that alcoholics are sensitised to hints of rejection in what a doctor says and how they say it. The doctors concerned were nine of the emergency physicians involved the year before in the studies. At issue was whether emotion betrayed months later in recordings of their responses to the question, "What has been your experience with alcoholics?" would correlate with how many of their patients had followed through on a referral to the alcohol clinic. Ratings were made of the unaltered recordings, of recordings filtered to obscure the words but leave emotional tone, and of transcripts.

As expected, ratings were related to referral success only when the treatment catalyst teams had not intervened to override the doctors' influence. Also not unexpectedly (all the patients had been men), the only significant relationships derived from male raters. The more anxious they felt the doctor sounded and (in filtered speech) the less angry, the more their referrals had been successful. The correlations were substantial and statistically significant. Just missing significance was a trend for more matter-of-fact and 'professional' sounding doctors to have a lower success rate. Assuming 'anxiety' was proxy for concern, it seemed that the more a doctor showed personal (rather than 'coldly professional') concern for a patient's welfare, and evidenced this in tone as well as words, the more likely the patient was to treat this as the start of a therapeutic relationship with which they wished to continue.

istrative procedures. To the contrary, such procedures are needed to give practical expression to the qualities and values which motivate them. Both are required. Another important lesson from the research is that there is nothing special about retention-enhancement or about how substance misuse patients react. Reflection on how we might react if we were in their shoes can predict much of what researchers have painstakingly set out to prove.

NOTES

i Includes readmissions. Not statistically significant.
ii The authors attribute the result to patients having effectively to decide twice whether to seek treatment since they did not see the initial contact as treatment.
iii Linda Sobell, already well known for her work on controlled drinking as a treatment objective.
iv Though more of her patients did attend hospital meetings.
v Later the alcoholic clinic's psychiatrists took on the screening role at the emergency service. The result was to identify and refer less socially isolated patients but they too attended far more often if the catalyst teams started the process in the emergency department: 62% made an initial visit versus 21%; 27% versus none made five or more visits.

REFERENCES

1 *Treatment Protocol Effectiveness Study*. Office of National Drug Control Policy, 1996.
2 Zhang Z. *et al*. "Does retention matter? Treatment duration and improvement in drug use." *Addiction*: 2003, 98, p. 673–684.
3 Hubbard R.L. *et al*. "Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS)." *Psych. Addict. Beh.*: 1997, 11(4), p. 261–278.
4 Simpson D.D. *et al*. "Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS)." *Psych. Addict. Beh.*: 1997, 11(4), p. 294–307.
5 Gossop M. *et al*. "Treatment retention and 1 year outcomes for residential programmes in England." *Drug Alc.*

Dep.: 1999, 57, p. 89–98.

6 Gossop M. *et al*. "Outcomes after methadone maintenance and methadone reduction treatments: two-year follow-up results from the National Treatment Outcome Research Study." *Drug Alc. Dep*: 2001, 62, p. 255–264.

7 Simpson D.D. "Modeling treatment process and outcomes." *Addiction*: 2001, 96, p. 207–211.

8 Joe G.W. *et al*. "Relationship between counseling rapport and drug abuse treatment outcomes." *Psychiatric Services*: 2001, 52(9), p. 1223–1229.

9 Fiorentine R. *et al*. "Does increasing the opportunity for counseling increase the effectiveness of outpatient drug treatment?" *Am. J. Drug Alc. Abuse*: 1997, 23, p. 369–382.

10 Fiorentine R. *et al*. "More is better: counseling participation and the effectiveness of outpatient drug treatment." *J. Subst. Abuse Treat.*: 1996, 13 (4), p. 341–348.

11 We are grateful to Bob Purser of Aquarias Action Projects for reminding us of such barriers.

12 American College of Emergency Physicians. *New studies on asthma and ED waiting times show changes in emergency practice and improved care*. 2004.

13 Kennedy J. *et al*. "Access to emergency care: restricted by long waiting times and cost and coverage concerns." *Annals Em. Med.*: 2004, 43(5).

14 Summers M. *et al*. *The triage of psychiatric patients in the hospital emergency department*. Centre for Psychiatric Nursing Research and Practice, undated.

15 Festinger D.S. *et al*. "Pretreatment dropout as a function of treatment delay and client variables." *Addict. Beh.*: 1995, 20, p. 111–115.

16 Hser Y-I. *et al*. "Predicting drug treatment entry among treatment-seeking individuals." *J. Subst. Abuse Treat.*: 1998, 15(3), p. 213–220.

17 Longhi D. *et al*. *The ADATSA Program: clients, services and treatment outcomes*. Washington State Dept. of Social and Health Services, 1991. Cited in: Donovan D. M. "Attrition prevention with individuals awaiting publicly funded drug treatment." *Addiction*: 2001, 96, p. 1149–1160.

18 Fehr B.J. *et al*. "'As soon as possible': an initial treatment engagement strategy." *Subst. Abuse*: 1991, 12, p. 183–189.

19 Rees D.W. *et al*. "Some factors associated with compliance in the treatment of alcoholism." *Alcohol and Alcoholism*: 1984, 19(4), p. 303-307.

20 Leigh G. *et al*. "Factors associated with patient dropout from an outpatient alcoholism treatment service." *J. Studies Alc.*: 1984, 45(4), p. 359–362.

21 Mayer J. *et al*. "Contact and initial attendance at an alcoholism clinic." *Q. J. Studies Alc*: 1965, 26, p. 480–485.

22 Stark M.J. "Dropping out of substance abuse treatment. A clinically oriented review." *Clin. Psych. Rev.*: 1992, 12, p. 93–116.

23 Georgakis A. *An investigation into the relationship between waiting times and outcomes in the treatment of substance dependency*. European Association for the Treatment of Addiction, 1999.

24 Addenbrooke W.M. *et al*. "Relationship between waiting time and retention in treatment amongst substance abusers." *Drug Alc. Dep.*: 1990, 26(3), p. 255–264.

25 Dennis M.L. *et al*. "Effectiveness of streamlined admissions to methadone treatment: a simplified time-series analysis." *J. Psychoact. Drugs*: 1994, 26(2), p. 207–216.

26 Woody G. *et al*. "Rapid intake: a method for increasing retention rate of heroin addicts seeking methadone treatment." *Comprehensive Psychiatry*: 1975, 16(2), p. 165–169.

27 Friedmann P. *et al*. "Retention of patients who entered methadone maintenance via an interim methadone clinic." *J. Psychoact. Drugs*: 1994, 26(2), p. 217–221.

28 Maddux J.F. *et al*. "Rapid admission and retention on methadone." *Am. J. Drug Alc. Abuse*: 1995, 21, p. 533–547.

29 Festinger D.S. *et al*. "From telephone to office. Intake attendance as a function of appointment delay." *Addict. Beh.*: 2002, 27, p. 131–137.

30 We are grateful to Bob Purser of Aquarias Action Projects for this formulation.

31 *Treating crack cocaine dependence*. NTA, 2002.

32 *Tackling crack. A national plan*. Home Office, 2002.

33 Chafetz M.E. *et al, eds. Frontiers of alcoholism*. New York: Science House, 1970.

34 Stark M.J. *et al*. "'Hello, may we help you?' A study of attrition prevention at the time of the first phone contact with substance-abusing clients." *Am. J. Drug Alc. Abuse*: 1990, 16(1&2), p. 67–76.

35 Festinger D.S. *et al*. "The accelerated intake: a method for increasing initial attendance to outpatient treatment for cocaine addiction." *J. App. Beh. Analysis*: 1996, 29(3), p. 118–122. Cited in: Kirby K.C. *et al*. "Behavioral treatments of cocaine addiction: assessing patient needs and improving treatment entry and outcome." *J. Drug Issues*: 1997, 27(2), p. 417–429.

36 Best D. *et al*. "The relative impact of waiting time and treatment entry on drug and alcohol use." *Addict. Biol.*: 2002, 7, p. 67–74.

37 Miller W.R. "Increasing motivation for change." In: Hester R.K. *et al, eds. Handbook of alcoholism treatment approaches: effective alternatives*. 2nd edition. Allyn and Bacon, 1995, p. 89–10.

38 Donohue B. *et al*. "Improving session attendance of substance abusing and conduct disordered adolescents: a controlled study." *J. Child Adolesc. Subst. Abuse*: 1998, 8(1), p. 1–13.

39 [UK] Department of Health. www.doh.gov.uk/pspp/psppguide.htm#Step5. December 2002

40 NTA. *Opening doors – issue no. 1, March 2003*.

41 We are grateful to Dr William Shanahan of the Soho Alcohol Treatment Service for pointing out this possibility.

42 Panepinto W.C. *et al*. "Keeping alcoholics in treatment: effective follow-through procedures." *Q. J. Studies Alc*: 1969, 30, p. 414–419.

43 Nirenberg T.D. *et al*. "Effective inexpensive procedures for decreasing client attrition in an outpatient alcohol treatment center." *Am. J. Drug Alc. Abuse*: 1980, 7, p. 73–82.

44 Personal communication from Bradley Donohue, University of Nevada, May 2004.

45 Lash S.J. *et al*. "Increasing adherence to substance abuse aftercare group therapy." *J. Subst. Abuse Treat.*: 1999, 16(1), p. 55–60.

46 Intagliata J. "A telephone follow-up procedure for increasing the effectiveness of a treatment program for alcoholics." *J. Studies Alc*: 1976, 37, p. 1330–1335.

47 Gilbert F.S. "The effect of type of aftercare follow-up on treatment outcome among alcoholics." *J. Studies Alc*: 1988, 49(2), p. 149–159.

48 Stanton M.D. *et al*. "Outcome, attrition, and family—couples treatment for drug abuse: a meta-analysis and review of the controlled, comparative studies." *Psychological Bull.*: 1997, 122(2), p. 170–191.

49 Moyer A. *et al*. "Randomized versus nonrandomized studies of alcohol treatment: participants, methodological features and posttreatment functioning." *J. Studies Alc*: 2002, 63(5), p. 542–550.

50 Stinchfield R. *et al*. "Hazelden's model of treatment and its outcome." *Addict. Beh.*: 1998, 23(5), p. 669–683.

51 Dennis M. *et al*. "An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders." *Eval. and Prog. Planning*: 2003, 26(3), p. 339–352.

52 Stout R.L. *et al*. "Optimizing the cost-effectiveness of alcohol treatment: a rationale for extended case monitoring." *Addictive. Behav.*: 1999, 24(1), p. 17—35.

53 Stout R.L. *et al*. "Case monitoring for alcoholics: one year clinical and health cost effects." *Alc.: Clin. Exp. Res.*: 2001, 25(1), p. 133—134.

54 Patterson D.G. *et al*. "Community psychiatric nurse aftercare for alcoholics: a five-year follow-up study." *Addiction*: 1997, 92, p. 459–468.

55 Foote A. *et al*. "Effects of EAP follow-up on prevention of relapse among substance abuse clients." *J. Studies Alc*: 1991, 52, p. 241–248.

56 *Meet the MATCH makers conference*.14–15 May 1998, Leeds.

57 Clifford P.R. *et al*. "Alcohol treatment research follow-up interviews and drinking behaviors." *J. Studies Alc*: 2000, 61, p. 736–743.

58 Ashton M. "Project MATCH: unseen colossus." *Drug and Alcohol Findings*: 1999, 1, p. 15–21.

59 Van den Hoek J.A.R. *et al*. "Risk reduction among intravenous drug users in Amsterdam under the influence of AIDS." *Am. J. Public Health*: 1989, 79(10), p. 1355–1357.

60 Van Ameijden E.J.C. *et al*. "Maximum impact of HIV prevention measures targeted at injecting drug users." *AIDS*: 1998, 12(6), p. 625–633.

61 Helzer J.E. *et al*. "Decline in alcohol consumption during two years of daily reporting." *J. Studies Alc*: 2002, 63(5), p. 551–558.

62 Shand F. *et al*. *The treatment of alcohol problems: a review of the evidence*. [Australian] Department of Health and Ageing, 2003.

63 Moos R.H. "Addictive disorders in context: principles and puzzles of effective treatment and recovery." *Psych. Addict. Beh.*: 2003, 17(1), p. 13–19.

64 Burdon W.M. *et al*. "The California treatment expansion initiative: aftercare participation, recidivism, and predictors of outcomes." *The Prison Journal*: 2004, 84(1), p. 61–80.

65 Ritsher J.B. *et al*. "Relationship of treatment orientation and continuing care to remission among substance abuse patients." *Psychiatric Services*: 2002, 53, p. 595–601.

66 Siegal H.A. *et al*. "Abstinence trajectories among treated crack cocaine users." *Addict. Beh.*: 2002, 27, p. 437–449.

67 Ghodse A.H. *et al*. "Treating an opiate-dependent inpatient population: a one-year follow-up study of treatment completers and noncompleters." *Addict. Beh.*: 2002, 27, p. 765–778.

68 Tober G. *et al*. "Measuring outcomes in a health service addiction clinic." *Addict. Res.*: 2000, 8(2), p. 169–182.

69 Nemes S. *et al*. "Correlates of treatment follow-up difficulty." *Subst. Use & Misuse*: 2002, 37(1), p. 19–45.

70 Meyers K. *et al*. "What does it take to retain substance-abusing adolescents in research protocols? Delineation of effort required, strategies undertaken, costs incurred, and 6-month post-treatment differences by retention difficulty." *Drug Alc. Dep.*: 2003, 69, p. 73–85.

71 Hansten M. *et al*. "Relationship between follow-up rates and treatment outcomes in substance abuse research: more is better but when is 'enough' enough?" *Addiction*: 2000, 95(9), p. 1403–1416.

72 Harrison P.A. *et al*. "Outcomes monitoring in Minnesota: treatment implications, practical limitations." *J. Subst. Abuse Treat.*: 2001, 21, p. 173–183.

73 Scott C.K. "A replicable model for achieving over 90% follow-up rates in longitudinal studies of substance abusers." *Drug Alc. Dep.*: 2004, 74(1), p. 21–36.

74 We are grateful to Dr William Shanahan of the Soho Alcohol Treatment Service for reminding us of these risks.

75 Bamford Z. *et al*. "Maximizing patient follow-up after alcohol treatment: the effect of a three-step reminding system on response rates." *J. Subst. Use*: 2004, 9, p. 36–43.

76 President of the Council. *Tackling drugs to build a better Britain. The Government's ten-year strategy for tackling drugs misuse*. April 1998.

77 Drug Strategy Directorate. *National Drug Strategy Performance Management Framework. Resource pack*. Effective March 2004.

78 NTA. *Business plan 2003/04*. 2003.

79 *Scottish Executive's annual report on drug misuse*. 2003.

80 *Tackling substance misuse in Wales. A partnership approach*. Welsh National Assembly, 2000.

81 NTA. *Drug treatment performance data – summary briefing*. 11 December 2003.

82 Day E. *et al*. "The role of detoxification using methadone reduction in a drug treatment service." *J. Subst. Use*: 2003, 8(4), p. 252–259.

83 Sees K.L. *et al*. "Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence. A randomized controlled trial." *JAMA*: 2000, 283, p. 1030–1310.

84 Strang J. *et al*. "Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study." *BMJ*: 2003, 326, p. 959–960.

85 Best D. *et al*. "Overdosing on opiates." *Drug and Alcohol Findings*: 2000, 4, p. 4–7, 16–20.

86 Shanley J. *et al*. "Evaluation of a pilot low-threshold methadone programme." *J. Subst. Use*: 2003, 8(4), p. 271–278.

87 McLellan A.T. "The role of psychosocial services in drug abuse treatment: a re-examination of on-site and off-site delivery methods." In: Waal H. *et al, eds. Maintenance treatment of heroin addiction: evidence at the crossroads*. Oslo: Cappelans, 2003, p. 267–295.

88 McLellan A.T. *et al*. "The effects of psychosocial services in substance abuse treatment." *JAMA*: 1993, 269, p. 1953–1959.

89 Ward J. *et al*. "How long is long enough? Answers to questions about the duration of methadone maintenance treatment." In: Ward J. *et al, eds. Methadone maintenance treatment and other opioid replacement therapies*. Harwood Academic Publishers, 1998, p. 305–336.

90 *NTIES. National Treatment Improvement Evaluation Study. Preliminary report: the persistent effects of substance abuse treatment – one year later*. Department of Health and Human Services, etc, 1996.

91 National Statistics and Department of Health. *Provisional statistics from the national drug treatment monitoring system in England, 2001/02 and 2002/03*.

92 Strang J. *et al*. "Effect of national guidelines on prescription of methadone: analysis of NHS prescription data, England 1990–2001." *BMJ*: 2003, 327, p. 321–322.

93 Government Statistical Service. *Prescription cost analysis. England 2002*. 2003.

94 *Prescription cost analysis for Scotland: year ending 31 March 2001*.

95 *Prescription cost analysis for Scotland: year ending 31 March 2003*.

96 Siegal H.A. *et al, eds. Case management and substance abuse treatment: practice and experience*. Springer Publishing Co., 1996.

97 *Drug strategy for Northern Ireland*. Undated.

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