Influencing factors and implications of unplanned drop out from substance misuse services in Wales

Guidance for reducing unplanned drop out from and promoting reengagement with substance misuse services

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Purpose and Summary of Document:

This document provides evidence based guidance on reducing unplanned drop out, and promoting re-engagement with, substance misuse services in Wales

Contents

Executive Summary

This report represents a summary of the findings from a project designed to identify the range of factors influencing unplanned drop out from, and reengagement with, drug and alcohol treatment services in Wales from both service user and service provider perspectives. The research was undertaken in 2008 by National Public Health Service for Wales and commissioned by Welsh Assembly Government as part of the substance misuse strategy 'Working together to reduce harm 2008 – 2018'.

Key aims

1. Determine factors reported by both service users and service providers as influencing, or leading to, unplanned drop-out at various stages in the treatment process and identifying those factors influencing reengagement, or otherwise, with substance misuse treatment services following unplanned drop out

2. Identify operational practice that contributes to both retention in, and reducing unplanned drop out from, substance misuse treatment

3. Develop and issue guidance for service providers and commissioners on service improvements aimed at reducing drop out rates and maximising reengagement following unplanned drop out from substance misuse treatment services

Method

Two questionnaires were designed:

- A postal questionnaire distributed to all substance misuse services in Wales routinely providing data to the Welsh National Database for Substance Misuse. The questionnaire was designed to gather information on factors influencing unplanned drop out from services and impact of unplanned drop out. A total of 65 questionnaires were issued and a response rate of 88% was achieved.

- A structured mixed-method questionnaire for service users designed to gather information on history of problematic substance use, contact with substance misuse treatment services, factors influencing unplanned drop out from services and impact of unplanned drop out. During 2008 a total of 559 valid interviews were completed with community-recruited current and ex-service users from across Wales, all of whom had experienced unplanned drop out from substance misuse services within the previous two years.

Key findings

The factors identified as influencing unplanned drop out included those relating to operational practice; service design, resource issues and, perhaps most importantly, the culture of substance misuse services and their commissioning bodies. Examples of good practice, initiatives and working practices aimed at retention of service users in treatment and re-engagement of those not currently in contact with services were provided by both service users and service providers.

Factors influencing unplanned drop out at post-referral stage included:

- Inappropriate referral
- Lengthy waiting times to assessment
- Inconvenient opening times
- 'Chaotic' lifestyle / nature of substance misuse
- Lack of co-ordination between professionals / confusion between appointments with difference providers, including criminal justice

Factors influencing unplanned drop out at post-assessment stage included:

- Lengthy waiting times to treatment
- Lack of support or contact before treatment
- Fear of treatment / peer pressures / lack of social support
- Attitude of staff team / attitude of keyworker
- Lack of mutual understanding, agreement or shared expectations of treatment between service user and provider

Factors influencing unplanned drop out during treatment included:

- Failure to engage with the treatment programme
- Lack of mutual understanding, agreement or shared expectations of treatment between service user and provider
- No longer felt that treatment was needed
- Crisis leading to relapse due to lack of stable accommodation/ family issues/ relationship breakdown
- Poor or fluctuating motivation
- Lack of family support and social network

Additional factors influencing unplanned drop out at all stages:

- Geographic distance to travel
- Environment of the treatment service
- Child care
- Care planning
- Quality of service

Impact of unplanned drop out from substance misuse treatment services on problematic substance users

A range of impacts and outcomes were identified including those relating to substance misuse, physical and psychological health, family and relationships, housing and social circumstances, and crime and criminal justice services.

Following unplanned drop out:

- 83% of previously injecting drug users reported an increase in levels of injecting
- 61% reported an increase in drug use
- 25% reported an increase in alcohol use
- 26% reported losing their housing
- 34% reported an increase in criminal activity and a further 9% reported imprisonment following unplanned drop out
- Around 50% reported onset of depression and other negative psychological symptoms
- Increased risk of drug related overdose and death
- Decrease in likelihood of returning to service or recommending service to peers

Negative consequences of unplanned drop out were also reported by service providers in relation to staff motivation and morale, the potential impact of negative messages relating to service users having been 'failed' by the services, and concern regarding the possible impact of reduced funding

Guidance and recommendations

Each factor influencing unplanned drop out at the various stages of treatment has been described and guidance and recommendations outlined to address these factors. This document is aimed at service providers and planners and outlines clear actions required to reduce levels of unplanned drop out and improve the quality of substance misuse services both for service users and those working within services.

The evidence provided on the consequences of unplanned drop out highlights not only the negative personal and social impacts on an individual but also the cost implications in terms of increased criminal activity and burden on criminal justice, health, housing and social services. Failure to address unplanned drop out from treatment and appropriately resource and support substance misuse services and other organisations designed to work with and support problematic substance users, including housing services, will result in further costs to individuals, their families and communities.

Section 1: Introduction and existing evidence

1.1 Introduction

The Welsh Assembly Government (WAG) and the National Treatment Agency (NTA) have identified the importance of retaining clients in, or minimising drop out from, specialist drug and alcohol treatment services, and view this as a measure of the effectiveness and cost-effectiveness of treatment services both in the UK. [1,2,3] The recent WAG substance misuse strategy 'Working together to reduce harm 2008 – 2018' [1] identifies 'reduction in the number of incidences of unplanned ending of contact with services' as a key performance indicator for treatment services over the next ten years.

For the period 2006/07, data from the Welsh National Database for Substance Misuse (WNDSM) indicated that, of the total number of cases closed within drug and alcohol treatment services during this period, 46% (7617 of 16551) had dropped out from treatment. This rate of unplanned drop out was higher than any other recorded in the UK over this period. Unplanned drop out from treatment is defined as drop out for reasons other than hospitalisation, imprisonment, movement out of the area, death or treatment being withdrawn as a result of breach of contract. Drop out from treatment services may occur at three stages:

i. Post referral / pre-assessment
ii. Post-assessment / pre-treatment
iii. During treatment

Unplanned drop out rates can be indicative of the quality and appropriateness of treatment services. The level of drop out within a service may be an important measure of the relevance and efficacy of that service to engage, support and treat an individual with problematic drug or alcohol use, or both. Unplanned drop out may also reflect a measure of the client's relevant need and preparedness for the treatment interventions provided by the service. In addition, unplanned drop out from services carry potentially serious implications for both service user and service provider. Failure to successfully complete treatment once sought may have negative consequences on the service user, and influence their future behaviour in seeking contact with services. Unplanned drop out may also impact on service providers in terms of effectiveness, cost-effectiveness and future resource allocation. In addition, drop out rates may impact on staff by the reinforcement of negative stereotypes regarding the client group and staff morale.

In order to establish an evidence base of unplanned drop out in Wales, WAG commissioned the National Public Health Service for

Wales (NPHS) to design and undertake research across Wales during 2008. The study's aims were to:

1. Determine factors reported by service users as influencing, or being associated with, drop-out at various stages in the treatment process and those factors influencing re-engagement, or otherwise, with substance misuse treatment services following drop out

2. Identify operational practice that contributes to both retention in, and drop out from, substance misuse treatment services

3. Develop and issue guidance for service providers and planners on service improvements aimed at reducing drop out rates and maximising reengagement following drop out

In order to achieve this, a database was established of all substance misuse treatment services routinely reporting to WNDSM including a breakdown of specific sites and specialist services provided by umbrella organisations. A total of 78 services were identified and contacted via postal questionnaire for their views and experience on:

- the factors influencing unplanned drop out at each stage
- the impact of unplanned drop out for both their services and on the service users who have dropped out
- those interventions or methods of operational practice that have been useful in reducing unplanned drop out or promoting reengagement with their services.

Alongside this assessment from service providers, field work was undertaken during 2008 recruiting and interviewing current and ex-service users. All the service users interviewed had been in contact with a substance misuse service provider for either problematic drug, alcohol or drug and alcohol use. Ex-service users were those individuals who had been in contact with treatment services within the previous two years, had an unplanned drop out and had not since re-engaged with services. Current service users were those that had an unplanned drop out from treatment services within the last two years but who had subsequently reengaged and were currently accessing substance misuse treatment services.

A total of 559 valid interviews were undertaken across Wales. The aim of the interviews was to gain current and ex-service users' experience and perspective on:

- factors influencing unplanned drop out
- the impact this has on individuals
- recommendations on how services might adapt to facilitate reengagement or reduce unplanned drop out

The guidance draws on this robust and contemporary evidence base to provide clear guidance on mechanisms to reduce unplanned drop out and promote reengagement with substance misuse treatment based upon this and existing UK evidence. This guidance is aimed at those working within or managing existing substance misuse services, those responsible for commissioning services, and for the development and commissioning of future services and policy development. In order to maximise the benefits of this evidence base, the views of the service users have been sought alongside those of service providers and it is hoped that services will consider:

- what the findings mean for them
- what changes to service delivery are required to meet the needs of the served population
- how services users can be engaged in the future development and provision of services

The first section of this report provides a brief overview on existing UK evidence on unplanned drop out and client retention in services. Section 2 focuses on the three stages at which unplanned drop out may occur and describes the key findings on factors influencing unplanned drop out as reported by services providers and current and ex-service users in Wales along with guidance and recommendations to address the issues. As the full range of services providers was included covering specialist alcohol only and drug only services as well as those providing both drug and alcohol services, where differences were highlighted by services, these are reflected in the discussion of each section. Section 3 outlines the impact that unplanned drop out may have both on the individual service users and service providers and aims to provide a clear understanding of, and weight to, the importance of retaining service users. Section 4 provides a summary of recommendations aimed at reducing unplanned drop out and highlights best practice and initiatives already being undertaken by services in Wales as well as those proposed by current and ex-service users.

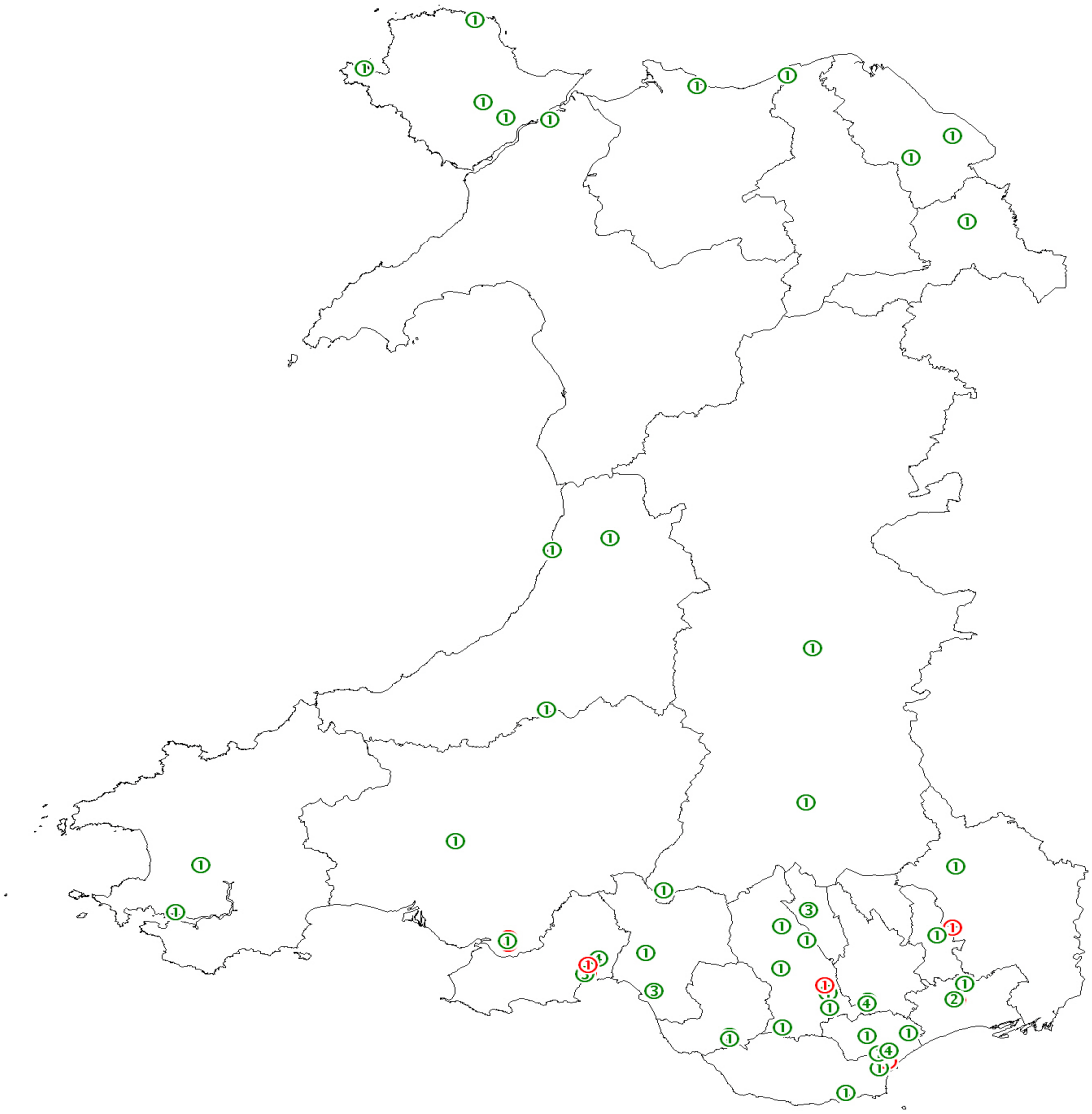
1.2 Geographic profile of service provider respondents in Wales

Substance misuse services*

Did not return completed form
Returned completed form

*Number in marker shows count of services with same postcode

③ e.g. three services located at this postcode which returned completed forms



1.3 Existing evidence - UK evidence

A number of studies within the UK have focused on unplanned drop out, or retaining clients in treatment, as part of wider research focusing on drug treatment outcomes and measures of effectiveness of treatment services. The National Treatment Outcome Research Study (NTORS) undertook a five year review and found that amongst drug users, length of time in treatment was one of the most consistent predictors of positive treatment outcomes. A critical time of 90 days retention, for longer term treatments including methadone maintenance, predicted significant positive outcomes for the client in relation to ongoing drug use, risk behaviour and related criminal activity.[4]

The National Drug Evidence Centre (NDEC) provided further evidence regarding the nature of drop-out from drug treatment. From a sample of over 2,500 drug users entering treatment, 44% had dropped out of treatment within six months, one in four of which had dropped out following initial request for treatment, for reasons unknown by the treatment agency.[2] Whilst drop out from treatment services may occur at any of the three stages of treatment process, the highest rates of attrition were observed in the first and second stages i.e. between referral and assessment, and between assessment and initiation of treatment. [2]

Evidence from the NDEC regarding client profiles highlights younger age, being male rather than female, having no previous treatment experience and referral through the criminal justice system, as predictors of drop out from treatment. Neither type of drug used nor ethnicity were found to be associated.[2] However, analysis of the National Drug Treatment monitoring Service North West data found that ethnicity was associated with unplanned drop out, with higher rates of drop out amongst Asian drug users than their white equivalents. In addition, level of deprivation (as measured by indices of multiple deprivation by area of residence) significantly interacted with age. [5] External factors including geographic proximity to services, employment and housing status also impact on drop out rates.[6,7,8] From a service provider perspective, evidence exists of the impact of worker attitude on unplanned drop out. [9]

1.4 Existing guidance on reducing unplanned drop out from treatment services and increasing retention rates

There are a number of guidance documents produced for drug treatment service providers within the UK aimed at increasing client retention, and thus reducing drop out rates, in drug services. [11, 12] Recommendations include:

- Client induction (ensuring client aware of what to expect from treatment),
- Motivational interviewing
- Reducing waiting times
- Recognition of the importance of the 'therapeutic alliance' (the relationship between client and practitioner)
- Increased flexibility within treatment services e.g. opening times, child care and transport
- Engaging with homeless and other vulnerable groups

Studies from the USA have also highlighted the fact that some simple cost effective measures such as personal phone calls to people who have missed appointments and individual, personalised letters to clients can make a significant difference without carrying a financial burden. [13]

Section 2: Key findings and recommendations

2.1 Unplanned drop out at post-referral stage: Key themes

The referral process may be initiated by a number of sources including self, family or friends, primary care, criminal justice, social and mental health services and represents the first opportunity for services to engage with a new service user. The route of referral is important as it can be predictive of unplanned drop out at this early stage in the treatment process, for example, those referred through criminal justice are more likely to drop out. [2,5,14] In addition, referrals made through a third party are more likely to be inappropriate for a number of reasons including referral to the wrong service or referral without the explicit awareness or agreement of the individual concerned. Self-referral represents the clearest statement of intent and readiness to engage in treatment service and should be facilitated by services. Once a referral has been accepted, services need to quickly engage with the clients as most drop outs take place within the first two weeks.[2] Outlined below are the key factors indicated by both service providers and service users in relation to unplanned drop out post referral and are addressed in the order most frequently cited by service providers and service users:

2.1.1 Inappropriate referral was cited by service providers as the primary cause of unplanned drop out at this early stage and may occur for a number of reasons:

"Inappropriate referral-usually from 3rd party and not with consent"

"permission not sought, client not aware of referral"

"Detainees may agree to a referral at the police station, however the outcome of their arrest may influence whether or not they attend the agency"

"Wrong contact details provided"

Service users who had dropped out at this stage supported this factor indicating that they either did not want contact with a treatment service or that they did not feel ready to start the treatment process.

Guidance and recommendations: In order to reduce the number of non-referrals being recorded as inappropriate referrals, the following guidance is outlined to provide a consistent and pragmatic resolution to this issue:

An inappropriate referral may be defined as either:

- a direct contact with an individual seeking intervention for problematic substance misuse and the service contacted does not or cannot provide the type of intervention sought. The service can then provide the individual with the contact details of a service able to provide the interventions required

- a direct contact with an individual seeking intervention for problematic substance misuse, establishment of an appointment and subsequent non-attendance of that individual as the individual does not wish to engage with services at that time.

All referrals made by third parties should be logged but not entered onto the WNDSM database until direct contact has been made with the individual to ensure that the referral was sought by the individual and they are aware that referral was made

All logged referrals should be periodically reviewed to assess whether there are individuals or organisations (e.g. GP's, social service) that are regularly referring individuals without their explicit awareness or agreement. Services could then contact these individuals or organisations to provide clearer guidance on referral.

2.1.2 Lengthy waiting times to assessment was reported by more than a third of services and service users as a key factor in unplanned drop out.

Lack of community based support for those awaiting assessment was highlighted as an issue during this period and may provide a means of promoting continued engagement and preparation for treatment during this period.

Guidance and recommendations: Reducing waiting times to assessment is already high on the agenda for all service providers and relies on available resources and good operational planning. The further development of open access services that are able to provide ongoing support and engagement with service users, including participation in diversionary activities, may reduce unplanned drop out, and resultant negative impact, at this stage. Planners and service providers need to ensure that there is an integrated network of services offering a range of both open-access and more formal treatment providers within their region. CSPs should ensure that services are commissioned to manage their waiting times using proactive client engagement methods, and to monitor trends in DNA rates for clients waiting to access services.

2.1.3 Inconvenient opening and appointment times particularly for those individuals who are employed, indicating limited flexibility and service planning.

Guidance and recommendations: Greater flexibility and range of opening times is required as evidenced by both this and previous research. [9, 12] Provision of out-of-hours services and flexible outreach provision would facilitate the engagement and early intervention for those who are unable to attend services during normal working hours.

2.1.4 Chaotic lifestyle / chaotic nature of problematic substance users

The inclusion of this factor indicates that, from a service provider perspective, the potential service user is not currently in a stable enough environment or social circumstance to access the type of support and structured treatment offered. Challenge has been made to the use of the term 'chaotic' as representing a deficit on the part of services in providing a flexible and pragmatic approach to individuals who are currently using either drugs or alcohol or both.[12] This perspective is supported here. Recognition of, and support to address, the range of wider factors including lack of stable housing, poly-drug use and mental health issues, relating to a referred individual alongside the substance misuse issues may promote continued engagement with services even if formal treatment is not appropriate in the early stages of contact.

Guidance and recommendations: Flexibility of services in relation to location and opening times is required, as is the increased use and availability of open access and outreach support services and personnel. Flexible services that facilitate continued contact with the service user and help to address wider issues will assist in reducing unplanned drop out. It is the role of the planners, with the service providers, to ensure that the needs problematic substance users are met, not to preclude engagement due to an inability to meet service user needs. Planners should ensure that services in their area are able to respond to the needs of clients at all levels of complexity.

2.1.5 Lack of co-ordination between professionals – confusion between appointments with different providers, including criminal justice services

This factor was primarily cited by service providers and represents a recognition of failure in operational process. Communication between a range of organisations who may all be working with an individual is vital to ensure initiation into treatment services for

problematic substance misuse is unimpaired. This is particularly relevant with treatment and criminal justice organisations where the outcomes could directly affect their freedoms and future opportunities.

Guidance and recommendations: All service users contacting services should have a nominated care co-ordinating organisation and a clear communication protocol should be agreed when working with service users who have contact with more than one organisation.

2.2 Unplanned drop out at post-assessment / pre-treatment stage: Key themes

Having completed the referral and assessment process, resources in time and effort have already been given by both service provider and service user. Unplanned drop out at this stage can impact more significantly on both the service user and service provider. Expectations have been raised, not only by the individuals accessing services but also their families, social networks and other professionals working with them. The issues outlined below represent those most readily cited by service users and service providers as factors influencing unplanned drop out at this stage.

2.2.1 Lengthy waiting times to treatment were reported as the primary factor in unplanned drop out at the post assessment – pre treatment phase.

Time taken to access funding or in processing applications for treatment was specifically cited in relation to alcohol treatment and detoxification services.

Service users closely tied this factor with 'relapsed or started to use/drink again' indicating clearly that there was an expectation on their part that if relapse occurred, the treatment process could not continue and, as such, unplanned drop out occurred.

Guidance and recommendations: Reducing waiting times is clearly resource dependent and remains high on the agenda for all service providers and commissioners. However, the development and increased use of open access, low-threshold support services with opportunities for diversionary activities, and informal but regular ongoing support for the service user may help to reduce unplanned drop out at this stage. As part of the assessment process it must be made clear that ongoing problematic substance use or relapse will not result in closure of the treatment process.

2.2.2 Lack of support or contact before treatment was cited as a key factor by service users whilst service providers cited the more general issue of 'lack of support'.

There was clear evidence that during the waiting period, crises or changes in the service user's personal circumstances, especially housing, may lead to unplanned drop out at this stage. Preparation to plan for potential crises or changes in a service user's personal circumstances, as well as development of the relationship between treatment staff and service user through increased contact, may promote continued engagement.

Guidance and recommendations: As outlined above, the development and increased use of open access support services with opportunities for diversionary activities, and informal but regular ongoing support for the service user may help to reduce unplanned drop out at this stage.

2.2.3 Fear of treatment / peer pressures / lack of social support

Service users were clearly aware of the implications of life change at the prospect of entering treatment. Given the often lengthy waiting times to begin treatment, service users may require support in developing new mechanisms to cope and manage changes to elements of their lives. Increased use and development of support networks designed to work with those waiting for treatment available to individuals who are continuing problematic use of drugs and/or alcohol may assist in reducing the fears and uncertainty experienced while waiting for treatment to begin. Retention can be helped by acknowledging the role family members play in supporting the service user. This could even be supplemented by training for family members. [12]

Guidance and recommendations: Full discussion of the treatment process, and the fears associated with it should be addressed at assessment and regularly thereafter to promote confidence and a sense of control for the service user. Development or increased use of existing support networks designed to support those waiting for treatment may assist in reducing unplanned drop out at this stage. Provision of support and training for family members may also increase the support network available for the service user.

2.2.4 Attitude of staff team / attitude of keyworker

This and previous research has shown that service users highly value a good relationship with their keyworker and service staff. [15] It is important to state that the vast majority of service users described their experience of service provider staff and keyworkers as positive. However, around a fifth of service users cited poor attitude of staff team and / or negative relationship with their keyworker as a factor in their unplanned drop out at this stage. Whilst it is not possible to maintain positive and enduring relationships with 100% of service users, it may be useful to address some of the specific concerns raised:

"Staff condescending and uninterested"

"Staff were nice but inexperienced – 'textbook junkies'"

"Staff kept changing all the time"

"Some staff ok but some didn't understand - wanted clients in and out, didn't want to listen"

"Confidentiality was breached and I couldn't trust them anymore"

Service users' experience of the attitude and behaviours of the wider staff team also impacts on their willingness to engage and maintain contact. Bad experiences may lead to a poor perception of the service in a wider community especially amongst other potential service users. There has been an increase in the size of the drug and alcohol field over the past few years and consequently there has been an increase in numbers of workers. This has brought with it some concerns that a higher proportion of inexperienced staff may be coming into the field. [16] In addition, this issue covers all staff including reception staff who play a significant role in helping clients feel good about the service.[12]

The values, training, attitudes and beliefs held by staff are crucial in determining 'success.' The beliefs held by the staff affect their work and UK research has shown that positive staff attitudes can lead to improvements, [17] and service users are more likely to attend treatment regularly if the practitioner and client felt positive about the nature of their relationship and are optimistic about the outcomes. [18]

Guidance and recommendations: Rigorous and consistent recruitment procedures, and ongoing training and supervision provide opportunities to address concerns from service users and members of the staff team alike. The use of in-house anonymous surveys designed to assess the service user's perceptions of staff attitude and, more generally, perceptions of the service may provide valuable insight into positive changes that may be made to improve services.

2.2.5 Lack of mutual understanding, agreement or shared expectations of treatment between service user and provider

This factor reflects both the service user and service provider need to establish a clear understanding of expectations from both sides. The service user may only at this stage fully understand what it expected of them in relation to initiation and adherence to treatment and also what they in turn may expect from the service provider in terms of treatment and support. A disparity in expectations from either perspective may lead to unplanned drop out at this stage.

Guidance and recommendations: Clear discussion should be had early on as to what will be expected from the service user and likewise what the service will deliver so that any discrepancies may be addressed in advance of unplanned drop out. Development of the care plan should clarify these issues and revisiting the care plan periodically should ensure that any changes required are well explained and mutually agreed.

2.3 Unplanned drop out during treatment: Key themes

Unplanned drop out during treatment has greater impact both on service user and service provider given that relationships have been established, during the wait for treatment, appropriate preparations have been made to address issues around change, both in lifestyle and motivation, and expectations have been raised by all involved.

Failure to engage with treatment programme: There were a number of specific issues raised that may result in unplanned drop out as a result of failure to engage or maintain on treatment that require clarification:

2.3.1 The type of treatment offered was not what was sought

This issue was highlighted specifically in relation to alcohol services where the need for detoxification and residential rehabilitation was outlined but counselling and support was offered due to pressures on existing detoxification services and residential rehabilitation places available. In the case of drug treatment, service users reported either being offered a treatment that did not work for them, made them feel unwell or, in the case of psychosocial interventions, felt that they needed more input rather than just to continue to talk about their issues.

Guidance and recommendations: Service users should be instrumental in the development and agreement of their care plan. Where there is limited availability or capacity for specific services, these should be made explicit to service users and alternatives discussed. The shortfall in treatment availability must also be highlighted to commissioners. Adoption of the Treatment Outcomes Profile (TOPs) tool in Wales should ensure the opportunity for regular review of treatment progress with the service user where treatment issues may be addressed. In addition the use of outcome/session rating scales completed with the service user at the end of a session may assist in assessing progress or identifying problems.

2.3.2 Dosage was too low (in the case of opioid substitute treatment) so continued to use illicit drugs in addition to prescription

Although only one of the treatments available, methadone prescribing is widely used. Based on national and international evidence, the Department of Health guidelines[19] state "there is a consistent finding of greater benefit from maintaining individuals on

a daily dose of between 60 mg and 120 mg (and higher in exceptional cases)". There is evidence that many services in the UK are routinely providing the minimum dose. [12]

Guidance and recommendations: Dosage regimes should be reviewed as part of care plan progress and in every instance where the test results of prescribed clients are indicating their continued use of illicit drugs on top of their prescription. In instances of sub-optimal prescribing, renegotiation of dosage should be undertaken with clear progress outlined in the amended care plan thus precluding unplanned drop out from the service. DoH guidelines[19] should be referenced and consensus worked towards amongst Clinical Directors of services in Wales. All prescribing services should regularly conduct internal prescribing audits, and review trends in dosage across services.

2.3.3 Lack of support and contact once on treatment

Guidance and recommendations: The development and increased use of open access support services and networks within other organisations, with opportunities for diversionary activities and informal but regular ongoing support for the service user may help to reduce unplanned drop out at this stage. Ongoing support and contact should be outlined and agreed within the care plan to promote retention in treatment.

2.3.4 Treatment dosage was reduced too quickly (in the case of 14 week opioid substitute treatment programme)

The introduction of rapid access to treatment was indicated as a positive move by problematic drug service users involved with criminal justice services, however, the intervention is implemented as a 14 week programme involving a rapid reduction in OST. Unplanned drop out at the 10 to 12 week stage was reported.

Guidance and recommendations: The programme outlines referral to existing drug treatment services following on from the 14 week programme however this does not appear to be the case. Rapid access to OST should remain with the aim of a cessation of illicit drug use in an agreed rather than a set period. Individual care plans should outline the structure of the rapid access / reduction programme and may be subject to amendments to reduce unplanned drop out from the programme. Drug Intervention Programme (DIP) contract monitoring systems should be used to regularly review and monitor the suitability of clients commencing a short term prescribing programme. Eligibility for the programme should continue to be on the basis of either clinically suitable for a

treatment programme of the duration available through DIP, or a confirmed ability to transfer into core services at the end of the DIP element of care.

2.3.5 Service user no longer felt treatment was needed / wanted to manage on own

This issue was cited by both alcohol and drug service users and service providers and represents a specific phase in the treatment process where progress has been made to the point that the service user feels able to proceed without the continued support of services.

This point was well made by an alcohol service provider:

"Length of care plan / progress made allows client to feel that they are in control of their substance misuse problem without taking full advantage of the service leading to a greater chance of a relapse".

Addressing this potential issue, as part of a flexible care plan, may reduce drop out during treatment if the service user feels able to reduce rather than stop contact and, if difficulties arise, resume closer contact and access support and treatment when required. Whilst it is clearly important that increased confidence and sense of control on the part of the service user is to be encouraged and supported, services must have mechanisms in place to respond rapidly to existing service users rather than close a case and have to start the process again. Likewise, commissioners and policy makers must recognise that the process of treatment may be lengthy and the consequences of premature withdrawal of support may result in lengthier waiting lists.

Guidance and recommendations: A mechanism should be in place within services, explicit within the care plan, to allow for reduced or minimal formal treatment contact, for a given period on achievement of care plan objectives, to be negotiated between service and client. At the end of this period, the case would be formally closed. If the service user relapsed or experienced changes or crises that impacted on their substance misuse during this period, immediate contact could be made with the service provider to reengage and receive treatment as agreed in the flexible care plan. This should be considered the provision of formal aftercare, as a prelude to client discharge on successful treatment completion

2.3.6 Service users experiencing a crisis leading to relapse including lack of stable accommodation / family issues / relationship breakdown

Many service users have multiple problems including homelessness. Services that aim to deal with all the issues that face the service

user, rather than the single issue of substance misuse have a better chance at retaining clients.[12] Flexible working and interagency involvement with a range of organisations and professions whilst the service user is engaged in a treatment programme may reduce the requirement for unplanned drop out due to crises in the service users life. Lack of support and contact by service providers once the service user is on treatment, as reported above, indicates more emphasis could be placed on the provision of support not only from the substance misuse provider but from other related services. Increased flexibility in terms of treatment requirement, access and support may reduce unplanned drop out at this stage.

Guidance and recommendations: Flexible care planning and the development and maintenance of strong relationships with other provider organisations e.g. housing, involved in the care of the service user should enable continued treatment to be provided.

2.3.7 Poor or fluctuating motivation reported by both service users and service providers.

Existing research on early exit from treatment has addressed this issue and outlines that 'motivation is mutable and can be developed or damaged by the quality and type of treatment offered'.[12] Poor or fluctuating motivation is as likely to affect staff as it is service users and may be addressed through training and the use of interventions such as motivational interview, diversionary and social activities and skill/ training for employment, all of which were cited as examples of useful interventions by service users to improve and maintain motivation.

Guidance and recommendations: The use of motivational enhancement approaches[12] should be built into the care plans alongside regular support and contact. Diversionary and social activities and skill/ training for employment should be developed to improve and maintain motivation. Alongside this, individual staff members or staff teams within organisations should have access to training in the use of motivational enhancement approaches and regular supervision.

2.3.8 Lack of family support and social network

Retention can be helped by acknowledging the role family members play in supporting the service user. This could even be supplemented by training for family members. [12]

Guidance and recommendations: As outlined in the Substance Misuse strategy 'working together to reduce harm', "carers including family members play a vital role in helping substance

misusers remain in treatment and reintegrate into society as their treatment progresses".[1] Providers and commissioners need to ensure that, as part of the agreed care plan, family and carers are provided with information, training and support to, in turn, support those with substance misuse problems.

2.4 Additional factors influencing unplanned drop out at all stages of the treatment process

Alongside those factors reported by the majority of service users and service providers in Wales, there are a number of additional factors reported by service users of specific services or in distinct geographic areas:

2.4.1 Geographic distance to travel

This factor impacted on unplanned drop out rates for a number of service users across Wales. Specific areas of Wales were highlighted including parts of Caerphilly, Gwynedd, Carmarthenshire, Merthyr Tydfil, Torfaen and Swansea CSP areas. Just less than one quarter of the whole service user sample cited distance to travel, lack of transport or the finances to pay for the necessary public transport as factors influencing their drop out from services. Initiatives such as outreach, holding clinics in related services and improved shared care provision may facilitate retention in treatment. There is some support in existing research to suggest that escorting clients to treatment may help. [12]

Guidance and recommendations: Planners should ensure that the travel and transport needs of clients are considered alongside other needs when planning services. Planners should also address the geographical distribution of services.

2.4.2 Environment of treatment service

The way a service looks and feels has an impact on the clients perception of the service and first impressions can and do count. Clients need to feel comfortable and at ease and the environment they find themselves in is important. [12] Environment was particularly an issue cited by two main groups:

i. Individuals approaching services for support and treatment for problematic alcohol use. Problematic alcohol service users reported ceasing contact with treatment services where those services where geared towards both alcohol and drug users. The environment, particularly the waiting areas tended to put these potential service users off. Effort should be made to ensure that all areas of the

service are sensitive to the concerns of specific groups to ensure that all feel welcome.

ii. Service users trying to maintain or reduce on opioid substitute treatment, who find entering the drug treatment service difficult due to large numbers of individuals who are under-the-influence of illicit drugs and/or alcohol. The environment in the vicinity and inside the service is important to current service users as it is to the community at large.

Guidance and recommendations: Premises management, where possible, should account for the specific needs of different current or ex-substance using client groups, their carers, and other users of services.

2.4.3 Child care

Clients with children may find the process of engaging with treatment services frightening with concerns over social service contact and impact on family.

Guidance and recommendations: Service providers should consider existing potential to accommodate the needs of substance using parents, including the provision of information that can minimise anxiety in relation to the risk of children being taken into care.

2.4.4 Care Planning

Good assessment and care planning is crucial in retaining clients, particularly when they are designed to address the wider needs of the individual. Of course a service may not be able to meet every need a client has but a good service will know where to refer,[12] and the recommended development of integrated networks of services within an area should facilitate this. The Audit Commission pointed out in 2004 that more choice, greater flexibility and responsiveness to drug user needs is still required, especially for people with complex problems.[21]

Guidance and recommendations: Care plans should be developed with the service user and adapted to reduce the likelihood of unplanned drop out. For example, when working with problematic alcohol users, the use of shorter care plans both describes attainable goals and reduces the likelihood of unplanned drop out when the client feels more in control of their substance misuse. In addition, services that attempt to meet all of service users needs have a better chance of retaining them.[9]

2.4.5 The quality of the service

The quality of services is reflected in their success or failure in retaining clients for a sufficient period. It may well be the case that overall service quality, i.e. the way all the parts of the service fit together, is the main reason why some services fair better than others.

There exists a broad and quantifiable range in the performance of different services. Research undertaken in England showed that clients in the "worst" performing services were 7.1 times more likely to drop out in the "best" performing services.[2] This was due to factors associated with the service rather than those associated with the service user. [2]

In the substance misuse field it can be true that some services will "blame" clients, particularly those with chaotic behaviour but research now challenges this assertion, looking more at the services themselves for the reasons why clients drop out.[9]

Guidance and recommendations: Planners need to be aware of levels of unplanned drop out within their services, especially where better performance levels can be found in comparable services. All services, in collaboration with their planners, should be delivering a continuous programme of holistic service development and improvement – these development programmes should be informed by, and respond to, the views of all groups of service users.

Section 3: Impacts and implications of unplanned drop out from treatment services

3.1 Impact on service users

Often unreported are the ways in which unplanned drop out from specialist support or treatment impact on the service user, their families and carers and the wider community. Whilst it is frequently clear to service providers that the consequences of unplanned drop out range from negative to devastating for the individual, policy makers and planners of services may not gain the insight required to support changes in operational practice. This report provides unique evidence on the range of ways in which unplanned drop out may impact on those involved from behavioural, psychological and societal perspectives as indicated in Table 1.

The impacts, self-reported by service users as a consequence of unplanned drop out, indicated an increase in the use of either drug or alcohol or both, in some cases even above levels prior to treatment initiation. In the case of injecting drug users, the reported increase in frequency of injecting represents elevated risk of overdose, blood borne virus transmission and other potentially serious health issues. Negative psychological symptoms were reported by around half of the respondents. In addition, family and relationship breakdown were reported in around one third of cases.

The evidence on the range of consequences and outcomes of unplanned drop out highlights not only the negative personal and social impacts on an individual and their families but also the cost implications in terms of increased criminal activity and burden on criminal justice, health, housing and social services. Failure to address unplanned drop out from treatment and appropriately resource and support substance misuse and other related services, including housing services, will result in further costs to individuals, their families and communities.

In addition to those impacts identified by service users and outlined in Table 1 a number of further impacts were also reported by service providers relating to experiences with ex-service users:

- increased sense of isolation
- increased risk of accidental overdose and death
- successful changes already made through treatment may not be sustained
- decreased likelihood of contacting other services for help

Table 1: Impact of unplanned drop out – self report

Self – reported impacts of unplanned drop out	Percentage (%) of service users reporting impact	Number (n) reporting impact from overall sample (N=559)
Impact on levels of substance misuse		
Increase in level of injecting (in previous injectors)	**83 %**	239 of 286
Increase in drug use	**61 %**	341
Increase in alcohol use	**25 %**	138
Negative physical and psychological impact		
Increase in physical ill-health	**38 %**	211
Depression	**50 %**	278
Sense of helplessness	**46 %**	258
Feelings of frustration	**50 %**	281
Suicidal ideation	**6 %**	33
Impact on family and relationships		
Negative impact on family	**35 %**	196
Family breakdown	**27 %**	152
Lost contact with children	**13 %**	74
Impact on crime and criminal justice services		
Increase in criminal activity	**34 %**	189
Increase in contact with courts / legal system	**28 %**	155
Prison	**9 %**	51
Impact on housing and social circumstances		
Lost housing	**26 %**	143
Had to leave family home	**14 %**	78
Increased debt	**16 %**	89
No impact (all dropped out post referral)	**15%**	85

3.2 Impact on substance misuse service providers

As with service users, unplanned drop out may have negative consequences for service providers both in the short and longer term. The following impacts were reported by service providers:

- Staff felt frustration
- Sense that time and effort were being wasted
- Staff motivation and morale can be severely affected
- Negative messages sent to other service users and their peers that the service had 'failed' possibly resulting in a reduction in applications to the service
- An undermining of the reputation of the service and staff
- Concern regarding the possible impact of reduced funding

Given the influence of negative staff attitude on unplanned drop out, there appears to be the potential for 'vicious circle' dynamics. Staff morale and motivation is negatively affected, attitudes may become increasingly negative over time (unless addressed in supervision and training) and more service users drop out due to negative staff attitude. Pragmatically, some unplanned drop outs will occur but much can be done and is currently being done by services to reduce these through good practice and the delivery of a quality service.

Section 4 Summary of best practice and recommendations

4.1 Recommendations by service users

A number of priority recommendations were made by current and ex-service users of both alcohol and drug services that were felt would directly contribute to a reduction in unplanned drop out rates and an increase in subsequent re-engagement with services. The recommendations are wide ranging and include both the need for improvements to existing services and the development of new services or operational practices:

- **Treat each service user as an individual**
- **Daily activities –** including diversionary activities designed to increase an individual's life skills and interests as well as those more focused on achieving employment.
- **Reduce waiting times at all points along the care pathway**
- **If a gradual reduction programme of opioid substitute treatment is sought – aim for this rather than aiming for maintenance -** A number of current and ex-service users contacting treatment services for problematic drug use indicated they did so with the expectation of a reduction programme of opioid substitute treatment and instead were offered and received a maintenance programme
- **Treat drug and alcohol problems in tandem – rather than treating one problem then the other**
- **More outreach services and workers / assertive outreach for problematic substance users –** Respondents indicated a clear need for access to support in a range of environments (including street level engagement) and times, to provide ongoing support and also to assist in maintaining contact with complex and ex-service users whilst they are awaiting referral or access to treatment
- **Flexibility in appointment times –** to take into account an individuals personal circumstances and schedules and also the occasional disruption to normal arrangements e.g. child care or transport issues
- **Inclusive opening times for working people –** early morning and evening appointments would allow those in

employment to access treatment and support. This would also allow those currently not working to have continued support if employment was achieved

- **Improved access to detoxification and rehabilitation services** - primary alcohol respondents indicated that accessing treatment other than counselling was an extremely challenging, complex and lengthy process with information regarding options for detoxification and residential rehabilitation services being scarce. In the case of primary drug users, it was noted that residential rehabilitation services were often religion-based which was felt by some to be inappropriate.

- **Longer detoxification programmes –** respondents, primarily those accessing alcohol treatment services, indicated that a one week detoxification programme was insufficient and that more benefit would be gained in terms of successful outcomes if this period could be extended along with provision of appropriate support

- **An increase in the number of drop-in services –** drop-in services were felt to be very valuable in providing on-going support and access to information and advice regarding a range of issues including substance misuse, housing, benefits, health, child care and employment. A range of drop-in services should be available in a given location to meet the differing needs of the population requiring support and treatment for problematic substance users

- **Development of services for crack and stimulant users**

- **More ex-user staff or more experienced staff, peer workers** – whilst the majority of service users felt positive about the staff and key workers within substance misuse services, there was clear expression for the need for more experienced staff and perhaps workers who had first hand knowledge and experience of the issues

- **Better transition services between young and adult services** – the transition process is vital in ensuring continuity of care and local arrangements should be in place to minimise disruption both in terms of treatment and personnel involved with a young person. This may be facilitated through development of robust integrated care pathways within local substance misuse services

- **More assistance in securing and maintaining stable housing –** this could be facilitated by ongoing contact with

drop-in and wraparound services provided within treatment settings

- **Inequalities –** staff cancel or fail to attend appointments at short or no notice, however, if service user misses an appointment they are threatened with or are actually removed from treatment

- **Training for work –** providing access to employment related skills training was frequently cited as a proactive means of engaging and retaining service users given much needed focus and opportunity

- **Assistance with travel costs / limited bus passes**

4.2 Recommendations by Service Providers

Service providers were asked to indicate the interventions and current operational practices that were proven to be effective in reducing unplanned drop out and promote re-engagement with specialist substance misuse services. The responses have been broken down by service type to allow for differences in service delivery and service user engagement.

Responses from alcohol service providers

The following practices were highlighted by those providers working with problematic primary alcohol users:

- Ensure service users fully understand what they can expect from the provider and what is expected from them as service users in the form of a care plan agreement or individual contract

- Build up links between the client and other services involved with them

- Stay in regular contact with the client throughout their time with the service

Responses from drug service providers

The following practices were highlighted by those providers working with problematic primary drug users:

- Rapid first engagement with service users

- Reducing waiting lists

- Regular meetings

- Assertive outreach and engagement
- Good care planning
- Close client involvement
- Use of motivational interviewing techniques and other related methods including S.M.A.R.T. (Specific, Measurable, Attainable, Realistic and Timely) goals

Responses from drug and alcohol service providers

The following practices were highlighted by those providers working with problematic drug and alcohol users

- Analysis of unplanned drop out rates providing an opportunity to improve services e.g. identification of referring agency repeatedly making inappropriate referrals
- Focus on self referring clients as potentially more highly motivated
- Rapid response to new referrals
- Clear agreement on expectations - ensure service users fully understand what they can expect from the provider and what is expected from them as service users, formally reflected in individual contracts
- Close case management

Common themes relating to good practice in retaining service users in treatment

A number of common themes were identified by service providers from a range of substance misuse treatment settings designed to promote retention in services:

- Staying in touch via personal letters, phone calls and text messages
- Assistance with transport costs
- Rapid response to problems as they emerge
- Client involvement
- Flexibility in opening times
- Flexibility and an individualised approach

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Appendix A: Substance Misuse Service Provider profile

A total of 39 unique organisations were contacted throughout Wales requesting their contribution to the research project. These organisations were identified as those routinely reporting data to the Welsh National Database of Substance Misuse (WNDSM). As many of the organisations have a number of sites and strands to their services (e.g. young peoples' services, DIP, arrest referral, counselling services), a total of 78 questionnaires were sent out. When completing the questionnaire, the service provider either completed a form for each element or site of their organisation if it was felt that different factors influenced unplanned drop out, or if this was not the case, one form was completed for the whole organisation. Following clarification with the services, this resulted in a potential return of 65 forms.

Nine organisations failed to return a completed questionnaire. A total of 57 completed questionnaires were returned representing an overall response rate of 88% (57 of 65 forms). The completed questionnaires provided relatively good coverage of services across Wales.

Service provider responder profile

Drug only providers

Tier 1	0
Tier 2	4
Tier 3	2
Tier 2 & 3	3
Tier 2 & 3 & 4	1
Tier 4	0

Alcohol only providers

Tier 1	0
Tier 2	2
Tier 3	0
Tier 2 & 3	2
Tier 2 & 3 & 4	0
Tier 4	1

Drug and alcohol providers

Tier 1	1
Tier 2	9
Tier 3	12
Tier 2 & 3	15
Tier 2 & 3 & 4	3
Tier 4	2

Appendix B: Service user profile

The aims of the service user survey included identifying the range of factors relating to drop out from the service users perspective, identifying key predictive factors influencing drop out from, and re-engagement with, both alcohol and drug services across Wales at all stages from referral through to treatment

A structured questionnaire was designed for use with two groups of service users:

a. those who have been discharged from a previous episode of treatment as a result of drop out and who have subsequently reengaged with treatment services (drop out/reengage)

b. those who have been discharged from a previous episode of treatment as a result of drop out and who have not reengaged with treatment services (drop out/not reengage).

The first group were recruited through contact with current treatment services and community based opportunistic sampling and those in the latter group were all opportunistically recruited in the community.

The service user survey questionnaire was anonymous and was completed by a member of the project team. Participants were paid for their participation. Full MREC and NHS trust approval was achieved.

A total of 559 valid questionnaires were completed with current and ex-service users (contact with treatment services within the previous two years) recruited across Wales. The sampling framework, based on proportional population data, was designed to ensure that both primary drug and primary alcohol users were equally represented given the understanding that the majority of individuals were likely to be poly-drug users

Geographic profile of interviewed current and ex-service users

Area	Number of completed interviews
North Wales (Bangor, Blaenau Ffestiniog, Caernarfon, Colwyn Bay, Deeside, Flint, Holyhead, Llandudno, Mold, Rhyl, Wrexham)	**129**
Mid and West Wales (Aberystwyth, Carmarthen, Haverford West, Milford Haven, Llanelli, Pembroke Dock, Newtown, Welshpool)	**71**
South West Wales (Bridgend, Neath, Port Talbot, Swansea)	**119**
South East Wales (RCT Valleys, Barry, Bargoed, Blackwood, Llanharan, Caerphilly, Cardiff, Merthyr Tydfil, Pontypridd, Newport)	**240**

- 57% (320 of 559) of the participants were currently in contact with substance misuse treatment services with the remaining 43% (239 of 559) not currently in contact with any treatment services but still using either illicit drugs or alcohol or both
- Male 70% Female 30%

Ethnic Profile

White British	26%
White Irish	1.6%
White Welsh	70%
White other	0.4%
Mixed race	1%
Pakistani	0.2%
Black British	0.5%
Black Caribbean	0.2%
Black African	0.5%

Housing

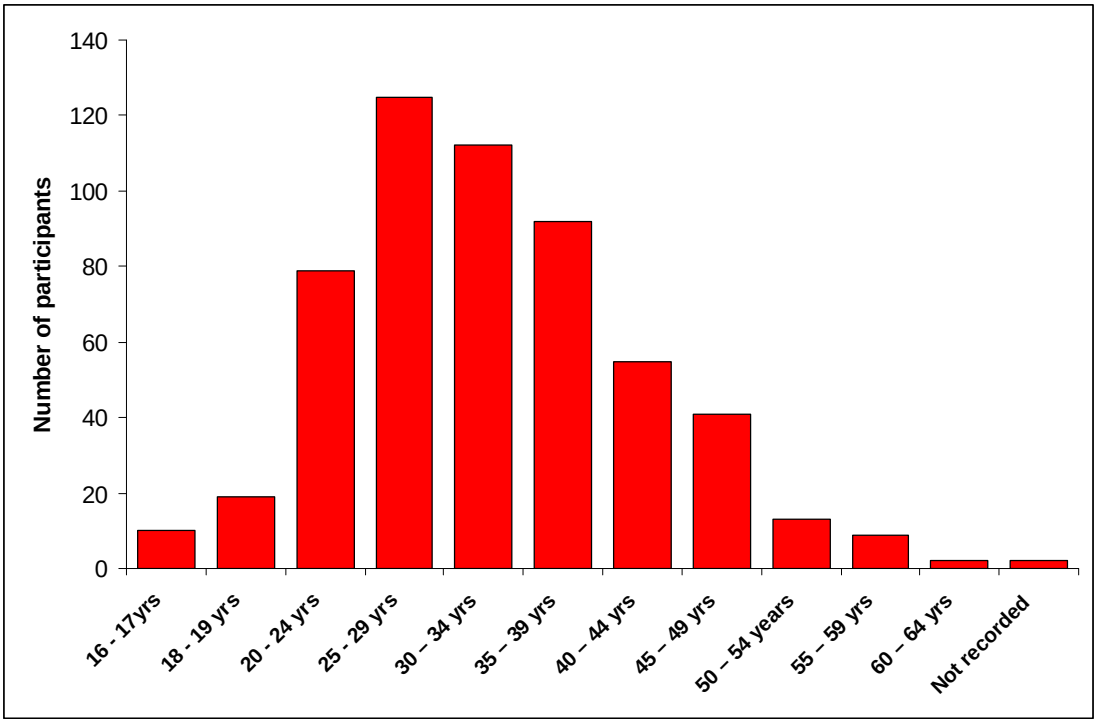
Private rented	17.2%
Housing association / council	30%
Owner occupier	3%
Living with family	14.3%
Living with friends	7.3%
Living in hostels / B & B	14.3%
Homeless/ rough sleeping	13.2%
(Unstable housing total)	34.8%

- 58% (n=323) of participants were parents however only 20% (n=64) of these had their children living with them

- 8% of the sample were working, the remainder were unemployed

- The majority of those interviewed were aged between 20 – 40 years

Age profile of service users



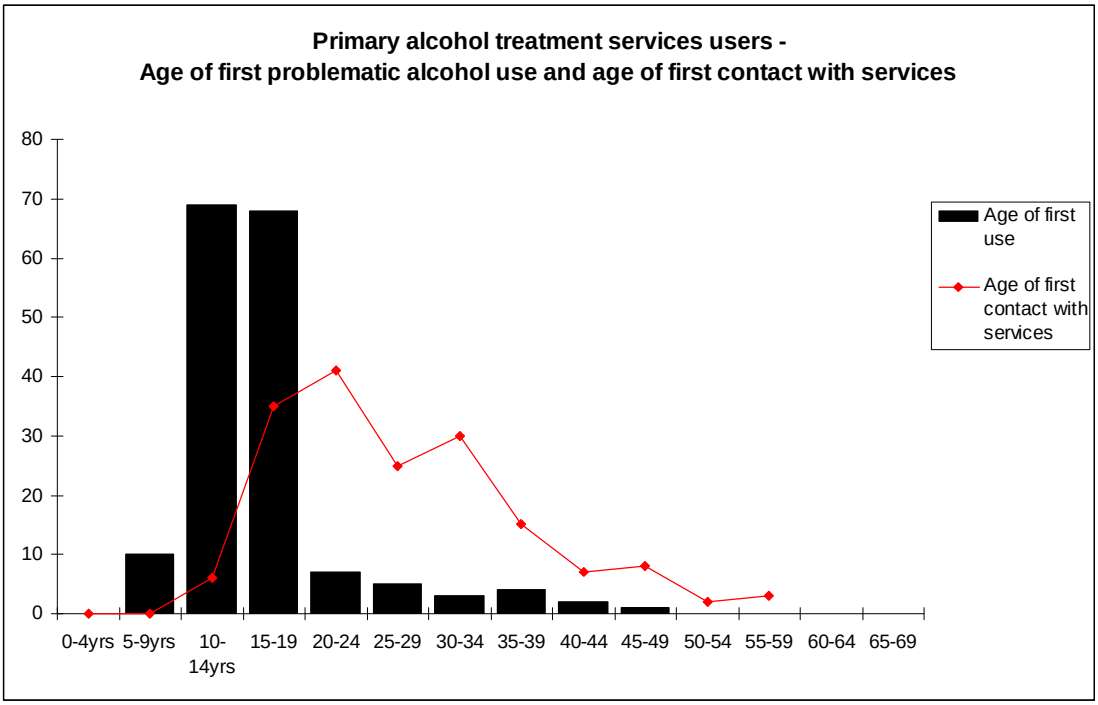
Service users substance misuse profile – Primary alcohol use

- 51.2% (n=286) reported regular and problematic alcohol use in the previous year
- Of these 60% (n=174) were primary alcohol users where alcohol was ranked as the most frequent and problematic substance used. Primary alcohol users represented 31% of the overall sample however, in a number of cases, both alcohol and heroin were given rank 1 (the most frequent and problematic substance used)
- The average age of first use of alcohol was 14.4 years (range 5 to 48 years)

- Of the primary alcohol users, 26% were female and 74% were male. This ratio is consistent with that observed in existing literature and treatment service data
- 63% of the participants indicating primary alcohol use were currently in treatment for alcohol or alcohol and drug use
- Polydrug use:

  Of those participants indicating primary alcohol use:
  - 38.5% (n=67) also regularly used heroin
  - 12.6% (n=22) also regularly used cocaine
  - 29% (n=51) also regularly used benzodiazepines
  - 17% (n=30) also regularly used crack

Age profile of primary alcohol users

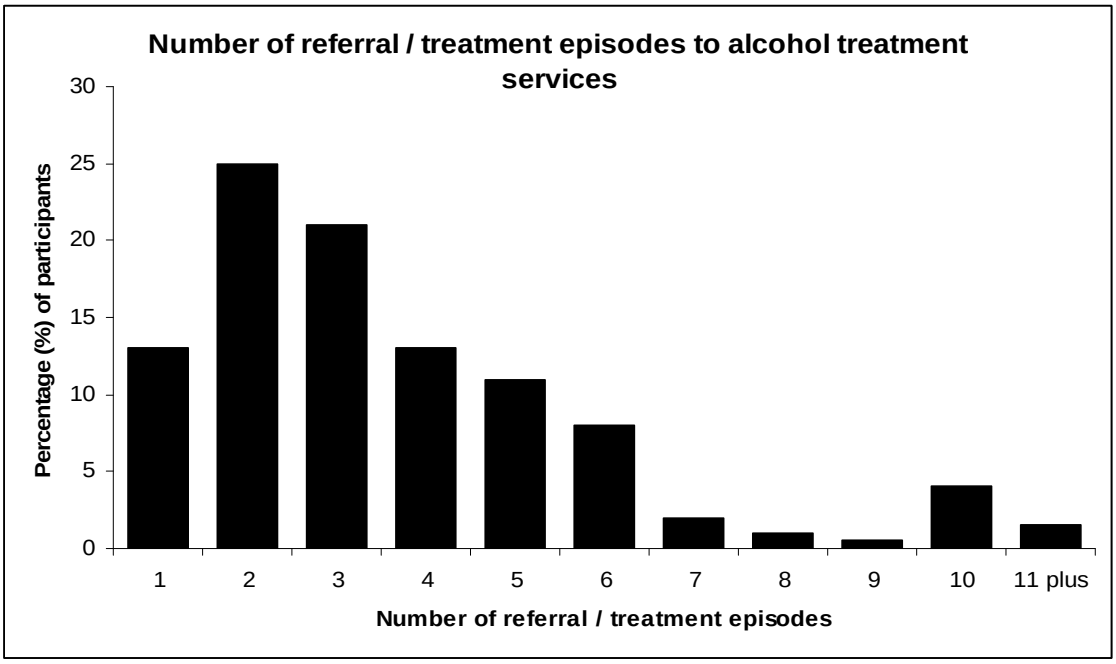


Contact with specialist alcohol services in Wales

Initials referrals

The majority (33%) of initial referrals to alcohol treatment services were initiated by GP, with the remaining referral sources including friends and family (19%), self referral (16%), criminal justice services (12%), social services (11%), hospital (6%) and a small number of initial referrals made by employers, schools and housing support staff.

Close to two thirds (62%) of primary alcohol participants interviewed had been referred / undertaken a treatment episode on at least three occasions as indicated below.



Substance misuse profile – Primary drug use

Heroin

- 76% (n=425) of the sample reported regular and problematic use of heroin, of which 67% (n=286) injected, 28% (n=118) smoked, and 5% both smoked and injected dependent of circumstances
- The average age of first use of heroin was 20.6 years (range 8 to 45 years)
- 53% (n=181) were currently in contact with treatment services
- 68% were males, 32% were female
- Polydrug use:

  Of those participants indicating primary heroin use:
  - 31% (n=181) also regularly used alcohol
  - 12.3% (n=42) also regularly used cocaine
  - 44% (n=150) also regularly used benzodiazepines
  - 51% (n=174) also regularly used crack

Crack

- Of the total sample, 39% (n=218) reported regular use of crack cocaine
- The average age of first use 22.4 years

- Of those reporting regular use of crack, 8% ranked crack as their primary drug, 45.4% as their secondary drug and 33% as their tertiary drug
- The majority, 83.5%, of regular users smoked crack compared to 14% who injected and 2.5% who reported injecting and smoking
- 73% were male, 27% were female

Appendix C: Summary of Service Provider responses - reasons for unplanned drop out

Unplanned drop out post referral

Alcohol service provision:

Alcohol only service providers

- Inappropriate referral
- Waiting times to assessment
- Clients not ready for treatment / lack of commitment
- Inconvenient appointment times (e.g. if employed)
- Waiting list for funding assessment (in the case of residential rehabilitation)
- Incorrect contact details
- Family issues

Drug and alcohol service providers

- Inappropriate referral (including criminal justice referrals)
- Lengthy waiting times
- Inconvenient appointment times
- Clients not ready for treatment / lack of commitment / still drinking [1]
- Family issues / pressures
- Lack of stability in housing, finances or mental health issues
- Chaotic nature of substance misuse
- Lack of co-ordination between professionals – confusion between appointments with different providers including criminal justice

Drug Service provision

Drug only service providers

- Inappropriate referral / client unaware of referral
- Inconvenient referral times
- Clients not ready for treatment / lack of commitment and motivation
- Family issues
- Lack of stability in housing / homelessness
- Chaotic nature of drug use

Drug and alcohol service providers

- Inappropriate referral / client unaware of referral
- Lengthy waiting times to assessment / waiting lists too long
- Inconvenient appointment times

[1] Use of the phrase "still drinking" is, in this situation, inferred to mean drinking patterns that prohibit meaningful participation in a structured treatment programme

- Clients not ready for treatment / poor motivation
- Family pressure
- Chaotic nature of substance misuse
- Incorrect contact details
- Lack of co-ordination between professionals – confusion between appointments with different providers including criminal justice

Unplanned drop out post assessment / pre-treatment

Alcohol service provision

Alcohol only service providers

- Long waiting lists
- Realisation of service expectancies
- Expectations of service user not met / service not adequate
- Crisis leads to relapse
- Inconvenient opening hours of service
- Lack of family or peer support

Drug and alcohol service providers

- Lack of access to timely detox / waiting times for treatment too long
- Client not ready to change / fear of change / fear of treatment
- Expectations of service user not met by service
- Too much time taken to arrange funding / processing of applications
- Confidentiality / information sharing issues
- Inconvenient opening hours of service
- Chaotic nature of substance misuse
- Lack of stable housing / family or peer support

Drug service provision

Drug only service providers

- Waiting times to access substitute prescribing
- Expectation of service user not met
- Chaotic lifestyles
- Lack of motivation
- Lack of stable accommodation
- May only want prescribing, not other interventions or support offered

Drug and alcohol service providers

- Expectations of the service user are not met
- Waiting times for treatment
- Poor motivation / engagement
- Client may need to address other important aspects in life before treatment

- Confidentiality / information sharing issues
- Inconvenient opening hours
- Chaotic lifestyles
- Peer pressures/ loss of social networks
- Lack of diversionary activities
- Lack of rapport with keyworker

Unplanned drop out during treatment

Unplanned drop out during treatment has greater impact both on service user and service provider given that relationships have been established, during the wait for treatment appropriate preparations have been made to address issues around change, both in lifestyle and motivation, and expectations have been raised by all involved.

Alcohol service provision

Alcohol only services

- Length of care plan / progress made allows client to feel that they are in control of their substance misuse problem without taking full advantage of the service leading to a greater chance of a relapse
- Crisis leading to relapse
- Family issues
- Poor health
- Long waiting lists for detox or other facilities
- Client has had enough treatment

Drug and alcohol service provision

- Relapse (as a result of crisis in family or other circumstances or as a result of complacency following successful detox)
- Poor or fluctuating motivation
- Failure to engage with treatment programme
- Client feels treatment is completed or has had enough of treatment
- Poor health
- Long waiting lists for detox or other facilities
- Stigma associated with treatment for alcohol misuse
- Unrealistic expectation of treatment
- Financial resources are limited so client not able to travel to agency for treatment
- Lack of family support and social networks

Drug service provision

Drug only services

- De-motivation, lack of commitment, complacency

- Peer pressure
- Co-dependency
- Lack of stable housing,
- Not ready to address their substance misuse

Drug and alcohol service providers

- Unable to function properly on medication or cannot obtain it from chemist
- De-motivation, lack of commitment, complacency
- Expectations of client not met / service does not meet their needs
- Inconvenient opening hour
- Lack of stable accommodation, finances
- Failure to engage with treatment programme
- Mental health issues
- Lack of family support and social networks
- Peer pressure
- Lack of out of hours service for those in employment
- Lack of co-ordination from professionals

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