Treatment: Dropping Out

Substance User Treatment Dropout from Client and Clinician Perspectives: A Pilot Study

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Reasons for premature termination of outpatient substance user treatment were evaluated from client and clinician perspectives using qualitative (focus groups) and quantitative (survey) methods in a pilot study (N = 44). The sample consisted of clients (n = 22), the majority of whom were male (73%) and African American (50%) or Caucasian (41%). The sample of clinicians (n = 22) were predominantly female (64%), and Caucasian (52%) or African American (24%). The most frequently endorsed reasons for leaving treatment were related to individual rather than program characteristics with heavy drug or alcohol use, transportation or financial problems, and ambivalence about abstinence being highly rated by both clinicians and clients. Survey results indicated that clinicians more frequently attributed treatment dropout to individual- or client-level factors than did clients. Focus group ratings indicated that clinicians felt client motivation and staff connection issues were primary reasons for dropout, whereas clients indicated social support and staff connection issues. The findings suggest that the development of early therapeutic alliance and active problem solving of potential barriers to treatment attendance may influence treatment retention.

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Introduction

The National Survey on Drug Use and Health reported approximately 3.9 million people over the age of 12 received some type of treatment for substance misuse in the past year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006). However, early client attrition from substance abuse treatment is a major barrier for successful outcomes typically defined as the reduction or cessation of substance use or improved psychosocial functioning or physical health. Rates of first-month attrition in outpatient (nonmethadone) substance user treatment programs are approximately 30% and dropout prior to 3 months can be 50% or more (Harris, 1998; Hubbard et al., 1989; Kang et al., 1991; Simpson, 1981; Simpson, Joe, and Brown, 1997). Three months of treatment is considered the minimum to see symptom improvement (Katz et al., 2004; Simpson and Joe, 2004; Simpson et al., 1997), and length of time in treatment has been associated with positive treatment outcomes (Hubbard, Craddock, Flynn, Anderson, and Etheridge, 1997; Hubbard et al., 1989; Simpson and Sells, 1982; Simpson et al., 1997; Zhang, Friedmann, and Gerstein, 2003). The current study evaluated reasons for remaining versus leaving treatment from both client and clinician perspectives.

A number of studies have examined demographic and clinical variables among clients who completed or stayed in different types of treatment for a longer period versus those who left early (Chou, Hser, and Anglin, 1998; Doumas, Blasey, and Thacker, 2005; McCaul, Svikis, and Moore, 2001; Ross, Cutler, and Skylar, 1997). Other studies have examined dropout, retention, and attrition within different types of substance user treatment such as long-term residential, outpatient, and methadone programs (Beardsley, Wish, Fitzelle, O’Grady, and Arria, 2003; Grella, Hser, Joshi, and Anglin, 1999; Joe, Simpson, and Broome, 1999), as well as focusing on the effect of specific drugs such as cocaine or methamphetamine (Maglione, Chao, and Anglin, 2000; Rawson et al., 2000). Specific demographic characteristics associated with dropout from substance user treatment include being a member of a minority group (Agosti, Nunes, and Ocepeck-Welikson, 1996; Veach, Remley, Kippers, and Sorg, 2000), unemployed (Veach et al., 2000), and younger in age (Agosti et al., 1996; Grella et al., 1999). Gender is an inconsistent predictor of treatment dropout (Greenfield et al., 2007).

Clinical predictors of dropout include early onset of substance use (Agosti et al., 1996), more alcohol use–related problems on the Alcohol Problems Questionnaire (APQ; Drummond, 1990; Martinez-Raga, Marshall, Keaney, Ball, and Strang, 2002), polydrug use (Fishman, Reynolds, and Riedel, 1999; Wickizer et al., 1994), impaired coping, as

1 The journal’s style utilizes the category substance abuse as a diagnostic category. Substances are used or misused; living organisms are and can be abused. Editor’s note.

2 Treatment can be briefly and usefully defined as a planned, goal-directed change process, of necessary quality, appropriateness, and conditions (endogenous and exogenous), which is bounded (culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual-help-based (AA, NA, etc.) and self-help (“natural recovery”) models. There are no unique models or techniques used with substance users—of whatever types—which are not also used with non–substance users. In the West, with the relatively new ideology of “harm reduction” and the even newer Quality of Life (QOL) treatment-driven model there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence-driven models. Editor’s note.
well as lower motivation and social support (Anderson and Berg, 2001; Dobkin, De Civita, Paraherakis, and Gill, 2002). Treatment retention appears to be positively influenced by the presence of support systems (Sayre et al., 2002; White, Winn, and Young, 1998); however, this finding has been inconsistently replicated (McMahon, Kouzekanani, and Malow, 1999). Studies also have found mixed effects of co-occurring psychiatric diagnoses as a predictor of treatment dropout (Green, Polen, Dickinson, Lynch, and Bennett, 2002; Kokkevi, Stefanis, Anastasopoulou, and Kostogianni, 1998; McKellar, Kelly, Harris, and Moos, 2006; Miller, Ninonuevo, Hoffman, and Astrachan, 1999; Siqueland et al., 1998). Ball, Carroll, Canning-Ball, and Rounsaville (2006) conducted a retrospective assessment of reasons for early attrition and found client motivation and conflicts with program staff were most frequently endorsed. To date, no research has prospectively evaluated reasons for client dropout from the clinicians’ perspective and made comparisons to dropout reasons from the clients’ perspective within an adult substance user outpatient treatment sample. Only one study has previously examined both clients’ and clinicians’ perceptions of barriers to attending treatment. Mensinger, Diamond, Kaminer, and Wintersteen (2006) utilized the Perceived Barriers to Treatment scale (Diamond and Kaminer, 1998) posttreatment among adolescents and their therapists to retrospectively assess factors that made it difficult to attend treatment within the Cannabis Youth Treatment project. They found few differences in perspectives, except that therapists’ ratings of the “treatment compatibility” (i.e., the therapist and the program) was related to treatment attendance whereas adolescents’ rating of compatibility was not.

Shared perspective between clients and clinicians with regard to agreement on goals, tasks, and reasons for treatment are considered by many to comprise the core components of a working or therapeutic alliance (Bordin, 1979). Several studies have suggested the importance of the therapeutic relationship and characteristics for treatment retention (De Weert-Van Oene, Schippers, De Jong, and Schrijvers, 2001; Joe, Simpson, Dansereau and Rowan-Szal, 2001; Meier, Donmall, McElduff, Barrowclough, and Heller, 2006). However, these results have been inconsistent based on whether the alliance was rated by clients, clinicians, or observers (Barber et al., 1999, 2001; De Weert-Van Oene, De Jong, Jorg, and Schrijvers, 1999; De Weert-Van Oene et al., 2001; Fenton, Cecero, Nich, Frankforter, and Carroll, 2001; Meier et al., 2006). Thus, further research on the discordance or concordance of client and clinician perspectives on goals, tasks, and reasons for treatment may shed light on the quality of the therapeutic alliance, which in turn could lead to improvements in retention or outcomes.

This study is the first to examine client and clinician perspectives of contributory factors to reasons for treatment dropout and focused on both individual concerns and program or staff factors that may impact retention. We used both quantitative (survey) and qualitative (focus groups) methods to evaluate reasons for retention versus dropout from treatment. Consistent with Ball et al.’s (2006) study of client perceptions, we predicted that the most common reasons for dropout would be individual or personal factors such as motivation and limited support from family and friends, as well as program-related factors such as limited connection with staff. Research on attribution theory suggests that individuals make external attributions for negative events that they experience and internal attributions for negative events experienced by others (Heider, 1958; Kelley, 1967). Based on this theory, prior research, and clinical experience, we expected that clients would report more staff- and program-related issues (e.g., program rules) and logistical issues (e.g., transportation) than clinicians who would report more client-related or personal reasons (e.g., motivation).
Method

Participants

The client sample \((n = 22)\) ranged in age from 20 to 57 with a mean of 39.1 \((SD = 9.8)\). The majority \((73\%)\) were men, and 50\% were African American, 41\% Caucasian, 4\% Hispanic Latino, and 4\% Multi-Ethnic. Clients reported initiating treatment an average of 4.8 \((SD = 3.4)\) times in their lifetime. At the time of assessment, 36\% had been in treatment approximately 1–4 weeks, 14\% for 5–8 weeks, 23\% for 9–12 weeks, 23\% for 3–6 months, and 5\% for 1–2 years (see Figure 1).

The staff sample \((n = 22)\) ranged in age from 25 to 76 with a mean of 43.8 \((SD = 13.9)\). Approximately 64\% were female, 52\% were Caucasian, 24\% African American, 10\% Hispanic Latino, 5\% Asian Pacific Islander, 5\% Native American, and 5\% Multi-Ethnic. Staff averaged 10.1 \((SD = 7.9)\) years of experience in substance user counseling, 6.1 \((SD = 7.7)\) years of supervisory experience, and 7.1 \((SD = 7.6)\) years working for the clinic. The average years of education was 15.2 \((SD = 4.8)\), and 41\% had obtained a master’s degree and 27\% a doctorate.

Both clients and clinicians were recruited from two drug-free outpatient programs located in the same building in New Haven, Connecticut. The Connecticut Mental Health Center, Substance Abuse Treatment Unit (SATU) and the APT Foundation, Central Treatment Unit (CTU) both provide substance user counseling services primarily to low or no income residents of the Greater New Haven area. Each clinic receives a significant number of mandatory referrals for substance user evaluations from the Departments of Probation, Parole, and Children and Family Services. Both programs admit a wide range of patients including those with co-occurring, nonacute mental health conditions and a range of substances (alcohol, opiates, cocaine, marijuana). At the time of this study, the average staffing and daily census for the CTU clinic was approximately 6 staff members to 68 patients and the SATU clinic was approximately 16 staff members to 313 patients.

Standard outpatient care at these clinics begins with a one-time initial evaluation conducted by a clinician. At the initial evaluation a psychosocial history is obtained that
Table 1
Responses from the reasons for leaving treatment questionnaire

<table>
<thead>
<tr>
<th>Items</th>
<th>Clients (n = 21)</th>
<th>Clinicians (n = 22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>(α = .93)</td>
<td>(α = .55)</td>
</tr>
<tr>
<td>Physical or mental health problems</td>
<td>1.52 (1.21)</td>
<td>2.50 (.86)**</td>
</tr>
<tr>
<td>Transportation or financial problems</td>
<td>2.33 (1.39)</td>
<td>2.86 (.83)</td>
</tr>
<tr>
<td>Unsure if needed to stop using</td>
<td>2.00 (1.76)</td>
<td>2.81 (.93)</td>
</tr>
<tr>
<td>Family responsibility or problems</td>
<td>2.33 (1.43)</td>
<td>2.55 (.80)</td>
</tr>
<tr>
<td>Heavy drug or alcohol use</td>
<td>2.62 (1.75)</td>
<td>3.14 (.94)</td>
</tr>
<tr>
<td>Feel could get better on own</td>
<td>1.43 (1.47)</td>
<td>2.05 (1.05)</td>
</tr>
<tr>
<td>Unmotivated to keep appointments</td>
<td>1.43 (1.36)</td>
<td>2.64 (.73)**</td>
</tr>
<tr>
<td>Limited support from family friends</td>
<td>1.62 (1.59)</td>
<td>2.45 (.91)*</td>
</tr>
<tr>
<td>Regret what said or did at program</td>
<td>1.67 (1.71)</td>
<td>.86 (.65)*</td>
</tr>
<tr>
<td>Little hope in ability to change</td>
<td>1.52 (1.54)</td>
<td>2.48 (.93)*</td>
</tr>
<tr>
<td>Total</td>
<td>18.47 (11.95)</td>
<td>24.05 (4.02)*</td>
</tr>
<tr>
<td>Program</td>
<td>(α = .87)</td>
<td>(α = .66)</td>
</tr>
<tr>
<td>Conflict with people at program</td>
<td>1.14 (1.23)</td>
<td>1.27 (.88)</td>
</tr>
<tr>
<td>Disagree with what staff expects</td>
<td>1.52 (1.40)</td>
<td>2.18 (.91)</td>
</tr>
<tr>
<td>Concern about personal privacy</td>
<td>1.62 (1.35)</td>
<td>1.77 (1.15)</td>
</tr>
<tr>
<td>Dislike or distrust people at program</td>
<td>1.67 (1.28)</td>
<td>1.73 (.94)</td>
</tr>
<tr>
<td>Staff not helpful or respectful</td>
<td>1.43 (1.36)</td>
<td>1.14 (.94)</td>
</tr>
<tr>
<td>Program hours or location a problem</td>
<td>1.05 (1.11)</td>
<td>2.14 (1.08)</td>
</tr>
<tr>
<td>Dislike program services or rules</td>
<td>1.33 (1.46)</td>
<td>1.86 (.89)</td>
</tr>
<tr>
<td>Need help of a different program</td>
<td>1.19 (1.21)</td>
<td>2.14 (.66)</td>
</tr>
<tr>
<td>Total</td>
<td>10.95 (7.61)</td>
<td>14.10 (3.97)</td>
</tr>
<tr>
<td>Total score</td>
<td>29.43 (19.21)</td>
<td>38.20 (6.51)*</td>
</tr>
</tbody>
</table>

Note. Values represent the mean (SD). α = coefficient alpha *p < .05, **p < .01.

focuses on: substance use, mental illness, trauma, prior treatment(s), and family history of substance use or mental illness. Clients are discussed in team meetings to determine their appropriateness for outpatient treatment based on past and present substance use and mental illness. If clients are appropriate for outpatient treatment, they are admitted and receive group or individual substance user counseling one to two times weekly. Both programs utilize a mixture of motivational enhancement, cognitive-behavioral, and 12-step counseling approaches. Patients at the clinics typically are expected to attend treatment for a minimum of 12 weeks; however, a collaborative treatment planning approach is utilized and some clients continue in treatment for extended periods based on their individual needs.

Measures

An 18-item version of the Reasons for Leaving Treatment Questionnaire (RLTQ; Ball et al., 2006) consists of two subscales: (1) individual-level reasons and (2) treatment program–related reasons for leaving treatment (see Table 1 and Appendix C for scale items). Clients and staff rated the same items but with different instructions: (1) Staff—“Consider all clients you may know that recently have left treatment early. Please estimate on a scale
from 1 (not at all) to 5 (very much) how much the following reasons for leaving treatment early might have been true for these clients” and (2) Clients—“The next page lists some problems or concerns that people have that may influence their decision to leave treatment early. Please rate on a scale from 1 (not at all) to 5 (very much) how much these reasons for leaving treatment are true for you.” The scale reliability was high ($\alpha = .93$) for the full sample ($n = 43$), but lower for staff ($\alpha = .72$) than for clients ($\alpha = .95$).

**Procedures**

Participants were asked to complete a demographics form, an audiotape consent, and the RLTQ before participating in a focus group discussion. Participants were compensated $20 and provided with pizza and soda after the focus group. All study procedures were approved by the Yale Medical School Human Investigation Committee. A total of seven focus groups (four clinician, three client) were conducted at the two sites. Appendix A provides the instructions and open-ended questions used to conduct the focus groups. The staff size at one clinic necessitated conducting a focus group with the supervisory staff and a separate group for the counselors. Clients were invited to participate in the focus groups via flyers posted in the waiting rooms and announcements made in therapy groups. Clinicians were recruited by announcements made in staff meetings. The focus groups lasted 90 minutes and were led by two research staff, with one person conducting the group and the other writing and summarizing participant responses.

Qualitative responses were rated for thematic content using a quantitative assessment developed by the senior author (S.B.) to rate participant reasons for leaving treatment. The rating form categorized responses into the following: (1) patient-related issues such as negative reactions, health concerns, motivation and readiness to change, substance use recovery; (2) program- or staff-related issues such as reactions and relations with other patients, staff limitations or connection issues, confidentiality and privacy concerns, program services, rules, or expectations; and (3) external issues such as limited resources, referral sources, life stressors, social supports. The focus groups were audiotaped, fully transcribed, and then rated independently by the first three authors (R.P., M.M., A.P.) using the 12 rating categories. Cases of disagreements were resolved by the senior author (S.B.) (see Appendix B for focus group rating guidelines). The frequencies of endorsed reasons were used to create scores for two subscales and their respective items: (1) individual issues scale, consisting of two subscales—intrapersonal concerns and psychosocial concerns, and (2) program- or staff-related issues scale.

**Data Analysis**

This report used summary statistics (means, frequencies, percents) for item endorsements and one-way ANOVAs to examine group (client, clinician) differences on both the survey (individual-level reasons; program-related reasons) and focus group (individual issues; program- or staff-related issues) scales. We explored item-level differences only when there was a significant subscale difference to provide some control for multiple comparisons. Paired $t$-tests assessed differences between the individual-level and program-related scales on the RLTQ and the focus group ratings within the groups (i.e., client and clinician). In addition, on the focus group ratings, a frequency count was conducted separately among clients and clinicians for the number of times a category was endorsed and a percentage was

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3We are missing the RLTQ data from 1 client participant.
calculated based on the number of these responses relative to the frequency of all response categories. In addition, we included qualitative responses for descriptive purposes.

Results

RLTQ Scores and Items
Clients scored lower than clinicians on their total RLTQ scores, $F(1, 41) = 4.08, p < .05$, which indicated that staff attribute each “reason for leaving treatment” item to have a greater contribution to overall treatment dropout. Both clients, $t(20) = 6.04, p < .001$, and clinicians, $t(21) = 10.07, p < .001$, reported significantly more individual-level reasons than program-level reasons for dropout. When the two subscales were examined between groups, clients reported significantly lower endorsements of the individual-level subscale than clinicians, $F(1, 41) = 4.28, p < .05$, and there were no differences between clients and clinicians on the program-related subscale of the RLTQ. Further analyses of items within the individual-level subscale revealed that clinicians reported significantly higher ratings than clients for “physical or mental health problems,” $F(1, 41) = 9.38, p < .01$; “unmotivated to keep appointments,” $F(1, 41) = 13.32, p < .001$; “limited support from family friends,” $F(1, 41) = 4.49, p < .05$; and “little hope in ability to change,” $F(1, 41) = 5.90, p < .05$. The only item where clients reported higher endorsements than clinicians was for “regret what said or did at program,” $F(1, 41) = 4.09, p < .05$, which indicated that clients more often felt they had dropped out because of some regrettable action, whereas clinicians perceived this as less relevant to dropout. An examination of the more highly endorsed individual-level reasons indicated that both clients and clinicians rated “heavy” drug or alcohol use, transportation or financial problems, and ambivalence about stopping as common reasons for dropout (see Table 1).

Focus Group Ratings
Overall, clients and clinicians reported similar reasons for dropout in the focus groups. Frequencies and percentages of endorsements within the individual issues category and the program- or staff-related issues category were tested which indicated that the frequency of responses between clients and clinicians did not significantly differ. As well, within client and clinician groups the frequency of endorsements of individual- versus program- or staff-related issues were tested, indicating no significant differences (see Table 2).

Clients most frequently reported social supports (19%), staff limitations and connection issues (18%), and motivation or readiness to change (15%). Clinicians differed minimally in their patterns of responses and frequently indicated: motivation or readiness to change (16%), staff limitations and connection issues (15%) and program services, rules, or expectations (12%).

Focus Group Responses
We provide several examples of focus group responses to further illustrate some of the common and different perspectives of dropout reasons among clients and clinicians reported in the rating scale analyses reported above.
Table 2  
Frequencies of ratings for focus group responses

<table>
<thead>
<tr>
<th>Response Category</th>
<th>Client Groups (n = 3)</th>
<th>Clinician Groups (n = 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Issues:</td>
<td>249 (65)</td>
<td>312 (66)</td>
</tr>
<tr>
<td>Intrapersonal concerns</td>
<td>152 (40)</td>
<td>172 (36)</td>
</tr>
<tr>
<td>Negative reactions</td>
<td>51 (13)</td>
<td>54 (11)</td>
</tr>
<tr>
<td>Health concern</td>
<td>0 (0)</td>
<td>7 (1)</td>
</tr>
<tr>
<td>Motivation or readiness to change</td>
<td>56 (15)</td>
<td>76 (16)</td>
</tr>
<tr>
<td>Substance use recovery</td>
<td>45 (12)</td>
<td>35 (7)</td>
</tr>
<tr>
<td>Psychosocial concerns</td>
<td>97 (25)</td>
<td>140 (30)</td>
</tr>
<tr>
<td>Limited resources</td>
<td>4 (1)</td>
<td>42 (9)</td>
</tr>
<tr>
<td>Referral sources</td>
<td>12 (3)</td>
<td>47 (10)</td>
</tr>
<tr>
<td>Life stressors</td>
<td>7 (2)</td>
<td>14 (3)</td>
</tr>
<tr>
<td>Social supports</td>
<td>74 (19)</td>
<td>37 (8)</td>
</tr>
<tr>
<td>Program- or staff-related issues:</td>
<td>134 (35)</td>
<td>162 (34)</td>
</tr>
<tr>
<td>Reactions and relations with other patients</td>
<td>34 (9)</td>
<td>10 (2)</td>
</tr>
<tr>
<td>Staff limitations or connection</td>
<td>68 (18)</td>
<td>69 (15)</td>
</tr>
<tr>
<td>Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality or privacy concerns</td>
<td>5 (1)</td>
<td>28 (6)</td>
</tr>
<tr>
<td>Program services, rules, or expectations</td>
<td>27 (7)</td>
<td>55 (12)</td>
</tr>
<tr>
<td>Total number of responses rated</td>
<td>383 (100)</td>
<td>474 (100)</td>
</tr>
</tbody>
</table>

Note. Focus groups included clients (n = 21) and clinicians (n = 22). Values represent the percentage (%) of times a category was endorsed in each focus group. *p < .05, **p < .01.

Common Perceptions Among Clients and Clinicians. Both participant groups identified “staff limitations and connections” and “client motivation” as common reasons for dropout.

Staff Limitations and Connections. Clients repeatedly emphasized the importance of a connection or working alliance with the program staff as important for retention. Clients conveyed a sense that they wanted clinicians to care and be invested in their recovery.

Try to connect more but I think empathizing with us is important. I mean we read a lot when we see people. What they can do really is get more involved, don’t just treat us like a child, or like it’s just a job that they do for eight hours and then they’re out. They need to listen more.

Staff also acknowledged the challenge of meeting the demands of their caseloads and how their interactions with clients can either add or detract from the connection they develop.

QUALITY before quantity, I mean I think we all provide quality care for our clients for the most part but sometimes find quantity getting more time. We need more time to not treat the clients like they’re “these people” or “those people” and just treat them like they’re somebody who’s trying to get treatment for whatever it is that they need treatment for.
Motivation or Readiness. Clients readily endorsed that they had experienced times when they had entered treatment and were not ready to engage in treatment and dropped out.

I dropped out early a couple times. Wasn’t ready, you know, didn’t think it was that bad, I could handle it. You know, felt I just wanted to keep running. Then over time, after running for a few years, I voluntarily went on a program, stayed clean, followed it till I came here.

Clinicians also frequently reported clients were not yet ready to change their substance use or see their use as a problem.

And they feel that other than getting arrested for buying it there’s no real negative consequences yet. So they don’t see it as a problem. Every once in a great while we get someone that’s mandated that comes in starts off saying, “I don’t have a problem,” and then part way through all of the sudden realize that well “yeah maybe it is” and they reach that awareness.

Different Perceptions Among Clients and Clinicians. Clients and clinicians differed in the emphasis placed on a couple of areas related to dropout.

Program Services, Rules, or Expectations. Clinicians reported that the treatment initiation process and clients’ lack of familiarity with treatment programs acted as barriers to remaining in treatment.

I think that a lot of clients come from unstable households, and they don’t understand what treatment is, what treatment means, so they drop out right away ’cause they don’t understand the meaning of treatment.

Social Support. Clients often reported that treatment retention was related to the support they received from family, friends, their church, and others in recovery.

I think listening, my family listens more. I don’t know, sometimes when you’re an addict you want to reach out and tell them you’ve got a problem but you just don’t know how and sometimes it’s tough to talk to your family about being, you know. Probably encouragement, if they encourage you to get help, you know, stay on top of things.

Discussion
Consistent with our prediction and prior findings (Ball et al., 2006), we found that the most commonly reported reasons for dropout were individual or personal factors rather than program-related factors. However, our expectation that clients would report more staff- and program-related reasons and clinicians would report more client-related or personal reasons was only partially supported. Client and clinician responses to our quantitative survey and qualitative focus group methods indicated more similarities than differences. Overall, clinicians endorsed higher levels of RLTQ dropout reasons than clients. Although both groups scored higher on individual- than program-related reasons, clinicians endorsed significantly more individual-related reasons than clients. Item-level analyses of the
individual-level subscale highlighted interesting similarities as well as differences between
the groups. Although both groups reported that substance use, motivation, ambivalence,
transportation or financial difficulties, and staff connection issues (evident in both survey
and focus group responses), they significantly differed on individual- or client-level reasons
such as physical or mental health, motivation, limited support, regrets about behavior at
the program, and little hope in ability to change. Our expectation that clients would report
more staff- and program-related issues (e.g., program rules) and logistical issues (e.g.,
transportation) was not supported. We also noted that clinicians reported social support
as having a greater impact on treatment dropout on the RLTQ whereas clients more often
cited social support in the focus groups. This inconsistency in the findings could be due to
differences in the nature of each method of collecting data (i.e., a quantitative paper–pencil
item endorsement versus a qualitative focus group discussion).

Study Limitations

Data from the current pilot study should be interpreted with caution and generalizability
may be limited as the results of the study are affected by the small sample size, self-report
data, and the predominance of men within the client sample. In addition, this sample is
based on two clinics from a U.S. outpatient treatment program and almost half of the
client sample had been enrolled in treatment for approximately 2–6 months, suggesting
they may have a strong therapeutic alliance with their clinicians and possibly making it
difficult for them to consider potential reasons for dropping out from a prior treatment
episode. We did not ask participants about the number of treatment dropouts they had
experienced; instead we asked about the number of treatment episodes they had previ-
ously attended, which may not reflect the quality of their level of engagement in previous
treatment attempts. Within the focus groups, participants who were currently in treatment
were asked to speculate on reasons why they or others may have left treatment. How-
ever, client report likely has some validity as most participants reported multiple prior
treatments on which to base their responses regarding the dropout process. It also should
be noted that client and clinician differences (both in subscale scores and internal consis-
tency) on the RLTQ might be attributed in part to differences in the instructional set
for these two participant groups. Specifically, clinicians were instructed to “consider your
caseload,” thus covering a broad range of patient and a broader range of dropout reasons
than would be considered by one client completing the questionnaire about him self or
herself.

Our efforts to protect participants’ (clients and clinicians) confidentiality and
anonymity precluded us from gathering additional data regarding the complex and dynamic
relationships between clients and clinicians, which would have allowed a richer contextual
description and understanding of our findings. Future research may want to consider these
aspects of treatment including clinicians’ judgments, the diagnostic process, the treatment
goal selection process, treatment technique selection or other characteristics related to the
temporal staging of treatment. In addition, we acknowledge the ethical issues in asking
participants (clients and clinicians) in this study about their experiences as they were not
likely to benefit directly from their participation (Kleinig and Einstein, 2006). Participants
were generous in sharing their opinions and understood the goal of the study was to un-
derstand more about treatment dropout to improve outcomes for clients and inform future
research.
Despite these limitations, this study provides some insight into clinician and client perspectives on substance user treatment dropout. The quantitative and qualitative measures highlighted both differences and similarities in their perspectives. Both clients and clinicians emphasized the importance of staff connection issues and motivation, and this may be an important early treatment goal given the high rates of dropout within the first 3 months of treatment. Other important dropout reasons noted by both groups could be influenced by the development of an early therapeutic alliance, with a specific focus on enhancing client trust, engagement, and motivation. In addition, clients may need assistance in problem solving potential barriers to attending treatment (i.e., transportation, child care, or financial difficulties) as well as assistance in improving their ability to cope with life stressors. A motivational interviewing style incorporating reflective listening, rolling with resistance, and maintaining an empathic and nonjudgmental stance may strengthen the therapeutic alliance and promote better retention in treatment.

**RÉSUMÉ**

La remise en jeu de traitement d’abus de substance des perspectives de client et praticien : Une étude de pilote

Les raisons pour la conclusion prématurée de traitement d’abus de substance de malade externe ont été évaluées des perspectives de client et praticien utilisant qualitatif (les groupes de foyer) et quantitatif (l’étude) les méthodes dans une étude de pilote (N = 44). Les raisons le plus fréquemment endossées ont été relatées à l’individu au lieu des caractéristiques de programme avec le drogue lourd ou à l’usage d’alcool, au transport ou aux problèmes financiers, et l’ambivalence de l’abstinence est extrêmement évaluée par les practiciens et les clients. L’étude résulte a indiqué que les praticiens fréquemment ont attribué plus la baisse de traitement hors à l’individuel/client facteurs égaux qu’a fait des clients. Converger les classements de groupe ont indiqué que les praticiens ont senti que la motivation de client et les problèmes de connexion de personnel étaient des raisons primaires pour la remise en jeu, tandis que les clients ont indiqué le soutien sociaux et les problèmes de connexion de personnel. Les conclusions suggèrent que le développement d’alliance thérapeutique première et résolution de problèmes active de barrières potentielles à l’assistance de traitement influence la rétention de traitement.

Mots clés : le traitement d’abus de substance, la remise en jeu, les clients, les praticiens

**RESUMEN**

El tratamiento del uso de la sustancia marginado de perspectivas de cliente y clínico: Un estudio piloto

Las razones para la terminación prematura del tratamiento del uso de sustancia de paciente externo fueron evaluadas de las perspectivas de cliente y clínico que utilizan cualitativo (los grupos del foco) y cuantitativo (la inspección) los métodos en un estudio piloto (N = 44). Las razones normalmente aprobadas fueron relacionadas al individuo antes que características de programa con el uso pesado de la droga o el alcohol, con el transporte o los problemas financieros, y con la ambivalencia acerca de abstinencia para ser valorada sumamente por tanto por los clínicos como los clientes. La
inspección resulta indicó que clínicos más atribuyeron con frecuencia gota de tratamiento fuera al individual/cliente los factores planos que hizo a clientes. Enfoque las calificaciones del grupo indicaron que clínicos sentían el motivo de cliente y los asuntos de la conexión del personal fueron las razones primarios para marginado, mientras que clientes apoyo y asuntos de conexión de personal social indicado. Las conclusiones sugieren que el desarrollo de la alianza terapéutica temprana y la resolución de problemas activa de barreras potenciales a la asistencia del tratamiento puede influir la retención del tratamiento.

Palabras Clave: el tratamiento del uso de la sustancia, marginado, los clientes, los clínicos

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Dr. Mary K. Murphy received her PhD from the Ferkauf Graduate School of Psychology at Yeshiva University. She served as research coordinator for the current study and now serves as consultant to ongoing projects. Presently, she is a member of the faculty at the Albert Einstein College of Medicine in the Department of Emergency Medicine. Her primary research interests are on developing standardized methods to deliver brief motivational interventions utilizing innovative technologies that can be tailored for language, cultural competence, and health literacy in order to reach the largest numbers of people in need of substance abuse services. Her current research focuses on delivering alcohol abuse screening and intervention services for patients in the acute care setting.
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**References**


Appendix A

Participant Instructions

“We should first offer some guidelines for how the group will be conducted. It is important for you to know that we feel there are no right or wrong answers; it is important for you to share your views and opinions, not what you may think we want to hear. We would appreciate if each of you took turns in answering the questions and try not to interrupt while others are speaking. We would like to emphasize that we are here to learn from you and would really like to know your thoughts on these questions. We are happy to answer any questions if something is unclear or if you would like a question repeated. Also, we want to respect everyone’s confidentiality so we ask that the things said in this room remain here. Does anyone have any questions? Before we start the group we would like to go through the consent form.”

Open-Ended Questions Used in the Focus Groups:

1. Based on your own experience and people you’ve known, what are the most common reasons people drop out of substance abuse treatment early?
2. What could the person who dropped out have done differently to prevent dropping out?
3. What could the family or friends of the person who dropped out done differently to prevent treatment dropout?
4. What could the program or staff done differently to prevent this dropout?

Appendix B

Focus Group Rating Guidelines

Instructions: Read through the transcript and write one or more rating numbers for each sentence. If the next sentence is clearly identified as spoken by the same individual and simply elaborates upon the prior sentence, write the same rating number(s) above but in parentheses. If additional content is added into the next sentence, then write one or more new rating numbers above without parentheses the first time it occurs and with parentheses if repeated in subsequent sessions. Once a new speaker begins talking, then the process begins again with no parentheses on the first introduction of a category. When a speaker is interrupted by a full comment or question made by another group member or facilitator (discounting short phrases encouraging communication), the next statement should be rated without parentheses even if it obviously continues a point they were making before being interrupted.

Patient-Related Issues

1. Negative Reactions: e.g., fear; distrust; anger; pessimism; avoidance; specific reaction to an event; negative attitude or expectancies; poor coping, planning, or problem solving;
blaming; externalizing responsibility; overconfident with minimization of problems; anxiety about expectations or consequences of treatment

2. Health Concern: e.g., psychological distress; psychiatric symptoms; medical illness

3. Motivation/Readiness to Change: e.g., denial; resistance; ambivalence; treatment not a priority; hope or optimism about change; low confidence in treatment or ability to change

4. Substance Use Recovery: e.g., relapse; recover is challenging; limited knowledge of addiction; need different or more intensive treatment; implementing recovery tools and making lifestyle changes at home; insufficient participation in treatment

**Program- or Staff-Related Issues**

1. Reactions and Relations with other Patients: e.g., negative reactions to group members; lack of connection or cohesion with fellow patients; reminders of substance use lifestyle; lack of safety with other patients; feeling different from other patients and don’t believe can help

2. Staff Limitations or Connection Issues: e.g., weak working alliance; lack of positive reinforcement; lack of education about treatment and recovery; inflexibility or lack of individualization in counseling; unrealistic expectations; failure to follow-up; lack of caring; poor communication; problematic boundaries or limit setting; staff enabling; authority outweighs collaboration

3. Confidentiality and Privacy Concerns: e.g., distrust of peer maintaining confidentiality; fear of exposure to those known in the community; worried about staff sharing information with referral source or significant others; worried about health and life insurance labeling as substance abuser; information sharing across groups

4. Program Services, Rules, or Expectations: e.g., confusion about expectations; rule changes or inconsistencies; unresponsive procedures; feared consequences; services not matching needs; insufficient attention to other psychosocial needs; insufficient involvement of family in treatment; limited treatment options

**External Issues:**

1. Limited Resources: e.g., transportation, finances; child care; housing or employment instability; insurance

2. Referral Sources: e.g., criminal justice; child protection; return to jail; work or health care referral

3. Life Stressors: e.g., death, serious illness, or loss of significant others; loss of job; domestic violence; housing eviction; loss of basic services; arrest of self or others; trauma

4. Social Supports: e.g., prefer to make changes without other’s help; lack of support from family or peers for recovery; active use in home; substance-using peer group; seeking or failing to seek support from others including self-help groups

**Appendix C**

Reasons for Leaving Treatment Questionnaire (Ball et al., 2006):
(Different directions are provided based on whether administered to a client or a clinician as described in the Method section). Responses range from: 1 = “not at all,” 2 = “very little,” 3 = “somewhat,” 4 = “much,” 5 = “very much.”

1. Physical or mental health problems
2. Transportation or financial problems
3. Conflict with people at program
4. Unsure if needed to stop using
5. Disagree with what staff expects
6. Concern about personal privacy
7. Family responsibility or problems
8. Heavy drug or alcohol use
9. Dislike or distrust people at program
10. Staff not helpful or respectful
11. Feel could get better on own
12. Program hours or location a problem
13. Unmotivated to keep appointments
14. Dislike program services or rules
15. Limited support from family/ and friends
16. Regret what said or did at program
17. Little hope in ability to change
18. Need help of a different program