

Increasing attendances in drug services

IN 1993, THE NORTHUMBERLAND Community Substance Misuse Team found itself faced with one of the drug field's most disheartening but perennial problems – clients weren't turning up. Forty per cent of referred clients were dropping out even before their first appointment. Needless to say, everyone involved found this incredibly frustrating – referral agents and service users voiced frequent objections about our long waiting list, while staff were annoyed about setting up meetings for people who never showed up, often in venues far away from the office base.

But apart from these concerns about how missed appointments affected them personally, all staff were also worried for these 'lost' clients. They were often described by their referral agents as having particularly severe problems requiring urgent advice and assistance, but because they dropped out of the system, they didn't get this help. And so, we found ourselves asking the thorny question – *why were these clients not accessing our service when offered the opportunity?*

Understanding non attendance

We decided that the only way to begin to understand this trend was to monitor our referrals and attendances. We did this over a nine month period in 1993, studying all the clients referred to the team – 190 of them – and identified the following trends.

Referral agents Certain referral agents were more likely than others to ask us to see people who then did not turn up for appointments. Staff from hospitals (both general and psychiatric) often referred people as part of a patient's discharge plan, but over half of these referrals didn't turn up for appointment. Self-referral and referral from family or a GP had a smaller drop out rate of around 40 per cent. Probation and social services, although referring less often, gave rise to the best drop out rate of 27 per cent or less.

A research study of clinical psychiatric patients perhaps offers a possible explanation for

Why is it that so many people who request help with a drug problem – or agree to be referred for help – just don't turn up when given an appointment by a specialist agency? And what can you do to try and stop them dropping out at this stage?

by
Judy Milne

*Social Worker,
Substance Misuse
Northumberland County
Council*

&

Ian James

*Clinical Psychologist
Northumberland Mental
Health Trust*

SUMMARY

Forty per cent of this substance misuse team's clients were dropping out before first attendance. A period of monitoring referrals led to the introduction of a simple 'opt-in' procedure, which cut drop outs to under 20 per cent.

these observations.¹ Initial attendance rates appear to improve when referral agents are well informed about the service, when they negotiate the referral more than once before proceeding (but not too often) or when they encourage the service user to actually make the referral themselves.

This last finding seems to contradict our own experience of self-referred patients, and we were puzzled why so few self-referrals turned up for their first appointment. It may simply be that the users of clinical psychiatric services tend to lead less chaotic lives than problem drug users, making it easier for them to attend planned appointments and maintain motivation after the initial help-seeking desire has passed.

As for the good attendance rates for clients referred to us by probation and social services, many clients may turn up just because they perceive these agencies as carrying heavier sanctions for non-attendance.

Waiting time Unsurprisingly, we also found that the longer people had to wait for an initial appointment, the less likely they were to attend. The attendance rate for appointments offered within four weeks was about 68 per cent but this fell to 43 per cent thereafter.

Drugs used Opiate users showed the highest rate of attendance at first appointment, with a 72 per cent turn up rate. Other drug users were less likely to turn up at first appointment, with figures approaching 50 per cent. The fact that our team was widely known to provide a methadone prescribing service is one possible explanation for why opiate users attended more reliably than most.

Client fears For some clients, the prospect of seeking professional help is a fearful undertaking. Stigma, shame and guilt are commonly experienced, as are the fear of failure and the very real worry of not getting on with the therapist.³ For others, not knowing exactly what kind of help is on offer, or indeed what might help at all, could easily act as a deterrent to attending. This is backed up by a study which

PLANNING A SERVICE TO CUT NON-ATTENDANCE

There is no single cause of non attendance and therefore no single strategy which will effectively ensure 100 per cent take up of services by drug users. However, assuming that there are a number of steps a drug user needs to take in order to engage successfully with services, the following pointers can make it less likely that he or she does not "trip up" on the way.

- Encourage referral agents to be sure about the user's motivation before they request an initial appointment, and ensure referrers are well briefed about the service and what it offers.
- Keep waiting time for initial appointments down to a minimum, preferably to less than four weeks.
- Engage with new service users as soon as possible, by letter or by one-off appointment.
- Don't assume that new service users know what's in store for them when they attend a first appointment. They ought to know beforehand not only what the agency offers, but also what will happen to the information they give you and what is expected of them throughout the treatment process.
- Encourage a commitment from service users about their intention to attend (for instance, by providing a reply slip in the initial letter).
- Avoid creating practical obstacles for service users when setting up initial appointments, by taking account of their preferences for times and venues, and offering reimbursement of travel costs where this is payable.

1. Munroe J. and Blakey R. "A study of non-attendance in first appointments with clinical psychology." *Clinical Psychology Forum*: 1988, 17.
2. Gallant D. and Bishop M. "The value of a first contact group intake session in an alcoholism outpatient clinic." *Psychometrics*: 1966, 7, p.349-52.
3. Sheehan M. et al. "Who came for treatment: drug misusers at three London Clinics." *British Journal of Addiction*: 1988, 83, p.311-20.
4. Oppenheimer E. et al. "Letting the client speak: drug misusers and the process of help-seeking." *British Journal of Addiction*: 1988, 83, p.633-47.
5. Spector K. "Increasing take up rate of clinical psychology services." *Clinical Psychology Forum*: 1988, 13.
6. Webster A. "The effect of pre-assessment information on client satisfaction, expectations and attendance at a mental health day centre." *British Journal of Medical Psychology*: 1992, 65, p.89-93.
7. Green B. and Giblin M. "Screening out non-attenders." *Clinical Psychology Forum*: 1985, 1/8.
8. Markman P. and Beaney E. "DNA rate and effect of opting in to a clinical psychology service." *Clinical Psychology Forum*: 1990, 29.
9. Crawford J. et al. "The venue for clinical psychology appointments." *Clinical Psychology Forum*: 1987, 7.
10. Grover S. et al. "Improving appointment keeping by patients new to a hospital medical clinic with telephone or mailed reminders." *Canadian Medical Association Journal*: 1983, 129, p.1101-3.
11. Weighill V. et al. "Keeping appointments with clinical psychologists." *British Journal of Clinical Psychology*: 1983, 22, p.143-4.
12. Copeland J. and Hall W. "A comparison of predictors of treatment dropout of women seeking drug and alcohol treatment in a specialist women and two traditional mixed-sex services." *British Journal of the Addictions*: 1992, 87(6).
13. Heng S. et al. "Adding value to early client contact." *New Directions in the Study of Alcohol Group*: 1994, 19, p.7-12.

These 'lost' clients needed urgent help but because they dropped out, they didn't get it

found that many users of drug services knew very little about the service being offered, the route to accessing that service, or even who the service was aimed at.⁴ This was largely because professional agencies were not seen as the "first port of call", generally being used as the last resort, while initial help was more usually sought through informal social networks. Agencies were often seen as failing to meet the needs of certain groups, such as women and ethnic minorities.

What can we do?

A couple of studies of clinical psychiatric services have found that sending users information about the service prior to a first appointment could reduce initial drop

out by up to 25 per cent.^{5,6} This information should offer reassurance about issues which might deter some people from attending, such as confidentiality, the agency's attitude towards service users, and what form 'treatment' would take.

Research also suggests that asking service users to take an active role in the referral process (for instance, by completing part of the process themselves) significantly reduces initial drop out. One study of clinical psychiatric services found that drop out fell by 20 per cent after service users were encouraged to play such a role.⁷ Another study found that by combining an "opt in" option and giving prior information, initial non attendance could be cut by as much as 50 per cent.⁸

Similarly, first appointment attendance tends to be low when venues are stigmatising or inconveniently located,⁹ when there is poor communication and administrative errors on the part of the service,¹⁰ or when users are young, single, female or unemployed.^{11,12} While there is little we could do about these last factors, we could at least turn our attention to organisational improvement.

Introducing 'opt in'

On the basis of what we understood about initial drop out, and using only resources readily available to the team, we introduced a new system for a further nine months. This involved sending everyone referred to us an information leaflet explaining what the service offered, what would happen at the first appointment, what the boundaries of confidentiality were, and what role the new service user should expect to play in the process. A freepost return slip was included which asked the person to confirm that they still wished to be seen, and where and when this would be convenient. Information about travel expenses was also provided. Only on return of this slip was the person's name added to the waiting list.

Referrals which the team coordinator saw as urgent on the grounds of physical, psychological or social risk (about 28 per cent of the total) were prioritised and given an immediate appointment without the 'opt in' procedure. Only 80 per cent of these prioritised clients attended these initial appointments. This raises a number

of interesting questions (which cannot all be answered) as to why these people were prioritised – did they require an immediate response because they had an 'urgent' need or was there only a narrow window of opportunity in terms of hours rather than days? Is the fact that they missed out on the information leaflet

The 'opt in' procedure plus a shorter waiting time cut the drop out rate to 17 per cent

significant in any way? Or should we as an agency focus our attention instead on referral agents who are trying to manage difficult situations?

Seventeen per cent of the remaining 'non-urgent' referrals did not return their reply slips and were discharged without an appointment. The non attendance rate for all other referrals dropped to 28 per

cent, almost half our previous rate. Although the filtering out of 'the 17 per cent' could be seen as a sneaky way of weeding out non-attenders at an early stage, the prioritising of the most 'at risk' group was actually a guard against us losing those clients most in need of help.

By combining the 'opt in' procedure with a shorter waiting time of less than two weeks (negotiated on a case-by-case basis) the drop out rate was reduced even further, to 17 per cent.

Improvement can be cheap

Non attendance at initial appointments offered by community treatment services to substance misusers is known to be higher than in many other health care services.¹³ Our efforts, however, have shown that better attendance is possible given a relatively small change in the way the service responds to initial referrals. For our service users, an opting in and prior information procedure did make an impact on initial attendances, especially if combined with a shorter waiting time. And all it costs are a few freepost envelopes. ○

CONNECTIONS

SURF THE EUROPEAN NET WITH ISDD

Frustrated with useless information on the Internet? Looking for a web site that's worth visiting? Do you want to be part of the most exciting electronic development in the European drug field?

Then REITOX.NET is for you.

REITOX.NET is a brand new electronic network associated with the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). It reaches out to all 15 European Union states, and is Europe's electronic interchange for drug information. Everyone who joins the net (for free) can expect to receive periodic news not only from the EMCDDA and from ISDD (the UK operational 'focal point'), but also from other REITOX.NET participants. And of course, everyone can also e-mail to other members on the network. This is the first time such a European network has been 'road-tested' and it could be the best opportunity yet to be part of a worthwhile electronic network.

An invitation is now being extended to take part in and assess the prospects for development of the network. This invitation is open to e-mail capable organisations throughout the UK which work in the areas of demand reduction, prevalence and policy.

For practical and administrative reasons, UK participation in the initial assessment period will be limited in

numbers, after which ISDD will invite comments and evaluate the network's performance. We expect between 50 and 100 organisations throughout the UK to participate, drawn more or less evenly from Northern Ireland, Scotland, England and Wales.

If you want to join, check with your colleagues and IT systems administrator, then send one e-mail per organisation no later than November 1st to the internet address below (when more than one person has the same address, it's a case of first come, first served).

In the header of the e-mail please type **REIT-SUB** (so we can easily identify your message). In the message part of your e-mail, give your name, full address, telephone and fax number. Please also indicate a primary interest in either prevalence, demand reduction or drug policy, and tell us which of the following sectors you work in – criminal justice, health/social/community, or education. Please do *not* attach any other file. Send only once to:

nicholas.dorn@reitox.net

You will then be allocated another e-mail address and any information sent to that address will automatically be re-routed to your existing e-mail address.

This is not an ISDD internet page, so please address all your regular correspondence to our usual postal address.

WARNING! REITOX.NET is a standard Internet e-mail network, set up and maintained by a variety of agencies in the EU. It is an open network and is not 100 per cent secure. Joiners are responsible for safeguarding their system against possible viruses and are strongly advised to check with their IT systems administrator before joining. ISDD accepts no responsibility whatsoever for the amount, quality or consequences of information that REITOX.NET may transit or fail to transmit to individuals voluntarily connecting to it. This is an experimental network and must not be relied upon for urgent, sensitive, confidential or business purposes.