



## Clinic Drop Outs: Slowing the Stampede



### Ouch! Drop Outs Hurt

Outpatient participants decide each day whether they want to show up for their session. This unique feature of outpatient presents a particular challenge since one missed session easily leads to another, and another, and so on... Early drop outs can destroy the quality of a program in at least four ways.

First, when there is frequent turnover in group, there is no opportunity for program participants to connect with the clinician, develop an alliance, and feel safe enough to discuss what is really happening in their lives. Constant introduction of new people into group is disruptive and a source of dissatisfaction among current group members.

Second, when clients see dropping out as a  
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**P**atient Feedback is just one approach to quality improvement (QI) for substance abuse treatment programs. There are many others that should be tried. The following is a summary of a one-shot QI study that can be eye opening.

A grad student came to me for suggestions on a practicum project. Our clinics just had a stampede of early terminations and so the problem of what to do about it was on my mind. With this offer of free help, we planned a quick QI study:

She was to call the last 100 clients who dropped out of our intensive outpatient program prior to attending 5 or fewer sessions and simply find out "Why?" From a QI perspective, studying drop outs offers the best opportunity for positive impact. **Opportunities are**

Could not Reach	Agree to Re-admit	Still using	Did not like hours	Other
11%	26%	9%	42%	12%

Figure 1—Client reasons for dropping out of treatment

**in the waste.** Naturally, on each call, she would also try to coax each person back into treatment.

### Results & Revelations

Eleven percent could not be reached after 3 or more attempts. Happily, 26% said something like "they weren't ready before," but now agreed to try again. Nine percent flatly said they preferred to keep drinking/using.

What caught us by surprise was that **42% did not like our hours!**

Ours was an intense, intensive outpatient program, in which participants were required to come three times a week by themselves and once

a week with a significant other. Each session was 4.5 hours in length and we rigidly adhered to the program structure<sup>2</sup>. We felt that folks who qualified for admission into IOT needed an intense dose of good orderly direction. This belief was central to our program design, and something that we never considered changing.

The remaining 12%, was a fascinating hodgepodge of replies, such as "I just took over as den mother for my daughter's Girl Scout troop—I think this will keep me clean," and "My dog likes to get walked at night during the hours of your program; switching him would be traumatic," and best of

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## Clinic Dropouts (continued)

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common event, it tends to normalize the idea that sticking around isn't such a good idea. "What am I doing here?"

Third, the most expensive sessions are the first couple since substantial resources go into opening a new chart, verifying coverage, completing the assessment, and so on. When a person enters outpatient, then drops out shortly thereafter, the clinic must cover the cost of those early sessions somehow.

Finally, one of the more disheartening facts of outpatient work are dropouts. Somehow the clinician must grapple with the rejection – more often than not – blaming the ex-participant. Even the most veteran clinician sometimes questions "am I any good?"

Often, there are simple programmatic structures that contribute to drop out. A simple QI audit can help determine the causes, to the benefit of all.

all, "There's a flood in my house; I can't talk right now."

Presented with these data, it was clear that the one cause of early termination that we could do anything about was the "one-size-fits-all" aspect of our program structure. No one in management felt we should water down our program, or make it more convenient just to pacify the discontented minority. At the same time, it was also clear that we weren't helping those who dropped out early. Sure, they shared responsibility, but what portion of that responsibility was ours?

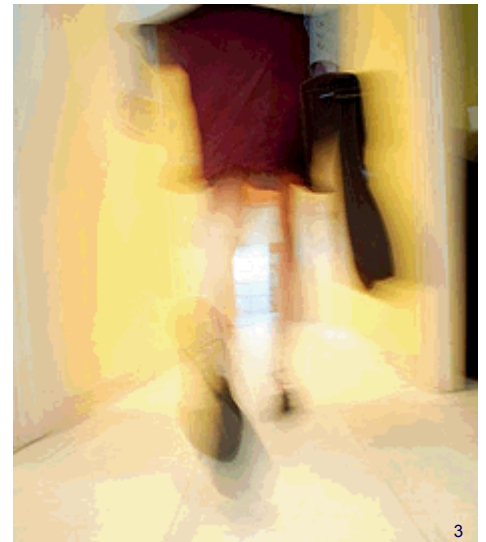
### The Addiction Awareness Program is Born

After considerable discussion, we came up with a new outpatient treatment track for individuals who were ambivalent about the idea of "being in recovery." We called it the "Addictions Awareness Program" and it was tailored to meet the needs of this newly identified group.

Essentially, we created a program that "rolled with their resistance" a la Miller, Prochaska and DiClemente<sup>4</sup>. Since these individuals said they were not *really* addicted, and denied symptoms of addiction, we would not charge their insurance plan for treatment – instead it would be a cash only program. We kept the price tag low, and used a rolling fee schedule so that cost would not be a barrier.

Our primary goals were to: a) **make recovery appealing**, and b) **provide participants with knowledge so they could make their own diagnosis—now or later**.

Space prohibits a detailed description of this service, and it is somewhat beside the point of this little tale<sup>5</sup>. More to the point: as a result of this simple QI study, we: a) re-admitted about a fourth of our drop outs immediately, and b) about a third of the folks who enrolled in the Addiction Awareness Program decided that,



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they would "give this recovery thing a try" - and transferred over to IOT with a clearer sense of commitment to their recovery.

QI is a flexible set of tools which can be employed in a variety of ways. The current Patient Feedback system is just one of many valuable approaches. In the coming year, we will discuss a variety of other QI approaches that we've tried over the years.

## Get a Free TIP



The idea of "rolling with resistance" comes from motivational interviewing—an approach described in detail in an excellent SAMHSA/CSAT manual entitled: *Enhancing Motivation for Change in Substance Abuse Treatment*. We have several free copies; if you'd like one sent to you at no cost, please write to: [hoover\\_v@mail.trc.upenn.edu](mailto:hoover_v@mail.trc.upenn.edu) and request your free copy.



# Clinician Resources: *Mapping New Roads to Recovery*

## Mapping can be used in group counseling to

- ❖ show—visually—that group members’ own ideas can be organized and combined to help them deal with common problems,
- ❖ provide a springboard for further discussion and elaboration,
- ❖ help maintain the focus of discussion,
- ❖ produce an on-going record of the group’s interaction that can be used in later thinking and discussion about this topic, and
- ❖ provide a basis for “**shared ownership.**” That is, seeing one’s own ideas integrated with those of others can create or intensify
  - group cohesion,
  - motivation to participate, and
  - acceptance or internalization of ideas (contributing to a set of ideas can lead to a feeling of “owning” the whole set).

In this issue we highlight one of the new clinical tools that can be downloaded from the **Clinician Resources** section of the Patient Feedback website.

### Lost your way?

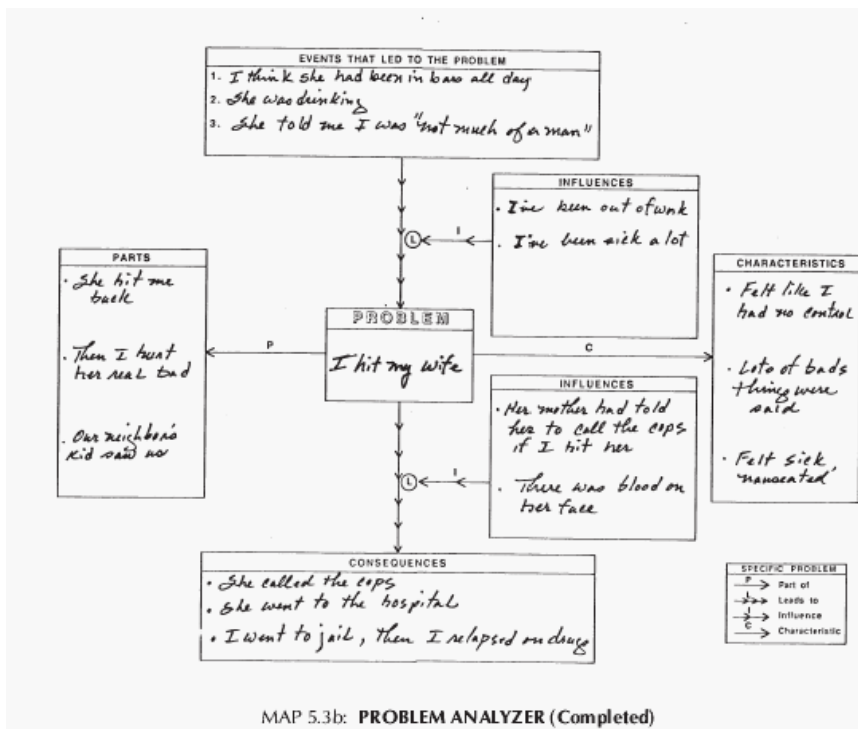
This self-paced training manual is designed for substance abuse counselors interested in **node-link mapping**, a visual representation technique for helping clients improve problem-solving and decision making skills.

### Using this Manual

A step-by-step format is used to explain both the theory and application of node-link mapping for both individual and group counseling. Studies by the authors suggest that incorporation of node-link mapping in counseling enhances client commitment to treatment, counseling efficiency, and therapeutic alliance.

### Group Supplement

The Mapping Manual contains blank maps that can be printed and used in groups or in individual counseling. There are also completed examples like the one seen at left. This manual was downloaded on [www.ibr.tcu.edu](http://www.ibr.tcu.edu). Please see the next page to learn more about the IRB and what their website has to offer.



### About this Manual

This manual was developed as part of the National Institute on Drug Abuse (NIDA) Grant DA08608, [Cognitive Enhancements for the Treatment of Probationers \(CETOP\)](#). Dansereau, D. F., Dees, S. M., Chatham, L. R., Boatler, J. F., & Simpson, D. D. (1993). *Mapping New Roads to Recovery: Cognitive Enhancements to Counseling*. Fort Worth: Texas Christian University, Institute of Behavioral Research. Available: Lighthouse Institute Publications, 720 West Chestnut Street, Bloomington, IL 61701 (Phone toll-free: 888-547-8271) and the IBR Web site: [www.ibr.tcu.edu](http://www.ibr.tcu.edu).



# Spotlight on Institute of Behavioral Research at Texas Christian University



I recently read an excellent article in JSAT by the Director of the Institute of Behavior Research (IRB) - Dwayne Simpson—and was so impressed, I spent some time on his organization's website. IBR's mission is to evaluate and improve the effectiveness of programs for reducing drug abuse and related problems. It is striking how many extraordinary resources our field has—and how little we know about each other's work. One

**Go Ahead, Get in Touch**

**Website URL**

<http://dmu.trc.upenn.edu/patientfeedback>

**ID:** pfguest  
**Password:** pfguest

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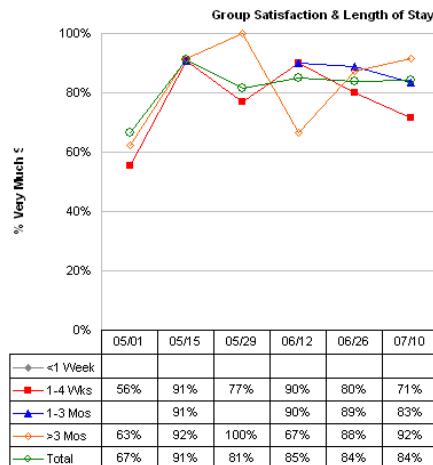
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of the major contributions Dr. Simpson's group has made is the development of organizational assessment tools that can be used to evaluate your organization's readiness to adopt new innovations. Additionally, there are several treatment manuals which he and his faculty have developed for a wide range of special populations. All free of charge. On page 3 of this newsletter we highlighted a group therapy technique developed by members of his faculty—to learn more visit their website:

<http://www.ibr.tcu.edu/index.htm>

## See you in Miami

The Patient Feedback presentation is scheduled for the June 2005 Steering Committee in Miami, Florida. We would like to invite anyone who is interested in taking part in the presentation to let us know. If you are interested please contact Övgü by email at [kaynak\\_o@mail.trc.upenn.edu](mailto:kaynak_o@mail.trc.upenn.edu). Whether you plan on participating in the presentation or not, we hope you will join us for a celebratory dinner directly following the meeting—details to follow. This will be a chance to pat ourselves on the back for a job well done! We hope to see you all there!



**Notes**

- Cover Image: Dancing Horses, <http://www.dancingpelican.com>
- Of the 4.5 hours, 1.5 involved them attending and returning from a real, community AA or NA meeting, accompanied by one of our co-therapists.
- Story Image: [ago fotostock](http://www.ago.com)/SuperStock
- Miller, W.R. Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series #35. U.S. Department of Health and Human Services, Publication No. (SMA) 02-3693, 1999.
- For details about the Addiction Awareness Program, email me at [bforman@tresearch.org](mailto:bforman@tresearch.org)
- Simpson, D.D. (2004). A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment*, 27, 99-121.