



Pretreatment and during treatment risk factors for dropout among patients with substance use disorders

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Abstract

Objective: The aim of this study was to use pretreatment and treatment factors to predict dropout from residential substance use disorder program and to examine how the treatment environment modifies the risk for dropout.

Method: This study assessed 3649 male patients at entry to residential substance use disorder treatment and obtained information about their perceptions of the treatment environment.

Results: Baseline factors that predicted dropout included younger age, greater cognitive dysfunction, more drug use, and lower severity of alcohol dependence. Patients in treatment environments appraised as low in support or high in control also were more likely to drop out. Further, patients at high risk of dropout were especially likely to dropout when treated in a highly controlling treatment environment.

Conclusion: Better screening of risk factors for dropout and efforts to create a less controlling treatment environment may result in increased retention in substance use disorder treatment.

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1. Introduction

Studies of treatment-seeking individuals with substance use disorders (SUD) suggest that, on average, treatment is beneficial (Moyer & Finney, 2002; Weisner, Matzger, & Kaskutas, 2003) and that time spent

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in treatment is one of the strongest predictors of posttreatment outcomes (McLellan, Luborsky, Woody, O'Brien, & Druley, 1983; Moos & Moos, 2003; Simpson, 1981). Patients who have shorter stays or elect not to complete treatment are at increased risk of readmissions (Moos, Pettit, & Gruber, 1995). Accordingly, it is distressing to note that 10% to 30% of individuals with SUD drop out of treatment (De Leon, 1991; Rabinowitz & Marjefsky, 1998).

1.1. Pretreatment variables predicting dropout from substance use disorder treatment

Although some inconsistency exists across studies, demographic predictors of dropout have included younger age (Joe, Simpson, & Broome, 1999; Leigh, Ogborne, & Cleland, 1984; Mammo & Weinbaum, 1993; Mertens & Weisner, 2000), less education (Mammo & Weinbaum, 1993; Siqueland et al., 1998), being unemployed (Mertens & Weisner, 2000) and being African American (Milligan, Nich, & Carroll, 2004).

Lack of motivation for treatment (Cahill, Adinoff, Hosig, Muller, & Pulliam, 2003; Joe et al., 1999; Ryan, Plant, & O' Malley, 1995; Simpson & Joe, 1993) may be a significant predictor of dropout, however, interpretation of the findings is complicated by the diversity of measures used to assess the construct. Lower severity of substance use problems and fewer dependence symptoms, which may be associated with lower motivation for treatment, are also a predictor of attrition (Joe et al., 1999; Rees, Beech, & Hore, 1984; Ryan, Plant, & O' Malley, 1995). In addition, more drug use (Mertens & Weisner, 2000) and lower cognitive functioning (Erwin & Hunter, 1984) have been associated with drop out.

Studies report that the presence of an additional axis I disorder increases retention (Siqueland et al., 1998), decreases retention (Green, Polen, Dickinson, Lynch, & Bennett, 2002; Kokkevi, Stefanis, Anastasopoulou, & Kostogianni, 1998), or is unrelated to retention (Miller, Ninonuevo, Hoffmann, & Astrachan, 1999). Taken together, these studies suggest that younger patients who are more involved with drugs and have some cognitive impairment and are more likely to drop out of treatment, as are patients who have less severe alcohol problems. However, these person-related variables typically predict only a small proportion of the variance in dropout; thus, it is important to examine treatment-related variables that may predict dropout.

1.2. In-treatment factors related to dropout

One series of studies investigated the relationship between therapeutic alliance, level of treatment engagement, and retention (Broome, Flynn, & Simpson, 1999; Joe et al., 1999; Joe, Simpson, Dansereau, & Rowan-Szal, 2001; Simpson, Joe, & Rowan Szal, 1997). Therapeutic alliance and treatment engagement (e.g., number of sessions during first 3 months of treatment) were positively correlated and, together, these factors predicted long-term retention in treatment (Joe et al., 1999).

Despite these studies' innovative approach to predicting treatment retention, their results are weakened by the lack of data on early dropouts (patients who left treatment in the first 1–3 months), who were excluded. In fact, no studies in our review of the literature obtained follow-up data on patients who dropped out within the first 3 months of treatment.

Nevertheless these more recent treatment retention studies reflect a shift in focus. Implicit in this shift is the understanding that dropping out of treatment is not a static process driven purely by the patient but, instead, is a dynamic process that reflects the interaction between the patient and the treatment

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