

Young adults' reasons for dropout from residential substance use disorder treatment



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Abstract

Dropout from substance use disorder treatment is usually investigated and understood from a perspective of quantitative patient-related factors. Patients' own perspectives (user perspective) are rarely reported. This study, therefore, aimed to explore patients' own understanding of their dropout from residential substance use disorder treatment. The participants were 15 males and females, aged 19–29 years, who had dropped out of residential substance use disorder treatment at the Department of Addiction Treatment, Oslo University Hospital, Norway. Qualitative methodology with semistructured interviews was used to explore how the participants described their dropout and their reasons for doing so. Thematic analysis was used as the framework for analyzing the data derived from the interviews. Dropout had different meanings for different participants. It was understood as a *break from* treatment, as an *end to* treatment, or as a means of *reduced treatment intensity*. Against that background, four main themes for dropout were found: *drug craving*, *negative emotions*, *personal contact*, and *activity*. Patient and treatment factors seem to interact when participants explore reasons for their dropout. A complex pattern of variables is involved. As remedies, participants suggested that substance use disorder treatment should provide more focus on drug craving and training to understand and tolerate emotional discomfort. They also wanted closer contact with the staff during treatment, more activities, and rigorous posttreatment

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follow-up. These findings from the user perspective have important implications for substance use disorder treatment, clinical and social work practice, management, and research.

Keywords

Addiction, substance use disorder, dropout, drop-out, treatment dropout, treatment retention, social work, user perspective, qualitative research, thematic analysis

Background

Treatment dropout is a common mental health services challenge (Masson et al., 2007; Simon et al., 2012). Two meta-analyses of psychotherapy found a dropout rate between 19 and 47% (Swift and Greenberg, 2012; Wierzbicki and Pekarik, 1993). In the early 1990s, Stark's (1992) review of substance use disorder (SUD) treatment found a dropout rate of around 50%, and Brorson et al.'s (2013) more recent systematic review found that dropout rates from SUD treatment varied between 0 and 90%. Best treatment results are obtained by patients who remain in treatment longer and patients who complete the treatment (Beynon et al., 2008; Meier et al., 2005; Ravndal et al., 2005; Zhang et al., 2003). Investigating factors leading to treatment dropout and identifying possible causal mechanisms can enhance the treatment effect (Lambert et al., 2004).

Stark's (1992) literature review examined how factors such as age, sex, drug use, and socioeconomic status influenced treatment dropout. None was consistently associated with dropout. However, he did find that patients who perceived their addiction as serious, patients with higher expectations of improvement, and patients with greater confidence that they would attain the treatment demands remained in treatment longer. Brorson et al. (2013) found that the last two decades of research on dropout from SUD treatment have primarily been concerned with patient factors. Few studies have looked at factors associated with the treatment program such as treatment length, treatment ideology, patient/employee ratio, or interacting treatment factors. In addition, few studies have assessed the therapeutic relationship in SUD treatment (Kothari et al., 2010). This is in contrast to research indicating that the quality of the therapeutic relationship is among the strongest of predictors of both treatment outcome (Lambert et al., 2004; Miller and Moyers, 2014; Najavits et al., 2000) and treatment retention (Cournoyer et al., 2007; De Weert-Van Oene et al., 2001; Meier et al., 2006; Wampold, 2001).

In sum, the research on patient factors does not provide consistent answers about how potential treatment dropout can be identified and rates reduced. Further, the user perspective has rarely been explored in the SUD field (Ball et al., 2006; Carlson, 2006; Laudet et al., 2009; Lee et al., 2007). This study aims to investigate the reasons young adults give for dropping out of residential SUD treatment.

Methods

The study was part of the Youth Addiction Treatment Evaluation Project (YATEP). YATEP was approved by the Norwegian Data Protection Official for Research, the Norwegian Regional Committees for Medical Research Ethics (REK), and the Oslo University Hospital Human Subjects Subcommittee. This study was reviewed and approved by the REK (reference number 2011/1958D) and performed according to their guidelines and the Helsinki Declaration (1975). Signed informed consent, both for YATEP and for this specific study, was obtained from all the participants.

Treatment site

The Department of Addiction Treatment—Youth at Oslo University Hospital (OUS) is part of the specialist health care under Norway's public health system. SUD patients have equal rights to treatment. This is the case for all patient groups under Norwegian health care. It offers different levels of treatment and assessment to young adults with problems related to substance misuse. Patients are referred by the municipal social services, general practitioners, specialists, or by another hospital department. These patients have a primary diagnosis of mental and behavioral disorders due to psychoactive substance use (ICD 10) and additional comorbidity is common.

Treatment is a person-centered program that comprises individual and group therapy based on a biopsychosocial model with emphasis on mentalization-based theory and practice (Skårderud and Sommerfeldt, 2013). Psychological treatment is provided according to the individual's specific problems and treatment goals. Medical treatment is offered, plus assistance/counseling on accommodation, education, employment and posttreatment living, adjustment, and support. Patients in residence spend their time, according to their treatment plan, in individual or group work, therapy, designated tasks (such as caring for horses), and structured or unstructured recreational activities. Every patient is given a primary contact when starting treatment, usually a social worker or a nurse who is required to spend most of their time in the milieu with the patients. The likely duration of treatment (3–12 months) is decided with the patient as part of the treatment plan.

The treatment site is located 15 min from the center of Oslo, in a rural-like setting. At the on-site stables, professional staff with relevant qualifications offers horse-assisted therapy as an integral part of the SUD treatment program (Kern-Godal et al., 2015).

At the time of the study (January and February 2012), the Department of Addiction Treatment—Youth was in the early stages of an organizational change involving harmonizing treatment methods in two different units, downsizing, reduction in treatment duration, and consequent staff changes.

Participants

The participants were selected from a pool of patients who had dropped out of SUD treatment at the Department of Addiction Treatment at OUS.

The background information was collected from the electronic hospital records. The sample consisted of 15 respondents (four women, 11 men) aged 19–29 years (mean 23.5 years). All participants had mental and behavioral disorders due to psychoactive substance use (ICD-10; F10.2–F19.2). In addition to SUD diagnoses, 11 of the 15 participants had one or more additional comorbid psychiatric diagnoses (four with attention-deficit hyperactivity disorder, three with posttraumatic stress disorder, three with mood disorders (depression and/or anxiety), and one personality disorder). At the time of admission to the treatment site, seven of the 15 participants had been diagnosed with three or more different SUDs (ICD-10; F10.2–F19.2). Limiting the maximum to three diagnoses for the seven multidrug individuals, the 15 participants had 30 SUD diagnoses in total (three multiple drug use (F19.2), eight cannabinoids, seven stimulants (including cocaine), six sedatives, four opioids, and two alcohol).

Five participants had not previously received residential SUD treatment and 10 had one or more previous SUD treatment experience(s). The average time at the treatment site before dropout was close to 10 weeks (range 2–40 weeks). The participants had dropped out of voluntary SUD treatment; none were under mandatory court or legislative sanction during the study.

Data collection

The inclusion criterion for study enrollment was dropout from residential treatment for a minimum of one week to a maximum of six months. Patients who left treatment on their own initiative before planned treatment completion and failed to return within one week were eligible for study participation.

Within the time period of the data collection (January and February 2012), a total of 26 participants were eligible according to the inclusion criteria. We were unable to contact 10 of the potential participants, and one declined to participate. The remaining 15 agreed to participate and were included in this study.

The study site was chosen because four of the authors worked at the site, were familiar with the treatment method and processes, had access to the information systems and shared a concern about the patient dropout rate of about 60% of patients (Kern-Godal et al., 2015).

Six of the participants had dropped out of treatment for more than a week and then returned to the treatment site. Nine dropped out of treatment and did not return. They were contacted by telephone and given information about the purpose of the study. They were told that participation was voluntary, that all the information collected would be treated confidentially and published anonymously, and that they would be compensated for the interview with a NOK 500 (USD 80) electronic gift card. Participants were interviewed at home or at a neutral site nearby. The six who had returned to residential treatment following dropout were given the same written and verbal information about the study by their appointed clinical contact person. Prior to the interview, all participants signed an additional consent form giving the researchers permission to audio record the

interviews. The participants were reminded that participation was voluntary and that they could terminate the interview at any time.

The interview

We chose qualitative as the preferred methodology at this stage to explore a largely uncharted and challenging aspect of SUD treatment (Patton, 2015). We used a semistructured interview with open-ended questions focused around four main topics: “Current life situation,” “Reasons for seeking treatment,” “Dropout from treatment,” and “What could have been done differently in treatment to prevent dropout.” The six participants who were back in treatment were in addition asked about what made them come back to treatment, and what they now needed to complete the treatment program. The questions were compiled based on previous SUD treatment research, especially those studies calling for a better understanding of dropout in terms of program-related factors (Brorson et al., 2013), more knowledge about the therapeutic relationship (Kothari et al., 2010), and focus on the user perspective (Laudet et al., 2009). The authors met regularly during development of the questions and the interview guide. KN and SA divided the interviews between them, each of which lasted between 17 and 68 min (average 28 min). At the end of the interview, all participants were given their interviewer’s contact information. The two interviewers each transcribed their own interviews during the data collection, which enabled them to check the quality of the data (Hennink et al., 2011). KN then reviewed all the recordings and transcriptions to familiarize himself with all participants, to ensure transcription accuracy and to enhance consistency (Kvale, 1996).

Data analyses

The transcribed data were investigated using Braun and Clarke’s (2006) six-step thematic analysis, a flexible and a useful tool to examine rich and detailed data. All sentences with relevant meaning were reviewed and coded by KN. During the analytical phase, the authors met to discuss the different codes and thematic labels in the data to prevent subjective bias (Elliott et al., 1999). A combination of inductive and deductive codes was developed throughout the analysis (Hennink et al., 2011). This approach was divided into three phases. The first phase used a deductive approach to generate codes from the research literature. The second phase used an inductive approach to recode with a focus on issues raised by the participants themselves. The last phase used a theme labeling approach to compare and merge the two sets of codes into a single set of codes. For example: in phase 1, during the first search for codes, we identified “negative affect” as a code, closely related to the research literature. In phase 2, we found that the participants talked about their struggle concerning difficult emotions, but none used the word “affect” to describe their inner state. In phase 3, as the intention of the study was to explore the users’ perspectives, we named this theme “negative emotions.”

Norwegian was used in the interviews, transcriptions, coding, and selection of quotations. All quotations were subsequently translated to English by KN and EW, and pseudonyms were used for all participants. An oral presentation of the findings of the identified themes was made to the staff at the treatment site in order to enhance validity (Nordheim, 2012).

Results

Dropout was found to have different meanings for different participants. For some it was understood as a *break from treatment*, with Live (19 years) describing her dropout as a self-initiated break:

Sometimes one just has to get out to think. Not necessarily to use drugs but kind of just get a little distance from the whole place. Because you live so close to others, so finally it's too much...if you are not able to get out, at least in the period of quarantine.

Other participants understood their dropout as an *end to treatment*, not having received what they needed from treatment, like Erik (28 years): "I wanted to get closer to my family, to find a job, I wanted to start school, everything that life contains, that I couldn't do while being there." Finally, it could also be understood as a *means of reduced treatment intensity*. Despite not returning to residential treatment, three participants maintained contact with the treatment site through meetings with their psychologist or former primary contact. In the words of Jeanne (21 years): "I got to retain my psychologist. I told them that it is very important to me that I have a psychologist I have a good relationship with, so it's been arranged for me to continue the psychotherapy." Analysis of the reasons for dropping out of treatment identified four main themes from the interviews: *drug craving*, *negative emotions*, *personal contact*, and *activity*. These are presented below. A subtheme, *treatment remedies*, addresses the changes that participants felt could have induced them to remain in treatment longer.

Drug craving

Many participants reported situations related to drugs or drug craving as a triggering factor to treatment dropout, like Afzal (19 years): "It was not intentional to drop out. What should I say... I wanted to get wasted, but not here at (the treatment site) or take drugs into (the treatment site), so I left instead." Aslak (23 years) terminated SUD treatment because he wanted to get home to his family but also to his hashish pipe. For some, the desire to take drugs came and went in waves. Magnus (26 years) explained that following a month or two of daily drug use, he felt disappointed and like a failure. Bad conscience would emerge together with an increased motivation to quit drug use. The opposite was equally true,

following a period of abstinence the drug craving would return. This periodic craving for drugs was the reason he gave for leaving the SUD treatment.

Hedda (27 years) described how she awoke every morning and reached for the “ready-made fix” on the nightstand. She continued to reach for the nightstand while in SUD treatment. She described a drug craving that depleted her energy and concentration. It took a lot of effort to get rid of these thoughts and when the craving emerged, she said she felt it as a physical activation.

Negative emotions

The interviews revealed that many of the participants struggled with difficult emotions that they found hard to control. Participants related treatment dropout to feelings or emotional states. For some, this could be specific present events while for others it was triggered by past events. For example, like Trym (21 years) described:

I'm a man, right? One should not show feelings, not be alone, not cry or any of that—right? And when I have the opportunity to hide and not show it to anyone, I do that. (. . .). It was not like I was going out to get high; it was just—now I leave. I don't know why. It was an impulsive act (. . .). I was unable to deal with the feelings after the breakup.

By quitting drugs, Lars (28 years) became more aware of all the other problems he had. Getting high had previously been a coping strategy but with abstinence, he experienced grief:

. . . had a heartbreak that has lasted almost to this day. I was with her for four years and it ended because I couldn't stop getting high. I recognize that I didn't grieve because of my relapses; still it (the pain) doesn't quite go away. So there is pain, but I'm not going to give up (trying to recover).

In contrast to looking at drugs as a way to escape painful feelings, Live (19 years) described an empty and emotionally stunted feeling from drugs. She thought it was strange not to have any feelings associated with everything that had happened to her during the time she was “wasted.” Several participants described drugs as a way to regulate themselves, as a way to self-medicate, as illustrated in the words of Jakob (23 years): “You just realize that you are an addict in a bad and dark way and it is not particularly attractive. To deal with it I had to go on heavy drugs to avoid thinking about that.”

Personal contact

Some participants reported situations where lack of contact with the staff was a contributing factor to treatment dropout. Erik (28 years) experienced that the staff

were absent from the “day-to-day milieu,” so they hardly ever saw what was going on. He found 2 h with his primary contact per week to be insufficient. Also Hedda (27 years) pointed out that she had too much time to herself:

I started to get really depressed. I felt I got angry, a lot of anger came up, and I felt I couldn't deal with having people around, so I was put in the (semi-isolation) unit. Consequently, there was little contact with the staff, which gave me too much time on my own...then I met this other guy from another unit, who sold me heroin (...). I was forgotten, like out of sight, out of mind. That's how it was.

Brage (24 years) had expectations that were not fulfilled by the staff:

He (the primary contact) told me that I should take a break from the treatment and come back in a month; meanwhile I would receive counseling from a psychologist (at the treatment site). I was not contacted once by the psychologist. I feel cheated out of an opportunity; I feel they didn't try as hard with me as they did with the others.

The treatment site was going through a period of reorganization and this became a theme among the participants, as Sigve (23 years) described:

The relationship with the patients has changed a lot since the new system was introduced. It's become very different, for better and for worse. You have to stand up more for yourself, but for me, I needed it to be like it was when I first got here. I felt more support from the community/fellowship back then.

Jeanne (21 years) experienced the reorganization as reducing the treatment quality: “The reorganization with lots of cutbacks made things very much reduced. The treatment was reduced, the food worse, with less dedicated (staff) time with the individual patient.”

Activity

The absence of activity and the importance of having something to do during residential SUD treatment were raised by many participants, in Erik's (28 years) words: “There were so many things I wanted to do on the outside (away from the treatment site) that I could not do. I mean positive things I wanted to continue (hobbies), and to do recreational activities.” Jakob (23 years) felt that he became lazy and had nothing to do during the day:

In the beginning I did very well, I worked as a volunteer in a company nearby, but then I started to not give a damn about anything, sleep late into the day, which started a really bad pattern. That became the beginning of things slipping.

Some participants, like Aslak (23 years), mentioned the lack of opportunities for physical exercise: “I really liked the work in the stables. Having something to do, using the body. For instance, we could have had some duties, also physical activity, so that we could move around a bit, getting exhausted.”

Treatment remedies: What could have induced participants to stay longer in treatment?

Trym (21 years) wished that the staff would take on a kind of “parental” role in order to teach him what emotions were. He pointed out that having “drugged away” much of his life, he had not learned this when he was young:

I believe there should be a system that makes it impossible to dodge (emotional feeling). It must be caring and loving and it must be set up to educate about how many pleasures there are in life, or how many nice things are around you that you don't see because either you have it too good or you have it too bad. In between best and worst there's a massive range of different emotions that you get from different things. And that's what we lose when we get high, right? So simply learn how to feel emotions. And like it, of course.

Many of the participants said closer contact with the staff combined with more trust and understanding would make them stay in treatment longer. They also stressed the need for more activities, like Jeanne (21 years): “They have to get people out, must somehow get people to do something that gives them pleasure, something you can do without using drugs.” Thomas (29 years) said the only thing he looked forward to during the week was the one day they went to the stables and to be with the horses.

Jakob (23 years) was clear about the need to do something healthy following the residential treatment. So he had an agreement with the day treatment unit and the polyclinic (to attend the stables) for follow-up, while living independently. He was confident this would give him the starting point he needed to make it on his own. Lars (28 years) also stressed the importance of postcare and follow-up. He experienced “being completely free” after ending residential treatment. This meant that he was all alone, and loneliness was something he had never been able to deal with. To avoid this, he asked the treatment site if he could be readmitted as a backup plan. This safeguarded him and made it less difficult to deal with the life challenges he faced.

Discussion

The study findings fall into two related categories: the meaning of dropout and reasons for dropping out. As seen from the participants' perspective, both appear to have important implications for SUD treatment. Neither has been adequately studied or reported to date.

Participants understood dropout as a break from treatment, an end to treatment, or reduced treatment intensity. In this study, dropout did not mean that patients would not return to residential treatment. Nine of the 15 participants were either back in residence at the Department of Addiction Treatment—Youth or were engaged in nonresidential, reduced intensity treatment. Behavior we initially perceived as dropout from treatment is now understood, among more than half of our study population, as a patient-initiated *break* from treatment.

The consequences of dropout are not always negative (Stark, 1992) and should be framed when possible as a learning experience instead of as defeat (Saarnio and Knuuttila, 2003). Most of the participants reported having gained something during treatment, irrespective of whether they reentered treatment following dropout. They reported a greater tolerance for difficult feelings and an increased ability to share difficult feelings with others. They also acknowledged that SUD treatment was better than the alternative. It is possible that participants' increased awareness of their emotional state prompted their requests for more personal support both during and following residential treatment.

Four themes emerged as to why the 15 participants we interviewed took a break or dropped out of residential SUD treatment. It is difficult to see these themes (drug craving, negative emotions, personal contact, and activity) as completely separate from each other. Similarly, external factors such as family issues are often important and influential patient variables. Drug craving is described as a periodic craving, a yearning for what also constituted a way to regulate oneself. Drugs were used to regulate difficult emotions, and participants mentioned an increase in drug use and the use of harder drugs following SUD treatment to dull the awareness of their earlier wrongdoings and misfortunes in life. Being abstinent over time during SUD treatment provided insight into issues that had led many participants to take drugs in order to avoid thinking about them. This is relevant to studies reporting that risk of substance abuse relapse (Brownell et al., 1986; Nordfjaern et al., 2010) and mortality (Ravndal and Amundsen, 2010) are highest in the first months after SUD treatment. Substance abuse and emotional difficulties were interconnected for these participants. Drug abuse was reported as a common way to avoid having to deal with their negative emotions. This was supported by the request to “be educated on what emotions are” as a part of SUD treatment. It is consistent with research findings which indicate that deficits in coping with negative affect are an important factor in SUD treatment (Berking and Wupperman, 2012).

The participants called for closer monitoring by, and personal contact with, the treatment site staff. They wanted more time with their psychologist and primary contact. They also needed more time to build trust. Positive treatment outcomes have been associated with continuity in the alliance with the therapist while struggling with difficult emotions of discontinuity (Binder et al., 2009). Positive treatment outcomes have also been associated with continuity and follow-up in the form of a positive relationship with the therapist and regular appointments (Alverson et al., 2000). Continuity of care is important for providing a sense of security

and hope. It is consistent with findings that patients with a low degree of attachment and identification with the treatment program, co-tenants, and staff, are more likely to drop out of treatment (Ravndal and Vaglum, 1994). In Norway, patients exiting residential treatment are referred to their local health and social welfare service for follow-up and, if necessary, community-based treatment. This process breaks continuity of care at precisely the time when many recovering SUD patients are most vulnerable and may struggle to establish good therapeutic contact with a new therapist or team.

Working with SUD patients requires patience on the part of staff because it is time consuming and most patients will relapse (Sellman, 2010). A follow-up study of adolescents with SUD found a relapse rate higher than 90% (Spear et al., 1999). Dennis et al. (2005) found that the median time from first SUD treatment to patients' achieving one year of abstinence was nine years. Relapse can be viewed as a part of the SUD treatment process, rather than a termination of treatment (Rahill et al., 2009; White et al., 2005). This form of testing boundaries, with a break from therapy (with or without substance abuse), may be considered a small step towards behavioral change. The fragile attachment must be built up over time with continuity, safety, and predictability. A Norwegian study found that inconsistent responses from the staff following dropout was reported by the patients to be the most negative aspect of the SUD treatment (Nordfjaern et al., 2010).

Our study was conducted during the early stages of a treatment site reorganization and downsizing, which was generally perceived by participants to have had a negative effect on their treatment. They expressed concern about the continual change in rules and procedures resulting from the reorganization. They said their treatment and the site became less safe, less predictable, and that these changes had a negative impact on their relationships with the staff and fellow patients. Continuity is important for successful therapy (Alverson et al., 2000; Binder et al., 2009). We are unaware of other reported studies of the impact of organizational change on SUD staff or patients. Norway's labor laws provide staff employment security. They have mandatory staff reallocation procedures that can lead to protracted processing and negotiations. The reorganization at the study site took approximately nine months before units were finally merged/created and all staff were in position. The treatment implications of the associated uncertainty, discontinuity, and other adverse conditions that prevailed during this period may have been more apparent to the patients than to management.

The participants called for more activity, such as hobbies or exercise, citing their work with the horses and the stables as a positive example. Work in the stables is reported to be significantly associated with longer time in treatment and completion of agreed treatment regimens (Kern-Godal et al., 2015). Being passive and lacking meaningful activity or scheduled tasks could trigger drug craving and negative emotions. Inclusion of hobbies in therapy has been associated with improved treatment completion (Decker et al., 2014). Physical activity can improve abstinence, comorbid anxiety and depression symptoms (Mamen et al., 2011; Wolff et al., 2011).

Several participants experienced little or no support in the transition from SUD treatment into “real life.” To meet the acknowledged needs among most SUD patients for continued care, treatment approaches focusing on comprehensive care, including postdischarge care and hospital-initiated follow-up should be developed and evaluated.

Reflexivity

One’s own background and situation can influence what one chooses to study and the research methods used (Green and Thorogood, 2004; Malterud, 2001). This also applies to our investigator team. All of its members worked in SUD treatment and/or research, and were aware that reducing SUD treatment dropout was a priority for the Department. This exploratory study was characterized by a naïve clinical interest, where the main goal was to gain a better understanding of dropout from a user perspective. The participants were essentially given the research question in a semistructured interview situation with standard prompts if they fell silent. KN was a student in his last year of a professional degree in psychology at the time of the interviews. SA had earned a Master of Science in nursing, in addition to many years of clinical SUD therapy experience. KN had little experience with or knowledge of the Department of Addiction Treatment—Youth, while SA had an insider’s knowledge and knew some of the participants. Both interviewers thus had possible strengths and weaknesses in terms of how participants were likely to respond to their questions. Some participants may have felt safer talking with someone they already knew, whereas others may have found it easier to talk with a “neutral” person, who was not attached to the Department. KN and SA complemented one another across the study procedures.

Limitations

This study was designed to specifically investigate dropout from the patient users’ perspectives. As such, it presents the views and experience of only one group which was targeted precisely because they had recently dropped out of the treatment. The participants’ responses, both positive and critical, raise fundamental and rarely reported programmatic and therapeutic relationship issues. Their insight provides new and valuable information which requires further investigation. However, the perspectives of patients who remain in treatment, and the perspectives of clinicians, program managers, and the policy makers are also required in order to fully understand how SUD treatment can be made more responsive to the needs of patients and enhance retention.

The nature and size of the sample have implications for the generalizability of the findings. We worked with a sample of 15 participants and have no means of knowing whether the views expressed are representative of all SUD treatments in Norway or elsewhere. With one exception, nonparticipation was due to inability

to make contact, so the underlying reason for nonparticipation is unknown. The telephone could have been lost or the telephone number changed. It could also have been due to relapse or a desire to put treatment behind and get on with a new life. However, our findings are consistent with both quantitative SUD treatment studies (Cournoyer et al., 2007; Meier et al., 2006; Palmer et al., 2009; Ravndal and Amundsen, 2010) and the few qualitative studies of SUD treatment dropout (Kothari et al., 2010; Laudet et al., 2009). We consider the findings to have implications for clinical and social work practice, management, and research.

Implications

Clinical and social work practice

The study findings point to a need for greater focus on emotions and on the importance of staff working more closely with patients and being more available in the “day-to-day milieu.” Furthermore, the staff should strive for equal, fair and predictable conduct and patient treatment. Rules and procedures should be transparent and well known. To ensure continuity, all patients should be offered treatment follow-up whether they drop out or complete their planned treatment. Follow-up should be initiated by the treatment site and utilize existing patient–staff alliances to the extent possible. Post-treatment telephone follow-up was established in 2015 at the Department of Addiction Treatment—Youth in response to these findings. The patients have overwhelmingly opted in to this voluntary treatment service. The patient must have an active part in his or her own treatment, and staff should facilitate this. The treatment site should also provide a range of activities including hobbies, physical exercise, and job-relevant training.

Management

The participants’ definitions of dropout, reasons for dropping out, and suggested changes to SUD treatment regimens indicate a need to rethink SUD treatment management. The findings call for resourcing more integrated SUD treatment services to provide easily accessible meaningful activities and continuity of care (from initial residential care, through transitional phase care, to end-stage community-based services). Provisions to enable continuity of contact with key staff should be part of this transition process.

Reorganization and change are inevitable, and indeed necessary, in the rapidly evolving, high-cost health sector. However, in the planning for and implementation of change, adverse effects such as uncertainty need to be minimized. Care and adequate resourcing are required to ensure that patient needs are met and preventable treatment failure is avoided during the transition from old to new organizational arrangements.

Research

Our findings suggest a need for additional dropout studies using more nuanced definitions of the term and greater exploration of the patients' reasons for dropout from the user perspective. As this study shows, active patient participation can indicate new directions and treatment aspects which are rarely addressed in the largely service provider-oriented SUD discourse. The participants in this study emphasized factors involving the organization of the treatment, personal contact with the staff, the importance of activity and of follow-up, plus the impact of organizational change on treatment quality. All of these factors, together with the programmatic, therapeutic alliance and staff perspective factors referred to above merit further investigation. The findings presented here are empirical and report the results from a thematic analysis of the transcripts from interviews of SUD treatment dropout participants. The user perspective is generally underreported, and we hope the findings are useful contributions to multidisciplinary theoretical debates.

Conclusions

This study was based on the user perspective and experiences in dropping out of SUD treatment. The results indicate that dropout is a more diverse and complex phenomenon than previously described in the literature.

The participants called for more treatment focus on drug craving, interaction between drug abuse and difficult emotions, knowledge about those emotions, and training in tolerating emotional discomfort. They wanted closer contact with the treatment staff and closer posttreatment follow-up. They wanted more activity during treatment and assistance during the transition phase from treatment to their new life. These findings show a complex pattern of variables involved in SUD treatment dropout, in which both patient factors and treatment factors seem to interact.

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