Outcome of waiting lists (OWL) study
Waiting times for drug treatment: effects on uptake and immediate outcomes
Michael Donmall, Alison Watson, Tim Millar, Graham Dunn

In brief

Background and aims
This study looked at waiting times for prescribing and inpatient services and their effect on treatment uptake and engagement with services. It was undertaken between 2000 and 2002, prior to the development of the NTA’s national programme to improve access and waiting times (for information on current waiting times, visit www.nta.nhs.uk).

Methods
Four components made up the study: a postal survey, prospective and retrospective cohort studies and qualitative interviews.

Findings and implications
• At the time of the study, the majority of drug treatment services, which provided prescribing or inpatient services, had waiting lists. On average, there was an eight week wait between referral and assessment and a four week wait between assessment and the start of structured treatment. The average wait from referral to treatment was twelve weeks
• Waiting for treatment and perceptions of waiting times could have discouraged potential service users from presenting to and engaging with treatment services
• Services reported a range of waiting times and variations in waiting times for their own programmes
• Nearly half (41%) of services did not formally manage their waiting lists
• Most services provided support for people waiting for treatment, although those awaiting treatment were critical of the lack of contact from services and felt they needed information about the length of the wait, as well as support during this period
• Most of the clients who dropped out of agency contact did so between the referral and assessment stages. Relatively few disengaged from treatment services after assessment
• Waiting times did not predict uptake of treatment. Neither did they predict retention in treatment at three or six months. Other factors that predicted uptake and retention were identified
• Uptake was significantly higher in some services than in others. Similarly, clients at some services were much more likely to be retained at three and six months. The service itself had a greater influence on uptake and retention than waiting times
• Some clients increased their drug use while waiting for treatment, though others were helped to reduce their illicit drug use through interim prescribing by their GP.
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**Background**
This study was conducted between 2000 and 2002, prior to the development of the NTA’s national programme on improving treatment access and reducing waiting times, which included the development of a national definition for waiting times, waiting times targets for each treatment modality, and tools and techniques to support improvements.

**Aims**
Prior to this study, very little research was available on the effects of waiting times on uptake and engagement with treatment services in England. The results of existing studies were inconclusive. This study aimed to investigate:

- the status of waiting lists and times on methadone prescribing and inpatient treatment for opiate users in England
- the impact of waiting on treatment uptake and retention
- the effects of waiting on those seeking treatment.

**Methods**
The overall project consisted of four component studies, carried out between 2000 and 2002:

1. **National survey of drug services**
   A national questionnaire sent to drug services in 2000/01, which aimed to identify, quantify and describe factors which influence waiting lists and their management

2. **The effect of waiting times on treatment uptake**
   A prospective study of new referrals in 15 services in 2001/02, representing a spectrum of waiting times. Clients were tracked from the point of referral, through assessment and up to the start of treatment.

3. **The effect of waiting times on retention in treatment**
   A retrospective study of client records at 16 services – carried out in 2001/02 – from the point of referral, for up to six months from the start of prescribing

4. **Client perspectives of waiting for treatment**
   Case studies, by interview, of drug users’ perspectives of the effect of waiting for treatment.
Findings

Caseload
Services reported an mean client caseload of just over 200 (range 6–1,200), although a quarter had service caseloads of 50 or less.

Staffing levels
Many services indicated that they were operating close to capacity and nearly half reported a current staff shortfall (0.5 to 6 whole time equivalent). Half of these services had lost at least 1.5 whole time equivalent clinical workers at the time the survey was carried out.

Resources and budgets
At the time of the study, nearly half of services said their annual prescribing budget was usually overspent. Almost the same percentage said it was spent up to the limit.

Waiting lists for prescribing and inpatient services
Waiting lists were apparent in all areas of service provision investigated. Two-thirds of services providing substitute prescribing had a current waiting list, as did over three-quarters of inpatient treatment providers (this did not include residential rehabilitation services).

Waiting times for prescribing and inpatient services
Services reported average waiting times from referral to assessment of eight weeks (range 0–52 weeks), although 50 per cent reported waits of four weeks or less.

Following assessment, services reported a mean waiting time of four weeks until start of treatment (range 0–30 weeks), although 50 per cent reported waits of two weeks or less.

The average total wait from referral to treatment was 12 weeks (range 0–54 weeks), with half waiting up to eight weeks and a quarter waiting for 16 weeks or more.

Support for people on waiting lists
Nearly 75 per cent of services said they provided interim support for people waiting for drug treatment. The definitions of support varied widely and included telephone and written contact, motivational interviewing, complementary therapies, drop-in sessions and interim prescribing. However clients suggested that such interim support was inadequate and their expected wait unclear.

Two-thirds of services said they attempted to arrange interim prescribing via GPs for their waiting list clients.

Client attrition
The bulk of client attrition (dropping out or disengagement) occurred between referral and assessment. Relatively few clients were ‘lost’ following assessment.

Waiting list volatility
There was considerable volatility in waiting times within services, which seems to be a feature of drug service provision. Possible reasons for increases in waiting times included:

- resource problems (e.g. staff shortage, lack of medical cover, accommodation)
- changes in caseload profile (increased referrals, increased number of priority clients, more complex clients)
- procedural changes (e.g. shared care arrangements, introduction of dose testing).

Possible reasons for decreases in waiting times suggested by service managers included:

- resource issues (filling vacant posts, increased doctor time, extra financial resources)
- procedural changes (introduction of triage system, employment of dedicated detoxification worker, deliberate overbooking of assessment clinics, alternatives to methadone, stricter rules, shared care).

Relatively minor changes often had a profound effect on service delivery.

Perceptions of waiting times by services
Agencies’ perceptions about the length of waiting times for treatment were not always accurate.

“Waiting reputations” and people seeking treatment
Clients’ perceptions of how long they will have to wait sometimes affected whether they felt it was worth seeking treatment in the first place.

Effect of waiting on treatment uptake
The length of time clients waited between initial referral and assessment did not have a significant effect on whether they took up an offer of an assessment appointment. Waiting times did not predict treatment uptake.
Predictors of treatment uptake
Statistical analysis suggested that the uptake of an offer of an assessment appointment was more likely to be taken up by the client if they:
• attend some agencies rather than others
• were older
• had already experienced drug treatment
• had admitted themselves (self-referral) or were referred by a GP.

Effect of waiting on treatment retention
The length of time clients waited between referral and the start of prescribing did not have a significant effect on retention at either three or six months. Waiting times did not predict retention in treatment.

Predictors of retention in treatment
Statistical analysis suggested that retention at both three and six months was predicted by:
• the service attended
• whether clients were self/GP-referred or referred by other routes
The use of a daily methadone pick-up regime for some of the treatment time also predicted retention, although it should be noted that clients given this regime are likely to have been a different group to the rest.

Analysis of retention in treatment at three and six months is shown in Table 1.

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<th>Retention at three months</th>
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| **Clients were more likely to be retained in treatment** | • The longer they had been using opiates  
  • If they were also problematic alcohol misusers  
  • If they received a daily pick-up of methadone  
  • If they were already using (illicit) methadone on presentation  
  • If they received a daily pick-up of methadone |
| **Clients were less likely to be retained in treatment** | • If they were on a supervised consumption regime. (Note: those on such a regime may be a different group to others).  
  • If they were combined users of heroin and benzodiazepines on presentation. |

Table 1: Retention in treatment at three and six months

The most consistent finding was the highly significant effect a treatment service had on whether clients took up treatment and were retained in treatment. The authors suggest that some services were evidently much better than others at engaging clients and retaining them. They recommend that further research be carried out to investigate the factors that influence service providers’ attractiveness to clients and the characteristics of these services. This was outside the remit of this project.

Client perspectives on waiting for treatment
Interviews conducted with clients showed that perceptions about waiting were important in determining whether clients presented for treatment. Clients also believed that it would be helpful if services gave them a clearer idea of how long they would be expected to wait.

A recurring criticism was the lack of contact from the drug service during the waiting period, although this was offset when other support was available, for example from a partner or family member. Some said they would have appreciated a day or drop-in service while waiting.

While some clients had undoubtedly increased their drug use during the waiting period, others had cut down their illicit use through interim prescribing.

Consequences of waiting
A substantial minority of people on waiting lists reported an increase in their drug use while waiting. Negative personal and/or social consequences are to be expected while waiting for treatment, as drug misuse and associated peer behaviour continues.
Policy and practice implications

This study confirms the need for a national definition and understanding of waiting times. It concludes that efforts to reduce waiting times are justified, even though waiting *per se* may not significantly affect uptake or retention over and above any other effects of the particular service provision. Lengthy waits for treatment, whether real or perceived, can act as a barrier to treatment presentation and uptake. Drug users on waiting lists are likely to continue to engage in drug misuse and associated risk behaviours while waiting.

However, waiting times should not be used on their own as a measure of the quality of service provision, at least in terms of uptake and retention in treatment. Waiting times did not predict uptake of treatment or retention in treatment.

The study shows that the processes of access and care, that characterise a service provider’s style of operation, have an important role in encouraging treatment uptake, as well as retaining clients in treatment. Other research by the National Drug Evidence Centre suggests that some agencies are simply more effective at engaging and retaining clients in treatment than others. Clearly there are operational factors that increase client engagement and retention. The factors that determine this need to be further investigated.

Suggestions that most disengagements take place between referral and assessment imply that concentrated efforts should be made at this stage to engage people in the treatment system. Efforts to promote retention should continue throughout the treatment process.

Services should maintain contact with people waiting for treatment and provide them with information about waiting times. They should also provide them with support while waiting, which includes, but is not limited to, drop-in facilities and interim prescribing through GPs.
Further information

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For further relevant information see:

DMRI-funded studies on waiting times

Executive summaries of DMRI studies are available on http://www.mdx.ac.uk/www/drugsmisuse. They provide more details on research design and methodology than the summaries published by this series.

For the executive summary of the report of Donmall et al see:
http://www.mdx.ac.uk/www/drugsmisuse/donmall.doc

Further information:


Waiting times national programmes
For more information on NTA national and regional programmes on waiting times and access see: http://www.nta.nhs.uk

Also see the National Institute of Mental Health England http://www.nimhe.org.uk