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THE ACCELERATED INTAKE: A METHOD FOR INCREASING INITIAL ATTENDANCE TO OUTPATIENT COCAINE TREATMENT

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We examined whether offering an accelerated (same-day) versus a standard (1- to 7-day delay) intake appointment increased initial attendance at an outpatient cocaine treatment program. Significantly more of the subjects who were offered an accelerated intake (59%) attended than those who were given a standard intake (33%), χ^2 (2, N = 78) = 4.198, $p < .05$. The accelerated intake procedure appears to be useful for enhancing enrollment in outpatient addiction treatment.

DESCRIPTORS: drug abuse treatment, adherence, appointment keeping, call-appointment interval

Potential clients who call to schedule initial appointments for substance abuse treatment are often lost to treatment because they fail to attend their scheduled appointments (Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Stark, Campbell, & Brinkerhoff, 1990). Innovative intake procedures may increase the likelihood that substance abusers will attend their scheduled intakes. The present study examined the effectiveness of offering accelerated (same-day) intake appointments to increase intake attendance.

METHOD

We randomly assigned 78 clients who called an outpatient cocaine treatment clinic between January 4 and March 3, 1993, to either a standard or an accelerated intake group. The same ratio of male to female subjects (24:15) was assigned to each group. Upon calling the treatment clinic, clients completed a brief phone inquiry to provide demographic information. The agency had three admission criteria unrelated to the current study: (a) the use of cocaine or other illicit stimulants within the last 30 days, (b) age between 18 and 65, and (c) cocaine as their primary drug of abuse. All clients who called during the study met these criteria. Phone operators were instructed to schedule an appointment 1 to 7 days later for clients who were assigned to standard intake and to offer a same-day appointment to clients in the accelerated group. The following guidelines were used for accelerated intake assignments: (a) Clients who called after 3:00 p.m. were scheduled for the following morning, and (b) clients currently in inpatient programs were scheduled immediately after their discharge. Regarding the first guideline, 7 clients who called after 3:00 p.m. were scheduled for the following morning. One client who called on a Friday afternoon was scheduled for the following Monday morning. This client and 2 others who called after 3:00 p.m. did not show for their scheduled intake appointments. No-shows were defined as clients who did not attend within 7 days of their scheduled appointments. Eight

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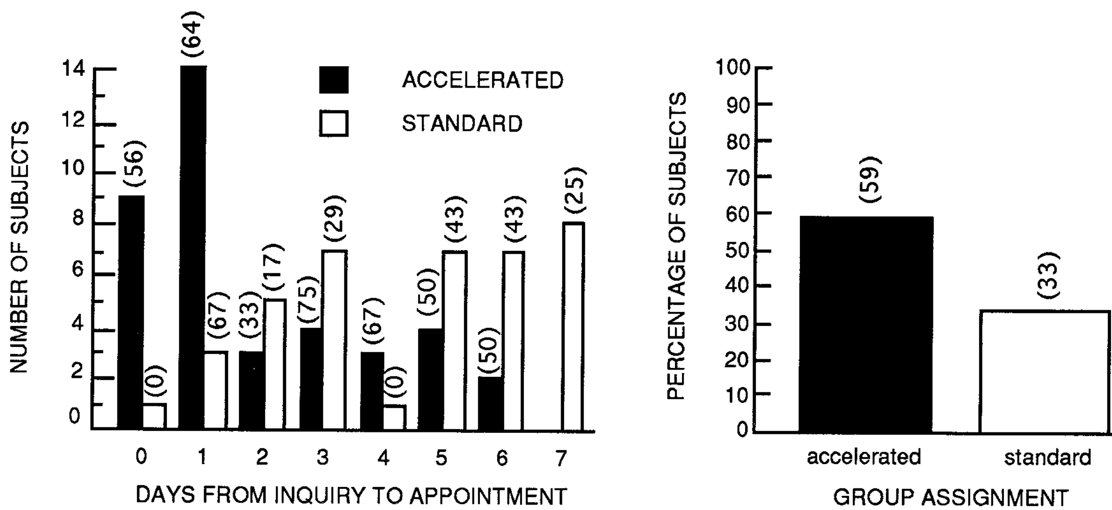

Figure 1. Distribution of subjects and percentage of attendance by group across days of delay from inquiry to scheduled appointment (left panel) and percentage of subjects showing for initial intake (right panel).

accelerated intake clients calling from other drug treatment facilities were scheduled to come in on the day of their discharge, at which time the 7-day no-show criterion began. Their delays were as follows: 1, 1, 2, 3, 3, 5, 5, and 6 days. Four of these clients (2-, 3-, 5-, and 5-day delays) did not show for their scheduled appointment. All clients called to schedule appointments on their own rather than through institutional arrangements. Although all accelerated clients were offered an immediate appointment, some did not accept and were scheduled later.

RESULTS AND DISCUSSION

Although subjects in the accelerated group did not always accept an immediate appointment, they did have significantly shorter scheduled appointment delays, $t(78) = 2.9, p < .05$; $M = 1.94$ days ($SD = 0.30$) and 4.39 days ($SD = 0.34$) for the accelerated and standard groups, respectively (see Figure 1). Thirteen (33%) of the 39 clients assigned to standard intake showed for their scheduled appointment (Figure 1), whereas 23 (59%) assigned to accelerated intake showed, $\chi^2(2, N = 78) = 4.198, p < .05$. All 36 attending clients met the 7-day no-show criterion, with an overall mean delay between scheduled appointment and actual attendance of 0.583 days ($SD = 1.481$). There were no significant between-group differences on this delay, $t(34) = 1.3, p > .05$), with the accelerated and standard attendees showing within 0.348 days ($SD = 0.88$) and 1.0 days ($SD = 2.16$) of their scheduled appointments, respectively.

Also evident in the distribution of delay and attendance by group is the general consistency of attendance percentages (see numbers above columns in left panel of Figure 1) for the accelerated group across days of appointment delay, with a mean attendance of 56% (range, 33% to 75%) compared to a mean of 28% (range, 0% to 67%) for the standard group. Of the clients who attended their intake appointment, the mean number of attended counseling sessions during the course of treatment was not significantly different, $t(34) = .286, p > .10$, for the accelerated ($M = 11.1$) versus the standard ($M = 10.1$) intake clients.

These results extend previous studies in-

dicating that treatment delay is an important determinant of initial attendance (e.g., Benjamin-Bauman, Reiss, & Bailey, 1984; Festinger et al., 1995). Our findings suggest that offering individuals an appointment on the same day as their inquiry significantly increased their likelihood of entering treatment. Moreover, the intervention was more effective than a standard procedure that resulted in a mean delay of only 5 days until intake appointments, a delay that is well within the range of common clinical practice. These results extend the work of Stark et al. (1990) that compared asking clients to come in for intake as soon as possible to scheduling intakes a week or more later. Stark et al. found that clients who were asked to come in as soon as possible were more likely to attend their intake. Our findings suggest that immediate appointments or some aspect of offering them may be more effective for increasing initial attendance than simply shortening delays.

One possible reason for the success of the accelerated procedure is that it provides immediate positive feedback and reinforces the individual's initial recovery efforts. When an individual first contacts an agency, an immediate acknowledgment, in the form of being asked to come in right away, may be effective in maintaining recovery efforts. This acknowledgment may influence the individual's next major decision: whether to attend the scheduled intake.

There were no significant differences in treatment retention between the two groups. This suggests that when brought into treatment by the accelerated intake procedure, clients who may not have come in otherwise are at least as likely to stay in treatment as clients coming into treatment without the use of the accelerated procedures.

One limitation of this study concerns the relatively liberal 7-day no-show criterion. This may limit the utility of our findings in developing a cost-benefit analysis. Although clients' attendance may be seen as beneficial regardless of when they show, missed appointments still present difficulties for clinic and staff. This issue, however, is tempered somewhat by the attending clients' general adherence to their scheduled appointments.

Another limitation of the study is that it does not isolate the functional independent variable. Although our findings suggest that clients who were offered accelerated intake appointments were more likely to attend, it is impossible in the current study to determine whether the functional component of the intervention was the shortened delay or some aspect of being offered an accelerated appointment.

Findings of this study combined with earlier findings (Benjamin-Bauman et al., 1984; Festinger et al., 1995; Stark et al., 1990) illustrate the utility of offering rapid treatment entry. A slight change in clinic procedure resulted in nearly doubling intake attendance. This allows many individuals who otherwise may not enter treatment to take their first step towards recovery.

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