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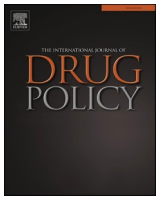

Research Paper

Waiting for inpatient detoxification: A qualitative analysis of patient experiences

Joanne Neale [a,*], Beth Cairns [b], Kevin Gardiner [b], Wulf Livingston [c], Trevor McCarthy [b], Andrew Perkins [b]

[a] National Addiction Centre, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, SE5 8BB, UK
[b] Figure 8 Consultancy Services Ltd, Dundee, DD4 OHU, UK
[c] Faculty of Social and Life Sciences, Glyndwr University, Wrexham, LL11 2AW, UK

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ABSTRACT

Background: There is limited provision of inpatient detoxification relative to other treatments for alcohol and other drug (AOD) use. This means people often need to wait prior to detoxifying. However, waiting for healthcare is generally perceived as negative and stressful. This paper aims to understand patients' experiences of waiting for inpatient AOD detoxification to ascertain whether and how service-level policies and practices might be improved.

Methods: Semi-structured telephone interviews were conducted with 32 people (20 males, 12 females; aged 25–67 years) who were waiting for inpatient detoxification. Data collection was part of a wider evaluation of a policy initiative started in 2021 to increase detoxification service capacity in England, UK. Interviews were professionally transcribed and data on waiting experiences were coded using qualitative software. Analyses were informed by new materialist thinking and undertaken via Iterative Categorisation.

Results: We found that waiting was constituted through five dimensions: i. duration; ii. support; iii. information; iv. preparations; and v. emotions. These five dimensions were multi-faceted and operated in and through wider interacting social, material, and affective forces (e.g., professional judgements, formal and informal relationships, the availability of beds and funding, bureaucratic procedures, the utility and relevance of information, and participants' diverse feelings, including desperation for treatment). Not all accounts of waiting were negative. The experience was complex, non-uniform and variable over time. Moreover, it affected how people felt and how they behaved.

Conclusions: Changes to service-level policies and practices can potentially minimise the stress of waiting for inpatient AOD detoxification. The negative impact of waiting may be reduced if professionals more consistently engage patients in a wider range of constructive pre-treatment activities, offer regular 'check-ins' to mitigate any anxiety, explain changes in wait duration to help with planning and demonstrate fairness, and facilitate contact between those waiting to lessen feelings of isolation.

Background

Detoxification is a therapeutic procedure that seeks to remove toxins from the body of someone who is acutely affected and/or dependent on substances and to manage them safely through substance withdrawal (American Psychological Association, 2023; Center for Substance Abuse Treatment, 2006; McCorry et al., 2000; Timko et al., 2016). The complex psychological and social problems often associated with substance use cannot, however, be resolved through the process of detoxification alone; consequently, adjunctive treatments and support are also required (Center for Substance Abuse Treatment, 2006; McCorry et al., 2000; Timko et al., 2016). In recent years, medication assisted treatment has tended to be used internationally in preference to inpatient detoxification for people dependent on opioids (Di Patrizio et al., 2022) and inpatient detoxification has been deemed costly relative to community-based treatments (Zhu & Wu, 2018). As a result, inpatient detoxification availability has been limited and the treatment has not always been accessible to those who may benefit (Di Patrizio et al, 2022;

* Corresponding author.
E-mail address: joanne.neale@kcl.ac.uk (J. Neale).

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Zhu & Wu, 2018). For example, an independent review published in 2020 found that inpatient detoxification had been rationed and had almost disappeared in some parts of England, UK, resulting in significant unmet need (Black, 2020). One obvious consequence of insufficient availability is people having to wait for treatment.

Having to wait is widely associated with powerlessness and is common amongst groups who are stigmatised and labelled as 'undeserving', including people who use substances (Bourdieu, 2000; Fraser & valentine, 2008; Harris & McElrath, 2012). Being placed on a waiting list has repeatedly been identified as a barrier to entering treatment for alcohol and other drug (AOD) use, and this tends to hold regardless of patient characteristics and service type (Appel et al., 2004; Farabee et al., 1998; Gerassi, 2018; Redko et al., 2006). Furthermore, research has shown that longer waits for AOD treatment result in reduced treatment entry (Chun et al., 2008; Festinger et al., 1995; Hser et al., 1998; Redko et al., 2006). This can occur because waiting increases the likelihood that other life circumstances (e.g., changes in housing, employment, or family) will happen and disrupt treatment plans (Redko et al., 2006). In relation to inpatient detoxification programmes specifically, failing to admit patients in a timely fashion may miss the window of opportunity in which individuals are motivated for care, so leaving them dealing with the discomfort and associated medical issues of withdrawal alone (Lenardson et al., 2009).

Whilst there have been inconsistent findings relating to the impact of waiting times on treatment retention and outcomes (Redko et al., 2006), increased time spent waiting tends to negatively affect how satisfied patients are with the healthcare they receive (Dansky & Miles, 1997; DiTomasso & Willard, 1991; Fogarty & Cronin, 2008; Knudtson, 2000). Waiting is demoralising and can create stress, anxiety, anger, and frustration (Derrett et al., 1999; Irvin, 2001; Sampalis et al., 2001; Thorne et al., 1999; Vermeulen et al., 2005). Moreover, waiting for health care is associated with feelings of uncertainty and loss of control (Irvin, 2001; Fogarty & Cronin, 2008). In a qualitative study of waiting for methadone treatment, Fraser (2006) described how making patients wait whilst they were experiencing withdrawal symptoms generated anxiety, boredom, and frustration. Meanwhile, other research has revealed how waiting for substance use treatment can result in people trying to prove that they are more motivated for treatment than others and/or turning to alternative sources of support (Bryant et al., 2022; Gerassi, 2018).

Various strategies have been used or recommended to improve the experience of waiting for substance use treatment when waiting cannot be avoided because of organisational factors or resource constraints. For example, patients may be required to attend pre-treatment meetings or groups to keep them motivated (Redko et al., 2006). In research conducted in Australia, Bryant et al. (2022) suggested that any contact with services during the waiting period should be warm and welcoming. Equally, peer support could be helpful for those who do not have family or friends to help whilst they are waiting and for those who might be new to treatment and who therefore do not have knowledge and information about what to expect or how to negotiate treatment access (Bryant et al., 2022). In more general healthcare literature, the importance of retaining contact with patients through pre-assessment clinics, providing them with a contact point for any questions, and giving them written information have all been highlighted as valuable ways of reducing uncertainty and enabling patients to retain a sense of control over their waiting experiences (Fogarty & Cronin, 2008; Giske & Gjengedal, 2006).

In January 2021, the UK Government announced an initiative to increase service capacity for detoxification from AOD across England (Home Office, 2021). Grants were awarded to fifteen regional and sub-regional English consortia to commission inpatient detoxification beds, with medically managed inpatient detoxification provision being the priority. The Office for Health Improvement and Disparities (OHID) (a government unit within the British Department of Health and Social Care) commissioned a qualitative evaluation of this initiative through the National Institute for Health and Care Research (NIHR). The evaluation included interviews with patients who had been offered one of the beds, with interviews scheduled to occur at three time points in their journey: i. after a patient had been referred to, but before they started, detoxification, ii. immediately after they left detoxification, and iii. twelve weeks after they left detoxification. This paper draws upon the initial interviews conducted between referral and treatment starting, so whilst patients were waiting. Given widespread recognition that delayed treatment initiation tends to be negative, the aim of the analysis is to understand patients' experiences of waiting for inpatient AOD detoxification to ascertain whether and how service-level policies and practices might be improved. Information on this issue is notably lacking in the existing literature.

Methods

Ethical approval to conduct the research was received from Glyndwr University, Wales, (Ein Cyf 497), and the study was undertaken by a team of qualitative researchers who had diverse personal and professional backgrounds but who were all familiar with AOD treatment services. Fieldwork started in March 2022 and the initial interviews were completed by the end of March 2023. As the initiative to increase detoxification capacity was still relatively new, officers of OHID connected the researchers to members of the consortia who had been tasked with commissioning the additional detoxification beds across England. These commissioners provided the research team with details of professionals and agencies that were referring patients to the new detoxification beds ('referrers'). One team member (AP) contacted a purposively diverse selection of referrers from across England, explained the study to them, and requested that they provide a study information sheet to, and discuss the study with, any individuals who had been offered a detoxification place and were waiting for this to start ('patients').

If patients expressed interest in participating in the research, the referrers requested permission to pass their details to AP. On receiving the details of a patient, AP forwarded these to one of the study researchers. The allocated study researcher then contacted the patient by telephone, explained the study again, double-checked the patient's eligibility (that they had been offered inpatient detoxification and were currently waiting for treatment), and arranged to conduct the initial interview. Whilst the researchers' knowledge of AOD treatment services was very useful in building rapport with potential participants, their diverse backgrounds could have resulted in them approaching the interviews very differently. To increase consistency, all team members therefore attended two separate 2-hour briefing sessions about handling patient details and the interviewing process and were given accompanying notes for reference. The initial interviews then followed a semi-structured topic guide, with clear prompts and probes, that covered participants' background and personal circumstances; substance use and prior treatment experiences; reasons for seeking inpatient detoxification; experiences of securing detoxification so far (including the waiting process); expectations of the detoxification; and any plans for life after the detoxification. Interviews were conducted by telephone, lasted approximately one hour, and were audio recorded. At the end, each participant was thanked with £20, and their interview was given a unique identifier.

During the initial stages of fieldwork, one team member listened to a selection of the interview recordings to ensure that there were no significant deviations from the topic guide. The audio files were next transcribed verbatim by a professional transcription service and the interview transcriptions were entered into the qualitative software programme MAXQDA (VERBI Software 2017) for coding. All data (audio and text) were stored securely in Microsoft's online cloud storage service. For the current analyses, the transcribed interview data were reviewed line by line in the MAXQDA file and all content relating to the experience of waiting was assigned to a single code labelled 'waiting'. The coded 'waiting' data were then exported to Microsoft Word and

analysed via a process of Iterative Categorisation (Neale et al., 2016, 2021). This involved reviewing all the waiting data, summarising it into bullet points whilst retaining the interview identifier so it was always possible to see who had said what, organising and re-organising the bullet points into meaningful groupings, and then naming the groupings. All team members reviewed the findings to ensure that they were consistent with their respective understandings of the data. After this, they utilised their collective knowledge of AOD services to suggest practical strategies for improving inpatient detoxification waits that would be feasible within the current treatment system.

Ontologically, the analyses were informed by new materialist thinking. This is an interdisciplinary approach to understanding the world which assumes that all phenomena (things, places, spaces, time, and practices) are relational and contingent rather than fixed or stable (Barad, 1996; Braidotti, 2013; Coole & Frost, 2010; Fox, 2016). Accordingly, waiting was assumed to be a complex practice enacted by patients who were waiting in particular spaces and contexts (Barad, 1996; Deleuze & Guattari, 1988; Duff, 2013; Fraser, 2006; Fraser et al., 2014; Nettleton et al., 2017). Thus, there would be no single definition of waiting and people would not necessarily have choice over how they waited. Rather, waiting would vary between individuals and over time and would be 'performed', 'assembled' and 'hung together' within broader networks of social, material, and affective forces (Barad, 1996; Deleuze & Guattari, 1988; Duff, 2013; Mol, 2002; Mol & Law, 2004). The experience of waiting was therefore likely to be a function of who else was present during the wait, the resources people had to mitigate the wait, and how people felt whilst they were waiting. Furthermore, the process of waiting might itself generate new interactions, material losses or gains, and unexpected emotions.

Table 1
Participant characteristics (self-reported).

Characteristic	$N = 32$
Sex	
Male	20
Female	12
Age (years)	
Mean (range)	44 (25–67)
Ethnicity	
White British	26
White English	3
White Irish	2
White Other	1
Relationship status	
Single	20
In a relationship	8
Separated	3
Divorced	1
Housing	
Lives alone	13
Lives with partner/family/children/parents	12
Hostel/shelter/safe house	3
Shared house	2
Supported accommodation	2
Current physical health problem	
Yes	29
No	3
Current mental health problem	
Yes	30
No	2
Current employment status	
Not working/benefits	31
Retired	1
Substance being treated	
Alcohol	23
Opioids	8
Ketamine	1

Participants

In total, 32 people from ten different consortia across England were interviewed (see Table 1). They had all recently been offered inpatient detoxification and were waiting for their treatment to start. They included 20 males and 12 females, age range 25–67 years. All were White (British, English, Irish or Other), over a half ($n = 20$) were single and just under a half ($n = 13$) lived alone. Nearly all ($n = 29$) reported current physical health problems, nearly all ($n = 30$) reported current mental health problems, and none was currently in paid work. Most ($n = 23$) were waiting to be detoxed from alcohol, a quarter ($n = 8$) were waiting to be detoxed from opioids, and one was waiting to be detoxed from ketamine. For context, national data for 2021 and 2022 indicate that under a third of the adult treatment population in England were receiving treatment for alcohol only, about half were receiving treatment for opiates, and over a fifth were receiving treatment for other drugs (Office for Health Improvement & Disparities, 2023).

Findings

Analyses revealed that the waiting experience was constituted through five main dimensions which we have labelled: i. duration; ii. support; iii. information; iv. preparations; and v. emotions. These are each described below, with quotations used to illustrate key points. After each quotation, the participant's study number, sex, and the substance from which they were waiting to be detoxified are provided in parentheses.

i. Duration

The length of time between participants first requesting inpatient detoxification and eventually entering the treatment was a central dimension of the waiting experience. Participants generally appreciated that this period comprised several stages, including securing support from an AOD treatment service to apply for a place; completing forms and deciding which would be the most appropriate detoxification service to attend; having their 'case' presented to, and approved by, a funding panel; and being given a date when detoxification treatment would begin. Participant 25 summarised key aspects of this process as follows:

> 'I think it's once a month… You have a panel that sits and your key workers take your case to that panel, and it's sort of like senior managers and people like that and the doctor who decides whether you fit the criteria for inpatient detox. Then you get a phone call from your key worker saying you've been approved.' (Participant 25, male, alcohol)

Participants mostly reported that this process took a few months, although a few described waiting for more than a year. Whilst some considered their wait to be short and were pleased about this, others complained that it had been 'long and drawn out'. By the time of their interviews, most participants had an exact day for when their detoxification would begin. Nonetheless, about a quarter still had no, or only a vague, idea that it would be 'soon'. Reflecting on this uncertainty, Participant 17 (female, alcohol) stated that she felt as if she would be 'dead' before her detoxification started, whilst Participant 11 (female, alcohol) reported that her life was 'dangling'.

Occasionally, participants said that delays had occurred because they had a health condition that prohibited immediate detoxification, or because they had temporarily disengaged from treatment. This had been the case for Participant 29 who had been waiting for a bedspace to detoxify from heroin and prescribed methadone for almost twelve months. Thinking about why he had not progressed to detoxification sooner, he commented:

'I've been in treatment but then I've fell off a couple of times. [My] head's not been in the right place or this and that. But I managed to stay on the script [methadone] this time, so hopefully, this [inpatient detoxification] is the thing for me.' (Participant 29, male, opioids)

More frequently, delays in starting detoxification related to service-level factors, such as there being no local detoxification bedspace; the referring service losing its funding; staff absences or holidays; or no available post-detoxification accommodation. In addition, participants were sometimes told that they could not proceed with their detoxification until they first demonstrated greater commitment to addressing their substance use; for example, by engaging with services more often or by waiting longer following a previous detoxification. As Participant 02 explained:

'She [key worker] said, "Well right, I can't put you forward for a detox yet because it's too soon, because you'll only fail again." So, I had to sort of wait a few months and then she took it to one of the weekly meetings and put it to them, and the doctor said… "There seems to be a pattern forming here. He seems to think he can just treat this like… go out and get drunk and come back and get a detox again." And that upset me a bit because I thought, "Well… no… I don't want to drink… that's not me".' (Participant 02, male, alcohol)

In contrast to these delays, other participants identified factors that they believed had reduced their waiting time. These included them demonstrating their commitment to detoxification by voluntarily reducing their use of substances, repeatedly asking for a bedspace, or having a supportive worker who championed their 'case'. Several participants also said that they had suddenly been 'fast tracked', which they variously attributed to their specific health problems, a cancellation at the service they were waiting to attend, or an underspend on detoxification beds in their area. These shorter waits were universally appreciated. For example, Participant 05 recounted how he was 'over the moon' when his AOD worker contacted him to offer him an imminent start date:

'When you feel really down… and you've got all this weight on your shoulders and then [worker] just rings me. She's like, "How about [date]?" I was like, "That's… brilliant, yes, please"… I'm buzzing over it and telling my dad. About an hour later, she rings me again, "We've just had a cancellation. How's about [imminent date]?" And I was over the fucking moon.' (Participant 05, male, alcohol)

ii. **Support**

A second key dimension of the waiting experience related to the support available to participants between referral and initiating detoxification. In this regard, many spoke positively of the relationship they had with their AOD worker, often stating that these professionals had stayed in touch to see how they were, provided helpful advice, and brokered contact with the detoxification provider for them. However, other participants were neutral about their interactions with AOD workers and a few expressed disappointment that professionals had not been more proactive during the waiting period. At the time of her interview, Participant 11 still did not know when her detoxification treatment would begin and described feeling 'let down' by an AOD worker who failed to return her calls:

'They [AOD worker] just told me to reduce my drink, which I did do, and that I were looking at about two or three weeks. This was about two or three months ago… I just had to wait until they phoned… She's contacted me when I've dropped her a message… but other than that, no [contact from her].' (Participant 11, female, alcohol)

Many participants had been attending groups whilst waiting for their detoxification, but this was often a condition of receiving treatment and their experiences were very diverse. Some stated that they found groups tedious, disliked having to constantly explain themselves to other group members, or resented having to mix with people who committed crime or used illicit substances. In addition, a few said that the groups did not provide any new information, or attendance made them feel worse about themselves, resulted in their substance use increasing, or caused frustration when they compared themselves to other group members who secured detoxification before them:

'I was just doing the groups… Then obviously COVID's been again, so I've had to do them all again. I'm on the third time up there now doing these groups, and... I'm like, "Come on, [name of worker], I need help. I want to go..." When I'm seeing people walking up and down the street who I've tried to help [in the groups], and they're walking up and down now with a brand-new start, it's like, "Come on, when's it my turn?"' (Participant 23, male, opioids)

Despite these negative experiences, some participants also commented on how going to groups was helping them during the waiting period, particularly if they lived alone. They said that this was because attending groups gave them a reason to leave the house and provided opportunities to meet people facing similar challenges. Sometimes this resulted in participants gaining a sense of perspective about their own problems which made them feel better about themselves. Additionally, some said that they were able to access useful information from other group members, including insights into what inpatient detoxification would be like. For example, one female explained how she had been required to attend groups to demonstrate her commitment to detoxifying but had found them helpful nonetheless:

'I had to go to a lot of group therapy classes as well, which helped. Because I knew I wasn't the worst one there. You always think the worst of yourself, but I knew I wasn't. So… it's been good for me, because… I've met people that I probably would never have spoken to in my life before.' (Participant 06, female, alcohol)

Although most participants spoke of family or friends who were helping them during their wait, support networks tended to be small. Generally, participants reported having only one or two people on whom they could rely. Often participants explained that they needed support from others because they were struggling with physical and/or psychological problems that limited their ability to do things, go places, or care for themselves. Indeed, many participants reported pain, low energy, depression, anxiety, or suicidality which meant that they spent most of their days sitting at home waiting in discomfort with little to engage them:

'I'm getting pains in my hips, and I feel sick all the time, obviously due to the drink… I've just no energy. I just can't be bothered because I'm drinking all the time and I don't go out. I don't go anywhere. I get my carer to fetch my drinks. I just sit in the house and just look through the window. I don't go anywhere. I don't get any exercise.' (Participant 08, female, alcohol)

iii. **Information**

Knowing what would happen when it was finally time for their detoxification to start was a further dimension of the waiting experience. Participants often reported that the service they would be attending was many miles from their home, so they needed information on how they would get there (particularly as many were unable to travel by public transport and did not have anyone to take them). Whilst a few said that a family member or friend would drive them, and a small number had arranged to travel by train, others had been told that the detoxification service would send a taxi or other transport to pick them up on the day and return them home once their detoxification was complete. Having this information appeared to relieve waiting stress and enabled

participants to feel more relaxed about starting their treatment:

> 'Taxi is taking me. [Detoxification service] is paying for it… I'm looking forward to the journey in a way... I'll have that three and a half hours to get my mind set, ready to meet all the people and do the detox.' (Participant 19, male, opioids)

Meanwhile, participants' knowledge about the detoxification itself was comparatively vague and their interest in knowing details in advance of treatment starting was more mixed. Some knew exactly how many days their detoxification would take, others had a general idea, and a few had 'no idea' at all. Frequently, participants explained that they were waiting for someone from the detoxification service to contact them with more details, and those who had received information always expressed gratitude for this. Participant 08 (female, alcohol) also stated that she had visited the detoxification service and met some of the staff in advance of her treatment starting and this had been very helpful. Other participants said that they did not need more information as they were trying not to think about it, had previously been to inpatient services so knew what to expect, or would struggle to absorb or retain details:

> 'They did give me a pretty full itinerary of what they were going to do while I was in there. But obviously I've only got one brain cell left now, so I couldn't take it all in.' (Participant 02, male, alcohol)

Despite their different information needs and preferences, many participants expressed frustration at the lack of information they had received whilst waiting. For example, Participant 04 (male, alcohol) reflected on how difficult it was to prepare when nobody had been in touch to tell him what he could take, and he was annoyed at the prospect of arriving with something that was then not allowed. When faced with insufficient information, several participants had phoned the detoxification service to secure answers to their questions, looked the detoxification service up on the Internet, or sought information and reassurance from their peers:

> 'There is one gentleman, yeah, that I've spoken to… He went to [detoxification service] and he said it's like… you're not even going to want to go home. He said it's an amazing place to be, positive, you get a buddy. If you're struggling, you can speak to somebody that's been through it and basically not to worry… It's nice to know that… If you've got a question, it's always nice to have an answer.' (Participant 17, female, alcohol)

The main information participants expressed interest in receiving during the waiting period related to the accommodation itself (e.g., whether they would be in a hospital bed, whether they would have their own bathroom, or whether there was general medical care on site); what they should bring with them (e.g., whether they needed to have cash or whether they could take their mobile phone); the daily routines (e.g., what would happen on their first day or who would prepare food, clean rooms and manage laundry); and permitted activities (e.g., whether they would be allowed visitors or whether they could smoke tobacco). Generally, participants seemed less interested in receiving information about other patients or about any rules, which were presumed to be common-sense and could easily be explained on arrival.

iv. **Preparations**

The waiting period was also a time when participants completed more practical preparations for detoxification. Often, this began with stabilising or reducing their substance use and attending all their treatment-related appointments; although Participant 04 (male, alcohol) reported 'blitzing' on drink in the run up to his detoxification. Sometimes professionals had advised participants to reduce their substance use and, on other occasions, participants had decided to do this themselves. Those awaiting detoxification from alcohol were aware that this was potentially dangerous, and they should not attempt to stop on their own. Rather, they understood that they should manage their drinking, which some achieved by diluting their alcohol or by delaying drinking until as late in the day as possible:

> 'What they've told me is just to try and cut it [alcohol] down. So, what I've been doing is like diluting my wine with apple juice… So, on a daily basis, I won't just like wake up and have a bottle of wine. I'll dilute it with apple juice, or I'll wait for as long as I can until my body actually physically needs it. So, they've advised that. It's been really, really good.' (Participant 28, female, alcohol)

Participants sometimes explained that they had packed a bag or suitcase whilst waiting, an activity which a few had undertaken weeks in advance 'just in case' there was a cancellation, or they were contacted to enter detoxification earlier. Nonetheless, the process of packing was complicated when participants did not know what to take or felt depressed or unwell and were therefore unmotivated to pack. As a precursor to packing, some participants also stated that they had made a list of what to take, were washing clothes, or were planning to go shopping for snacks and other items they thought they might need:

> 'I've already started packing my stuff in a suitcase and stuff. I'm going to go to [supermarket] and get a bit of shopping, stuff like that.' (Participant 09, male, opioids)

Additionally, participants reported that they needed to order and collect prescriptions from the pharmacy, pre-pay gas and electricity, make plans for pets, or ask a neighbour to have their key. For three women, planning crucially involved arranging for others to care for their children whilst they were away; a process that was made more difficult when treatment dates were uncertain or, as happened to Participant 11, her detoxification was postponed:

> 'I felt so positive when she said [detoxification service] had accepted me. I packed my case, I reduced my drink, got the kids prepared, and then "boom" [detoxification was postponed].' (Participant 11, female, alcohol)

A further activity that many participants undertook during the waiting period was planning for life after detoxification. Some stated that they would be moving directly into residential rehabilitation, others said that they would be returning home, several planned to stay with friends or family, and a few anticipated moving to a new home and area. Only a very small number of participants were not certain where they would go next. Many expected that they would need ongoing professional support, particularly for mental health problems, or medication to help prevent alcohol cravings. Others had decided they would continue to attend groups or were planning new activities and daily routines (e.g., exercising, eating healthily, buying a car, learning to drive, looking after grandchildren, volunteering, or securing paid work). Importantly, some participants had also been considering with whom they would spend time and how they would distance themselves from friends and family who continued to use substances. This was the case for Participant 07 who explained:

> 'I'll still be engaged with [AOD service] and they have groups… to build you up a network of friends that are not using and stuff. So, I might be interested in that. They go camping and stuff, and you can make friends from that… I'm not going to be living in [location]… because everybody that I do know is on drugs… There's plans in place with my children. The straight [non-substance using] friends that I've got, they know what's going on, so I know they're going to be around me… I don't want to sit on my arse… I might be able to get a job…, so there's positive things for when I come out.' (Participant 07, female, opioids)

v. **Emotions**

A final dimension of the waiting experience related to the emotions participants experienced as they contemplated their future detoxification. In this regard, participants sometimes expressed only optimistic feelings, stating that they were 'looking forward to it', 'over the moon', 'excited', 'positive', or 'confident'. Accordingly, a few noted that they had been given 'another chance' or said that they felt a weight had been 'lifted off their shoulders' after being told their entry date. Others said that they were ready for a routine and some structure or felt that it was time to 'get a little bit of life back':

> 'I want to try and get a little bit of life back. I just want to enjoy it… It's going to work this time, yeah. I'll make it work.' (Participant 32, male, alcohol)

Conversely, other participants felt overwhelmingly negative or anxious about initiating detoxification, observing that it 'had to be done' and 'won't be pleasant'. These emotions tended to be stronger amongst participants who had previously had a difficult detoxification that had made them unwell or had not led them to the abstinence they had wanted. Negative emotions also surfaced when participants experienced more generalised anxiety or were weary from a lengthy period of waiting. This was the situation for Participant 15 whose low-level nervousness had been building over the last year:

> 'I've been waiting for a year. So, it's been in my head for just under a year. So, I know I'm going. I'm a little bit anxious. I felt a little bit cold and tingly when she said it was happening last week.' (Participant 15, male, alcohol)

For the most part, however, participants described complicated, mixed emotions that included feeling simultaneously terrified, anxious, scared, and nervous, but also excited, optimistic, and desperate to start. For those with partners or children, there was an added ambivalence of saying goodbye to them and missing them whilst equally wanting to complete the treatment. Some participants also said that they were dreading going into detoxification but thought that it would be alright once they were there, or they would feel 'great once it was over' and it would be 'worth it in the long run'. Others were not worried about the detoxification itself but were anxious about how life would be for them afterwards. For several participants, these positive and negative experiences oscillated throughout the waiting period:

> 'Emotions are running high. I'm excited, then shitting it, then excited, then shitting it. I just can't wait to get it out my life, to be honest, and then progress. It [substance use] has been holding me back too long now.' (Participant 23, male, opioids)

Discussion

The aim of this paper was to understand patients' experiences of waiting for inpatient AOD detoxification to identify ways of potentially improving service-level policies and practices. Consistent with our starting ontological assumption, we found that waiting was a complex phenomenon that people enacted in particular sets of circumstances. Moreover, waiting was not exclusively negative. Our analyses identified five main wait dimensions that we categorised as i. duration, ii. support, iii. information, iv. preparations, and v. emotions. These dimensions were multifaceted and operated in and through wider interacting social, material, and affective forces (Barad, 1996; Deleuze & Guattari, 1988; Duff, 2013; Mol, 2002; Mol & Law, 2004). Thus, we saw how the experience of waiting was assembled and 'hung together' through professional decision-making, formal and informal relationships, the availability of beds and funding, bureaucratic procedures, the value and relevance of information, and diverse feelings (including desperation to detoxify) (Mol, 2002).

The waiting experience was consequently not uniform. Some participants were pleased at how quickly they had been offered a place, whereas others were exasperated at how long the process had taken. Support groups were considered helpful and enjoyable by some but tedious and even harmful by others. Participants sometimes wanted more information, so they knew what to expect. Conversely, others wanted to avoid information overload. Whilst some had packed and organised themselves ready for departure, poor health and/or lack of motivation compromised the ability of others to undertake such preparations. The prospect of starting treatment could be exciting but equally generate anxiety and fear depending on the individual. Such experiences could also change suddenly; for example, when a planned detoxification was postponed or a phone call with an imminent start date was received. Equally, waiting could itself affect how patients felt and behaved (Fraser, 2006); for example, when participants used their time to reduce their substance use, attend all their appointments, or seek out information.

Our findings confirm that waiting is an enduring feature of inpatient detoxification in England despite recent investment. The speed of entry to detoxification was not solely a function of resource availability but also related to local policies and procedures, eligibility criteria, having a supportive worker to 'make a case', and a patient repeatedly asking for treatment or making every effort to demonstrate their commitment to detoxifying (Bryant et al., 2022). Although our recruitment process and study design prohibited us from capturing whether waiting caused pre-treatment drop out (because all people interviewed were actively waiting for treatment), participants appeared very committed to their detoxification and we did not tend to find that waiting increased their substance use (Chun et al., 2008; Festinger et al., 1995; Fraser, 2006; Hser et al., 1998; Redko et al., 2006). Nonetheless, our analyses revealed how failing to admit patients to detoxification in a timely fashion often caused discomfort, stress, frustration, and uncertainty (Derrett et al., 1999; Irvin, 2001; Lenardson et al., 2009; Sampalis et al., 2001; Thorne et al., 1999; Vermeulen et al., 2005). Moreover, participants generally had only small networks of people to support them (Bryant et al., 2022; Gerassi, 2018) and poor physical or mental health that limited their capacity to manage whilst waiting.

Various strategies to mitigate the problems of unavoidable delays in treatment entry have already been identified in the literature. These include the provision of pre-treatment appointments, opportunities to attend groups and other forms of peer support, written information, and a contact point for questions (Fogarty & Cronin, 2008; Giske & Gjengedal, 2006; Redko et al., 2006). Our findings support all of these, but we also note that the psychology of waiting can offer further insights. In his classic work on waiting lines, the business management consultant David Maister documents eight useful psychological propositions about waiting, namely: i. occupied time feels shorter than unoccupied time; ii. people want to get started; iii. anxiety makes waits seem longer; iv. uncertain waits are longer than known, finite waits; v. unexplained waits are longer than explained waits; vi. unfair waits are longer than equitable waits; vii. the more valuable the service, the longer the customer will wait; and viii. solo waits feel longer than group waits (Maister, 1985). Our data resonate with all these propositions, meaning that additional strategies for improving waits for inpatient detoxification may be possible.

To begin, we suggest that any negative impact of waiting may be reduced if patients feel occupied and not bored between referral and detoxification starting. This might be achieved if service providers were more consistent in engaging patients in a wider range of constructive pre-treatment activities that were tailored to their individual needs and preferences. For example, professionals could routinely provide information about a detoxification service in easily digestible formats (e.g., text, email, phone call, video) as soon as a place is offered. Similarly, they could give advice and support with practical tasks (e.g., packing, shopping, planning childcare, and preparing for leaving a house unoccupied) and encourage patients to plan new activities and routines for life post detoxification. Focusing on these activities may help patients feel like they are starting on their detoxification even though they have not yet entered the treatment. Offering a visit to detoxification services

prior to admission would also undoubtedly be welcomed but will often not be practical given the distances involved. Instead, video calls and virtual tours could be useful alternatives, especially if they were led by people who had already been through the treatment.

In addition, regular text messages or phone calls from professionals to 'check in' (even when there is no new information to impart) might help to mitigate any anxiety waiting patients may be experiencing by reminding them that they have not been forgotten. Although it will often be impossible to provide patients with an exact wait duration, giving them unrealistic or inaccurate waiting times should be avoided as this will likely cause confusion, disappointment, and disruption to planning. Instead, delays should be explained in as much detail as possible so that patients understand why they are having to wait longer than expected and can adjust their preparations accordingly. Reasons why other people may be fast-tracked into detoxification should also always be discussed to ensure that the system is perceived as being transparent and fair. Furthermore, those making referrals to inpatient detoxification may wish to consider whether it is ethical to make people wait longer to demonstrate their commitment to treatment if those patients are already struggling and desperate to start to detoxify. Lastly, there may be scope for introducing virtual waiting rooms to help patients feel less alone. These might take the form of informal online meetings, chat rooms or messenger app groups where those who have been referred to a particular service can share their questions, concerns, and experiences with each other and receive information from detoxification staff.

Limitations

The findings we present have limitations. In terms of the sample, the data analysed relate to people who had been offered, and were waiting for, inpatient detoxification during a period when capacity was being expanded to rectify significant unmet need in England (Black, 2020). As such, the findings may not be generalisable to other settings and time-points, to those not offered detoxification, or to those who may be paying for their treatment privately. Additionally, participants were referred to the research team by professionals. Therefore, we cannot discount the possibility that participants may have been selected because they were likely to voice positive views. Furthermore, the sample size is small, meaning that we have not been able to thoroughly explore similarities and differences between subgroups of participants based on their age, sex, ethnicity, relationship status or primary substance etc. We also note that over two-thirds of our participants were accessing treatment for alcohol compared with under a third of the adult treatment population in England, and all study participants were White. This raises uncomfortable questions about who may not be making it to the waiting stage and whether there are deeper inequalities within the system that our research has not been able to identify or unpack.

In terms of our recommendations, we have focused on changes that could be implemented within the context of existing capacity rather than advocate for more inpatient detoxification. We also appreciate that some of our suggestions for improving the wait experience may already be occurring but not yet be routine and therefore were not picked up by our research. Meanwhile, other proposals will depend on structural factors that cannot easily be modified at a service level; for example, changes in patients' interest in, or capacity to absorb, information and their ability to engage with mobile phones and electronic media for communications (Neale et al., 2019, 2023). Furthermore, we have not considered which of the suggested strategies should be led by community services and which by inpatient detoxification services. Professionals need to be clear on where responsibilities lie, and which providers will take which actions. Given that our data focused only on the patient perspective, we cannot conclude that responsibilities were not clearly delineated. We can only state that patients often did not know who would be contacting them when and for what purpose, which negatively affected the waiting experience.

Conclusions

Waiting for inpatient AOD detoxification is a complex and multi-faceted experience. We identified five main dimensions of waiting: i. duration; ii. support; iii. information; iv. preparations; and v. emotions. We have also suggested various adaptations to service-level policies and practices that might help to minimise the stress of waiting. These included strategies to help patients occupy their time, lessen their uncertainty, demonstrate fairness, and reduce isolation. Importantly, we do not suggest that all aspects of waiting as currently experienced by people in England are negative. Some participants were pleased at how short the waiting period had been, all appreciated the support and information they had received (particularly in respect of travelling to the detoxification service), and several acknowledged how they had benefited from attending groups between referral and starting treatment. Despite this, our analyses showed how more can and should be done to improve the experience of waiting for inpatient detoxification. Having to wait is symbolic of an individual's powerlessness (Bourdieu, 2000) and waiting is known to (re)create subordination by producing uncertainty and arbitrariness (Auyero, 2012; Biner & Biner, 2021; Schwartz, 1974). It can also exacerbate stigma and feelings of being undeserving of support (Bourdieu, 2000; Fraser & valentine, 2008; Harris & McElrath, 2012). People who use substances are already often marginalised and hindered by barriers when they try to access treatment (Cunningham et al., 1993; Farhoudian et al., 2022; Neale et al., 2008; Notley et al., 2013). It is therefore essential that we address any additional negative impact that waiting might have on them.

Ethics approval

The authors declare that they have obtained ethics approval from an appropriately constituted ethics committee/institutional review board where the research entailed animal or human participation.

Glyndwr University, Wales, (Ein Cyf 497).

CRediT authorship contribution statement

Joanne Neale: Writing – review & editing, Writing – original draft, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Beth Cairns:** Writing – review & editing, Data curation. **Kevin Gardiner:** Writing – review & editing, Data curation. **Wulf Livingston:** Writing – review & editing, Supervision, Project administration. **Trevor McCarthy:** Writing – review & editing, Data curation. **Andrew Perkins:** Writing – review & editing, Resources, Project administration, Funding acquisition, Data curation, Conceptualization.

Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

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