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A Preliminary Comparison of Major Kinds of Obstacles to Enrolling in Substance Abuse Treatment (AOD) Reported by Injecting Street Outreach Clients and Other Stakeholders

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Abstract: Injecting drug users (IDU) (n = 144), street outreach (n = 55), and treatment program (n = 71) staff and managers in stakeholder government agencies (n = 11) cited or mentioned many barriers to enrolling in substance abuse treatment (AOD), using varied assessment instruments (1). Here, we aimed to investigate a possible overemphasis on individual client factors (e.g., "readiness," denial) as barriers to enrollment and the relative importance of other kinds of barriers, e.g., limitations using a four-category classification of: individual client factors (IC), treatment accessibility (TAX), treatment availability (AVL), and (lack of) client acceptability (CA), reflecting stigmatization of IDUs. TAX responses predominated for outreach staff (51%), government managers (39%), and barriers implied by client suggestions (52%). IC (60%) followed by TAX (36%) factors characterized barriers clients generated directly. The IC factor thus appears overrepresented among IDUs and TAX is important for all groups suggesting a greater focus on access may be more cost-effective than on individual treatment motivation interventions.

Keywords: Injecting drug users, types of barriers to treatment enrollment

BACKGROUND

Appel et al. (1) found a great variety of obstacles to enrolling in substance abuse treatment (AOD) for heroin-injecting street outreach clients

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(IDU), notwithstanding the effectiveness of treatment for reducing drug abuse and AIDS risk (2,3). Paralleling Grant's (4) and Zerger's (5) results on alcoholism treatment and on utilization of mental health services, respectively, Appel et al. identified many institutional, policy, fiscal, and social barriers at least if not more significant than conventionally emphasized individual factors, e.g., anxiety, "not being ready," denial.

This report is a preliminary assessment of the importance of various categories of obstacles, motivated by skepticism that client-related impediments form the major barriers to enrollment as opposed, for example, to limitations on access and inadequate treatment capacity. Further, knowing the relative importance of key kinds of barriers could help guide development of remedial measures.

A set of four barrier categories was developed to achieve study objectives from data obtained in (1) from IDUs, staffs of street outreach and treatment programs, and government AOD, health and social service agencies, using somewhat dissimilar instruments. The original barrier data were recoded to do the needed between group comparisons.

FOUR-FACTOR CLASSIFICATION OF TREATMENT ENROLLMENT BARRIERS

The four factors are: 1) Individual Client Issues (IC), 2) Access to Treatment (TAX), 3) Availability of Treatment (AVL), and 4) Acceptability of Clients (CA). The IC factor captures motives and beliefs given by IDUs when asked what prevents them from enrolling in treatment now such as: not being ready, fear of treatment, ignorance (what it involves), aversion to treatment, principally methadone maintenance (MMT), anticipated negative emotional consequences, e.g., shame from revealing addiction to intimates (by enrolling in treatment), anticipated negative objective consequences, e.g., feared loss of child custody, loss of subsidized housing requiring tenant abstinence, and the belief that treatment does not work.

The TAX factor refers to "red tape," e.g., need for identification or other documentation (e.g., medical test results), insurance or Medicaid; Medicaid Managed Care limits on treatment duration/number of visits; and if having applied, not reporting because of onerous cost, time, and travel requirements to be in treatment.

The AVL factor refers to a slot or bed within reach at the appropriate level of care (e.g., inpatient, outpatient, residential), consistent with the candidate's needs and preferences. While not cut and dried, the issue is whether an opening exists when a candidate makes application. Lack of availability is least ambiguous when a needed treatment modality does not exist in an area.

The CA factor (principally, the *lack* of it), refers to discrimination or stigmatization—the tendency for (usually public) institutions to view IDUs as unworthy, repugnant, mildly threatening, and thus not deserving of prompt attention, choices, insurance coverage, adequate palliative care, and basic respect.

METHOD

The original barrier data for 1) outreach staff, 2) government agency staff, and 3) for barriers implied by remedial *suggestions* made by outreach clients, were coded into the four categories. (Treatment staff data were excluded for technical reasons.)

For outreach clients, we initially inferred barriers from their remedial suggestions, e.g., if a client said there should be more openings or programs, we inferred the AVL factor. Our rationale was that the direct barrier question for clients required *generating* barriers (i.e., What are the "main things" in the way of you going into treatment now?) while the format for the other study groups asked them to *select* which possible barrier domains (see below), or which constituent barriers within a domain, presented as a list, were or contained barriers.

We also coded the barriers generated directly by clients and tabulated them separately, i.e., each of the "main things" in the way of them going into treatment now. Thus, each specific obstacle ("main thing") and the single barrier inferred from each client suggestion, was coded into one of the four categories.

Outreach staff data were coded from their responses to items presenting barrier domains (e.g., "clients," "treatment programs," "hospitals," "public assistance/welfare," "police," totaling 16 domains) and whether the domain was a barrier (e.g., "Yes, 'hospitals'" are a barrier), whether specific barriers listed in a domain were barriers or not, and a unique barrier inferred for each remedial suggestion. Outreach staff data thus consisted of aggregated "Yes" responses to a domain as involving a barrier, "Yes" responses to any constituent barriers within a domain and all inferred barriers. Any specific response added as an "other" barrier was also coded.

The data for agency staff was obtained by coding complete statements or phrases in transcribed interview summaries where eliciting questions involved 12 obstacle domains similar to those in the questionnaires of the other staff groups. Each complete statement or phrase reflecting a barrier or the barrier implied by a proposed solution was coded into one of the four obstacle categories.

Coding was done separately by PWA and RO and then reconciled. The variety of data sources, in volume of codable responses between

subgroups, and the exclusion of treatment staff data limit statistical comparisons. Nevertheless, the percentages for the major barrier categories do provide a gross picture of how each group sees each broad category's role and whether the IC factor emerges as central.

FINDINGS

Table 1 presents the distributions of (direct) barrier responses for the outreach clients, outreach staff, and agency managers and the barrier responses for clients inferred from their remedial suggestions.

The *most* common obstacle category for outreach and agency staff was access to treatment, while obstacles involving the IC factor were their *least* mentioned, 11% and 19%, respectively. Further, barrier categories inferred from clients' own suggestions show a distribution more like the ones for outreach and agency staff than the one for their *direct* barrier responses. TAX was mentioned most, 52%, followed by treatment availability, 28%; IC factor mentions were third, 19%.

Table 1. Percentage of treatment barrier responses in four categories for outreach clients (N = 144), outreach program workers and staff (N = 55), and agency managers and officials (N = 11)

	Group and data source			
	Outreach client			
	Direct barrier responses	Inferred barrier responses	Agency staff combined*	Outreach staff combined
No. of responses	(N = 223)	(N = 167)	(N = 138)	(N = 843)
Barrier category				
Individual client factors	60.2%	19.2	19.0	11.0
Accessibility of treatment	35.7	52.1	39.5	51.0
Availability of treatment	4.1	28.1	22.5	15.0
Acceptability of clients	—	.6	19.0	23.0

*Barriers aggregated from codings of "Yes" responses to barrier domains or constituent barriers in a domain and from barriers implied by suggestions or proposed solutions.

By contrast, the IDUs mainly saw aspects of themselves (60%) as the key impediment to enrolling in treatment followed by access to treatment (36%), in their direct barrier responses.

DISCUSSION AND CONCLUSIONS

In contrast to the traditional primacy accorded individual factors in deterring AOD treatment enrollment for IDUs, e.g., "lack of readiness," denial, we found the principal factor for outreach program staff, government agency managers, and for barriers implied by IDUs' suggestions (for enhancing enrollment), to be limits on access to treatment. However, among the barriers outreach clients mentioned directly, the IC factor was clearly primary while the access factor ranked second.

Some account is needed on why IDUs give client factors primacy when asked directly what is deterring them. No doubt, objective pressures building during an addiction episode contribute to this emphasis on oneself. Yet anecdotal accounts of IDUs commonly focus on {me} not wanting "it" (*sic* treatment) "enough" and even mentions of a flawed "system" are often framed as a *personal* deficiency, i.e., "{me} not knowing how to negotiate the system."

Our perspective is that the AOD system and larger culture reinforce individual factors as the key to getting services. While "not being ready" may be a convenient, self-referential shorthand for clients to describe what has deterred them, it obscures the wide range of genuine levers that deter enrollment. Bux et al. (6) showed that large numbers of IDUs could be readily induced to enroll in treatment (long-term detoxification), many for the first time, by the access-improving expedient of providing vouchers for free services. The recent federal initiative Access to Recovery (7) is a welcome though quite belated acknowledgement of the importance of improving access to increase enrollment in AOD treatment.

After access to treatment, availability was the factor most commonly coded from outreach client suggestions and for agency officials. As highlighted by Cartwright and Solano (8) in their analysis of AOD treatment funding, they indicate that "*. . . it is perplexing that treatment financing stops with a* ***rationing*** *outcome that inhibits social welfare* (our emphasis)." (p. 247).

An obvious limitation of this study is that the original data for treatment program staff could not be recoded. Their *group specific obstacle data* indicated they saw client readiness and motivation (1) as important but they had even more aggregate responses reflecting treatment access followed by treatment availability. Another limitation was the small size of the governmental agency staff sample.

The present results suggest that IDUs and other key stakeholder groups see limits on access to and availability of AOD services, and for outreach workers (intimately involved in securing treatment for their clients), stigmatization of IDUs, as major hurdles for heroin-injecting street outreach clients and perhaps, IDUs generally. While individual factors remain a core influence in AOD treatment enrollment, our findings suggest their traditional primacy is unwarranted. Future research is needed to more rigorously assess the comparative weight of the four factors in treatment enrollment.

From a practical standpoint, improvements in access to and availability of services may have a greater impact than individualized treatment enrollment enhancement interventions such as motivational interviewing (MI) (8). The striking and prompt increase in enrollment found by Bux et al. using a concrete incentive supports this conjecture. It remains to be determined whether increased access is more cost-beneficial than say MI, and whether the associated treatment courses and outcomes are comparable.

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