

**Barriers to Enrollment in Drug Abuse Treatment
and Suggestions for Reducing Them: Opinions
of Drug Injecting Street Outreach Clients
and Other System Stakeholders**

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ABSTRACT

Alcohol and other drug abuse (AOD) treatment is a major means of HIV/AIDS prevention, yet clients of street outreach programs (SOP) who are injection drug users (IDU), and outreach workers and staff as well, report various obstacles to enrolling clients in AOD programs. This study assessed the barriers to AOD enrollment facing high risk street outreach clients and obtained suggestions for reducing them. Data were obtained

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from semistructured field interviews with: 1) IDU outreach clients (N = 144) of the six SOPs in New York City (NYC) and northern suburbs supported by the Office of Alcoholism and Substance Abuse Services (OASAS), the single state agency in New York State for AOD prevention and treatment, 2) outreach workers and staff of the six SOPs (N = 55), 3) staff of detox and AOD treatment programs in major modalities treating IDUs (N = 71), and 4) officials and administrators (N = 11) in OASAS, the AIDS Institute of the Department of Health (addresses all aspects of the HIV/AIDS epidemic in New York State), and the agency for public assistance in New York City, the Human Resources Administration (HRA). Principal barriers for street outreach clients included personal–family issues, lack of insurance/Medicaid, ignorance, suspicion, and/or aversion to AOD treatment (methadone maintenance especially), “hassles” with Medicaid, lack of personal ID, lack of “slots,” limited access to intake, homelessness, childcare–child custody issues. Further, about 18% had no desire for AOD services, reported no barriers, or were too enmeshed in addiction to enroll. Outreach staff cited prospective client’s lack of ID and lack of Medicaid, lack of “slots,” and stakeholder agency bureaucracy. Treatment staff cited lack of client readiness, “hassles” posed by welfare reform, AOD programs’ own “red tape,” waiting lists, and near exclusionary preference for the Medicaid-eligible. Finally, agency managers cited client factors, inadequate funding and lack of appropriate programs, treatment program requirements, and societal stigmatization of addicts. Proposed remedies included dropping ID and insurance requirements for admission, major increases in resources, funding the transporting of outreach client treatment candidates to AOD services sites, education and training initiatives, increased inter-agency cooperation, and the need for stakeholder agencies, OASAS especially, to more effectively integrate abstinence-oriented AOD services with harm reduction and the public health aspects of AOD problems.

Key Words: Street outreach; Drug abuse treatment; Injecting drug users; HIV/AIDS prevention; Harm reduction; Obstacles to admission to treatment; Remedies for reducing obstacles to admission.

INTRODUCTION

By the mid 1980s, it was apparent that injecting drug users (IDU) were a significant source for the spread of HIV/AIDS. Harm reduction efforts such as street outreach focused on safer injecting (and sexual) practices, and for amenable outreach clients, referrals to substance abuse treatment. The full efficacy of treatment for preventing HIV/AIDS could be realized, however, only if motivated IDUs could readily enroll in treatment.



Outreach workers and IDUs report anecdotally, however, that enrolling in treatment is fraught with obstacles. This study was done to identify the obstacles systematically and to specify remedies with aim of reducing HIV/AIDS morbidity and mortality.

BACKGROUND

In 1989–1990, the Office of Alcoholism and Substance Abuse Services (OASAS), New York’s single state agency for substance abuse treatment and prevention, set up a network of street outreach programs to provide HIV/AIDS prevention services. Focused on injecting drug users (IDUs), the street-based interventions evolved from HIV/AIDS education and securing HIV testing and counseling services to a wider variety of services but with a continued emphasis on harm reduction.

The harm reduction approach involves providing a broad range of risk reduction, health, social, and related services aimed colloquially at “meeting the client where they’re at.” Referring interested clients to alcohol and other drug (AOD) treatment is integral to outreach workers’ street contacts with IDUs, which clearly imply offering them help to get these services. However, the impetus for addressing an abuse or dependency problem and initiating the process of enrollment depends on explicit direction from the client. Rates of referral and admission of OASAS outreach clients to AOD services have been around 5% of all IDUs contacted and while low, these results are consistent with results achieved elsewhere (R.E. Booth, Field Consensus Regarding AOD Treatment Enrollment Rates for Street Outreach Clients. Personal Communication, 1999).

The stimulus for this study arose from reports of IDUs and street outreach workers that there are a variety of obstacles to enrollment in AOD programs apart from the low expected rate associated with the harm reduction approach to risk reduction. The concern is that since IDUs continue to be a major source of HIV/AIDS and other infectious disease transmission (1), a comprehensive prevention strategy *must* use the prophylactic effects of AOD treatment [recognized early in the HIV/AIDS epidemic (2)]. Thus, there is particular urgency in identifying and reducing obstacles to enrollment in AOD services for injecting drug users.

Barriers and remedies were specified analytically by examining the actors and institutions involved in treatment referrals and admission, and what could obstruct these activities. For convenience, these activities are called “treatment enrollment.” Nominations were obtained from OASAS, outreach, and treatment program staff with firsthand knowledge of treatment enrollment issues for IDUs. Nominees included IDUs



themselves and the practices, policies, and attitudes of staff of street outreach programs, treatment programs, and directly involved government agencies including OASAS, the AIDS Institute of the New York State Department of Health (the agency that coordinates New York's response to the HIV/AIDS epidemic), the Human Resources Administration (the local social services agency in New York City), and the New York City Police Department.

Literature

While some work has been done on client and admissions process factors (3) affecting enrollment in treatment, there has been little on organizational, policy, or systemic factors that impede the process. Bux et al. (4), for example, found, in a study done in New Jersey, that the majority of coupons for free 21- or 90-day methadone detoxification were redeemed (58.5%), many by first-time treatment participants. The relevance of Bux et al.'s coupon initiative is that New Jersey eliminated most "free" (publicly-funded) AOD services in 1981, a policy change with obvious impact on HIV/AIDS prevention and treatment enrollment for that state's IDUs.

Fifteen percent is an oft-cited figure for the number of drug abusers in treatment relative to the total in need (5). Limited though it may be, the effectiveness of AOD services for HIV/AIDS prevention is unequivocal (6). Nevertheless, the rate of enrollment from street outreach and other harm reduction efforts remains low aside from exceptional gains resulting from specialized research interventions (7). The present study was designed to assess the obstacles to AOD enrollment inherent in the policies, practices, and attitudes of various institutions that affect IDUs who are potential recipients of care as well as obstacles associated with the IDUs themselves. Secondly, the study aimed to identify suggestions for remedial measures to address the various barriers. Information on obstacles and suggestions was obtained from interviews of IDUs and from staff of the organizations and institutions nominated as presenting barriers to treatment enrollment.

METHOD

Separate, semi-structured questionnaires were used to interview: 1) IDUs contacted by street outreach workers, 2) staff of street outreach programs, 3) staff of treatment programs, and 4) staff of OASAS, the AIDS Institute, and the Human Resources Administration (HRA). (Persistent efforts to access Police Department policy managers were to no avail).



Injecting Street Outreach Clients

The six OASAS street outreach providers all agreed to facilitate recruitment of IDUs for interviews. Four operated in New York City proper, one served Westchester County just north of New York City, and one served the mid-Hudson area about 100 miles north of the city.

Sample

Street outreach clients could be known or likely injecting drug users engaged by an outreach worker for the first time as part of the study. To be eligible, an outreach client had to be screened in as an IDU by the outreach worker and the research interviewer. The latter screened candidates by observing track marks, asking to see them if not evident, and by probing the candidate's use pattern for additional verification. Subjects had to be 18 or older, to have injected heroin or cocaine at least once in the past week, and not have been in drug detoxification or treatment in the past 30 days.

Instrument

The questionnaire took 20–30 minutes and covered: demographics, living arrangements, employment, criminal justice status, medical and psychiatric history, illicit drug use and modes of consumption, HIV/AIDS injection risk behaviors, perceived risk of contracting HIV, current HIV/AIDS status, precautions taken, number and type of previous AOD treatment episodes longer than 2 weeks, main things/reasons in the way of enrolling in drug treatment now, personal relevance of 21 specific obstacles to treatment enrollment, and suggestions for making it easier to enroll.

Design

The initial quota sampling plan of $N = 20$ per outreach provider was modified because of variations in yield and geographical coverage. The final $N = 144$ was distributed geographically as follows: Manhattan = 40, Bronx = 40, Brooklyn = 10, Queens = 10, Westchester County = 30, and Ulster County = 14.

Procedure

Interviewers accompanied workers as they did outreach during the day and on occasional evening stretches. As a worker completed their primary



service with a client, they would indicate that the person(s) (interviewer) standing nearby wanted to do a private, paid interview with them about things standing in the way of them going into treatment and about suggestions for making it easier to enroll. Interested candidates were screened for eligibility and arrangements were made for an interview.

The client was told the purpose of the project, that their responses were confidential and anonymous, and that they would be paid \$15 after completing the interview. After signing an informed consent using a pseudonym, the subject was interviewed, paid, and thanked for their assistance. All subject recruitment and data collection procedures for the outreach clients and agency staff participants were approved by the OASAS Institutional Review Board (IRB) at the University of Buffalo.

Interviews were done in a variety of settings with a focus on the privacy of the interview and the security of the interviewer. The settings ranged from the field or central offices of the outreach program to various street or public settings (see Table 1).

Street Outreach Program Staff

Outreach program staff interviews were done with the executive director of the parent agency, the director and/or supervisor(s) of the outreach program, nearly all street outreach workers, and several counselors and storefront assistants. The latter provide clerical and advocacy support for clients. The outreach staff sample consisted of N = 55: seven directors, 11 supervisors, 29 outreach workers, four counselors, and four storefront assistants.

Table 1. Numbers and percentages of street outreach client interviews (N = 144) done in various field settings.

Interview setting	N	%
Storefront field office	50	34.7
Street	36	25.0
Park bench	27	18.8
Abandoned building/single room occupancy hotel (SRO)	2	1.4
Bus stop/train station	2	1.4
Other	17	11.8
Missing	10	6.9
Total	144	100.0



Instrument

The questionnaire took 45–60 minutes and covered: demographics, work role, present job, previous AOD and human service employment, personal AOD treatment experience, HIV/AIDS status, program’s philosophy of harm reduction and AOD treatment, main barriers to treatment enrollment for IDUs and their judged level of seriousness, seriousness of other indicated barriers in 17 domains, suggestions for reducing obstacles and their judged degree of promise, any changes in obstacles in the past 10 years, and if so, the reason(s).

At interview, the project person reviewed the purpose of the study and secured informed consent, which asked for permission to audiotape the interview and to use the person’s job title and their organization name. Any refusal was honored.

Drug Abuse Treatment Program Staff

Drug treatment and detoxification program staff receive referrals from many sources, including outreach programs. We selected five types of treatment programs that IDUs may enroll in to receive treatment: 1) methadone maintenance, 2) residential drug-free (e.g., therapeutic community), 3) outpatient drug-free, 4) medically supervised outpatient, and 5) day service drug-free, which involves several hours to full-day programming, up to 5 days a week. Though not treatment, we included detoxification programs as a sixth service venue because injecting outreach clients commonly seek this service. Program role positions selected for interviews were the director or site supervisor, an intake or admissions worker, and a line counselor.

Sample

We selected four treatment sites of each program type, including detoxification and the above three staff roles, at each site, N = 71 (one intake person left before an interview could be done).

Instrument

The questionnaire took 45–60 minutes and covered: subject demographics and program role, previous AOD and social service employment experience, personal AOD treatment experience, HIV/AIDS status, admission requirements to their program, the kinds of AOD problems the program will and will not address, sources of referral and how the program



works with their referral sources, experience with street outreach program referrals, program philosophy regarding AOD treatment and harm reduction, program harm reduction activities and funding, specific barriers to treatment enrollment in 16 domains, remedies for obstacles noted and rated level of promise, and changes in obstacles in the past 10 years and the reason(s).

Design

Treatment sites were selected to get representation of: 1) specific programs that outreach providers could refer their clients to as well as 2) programs they already had experience with. For each program type (methadone maintenance, residential, etc.), we selected one with which an outreach program had a “good” referral experience(s) and one with which they had a “bad” experience(s). The remaining two were drawn randomly from a pool of appropriate providers. “Good” referral experience meant accepting a procedurally difficult referral and/or one that posed a temporary fiscal liability; “bad” experience entailed the opposite. All programs readily offered nominations except of day service programs due to inexperience with them.

Procedure

Two proprietary detoxification programs declined to participate; they were replaced. At interview, the purpose of the study was reviewed and the interviewee was given an informed consent. When finished, subjects were thanked and told that project results would be given to all participants around mid-year, 2001.

Agency Managers and Policy Makers

Interviews were done with selected officials and managers in OASAS, the AIDS Institute, and the Human Resources Administration. The OASAS certifies and monitors all treatment providers in New York, and funds most (nonprofit); it also administers, and at least partly funds, the six street outreach programs in this study. Interviews were done with the Commissioner, the acting Associate Commissioner in the health services division (the primary area for health and HIV/AIDS programming), the Director and former Assistant Director of Clinical Services, and the former and current coordinator of street outreach programs.

The AIDS Institute is the principal agency in New York (a component of the Health Department) addressing epidemiological, prevention, and



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treatment issues for HIV/AIDS. It collaborates actively with OASAS. The AIDS Institute sample (N = 4) consisted of the Executive Deputy Commissioner, the Director of HIV prevention, the Director of Substance Abuse Treatment programming, and the Director of HIV Primary Care services.

One representative from HRA was interviewed. The importance of HRA policies and practices is that applicants for public assistance and Medicaid who have substance abuse problems, such as injecting street outreach clients, must be screened and referred for services by HRA. Having control over the major source of revenue for treatment programs has given local social service agencies a major influence on access to treatment since the advent of welfare reform in the mid-1990s. Requests to interview other managers were denied due to generally acknowledged interagency friction over implementing welfare reform mandates within the AOD treatment system.

Instrument

The interview schedule took about an hour and covered: subject title, position, longevity, and demographics; previous AOD, social service, public employment positions, view of specific obstacles to treatment enrollment for IDUs, perceived obstacles in 10 barrier domains and judged level of seriousness, knowledge of actions taken or planned to address known barriers, suggestions to address barriers and their degree of promise, agency knowledge of specific barriers, actions taken and reasons for inaction, if relevant, view of AOD services and harm reduction for combating disease transmission among IDUs, changes in the tendency of IDUs to seek AOD treatment in the past 10 years and the reason(s).

Procedure

At interview, the subject was given a brief overview of the project and then an informed consent. There were follow up conversations to complete an interview or clarify responses for three of the 11 subjects. Subjects were thanked and told that findings would be available mid-year, 2001.

FINDINGS

Street Outreach Clients

As shown in Table 2, the sample was 66% male and overwhelmingly, members of ethnic minority groups—90.3% were African-American or



Table 2. Selected demographic, background, and drug use characteristics of the street outreach clients (N = 144).

Variable	N	%
Age		
20–29	25	17.4
30–39	57	39.6
40–49	46	31.9
= / > 50	16	11.1
Gender		
Male	95	66.0
Female	49	34.0
Ethnicity		
Hispanic	87	60.4
African–American	43	29.9
Caucasian	13	9.0
Other	1	0.7
Education		
K–12th	78	54.2
HS Grad–GED	40	27.8
Some college / >	26	18.1
Employed?		
Yes	16	11.1
No	128	88.9
Marital status		
Single, divorced, separated, widowed	112	77.7
Married, cohabiting	32	22.3
Resides in?		
Apartment	67	46.5
Homeless, abandoned		
Building, paper box	31	21.5
SRO, hotel, shelter	17	11.8
Friends, relatives	17	11.8
Missing data	12	8.3
Percentage of clients injecting a specific drug(s) in past week		
Heroin		100.0
Cocaine		31.9
Speedball ^a		25.0
Methamphetamine		2.1
PCP		1.9
Other		2.8
Frequency of injection of preferred drug		
6 × / > /day		26.4
4 × – 5 × /day		26.4

(continued)



Table 2. Continued.

Variable	N	%
3 × /day		21.2
2 × /day		20.8
1 × /day		5.6
Previous drug abuse treatment?		
Yes		46.2
No		53.8

^aSpeedball = mixture of heroin and cocaine.

Latino. Forty-five percent were homeless or unstably domiciled, over three-fourths were living as single, and 89% were unemployed.

By design, injection drug use was universal. All subjects reported injecting heroin, nearly 32% also injected cocaine while a quarter reported use of a “speedball” (injection of a heroin–cocaine mixture). Almost 75% injected their preferred drug (s) at least three times a day and over 46% had previous episodes of drug abuse treatment (lasting at least 2 weeks).

Subjects were asked for the three main reasons standing in the way of them going into treatment now and whether any of 21 obstacles reported by “other drug users” applied to them, e.g., “Intake is not available when I

Table 3. “Main” barriers^a for street outreach clients^b deterring their enrollment in drug abuse treatment (209 barrier mentions for 144 clients).

Main barrier area	N	%
1. Family–personal issues	48	22.9
2. Nothing, no desire, demands of addiction	37	17.7
3. Lack of insurance/medicaid	36	17.2
4. Treatment aversion	27	12.9
5. Lack of personal identification, documents	12	5.8
6. Homelessness–housing issues	9	4.3
7. Slow admission process—long waiting period	8	3.8
8. Childcare issue—feared loss of custody	5	2.5
9. No response	1	0.5
10. Other ^c	26	12.4
Total	209	100.0

^aBarriers were categorized into types; see text for specific examples.

^b144 clients gave a total of 209 main or principal barriers.

^c“Other” barriers consisted of responses that could not be assigned to a primary category and though groupable in some instances, were not given by more than five subjects.



want to go,” “I don’t have identification, a birth certificate, social security card or driver’s license,” “There is no program of the type I want close to where I live,” “I feel discriminated against (minorities, homosexual, transgender),” “It’s too much of a hassle to apply for Medicaid.”

The research interviewers independently developed coding categories for the “main reasons” and negotiated a final set. Then, they coded one another’s interviews and independently coded their own; coding discrepancies were resolved through discussion with the P.I. serving as arbitrator. Table 3 presents the frequencies and percentages by category for all responses (N = 209) given by the 144 subjects, to the “main reasons” question. The data show moderate dispersion with peaks on “Family–personal” issues, “Nothing (standing in the way), no desire, demands of addiction,” “Treatment aversion,” and almost as common, “Lack of insurance/Medicaid.” The high prevalence of selections in the second category was unanticipated: nearly 18% of the sample reported no barriers to enrolling, had no desire for treatment, or found the demands and/or rewards of addiction incompatible with seeking entry.

The main obstacle category, “Family–personal,” included such reasons as wanting to conceal addiction from a spouse, having to care

Table 4. Outreach client suggestions or remedies to facilitate their enrollment in drug abuse treatment (clients could give more than one suggestion; N = 144 clients).

Suggestion	N	%
1. Treatment and detoxification programs should admit people without insurance or Medicaid.	43	29.9
2. Treatment and detoxification programs should admit people who have no identification or documents.	33	22.9
3. Reduce waiting periods; more treatment beds or slots.	12	8.3
4. More education—training about treatment needs to be provided to IDUs ^a , outreach and treatment program staff.	9	6.2
5. Longer detox periods with better follow-up.	7	4.9
6. Provide childcare.	7	4.9
7. IDUs need an advocate, go-between.	4	2.8
8. Other ^b	51	35.4
9. No suggestions offered	30	20.8
Total	166	

^aIDUs = injection drug users.

^b“Other” refers to a variety of suggestions that did not fit into the categories above, or if classifiable, were not given by more than three subjects.

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for an ill family member, not wanting to leave a significant other alone while in treatment, and being the sole breadwinner. Following closely was a somewhat diverse “treatment” category including such reasons as fear of treatment, bad previous treatment experience(s), or aversion to a specific type, mostly methadone maintenance. Lack of identification or documents, homelessness, admissions process-treatment capacity factors delaying entry, and childcare/child custody issues, were cited less frequently.

Asked if any of 21 obstacles to enrollment applied to them, at least a third of the sample selected one or more of the following barriers: 47.9% agreed that it was too much of a “hassle” to apply for Medicaid, 43.8% indicated they had to wait too long to get in where they wanted to go, and nearly 42% indicated that intake was unavailable when they wanted to go. Other common selections were that the programs known about did not meet their needs, that they were anxious about enrolling because of ignorance about treatment, and that they needed a referral to get into a desired program.

Asked for five suggestions to make it easier to get into a treatment program, the two most commonly given (Table 4) focused on reduced admissions requirements. Mentioned most was that programs should admit applicants without insurance or Medicaid, and next, that programs should waive the requirement of personal identification. Other categories included reducing waiting periods and providing more treatment slots, providing more information and education to IDUs about treatment, longer detoxification with better discharge planning, providing childcare, and least common, having an advocate or “go-between” for IDUs. Three or fewer clients offered a variety of other solutions (35%), and over 20% offered none.

Street Outreach Program Staff

Table 5 shows the sample of street outreach program staff was 50.9% male and over 60% were 40 years of age or older. Forty percent were in a monogamous relationship and over two-thirds had post-high school education or training, including senior college, graduate school, and/or a CASAC (certified alcoholism and substance abuse counselor) credential.

There was a low-to-moderate degree of job longevity: 49.1% were in their positions 1–5 years, while over 29%, 6 years or more. Seventy-one percent had personal drug abuse treatment histories compared to 46% for the outreach clients. (The major type for outreach staff was residential drug-free).

Outreach staff were first asked for the five main barriers to enrollment in treatment. They were then asked about specified barriers within 17 “domains” such as “outreach clients,” “the police,” “hospitals,”



Table 5. Demographic, background, and treatment history characteristics of street outreach program staff (N = 55).

Variable	N	%
Age		
< 30	2	3.6
30–39	20	36.4
40–49	19	34.5
= 50/>	14	25.5
Gender		
Male	28	50.9
Female	27	49.1
Ethnicity		
African-American	24	43.6
Hispanic	23	41.8
Caucasian	7	12.7
Asian	1	1.8
Education		
< / = HS grad	18	32.8
Jr. College, Trade, Voc	16	29.1
Senior college +	17	30.9
CASAC	4	7.3
Marital status		
Single	25	45.5
Married/cohabiting	22	40.0
Divorced/separated/widowed	8	14.5
Personal substance abuse treatment history?		
Yes	39	70.9
No	16	29.1

“OASAS,” “AOD programs,” and whether they viewed the indicated obstacles as real barriers. They could also offer other barriers at their discretion.

Combining results from both barriers questions, at least half the sample cited: lack of insurance or Medicaid, lack of personal ID, lack of uniform admissions criteria, waiting list/shortage of beds, “bureaucracy,” and insensitivity of social services benefits examiners and screening personnel. Additional barriers of interest were found in the domains “OASAS,” the “Police” (New York City only), “AOD treatment” programs, and clients themselves. For OASAS, barriers were: 1) not having a policy to set aside beds or other capacity for outreach program referrals, 54.5%, and 2) not



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funding transportation of outreach clients to treatment sites, 58.2%. Of the sample, 52.7 percent saw the police as insensitive to outreach clients and program staff, 60% felt they lacked understanding of harm reduction and addiction, and 63.6% reported they harassed outreach clients. Treatment program staff were viewed as insensitive to clients' needs by 40% of the sample, a reputation that discouraged enrollment. Finally, clients' lack of readiness for treatment was cited by 49.1%.

As for remedial measures, the entire sample cited the need for additional "resources" such as increased funding for transporting outreach clients to treatment sites, funding for more treatment slots, funding for an onsite, credentialed case manager (a CASAC or MSW), and additional training for outreach workers in addiction and selected health related topics. Next, 80% made suggestions to directly expedite treatment enrollment, e.g., admitting IDUs without ID or insurance, liberalizing welfare reform mandates that affect eligibility for and referrals to treatment, and expanding availability of intake (sites/hours of operation).

Sixty percent of the sample proposed remedies involving increased interagency cooperation and modifying programs to better meet client needs. Almost as common were quite varied proposals in a category labeled "education" (58.2%)—increasing education of outreach clients about treatment options, program types and their features, and educating police about harm reduction and outreach operations. About 22% of outreach staff offered proposals involving training/education focused on outreach workers themselves.

Treatment Program Staff

Most treatment staff (N = 71), 67%, were 40 or older, 49% were male, 51% female, and 59% were either African-Americans and Hispanics, a smaller majority than the 85% for outreach staff. As shown in Table 6, over 46% were in a monogamous relationship. College level education was ubiquitous: 96% had some college and at least 44% had attended graduate school. Further, 30% had a CASAC credential. There was a moderate degree of job longevity with 52% in their positions 1–5 years and 28%, 6 years or more. Many fewer treatment than outreach staff had personal drug abuse treatment histories, 42% vs. 71%, respectively.

Treatment staff were asked to indicate whether there were any obstacles in each of 16 domains and how serious they were, from *not to somewhat*, *moderately*, or *extremely* serious. Frequency of citation as *at least a somewhat serious* barrier area was tabulated for all domains.

Most mentions were for the domains "Client," 75% (e.g., not ready or motivated for treatment) and "Social Services" (Human Resources



Table 6. Demographic, background, and treatment history characteristics of detoxification and drug abuse treatment program staff (N = 71).

Variable	N	%
Age		
20–29	4	5.6
30–39	18	25.7
40–49	31	44.3
50 +	18	25.3
Gender		
Male	35	49.3
Female	36	50.7
Ethnicity		
Caucasian	27	38.0
African–American	24	33.8
Hispanic	18	25.4
Other	2	2.8
Education		
< / = HS grad, GED	3	4.2
< / = Bachelor’s degree	29	40.8
CASAC	8	11.3
Some graduate school	9	12.7
Masters of social work	9	12.7
Masters degree + CASAC	13	18.3
Marital status		
Single, divorced, separated	38	53.5
Married, cohabiting	33	46.5
Personal substance abuse treatment history?		
Yes	30	42.3
No	39	54.9
Other	2	2.8

Administration), also 75% (e.g., threats posed by welfare reform mandates and sanctions for noncompliance discourage enrollment). These were followed by “Treatment Programs,” 62%, (e.g., “red tape”, strong preference for the Medicaid-eligible, waiting lists); and lack of (appropriate) capacity or “slots,” 51% (partially overlapping the latter domain but cited separately by respondents).

Three domains were cited by 49% of the sample: 1) OASAS (e.g., not rigorously enforcing “ability to pay shall not be a barrier” provision of



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mental hygiene rules, not supporting a treatment slot set aside for outreach referrals); 2) Hospitals (e.g., lack of discharge planning and referrals to treatment for detox patients); and 3) Court system (ignorance about or prejudice against treatment or against specific modalities).

Finally, three domains were cited by at least 40% of the sample. These were: 1) Population (of IDUs) (e.g., recent IDUs are more alienated); 2) NYC Police Department (penetration of outreach and treatment referral activity undermined by “sweeps,” “harassment” of IDUs and outreach workers); and 3) Needle exchange programs (at worst, suspicion or hostility toward drug abuse treatment programs; at best, insufficient emphasis on treatment).

Treatment staff recommendations were coded into six broad categories. Over 80% cited “increased funding/adding resources;” and nearly the same, 77%, offered suggestions in the area of “streamlining or facilitating admission to treatment.” Educational programs and initiatives were cited by 61%, and the fourth, 44%, involved “hiring more staff and providing better incentives.” (Though overlapping the first category, the latter was separated because of explicit and frequent mention.) The fifth category, 24%, involves suggestions for “increased collaboration between agencies involved in treatment enrollment;” and the last, 17%, involved “increased community involvement.”

Agency Managers and Administrators

Eleven current and former managers and officials in OASAS, the AIDS Institute, and the Human Resources Administration were interviewed. The sample ranged from 46–57 years old, six were male, five were married, the remainder, single or divorced; eight of the 11 were white; seven had advanced degrees. And except for a few recent changes, median years in current position was six.

Subjects were asked about barriers in 10 domains and for comments on whether specific barriers frequently cited by outreach and treatment program staff were also barriers in their view. Barrier mentions were coded into eight areas: 1) Criminalization (i.e., the tendency to deal with addiction as a matter for the law, the courts, the police, as largely a criminal matter despite recent efforts to present addictions as brain disorders or as issues of behavioral health); 2) OASAS philosophy: focused on abstinence, OASAS is ambivalent about harm reduction and about how much of a public health focus there should be in its policies and operations; 3) Negative attitudes toward and social demonization of IDUs by society, hospitals, and some treatment program staff; 4) Client characteristics that



discourage treatment-seeking, including denial, distrust, low self-esteem, ignorance of treatment options, and suspicion of treatment; 5) Treatment program requirements such as the need for ID, insurance, other red tape; 6) Lack of resources and/or appropriate programs; 7) Lack of coordination between agencies in qualifying, insuring, enrolling, and supporting applicants seeking enrollment; and 8) eligibility for public assistance and Medicaid for IDUs may involve burdensome, insensitive screening, threats of lost support once enrolled and/or from self-disclosure as an IDU, which discourage enrollment. Barriers most commonly mentioned were client characteristics, lack of resources and/or appropriate programs, and treatment program requirements, in that order, followed closely by lack of interagency coordination.

Protocols were screened for remedies and these were reduced to four broad categories: 1) the need for OASAS to reexamine its policies, 2) the need for additional funding, 3) modification and expansion of the models of treatment, and 4) the need for additional training, education, and increased awareness of IDU issues.

The main suggestion in the first category was for OASAS to address internal philosophical differences regarding the place of harm reduction in an agency focused on drug abuse prevention and treatment and on the goal of abstinence. A related suggestion was that the AIDS Institute needs to implement measures to enhance enrollment of needle exchange program clients in treatment. In the second category, proposed measures include more beds for women with children, funding of outreach programs for case management and client transportation services, and computerization of bed availability. Sample suggestions in the third category include integrating more services for co-occurring morbidities such as mental health problems, developing low threshold program components that permit a transition period of active drug use, and increasing street outreach components of treatment programs. Suggestions in the fourth category include implementing consumer advisory boards for relevant agencies, education of agency policy makers about harm reduction and treatment, and educating program staff and physicians about the pernicious clinical effects of prejudicial attitudes toward IDUs.

Qualitative Comparison of Reported Barriers and Remedies Among the Four Respondent Groups

Not having ID or documentation and not having insurance or Medicaid, were fairly consistently reported as barriers though the relative emphasis given to them varied widely among the major respondent groups. Highlighted by outreach and treatment program staff, and by AIDS



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Institute managers, these barriers were given some emphasis by clients, but relatively little by OASAS and HRA. The difference in the degree these barriers are seen as obstacles may itself be a barrier.

Another consistent theme as both a barrier and an area for remedial measures, was funding and resources. Clients gave less emphasis to this area compared to the moderate importance given it by outreach and treatment program staff. Agency managers, however, saw funding and resources as one of the major obstacles exceeded only by client-level factors such as denial, low self-esteem, etc.

A major difference in the findings contrasts those for outreach clients and the other respondent groups. Specifically, about 18% of the clients indicated there were no barriers for them, they had no desire for treatment, or found treatment seeking incompatible with the rewards and/or demands of their addiction. Very little of this theme was present in the responses of the other groups, though it may have been reflected indirectly in material referring to clients' lack of readiness, denial, and low self-esteem.

DISCUSSION AND CONCLUSIONS

The impetus for this study was the small percentage of injection drug users contacted by street outreach programs in New York State's network who get referred and admitted to AOD services. The concern is that since treatment *is* an effective HIV/AIDS preventative, failure to reduce obstacles to enrollment for these high risk individuals avoidably supports continued disease transmission. In addition, the treatment needs of this socially marginalized group with virulent drug dependency remain largely unaddressed. The results of this study show there are potent obstacles to treatment enrollment for IDUs aside from the admittedly crucial factors of client readiness and motivation. Further, a variety of concrete remedial suggestions were made, focusing on the need for additional funding and other resources; however, some suggestions made required minimal or no expenditures.

Placing the various barriers and proposed solutions in context reveals a rich set of connections not evident when just looking at the similarities and differences between groups. For example, nearly half the outreach clients indicated that the "hassle of applying for Medicaid" was a barrier. One part of the hassle is that the applicant needs to have valid identification because Medicaid is a means-tested benefit. Given the disorganized lives and homeless/transient status of many clients, keeping, locating, and providing satisfactory personal ID (e.g., birth certificate, social security card) at the point of application can be problematic. Furthermore, there are time, effort, and expense disincentives to replace a lost birth certificate, as



much as a full day waiting at the Bureau of Vital Statistics, a \$15 fee, and transportation costs. Additional delays could arise if the client was not born in the United States. While outreach programs have devised effective proxy measures to identify a client for referral purposes (a printout from a social security administration office showing application for a replacement card, a letter from a state employment office indicating ineligibility for unemployment benefits), valid, conventional ID is required ultimately (principally, by methadone maintenance treatment (MMT) programs to prevent duplicate enrollment). Outreach workers are intimately involved in securing valid ID for their clients and this was evident in how frequently they cited lack of ID as a primary barrier to treatment enrollment. By contrast, this obstacle got minimal recognition from most agency respondents except a few of the AIDS Institute interviewees who had been made aware of the barrier by findings of focus groups done with their own harm reduction workers.

Lack of insurance or Medicaid is another significant barrier with multiple connections to other barriers and proposed remedies. As discussed already, the “hassle” of applying for Medicaid is a commonly reported barrier by outreach clients. The major remedy they proposed was for detoxification and treatment programs to drop the insurance or Medicaid requirement for admission. According to state law, however, having insurance or an open Medicaid account is not a requirement for admission. While clients are supposed to be admitted regardless of ability to pay, those without Medicaid (or not readily “Medicaidable”) are often turned away (though not for the operative fiscal reason), according to agency and treatment program respondents.

The budgeting of AOD programs in New York helps account for the critical role in admission decisions of whether the client has insurance (or Medicaid) and is the basis for additional dependencies between obstacles to enrollment and remedies. Total program budgets are built from anticipated third party revenues, principally Medicaid, with the difference between the total and anticipated third party funds, the so-called “net deficit,” being bridged by local assistance funds from OASAS to treatment programs. Programs are managed closely by OASAS in terms of Medicaid revenue targets in order to husband limited local assistance funds. Programs also are managed closely to maintain a high level of utilization, generally, about 90% “filled.” Since local assistance funds have been declining in absolute terms during the past 10 years, the urgency among providers to assure Medicaid revenue, and the aversion to risking or delaying receipt of it, is an understandable outcome of the need to remain fiscally viable. As a practical matter, AOD programs limit admission of applicants without Medicaid or for whom there may be difficulty getting it. It would be unfair to call the solution of increased funding, proposed by agency and program



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respondents, as self-serving or exculpatory. Illustrative of the decline in funding through the 1990s is that a cost-of-living increase for treatment provider staff in 1998 was the first they received in 8 years. And while there have been three increases since, salary and benefits remain sub par and treatment providers have many unfilled positions.

Another significant aspect of the resources barrier pertains to the lack of (appropriate) slots or beds and the related issue of waiting periods being too long, claims made by all the respondent groups. However, some skepticism regarding this claim was expressed by an OASAS respondent. She indicated there are about 700–800 vacant beds statewide on an average day. The beds referred to residential treatment. (Talking of outpatient beds is not regarded as meaningful by OASAS managers). Further, assessment staff rarely had trouble referring public assistance clients to treatment because of a lack of vacancies, according to the HRA interviewee.

The existence of 700–800 vacancies is far from decisive on the matter of slots, however. While OASAS manages a treatment system with about 670 treatment providers (some with multiple treatment sites), the main issue is the availability of treatment slots at the appropriate level of care and appropriate to a client’s life situation, constraints, and preferences.

The OASAS’ 2002 county resource book (8) indicates that the long-term treatment capacity relevant to IDUs (assuming injection drug use involves moderate-to-severe drug dependence) is about 57,140. Seven hundred to 800 entails a vacancy rate of about 1.4%. Of course, this rate needs to be supplemented by some measure of vacant outpatient treatment capacity containing methadone maintenance, a modality of obvious relevance for opiate IDUs. Late 2000 and early 2001 OASAS vacancy estimates for all outpatient treatment ranged between 2000 and 3000 statewide (licensed treatment capacity less average end-of-the-month census). With total relevant vacancies ranging between 2700–3800 per month, the resultant vacancy rate is still only 4.9% to 6.8%, a very high level of utilization. Adding such reasonable search constraints as provider location, client life situation factors, and client preference, the probability of finding an open slot immediately is very low. Furthermore, providers are sometimes funded at less than their licensed capacity, which could make the operational vacancy rate range even smaller.

Ramifying connections between barriers and remedies is further illustrated by the relations between the following: 1) the resources/funding barrier, 2) the need for education and training, and 3) the outreach client barrier of anxiety about enrolling due to suspicion and/or ignorance about treatment. Specifically, outreach workers recommended educating clients to reduce their ignorance and suspicion of treatment. An informal job analysis for an outreach worker, however, suggests that direct instruction of individual



clients “in the street” or in a field office is liable to reach very few clients. Yet a more efficient group mode of instruction is of dubious practicality given the difficulties of keeping a group of street addicts intact even short-term. The resources issue also comes into play since conducting groups requires time for organization, may take away from primary street outreach activity, and could require a modest incentive(s) to secure client attendance.

Other barriers and remedies further complicate the above relationships. For example, episodically through the 1990s and more recently, police have harassed and “swept” areas in New York City having many IDUs. Such activity drives outreach clients indoors or to areas less accessible and more risky for outreach workers to service. As a result, outreach workers have had more difficulty performing their primary street outreach duties let alone educating interested clients about treatment services. (A recent added pressure is from harassment of IDUs by private security guards hired by owner/renter associations on blocks undergoing gentrification).

Pursuing the theme of interaction, the proposal to educate police about harm reduction, treatment, and street outreach depends on establishing a workable interagency relationship at a sufficiently high management level so that functional coordination can be implemented. During the mid 1990s, an OASAS’ outreach network coordinator was able to contact police headquarters personnel and got access to local precincts for education sessions with patrol police about to start their shifts. Ranging from outright rejection and derision to genuine interest among some of the police, judged impact of the sessions on street policing activities was limited. As indicated earlier, agency managers and treatment staff offered the remedy of interagency coordination, especially between those agencies involved in treatment enrollment. The OASAS relationship with New York City police, limited as it was, lapsed with a change in coordinators and perhaps, because of a mayoral administration at the time that was indifferent to such efforts. However, it is clearly a worthy coordination target for reducing antipathy toward injection drug users and the activities of street outreach workers, and indirectly, for facilitating treatment enrollment.

Other interactions suggested by the findings remain to be explored to identify dynamics of treatment enrollment and other points of leverage to facilitate change. At this point, however, we focus briefly on the 18% of outreach clients who indicated no desire for treatment, or could or would not extricate themselves from their addiction to seek treatment. The policy issue emerging from this result is the degree an AOD treatment agency should provide appropriate (social, health-related?) services to the out-of-treatment, addicted population not directly related to recovery or rehabilitation.

On this issue, the findings are far from definitive. Agency manager data suggest that OASAS needs to review its policies and resolve how it



wants to contend with the health and disease prevention needs of the out-of-treatment AOD population, outreach being one kind of intervention. Specific positions ranged from seeing current support as adequate, to a minority position supporting transfer of the street outreach function to the NYS Department of Health. The third position favored expanded support for street outreach and mainstreaming it as part of the spectrum of intervention services offered by OASAS. While limited resources makes the latter option seem remote, expanded interagency cooperation with the Department of Health and other partners such as CSAT and the CDC might be a means of accomplishing such an expansion. This begs the question, however, of what outcome would emerge from an internal policy discussion regarding OASAS' approach to the social-health needs of out-of-treatment injecting drug users given their high exposure to HIV/AIDS and other disease risks.

A response of an agency interviewee to the final report points to a limitation of this study. Specifically, the question was raised as to what extent the obstacles cited by street outreach clients, especially lack of Medicaid, are rationalizations for a lack of readiness or motivation for treatment. While the present findings cannot resolve this issue, nearly a fifth of the sample offered a reason indicating there were no obstacles or that the demands/rewards of addiction precluded enrolling. Secondly, most treatment staff cited lack of client readiness or motivation as a major obstacle but at least as often, cited policies, practices, and resource limitations of pertinent systems as impediments. These included limitations of their own programs or the systems by which they were regulated and/or funded.

The second of the National Institute of Drug Abuse's (NIDA) 13 Principles of Effective (Drug Addiction) Treatment (9) is very germane here. "Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not *immediately* available or not *readily* accessible" (our emphasis). The research reported here strongly suggests that there are significant limits on the availability and accessibility of AOD services for injecting street outreach clients, and perhaps, for IDUs generally. In informal conversation with some street outreach workers, the acute frustration they felt in the face of obstacles to enrolling a client was the recognition that the window of opportunity was very narrow, a few hours to a day or more, at most. The disturbing aspect of the results is that not only are opportunities being lost to intervene with drug dependence, desirable per se, but that the health services community is also losing ground in its effort to reduce the incidence of a fatal disease, HIV/AIDS, among a major group involved in its transmission, injecting drug users.



Another limitation of the study was a psychometric deficiency in the procedure for obtaining ratings of seriousness of obstacles to enrollment and the degree of promise of proposed remedies. In developing the categories for eliciting obstacles, we examined those that appeared relevant to the particular respondent group with some regard to those to be used for the other respondent groups. As a result, there was some variation in the number of categories and the features of particular categories, making between-group comparisons of ratings dubious. Another constraint on between-group comparisons, of course, was the small N for the agency managers. Additional analyses are underway to find a common set of categories for barriers and remedies so that comparative assessments can be made in the future. Such comparisons would go toward specifying the relative weight of various explanatory factors in limiting enrollment for IDUs and in ordering areas of intervention that offer the most potential for ameliorating barriers to treatment enrollment.

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