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with Treatment:
Admissions Counselors
Describe the Barriers*

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**LINKING DRUG USERS WITH TREATMENT:
ADMISSIONS COUNSELORS DESCRIBE THE BARRIERS**

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Getting in the Van

Some summer afternoons in New York City can be grueling hot. Sitting in an air-conditioned reception area of a treatment program's admissions office, one begins to wonder how many of those in the room are just there to evade the heat and humidity. Soon a staff member invites everyone to present their bags for inspection before boarding the van that will convey them to their treatment program. Few in need of treatment get to this cool and quiet place where only one more obstacle could keep them from a seat on the van and a bed in a treatment program-- have they packed according to instructions and left out of the bag all the disallowed items? Getting here was quite an ordeal for most of the five individuals (four men, one woman) entering treatment today. Others expected to join them but they were not able to get on the van; not because of what they packed, but because they failed to overcome a number of obstacles – personal, financial, bureaucratic, and logistical—that stand in the way of getting in the van, even when a space awaits them in a treatment program.

We spoke with staff at this New York admissions office and others around the country about the details of actually gaining entry for an applicant who has been approved for admission into treatment. Their stories shed new light on the problem of filling the treatment gap. While policymakers call for expanding treatment services and increased funding is being made available in many sectors, admissions have not been

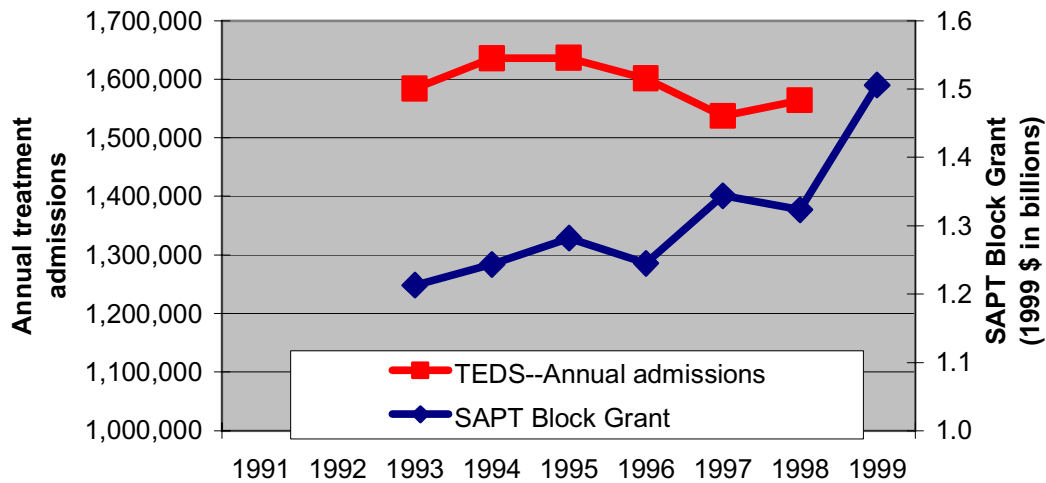
rising in many places and in many programs. From the perspective of admissions counselors, the devil is, as usual, in the details.

Expanding Capacity Without Increasing Utilization.

Not only do we know that need for treatment far exceeds utilization (Woodward, et al., 1997; Gfroerrer and Brodsky, 1993), and that treatment on demand is far from a reality (Wenger and Rosenbaum, 1994), but also that treatment services are effective in reducing drug use and the consequences of drug use, such as crime and unemployment (NIJ; NORC.) So it is not surprising that expanding treatment has become a goal of many who observe the consequences of addiction and drug abuse. The Office of National Drug Control Policy requested an increase in federal treatment funding for the 12th consecutive year¹ and, as shown in Figure 1, federal Block Grant funding has increased. Other sources of treatment funding have also increased. Welfare reform laws in several states call for providing treatment to mothers whose alcohol and drug problems pose barriers to obtaining or retaining work and leaving the welfare roles (California Statutes, AB 1542, 8/11/97). Prison programs across the country are contracting with treatment providers to expand the availability of treatment for drug-addicted inmates. California increased in-prison treatment capacity from 400 beds in 1996 to 3,000 in 1999 and plans to increase capacity to 5,000 by 2002 (Clavecilla & Lowe, 1999). Finally, schools, community organizations, and juvenile justice officials are shifting priority to obtaining additional funding for treating adolescent drug abusers (Santa Barbara Fighting Back, 1999).

At the same time, some treatment providers indicate that they sometimes operate below capacity and have space waiting for clients who supposedly have priority for

treatment (e.g., welfare mothers) (Klerman et al., 2001). Nationally, admissions to treatment programs have not increased. Figure 1 shows the downturn in admissions in recent years while the Substance Abuse Prevention and Treatment Block Grant funding increased. Current data on admissions are not yet available, but comparing funding and admissions for the years between 1993 and 1998, public spending increased by 24 percent while admissions admitted to programs receiving public funding decreased by 1.2 percent.



Sources: Rice, 2000; SAMHSA, 1999B

Figure 1

While many in need of treatment fail to seek treatment, others apply and meet a number of barriers that preclude their entry. For example, many programs do not accept women with children, the dually diagnosed, those with a history of violence, and those without insurance or public subsidy. In addition, it is common to have clients, who have been accepted to enter treatment, fail to arrive at the appointed time and place to be admitted. One analysis documents that almost half of applicants approved for admission

¹ Although the increases are only slightly greater than the level of inflation.

did not enter the program for which they were accepted (Farley & Ebener, 1998). If more were understood about the reasons why this group fails to attend after being accepted, interventions might be designed to facilitate their admission. This is the question that Phoenix House asked RAND to address when preliminary analyses showed that many fail to enter after being accepted for treatment.

Types of Barriers

Much of the research on barriers primarily focuses on in-treatment populations, not on those failing to enter treatment (see Farabee, Leukefeld, and Hayes, 1998 for a brief analysis). However, Farabee and colleagues (1998) recently interviewed 2,600 out-of-treatment injection drug users who attempted and failed to enter treatment in the past year. They found that program barriers were more prevalent than individual barriers, but the latter were still significant. Stasiewicz and Stalker's (1999) recent discussion of pretreatment dropout rates and Hser, Maglione, Polinsky, and Anglin's (1998) analysis to predict treatment entry also focused on these barriers. Hser et al. (1998) conclude that "structural barriers to treatment access (whether real or perceived) also need to be examined. . . . [A]ttention is needed to address issues such as eligibility criteria, waiting list alternatives, and transportation" (219; parentheses in original).

Our research took a different approach by focusing only on what obstacles arise after a candidate is approved to enter a program. It seemed to us that frontline workers in the business of admitting treatment clients would have an interesting perspective on these problems. Bringing their experience to the fore might help treatment providers and policy makers mitigate the inter-organizational and programmatic barriers that in turn

would increase entry and alter the perceptions candidates have about gaining access to treatment.

With the encouragement of Phoenix House managers, we conducted 30 interviews within their organization, including managers of admissions offices and 18 admissions counselors for 20 programs in three states. The interviews included specific discussions about adolescents and adults (over 50 cases) that were approved for admission but did not enter.

As others have shown, the interviewees listed a variety of problems that interfere with moving someone directly into a treatment slot. Personal reasons unknown to the admissions counselor and lack of space in a program at the time it is needed were often mentioned but we also learned about how the interaction of provider and referring or payor agency policies can create additional obstacles that candidates need to overcome before they can gain admission. These activities, such as obtaining proof of identification, closing an existing welfare case, or obtaining approval from referring agencies often involve other agencies which lack staff or incentives to expedite such needs for would be treatment admissions. The problems counselors told us about varied by type of admission candidate. Here we describe what we learned is necessary for welfare recipients in New York, parolees leaving prison in California, and adolescents in California, New York, and Texas to accomplish after acceptance and before admission to treatment.

Welfare Recipients in New York: Paperwork

Federal and state welfare reforms acknowledge the role of substance abuse in causing and exacerbating other barriers to employment and some reforms included new

funding to provide treatment for welfare recipients. Unfortunately implementing such programs has gone poorly. In California, for example, much of the new funding to provide treatment has gone unspent. A recent report by the Legal Action Center (1999) suggests that few welfare workers are trained to screen for substance abuse disorders; contributing to why referrals are considerably lower than estimated need for treatment in this population. Further exogenous barriers include unwillingness of welfare clients to disclose their drug use to welfare workers, little coordination with existing treatment networks, and the lack of outreach to addicts and alcoholics among this population. One program for women with children in New York noted that several years into welfare reform its phones hardly ever rang with referrals from the welfare department. But for those that are referred and approved to enter a treatment program, there are still barriers that make entry difficult, if not impossible.

In theory, funding is not a problem for those seeking treatment in New York City. The state welfare Home Relief program pays an eligible client's welfare benefit to a treatment provider to cover costs of treatment. Those who are not currently receiving welfare, but qualify for assistance, can have a case opened for them by their treatment program; however, this can be difficult. The treatment program must prove that a client is a legal resident in order to secure funding. This sometimes means that the admissions office must send an accepted applicant away to obtain proof of residency from immigration officials. The program must also provide two pieces of identification to open a welfare case for a new admission and often applicants approved for treatment have none (having lost, sold or had it stolen). The treatment program cannot accept them without funding to cover their treatment so candidates must make a visit to the social

security office before entering treatment to obtain a verification of their identification suitable for opening a welfare case. Some embark on this mission, but never return to the treatment admissions office. Whether they were denied the necessary documents, encountered problems, or scored drugs and had a “change of heart” before reaching their destination, the counselors never know.

Accessing welfare dollars to pay for treatment for someone already on welfare is more complicated. The welfare recipient must close their existing case (in person, at the office where they originally opened that case) and then the treatment program can apply for a new case that will pay the welfare benefit to the treatment provider to cover the client’s housing and other costs. Counsellors described to us the following scenario:

A crack-addicted woman is convinced by her family to enter a residential program. She contacts a provider and is to be assessed the next day. The woman is successfully assessed but she cannot enter the program until she closes her current welfare case. To do this she must visit the welfare office where she originally opened the case (which could have been years ago) to have a welfare caseworker sign the M-3e, the form acknowledging a change in benefits, in this case termination². The woman is able to find a way to the welfare office the next day but is overwhelmed by the New York City welfare office congestion and confusing protocol. After waiting a few hours before speaking with someone, the candidate is dependent on the knowledge and efficiency of the case-worker. If the caseworker is having a good day she can be out of the welfare office in 20 minutes; this apparently isn’t the norm. According to counselors who sometimes receive calls from frustrated candidates at the welfare office, there is no one to expedite this process and this candidate is been turned away at the end of the work day

without having the M-3e signed. It has now been three days since she first inquired about treatment and the woman may not return next day to get the M-3e signed and cannot enter the treatment program without it. The “treatment window” may have closed and this candidate is likely to be using again.

But the M-3e situation in New York wasn’t always this way. Prior to welfare reform, treatment providers could call the welfare office and take care of the situation on the phone between the two organizations; there was no need for the candidate to go through bureaucratic hoops. The reason for the change in procedure was not clear to admissions counselors but they could readily suggest an easier path. The change in procedure was no doubt necessitated by sound regulatory policy on the part of welfare and fiscal policy on the part of programs but it resulted in a new obstacle to treatment entry for a population that is meant to have increased priority for treatment.

Admissions counselors try to help overcome such obstacles as getting identification verification and paperwork signed. For example, they provide the form that clients need to have signed and they give directions and instructions on how to accomplish the tasks. But they are strapped for time and often cannot follow-up and don’t pursue the candidates who fail to return. Next day they have another group of clients to assess, encourage and instruct in how to overcome barriers to gaining entry to treatment.

Criminal Offenders in California: Need for Incentives

It is estimated that 75% of state inmates and 31% of federal inmates need substance abuse treatment (CASA, 1998). While the number of in-prison treatment (IPT) beds available for prisoners is increasing, new studies suggest that the effects of this

² Further steps may be necessary if the woman has children who are part of her welfare case.

treatment will diminish unless the inmates receive additional treatment in the community (CBT) (Martin, Butzin, Saum, & Inciardi, 1999; Wexler, Melnick, Lowe, & Peters, 1999). Research in California demonstrated that those who complete CBT upon release from prison have lower rates of reincarceration than those who complete only IPT.

Some states mandate that individuals paroled from IPT enter CBT; some states and federal programs (TRIAD) have programs where inmates enter CBT as part of an early release program; and some states only encourage IPT participants to enter CBT. The states that offer some incentive at least accomplish the entry of inmates into CBT. For example, programs that make CBT a condition of parole or offer early release in exchange for CBT participation for IPT participants have nearly 100% uptake rates (Martin et al., 1999; New York Department of Correctional Services, 1999). Programs that do not provide incentives or mandate CBT, such as the Amity continuum in California, have uptake rates closer to 30%-40% (Clavecilla & Lowe, 1999). According to an evaluation of the Amity program, by three years after release the benefits of IPT washed out for the 60%-70% of the IPT completers who did not enter CBT. Their 36-month re-incarceration rate of 78% equaled that of parolees who did not receive IPT.

Treatment counselors we spoke with at the IPT operated by Phoenix House at Corcoran prison in California know the value added of CBT and are very motivated to help their IPT program participants transition to CBT upon release on parole. Transitional counselors are assigned to this task. As the figures above indicate, their job is difficult. Counselors reported that all the incentives are in the wrong direction. Upon release on parole they say most inmates are highly motivated to reunite with family and friends and to escape from the restrictions that prison placed on their lives. Some are

motivated to seek out prostitutes in parts of communities where access to drugs is also easy to come by. Few want to enter drug treatment, especially residential drug treatment immediately upon release. While admissions dates are usually a few days after prison release, pre-CBT activities often take the parolees to drug-plagued neighborhoods or put them in contact with former drug associates—making treatment a less attractive option. Because CBT is voluntary in California most parolees don't make the transition.

IPT transitional counselors, case managers and CBT admissions counselors work tirelessly to encourage inmates to enter CBT immediately upon release. Strategies range from including education about the benefits of CBT throughout the course of IPT, having CBT fairs, conducting encounter groups for those who refuse CBT, and arranging transportation from the prison directly to the CBT program. While results are less than satisfying, transition counselors offered suggestions that might help improve rates of uptake. They believe that family members could be helpful if they knew more about transitional CBT. They also suggested that graduates of CBT should be allowed to return to the prisons to help motivate uptake of CBT among inmates nearing parole dates. They also believe that greater motivation, e.g. in the form of early release from prison custody, or mandatory treatment participation, is required to boost the rate of uptake of CBT after IPT. It may also be that the transitional counselors, placement case managers, CBT admissions counselors and parole officers need more resources to work with these inmates *after* they are released, when many with intentions to enter CBT lose their motivation. As it is now, no one has responsibility for outreach to the inmates who fail to attend the CBT treatment programs they are assigned to.

A different type of barrier for parolees is that in some regions there is a waiting list for parolees seeking CBT. Although there may be beds available at a CBT facility, they are earmarked for non-criminal justice funding sources. Some facilities have slots reserved for residents receiving welfare, for which only some parolees can qualify. However, in most states drug felons are now barred from welfare eligibility. Thus, convicted robbers and other felons could fill the General Relief slot at a CBT facility—but not the person incarcerated for a felony drug offense who has been attending an IPT program at state expense.

Adolescent treatment: Availability and Coordination

Despite national reports that monthly teen drug use is decreasing (Johnston et al., 1999; SAMHSA, 1999a), the number of adolescents entering treatment continues to increase (SAMHSA, 1999b). A recent report by California’s Legislative Analyst’s Office (LAO; 1999) suggests that only 10% of California adolescents needing treatment receive it (comparable figure for adults is 17%). The barriers facing adolescents requiring treatment are so significant the LAO recommended that the California Department of Alcohol and Drug Programs: “Identify Effective Treatment Models and Strategies to Overcome Barriers to Treatment of Adolescents.”³ There is little reason to believe the situation is much better in other states.

In February 1995, the American Academy of Pediatrics (AAP) released a policy statement on adolescent treatment arguing that private insurers, as well as Medicaid, do not cover the services appropriate for adolescent populations. Adolescents are a special population, often requiring more than substance abuse treatment. Services for teens are

³ It is important to note the LAO only made two recommendations. The other: Develop Short-Term and Long-Term Statewide Plans to Address the Need for Treatment Services.

very costly and many who gain entry do so only with funding from a juvenile justice or mental health agency with which they are already involved. One counselor in California told us that some parents have requested the juvenile court to place their child under court jurisdiction so that they would qualify for treatment funding and be able to gain entry.

Although the AAP advocates for universal coverage for substance abuse treatment, this does not equate to universal access. As mentioned earlier, there are sometimes only a limited number of slots available for adolescents who have no insurance or funding from a referring agency.⁴ More than one admissions staffer with Phoenix House told us that it is much harder to get an adolescent into treatment who is not in the juvenile justice system. They reported frustration with a system that forces them to turn away or wait list adolescents without funding, while beds dedicated to a particular funding stream are empty. Among the cases we reviewed it seemed that few who had been placed on wait lists eventually entered treatment. Instead, in most cases, either the parent or the adolescent had a change of heart during the waiting period.

For those in the juvenile justice system needing treatment there are often interagency (systemic) barriers making treatment entry more difficult. Treatment providers, judges, probation officers and families need to coordinate to obtain approvals, permission and admission in a timely manner. Counselors say that probation officers, who are under pressure to reduce their caseloads in juvenile halls as soon as possible, will refer adolescents who are inappropriate for a particular program or refer without convincing the adolescent why they need a particular type of treatment. On the other hand, probation officers sometimes “shop” for programs, making the adolescent available

for multiple interviews by multiple agencies. While it is better to be safe than sorry, superfluous referrals detract counselors from assessing potentially better candidates.⁵

This is especially taxing for facilities with only one adolescent admissions counselor.

But if court and probation officials and providers are to coordinate, mutual information sharing and education about needs and services is an important task that also often falls on the admissions office. While counselors reported that they had very successful working relationships with many probation officers, they recognized that greater outreach with juvenile justice officials was sorely needed. In one program in New York City, treatment program staff are placed in the courthouse to receive referrals directly from officials and to do outreach with inmates.

For adolescents approved to enter a program, there is the additional problem of acquiring parental consent before entry. It is sometimes difficult to contact family members who can sign the appropriate forms required by treatment providers. And contact does not mean the family member will comply. Some families are reliant on the additional social security and/or welfare funds they receive for their dependents and do not want to lose that money (these funds are transferred to the treatment provider to defer costs), even if the opportunity cost is the child's treatment. Thus, they will not sign the consent forms. The early emancipation process which would waive parental consent is not a viable option in many states. The alternative of making repeated efforts to inform and educate and meet the needs of parents is one that admissions counselors' workloads

⁴ At the time of our interviews capacity expansion had recently begun in the Texas and San Diego California adolescent programs due to increased public funding for adolescent treatment. This was not the case in Los Angeles.

⁵ Assessment is an all-encompassing term and a very timely process. In most cases it includes driving to juvenile hall (sometimes in a different county), interviewing the candidate, assessing the candidate, confirming decision with admissions coordinator, contacting the probation officer and arranging induction or referring the client to another treatment provider (the latter is required by law).

rarely permit time for. One told us that getting one adolescent admitted to treatment can often require convincing two people to enter treatment – first the teen in need of treatment and then the parent whose consent is needed.

Permeating the Barriers to Treatment

The systemic barriers described above are mitigating the mandates to increase treatment utilization set forth by various government programs and are keeping a significant number of substance abusers, who have already asked for help, from gaining entry to treatment. These examples from the front lines suggest that changes and improvements are needed and focus attention on the problems of competing institutional goals among interdependent organizations and the need for inter-organizational solutions. They also point to the need for better understanding of the complex functions that admissions offices perform and the trade-offs they sometimes face between assessing the next applicant and facilitating entry for the approved candidate for treatment. Further, it is clear that solutions should be guided by a better understanding of how treatment seekers' motivation and readiness for treatment may change in the face of added delays and obstacles to gaining entry.

Admissions counselors offered many suggestions for overcoming obstacles to treatment entry. In the case of welfare applicants in New York they would like to see a return to the time when their organization and the welfare department arranged for treatment payment without involving the client in the arduous, bureaucratic steps now required. Phoenix House and the New York welfare agency might negotiate a more flexible mutually satisfactory process. In the case of parolees in California the counselors would like to see a policy change that would increase parolees' incentives to

enter community treatment upon leaving prison. Such a change would require an extended policy debate at the state level that could be informed by comparative analyses of treatment cost effectiveness under early release, mandatory and voluntary community corrections treatment models. In the meantime programmatic changes (such as increase family member education about the benefits of entering community based treatment) could be tested and evaluated to determine their impact on admission rates. In the case of barriers to adolescent admissions, it was clear that funding from the juvenile justice system is the primary source for payment and those without this involvement are less likely to find available space in treatment programs. Where the funding is available, the counselors could identify several options for improving the coordination between probation and the provider to move adolescents into treatment more quickly. But it is not clear what impacts such changes would have on Phoenix House admissions or the agencies they receive referrals from.

With regard to policy initiatives to expand treatment, it seems clear now that it takes more than a mandate to increase treatment utilization. Careful attention to program implementation strategies and barriers that might be created along the way seems warranted. Planners might ask what incentives and disincentives their programs provide for drug users. They might also consider their track record for offering services to overcome barriers and ask whether another partner agency might be able to boost their likely outcomes. Planners in the future might anticipate low uptake and focus more on outreach efforts into new funding and capacity expansion. Certainly this is an approach that California counties have adopted in the wake of evidence that welfare recipients

were not self-disclosing and workers were not screening expected candidates for treatment.

Demonstrations and experiments could shed further light on which strategies are most cost-effective. Gaming techniques could also be used to shed light on the strengths and weaknesses of different perspectives and how they might be better coordinated.

What immediate steps could Phoenix House and other treatment programs take to boost admission among candidates accepted for treatment? It isn't clear from our small study how they might respond to the obstacles identified. After all, some candidates for treatment manage to overcome whatever obstacles are presented. Those who fail may simply be poor candidates for treatment. Some clinicians argue that accomplishing such pre-treatment tasks as chasing down welfare paperwork and obtaining proper identification are indicators of readiness for treatment. Those who fall through the cracks should not have been accepted in the first place. To test this theory, it might be informative to select a group of accepted applicants who face these obstacles and assist some of them while leaving others to their own resources and measure differences in rates of entry and treatment outcomes for the two groups. After all, it would be costly for treatment programs to add staff to admissions for follow-up outreach when other clinical areas are also typically short of staff. Such an experiment seems worthwhile because every program that assesses a candidate for treatment, finds a slot, and makes arrangement for admission already has a significant investment in a candidate. Helping to eliminate the final set of barriers might be a cost effective strategy.

At a minimum, treatment providers might become more informed about what happens to those who are accepted but fail to enter their programs. Systematic follow-up

by admissions staff might reveal additional barriers, but also inform program management about needed interventions, such as eliminating the bureaucratic maze associated with obtaining funding. Closer collaboration with referring agencies would be required to implement some of the resulting solutions.

Finally, admissions staff have their share of rewarding and disappointing moments. They must balance the competing demands of those awaiting assessment and those approved for treatment admission. It seems that increased training and support of these staff could help boost sometimes flagging morale and increasing frustration.

The role of admissions counselors in obtaining treatment admissions is a critical yet little understood component in the process of treatment access. Based on our small scale study the role of admissions counselors' merits further attention from treatment services researchers.

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