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Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users

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Abstract

Many substance users report that they experience multiple barriers that produce significant challenges to linking with treatment services. Being on a waiting list is frequently mentioned as a barrier, leading some people to give up on treatment and to continue using, while prompting others to view sobriety during the waiting period as proof they do not need treatment. This ethnographic study examines the views that 52 substance users have of the waiting time before treatment and the strategies they created to overcome it. Understanding how substance users react to waiting time itself and in relation to other barriers can lead to services that are effective in encouraging treatment linkage.

Introduction

Participation in treatment has generally been associated with positive outcomes among substance users (McLellan et al., 1994). To achieve these benefits, however, it is important that substance users enter treatment in the first place, a significant problem in many settings. The waiting period (including being on a program generated waiting list) is often listed among the most common barriers for those seeking treatment (Appel, Ellison, Jansky, & Oldak, 2004; Farabee, Leukefeld, & Hayes, 1998). Typically, the longer substance users have to wait to be admitted to treatment, the more likely they are to not follow through with treatment. (Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Hser, Maglione, Polinsky, & Anglin, 1998).

The relationship between waiting time and treatment linkage (first attendance) has been fairly consistent. Offering a treatment appointment date immediately (Stark, Campbell, & Brinkerhoff, 1990) and reminding clients of their initial scheduled appointment usually improves the rate at which clients will begin treatment (Gariti et al., 1995). Festinger and colleagues (1995) proposed that the first 24 hours after a client's initial phone contact is a critical period in initiating treatment. One possible reason may be that clients are often in crisis when contacting the agency. Another possibility is that clients may have only temporarily overcome internal or external barriers to treatment.

Studies evaluating the impact of waiting times on retention and on treatment outcomes have not been consistent in their findings. There is little evidence that either reduced waiting times increase retention or that longer waiting times would be associated with higher client motivation (Addenbrooke & Rathod, 1990; Best et al., 2002)

Many individuals on a waiting list attempt to reduce substance use in association with their decision to seek treatment. Being placed on a waiting list raises many second thoughts for clients about the willingness, if not the capacity, of treatment services to provide the support they need. Besides, Brown, Hickey, Chung, Craig, and Jaffe (1989) demonstrated that waiting for long periods without receiving some form of treatment is associated with decreased functioning, an increase in criminal justice involvement, and decreased motivation for undergoing treatment.

Since waiting time before treatment entry is generally a result of organizational factors, such as a shortage of staff, many interventions designed to reduce waiting time are targeted to system factors (Festinger et al., 1995; Stasiewicz & Stalker, 1999). As an example, centralized assessment and referral services that accelerate treatment entry and ensure that participants entered the appropriate treatment have been part of a comprehensive system intervention. This centralized intake unit (CIU) approach has been applied in a variety of locations and ways since the 1970s. The rationale behind this approach, as operationalized in the Target Cities Demonstration Program, is that more efficient treatment systems make better use of existing treatment capacity, thereby increasing access (Stephens, Scott, & Muck, 2003). In the St. Louis Target City site, participants who had a shorter wait between assessment at the CIU and their initial treatment appointment were more likely to show up for their treatment appointment. Longer delays before admission to treatment were also associated with increased dropout rates after admission (Claus & Kindleberger, 2002).

Since the 1980s, another strategy to improve accessibility has been the “treatment on demand” adopted by a number of cities in the late 1990s, including Baltimore, Sacramento, San Diego, and San Francisco (Guydish et al., 2000). Treatment on demand makes treatment available as soon as the substance abuser expresses readiness and in this way increases availability of publicly funded drug abuse treatment. Timely access is crucial because many substance users are ambivalent about seeking treatment, have little tolerance for waiting, and will continue to use drugs while on waiting lists. Treatment on demand requires treatment capacity sufficient to minimize waiting lists; however, current capacity is considered inadequate to meet need in the United States (Friedmann, Lemon, Stein, & D’Aunno, 2003; Guydish & Muck, 1999).

Interim methadone maintenance has been tested as a rapid intake alternative for heroin addicts waiting for treatment. The retention rates of this rapid intake procedure were compared to the retention rates of clients admitted directly to the regular methadone clinic (Yancovitz et al., 1991; Friedmann et al., 1994). For instance, Bell, Caplehorn, and McNeil (1994) found that heroin addicts entering methadone maintenance after a wait of up to eight weeks were more likely to be discharged or drop out of treatment when compared to a sample of rapid intake clients who commenced treatment the same day as initial assessment. Dennis, Ingram, Burks, and Rachal (1994) evaluated the impact of increasing publicly funded treatment in relation to demand. They concluded that when more methadone treatment is available on demand, the number of people requesting intake appointments increases.

Substance Users’ Perceptions

The perceptions that substance users have about waiting time have been described in qualitative studies of treatment barriers. For instance, Porter (1999) found that Puerto Rican long-term heroin injectors identified cultural, structural, and personal barriers to treatment entry. The waiting period to get into treatment initially and between detoxifications and “rehab” was described as a major structural barrier that affected all heroin injectors. In another study, Wenger and Rosenbaum (1994) advocated the necessity of treatment on demand after analyzing the life histories of heroin addicts who were seeking methadone maintenance. The authors included waiting list experiences among the major treatment barriers and described the impact of all these barriers on substance use, substance-using behavior, and the emotional well-

being of heroin addicts. There is a lack of qualitative studies that focus exclusively on the effects of the waiting time on treatment entry and engagement.

The purpose of this paper is to describe how waiting time is perceived by substance users assessed and referred by a centralized intake unit in the Midwest. For these substance users, waiting time includes the period before assessment and referral and after the referral is made. The post-referral period may include time on a treatment program's waiting list. The study is based on qualitative interviews and focus groups conducted with a total of 52 substance users who were waiting to get into treatment. Qualitative methods were selected because they can provide an in-depth understanding of the perspectives of substance users, which have been largely ignored in most reported studies on treatment entry and engagement (Tsogia, Copello, & Orford, 2001; Carlson, 2006). This paper will address two research questions: How do people with substance abuse problems perceive and cope with two periods of waiting time? What strategies do substance abusers use to cope with waiting time? In this study substance abusers had to wait before being assessed at a centralized intake unit and then again after the assessment when they were referred to treatment.

Methods

The paper is based on qualitative interviews and focus groups conducted as part of the Reducing Barriers to Drug Abuse Treatment Services Project (RBP), a five-year study funded by the National Institute on Drug Abuse. The RBP is a three arm clinical trial designed to assess the effectiveness of strengths based case management and motivational interviewing, relative to a standard referral process, in linking clients with treatment services and subsequently engaging them in services (Burke, Arkowitz, & Menchola, 2003; Rapp et al., 2006; Siegal, Li, & Rapp, 2002). This paper focuses on the waiting period as a barrier to treatment for those clients who were participating in the clinical trial. Eligible participants were (a) over 18 years of age, (b) diagnosed as having a substance abuse and or dependence disorder using criteria from the Diagnostic and Statistical Manual (DSM-IVR)(American Psychiatric Association, 2001), (c) not suffering from schizophrenia or any other psychotic disorder, and (d) referred to either residential or outpatient substance abuse services. Alcohol abusing or alcohol dependent individuals without other substance disorders were not eligible.

The RBP is located in a centralized intake unit (CIU) in a Midwestern region with a county population of 552,000 according to the 2000 census. Any person who wants to enter substance abuse or mental health treatment must be assessed at the CIU. Substance abusers may experience a waiting period before the assessment and then again once they are referred to a treatment program. Assessment therapists conduct psychosocial, mental health, and substance abuse assessments to determine the nature and extent of clients' problems. Clients are referred to an appropriate level of care within the community treatment system based on American Society for Addiction Medicine criteria (American Society of Addiction Medicine, 2001) and situational factors such as treatment availability and client preference. Referrals are made to eight state-certified, specialty substance abuse treatment programs. Clients generally do not contact the treatment program immediately after the assessment, but must wait to get a specific date from the CIU. Notification of the treatment date may occur several days to over a week after the assessment. Clients who are admitted to the trial are randomized into either the standard services provided by the CIU while awaiting substance abuse treatment or one of the clinical trial's two experimental arms. During the 60 days after recruitment, clients received up to five sessions of strengths based case management (Rapp, 2006) or one session of motivational interviewing (Miller, Rollnick, & Conforti, 2002). The study seeks to determine whether one or both of the interventions will increase the likelihood that clients will link with and more fully engage in treatment services.

The project ethnographer (first author) selected a convenience sample from the clinical trial population attempting to diversify the sample in terms of gender, ethnicity, age, and primary substance used. Audiotape-recorded interviews averaging 90 minutes were conducted by the project ethnographer at the CIU. The interview protocol covered history of substance use, abstinence, help-seeking attempts, history of substance abuse treatment, barriers to treatment, treatment engagement, and interactions with health services and study interventions. Two focus groups were also conducted to explore the range of views and opinions clients expressed regarding one of the study's interventions, although barriers to treatment were also discussed. For each qualitative interview or focus group clients were compensated \$20 for their time. Participants completed an informed consent form approved by the University's Institutional Review Board. Participants were given fictitious names to protect their anonymity. The real name of the centralized intake unit was often mentioned in participants' narratives; however, to preserve confidentiality, "CIU" was substituted for the real name. Specific treatment programs are not named; they are indicated by capital letters.

Audiotapes of qualitative interviews, and focus groups were transcribed verbatim and then coded by the project ethnographer using Nvivo®, a program designed for qualitative data analysis (Richards, 1999). Research codes for predefined and emergent categories were generated to index segments of text that referred to specific themes. This process is called open coding in the grounded theory approach to the analysis of ethnographic data (Fielding & Lee, 1998; Glaser & Strauss, 1967; Strauss & Corbin, 1998). For example, open codes identifying sections of text in which clients discussed barriers to treatment were coded as *barriers*. This coding system was subdivided into more specific codes for barriers like *waiting*, *job as barrier*, *self as barrier*, and so forth. Afterwards, open codes pertaining to specific themes of interest were searched, compared, and then summarized.

Results

Characteristics of Study Participants

Thirty-three men (63.5%) and nineteen women (36.5%) who participated in the larger clinical trial agreed to participate in either a qualitative interview (43) or focus group (14), while five of these participants participated in both. In reference to the three arms of the clinical trial, 26 participants (50%) were enrolled in strengths based case management, 14 participants (26.9%) were enrolled in motivational interviewing, and the remaining 12 participants (23.1%) were in the control group. Qualitative interviews took place in a private office at the CIU between May 2004 and February 2005. The two focus groups made up of case management participants occurred in January 2005.

The average age of participants was 37.8 years (SD = 10.7). Twenty-nine of the 52 study participants were White (55.8%), 22(42.3%) were African American, and one participant was Native American. Regarding marital status, 50.0% (26) were single, 44.2% (23) were separated, divorced, or widowed, and 5.7% (3) were married or living as married. Twenty (38.5%) participants had completed high school or received a GED, 14 (26.9%) participants had some college education, and the remaining 18 participants (34.6%) had less than high school education. During the six months prior to the CIU assessment, 53.9% (28) were unemployed, and most participants either lived with family (50%) or were homeless (26.9%) at the time of the assessment.

The most frequently mentioned drugs of choice were crack or powdered cocaine 63.5% of the participants (33), 30.7% of participants (16) preferred heroin and/or nonprescribed opiates, and the remaining 5.8% (3) preferred marijuana. The majority of the participants, 75% (39) had previously attended some form of substance abuse treatment. Of those, 25% (13) had one treatment episode, and 50% (26) had multiple treatment episodes. Twenty-two participants

(42.3%) had attended treatment within the past two years. Thirteen (25 %) participants had no previous treatment experience. Seventeen participants (32.7%) were attending Alcoholics Anonymous or another self-help meeting during the month prior to the CIU assessment, and 14 of them mentioned that these self-help-meetings were often/always helpful.

Referral sources to the CIU included 46.0% (24) who arrived at the CIU on their own initiative, 21.2% (11) who were court ordered for the CIU assessment, 11.6% (six) who were initially referred for assessment by another health care provider, and 9.6% (five) who contacted the CIU because of family or friends. The remaining 11.6% (six) were referred by a homeless shelter or by children services. For twenty-one participants (40.4%), this was their first CIU assessment; for 19 participants (36.5%), this was the second CIU assessment; and the remaining 12 participants (23.1%) had attended a CIU assessment three or more times.

When participants called the CIU, 28.8% (15) came for an appointment within 24 hours, 19.2% (10) had to wait 48 hours, 40.4% (21) waited between three and seven days, while 11.5% (six) waited more than one week. The time participants spent in the CIU for the assessment lasted an average of 126 minutes ($SD = 79.7$). Thirty-two participants (61.5%) linked with a treatment provider within 90 days. The average waiting time before treatment entry for those who linked with treatment was 42.6 days ($SD = 29.1$), with a median of 40 days.

Waiting Time as a Barrier to Treatment Entry

More than half of the participants, twenty eight (53.8%), have emphasized waiting time as a significant barrier to treatment entry. Most of them discussed negative perceptions about waiting time. Likewise, no particular trend was noted regarding these negative perceptions of waiting time in relation to cohort factors that might influence participants' perceptions. For instance, crack/cocaine users complained about waiting time in the same ways that heroin users did. Differences in previous treatment experience and previous participation in self-help groups did not influence the ways participants talked about waiting time because they all wanted immediate treatment entry.

Participants discussed three major themes relative to waiting time. First, they talked about the waiting that occurred between calling for an assessment appointment and actually receiving the assessment. They also identified the second period of waiting, after assessment but before treatment entry, as a barrier. The strategies they created to cope with the waiting time was also a major theme in their narratives.

Waiting Time Before Assessment

During qualitative interviews many participants spontaneously commented on the waiting time they were experiencing before getting into treatment. Lilian, a 19-year-old White female heroin user was becoming confused with the waiting time after the CIU assessment and referral since she was court ordered to treatment. She stated:

The CIU is my barrier. These people are throwing me around, insurance, my probation officer, they all just saying different stuff, and I just want help. Why can't I get help? It's frustrating me, because my probation officer said you need to get into treatment soon.

Lilian was getting so impatient with the wait that she took the initiative to call several physicians to find a place where she could be "detoxed" from heroin. She said:

I don't know what the heck I'm supposed to do. I'm at my house, calling doctors trying to get admitted to 'detox.' I shouldn't have to do that. That should be set up through here. If they want me 'detoxed', if they want me in 'rehab,' they need to send me.

Paul, a 26-year-old White man who was a heavy drinker and crack user, wanted very badly to be detoxified from alcohol, which he believed was his biggest addiction:

I went to the hospital, somebody told my dad I should and they took me there. Sat there for eight hours and finally the guy said they couldn't accept me because I didn't have insurance. So they sent me here to the CIU.

In this case the CIU itself was perceived as a barrier because the participant had to wait longer for treatment since he had first to be referred through the CIU due to lack of health insurance. From a broader perspective, if the CIU did not exist, substance users with no health insurance would have a harder time receiving any substance abuse treatment.

A few participants perceived the CIU as a barrier because they preferred to be detoxified in the hospital first and then fast-tracked to treatment, instead of being assessed and referred by the CIU. Ted, a 51-year-old White male heroin user who was treated in methadone clinics multiple times before, commented:

People come out of the hospital and get fast tracked, they come down (to the methadone clinic) and get their dose the first day, but they have to go in the hospital and come through that route otherwise you have to wait two to three weeks. As soon as you come down here (CIU) and apply to get in the methadone clinic, within 72 hours they should be medicating you, while you're taking care, of all you're paperwork, while you're getting your blood work done. They should be dosing you that whole time, so you can be off the street, that's the number one priority!

Participants did not always agree with the treatment referral they received, and this often caused a longer waiting time. Several participants demanded a level of care change because they preferred another treatment modality (e.g. residential instead of outpatient) or another treatment program altogether. In short, participants perceived the referral itself as a barrier that forced them to wait longer before getting into preferred treatment. For instance, Victoria, a 30-year-old White woman who abused Vicodin® expressed her unhappiness with the pre-intake procedures of the methadone clinic. For this reason she managed to convince the CIU assessor to change the level of care to a regular outpatient treatment program:

I'm not sure how this methadone thing works. I don't want the methadone! She was like "well I don't have the time to tell you about it." What if I did need the methadone? What are these people supposed to do, if they go for the urine drop and then not until three weeks later can they start the methadone dosage. What do they do in between? I mean, they're dope sick. That's just not right. I wasn't very happy there, so I came and did a level change.

When participants are not satisfied with the treatment referral they receive, they may also decide not to follow through with treatment. Daniel, a 45-year-old African-American man who abused crack had previously attended a treatment program. He despised the experience because he perceived himself as a "functional addict" and believed that the program to where he was now referred was tailored to heavy drug addicts. Daniel said:

My difficulty was I didn't want to go to that program, and I could do it by myself. I didn't want... they wouldn't let me say where I wanted to go. I told them when they did the assessment "I'm not going." They told me at the second assessment "I was going," I told them "I'm not going!"

A few participants offered constructive criticism regarding the way the system of treatment referral is organized at the CIU. Although all treatment referrals for uninsured clients have to originate from the CIU, it does not have a centralized waiting list. In other words, each treatment program has their own waiting list, and if a client is referred to one treatment program, the

client is not allowed to be on the waiting list of any other program. Sophia, a 36-year-old White woman who used crack commented:

When they assess you, they pick one program, but they have these beds open for women at another program, but you can't be on both waiting lists, and I think that kind of fails. If they had a bed for me at one program ... I could have been there 10 days ago, but they make you go through a whole new assessment down at the CIU, and that would blow my case at the other program.

Waiting Time Before Entering Treatment

Following the waiting time before being assessed at the CIU, participants experienced another wait. They had to wait at least one week before receiving the treatment admission date, a date that could be days or months away because they were being placed on the treatment program's waiting list.

Perceptions of time—Participants repeatedly discussed the meaning that the waiting time held for them. Participants complained that the treatment schedule often did not allow them to join the workforce or conflicted with the job hours of those few who were already working. Besides, those who had a job often worked in shifts or in odd jobs that do not follow the regular work schedule. The fear of losing or not getting a job because of treatment was also mentioned.

Julia, a 35-year-old college educated White woman who smoked crack, was extremely anxious to enter treatment. She said: "I pursued treatment pretty hard, probably for two and a half months, I wrote them (treatment program), and bugged, and nagged them, and didn't get anywhere, until about the time I got the job as a waiter." Julia felt discouraged because now she had to work a few weeks to obtain pay stubs to calculate how much she would have to pay to go to treatment. Since Julia had been completely abstinent during the waiting time, she decided that she was going to quit drugs on her own. But Julia soon lost her job, and the urge to enter treatment resurfaced. However her referral was no longer valid (more than 90 days), and she had to return to the CIU for another assessment. She ran away from home before entering any treatment program.

Several participants alluded to experiencing time differently than normal people did. This gave a stronger connotation to the waiting time they had to experience. Ted, a White male heroin user commented:

The time factor to somebody addicted to heroin, two weeks is like forever to try to wait, when they finally get enough courage to come to the CIU, to get in the methadone clinic, they're desperate! I don't think they (assessors) understand the urgency that the heroin addict feels. Two weeks is life or death!

A similar sense of urgency was also experienced by those who primarily abused crack. Karl, a 37-year-old African-American man who used crack reported: "Being able to go to a drug facility normally has a 90 day waiting period, something like that. An addict can't wait that long, you know what I'm saying ... that causes a lot of problems." One may suspect that those substance users who were homeless also felt a sense of urgency to get into treatment since they had no place to live.

A long waiting time is often associated with "life or death" because participants feared the occurrence of dangerous and extreme consequences to their daily life during this period. As Maurice, a 45-year-old White male crack user stated:

You can't just walk right in and get in (treatment). I don't want to come back next week. Maybe I won't feel like I need help next week. To come back to see if you're telling the truth, you know why wait a week, why wait seven weeks? Maybe I won't

feel that way anymore. You know a lot can happen in a week. I can go right out here and jump out one of these windows, I can go stand on the corner and kill 40 people.

Program rules—In some treatment programs, participants are required to attend pretreatment meetings while they are waiting for treatment to show that they remain motivated. Some participants took this waiting time positively, while others perceived these pretreatment meetings as another barrier. On the one hand, Thomas, a 33-year-old White man who abused crack and alcohol, was very proud that he was not using any drugs while attending pretreatment meetings:

I'm waiting on a bed to open. Yeah, but we have to be there every Friday. Be there and sit in meetings, lets them know that you're serious about going. If I miss a meeting, they're like 'well you really don't care.' This is my first time. So I'll be there every Friday, until they let me go in.

On the other hand, Maurice, a White man, just quit his job so he wouldn't have any money to buy crack. He complained about the pretreatment meetings because he was being referred to a 28 day residential program and during the long waiting period was required to go to pretreatment meetings weekly. Maurice reasoned that it would have been more productive if he was referred to outpatient treatment instead of attending pretreatment meetings. He added that he was currently homeless with no car, job, or money, which made it more difficult for him to wait that long while only going to pretreatment meetings. Maurice also perceived having money as a barrier; if he had still been working he would not have been eligible for subsidized treatment, but he could never have afforded to pay for the residential program with his salary.

Another common barrier to participants was that they were not allowed to enter a treatment program when someone they knew was already attending the program. In this case they had to wait until the acquaintance completed treatment or they were referred to another program. This was very common since participants frequently had intimate relationships with people who shared the same addict lifestyle. Carla, a 39-year-old White woman who abused pain killers and was homeless fell in love with an African American who abused crack: "We were supposed to go in together (treatment program), good thing we didn't. I was supposed to come 'cause I had my date too. And they wouldn't let me come in because they found out we were seeing each other." Katherine, a 25-year-old White woman who snorted heroin and abused OxyContin® was desperately phoning treatment programs in the area because she was not allowed to attend the residential part of the methadone clinic since her boyfriend was already in the program. She was trying to "detox" on her own, but after five days of suffering and dope sickness, her own mother took her to get more heroin to alleviate her suffering.

Strategies to Cope With Waiting Time

Some participants mentioned that they were attending Alcoholic Anonymous (AA) or Narcotic Anonymous (NA) meetings to help them cope with the waiting period. For instance, Mark, a 25-year-old man, had quit drinking for a month but was still using marijuana, until he started to attend AA. He said, "Yep, AA must be doing something 'cause I ain't used no marijuana in about two weeks. I need both AA and treatment. 'Cause you can't be at the treatment program all the time." Besides attending Alcoholic Anonymous, Julia developed an additional strategy to cope with the waiting time. She decided to write a detailed diary and create a scrapbook where she described all her efforts to maintain abstinence from crack, in addition to her struggles, while seeking treatment.

Another strategy participants used was to go on a binge or overdose intentionally in order to get fast tracked to treatment. Brian, a 22-year-old White male heroin user, told the story that three months earlier he went directly to detox in the hospital because he wanted to be fast

tracked to the methadone clinic. However, Brian was immediately referred to the CIU because there were no beds available. Instead of coming to the CIU appointment, he started shooting heroin again. Brian then decided to go on a binge to force his treatment entry: "I did \$200 worth of heroin in less than six hours. The next day I was feeling so sick, I was so bad off, I had a temperature, and that's what got me a bed at the hospital."

Steve, a Native American who abused alcohol, crack, and methamphetamine said that when he wanted to go through treatment quickly, he sometimes used the strategy of getting very drunk, which allowed him a hospital bed for detoxification immediately. Soon after the qualitative interview, Steve became so impatient with the waiting time that he deliberately committed a small offense to go to jail instead, as a way to avoid street drugs and as a substitute for treatment. In this context, some participants lamented that treatment is only available for those who are truly "hitting rock bottom" or for those who were able to convince health professionals they were in a severe crisis, suicidal, homicidal, or close to dying because of bingeing or overdose. No participant was suicidal or homicidal while waiting for the current treatment entry.

Waiting Time and Substance Use

During the waiting period several participants continued using drugs for different reasons. Leah, a 48-year-old White woman who engaged in prostitution to get money for heroin said, "I was supposed to go to the methadone clinic one year ago and just didn't go. Just kept on shooting dope, so I said screw it! The waiting time and the way they do things is retarded." She did not link to treatment this time either. Other participants continued using drugs only while they waited for treatment. For instance, Ned, a 53-year-old African-American man, continued abusing crack before linking to treatment. As he commented, "Still having to use drugs because I'm getting sick every day, and it's been over two weeks. But my mind is still made up on what I got to do, I don't like this waiting." While participants like Leah felt the waiting period was too long, other participants, like Ned, continued to be motivated to go to treatment.

Other participants in preparation for treatment managed to reduce their drug use during the waiting period, like Lilian, a 19-year-old White woman who abused heroin. As she commented, "I'm not trying to get high I'm just trying to maintain, so I'm not ridiculously ill you know all over the house when I don't need to be. Because I'm going to 'rehab', I should have been there already." Additionally, the urgency she was experiencing conflicted with the idleness of the waiting period. She said, "I'm sort of in a 'catch 22' right now, I can't, I can't really do anything, I can't sign up for school, I can't go apply for a job, I can't do anything until they put me into this rehab. So I'm sitting at home not doing anything, they need to get me in this 'rehab'."

Several participants decided to quit using drugs and remain abstinent while waiting for treatment. For instance, Karina, a 24-year-old White single mother of three children who abused heroin and Vicodin® explained: "I just want to stay clean. I am using nothing, I don't want to use anything. I don't want to have four Vicodins® sitting in my purse, just sitting there taunting me. I have people offer me pot, and I've turned it all down. I'm quite proud of myself about that." In some cases, participants maintained abstinence from the drug they considered most problematic, but they still used other drugs. An example was Steve, a Native American who abused crack and alcohol, and stopped using crack while waiting for treatment but continued to drink heavily.

Some participants who became abstinent prior to treatment still believed they needed treatment. For instance, Louise, a 40-year-old African-American woman who abused crack said: "I'm working this out real good so far (abstinence). But, I need the treatment to help me. The treatment is the strong backbone for me. I can do it, but the treatment will help me to stay

stronger.” Other participants who were maintaining abstinence on their own started questioning the need for formal treatment. Wilson, a 36-year-old White heroin/cocaine user was also in doubt about going to treatment after such a long wait said: “I will probably choose the methadone clinic, but if I feel if everything is going fine, they are not going to call tomorrow, but if they call a month from now and I’m still clean, and I ‘m feeling strong, working, I might just not go.” Wilson stayed clean for 78 days before relapsing because, as he notes, “you have nothing, no house, no job, no family, so you might as well get high!”

Discussion

Participants who were a part of this study faced two waiting time periods, one occurring before they were able to get an assessment at the CIU and another once the CIU had referred them to a community treatment program. They identified both periods of waiting as a significant barrier to entering treatment. Learning that they must wait for treatment was a surprise as most participants in this study expected that treatment would be available as soon as they were assessed, very much like what is proposed by treatment on demand initiatives (Friedmann et al., 2003; Donovan, Rosengren, Downey, Cox, & Sloan, 2001; Yancovitz et al., 1991). The finding is particularly important given the observation that up to 50% of substance abusers will drop off a waiting list between initial assessment and treatment entry, and that longer waiting times increase attrition (Stark et al., 1990; Donovan et al., 2001; Festinger et al., 1995; Hser et al., 1998).

Limitations to this study start with a convenience sample drawn from substance users who participated in an assessment. For them waiting time is very relevant. This group may think more about waiting time than those not seeking treatment. We are not able to make inferences about how nonassessed substance users view waiting for treatment entry. As always subject self-report that is not substantiated should be viewed accordingly. While there seems to be little reason to deliberately fabricate information, it is still possible that some individuals have inaccurate recall of events. Studies of self-reported drug use suggest that self-report data from such samples tend to be reasonably reliable (Adair, Craddock, Miller, & Turner, 1995; Needle et al., 1995; Siegal, Falck, Wang, & Carlson, 2002)

Our results provide some insights into the reasons that waiting lists are deleterious to the very goals that treatment programs promote, substance abusers entering treatment. Substance abusers perceived delayed treatment entry as a problem that also was compounded by tangible individual and system level barriers. In some cases the waiting time was so long that individuals found jobs that conflicted with their proposed treatment schedule. Similarly, some individuals moved out of town to avoid homelessness and/or the drug using environment and during this process lost their place on a program’s waiting list. Longer waits for treatment increase the opportunities that other events will arise, thereby further interfering with treatment entry.

It was not only the actual passage of time and tangible barriers that were a barrier. Several characteristics of a drug using lifestyle interacted with the actual passage of time to make waiting especially troubling for this population. One such characteristic was substance abusers’ subjective experiences of the passage of time. Some participants emphasized the sense of urgency they had to begin treatment immediately to counteract the idleness and emptiness of daily life. Other participants interpreted this sense of urgency as their only way out of “a life or death” situation. While health professionals may see one week of waiting time as reasonable, participants may experience the same week as “never ending” or “eternal.” Very little research has been done on how people with substance abuse problems experience time differently (Henik & Domino, 1975), or how time is also experienced as a symbolic process that is continually being produced in everyday practices (Munn, 1992).

Some substance users took their success at achieving abstinence during the waiting period as a sign that they did not need treatment after all. As such, they had diminished interest to link and engage in treatment services, and their abstinence actually could be understood as a barrier; a few believed they still needed the reinforcement of treatment, even though they were maintaining abstinence. Most reasoned that treatment was only necessary for those who were still using and were not capable of quitting on their own. Even as some started following the path of natural recovery, many others relapsed into drugs. While techniques such as motivational interviewing or case management may help to maintain readiness for treatment, the primary solution to the unintended consequences of waiting time is to make treatment available on demand.

Participants found ways to cope with the waiting time. Examples included attending self-help groups as an interim solution to formal help, or drastic measures like faking suicidal behaviors and engaging in a deliberate overdose. Both strategies reveal strong treatment motivation. Despite dissatisfaction with the waiting time, most participants in this study verbalized a strong desire to enter treatment. Several participants commented that they had stopped using drugs for a few days or even weeks before the CIU assessment, although this abstinence was more common among those participants who had come to treatment voluntarily and were not court ordered. This is in keeping with estimates that between 50% to 85% of individuals seeking treatment for substance abuse report at least one day of abstinence when seeking help (Moore & Budney, 2002; Tucker, 1995). Substance abusers identified the commitment to abstinence prior to the CIU assessment as an unmistakable sign of their motivation for treatment. This was particularly helpful for those participants who received a referral to residential treatment, because some treatment settings only accept drug users who go through detoxification first. This short-term abstinence related to detoxification also helped participants feel more confident that they were capable of stopping their drug use.

Overall, these findings support the importance of system oriented treatment interventions that are designed to reduce the waiting time before treatment entry. Centralized intake units are intended to do this by rationalizing assessment and referral, facilitating treatment linkage by establishing a common assessment standard and ensuring a better match between client and treatment program (Claus, Barron, & Pascual, 2003). In theory, these steps should add to the efficiency of the system and produce shorter waiting times before initiating treatment. In contradiction to its intended purpose though, some participants saw the CIU itself as a barrier that only increased the waiting time before treatment entry. Clients who experience the additive effects of waiting both before and after assessment are likely to be at even greater disadvantage than when CIUs are not present.

While waiting times are usually the result of system factors, individually oriented interventions may serve to ameliorate the full impact of having to wait for treatment. In the Reducing Barriers Project clinical trial, two interventions are being tested for their impact on waiting lists and treatment linkage. The first, one session of motivational interviewing, may be useful in helping substance abusers maintain readiness for treatment. Still, it is possible that the value of increased motivation immediately after assessment may be time-limited and dampened by waiting times that are excessive. A longer pretreatment intervention, strengths-based case management, has been shown to be effective in improving linkage of HIV-positive individuals with medical care (Gardner et al., 2005). This intervention is designed to reduce the impact of waiting time through the advocacy of case managers and by assisting substance abusers to identify and resolve other barriers to treatment.

Qualitative research is ideal for assessing the effectiveness of motivational interviewing, strengths-based case management, or other interventions. The perspectives and opinions of substance users offer an intimate understanding of how the interventions are received and how

effective they are in resolving barriers to treatment. Future investigation whether any of these interventions help to reduce waiting time, and whether this reduction is related to improved treatment linkage.

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Table 1

Characteristics of Study Participants (N=52)

Characteristic	N(%)
Age (years)	
Range	18–64
Mean (Std)	37.8(10.7)
Gender	
Male	33(66.5%)
Female	19(36.5%)
Ethnicity	
White	29 (55.8%)
African American	22(42.3%)
Native American	1(1.9%)
Education	
< High School	18(34.6%)
High School or GED	20(38.5%)
> High School	14(26.9%)
Employment	
Yes	24(46.1%)
No	28(53.9%)
Living Situation	
With family	26(50%)
With friends	7(13.5%)
Alone	4(7.7%)
Homeless	14(26.9%)
Other	1(1.9%)
Primary Drug	
Crack/cocaine	33(63.5%)
Heroin/opiates	16(30.7%)
Marijuana	3(5.8%)
Previous Treatment	
None	13(25%)
Once	13(25%)
Two or more	26(50%)

Table 2

Waiting Time Before Treatment Entry

Waiting Time	N days
Before CIU appointment	
Range	0–13 days
Mean(Std)	3.8(3.2)
Median	3.0 days
Waiting for treatment	
Range	4–163 days
Mean (Std)	42.6 days (29.1)
Median	40 days
Treatment entry	N(%)
Yes	32(61.5%)
No	20(38.5%)