Regular article

Process improvement needs in substance abuse treatment: Admissions walk-through results

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Abstract

Researchers have questioned whether the addiction treatment infrastructure will be able to deliver high-quality care to the large numbers of people in need. In this context, the Robert Wood Johnson Foundation and the Center for Substance Abuse Treatment created a nationwide network to improve access and retention in treatment. Applicant agencies described results of an admission process walk-through. This qualitative study used narrative text from 327 applications to the Robert Wood Johnson Foundation, focusing on admissions-related problems. We developed and applied a coding scheme and then extracted themes from code-derived text. Primary themes described problems reported during treatment admissions: poor staff engagement with clients; burdensome procedures and processes; difficulties with addressing the clients' complex lives and needs; and infrastructure problems. Subthemes elucidated specific process-related problems. Although the findings from our analyses are descriptive and exploratory, they suggest the value of walk-through exercises for program assessment and program-level factors that may affect treatment access and retention. © 2007 Published by Elsevier Inc.

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1. Introduction

Substance abuse problems are a major source of dysfunction as well as diminished quality of life and have high economic, medical, family, and social costs (Donnermeyer, 1997; Mark, Woody, Juday, & Kleber, 2001; Office of National Drug Control Policy, 2004; Rosenheck & Kosten, 2001; Substance Abuse and Mental Health Services Administration [SAMHSA], 2004). Despite these negative consequences, only approximately 2.3 million of an estimated 23.2 million Americans with substance-related

problems received some form of treatment in 2005, and many who sought help were unable to obtain treatment (SAMHSA, 2006). In addition, only approximately 51% of those who enter care complete treatment (SAMHSA, 2002). These findings show that substance-related problems remain underaddressed in our health care system and that significant barriers exist for those who need care.

Such systemic problems suggest that major changes are needed to improve access and delivery of substance abuse treatment, yet poor treatment results have often been blamed on patients—with little attention given on the way care is organized or delivered or on the extent to which available care meets patients' needs (Broome, Simpson, & Joe, 1999). Recently, greater attention has been focused on treatment facilities, their ability to engage and retain clients in treatment for prescribed lengths of time, and their ability

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to provide appropriate therapeutic services (Simpson, Joe, Rowan-Szal, & Greener, 1997). Moreover, McLellan, Carise, and Kleber (2003) questioned whether the addiction service infrastructure, in its current form, can support adequate provision of high-quality care.

In addition, a host of treatment access and other difficulties is compounded by problematic business processes that negatively affect individuals seeking care (Ebener & Kilmer, 2001). Furthermore, these problems are exacerbated by regulatory requirements that add barriers through increased paperwork, assessment requirements, and financial screening (Martin, 2005; Soman, Brindis, & Dunn-Malhotra, 1996). Altogether, these barriers can hinder initial intake assessments, delay entry into treatment, and lead to missed treatment opportunities (Farabee, Leukefeld, & Hays, 1998; Hser, Maglione, Polinsky, & Anglin, 1998).

To address these problems, the Robert Wood Johnson Foundation (RWJF) and the Center for Substance Abuse Treatment (CSAT) created a nationwide effort to identify and address barriers to access and retention in addiction treatment. RWJF's Paths to Recovery initiative and CSAT's Strengthening Treatment Access and Retention program formed a nationwide learning collaborative called the Network for the Improvement of Addiction Treatment (NIATx; Capoccia et al., 2007). NIATx provides collaborative learning opportunities and technical support to agencies so they can improve treatment access and retention. NIATx's central tenets are that patient-level outcomes are directly and indirectly affected by agency practices as well as policies and by organizational influences (Heinrich & Fournier, 2005) and that process improvement can make organizational systems more consumer friendly, improving outcomes.

Substance abuse treatment agencies seeking participation in RWJF's Paths to Recovery program submitted six-page letters of intent that are the focus of the work presented in this article. As part of the application process and as an introduction to process improvement, Paths to Recovery applicants received instructions for completing an admissions walk-through exercise and described their agency's strengths and weaknesses in their letter of intent, basing their answers on the walk-through findings.

Walk-throughs are typically conducted by an employee of an organization who assumes the role of a prospective client and interacts with the organization as would a client. Such walk-throughs (a) enable organizations to better understand their clients' points of view, (b) can uncover assumptions, inconsistencies, and limitations of systems, and (c) can generate ideas for improving organizational processes (Gustafson, 2004). Such patient-centered approaches have increasingly been called for to improve the quality of medical care (Institute of Medicine, 2001).

We examined agency and process data submitted as part of the first series of Paths to Recovery letters of intent, focusing on use of patient-centered walk-through exercises and describing potential barriers to treatment identified in the context of these exercises. Based on this work, we describe the organizational processes that the agencies identified as having the potential to impede access to care or affect treatment continuation.

2. Materials and methods

The overarching goal of walk-through exercises is to identify problematic practices and processes to improve service delivery and address customers' needs by enabling providers to understand the experience of receiving care from the perspectives of patients and their families (Gustafson, 2004); that is, a walk-through answers the question, "What is it like to be our customer?" The specific objectives of the walk-through exercises reported in this article were to (a) identify potential service barriers and process problems experienced by clients attempting to obtain substance abuse treatment and (b) uncover methods for reducing or eliminating the problems identified.

2.1. Instructions for the walk-through exercise

Applicants were instructed to select two detail-oriented people who were committed to enhancing customer service to play the roles of a client and a family member. These individuals were to try to make the walk-through as realistic and informative as possible and were instructed to choose a particular addiction problem to explore. For example, walk-through clients might present with the profile of a typical client, or a client of the type that the agency identifies as having special needs. Alternatively, they might choose to represent a type of client that the agency is concerned about serving well. Applicants were told to let admissions staff know about the walk-through before conducting the exercise to ensure that staff did not feel undermined, examined surreptitiously, or tricked. Applicants were also reminded that admissions staff would likely be on their best behavior because they knew about the walk-through and, for this reason, that it was important for them to ask staff to treat the walk-through clients as they would anyone else.

Applicants were told to walk through the admission process just as a typical client and family member would experience it, starting with the customer's first contact and extending through the third outpatient visit, the third day in inpatient care, or a transfer between levels of care. During this time, walk-through clients were to try to think and feel as a client or family member would think and feel, be sure to look around and ask themselves, "What might a customer be thinking? How might she or he feel?," as well as document those observations and feelings. Clients were also instructed to ask the staff, at each step in the process, about any change that would improve the process for the client or for the staff working with the client that they could think of, again documenting all ideas and feelings.

After the exercise, the walk-through client and family member were instructed to record a list of the needs and problems identified and to write a brief report outlining the experience. In this report, they were to answer two questions: (a) What most surprised you during the walk-through? and (b) What two things would you most want to change? In addition to these instructions, agencies were also provided with some additional suggestions, including a series of questions to help direct their focus toward key aspects of the admission process and to guide collection of appropriate and useful information (Fig. 1).

2.2. Participants

Paths to Recovery applicants were 327 addiction treatment agencies that submitted a letter of intent to the RWJF in the spring of 2003. All applicants were required to have a nonprofit status and to serve a client base that was at least 50% publicly funded. Letters of intent also included descriptive information about the agency and its setting (Table 1), a report on the walk-through findings, and a description of areas for improvement that the agency identified as primary foci for possible intervention.

2.3. Qualitative analyses

We analyzed text from the applicants' letters of intent, focusing on the walk-through exercise and agencies' self-identified strengths and weaknesses. All related text were coded and analyzed using Atlas.ti (Muhr, 1997). Atlas.ti is a software program that aids in the coding and retrieval of qualitative data. Electronic text files are attached to Atlas projects (Hermeneutic Units), and a coding scheme (developed by the researcher or research team) is either uploaded or entered directly into the Atlas.ti project. Trained coders then code by reading text online, selecting text that is consistent with a particular code or codes (based on code definitions created by the team), and then applying the appropriate code to the text (electronically, typically via dragging and dropping the code onto the selected text). When text had been coded, the Atlas query tool can be used to retrieve text associated with a particular code or a combination of codes (the latter using Boolean logic). Each

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1. Call for an appointment. Were you told to call back or transferred to voicemail? Were you given an appointment on your first call? How long would clients need to wait for an appointment? Would they have to miss work to get an appointment? Record your experience.

2. On the day of the appointment, arrive at the clinic or office, thinking what it would be like if you had never been to the site before. Is transportation to your site an issue? Are parking, directions, and signage adequate? Does the site feel welcoming or cold and harsh? Record your experience.

3. Once you arrive, think about the perspective of the client and the client's family coming in for the first time. Go through the entire intake process. Fill out all required forms. Does the family member typically accompany the client through the entire intake process? How long does a typical client spend in the waiting room? Wait for that amount of time. If the client is required to undress, you should undress. Is a urine test required? Will you have to wait between your assessment and your first treatment session, and if so, how long? Experience it all, and record your experience.

4. Experience the process of transferring between levels of care; for instance, going from detox to residential or from outpatient to intensive outpatient or whatever levels of care you provide. How much paperwork do you have to fill out? Are you answering the same questions you did initially? Do you feel like you've had a smooth and consistent transition, or are you starting again from the beginning?

Fig. 1. Suggestions and questions provided by RWJF to potential Paths to Recovery applicants for use in conducting the walk-through exercise.

Table 1

Characteristics of agencies that submitted letters of intent for the RWJF's Paths to Recovery program

Characteristic	Percentage of applicant agencies (N = 327)
Treatment setting	
Free-standing substance abuse treatment center	56.4
Mental health agency	13.3
Hospital or health center	7.2
Social service agency	5.5
Family and/or children's service agency	5.0
Other (e.g., local health department, integrated system of care, and county jail)	11.0
Location	
Urban	75.0
Rural	25.0
Organization type	
Private not-for-profit organization	88.41
Unit of state government	3.05
Unit of local county or community government	6.71
Unit of tribal government	1.22
Federal Department of Veterans Affairs	0.30
Missing data	0.30
Region of the United States and states represented	
Mountain (Arizona, Colorado, Idaho, Montana, New Mexico, North Dakota, South Dakota, Texas, Utah, and Wyoming)	7.93
Midwest (Arkansas, Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Oklahoma, and Wisconsin)	28.35
Northeast (Connecticut, Delaware, Massachusetts, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont)	23.17
Southeast (Alabama, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia)	18.29
West (Alaska, California, Hawaii, Nevada, Oregon, and Washington)	21.95
Missing data	0.30
No. of employees (based on the no. of full-time equivalents)	
≤25	23.17
26–50	17.07
51–100	17.07
101–150	10.37
151–250	12.50
≥251	19.82
Size of agency board of directors (no. of members)	
0–10	36.6
11–20	47.9
21–30	10.8
≥31	4.7
Percentage of agency board of director members who are of ethnic minority	
≤10	33.2
11–20	25.0
21–49	25.7
50–99	12.0
100	4.1

Table 1 (continued)

Characteristic	Percentage of applicant agencies (N = 327)
Percentage of agency board of director female members	
≤10	5.9
11–20	11.1
21–49	54.2
50–99	27.6
100	1.2
Percentage of agency board of director members indicating they were in recovery (n = 212, 115 agencies did not provide data)	
0	17.5
1–10	13.2
11–20	26.8
21–49	26.0
50–99	15.1
100	1.4

query produces an electronic text file that includes all text meeting the criteria specified in the query. Queries identify each separately coded section with the filename of the document from which it was drawn and the line numbers of that document. This allows for easy return to the full document if additional information or clarification of the text is needed.

We used two primary sources of information for developing our coding scheme. First, we began with a list of preliminary descriptive codes derived from eight practices and strategies deemed to be promising for process improvement in addiction treatment settings (NIATx, 2006) that were developed based on a systematic review of the relevant process improvement literature commissioned by the national program office for Pathways to Recovery (NIATx, 2007). When the coding scheme was complete, we included six descriptive categories derived (at least in part) from this review and the eight promising practices. These descriptive codes included the following: *initial contact*, *assessment/intake appointment*, *levels of care*, *engagement*, *paperwork*, and *family involvement*.

Because this study was exploratory in nature, we also used inductive methods for generating codes. Over several weeks, five of the authors (J.F., C.G., J.W., K.R., and L.B.) reviewed the same text from a subset of the letters of intent. For each application, the authors independently created a set of descriptive categories or codes that reflected what they believed to reflect the information found in each application reviewed. The authors then met to discuss the text, line by line, creating a preliminary list of codes that identified common descriptive patterns or interpretive components (based on content, relevance, and prevalence) that occurred across the applications reviewed (Lofland & Lofland, 1995; Luborsky, 1994; Miles & Huberman, 1994). During this process, we resolved disagreements through discussion and then created and refined the definitions for each code (Leininger, 1985). We then began to independently apply the preliminary coding scheme to the text from several additional applications, jointly reviewing the text and

associated codes line by line, discussing and resolving cases of disagreement, and finalizing codes and definitions (final number of codes = 39). When agreement across coders was consistently good, the coding scheme was finalized and all documents were coded. To maintain consistency, we asked the coders to code a new section of text each week for review and discussion during a weekly project meeting.

Once all text were coded, we used the Atlas.ti query tool to produce reports on text related to the admission process. Themes and subthemes were identified by having two authors independently review all text for each of these queries and create a report on the themes that they identified. The first three authors then reviewed, discussed, and consolidated the themes identified. To ensure validity, we also resolved discrepancies and looked for contradictory cases or examples in which the themes did not apply (Bernard, 1994; Miller & Crabtree, 1998; Spradley, 1980). The themes reported in the sections that follow were those that applied to the admission process and appeared repeatedly in the data. Examples of contradictions are presented with the primary themes.

3. Results

Despite the heterogeneity among the applicant agencies in treatment processes, philosophies, staffing, and other characteristics, we found four primary themes associated with agency barriers to admissions: poor staff engagement with clients; burdensome procedures and processes; difficulties with addressing the complex lives and needs of clients; and infrastructure problems. We describe these themes (as well as some subthemes) and provide examples of themes from agency applications. When quotations or our interpretations refer to the experiences of clients, these "clients" are represented by agency staff playing the role of clients as part of the walk-through exercise.

3.1. Poor staff engagement and interaction with clients

Applicants reported that they found (a) staff to play a vital role in framing the experience of clients, fostering open communication, and engendering trust and (b) information provided by staff and the ways in which it was provided could affect client engagement. For example, some applicants reported that information was improperly disseminated or that clients received outdated or conflicting information from staff. Indeed, walk-through clients sometimes received different information and directions for the same treatment agency from different staff. This misinformation was seen to affect the clients' ability to successfully navigate treatment admission processes and possibly influence clients' ability to make informed decisions about treatment. In the sections that follow, we describe themes derived from text that related how staff communicated and interacted with clients.

3.1.1. Setting the tone

Typically, the first contact of a prospective client or family member with the treatment agency was by telephone. One applicant reported that initial contacts have the potential to produce apprehension and uncertainty on the part of the caller, and some agencies were concerned that the success of the interaction during that first call might affect treatment entry. Various walk-through clients (and walk-through family members) described frustrations when their initial telephone calls were improperly handled; for example:

> The initial phone call was routed incorrectly and then dropped. This was followed by a second phone call that was handled very poorly by a nonclinical admissions staff person such that an appointment was not made.

> A total of five different persons became involved in responding to the first caller's inquiry for help, and the caller was passed to different people in an effort to find the right person with whom to speak. Both callers had numerous interruptions due to other calls coming into the agency. In the end, neither caller was able to successfully complete an intake process.

Some walk-through clients mentioned that information provided to them about the treatment program would have been easier to understand and remember if the staff had been following a well-written script or had clear guidance about information that needed to be reviewed.

> There is no universal script at [agency] about what to say during the initial contact and, therefore, the potential client's experience can vary depending on who answers the telephone or receives the client in the waiting area. There is no set process for training those who answer the phone or receive clients at reception.

As a result of these kinds of inconsistencies, some agencies reported that initial contact experiences could be quite different from client to client, even within the same agency. The absence of clear guidelines for initial contacts was also seen to result in incomplete information being provided to clients about treatment, particularly regarding paperwork requirements. Failure by staff to relay important information was identified by some agencies as having the potential to produce unexpected financial or other difficulties and caused some clients to distrust the reliability of future information. For example, one client described not being instructed to bring required financial documents that would have necessitated an additional trip to the clinic had he been an actual client. Worse, some applicants discovered that staff disseminated incorrect information that could affect access to treatment. As an example, one agency found that walk-through clients were erroneously told that a school or family court would have to make a referral when that was not the case; in addition, it reported that the time associated with obtaining an external agency referral could increase the time between the first contact and treatment admission.

Some applicants also identified improved telephone protocols as having the potential to address another problem that they encountered—the assumption that the con-

sumer knew about substance abuse treatment procedures and practices.

> Clients are assumed to be knowledgeable about treatment and the various levels of treatment available. This is not always the case. The first question the posing client was asked on the telephone was, 'Do you want outpatient or inpatient treatment?' The staff person answering the telephone is assuming the client knows the difference and can make that determination.

Other applicant agencies reported that their staff had provided complete and accurate information at the initial telephone call and beyond. These interactions included well-presented information about the agency, including funding and treatment options.

> The client was given explicit written instructions on the next step, including where to go for initial counselor and group meetings and what to expect at that time.

> The substance abuse secretary did a good job explaining the state-funded plan for low-income clients. When she had to check on the client's question, she came back quickly with the answer.

3.1.2. Facilitating understanding of the treatment process

Although sharing information with clients is often considered a patient-centered practice, the information provided at the assessment visit was noted as overwhelming and confusing in some agencies, making comprehension difficult and potentially impairing clients' ability to make decisions about treatment options. Agencies discovered that simply being informed was not sufficient to support successful entry into treatment, particularly for those whose cognitive capacity was diminished as a result of their substance use or comorbid mental health problems; for example:

> There was a lot of information to absorb, and it was confusing to have the treatment program revealed piecemeal.

Another applicant noted that the walk-through clients "were given so much information [that] they could not remember it all, and they ended up not being sure of when their appointment for orientation was scheduled." As a result, clients and staff may end up with contradictory expectations about important aspects of care, such as length and intensity of treatment.

In addition to providing patients with information, the admission process affords an opportunity for engaging clients and forming a therapeutic alliance. Some walk-through clients reported that their agency did not perform well with regard to encouraging client participation or making clients feel comfortable about entering treatment.

> The intake and follow-up...[were] not very engaging. The intake was dominated by a series of questions required to meet regulatory requirements. As a result, the intake felt somewhat rushed and formulaic. It did not feel as if there was much time for finding out how the program worked. The intake appointment ended with a recommendation for a group and only a vague sense that the intake clinician would serve as a 'primary clinician.' There was little sense

that the clinician would be 'checking in' to make sure the client was seeing a benefit.

At the same time, attributes or qualities in staff that enhance the admission process can be elusive. One participant noted that she missed "the kind of personal attention that would be reassuring to a client."

On the other hand, applicants reported many examples of staff performing well at recruiting, engaging, and retaining clients. In these instances, agency staff were often thorough, sympathetic, and caring in their interactions with clients. Such examples can provide useful information for agencies that want to improve their processes.

> At the intake appointment, a counselor walked the client through several forms to further identify treatment needs. The counselor, who was extremely empathetic toward the client's frustration with the involved intake appointment, informed her of the program process and of her rights during treatment.

3.2. Burdensome procedures and processes

Walk-through clients identified various procedural problems that could create barriers to treatment and negatively affect client engagement. A common concern was the length of time required to successfully complete intake procedures. Other observations included frustration with the overwhelming amount of paperwork and forms, redundancies in paperwork, and the sometimes mechanical and routine feeling of the intake (examples follow).

3.2.1. Slow processes

Among problems noted by applicants was the need for improving the speed—and therefore the method—by which they moved clients through the intake process. Most commonly, the length of time from the first point of contact to completion of the assessment was deemed unacceptable. One walk-through client who described the process as "stressful and frustrating" noted that a 2-week wait to be admitted into the program made her feel "scared and devalued." Long delays and burdensome processes between the first contact and scheduling an assessment appointment were also identified as having the potential to increase no-show rates among clients. The following provides an example of the kinds of burdensome processes that the applicants identified:

> [Client] was informed about the waiting list and that he needed to call in to the receptionist to be put on the waiting list. He would then need to call on 3 separate days during each week to remain active on the waiting list until his slot became available. If he failed to do that, he would be dropped from the waiting list.

Walk-through clients also found themselves disappointed by the length of time it took to get an initial appointment—longer than 2 months in some cases. Long waits were seen to fuel anxiety in already uncertain clients

and family members, and delays were expected to affect whether or not a patient continued seeking treatment. The following examples were provided by agencies that treated adolescents:

> The [walk-through] 'parents' who were distraught and seeking urgent help were very frustrated at being referred from one department to another, only to learn then that it would be 5 days before an assessment could be completed, an additional week of delay before outpatient treatment could begin, and nearly 2 months to gain admission to inpatient services.

> The [client] made it through the orientation/intake process easily-...Asked when [client] could begin treatment, [staff] stated that the wait for treatment could be from 6 to 8 weeks....Both the client and the family member were disillusioned with this long wait, especially since the telephone screening and intake procedure had been handled so expediently. The family member became especially anxious about the wait, stating that surely the client would relapse during that time and might be unwilling to come to treatment by then.

Some applicants noted unacceptable time lags in providing client information, gaining an evaluation appointment, and progressing to the next level of care. One applicant stated that time delays in the intake process would "irritate and discourage the client" and increase the likelihood of treatment dropout. In some instances, the length of the intake process and access to services varied by level of care.

Walk-through clients who presented with substance abuse problems and comorbid mental illnesses voiced additional concerns. Some encountered long waits that were identified as particularly problematic for people with dual diagnoses or for those who had needs for psychiatric medications that were not addressed. In the following example, the client's need for medication was addressed but other delays and process problems were uncovered:

> My [co-occurring disorder] status is discovered after I mention 'my bipolar illness' after 45 minutes. Another counselor is called, I am told to call 'dual diagnosis' intake, two offices away, and am informed that 'most dually diagnosed clients come through the intake group.' I call, get a busy signal for 20 minutes, leave a message, and get a callback on Tuesday with an appointment for Friday 1 p.m. I attend my intake and have to 'wait' for a call for my psychiatric evaluation. They call Tuesday with an appointment Thursday 6 p.m. I attend my appointment, am deemed eligible, and am told I will be on a waiting list 'for up to 3 weeks.' I'm asked, 'do you have a month's medication or do you need a prescription?'

3.2.2. Redundancy in processes

Applicants also expressed concerns over the repetition that occurred in the intake process and the intake paperwork. Duplication, such as multiple and repeated administrations of assessments for placement, led to frustration among clients. Irritation also emerged when redundant information was gathering within a single visit, when information provided in prior visits was not used in subsequent visits, and when information collection was duplicated during transitions from one level of service to another. One applicant noted that redundant data collection during intake

processes appeared to be designed to meet the needs of the agency rather than the needs of its clients.

> One of the most salient observations about this process [intake] was that there [are] way too much redundant data gathered in this process. Mr. Doe's [walk-through client] medical history was requested three times in detail.

Several clients were also surprised and dissatisfied with the number of staff, who were often asking duplicative questions, they were required to interact with during intakes.

> ...the client...became frustrated with the repetition of questions posed by the counselor and then the nurse.

Some applicants were concerned that redundancy and lengthy paperwork, in addition to inducing client fatigue, could interfere with the creation of a successful relationship with providers:

> The diagnostic interview lasted for 2 hours, but the need for, often redundant, paperwork to get done seemed to take precedence over any therapeutic aspect of the interview.

Redundancies in financial assessments and a focus on finances to the exclusion of clients' needs were also perceived negatively by some walk-through clients. In addition, treatment could be delayed while the agency worked to confirm insurance, and costs were seen as having the potential to impede treatment entry.

> The women [walk-through clients] felt that the paperwork seemed to take too much time and that too much focus was placed on the client's financial situation. For an individual already burdened by legal issues and a drug problem, the invasive nature of these questions and the implication that the client should contribute financially to his/her treatment to the extent possible may well serve as a deterrent to seeking treatment.

> If the patient is not aware of the sliding fee program, the apparent cost of treatment may seem prohibitive...

3.3. Difficulties with addressing clients' complex lives and needs

By the time people seek treatment, they are often in considerable distress and may be experiencing multiple emotional, medical, financial, housing, family, and social problems. A recurrent theme in the Paths to Recovery walk-throughs concerned missed opportunities for addressing these issues, with several applicants noting that there was little if any support available to assist patients struggling with various complexities, including language barriers. One applicant noted that such problems could be compounded when walk-through family members (who often provide support to individuals with difficult lives) were excluded from planning and treatment. Language barriers between clients and staff were also reported as lengthening an already long intake process.

> One 'client' remarked how long it actually takes to conduct an assessment in a non-English language. Intake and assessment questions

are long and unfamiliar, and much effort is required to accurately capture the necessary information.

3.3.1. Mental health and comorbidities

A number of walk-through clients who presented with comorbid mental health problems were turned away from treatment because dual-diagnosis programs were full or, more often, because substance abuse treatment programs did not provide mental health services and mental health programs did not provide addiction services. An adolescent treatment facility applicant expressed concern for the "youth who fall through the cracks each year" who were unable to access the services that they need for co-occurring disorders, indicating:

> They are [sent to either] psychiatric services or substance abuse services, when they need a combination of both.

The Paths to Recovery walk-through clients found that they had to jump through several hoops in the few agencies that provided integrated treatment to receive care for both mental health and substance abuse; for example:

> Consumers with co-occurring disorders, if not identified through our substance abuse unit, are categorized into one of two headings: substance abuse or mental health. Time constraints, physical location, multiple screening and assessments, [and] waiting time for referral to other units all add to the prospective client's barriers to quality care and service.

These barriers triggered additional steps in the intake process that could serve to create longer delays for clients with co-occurring disorders.

3.3.2. Court- and child welfare-mandated clients

Mandated or court-referred walk-through clients seeking treatment to resolve or avoid legal consequences were faced with additional barriers to treatment entry. These applicants reported that a lack of coordination between courts and agencies resulted in significant frustration and that, without appropriate linkages or mechanisms to share information, the client from the court system had to repeat paperwork at the treatment agency, adding time and tedium to the process of seeking treatment. Some mandated clients also reported concerns that they would face incarceration if the agency was not able to admit them quickly.

> The client...had to play 'telephone tag' with the case manager for several days before contact was made. This was very frustrating to her because a court appearance was upcoming and she was threatened with jail if she was not in treatment by that date.

3.3.3. Clients with disrupted lives and limited resources

Individuals with substance abuse problems often have mobile and turbulent lives and may not have consistent access to a telephone for making or receiving calls. An applicant noted that access to a telephone could be very important during a 3-day delay in intake:

> Clients may not have a phone [and] often are transient, so contacting them may be difficult. In 3 days, they may have changed their mind...gone back out using, et cetera. It delays the opportunity for intervention, and the client feels unimportant or disposable.

Walk-through clients also presented with transportation challenges that could interfere with their ability to reach the treatment agency and compromise their ability to seek treatment in a timely manner. Agency responses were sometimes found to be inadequate, and other transportation options were deemed limited.

> Logistics play an important role in having clients initiate and remain in treatment. Many, if not most, of our clients are dependent on public transportation. [City] has few options for transportation except the bus line, which runs infrequently at best. Most treatment programs are spread out away from the neighborhoods where people live—an average bus trip is 1 hour. With this, clients may be asked to go to different sites for different purposes—one for funding approval, one for intake, one for programming, one for AA/NA. This makes seeking and maintaining treatment services costly in terms of time and money.

The lack of adequate transportation or parking, combined with limited appointment times and the need for child care, was also perceived as affecting the timing of treatment entry.

> All the appointments were during 'traditional work hours,' and parking and child care are not available.

Among the walk-through clients whose role included having small children, some found that inadequate access to child care was a complete barrier to treatment participation.

> Clients are not able to be seen if they come in with children. No child care or activities for children were offered.

3.4. Problems with infrastructure

Intake process barriers, such as repetitive paperwork, did not exist in isolation. Some applicants noted poorly designed intake processes combined with other problems, such as antiquated phone systems, crowded waiting rooms, "uncomfortable chairs," and "unpleasant bathroom facilities," to create an environment in which engagement between the client and the treatment agency could be disrupted. Applicants identified several types of infra-structure problems; these are described in the following subsections.

3.4.1. Poor and antiquated telephone systems

Applicants reported various problems with telephone systems. Walk-through clients often reached automated systems that dropped their calls or routed them to an individual who was not able to resolve their request. In other instances, the phone system was circuitous or made it impossible to reach a live person to request services from or to answer questions.

> The initial call into the system is very confusing, even before the caller hits a 'live' person; the voice prompts and even the agency

listing in the phone directory are vague and unclear. Finding us is difficult.

The process was especially frustrating when the system required the prospective client to know names or numbers of program personnel with whom to be connected, as some applicants discovered. Applicants were also concerned that those without telephones would give up when faced with needing to leave a message for a return call or about delays related to "playing telephone tag" when a live person was not available.

> The urgent care department, which schedules intake appointments and does a quick phone screening, receives 30–50 calls a day. Most callers leave a message in voice mail, and it may take several days of voice mail phone tag before the client actually talks to an urgent care staff member for an initial screening and scheduling of the intake appointment.

Not all treatment agencies had inefficient telephone systems; however, some walk-through clients reported encountering robust systems that routed them quickly and efficiently. A few discovered that they were able to reach a live person 24/7. Likewise, some agencies operated state-of-the-art call centers capable of quickly linking clients with the appropriate treatment within their agency. These instances provide positive examples for process improvements that might be implemented elsewhere.

> By far, the greatest strength of [agency] is our customer service center, which utilizes customized computer technology and telephone linkages to respond to all new requests for services...

3.4.2. Inadequate intake facilities

Walk-through clients also noted a lack of privacy and other problems in their waiting rooms and intake facilities. Concerns included crowded waiting areas, lack of confidentiality in waiting areas ("all conversations at the front desk could be overheard"), and intake rooms that did not provide adequate privacy.

> They [walk-through clients] felt at ease with all staff but felt somewhat uncomfortable in the waiting room because of who might walk in and see them.

> The assessment in this group was conducted in a large room with the other potential clients sitting around—no privacy for initial individual contact.

Because substance abuse treatment can be stigmatizing (Centers for Disease Control and Prevention, 2005; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997), treatment entry can depend on patients' perception of an atmosphere of confidence and trust in which they are willing to divulge uncomfortable facts and issues that may be germane to treatment. In the absence of this perception of confidentiality, agencies were concerned that some individuals with substance abuse disorders might refuse or fail to seek treatment, going without needed services.

4. Discussion

These qualitative analyses provide important information about admission processes at substance abuse treatment agencies from the perspective of would-be consumers and about the value of using walk-through exercises as a method for learning about consumers' perspectives. Our findings highlight a series of problems that, if common across other agencies, could hamper efforts to successfully engage individuals in substance abuse treatment. These results also suggest that walk-through exercises provide valuable information that may assist agencies and providers in targeting and framing process improvements for the greatest impact.

The details of the exercises reported in this article also suggest processes that other agencies or clinicians may want to explore when they conduct walk-through exercises. For agencies that are already aware of problems in their admission process, our findings provide information about possible opportunities and methods for improvement. For example, client-level complexities offer opportunities for improving the system broadly, perhaps by adding ancillary or wraparound services or case management functions. Addressing telephone systems and procedures may provide a relatively easy avenue for improving client contacts throughout the treatment process. Other possible responses to the kinds of problems identified in our analyses include the following:

- have a person answer the phone; avoid answering machines and voice mail;
- make assessments short and focused on the individual client's clinical concern;
- avoid repetition during the admission process;
- identify common needs among clients, such as needs for day care, transportation, and mental health services, and create systems to address these issues when they arise;
- ensure confidentiality by having assessments occur in private settings;
- eliminate delays; and
- make sure consumers know what to expect from treatment.

Although such changes may seem difficult to implement, organizations now participating in the NIATx program have found that seemingly minor changes have the potential to improve consumers' experiences in important ways. As one example, NIATx agencies have begun to adopt more mindful and client-centered approaches—those involving enhancing trust, caring, expertise, and an appropriate amount of autonomy. Such methods can help clients (who may otherwise feel devalued) experience a sense of receiving individualized and attentive care (Epstein, 1999). They can also help make intake processes easier to complete, more timely, confidential, build rapport, and oriented toward the goal of engaging individuals in treatment, thus affording clients opportunities to develop relationships with program staff.

Finally, the richness of these data, which come from a large number of agency applicants adopting a consumer lens, suggests that clients themselves should also be considered a relevant resource for developing innovative solutions in addressing barriers to substance abuse treatment. In the absence of client assessments, or in combination with them, walk-throughs can help providers understand clients in ways that can produce the "deep knowledge of the underlying needs of the individual patients served. . ." (Berwick, 2005, p. 325) that is needed to provide high-quality care.

4.1. Study limitations

The data presented in this article are from letters of intent submitted by agencies seeking funding. As such, the accounts of their walk-through exercises are necessarily streamlined and were likely presented in ways that the agencies expected would appeal to the funding agency. The data are useful, however, in that they are, to our knowledge, the first presentation of a systematic exercise by a large number of substance abuse treatment agencies to understand consumers' perspectives and identify problematic agency processes. However, even with the large number of agencies represented, the characteristics of these agencies may not be representative of the field in general. The extent and depth of the problems identified, however, provide indications that the agencies were reasonably candid in their reports.

4.2. Implications and future research

Our findings suggest that when admission processes are burdensome, much can be done so that such processes more closely reflect clients', rather than agencies', needs. Our findings also imply methods that treatment agencies might adopt to create more accessible, efficient, and welcoming settings for clients. Although it is beyond the scope of this article to discuss solutions undertaken by treatment agencies to address the barriers discovered from the walk-throughs, other research studies suggest that treatment agencies that offer walk-in appointments, use reminder phone calls, or help facilitate client linkages between levels of care (e.g., residential to outpatient) can reduce barriers to treatment, time required to enter treatment, and assessment no-shows as well as engage clients more successfully in the next level of care (Capoccia et al., 2007; Molfenter et al., 2005). Future research should consider the bidirectionality of the intake process and how the complex lives of clients affect this process. Clients themselves may also be an important resource for identifying areas for future system improvements.

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