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Factors Contributing to Enrollment in Treatment Programs for Adults

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1. Introduction

The concept of enrollment can mean different things to different groups. For purposes of the current chapter, it specifically refers to treatment entry only. It does not address treatment retention or completion. In general, treatment tends to refer to formal treatment programs. However, we will also include findings from research on enrollment into drug courts. While enrollment in mental health treatment or mental health courts will be discussed, the extent is limited by the lack of extensive literature on mental health treatment entry. Thus, the major focus of the current chapter will be on enrollment into substance abuse treatment. Furthermore, the chapter focuses on adult entry into treatment; adolescent treatment entry is not discussed.

2. Factors related to enrolling in substance abuse treatment

Overview

While there has been some research into factors that influence whether an individual will enroll into substance abuse treatment programs, there is a need to consider the research in an aggregate form to better understand how we might better serve individuals who might benefit from formal treatment but for various reasons never seek it out. In terms of the current chapter, this is not a meta-analysis, nor is it a critical review; rather, it is a summary of what we know influences treatment entry. As such, we first discuss reasons why individuals may not seek treatment for substance use problems. We then consider factors associated with treatment entry. As we present this information, we will also consider various groups, where factors may differ, including individuals mandated to treatment, injection drug users, and drug court participants. Finally, we propose a model for substance abuse treatment entry.

3. Reasons for not seeking treatment

In general, the main reason that individuals do not seek treatment is that they see no need for it. Within the general population, Schmidt and Weisner (1999) found that many individuals who were identified as problem drinkers did not consider themselves as such. Specifically, Schmidt and Weisner (1999) found that 11.3% of the individuals in a general

population sample met objective problem drinking criteria, whereas only 5.4% of respondents labeled themselves as a problem drinker or alcoholic. Furthermore, Hedden and Gfroerer (2011) point out that only 3.3% of individuals in need of treatment for an alcohol use disorder who did not receive treatment actually perceived a need for treatment. While the percentage increases for drug use disorders to 8.3% and for drug and alcohol disorders combined to 12.5%, the numbers are still very low. Another study that considered illicit stimulant users in rural areas of the United States found that those who had a perceived need for substance abuse treatment were positively associated with enrolling in drug treatment (Carlson et al., 2010). Furthermore, consistent with other research examining one's perception or personal state of readiness, a form of perceived need, opiate-using IDUs recruited from the street who were in the contemplation or determination stage of change were also associated with enrollment in the drug treatment program (Corsi et al., 2007).

Given the large number of individuals who meet criteria for a substance use disorder but see no need for treatment, the next aspect to consider is the reason that might be the case, and what the ramifications of this lack of perceived need are. The one group that has had some research with respect to why the perception of a need for treatment is lacking is the DWI area. A primary problem is that a large portion of DUI offenders do not want to change their substance use behavior, especially if the intended outcome is abstinence. As a result, they are disinclined to admit they have problems (Lapham, C'de Baca, McMillan, & Hunt, 2004; Lapham, C'de Baca, Chang, Hunt, &Berger; 2002; Lincourt, Kuettel, & Bombardier, 2002; Nochajski & Wieczorek, 1998; Nochajski &Stasiewicz, 2001; Vingilis, 1983). Additionally, DUI offenders tend to be angry about the arrest and what has occurred to them; they may be even angrier if referred for an evaluation and fearful of the consequences for failing to comply with the treatment provider's recommendations (Cavaiola & Wuth, 2002; Wieczorek, Callahan, & Morales, 1997). Another potential reason for use of discretion in following treatment referrals or seeking treatment is that many of these individuals do not meet criteria for dependence as determined by a structured interview (Lapham et al., 2001; Stasiewicz & Nochajski, 2003; Stasiewicz, Nochajski, & Homish, 2007). Thus, when mandated for an evaluation and then told to go for treatment, these individuals may remain unconvinced about the necessity of formal treatment.

Stigma is also a major reason that individuals may not seek treatment (Corrigan, 2004; Corrigan, Kuwabara, & O'Shaughnessy, 2009; Corrigan, Larson, & Rusch, 2009; Corrigan & Penn, 1999; Corrigan & Wassel, 2008; Gibbs et al., 2011; McFarling, D'Angelo, & Drain, 2011). There has been a large amount of research on the effects of stigma and a thorough review of this topic is beyond the scope of the current chapter. However, because of the relationship with treatment entry, it is prudent to point out that Corrigan and his colleagues have done extensive work with the stigma of mental health problems showing how it may influence the decision to seek out formal treatment. They suggest that because of the stigma associated with mental illness, individuals may feel shame and guilt, and low self-esteem and self-efficacy towards the ability to change their life. The low self-efficacy can then lead to beliefs that nothing will help them, resulting in a belief that formal treatment will not work; thus, it raises the reasoning of why one would seek out help. Additionally, Gibbs et al. (2011) and McFarling et al. (2011) consider stigma associated with mental health and substance abuse in the military, pointing out that many in need of help never seek it out because of the stigma that the military culture has imposed on these problems.

Another reason for not seeking treatment is a lack of resources, or treatment availability. Appel et al.'s (2007) study with injection drug users (IDU) validated the presence of individual client factors that serve as barriers to enrollment, such as readiness to begin treatment or denial of having a substance problem; however, they also found that treatment accessibility is essential for all addiction treatment clients, suggesting that a larger concentration on accessibility may be more economical and efficient than on individualized treatment motivation interventions. The findings of Appel et al. on treatment accessibility may begin to explain realistic systematic constraints in society instead of solely focusing on individualized limitations, traits or factors of substance abusers seeking treatment. Ravarino et al. (2008) notes that dwindling state and federal budgets have contributed to deficiencies in funds allotted for public health for substance abuse and mental health treatment programs to assist towards recovery from substance abuse. Such decreases in funds have resulted in waiting lists for treatment programs that are subsidized by the government, and when services are finally made available to persons on the lists, many do not appear to receive such services. Limitations in funding, management information systems, and staffing have been the main perceived barriers to the linkage of services (Wenzel, Longshore, Turner, & Ridgely, 2001).

Possibly related to the issue of a lack of resources for treatment is transportation (Evans, Li, & Hser, 2008). This is especially true for rural areas, where the distance to and from the treatment agency may be such that public transportation is unreliable or unavailable. Additionally, even when public transportation is available, the individual may not have sufficient income to allow for use of the transportation system. Furthermore, when the individual has multiple problems, or a dual diagnosis (substance use and mental health), the treatment agencies may be housed in different places, adding further to the transportation issue. As with resources for treatment services, transportation is another area that needs consideration.

Type of insurance or whether the individual has insurance coverage is also a factor when looking at treatment enrollment (Lundgren, Amaro, & Ben-Ami, 2005; Schmidt &Weisner, 2005). The relationship between drug court completion and structural-level barriers is particularly strong, ranging from barriers such as 'the system' and insurance requirements (Wolf & Colyer, 2001). When individuals have private insurance or are covered by Medicaid, they are more likely to enter treatment then those covered by Medicare. However, it is also known that dropout from treatment is associated with insurance coverage. Individuals will generally maintain treatment for as long as the insurance they have pays for it. Once the insurance provider will no longer cover treatment, the odds of dropping out increase significantly. The number of sessions covered by private insurance and what Medicaid and Medicare will cover are areas to consider when evaluating how to get more people in need to enroll in treatment.

Summary. In summary, individuals with substance use or mental health problems elect not to seek treatment for a variety of reasons. Some of these, such as lack of availability, transportation, and insurance, are systemic in nature. Having influence in these areas means working within systems to create sufficient resources for individuals in need of treatment. In contrast, perceived need for treatment and stigma can be construed as individually based, although some systemic issues may also play a role in how these factors influence treatment seeking. Nonetheless, individual focused interventions can be utilized to help improve rates

for treatment entry among those in need of treatment. With respect to stigma, In Our Own Voice and Cognitive Behavioral Therapy have been used to decrease the impact of stigma (Corrigan, Rafacz, Hautamaki et al., 2010; Corrigan & Wassel, 2008). For the perceived need for treatment, Motivational Interviewing (Miller & Rollnick, 2002) has shown some promise in helping individuals recognize the severity of their problems and the need for treatment (Wain, Wilbourne, Harris et al., 2011).

4. Factors associated with treatment entry

The information provided in the previous section focused on possible barriers or reasons why individuals may not seek treatment. This section now considers factors that have shown either a positive or negative relationship with treatment entry.

Demographics. A number of characteristics have been associated with entry into substance abuse treatment. These include demographic characteristics. Gender is one element that seems to influence treatment entry. Jakobson, Hensing, and Spak (2008) compared treatment entry factors for men and women. Their findings indicated that women showed greater stigma over substance use problems than men, which hindered their entrance into formal treatment. Additionally, men entered treatment because they had a belief they could change and were looking to the future. In contrast, women entered treatment because of pressure from someone close and a need to talk to someone about their problems. Tuchman (2010) also indicates that stigma of a substance use disorder appears to be greater for women than men. She also goes on to suggest that women are more likely to face greater barriers to treatment access than men, pointing out the differences in biological vulnerabilities as a potential issue for women. Hernandez-Avila, Rounsaville and Kranzler (2004) considered differences in men and women with regard to age of substance use onset and time to treatment entry. Their findings show that women showed less time between onset of substance use and entry into treatment. Likewise, women and men did not differ in severity of substance use problems; however, women reported more severe psychiatric, medical, and employment complications. In addition, Greenfield et al. (2007) noted that the collective evidence related to substance disorders supports that women with substance use disorders have less of a likelihood, across the lifespan, to enroll in treatment, compared to males with substance use disorders. The above information suggests that gender can influence the types of problems experienced, the severity of those problems, as well as self-efficacy and readiness to change.

Age may also influence treatment entry. Shin, Lundgren, and Chassler (2007) considered admissions to all state-licensed drug treatment programs, looking at differences between younger (18-25) and older injection drug users (IDUs). Results showed that the younger IDUs were more likely to use only detoxification and not enter additional treatment. Additionally, they point out that the younger individuals were less likely to use methadone maintenance and more likely to use residential treatment services than the older group of IDUs. These findings might suggest that the younger individuals have different sets of perceived needs and that clinicians may need to consider age as a critical factor when determining treatment.

Ethnicity, race and culture may also influence entry into treatment. Cannavo and Nochajski (2011) found that African Americans were more likely to enroll in a Family Treatment Court

than Caucasians. With regard to AIDS care, findings suggest that African Americans and Latinos were more likely to be highly engaged in services than were Caucasians (Bastaa, Shachamb, and Reecec, 2008). Culture may play a significant role in subsequent treatment seeking behavior. Depending on cultural beliefs with respect to mental illness and substance abuse, individuals may be more or less likely to seek out treatment. While there has been some work on treatment dropout and treatment outcomes, studies are limited for treatment entry. More work in this area could help define interventions for specific subgroups to get people in need to treatment services.

It is also interesting to note that employment at the time of drug court enrollment was found to be predictive of successful completion of the drug court treatment program (Roll, Prendergast, Richardson, Burdon, & Ramirez, 2005); this court was mostly methamphetamine abusers. Logistic regression analysis by Cannavo (2008) for a study of a Family Treatment Court found that unemployment showed a marginal trend for significance to identify those individuals who may be more likely to enroll in the FTC program.

Substance Abuse Behaviors. Various substance use behaviors were also predictors of enrollment. Cannavo & Nochajski (2011) found that substance users who shared needles were less likely to enroll in an FTC; however, as the number of drugs used in the last six months increased, the likelihood of enrolling in the FTC also increased. Prior treatment for substance abuse also led to a greater likelihood of enrolling in an FTC. In addition, Corsi et al. (2007) found that having fewer problems with alcohol yet more problems with opiate drugs were associated with enrolling in drug treatment among IDUs recruited from the street. In a study of illicit stimulant users in rural United States, those who had higher Addiction Severity Index (ASI) legal problem composite scores were positively associated with enrollment into treatment; having had a history of experiencing substance abuse treatment as well as tranquilizer use were also positively associated with enrolling into treatment. Those who did not use crack cocaine or marijuana on a daily basis were less likely to enter treatment (Carlson et al., 2010).

Also among the limited enrollment literature related to substance abuse enrollment, Booth et al. (2004, 1996) studied enrollment in the form of treatment entry and retention on the IDU population. Booth et al. (2004) examined factors associated with methadone maintenance retention, which the authors defined as remaining in treatment for a minimum of 90 days, and the injection drug users (IDUs) was again examined. A sum of 577 IDUs were randomly assigned to either a risk reduction intervention, focusing on safer injection and sex behaviors, or motivational interviewing, addressing more sweeping lifestyle changes including drug treatment. All persons who wanted treatment were given transportation, expedited intake process and a waiver of the intake fee. In addition, 50% were randomly assigned a voucher for ninety days of treatment free of cost. In total, 33% entered treatment and 60% of those who entered treatment remained for at least ninety days. Factors associated with retention that are relevant to enrollment included higher methadone dose, treatment at no cost, as well as greater contacts with the clinic. Interestingly, although desire for treatment, or motivation, was associated in univariate analyses with greater retention, no differences were noted between motivational interviewing and risk reduction interventions (Booth et al., 2004). In addition, in an earlier study, Booth et al. (1996) studied the same population. Factors positively correlated with

treatment entry included having had the experience of prior treatment, outreach intervention by community workers, not injecting cocaine, and injecting opiates. Sites where the enhanced intervention included an active referral achieved significantly higher treatment entry rates than sites where the enhanced intervention did not include an active referral. The addition of staff assistance to facilitate clients' entry into treatment and the involvement of community outreach workers were both noted in achieving treatment entry.

Consistent with such findings related to enrollment and community outreach, Coviello et al. (2006) studied outreach case management for post-discharged methadone patients. Heroin dependence is a chronic relapsing disease often requiring multiple treatment experiences; however, a minimal number of methadone programs follow-up with clients who have been discharged. At 6 months following the start of intervention, 29% of the outreach case management clients had successfully re-enrolled in drug treatment compared to 8% of former participants who had received the standard referral for services. A logistic regression analysis showed that outreach case management clients were almost six times more likely than standard referral clients to re-engage in methadone maintenance treatment. In addition, outreach case management clients had fewer opiate and cocaine positive toxicologies at the 6-month follow-up compared to standard referral participants. The findings demonstrate the significance in engaging former clients in treatment and actively supporting them towards treatment re-entry (Coviello et al., 2006). In addition, support for professional outreach was also found in a study of 491 opiate-using IDUs recruited from the street, where more outreach contacts increased the likelihood of treatment entry (Corsi et al., 2007). There has been much support for outreach case management, as it is a straightforward approach to reduce the number of out-of-treatment drug users. The previous data reinforce the need for active referral processes, good follow-up with referrals, and available resources to allow for timely treatment entry. The issue seems to be one of increasing the load on an individual who may already be at capacity. Asking them to perform another task, or wait for available spots in treatment programs, may push them towards avoiding treatment. These findings also underscore the limited enrollment opportunities due to the often compromised availability of treatment funding (Coviello et al., 2006)

Alcohol Use. In terms of potential predictors of help-seeking for alcohol problems, studies have found that entering treatment is related to various demographic characteristics (Kaskutas, Weisner, & Caetano, 1997; Weisner, Matzger, Tam, & Schmidt, 2002), environmental contexts (Tucker, Vuchinich, & Pukish, 1995), perceived barriers to treatment (Cunningham et al., 1993), and history of prior treatment (Freyer et al., 2007; Weisner & Matzger, 2002; Wieczorek & Nochajski, 2005). Although greater problem severity predicts treatment entry (Bannenberg, Raat, & Plomp, 1992; Freyer et al., 2007; Hingson, Mangione, Meyers, & Scotch, 1982; Weisner & Matzger, 2002; Weisner et al., 2002; Wieczorek & Nochajski, 2005), help-seeking is less influenced by amount of alcohol consumed, and more by the degree to which drinking contributes to adverse health, relationship, and work-related consequences (Beckman & Amaro, 1986; Hingson et al., 1982; Simpson & Tucker, 2002; Tucker & Gladsjo, 1993; Tucker & King, 1999). In one study, individuals who had 3 or more lifetime drinking-related consequences were 4.5 times more likely to seek help during an 8-year follow-up than those who had less than three drinking-related consequences (Kaskutas et al., 1997). In a study looking at treatment engagement and treatment readiness or motivation, Knight, Hiller, Broome,

and Simpson (2000) found that the best predictor of engagement and outcomes was the individual's readiness or motivation for treatment. When comparing individuals entering treatment with individuals in the general population, Storbjork and Room (2008) found that previous treatment, unemployment, age, problem severity, and consumption were related to treatment entry. Finally, in a study involving DUI offenders, Wells-Parker, Dill, Williams and Stoduto (2006) found that depression was related to a willingness to seek treatment.

Therapeutic Courts. A study by Cannavo and Nochajski (2011) on enrollment in a Family Treatment Court found that African Americans were marginally more likely than all others to enroll in the FTC. In addition, if the individuals received more than $3000 in government assistance over the previous year, they were 2.4 times more likely to refuse to enroll in the FTC. Prior treatment for substance use showed a marginal trend, indicating that individuals who had prior treatment for substance use were over twice as likely to enroll than those who did not have prior treatment for substance use. There was a significant effect for the total number of drugs used in the 6 months prior to the FTC assessment, reflecting that for every unit increase in the number of drugs, there was a 49% increase in the likelihood that the individual would enroll in the FTC. There was also a significant effect for sharing needles, indicating that those who shared needles were approximately 76% less likely to enroll in the FTC than those who did not share needles. Finally, the motivation to change substance use behavior showed a marginal trend reflecting an increase in the likelihood of enrollment of approximately 5% for every unit increase in motivation to change. Regarding aspects of parenting factors, for every unit increase in the number of activities parents engaged in with their children, there was a 21% increase in the likelihood they would enroll in the FTC. Of specific interest, in terms of the activities, were reading and doing chores. Parents who engaged in reading activities with their children, were over 3 times more likely to enroll in the FTC than parents who did not engage in this activity with their children. Those parents who engaged in chores with their children were almost 3 times more likely than parents who did not do so to enroll in the FTC. In regards to recognizing the impact of substance use on parenting, relative to the individuals who did not recognize that drug and alcohol use had an impact on their parenting, those who did recognize this were over twice as likely to enroll in the FTC. While some of the variables noted here play a role in the decision to enroll in the FTC, there are other factors that also contribute to the decision-making process that were not included in the study which suggest various other reasons to enroll that exist and supports the needs for further study in this area (Cannavo & Nochajski, 2011).

5. Model for treatment entry

The information presented thus far suggests that treatment entry may be a complex issue, with numerous elements to consider if we wish to increase treatment experience for those who need it. However, from a standpoint of actual development of intervention strategies to help increase treatment experience, it would suggest that we need to consider a range of things. In Figure 1, we propose a model of treatment entry that suggests the best point for interventions might be readiness for change. Let's consider the model in that context. Stigma would be represented as psychological distress in the current model. For substance use, we include the type of substance, type of use, severity of the problems, frequency of use, and expectancies related to the primary substances of use. Personal

history would include any childhood or adult victimization, interpersonal relationships, peer-related issues, family-related issues, school-related issues, and work-related issues. For self-efficacy, we are focused on the confidence the individual has that they will be able to remain abstinent, or at a minimum reduce the risky use of substances to a less harmful consumption pattern. Within the mandates we are including only criminal justice and work-related referrals. Family referrals would fall under substance use problem severity.

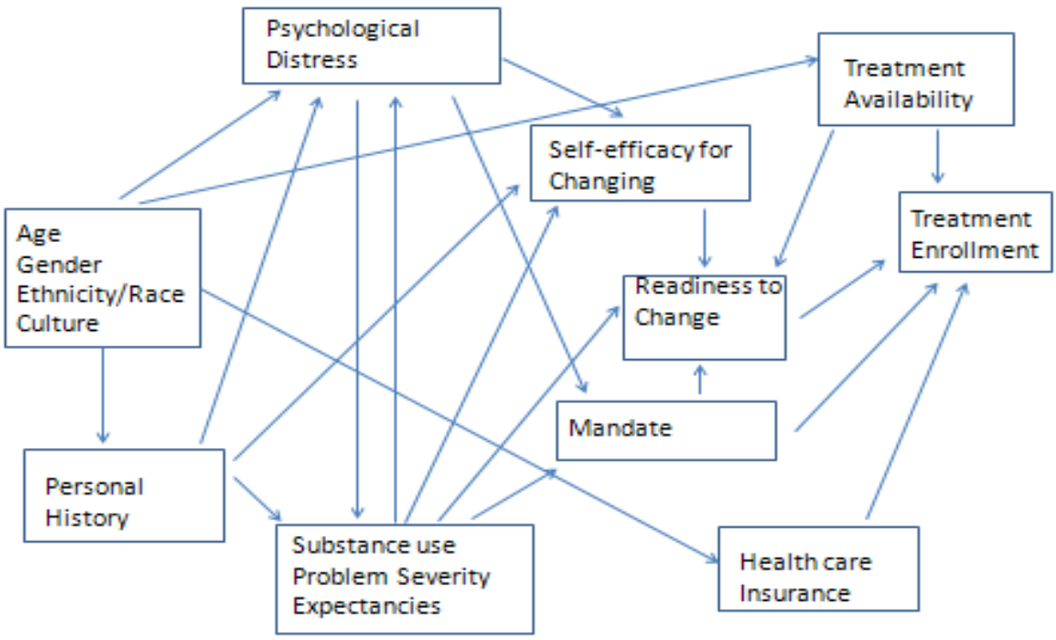

Fig. 1. Model for treatment enrollment in substance abuse treatment agencies.

With respect to readiness to change, there are two forms, readiness to change risky behavior, and readiness to enter treatment. While the readiness to enter treatment may reflect a readiness to change, that may not always be the case; as such, we have chosen to focus on treatment readiness. However, we use the Transtheoretical Model of Change for the purposes of this chapter, even though progression and tasks might differ between the two forms of readiness. The Transtheoretical Model of Change views motivation or readiness to change behavior as a multidimensional series of tasks or stages that are part of intentional behavior change processes (DiClemente, 2003; Prochaska & DiClemente, 1984). While the literature is mixed on the idea of whether intentional behavior change follows discrete stages or is more continuous in nature, the stage approach provides a good mechanism for understanding the underlying mechanisms for change that are needed to be in play as the person moves towards recovery or a better quality of life. The model proposes five stages that move from problem non-recognition to problem resolved and behavior change attained and stable. The first stage is that of precontemplation. This stage can be construed in two ways. One is when the individual does not see a need for changing their behaviors because

they may not perceive sufficient evidence to suggest that change is necessary. A second group may know they have problems but elect not to change their behaviors for various reasons. Within the context of information we have presented thus far, stigma might result in the latter, where individuals recognize they have a problem but see no way to change their behavior. Likewise, individuals may recognize they have problems but not have the resources for formal treatment entry. As such, we need to consider these elements as we look at readiness to change.

The second stage is that of contemplation. In this stage, the individuals have recognized their vulnerability but are not yet completely swayed that they need treatment or that treatment will be effective in reducing their problems. Self-efficacy may enter into this decision process, as a lack of belief in the ability to successfully change behavior could result in a decision not to enter treatment and a move back to precontemplation status. Another way that self-efficacy may enter into the decision is when it is actually very high, where the individual may believe that 'I can quit anytime I want to,' which would lead to non-entry into treatment. However, Davey-Rothwell, Frydl, and Latkin (2009) showed that individuals who engaged in attempts at trying to change their behavior were more likely to engage in treatment. The authors suggested that it may have been due to the social networks they formed when attempting to quit, pointing out that research suggests that if the social network contains more individuals who are in treatment or attending AA or NA, the individual is more likely to engage in treatment. What this means is that the issue of self-efficacy is complex and needs to be understood within the context of other elements in the model.

The next stage in the process is preparation. If the individual moves towards making the behavioral change, they next need to make a commitment to the change and develop a plan. Here we might see the individual begin the process of making some of the changes that Davey-Rothwell and colleagues indicated in their study but from a treatment entry perspective. They may begin to think about how they will get to the treatment agency, and what they need to take care of prior to entry, especially if it is an inpatient or residential treatment setting. If they stay committed, they will then move into the action stage and begin to take the actual steps of entering treatment. The dynamic nature of the model allows for set-backs, such that individuals may return to prior stages for various reasons. If there is a wait list for treatment, the individuals' readiness may lessen and they may end up not entering treatment. Likewise, if something happens in the person's life, the individual may shift again towards an earlier stage where treatment entry is not an option. If the individual has a dual diagnosis, this may be a significant factor. How is the mental health treatment being handled? Is it in a different agency from that where the substance abuse is being treated? If yes, there may be a chance for the individual to not enroll in one or the other treatment programs, increasing the likelihood for relapse. Insurance payments, or lack of economic ability to pay for treatment, is another factor that may result in relapse, as the individual may drop out of treatment before the positive benefits have been attained.

The final stage is that of maintenance, where the task is to sustain the behavior change. Here the individual should normalize the new behavior so that it becomes second nature. However, as with the other stages, the dynamic nature of the model allows for regression to occur. Until the individual has completely incorporated the new behavior into his/her

lifestyle, there is always the potential for a relapse. Considering the model, this may occur if new life events unfold that result in trauma for the individual, which may trigger old cues for substance use, which result in the increase of use until it becomes hazardous, increasing the psychological distress, decreasing the belief that change can occur, and deflating the readiness to change the risky behavior which they make an everyday experience. Thus, the model we propose has the flexibility to handle the varied situations that may arise concerning treatment entry.

Summary. In summary, the model recognizes that demographic factors such as age, gender, race/ethnicity, education, income, employment and culture can influence the personal history of the individual, as well as the development of psychiatric problems and substance use issues, and treatment availability. We also recognize that personal characteristics like childhood sex abuse or other forms of traumatic exposure can result in psychological distress that persists into adulthood. Similarly, we also recognize that trauma of any type may influence the psychological distress of the individual. Additionally, we recognize that personal factors like family relations, interpersonal relations, and work relations, may result in specific mental health or substance use patterns. The model also recognizes that psychological distress both influences and is influenced by substance use. Personal history also shows a relationship with self-efficacy, as patterns of substance use in the family, family history of mental illness, family functioning, and interpersonal relationships may all influence the development of self-efficacy.

Mandates show both a direct path to treatment entry, as well as an indirect pathway through readiness to change. This gives recognition to the fact that many individuals may be mandated to treatment but not all enroll and many who do enroll never fully engage in the process, suggesting that readiness to change may be low. We expect a similar effect for treatment entry. In the model that is presented (Figure 1), we also show direct paths to treatment entry for insurance and treatment availability. For treatment availability we show an indirect path through readiness to change. This reflects the effects of time delays on an individual's motivation level for treatment entry. The longer the period of time between the initial attempt at treatment entry, or the more energy an individual needs to expend to enter treatment, the less likely they are to enroll in treatment.

In essence, the model gives credence to all the factors that have shown a relationship with treatment entry but places them in a context where potential associations between factors may be identified. While placing emphasis on readiness to change, the model gives recognition to all factors of importance; but basically it is suggesting that when we consider how to increase treatment entry for those in need, an area that may provide more cost-effective outcomes is readiness to change. Within that context we can consider the influence of gender on personal history, psychological distress, and substance use and how those factors may interact to produce specific levels of readiness to enter treatment, which will inform the approaches used to increase the motivation to change of the individual. Similar statements can be made for ethnicity and culture.

The underlying point is that one can consider how all other factors may relate to readiness to enter treatment and then develop a plan to increase the entry into treatment for those who are in need.

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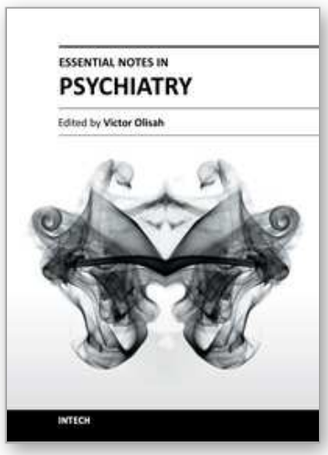

Essential Notes in Psychiatry

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Psychiatry is one of the major specialties of medicine, and is concerned with the study and treatment of mental disorders. In recent times the field is growing with the discovery of effective therapies and interventions that alleviate suffering in people with mental disorders. This book of psychiatry is concise and clearly written so that it is usable for doctors in training, students and clinicians dealing with psychiatric illness in everyday practice. The book is a primer for those beginning to learn about emotional disorders and psychosocial consequences of severe physical and psychological trauma; and violence. Emphasis is placed on effective therapies and interventions for selected conditions such as dementia and suicide among others and the consequences of stress in the workplace. The book also highlights important causes of mental disorders in children.

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