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BARRIERS TO DRUG TREATMENT FOR IDU COUPLES: THE NEED FOR COUPLE-BASED APPROACHES

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This qualitative study examines the interpersonal and structural barriers to drug treatment program entry, retention, and outcomes experienced by injection drug-using couples, and the program policies regarding injection drug-using couples seeking treatment in New York, New York. Our findings reveal a mismatch between the substantial need for concurrent and coordinated treatment for partnered injection-drug users and programmatic policies that are antithetical to such treatment approaches. This discrepancy can be attributed to the lack of viable options for couple-focused treatment approaches that fit within the current drug treatment system. We provide a rationale and a roadmap for the development of innovative approaches for couple-based drug treatment.

KEYWORDS. IDU couples, partnered IDUs, injection drug use, drug treatment barriers, couples-based drug treatment

INTRODUCTION

This article presents the results of ethnographic research on barriers to drug treatment experienced by drug-using heterosexual couples in New York, New York. Drawing on the results of our research, we provide a rationale and a roadmap for developing couple-based interventions in a transformed drug-treatment system. In the current system, couple-based treatment approaches could help to motivate many drug users and their partners to enter and stay in the system. However, couple-based treatment holds even greater promise within a reformed system operating within a chronic-care model that prioritizes harm reduction and recovery.¹ This chronic-care model integrates a variety of evidence-based, drug-treatment options, med-

ical and mental health care, and community supports (e.g., housing, vocational training, and job placement). We discuss the results of our study in light of the critical need and the transformative potential of these emergent changes.

Calls to transform the drug treatment system are not new.^{2,3} However, there is growing recognition that current approaches to drug treatment in the United States must change.¹ The current system is characterized by an acute care model,⁴ the perpetuation of treatment silos, the marginalization of drug treatment from medical and mental health care, insufficient support for high-quality counseling, and the polarization of harm reduction and drug treatment. Ambivalence about those who are dependent on illicit drugs (“not quite a patient, not quite a criminal”)² and the stigmatization of

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methadone and methadone patients have also greatly limited treatment effectiveness.^{5,6} However, despite these considerable limitations, it is important to emphasize that, compared with out-of-treatment drug users, those in treatment show improvements on a broad range of quality of life and critical health outcomes.⁷ Drug treatment has proven to be an effective method for reducing drug use, as well as drug and sex-related HIV risk among injection drug users (IDUs),⁷ increasing adherence to antiretrovirals,⁷ decreasing mortality from overdose,⁸ and improving quality of life.⁹

However, the current drug treatment system serves only a small percentage of those in need. In the United States, only 8% of IDUs in need of treatment receive services. This low coverage has changed little since the 1980s,⁸ despite the fact that injection remains a predominate mode of administration for illicit drugs.¹⁰ Research conducted by Appel et al.¹¹ to account for low coverage rates for IDUs in New York City revealed that different barriers to treatment were identified by different stakeholders. Service providers and administrators focused on structural barriers to treatment, but the most significant barriers identified by IDUs centered on family/personal issues and the demands of addiction. These issues included having to care for, or not wanting to abandon, a significant other. Research by Simmons¹² and Simmons and Singer¹³ about drug-using couples in Hartford, Connecticut, revealed similar concerns when both partners were using. These studies point to the importance that IDUs give their intimate relationships and (to some extent) the relative unimportance that other stakeholders place on partners and families in the publicly funded treatment system.

Relationship-level barriers become even more complex when both members of a couple are injectors. According to our own data from New York City, more than 40% of IDUs are sexually partnered with other IDUs.¹⁴ However, research on partnered IDUs is scarce. The few studies that have been conducted demonstrate that the intimate partners of drug users play important roles in determining treatment options, particularly for women (see Sim-

mons for a review).¹² For example, Riehm et al.¹⁵ found that having a partner who had been in treatment increased women's interest in treatment, but having a partner who used drugs and was not in treatment decreased their interest. McCollum et al.¹⁶ found that relationships that were closer and more satisfying predicted negative treatment outcomes for women, including more days using drugs and failure to complete treatment. These findings underscore the complex interpersonal dynamics enacted among couples that impact treatment entry, retention, and posttreatment outcomes.

In prior research with couples where both partners use drugs—particularly heroin—Simmons and Singer¹³ found that partners cared for each other by helping each other avoid the pain of withdrawal. A care and collusion dynamic served to maintain their relationships and their addictions.¹³ Gendered dynamics also came into play. A companion article to the current study describes how complex these gendered dynamics can be.¹⁷ The desire of women to feel closer to their partners and men's belief that they could control their partner's use often led men to initiate their non-injecting partners to injection. Structural dynamics also played a part in these injection initiation scenarios.

The existence of complex interpersonal and structural dynamics underscores the need for new approaches to drug treatment for injection-drug using couples. In addition, the risk profiles of partnered IDUs make the need for successful treatment particularly acute. Partnered IDUs have limited success in reducing drug use¹⁸ and accessing drug treatment compared with their non-partnered peers.^{12,15} They report high rates of injection drug use¹⁹ and needle sharing^{20,21} and low rates of condom use,²² leading to a high risk for HIV from both drug-related and sexual-risk behavior.^{20–26} Partnered IDU women are especially vulnerable to poor health and drug treatment outcomes due to gender-based social inequalities and greater biological susceptibility to HIV infection.²⁷ The development of successful couple-based treatment approaches that overcome relationship-level and structural barriers to drug treatment could have a substantial

effect on drug use, HIV risk reduction, and improved quality of life.

The current study builds on preliminary research conducted in Hartford^{12,13} with a similar population in New York City—primarily African American and Puerto Rican injection-drug using couples. We conducted qualitative interviews with partnered IDUs and treatment providers with the aim of identifying relationship and structural barriers to drug treatment. In this article, we used these findings to provide a rationale and a roadmap for developing couple-based interventions to improve access and retention in drug treatment, both as it exists currently and in the context of a transition to a much improved drug treatment system in the future.

METHODS

Recruitment of Study Participants

Couples Twenty-five relatively stable, drug-using couples (20 IDU/IDU partnerships in which both partners inject; 5 IDU/NIDU partnerships in which one partner injects and the other is a non-injecting drug user) were recruited from two of New York City's most impoverished neighborhoods—Harlem and the South Bronx. HIV/AIDS prevalence and incidence in New York City is among the nations' highest. Rates of new HIV diagnoses and rates of people living (and dying) with HIV/AIDS in these neighborhoods are more than twice the rates in New York City overall.²⁸ The majority of those recruited were African American or Puerto Rican. All partners were screened prior to enrollment according to the following eligibility criteria: (1) they both identified as a couple; (2) they had been together for at least 2 years; (3) they both used heroin or cocaine; (4) at least one partner had injected heroin or cocaine in the past 30 days or had a history of injection prior to entering drug treatment (for those currently in drug treatment); (5) they resided together in Harlem or the South Bronx; (6) both were between the ages of 18 and 65 years; and (7) both consented to participate in the study. To gain a broad range of experiences,

the sample included couples who had been out of treatment for at least 2 years, who were currently in treatment, or had recently left treatment. HIV seroconcordant and serodiscordant couples were also represented. HIV and HCV status were provided via self-report. A couple-verification screening instrument was also administered.²⁹ Each participant was remunerated (\$25 for initial interviews; \$15 for follow-up field visits; \$50 for final interviews). Recruitment and data collection occurred between 2007 and 2009. A federal certificate of confidentiality was granted, and an institutional review board approved the study.

Treatment Providers Treatment providers were recruited from the 3 main treatment modalities operating in New York City: residential treatment, outpatient, and methadone maintenance programs. A total of 19 treatment providers from 11 sites were interviewed. The sites included 5 residential and 3 outpatient programs, 2 methadone maintenance programs, and 1 buprenorphine provider. In most sites, both a program director and a frontline worker were interviewed. Recruitment and data collection occurred between August 2008 and February 2009. Providers received a \$20 gift card for their participation.

Data Collection

Individual ethnographic interviews were conducted with each partner at our Harlem field site. The interviews lasted between 45 minutes and 1.5 hours. Questions incorporated into our interview guide were drawn from our study aims. Topics included drug-use and treatment history, including obstacles to access, retention, and maintenance of treatment outcomes, attitudes toward treatment, relationship history and dynamics, risk practices, housing status, and work history. A subset of 10 couples was selected for follow-up field visits conducted over a 9- to 12-month period. Couples were interviewed jointly at the conclusion of the study. A second set of hour-long ethnographic interviews was conducted with the 19 treatment providers. Topics included history of work in the addictions field, experience with special populations (especially couples),

couples-related issues and challenges, and policies regarding couples.

Data Analysis

Interviews were recorded and transcribed verbatim and then coded and analyzed with the aid of Atlas ti³⁰ using a modified grounded-theory approach.³¹ At the outset of the study, a set of deductive codes was drawn from the interview guide. An additional set of inductive codes was created to capture themes that emerged from the data. Descriptive summaries of couple characteristics, drug use, treatment histories, and key life events were compiled to further contextualize analyses. Using a dyadic risk environment conceptual framework,¹⁷ summaries and coded segments were compared and contrasted. Analyses of provider interviews were conducted separately and compared and contrasted with key findings from the couples' interviews. All names used are pseudonyms to protect confidentiality.

RESULTS

In this study, our dual client–provider approach provided valuable insights into the drug use and treatment experiences of partnered IDUs, as well as the treatment provision experiences of administrators and providers. Injection-drug using couples experienced numerous barriers to treatment entry, retention, and maintenance of outcomes. Some barriers were not exclusive to couples: the demands of addiction, stigma, trauma, past negative treatment experience, problems with Medicaid, resistance to (and lack of knowledge about) particular treatment modalities, and lack of access to comprehensive treatment services. However, we also found that couples experienced a unique set of challenges related to interpersonal dynamics, as well as structural barriers encountered in the provision of treatment and related services (e.g., New York City shelter system). Treatment providers reported challenges dealing with injection-drug using couples. The combination of interpersonal dynamics and structural barriers often worked to delay treatment entry or adversely affected retention and treat-

ment outcomes. We present recurring themes relating to interpersonal and structural barriers (and their interplay) that effect the treatment experiences of injection-drug using couples.

Interpersonal Dynamics

“We’re Like Any Other Couple” As in the Hartford study, patterns of caring for each other in sickness and in health bound couples together in a dynamic of care and collusion, which tended to reinforce continued drug use.^{12,13} Love, loyalty, guilt, or fear of losing the relationship often made it difficult to seriously consider treatment options. For the majority of men and women in this study, their relationships were their primary source of emotional support. A large percentage had been with their partners for many years. For example, María had been with her partner for 36 years.

Despite decades using heroin together, she had a positive view of her marriage:

It’s always been something that I could come back and lean on. I don’t know what I would have did [sic]. With him, no matter how bad I feel, I always go and lean on him, and he knows the same about me. I know I can always go and tell him anything and he’ll try and help me.

Alicia also stressed the importance of her long-term relationship: “We love each other, and we talk about everything.” Camilo defended his love for his long-term partner even though he was often frustrated by her inability to lower her drug use as much as he had:

Clarisa is the greatest person you’ll ever run into. She’s really a great person. She just likes her heroin.

Raúl, who had previously been married to a non-user, declared:

I love the shit out of my wife. We have a beautiful relationship. We can communicate. We help each other. We’re like any other couple but, you know, it gets crazy when we use.

Like Raúl, several other men had been married to non-users, and valued the openness and honesty that their current relationship with another drug user afforded them. Nevertheless, conflict

was also common among some partners, and the discord was often attributed to drugs:

Our fighting was because of the fuckin' drugs. That's crazy. I've said some cruel things because of the drugs. This isn't me. And he's done it to me too, and I say, "Look at us. We're turning on each other because of the drugs!"

While interpersonal violence in drug-using relationships is common, most of our participants recounted interpersonal violence in former but not current relationships. (Although it is possible that partners are less likely to reveal violence with current partners,³² it is more likely that couples who chose to enroll in this study had more stable relationships.) Much of the violence recounted with former partners was extreme (shot at, stabbed, hit with heavy objects) and some of it (2 rapes and 1 abduction/rape) preceded initiation to injection.¹⁷

"If I See Him Do It, I'm Gonna Do It"

Eventually, problems caused by escalating drug use made one or both partners want to reduce or end their dependence on illicit drugs. But accomplishing this within the context of a shared addiction is uniquely challenging. When one partner is using, it is difficult for the other to stop, as Marta made clear: "If I see him do it, I'm gonna do it 'cause I'm an addict too." When one partner desires to seek treatment, they often feel that the effort will be futile. When they return home their partner will still be using:

I could [go to treatment] but it makes no sense. If he's doing it [using drugs], when I come back home, forget it. You understand?

Even when both partners are willing to enter treatment and concurrently stop using, if one relapses, the other is almost always sure to follow. To stay clean, both members of a drug-using couple must be ready to seek and maintain treatment. Depending on the couple and the conditions surrounding their drug use, this can represent either a mutual barrier or a mutual catalyst for seeking treatment and reducing drug use. Here, Jacinto relates his confidence that he can convince his partner to enter treatment with him:

We just talk about it. If I feel strongly about it, I can talk her into it 'cause I'm tired of this shit. We could do better.

After a period of abstinence, a relapsing partner may attempt to hide his or her drug use so as not to trigger use by the other, as in the case of Nelson and Natalia. Both had been clean for some time but Nelson relapsed. Not wanting Natalia to relapse as well, he hid his use from her. Natalia explains how this ultimately resulted in a threat to their relationship—he found another woman to use with:

He said it was just a fling from getting high. It was more like a runnin' partner. He used to do things in the street more than being home 'cause he didn't want me to get high. So, I guess he met this girl and they kind of liked each other.

Nelson's infidelity led Natalia to relapse, but she was comforted with the knowledge that he would be less likely to use with other women when they used together.

Couples often faced substantial challenges when trying to leverage mutual support to quit or reduce drug use without entering treatment. Marta talked about how she and her partner desired to reduce their dependence on drugs, but their mutual addiction and the dynamics of their relationship made this difficult to achieve on their own. Often, one partner could not gain support from the other. Although both Milagros and Matthew were using methadone, Matthew also supplied cocaine for their consumption. Milagros expressed a desire to stop but could not resist using cocaine when Matthew made it available to her. It was only after Matthew was incarcerated that she was able to enter a program and stop using.

"If I Go In, What's Going to Happen to Her?" The sense of obligation to take care of a partner prevents many partnered drug users from seeking or even discussing treatment options. This is especially true for women, but men also describe this predicament. When asked whether she and her partner discussed treatment options together, Dolores recounted the difficulty:

I wanna talk to him about it, but then sometimes I don't wanna talk about it because sometimes I wanna go, but then he's gonna be out by himself. Who's gonna help him? Who's gonna cook for him? Who's gonna wash his clothes? Who's gonna be there for him? He'll probably wanna go too. But he's probably worried about "What is she gonna do? I'm going in, what's gonna happen with her? Is she gonna be all right? Is she gonna do this?" We [are] each other's backbone.

Alejandro talked about confronting the same dilemma.

I think about going into a treatment program. But to leave her by herself, I don't wanna do that. They won't put us together. They won't do that. We talked about that. They can't have a couple together because of jealousies, this and that, blah-blah-blah. I asked before, and they told me that.

When one partner is able to enter treatment or leave the relationship, the fate of the partner left behind can be affected in a dramatic way, positively or negatively. Chris managed to leave a former partner to enter a drug treatment program.

It was too much. That's when I went to the drug program for the first time. I was using too much and had started shooting coke. I never even did that before, and it was spiraling out of control. I told her, "I can't do this. I'm going to go into long-term treatment."

While he was in treatment, her drinking and drug use escalated. Chris found a new partner while receiving treatment, and he later learned that his former girlfriend succumbed to a fatal overdose.

"We're Going To Do This Together"

... When both members of a couple are ready to seek treatment and communicate this readiness, their mutual decision-making and support is essential to enactment. Juanita described her experience:

We decided [to get on methadone maintenance] together. We always make decisions together. Maybe if he wouldn't want to do it, I wouldn't want to do it, you know what I'm saying?"

The benefits—even necessity—of mutual agreement and support for seeking out and staying in treatment together were exemplified by Caridad:

We love each other, so we're going to do this together. We're both going in at the same time, and we'll both finish at the same time . . . and we'll both be straight and clear. 'Cause [if] one can go do it and not the other, then it's not going to work.

"I Have Too Much To Lose . . . My Kids"

Mothers described leaving, or threatening to leave, a spouse to enter treatment in order to motivate him and to keep or regain custody of their children. Maggie used her relationship and children to overcome her husband's resistance to entering treatment. Once he agreed, she entered first, and then he followed:

I told him I was going into treatment and if he didn't want to go, I wasn't staying with him. I knew people that had tried it with their spouses using and they would always relapse. I told him, "I won't hold your kids from you, but you will be clean to see the kids." So, he went in and he hasn't relapsed either. Something just told me that if he doesn't go in now, he'll never go in. So I just said, "I'll go in first and check in, and then you come in after me." He went in the day after. He just walked in and said, "I need to get treated."

Structural Barriers to Treatment

"No Couples" Policies All but 2 treatment programs in this study had a "No Couples" policy. Couples were prohibited from entering the same program together. Some programs attempted to refer one partner to an alternative treatment site while retaining the other in their program. Almost all providers justified these policies, highlighting the complex dynamics that couples bring to treatment. Providers held that "No Couples" policies were established to help individuals participate more fully and more effectively in their own recovery and safeguard the recovery of others:

Their recovery comes first, and that's what we emphasize. There's no way that you're going to get the help that you need if you're in there with your significant other. I don't

think it's the recommended route of treatment for anyone.

We can't [admit couples] because of what happens in groups. . . . We're just not equipped to handle it.

Several providers recounted incidents involving couples in the treatment setting who had covertly bypassed the "No Couples" policy.

Every once in a while, we get a husband and wife that has snuck in and not told us. They do it sometimes, not a lot though, because they know that we don't operate like that. They get split up. One of them is going to have to go to another agency for their help. That's probably the healthiest way to do this.

Another provider described how an undisclosed couple with a child was accommodated.

Sometimes a family comes in and they don't realize it until stabilization. They didn't kick them out, just moved the father into the adult program and kept the mother and child in the family program. They worked with them as long as their goal was reunification and a drug-free lifestyle post-treatment.

Although "No Couples" policies made sense to providers from a clinical (need to focus on self) and programmatic (use of peer groups) perspective, they nonetheless served as a barrier to treatment entry for many couples, who perceived the policy as discriminatory.

There's a lot of couples out there that don't fight; they want to be together, but they don't know how to go and get help together and they don't want to leave each other. They want to be together. They feel more comfortable that way.

Many of the couples in this study actually met and started their relationship in detoxification or treatment programs (both residential and outpatient). Several who met in therapeutic communities were summarily discharged or left on their own accord after being disciplined for sitting together, sending notes back and forth, or otherwise displaying affection to one another. The dual-gender residential treatment programs participating in this study use a "contract" system. Displaying any affection is a rule violation,

and couples caught in one of these infractions are expected to refrain from seeing each other and are given a contract for a predetermined time (often weeks) that takes away earned privileges, such as phone calls to relatives, movies, field trips, and visitation passes.

Rationales for prohibiting romantic attachments in treatment, especially early treatment, were well articulated by many providers. All programs, whether they penalized clients or moved them out of programs because of attachments formed in treatment, attempted to educate their clients about healthy relationships.

One of the first things people will do when they're confronted with the vacuum that active addiction leaves inside of them when they get sober, especially in early recovery, is grasp onto other things to fill that void. And one of the things they do is use other people to do that. And so, you know, it's a good time to begin to do some education with them around that kind of a substitution.

Relationships tend to blossom here by themselves. And it really causes the client to be more concerned about what their significant other is thinking about them, rather than what they need to do to focus on themselves. So we talk about getting the client to really have their own autonomy and speak to the fact that they're doing this for themselves, that they're not going to even be able to be a comprehensive part of a couple if they're high all the time.

However, the participants often felt that these policies were unfair and unjustified. One of the couples who met in residential treatment and ended up leaving together, explained:

They don't want you getting into a relationship, but we're grown-ups. We're not kids. You can't tell grown-ups what to do. They put me on a contract, and that's why I had to leave.

The program's theory is that no two addicts can make it and I feel that's totally wrong 'cause we're a perfect example. We've been together years. Even though we're not clean right now, the drugs aren't the main reason for our staying together. I love her; she loves me. We have a good relationship.

Moreover, comparing couples who recently met in treatment with those who had been together for years was nonsensical to study participants. They stressed the importance of receiving treatment together as a couple.

We tried to explain to them that we went into this together. We've been together a long time. We had been together years before we started getting high together [and] that we want to come out of it together also. It's not like I'm going to get out of it and he's not going to. This has to be done together.

Raúl, who was married 6 years with children, recounted his experience when both he and his partner unsuccessfully attempted to enter a treatment program together.

We got the interview on the same day and got caught talking . . . so they knew [we were a couple]. She ended up going to a program, and I ended up on the streets. But I think it would have been a huge problem. I am a very jealous person, but I would have liked for us to come together at particular times to work in a therapeutic way as a couple.

Although conceding that his jealousy may have caused problems in the program, Raúl pointed out that the "No Couples" policy sent him back to the street. He suggested an alternative approach in which couple-based therapy is provided to partners enrolled in separate programs. Given the focus on groups in treatment, another participant supported the idea of having a group for couples.

They need one for women, one for men, and they need one that is unisex, for couples if they want to go. Because the couples, if they plan on staying together, staying in treatment [they need it], not only for the methadone, [but for] some kind of mental health treatment together also.

"No Couples" policies also reflect broader perspectives in the treatment system that discourages contact and communication between drug-using partners. These partnerships are believed to be enabling, often violent, and ultimately an obstacle to successful treatment. A provider from a "Women Only" program shared this perspective:

We don't have too many couples. A woman may come in and say, "Well, my significant other doesn't use." But usually you find out that they are both using and most of them have domestic violence issues. When one uses, the other one is usually the enabler. It's hard to have two people that use and one goes to treatment and the other one doesn't 'cause what ends up happening is that the one that's in treatment is pulled out because why is she going to stay in there while he continues to get high?

Not all providers unequivocally supported the "No Couples" policies. After reflecting on these topics in the interview, one program director stated:

It's no wonder why we don't see many couples in treatment. We tell them "no" at the door. If it is important to them, it should be important to us.

In addition, providers who had been trained in family systems and couples therapy were frustrated with their inability to use their skills in their respective programs to the benefit of their clients. They blamed overly prescriptive rules and regulations that limit providers from communicating with individuals and agencies outside of their own facility. However, most programs did not have providers with training in couples-specific therapies.

Little Coordination of Treatment Despite the tendency to refuse couple-based treatment, several programs did recognize the need to coordinate treatment when couples attempted to enter treatment at the same time. Programs with more than one site could, theoretically, transfer one partner off-site. However, an extended evaluation period often preceded admittance to a particular program in multi-site settings. Evaluating partners at the same time was not possible in these situations. Given these obstacles, providers noted that coordinating treatment for couples was often unsuccessful and sometimes resulted in both partners leaving with no admittance of either partner into a treatment facility: "One could stay, but they usually leave together. We've had a number of cases."

Even when both partners are in treatment at different sites, the need for coordination and collaboration between sites is evidenced in the following excerpt in which a provider shared an experience of “losing” a client who had been advancing in treatment when his partner in another facility left prematurely.

The couple came to treatment; the husband stayed here, [and] the wife went to a different program. We tried to coordinate their passes after a certain period, and we tried to plug them into couples’ therapy. But the wife relapsed and that affected him here. She left, he lost focus; then he ended up splitting because he wanted to go find his wife. It is a struggle because they can be really supportive to each other when they are both in treatment. But at the same time when something happens, it can be a great disruption. I know they tried to encourage him to complete his treatment. He left to make sure she’s okay. He tried to find her, tried to support her. But he could have relapsed too. We haven’t heard from them since. It was demoralizing for everybody.

Even under the best circumstances, clients do leave treatment, but this provider thought the situation could have been addressed differently.

If we have more communication with other facilities, we’d have a better idea of what’s going on. When it happened, we only knew that she relapsed. And he found out before we did, so the communication between those two facilities wasn’t that great. This still is a big barrier. We don’t interact with other facilities that much. It could be understaffing at both ends. I really don’t know what is going on. We all have to get together and talk about the partners if we’re dealing with couples. But it’s part of the culture. It’s been going on so many years so it’s hard to break the pattern.

Limited Communication and Visitation

Despite the concerns raised above, most programs severely limit communication and visitation with family members, particularly in the early stages of treatment. Disciplinary actions, sometimes involving the whole population of residents, often meant lengthy limits on communication. When children were living at one phone number and a partner at another, a limit

of one phone call could mean residents would have to choose between communicating with children or partners. One couple in the study found a way around this predicament. They both called his mother while maintaining contact with their children.

I would ask his mother, “How’s he doing today? Is he saying that he wants to leave?” She would say, “No, he’s doing good.” And I would say, “Are you sure? Because I wanted to know.” She was like, “No, he’s doing really well.” He would ask how I was doing too [but] my main concern was my children, though, more than it was him, but I just wanted to make sure that he was gonna stay in. If he messes up, I could mess up, too. I hope he never does.

Staff at a “Women Only” site also mentioned how highly regulated visitation was in the program. Drug-using partners were not allowed to visit. However, the staff believed that the majority of women, most of who were mandated to treatment, returned to their drug-using partners post-treatment.

The odds of a client going back to their significant other triple-folds after they complete treatment, but particularly once [Children’s Services] is out of their lives.

Successful Experiences with Couples

Given the ubiquity of “No Couples” policies in the New York City treatment system, we were especially interested in the 2 programs that did successfully enroll and retain couples. Both were harm-reduction-oriented treatment programs and neither had “No Couples” policies.

We have allowed couples to come through. There’s nothing in our funding sources that negates that. The theory that we hold is much different. We roll with people until we see that it’s going to be harmful to those individuals, and that we’re doing a disservice or it’s going to be harmful to the community.

This provider also noted that, given the concern for interpersonal violence, relatively healthy relationships tend not to be recognized by treatment professionals. However, this provider observed that drug-using relationships can be particularly strong.

They find somebody that they can trust, then they click and they survive out there, helping each other out. Sometimes it just takes that. That's an aspect that the active drug user has, the caring and the concern and the support that they give one another through hell and high water. It's amazing.

Nevertheless, providers in both programs acknowledged the jealousies that often arise:

Once they adhere to medications, start going to the dentist, become healthier looking, then they start looking much different than they were out there. Then the man says, "Before, nobody noticed her, but now, what a mommy! Somebody might try to take her away from me!" Then the jealousies and the insecurities become prevalent.

However, it was also mentioned that these issues can be dealt with in treatment plans, and that they tend to happen anyway in programs where both men and women come together.

We set it up from the very beginning that these are the dynamics that are going to happen. If you stay here long enough, somebody's going to get jealous. That might happen even if people come in and they don't know each other, just men and women together.

One provider described admitting couples but assigning each member to a different group. If both insisted on staying together, they were allowed. Although having both partners in the same group can be distracting and can mean that both are reluctant to reveal much about the relationship, at least they are both in treatment. Furthermore, even if bringing a partner stemmed from insecurity, this issue could be gradually dealt with in the treatment setting.

The main concern in admitting couples occurred when the treatment site was appropriate for one partner but not the other.

I think what we learned through these experiences [with couples] is to be more mindful of the individual assessments. We need to be able to convey to them if we find a couple where one is absolutely appropriate but the other needs a higher level of care [that partner needs to go to another program]. So we try to convey to the other person that

we're not separating you, it's to get you the appropriate services that you need so you can become better at the tail end of your process. I think that we can do that.

In one instance, both partners began to use substances while in the program. The provider described the dilemma:

We had to pull the both of them in as a couple and tell them: "We can't continue to do this, and it's more than just because you guys are with each other. It's more about the drinking and the drug use. It may not be obvious to you now, but your relationship is not tangible enough to assist each other with abstinence and recovery, so we're going to have to make a clinical decision. Hopefully, you guys will follow our guidance and see down the line whether or not you can re-solidify your relationship."

The intervention worked. The female partner was sent to a residential facility that could best deal with her co-occurring issue. The male partner stayed and had daily sessions with the provider who helped him through the transition. Because they had clarified right from the beginning what could happen if there were setbacks, the transition for both was easier.

Mandatory Detoxification Administrative detox refers to the practice of mandatory detoxification from methadone due to rule violations or inability to pay. Experience with administrative detox was common in our study population and negatively affected couples. The reasons for administratively detoxing clients included loitering near the methadone clinic, a patient's refusal to have his or her methadone dose increased, refusal to transfer to a residential program, positive cocaine urine screens, altercations with another patient or staff member, problems with Medicaid, or inability to pay. When one partner was forced out of methadone treatment through detox, the other almost always invariably left as well. The medical directors interviewed for this study did not support detoxing for most of these "violations." However, an inability to pay was an unfortunate reality for all programs. In the following excerpt, one partnered IDU described leaving methadone treatment while

he was being administratively detoxed from the program. He subsequently started using again. His partner gradually stopped attending as well.

We're not in a program. We were in one but his Medicaid started having a problem. He was detoxed before he could take care of it [the Medicaid]. And then I followed him. When he stopped going, I was like . . . why bother. It's been a year now.

Although this situation involved a partner who, it could be argued, was negligent in maintaining his Medicaid eligibility, several couples discussed similar problems with Medicaid due to no fault of their own—computer glitches or lost records. Although couples were usually offered a transfer to residential treatment, most felt this was not a viable option. Some simply refused due to past—often distant past—negative experiences. They recounted experiences of humiliation, sanctions leveled against all for fault of one resident, staff that were using drugs or difficulty with an authoritarian use of “contracts.” This participant weighed treatment entry against the loss of a subsidized apartment.

When I was on the methadone, they had options for residential, but like I used to tell them, I will lose my apartment. They didn't care. They're like, it's either go or [mandatory detox]. I was like, I'm not losing my apartment. Then they cut me off. It was really hard. It's hard. But after waiting so many years . . .

Even transfer to another methadone program could present problems for both partners. Antonia had been administratively discharged but was able to enroll in another program. However, this change meant the HIV specialist who coordinated her health care at her former program could no longer follow her. A lack of comfort with her new physician led to miscommunication when she was told the HIV virus was now detectable in her blood. She explained what happened as a result:

Lately, the past few months, I haven't been taking my medication. I've been selling it because every time they check my blood, it's not helping, so I've given up. He just

took more blood and told me he'd tell me later what was going on. I was undetectable for years.

Soon after she received this news, her husband (also HIV + /HCV +) started selling his HIV drugs as well and their drug use escalated.

Homelessness and Housing Problems with housing also affected entrance into short- or long-term treatment for several couples. Almost all of the housed couples lived together in temporary housing administered by the New York City shelter system. These rooms offered a reliable alternative to literal homelessness. However, they were “family” shelters. If one partner left—usually as a result of incarceration—the other partner was forced to leave within a very short period. Fear of the shelter system for single individuals meant that partners ended up homeless again. Milagros related her experience:

I was in the shelter with him, and the reason that they threw me out is 'cause he got locked up and I can't stay. It's a couples' shelter, so I can't stay there by myself. So I was out there in the street, again!

Another couple decided to move out of the shelter system and stayed with friends until they could find a better arrangement. The constant use of drugs in the shelter they were living in threatened their attempts to maintain their hard-earned sobriety. Even couples living in HASA housing (for HIV + individuals run by the HIV/AIDS Services Administration) faced the prospect of losing their housing if they entered long-term treatment. Given the precarious health of both Alejandro and Antonia, even a concerted attempt to help them enter long-term treatment failed. Alejandro described their predicament:

But then she has to leave her apartment because if you go on long-term treatment, HASA is not going to pay the rent. [Afterward] they'll put you in an SRO [single room occupancy] or something. . . . I want to take care of me and take care of her too. On Monday, she caught a seizure, and on Tuesday, I caught an asthma attack. I keep forgetting my medication [for asthma]. I forget things because I have Hep C too.

Several of the couples in the study were homeless. Their extreme living conditions also underscores the interplay between interpersonal and structural barriers to treatment. Marta described why she stayed homeless when she was eligible for HASA housing.

We're both on the street. I don't have to be homeless 'cause I'm in HASA. I'm on the street because I want to be with Marcos. I got a domestic partnership with my ex, and I'm in the computer with him, so they won't put us in a shelter together. It just feels like there's nowhere to run to. I know I could go somewhere, but I'm with Marcos. I don't wanna live in the street, [but] I don't wanna be worried, and I know myself, I'll start getting worried, worried something happened to him or he's doing something stupid because he's getting high—robbing somebody or something.

For this couple to be eligible for housing, Marta would have to form a new domestic partnership with Marcos. Marcos also expressed frustration with being homeless. It is, he said, “the most difficult thing right now.” When asked why he is homeless, he replied, “They help people who are HIV-positive, but not the ones who aren't positive.” Marta's relationship with Marcos clearly created both interpersonal and structural barriers to shelter and treatment. When asked what she would do if Marcos was arrested and incarcerated, she replied:

I would move on. Just go to HASA and get into a shelter. [INT: You think you could leave the drugs?] Yeah. [INT: So he's the one that's keeping you on the drugs?] No, he's not the one If I see him do it, I'm gonna do it 'cause I'm an addict too. [INT: So do you think he wants you to stop?] Yeah, and he wants to stop too.

DISCUSSION

Our findings reveal the extent and effect of both interpersonal and structural barriers—and the interplay between these factors—that delay treatment entry, retention, and the success of treatment for many partnered IDUs. The majority of men and women in this study emphasized the importance of their relationship as the

primary source of emotional support in their lives. These strong emotional ties not only make it difficult for one partner to leave the other to seek treatment, but also serve to magnify drug-use cues in their shared addiction, rendering the treatment of only one partner unlikely to succeed. Couples explicitly recognized that both partners must desire and seek treatment concurrently to overcome their mutual dependence on drugs. Many couples in the study expressed this desire.

However, the drug-treatment system has not adequately addressed or made provisions for the unique challenges of drug-using couples. As a result, couples have often been left to their own devices when seeking to reduce their drug use and address related health risks. This state of affairs can be attributed primarily to the lack of viable options for couple-focused treatment approaches that fit within the structure of the current drug treatment system. Indeed, most programs enforce strict policies that prohibit couples from admission into the same program, impose contracted sanctions for displaying intimate behavior, or limit communication between partners. Whereas most partnered IDUs viewed these “No Couples” policies as unfair, prohibitive, and, in some cases, counter to effective treatment, the majority of treatment providers viewed these policies as necessary from practical and clinical perspectives. We argue that both perspectives are valid, that the tensions between the respective viewpoints derive from limitations of the current treatment system, and that, most importantly, the convictions and requirements of each group can be reconciled through a tailored approach to the treatment of couples.

Our research indicates that a roadmap for such an approach involves the following key principles: (1) drug-using couples need to enter drug treatment concurrently; (2) the individual treatment needs of each member of the couple and relationship (couple-specific) treatment needs must be assessed and addressed in the development of a tailored treatment plan; and (3) a chronic-care model is needed that integrates various treatment options and includes treatment of comorbid conditions (e.g.,

HIV/HCV, mental health, interpersonal violence) and community supports (e.g., housing, education).

The seemingly divergent views of injection-drug using couples and treatment providers can be reconciled by recognizing that concurrent treatment does not necessarily mean that both partners are treated together in the same program. It could mean that both members of a drug-using couple begin treatment at the same time and are retained in treatment simultaneously with coordinated care. Obviously, both partners must be internally motivated and committed to seeking treatment. Such couples could be actively recruited through outreach and clinical screening. The main goal here is engaging injection-drug using couples in the treatment system and retaining them. Once admitted into treatment, an initial assessment is essential to determine the individual treatment needs of each partner, as well as the strengths, weaknesses, and needs of the couple. This assessment is critical to the development of a customized treatment plan that leverages the couple's support for treatment retention and outcomes while at the same time tailoring treatment options to the needs of the individual.

The finding that several programs have met the challenge of serving drug-using IDUs with relative success is encouraging. These programs incorporated more flexible and client-centered programming in a harm-reduction framework. Although they do not encourage couples to engage in groups together, they do not prohibit entry to couples who want to stay together. Once in the program, providers are in a better position to work with couples and help them understand what treatment options are best both for each individual and for their relationship. Programs that have succeeded in engaging couples demonstrate that client-centered approaches are individualized (e.g., individual treatment plans) but include a tailored, couple-based component could be effective in raising the standard of care for injection-drug using couples. Such couple-based components could range from simple communication and coordination of treatment to more intense couple-based therapy. The overall goal

is not to assist couples in the maintenance of their relationship—drug treatment is not marriage counseling—but to address relationship barriers to treatment success and engage and educate couples about the challenges and supports unique to drug-using partnerships.

Given that many partnered IDUs (and other drug-using couples) are poly-drug users who struggle with their addictions over many years and often suffer from considerable co-occurring medical (e.g., HIV, HCV) and mental health (e.g., trauma, discrimination, shame, stigma) issues, the challenge of designing and providing “best practices” is considerable. Providers are justified in recognizing this challenge. However, the need for couple-based drug treatment programs is clear, and the success of several existing programs that are attempting to confront these challenges in innovative ways suggests that other programs could be supported in doing similar work.

Another structural barrier that had a negative effect on the ability to stay in treatment involved mandatory detoxification from methadone or what is commonly called administrative detox. This occurs when methadone treatment is administratively discontinued in a tapered manner because of a rule infraction or because the patient no longer has health insurance. Mandatory detoxification was common and usually affected both partners even when the regulation targeted only one. An unwillingness to supply buprenorphine to clients for ideological reasons or due to an insufficient number of qualified physicians or insurance issues was also noteworthy. There is ample evidence of buprenorphine's effectiveness.² The drug could be combined with other types of treatment intervention (e.g., outpatient or residential).

Outside of the treatment system, we found that policies in the New York City shelter/subsidized housing system offered an alternative to homelessness for most couples, but paradoxically deterred entrance into short- or long-term treatment. As a result of these barriers, some couples were forced to choose between their relationship, adequate housing, or drug treatment, and these choices affected not

only their drug dependence, but also HIV disease and other health risks. There is a critical need to provide permanent rather than temporary housing for stable couples, including HIV-negative and serodiscordant couples. Housing options are needed that do not replicate the drug scene from which couples are attempting to disengage.

CONCLUSION

New York City has a wide array of effective drug treatment programs, as well as numerous specialty programs. However, there are no treatment programs designed to address the special needs and challenges of partnered IDUs, despite the fact that injection-drug using couples comprise a significant percentage of IDUs and have high HIV (and other health) risk profiles. Indeed, the majority of programs enforce policies that serve as deterrents to treatment by partnered IDUs. New approaches to couple-based drug treatment should include concurrent treatment for partners, a tailored treatment plan that addresses both individual needs and those of the couple, and a chronic-care model that integrates best-practice treatment options, treatment of comorbid conditions, and community supports. In addition, injection-drug using couples in particular would benefit from a reconsideration of administrative detoxification in methadone clinics and an overall improvement in the quality (and funding) of these programs, the elimination of treatment silos, including a reconsideration of the use of methadone or buprenorphine in residential treatment centers, and strong linkages between harm-reduction programs and drug treatment. Services would not be time-limited; patients would not be penalized when they are unable to follow their doctors' orders; and global assessments of overall functioning and quality of life would be the outcomes rather than a narrow focus on abstinence or adherence to medication. In addition, strength-based assessments would identify "personal, family and community/cultural assets" to support treatment initiation and ongoing rehabilitation and recovery.¹ Rather than define *family* solely as parent and child, part-

ners must also be included. Our study results demonstrate an unmet but urgent need in the current drug treatment system for programs and policy changes that address the special challenges of dual-using partnered IDUs. Innovation and research will eventually refine our understanding of the best practices for treatment entry, retention and outcomes for injection-drug using couples.

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