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Perceived Barriers to Treatment in a Community-Based Sample of Illicit-Drug-Using African American Men and Women

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Abstract

This study examines perceived substance use treatment barriers in a community-based sample of 267 African Americans from Baltimore, MD. Both men and women endorsed “they can handle it alone” as a primary reason they were not currently in treatment. However, men were two times more likely ($AOR = 2.29$ CI = 1.05, 5.02) to endorse “concerns about losing family” as the reason they are not currently in treatment. The present study yields interesting findings among African Americans, which should be considered when creating interventions for particular groups of African Americans.

Keywords

adults; African American; gender; substance use; treatment

INTRODUCTION

In 2007, the National Survey on Drug Use and Health reported over 22 million Americans engaged in illicit drug use during the prior month, with an estimated \$193 billion in associated direct and indirect costs to the U.S. (National Drug Intelligence Center, 2011). This cost includes the loss of productivity associated with individuals in substance use treatment. Given the public health significance of the current problems associated with illicit drug use, it is imperative that barriers to treatment initiation and engagement are identified in order to more effectively provide treatment to at risk substance users.

Current literature indicates that substance use treatment programs are more effective when tailored to meet the needs of patients (Nation et al. 2003; Moser, Monroe-DeVita & Teague

2013). In order to create more effective programs, researchers have examined key differences among substance users and treatment initiation and engagement. Specifically, previous research has focused on the effects of ethnicity/race and gender on perceptions of substance abuse treatment engagement. However, research on factors that influence treatment engagement within specific racial/ethnic minority groups remains unclear. The literature suggests that African Americans initiate substance use treatment less frequently compared to White drug users (Perron et al. 2009a; Acevedo et al. 2012). African Americans are also less likely to have access to or utilize substance use treatment facilities (Wells et al. 2001; Hesselbrock et al. 2003) and less likely than their White counterparts to complete treatment programs (Milligan, Nich & Carroll 2004). This suggests that existing treatment programs may not be meeting the needs of this population and highlights the need for research to examine specific psychosocial factors (Buka 2002) that may be associated with perceived barriers to substance abuse treatment among African American men and women with a history of illicit drug use.

Previous research has explored barriers to treatment engagement among African American women compared to women in other ethnic groups. Allen (1995) found that substance addicted and abusing African American women were more likely to endorse the lack of child care, cost of treatment, and waitlist assignment as key barriers to treatment. To the best of our knowledge, no previous studies have examined the effects of gender on perceived barriers to substance use treatment within African Americans. Given the research which reports that African Americans differ in the reasons they are not attending treatment in comparison to their White counterparts, it is important to understand whether these differences vary within group on factors such as gender among African Americans. Moreover, given the public economic and health impact of substance use in African Americans, it is important to identify gender differences in perceived barriers to treatment so findings can be translated to tailored intervention programs and become more effective in treating African American substance users. By including only substance users who are not currently in treatment, we sought to understand the factors this sample of African Americans endorsed as reasons why they were not currently in treatment.

METHOD

Procedure

Participants in this study consisted of African American adults taken from the baseline assessment of the NEURO-HIV Epidemiologic Study. The study was originally designed to explore the behavioral and neuropsychological risk factors associated with HIV and sexually transmitted infections among injection and non-injection drug users. The current study was approved by the University of Florida Institutional Review Board. Participants were recruited using referrals and advertisements from the Baltimore City area. Upon entering the study, participants were given detailed information about the study and completed informed consent procedures. Participants received \$45 for the completion of the baseline assessment. Participants were excluded from the current study if they were currently in treatment for substance use.

Participants

The current study included a community-based sample of 267 African American adults. Inclusion criteria for the parent study were that participants must be 18 years of age and older, have no history of brain injury, and must have used an illicit drug in the past six months. A total of 726 participated in the parent study, but only African American participants with completed data regarding illicit drug use treatment attendance were included in the current study.

Measures

The HIV-Risk Behavior Interview is a semi-structured, face-to-face interview administered by a trained research assistant. This assessment was previously used to examine HIV risk behaviors in injection and non-injection illicit drug users in the AIDS Linked to the Intravenous Experience study (Vlahov 1991). This interview included questions pertaining to sociodemographic characteristics including age, marital status, history of homelessness in the past six months, income from a regular job in the past six months, and education background. Information on drug use history and barriers to treatment were also obtained as part of the HIV-Risk Behavior Interview.

Data Analysis

Associations between categorical variables were examined using chi-square and logistic regression analyses. A series of multiple logistic regression analyses were conducted to assess the effects of gender on the odds of endorsing barriers of treatment items. For the predictor variable gender, the reference group was females. Adjusted odds ratios were determined by incorporating age, education, marital status, money from a regular job in the past six months, homelessness in the past six months, and ever injecting drugs as covariates.

RESULTS

Demographic Information

As seen in Table 1, there were no significant differences between men and women based on age ($X^2(2) = 1.38$ $p = .240$), homelessness in the past six months ($X^2(2) = 0.001$ $p = .983$), money from a regular job in the past six months ($X^2(2) = 3.21$ $p = .073$), education ($X^2(2) = 0.37$ $p = .829$), and lifetime injection drug use ($X^2(2) = 1.13$ $p = .288$). Significant differences were found in marital status between men and women, with more women endorsing being single ($X^2(2) = 8.10$ $p = .017$).

Illicit Drug Use and Treatment Attendance Prevalence

Approximately 37% reported attending treatment in the past six months. The majority of men identified heroin as their primary drug of choice (40%), followed by crack/cocaine (32%), marijuana (22%), and speedball (6%). The majority of women identified heroin as their primary drug of choice (36%), followed by marijuana (28%), crack/cocaine (24%), speedball (10%), and other (2%).

Barriers to Treatment Regressed on Gender

Results from multiple logistic regression analyses for the barriers to treatment items yielded significant effects based on gender (see Table 2). Specifically, men were less likely to endorse “on a waiting list” as the reason they were not in treatment (Adjusted Odds Ratio [AOR] = 0.41, CI = 0.19, 0.91). However, males were two times more likely to not be in treatment due to “concern about losing family” (AOR = 2.29 CI = 1.05, 5.02).

Rank-Order Barriers to Treatment Items

Table 3 presents barriers to treatment items in rank-order stratified by gender. Highest item percentage endorsements for women were for items “can handle it alone” (37%), “don’t have a problem” (28%), “no need to stop” (23%), and “cannot afford treatment” (21%). The items men endorsed the most were “can handle it alone” (43%), “cannot afford treatment” (27%), “do not have a problem” (26%), “no need to stop” (26%), “habit is affordable” (23%), and “failed previously” (20%).

DISCUSSION

Internal or individual factors (Macmaster 2005), such as “I can handle my drug use on my own” and “I have no need to stop,” were the most endorsed responses by both men and women in the current sample. This suggests that some drug users lack the motivation to seek and/or receive help with their problem. The most endorsed item by participants as the reason they were not in treatment was because they believed they could “handle it” on their own. This finding is in line with previous research that presents similar items stating that the participants felt they could handle stopping their substance use on their own (George & Tucker 1996; Hser et al. 1998). Additionally, this furthers the findings by Roberts and Nishimoto (2006), who found in a sample of women that over 20% of women reported that they did not go to treatment because they “did not have a problem” or “could manage on their own.” These findings suggest that one of the most common barriers to treatment engagement across gender is the belief that treatment is not needed. It is plausible that an individual’s lack of motivation to seek and/or receive help to treat substance use may be rooted in feelings of shame, which in turn provoke defensive mechanisms that lead to denial of problem severity and the need for treatment (Reid, Crofts & Beyer 2001). Overall, African American men and women did not differ in their perceptions on why they were not in treatment. More specifically, a substantial portion of men and women both believed that they did not need treatment. This finding supports similar research in alcohol-dependent subjects (Green 2006). It appears that understanding the underlying mechanisms of denial could lead to improved methods of reaching and engaging at-risk populations in need of treatment.

In the current study, men were less likely to endorse “being on the waiting list” as a barrier to substance use treatment engagement. This structural barrier to treatment is in line with previous research in racially diverse samples of drug users (Hser et al. 1998). Given that women are reportedly more likely to seek and initiate treatment (Brown et al. 2011), findings suggest that institutions look to modify waiting lists or present alternative forms of care when they are unable to attend to the needs of drug users as they apply. This seems

imperative, as African Americans are less likely to utilize treatment (Perron et al. 2009b) and waiting lists only further current disparities in treatment and care. When individuals seek substance use treatment, facilities could be more effective by engaging patients in alternatives as they are waiting to receive treatment.

Men were twice as likely to endorse the reason of “concern for losing family” as to why they were not currently in treatment. This finding provides interesting insight into the perceived importance of family to African American men. Though previous research has presented social support as a critical factor in initiating and staying in substance use treatment programs, little is known about how men and women actually utilize their social and familial networks. Less is known about how the families and friends interact with a substance-using individual. Moreover, the fear of social attrition of friends or loved ones due to individuals’ substance use problems could prevent a person from treatment processes (Green 2006). This suggests that treatment facilities must be sure to include assessment of familial and social responsibilities in a culturally relevant manner in order to alleviate potentially obscured barriers to treatment engagement behaviors (Acevedo et al. 2012). In addition, the risk of losing children is critical in treatment engagement (Longshore et al. 1992) and is also potentially a barrier to treatment for African American men. It is possible that individuals may actually wish to stop their substance use, but do not attend treatment out of fear of losing or leaving their children (Bell-Tolliver et al. 2012). Understanding the complex interplay among substance users in need of treatment and their familial networks could be a key factor in getting more African American men to enter treatment for their substance use.

Study limitations include the use of cross-sectional data, which should be approached with some caution in interpretation. In addition, this sample was collected from street recruitment in Baltimore, MD, and therefore may not generalize to other populations such as rural settings or other cities. Lastly, the sample sizes for some of the barrier-to-treatment questions were small. These results should be interpreted with caution and cannot be generalized.

Despite these limitations, our study was successful in street recruitment of self-reported drug-using African Americans, a hard-to-reach population. Moreover, this study includes only individuals who are not currently in treatment. This enables researchers to interpret findings without having to adjust for the impact of currently being in treatment. Additionally, we are able to obtain accurate perceptions of those not in treatment, given they were not recruited from a treatment facility or referred by a judicial entity.

Overall, this study was novel in that it explored barriers to treatment in African American drug users who were not in treatment. Previous research has explored barriers to treatment (Rapp et al. 2006), but these samples included persons already in treatment, so that findings may not apply to those who are not in treatment. Focusing on those not currently in treatment is vital to develop an accurate understanding of barriers to treatment. Moreover, understanding the need for tailored intervention programs, and having individuals of the same ethnicity, gender, and life experiences, is critical to increasing the amount of African American substance users who utilize treatment (VanderWaal et al. 2001). The need for

community-specific treatment programs is also critical for engaging African American substance users in treatment.

Future research is needed to extend the findings focusing on gender differences in barriers to treatment within African Americans. In replication, researchers will elucidate barriers that are specific to this ethnic group. Additionally, taking a critical look at the heterogeneity of African Americans, taking into account location and familial networks, will enable those in prevention and policy to translate the findings to tailor substance use treatment programs in the African American community.

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TABLE 1
Demographic Information for Out of Treatment Substance Users, by Gender (N = 267)

Demographic Variable	Male		Female		X ² Statistic	P
	N = 133	n(%)	N = 134	n(%)		
Age					1.38	.240
< 36 years	55	(41%)	65	(48%)		
> 36 years	78	(59%)	69	(52%)		
Marital Status					8.10	.017
Single	97	(73%)	113	(84%)		
Married	17	(13%)	15	(11%)		
Other	19	(14%)	6	(5%)		
Homeless in Last 6 Months					0.001	.983
No	118	(89%)	119	(89%)		
Yes	15	(11%)	15	(11%)		
Money from Regular Job					3.21	.073
No	71	(53%)	86	(64%)		
Yes	62	(47%)	48	(36%)		
Education					0.37	.829
Some HS & Below	41	(31%)	46	(34%)		
HS Graduate	63	(47%)	60	(45%)		
College or Training	29	(22%)	28	(21%)		
Lifetime IDU					1.13	.288
No	80	(60%)	89	(63%)		
Yes	53	(40%)	45	(37%)		

TABLE 2

Gender Predicting Item Endorsement

Reasons Not in Treatment Past 6 Months	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
On a Waiting List	0.41 (0.19, 0.91)*	0.40 (0.17, 0.95)*
Habit is Affordable	1.39 (0.77, 2.53)	1.41 (0.76, 2.64)
Do Not Feel a Need to Stop Using Drugs	1.17 (0.67, 2.05)	1.23 (0.68, 2.22)
Can Handle it on Your Own	1.26 (0.77, 2.06)	1.41 (0.83, 2.40)
Treatment is for Weak People	1.73 (0.61, 4.92)	1.73 (0.54, 5.59)
Treatment Programs Do Not Work for You	0.68 (0.34, 1.39)	0.66 (0.32, 1.39)
Tried a Program Before and Failed	1.30 (0.70, 2.42)	1.27 (0.66, 2.46)
Concerned about Losing Family	2.13 (1.01, 4.47)*	2.29 (1.05, 5.02)*
Turned Down by Treatment Program	0.68 (0.31, 1.49)	0.68 (0.30, 1.53)
No Treatment Program Nearby	1.01 (0.42, 2.41)	0.96 (0.39, 2.37)
Do Not Have Type of Treatment Program You Want/Need	1.01 (0.45, 2.27)	1.01 (0.44, 2.33)
Do Not Have a Problem with Drugs	0.90 (0.53, 1.55)	1.11 (0.63, 1.99)
Do Not Know about Treatment	0.84 (0.36, 1.95)	0.75 (0.31, 1.83)
Cannot Afford Fees	1.41 (0.80, 2.47)	1.34 (0.74, 2.42)

*
p < 0.05;

**
p < 0.01.

Adjusted models include age, education, sex, marital status, income, homelessness, and lifetime injection drug use status as covariates.

TABLE 3**Rank Order Reasons Why Men and Women are Not in Treatment**

Men (n = 133)	Women (n = 134)
Can Handle it Alone (43%)	Can Handle it Alone (37%)
Cannot Afford (27%)	Don't Have a Problem (28%)
Don't Have A Problem (26%)	No Need to Stop (23%)
No Need to Stop (26%)	Cannot Afford (21%)
Habit is Affordable (23%)	Habit is Affordable (18%)
Failed Previously (20%)	On a Waiting List (16%)
Family Concerns (17%)	Does Not Work (16%)
Treatment Does Not Work (11%)	Failed Previously (16%)
Not Treatment that is Needed/Wanted (10%)	Were Turned Down (13%)
Were Turned Down (9%)	Unaware of Treatment (10%)
Unaware of Treatment (8%)	Not the Treatment Wanted/Needed (10%)
No Treatment Nearby (8%)	Family Concerns (9%)
Treatment is for the Weak (7%)	No Treatment Nearby (8%)
On a Waiting List (7%)	Treatment is for the Weak (5%)