



## Illicit and nonmedical drug use among Asian Americans, Native Hawaiians/Pacific Islanders, and mixed-race individuals



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### ABSTRACT

**Background:** The racial/ethnic composition of the United States is shifting rapidly, with non-Hispanic Asian-Americans, Native Hawaiians/Pacific Islanders (NHs/PIs), and mixed-race individuals the fastest growing segments of the population. We determined new drug use estimates for these rising groups. Prevalences among Whites were included as a comparison.

**Methods:** Data were from the 2005–2011 National Surveys on Drug Use and Health. Substance use among respondents aged  $\geq 12$  years was assessed by computer-assisted self-interviewing methods. Respondents' self-reported race/ethnicity, age, gender, household income, government assistance, county type, residential stability, major depressive episode, history of being arrested, tobacco use, and alcohol use were examined as correlates. We stratified the analysis by race/ethnicity and used logistic regression to estimate odds of drug use.

**Results:** Prevalence of past-year marijuana use among Whites increased from 10.7% in 2005 to 11.6–11.8% in 2009–2011 ( $P < 0.05$ ). There were no significant yearly changes in drug use prevalences among Asian-Americans, NHs/PIs, and mixed-race people; but use of any drug, especially marijuana, was prevalent among NHs/PIs and mixed-race people (21.2% and 23.3%, respectively, in 2011). Compared with Asian-Americans, NHs/PIs had higher odds of marijuana use, and mixed-race individuals had higher odds of using marijuana, cocaine, hallucinogens, stimulants, sedatives, and tranquilizers. Compared with Whites, mixed-race individuals had greater odds of any drug use, mainly marijuana, and NHs/PIs resembled Whites in odds of any drug use.

**Conclusions:** Findings reveal alarmingly prevalent drug use among NHs/PIs and mixed-race people. Research on drug use is needed in these rising populations to inform prevention and treatment efforts.

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### 1. Introduction

During the past decade, there have been important shifts in the racial/ethnic composition of the US population, particularly Asian-Americans, Native Hawaiians/Pacific Islanders (NHs/PIs), and mixed-race individuals (people of multiple races). This study determines new nonmedical/illicit drug use estimates for these rising populations. Asian-Americans alone (14.7 million; 4.8% of the US population), NHs/PIs (0.5 million; 0.2%), and mixed-race persons (9.0 million; 2.9%) are the fastest growing US populations (Hoeffel et al., 2012; US Census Bureau, 2011). The 2010 census data showed

that these populations grew about three times faster than the total US population (US Census Bureau, 2011). Because drug use studies typically enroll small numbers of members from these groups, there are limited data available to inform prevention and health policy. Members of these groups are often pooled as “others” or omitted from reports. Even population-based studies have focused mainly on Whites, Blacks, and Hispanics. The Monitoring the Future studies have not regularly reported drug use estimates for these three groups (Johnston et al., 2012). The Treatment Episode Data Set (TEDS) reports, which examine substance abuse treatment admissions collected by states in monitoring their treatment systems, have aggregated Asian-Americans and NHs/PIs into a single group and omitted mixed-race individuals from reports (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012c). There are scarce data on drug use estimates for these populations.

The lack of data may obscure intervention needs for Asian-Americans, NHs/PIs, and mixed-race individuals, and hinder

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development of preventive services and health policies to address drug use problems. Because of socioeconomic stress or cultural factors (e.g., cost, language), members of minority populations generally underutilize substance abuse and mental health care (Fong and Tsuang, 2007; Garland et al., 2005; Han and Liu, 2005). Asian-Americans and NHs/PIs appear to face additional culture-related stigma and barriers to utilizing substance abuse care (e.g., lack of culturally sensitive interventions), which may contribute to undertreatment and escalation of drug problems (Edwards et al., 2010; Mercado, 2000; Yu et al., 2009). Drug use may have a particularly negative impact on these groups. For Asian-Americans, shame in asking for help and preferring to keep substance problems within the family to avoid disgrace may result in delay in seeking care or difficulty in treatment engagement (Fong and Tsuang, 2007). Although data suggest that NHs/PIs were exposed to more substance-using peers than other racial/ethnic groups, there is a dearth of information on substance use intervention for NHs/PIs (Edwards et al., 2010; Okamoto et al., 2010).

When Asian-Americans and NHs/PIs are included in a study, they are often pooled as a single group. Substance use estimates from this combined group may obscure their differences. Studies suggest prevalent substance use among NHs/PIs (Kim and McCarthy, 2006). In a sample of 10th-graders, 51.6% of Native Hawaiian adolescents reported lifetime marijuana use, compared with 45.8% of Whites (Wong et al., 2004). Mixed-race individuals also may have a higher prevalence of drug use than Asian-Americans and NHs/PIs (Price et al., 2002; Wu et al., 2007, 2011a, 2011b). In a sample of youth aged 16–23 years, mixed-race individuals had prevalent rates of lifetime use of methamphetamine (mixed-race: 11.4%, White: 6.1%, Black: 0.5%, Hispanic: 3.4%) and ecstasy (mixed-race: 21.9%, White: 16.8%, Black: 4.2%, Hispanic: 8.9%) (Wu et al., 2006). These descriptive data point to a need for research to evaluate their drug use.

Further, findings from earlier studies may not reflect recent patterns in drug use. Opioid analgesics are now the second most commonly used illicit drugs after marijuana (Paulozzi, 2012; SAMHSA, 2012b). The number of opioid analgesics-related overdose mortalities has exceeded that of heroin and cocaine combined (Paulozzi, 2012). Substance use, involvement with the legal system, and mental health problems are associated with nonmedical opioid use (Wu et al., 2008). The TEDS data showed that the majority of admissions for primary opioid analgesic abuse treatment were young adults (20–29 years) and Whites (SAMHSA, 2012c). Non-medical opioid use is epidemic in the United States (Centers for Disease Control and Prevention [CDC], 2012), but little is known about the extent of nonmedical opioid use relative to other drug use among Asian-Americans, NHs/PIs, and mixed-race individuals.

Additionally, there are concerns about the potential effects of legalizing medical marijuana (e.g., increasing the drug's availability) on illicit marijuana use problems. Presently, 18 states and Washington, DC, have legalized medical marijuana; 10 states have legislation pending (medicalmarijuana.procon.org). States with legalized medical marijuana had a higher prevalence of illicit marijuana use than states without (Cerdá et al., 2012). Studies have found common medical marijuana diversion and illicit marijuana use among adolescents in substance abuse treatment (Salomonsen-Sautel et al., 2012; Thurstone et al., 2011). While the data do not confirm a causality between legalizing medical marijuana and illicit use, national data also reveal increased prevalences of illicit marijuana use and marijuana-related treatment (Johnston et al., 2012; SAMHSA, 2012b,c). No recent studies have examined the extent of marijuana use among Asian-Americans, NHs/PIs, and mixed-race individuals.

Given the lack of drug use estimates and the need to better inform prevention and treatment, we examined recent national trends in past-year prevalence of (illicit or nonmedical) drug use

among these groups to determine racial/ethnic differences and identify correlates of use in each group. Because of reported increases in marijuana and opioid analgesic use, we focused on these two commonly used drug classes. Prevalences for other drugs were included for comparison, as were estimates among Whites for informing racial/ethnic disparity (CDC, 2011). We analyzed data files from national samples of non-Hispanic Asian-Americans, non-Hispanic NHs/PIs, and non-Hispanic mixed-race individuals from the National Surveys on Drug Use and Health (NSDUH). The independent, cross-sectional 2005–2011 NSDUH used similar designs and allowed analysis of the same variables from the pooled sample, which enabled us to generate reliable estimates for correlates of drug use.

## 2. Methods

### 2.1. Data source

Public-use data files from the 2005–2011 NSDUH were analyzed to characterize recent national trends in drug use and correlates of use. All respondents aged  $\geq 12$  years were included to determine age-related changes in drug use. NSDUH is the only national survey designed to provide ongoing estimates of drug use in the United States (SAMHSA, 2006, 2012b). The 2005–2011 surveys used multistage area probability sampling methods to select a representative sample of the civilian, non-institutionalized population aged  $\geq 12$  years. Residents of households from the 50 states (including shelters, rooming houses, group homes) and civilians residing on military bases were included. The design oversampled people aged 12–25 years. Due to a large sample size, there was no need to oversample racial/ethnic groups, as was done before 1999.

Respondents were interviewed at their home for about an hour. They were assured that their names would not be recorded and their responses would be kept strictly confidential, and all study procedures and protections were carefully explained. Respondents' sociodemographics were assessed by computer-assisted personal interviews; substance use questions were assessed using a computer-assisted self-interviewing method. The latter was designed to increase honest reports of substance use by allowing respondents to either read the questions on a computer screen or listen to the questions read aloud by the computer through headphones, and then enter their responses directly into the computer.

The NSDUH's annual sample was considered representative of the US general population aged  $\geq 12$  years. To include adequate numbers of Asian-Americans, NHs/PIs, and mixed-race individuals for detecting meaningful racial/ethnic differences in drug use, we pooled the public-use data files from 2005–2011 ( $n = 55,279$ – $58,379$ /year). They used similar designs, allowing pooled analyses of the same variables (SAMHSA, 2006, 2012b). Weighted response rates of household screening and interviewing for these years were 87–91% and 73–76%, respectively. The pooled sample included 13,623 Asian-Americans, 1826 NHs/PIs, 12,209 mixed-race individuals, and 248,027 Whites.

### 2.2. Study variables

Respondents' self-reported race/ethnicity, age, gender, annual household income, government assistance, county type (large, small, nonmetropolitan areas), and residential stability ("How many times in the past 12 months have you moved?") were examined. The latter variables were included in the logistic regression analysis to take into account race/ethnicity-related differences in socioeconomic and residential factors (Duncan et al., 2002; Wilson and Donnermeyer, 2006). Based on respondents' self-reported responses to race and ethnicity questions, NSDUH defined mutually exclusive groups: non-Hispanic White, non-Hispanic Asian-American (e.g., Asian Indian, Chinese, Filipino, Japanese, Korean, or Vietnamese), non-Hispanic NH/PI (Native Hawaiian, other Pacific Islander), and mixed-race individuals ( $\geq 2$  races). The data do not distinguish between specific racial groups of mixed-race individuals. The 2010 census data showed that about 83% of mixed-race individuals were White in combination with  $\geq 1$  other race (Black, Asian-American, NH/PI, native-American, other race); NHs/PIs, Asian-Americans, and native-Americans were more likely than other nonwhites to be mixed-race individuals (US Census Bureau, 2011).

Illicit/nonmedical drug use assessments included a detailed description of each drug group and lists of qualifying drugs. It used separate questions to assess respondents' use of marijuana/hashish, cocaine/crack, inhalants, hallucinogens, heroin, opioid analgesics, stimulants, sedatives, and tranquilizers. We examined past-year drug use; past-year use of alcohol and any tobacco (cigarettes, cigars, smokeless tobacco, pipe tobacco) were included in the adjusted analysis to mitigate their confounding effects on associations between drug use and race/ethnicity (Wu et al., 2013). Additionally, respondents' history of DSM-IV major depressive episodes (MDE) and being arrested ("Not counting minor traffic violations, have you ever been arrested and booked for breaking the law?") were included as control variables due to their associations with drug use (Bennett et al., 2008; Wu et al., 2008). We

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