



## African American cocaine users' preferred treatment site: variations by rural/urban residence, stigma, and treatment effectiveness



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### ABSTRACT

To encourage access, policy makers and providers need information about variations in drug users' treatment preferences. This study examined how rural/urban residence, stigma surrounding drug use, and perceived treatment availability and effectiveness are associated with African American cocaine users' preferences for the site of treatment (local, or in one's home town; nearby, or in a town nearby; and distant, or in a town farther away). Two hundred rural and 200 urban cocaine users were recruited using respondent-driven sampling and completed in-person interviews. Multinomial logit regression analyses were conducted to estimate the relative odds of preferring local vs. nearby and local vs. distant treatment. Rural cocaine users preferred distant (58%), and urban users preferred local (57%) treatment. Rural residence and a lifetime history of treatment were associated with higher odds of preferring nearby vs. local treatment; older age and greater perceived local treatment effectiveness were associated with lower odds of preferring nearby vs. local treatment. Rural residence, access to an automobile, higher rejection/discrimination stigma scores, and higher Brief Symptom Inventory-Global Severity Index scores were associated with higher odds of preferring distant vs. local treatment; older age, lower educational attainment, and greater perceived discrimination after treatment were associated with lower odds of preferring distant vs. local treatment. The findings from this study suggest that a regional approach to organizing drug use treatment services could better satisfy the preferences of rural African American cocaine users, whereas local treatment services should be expanded to meet the needs of urban cocaine users.

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### 1. Introduction

Substance use researchers, policy-makers, and managers often assume that rural drug users have worse access to treatment, but very little research has actually examined this issue, especially how rural drug users' treatment preferences may differ from their urban counterparts (Borders & Booth, 2007; Fortney & Booth, 2001). To create policies and programs that better accommodate rural as well as urban illicit drug users and encourage treatment utilization, health policy makers and treatment managers would potentially benefit from learning more about variations in preferences for the site of treatment, such as treatment based locally or in another community.

According to our review of the current literature, no prior studies have examined potential preferences for drug use treatment location. However, research from the general medical care field has shown that many rural residents migrate or travel for hospital services (Radcliff, Brasure, Moscovice, & Stensland, 2003), primary care (Borders, Rohrer,

Hilsenrath, & Ward, 2000), specialty medical care (Borders & Rohrer, 2001), and pharmaceuticals (Xu & Borders, 2003). Consumer perceptions of the accessibility and quality of local services have been cited as explanations for rural residents' medical care migration (Borders & Rohrer, 2001; Borders et al., 2000; Nesbitt, Marcin, Martha, & Cole, 2005). Comparable factors may influence rural, as well as urban, drug users' preferences to travel for drug use treatment.

In addition, stigma related to drug use could be associated with illicit drug users' preferred treatment location. Several prior studies of illicit drug users suggest that stigma is a barrier to seeking formal treatment services (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Sexton, Carlson, Leukefeld, & Booth, 2008). Stigma has been defined generally as differentiating individuals by characteristics deemed socially objectionable (Goffman, 2009; Major & O'Brien, 2005). Link et al. more discretely defined and measured 3 components of stigma, which they refer to as "culturally induced expectations of rejection," "experiences of rejection," and "efforts at coping with stigma" (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997) (p. 179). Other research provides supporting evidence of similar components of stigma, including perceived devaluation and self-stigma/internalized shame (Luoma et al., 2007). Perceptions of negative societal beliefs about illicit drug use may lead drug users to experience perceived or actual devaluation or

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discrimination (Link et al., 1997). In turn, drug users may cope with perceived societal devaluation by trying to maintain secrecy of their drug use.

Stigma could be especially important among persons residing in rural communities where maintaining anonymity is difficult. Many rural drug users might prefer to seek treatment outside of their home town simply to avoid the risk of being seen walking through the door of a local treatment center. In a qualitative study of rural stimulant users, one participant summed up the sentiment in this way, “I wouldn’t want to do it, because the whole town would be talking about it” (Sexton et al., 2005) (p. 125). Moreover, from the broader substance use literature, a multi-state study of at-risk drinkers showed that those residing in rural areas were more likely than urban dwellers to report a lack of privacy when accessing local alcohol treatment services (Fortney et al., 2004).

The purpose of this study was to examine how preferences for the site of drug use treatment (local, or in one’s home town; nearby, or in a town nearby; and distant, or in a town farther away) are associated with rural/urban residence, perceived local drug use treatment accessibility and effectiveness, and unique dimensions of stigma. The data are from a study of perceived need for treatment among a cohort of rural and urban African American cocaine users who were not currently receiving informal or formal substance use services or counseling (Booth, Stewart, Curran, Cheney, & Borders, 2014; Borders, Booth, Stewart, Cheney, & Curran, 2014). Our findings provide insightful information that could be applied to better organize drug treatment services and encourage treatment access among a population subgroup with overall inadequate access to health services.

## 2. Materials and methods

### 2.1. Study sites

Participants were recruited within 1 urban and 2 rural Arkansas counties, as designated by the U.S. Office of Management and Budget definitions of non-metropolitan and metropolitan statistical areas (Office of Management and Budget, 2010). The 2 rural counties, Lee and St. Francis, vary in population size (28,258 and 10,424) but are predominantly African American (52%–55%) (U.S. Census Bureau, 2013). The urban area, Little Rock and greater Pulaski County, has a population of 382,748 and is 35% African American (U.S. Census Bureau, 2013). Prior research (Booth, Leukefeld, Falck, Wang, & Carlson, 2006) and treatment admissions data (State Epidemiological Workgroup, 2008) indicated large numbers of cocaine users in the selected counties.

### 2.2. Eligibility and sampling

In addition to African American race, other minimal eligibility criteria included 1) age at least 18 years, 2) the use of cocaine at least 2 times in the past 30 days by any route other than injection, and 3) the receipt of no formal or informal drug treatment service use in the past 30 days, defined as receiving any services at a drug treatment facility, counseling on drug use, or attendance at any self-help meetings. To help reduce the chances of individuals faking cocaine use to be eligible for study participation and receive the monetary incentive, research staff members did not disclose the specific eligibility criteria while recruiting or screening potential participants.

Respondent-driven sampling, or RDS, was employed to identify and recruit our sample of not-in-treatment cocaine users (Heckathorn, 1997; Heckathorn, 2002; Heckathorn, Semaan, Broadhead, & Hughes, 2002). Respondent-driven sampling has frequently been used to identify “hidden populations,” such as illicit drug users and persons with HIV (Heckathorn, 2002). This type of sampling has been shown to yield a more representative sample than targeted sampling, which involves establishing quotas for demographic and other groups, or snowball sampling (Watters & Biernacki, 1989), which unlike RDS does not have limitations on the number of referrals from a single participant. We

stratified the sampling by age to assure that we would have balanced samples of crack and powder cocaine users, knowing from prior research that crack cocaine tends to be used by older and powder cocaine by younger African Americans in Arkansas. Moreover, we stratified the sampling by gender to assure that samples were at least one-third female to enable us to test for gender differences.

To initiate recruitment, trained research staff members canvassed areas of the selected communities where substance users were thought to reside or congregate. While at those locations, they posted flyers and distributed business cards that described the research in general terms as a “Healthcare Access Study” and asked individuals to call the study phone number for more information and to be screened. Persons eligible for participation were scheduled a time to complete an in-person structured interview at one of the study offices. All of the study variables were assessed via a structured, in-person interview. Because questions regarding drug use and stigma could be susceptible to respondent bias, we trained the study interviewers to make the study participants comfortable to answer the interview questions honestly. Participants who completed an interview were paid \$50 for the interview and \$10 for travel, for a total of \$60. As part of the RDS, study seeds were given referral coupons to pass along to 3 other persons who were “like them.” Participants received \$10 for each referral that resulted in a completed interview, or a maximum of \$30 for 3 successful referrals. All recruitment took place between May 2011 and April 2012 and resulted in a final sample size of 400 (200 rural and 200 urban) participants, which was predetermined by sample size calculations to test main hypotheses for the overall project.

The research was approved by investigators’ university institutional review board, and participants’ identities were further protected by a Certificate of Confidentiality issued by the National Institute on Drug Abuse.

### 2.3. Dependent variable

Preferred treatment site was assessed by a single item that asked, “if you decided to get substance abuse treatment, where would you prefer to get it?” Responses options were, “in the town where I live,” “in a nearby town, but not in the town where I live,” and “in a town farther away from where I live.” We refer to these 3 responses as local, nearby, and distant treatment.

### 2.4. Independent variables

Demographics included age in years and gender. Socio-economic factors included marital status, which was re-categorized as single vs. married or living with a partner; educational status, which was re-categorized as having less than a high school degree or equivalency vs. at least a high school degree or equivalency; and any access to an automobile vs. no access. A lifetime history of any substance use treatment was based on the following item, “In your lifetime, how many different times have you been a patient or client in a drug abuse treatment or detox program, including residential, inpatient, or outpatient programs (not counting self-help programs like AA or NA)?”

To assess stigma associated with drug use, we modified items adapted from an instrument developed by Link et al. that assesses stigma associated with mental health problems and drug use (Link et al., 1997). We performed a factor analysis that identified 4 factors (experienced rejection/discrimination, secrecy, perceived devaluation, and perceived discrimination after treatment). We then created 4 scale scores using the mean of the responses to items corresponding to the respective factors. Experienced rejection/discrimination was based on 5 questions that had no/yes responses coded as 0 and 1: Did some of your friends reject you after they found out you were using drugs, did some of your family give up on you when they found out you were using drugs, were some people afraid of you when they found out you were using drugs, have people treated you unfairly because they knew you were a drug user, and do you sometimes avoid people because

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