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Failure to get into substance abuse treatment

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ABSTRACT

Among substance abusers in the US, the discrepancy in the number who access substance abuse treatment and the number who need treatment is sizable. This results in a major public health problem of access to treatment. The purpose of this study was to examine characteristics of Persons Who Use Drugs (PWUDs) that either hinder or facilitate access to treatment. 2646 participants were administered the Risk Behavior Assessment (RBA) and the Barratt Impulsiveness Scale. The RBA included the dependent variable which was responses to the question "During the last year, have you ever tried, but been unable, to get into a drug treatment or detox program?" In multivariate analysis, factors associated with being unable to access treatment included: Previously been in drug treatment ($OR = 4.51$), number of days taken amphetamines in the last 30 days ($OR = 1.18$), traded sex for drugs ($OR = 1.53$), homeless ($OR = 1.73$), Nonplanning subscale of the Barratt Impulsiveness Scale ($OR = 1.19$), age at interview ($OR = 0.91$), and sexual orientation, with bisexual men and women significantly more likely than heterosexuals to have tried but been unable to get into treatment. The answers to the question on "why were you unable to get into treatment" included: No room, waiting list; not enough money, did not qualify, got appointment but no follow through, still using drugs, and went to jail before program start. As expected, findings suggest that limiting organizational and financial obstacles to treatment may go a long way in increasing drug abuse treatment accessibility to individuals in need. Additionally, our study points to the importance of developing approaches for increasing personal planning skills/reducing Nonplanning impulsivity among PWUDs when they are in treatment as a key strategy to ensure access to additional substance abuse treatment in the future.

1. Introduction

Among substance abusers in the US, the discrepancy in the number who access substance abuse treatment and the number who need treatment is sizable, resulting in a major public health problem. In a report combining data from the National Survey on Drug Use and Health (NSDUH) and Treatment Episode Data Set (TEDS), over 23 million persons aged 12 or older needed treatment, but of those, the percentage who did not receive it varied from 89.3% in NSUDH to 91.7% in TEDS (Batts et al., 2014). A Massachusetts study showed that 85.6% of those who had a substance use disorder did not receive treatment in the past year, and of those with a lifetime substance use disorder only 33% had ever received any treatment (Falck et al., 2007; Shepard et al., 2005).

A major approach in the literature has been to look at treatment program factors that hinder access such as waiting lists (Brown, Hickey, Chung, Craig, & Jaffe, 1989; Carr et al., 2008; Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Quanbeck et al., 2013), along with possible remedies such as appointment reminder telephone calls (Gariti et al., 1995). A study of applicants to a residential treatment program for cocaine abuse who had been placed on a waiting list found that the longer people were on the waiting list, the more likely they were to have criminal justice system involvement (Brown et al., 1989). A retrospective study of people trying to get into a treatment program for cocaine abuse found that the longer the delay between initial contact and treatment entry, the less likely the person was to actually enter treatment (Festinger et al., 1995). This same research group then conducted a prospective experimental study in which applicants were randomly assigned to have their intake either 1 day, 3 days, or 7 days after initial contact. Those who had their intake within 24 h of initial contact were four times more likely to attend the intake session (Festinger, Lamb,

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Marlowe, & Kirby, 2002). A study of injection drug users who had overdosed on heroin in Baltimore found that being placed on a waiting list was the most common reason for not enrolling in treatment (Pollini, McCall, Mehta, Vlahov, & Strathdee, 2006). This leads to

Hypothesis 1.0. There will be evidence that being placed on a waiting list is a major reason for tying but failing to get into drug treatment.

1.1. Drug use factors

The data on how drug use affects treatment entry has been mixed. Some findings suggest that drug use predicted treatment entry (Booth, Crowley, & Zhang, 1996; Grella, Hser, & Hsieh, 2003; Zule & Desmond, 2000), while others indicate that drug use predicted treatment non-entry (Booth, Corsi, & Mikulich, 2003; Carroll & Rounsaville, 1992; Hser, Maglione, Polinsky, & Anglin, 1998).

Hypothesis 1.1. There will be a positive association between illicit drug use and trying but failing to get into subsequent treatment.

1.2. Prior treatment experience

The literature has consistently shown that those PWUDs who have been in treatment previously are more likely to seek and enter treatment later (Booth et al., 1996; Booth et al., 2003; Falck et al., 2007; Hser et al., 1998; Siegal, Falck, Wang, & Carlson, 2002; Zule & Desmond, 2000). It would seem that drug users were able to access treatment when they were in need of it. They also appear to have entered treatment as a solution to problems caused by their substance use.

Hypothesis 1.2. There will be a positive association between previous treatment and trying but failing to get into treatment.

1.3. Psychological problems

Psychological problems may adversely affect an individual's ability to deal with the various requirements of being able to get into treatment. Those individuals in a California study who were successful at entering treatment had lower levels of psychological distress than those who were not successful (Hser et al., 1998). A study of Medicaid claims data reported that those with intellectual disabilities, and serious mental illness were less likely to access treatment than those without those handicaps (Slayter, 2010). The demands of addiction were the second main barrier to seeking substance abuse treatment among 144 injecting drug users in New York. Moreover, homelessness, lack of desire, and family-personal issues were identified as major obstacles (Appel, Ellison, Jansky, & Oldak, 2004).

Hypothesis 1.3. There will be a positive association between personality constructs and trying but failing to get into treatment.

1.4. Sexual orientation

The literature on lesbian, gay, and bisexual (LGB) has consistently established that there is a higher prevalence of alcohol and other drug use in these populations (S. D. Cochran, Ackerman, Mays, & Ross, 2004), and that LGB persons who enter substance abuse treatment have more severe substance abuse problems (B. N. Cochran & Cauce, 2006). Specifically, bisexual men and women are reported to have higher rates of driving under the influence (DUI) than either lesbian, gay, or heterosexual individuals (Jessup & Dibble, 2012) and higher rates of having five or more drinks in a day (Ward, Dahlhamer, Galinsky, & Joestl, 2014). They were also more likely to report use of marijuana and other illicit drugs than either gay, lesbian, or heterosexuals (Ford & Jasinski, 2006). It is therefore not surprising that bisexual men and women had more than twice the odds of substance abuse treatment than heterosexuals (McCabe, West, Hughes, & Boyd, 2013).

Hypothesis 1.4. There will be a positive association between sexual orientation, especially for bisexuals, and trying but failing to get into treatment.

1.5. Homelessness

A study in Los Angeles demonstrated that PWUDs who were also receiving HIV/AIDS prevention services were more likely to receive substance abuse treatment if their living situation was unstable (Brocato, Fisher, Reynolds, & Janson, 2014). A study in Ohio reported that homelessness was significantly associated with longer wait times to get into treatment (Carr et al., 2008). Forty percent of a sample of homeless individuals reported that they had a substance abuse problem, but only 14% reported any substance abuse treatment and 25% of the sample reported that they had tried but failed to get into substance abuse treatment (Cousineau, 1997). A study of men on skid row reported that those with a history of hard drug use or prescription drug misuse had increased odds of receiving mental health counseling, as did those who had ever received alcohol or drug counseling (Rhoades et al., 2014).

Hypothesis 1.5. There will be a positive association between homelessness and trying but failing to get into treatment.

1.6. Economic issues

There is a large body of literature focusing on economic issues regarding substance abuse treatment. We will not present an exhaustive literature review on this topic and only present selected highlights that are relevant to our data. An early Texas study of opioid users found that requiring the user to pay even a relatively nominal fee of $2.50 per day was associated with a significantly lower retention rate at one year (Maddux, Prihoda, & Desmond, 1994). Similarly an Alaskan study found that a primary barrier to treatment entry was excessive treatment costs (Johnson, Brems, & Fisher, 1998). Private for-profit programs had lower access than private nonprofit and publicly funded programs for clients who were unable to pay for treatment (Nahra, Alexander, & Pollack, 2009). A California study found that programs that accepted public insurance had lower wait times to get into treatment (Guerrero, 2013). Not being able to afford treatment cost was the most common barrier in a 2014 study of data from the NSDUH (Mojtabai, Chen, Kaufmann, & Crum, 2014). Many economic factors were reported as barriers to access substance abuse treatment among consumers with AIDS (Cooper, Cloud, Besel, & Bennett, 2010).

Hypothesis 1.6. Economic factors such as income level and holding a paid job will be inversely associated with trying but failing to get into treatment.

Hypothesis 1.6.1. Cost will be a major reason for failing to get into treatment.

1.7. Effects of race/ethnicity

The literature on race/ethnicity and treatment access has made distinctions among different types of substance abuse treatment. For residential treatment, there is a report that Latinos are significantly less likely to enter treatment than Whites (Lundgren, Amodeo, Ferguson, & Davis, 2001). However, when it comes to methadone maintenance treatment, Hispanics are more likely to have entered treatment (Fisher et al., 2004). African Americans have more delay in getting into methadone maintenance treatment (Gryczynski, Schwartz,