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A 10-year study of factors associated with alcohol treatment use and non-use in a U.S. population sample

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ABSTRACT

Background: This study seeks to identify changes in perceived barriers to alcohol treatment and predictors of treatment use between 1991–92 and 2001–02, to potentially help understand reported reductions in treatment use at this time. Social, economic, and health trends during these 10 years provide a context for the study.
Methods: Subjects were Whites, Blacks, and Hispanics. The data were from the National Longitudinal Alcohol Epidemiologic Survey (NLAES) and the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). We conducted two analyses that compared the surveys on: (1) perceived treatment barriers for subjects who thought they should get help for their drinking, and (2) variables predicting past-year treatment use in an alcohol use disorder subsample using a multi-group multivariate regression model.
Results: In the first analysis, those barriers that reflected negative beliefs and fears about seeking treatment as well as perceptions about the lack of need for treatment were more prevalent in 2001–02. The second analysis showed that survey year moderated the relationship between public insurance coverage and treatment use. This relationship was not statistically significant in 1991–92 but was significant and positive in 2001–02, although the effect of this change on treatment use was small.
Conclusions: Use of alcohol treatment in the U.S. may be affected by a number of factors, such as trends in public knowledge about treatment, social pressures to reduce drinking, and changes in the public financing of treatment.

1. Introduction

In 1991–92 and 2001–02, respectively, 7.4 and 8.5% of the U.S. population were reported to have an alcohol use disorder (AUD; Grant and Dawson, 1999; Hasin et al., 2007). Most of these individuals never seek treatment or delay seeking treatment for many years (Cohen et al., 2007; Grant, 1997). On top of that, over this 10-year time period, there was a marked reduction in treatment use for White, Black, and Hispanic individuals with AUD (Chartier and Caetano, 2011). These 10-years, therefore, may offer important information about the factors that inhibit or facilitate help seeking for alcohol problems. In the current study, we sought to describe the changes in factors predicting treatment use between these years, using data from the National Longitudinal Alcohol Epidemiologic Survey (NLAES) and the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). The current analysis focused on these same ethnic groups for consistency between studies in seeking potential explanations for the reduction. Sociodemographic characteristics (e.g., ethnicity and gender), public beliefs and knowledge about alcohol problems, financial resources, and comorbid psychiatric disorders are associated with treatment use in the U.S. population (Cohen et al., 2007; Grant, 1997; Kaskutas et al., 1997; Schmidt et al., 2007). Some temporal trends related to these factors were observed during the time period for these

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surveys. We start with a review of studies that documented these trends in order to inform the current analysis.

1.1. Stigma and social pressures for treatment

The U.S. general public tends to view alcoholism as a moral issue, resulting in the stigmatization and social marginalization of those who are affected (Room, 2005). The public has become more cognizant of the biological causes of psychological disorders including alcohol-related problems. Although, despite this, the prevalence of stigma and community rejection related to such conditions remains high (Pescosolido et al., 2010). Social pressures to stop drinking reportedly intensified during the 1980s and 1990s in association with the national war on drugs and drunk-driving campaigns (Schmidt and Weisner, 1993; Weisner and Schmidt, 2001). However, Korcha et al.'s (2013) analysis of national data identified an overall decline, including from 1990 to 2000, in pressures to decrease drinking from a spouse/partner, family and friends, physician, work, or the police in those seeking treatment.

1.2. Resources for treatment: insurance and income

Prior to 1990, a movement to deregulate and privatize health services shifted the majority of Americans into private insurance plans (Schmidt and Weisner, 1993). State mandates sought to guarantee alcohol treatment coverage by insurance plans; however, efforts during the 1990s to contain healthcare costs saw the implementation of managed care techniques to cut spending in private insurance companies and later public programs (Steenrod et al., 2001). Coverage of alcohol treatment programs diminished, with the majority of remaining costs delegated to government programs (Cartwright and Solano, 2003; Mark et al., 2007). These government funds for alcohol treatment improve access to care for those with lower incomes. However, income is still a useful predictor when analyzing treatment utilization due to the hefty indirect costs of treatment, such as childcare, transportation, and lost work time. The 1990s was a time of strong economic growth in the U.S. Overall, households experienced a 14.7% increase in income from 1993 to 2000, with White households experiencing a 14.2% increase and Black and Hispanic households experiencing larger gains, i.e., 32.5% and 24.3%, respectively (U.S. Census Bureau, 2001).

1.3. U.S. rates of drug use and major depression

Drug use disorders, particularly tobacco and marijuana use disorders, are the most common comorbid psychiatric disorders among those with an AUD (Stinson et al., 2005). Based on NLAES and NESARC data, Compton et al. (2004) reported an increased prevalence of marijuana use disorders in the U.S. Treatment admissions for marijuana abuse increased, based on a 1992–2002 Treatment Episode Data Set, as well as admissions for opiates, non-prescription opiates, and stimulates (Substance Abuse and Mental Health Services Administration, 2004). Non-medical prescription drug use increased during this time period (Blanco et al., 2007). The U.S. prevalence of prescription drug use in 2001–02 was 8% among those with past-year alcohol abuse and 22% for past-year alcohol dependence (McCabe et al., 2006). Additionally, individuals with comorbid alcohol use and mood disorders are more likely to seek alcohol treatment (Cohen et al., 2007; Kaufmann et al., 2014). According to investigators comparing the NLAES and NESARC, the rate of past-year major depressive episodes increased from about 3–7% (Compton et al., 2006). Other psychiatric comorbidities are associated with increased alcohol treatment use (e.g., personality and anxiety disorders) (Cohen et al., 2007; Kaufmann et al., 2014), but changes in their prevalence rates in the general population were not observed during this period.

1.4. Study hypotheses

The aforementioned social, economic, and health changes during the 1990's lay a foundation to formulate hypotheses for this study. We hypothesized that the relationship of stigma as a barrier to treatment would remain consistent over the 10 years, while social pressures as a facilitator to seek treatment would be reduced. Due to the shift from private to public spending as the primary funding source for alcohol treatment, we hypothesized that the relationship between public health insurance and treatment use would become more significant, while the opposite was expected of the relationship between private insurance and treatment. The observed rise in household income seemed substantial, and we expected the relationships between income and treatment use would become stronger during the 10-year period by reducing financial barriers to treatment. Based on the reported increases in drug abuse and the prevalence of major depression during the 1990s, we expected an increased effect for these variables in predicting treatment use. Some of these hypothesized relationships will be tested by examining differences by survey year in perceived barriers to seeking help for alcohol problems, while others by examining a multivariate regression model with variables predicting treatment use. The identification of changes in the barriers and predictors of treatment use could offer explanations for fluctuations in the use of alcohol treatment services during this period, as well as identifying important targets for improving rates of help seeking.

2. Methods

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) sponsored the 1991–92 NLAES and 2001–02 NESARC (Chen et al., 2006; Stinson et al., 1998). The U.S. Census Bureau conducted the fieldwork for both surveys using trained, face-to-face interviewers. A multistage stratified probability sampling method was used to select the samples. The overall response rate for the NLAES was 90% and for the NESARC was 81%. The samples were representative of the U.S. civilian, non-institutionalized adult (18 years of age and older) population.

2.1. Study samples

Subjects were selected who self-identified as non-Hispanic White, non-Hispanic Black, and Hispanic (NLAES $n = 40{,}707$; NESARC $n = 41{,}060$). First, we analyzed perceived barriers to treatment use for respondents who thought they should get help for their drinking, but failed to do so (NLAES $n = 1072$; NESARC $n = 1012$). These respondents were 4.13% (NLAES) and 4.11% (NESEARC) of selected subjects who, in both surveys, answered positively to the question, "was there ever a time when you thought you should see a doctor, counselor, or other health professional or seek any other help for your drinking, but didn't go?" Second, we examined variables for predicting treatment use in an AUD subsample (NLAES $n = 2{,}860$; NESARC $n = 3{,}168$). These were respondents who had a positive 12-month DSM-IV alcohol abuse and/or dependence diagnosis and reported at least 12 alcoholic drinks in the past year.

2.2. Measures

2.2.1. Perceived barriers. For the first analysis, the reasons for not seeking help for alcohol problems were grouped into 3 categories based on Andersen's health services utilization model (Aday and