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An assessment of individual-level factors associated with alcohol treatment utilization among Mexican Americans

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ABSTRACT

The purpose of this study is to identify enabling factors for treatment utilization for alcohol-related problems, and to evaluate how enabling factors vary by need for treatment, among two samples of Mexican American adults. These two distinct samples included 2,595 current and former drinkers (one sample included 787 U.S./Mexico border residents; the other sample included 740 Mexican Americans living in U.S. cities not proximal to the border). Need for treatment (alcohol disorder severity) and (male) gender were the primary correlates of treatment utilization; and there was no moderation in the enabling factors by need for treatment as "enablers" of utilization. Further theoretical and empirical research is necessary to determine which mechanisms are driving disparities in treatment utilization across racial/ethnic groups generally, and Hispanic national groups specifically.

1. Introduction

Between 2006 and 2009, an estimated 7.4 million adults between the ages of 21 and 64 suffered from untreated alcohol use disorders in the United States (SAMHSA, 2011). Of those who have an alcohol use disorder (AUD), only 14.6% sought treatment at any point during their lifetime (Cohen, Feinn, Arias, & Kranzler, 2007). When AUDs are left untreated, the public health costs are broad, including child welfare, criminal justice, hospital emergency rooms, and other healthcare systems that treat co-morbidities and outcomes of alcohol use (Sacks et al., 2013). The costs of untreated AUDs to society have been estimated as high as 2.9 billion in 2006 (Sacks et al., 2013).

In light of these costs, several types of AUD treatment have been successful at reducing AUDs and associated negative health and behavioral outcomes. Pharmaceuticals (acamprosate and naltrexone), peer groups, behavioral therapies, Web-based treatment, and community-based services have been demonstrated as effective in reducing the burden of AUDs (Fleming et al., 2000; Kranzler & Kirk, 2001; McLellan et al., 1998; O'Malley et al., 2003). Alcoholics Anonymous (AA) has been effective in reducing alcohol use, particularly when combined with other types of treatment (Emrick et al., 1993; Kaskutas, Kaskutas, Bond, & Weisner, 2003).

Several theoretical models have been proposed to explain why certain people seek out treatment for alcohol-related problems (and, conversely, why others do not). The Andersen and Newman (1973) model is commonly cited in studies evaluating treatment seeking for alcohol use. This model posits that persons with alcohol use disorders obtain treatment due to a combination of predisposing (greater income, access/availability of treatment, older age, higher level of education, male gender, and more knowledge about the healthcare system), enabling (healthcare coverage, having the ability to travel for treatment, visiting a physician regularly, and having higher quality social relationships), and need (more severe AUD and greater perceived need for treatment) factors. This model has been interpreted and applied in many ways across various populations for more than three decades (Arroyo, Westerberg, & Tonigan, 1998; Grant, 1996; Padgett, Struening, Andrews, & Pittman, 1995; Weisner, 1993). For instance, Brennan, Moos, and Mertens (1994) assessed predictors of alcohol treatment seeking among older problem drinkers. This study found that male gender, avoidance coping strategies, chronic health problems, general life stressors, and having fewer peers who approved of alcohol use were predictive of treatment seeking. Weisner (1993) used a general population sample to understand treatment utilization, and found strong gender differences in treatment seeking. Specifically, a shorter treatment history and employment status (specifically, having a job), were predictive of treatment usage for both genders; however, predisposing variables were most closely associated with treatment utilization among women, while need, enabling and predisposing variables predicted treatment for men. Overall, independent of need, it appears that

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various indicators of socioeconomic status and social capital have been identified as strong correlates with treatment utilization across various populations.

Socioeconomic status is rarely assessed independently of race and ethnicity, and there are clear racial and ethnic disparities in treatment utilization for AUDs. One study by Chartier and Caetano (2011) used data from the National Epidemiological Survey on Alcohol and Related Conditions and the National Longitudinal Alcohol Epidemiologic Survey to examine both racial and ethnic differences in alcohol treatment utilization. Chartier and Caetano reported that Hispanics with AUDs were less likely than Whites with AUDs to use alcohol programs, specifically defined to include alcohol "detoxification and rehabilitation clinics", outpatient and inpatient services provided by a general hospital, community mental health center, or "outreach and day or partial day patient programs" for alcohol-related problems. Further, as the number of symptoms of alcohol dependence in one's lifetime increased (according to the DSM-IV), Hispanics were increasingly less likely than Whites to use alcohol treatment programs (Chartier & Caetano, 2011).

Hispanics have been identified as a group that has particularly high need for drug and alcohol treatment (Chartier & Caetano, 2011; Schmidt, Ye, Greenfield, & Bond, 2007; Schmidt, Greenfield, & Mulia, 2006); however, they are less likely than any other racial or ethnic group to receive such treatment (SAMHSA, 2012). In light of these overarching ethnic disparities between Hispanics and non-Hispanics in need for and use of alcohol treatment, national differences among Hispanics demonstrate heterogeneity in the alcohol use and treatment utilization patterns. Mexican American men report more binge drinking (46.2% of men binge drank in the past year) than South/Central American men (42.9% binge drank), or Cuban men (27.3% binge drank). Mexican Americans also have a higher rate of alcohol dependence than Hispanics from South/Central American or Cuba. Mexican Americans are also the national group most likely to receive a citation for driving under the influence of alcohol (Chartier & Caetano, 2011; Ramisetty-Mikler, Caetano, & Rodriguez, 2010). In addition, according to data from the National Survey on Drug Use and Health (NSDUH), Mexican Americans have the greatest need for alcohol treatment (as operationalized by DSM-IV "abuse" or "dependence") among any national group of Hispanics (9.2%, versus 7.7 for Puerto Ricans, 6.8% for South/Central Americans, and 5.2% for Cubans) (SAMHSA, 2008).

Among the 33.7 million Mexican Americans in the U.S., more than seven million reside along the U.S.–Mexico border (Pew Research Center, 2013; U.S. Department of Health and Human Services, 2009). Residents of this region are at elevated risk for a broad range of negative health outcomes due to concentrated poverty, undereducation, and problematic alcohol use. For example, the border population's relative youth ((CHC Border Health Forum, 2006) and the overwhelmingly Mexican American composition of its Hispanic residents are each known risk factors for both drinking and more liberal beliefs, attitudes, and norms concerning the use of alcohol (Mills & Caetano, 2010). At a macro level, alcohol is particularly visible and available on the border. Mexico's legal drinking age is 18, making it an easily accessible, geographically proximal location where younger U.S. residents can legally drink. In Mexico, marketing tactics of on-site alcohol outlets target younger age groups and encourage binge drinking (Lange, Voas, & Johnson, 2002). Previous epidemiological studies have generally confirmed elevated levels of drinking and associated problems on the border (e.g., Caetano, Mills, & Vaeth, 2012; Caetano et al., 2008; Wallisch & Spence, 2006).

In light of these potentially harmful behaviors that occur on the U.S.–Mexico border, the purpose of this paper is threefold: 1) to test for and explain differences in enabling factors for treatment utilization across two independent samples; 2) to identify factors that explain the use of treatment for alcohol-related problems among the two samples of Mexican Americans; and 3) to assess how differential enabling factors vary by need for treatment. We expect that differential enabling factors emerge as key enabling factors for treatment utilization across both populations: Mexican Americans living proximal to the U.S./Mexico border, and Mexican Americans living in large cities farther away from the border.

2. Methods

2.1. Data collection

These datasets used for this analysis include two distinct samples of Mexican American adults. Both sampling designs and questionnaires were nearly identical, allowing us to draw comparisons between settings within one Hispanic national group. One sample includes a Health Resources and Services Administration (HRSA) "medically underserved group" (characterized by cultural or linguistic barriers to healthcare, low rates of access to physicians, high infant mortality rate, high proportion of persons living below the poverty level, and a large proportion of the population aged 65 and older; HRSA, 1995) who resides proximal to the U.S.–Mexico border, and the other is comprised of a group of Mexican Americans who reside in large U.S. cities that are not proximal to the border. Both studies sampled the adult population 18 years or older and determined Hispanic ethnicity via self-identification. The 2 studies also used an identical questionnaire, which was pre-tested in English, then translated into Spanish, then back-translated to English. Trained bilingual interviewers conducted computer assisted personal interviews at the respondents' home that lasted about 1 hour. In both studies, respondents received a $25 incentive for participation and provided written informed consent. The distinctions between the two studies are discussed below.

Mexican Americans in the non-border group were interviewed as part of the 2006 Hispanic Americans Baseline Alcohol Survey (HABLAS), a study of 5,224 Hispanics from randomly selected households in five metropolitan areas of the U.S. Most of the non-border respondents were interviewed in Los Angeles (n = 609) and Houston (n = 513); however, additional interviews were conducted in New York (n = 86), Philadelphia (n = 59), and Miami (n = 21). The response rate in the HABLAS sample was 76%. For the purposes of the current study (and to avoid confounding by national group), only the Mexican Americans interviewed as a part of this study were included in the present analysis (N = 1,288). After removing those who have never used alcohol from the sample, 787 Mexican Americans were retained for analysis.

The border study was conducted between March 2009 and July 2010. During this time frame, 1,307 Mexican Americans who were 18 or older and resided along the U.S./Mexico border in California (Imperial County, n = 365), Arizona (Cochise, Santa Cruz, and Yuma Counties, n = 173), New Mexico (Dona Ana County, n = 65), and Texas (Cameron, El Paso, Hidalgo and Webb Counties, n = 704) were interviewed. Only urban areas were included in the primary sampling frame to ensure sampling comparability with the HABLAS sampling design. Therefore, border residents who lived in the rural areas of the region were not included in this analysis. The response rate among the border sample was 67%. After excluding respondents who reported never drinking alcohol in their lifetime, our final sample included 1,527 Mexican Americans (n = 787 non-border; n = 740 border).

2.2. Measures

Treatment utilization for alcohol-related problems. Our dependent variable, treatment utilization, was measured using the following item, "have you ever gone to anyone—a physician, AA (Alcoholics Anonymous), a treatment agency, anyone at all—for a problem related in any way to your drinking?" Responses were dichotomized as "used treatment" or "have never used treatment". Respondents who reported ever using treatment services were asked to identify which