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Influence of gender and race/ethnicity on perceived barriers to help-seeking for alcohol or drug problems

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ABSTRACT

This study examines reasons why people do not seek help for alcohol or drug problems by gender and race/ethnicity using data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationally representative survey. Multivariate models were fit for 3 barriers to seeking help (structural, attitudinal, and readiness for change) for either alcohol or drug problems, controlling for socio-demographic characteristics and problem severity. Predicted probabilities were generated to evaluate gender differences by racial/ethnic subgroups. Over three quarters of the samples endorsed attitudinal barriers related to either alcohol or drug use. Generally, women were less likely to endorse attitudinal barriers for alcohol problems. African Americans and Latina/os were less likely than Whites to endorse attitudinal barriers for alcohol problems, Latina/os were less likely than Whites to endorse readiness for change barriers for alcohol and drug problems, however, African Americans were more likely to endorse structural barriers for alcohol problems. Comparisons within racial/ethnic subgroups by gender revealed more complex findings, although across all racial/ethnic groups women endorsed attitudinal barriers for alcohol problems more than men. Study findings suggest the need to tailor interventions to increase access to help for alcohol and drug problems that take into consideration both attitudinal and structural barriers and how these vary across groups.

1. Introduction

It has been widely shown that a minority of individuals who have a substance use disorder (either alcohol or drug) actually seek and receive treatment for these problems. The most recent data from the National Survey on Drug Use and Health (NSDUH) estimates that only 10.8% of individuals who met criteria for needing substance use disorder [SUD] treatment actually received treatment at a specialty addiction treatment facility in 2015 (Center for Behavioral Health Statistics and Quality, 2016). Although the rate is higher when other forms of help-seeking are included (e.g., 12-step groups, pastoral care, private physicians), most individuals with substance use problems neither seek nor receive help for these problems.

1.1. Health Belief Model and barriers to care

The Health Belief Model is a useful theoretical framework to help understand why individuals do not utilize health services. The Health Belief Model posits that service utilization is influenced by health belief factors including perceived barriers to obtaining care as well as the perceived threat of a disease, perceived efficacy of health care, and cues to action (Janz & Becker, 1984; Schempf & Strobino, 2009; Rosenstock, Strecher, & Becker, 1988). In addition, the Health Belief Model recognizes that demographic characteristics, such as gender and race/ethnicity, are modifying variables that can influence service utilization directly and indirectly through the aforementioned health belief factors. Therefore, this model can be applied when assessing SUD treatment service utilization among diverse populations. Identifying the barriers to treatment and how they may vary by gender and race/ethnicity are fundamental to developing culturally appropriate services.

Using the Health Belief Model, we first consider perceived barriers to obtaining care. Overall, the literature distinguishes barriers to utilizing mental health services into two major categories: attitudinal versus structural (Crisp et al., 2000; Issakidis & Andrews, 2002; Saldivia et al., 2004; Sareen et al., 2007; Thompson, Hunt, & Issakidis, 2004; Wells et al., 1994). These two major categories may also be further subdivided to distinguish nuances among perceived barriers to obtaining care. For example, researchers have identified financial barriers separate from other logistical barriers when assessing structural barriers (Chen, Strain, Crum, & Mojtabai, 2013; Mojtabai, Chen, Kaufmann, & Crum, 2014; Schuler, Puttaiah, Mojtabai, & Crum, 2015). Similarly, perceived stigma has been identified as distinct among other attitudinal barriers,

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such as pessimism about treatment (Chen et al., 2013; Schuler et al., 2015). Taken as a whole, various studies using national samples have found that individuals are more apt to cite beliefs and attitudes about treatment compared to structural barriers (e.g., cost, lack of transportation, lack of information) when asked why they did not seek help for a substance use problem (Mojtabai et al., 2011; Chen et al., 2013; Schuler et al., 2015).

Another key construct in the Health Belief Model is the perceived threat of a disease. Generally, severity of substance use, psychological distress, and a greater number of perceived problems related to one's substance use increase an individual's perception of need for help (Grella et al., 2009). A recent study found that individuals with more severe disorders were more likely to perceive a need for help and to cite structural and attitudinal/evaluative barriers (e.g., stigma, negative experience with prior treatment, perceived ineffectiveness of treatment) as compared with those with less severe disorders (Chen, Strain, Crum & Mojtabai, 2013). Another study showed that among individuals with alcohol use disorders, those with comorbid mood or anxiety disorders were more likely to seek help, but were also more likely to perceive an unmet need for treatment and to report more barriers to obtaining care (Kaufmann, Chen, Crum, & Mojtabai, 2014). Similarly, a recent study conducted with national survey data found that individuals with unmet needs for treatment of co-occurring substance use and depressive disorders most often cited structural barriers, specifically, concerns about the cost of treatment as a barrier to receiving these services (Mojtabai, Chen, Kaufmann, & Crum, 2014).

In addition to perceived barriers to obtaining care and perceived threat of a disease, the Health Belief Model highlights the important role that demographic characteristics play in determining service utilization. Several demographic characteristics influence perceived need for treatment, with lower levels of perceived need among younger and middle-aged adults, compared with those older; males compared with females; and individuals with higher education levels compared with lower. With regard to race/ethnicity, Latina/os were more likely to report structural barriers to accessing treatment, but only among individuals with mild or moderate severity, as compared with non-Hispanic Whites (Mojtabai et al., 2014).

Thus, drawing from the Health Belief Model, it is important to understand the factors that inhibit help-seeking for substance use problems and, specifically, how these factors vary across subgroups. A better understanding of the barriers that individuals experience or perceive when seeking help for substance use problems may shed light on disparities in access to treatment among key demographic groups and suggest strategies that can be undertaken to alleviate these barriers and the resultant health disparities in treatment access. The goal of the present study is to examine differences by gender and race/ethnicity in perceived barriers to seeking help for substance use problems.

1.2. Gender differences in seeking help for substance use problems

National survey data has shown that women underutilize substance abuse treatment relative to men (Greenfield et al., 2007). A recent study found that women with alcohol dependence were less likely to receive help compared with men, although those who did receive treatment were younger at first service utilization and had a shorter interval between drinking onset and service use (Alvanzo et al., 2014). Moreover, women with substance use problems encounter unique barriers to seeking help, as compared with seeking other forms of health services use. These include factors such as greater stigma, less access to insurance coverage for addiction treatment, less family or other support for seeking treatment, concerns about jeopardizing custody of children or parental rights, and family-related demands that hinder their treatment participation (Grella, 2009; Grella & Joshi, 1999; Haller, Miles, & Dawson, 2003; Jessup, Humphreys, Brindis, & Lee, 2003).

In the past, traditional gender roles and marital relationships may have inhibited treatment participation among alcohol-dependent women. The dynamics of help-seeking may differ among women drug users, particularly if involvement in sex work or criminal behavior leads to supervision by the criminal justice or child welfare systems (Grella & Joshi, 1999), both of which may lead to diversion into drug treatment. Further, pregnant and parenting women who seek drug treatment may risk loss of child custody, or criminal prosecution (Paltrow & Flavin, 2010).

Logistical issues and access to resources, such as transportation, employment or health insurance coverage, may also facilitate or inhibit treatment use among women, (Saum, Hiller, Leigey, Inciardi, & Surratt, 2007). In addition to these, one study of women in recovery who had not participated in treatment found that they were concerned about the confrontational approaches that were pervasive in traditional substance use treatment and they held stereotyped perceptions of treatment services (e.g., the “religious” nature of 12-step groups; Copeland, 1997). However, much of the research documenting barriers to substance use treatment among women has not directly examined gender differences, nor differences within gender by race/ethnicity. Moreover, experiences of socio-economic disadvantage, exposure to community violence, criminal justice system interactions, and access to resources among women vary by race/ethnicity and influence perceptions of treatment needs and treatment access (Amaro et al., 2005, 2007).

1.3. Racial/ethnic differences in seeking help for substance use problems

Prior research has found higher rates of unmet need for mental health treatment among African American and Latina/os relative to Whites, although findings are mixed with regard to utilization of treatment for alcohol or drug problems (Hatzenbuehler, Keyes, Narrow, Grant, & Hasin, 2008). In one study using national survey data (Wells, Klap, Koike, & Sherbourne, 2001), among those with perceived need for treatment, compared to Whites, African Americans were more likely to have no access to treatment for alcohol, drug abuse, or mental health problems (25.4% vs. 12.5%), and Latina/os were more likely to have less care than needed or delayed care (22.7% vs. 10.7%). Among those with need, Whites were more likely than Latina/os or African Americans to be receiving treatment (37.6%, 22.4%, and 25.0%, respectively).

Prior research has shown that attitudinal and perceptual factors account for some of the underutilization of mental health services among ethnic minorities; these may include perceived discriminatory practices in service provision, prior negative experiences associated with services utilization, and limited knowledge regarding available treatment/services (Alegria et al., 2002; Diala et al., 2000; Hines-Martin, Usui, Kim, & Furr, 2004; Keyes et al., 2008). Higher levels of Latino ethnic identity and Spanish language preference have also been associated with lower mental health service utilization among Latino/as, but these had no effect on service use for substance use problems, although service use was generally low (Keyes, et al., 2012). However, other research has found that Whites were less likely to report receiving help for drug use disorders than African Americans, and that there were no differences by race/ethnicity with regard to perceived barriers to drug treatment (Perron, Mowbray, et al., 2009) or time to enter treatment for alcohol or drug disorders (Alvanzo et al., 2014; Perron, Alexander-Eitzman, et al., 2009).

Further, a recent study using data from a national sample of individuals in drug treatment found that gender was a consistent moderator of receipt of treatment services across racial/ethnic groups. African American, Latina, and White women all received significantly more comprehensive services than men while in treatment, both overall and matched to their self-reported treatment needs. Moreover, among all racial/ethnic groups, women attained significantly greater reductions in substance use post-treatment compared with their male counterparts who had received the same level of service, with especially large effects in this relationship among Latina women compared with Latino