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Predictors of treatment utilization and barriers to treatment utilization among individuals with lifetime cannabis use disorder in the United States



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ABSTRACT

Objective: To present information on predictors of treatment utilization and barriers to treatment utilization among individuals with lifetime DSM-5 cannabis use disorder (CUD).

Method: Face-to-face survey of a representative sample of the adult US general population (n = 36,309).

Results: Treatment rates for CUD were low in this general population survey (13.7%). Severity of CUD and comorbidity of other lifetime drug use disorders were significant predictors of lifetime treatment utilization for CUD. Preference for self-reliance, minimizing problems, fear of stigma, and financial and structural issues were among the most frequently endorsed reasons for respondents not seeking treatment when they perceived the need for treatment among individuals with lifetime CUD, regardless of whether they eventually utilized treatment at some time in their lives.

Conclusions: Given the rising prevalence of CUD in the US over the past decade and currently low treatment rates for CUD, increased provision for services for CUD appears critically needed, especially those that screen for and treat, when present, other drug use disorders. Programs to reduce stigma and financial barriers are needed, as well as programs to increase awareness among the general public, health care professionals about the nature and seriousness of CUD, and the availability and effectiveness of treatment for this disorder.

1. Introduction

Americans increasingly see cannabis use as harmless (Compton et al., 2016; Pacek et al., 2015). While some individuals can use cannabis without harm, its use does involve risk for various adverse health consequences including cannabis use disorder (CUD) (Hasin et al., 2016). CUD is associated with considerable impairment and comorbidity (Stinson et al., 2006), and its prevalence has increased substantially in the United States (US) and in clinical samples over the last 15 years (Bonn-Miller et al., 2012; Charilaou et al., 2017; Gubatan et al., 2016). However, despite the fact that evidence-based treatments for CUD are available (Copeland et al., 2014; Danovitch and Gorelick, 2012; Dutra et al., 2008; Marshall et al., 2014), CUD goes largely untreated in the US. Current national estimates of cannabis-specific treatment among adults with lifetime CUD are very low (13.7%; Hasin et al., 2016).

Little is known about predictors of and barriers to CUD treatment that can increase our understanding of access to treatment at a time

when treatment rates for CUD are so low. Based on the broader health services utilization literature, characteristics associated with receiving cannabis-specific treatment and barriers to treatment can be partitioned into predisposing, enabling and need factors (Aday and Anderson, 1974; Andersen and Newman, 1973; Andersen, 2008; Andersen et al., 2013). Predisposing factors are individual characteristics such as sociodemographic variables that influence treatment utilization. Enabling factors are available resources that can facilitate the use of services (e.g., health insurance). In this paper, we refer to such factors as “enabling/impeding”, since such factors may impede use of services rather than enable them. Need factors are conditions that individuals or others recognize as requiring treatment (e.g., severity of CUD). Information about the characteristics associated with CUD treatment utilization is needed in order to achieve equitable access to treatment services.

Two studies on barriers to seeking treatment compared small numbers of patients in cannabis treatment with non-treatment heavy cannabis users or cannabis dependent individuals in the community (Gates et al., 2012; van der Pol et al., 2013). In general, these

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comparative treatment studies found that CUD severity, not wanting to stop using cannabis, low treatment awareness, psychiatric comorbidity, and fear of stigma were important barriers to CUD treatment. A national survey conducted in 2001–2002 (Khan et al., 2013) assessed treatment utilization and/or barriers to seeking any drug treatment among individuals with CUD, regardless of whether treatment was specifically sought for cannabis. These studies identified psychiatric comorbidity as an important predictor of treatment utilization, and identified barriers including minimizing CUD problems, self-reliance, and fear of stigma. While informative, the national survey was conducted several years ago, was not based on disorders diagnosed with DSM-5 criteria, and did not address treatment specifically for CUD. Thus, current information is lacking at the national level on predictors of treatment utilization specifically for CUD, which is acutely needed given the increases in cannabis use and CUD in conjunction with the public perception that cannabis is a harmless substance (Hasin et al., 2015b).

The purpose of this study was therefore to present current information on predisposing, enabling/impeding, and need factors as predictors of and barriers to treatment among individuals with lifetime Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5: American Psychiatric Association, 2013) CUD using a large nationally representative sample of US adults.

2. Methods

2.1. Sample

The present study utilized data from the 2012–2013 National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III), described in detail elsewhere (Grant et al., 2014). The NESARC-III target population was the US noninstitutionalized adult civilian population, including residents of selected group quarters. Respondents were selected through multistage probability sampling. Sample size was 36,309, with a household response rate of 72%, and person-level response rate of 84%, giving a total response rate of 60.1%, which is comparable to other contemporary national surveys (Centers for Disease Control and Prevention, 2014; Substance Abuse and Mental Health Services Administration, 2014). The study protocol was approved by institutional review boards of the National Institutes of Health and Westat.

2.2. Assessments

The diagnostic interview was the Alcohol Use Disorder and Associated Disabilities Interview Schedule-5 (AUDADIS-5) (Grant et al., 2011). The AUDADIS-5 measures DSM-5 alcohol, drug, and nicotine use and disorders, as well as common psychiatric disorders in the last 12-months and prior to the last 12-months. DSM-5 lifetime CUD diagnoses required ≥ 2 of 11 criteria in the last 12-months or prior to the last 12-months.

Test-retest reliabilities of CUD diagnoses ($\kappa = 0.41, 0.41$) and their dimensional criteria scales (intraclass coefficients [ICC] = 0.70, 0.71) were fair to substantial in a general population sample (Grant et al., 2015b). Procedural validity was established through blind re-appraisal using the semi-structured, clinician-administered Psychiatric Research Interview for Substance and Mental Disorders, DSM-5 version (PRISM-5) (Hasin et al., 2011). AUDADIS-5/PRISM-5 concordance was moderate for CUD ($\kappa = 0.60, 0.51$) and substantial for its dimensional criteria scales ($ICC = 0.79, 0.78$) (Hasin et al., 2015a).

2.3. Treatment

Respondents were asked if they ever went anywhere or saw anyone for problems related to their cannabis use in the last 12-months or prior to last 12 months. This included 14 potential sources of help for CUD,

including professional inpatient and outpatient settings, and 12-step programs. Twelve-month and prior to last 12-month CUD treatment were combined to form a single measure of lifetime CUD treatment.

2.4. Predictors of treatment utilization

Predictors of treatment utilization were organized into three categories: predisposing, enabling/impeding, and need factors (Andersen, 2008, 2013; Andersen et al., 2013; Andersen and Newman, 1973). Predisposing factors included sex, age, race-ethnicity, education, marital status, and family history of drug problems. Enabling/impeding factors included urbanicity, family income, employment status and health insurance in the last 12 months. Need factors included CUD severity level (mild, moderate, severe, as defined in DSM-5), cannabis withdrawal, age at onset of cannabis use, age of onset of CUD, frequency of cannabis use during period of heaviest use, duration of longest episode (in months), lifetime mood, anxiety, personality, other substance use disorders, and presence of three or more medical conditions in the past year.

2.5. Reasons for not seeking treatment

Respondents were asked if there was ever a time when they thought they should see a doctor, counselor or any other health professional for any reason that was related to their drug use, even though they failed to go. Those who responded positively were asked whether any of 27 items listing reasons for not seeking treatment pertained to them. Reasons for not seeking treatment were also organized into more refined conceptual groupings, including predisposing (fear of stigma/social consequences, fear of treatment, treatment pessimism), enabling/impeding (financial and logistical/structural) and perceived need (self-reliance, minimizing problems), factors consistent with conceptual and factor analytic results on treatment barriers among substance users (Mojtabai and Crum, 2013; Rap et al., 2006).

2.6. Statistical analyses

Weighted percentages were computed for predictors of lifetime cannabis-specific treatment utilization among those with lifetime CUD. Bivariate odds ratios (ORs) were computed for each predictor and cannabis-specific treatment utilization. Adjusted ORs estimated from a multivariable logistic regression indicated associations between each predisposing, enabling and need factor and cannabis-specific treatment utilization, adjusted for all others. Weighted percentages were also calculated for each reason for not seeking treatment among all individuals with lifetime CUD and separately by whether respondents indicated seeking treatment at some point in their lifetime. All analyses were restricted to lifetime measures based on sample size considerations. To account for the complex survey design of the NESARC-III, SUDAAN 11.0.1 (Research Triangle Institute, 2012) was used to produce standard errors and confidence limits for estimates presented here.

3. Results

The weighted prevalence of DSM-5 lifetime CUD was 6.3% ($n = 2242$). The prevalence of cannabis-specific treatment among those with lifetime CUD was 13.7% ($n = 300$). Bivariate ORs reflected associations between predictors and cannabis-specific treatment utilization (Table 1). Compared to married individuals, the odds of cannabis-specific treatment utilization were significantly greater among those previously married (widowed, separated or divorced; $OR = 1.64$). Having a family history of drug problems also increased the odds of cannabis-specific treatment utilization ($OR = 1.65$), as did being in the lowest income category compared to the highest income ($OR = 1.75$). Compared to those with mild CUD, respondents with moderate or severe DSM-5 CUD had greater odds of cannabis-specific treatment

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