BARRIERS TO TREATMENT FOR ADDICTED AFRICAN-AMERICAN WOMEN

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This article describes barriers to treatment identified by a sample of substance-abusing/addicted women (mostly African-American). A self-administered questionnaire, the Allen Barriers to Treatment Instrument, was submitted to 97 substance-abusing/addicted women throughout the state of Illinois who were not in treatment. Results showed that the barriers most identified by these subjects included responsibility for child care, lack of insurance or money, and community issues. (*J Natl Med Assoc.* 1995;87:751-756.)

Key words • substance abuse • substance addiction • treatment barriers • African-American women

Substance abuse/addiction is a major public health problem in the United States, and adverse consequences are manifested disproportionately among African Americans and women. A 1-year point prevalence study found that 9.5% of the total adult US population (15.1 million people) had an addictive disorder. An alcohol disorder was diagnosed among 7.4% and other drug abuse and dependence disorders were diagnosed among 3.1%; of these, 1% had both alcohol and other drug abuse disorders.[1]

African Americans have a significantly higher rate of mental disorders than any other group.[2] Approximately 12% of the total African-American population in the United States were found to have used illicit drugs,[3] and African Americans have a higher drug abuse or dependency rate than whites or Hispanics.[2] There are several reasons why African Americans are regarded as being at risk for a range of adverse consequences from substance abuse. First, they are more likely to use these drugs intravenously.[4] Second, they have more persons with lower levels of education, and level of education is increasingly being recognized as an important correlate of substance use in that those who are less educated have heavier use.[4] In addition, poor socioeconomic and socioenvironmental conditions—in which a large percentage of African Americans exist—contribute to high incidence and prevalence of substance abuse/addiction. Finally, the rate of illicit drug deaths are higher for African Americans than for whites, and African-American women are nearly twice as likely as white women to die from drug use.[4]

Reports show that 34 million women in the United States drink alcoholic beverages, and at least 4.6 million are alcohol abusers or alcoholics.[5,6] In addition, an estimated 5.4 million women use illicit drugs.[7] Substance-abusing/addicted women:

- are more susceptible to alcohol-related liver damage,
- develop liver disease in a shorter period of time at lower levels of consumption,
- are at risk for suppressed hormonal activity from repeated or sustained episodes of alcohol intoxication,
- are more likely to become victims of alcohol-related aggression of others,[8] and
- are at high risk for contracting the human immunodeficiency virus (HIV) from intravenous drug use—the number one cause of acquired immunodeficiency syndrome (AIDS) among inner-city women, particularly African Americans.[9]

The above information is evidence of the need for substance-abusing/addicted African-American women to acquire treatment for their disease. Of all addicted persons needing treatment, only 23.6% received any service (less than one fourth)[4]; of these, only 27.5%

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were women, and 21.2% were African Americans.[10]

Due to a lack of data, it is unclear what percentage of persons who received treatment for substance abuse/addictions were African-American women; however, based on the low percentages of female and African-American presence in treatment as a whole, it is reasonable to suspect that the presence of these women in treatment is low as well. As a result, research was designed to determine what prevents African-American women from getting help for their addiction. This article documents barriers to treatment identified by a sample of substance-abusing/addicted women (mostly African American).

It is a common belief that these women are not in treatment because of lack of space, funds, or their own denial about being a substance abuser or addict.[4] However, more often than not, the data on which this belief is based were received from someone other than the women themselves who experience barriers to treatment.

CONCEPTUAL FRAMEWORK

In literature discussions of barriers, the terms "access to care" and "utilization of services" are often used interchangeably. "Access to health care'" is used by one expert in conjunction with three associated components: affordability, acceptability, and availability. Each of these components permit a description of the compatibility or the fit between prospective clients and the health-care system in that, if it is affordable, acceptable, and available, then it is accessible.[11] The onus for whether a client receives care seems to be placed on the facility providing the correct access to care, and consequently, barriers would be viewed as coming from external phenomena.

When access to health care is defined as those dimensions that describe the potential and actual entry of a given population group to the health-care delivery system,[12] then the onus for whether a client receives care seems to lie with the clients and their utilization of the available services. Consequently, barriers would be viewed as coming from subjective or internal phenomena. Hence, barriers are conceptualized as external and subjective (internal) phenomena that obstruct, restrain, or serve as obstacles to receiving health care.[13]

LITERATURE REVIEW

A review of research specifically related to barriers to treatment for addicted women revealed the following: Beckman and Kocel[14] reported that certain systems' factors appear to be greater barriers to treatment for women alcoholics, in that more women were admitted to agencies that were private, had more professionals and women on staff, and provided aftercare and treatment for children. These data support the concept that barriers to treatment are external and relate to lack of access based on acceptability of services. However, the data were obtained from interviews with program directors and retrospective record review rather than from addicted women who experienced the barriers.

Beckman[15] conducted a study using personal interviews with program directors and clients, and telephone surveys with gatekeepers (ie, lawyers, law enforcers, physicians, clergy, social services, etc). Results revealed that in addition to critical cognitive factors, a major barrier to substance abusing/addicted women entering treatment was that the services were not structured to appeal to them. These results provide evidence that barriers to treatment do come from subjective (internal) as well as external sources, and access to care as well as utilization of services can be issues for barriers. However, most of the sources for data collection were not addicted women experiencing barriers themselves.

Interviews with addicted women in England revealed subjective (internal) sources of barriers that led to underutilization of services. These barriers were:

- failure to recognize having a problem with alcohol use/abuse,
- fear of others' reactions causing shame, guilt, embarrassment, and possible rejection,
- prevailing stereotypes of "the alcoholic" and the desire to protect their self-image,
- fear of the stigma associated with addiction,
- inability to get time off from work to go to treatment,
- fear of the unknown related to treatment, and
- spouses wanting a drinking partner.[16]

Wilsnack[17] conducted an extensive survey on barriers to treatment for addicted women throughout the United States in 39 different communities. Subjects in the study included 463 representatives of alcohol authorities, 596 representatives of treatment centers, and 1487 community gatekeepers. Results showed that these subjects—based on their experiences—viewed personal denial on the part of the addicted women, responsibility for care of dependent children, and family denial as barriers to treatment. Hence, according to these subjects, barriers to treatment for addicted women are related to subjective (internal) issues and therefore are a result of their underutilization of the services that are available. However, none of the subjects in this study were addicted women experiencing difficulty getting into treatment; frequently, what addicted women view as barriers and what persons such as program direc-

tors and gatekeepers view as barriers are different.

For example, recent interviews conducted with 180 addicted women in the southern United States revealed that the women identified treatment barriers as being fear that their children will be taken away; shame about being an alcoholic or addict; depression, which causes inaction; and denial of addiction. However, in this same study, when program directors were asked what barriers to treatment addicted women experienced, they identified lack of child care, lack of money or insurance to pay for treatment, no treatment available, and lack of transportation.[18] These entirely different responses shows support for the need to ask addicted women themselves what their barriers to treatment are, if we are to be successful in helping to remove them. While this study did accomplish this, most of the women in the study were white, which leaves us without the perspective of African-American women who abuse substances or are addicted.

Few studies address barriers to treatment specific to African-American women who are substance abusing or addicted. Beckman[15] states that barriers to treatment for African-American women most likely arise from program characteristics of the alcoholism treatment delivery system with regard to meeting their needs. Specifically, issues such as lack of direct financial and indirect opportunity costs were hindering, lack of culturally and linguistically relevant services, a lower proportion of professionally trained treatment providers in ethnic services, and unmet child care needs were all hindering. These findings provide support for the idea that external phenomena cause lack of access to treatment. Amaro et al[19] reported that the most outstanding variable between African-American and white women related to barriers to treatment was lack of access to insurance coverage as well as significantly lower financial resources for African-American women.

There is a need for more information in the literature regarding barriers to addictions treatment from the perspective of African-American women experiencing the problem. The data presented will contribute to fulfilling that need.

METHODOLOGY

Survey methodology was used to answer the question: What barriers do addicted women say keep them out of treatment?

Study Population

All subjects for the study were selected using the nonprobability method of purposive sampling. The target population was substance abusing and/or addicted women age 18 and older who were not in treatment and lived in the state of Illinois. A total of 97 subjects were obtained from outpatient treatment programs where women could come seeking treatment, but not follow through on getting it; detoxification and inpatient programs where women were admitted, and had become detoxed, but declined to go on for further treatment; and women living at home in communities.

Addicted women at facilities were approached by staff and asked to participate in the study. Addicted women in the communities were approached by "recovering women" who knew of their addiction and the fact that they were not in treatment.

TABLE 1. SAMPLE ITEMS FROM THE ALLEN BARRIERS TO TREATMENT INSTRUMENT

- **Treatment Program Characteristics**
  - The far distance of treatment programs from my home
  - Possibly having to talk in a group where men are present
  - No help from treatment programs for staying alcohol-free and/or drug-free after treatment
- **Personal Beliefs, Feelings, or Thoughts**
  - I do not feel that drinking and drug use is a problem for me
  - I do not have health insurance for this problem
  - I have responsibilities at home as a mother, wife, or partner
- **Issues**
  - No encouragement from family and friends to get help for the problem
  - Having no one in my family or community to take care of my children
  - Not being able to get time off from work

Data Collection Instrument

The research questionnaire used to conduct the survey was the Allen Barriers to Treatment Instrument (ABTI). The ABTI is a 41-item self-administered interval rating scale. It uses a four-point Likert response format and has 30 items that are subject-matter or content related divided into three subsections. The three subsections are: treatment program characteristics; personal beliefs, feelings, and thoughts; and socioenvironmental issues. Table 1 provides an example of some of the ABTI items. In addition to the 30 standardized items, each section has an open-ended question that asks subjects what else keeps them from getting help.[13]

Psychometric properties of the ABTI reveal an internal consistency reliability of .87 for the overall instrument; .84 for the treatment program characteristics subsection; .67 for the personal beliefs, feelings, and thoughts sub-

TABLE 2. SOCIODEMOGRAPHIC, TREATMENT, AND DRUG USE CHARACTERISTICS

Variable	% of Subjects
Sociodemographics	
Age (years)	
18 to 25	16
26 to 34	48
35+	35
Race	
African American	64
White	30
Hispanic	3
American Indian	1
Education	
Grade 8 or less	7
Some high school	32
High school graduate	31
Some college	23
College graduate	6
Marital status	
Single	40
Divorced	26
Married	12
Living with someone	21
Employment	
Full time	13
Part time	9
Unemployed	75
Monthly income	
0 to $500	56
$501 to $1000	13
$1001 to $1500	6
$1501 to $2500	6
$2501+	3
Main source of income	
Public aid	50
Family or friends	13
Job	12
Spouse	7
Number of children	
0	12
1	27
2	24
3	12
4	9
5 or more	10
Treatment and Drug Use	
Undergone previous detoxification	
Yes	66
No	28
Undergone previous treatment	
Yes	50
No	38
Drug of choice	
Cocaine	30
Alcohol	22
Heroin	8
Other/combination	24

section; and .75 for the issues subsection. In addition, the instrument has documented face, content, criterion-related, and construct validity.[20]

Data Analysis

To describe barriers to treatment identified by the addicted women in this sample, data were analyzed using summary statistics. Frequencies, means, and standard deviations were obtained on the responses of the 97 subjects to the 30 items. Demographic data also were analyzed. In addition, barriers were rank ordered according to the frequency with which they were identified by the women as keeping them out of treatment.

RESULTS

As can be seen in Table 2, most of the subjects were single, unemployed African-American women between the ages of 26 and 34 who had an educational level of "some high school only." Most of the subjects named public aid as their source of income—with an income of $6000/year. Eighty-two percent of the women had children and 87% claimed a religious affiliation. Sixty-six percent of the women had previous detoxification experiences; however, only 50% had prior treatment. Cocaine was the drug of choice among the women in this sample.

Table 3 shows the barriers identified by the addicted women in this sample that kept them out of treatment. The first three barriers listed most frequently were: responsibilities at home as a mother, wife, or partner; the inability to pay; and the lack of insurance, which fit with the above outlined socioeconomic and demographic data presented on the women. It also supports what other literature reports. However, the fourth barrier that the addicted women identified as having kept them out of treatment—needing alcohol and/or drugs to deal with stress of daily life in my community—has not been documented in other studies. These results provide empirical evidence in addition to the experiential knowledge that certain neighborhood and community issues contribute to addicted women not getting in treatment, and underscore the importance of asking women what keeps them out of treatment.

The fifth and sixth barriers identified by the women in the sample—fear that admission of this problem could be used by someone to take their children away and the shame felt when they admitted to having a problem—concur with data obtained from interviews with addicted women in the recent southern region study. The barrier ("in the past, I have been unable to stay alcohol- or drug-free after treatment") shows the need for strong aftercare programs and self-help groups in African-American communities for those who are able to get help.

Most of the eight barriers identified with the most frequency in this study were from the personal beliefs, feelings, or thoughts subsection of the questionnaire. This suggests that although barriers to treatment exist due to external issues that cause a lack of access, this sample of primarily African-American women reported more barriers due to subjective (internal) issues. This lends support to the concept of underutilization of services by the women by choice due to internal problems. Therefore, barriers to treatment for this sample fit the conceptualization outlined earlier—that they are both internal and externally motivated.

IMPLICATIONS FOR HEALTH CARE

Allowing addicted women to identify barriers to treatment that they experience provides greater insight into increasing their admission rates. Programs that circumvent these barriers can be initiated in the health-care field based on data obtained from individuals who experience the barriers. As this study showed, while it was expected that the women would say being a mother and wife, and having no insurance or money would keep them from getting help, it was not expected that problems in the community would be stressful to the point of contributing to the continued use of alcohol and drugs rather than seeking treatment.

It is expected that barriers will vary for women of different socioeconomic, educational, or even ethnic status. However, the process of allowing the women themselves to identify what keeps them from getting help is the essential key in changing underrepresentation of African-American women in treatment.

STUDY LIMITATIONS

The primary limitation to this study was that the sample was not randomly selected; therefore, results cannot be generalized to all African-American women who abuse substances or are addicted. Another limitation to the study was the inability to verify the substance abuse/addiction status of the subjects. However, because of logistics, the decision was made to accept the diagnosis assigned by the facility in which the subject was a client. For women in the community, the decision was made to accept their self-diagnosis or admission of a substance abuse/addiction problem.

TABLE 3. BARRIERS TO TREATMENT AS IDENTIFIED BY ADDICTED WOMEN

Barrier	Response of Subjects (%)
Having responsibilities at home as a mother, wife, or partner	55
I cannot pay for treatment of this problem	46
I do not have health insurance for this problem	45
Needing alcohol and/or drugs to deal with stress of daily life in my community	42
Fear that my admission of this problem could be used by someone to take my children away	40
I feel ashamed when I admit to having this problem	40
In the past I have been unable to stay alcohol or drug-free after treatment	39
Having to wait for an opening because the program is full	38

Acknowledgments

This research was completed as dissertation work at the University of Illinois at Chicago, School of Nursing. The author thanks her dissertation chair, Dr Marguerite Dixon, and other members of her committee: Dr Karyn Holm, Dr Barbara Logan, Dr Diana Biordi, Dr Kathleen Knafl, and Dr Joseph Levin. The author also acknowledges that this research received funding from the Centers for Disease Control, Atlanta, Georgia through the Prevention Research Center of the University of Illinois at Chicago.

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