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Exploring African American Women's' experiences with substance use treatment: A Review of the Literature

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Abstract

Aims: The aim of this systematic review is to synthesize evidence on treatment barriers among African American women who seek treatment for substance use disorders.

Methods: The authors reviewed articles from 1995–2018 on the topic of substance use disorders among African American women.

Results: Based on the review of thirteen articles, we found African American women were more likely to encounter treatment readiness barriers compared to access barriers, and system-related barriers.

Conclusions: Personal and interpersonal barriers were more readily identified throughout the literature reviewed. However, African American women did encounter other barriers such as access and system-related barriers. In addition, the intersection of race, gender, and class was not addressed in the specific articles, but should be considered when working to remove treatment barriers for this population. While prevalence of alcohol and drug use is limited among African American women, it is important to understand how treatment readiness barriers may limit successful completion of treatment and ongoing progress. Implications for treatment and future research in addressing barriers to treatment for African American women are discussed.

Keywords

Treatment barriers; African American women; dual diagnosis; substance use; mental health

Introduction

The treatment engagement process of women seeking help for substance use/abuse is complicated and understudied. Treatment engagement is commonly defined as a continuum between the first initiation of treatment, to attending a specified number of sessions, to treatment outcomes (Brown, Bennett, Li, & Bellack, 2011; Siqueland et al., 2002). Historically, women have suffered challenges in terms of accessing quality care and ancillary services in substance use treatment (Green, 2006; National Institute of Drug Abuse,

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[NIDA], 2018). The prevalence of substance use help-seeking is lower for African American women. There is a dearth of information on how they access and utilize services and the extenuating psychosocial consequences that may affect their lives because of substance use (Schmidt, Greenfield & Mulia, 2006). This review will help bring light to what barriers may exist and how these barriers may interfere with treatment seeking and the engagement process.

Substance use treatment prevalence

According to the National Survey on Drug Use and Health (NSDUH) from 2004–2006, 6.3 million women were in need of some type of substance use treatment (Substance Abuse and Mental Health Services Administration, SAMHSA, 2008). In recent NSDUH data, (SAMHSA, 2018), 89.6% of women did not receive treatment compared to 88.8% for men. When looking at African American and Non-Hispanic white females, there are differences and similarities in substance use. The initiation of illicit drug use tends to happen earlier with Non-Hispanic white women compared to other races/ethnicities. While over time African American and Hispanic women eventually catch up and start using illicit drugs (Wu, Temple, Shoker et al, 2010). The persistence of using or having a substance use disorder is similar among African American women (40.6%) and Non-Hispanic white women (40.3%) (Evans, Grella, Washington, & Upchurch, 2017). While drug prevalence and initiation eventually evens out, treatment engagement is not the same (Breslau et al., 2005; Ojeda & McGuire, 2006; Schmidt, Greenfield, & Mulia, 2006).

For African Americans, 5.8% of those who needed treatment did not make an effort to find treatment compared to 3.5% from other racial/ethnic groups (SAMHSA, 2013). Siqueland et al., (2002) found Non-Hispanic whites were 62% more likely to complete substance use treatment intake compared to 44% of African Americans. Based on a national sample of black Americans, female participants often reported they did not seek help because they felt their problems were not serious enough, while males did not seek help because they thought things would get better (Redmond, Watkins, Broman, Abelson, & Neighbors, 2017). The issue for African Americans whether male or female is once in treatment, they do not complete the entire treatment process and have shorter treatment durations compared to white Americans (Breslau et al., 2005; Ojeda & McGuire, 2006; Schmidt, Greenfield, & Mulia, 2006). This is of concern since African Americans compared to other racial/ethnic groups have a longer duration of substance use and tend to seek help once the problem is severe. (Schmidt, Ye, Greenfield, & Bond, 2007; Woodward et al., 2008). When looking at lifetime substance use prevalence within a nationally representative sample of black Americans (African Americans and Caribbean blacks), African American women have lower prevalence rates for substance use (6.3%) compared to their male counterparts (18.1%) (Broman, Neighbors, Delva, Torres, & Jackson, 2008). Even with the lower prevalence, African American women still have a need for more treatment than they are seeking or receiving and little is known about how they engage in the treatment seeking process (Schmidt, et al., 2006).

Unmet treatment needs for African American women with substance use disorders are not well defined in the literature (Schmidt, Greenfield, & Mulia, 2006). Substance use disorders

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are serious issues that often go untreated (Schmidt et al., 2006; Ojeda & McGuire, 2006). Women suffer direr health-related consequences from their substance use while carrying greater social stigma or guilt because of drug and alcohol use compared to men (Green, 2006; McHugh et al., 2018). According to the World Health Organization (2008) [WHO], mental health issues disproportionately affect women compared to men. Consequently, pre-existing mental health issues in many women may act as a precursor to substance use (Amodeo, Chassler, Ferguson, Fitzgerald & Lundgren, 2004; El-Mallakh, 1998). Women also tend to have greater gender specific risk factors such as poverty, as more women tend to live in poverty, earn lower wages and have lower employment, and experience relationship violence. These factors often make them more susceptible to psychological distress (Becker & Walton-Moss, 2001). Barriers in finding adequate childcare while in treatment, paying for treatment services and the overwhelming stigma of guilt and shame in needing to go to treatment for their substance use disorder is common among many women (Brady & Ashley, 2005; Ehrmin, 2001; Khan et al., 2013; Verissimo & Grella, 2017).

Intersectionality and Substance Use Treatment

The term Intersectionality was first introduced by Crenshaw (1991) to explain the exclusion of black women from the then feminist discourse in the 1990s. Crenshaw used this term to explain how marginalized or historically oppressed individual's lives (i.e. black women), were affected by their racial background, their socio economic class, and their gender. Crenshaw's theory proves it is important to understand the role of race, class, and gender for women of color, particularly how these roles interact when thinking of social justice, health issues, and discrimination. Intersectionality theory has further evolved into how these interactions relate to issues for healthcare access and outcomes, interactions with the criminal justice system, and even substance use treatment services (Bowleg, 2012; Cairney et al., 2014; Mereish & Bradford, 2013). The interaction of race, class, and gender especially for health and behavioral health is uniquely tied to the social determinants of health, thus affecting how women approach, enter, and progress through the substance use treatment process (Verissimo, Gee, Ford, Iguchi, 2014). For African American women seeking care for substance use treatment, intersectionality theory is relevant when thinking about racial discrimination (Bowleg, 2012; Carliner, Delker, Fink, Keyes, & Hasin, 2016; Curtis-Boles & Monroe, 2000). There are the issues of race and possible perceived discrimination from the systems where they seek care, there are cultural/community factors which may impact their belief or ability to seek treatment such as family responsibility or cultural beliefs about treatment, and there is gender, being a mother, needing child care services, and family responsibilities. These three areas all contribute to how, when, and why some African American women may seek or even delay receiving the treatment they need.

National Focus on Substance Use Treatment and African American women

In previous years, specifically in 2001 and 2006, there was a national push to understand the implications of unmet need for substance use and mental health, particularly among populations of color and before Schmidt et al (U.S. Department of Health and Human Services[DHHS], 2001;Schmidt, Greenfield, & Mulia, 2006). From some of this work, the importance of tailored treatment for women's behavioral health services have been targeted and implemented. Recently the Substance Abuse Mental Health Association (2009)

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provided a protocol guide for women and substance use treatment, with specific guidelines for African American patients were including clinical services, clinic staff, and strategies to engage African American women in treatment, such as a strengths approach and connection with community. National organizations, such as the American Psychological Association (APA) and The National Association for Alcoholism and Drug Abuse Counselors (NAADAC) have made a step forward in recognizing the need for culturally competent care, providing guidelines and webinars for additional training when working with populations of color (APA, 2018; NAADAC, 2015). While this is an important step, more work is needed to further understand potential barriers that impede the progress of African American women from seeking and successfully progressing through the substance use treatment continuum.

One way to understand why unmet treatment needs exist is to identify barriers within the treatment engagement process. This study will review the literature to explore how various barriers affect the use of services for African American women who have a substance disorder or who are dealing with substance abuse. By investigating the underlining cultural, social and economic influences of barriers, this will help substance use researchers and practitioners understand how to better engage and treat this population of women.

Methods

Electronic database searches of PUBMED, Google Scholar, PsychINFO, and MEDLINE using the following keywords and phrases: substance use, mental disorders, mental illness, African American women, barriers, treatment barriers, substance use treatment, mental health treatment, women and treatment barriers, treatment engagement and African American women, and help-seeking were carried out for research published between 1995 to 2017. We also checked all relevant reference lists from retrieved articles to further our search on treatment barriers.

The selection criteria for the study was the description and inclusion of factors associated with barriers to treatment for behavioral health services. Included in this study are 10 studies on substance use treatment barriers, and because substance use is often treated along with mental health, three studies on substance use/mental health treatment barriers are included. No specific type of substance use was included in the search. However, most articles included alcohol, cocaine, and heroin use. Both quantitative and qualitative studies that specifically looked at African American women 18 years or older were included, as well as studies that had a multi-racial/ethnic population which included African American women and studies that were strictly African American with mixed gender populations. Studies focused on African American adolescent females were not included in this review.

Results

Search results

We obtained 27 potentially relevant studies from PUBMED, Google Scholar, MEDLINE, and Psych INFO databases, using permutations of the following key words: African American, Female, co-occurring, behavioral health, substance use treatment, treatment barriers, mental health treatment, and access to care. Seventeen citations were excluded for

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failing to meet the study's inclusion criteria, either because they did not address any issues relevant to an African American female population or did not cover barriers that were relevant to behavioral health issues. Thirteen studies were included in the final review. Based on content and relevance these 13 studies covered issues related to treatment barriers either specifically for African American women or included a substantial population of African American women in the study.

Study Characteristics

The studies included in the review are a combination of quantitative and qualitative studies. There were 13 studies that examined treatment barriers among African American women. The studies selected included the following drug types for treatment: polydrug use, cocaine/crack, heroin, marijuana, methamphetamine, non-prescription opiates, and other drugs (see Table 1). From these studies, seven used a qualitative method in uncovering barriers among this population. One study examined treatement barriers for both African American men and women however only barriers for women were included in this study. The remaining studies examined exclusively at female populations that were multi-ethnic and multi-racial. Additionally, one other literature review was included in this analysis (Brown, 1992). Among the 13 studies reviewed, the following barriers were identified: treatment readiness barriers, access barriers, and treatment-related system barriers.

Barriers Cited

This review focuses on three specific types of barriers known to interfere with the utilization and treatment engagement for those living with a substance use problem. These barriers are treatment readiness, access, and system-related barriers. We discovered most barriers were classified under the treatment readiness category (see Table 1). Eleven studies cited treatment readiness barriers related to personal and interpersonal reasons for delaying treatment, while nine of the eleven studies cited access barriers that were described as reasons for delaying treatment. Access barriers were generally associated with social-environmental issues. Nine studies cited treatment-related system barriers associated with the operation of the treatment center or interaction with available therapists and center staff.

Treatment readiness barriers

Treatment readiness barriers were identified as issues that focused on fear of seeking treatment (guilt or shame), lack of motivation for treatment (personal), the belief that treatment was not needed (personal) and the obstacle of interpersonal relationships with family and childcare (interpersonal reasons) (see Table 2). For Personal barriers women often delayed or avoided treatment because they changed their mind, wanted to manage on their own, or had problems making arrangements (Allen, 1995; Brown, 1992; Ehrmin, 2001, 2005; Hser et al., 1998; Jones et al., 2015; MacMaster, 2005; Roberts & Nishimoto, 2006; Rosen, Tolman & Warner, 2004). Interpersonal barriers were more specific to caring for children, a spouse/partner, and other family members.

Four studies reported social support or interpersonal issues as barriers to treatment (Allen, 1995; Jones et al., 2015, MacMaster, 2005; Roberts & Nishimoto, 2006). Allen (1995) found that participant's role as a wife and mother interfered with seeking treatment. Other studies

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cited lack of available childcare as reasons for not seeking treatment (MacMaster, 2005; Roberts & Nishimoto, 2006; Wechsberg, Zule, Riehman, Luseno & Lam, 2007). Guilt or shame related to the need for treatment was also common among barriers cited (Allen, 1995; Ehrmin, 2001, 2005; Jones et al., 2015, MacMaster, 2005; Roberts & Nishimoto, 2006,). Ehrmin (2005) found women who needed to enter treatment were sensitive to judgment by others because of their substance use. The idea of losing custody of their children because of substance use was also relevant for some women (Allen, 1995). Treatment readiness barriers also encompassed cultural issues with seeking help (Jones et al., 2015). Jones et al. found African American women had a preference for same race, same gender therapist when possible.

Access barriers

Access barriers focused on issues such as inadequate amount of treatment facilities in the neighborhood, financial barriers, a lack of transportation, and issues dealing with the community (see Table 3). Four studies reported transportation barriers (MacMaster, 2005; Roberts & Nishimoto, 2006; Wechsberg, et al., 2007; Zule, Lam & Wechsberg, 2003). Paying for treatment was a common access barrier; however, a few studies also found that a lack of proper insurance and employment were also related to access barriers (Allen, 1995; Hser, Maglione, Polinsky, & Anglin, 1998; Weisner, Matzger, Tam, & Schmidt, 2002; MacMaster, 2005; Roberts & Nishimoto, 2006; Wechsberg et al., 2007; Zule, Lam, & Wechsberg, 2003).

Treatment-related system barriers

Treatment-related system barriers were characterized as long waiting times, limited access to treatment facilities, improper training of treatment staff, being turned away from needed treatment and a lack of culturally component care by staff (see Table 4). Three studies reported that participants wait time was a barrier to entering treatment (Hser, et al., 1998; MacMaster, 2005; Becker, et al., 2005). Four studies reported program staff and clinician attitudes were a barrier to entering treatment (Becker, et al., 2005; Ehrmin, 2005; Roberts & Nishimoto, 2006; Jones et al., 2015). Jones et al. (2015) found participants were concerned about the racial/ethnic background of counseling staff and felt disconnected when talking with staff about how race affected their substance use and mental health issues. One study, focused on co-occurring issues for women, found respondents were dissatisfied with the type of psychological services received in terms of treatment centers directly addressing their past trauma (Mockus, et al., 2005). Jones et al. (2015) found a lack of seriousness among treatment staff in accepting the client's concerns about experiencing a mental health disorder in addition to their substance use issues.

Discussion

African American women with substance use disorders have difficulty engaging in and retaining treatment (Bowser & Bilal, 2001; Grella & Greenwell, 2007). In this review of the available literature on substance use treatment engagement, three themes of barriers emerged: treatment readiness, access barriers, and system-related barriers. What follows is a discussion of the barriers as well as implications for the intersectionality of race, class, and

gender on the treatment process (Crenshaw, 1991; Bowleg, 2012; Mereish & Bradford, 2014).

Treatment Barriers

Treatment readiness barriers

The treatment readiness barriers in this study centered on personal and interpersonal issues African American women encountered throughout the treatment engagement process. Treatment readiness barriers that were cited were closely aligned with the motivation to seek help, the desire to recover, and the complications that exist on an interpersonal level. The issue of motivation for treatment was examined with African American women who were crack cocaine users. MacMaster (2005) found participants had general lack of desire or motivation to seek treatment for their substance dependence. This was a barrier to recovery and to the treatment engagement process. In another study, which examined co-occurring issues of substance use and mental health disorders in women, reportedly 50% of women were seeking treatment because of a court-ordered mandate (Becker et al., 2005). This percentage may explain the level of motivation in women seeking treatment.

In the articles reviewed, certain interpersonal barriers were also a hindrance to the treatment engagement process for some African American women. As mentioned earlier, the family is an important part of African American culture and should be considered when looking at potential interpersonal barriers that affect women in this population. For instance, Allen (1995) found in her study of African American women the responsibility of family was the most frequently cited reason for not seeking treatment. The opposition from family, friends, a spouse or partner may impede their help-seeking efforts. Interpersonal barriers can happen because of perceived stigma or judgment from others that may exist in seeking help for substance use and mental health issues. When it comes to individual barriers to seeking and engaging in treatment, women are known to cite personal reasons such as embarrassment or shame for needing treatment (Green, 2006; MacMaster, 2005). One major influence on treatment readiness appeared to be the internal struggle women had with the stigma often attached to those with substance use and mental health disorders (Ehrmin, 2001). Women dealing with addiction are often compounded by guilt or shame resulting from their substance use and or mental health disorder (Ehrmin, 2001). Interpersonal barriers such as stigma, guilt, shame, culture, and family responsibilities are important to address to secure stronger support systems for women in substance abuse treatment. Addressing these interpersonal issues could involve interventions to reduce barriers from a social ecological approach. Meaning, intervening on the issue of stigma, guilt, and shame on levels directly addressing family, culture, community and environment. Intervening at each level to address the source of stigma, guilt, and shame could bring about awareness for African American women who need treatment, allow the community to have more awareness about seeking help, and reduce potential stressors or risk in the environment.

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Access barriers

Based on the findings from our review of the substance use literature, access barriers were relatively centered on two main issues for African American women. These issues were transportation and financial resources.

This may speak to the disenfranchisement some women of color experience through their communities and by virtue of having lower social economic status. Access barriers exist in many aspects such as limited resources to pay for treatment, transportation to the treatment facilities, and even communities not conducive to recovery (high drug activity or violence). A lack of affordable and safe housing is a serious issue for low-income women who are getting out of recovery and having to return to their previous environments. Based on this review, some women indicated that being homeless made it difficult to access treatment services and that living on the streets also made drugs more readily available, thus their environments were not changing even if their desire to "get clean" was changing. Economic disenfranchisement creates several barriers to health and behavioral health care services for many populations, ultimately preventing one from having benefits to pay for services or access services.

Financial barriers to entering substance use treatment can range from a lack of insurance to limited availability of suitable treatment facilities in the community (Weisner, Matzger, Tam & Schmidt, 2002). While only a few studies have found differences in insurance as being a factor in who enters treatment, this is still an important variable to consider when looking at barriers to treatment entry and engagement (Weisner, et al., 2002). Access barriers can also be defined in terms of how women were entering treatment. In a 1999 report by SAMHSA, their findings highlighted the way in which African Americans enter treatment for substance use. They found that African American women were more likely to enter treatment from referral by family, self or their employer, while African American men tend to overwhelmingly enter treatment through the criminal justice system (SAMHSA, 2002). Previous substance use treatment literature has shown that women are more likely to enter treatment from social service agencies, and Redko, Rapp and Carlson (2006) reported among women, 46% entered treatment under their own volition, while 21% were court ordered and only 11% entered treatment by way of children services. Treatment entry or the complications that can exist with how an individual eventually enters into treatment is complicated and rather convoluted for African American women, particularly for those with a substance use and mental issues.

Treatment-related system barriers

Treatment-related system barriers occur when services are inaccessible, inadequate, and not readily available (Schmidt, et al., 2006). Our findings suggest African American women experience less system-related barriers compared to treatment readiness and access barriers. This discrepancy could be due to once in treatment, the barriers are minimal compared to making the decision to seek treatment. The treatment-related system barriers most readily found in this review had to do with trust among African American women. Two studies cited participants felt uncomfortable or felt the treatment center staff had negative attitudes towards them (Becker, et al., 2005; Roberts & Nishimoto, 2006). Becker et al. (2005) also

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found women felt the program or treatment staff, which in turn caused them to drop out of treatment, treated them poorly. Perceived mistrust of health, behavioral health, and social service systems is a common belief in African American ideology, and perhaps these women were embracing these sentiments as they were engaging in substance use treatment (Suite, La Bril, prim, & Harrison-Ross, 2007). This is another place to intervene. Implementing culturally competent practices, which really addresses the intersectionality of race, discrimination and gender for African American women, would be beneficial in improving system level barriers.

The other treatment-related system barriers dealt specifically with issues encountered in terms of how services were provided at treatment centers. Experiencing long waiting times and the lack of available services was a common theme for many of the respondents from these studies (Redko, Rapp, & Carlson, 2006). In Becker et al. (2005) they found that 30% of the system barriers were related to waiting times, 17% of reported barriers were related to consumers being unaware of where to go for treatment, and another 17% discovered that needed services were unavailable. There was also concern about the lack of attention of the role trauma played in many women's lives that were in need of treatment. In a recent study conducted with women dealing with a co-occurring issue of substance use and mental health disorder, participants stated that treatment facilities did not adequately address the trauma that is often connected with their substance use and mental health (Gatz, Brown, Hennigan, Rechberger, et al., 2007). This was also a concern among a group of participants in a co-occurring treatment services program. Women in this group felt the treatment centers were not equipped to help them deal with the trauma and other psychological issues in their lives, such as post-traumatic stress disorder (Mockus, et. al, 2005). System-related barriers bring up questions about the quality of care African American women encounter in their communities and the availability of ancillary services such as childcare, education, and other social service-related services. While issues with waiting time, staff training and even ancillary services are probably felt across the board for women of all races and ethnicities who seek care, these issues once again have a greater negative effect on women of color because of the documented disparities in care and services for this population (Lasser, Himmelstien, Woolhandler, McCormick & Bor, 2002). This can also become a concern for communities that have lower social economic resources and already have an overburden treatment system.

System-related barriers are serious and have the potential to impede the treatment engagement process for several reasons. Prolonged waiting times may hinder the motivation of clients who are under a mandate to seek care. The lack of trained staff to deal with women who have a substance use and mental health comorbidity causes further unmet treatment needs. Without sufficiently trained staff and clinicians to deal with co-occurring disorders, the underlying reasons for substance use or psychological distress are not being adequately addressed and treated. Clinicians and clinic staff who lack cultural competency training is also an issue. The initiation of treatment or engagement at the first visit can be hindered if African American women feel unwelcomed as they attend the first session (NAADAC, 2015). Failing to have ancillary services puts women at a particular disadvantage when considering childcare needs, lack of adequate financial resources, and co morbid treatment need. Researchers and practitioners need to understand the full impact of

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system-related barriers for African American women seeking treatment for substance use, thus more work needed.

Implications of the intersectionality of race, class, and gender on substance use treatment

For many African American women in need of substance use treatment, they are living in social environments exacerbated by poor economic status and conditions. For instance, African Americans have lower incomes compared to non-Hispanic white Americans, are more likely to be unemployed or underemployed and live in poverty-stricken environments (Wingo, 2001). Environmental disparities can directly relate to which services are available and how people are able to access needed treatment. Living in economically depressed areas can also attribute to poor health outcomes and less opportunity to access quality care (Wingo, 2001).

The second barrier unique to African American women is the role of the family. In the African American community, one important cultural phenomenon is the role of the extended family and the collective group identity (White & Parham, 1990). The significance of the family phenomenon can be a double-edged sword for many in need of treatment. If the family is providing support and encouragement to seek treatment, then this can be a benefit for women. On the other hand, if the family is against seeking traditional methods of help for substance and or mental health issues this can be an additional obstacle for those women who are willing to seek help or in some instances have been mandated to seek professional help. This may be an outside contributor to the relatively low completion rates of African Americans who do enter treatment (Jacobson, Robinson, & Bluthenthal, 2007). Another factor important to treatment engagement is the inclusion of culturally competent care. This should generally involve more than just employing racially ethnic staff. This is a practice that should seriously consider the issues of gender and race and how they influences a woman's drug use and mental health as well as her possible reluctance to seek treatment in certain facilities.

The final possible barrier is that of the health care and behavioral health care system in general (Aponte & Barnes, 1995). There is still an undercurrent of mistrust and suspicions among certain racial and ethnic groups about the honesty and trustworthiness of the U.S. health care system after a strained relationship based on past unethical practices (Suite, La Bril, Prim, & Harrison-Ross, 2007). There is also a history of discrimination, which often translates into less than adequate care or different levels of care based on race and class (Kimmerling & Baumrind, 2005). For instance, take the case of referrals for specialty mental health services among different racial and ethnic groups. African American women are less likely to use specialty mental health services in comparison to white women (Kimerling & Baumrind, 2005). African American women are also less likely to receive referrals for specialty mental health care and are less likely to seek services for mental health (Kimerling & Baumrind, 2005). The substance use literature has not adequately dealt with the issue of barriers for African American women, but based on available research we know some African American women who are receiving services for substance use have greater burdens with treatment readiness than compared to other areas. For instance, Allen (1995) found that African American female substance users were more likely to report issues of personal and

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interpersonal barriers. MacMaster's (2005) found that African American women reported barriers across several areas such as long waiting list, lack of childcare and social support, financial reasons, and more interestingly the fear of losing entitlements such as food stamps and or public housing. The available literature on substance use helps point future studies in the right direction in examining the context of treatment engagement barriers for African American women, but more needs to be accomplished.

Implications for treatment

The mental health literature, as well as the substance use literature, is sparse in their exploration of how racial and ethnic minority women deal with behavioral health problems and what treatments seem to work best for these populations. One major issue for African American women are the various barriers that impede the treatment engagement process. Based on this review, researchers now know treatment readiness and access barriers were widely cited as reasons for delaying or avoiding substance use treatment. To serve this particular population of women, practitioners and researchers alike must strive to understand the complex role of treatment barriers in the lives of African American women. In terms of intervention or improving service utilization for African American women with substance use issues, it is important to further explore the role treatment readiness plays in the lack of help-seeking within this population and how it might contribute directly to unmet service needs. While this study does not cover the issue of referral source as it relates to treatment barriers, it is important to look at what role referral sources have on treatment readiness, access barriers, and system related barriers. It is this author's belief that referral source plays a great deal in how and when African American women seek treatment for substance use. As a policy implication, it is evident African American women, while prevalence is low would benefit from culturally competent treatment options first, with less funneling into the criminal justice system and more direct referrals to treatment. There are models available with some success in getting African Americans to initiate and engage in treatment (Bensley et al., 2017). More work needs to be done to achieve similar results as African American veterans who actively and successfully engaged in alcohol treatment with the veterans' health administration into non-veteran populations (Bensley et al., 2017).

In closing, while treatment barriers exist for all populations seeking and needing care for behavioral health services, the complexity of substance use treatment and the added dimension of race, gender, and class should not be ignored when striving to improve treatments and services across populations. It is also the author's conclusion more updated studies are needed to fully understand the impact of barriers to substance use and mental health disorder treatment for African American women. Many studies available for this review were dated, and the field would benefit from new data and outlook on what is currently going on with treatment barriers for this population. By knowing the type of barriers affecting African American women, researchers and practitioners can help lessen the disparities in treatment for this population.

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Table 1.

Characteristics of studies that identified treatment barriers for African American Women

Study	Race	Gender	Average Age	Drug Type(s)	Methods	Treatment Readiness	Access	System	SU	SU/ MH
Allen (1995)	AA	F	18 & older	Alcohol & Illicit drugs	Quantitative	X	X	X	X	
Becker, Noether, Larson et al. (2005)	Multi	F	31–40 years	Alcohol; multiple illicit drugs (Crack/Cocaine, Heroin, Methamphetamine, Marijuana	Quantitative			X	X	
Ehrmin (2001)	AA	F	23–44 years	Polydrug use; Crack, Heroin, Cocaine, Alcohol, Marijuana	Quantitative	X			X	
Ehrmin (2005)	AA	F	23–44 years	Polydrug use; Crack, Heroin, Cocaine, Alcohol, Marijuana	Qualitative	X		X	X	
Hser, Maglione, Polinsky et al. (1998)	Multi	M/F	18–59 years	Polydrug use; Crack, Heroin, Cocaine, Alcohol, Marijuana, and other drugs	Qualitative	X	X	X	X	
Jones, Hopson, Warner, Hardiman & James (2015)	AA	F	37 years	Drug type non-specified: Multiple	Quantitative	X		X		X
MacMaster (2005)	AA	F	18 & older	Crack Cocaine	Qualitative	X	X	X	X	
Redko, Rapp, & Carlson (2006)	Multi	M/F	37.8 years	Cocaine, Heroin, Opiates, &Marijuana	Qualitative			X		X
Roberts & Nishimoto (2006)	AA	F	31.2 years	Cocaine and Polydrug use w/Cocaine	Qualitative	X	X	X	X	
Rosen, Tolman, & Warner (2004)	Multi	F	18–54 years	Drug type non-specified: Multiple	Quantitative	X	X			X
Wechsberg, Zule, Riehman & Lam (2007)	AA	M/F	39.9	Crack	Quantitative	X	X			
Weisner, et al (2002)	Multi	M/F	18 & older	Alcohol & Illicit drugs	Quantitative		X		X	
Zule, Lan & Wechsberg (2003)	AA	M/F	39.8	Crack	Quantitative		X		X	

*SU: Substnace Use/Abuse; MH: Mental Health Illness

*Multi: Multiple races/ethnicities

*Poly drug use: Multiple drugs

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Table 2.

Treatment Readiness Barriers

Study	Personal	Interpersonal	Guilt or Shame	Culture
Hser et al. (1998)	X			
MacMaster (2005)	X	X	X	
Allen, K. (1995)	X	X	X	
Roberts & Nishimoto (2006)	X	X	X	
Jones et al. (2015)	X	X	X	X
Ehrmin (2005)	X		X	
Ehrmin (2001)	X		X	
Rosen, Tolman, & Warner (2004)	X			
Wechsberg, Zule, Riehman, Luseno, & Lam (2007)		X		

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Table 3.

Access Related Barriers

Study	Transportation	Financial Resources
Hser et al. (1998)	X	
MacMaster (2005)	X	X
Allen, K. (1995)	X	X
Roberts & Nishimoto (2006)	X	X
Weisner, Matzger, Tam & Schmidt (2002)		X
Rosen, Tolman, & Warner (2004)	X	X
Zule, Lam, & Weschsberg (2003)	X	X

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Table 4.

System Related Barriers

Study	Waiting Time	Center Hours	Staff Attitudes or Problems	Availability of Services
Hser et al. (1998)	X			X
MacMaster (2005)	X			
Allen (1995)				X
Jones et al. (2015)			X	
Ehrmin (2005)			X	
Redko, Rapp & Carlson (2006)	X			
Roberts & Nishimoto (2006)		X	X	
Becker, Noether, Larson, Gatz, et al. (2005)	X	X	X	X