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Women's barriers to specialty substance abuse treatment: A qualitative exploration of racial/ethnic differences

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Abstract

Objective—To explore barriers to specialty substance abuse treatment programs among women with recent substance use disorders by race/ethnicity.

Methods—Qualitative interviews were conducted with 28 women of White, Black, and Latino racial/ethnic descent who reported a substance use disorder in the past five years. Interviews were conducted by telephone and were audio-recorded. A codebook was developed using the Theory of Planned Behavior to code and identify barriers within the domains of attitudes, subjective norms, and perceived control toward specialty treatment. Frequencies for coded themes were then compared across all participants and by race/ethnicity.

Results—We identified several key differences in barriers to treatment by race/ethnicity. Attitudinal barriers were more pervasive among the narratives of Latinas relative to Black and White women. Latinas were more likely to report not needing treatment and that treatment would not be effective; Latinas were the only group to describe cultural barriers to treatment. Within the subjective norms domain, namely stigma and lack of support, were key barriers. Stigma was more pervasive among the narratives of Latinas and Black women than White women; Latinas were more likely to report a lack of social support for using treatment than both Black and White women.

Conclusions—Findings provide deeper insight into barriers that may be contributing to racial/ethnic disparities in the use of substance abuse treatment among women.

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1. Introduction

Gender disparities in the use of substance abuse treatment services are substantial. In general, women with substance use disorders (SUD) are significantly less likely than their male counterparts to seek help, independent of race/ethnicity, socio-economic status, and problem severity (Alvanzo et al., 2014; Greenfield et al., 2007; Constance Weisner, 1993; Constance Weisner & Schmidt, 1992; Witbrodt, Mulia, Zemore, & Kerr, 2014; Zemore, Mulia, Ye, Borges, & Greenfield, 2009). Compared to men, women especially underutilize services that are specific to alcohol and drug abuse (e.g., specialty substance abuse treatment, Alcoholics/Narcotics Anonymous) (Greenfield et al., 2007; Constance Weisner, 1993; Constance Weisner & Schmidt, 1992; Witbrodt et al., 2014; Zemore et al., 2009). This underutilization is in part explained by the heightened stigma women experience for having a SUD. Women may be more fearful of being identified or labeled as having an alcohol or drug problem if they are seen using these services, making them less likely than men to seek treatment. Additionally, research has documented lower problem recognition, lower perceived need for treatment, and logistical barriers (e.g., childcare concerns) among women, which contribute to gender disparities (Brienza & Stein, 2002; Schober & Annis, 1996; Thom, 1986; Zemore et al., 2014). Notably, women also experience less social pressure to seek treatment than men. Compared to men, women are less likely to report work-related problems, legal consequences (e.g., driving under the influence), and pressure from family and friends to cut down and/or abstain from substance use or seek treatment (Room, Greenfield, & Weisner, 1991; Schober & Annis, 1996; Connie Weisner, 1990; Witbrodt et al., 2014). This may be potentially explained by women's clandestine substance use patterns. Women are more likely to hide their substance use and avoid using in public settings (e.g., bars, restaurants) as a strategy to avoid experiencing adverse social consequences (Bond et al., 2010). Thus, decreased social pressure to seek help among women may be an important driver of gender disparities.

Race/ethnicity is an important factor to consider within the context of gender disparities in treatment utilization. However, few studies have considered the role of *both* gender and race/ethnicity on treatment utilization. We were only able to identify one national study that investigated gender disparities by race/ethnicity. Zemore et al. (2014) found pronounced, significant Black-White and Latino-White disparities in the use of specialty alcohol treatment services among women only, although Latino-White disparities were significant among men in multivariate analyses. After controlling for socio-demographic characteristics, dependence severity, and social influences (i.e., pressures from family to abstain from drinking, work-related consequences, and legal consequences) Latino-White disparities persisted, while Black-White disparities did not (Zemore et al., 2014). Findings from this study suggest that social pressures are greater contributors to Black-White disparities, compared to Latina-White disparities. It is likely that other factors or barriers to treatment (e.g., stigma, logistical barriers) may be more pronounced among Latinas relative to White women, but were not examined by this study.

Currently, very little is known about why Latinas and Black women may be less likely than White women to seek treatment. The literature examining barriers to treatment suggests that Latinos and Blacks may experience more pronounced barriers to treatment than Whites,

especially logistical barriers (e.g., not having health insurance to cover expenses, not having time, and not knowing where to go for help) (Perron et al., 2009; Schmidt, Ye, Greenfield, & Bond, 2007; Verissimo & Grella, 2017). These barriers have been hypothesized to especially impact Latina and Black women (Rouse, Carter, & Rodriguez-Andrew, 2002; Zemore et al., 2014). However, much of the literature on racial/ethnic differences in treatment barriers is sparse and mixed, and none have considered both race/ethnicity *and* gender (Perron et al., 2009; Schmidt et al., 2007; Verissimo & Grella, 2017). Significant questions remain about treatment barriers that may be particularly pronounced among Latinas and Black women with SUD, relative to their White counterparts. Thus, this area warrants further research to better inform the development of interventions specifically designed to target Latinas and Black women in need of treatment. Such data is critical to reducing racial/ethnic and gender health disparities related to substance abuse.

In order to better understand racial/ethnic barriers to treatment we undertook a qualitative study among Black, White, and Latino participants with recent (i.e., past-5-year) substance use disorder (SUD) (Pinedo, Zemore, & Rogers, 2018). This study was specifically designed to explore barriers to specialty substance abuse treatment (e.g., in/out patient services, rehabilitation) given that these services (1) have been shown to be effective in treating SUD (Alegria, Carson, Goncalves, & Keefe, 2011; Alvarez, Jason, Olson, Ferrari, & Davis, 2007; Arroyo, Westerberg, & Tonigan, 1998; Guerrero, Marsh, Cao, Shin, & Andrews, 2014); and (2) pronounced racial/ethnic disparities have been documented (Zemore et al., 2014). For the present analysis, we focus on a subset of women participants (n=28). This study was guided by concepts of the Theory of Planned Behavior (TPB), which has been used to predict and explain diverse behaviors, including treatment seeking (Ajzen, 1985; Armitage, Armitage, Conner, Loach, & Willetts, 1999; Collins & Carey, 2007; Kam, Matsunaga, Hecht, & Ndiaye, 2009; Mcmillan & Conner, 2003; Wall, Hinson, & McKee, 1998). This perspective posits that intention to engage in a behavior (i.e., treatment seeking) is influenced by an individual's attitudes (e.g., beliefs treatment will be beneficial), subjective norms (e.g., beliefs that important people will be supportive of using treatment), and perceived control (e.g., beliefs about the presence of factors that facilitate the use of treatment, such as being able to afford it) toward the behavior. Utilizing this framework, we conducted an in-depth exploration and analysis of barriers to specialty treatment among women by race/ethnicity to elucidate similarities and differences.

2. Methods

2.1. Study Design and Participants

This study draws on data from a recently completed qualitative study that recruited 54 adult participants with a recent (i.e., past-5-year) SUD to participate in a qualitative telephone interview (Pinedo et al., 2018). The objective of the parent study was to qualitatively examine racial/ethnic differences in barriers to specialty substance abuse treatment. The present analysis is limited to women (n=28) and excludes men (n=26). From 2017–2018, eight Craigslist ads advertising our study were posted in racially/ethnically diverse cities (Riverside, Los Angeles, San Diego, and Oakland, CA; Brooklyn, NY; Chicago, IL; Miami, FL; and San Antonio, TX). These ads contained basic study information and a link to the

study's screener questionnaire that interested participants could complete to determine eligibility. Eligible participants were adults of White, Black, or Latino racial/ethnic descent who met DSM-5 diagnostic criteria for a past-5-year SUD. The screener survey included questions on socio-demographics, past-5-year substance use history, lifetime and past-5-year treatment history, and DSM-5 diagnostic criteria, using a past-5-year timeframe, for an alcohol use disorder (AUD) and a drug use disorder (DUD). Potential participants who met diagnostic criteria for AUD, DUD, or both were characterized as having a recent SUD. At the conclusion of the screener survey, those who met study eligibility criteria were prompted to provide contact information if they were interested in participating in the qualitative interview.

A total of 223 (out of 341) potential participants who completed our screener questionnaire were eligible for the study. Participants were purposefully selected to have equitable distribution across race/ethnicity, gender, age, and primary disorder type (alcohol vs. drug problem). Given the study objective, those who reported no prior use of specialty substance abuse treatment were specifically targeted. Interested participants were contacted by email or phone to conduct the interview. A total of 74 potential participants were contacted and 54 agreed to be interviewed. We terminated recruitment when saturation of themes was obtained (i.e., when additional interviews did not lead to any new emergent themes).

Participants provided verbal informed consent before beginning the interview. On average, interviews lasted 41 minutes, were audio-recorded, and transcribed verbatim. A trained interviewer conducted the interview using semi-structured interview guide. The interview guide was developed by the first author and was grounded in the TPB. Open-ended questions referred to participants' attitudes (e.g., Have you ever considered cutting down or getting help for your substance use? Do you think treatment would be helpful, why or why not?), subjective norms (e.g., How would your family members react if they knew you were in treatment?), and perceived control (e.g., If you wanted to get help, are there any circumstances that would make it difficult?) toward specialty substance abuse treatment. Participants were specifically informed that for the purpose of this interview, treatment referred to specialty treatment services and not other forms of treatment (e.g., primary care, hospital, general therapy, mutual help groups). Participants received a $50 Amazon Gift card for their participation. The Institutional Review Boards of the Public Health Institute and the University of Texas at Austin approved all study protocols.

2.2. Analyses

Using data from participants' screener questionnaire, we first conducted descriptive analyses to characterize our sample. Following, a thematic analysis of participants' narratives was conducted using NVivo 11 software (QSR International Pty Ltd. Version 11). First, a coding scheme was developed using the TPB as our analytic guide. The first author and a graduate research assistant (RA) independently read several interviews and discussed common themes until a codebook of key themes (i.e., barriers) was developed and finalized. Next, the first author and RA independently applied the coding scheme to 11 transcripts and met to discuss any inconsistencies. Discrepancies were discussed and resolved through consensus (Onwuegbuzie, 2003). These steps ensured that coders had the same understanding of the

coding scheme. Once a 90% consistency of applying the coding scheme was achieved, subsequent interviews were coded by one independent coder. Throughout this whole process, if any new themes emerged, coded interviews were re-read and re-coded. To explore similarities and differences in treatment barriers among women by race/ethnicity, we compared frequencies of coded themes within the domains of the TPB.

3. Results

3.1. Sample characteristics

Table 1 displays socio-demographic characteristics, substance using behaviors, and past treatment utilization history of our sample. Our sample of women with SUD was comprised of 9 White women, 9 Black women, and 10 Latinas. On average, women in this study were about 40 years of age; the majority completed high school and were currently employed. In terms of substance use, a minority (n=9; 32%) of women met clinical diagnostic criteria for AUD only; only one woman met clinical diagnostic criteria for DUD only; and the majority (n=18; 64%) reported having co-occurring AUD-DUD. Co-occurring AUD-DUD (vs. AUD only or DUD only) was more common among White and Black women. Half of Latinas reported AUD, while the other half reported co-occurring AUD-DUD. Further, just over half (54%) of the sample reported using any form of treatment in the past five years. Most common forms of treatment use included: Alcoholics Anonymous (32%), hospital or clinic (25%), and medical group or physician (21%). Only one participant, a Black woman, reported using specialty treatment in the past five years.

3.2. Overview of key barriers to specialty treatment among women with SUD

Key attitudinal barriers that emerged were low problem recognition, low perceived treatment efficacy, and cultural barriers. Within the subjective norms domain, women in this study reported not going to treatment due to stigma and perceived lack of family support. Logistical barriers (e.g., cost, trouble finding services) were common barriers within the perceived controls domain. Important racial/ethnic differences in barriers to treatment emerged among women in this study, which are discussed in greater detail below.

3.3. Attitudinal barriers toward specialty treatment

Low perceived treatment need and low perceived treatment efficacy were important barriers among women in this study across all racial/ethnic groups. Women regularly described not having a problem and not needing treatment because their substance use did not interfere with their personal life (e.g., work, family). Women often differentiated themselves from those with SUD by underscoring that people with SUD were unable to meet important life responsibilities (e.g., were homeless, had lost the support of family), unlike them. Low perceived treatment need was especially pervasive in the narratives of Latinas, relative to White and Black women, and comparable between White and Black women. In the following passage, one Latina describes why she did not perceive needing treatment for her drug use:

> I would like you to understand that I am not a drug addict like others, that I don’t need it [drugs] every day to function. I have my very serious side. I am a

> professional. When I go to work, I do my job well. I try to sleep 8 or 9 hours to be alert. This [drug use] is something I do when I do not have to go to work or anything.
>
> –Latina, age 55, AUD-DUD

Similarly, when asked whether she had ever considered treatment in the past, one participant responded:

> No. I guess to the point now, I feel like I can still control it. I have done, you know, certain diets where I don't drink and stuff. So, I feel like I can control it now, but if I felt like I couldn't then I might have to [go to treatment] […] I don't think I'm at that point. You know I don't think it's that extreme or affecting me that much.
>
> –White woman, age 36, AUD only

Further, many women in this study did not believe that specialty treatment would be effective. However, this barrier was more prominent in the narratives of Latinas than White and Black women, and comparable between Black and White women. Women especially had concerns that treatment providers had never experienced a SUD and were therefore unable to effectively provide treatment, regardless of their educational training. For instance, when asked if she had ever wanted to talk to someone about her alcohol or drug use, one participant explained:

> One reason why I wouldn't go to that [go to treatment] no matter where it was at is: void of spirituality. Two is: void of people with experience. You [are] coming to me from a book checked. I need you to come from experience […] I just couldn't see how would you know how it feels [to struggle with a SUD] if you hadn't been in any, you wouldn't know.
>
> –Black woman, age 40, AUD-DUD

Although low perceived treatment efficacy was an important barrier for women of all racial/ethnic groups, Latinas in this study differed in that treatment efficacy was also linked to cultural factors. Latinas believed that treatment providers lacked knowledge on their cultural background. Especially within the context of alcohol, some Latinas explained that drinking was commonplace at home and perceived drinking as part of their culture, which treatment providers would not understand or be able to treat in a culturally competent manner. One Latina described:

> I think because, we Latinos, we think we do not need those services. We do not want to help because we feel that we can solve our problems at home. And since it is a culture in which we drink, it is acceptable at home.
>
> –Latina, age 54, AUD only

Being able to relate to a treatment provider was important for Latinas. Treatment providers were normally described as being White and not culturally competent. For instance, when asked what would be most important to her if she wanted to get help for her drinking, one Latina replied:

> The people that are there [providers, staff], I guess. I don't want like a super White person judging me about it. I guess I want people like me, other women, other Latina women, that have gone through the most similar thing as me to understand how I'm feeling.
>
> –Latina, age 48, AUD only

3.4. Subjective norms toward specialty treatment

Stigma and lack of social support were key barriers to seeking treatment among women in this study. Stigma was more pervasive in the narratives of Black women and Latinas than White women. Stigma was directly related to fears of being shunned or judged by family members for having a substance abuse problem. Many described keeping their problems with addiction from their families and avoided seeking help. For example, when describing why she has not opened up to her family about her struggles with substance misuse, one Black participant explained:

> They're very strict and they're very judgmental […] there are certain things [people] don't tell their family, they don't want them to know. I can't even stand being around [them], that's why I feel some people keep things to themselves in a big family […] They are religious, not only that, just how they are, they're just judgmental.
>
> –Black woman, age 32, AUD only

Similarly, when asked if she has ever encountered challenges in getting help for her drinking, a White participant replied:

> I think that I have so much... I feel like there's a lot of shame in this. So it's not, I don't know, it's not talked about as much. People think of people who are, you know like, alcoholics or drink too much as maybe they're homeless, or don't work, and I do work. Unless I tell them, they would have no clue that I sometimes drink too much because I don't smell of alcohol. So, you can't really tell unless I tell you, you know?
>
> –White woman, age 39, AUD-DUD

Compared to White and Black women, Latinas in this study were especially concerned about running into someone they knew in treatment or being seen by someone using treatment services. This fear was linked to being stigmatized by their community members. When asked if she had ever considered getting help, one Latina responded:

> First of all, I wouldn't want to go in person because what if I know somebody? Like, what if the people are my neighbors or what if their kids go to school with my kids? There is a huge negative stigma to people who have alcohol and drug problems […] I have heard people say like, you know, friends or at school or when I go on playdates, I hear people say like 'Oh, that crack head' or 'that drug addict' or 'that tweaker' and I am not trying to get called that. So, I wouldn't go in person. If I were to do something [get help] I would probably do it online because I would feel like I could still keep me anonymous.
>
> –Latina, age 30, AUD-DUD

Lack of perceived support from family for seeking help was also a prominent theme among women in our study. However, this theme was more ubiquitous in the interviews of Latinas than their Black and White counterparts. Latinas described that their family members would not be supportive if they sought any form treatment. One Latina described how she previously sought help from a psychologist for her drinking, which she hid from family members, and influenced her decision to not use specialty treatment services. She explained:

> I guess in my family, I've grown up with these thoughts that going to get help means that you're crazy, which is definitely not a joke, but they're just like that […] When I first went to get help, I just wanted this to be for myself. I didn't tell anyone that I went to the psychologist because I felt like they would judge me. Ever since I was young, my grandparents kept on making jokes and kind of like gossips like, "he [participant's uncle] went to treatment, yeah he's crazy." I don't know, stuff like that. So, obviously, I didn't want rumors or jokes like that being made about me. So, I went by myself and that's it.
>
> –Latina, age 48, AUD only

3.5. Perceived control towards specialty treatment

White women in our study were more likely to describe logistical barriers to treatment than Black women and Latinas. Latinas and Black women hardly made any mention of logistical barriers, which may be in part explained by them being more likely to perceive not needing treatment. Logistical barriers among White women were related to cost and difficulty findings services. For instance, one participant suggested:

> Make it more affordable. Make sure you say affordable there because, you know again, I've looked in to therapy and treatment for the family and it was very pricey even with insurance. If it's not affordable for people how do they do that when most people are middle class or even, you know low income?
>
> –White Woman, age 51, DUD only

4. Discussion

This study expands our knowledge regarding the role of race/ethnicity on barriers to specialty treatment among women, which may help explain Latina-White and Black-White treatment utilization disparities. Overall, Latinas and Black women in our study were more likely to report barriers across the attitudes and subjective norms domain. White women were more likely to report logistical barriers (perceive control domain) than Black women and Latinas. Findings can be used to inform strategies to increase utilization of treatment services among women in need, especially Black women and Latinas.

We found that low perceived treatment need and low perceived treatment efficacy were important attitudinal barriers among women in our study, and especially for Latinas and Black women. This finding is aligned with other studies that have found that women may be less likely than men to recognize needing treatment and hide their substance use from others (Brienza & Stein, 2002; Schober & Annis, 1996). Covert substance use patterns may decrease adverse consequences (e.g., work-related, legal) and social pressures, thereby

decreasing the likelihood of recognizing having a problem and needing treatment (Bond et al., 2010). Additionally, lower perceived treatment need may be also a function of avoiding stigma (discussed in greater detail below). Our findings that Latinas and Black women are less likely to perceive needing treatment than White women may be an important driver of gender and racial/ethnic disparities. This finding also suggests that innovative prevention strategies to engage Latinas and Black women with low perceived treatment need are needed, especially beyond a health care setting. For example, training community health workers to conduct brief screening interventions, which has been shown to be efficacious, in community settings (e.g., community events) may be a viable strategy to reach Latinas and Black women in need of treatment. Similarly, prevention efforts (e.g., screening, health education) that target spaces that are commonly utilized by Latinos and Blacks (e.g., churches, barbershops, and beauty shops) have shown to be successful in reaching and engaging this population in health care (Browne, Ford, & Thomas, 2006; Derose et al., 2016; Luque, Ross, & Gwede, 2014). Adapting these approaches to target Latinas and Black women's substance use may be an effective, and culturally appropriate, approach to reach women with SUD who do not perceive needing treatment.

We also found that Latinas were more likely than White and Black women to not perceive specialty treatment to be effective. In general, women highlighted the importance of having a provider who had previously overcome addiction to increase sentiments that treatment would be effective. Research has documented that people in recovery can inspire and motivate others to seek treatment (Best & Lubman, 2012). Specialty treatment services may benefit from recruiting providers who have overcome addiction or incorporating past clients who are in recovery as part of treatment, particularly women. For Latinas, low treatment efficacy was closely linked to cultural factors. They underscored the importance of culturally competent treatment providers. Culturally tailored treatment services have been found to increase utilization and improve treatment retention and completion among Latinos (A. Copello & Orford, 2002; A. G. Copello, Copello, Velleman, & Templeton, 2005; A. G. Copello, Templeton, & Velleman, 2006; Kumpfer, Alvarado, & Whiteside, 2003; Liddle, 2004). Investing in culturally competent staff and provider training to increase understanding of important cultural beliefs, customs, and social contexts (e.g., family dynamics, traditional gender roles, immigration experiences) may increase appeal and utilization of specialty treatment services among Latinos, including Latinas.

Within the subjective norms domain, stigma and lack of perceived social support were important reasons why women avoided specialty treatment. Stigma was particularly pervasive in the narratives of Latinas and Black women as compared to White women. Women in general experience intensified stigma for having a substance abuse problem. The stigma that women experience for having a SUD, which is associated with negative images regarding their sexuality and fitness as mothers, coupled with fears of being socially shunned by family and friends, is a common reason they do not seek treatment (Greenfield & Grella, 2009). Stigma for having a SUD and using treatment may be particularly intensified among Black women and Latinas. In the Black community, substance use is often associated with deviant and criminalized behaviors (Scott & Wahl, 2011; Van Olphen, Eliason, Freudenberg, & Barnes, 2009). Whereas in Latino culture, norms surrounding women's drinking and drug use are more conservative and addiction problems are

commonly perceived as a ‘male disease’ (Alvarez et al., 2007; Amaro, Arévalo, Gonzalez, Szapocznik, & Iguchi, 2006; Amaro, Nieves, Johannes, & Labault Cabeza, 1999; Mora, 2002; Trepper, Nelson, McCollum, & McAvoy, 1997). These cultural norms may also in part contextualize why Latinas feared being seen using treatment and lower perceived social support from family. Thus, Latinas and Black women may experience more stigma, relative to their male counterparts and White women. Our findings suggest that strategies to combat stigma may increase use of specialty treatment services among women with SUD, especially among Latinas and Black women. This may entail innovative methods of delivering specialty treatment that are less conspicuous such as via online modalities to reduce fears of being seen using treatment and stigma, as has been previously recommended by our research team (Pinedo et al., 2018).

White women were more likely to report treatment barriers within the perceived control domain, namely logistical barriers, than Latinas and Black women. This finding contradicts other studies that have found that Latinos and Blacks, in general, are more likely to experience logistical barriers to treatment than Whites (Perron et al., 2009; Schmidt et al., 2007; Verissimo & Grella, 2017). In our sample White women were more likely to describe needing treatment than Latinas and Black women. This may indicate that White women may have already been contemplating treatment and thus more aware of potential logistical issues (e.g., paying for services) they may face than Latinas and Black women.

Some limitations should be considered when interpreting our findings. Participants were recruited through Craigslist ads, which may have excluded women of with less resources and access to the Internet, which may have affected the barriers identified here. However, Craigslist has been documented to be an effective strategy to recruit participants from hard-to-reach populations, particularly racial/ethnic minorities and people of lower socio-economic status, then other sampling techniques (Alto, McCullough, & Levant, 2018; Grov, 2012; Head, Dean, Flanigan, Swicegood, & Keating, 2016; Ramo, Hall, & Prochaska, 2010; Worthen, 2014). Our sample of women within each racial/ethnic group may not have been large enough to reach saturation of themes. Nonetheless, findings provide a first step that can guide future research. The methods used here produced specific results based on these participants and their experiences; findings may not be transferable to other women with SUD. Additionally, given the sensitive nature and heightened stigma women experience for having a substance use problem, women may have underreported their substance use behaviors and treatment utilization. However, we relied on highly trained interviewers with significant experience working with substance using populations. Our qualitative interviewers were also women, which may have increased sentiments of trust and rapport, creating a more comfortable environment for women participants to share their experiences. Lastly, our findings merit replication with a larger representative sample of women with SUD to confirm findings from this study and determine if findings are generalizable. Notwithstanding these limitations, this study highlights key differences in barriers to treatment by race/ethnicity and underscores the need to targeted interventions that are specifically designed for the needs of Latinas and Black women. Addressing these barriers may also be key to reducing gender disparities.

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Table 1.

Socio-demographic and substance use characteristics among women with past 5-year substance use disorders by race/ethnicity, 2017–2018, N=28.

	Total Sample 28 (%)	Whites 9 (%)	Blacks 9 (%)	Latinas 10 (%)
Socio-demographic characteristics				
Mean age (SD)	40 (2.10)	41 (3.46)	38 (3.62)	40 (2.09)
Completed high school or higher	26 (93%)	9 (100%)	8 (89%)	9 (90%)
Currently employed	22 (79%)	8 (89%)	6 (67%)	8 (80%)
Country of origin (Latinas)				
Mexico	3 (30%)	-	-	3 (30%)
Puerto Rico	2 (20%)	-	-	2 (20%)
Dominican Republic	1 (10%)	-	-	1 (10%)
Central America	0 (0%)	-	-	0 (0%)
South America	0 (0%)	-	-	0 (0%)
Unknown	4 (40%)	-	-	4 (40%)
Foreign-born	4 (15%)	-	-	4 (15%)
Substance use characteristics				
Alcohol use disorder (AUD) only	9 (32%)	3 (33%)	1 (11%)	5 (50%)
Drug use disorder (DUD) only	1 (11%)	1 (11%)	0 (0%)	0 (0%)
Co-occurring AUD-DUD	18 (64%)	5 (55%)	8 (88%)	5 (50%)
Treatment history (past 5 years)				
Any treatment use	15 (54%)	5 (56%)	6 (67%)	4 (40%)
Types of treatment				
Mutual help groups	9 (32%)	3 (33%)	3 (33%)	3 (30%)
Specialty alcohol or drug treatment	1 (4%)	0 (0%)	1 (11%)	0 (0%)
Hospital or clinic	7 (25%)	1 (11%)	2 (22%)	2 (20%)
Social services program	3 (11%)	1 (11%)	1 (11%)	1 (10%)
Medical group or physician	6 (21%)	3 (33%)	1 (11%)	2 (20%)
Other agency/professional	0 (0%)	0 (0%)	1 (1%)	0 (0%)