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# Black-White differences in barriers to specialty alcohol and drug treatment: findings from a qualitative study

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## Abstract

The objective of this study was to explore, in-depth, differences in barriers to specialty alcohol and drug treatment services between Black and White participants with recent substance use disorders (SUD). We recruited 34 participants with a recent SUD of White and Black racial/ethnic descent for qualitative interviews. Interviews were coded to identify barriers to specialty treatment. We found that barriers related to stigma and lack of social support were more pervasive in the narratives of Blacks as compared to Whites. Results suggest that stigma and lack of perceived social support may impact Blacks more than Whites in seeking SUD treatment.

### Keywords

Substance abuse disorders; alcohol and drug treatment; specialty substance abuse treatment; Blacks; health disparities

## Introduction

Blacks are disproportionately burdened by alcohol and drug-related problems, including recurrent or persistent dependence, morbidity and mortality linked to alcohol and drug abuse, and adverse social and legal consequences (Galea et al., 2003; Mulia, Ye, Greenfield, & Zemore, 2009; Ramchand, Pacula, & Iguchi, 2006; Witbrodt, Mulia, Zemore, & Kerr, 2014; Zemore et al., 2016), despite the availability of treatment services. Specialty alcohol and drug treatment services have proven to be effective in treating addiction and associated risk behaviors (Alegria, Carson, Goncalves, & Keefe, 2011; Alvarez, Jason, Olson, Ferrari, & Davis, 2007; Arroyo, Westerberg, & Tonigan, 1998; Guerrero, Marsh, Cao, Shin, & Andrews, 2014). Specialty treatment refers to formal programs or services that were designed to treat those with an alcohol or drug problem, including in- and out-patient

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Contributors

MP and SZ conceptualized and designed the study. MP conducted the analyses of the data and wrote the initial draft of the manuscript. NM and SZ contributed significantly to the interpretation of the findings and subsequent drafts of the manuscript. All authors approved the final manuscript.

Conflict of Interest

None.

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services and rehabilitation services. Specialty treatment does not include informal services (e.g., mutual help groups, 12-step programs) or non-specialized services (e.g., primary care, hospital).

While research on disparities in treatment use has shown mixed results, some studies have found that among those with substance use disorders (SUD), Blacks may be less likely than Whites to use specialty treatment (Chartier & Caetano, 2010; Schmidt, Ye, Greenfield, & Bond, 2007), particularly when controlling for racial/ethnic differences in criminal justice involvement and socioeconomic status (Lê Cook & Alegría, 2011). One study found that Black-White disparities in treatment utilization may be most pronounced at higher levels of problem severity ( Schmidt et al., 2007), which suggests that Blacks with the greatest need for treatment may be least likely to seek help. Why Blacks may be less likely than Whites to use specialty treatment is not well understood. Large representative studies that have documented Black-White disparities in treatment utilization have found that socio-demographic characteristics and key predictors of treatment utilization (e.g., gender, greater problem severity, experiencing social, legal, and/or work-related consequences) do not fully explain racial/ethnic differences (Schmidt, Greenfield, & Mulia, 2006a; Schmidt et al., 2007; Wells et al., 2001; Zemore et al., 2014). Thus, continued research in this area is warranted to better address racial/ethnic health disparities related to substance abuse.

Researchers have suggested that Blacks may face greater barriers to treatment (e.g., lack of health insurance, high cost of treatment, logistical concerns, stigma, lack of perceived treatment need) than Whites, and that this may explain Black-White disparities in the use of treatment services (Schmidt, Greenfield, & Mulia, 2006b). However, empirical support for this claim is not strong. In fact, only four population-based studies have explicitly investigated whether barriers to treatment disproportionately burden Blacks relative to Whites. Racial/ethnic differences in barriers from this small body of work are inconsistent are statistically non-significant in most cases. In the first study, Grant (1997) analyzed data from the 1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES) and found that among Blacks and Whites who perceived a need for treatment but had not utilized it, Blacks were less likely than Whites to report alcohol stigma as a barrier to treatment, but more likely to report logistical concerns (e.g., childcare issues, long wait times), not wanting treatment, and denial as reasons for not seeking alcohol treatment. However, these results were based on bivariate associations, which limit their interpretation, as it is unclear if associations would be retained after adjusting for socio-demographic characteristics and other important contextual factors. In the second study, Schmidt et al. (2007), using data from the 1995 and 2000 National Alcohol Survey (NAS), investigated how stigma-related concerns (e.g., fears that people would find out), logistical barriers (e.g., concerns about paying for treatment), and cultural barriers (e.g., concerns that providers would not understand or share one's race) related to treatment utilization among persons reporting a lifetime alcohol use disorder (AUD) by race/ethnicity and found no statistical differences between Whites and Blacks.

The third study by Perron et al. (2009) examined 27 potential barriers to drug treatment among those with a lifetime drug use disorder (DUD) using data from the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). Barriers

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included attitudinal barriers, stigma, and logistical barriers. No statistically significant differences in barriers to treatment between Blacks and Whites were documented. Finally, Verissimo et al. (2017) also used NESARC data to examine structural barriers (e.g., couldn't afford treatment), attitudinal barriers (e.g., didn't think anyone could help), and readiness for change barriers (e.g., wanted to keep drinking/using) to drug and alcohol treatment, separately, by race/ethnicity. In multivariate analyses, they found no significant Black-White differences in barriers to drug treatment. However, in terms of alcohol treatment, Blacks were more likely than Whites to report logistical barriers, although less likely to report attitudinal barriers to alcohol treatment.

Given the general lack of consistent and significant findings for Black-White differences in treatment barriers, it is difficult to identify which barriers, if any, may be disproportionally impacting Blacks. Much of the literature focused on racial/ethnic differences in treatment barriers has focused on quantitative data using measures that are not theoretically informed (Pinedo et al., 2019). It may be that existing measures are not adequately assessing reasons why Blacks are not using treatment. Qualitative data can potentially fill gaps in the existing literature by identifying novel barriers not may currently being overlooked by quantitative studies. Thus, in order to advance prior research, we conducted a qualitative exploration of barriers that may be contributing to Black-White disparities in the use of specialty treatment.

## Methods

### Theoretical Framework

We used the Theory of Planned Behavior (TPB) to guide this study (Ajzen, 1985). The TPB postulates that behavior is largely predicted by a person's intention to engage in that behavior. A person's intention to engage in a behavior is largely shaped by his or her attitudes, subjective norms, and perceived control toward that behavior. The TPB has a strong history of empirical support in explaining diverse health behaviors, including substance abuse (Collins & Carey, 2007; Godin & Kok, 1996; Kam, Matsunaga, Hecht, & Ndiaye, 2009). The theory's success in predicting behaviors partly stems from its stipulation that each of the constructs be measured at the level of specificity that is consistent with the behavior under investigation. For instance, in the case of specialty substance abuse treatment utilization, the TPB dictates that attitudes, subjective norms, and perceived control relevant to specialty treatment utilization should be assessed. Thus, the TPB can be used as a guiding framework to better understand Black-White differences in barriers to specialty treatment.

### Study Design and Participants

From October 2017 to May 2018, 54 participants were recruited for in-depth qualitative telephone interviews. Eligible participants were adults of White, Black, or Latino racial/ethnic descent who met diagnostic criteria for a recent (i.e., past-5-year) SUD. In recruiting participants, we implemented a quota to recruit 20 participants within each racial/ethnic group. The purpose of this was to have enough power (i.e., reach data saturation) to conduct comparative analyses by race/ethnicity. To recruit participants, we advertised our study via Craigslist posts in racially/ethnically diverse cities, including: Riverside, Los Angeles, San Diego, and Oakland, CA; Brooklyn, NY; Chicago, IL; Miami, FL; and San Antonio,

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TX. These ads contained basic study information and a link to the study's website where interested persons could complete the screener questionnaire to determine eligibility. The screener questionnaire was programmed using Qualtrics software, took ~10 minutes to complete, and was self-administered online. Survey questions included measures for socio-demographics, alcohol and drug use behaviors, and treatment utilization history. Recent SUD was assessed via 22 questions that pertained to DSM-5 diagnostic criteria for AUD and DUD (American Psychological Association, 2013). By definition, SUD is characterized as meeting diagnostic criteria for AUD, DUD, or both. Participants who reported two or more AUD and/or two or more DUD symptoms were characterized as having a recent SUD. AUD and DUD severity was calculated by using a continuous count of self-reported symptoms for each disorder. Participant were also asked: "In the past 5 years, have you ever gone to anyone—a physician, AA, a treatment agency, anyone at all—for a problem related in any way to your drinking or drug use?" Those who answered affirmatively were then asked to report all the types of services they had used. Response options included: Alcoholics Anonymous; specialty alcohol or drug treatment program (e.g., in/out-patient services, rehabilitation); hospital or clinic; medical group or physician; social services programs; other agencies/professional people. Upon completing the screener, potential participants who met eligibility criteria were prompted to provide contact information (first name, email and/or telephone number) and informed that they would be contacted at a later date to schedule an interview, if they were selected for the study.

Of the 341 potential participants that completed the screener questionnaire, 223 were eligible for the study. Participants were purposefully sampled based on race/ethnicity, gender, disorder type, and problem severity. Participants who reported never using specialty treatment were especially targeted, given the objective of the study. A total of 74 participants were contacted and invited to participate in the study; 54 participants agreed to be interviewed. Recruitment stopped once data saturation was reached.

Interviews were conducted over the phone, lasted about 40 minutes, and were audio-recorded. Before beginning the interview, the qualitative interviewer obtained verbal informed consent. Interview questions were grounded in the TPB. Participants were asked pre-determined opened-ended questions in relation to their attitudes, subjective norms, and perceived control toward specialty substance abuse treatment services. Example questions were as follows. Attitudes: "Have you considered getting help for your drinking or drug use problem?" What are some reasons why you have or have not? Subjective norms: "How would important people in your life react if they knew you were seeking treatment for a drinking or drug problem? Would they be supportive?" Perceived control: "Are there any circumstances that would make it difficult for you to seek treatment, such as transportation, cost issues, availability of services?" Interviews were semi-structured, and the qualitative interviewer was free to deviate from the guide to pursue relevant information. Importantly, interview questions were specific to specialty treatment (vs. other types of treatment). Participants were informed that for the purpose of this interview, treatment referred to specialty treatment, meaning services that are specifically designed to treat alcohol and drug problems. Participants were provided with a definition and various examples. The interviewer ensured that participants understood how specialty treatment differed from other forms of treatment such as mutual help groups, primary care, and general therapy,

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before continuing with the interview. Participants received a $50 Amazon Gift Card as compensation for their time. The Institutional Review Boards of the Public Health Institute and the University of Texas at Austin approved all study protocols.

### Analyses

We first conducted descriptive analyses to characterize our sample population using participant's responses to the screener questionnaire. Following, transcripts were coded using NVivo v11 software (QSR International Pty Ltd. Version 11). Using the TPB as our analytic framework, we developed a coding scheme using an iterative process (Creswell, 2009; Creswell & Creswell, 2013). The first author and a graduate-level research assistant (RA) read several interviews independently and recorded common themes within the domains of the TPB. Themes were discussed and used to develop an initial codebook. This process was repeated until a final codebook of key barriers was established. Next, the first author and RA independently coded the same 11 transcripts and met regularly to compare coded transcripts. Any inconsistencies were resolved through discussion and consensus. Once both coders reached a 90% consistency in applying the coding scheme, subsequent interviews were coded by one independent coder. For this analysis, we focus on barriers that may explain Black-White disparities in treatment utilization (n=34; 18 White and 16 Black participants) by comparing frequencies of coded themes (i.e., barriers) within each domain of the TPB.

## Results

### Participant Characteristics

Table 1 displays general characteristics of Black and White participants. On average, participants were 39 years of age, and the majority had completed high school and were currently employed. Just under half (47%) of the sample was male. In terms of past-5-year substance use disorder type, the majority (76%) met diagnostic criteria for co-occurring AUD-DUD; 17%(n=6) reported AUD only, and 6% (n=2) reported DUD only. Problem severity was high. On average, participants reported experiencing 9 out of 11 AUD symptoms and 8 out of 11 DUD symptoms. More than half (62%, n=21) reported using any form of treatment in the past five years. Most commonly used treatment services were mutual help groups and a hospital or clinic. No statistically Black-White significant differences among socio-demographic characteristics, substance abuse characteristics, and treatment use history were found.

### Overview of Qualitative Findings

Table 2 depicts several important barriers that were deterrents to treatment seeking among Black and White participants. Important distinctions between Blacks and Whites emerged within the subjective norms domain. Stigma and lack of perceived social support, though reported by both Black and White participants, were more *pronounced* in the narratives of Black participants. Blacks were not any more likely than Whites to describe barriers to treatment within the attitudes and perceived control domains. Given the objective of this study to explore Black-White disparities, we discuss barriers within the subjective norms domain in more detail below and provide representative quotes.

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Barriers driving Black-White Disparities in Specialty Treatment Utilization: Subjective Norms

## Stigma

Stigma was an important barrier among both Blacks and Whites, but was more pervasive in the narratives of Blacks. Black participants frequently described treatment as being for people who are criminals, addicts, and homeless; for those who have hit rock bottom. Many Black participants feared that using treatment would label them as having a substance abuse problem, resulting in being stigmatized by others. For example, when asked to describe an ideal treatment program, one Black participant responded:

> I'd probably go through a church or something because they have a lot of [experience] with rehabilitating former abusers, it's non-judgmental. I think it's the judgment of people that really drives people away, you know what I mean?

When asked to elaborate a bit more, this participant continued:

> *Well you know, [people] looking down on [you], like you know… 'they're terrible people, and how can you do this to your family?' That's not what it's all about, you know what I mean? If somebody has issues with addiction, I don't think they want to be running around robbing people or doing whatever, or prostituting themselves to get drugs, it's just what ends up happening with the addiction.* –Black participant, 52 years old

Black participants also explained that specialty treatment services were conspicuous and feared that being seen going into a treatment center by people they knew would immediately 'out' them as having a substance abuse problem. For example, in the following passage one Black participant described his trepidation surrounding using treatment, referring to treatment as unsafe because of the perceived lack of anonymity:

> "*I am saying there [are] so many places that are not safe places because there are so many people in the community or that you know […] it's like kind of running into somebody you know, or somebody in your group, not having your privacy in that situation"* –Black participant, 30 years old

Thus, Blacks commonly described avoiding specialty treatment as a strategy to evade being stigmatized or labeled as having a problem with alcohol and/or drugs. Interestingly, some participants explained that they would consider using specialty treatment services if they were not easily identifiable as substance abuse treatment programs. For instance, when asked what kinds of characteristics or services would increase motivation to seek treatment, one Black participant described:

> "*You know like somewhere discreet, you don't want a big flashing sign on the side of it, you know… Like wear a paper bag over your head to go in [a place like that]."* –Black participant, 38 years old

Similarly, a White participant described the appeal of receiving web-based treatment as a strategy to remain anonymous and avoid being stigmatized:

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> "The reason why I stopped [going to treatment] was because every time I would go to the center, I would run into people I know. And it was kind of like, not that I should not call it a shame, but I began getting nervous, so this is why I stopped. If I can do it anonymously, just with someone online, even if it's a group study, even if it's people from a different state, it would be so much better for me to address things […] Yeah, I guess I feel more comfortable if I can be anonymous." -White participant, 38 years old

### Perceived social support

Compared to White participants, Black participants were also more likely to report a lack of social support for using specialty treatment. This was closely linked to stigma associated with having a substance abuse problem. Many Black participants feared that being in treatment would result in being the source of gossip among their loved ones. As a result, many avoided speaking openly with family and friends, which ultimately influenced their decision to not seek help. For instance, one participant described:

> *"I don't tell my business, like even to my family and stuff. Certain things, for certain people, I believe you should have your own personal life and business. Personal things are personal to you, so I don't do that. So, it's good to talk to somebody without feeling like I'm being judged or being shamed or being like they can't wait to get off the phone with you so they can hurry up and call somebody else and tell them. You know, I've got one of those families."* –Black participant, 38 years old

Others who had previously sought help for their substance abuse problems described experiencing stigma after completing treatment. Thus, these Black participants were more opposed to using specialty treatment in the future, despite still struggling with drugs and/or alcohol. For example, after completing a 12-step-oriented treatment program, one participant who no longer uses illicit drugs but still struggles with alcohol explained feeling rejected by friends, as using treatment confirmed that she had a substance use problem:

> *"Old friends who come in from the past, I just walk away from because you go through things and you want to get away and you want things to make you feel better […] You know, and they [old friends] really, really, make you feel rejected, you know? […] When you did drugs so long in your life and you have a certain look on your face, you know, you really have like an ex-user look, and people can tell that about you. People look at you… people look at me and they can see, you know, and it feels bad."* –Black participant, 36 years old

Another Black participant described his parent's reaction when he informed them of wanting to get help for his drug use:

> "My mother is Christian, my dad is Muslim, they are both devout to their religion but somehow they made it work. They are both conservative on each end of their faith, so [they were] like 'oh my gosh why do you need that [treatment]? Even counseling has been… counseling is for the weak, for the simple minded. So [treatment] has always been looked down upon. I think people of color generally go to church when they need help." –Black participant, 30 years old

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Conversely, White participants were more likely to describe their family and friends as a source of social support in relation to their substance use problem and for seeking treatment, as illustrated in the following passage:

> "I have a lot of good friends who I can talk to about stuff, get their feedback, their opinions. You know therapy is what it is. I'm not sure how much I believe in it. If I'm sitting home drinking and not going to work and just being irresponsible […] I have family who are loving and supporting and I can talk to them about a lot of stuff and I don't blame. A lot of people blame their father or their parent for their inherited disease." –White participant, 52 years old

## Discussion

This study is the first known qualitative study to investigate differences in barriers to specialty alcohol and drug treatment programs among Black and White participants with recent SUD. No differences among attitudinal barriers and logistical barriers between Black and White participants were documented. A notable finding from our study was that barriers within the subjective norms domain, namely stigma and lack of perceived social support, differed between Blacks and Whites. Stigma and perceived lack of social support were more pronounced in the narratives of Blacks. This is significant because it suggests that stigma and lack of perceived social support may be important drivers of underutilization of treatment among Blacks, thereby contributing to racial/ethnic health disparities related to substance abuse.

Many Blacks reported avoiding treatment due to fears of being stigmatized and judged by others for having an alcohol or drug problem. This finding can be interpreted within the context of an intersectionality framework (Crenshaw, 2018), which suggests that multiple social identities that are devalued (e.g., race/ethnicity, female gender, low socioeconomic status, and stigmatizing characteristics such having a substance abuse problem) are interdependent and operate simultaneously. Persons who posses more than one socially devalued identity experience greater oppression and discrimination (Cole, 2009; Purdie-Vaughns & Eibach, 2008). Elaborating on this, Blacks in general commonly face stigma due to their race/ethnicity. Persons with substance abuse problems also experience stigma, regardless of race/ethnicity. However, possessing both devalued social characteristics (i.e., being Black and having a substance abuse problem) yields an intensified stigma that is greater than having only one stigmatizing characteristic, therefore Black people with SUDs may be especially reluctant to reveal or confirm that they have a substance abuse problem. This finding is aligned with other studies among Black persons with substance abuse problems. One qualitative study among Black males with SUDs found that participants believed that others viewed their substance abuse problems more negatively compared to how others viewed substance abuse problems among Whites because of their race (Scott & Wahl, 2011). The authors of that study described Blacks with SUDs as experiencing 'double stigma,' which adversely impacted their use of treatment services (Scott & Wahl, 2011).

Further, Blacks are more likely than Whites to be criminalized for their substance use behaviors (McElrath, Taylor, & Tran, 2016; Mulia et al., 2009; Mulvaney-Day, DeAngelo,

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Chen, Cook, & Alegría, 2012; Rounds-Bryant, Motivans, & Pelissier, 2003; Zemore et al., 2016). Even at equivalent levels of alcohol and marijuana consumption, Blacks (particularly men) are still more likely to experience legal problems than Whites (Mulia et al., 2009; Ramchand et al., 2006; Witbrodt et al., 2014; Zemore et al., 2016). This may in part be explained by disproportionate residence in low-SES, hyper-segregated neighborhoods that are subject to increased police surveillance and which result in greater penalties for substance use possession and distribution, among other crimes (Brunson, 2007; Brunson & Weitzer, 2009; Weitzer & Tuch, 2005; Witbrodt et al., 2014). Indeed, striking Black-White disparities in arrests for drug possession increased greatly in years following the War on Drugs (Mooney et al., 2018), with Black arrestees less likely than Whites to receive diversion to treatment instead of incarceration (Nicosia, MacDonald, & Arkes, 2013). This criminalization of Blacks with substance abuse problems serves to further exacerbate stigma among those in this community struggling with addiction. Overall, Blacks are likely to experience more stigma for having a substance abuse problem than their White counterparts. This heightened stigma may be contributing to Black trepidation to use of specialty treatment. The use of these services may serve as confirmation to others of having a problem with substance abuse, thereby adding another layer of stigma to their social identity.

Blacks were also likely than Whites to describe perceived lack of social support for using specialty treatment, which was partially influenced by stigma. Reducing stigma associated with substance use and treatment may increase utilization among Blacks and increase feelings of social support once treatment has been utilized. One approach may be to incorporate family members in treatment, which has been shown to increase feelings of support, increase empathy, and reduce stigma, resulting in improved treatment outcomes (Copello & Orford, 2002; A. G. Copello, Templeton, & Velleman, 2006; Liddle, 2004). Additionally, interventions targeting the general public to reduce stigma surrounding persons with SUD are warranted. Studies have shown that educational programs targeting students and professionals (e.g., police, physicians), especially those that incorporate persons in recovery to share their stories, can help reduce negative perceptions and stereotypes regarding addiction (Livingston, Milne, Fang, & Amari, 2012; Lloyd, 2013). Expanding these interventions to specifically target the Black community can potentially help increase use of specialty treatment services and help reduce existing substance abuse-related racial/ethnic disparities.

Findings should be interpreted with certain considerations in mind. Given that participants were recruited via online ads, findings may not be generalizable to all Blacks with SUD; we likely missed those with no access to computers or the internet. Further, given the stigmatizing nature of substance use, participants may have underreported their substance use and/or treatment utilization. Participants were also interviewed by telephone, which may have hindered rapport-building and influenced participants' responses. However, qualitative interviewers were highly trained to ask questions in a non-judgmental manner and had ample experience working with substance-using populations. Also, studies have shown that telephone interviews may be effective in reducing biased responding (i.e., social desirability biases given the increased anonymity of telephone interviews) (Drabble & Trocki, 2014; Drabble, Trocki, Salcedo, Walker, & Korcha, 2016; Mitchell & Chaboyer, 2010; Novick, 2008; Opdenakker, 2006; Sturges & Hanrahan, 2004; Waterman et al., 1999).

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Despite these limitations, the current study points to some potential sources of Black-White disparities in barriers to specialty substance abuse treatment utilization and to potential efforts that could reduce these disparities, as described above. Moreover, results from this study can be used to improve future research on racial/ethnic disparities in treatment utilization, which would help to confirm and extend the current findings. In particular, findings highlight the need for national studies to consider novel and more nuanced measures for key barriers. For example, although national studies have examined stigma as a barrier to treatment, current measures are limited. Current national studies assess stigma via one or two broad items (e.g., "I was too embarrassed," "I was afraid of what my boss, friends, family, or others would think"). Expanding on these measures to include more nuanced aspects of stigma (e.g., fears of being stereotyped, being labeled, and being judged by others) may be needed (Perron et al., 2009; Schmidt et al., 2007; Verissimo & Grella, 2017). Incorporating these recommendations into future research can potentially aid in identifying key barriers that contribute to racial/ethnic differences in treatment utilization and inform the design of tailored interventions.

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**Table 1.**

Socio-demographic and substance use characteristics among White and Black participants with past 5-year substance use disorders, 2017–2018, N=34.

| | Total Sample 34 (%) | Whites 18 (33%) | Blacks 16 (29%) | P-Value |
|---|---|---|---|---|
| ***Socio-demographic characteristics*** | | | | |
| Mean age (SD) | 39.65 (11.76) | 37.78 (2.53) | 41.75 (3.20) | 0.33 |
| Male gender | 16 (47%) | 9 (50%) | 7 (44%) | 0.71 |
| Completed high school or higher | 33 (97%) | 18 (100%) | 15 (94%) | 0.28 |
| Currently employed | 27 (79%) | 16 (89%) | 11 (69%) | 0.15 |
| **Substance use characteristics** | | | | |
| Alcohol use disorder (AUD) only | 6 (17%) | 3 (19%) | 3 (17%) | 0.87 |
| Drug use disorder (DUD) | 2 (6%) | 1 (6%) | 1 (5%) | 0.93 |
| Co-occurring AUD and DUD | 26 (76%) | 14 (78%) | 12 (75%) | 0.84 |
| Mean number of AUD symptoms[a] | 9.00 (3.27) | 9.06 (3.2) | 8.93 (3.4) | 0.92 |
| Mean number of DUD symptoms[b] | 8.62 (4.38) | 8.72 (1.00) | 8.50 (1.62) | 0.85 |
| ***Past Treatment History*** | | | | |
| Any past 5-year treatment use | 21 (62%) | 11 (61%) | 10 (62%) | 0.93 |
| Number of services of past 5-year treatment[c] | | | | |
| 1 type of treatment | 11 (32%) | 7 (39%) | 4 (25%) | 0.38 |
| 2 or more types of treatment | 10 (29%) | 5 (28%) | 5 (31%) | 0.82 |
| Past 5-year treatment use | | | | |
| Mutual help groups | 12 (35%) | 7 (39%) | 5 (31%) | 0.64 |
| Specialty alcohol or drug treatment | 7 (21%) | 3 (17%) | 4 (25%) | 0.54 |
| Hospital or clinic | 10 (29%) | 5 (28%) | 5 (31%) | 0.82 |
| Social services program | 5 (15%) | 2 (11%) | 3 (19%) | 0.53 |
| Medical group or physician | 9 (26%) | 6 (33%) | 3 (19%) | 0.33 |

[a]Includes all participants who met eligibility criteria for AUD; not mutually exclusive.

[b]Includes all participants who met eligibility criteria for DUD; not mutually exclusive.

[c]Partcipants were allowed to chose all that apply

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**Table 2.**

Frequencies of coded themes among White and Black participants with past 5-year substance use disorders, 2017–2018, N=34

| | Whites | Blacks |
|---|---|---|
| ***Attitudes*** | | |
| Low perceived treatment efficacy | 17 | 16 |
| Lack of perceived treatment need | 4 | 3 |
| ***Subjective Norms*** | | |
| Stigma | 10 | 15 |
| Lack of perceived social support | 1 | 6 |
| ***Perceived Controls*** | | |
| Logistical barriers | 11 | 10 |