Access to Treatment for Alcohol Use Disorder at US Health Centers: a National Study

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INTRODUCTION

Alcohol use disorder (AUD) is a substantial and growing public health problem in the USA,¹ particularly among medically underserved and low-income populations.² Treatment rates for AUD remain low despite the existence of evidence-based behavioral and pharmacologic treatment approaches.³ Little is known about the barriers to accessing AUD treatment at federally funded US health centers, which provide care to 26 million vulnerable individuals annually. The aim of this study was to examine the continuum of alcohol use disorder care, location of treatment delivery, and barriers to receiving AUD treatment among adult patients with symptoms of AUD attending HRSA-funded health centers.

METHODS

We analyzed data from adult (≥ 18 years old) respondents to the 2014 Health Center Patient Survey, a cross-sectional, nationally representative, in-person survey of Health Resources and Services Administration (HRSA) health center patients conducted between September 2014 and April 2015 with a three-stage sampling design described elsewhere.⁴ The main measure was self-reported symptoms of AUD, assessed using the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) questionnaire,⁵ which includes items that correspond to 5 of 11 Diagnostic and Statistical Manual of Mental Disorders (DSM-5) alcohol use disorder criteria.⁶ Individuals with ≥ 2 current symptoms were defined as having a diagnosis of AUD. Additional alcohol use behaviors included days of heavy alcohol use and average number of drinks on days of alcohol use in the past year. We examined responses to a series of questions regarding receipt of AUD-related counseling and care, the location of this care, and the primary reason

individuals were unable to access treatment. We examined whether these measures differed between two HRSA health center subtypes where AUD was most common: Community Health Centers (CHC) and Health Care for the Homeless (HCH) programs. We conducted analyses in SAS (SAS Institute), version 9.4, using strata, cluster, and weight variables to account for the complex sampling design. Percentages are weighted to reflect health center patients nationally. Rao-Scott χ^2 tests were used to compare proportions, and t tests were used to compare means, with a two-sided P value < 0.05 for significance. The Partners Human Research Committee exempted this study.

Data Availability. The datasets analyzed during the current study are available from HRSA repository, <https://bphc.hrsa.gov/datareporting/research/hcpsurvey/index.html>

RESULTS

Of 5547 eligible respondents, 555 (7.5%) had AUD. Table 1 summarizes alcohol use behavior, demographic, health status, and past-year health care access differences between those with and without AUD. Compared to those without AUD, those with AUD had significantly more days of heavy alcohol use and mean drinks per day in the past year. Among respondents with AUD, 37% reported discussing alcohol use with a health professional, 21% reported wanting or needing treatment, and less than 15% received treatment for AUD (Fig. 1). Individuals receiving care at HCH programs were significantly more likely to have discussed alcohol use (55%), want or need AUD treatment (36%), or receive AUD treatment (31%) relative to those attending a CHC (35%, 20%, and 13% respectively).

Among 98 individuals who received AUD treatment, 26% received treatment that was delivered at or paid for by a HRSA health center, while 74% sought treatment elsewhere. Among 62 respondents who wanted but did not receive AUD treatment, the most commonly reported reasons for not obtaining treatment were skepticism about

Table 1 Characteristics of Patients with and Without Evidence of Alcohol Use Disorders at US Health Centers

	Alcohol use disorder		No alcohol use disorder		
	N = 555 (7.5%)		N = 4992 (92.5%)		
Current alcohol use	Mean	SE	Mean	SE	P value
Number of AUD symptoms	3.0	0.1	0.1	0.0	
Days ≥ 5 drinks, past year	44.2	9.7	3.5	0.5	<0.001
Drinks per day	5.4	0.7	2.8	0.1	<0.001
Demographics	Unweighted no.	Weighted %	Unweighted no.	Weighted %	P value
Age					
18–44	211	56.4	2042	51.8	<0.001
45–64	336	42.6	2406	36.2	
≥ 65	8	1.0	544	12.0	
Women	198	63.3	3292	64.3	0.87
Race/ethnicity					0.04
Non-Hispanic White	147	50.8	1215	50.6	
Non-Hispanic Black	198	28.6	1095	18.6	
Non-Hispanic Asian	9	0.6	337	3.3	
Non-Hispanic other	83	3.7	576	3.0	
Hispanic	117	16.3	1767	24.6	
High school diploma	315	57.9	2794	66.6	0.23
Currently employed	136	35.5	1635	37.4	0.80
Federal poverty level, %					
≤ 100	405	62.8	3195	55.3	0.55
101–199	107	22.6	1306	29.5	
≥ 200	43	14.6	489	15.2	
Health insurance					
None	151	31.8	1210	26.5	0.24
Public	357	56.2	3045	53.5	
Private	47	12.0	737	20.0	
Health center type					
Community health center	209	86.3	2936	93.3	<0.001
Health care for the homeless	253	9.9	908	2.8	
Public housing primary care	41	1.0	406	1.0	
Migrant health center	52	2.8	742	3.0	
Health status	Unweighted no.	Weighted %	Unweighted no.	Weighted %	P value
Fair or poor general health	301	51.2	2443	41.7	0.15
Fair or poor oral health	270	59.7	1880	41.7	0.01
Severe psychological distress*	164	26.4	740	13.8	<0.001
Lifetime drug use†	430	81.8	2012	43.4	<0.001
Past-year health care use/access	Unweighted no.	Weighted %	Unweighted no.	Weighted %	P value
Emergency department use	364	69.9	2399	46.7	<0.001
Hospitalization	151	35.9	812	32.1	0.58
Delayed medical care‡	104	21.8	638	16.5	0.3
Delayed mental health care‡	54	15.9	243	18.0	0.74
Delayed prescriptions‡	131	26.1	963	23.4	0.64

*Score ≥ 13 on the Kessler 6-item scale of psychological distress

†Assessed with the WHO Alcohol, Smoking and Substance Involvement Screening Test

‡Among respondents who identified a need for medical care, mental health care, or prescription medications

Figure 1 Continuum of AUD care among health center attendees. Error bars represent 95% confidence intervals. Differences between CHC and HCH respondents are significant at $p < 0.05$ for each of the measures of AUD care.

treatment (46%), stigma (38%), logistical barriers (11%), and financial reasons (2%).

DISCUSSION

Symptoms of AUD were common in this nationally representative study of health center patients. A minority of individuals with AUD discussed their alcohol use with a health professional, even fewer reported wanting or receiving treatment, and three quarters of those who received treatment did so outside of the health center. Losses at each stage of the AUD care continuum were less pronounced at HCH relative to CHC settings. Barriers to receiving AUD-focused care appear to include skepticism about treatment, stigma, and logistical and financial barriers.

Limitations of this study include reliance on cross-sectional, self-reported data; an incomplete measure of AUD prevalence; and small sample sizes for some of the estimates presented (e.g., reasons for not receiving treatment), limiting the generalizability of our findings. However, marked decreases across the continuum of AUD care highlight the considerable barriers to routinely identifying, referring, and linking individuals to effective addiction care in US health centers.

Prior Presentations: No prior presentations.

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Compliance with Ethical Standards:

Conflict of Interest: Dr. Bearnot has no conflicts to report. Dr. Baggett receives royalties from UpToDate for authorship of a topic review on homeless health care. Dr. Rigotti receives royalties from UpToDate for reviews of tobacco cessation topics, consults with Achieve Life Sciences regarding tobacco cessation, and received a research grant and been as an unpaid consultant to Pfizer regarding tobacco cessation.

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