WHY DON'T DRUG USERS GET TREATMENT?

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ABSTRACT

Even when drug treatment is available, most drug users do not go to treatment. We examine several theoretical frameworks to identify three critical choice points along the route from drug use to treatment in order to help understand the process: the recognition that drug use is a problem; the desire to stop using drugs; and the desire for help. In a community sample of 131 drug users with complete data, 34% did not recognize that their drug use was a problem and 27% did not think that their problem was severe enough to stop using drugs. A relatively small proportion of the sample (24%) expressed a desire for help, and only 18% entered any kind of treatment during the four years of the study.

INTRODUCTION

In 2003, an estimated 3.8 million individuals aged 12 or older were dependent on or abused illicit drugs (SAMHSA, 2004). Of these, 500,000 individuals (13%) received some kind of treatment for their drug use. The remaining 87% of individuals who needed treatment did not receive treatment. The disconnect between the number of drug users who need treatment and the number who receive treatment points to the difficulty drug users have in moving from drug use to drug treatment. We examine several theoretical frameworks to identify the critical

choice points on the route from drug use to drug treatment. This article then investigates these choices underlying treatment-seeking behavior in order to understand why drug users don't get treatment.

A number of conceptual frameworks can be used to describe the route to drug treatment. One is the Transtheoretical Model (Prochaska, DiClemente, & Norcross, 1992). This model describes voluntary change in terms of a sequence of stages (first column of Figure 1). Individuals in the precontemplation stage do not see their drug use as a problem. If others mention their drug use, they think that those who refer to it as a problem are exaggerating. The contemplation stage is one in which a drug user begins to consider the possibility of change. Individuals in the preparation stage have become committed to change their drug use and make a realistic plan. In the action stage individuals take effective actions to
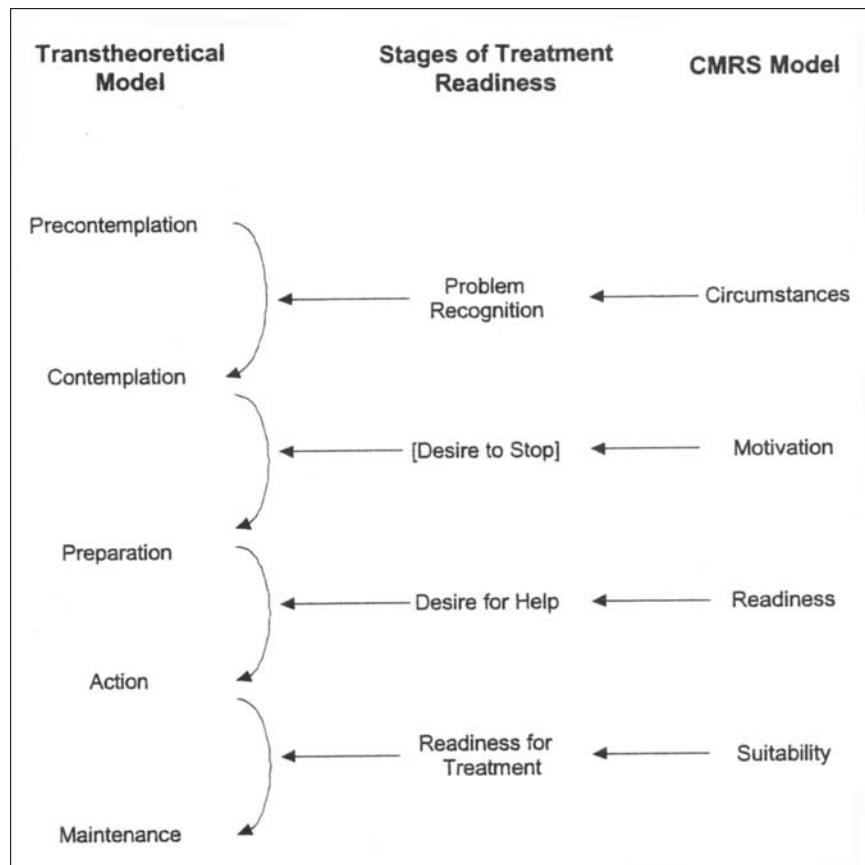

Figure 1. Models of treatment seeking.

make the change. The change represents a new drug-free life style. If the change is permanently integrated in one's lifestyle, this denotes the maintenance stage. The transtheoretical model describe concrete stages that are useful in identifying where in the process of treatment seeking any drug user or former drug user can be located.

To emphasize the dynamics of the treatment process, we focus on the personal choices that lead a person to make the transition from one stage to the next. Simpson and Joe (1993) present such a model wherein they conceptualize the treatment-seeking process as a sequence of choices (second column of Figure 1). The first choice is problem recognition. It is the drug user's decision to recognize that drug use is a problem that moves the person from the precontemplation to the contemplation stage of the Transtheoretical Model. We have drawn an arrow in Figure 1 from problem recognition to the precontemplation/contemplation transition to indicate how we see the fit of the two models. The second choice described by the Simpson and Joe model is the desire for help. This choice represents the transition from the preparation stage to the action stage of the Transtheoretical Model. The drug user is prepared to change and now chooses to take action to receive help toward a drug-free lifestyle. The third choice in the model is readiness for treatment. The drug user, having decided that help is needed, makes a plan to enter a treatment program. This choice represents the transition from action to maintenance of the Transtheoretical Model. We note that the Simpson and Joe model does not describe the decision that moves a person from the contemplation stage to the preparation stage. As a result, we have conceptualized this transition in terms of a desire to stop using drugs. When the drug user has made the choice to stop using drugs, she can then begin to make preparations to change.

The Circumstances, Motivation, Readiness, and Suitability (CMRS) Model focuses on the factors that influence the decision-making process leading to seeking treatment (De Leon, 1986). The relationship we see between the CMRS Model and the Simpson and Joe and Transtheoretical Models is depicted in the third column of Figure 1. Circumstances refers to the extrinsic pressures experienced by the individuals. These pressures are perceived as losses (such as family support, job, personal relationship) and as fears (such as fear of jail, suicide or death by overdose). These factors can be seen to contribute to the choice of problem recognition. Motivation refers to intrinsic pressure for personal change. This intrinsic pressure influences the changes in the person's internal values and beliefs, and can be seen to influence the person's desire to stop. Readiness can be seen to refer to the factors that affect the desire for help. Certain external factors such as friends and religion are seen to influence the amount of help that the drug user needs. Lastly, suitability refers to those factors that can be seen to affect the match between the individual and the appropriate treatment program. We see this match as a critical element in the drug user's readiness for treatment. This treatment of the CMRS Model is schematic and to an extent simplifies the

complexities of the original. For example we have not discussed the effect of motivation on desire for help.

Based on these models, we conceptualize the process leading up to treatment seeking as punctuated by three choice points: problem recognition, desire to stop, and desire for help. These choice points can be described in terms of a metaphor of a highway. Thus, we use this metaphor to speak of a drug user's route from drug use to treatment.

Problem Recognition

Drug use contributes to health and psychological problems. Certain health problems, such as cardiovascular problems, may result from drug use (Baigent, Holme, & Hafner, 1995; Gossop, Marsden, & Stewart, 2002; Green & Ritter, 2000; Marsden, Griffiths, Farrell, Gossop, & Strang, 1998). Psychological problems, such as depression, may be related to drug use (Koegel, Sullivan, & Burman, 1999; Mechanic, 1975; Wu, Kouzis, & Leaf, 1999), including the use of drugs for the self-medication of undiagnosed psychological problems (Green & Ritter, 2000; Powis, Gossop, Bury, Payne, & Griffiths, 2000; Sacks & Pearson, 2003; Smith, Molina, & Pelham, 2002). There are also social consequences to drug use. Social isolation may occur because the person's drug use may lead to stigmatization (Cunningham, Sobell, & Gaskin, 1994). Family separation may occur because the drug user may begin to value the drug more than familial relationships (Cunningham et al., 1994; Powis et al., 2000). Likewise, romantic relationships may be impacted by drug use (Anglin, 1992; Anglin, Kao, Harlow, Peters, & Booth, 1987; Powers et al., 2000; Wilson-Cohn, Strauss, & Falkin, 2002). Negative economic consequences may result from the drug user's tendency to fund their drug use rather than housing or other necessities (Boys, Marsden, Griffiths, & Strang, 2000). Drugs may also lead to employment instability (Magura, 2003). Finally, drug users may experience problems with the law, because in addition to possession being illegal (Hser, Boyle, & Anglin, 1998), the costs of drugs may be financed by illegal activities and some drugs may pharmacologically influence people to become reckless or violent (Goldstein, 1985).

The nature and seriousness of drug use consequences may induce a user to perceive them as severe and thus may influence the drug user to create a link between these consequences and his drug use. This link may lead the drug user to recognize her drug use as the source of her problems (Nwakeze, Magura, & Rosenblum, 2002). Thus, the first choice on the route to seeking treatment is the recognition of having a drug problem (De Leon, 1986; Simpson & Joe, 1993).

Initially, however, the consequences of drug use may not be perceived as problematic. The drug-related consequences described above may range from mild to severe. If the consequences are relatively mild, thus minimally impacting

the drug user's life, the drug user may not recognize her drug use as the problem (Nwakeze et al., 2002). If the consequences do significantly impact the drug user's life, but the drug user does not identify the source of these consequences as the drug use, the drug user may also not recognize his drug use as the problem. It is when the drug user realizes that the consequences are stemming from the drug use that the drug user may choose to recognize that he has a drug problem (Boys , et al., 2000; Gossop et al., 2002; Tessler & Mechanic, 1978). Thus, the key to the problem recognition is whether or not the drug user makes a connection between his drug use and the consequences of that drug use.

Drug users sometimes make the connection when they experience "hitting bottom" or "hitting rock bottom" (Bell, Montoya, Richard, & Dayton, 1998; Cunningham et al., 1994). However, drug users do not necessarily have to "hit bottom" in order to conclude that drug use is the problem. Often, continuing moderately severe consequences may serve as an impetus for drug users to make the connection, and therefore to choose to recognize their drug use as a problem (Hartnoll, 1992). Likewise, because drug users often experience social pressure from friends and family they may make the connection between the severity of consequences and their drug use (Cunningham et al., 1994). Researchers have found that when the consequences caused by continuous drug use are numerous, and physically, emotionally, or financially debilitating drug users may choose to recognize their use as the problem (Gossop et al., 2002; Hartnoll, 1992; Keene, James, & Willner, 1998).

Desire to Stop

Once drug use is recognized as a problem, the individual must decide whether or not to stop using drugs. This is the second choice point on the route to seeking treatment. At this choice point, the drug user faces three options: to continue using drugs; to reduce drug use; or to stop using drugs completely. Some drug users, despite recognizing that their drug use is a problem, may decide that they prefer the perceived rewards of drug use, therefore choose not to stop using drugs. Other drug users, recognizing that they cannot continue their high level of drug-use with its severe consequences, may choose to reduce their drug use and thereby reduce the severity of the consequences. Still others may recognize that their drug use is itself the problem and therefore have a desire to stop using drugs in order to completely eliminate the problem of drug use and its resulting consequences. The level of problem recognition is thus expected to affect level of desire to stop. With a greater recognition that drug use is the problem, drug users are more likely to attempt to control drug use or to choose to stop drug use completely. Another factor that may affect desire to stop, independent of problem recognition, is social pressure. Social pressure may come from family, friends, and partners (Cunningham et al., 1994).

Desire for Help

Once the individual has acknowledged the desire to stop using drugs, he has to decide how to stop. This leads to seeking different levels of help and represents our third choice point on the route to seeking treatment. Help, as sought by drug users, can be conceptually seen as a continuum.

Some drug users who decide to stop using drugs may decide that external help is not needed. These drug users choose the natural-recovery route, a kind of self-administered drug treatment process. Some individuals are successful at natural recovery. Of those drug users who succeed in stopping, most report stopping in this way. Waldorf and colleagues (Waldorf, Reinarman, & Murphy, 1991) found that of 106 former cocaine users, slightly over 70% had stopped successfully without treatment, the majority at their initial attempt. Among heavy alcohol users, 82% reported recovering without treatment (Sobell, Cunningham, & Sobell, 1996). However, natural recovery is less prevalent among those involved in criminal activities (Walters, 1996).

Along the continuum of desire for help, some other drug users may seek a minimum amount of help. If drug users have concluded that they cannot do it alone, they may select a relatively unstructured help such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Self-help group attendance has been found to be an effective way to stop using drugs for some users (Fiorentine, 1999; Timko, Finney, Moos, & Moos, 1995; Timko, Moos, Finney, & Lesar, 2000; Timko, Moos, Finney, & Moos, 1994).

Finally, some drug users may recognize that they cannot do it alone and need more help. These individuals may decide to enroll in structured outpatient or residential programs. The desire for help is not only reflected in the choice of treatment program; it is also reflected in the drug user's level of engagement in that treatment. Several factors can affect treatment engagement (Fiorentine, 1999; Simpson et al., 1997), including personal characteristics of the drug user such as psychological dysfunction. Other factors are barriers such as time investment and occasionally money investment, or facilitators, such as counselors' skills, variety of therapeutic activities, and ancillary support services.

METHOD

Data for this study were collected as part of the longitudinal continuation of the Risk Networks Study (RNS II), an investigation of relationships involved in risk among a community (non-clinical) sample of drug using and non-using persons and their partners. The sample for the RNS II was drawn from two previously recruited samples: the Risk Networks Study (RNS) and the Hispanic Cocaine Users Study (HCUS). The RNS sample had been recruited through random walk- and peer-driven recruitment methods (Bell, Montoya, & Atkinson,

2000; Bell, Montoya, Atkinson, & Yang, 2002) and the HCUS sample through targeted sampling (Montoya, Patek, Covarrubias, & Graves, 2000).

The second phase of the Risk networks Study (RNS II) recruited 150 persons from the RNS I and 52 persons from the Hispanic Cocaine Users Study (HCUS). One of the consequences of this study design, in which participants who remain have so far been interviewed for upwards of 7 years, is that study participants tend to be stable in residence and in relationships.

The RNS II collected longitudinal data at 3-month intervals. These data included a core instrument that collected individual-level information on drug use, sexual activity, and injection activity, as well as information about the participants' partners and the activities and behaviors engaged in with each. As part of the design of the project, separate trailer instruments that collected data on different topics were also administered at successive waves. This design enabled us to collect a wide variety of information from a diverse population without burdening the participants with an excessively long interview.

The current study examines core data as well as drug use attitudes and treatment data collected during the same interview. Attrition, incarceration, drug treatment facilities, and the longitudinal nature of the study dictate the number of subjects available for analysis. Of 202 drug-using and nonusing participants at baseline, 172 participants completed interviews at the current wave. Data for the current study were analyzed for 71% of the intake sample. Of these, 148 were classified as users of cocaine, heroin, or methamphetamine, and 24 were classified as nonusers. Data for 17 participants were not complete due to a programming error or other missing data. Thus, a subsample of 131 current drug users with complete data was included in all analyses.

Measures

Each participant was coded for gender and race/ethnicity. Race/ethnicity was represented by two dummy variables, Hispanic and Anglo, with African American as the reference group. Employment status was self-reported and was categorized as unemployed and employed (including odd jobs, part-time jobs, and full-time job).

Drug Use

Participants were asked how often they had used crack, powder cocaine, heroin, methamphetamine, and alcohol in the past 30 days. Responses ranged from 0, "never/not used," to 7, "about 4 or more times per day." Level of drug use was measured by taking the maximum value of the responses for all drugs. Severity of drug use was measured by the participant's self-report of whether or not they had binged on crack cocaine in the past 30 days.

Two measures were constructed to measure social pressure. Participants were asked to name partners with whom they had used drugs in the last 30 days. The

number of drug partners was computed as a measure of pressure to continue drug use. Social pressure to stop drug use was assessed by asking the number of people who want the participant to stop using drugs. Because this variable was highly skewed a log transformation was computed.

Choice 1: Problem Recognition — Single items were used to measure the three choices that can lead to treatment. Problem recognition was measured as the number of drug-related problems the participant reported experiencing in the past twelve months. Participants were given a list of problems, including whether or not they had experienced a drug or alcohol related overdose, D.T.s (delirium tremens), alcohol or drug related withdrawal, other health problems related to their use of drugs or alcohol, had experienced trouble finding or keeping a job, had problems with family or friends, problems thinking or doing their work, and problems with the law.

Choice 2: Desire to Stop — Participants were asked how much they wanted to stop using drugs. The responses were coded on a scale from 0 to 5 at the following levels: "don't want to stop using drugs," "don't want to stop, but someone else is making me," "I just want to get my drug use under control," "I want to become an occasional user," "I want to get straight for as long as I can," "I want to quit forever."

Choice 3: Desire for Help — Participants were asked to describe their need for drug treatment. Responses were coded on a scale from 0 to 5 as follows: "don't need drug treatment," "just need to get my drug use under control," "need to go to AA/NA/CA/etc. (a self-help group)," "need to go to detox," "need outpatient drug treatment," "need residential drug treatment."

Reasons for Not Going to Treatment

Participants were asked if they had participated in drug or alcohol treatment in the previous year. Participants who had not had treatment were asked for their main reason for not getting drug or alcohol treatment. These open-ended responses were coded into four categories: drug use is not a problem; drug use is a problem, but no desire to stop; desire to stop, but don't need treatment; and need treatment, but there are barriers.

RESULTS

The entire sample and the subsample of 131 drug-using participants with complete data are described in Table 1. For both the sample and the sub-sample, over half of the participants were male. Almost 60% were African American, less than a third were Hispanic. A majority of the sample participants were over 40 years of age. Slightly under half of the participants were employed. Crack

Table 1. Sample Characteristics

	All participants		Drug users (with complete data)	
	N	%	N	%
Gender				
Male	97	56	74	56
Female	75	44	57	44
Race				
African American	99	58	75	57
Anglo	23	13	16	12
Hispanic	50	29	40	31
Age				
30 and under	19	11	14	11
31-40	52	30	44	34
41 and older	101	29	73	56
Marital status				
Never married	39	23	28	21
Married or living as married	47	27	36	28
Formerly married	86	50	67	51
Employment (Last Three Months)				
Unemployed	90	52	70	53
Employed	82	48	61	47
Drug Use (Last Thirty Days)				
Powder Cocaine	35	20	35	27
Crack Cocaine	92	54	87	66
Heroin	27	16	25	19
Methamphetamine	7	4	6	5
N	172		131	

cocaine was the most frequently reported drug used. Two-thirds of the drug users reported having used crack in the last 30 days.

Each of the three variables representing choice points was regressed on the predictor variables listed above and on the previous choice variables. The results of the regression analyses are shown in Table 2.

The first regression analysis was used to examine the predictors of problem recognition ($F = 3.51$; $df = 10,120$; $p < .001$). We expected that the level and severity of drug use would predict the level of problem recognition. We found

Table 2. Predictors of the Choices Leading to Seeking Treatment

Independent variables	Problem recognition	Desire to stop using drugs	Desire for help
Level of alcohol use	.108	−.140	−.122
Level of drug use	−.139	−.109	.052
Severity of drug use	.230*	−.060	.246*
Number of drug use partners	.068	−.025	−.140
Social pressure to stop	.259**	.261**	−.028
Female	.017	.047	−.187*
Anglo	.357**	−.338**	−.051
Hispanic	.057	−.937	−.013
Employment status	−.034	.153	−.171*
Living arrangements	−.077	−.037	−.038
Problem recognition	—	.256**	.346**
Desire to stop using drugs		—	.157
R^2	.226	.252	.264

*$p < .05$. **$p < .01$.

that the severity of drug use had a significant effect on problem recognition, but that the level of drug use did not significantly predict problem recognition. In addition, social pressure had a significant effect on problem recognition. Anglo participants were more likely to recognize having a drug problem than were African American participants.

The second regression analysis was used to account for the desire to stop using drugs ($F = 3.61$; $df = 11,119$; $p < .001$). As expected, desire to stop using drugs was significantly predicted by problem recognition and social pressure. In addition, Anglos had less of a desire to stop.

The third regression analysis was used to predict the desire for help. Problem recognition significantly predicted the desire for help ($F = 3.52$; $df = 12,118$; $p < .001$). Individuals who had binged in the last 30 days had a greater desire for help. In addition, women and those who were employed reported a lower desire for help.

In order to examine the distribution of study participants along the continuum of treatment motivation, we asked current drug users why they were not in treatment (Figure 2). Of the 131 drug users on whom we had complete data, 66% were classified as recognizing that drug use was creating a problem in their lives, while 34% did not think they had a problem. Of the drug users, 39% not only recognized
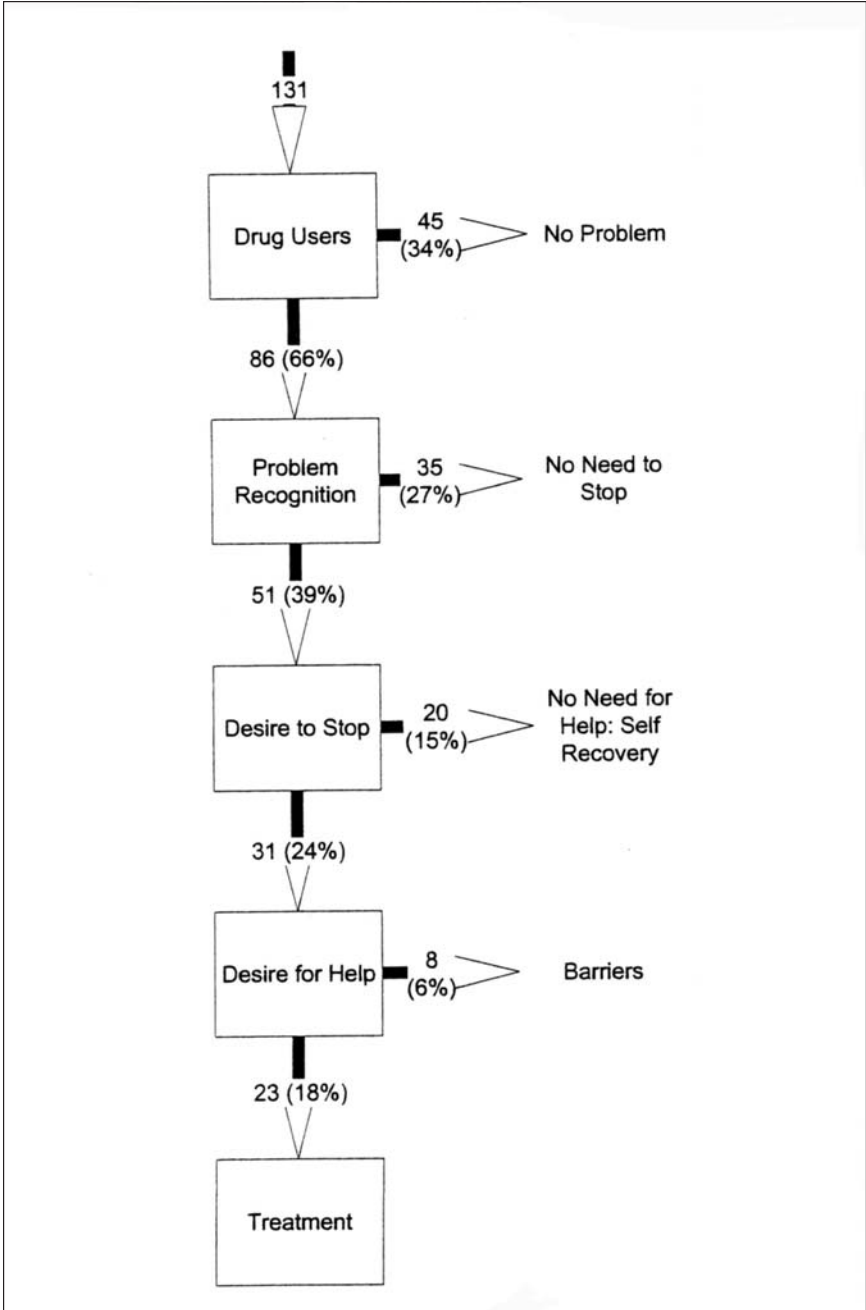
Figure 2. Choice points in the process of treatment seeking.

that they had a problem but also believed they needed to stop using drugs. Only 24% of the sample were classified as desiring help in giving up drugs through agencies such as drug treatment programs. Of these, 6% had experienced some sort of barrier to treatment, so that only 18% of the community sample of drug users were currently entered in treatment of some kind.

DISCUSSION

Because of the many costs to individuals, to families, and to society, it is socially desirable that drug users seek treatment. Nevertheless, even when drug treatment is available, most drug users do not voluntarily seek treatment. We use the metaphor of the highway to examine this sequence of voluntary decisions by which a person comes to desire treatment. Because drug use is a chronic, relapsing disease (Leshner, 1999), the road from use to recovery can be long, with many detours and barriers.

We approach the change process from the point of view of the sequence of choices that drug users must confront before they voluntarily seek treatment. These choice points mark the transitions from one stage of change to the next (Prochaska et al., 1992). The approach that we use is informed by Simpson and colleagues (1993) and by De Leon and colleagues (1986). In this approach, we look at the sequence of choices that leads to treatment seeking. That is, along the highway from drug use to treatment, there are a series of choice points where one must choose to stay on the highway and continue or else leave it.

The first choice point we considered was the recognition that drug use is a problem. We found that 66% of the drug users on whom we had adequate data recognized that drug use is a problem (and conversely, 34% did not consider the consequences of drug use to rise to the level of a problem). The expectation that problem recognition would be predicted by drug use was partially sustained. Severity of drug use, measured as the number of times the participant reported going on a binge in the previous 30 days, predicted the level of problem recognition, but frequency of drug use by itself did not. It appeared that more frequent drug users were not more likely to recognize the consequences of their drug use as being a problem , compared to less frequent drug users. The level of problem recognition was also predicted by social pressure from friends and family to stop using drugs.

The second choice point involved a drug user's decision to stop using drugs. A person who recognizes that drug use is causing problems may still decide that the problems are not severe enough to warrant giving up the "benefits" of drug use. Although we found that 66% of the sample recognized that drug use was a problem, only 39% of drug users in our community sample had reached the point of desiring to stop. We found that, as expected, the level of desire to stop using drugs was significantly predicted by the recognition of drug use as a problem, as well as by social pressure to stop.

A person who desires to stop using drugs has the first option to take care of it herself. This is the route of natural recovery (Miller, 1998; Russell et al., 2001). This is often the first route that a drug user takes. Those drug users for whom natural recovery is not a solution may choose to seek help. Of all the drug users in our sample, we found that 24% of them expressed a desire for help (compared to 15% who, while expressing a desire to stop, did not seek help). We found that the desire for help was statistically related to problem recognition, but not to the desire to stop using drugs. We suspect that this apparently anomalous result occurred because of those choosing natural recovery as a way to stop using drugs rather than choosing outside help in the form of a treatment program. Although desire for help was not significantly predicted by desire to stop, we found that the desire for help was predicted by problem recognition. It was independently related to severity of drug use and negative related to employment status. Severity had an independent effect besides its effect on problem recognition; thus binging not only led a drug user to recognize that drug use was a problem, but also led him to recognize that help would be needed to quit.

We must acknowledge a number of limitations in these data. Drug users constitute a hidden population, so the representativeness of the sample cannot be known for sure. Because of the longitudinal study design, the participants were recruited and retained tended to be relatively stable. For example, all study participants, drug users and nonusers, were covered by publicly funded health insurance. Furthermore, there is no single "drug culture." Drug users experience different social environments and different social networks even within a given neighborhood. In addition, cities differ in the drugs preferred, and in economic and political background. Thus, we cannot claim universal generality for the results we report here. And lastly, the approach that we describe here applies to voluntary seeking of treatment. For many drug users, especially those whose drug use has led to a confrontation with the criminal justice system, treatment is mandated involuntarily. We do not examine the issue of involuntary treatment here.

Using the metaphor of a highway to think about the process of recovery from drug use, we found that the road to recovery has many off-ramps. We found that as many as one-third of our sample had no intention of entering the highway in the first place. They apparently did not perceive problems from their drug use. Furthermore, of those who recognized their drug use as a problem, most of them either did not want to stop or felt that if they were to stop they could do so without help. Only 24% of drug users in our sample felt any desire for help in stopping their drug use, and only 18% actually entered any kind of treatment. This figure is comparable with 13% of the drug users who seek treatment found in the Substance Abuse and Mental Health Association study (SAMHSA, 2004).

Our results suggest that treatment barriers are actually a small part of the problem of getting drug users to treatment. Most drug users do not get to the point where barriers prevent treatment. Only 6% of our entire sample was affected

by barriers. As much as 76% of the sample never got to the point of desiring treatment and thus being confronted by barriers.

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