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Possible barriers to enrollment in substance abuse treatment among a diverse sample of Asian Americans and Pacific Islanders: Opinions of treatment clients

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ABSTRACT

This mixed methods study examined motivations and barriers to substance abuse treatment entry and treatment continuation among Asian American and Pacific Islander (AAPI) substance users. AAPI substance users ($N = 61$) were recruited from substance abuse treatment programs in California and Hawaii. Semi-structured interviews and interviewer-administered surveys assessed barriers and facilitators to entering substance abuse treatment. Barriers included peer pressure, family influences, and face loss concerns. Facilitators included peer support, involvement in the criminal justice system, a perceived need for treatment, and culturally competent substance abuse treatment services. Family and peer influences may act as both facilitators and impediments. AAPI substance using populations face many of the same individual-level and structural and systems barriers to entry to treatment as other substance using populations. However, similar to other racial/ethnic minority groups, it is important to address cultural differences and develop culturally competent substance abuse treatments for the AAPI population.

1. Introduction

Asian Americans and Pacific Islanders (AAPI) are one of the fastest growing groups in the United States comprising about 6% of the total population (U.S. Census Bureau, 2011). AAPIs comprise many different ethnicities, languages, cultures, a full range of socioeconomic groups, and different immigration patterns to the United States. The majority of AAPIs, about 67% are foreign born (U.S. Census Bureau, 2010), which illustrates how immigration to the United States continues. Information about substance use disorders (SUDs) among AAPIs is needed to identify possible health disparities within AAPI groups and to better address treatment needs.

Available data suggest that Asian Americans, in contrast to Pacific Islanders, have relatively low rates of SUDs compared to other racial/ethnic groups in the United States. In the aggregate, AAPIs use less alcohol and drugs, but substance use varies across AAPI subgroups. Pacific Islanders in the United States and Native Hawaiians have the highest rate of illicit substance use compared to all other ethnic groups (Substance Abuse and Health Services Administration, 2004). In a comparison of Asian American subgroups, Japanese Americans had the highest rate of alcohol use compared to other Asian American sub-groups, while Filipino Americans and Vietnamese Americans had the highest rates of illicit substance use (Price, Risk, Wong, & Klingle, 2002) compared to other Asian American sub-groups.

AAPIs underutilize health care services including substance abuse treatment services (Le Meyer, Zane, Cho, & Takeuchi, 2009; Yu, Clark, Chandra, Dias, & Lai, 2009). Sakai, Ho, Shore, Risk, and Price (2005) found that AAPIs with past-year substance dependence were less likely than substance-dependent Caucasians to report past-year treatment. From another perspective, in 2005 AAPIs accounted for 1.9% of illicit drug use in U.S. adults and for 1.3% of adult clients entering substance abuse treatment for the first time, which is a higher rate of first-time treatment than other racial/ethnic groups (Wong & Barnett, 2010). Some AAPIs with SUDs may delay treatment because they perceive that treatment program staff may not speak their native language, or AAPIs may be illegal immigrants who are afraid to reveal their immigration status (Yu et al., 2009). In a study of AAPIs enrolled in publicly funded treatment programs in California, however, AAPIs reported significantly fewer problems relative to a non-AAPI comparison group (Niv, Wong, & Hser, 2007). AAPIs entering drug treatment had more stable living conditions, lower

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levels of alcohol and drug use severity, and less criminal involvement. They viewed alcohol and drug treatment as significantly less important than the comparison group, and used less medical and psychiatric services while using significantly more legal services (Niv et al., 2007).

Previous studies of barriers to enrollment of substance abuse treatment showed that individuals with SUDs see personal factors as a common obstacle, such as not being ready for treatment, shame over revealing an SUD to friends, family members, and coworkers, or negative consequences from government agencies, such as a loss of custody or housing (Appel & Oldak, 2007; Grant, 1997). Appel and Oldak argue that personal factors were less of a barrier for enrollment in substance abuse treatment than treatment accessibility and availability, such as how to pay for treatment or having a means to travel to treatment.

AAPIs may share the same barriers to enrolling in substance abuse treatment as other racial/ethnic groups in the United States, but AAPIs may have unique barriers. For example, a common pathway for AAPIs who enroll in substance abuse treatment is through the criminal justice system. Park, Shibusawa, Yoon, and Son (2010), for example, reported that 95% of Chinese American and Korean American participants were mandated to enroll in alcohol abuse treatment by criminal justice system, but the AAPI participants in their study did not believe that they had any alcohol problems, which is similar to previous studies by Appel and Oldak (2007) and Grant (1997). Cultural factors may prevent AAPIs from seeking treatment for their SUDs (Fong & Tsuang, 2007). It appears that AAPIs use fewer substance abuse treatment services than other racial/ethnic groups in the United States, but the reasons for lower utilization are unknown. Individuals with SUDs, regardless of race/ethnicity, may avoid enrollment in treatment with SUDs to avoid embarrassment or shame (Grant, 1997), but AAPIs may not only experience personal shame from revealing a SUD to intimates and coworkers; AAPIs may also avoid substance abuse treatment because revealing a SUD to the AAPI community may bring shame to their family, and family members may pressure the individual with a SUD to solve the problem within the family (Sakai et al., 2005; Zane & Yeh, 2002). Whether AAPIs have unique barriers to entering substance abuse treatment is unknown since little information is available about the characteristics of AAPIs that seek treatment and the individual and structural/environmental factors that contribute to underutilization of substance abuse treatment services among AAPIs. Additional studies are required to address possible reasons for underutilization of substance abuse treatment services.

The purpose of this study was to identify and explore the possible barriers that may prevent AAPIs with SUDs from enrolling in substance abuse treatment. Past studies suggest that AAPIs tend to under-report SUDs and under-utilize substance abuse treatment services, but few studies have conducted more in-depth interviews with substance abuse treatment clients to explore their opinions as to why AAPIs may or may not enroll in substance abuse treatment. This exploratory study is a starting point for future studies to address this issue. Using a mixed methods research design, we asked AAPI substance abuse treatment clients to indicate the extent to which previously established barriers to substance abuse treatment were viewed as influencing their decisions to enroll in substance abuse treatment. We asked AAPI participants about their perceptions regarding practical barriers to treatment such as cost, location, eligibility, availability of services, and long waiting times. Given that a large percentage of AAPIs in the United States are foreign born, we expected AAPI clients would prefer substance abuse programs that provided services in their native language and addressed AAPI cultural issues. We also expected cultural factors to influence help seeking behaviors, including the role of the family, face loss concerns, and experiences of recent immigration to the United States.

2. Methods

2.1. Setting

The study was conducted in substance abuse treatment programs in California (Daly City, Los Angeles, San Jose, and San Francisco) and Hawaii (Hilo) to achieve a diverse ethnic sample of AAPIs. Daly City, CA has the largest concentration of Filipino Americans in the United States and the treatment program in Daly City primarily treated Filipino Americans. San Jose, CA has the second largest concentration of Vietnamese Americans in the United States, and we recruited Vietnamese participants at a treatment program in San Jose to include these individuals. We recruited Native Hawaiians and Pacific Islanders from a treatment program in Hilo, HI. The substance abuse treatment programs in this study specialized in providing culturally sensitive services for AAPIs. Programs had links to the criminal justice system and many clients were referrals from the criminal justice system. Attempts were made by the programs to offer services to clients who did not speak English. Although programs enrolled clients who were not AAPIs, treatment groups were formed based on AAPI group membership. For example, in some cases treatment groups were composed solely of Filipino Americans or monolingual Vietnamese speaking clients. Similarly, treatment was often provided by counselors who were AAPIs.

2.2. Procedures

Institutional review boards at the University of California, San Francisco, University of California, Los Angeles, and Oregon Health and Science University reviewed and approved study procedures. Participants who were enrolled in substance abuse treatment were recruited using flyers posted and distributed by clinicians at the substance abuse treatment programs. Semi-structured interviews and interviewer-administered questionnaires were conducted by trained Asian American interviewers in study sites in California. Interviewers were trained on the administration of standardized instruments and the use of data collection forms and interview guides. A non-Asian interviewer conducted interviews in Hawaii. Interviews were digitally recorded and transcribed. For interviews conducted in Vietnamese and Chinese, the participants' responses were translated into English by the bilingual interviewers who conducted the interviews. Filipino American, Korean American, and Japanese American participants were interviewed in English. Participants were paid with a $25 gift card for completing the study interview.

2.3. Measures

The semi-structured interview guide included open-ended questions about participants' substance abuse treatment experiences and that of their friends. Specifically, interview topics included past and present help seeking experiences, treatment history and perceptions of substance abuse treatment programs, help seeking by others in their social network, and perceptions of the role of family, culture, and language in influencing help seeking behaviors. The structured section of the interview included questions about participants' socioeconomic and demographic backgrounds, drug and alcohol use from the Addiction Severity Index (ASI; McLellan et al., 1992), and questions regarding potential barriers and facilitators related to substance abuse treatment entry. Participants were provided with a checklist of potential barriers and facilitators to substance abuse treatment and indicated their agreement by checking yes or no. To create a checklist of potential barriers we used items from the Barriers and Facilitators Form (Huba, Melchoir, Staff of the Measurement Group, & HRSA/HAB SPNS Cooperative Agreement Steering Committee, 1997) and included items previously cited by substance using populations as obstacles to enrolling in substance abuse

treatment (Appel & Oldak, 2007). In addition, cultural barriers that may impact the ability of AAPIs to receive care were also included in the checklist (Fong & Tsuang, 2007; Yu et al., 2009).

2.4. Qualitative data coding and analyses

The first step in the coding process involved open coding by four readers who reviewed the transcripts and discussed the emerging themes. The readers were blind to the racial and demographic characteristics of the participant's transcript. Using a content analysis approach, readers refined their notions about the themes and potential ways of coding the responses. Thematic codes were developed inductively as successive transcripts were reviewed, allowing the data to dictate the analytic categories. Readers continued reading and revising until no new codes emerged from the data. Through this iterative process of coding, review, discussion and revision, thematic codes were documented in a code book for categorizing responses. Transcripts were entered into ATLAS.ti (Scientific Software Development, Gmbh, ATLAS.ti Version 6.1.16. [Computer software], 2011) and the codes established from the code book were applied to the data set to facilitate organization and retrieval of text for qualitative analysis.

Research staff took several steps to increase methodological rigor: (a) multiple researchers participated in data coding and analysis to ensure multiple viewpoints and discussion of perceptions of data, (b) evaluators sought consensus on coder agreement to ensure more accurate coding, (c) and to ensure consistency across coders, we examined agreement across a random selection of interviews (10%; $n = 6$). An additional researcher reviewed inconsistencies between primary coders to resolve inconsistencies. Inter-coder reliability averaged 82% agreement between the coders (range 63% to 96%). All items with discrepant codes were discussed between coders until consensus was reached. Once all transcripts were coded, passages coded with individual themes were extracted from the data set for analysis.

2.5. Quantitative data analysis

Quantitative analysis consisted of descriptive statistics of participant demographic characteristics, responses to items on the alcohol and drug use sections of the ASI, and items on the checklist of barriers and facilitators to substance abuse treatment entry. Results of the content analysis were also described. Specifically, the frequency of participants who reported each theme was calculated, and frequencies for each racial/ethnic group were compared. All statistical analyses were performed using SAS version 9.2. (SAS Institute, Inc., Cary, NC; SAS Institute Inc., 2002).

3. Results

3.1. Participants

Substance abuse treatment clients ($N = 61$) included 17 multi-ethnic AAPIs (27%), 15 Filipino Americans (25%), 10 Vietnamese Americans (16%), 7 Chinese Americans (11%), 6 Korean Americans (10%), 3 Japanese Americans (5%), 2 other AAPI ethnicity (3%), and 1 Native Hawaiian (2%). Of the participants who reported multiple ethnicities, at least one of the other ethnicities was Asian, Native Hawaiian or Pacific Islander. All eight participants in Hawaii who reported multiple ethnicities reported one of their ethnicities as Native Hawaiian, which was expected considering that in Hawaii very few people indigenous to Hawaii are not members of another race/ethnicity. The Vietnamese American participants were mono-lingual and their interviews were conducted in Vietnamese. Two of the Chinese American participants were mono-lingual and their interviews were conducted in Chinese. Participants were required to be at least 18 years old, self-identify as Asian or Pacific Islander, and able to speak English, Vietnamese, or Chinese.

Demographic and substance use characteristics of AAPI clients from the three recruitment sites are presented in Table 1. All participants in the Hawaii subsample were born in the United States, and the majority of participants in the Los Angeles

Table 1
Participant demographic and substance use characteristics by recruitment site.

Characteristic	San Francisco Bay Area ($n = 40$)		Los Angeles ($n = 11$)		Hilo, Hawaii ($n = 10$)		Total	
	n	%	*n*	%	*n*	%	*n*	%
Male	32	80	8	73	3	30	43	71
U.S. born	11	27	8	73	10	100	29	48
First language learned Asian/Pacific Islander	29	72	3	27	–	–	32	53
Usual language spoken at home Asian/Pacific Islander	25	62	2	18	–	–	27	44
Ethnicity								
Filipino	15	38	–	–	–	–	15	25
Chinese	6	15	1	9	–	–	7	12
Vietnamese	10	25	–	–	–	–	10	16
Japanese	–	–	2	18	1	10	3	5
Korean	1	3	5	45	–	–	6	10
Native Hawaiian	–	–	–	–	1	10	1	2
Other AAPI ethnicity	2	3	–	–	–	–	2	3
Multiple Ethnicities	6	15	3	27	8	80	17	28
Never married	19	48	7	64	6	60	32	53
Unemployed	25	63	6	55	6	60	37	61
At least high school/GED	24	60	10	91	8	80	42	69
Living in house/apartment (rent/own)	10	25	–	–	3	30	13	21
Income less than $10,000	34	85	6	55	9	90	49	80
Past alcohol treatment	9	23	1	9	7	70	17	28
Past drug treatment	31	78	9	82	9	90	49	80
Age								
18–19	–	–	2	18	–	–	2	3
20–29	7	18	2	18	3	30	12	20
30–39	12	30	4	36	6	60	22	36
40–49	11	28	2	18	1	10	14	23
50–59	8	20	1	1	–	–	9	15
60 and above	2	5	–	–	–	–	2	3

subsample were born in the United States. In contrast, the majority of the 40 participants in the San Francisco Bay Area subsample were immigrants (73%; $n = 29$). Regarding history of substance use, 25 of the 40 participants in the San Francisco Bay Area subsample had a history of cocaine use and 19 had used amphetamines. In the Los Angeles subsample, 9 of the 10 participants had used amphetamines, 8 had used hallucinogens, 6 had a history of alcohol abuse, and 5 had used sedatives. In Hawaii, 9 of the 10 participants had a history of alcohol abuse, 8 had used amphetamines, 7 had used cocaine, and 5 had used opioids. With respect to recent use, participants were currently enrolled in substance abuse treatment, and thus, many participants reported low levels of substance use during the 30 days prior to the interview. In the San Francisco Bay Area subsample, 22 (55%) participants did not use any substances in the last 30 days; 10 (91%) did not use any substances in the Los Angeles subsample, and 8 (80%) in the Hawaii subsample.

3.2. Qualitative analysis

3.2.1. Themes

Seven primary categories of themes emerged from the content analysis of participants' responses to interview questions. The seven categories along with the number of respondents who reported at least one response in each category were as follows: peer support ($n = 17$, 28%), peer pressure from drug users ($n = 28$, 46%), involvement in the criminal justice system ($n = 27$, 44%), perceived need for treatment ($n = 21$, 34%), family influences ($n = 14$, 23%), culturally competent substance abuse treatment ($n = 9$, 15%), and face loss concerns and shame ($n = 6$, 10%).

3.2.2. Peer support

Respondents across all AAPI ethnic groups indicated that having friends that did not abuse drugs or having friends who had a history of substance abuse, but were currently abstinent, served as role models. These individuals supported respondents' efforts to complete substance abuse treatment.

> I had a couple of friends that told me about this program. It was easier for me when I actually saw them doing the program. Anybody can talk, but these guys were talking and they were walking it. They were happy. I saw them getting their families back together, good relationships with their parents. Just everything around them was positive. That's what I wanted too.

3.2.3. Peer pressure from drug users

Similar to substance users from other racial/ethnic groups, across all AAPI ethnic groups, associating with drug using peers prevented many participants from seeking treatment, but almost all participants of Native Hawaiian decent living in Hawaii reported peer pressure to use drugs. AAPI participants felt isolated from their families as they continued to keep the company of drug using peers. They turned to substance use to cope with these feelings of isolation.

> [My drug using friends] don't have jobs. They don't go to work. They don't go to school. We have to actually get clean in order to do things like that. So we've become outcasts in our families. We get shamed, and then we get more into the addiction because we're ashamed.

> All my friends smoked, so they didn't even think about it themselves. The good friends that I have…I didn't bother making connections with them due to the shame I felt. That is the reason why I was keeping contact with friends that [smoked]. So, when I tried to call my good friends, I felt ashamed. They probably thought that I [was] calling them to ask for help with money to smoke. This was why I don't call my good friends.

> When I first came to the United States, I did not seek treatment. I was in the phase of having fun and met bad friends who used cocaine. I tried it. I started smoking crack.

Other respondents discussed the potentially socially disruptive consequences of entering treatment and committing to a lifestyle of abstinence. For example, some discussed that successful treatment meant that they had to stop socializing with drug using friends and avoid environments in which others were using drugs. Respondents often experienced conflict between the loss of social relationships with drug using friends and the potential cost of maintaining friendships that could undermine their efforts to stay clean.

> …a lot of the relationships I had were based on selling drugs and based on doing drugs. There was only a handful of people that stuck with me as friends doing this, and I don't even really see them as much anymore because they know I'm in a treatment program.

> If I go to treatment, I lose my friends…[or] I can't finish the program or the treatment because I live at the drug house. ….Everything is [about] drugs over there."

3.2.4. Involvement in the criminal justice system

Encounters with the criminal justice system including child protective services were cited as instrumental in helping individuals access substance abuse treatment services across all AAPI ethnic groups. Respondents came into contact with the criminal justice system following arrests for drug possession, use, or sale. Others came to the attention of law enforcement officials because of charges of child abuse or neglect. Many discussed that they were found guilty of the offence and offered treatment for their addiction in lieu of jail time. In many cases, respondents chose to enter treatment.

> My house was raided and my dog was taken by the humane services. I had a dog, but the officers saw that we weren't taking care of the dog, not feeding it etc., so they took it away. That is when I was placed into this program. In the beginning, I thought that I just needed to place bail, but when they checked my records, they put me on probation and instructed me to come to this program.

> I consider [my arrest] as a blessing though…what's the difference between [being] mandated versus a person who just walked in here?…I haven't seen the clarity yet, but I think it's my journey.

3.2.5. Perceived need for treatment

A personal recognition that the participant had an addiction was a powerful motivator for seeking substance abuse treatment. Acknowledgement of the negative social consequences of addiction facilitated entry into substance abuse treatment.

> I didn't spend Christmas with my family because I had passed out, and I slept for 25 hours. And that was the first time in my life [that] I'd never spent Christmas with my family. That's when I knew I had a problem.

> The first time I came here was when I started to realize that I really needed help and started to…realize that I wasn't going to be able to just quit on my own, like I thought. My dad is like, why don't you just stop? I guess I thought that too. Why don't I just stop? I don't need one of these kinds of places or whatever. And I guess at some point I just realized I wasn't stopping on my own, like my plan. It just wasn't happening, so, I came here.

Across AAPI ethnic groups, many participants referred themselves to treatment, but Filipino participants, Vietnamese participants, and

participants of Native Hawaiian decent were less likely to refer themselves to treatment.

3.2.6. Family influences

Depending on the family, members of a family can facilitate treatment or hinder treatment. They may facilitate treatment by withdrawing financial support, encouraging the respondent to enroll in substance abuse treatment, or pressuring the respondent to remain in substance abuse treatment.

> [My father said] I don't want you home. You're a disgrace. If you stay here [at the treatment program], we will accept you back. But otherwise, I don't want you around.

In other families, however, family members may have hindered treatment by expecting the respondent to contribute to the income of the entire family, yet attending treatment was seen as interfering with this obligation. Furthermore, family members did not understand the potential benefits of substance abuse treatment. This often caused conflict about remaining in treatment.

> My mom says I gotta get a job. When I told my mom I have to go to treatment first she didn't understand it. It's very important to me how she feels about me or thinks about what I'm doing. And so that was a conflict….

Family members could also hamper treatment success if family members used alcohol and illicit substances as well. In particular, some participants in Hawaii reported that achieving and maintaining abstinence were difficult when family members, especially family members who lived with the participant, also used illicit substances.

> I function more when I'm stoned…I still like [to] smoke…Maybe down the line, who knows? I might smoke or I might not smoke. It depends on how I do in this program and how it's helping me when I get out. I'm still working on it. My whole family all burn and half of them drink.

Family members may also have hampered treatment once the client entered treatment. Some clients discontinued treatment because they found it difficult to conceal the fact they were in treatment from disapproving family members.

> I didn't want them to know I had a problem. And that was one of the things that almost made me leave….It took me about 2 months to tell my mom that I was here…She thought I was at work. I was lying…I'd been lying to everybody about everything in my addiction because I want to seem like I've got it together. I want to seem like these expectations that people had of me are met.

3.2.7. Culturally competent substance abuse treatment

Respondents reported that receiving services from culturally competent substance abuse treatment staff, or staff that provided services in the respondent's native language, was preferred. Participants believed that receiving services from staff that were of a similar ethnic background facilitated the counseling process. Counselors that were sensitive to cultural nuances were viewed as more effective.

> It kind of amazes me sometimes that they can actually relate because there are not a lot of people outside that actually can relate, and that know about drugs. When I called my mom the first time, I was crying because I didn't want to tell her I was scared. And the guy that was on shift that night, he was Chinese, and he [understood] everything I was going through, and that made me feel better about actually calling her.

> Of course they have separate Mandarin groups and stuff like that. And the Mandarin folks, I identify with them a lot easier than others, and so there is an Asian cultural thing…we just know each other a little bit; we know our behaviors a little bit.

3.2.8. Face loss concerns and shame

A few participants reported concerns over losing face and feeling shame because they had a SUD. These participants were Filipino participants from San Francisco and participants of Native Hawaiian decent. Concerns over losing face or feeling shame may be one reason for not seeking help (Zane & Yeh, 2002). These respondents described how AAPI family members would rather hide the fact that they had a SUD rather than face the possible shame. Often, the substance abusing individual was reluctant to disclose personal information to individuals outside the family. As a consequence, these participants felt pressure to resolve drug issues on their own or within the family.

> Most people that I know would not seek treatment…although [my father] hated me using…it's harder for him to know that I'm coming here and getting treatment than using. He's so uncomfortable with the fact that I'm going somewhere,…[and] that I couldn't solve the problem myself…that we couldn't solve it in our own family…[Another issue is] how it makes the family look…how shameful, how embarrassing, and [so], what do I talk about here? What are people going to think? You know, now people are going to know. [My father is] so uncomfortable talking about it, and I'm uncomfortable talking about it to him because it's just awkward.

3.3. Quantitative results

On the checklist of potential barriers to substance abuse treatment, endorsement of barriers ranged from 5% to 39%. The most frequently endorsed barrier to substance abuse treatment entry was a fear of loss of confidentiality ($n = 24$; 39%), but Filipino and Vietnamese participants were more concerned about a loss of confidentiality, and Korean participants were less concerned, than other AAPI ethnic groups. A belief that their substance abuse problem was not bad enough ($n = 23$; 38%) and a fear of losing one's employment ($n = 23$; 38%) were reported as barriers across all AAPI ethnic groups. Not knowing where to get services ($n = 22$; 36%) was a barrier for treatment entry reported across all AAPI ethnic groups, but Filipino and Vietnamese participants were less likely to know where to get services than other AAPI ethnic groups. Similarly, long waiting times to enter substance abuse treatment was a concern expressed across AAPI ethnic groups ($n = 22$; 36%), but Filipino, Vietnamese, and Korean participants more frequently expressed this concern than other AAPI ethnic groups. Korean and Vietnamese participants were more concerned with how to pay for treatment than other AAPI ethnic groups, but 26% ($n = 16$) of the sample expressed this concern. Similarly 26% ($n = 16$) of the sample expressed a concern that they were not eligible to receive services, but Vietnamese participants were more likely to express this concern than other AAPI ethnic groups. Across all AAPI ethnic groups few participants reported that family and friends were against substance abuse treatment ($n = 11$; 18%), but Filipino participants were more likely to report that family and friends were against substance abuse treatment ($n = 5$). Immigration status was not a concern for most AAPI ethnic groups with the exception of Filipino participants who were concerned about their immigration status ($n = 4$). Finally, few participants expressed concerns that treatment providers would not understand their culture ($n = 7$; 12%) or speak their native language ($n = 9$; 15%).

4. Discussion

In this exploratory analysis, we examined the treatment experiences of AAPIs enrolled in substance abuse treatment. Although these individuals may differ from AAPIs who have a SUD, but do not seek

treatment, this sample provides preliminary information about the possible barriers that may prevent AAPIs with SUDs from entering substance abuse treatment. The quantitative analysis focused on previously studied barriers among substance using populations. Using qualitative research methods, we explored and identified additional factors that were not previously explored among AAPIs with SUDs. We discuss each barrier that hindered enrollment in substance abuse treatment, and we discuss differences among AAPI ethnic groups when they were observed.

A frequently cited barrier and facilitator concerned relationships with peers. In the qualitative analysis, some participants across all AAPI ethnic groups reported that they viewed drug using peers as hindering the treatment process. It is worth noting, however, that all participants of Native Hawaiian decent in Hawaii experienced peer pressure to use substances. Similar to substance users from other racial/ethnic groups, associating with drug using peers prevented participants from seeking treatment (Buchanan & Latkin, 2008). AAPI respondents reported that it was necessary to avoid environments that elicit and maintain substance abuse and to avoid the negative influence of substance using friends. Social networks that provide models of abstinence are necessary for the treatment of substance use disorders.

Many participants seeking treatment in the programs from which they were recruited reported in the qualitative analysis that they were mandated to treatment by the criminal justice system. In a comparison of AAPI ethnic groups across sites, almost half of the participants were referred by the criminal justice system. This finding is consistent with the previous studies of Niv et al. (2007) and Park et al. (2010). In a sample of 452 AAPI and a matched sample of 403 non-AAPI persons who were admitted to drug abuse treatment programs, Niv et al. reported that more than 50% were on parole. Park et al. reported that 75% of their sample of 211 Asian Americans receiving outpatient substance abuse treatment was mandated to receive alcohol treatment by the criminal justice system. There are many possible reasons for referral from the criminal justice system, such as the sale of illicit substances, possession of an illegal substance, or operating a motor vehicle while intoxicated. The finding that AAPI substance abusing clients tend to only enter treatment when prosecuted for a criminal offense suggests that some AAPI participants attempted to hide or minimize their substance use, and only entered treatment when absolutely necessary.

In the quantitative analysis, many respondents reported concerns related to a loss of confidentiality and fears of losing one's employment. It is possible that respondents were afraid that if their employers discovered their SUDs, they would lose their jobs. Another possibility is that a loss of confidentiality is related to a fear of deportation. Filipino and Vietnamese participants were more likely to express concerns about their immigration status as well as expressing more concerns about a loss of confidentiality than other AAPI ethnic groups. Similar to many SUD clients, about 38% did not believe that their substance abuse problem was bad enough to warrant treatment (Appel & Oldak, 2007). Consistent with this finding, in our qualitative analysis, about 34% of the participants reported that when they recognized their SUDs was adversely impacting their lives, they were motivated to enter treatment.

The quantitative analysis showed that AAPI respondents, similar to other substance using populations, perceived that structural and systems barriers would prevent them from receiving substance abuse treatment services (Appel, Ellison, Jansky, & Oldak, 2004; Appel & Oldak, 2007). Specifically, they reported that they did not know where to get services, anticipated long waiting times, did not know how to pay for treatment and believed that they were not eligible to receive services.

Both quantitative and qualitative analyses identified how family members may hinder treatment. AAPI family members may minimize SUDs to save face (Naegle, Ng, Barron, & Lai, 2002). There is a reluctance to seek outside assistance for a SUD because it may reflect the family's inability to solve the situation, and may be inconsistent with the cultural mandate to maintain an appearance of harmony within the family (Fong & Tsuang, 2007). Participants reported that family members may not be supportive of substance abuse treatment, may be unfamiliar with the treatment process, and might view substance abuse treatment as interfering with family obligations to provide financial resources to benefit the family as a whole. In contrast, some families did see the merit of substance abuse treatment and pressured the substance user to enter and complete treatment. These differing opinions among APPI families may indicate that substance abuse treatment is not widely accepted in the AAPI community and that dissemination efforts should be used to inform the AAPI community about evidence-based substance abuse treatments and of the benefits of these approaches.

As demonstrated in both qualitative and quantitative data, approximately 15% of the participants reported they preferred culturally competent substance abuse treatment programs. Given that participants were recruited from substance abuse treatment programs that addressed the cultural and language needs of AAPIs, it is reasonable to expect the majority of the participants to not view cultural competence issues as a pressing concern. Of the individuals that were concerned about treatment programs addressing their cultural needs, an understanding of the clients' cultural background and ability to provide services in their native language were preferred. Our findings suggest that in order to reduce cultural barriers and enhance the treatment systems' effectiveness to treat AAPI clients, the workforce should be expanded to include trained health and social service providers that are familiar with AAPI beliefs and values, health-seeking behaviors, and culturally relevant treatment strategies (Fong & Tsuang, 2007; Yu et al., 2009).

The “fear of losing face” may result in denial of substance abuse problems, and may influence AAPI substance users' motivation to voluntarily seek substance abuse treatment (Sue & Sue, 1987). In contrast to our expectations, only 10% of our sample reported concerns over “losing face” (Fong & Tsuang, 2007; Park et al., 2010). One possible explanation is that our participants were enrolled in substance abuse treatment and were less concerned with saving face than AAPIs who use illicit substances or do not seek substance abuse treatment. Additional studies are needed to better understand the role that “saving face” plays in the initiation of substance use and voluntarily seeking substance abuse treatment (Zane & Yeh, 2002).

Several limitations of the study should be acknowledged. It is important to note that this study was exploratory, and assessed barriers to entering substance abuse treatment among a sample of individuals already enrolled in substance abuse treatment. Thus, the findings from this study may not generalize to AAPIs in need of treatment who do not successfully work through the barriers identified in our study. The small sample size of the study did not allow us to conduct statistical tests to examine differences by recruitment site, ethnicity, place of birth, education and level of acculturation. Furthermore, we conducted interviews with only a small number of AAPI monolingual Vietnamese-speaking and monolingual Chinese-speaking substance users. Therefore, the extent to which our findings generalize to various AAPI subgroups should be explored in future studies. Our sample is based on those receiving services from publicly funded treatment programs, and many participants were referred from the criminal justice system. Results may not be applicable to those receiving services in the private sector. In addition, we relied on self-reported outcome measures of stigmatized behaviors; thus, responses from study participants, particularly to the questions about substance use behaviors and illegal activities might have been biased by social desirability and cultural constraints against revealing private behaviors, but many participants did report engaging in illegal activities, which suggests that interviewers established good rapport with some participants.

This is one of the first studies to examine barriers to entry to substance abuse treatment among AAPIs. This exploratory study suggests that AAPIs are similar to other substance using populations. For example, many are not ready to enter substance abuse treatment, may fear treatment, and wish to avoid negative emotional consequences such as shame from revealing substance abuse problems to their family and friends, and may face similar structural and systems barriers (Appel & Oldak, 2007). AAPI populations, however, similar to other racial/ethnic minority substance abusers require culturally competent treatments. The AAPI population is heterogeneous, thus it is important to address cultural differences among the various ethnic groups within the AAPI population. For example, it is important to have an understanding of the socioeconomic status, degree of acculturation and education of the family of the AAPI client (Zane, 1992). Many AAPI clients are relatively recent immigrants to the United States, and may have family members whose primary interest is to improve their socioeconomic status. Therefore, it might be difficult for some family members to comprehend why the client is not able to control their substance use and succeed. In addition, in their struggle to improve their socioeconomic standing in the community, members of the client's family may not have the time or energy to provide the emotional support required by a person in treatment for a SUD. Indeed, AAPI family members in some cases may actually interfere with SUD treatment by placing unrealistic expectations an AAPI client to merely minimize the SUD and meet family obligations.

Successful treatment for SUDs in AAPI clients may require involvement of family members. At a minimum, it may be useful to educate AAPI family members about SUD treatment processes. In particular, it could be valuable to point out that the long term benefits of substance abuse treatment may be that the AAPI client will control his or her substance use and become a productive member of the family. In some cases, it may also be necessary to involve family members in the AAPI client's treatment. It may be important to keep in mind the ideas of family harmony, solidarity and subordination of individual goals for the sake of family goals while designing substance abuse treatments for this population (Naegle et al., 2002). In addition, integrating culturally sensitive screening tools, brief interventions, and referral to substance abuse treatment in medical care settings and non-traditional settings (e.g., health fairs, community cultural celebrations) may increase the numbers of AAPIs who seek substance abuse treatment.

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