Help-Seeking Patterns and Perceived Barriers to Care among Latino Immigrant Men with Unhealthy Alcohol Use

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Abstract

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Latino immigrant men have high rates of unhealthy alcohol use, yet we know little about their help-seeking patterns and barriers to care. We described the help-seeking patterns and perceived barriers to care of a sample of Latino immigrant men (N=121) recruited to a pilot randomized trial of a brief alcohol intervention (the Vida PURA study). All men were Latino, immigrant, spoke Spanish, and had an Alcohol Use Disorder Identification Test (AUDIT) score ≥ 6. Interviewer-administered survey data were used to describe help-seeking and barriers to care across alcohol use severity. AUDIT scores ranged from 6 –40 (*M* = 20, *SD* = 10); 49% (n=60) of men screened positive for severe unhealthy alcohol use (AUDIT score ≥ 20, and 30% (n=36) reported having sought help for drinking. 61% of men who had sought help for drinking (n-36) reported attending Alcoholics Anonymous (AA). All men reported perceived barriers to care, especially stigma and health care system related. Findings suggest further investigation of interventions based on severity level to address stigma and health care system barriers.

INTRODUCTION

Latinos are the largest growing ethnic minority group in the US, and the Census Bureau projects they will comprise more than a quarter of the population by 2050 (US Census Bureau, 2003). Recent nationally-representative studies suggest that there substantial racial/ethnic differences in unhealthy alcohol use—the spectrum ranging from risky use (average use exceeding recommended limits or any heavy episodic drinking) to meeting diagnostic criteria for alcohol use disorders (Saitz, 2005). In particular, Latinos report higher rates of heavy episodic drinking (24.7%), than blacks, whites, and Asians (Vaeth, Wang-Schweig, & Caetano, 2017), and are more likely to report alcohol-related consequences, such as driving under the influence of alcohol arrests and cirrhosis-related deaths, than any other racial/ethnic group in the United States (Caetano, 2003; Gomberg, 2003; Lê Cook & Alegría, 2011). Latino men who are immigrants may be particularly at risk for unhealthy alcohol use (Grzywacz, Quandt, Isom, & Arcury, 2007; Ornelas, Torres, & Serrano, 2016). Studies have shown that unhealthy alcohol use among Latino immigrants may be tied to immigration-related stressors (Cano et al., 2017; Ornelas et al., 2016).

Several evidence-based treatment options for unhealthy alcohol use exist. For those at low to moderate risk, brief interventions in primary care settings are effective in reducing the risk for unhealthy alcohol use (Kaner et al., 2007; Whitlock et al., 2004). For those with more severe unhealthy alcohol use, behavioral interventions delivered in specialty addictions treatment settings and medication are both effective and recommended. A host of self-help options (such as Alcoholic Anonymous) are also available and appear to improve outcomes among those who engage (Cunningham, Koski-Jännes, Wild, & Cordingley, 2002; Sullivan, Tetrault, Braithwaite, Turner, & Fiellin, 2011). Despite these options, r

Rates of treatment receipt and other help-seeking among Latinos and Latino immigrant men remain low. A national survey, found comparable rates of alcohol treatment utilization across racial/ethnic groups, less than 16% of foreign-born Latinos with alcohol use disorder reported ever seeking treatment for drinking in their lifetime compared to the 14.6% of the general population with an alcohol use disorder (Cohen, Feinn, Arias, & Kranzler, 2007; Grant et al., 2004). Other estimates from the National Survey of Drug Use and Health (NSDUH) suggests approximately 19% of Latinos are heavy alcohol users and are in need to alcohol treatment, while only 9% received treatment (SAMSHA, 2014).

There is limited knowledge of the treatment preferences and barriers among Latino immigrant men. Pinedo, Zemore, Rogers (2018) found in qualitative interviews of people with a recent diagnosis of a substance use disorder, Latinos were more likely to value cultural context integrated with treatment compared to whites and blacks. Latinos were also less likely to perceive specialty treatments (i.e.in/outpatient services) to be effective based on their perceptions of health providers lack cultural awareness or understanding (Pinedo, Zemore, & Rogers, 2018). Studies of nationally representative samples have found that cost, perceived treatment efficacy, and immigration status are likely the greatest barriers to care for Latinos (Saloner & Cook, 2013; Zemore, Mulia, Yu Ye, Borges, & Greenfield, 2009). For some Latino men, their immigration status restricts their access to health insurance, which also limits their access to health care (Alcalá, Chen, Langellier, Roby, & Ortega, 2017).

Our study sought to understand patterns of help-seeking and barriers to care in a sample of Latino immigrant men with unhealthy alcohol use. Also, due to the importance of matching treatment to the severity of unhealthy alcohol use, we sought to describe help-seeking and barriers to care by the severity of alcohol use.

Methods

Study Sample

We conducted a descriptive analysis of data collected for the Vida PURA study (Ornelas et al., in press), a pilot randomized control trial testing the efficacy and feasibility of a culturally adapted brief intervention for Latino Immigrant men with unhealthy alcohol use. The sample included Latino immigrant men who work as day laborers recruited from a community organization serving Latino immigrants in King County, Washington State. To participate in the study men had to identify as Latino, speak Spanish, be born outside of the United States, have a score of six or higher from the Alcohol Use Disorders Identification Test (AUDIT), and consent to participate.

Data Collection

Primary data collection occurred between July 2015 and October 2016. Surveys were administered in-person by a p*romotor* (culturally-appropriate community health workers) in Spanish in a private location at the community organization. The survey included questions on demographics, discrimination, social support, acculturation stress, alcohol use, help-seeking, barriers to care, and alcohol-related consequences. Surveys took an average of 40 minutes to complete, and participants received $30 for their time. The University of Washington's Institutional Review Board approved all study activities.

Measures

Participants. Participant demographic measures included, age, country of origin, length of time in the United States (in years), education (primary or less, high school diploma or GED, secondary school), weekly income (in USD $100 increments ranging from 200 to 400 or more), living situation (house/apartment, homeless/temporary housing, and staying with a

friend/family), and marital status (single, married or living with partner, and divorce or widowed).

To describe the help-seeking patterns and perceived barriers to care overall and across the severity of unhealthy alcohol use, we used the following measures:

Severity of Unhealthy Alcohol Use. The severity of unhealthy alcohol use was measured using the Alcohol Use Disorder Identification Test (AUDIT), a validated, self-report 10-item measure with total scores ranging from 0-40. For this study, participants were screened and enrolled in the study only if they had an AUDIT score of 6 or more, indicating unhealthy alcohol use (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). Higher AUDIT scores indicate increased risk for unhealthy alcohol use (Babor & Robaina, 2016; Donovan, Kivlahan, Doyle, Longabaugh, & Greenfield, 2006). Thus, consistent with Donovan, et al. (2006), participants were categorized into two groups: those with scores of 6-19 categorized as having less severe risk and scores 20-40 categorized as having more severe risk.

Help-Seeking Patterns. To understand help-seeking patterns, we adapted a measure used in previous national epidemiological studies to assess the help-seeking for health services among American Indian and Alaskan Native populations (Beals et al., 2005, 2006; Durran, Magarati, Parker, Egashira, & Kipp, 2013; Novins, Beals, Croy, Manson, & AI-SUPERPFP Team, 2008). The instrument includes 12 items assessing three domains: 1) help-seeking, 2) preferred sources of help, and 3) types of treatment they sought.

1. Sought Help for Drinking. Help-seeking for unhealthy alcohol use was assessed using a single yes/no question, "Have you ever sought help for your drinking?". Of those who endorsed a history of ever seeking help, we also asked whether they had sought help in the past

12 months. This measure consisted of a single yes/no question "If yes [to Help-Seeking History], was it in the last year?".

2. Preferred Sources of Help. All participants were asked, "Where would you go if you felt you needed help with your alcohol use?". Response options included: family, doctor, church/pastor, friend, agency, and no one.

3. Types of Treatment. Next, we asked those with a history of seeking help for unhealthy alcohol use the types of treatment they sought (Beals et al., 2006; Durran et al., 2013). Response options included health provider/counselor, other community agency, and Alcoholic Anonymous (AA). Participants could select all responses that applied, and responses grouped into three (3) categories: health provider/counselor, alcoholic anonymous or other.

Perceived Barriers to Care. To understand perceived barriers to care we adapted the barriers to care measure of the AI-SUPERPFP health services survey (Beals et al., 2005, 2006; Durran et al., 2013; Novins et al., 2008). This measure includes 20 items; participants could select all for the first six items and check yes to as many as were relevant for the last 14 items. We categorized responses into two domains: 1) perceived barriers to seeking help, and 2) perceived problems when seeking services.

1. Perceived Barriers to Seeking Help. We asked participants, "What reasons would keep you from seeking help for alcohol abuse?", with six response options, including: do not know whom to call; do not think the problem is bad enough; cost; do not believe treatment works; and, other.

2. Perceived problems when seeking services. We assessed perceived problems when seeking services with a question, "Please indicate if you (or someone you know) have had the following problems when seeking services for alcohol abuse or other physical, mental, or

behavioral health concerns in the past 12 months." Response options included 14-items, that were later grouped into the categories relating to health care system ("Quality of Care"), stigma ("Wanted to solve the problem on your own"), access/availability ("Interfered with home, work, or school"), and perceived efficacy ("Previous treatment did not help").

Analysis

We used descriptive statistics to describe the demographic characteristics of the sample by alcohol severity level. Second, we described help-seeking patterns by alcohol severity level. Third, we described perceived barriers to care by help-seeking patterns. Finally, we described perceived barriers to care for the entire sample by alcohol severity level. We conducted all analysis in Stata SE Edition v14.

Results

Table 1 describes the demographic characteristics of our sample (n=121), both overall and stratified by the severity level of unhealthy alcohol use. Overall, the average age was approximately 48 years. About half of the men (55%) were single, and 57% were living in a house or apartment, compared to 27% homeless or in temporary housing and 16% staying with friends or family. Just over half of the men (55%) completed primary school or less, and the majority of the men (65%) were from Mexico. About one-third of the men earned weekly incomes of $200 or less (31%). The average length of time in the United States was 20 years. The average AUDIT score was 20 (M = 6-40, SD = 10), with half having AUDIT scores indicating less severe unhealthy alcohol use (51%; n= 61), and half (49%; n=60) indicating more severe unhealthy alcohol use. Those with more severe unhealthy alcohol use were more likely to be single, to have lower levels of education and income, and to report being homeless or living in temporary housing than those with less severe unhealthy alcohol use (Table 1).

Table 2 shows overall, 30% (n=36) of participants reported seeking help for drinking, and 19% (n=23) reported it was within the past year. Among those reporting help-seeking, Alcoholics Anonymous (18%) was the most common type of help sought. As for preferred sources of help, 32% of men (N=121) endorsed an agency, 27% of men endorsed family, and 24% endorsed their church or pastor. Men with more severe unhealthy alcohol use most often cited seeking treatment from Alcoholics Anonymous (29%) and health providers or counselors (20%). Men with less severe unhealthy alcohol use reported lower rates of help-seeking and were more likely to report seeking help from other sources such as community agencies, in/outpatient treatment, or friends/family (10%). Men with more severe unhealthy alcohol use preferred seeking help from an agency (37%) or a doctor (30%). While men with less severe alcohol preferred help from family (31%) or an agency (28%).

Table 3 shows the perceived barriers to care for all participants (N=121), and also stratified by whether they had previously sought help for their drinking. The most commonly reported barrier was wanting to solve the problem on their own (65%), followed by thinking the problem was not serious enough (56%), cost (46%), that it interfered with home, work, or school duties (43%), or that they were concerned about what others might think (41%). Regardless of having sought help for drinking, the most common perceived problems when seeking services were stigma related. Among men who had sought help for drinking (n=36), the most common perceived problems when seeking services were wanting to solve the problem on their own (78%), believing the problem was not serious enough (66%), and the health care system barrier of cost of services (57%). Following cost, men who had previously sought help for drinking reported other health care system barriers including quality of care (51%), lack of privacy (50%), and 49% of men were concerned about racial prejudice and discrimination. Among those who

had not sought help for drinking, cost (41%) and concerns about racial prejudice or discrimination (35%) were the most common health care system barriers. For perceived efficacy problems when seeking services of those who had sought help for drinking (n=36), 54% of men who had sought help thought the treatment would not help compared to 33% of those who had not sought help for drinking (n=85). Additionally, of those who had sought help for drinking (n=36), 51% reported previous treatment did not help compared to 17% of those who had not sought help for drinking (n=85).

Table 4 describes the perceived barriers to care by the severity of alcohol use. Men with more severe unhealthy alcohol use (n=60) reported higher proportions of barriers to care that men with less severe unhealthy alcohol use (n=61) for 15 of the 20 items. Among men with more severe unhealthy alcohol use, cost (55%) and quality of care (50%) were the common health care system perceived problems with seeking services. Among men with less severe unhealthy alcohol use, cost (36%) and lack of trust in staff (33%) were common health care system perceived problems when seeking services. There was little difference between the rates of endorsing "wanted to solve the problem on your own" across the severity of unhealthy alcohol use (66% for less severe unhealthy alcohol use compared to 65% for more severe unhealthy alcohol use). Men with less severe unhealthy alcohol use endorsed “do not think the problem is bad enough” more so than men with more severe unhealthy alcohol use (43% compared to 28%). Additionally, 85% of men with less severe unhealthy alcohol use endorsed “previous treatment did not help” compared to 60% of men with more severe unhealthy alcohol use.

Discussion

Our study described help-seeking patterns and perceived barriers to care among Latino immigrant men by severity level. Half of our sample endorsed more severe unhealthy alcohol

use based on high AUDIT scores (Donovan et al., 2006). More than a quarter of men reported having sought help for drinking, and it varied by severity level. For perceived barriers to care, there were differences in perceived barriers to seeking help and perceived problems when seeking services by severity level and help-seeking patterns. Perceived problems when seeking services included the health care system, stigma, access/availability, and perceived efficacy of treatment.

Help-Seeking Patterns

Less than one-third of the men in our sample had ever sought help for drinking, and of those who had, the majority of men preferred treatment outside of the primary care (i.e., Doctors) setting. Majority of the men who had sought help reported the type of treatment was Alcoholics Anonymous. Unfortunately, programs like Alcoholics Anonymous may not be an appropriate or effective option for men in our sample with more severe unhealthy alcohol use (Donovan et al., 2006). Additionally, men with severe unhealthy alcohol use reported higher rates of homelessness or living in temporary housing, had lower levels of education and lower incomes than men with less severe risk. Our sample's demographics align with prior literature suggestions that economic and logistical barriers limit this population's ability to obtain treatment (Schmidt, Ye, Greenfield, & Bond, 2007). We believe that the same factors that may be causing unhealthy alcohol use may be contributing to their barriers to care. These factors may limit their options for treatment, causing men to seek out treatment that is low cost or free, such as Alcoholic Anonymous.

Perceived Barriers to Care

In our sample of recruited men, all perceived barriers to seeking help were endorsed, with the most common perceived barrier to seeking help for men was them not thinking the problem

was bad enough. When seeking services, almost half of the men reported health care systems problems; with the most commonly reported barrier was cost. The majority of the men reported stigma related problems when seeking services, and almost half of the men reported access/availability problems when seeking services. Nearly half of the men in the sample endorsed a lack of perceived efficacy of services. Prior literature on Latinos who had met criteria for a recent substance use disorder suggests that perceived efficacy is linked to one's perception of a provider's ability to treat a substance abuse problem (including unhealthy alcohol use) (Pinedo et al., 2018). Similarly, our sample of recruited Latino immigrant men with unhealthy alcohol use endorsed the perceived barrier of treatment not working and lack trust in the staff when seeking services.

Those with more severe unhealthy alcohol use are more likely to report negative consequences (Babor & Robaina, 2016). In our sample, men with severe unhealthy alcohol use, as measured by the AUDIT, likely had more alcohol-related consequences and may need more intensive than men with less severe unhealthy alcohol use. Additionally, men with more severe unhealthy alcohol use reported higher rates of perceived barriers when seeking services except for wanting to solve the problem on their own (stigma) and previous treatment did not help (perceived efficacy) compared to men with less severe unhealthy alcohol use. Prior literature aligns with our findings that perceived efficacy of treatment as an important barrier to care for Latinos (Saloner & Cook, 2013; Zemore, Mulia, Yu Ye, Borges, & Greenfield, 2009). Suggesting that these particular stigma and perceived efficacy items may be independent of the severity of unhealthy alcohol use and alcohol-related consequences, and all men perceived they would encounter barriers to seeking treatment if they wished to obtain the care they needed.

Perceived Barriers to Care and Help-Seeking Patterns by Severity Level

Men with more severe unhealthy alcohol use reported higher rates of help-seeking compared to men with less severe unhealthy alcohol use. Men with more severe unhealthy alcohol use likely had previously sought help for their drinking but also reported that they felt treatment did not work. Also, on average, men who had sought help for drinking reported higher rates of perceived barriers to care compared to men who had not sought help for drinking. Our findings suggest that men who had sought help for drinking experienced more barriers to care, and men with more severe unhealthy alcohol use perceived more barriers to care.

Limitations

There are several limitations to this descriptive study and the generalizability of our findings to the general population of Latino immigrant men. First, this is a small sample of men (N=121) recruited from a community-based organization that serves Latino immigrants. In the general population, Latino immigrant men may not have access to a community organization that specializes in health care for Latino immigrants. Secondly, our measures were all self-reported, subject to possible recall problems and a reporting bias leading to men under-reporting their levels of unhealthy alcohol use. Third, our sample consisted of men from a metropolitan area in the Pacific Northwest, and their demographic characteristics are not representative of all Latino immigrant men in the United States. A larger, nationally representative sample of Latino immigrant men with unhealthy alcohol use would help us understand their help-seeking patterns and perceived barriers to care.

Implications

Our findings suggest that the dominant barriers to care for Latino immigrant men with unhealthy alcohol use are their lack of financial power and experience internalized stigma. Latino immigrant men, especially Latino day laborers likely have the highest rates of unhealthy

alcohol, more alcohol-related consequences, and the least amount of options to treatment effectively barring them to effective recovery (Pagano, 2014; Vaeth et al., 2017).

Research should investigate more community-based prevention and health promotion interventions focused on addressing unhealthy alcohol use in this population. Prior literature shows that men of this sample were receptive to a brief intervention on unhealthy alcohol use in Spanish and in a community setting (Ornelas et al., in press). Interventions in community settings, such community organizations that serve Latino immigrants, may be particularly useful in addressing the structural barriers that prevent Latino immigrant men from receiving brief intervention and other forms of treatment in primary care settings (Alcalá et al., 2017; Pagano, 2014). Additionally, public health workers in community settings can work to destigmatize treatment for unhealthy alcohol use among all severity levels. Further work needs to be invested in culturally adapted interventions (Valdez et al., 2018) for men with more severe unhealthy alcohol use in a harm reductive approach, addressing stigma-related and structural barriers to care as well as cost.

Health promotion and interventions can increase help-seeking rates, reduce perceived barriers to care and improve treatment options for Latino immigrant men by engaging with the community to increase perceived efficacy of treatment with culturally appropriate options (Castañeda et al., 2015). Community-based organizations and culturally-appropriate community health workers (*promotors*) should implement treatment services that account for limited access, consumer and community preferences such as co-located services across severity level (Worby et al., 2014). A comprehensive menu of treatment options at the community-level is likely the most effective way to improve access and address the immediate needs of Latino immigrant men with unhealthy alcohol use across severity level. Both research and practice depend on policy funding

community programs that address health care system barriers (i.e., cost) with culturally-appropriate and responsive services.

In summary, our findings described help-seeking pattern rates and areas in research and community public health practice to reduce perceived barriers to care among Latino immigrant men with unhealthy alcohol use. Although a brief intervention may not be applicable for men with more severe unhealthy alcohol use (Ornelas et al., in press), men of this sample were receptive to a culturally-appropriate brief intervention on unhealthy alcohol use to inform their severity of alcohol use and begin a dialogue for further treatment. A menu of culturally adapted interventions tailored to the severity levels of unhealthy alcohol use among Latino immigrant men must be available in community settings (instead of primary care) to ensure men's access to treatment.

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Tables

Table 1

Characteristics of Recruited Latino Immigrant Men with Unhealthy Alcohol by Severity Level (N=121)

	Less Severe[1] (n=61)		More Severe[1] (n=60)		Total (N=121)	
Participant Characteristics	*Mean*/N	*SD*/%	*Mea*n/N	*SD*/%	*Mean*/N	*SD/%*
Socio-demographic Characteristics						
Age	*48.0*	*11.69*	*47.6*	*11.6*	*47.8*	*11.6*
Marital Status						
Single	26	42.6	40	66.6	66	54.6
Married or Living with Partner	23	37.7	11	18.4	34	28.1
Divorced or Widowed	12	19.7	9	15.0	21	17.4
Living Situation						
House/Apartment	41	67.2	28	46.7	69	57.0
Homeless/Temporary Housing	11	18.0	22	36.7	33	27.3
Staying with friends/family	9	14.8	10	16.6	19	15.7
Education						
Primary or Less	29	47.5	38	63.3	67	55.4
High School Diploma or More	32	52.5	22	36.7	54	44.6
Country of Origin						
Mexico	37	60.7	42	70.0	79	65.3
Other	24	39.3	18	30.0	42	34.7
Weekly Income[2]						
$200 or less	14	22.9	22	36.6	36	30.8
$200-$300	15	24.5	15	25.0	30	25.6
$300-$400	12	19.7	14	23.3	26	22.2
$400 or more	18	29.5	7	11.6	25	21.4
Length of time in the US (Years)	*18.2*	*11.3*	*22.15*	*11.2*	*20.1*	*11.4*
Alcohol-Related Characteristics						
Total AUDIT Score	*11.8*	*4.4*	*28.3*	*5.7*	*20.0*	*9.7*

[1] Audit Score ranging between 6-19 are less severe, and a score ranging from 20-40 are more severe.

[2]Weekly Income Characteristics totals are less than columns total is due to missing responses; Less Severe (n=59) and More Severe (n=58)

Table 2.

	Less Severe[1] (n=61)		More Severe[1] (n=60)		Total (N=121)	
Help-Seeking Patterns	*Mean*/N	*SD*/%	*Mean*/N	*SD*/%	*Mean*/N	*SD*/%
Has Sought Help for Drinking	9	14.8	27	45.0	36	29.8
Sought Help for Drinking within the Past Year[2]	3	5.0	20	33.3	23	19.0
Types of Treatment Sought[2,3]						
Alcoholic Anonymous	5	8.1	17	28.3	22	18.2
Health provider /counselor	2	3.2	12	20.0	14	11.6
Other[4]	6	9.8	5	8.3	11	9.1
Preferred Sources of Help						
Agency	17	27.9	22	36.7	39	32.2
Family	19	31.1	14	23.3	33	27.3
Church/Pastor	16	26.2	14	23.3	30	24.8
Doctor	11	18.0	18	30.0	29	24.0
Friend	11	18.0	10	16.7	21	17.4
No one	11	18.0	9	15.0	20	16.5

[1]Audit Score ranging between 6-19 are less severe, and a score ranging from 20-40 are more severe.

[2] Help-seeking with past year and type of treatment sought was assessed only for those who reported ever seeking help (n=36)

[3] Participants selected all; response may sum greater than 100%

[4]Other type of treatment include community agencies, Anexos, in/outpatient treatment, or friends/family

Table 3

Perceived Barriers to Care by Help-Seeking Patterns of Recruited Latino Immigrant Men with Unhealthy Alcohol (N=121)

	Sought Help for Drinking		Total (N=121)	
Perceived Barriers to Care	No (n=85) %	Yes (n=36) %	N	%
Perceived Barriers to Seeking Help				
Do not believe treatment works	18.8	38.9	30	24.8
Do not think the problem is bad enough	35.3	36.1	43	35.5
Do not want others to find out	14.1	33.3	24	19.8
Do not know whom to call	23.5	30.6	31	25.6
Cost	12.9	27.8	21	17.4
Other	20.0	16.7	23	19.0
Perceived Problems When Seeking Services				
Health Care System				
Cost	41.2	57.1	55	45.8
Quality of care	31.0	51.4	44	37.0
Lack of privacy	32.1	50.0	45	37.5
Lack of trust in staff	29.8	44.4	41	34.2
Problems communicating with staff	24.7	45.7	37	30.8
Concerns about racial prejudice or discrimination	35.7	48.6	47	39.5
Stigma				
Wanted to solve the problem on your own	60.0	77.8	79	65.3
Problem was not serious enough	51.8	65.7	67	55.8
Concerned about what others might think	35.7	52.8	49	40.8
Access/Availability				
Interfered with home, work, or school	41.2	48.6	52	43.3
Did not have transportation to get care	27.1	35.3	35	29.4
Kind of care you needed was not available	23.8	37.1	33	27.7
Perceived Efficacy				
Thought treatment would not help	32.9	54.3	47	39.2
Previous treatment did not help	16.5	51.4	32	26.7

Table 4

Help-Seeking Patterns and Perceived Barriers to Care of Recruited Latino Immigrant Men with Unhealthy Alcohol by Severity Level (N=121)

	Less Severe[1] (n=61)		More Severe[1] (n=60)		Total (N=121)	
Perceived Barriers to Care	N	%	N	%	N	%
Perceived Barriers to Seeking Help						
Do not believe treatment works	11	18.0	19	31.7	30	24.8
Do not think the problem is bad enough	26	42.6	17	28.3	43	35.5
Do not want others to find out	13	21.3	11	18.3	24	19.8
Do not know whom to call	14	23.0	17	28.3	31	25.6
Cost	8	13.1	13	21.7	21	17.4
Other	12	19.7	11	18.3	23	19.0
Perceived Problems When Seeking Services						
Health Care System						
Cost	22	36.1	33	55.0	55	45.5
Quality of Care	14	23.0	30	50.0	44	36.4
Lack of privacy	17	27.9	28	46.7	45	37.2
Lack of trust in staff	20	32.8	21	35.0	41	33.9
Problems communicating with staff	13	21.3	24	40.0	37	30.6
Concerns about racial prejudice or discrimination	18	29.5	29	48.3	47	38.8
Stigma						
Wanted to solve the problem on your own	40	65.6	39	65.0	79	65.3
Problem was not serious enough	27	44.3	40	66.7	67	55.4
Concerned about what others might think	20	32.8	29	48.3	49	40.5
Access/Availability						
Interfered with home, work, or school	21	34.4	31	51.7	52	43.0
Did not have transportation to get care	15	24.6	20	33.3	35	28.9
Kind of care you needed was not available	13	21.3	20	33.3	33	27.3
Perceived Efficacy						
Previous treatment did not help	52	85.2	36	60.0	88	72.7
Thought treatment would not help	9	14.8	23	38.3	32	26.4

[1]Audit Score ranging between 6-19 are less severe, and a score ranging from 20-40 are more severe