Substance Use Disorder: Racial Prevalence and the Likelihood of Participating in an Intervention.

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The Substance Abuse and Mental Health Services Administration defines substance use disorder (SUD) as “a diagnosis of substance use disorder . . . based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.”

In Pennsylvania during 2015, 28.36% of adults ages 18 and over used a tobacco product. In Pennsylvania during 2015, 6.82% of adults ages 18 and over used a tobacco product. In the U.S. during 2014, 1.2% of adults ages 18 and over used a tobacco product. As seen in Table 1 and Table 2, prevalence of SUD varied in comparison to the racial composition of the population. At LVHN-CC, 82.5% of patients who screened positively for SUD were white, though whites compose merely 43.2% of the population of Allentown. In contrast, Hispanic/Latino patients at LVHN-CC comprised only 5.8% of those with SUD, while the population in Allentown is approximately 42.8% Hispanic/Latino. At LVHN-M, whites had similar discrepancies: 79.7% of patients with SUD were white, which is greater than the percentage found in the population. Hispanic/Latino patients at LVHN-M comprised 2.9% of the total SUD patients while comprising 24.4% of the total population. In total, 32.4% of patients with SUD received an intervention. The most common reasons for lack of an intervention were that the patient was too sick, privacy was not obtainable, or reasons listed as “other.” Overall SUD prevalence rates were 24.3% and 22.3% at LVHN-CC and LVHN-M, respectively. The prevalence of SUD as of 2014 in the nation was 16.3% for ages 18-25 and 7.1% for ages 26 and older.

CONCLUSIONS

Lack of privacy was identified as the single greatest barrier to reception of an intervention. The most common reasons listed as “other” included patients who presented for psychiatric reasons, patients who were sleeping, and patients who were moved to other beds. In order to ensure that patients with SUD have the ability to receive an intervention, it is necessary to eliminate as many barriers to care as possible. Namely, adequate privacy for interventions needs to be attainable. Patients who use the emergency department for psychiatric reasons should not be automatically disqualified and should be considered for an intervention if applicable. Researchers conducting the interventions must be persistent in their goal of reaching all SUD patients.


Special thanks to Dr. Anisa Kurt, Dr. Marna Greenberg, Manuel Colin, Bernadette Glenn-Porter, and Micaela Wilson for all of their assistance with this project.

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