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Evidence-Based Practices, Attitudes, and Beliefs in Substance Abuse Treatment Programs Serving American Indians and Alaska Natives: A Qualitative Study

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Abstract

Substance abuse disproportionately impacts American Indian/Alaska Native (AI/AN) communities in the United States. For the increasing numbers of AI/AN individuals who enter and receive treatment for their alcohol or other drug problem it is imperative that the service they receive be effective. This study used qualitative methodology to examine attitudes toward evidence-based practices, also known as evidence-based treatments (EBTs) in minority-serving substance abuse treatment programs in the San Francisco Bay area. Twenty-two interviews were conducted in the study, of which seven were with program directors and substance abuse counselors at two urban AI/AN focused sites. These clinics were more likely than other minority-focused programs to have experience with research and knowledge about adapting EBTs. Only in the AI/AN specific sites did an issue arise concerning visibility, that is, undercounting AI/AN people in national and state databases. Similar to other minority-focused programs, these clinics described mistrust, fear of exploitation from the research community, and negative attitudes towards EBTs. The underutilization of EBTs in substance abuse programs is prevalent and detrimental to the health of patients who would benefit from their use. Future research should explore how to use this research involvement and experience with adaptation to increase the adoption of EBTs in AI/AN serving clinics.

Keywords

American Indian/Alaskan Native; evidence-based practice; health disparities; implementation; substance use

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Substance use is a particular problem in the American Indian/Alaskan Native (AI/AN) community. According to a recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA 2010), 14.8% of this population is in need of treatment for alcohol problems, while 6% requires treatment for other drugs. Morbidity and mortality from substance use disproportionately affects this community as well. Rates of alcohol-related deaths alone are double that of the non-AI/AN population (CDC 2008). These alarming statistics indicate a need for increased prevention efforts and availability of treatment for this population.

The literature has described many structural and individual barriers to treatment for this population. At the structural level, there can be low levels of cultural sensitivity or awareness in clinics. For example, a provider who does not know tribal custom could offend patients by asking questions in an inappropriate way (Good 1992).

There also tends to be a focus on Western medicine techniques that may be interpreted as belittling the culture's traditional practices (Beiser 1985) or not validating American Indian spiritual ceremonies as therapy (National Latino Behavioral Health Association 2009). Individuals entering treatment may desire treatment programs that are more culturally specific and can attend to the needs of their communities. Ethnic match between provider and patient has been shown to improve substance abuse outcomes among Hispanics (Field & Caetano 2010). The desire to not focus on Western medicine techniques may be a huge barrier to the use of evidence-based practices, also known as evidence-based treatments (EBTs), in AI/AN focused treatment programs. At the same time, funding sources require the use of EBTs and these programs find themselves adapting their treatments to fulfill these requirements.

EBTs are not widely used in substance abuse treatment programs (McGovern et al. 2004). As a result, policy makers and funding agencies have focused on facilitating the implementation of EBTs in substance abuse programs. For example, the Oregon state legislature directed five state agencies, which included substance abuse treatment programs, to spend 75% of state funds on evidence-based practices (Oregon Department of Human Services 2005). These types of mandates can pose special issues for minority-focused treatment programs since there may not be enough EBTs that are effective for the treatment of minorities.

A recent qualitative study exploring how traditional practices are incorporated into AI/AN substance abuse treatment found little use of EBTs and a focus on more "spiritual" and "new-age" treatments (e.g., inner child exploration) (Gone 2011). Although adapted interventions have been shown to be effective (Miranda et al. 2005), the dearth of literature on the subject does not allow for certainty as to whether adaptation can compromise validity (Isaacs et al. 2008).

Despite this need there are many barriers to the implementation of research in AI/AN specific treatment programs to evaluate the effectiveness of EBTs for this population. One of the biggest barriers to research of EBTs in AI/AN focused programs are feelings of exploitation or mistrust of outsiders (Crazy Bull 1997). Recent incidents involving

exploitation of AI/AN participants have occurred (Mello & Wolf 2010) leading to a schism between researchers and providers within the community that may be contributing to the lack of research studies in these communities. In addition, some AI/AN providers have expressed feelings that the EBTs being promoted ignore their cultural beliefs, and there might be resistance from treatment programs to evaluate EBTs for this reason (Isaacs et al. 2008). Other barriers to the evaluation of EBTs in AI/AN communities include small sample sizes and the associated difficulty of analyzing the many subgroups within ethnic minority populations. For instance, there are more than 500 different tribes in the Native American population (Miranda, Nakamura & Bernal 2003).

A better understanding is needed of the factors that contribute to research involvement and the use of EBTs in AI/AN communities. The present study used a qualitative approach to explore attitudes towards EBTs and attitudes towards research in AI/AN-serving substance abuse programs in northern California.

METHODS

Data were acquired from a larger qualitative study that explored attitudes towards evidence-based treatments in San Francisco-based substance abuse treatment programs serving minority communities. Using Internet searches and word of mouth, 10 minority focused treatment programs were located and approached for participation in the study. Once programs were located, investigators contacted clinic directors by phone or email to determine their interest in participating. A total of eight programs agreed to participate and within these eight programs 22 interviews were conducted. Approximately three interviews were performed at each site, two with clinic staff and one with each clinic director. Participants were compensated with a $40.00 gift card for their time. Interviews were transcribed and coded by trained staff and grounded theory (Glaser & Strauss 1967) was used to examine the transcripts for themes. All procedures were reviewed and approved by the UCSF Institutional Review Board.

The semistructured interview consisted of 17 items (available from the authors) that assessed experiences with research (e.g., how the research was carried out, who led the implementation, whose idea was the research project), ten items that assessed attitudes towards and experience with EBTs (e. g., what does EBT mean to you and your clinic?, What types of treatments do you use in your clinic?), and six items regarding specific needs of ethnic minority clinics (e.g., do you think that your culturally-developed practices should be used more widely by other clinics? What type of research needs do you believe are specific to ethnic minority focused treatments?). Interviews generally lasted one hour.

After interviews were transcribed, codes were developed using the approach of grounded theory. This theory describes the process of interviewing, transcribing, coding, and analysis happening concurrently in an iterative, constant comparative process. Each interview builds on the previous one, creating an evolving interview and coding process (Glaser & Strauss 1967).

Present Study

Of the 22 interviews conducted, five were conducted with two program directors and three substance abuse counselors at two AI/AN focused sites in the San Francisco Bay area of northern California. Of the interviews conducted in the AI/AN sites a majority of the interviewees were female (80%) and from minority backgrounds (60%).

RESULTS

Compared to the other minority-focused programs, AI/AN focused clinics were more likely to have experience with research and be knowledgeable about adapting EBTs for their population. Both treatment programs had adapted an evidence-based treatment for their community and discussed the steps they took in their adaptations. For example, one person commented:

> We're trying to look at adapting some of our traditional methodologies into something that can compliment the MATRIX manuals that can be designed for our target population. So we strategized and shot different ideas back and forth a lot with our internal staff and realized that a lot of the western evidence-based practices that aren't designed or geared toward American Indians consider a linear starting point and an ending point. And you should be able to progress A through Z. There's very little space for adaptation or any progression in it. So we started looking at that and realizing that yeah, it could be effective for our target population … we want to make this more secular, we want people to be able to come in at different levels and exit [at different levels].

In addition, it was only in the AI/AN specific sites that the issue of visibility arose. One interviewee stated,

> I think visibility is huge one [issue] and I think that carries on into data. The California Department of Finance has a lot to do with how racial data is looked at in the state, and because Hispanics are such a significant block, they maximize that group. Hispanic is an ethnicity, it's not a race. You could be White, Black, Indian and you could be Hispanic, and if we take out those that are Hispanic we lose half the population, half the numbers right there. So it's a pretty big factor in terms of data and nobody looks at data to maximize native people. The other thing is that native people often fall into the "other" category.

Similar to the other minority-focused programs, these clinics described a high level of mistrust and fear of exploitation from the research community and described negative attitudes towards EBTs developed in other communities.

> I don't think research is good work, and I think that you know what happened with Tuskegee … I mean that was African-American population, but there's stuff that's happened with Native populations. I think it was a diabetes study or something so they gave all these blood samples to researchers at Arizona State University and then they did a secondary analysis on it without going back to the tribe and getting permission. Then they did an analysis of schizophrenia, kinship, and inbreeding and that really made people angry.

In addition to discussing the perceived recent exploitations of researchers described above, participants also described other forms of exploitation and oppression of AI/AN communities by researchers. Specifically, they discussed how the use of cultural practices as treatments is another form of exploitation and that these practices should not be used in isolation by individuals who have not been trained in these practices.

> It has taken many years for some folks to learn these ceremonies, to learn the songs, to learn the languages, and I think it's beginning to be recognized. But one thing that is also part of that is exploitation of it as well. Other folks are getting a hold of it and may not be doing it correctly, but doing it to be documented like in a manual or whatnot. And there are harmful ramifications that come about because they're not looking at the whole big picture.

When discussing EBTs for AI/AN communities one participant discussed the impact that previous exploitations can have on the openness of treatment providers to adopt EBTs in their clinics:

> You can't come up with the best practice for the native community; you can't come up with something that's culturally competent and have it actually mean something in the community. I mean this community knows what it wants and needs. They know, and it's not what SAMSHA says it needs. It's particularly hard in this community where people can be distrustful. There are many many many many experiences of being mistreated by the government and so there's not a sense of let us work together and make it good.

DISCUSSION

Reducing the devastating impact of substance abuse in AI/AN communities is a goal shared by many stakeholders. Improving uptake of effective and successful intervention methods that are complementary to the cultural values found in both urban and rural AI/AN communities is a priority, but clear challenges exist. The present study found that staff working in these communities described unique barriers to the implementation of EBTs in their treatment programs. Compared to other minority-focused programs, AI/AN-focused programs were actively engaged in adapting EBTs for use with their clients. Program staff described the complexities of integrating traditional medicine techniques with EBTs and how this can sometimes increase feelings of exploitation. These practices have been co-opted from Native people to such an extent that AI/AN individuals take great efforts to ensure that religious and spiritual ceremonies are protected. These programs describe a lack of visibility of their community resulting from a lack of culturally sensitive government assessment measures. This lack of visibility can impact the level of funding they receive and make evaluation of treatments difficult. As was found in other minority-focused treatment programs, mistrust of research and researchers was extensive. This lack of trust was based on both a general mistrust of governmental systems and more specific examples of recent exploitation by university researchers. Findings showed that there are both group-specific and general barriers to the implementation and evaluation of EBTs in minority communities and a one size fits all approach will not be effective.

One area in which this may be especially important is in the development and evaluation of EBTs. It may be that AI/AN organizations define and evaluate EBTs differently from researchers. These agencies prefer to conduct their own evaluation activities, address quality improvement needs from analysis of internal evaluation findings, and have their own practices published as best practices rather than adopt externally developed programs or evaluations. EBTs as defined in native communities are comprised of traditions that have been passed down orally from one individual to another and vary from mainstream EBTs in their conception of health, which is based not on symptoms but rather on the rebalancing and healing of a whole person. Definitions of success also vary broadly by stakeholder. To be considered a viable EBT to some, interventions may be required to demonstrate improvements in 30-day abstinence outcomes. While this may well be an indicator of an intervention's viability, to the indigenous community this perspective may be viewed as highly limited, falling far outside the broader holistic conception of health that is valued in these communities.

One barrier to the implementation of EBTs described only in the AI/AN treatment programs was that of visibility. Local and statewide data on AI/AN's are often inaccurate and this can affect the visibility and sense of importance of this community, especially to funding sources. Racial misclassification of AI/AN on vital statistics records is well documented in California (Bertolli et al. 2007; West et al. 2005; Baumeister et al. 2000; Burhansstipanov & Satter 2000; Epstein, Moreno & Bacchetti 1997). Reservation data gives significant clues about the widespread issues of Native people; however, once AI/AN individuals become part of an urban data set they are often classified as "other" because of small numbers and their data cannot be analyzed due to small samples. Progress in this area is being made by the Indian Health Service, a program of the Department of Health and Human Services, although a majority of their data comes from census data which may suffer from similar misclassification issues (IHS 2011). To improve the measurement of outcomes in AI/AN communities, national and state surveillance data should be improved and care should be taken to analyze small samples to increase visibility of AI/AN needs.

Findings from the present study indicate that the significance of AI/AN history is still very prominent. The long history of oppression of Native Americans in the U.S. has had a negative effect on the health of Native people. This history, including colonization, outlawing Native languages and spiritual practices, and forced relocation, has created mistrust of government programs and health institutions (NIH 2006). As a result, historical trauma, attributed to a cultural history of oppression and genocide, is an important issue that must be understood when working with AI/AN individuals and treatment programs (Brave Heart 2003; Duran & Duran 1995). Historical trauma and its intergenerational effects must be acknowledged, not only within treatment but also with regard to the way in which interventions are created and tested. In its simplest form, it can manifest as suspicion and distrust of mainstream institutions and influence the way EBTs are viewed by program staff.

Mainstream institutions sometimes proceed with research on AI/AN people without awareness of the historic and current day abuse of American Indian communities/tribes. For example, researchers from Arizona State University conducted an unauthorized secondary analysis of blood specimens from the Havasupai tribe to examine the impacts of inbreeding

(Markow & Martin 1993) and schizophrenia (Havasupai Tribe of Havasupai Reservation v. Arizona Bd. of Regents 2008). These specimens had been collected for a primary analysis on diabetes and were not authorized for this secondary purpose. While this story is not a happy one, the end result of a multimillion dollar lawsuit brought by the tribe against the ASU Board of Regents has resulted in greater oversight in the conduct of human subjects research (Mello & Wolf 2010) and, potentially more importantly, has ushered in a new era of partnership between the two that focuses on health, education, economic development, and engineering planning (Harmon 2010). Researchers today, to work successfully with tribal people, must listen to the needs of the community and maintain respect for tribal priorities in order for research partnerships to develop trust, if any progress is to be made that is mutually satisfactory.

A recent systematic review exploring attitudes towards EBTs, adoption of EBTs, and the implementation of EBTs in substance abuse treatment programs found relatively positive attitudes towards manualized treatments (Garner 2009), which is in contrast to the findings from the present study. The history of oppression that was experienced in this community appears to be contributing to the negative attitudes towards EBTs. Despite these barriers, AI/AN community programs are actively using and adapting EBTs for use with their patients.

Limitations

Considering the small sample size of the present study it is difficult to generalize our findings to be representative of all AI/AN-focused substance abuse treatment programs. Similarly, both treatment programs are located in an urban setting and may not represent the experiences of treatment programs on reservations or in more rural settings.

There is a dearth of literature on EBTs in ethnic minority substance abuse treatment programs and the field is in its infancy in developing and testing EBTs for use with these communities. Understanding the barriers that are specific to minority-focused substance abuse treatment programs and how to overcome these barriers while respecting the traditions of these communities is important to the continuation of work in this area.

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