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Pathways to care: Narratives of American Indian adolescents entering substance abuse treatment

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ABSTRACT

Using data from 89 American Indian adolescents and guided by the Network Episode Model, this paper analyses pathways to residential substance abuse treatment and their correlates. These adolescents were recruited at admission to a tribally-operated substance abuse treatment program in the southern United States from October 1998 to May 2001. Results from the qualitative analyses of these adolescent's pathways to care narratives indicated that 35% ultimately agreed with the decision for their entry into treatment; 41% were Compelled to enter treatment by others, usually by their parents, parole officers, and judges; and 24% did not describe a clear pathway to care. In the multinomial logistic regression model examining correlates of these pathways to care classifications, adolescents who described pathways indicative of agreement also reported greater readiness for treatment than the adolescents who described compelled or no clear pathways to care. Adolescents who described a Compelled pathway were less likely to meet diagnostic criteria for Conduct Disorder and described fewer social network ties. We were unable to find a relationship between pathways classifications and referral source, suggesting these narratives were subjective constructions of pathways to care rather than a factual representation of this process. In the final logistic regression model examining correlates of treatment completion, articulating a pathway to care, whether it was one of agreement or of being compelled into treatment, predicted a greater likelihood of completing treatment. Overall, these narratives and their correlates are highly consistent with the Network-Episode Model's emphasis on the interaction of self, situation, and social network in shaping the treatment seeking process, demonstrating the applicability of this model to understanding the treatment seeking process in this special population and suggests important considerations for understanding the dynamics of service utilization across diverse communities.

Introduction

How American Indian (AI) adolescents conceptualize and describe their pathways to substance abuse treatment may have important implications for their ability to take advantage of such services and for the ability of treatment providers to create an effective treatment plan. For example, in Motivational Interviewing, which focuses specifically on the awareness of substance use problems and desire to change, perceptions of pathways to care can provide important clues regarding an adolescent's state of mind that are critical for assessing (and addressing) their readiness for substance abuse treatment (Miller & Rollnick, 2002). In Cognitive Behavioral Therapy, which utilizes an analysis of an individual's substance use patterns to develop a relapse prevention plan, perceptions of pathways to care provides information regarding an adolescent's thinking and behavior around their substance use which must be addressed in this plan (Waldron & Kaminer, 2004). Finally, twelve-step programs directly utilize an adolescent's perception of their pathway to care as a tool for healing. Indeed, it is the telling and retelling of this "story" to peers, the changes in its meaning as one progresses through the twelve steps, and the specific actions that are suggested by analyses of this story from the different perspectives suggested by each of these steps (e.g., emphasizing one's powerlessness to address addiction in Step 1 and developing an exhaustive list of all persons one has harmed in Step 8), that becomes the main vehicle for achieving recovery (White, 1998).

The focus on pathways to care is highly consistent with the traditions of many AI cultures, in which narratives and storytelling

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are integral parts of family and community gatherings as well as an important avenue used to pass tribal knowledge and traditions from generation to generation (Hodge, Pasqua, Marquez, & Geishirt-Cantrell, 2002; Rehyner, 1997). Indeed, these narrative traditions have been used by some researchers and clinical programs to address substance abuse problems among AI adolescents and adults (La Marr & Marlatt, 2007; Naquin, Trojan, O'Neil, & Manson, 2006).

One approach to conceptualizing and analyzing pathways to care is the Network-Episode Model (NEM)(Pescosolido, 2006; Pescosolido, Gardner, & Lubell, 1998), in which pathways to care result from an interactive process between "episodes" of illness-related problems (e.g., an adolescent being suspended from school for drug possession) and critical social interactions that shape the response (e.g., the school counselor supporting a parental decision to pursue substance use treatment for the adolescent despite her ongoing resistance to do so). An important assumption of the NEM is that the treatment seeking process does not occur through individually-based rational decision making, but is instead a complex social process in which illness-related problems, personal preferences, and the forces of one's personal ties interact with one another in a dynamic fashion over time (Pescosolido, 2006; Pescosolido et al., 1998).

This model may be particularly useful for understanding adolescents' pathways to care, as their status (both culturally and legally) likely limits their ability to make independent decisions to pursue treatment (Boydell, Gladstone, & Volpe, 2006; Costello, Pescosolido, Angold, & Burns, 1998; Millstein, Peterson, & Nightingale, 1993; Scott, 2000–2001; Stiffman et al., 2000). In this paper, we examine the pathway to care narratives provided by male and female AI adolescents who were admitted to a residential substance abuse treatment program (RSATP). Using these data, we attempt to answer the following research questions: How do AI adolescents entering/receiving treatment at an RSATP describe their pathways to care, and are these descriptions consistent with the NEM? What are the correlates of different pathways to care? And, are specific pathways associated with completing residential substance abuse treatment?

Methods

Setting and participants

Participants were recruited from a 24-bed RSATP for male and female AI adolescents. In working with AI communities, protection of the confidentiality of tribes and tribal clinical programs can be as important as protecting the confidentiality of the individual participants (Norton & Manson, 1996). The program, operated by a Southern AI tribe and funded by the Indian Health Service (IHS), was designed to provide specialized treatment of patients with substance use disorders, including those with comorbid psychiatric disorders. Most of the professional and technical staff were themselves AI. The clinical program consisted of three major components: (1) a therapy and counseling component (described further below); (2) an educational (school) component, which included a course in AI cultures and history; and (3) a nursing component, which provides linkages to the local IHS hospital for pediatric and psychiatric services. The therapy and counseling component utilized several treatment modalities: (1) substance abuse counseling, including individual and group treatment based on a 12-step treatment philosophy; (2) mental health counseling, including traditional counseling and art therapy, which draws on both cognitive behavioral and psychodynamic treatment philosophies; (3) family therapy, though most sessions were conducted telephonically as the majority of families lived too distant from the RSATP to make regular visits (4) recreation therapy, using an "Outward Bound" model to build trust, teamwork, and self-esteem; and (5) the Sweat Lodge (a traditional Indian healing ritual involving prayer and song that takes place inside a dark structure in which water is poured onto hot stones to make the occupants sweat for religious or medicinal purposes) (Colmant & Merta, 1999). Outreach staff provide local AI communities with information about the treatment program and facilitate the referral process. Aftercare staff coordinate ongoing treatment and develop an aftercare plan with the patient's family, community, and related agencies (e.g., social services agencies, juvenile justice system).

At the time of admission, each patient was assigned a primary therapist, who worked with the patient throughout treatment. The program used a point system in which patients earned and lost points on the basis of their performance within the treatment program (e.g., completing therapeutic assignments, participating in groups, compliance with the RSATP's rules regarding proper conduct during treatment). Earning points to specified levels resulted in an increasing number of privileges and advancement within the treatment program. The program was completed when the necessary number of points had been earned and the patient had made significant progress in addressing the goals outlined in their individualized treatment plan, which were often tied to 12-step (e.g., writing an autobiography with full acknowledgment of the seriousness their substance use problems) and cognitive behavioral (e.g., learning specific relapse prevention skills and demonstrating the use of these skills on therapeutic passes) concepts. The treatment completion rate was 39.4%.

As the goal of treatment completion was individualized for each participant, so too were the projected lengths of stay necessary for treatment completion. The program's suggested length of time for treatment completion is 30–120 days. In this study, length of stay for participants who successfully completed treatment ranged from 71 to 148 days (mean of 106.5 days) compared to a range of 7–140 days for those who did not complete (mean of 61.65 days, significantly shorter than those who completed; $t = -6.964$, $p < 0.001$).

At the time of discharge, the program provides therapeutic recommendations for follow-up treatment, but the nature of this treatment, and its length, was ultimately determined by the adolescent, their family, and the aftercare provider.

Data from this study has been analyzed previously to describe diagnostic patterns (e.g., prevalence and of substance use and mental health disorders, their correlates, and comorbidities), detailed analyses of specific diagnostic constructs (e.g., the application of the DSM-IV criteria for substance use disorders and Posttraumatic Stress Disorder in this unique sample), peyote abuse and dependence (particularly important given the cultural significance of this hallucinogen is some American Indian cultures), and the relationship of measures of motivations towards treatment and treatment completion (Deters, Novins, Fickenscher, & Beals, 2006; Fickenscher & Novins, 2003; Fickenscher et al., 2005a; Fickenscher, Novins, & Beals, 2005a; Fickenscher, Novins, & Beals, 2005b; Fickenscher, Novins, & Mason, 2006; Novins, 2006).

Clients admitted to this RSATP from October 1998 to May 2001 were approached, and 93 (77.5%) of youth and their parents agreed to participate in the study. Those who agreed did not differ in age or gender from those who refused. Four youth (4.3%) who consented to participate left the RSATP within their first week of treatment and were thus ineligible for inclusion in the study. Of the remaining 89 youth, 20 (22.5%) did not complete the pathways to care interview, which was administered one week a month when our research staff visited the RSATP. These 69 participants provided data for our initial qualitative analyses. Those who did not complete the qualitative interview differed from those who did on 4 of 21 measures: They were more likely to report prior use of substance use services (100.0% vs. 65.7%), scored lower on a scale measuring