Journal of Substance Abuse Treatment 90 (2018) 57–63

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Focus groups to increase the cultural acceptability of a contingency management intervention for American Indian and Alaska Native Communities

Katherine A. Hirchak[a,b], Emily Leickly[c], Jalene Herron[a], Jennifer Shaw[d], Jordan Skalisky[a,b], Lisa G. Dirks[d], Jaedon P. Avey[d], Sterling McPherson[b,e,f], Jenny Nepom[a], Dennis Donovan[g,h], Dedra Buchwald[a,e], Michael G. McDonell[a,b,e,*], the HONOR Study Team

[a] Initiative for Research and Education to Advance Community Health, Washington State University, Spokane, WA, USA
[b] Program of Excellence in Addictions Research, Washington State University, Spokane, WA, USA
[c] Department of Psychology, Portland State University, Portland, OR, USA
[d] Southcentral Foundation, Anchorage, AK, USA
[e] Department of Medical Education and Clinical Sciences, Washington State University Elson S. Floyd College of Medicine, Spokane, WA, USA
[f] Providence Medical Research Center, Providence Health Care, Spokane, WA, USA
[g] Alcohol and Drug Abuse Institute, University of Washington, Seattle, WA, USA
[h] Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA, USA

ARTICLE INFO

Keywords:
American Indian/Alaska Natives
Contingency management
Alcohol use treatment
Treatment adaptation

ABSTRACT

Introduction: Many American Indian and Alaska Native (AI/AN) people seek evidence-based, cost-effective, and culturally acceptable solutions for treating alcohol use disorders. Contingency management (CM) is a feasible, low-cost approach to treating alcohol use disorders that uses "reinforcers" to promote and support alcohol abstinence. CM has not been evaluated among AI/AN communities. This study explored the cultural acceptability of CM and adapted it for use in diverse AI/AN communities.

Methods: We conducted a total of nine focus groups in three AI/AN communities: a rural reservation, an urban health clinic, and a large Alaska Native healthcare system. Respondents included adults in recovery, adults with current drinking problems, service providers, and other interested community members (n = 61). Focus group questions centered on the cultural appropriateness of "reinforcers" used to incentivize abstinence and the cultural acceptability of the intervention. Focus groups were audio-recorded, transcribed, and coded independently by two study team members using both a priori and emergent codes. We then analyzed coded data.

Results: Across all three locations, focus group participants described the importance of providing both culturally specific (e.g., bead work and cultural art work supplies), as well as practical (e.g., gas cards and bus passes) reinforcers. Focus group participants underscored the importance of providing reinforcers for the children and family of intervention participants to assist with reengaging with family and rebuilding trust that may have been damaged during alcohol use. Respondents indicated that they believed CM was in alignment with AI/AN cultural values. There was consensus that Elders or a well-respected community member implementing this intervention would enhance participation. Focus group participants emphasized use of the local AI/AN language, in addition to the inclusion of appropriate cultural symbols and imagery in the delivery of the intervention.

Conclusions: A CM intervention for alcohol use disorders should be in alignment with existing cultural and community practices such as alcohol abstinence, is more likely to be successful when Elders and community leaders are champions of the intervention, the intervention is compatible with counseling or treatment methodologies, and the intervention provides rewards that are both culturally specific and practical.

* Corresponding author at: Elson S Floyd College of Medicine, PO Box 1495, Washington State University, Spokane, WA 99210-1495, USA.
E-mail address: mmcdonell@wsu.edu (M.G. McDonell).

https://doi.org/10.1016/j.jsat.2018.04.014
Received 26 September 2017; Received in revised form 27 April 2018; Accepted 30 April 2018

1. Introduction

1.1. Background

Although American Indian/Alaska Native (AI/AN) people have some of the highest rates of alcohol abstinence in the nation (Cunningham, Solomon, & Muramoto, 2016; National Institute on Alcohol Abuse and Alcoholism, 2006; Substance Abuse and Mental Health Services Adminstration, 2010), alcohol is also associated with many of the current health disparities experienced by AI/AN communities. Certain social determinants of health, such as unemployment, incarceration, violence, suicide and homelessness, are more prevalent in AI/AN communities than in the general US population (Gone & Trimble, 2012; Grant et al., 2009; Naimi et al., 2008; Shore, Beals, Orton, Buchwald, & AI-SUPERPFP Team, 2006; Indian Health Service, 2014). In addition, AI/AN communities experience higher alcohol-related mortality, as well as medical and behavioral morbidity, compared to the overall U.S. population (Indian Health Service, 2014). AI/AN communities also have a higher prevalence of liver disease, diabetes and depression. Historical and political factors including forced relocation, boarding schools, lack of funding, and inadequate healthcare services further compound health inequities (Gone & Trimble, 2012; Whitesell, Beals, Big Crow, Mitchell, & Novins, 2012).

Despite the need for effective alcohol use disorder (AUD) treatments for AI/AN people, a disparity in the availability and retention of treatment remains (Dickerson et al., 2011; Gone & Trimble, 2012). AI/AN adults are less likely than non-AI/AN adults to complete alcohol treatment (Evans, Spear, Huang, & Hser, 2006), which may be due in part to the lack of culturally grounded treatment options available to AI/AN people (Gone & Trimble, 2012). The Tribal Law and Order Act of 2010 called for more research on treatment for AUDs and implementation of evidence-based care in AI/AN communities (TAP, 2011). Policies of sovereignty and self-determination have also led AI/AN communities to develop health research with, for, and by AI/AN people. In other efforts, AI/AN organizations have established their own research enterprises, such as the Southcentral Foundation in Alaska, and have partnered with university-based researchers to develop, test, and implement evidence-based AUD treatments that are effective, culturally appropriate, and sustainable (Boyd-Ball, 2003; Gossage et al., 2003; Naquin et al., 2008).

1.2. Substance misuse interventions for American Indian/Alaska Native people

Few interventions for AUDs have been rigorously examined among AI/AN people (Gone & Trimble, 2012). One recent study is adapting and evaluating the effectiveness of AUD interventions in AI/AN communities with promising results (Venner et al., 2016). Only two randomized controlled trials (RCTs) of alcohol and drug disorder interventions among AI/AN adults have been published (Greenfield & Venner, 2012; O'Malley et al., 2008; Woodall, Delaney, Kunitz, Westerberg, & Zhao, 2007). Although both studies (O'Malley et al., 2008; Woodall et al., 2007) found evidence for effectiveness of the tested interventions, only one incorporated cultural values and practices (Woodall et al., 2007) and neither study assessed cultural acceptability of the interventions.

1.3. Cultural adaptation of substance misuse interventions

The importance of adapting and assessing interventions for cultural acceptability has become increasingly evident and practiced in health science research (Allen et al., 2006; Barrera, Castro, Strycker, & Toobert, 2013; Boyd-Ball, 2003; Lau, 2006; Naquin et al., 2008). Cultural adaptation of an intervention includes two components: efficacy and acceptability (Lau, 2006). Efficacy adaptations are needed when evidence suggests an intervention is less effective for a specific cultural group, relative to the original target population. In this case modifications to the "active ingredients" (e.g., specific techniques or core principles) of an intervention may address cultural factors that influence efficacy (Barrera et al., 2013; Lau, 2006).

Adaptations related to cultural acceptability on the other hand, involve modifying "non-active treatment ingredients" of the intervention, such as the style or language of the intervention, the person delivering the intervention, or the treatment setting. Cultural acceptance is defined as the extent to which a treatment is relevant and engaging among a cultural group in which the intervention has not been previously implemented (Barrera et al., 2013; Etz, Arroyo, Crump, Rosa, & Scott, 2012; Lau, 2006). Effective interventions consider both acceptability and efficacy within the context of the specific population the intervention targets. Culturally unacceptable interventions are less likely utilized and therefore less likely to result in improved health outcomes. Not considering the cultural acceptability of an intervention results in low rates of recruitment and enrollment and high rates of attrition in AUD treatment studies (Beals et al., 2006).

1.4. Contingency management

Contingency management (CM) is an effective intervention for the treatment of substance use disorders (SUDs) (Dutra et al., 2008; Roll, 2007). It is based primarily on the principle of operant conditioning. In CM, tangible positive reinforcers (for the remainder of the paper referred to simply as "reinforcers"), such as gift certificates or other desirable items (e.g., toiletries, household items, recreational items), are given to individuals each time they demonstrate alcohol or drug abstinence, typically measured using a urine drug or alcohol test (Lussier, Heil, Mongeon, Badger, & Higgins, 2006; Prendergast, Podus, Finney, Greenwell, & Roll, 2006). Reinforcers can be modified to meet the preferences of participants or tailored to the intervention setting. Further, non-clinicians can deliver CM, a strength in under-resourced areas such as AI/AN communities, where trained addiction counselors are typically scarce.

CM is equally effective in groups as socially and culturally diverse as African American adults, White Americans, Brazilians, and Chinese populations (Barry, Sullivan, & Petry, 2009; Bride & Humble, 2008; Hser et al., 2011). Despite being an effective intervention for many populations, to our knowledge qualitative methods were not used to maximize the cultural acceptability of CM for the previously mentioned populations. Doing so might maximize the acceptability of CM for AI/AN communities and potentially increase engagement in the intervention.

Given the efficacy of CM among a wide-range of populations and settings, a community-university partnership identified CM as an intervention with potential for cultural adaptation to reduce alcohol use among AI/AN people with AUDs in several geographically and culturally diverse communities. The university-based research team engaged stakeholders in each community through interviews, informal conversations, and meetings between clinicians, service providers, researchers, community members and tribal leaders to determine the potential fit of CM at each site resulting in the implementation of the RCT in three AI/AN communities. The result was the Honor Our Native Ongoing Recovery (HONOR) Study. The HONOR Study includes two phases. Focus groups to inform the adaptation of the CM intervention followed by an RCT of the modified CM intervention in three AI/AN communities, as described in McDonell et al. (2016).

2. Methods

2.1. Participants and recruitment

Focus group recruitment included three research sites: an urban Indian health organization in the Pacific Northwest, a large tribal healthcare system in Alaska serving both rural and urban communities,