Journal of Substance Abuse Treatment 68 (2016) 46–56

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

A National Study of American Indian and Alaska Native Substance Abuse Treatment: Provider and Program Characteristics

Traci Rieckmann, Ph.D. [a,*], Laurie A. Moore, M.P.H. [b], Calvin D. Croy, Ph.D. [b], Douglas K. Novins, M.D. [b], Gregory Aarons, Ph.D. [c]

[a] School of Public Health and Department of Psychiatry, Oregon Health and Science University, Portland, OR, 97239, United States
[b] Centers for American Indian and Alaska Native Health, University of Colorado Anschutz Medical Campus, Aurora, CO, 80045, United States
[c] University of California, San Diego School of Medicine, Department of Psychiatry, 9500 Gilman Drive (0812), San Diego, CA 92093, United States

ARTICLE INFO

Article history:
Received 11 December 2015
Received in revised form 2 May 2016
Accepted 23 May 2016

Keywords:
American Indian/Alaska Native
Workforce
Organizational characteristics
Evidence-based treatment
EBPAS
Substance use disorder

ABSTRACT

American Indians and Alaska Natives (AIANs) experience major disparities in accessing quality care for mental health and substance use disorders. There are long-standing concerns about access to and quality of care for AIANs in rural and urban areas including the influence of staff and organizational factors, and attitudes toward evidence-based treatment for addiction. We conducted the first national survey of programs serving AIAN communities and examined workforce and programmatic differences between clinics located in urban/suburban ($n = 50$) and rural ($n = 142$) communities. We explored the correlates of openness toward using evidence-based treatments (EBTs). Programs located in rural areas were significantly less likely to have nurses, traditional healing consultants, or ceremonial providers on staff, to consult outside evaluators, to use strategic planning to improve program quality, to offer pharmacotherapies, pipe ceremonies, and cultural activities among their services, and to participate in research or program evaluation studies. They were significantly more likely to employ elders among their traditional healers, offer AA-open group recovery services, and collect data on treatment outcomes. Greater openness toward EBTs was related to a larger clinical staff, having addiction providers, being led by directors who perceived a gap in access to EBTs, and working with key stakeholders to improve access to services. Programs that provided early intervention services (American Society of Addiction Medicine level 0.5) reported less openness. This research provides baseline workforce and program level data that can be used to better understand changes in access and quality for AIAN over time.

1. Introduction

1.1. AIAN health care disparities and substance use disorders

American Indians and Alaska Natives (AIANs) have the highest rates of binge drinking (30.2%) and heavy alcohol use (8.5%) of all racial groups in the United States (Substance Abuse and Mental Health Services Administration, 2013a). In 2012, 21.8% of AIANs 12 years and older were classified with substance dependence or abuse in the past year, as compared with 8.7% of Caucasians (Substance Abuse and Mental Health Services Administration, 2013a). AIANs who sought care for substance abuse experienced more chronic medical problems, psychiatric problems, sexual abuse, and number of months incarcerated in their lifetime compared with a matched comparison group (Dickerson et al., 2011; Kunitz, 2008). AIANs also experience higher rates of trauma, which likely contributes to their high rate of mental health disorders and substance use disorders (SUD) compared with other racial and ethnic groups. The rate of trauma among AIANs ranges from 5.9 to 14.8%, compared with 7.0 to 8.0% for the general population (Beals et al., 2013; Kessler et al., 2005).

Broadly, AIANs are a diverse population, with more than 564 federally recognized tribes and more than 5 million individuals identifying as AIAN either alone or in combination with one or more other races (Indian Entities Recognized, 2010; U.S. Census Bureau, 2012). About 3 million Americans identify as exclusively AIAN. The majority of the AIAN population resides in the western United States and is, on average, younger, less educated, and poorer than the general population (Whitesell, Beals, Big Crow, Mitchell, & Novins, 2012).

Disparities in access to health care between AIANs and Caucasians, including services for SUD, remain a significant concern (Centers for Disease Control and Prevention, 2011). These disparities may be due to the growing number of AIANs living in urban/suburban areas, away from most Indian Health Services facilities (Forquera, 2001; Whitesell et al., 2012). Other contributing factors could be limited access to skilled providers and comprehensive services, as well as high levels of poverty among the 20.5% of American Indians currently living on reservations (Brooks et al., 2013; Hoge et al., 2007, 2013; Thomas & Holzer, 2006; U.S. Census Bureau, 2012). In fact, approximately half of all AIANs earn

* Corresponding author at: 3181 SW Sam Jackson Park Rd., CSB 669, Portland, OR 97239. Tel.: +1 503 494 6739; fax: +1 503 494 4981.
E-mail address: rieckman@ohsu.edu (T. Rieckmann).

http://dx.doi.org/10.1016/j.jsat.2016.05.007
0740-5472/

less than 200% of the federal poverty level, compared with one-quarter of Caucasians (James, Schwartz, & Berndt, 2009). Socioeconomic disparities influence quality of life, educational attainment, health status and health care choices, creating a significant challenge for many AIAN families.

In terms of SUD rates and geography, research indicates that health care providers in rural communities report a greater number of patients with substance use problems on their caseload as compared to providers in urban communities (Brems, Johnson, Warner, & Roberts, 2007). In an effort to further understand the impact of residence and location on alcohol use, O′Connell and colleagues examined drinking habits among American Indians from three subgroups: reservation-based, a primarily-urban off-reservation sample, and a U.S. reference population (2005). Results indicated that American Indians living on reservations were more likely to report binge drinking and being intoxicated within the past year compared with the U.S. reference population (O'Connell et al., 2005). However, the urban sample of American Indians also reported unhealthy alcohol use behaviors (O'Connell et al., 2005), indicating that substance use persists across communities and settings for AIANs. Simultaneous to high rates of SUDs, many AIANs now live in urban areas which may reduce access to health care given the limited number of Indian Health Service (IHS) or tribally organized health service programs in more urban areas (Duran et al., 2005). This further compounds geographic disparities, though both rural and urban AIAN communities struggle with inadequate access to mental health and substance abuse services. In many cases rural and reservation communities may also lack qualified health care professionals, while both rural and urban AIAN communities face disparities in care due to the paucity of funding. In fact, research suggests that the majority of AIAN communities and reservations are located in rural areas with limited access to specialized services and physicians with cultural competency training (Brooks et al., 2013).

1.2. The National Substance Use Disorder Treatment Workforce

Over the past decade an extensive body of research has examined the characteristics and qualifications of the mainstream substance abuse counseling workforce (Libretto, Weil, Nemes, Linder, & Johansson, 2004; Mulvey, Hubbard, & Hayashi, 2003) with findings varying across treatment setting and study timeframe (Libretto et al., 2004; Mulvey et al., 2003). For example, an estimated 200,000 providers and counselors work in diverse settings and represent a variety of disciplines such as social work, psychology, medicine, and public health (Libretto et al., 2004; Substance Abuse and Mental Health Services Administration, 2013b). The workforce also varies in terms of training, interests, and preparation to provide clinical care. At the same time, they play a significant role in quality of care, patient satisfaction, health outcomes, and implementation of new practices. Individual characteristics and experiences influence provider's and counselor's willingness to support new, innovative practices (Abraham, Ducharme, & Roman, 2009; Knudsen, Ducharme, & Roman, 2007; Lundgren et al., 2011; Rieckmann, Daley, Fuller, Thomas, & McCarty, 2007; Santisteban, Vega, & Suarez-Morales, 2006).

A recent study of workforce characteristics in specialty substance-abuse treatment centers found that approximately 60% of providers were female and more than 70% identified as Caucasian (Rieckmann, Farentinos, Tillotson, Cocarnik, & McCarty, 2011). Interestingly, only 1% of the workforce identified as Native American (Rieckmann et al., 2011). Other workforce research also suggests that the majority of treatment professionals are Caucasian, middle-aged, and more often female than male (Abraham et al., 2009; Substance Abuse and Mental Health Services Administration, 2013b). While overall the nation's population of AIAN, including those of more than one race, is roughly only 2% of the total population, geography and location matter (Norris, Vines, & Hoeffel, 2012). Certain geographic locations have a higher percentage of AIANs such as in the West which has the largest proportion of AIAN population in the U.S. In American Indian and Alaska Native Village Statistical Areas, AIAN are roughly 22% of the population. In addition, between 2000 and 2010, the U.S. Census Bureau reports that the AIAN population grew at twice the rate of any other race and grew in every region of the U.S. (Norris et al., 2012). Given the disparities in rates of SUDs among AIAN populations, the mismatch between the geographic distribution of the AIAN population and access to Indian Health Service coverage, as well as the rate of population growth for AIAN's it is critical that research focuses on examining the quality, programming and workforce providing treatment services.

1.3. The AIAN substance use disorder workforce

To date, research on workforce characteristics and preparation has not included treatment providers from AIAN communities or urban treatment programs that serve AIAN populations. As a result, the specific skills, training, work settings, salary, years of experience, and recovery status of AIAN treatment providers remain unclear.

Overall improved quality of services and promotion of evidence-based treatments (EBTs) for substance abuse treatment programs is rapidly advancing. Yet this transition is proving especially problematic for AIAN communities. They face unique structural mechanisms that arise from IHS funding (the national health care for AIAN individuals with tribal affiliation), tribal operation of behavioral health programs, federal grants, Medicaid, and parity funding. They also must deal with social and geographic isolation of providers. Previous research has shown that access to adequate and timely behavioral health care is complicated in rural areas (Hoge et al., 2013). Eighty-five percent of the shortage areas for federally designated mental health professionals are located in rural locations (Substance Abuse and Mental Health Services Administration, 2007). Although the majority of AIANs live off reservations, urban Indian health boards chartered by IHS receive just 1% of the IHS budget (Novins et al., 2011). That is inadequate to address all of the health care needs of off-reservation AIANs (Novins et al., 2011).

An additional barrier to best treatment is the cultural distrust that many AIAN patients feel toward care providers. Many who receive care at clinics that serve AIANs have reported mistrust, fear of exploitation from the research community, and generally negative attitudes toward EBTs (Larios, Wright, Jernstrom, Lebron, & Sorensen, 2011). A low rate of diversity—only 1% of counselors report being AIAN—can contribute to negative provider–patient interactions and influence treatment outcomes (Rieckmann et al., 2011).

1.4. Quality of care

Facilitating providers' adoption of empirically supported interventions will improve quality of care among any population, but successful implementation of best practices remains challenging in many settings. It typically requires adjusting clinical services, enhanced workforce capacity and supervision, exposure to innovative practices, monitoring for adherence and fidelity, marketing, and attention to organization factors (Abraham et al., 2009; Knudsen et al., 2007; Rogers, 2003; Santisteban et al., 2006). In addition, implementation science literature suggests that core organization, human resource, and management factors such as administrative and leadership support, staff selection, training, coaching and feedback, and provider skills work synergistically to influence clinical decision-making and adoption of new practices (Aarons et al., 2012; Damschroder & Lowery, 2013; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Greenhalgh et al., 2008). Thus, provider characteristics and organizational dynamics are key factors that drive the adoption of EBTs. Efforts to improve quality, increase equitable access to care, and maintain or reduce costs will be most effective when provider perspectives, qualifications, and program-level factors are addressed within transformation initiatives.