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Use of evidence-based treatments in substance abuse treatment programs serving American Indian and Alaska Native communities

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ABSTRACT

Background: Research and health surveillance activities continue to document the substantial disparities in the impacts of substance abuse on the health of American Indian and Alaska Native (AI/AN) people. While Evidence-Based Treatments (EBTs) hold substantial promise for improving treatment for AI/ANs with substance use problems (as they do for non-AI/ANs), anecdotal reports suggest that their use is limited. In this study, we examine the awareness of, attitudes toward, and use of EBTs in substance abuse treatment programs serving AI/AN communities.
Methods: Data are drawn from the first national survey of tribal substance abuse treatment programs. Clinicians or clinical administrators from 192 programs completed the survey. Participants were queried about their awareness of, attitudes toward, and use of 9 psychosocial and 3 medication EBTs.
Results: Cognitive Behavioral Therapy (82.2%), Motivational Interviewing (68.6%), and Relapse Prevention Therapy (66.8%) were the most commonly implemented psychosocial EBTs; medications for psychiatric comorbidity was the most commonly implemented medication treatment (43.2%). Greater EBT knowledge and use were associated with both program (e.g., funding) and staff (e.g., educational attainment) characteristics. Only two of the commonly implemented psychosocial EBTs (Motivational Interviewing and Relapse Prevention Therapy) were endorsed as culturally appropriate by a majority of programs that had implemented them (55.9% and 58.1%, respectively).
Conclusions: EBT knowledge and use is higher in substance abuse treatment programs serving AI/AN communities than has been previously estimated. However, many users of these EBTs continue to have concerns about their cultural appropriateness, which likely limits their further dissemination.

1. Introduction

The dissemination and implementation of evidence-based treatments (EBTs) by substance abuse treatment programs remains one of the greatest challenges we face in improving the quality of such services (Institute of Medicine, 2006). In no part of American society is the need for quality substance abuse services greater than in American Indian and Alaska Native (AI/AN) communities, where the rates of substance use problems are higher than in the rest of the United States and access to care remains limited (Beals et al., 2006, 2005; O'Connell et al., 2005; Whitesell et al., 2012). While EBTs have the potential to improve substance abuse treatment services for AI/ANs, as they do for non-AI/AN populations, there have been a number of concerns raised by experts in this area regarding efforts to increase EBT use (Gone and Looking, 2011; Novins et al., 2011). These include longstanding concerns regarding the cultural appropriateness of many EBTs as well as a lack of guidance on how to adapt interventions for AI/AN populations while maintaining their effectiveness (Novins et al., 2011). Furthermore, the imposition of policy mandates by federal and state authorities to use EBTs in order to receive funding may inadvertently make them even more controversial by placing their use in opposition to tribes' continued efforts to maintain their sovereign status (Novins et al., 2011). Despite these long-standing concerns, engagement with EBTs (i.e., awareness, attitudes toward, and actual use) by substance abuse treatment programs serving AI/AN communities has not been studied systematically, leaving the above concerns in the realm of expert opinion and limiting our ability to improve the process of disseminating and implementing EBTs in programs serving AI/AN communities.

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In contrast with research on substance abuse programs serving AI/AN communities, there is a large and growing literature on the use of EBTs in substance abuse treatment programs more generally, enough to support at least two systematic reviews (Garner, 2009; Walters et al., 2005). Organizational factors associated with greater EBT engagement include larger program size (Guerrero et al., 2013), organizations that are younger (Lundgren et al., 2012), having better internet technology (Lundgren et al., 2011b), lower levels of organizational stress (Lundgren et al., 2012), accepting private insurance (Guerrero et al., 2013), the use of total quality management techniques (Fields and Roman, 2010), and supervisor expectations regarding EBT use (Guerrero et al., 2013).

Similarly, workforce factors associated with greater EBT engagement include higher levels of clinician education (Lundgren et al., 2011b) and clinical experience (Bride et al., 2010; Ducharme et al., 2010), positive attitudes to science-based treatments (Bride et al., 2010) as well as training in (Bride et al., 2010) and experience with specific EBTs (Bride et al., 2010; Lundgren et al., 2012).

There is also evidence of variation in the factors supporting the implementation of different EBTs, particularly between psychosocial and medication EBTs (Oliva et al., 2011). For example, McGovern et al. (2004) reported that while clinicians who labeled themselves as either using a 12-step model or cognitive behavioral model for treatment reported comparable interests in psychosocial EBTs such as Relapse Prevention Therapy and Motivational Interviewing, those therapists using a cognitive behavioral treatment model were more open to using medication EBTs. Rieckmann et al. (2011) reported similar findings regarding use of buprenorphine, with less emphasis on 12-step services and a greater percentage of clients with opiate use disorders being associated with a greater likelihood to offer buprenorphine treatment. Among the medication EBTs, Knudsen et al.'s (2011b) work suggests that use of medications for the treatment of comorbid psychiatric conditions was more common than the use of medications for relapse prevention. Organizational factors associated with use of medication EBTs include access to medical staff, for-profit institutional structure, larger program size, placement in a hospital setting, accreditation, and greater access to trainings and to web-based materials, and program participation in research (Abraham et al., 2009, 2013, 2011, 2010; Ducharme and Roman, 2009; Knudsen et al., 2011a; Krull et al., 2011; Roman et al., 2011; Savage et al., 2012).

Research also suggests that modifications to EBTs are often made in substance abuse treatment settings, but that these modifications vary substantially across settings (Lundgren et al., 2011a). Furthermore, many programs that use EBTs do not provide training and ongoing support for high quality implementation (Olmstead et al., 2012).

Drawing on data from the first national study of substance abuse treatment programs serving AI/AN communities, the goal of this paper is to examine the depth of engagement with EBTs in these programs.

2. Methods

Data for these analyses come from the Centers for American Indian and Alaska Native Health's Evidence-Based Practices and Substance Abuse Treatment for Native Americans project. This project focused on how substance abuse treatment programs serving AI/AN communities use and perceive EBTs. An advisory board of administrators, service providers, evaluators from the AI/AN substance abuse treatment community, and researchers with expertise in AI/AN substance abuse treatment and dissemination research supports this project.

This project consisted of three phases: (1) convening an advisory board to identify key issues in the dissemination and implementation process and to develop study measures and methods (Novins et al., 2011), (2) completion of qualitative case studies of 18 substance abuse treatment programs serving AI/AN communities (Legha et al., 2014; Legha and Novins, 2012; Moore et al., 2015), and (3) conducting a national survey of AI/AN substance abuse treatment programs to explore their use of EBTs (Novins et al., 2012). This paper draws on the data collected during this final phase.

2.1. Participants and study procedures

As described in detail elsewhere (Novins et al., 2012), data collection was conducted using a stratified sampling approach, dividing these programs into the following five strata: (1) the 20 largest AI/AN tribes, (2) urban AI/AN health clinics; (3) substance abuse services operated by the AN Health Corporations; (4) other tribes (federally recognized minus the 20 largest); and (5) other local and regional programs (independent nonprofit or for profit).

Using existing tribal, organizational and substance abuse program listings, consultation with Indian Health Service and state substance abuse treatment administrative staff, and the analysis of publicly-available information on the Worldwide Web, we identified specific treatment programs that had the potential to provide substance abuse services to AI/AN communities. We then contacted each identified program and determined whether it provided substance abuse treatment services to AI/AN communities. If the program confirmed providing such services, we described the project and asked whether there was a clinical administrator or other senior clinical staff whom we could ask to complete the survey (Novins et al., 2012). Once this staff member was identified and agreed to participate in the study, the staff member was given the choice of completing the survey online or over the telephone. Only two participants chose the telephone interview. The others were emailed a link to the survey for completion. Given the contingent question structure of the survey (with more questions asked when respondents endorsed greater experience with specific EBTs), completion time varied from 20–60 min. Once data collection was completed, all identifying information was deleted from the project databases, rendering these data anonymous. A total of 192 surveys were completed, yielding an overall participation rate of 63%, consistent with meta-analyses of participation rates in telephone and internet surveys (Cook et al., 2000; Van Horn et al., 2009).

Key sample characteristics are summarized in the left-hand columns of Table 1. The majority of programs were located in rural areas (74.0%) and were operated by a tribe or tribal consortium (63.0%); only 24.5% were accredited. The average number of frontline clinical staff was 5.6 with 83.3% reporting having at least one staff member who identified as AI/AN. The majority of programs reported that they collected data on treatment outcomes (64.2%) and consider EBTs in their strategic planning (58.3%). Study procedures were approved by the Colorado Multiple Institutional Review Board, who classified the study as exempt; and the Oregon Health and Science University's Institutional Review Board, who classified the study as expedited. The Indian Health Service Institutional Review Board classified the study as not human subjects research.

2.2. Measures

The survey was designed by the Advisory Board drawing on examples of other surveys of substance abuse treatment programs, including the National Drug Abuse Treatment System Survey (Andrews et al., 2014), the Comprehensive Community Mental Health Services for Children and Their Families Program Evaluation (Center for Mental Health Services, 2005), the University of Georgia National Treatment Center Study (Knudsen et al., 2011b), and the Assessment of the National Drug Abuse Treatment Clinical Trials Network Suvey (McCarty et al., 2008) as well as the results of the