

CLIENT AND PROVIDER VIEWS ON ACCESS TO CARE FOR SUBSTANCE-USING AMERICAN INDIANS: PERSPECTIVES FROM A NORTHERN PLAINS URBAN CLINIC

Frankie Kropp, MS, Maurine Lilleskov, PhD, MPH, Jennifer Richards, MPH,
and Eugene Somoza, MD, PhD; on behalf of the CTN0033-Ot-4 Team

Abstract: In addition to disparities in rates of substance use problems, American Indians (AIs) report multiple barriers to receiving treatment services. The present study utilized intake questionnaire data and focus groups to gain perspectives from 152 clients (65% male, 35% female; mean age 30 years) and 6 female providers on access to treatment for Northern Plains AIs in an urban, non-Native program. AI clients acknowledged the need for treatment more often than did substance users in general, but faced greater resource barriers. Both clients and providers offered specific recommendations for improving access to substance use treatment for AI populations in the Northern Plains.

INTRODUCTION

Despite well-documented disparities in rates of alcohol- and other substance-related problems (Centers for Disease Control and Prevention, 2011a, 2011b, 2011c; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012b), American Indians (AIs) receiving substance use treatment reportedly experience benefits and treatment outcomes that are similar to those of other racial groups (Dickerson et al., 2011; Evans, Spear, Huang, & Hser, 2006; Kidney, Alvarez, Jason, Ferrari, & Minich, 2011). However, previous research indicates that AIs face multiple barriers to accessing healthcare, including resource barriers, such as transportation needs, poverty, and lack of sufficient insurance (Goodkind et al., 2010; Johnson, Carlson, & Hearst, 2010; Lau, Lin, & Flores, 2012; Moulton, Miller, Offutt, & Gibbens, 2007; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004); health system barriers, such as underfunded care systems, less availability of specialized services, and lack of cultural competence among systems and providers (Dennis & Momper, 2012; Goodkind et al., 2010; Tripp-Reimer, Choi, Kelley, & Enslein, 2001); and patient/provider interpersonal barriers, such as medical mistrust and discrimination (Call et al., 2006;

Guadagnolo et al., 2009). Recent studies indicate that similar resource and system barriers exist for substance-using AIs (Dennis & Momper, 2012; Kropp et al., 2013; Venner et al., 2012), as well as other barriers common to substance users in general, such as comorbid mental health issues (Abbott, 2007; Kropp et al., 2013), stigma, and the belief that treatment is not necessary (Venner et al., 2012). Additionally, AIs seeking help for substance use problems face more limited treatment options, particularly options that address cultural beliefs, values, and practices (Gone, 2004; Jones-Saumty, Thomas, Phillips, Tivis, & Nixon, 2003; McFarland, Gabriel, Bigelow, & Walker, 2006; Radin, Banta-Green, Thomas, Kutz, & Donovan, 2012). Tribal nations are diverse, however, and some investigators have found evidence that factors associated with receiving substance use treatment may differ according to tribe, geographic region, and urban versus reservation location (Beals et al., 2005; Duran et al., 2005; Herman-Stahl & Chong, 2002; McFarland et al., 2006).

To address the need for additional data regarding alcohol and drug use in AI/AN communities, the National Institute on Drug Abuse's National Drug Abuse Treatment Clinical Trials Network (NIDA CTN) funded several projects in order to develop collaborative research partnerships with AI/AN communities (see Thomas, Rosa, Forcehimes, & Donovan, 2011 for a description of the overall project). As part of this larger project, researchers at the University of Cincinnati (NIDA CTN Ohio Valley Node; OVN) investigated substance use patterns and associated issues for AI substance use treatment clients at an urban, non-Native program in the Northern Plains. The OVN project was a joint effort of the CTN's OVN at the University of Cincinnati, the Northern Plains Tribal Epidemiology Center (NPTEC) of the Great Plains Tribal Chairmen's Health Board, and the City/County Alcohol and Drug Programs in Rapid City, South Dakota. Ongoing guidance was provided by a Community Advisory Board, which consisted of tribal members involved in substance abuse treatment and/or prevention on three area reservations and by a consultant from the Prairielands Addiction Technology Transfer Center, who was also an enrolled member of a Northern Plains tribe. Representatives from each of these groups collaborated to identify the study aims and procedures, which were endorsed through formal resolution by the Great Plains Tribal Chairmen. The overall project was reviewed and approved by the University of Cincinnati Institutional Review Board – Social and Behavioral Sciences (UC IRB-S) and by the Aberdeen Area Indian Health Service IRB, which provided approval specifically for activities occurring on Tribal lands; study activities represented in the present analyses were performed at a non-Tribal location and, therefore, were under the approval of the UC IRB-S. Details regarding the overall project, along with its primary findings, are described in Kropp et al. (2013).

One aim of the overall project was to gain the perspectives of AIs seeking treatment for methamphetamine and other substance use on issues related to treatment and the personal impact of use. This aim was met in two ways: first, by summarizing deidentified intake data from the

participating clinic, and second, by conducting focus groups with AIs in treatment. Another aim of the overall project was to gain the perspectives of urban treatment providers on issues of concern in providing treatment services for methamphetamine and other substance use with AIs; this aim was accomplished by conducting a focus group with treatment providers. The present study utilized this mixed methods approach to identify and seek potential solutions for perceived access barriers for substance use treatment-seeking AIs in the Northern Plains. Findings presented here will help fill the knowledge gap around barriers to treatment for urban AI substance users; it is hoped that these findings will help inform decisions in urban treatment programs about potential methods to increase access to care for this population.

METHODS

Participating Clinic

The participating clinic is a state-accredited provider of substance use treatment services located in the second-largest urban area in South Dakota. Services provided by the clinic include assessment, DUI classes, medically supervised detoxification, inpatient treatment, outpatient and intensive outpatient counseling, and transitional housing. Most referrals to the clinic come through the criminal justice system, although many clients are self-referred as well. Approximately 75% of clients are AI; although the clinic staff members have received training in understanding AI cultures and make provisions for AI clients to access some community cultural resources, the treatment provided at the clinic is not specific to AI cultural or healing practices. At the time of the study, the clinic did not have any AI treatment providers on staff.

Deidentified Intake Data

Intake data were obtained from the clinic intake questionnaire, which is a self-completed paper questionnaire administered to every treatment-seeking person who is admitted into program services at the clinic. It is not, however, administered to persons obtaining an evaluation only, nor is it readministered to persons who have repeat admissions within the course of a year. The questionnaire utilizes both categorical and open-ended responses covering a wide variety of topics, including substance use and treatment history, physical health, education, employment, finances, legal and social issues, family, spiritual beliefs and practice, and cultural identification. The questionnaire has not been assessed for psychometric properties. As part of the intake process, all treatment applicants completed a release indicating that the data they provided may be used for research purposes. No patient refused to sign the release; refusal to sign would not have excluded a

patient from receiving treatment services. Intake data from all ($N = 143$) self-identified AIs seeking treatment during the data collection period of the main study (2008-2009) were gathered by non-study-related clinic staff members, who then deidentified the data and provided them to the study team. Persons represented in the sample completed only those assessments normally collected during the intake process, and, thus, no study-specific informed consent was obtained. The study team selected a subset of questions from the deidentified intake questionnaire for analysis in the current study; because the data were deidentified, it is impossible to tell how many AIs completing the intake form actually attended their first treatment appointment. Some questions allowed the respondent to select more than one answer; as a result, respondents may be duplicated across the response options for such questions. Unanswered questions were coded as missing and removed from the sample size for that variable. To answer whether the setting in which the respondent was born and raised impacted the importance of cultural heritage, the study team categorized respondents by “Reservation only,” “City only,” “Rural/Ranch only,” or “Mixed.” The team then determined the percentage of respondents in each category who indicated that cultural heritage was “Important,” “Not Important,” or “Equivocal” (e.g., “not sure,” “maybe”). Because the intake questionnaire’s psychometric properties are unknown, information from it was summarized using only descriptive statistics.

Client Focus Groups

The second way in which we accomplished our aim of gaining perspectives of treatment-seeking AIs was by conducting gender-specific focus groups with AIs in treatment at the clinic. Candidates for the client focus groups were recruited from the pool of AI clients who were enrolled in services for methamphetamine and/or other substances at the clinic and had been receiving treatment for methamphetamine and/or other substances for the past 90 days or longer. A study team member who was a member of a local tribe made brief presentations to potentially eligible candidates at the beginning of group counseling sessions and invited interested persons to attend the focus groups.

Upon presenting for the focus groups, candidates were provided with information about the present study and, if interested, met with a study team member to review and ask questions about the informed consent form. Before signing, candidates demonstrated understanding of the information in the form by completing a brief comprehension tool. A study team member reviewed any missed questions to assist candidates in understanding the information.

A total of four male clients and five female clients presented for the focus group sessions, all of whom signed the consent and participated in the groups. No additional demographic information was collected for focus group participants; further, no information was available regarding differences between clients who chose to attend the focus groups and those who did not.

The research team, which included members of local tribes, developed a focus group manual; AI tribal treatment providers in the area provided additional input, and the Community Advisory Board provided a final review and approval. The manual provided a pool of potential questions from which the facilitators could select based on group composition and area of focus. Table 1 provides further descriptions of the areas of focus and question pool. The focus groups were facilitated by staff from the NPTEC, one of whom was a member of a local tribe. Both focus groups lasted approximately 2 hours and were audio recorded with participants' permission. Participants received retail gift cards worth \$15 as reimbursement for their participation.

Transcripts of the focus groups were analyzed post hoc rather than with a priori assumptions or hypotheses. In the first phase, transcripts were analyzed qualitatively using the thematic analysis method (Rice & Ezzy, 1999). A study team member with training and experience in qualitative analysis identified concepts, categories, and themes, which were grouped to form more abstract categories. Relationships among the categories were then identified. Next, team members coded the transcripts for comparisons between the interactions to expose meaning and processes that exist within the data. The codes were then carefully scrutinized to fully elaborate them and identify each of the emergent issues. Finally, members of the study team and Community Advisory Board reviewed the analysis to confirm that the findings were culturally congruent. Themes associated with access to treatment are included in the present study.

Provider Focus Groups

To accomplish the aim of gaining providers' perspectives, staff members at the clinic who provided substance use treatment services to AI clients were approached and invited to participate in the focus group. As with the client focus groups, candidates who presented for the provider focus group received information about the present study and, if interested, were given an opportunity to review, inquire about, and sign the informed consent form. Six female, non-AI treatment providers presented for, consented to, and participated in the 2-hour focus group. No additional demographic information was collected; further, no information is available regarding differences between providers who chose to attend the focus group and those who did not. Table 2 provides the areas of focus and question pool for the provider focus group. As with the client focus groups, the session was recorded and transcripts were analyzed post hoc using the method described above.

Table 1
Client Focus Group Areas of Focus and Question Pool

Focus Area - Use Pattern

Tell me a little about your history of using drugs and alcohol?

- How long have you been using Meth/other substances?
- Did you usually use 1 drug at a time or in combination?
- Under what circumstances did you use?
- What is your preferred drug of choice? Any special reasons?
- Without mentioning names, please tell me how you got access to substances?
- Did you commonly use on or off the reservation?

Focus Area - Treatment Entry

What are some of the reasons that made you seek this most recent treatment?

- How long had you been seeking treatment before coming to this program?
- What difficulties did you face in obtaining treatment?
- Did you seek help through the tribal treatment centers before coming to this program?
- Have you been a [Clinic] client before?
- What made you choose this program over the other? Or both?

Focus Area - Treatment Satisfaction

Tell me your opinion of this treatment program so far?

- What are some of the problems or issues you have with the kind of treatment you are receiving at [Clinic]?
- What do you like about [Clinic]?
- Tell me about the impact of any cultural differences on your treatment at [Clinic]?
- What are some suggestions for what could be done differently to make your treatment experience better?
- Have you ever been in treatment at a tribal treatment center?
(If yes) What are the major differences between the tribal treatment center and [Clinic]?
(If no) How do you think your treatment program would have been different at a tribal treatment center?

Focus Area - Tribal Identification

Are there any cultural practices you believe would enhance or increase your recovery?

- Where are you most likely to seek support to prevent relapse?
 - What role do your spiritual practices play in your recovery?
 - How do you address your spiritual needs at this point in your recovery?
-

Table 2
Provider Focus Group Areas of Focus and Question Pool

Focus Area - Prevalence

Tell me about trends in substance use you are seeing:

Among your American Indian clients? Among your clients in general?

- What 3 substances are you seeing the most problem with right now?
- What substances are significantly increasing in use?
- What other drugs are you seeing clients use problematically?
- How would you compare the use of Meth to the other drugs that you treat?
- How would you explain the trends that you see in Meth and other drug use?

Focus Area - Access to Care

Tell me about barriers faced by American Indians in accessing treatment for substance abuse problems?

- How do American Indian clients access treatment at this center?
- How do you ensure continuity of care for American Indian clients?
- What do you think could be done to increase access to treatment for American Indian clients?

Focus Area - Treatment Effectiveness

What are some of the challenges you experience with regard to treating American Indian clients?

- What changes in treatment do you believe would be most appropriate in impacting your American Indian clients for the better? For your clients in general?
- What are some mechanisms that you believe, if put in place, would ensure better care for your American Indian clients? For your clients in general?

Focus Area - Consultation and Referral

How often do you work in tandem with American Indian tribal treatment centers?

- (If work in tandem) What circumstances call for that collaboration? How does that influence the treatment of American Indian clients?
- (If not working in tandem) Do you believe it would make a difference if you did?
- Do you believe it is important for American Indian tribal treatment centers to work hand-in-hand with urban treatment centers? What effect would that have?

Focus Area - Culturally Specific Issues

What role do you believe cultural issues play in the treatment you provide for American Indian clients?

- What role do you believe traditional ceremonies and healing practices play in treating American Indians with substance abuse problems?
- Tell me about the role of spirituality for your American Indian clients?

RESULTS

Participant Characteristics

During the data collection period, 143 clients completing intake questionnaires identified as AI. Table 3 provides the characteristics of respondents to the intake questionnaire. Nineteen clients indicated an additional racial designation; “White” was indicated most often. Clients represented 18 different tribes, although 4 clients indicated no tribal affiliation. Sixteen records were missing gender information. Of the remaining records, 83 (65.4%) represented males and 44 (34.7%) represented females. The average age was 30 years overall (range, 20-63 years). More than half of the clients (58.0%) indicated that they had been raised in the city, and approximately one third (29.4%) reported having been raised on a reservation; the remaining 12.6% were raised in a rural/ranch (i.e., non-reservation) setting.

The 4 male focus group participants differed in the type of services they were receiving at the clinic and reported alcohol as the primary problem leading to treatment; additional drugs used included marijuana, methamphetamine, and cocaine. In contrast, the 5 female focus group participants were drawn exclusively from the clinic’s Intensive Methamphetamine Women’s Treatment Program for those transitioning out of the state prison system. All female participants also indicated significant alcohol and marijuana use, with use of cocaine, heroin, and psychedelic mushrooms reported to a lesser extent. It is unknown whether focus group participants also provided data via the intake form.

Table 3
Characteristics of Respondents on Clinic Intake Questionnaire

Characteristic	
Gender	<i>N</i> = 127
Male	83 (65.4%)
Female	44 (34.6%)
Additional Race	<i>N</i> = 143
White	14 (9.8%)
African American	1 (0.7%)
Other	4 (2.8%)
No additional race	124 (86.7%)
Age (mean average)	<i>N</i> = 85
All	30 years
Male	30 years
Female	31 years

continued on next page

Table 3, Continued
Characteristics of Respondents on Clinic Intake Questionnaire

Characteristic	
Where were you born? (type of setting)	<i>N</i> = 143
Reservation	42 (29.4%)
Rural/ranch	18 (12.6%)
City	83 (58.0%)
Where were you raised? (type of setting)	<i>N</i> = 137
Reservation	43 (31.4%)
Rural/Ranch	19 (13.9%)
City	75 (54.7%)
Difference in setting born/raised	<i>N</i> = 35
Reservation/Rural	4 (11.4%)
Reservation/City	9 (25.7%)
Rural/Reservation	2 (5.7%)
Rural/City	3 (8.6%)
City/Reservation	12 (34.3%)
City/Rural	5 (14.3%)

Specific Barriers to Treatment Identified

Table 4 provides the subset of access-related questions from clinic intake questionnaire. In addition, specific barriers to treatment were identified in the focus group responses.

Felt Treatment Not Necessary

When asked why they had not sought treatment earlier, 59.4% (*n* = 85) of the AI clients completing the intake questionnaire indicated they had not believed treatment was necessary until now. Most participants in the male focus group indicated they had not sought help on their own, but were now in treatment as a result of legal charges stemming from their substance use. Most of the female focus group participants stated they had never thought about treatment until provided with the opportunity to receive it as a part of their sentence. Conversely, treatment providers indicated that a great number of AIs readily seek admission to their programs, but are stopped by other barriers.

Table 4
Subset of Access-related Questions from Clinic Intake Questionnaire

Question	Number Responding, of 143 AIs seeking treatment (%)
What problems/issues have prevented you from seeking treatment earlier? (Select all that apply) ^a	
Didn't think I had a problem	85 (59.4%)
Cost of treatment	41 (28.7%)
Lack of transportation	14 (9.8%)
Child care needs	9 (6.3%)
Afraid of what family/friends would say/Other stigma	12 (8.4%)
Afraid significant other would not be supportive	3 (2.1%)
Afraid of legal problems if drug use was discovered/Other legal	15 (10.5%)
Long waiting list	8 (5.6%)
None	12 (8.4%)
How long did you have to wait for an intake appointment here (from first contact to today)?	
Less than 1 week	62 (43.3%)
1-3 weeks	46 (32.2%)
1 month or longer	3 (2.1%)
No response	32 (22.4%)
Did you call any other program for help before deciding to come here?	
Yes	34 (23.8%)
No	84 (58.7%)
No response	25 (17.5%)
If yes, why did you choose to come here? (Select all that apply) ^a	
No wait/waiting list shorter here	12 (35.3%)
Other program costs too much	21 (61.8%)
Transportation issues	11 (32.4%)
More convenient hours here	9 (26.5%)
Treatment staff more familiar with my racial/ethnic group here	2 (5.9%)
Wanted specific type of treatment available here	3 (8.8%)
Legal requirements	7 (20.6%)
Other unspecified	5 (14.7%)

^a Percentage totals are greater than 100% due to ability to select multiple answers

Resource Barriers

Lack of resources was the next most commonly indicated barrier to treatment by clients completing the intake questionnaire (44.8%; $n = 64$). Cost of treatment (28.7%; $n = 41$), transportation (9.8%; $n = 14$), and child care (6.3%; $n = 9$), were the resource needs most often mentioned in the intake data as barriers to treatment in the past. For those who had first sought treatment elsewhere ($n = 34$), most (79.4%; $n = 27$ unduplicated) indicated that resource barriers were a reason for completing the intake at the current clinic instead. Participants in the client focus groups also indicated lack of transportation as a barrier, as well as lack of access to other resources required to receive treatment, such as identification documents. Treatment providers indicated that transportation was particularly difficult for AI clients. For example, one provider noted that clients may need to travel to the reservation in order to obtain proof of tribal enrollment before accessing services. Putting herself in the client's shoes, she asked, "If I have to go get a tribal ID and need to go to [the reservation], how do I get there, how do I get back? Will I get back?" Treatment providers indicated that a lack of basic needs such as stable housing creates obstacles to entering treatment for many of their AI clients. A provider noted, "Native American clients that come in seeking treatment [...] might not have access to a phone, might not get their mail, you know, waiting lists can be anywhere from two weeks to two months [...] they don't get that phone call, or they don't get that letter until two weeks later, and so it's a logistics kind of issue, you know." Another indicated, "It's almost like you gotta start with the basic survival needs to help someone move through our basic process of getting treatment. Our [AI] clients, they don't have a whole lot of resources for that."

Stigma

Among clients completing the intake questionnaire, 10.5% ($n = 15$) indicated that stigma associated with substance use treatment had contributed to their not seeking treatment earlier. Specifically, most of these respondents indicated they had avoided entering treatment because they were afraid of what their family or friends would say; the remainder specified that they were afraid that their significant other would not support them receiving treatment. Providers indicated that stigma attached to receiving treatment, particularly treatment based in Western medicine, negatively impacts both treatment entry and retention for some AI clients.

Legal Issues

Among clients completing the intake questionnaire, 10.5% ($n = 15$) also indicated that legal issues had prevented them from seeking treatment earlier. Most of these respondents specified that they were afraid of getting into legal trouble if their substance use were discovered as a result of presenting for treatment. Clients in the focus groups, however, reported that engagement in the legal system facilitated access to treatment for them.

Treatment Availability

Only 5.6% ($n = 8$) of clients completing the intake questionnaire indicated that they had experienced difficulty with treatment availability prior to the current treatment episode, and 55.9% ($n = 62$) of the 111 clients responding to the question about length of wait indicated waiting less than a week to obtain their appointment for the intake interview. Approximately one third (35.3%; $n = 12$) of those 34 clients who had first sought treatment elsewhere indicated that the shorter wait list factored into their decision to enter treatment at the current clinic instead. Information from the client focus groups, however, indicated that accessing treatment can be quite problematic due to the lack of treatment slots in state, tribal, and Indian Health Service (IHS) treatment programs. One male client indicated “I had a hard time. I had to wait around town, ’cause everything was filled up, there wasn’t no openings at the...round here in [City], so during that time, you know, I was, you know, trying to hang on but I kept relapsing on my own, just falling off the wagon. It took me a while, took me at least a couple of months, before I got into treatment.” Participants in the provider focus group agreed that there are not enough treatment resources in the immediate area, noting that clients placed on a waiting list may lose motivation for treatment in the interim. Providers also indicated that the geographic distances involved in accessing most AI-specific treatment programs in the region render those options unavailable to many clients.

Cultural Differences

Clients were asked to describe the importance of their cultural heritage, with 129 responding to this question. Overall, respondents rated their cultural heritage as important (71.1%; $n = 91$), while 17.2% ($n = 22$) indicated it was not important and 11.7% ($n = 16$) gave equivocal responses. Importance of cultural heritage was then compared to setting born/raised; a total of 124 clients both gave complete responses to the setting born/raised questions and responded to the importance of cultural heritage question. Clients who had been born in one setting but raised in another tended to indicate that their cultural heritage was important more often (78.8%) than did clients who were both born and raised on a reservation (66.7%), in a city (69.5%), or in a rural/ranch setting (63.6%).

Although participants in all the focus groups recognized the value of having access to culturally specific elements in treatment, respondents varied in their estimation of the role cultural differences might play as a barrier to treatment. Male focus group participants consistently indicated a desire to incorporate Native ways into treatment for AI clients, and noted the frustration caused by not having access to those resources. One client noted, “Yeah, ’cause you know, once, um, you become sober, not everybody, but the majority of Native people want to get back into cultural stuff ’cause it’s like, you know, part of being sober.” Another added, “The Native people want, want to go into sweat and stuff and they don’t have no, no access to none here and you have some but you have to go to rez or out of town...” In addition, some male clients indicated having difficulty opening

up to non-AIs. Although all of the female participants agreed that including cultural elements to treatment would be beneficial, they did not view cultural differences as a barrier to treatment. Despite the clinic's lack of AI-specific services, participants in both client groups generally viewed their current treatment as beneficial. Participants in the treatment provider group cautioned that AI clients often differ in the importance they place on accessing elements of AI cultures. In addition, providers indicated that cultural differences exist in conceptualizing problems and approaching recovery. For example, one provider was discussing the differences in family relationships in AI culture as opposed to relationship concepts in mainstream substance abuse treatment. "Somebody could go to [non-tribal] treatment and have this extended family and certain roles of respect and you don't talk back and so on, you get labeled co-dependent. All of a sudden it's a problem in their treatment plan. So there's some basic differences in the dynamics that go on in family systems that we have to be sensitive to, because otherwise we tend to look at it as problematic." Another provider noted, "I was teaching a class at [Tribal College] and one of my people in class was white, sharing something she was dealing with and during the break, one of the Native American students came and didn't know how to take that, because that's not something you would share with people." Further, cultural differences exist among state, tribal, and IHS treatment programs, which impede communication and coordinating care. In speaking about attempting to refer AI clients to culturally specific programs, a provider noted, "We made the evaluation, we called that center, we get them placed, [but] because they don't accept our evaluations, they have to have a tribal evaluation, and it's a different process." Another noted, "When it comes to a tribal treatment program, I can't tell them much. I don't know much about the program. I couldn't tell them anything about the physical layout. If they have questions about what the treatment is going to be like, I can't answer a lot of them. I'm just more familiar with the system I've been working in so long. I know there's a real disconnect between the two systems."

Recommendations Made by Focus Group Participants

Focus group participants were asked to discuss ways in which urban, non-Native treatment programs in the Northern Plains could address the barriers to care noted above. Both clients and providers asserted that, in general, an increase in available treatment services and capacity is needed. There were no notable differences between client and provider focus group perspectives and recommendations on addressing barriers to care. In addition, participants offered the following specific recommendations:

1. Providing linkage services, such as case management, to clients on the waiting list would assist in stabilization and encourage ongoing motivation for treatment during the interim between the initial intake and treatment entry.

2. Providing assistance with transportation would increase clients' access to resources needed for treatment entry and program requirements, as well as allow clients greater access to AI cultural and spiritual resources during treatment.
3. Increasing outreach and education for clients' families and AI communities would help decrease the stigma associated with treatment for substance use and increase family support for client recovery.
4. Providing opportunities to incorporate elements of Native culture and spirituality into treatment through linkages to external resources (e.g., consulting with traditional healers, arranging for visits to purification lodges, inviting tribal elders to speak to client groups, finding local AIs in recovery to serve as sponsors or mentors) would help reduce cultural barriers by allowing individual clients to engage in AI practices at a level that is commensurate with their personal identification and interest. Further, increasing the number of AI staff members in the program would assist both AI clients and non-AI staff in bridging cultural gaps.
5. Increasing the exchange of information among state, tribal, and IHS programs would help reduce cultural barriers and improve coordination of care for AI clients. Providers stated, "Let's just get to know each other and maybe start there. That's what I need to do is, they come to our treatment facility and we talk about the commonalities we have and we go to theirs" and, "I think there's a lot of misunderstanding between people and things and businesses and whatever because they don't know." According to treatment providers, this process would involve multiple levels:
 - a. Individual: Non-Native treatment providers would benefit from receiving education regarding local AI cultures, including the similarities and differences among various tribes and their approaches to healing;
 - b. Institutional: Staff members in state, tribal, and IHS programs would benefit by visiting each other and gaining an understanding of services offered as well as issues related to intake, referral, and funding;
 - c. Systemic: Regional efforts should be made to identify and reduce systemic barriers to coordination of care among state, tribal, and IHS treatment programs.

DISCUSSION

Results from this study add to our understanding of issues facing AI substance users seeking treatment in urban settings and provide some specific recommendations from both providers and consumers on methods for improving access to treatment services for AI clients in the Northern Plains region. In general, study participants indicated that AIs in treatment at this urban, non-Native

program face similar challenges to treatment access to those reported by the U.S. substance-using population in general, although the extent to which some of these barriers are experienced may be different for AI clients.

Failure to acknowledge need for treatment is the primary roadblock for seeking treatment among substance users in the U.S. While this finding remained true for this study sample, 59.4% of clients indicated on the intake form that it had prevented them from seeking treatment—considerably less than the 95.3% reported for the U.S. overall (SAMHSA, 2012a). This difference may be due, in large part, to the fact that our finding came from retrospective information about AIs who had converted to a “treatment-seeking” status; we do not have information for substance-using AIs who did not present for treatment. However, information from the provider focus group supported a greater frequency of self-referral for treatment among their AI clients as compared to non-AI clients. The study findings offer no explanation for this difference; we postulate that the increased health disparities suffered by AI substance users may play a role. Tribes represented in the current study are part of the Aberdeen IHS catchment area, which has higher rates of substance-related health issues than both the U.S. general population and AIs in other IHS service areas (IHS, 2000). Other researchers (e.g., Dennis & Momper, 2012; Forcehimes et al., 2011) have reported that AI communities are concerned about the negative impact of substance use among their people and indicate that appropriate treatment services are needed.

As with other substance-using populations, resource barriers were prominently mentioned in this study. Transportation barriers contributed to difficulties in both entering treatment and meeting other resource needs. Because Native-specific treatment programs in the region are geographically dispersed, AIs seeking treatment in these facilities face numerous logistical problems, including the need to move away from their family and other support systems in order to enter treatment. AIs in treatment at the clinic also faced greater resource deficits in general (see Kropp et al., 2013).

While the clinic’s Westernized treatment services were seen as beneficial, both providers and clients indicated that access to elements of Native culture and spirituality should be, at a minimum, an elective adjunct to treatment. In a review of the literature, Greenfield & Venner (2012) reported a growing trend to incorporate elements of AI healing practices into substance use treatment and to investigate the impact of these on treatment outcomes, and noted that these inclusions have been indicated as helpful in increasing the appeal and efficacy of treatment, as well as contributing to better engagement and outcome. The availability of culturally specific services for urban AIs, however, is hampered by a number of issues. Although the majority of persons identifying themselves as AI live in urban areas, most AI-specific programs in the U.S. are located in rural settings (SAMHSA, 2009). McFarland et al. (2006) suggested that urban AIs may be underrepresented in the allocation of federal funds that are earmarked for providing treatment to Native populations.

Further, findings from a study on barriers to accessing federal grant opportunities (U.S. Department of Health and Human Services [US DHHS], 2006) indicated that staff members at tribal organizations often lack sufficient experience or time for tracking these opportunities that could increase treatment options. In addition, the short time between grant announcements and their due dates does not allow adequate time for coordinating with potential partners, obtaining tribal and regulatory approvals, and writing grant proposals. Consequently, many urban AI clients are being treated in non-AI-specific programs, such as the facility participating in the current study, where staff members may struggle with understanding exactly what would be helpful to their clients and access is challenged by the need to navigate separate treatment systems.

Recommendations from the focus groups can be characterized by two main themes: 1) increasing resources for urban AIs, and 2) addressing cultural gaps. Considering the recommendation to increase resources, it is important to note that SAMHSA funding for substance use treatment has declined in the past several years and, although IHS overall funding has increased, IHS funding for urban AI health has remained unchanged (US DHHS, 2012). Given this lack of additional monies, it is necessary to find ways to maximize existing resources to accomplish these recommendations. Toward this end, the study team suggests the following potentially cost-effective methods for implementing recommendations from the focus groups:

Expand the reach of case management

The expansion of case management services has the potential to reduce barriers to treatment entry and retention, as well as to help address cultural gaps. Focus group participants indicated three specific areas in which case management services might be particularly beneficial: 1) keeping wait-listed clients engaged prior to intake; 2) working with clients' families and communities to increase support for recovery; and 3) linking clients to culturally specific resources not provided by the treatment program. There is precedence for the effectiveness of case management in the region. In a 2008 study utilizing case management with at-risk AI women in the Northern Plains, May et al. successfully reduced rates of fetal alcohol spectrum disorders and demonstrated improvements in several other psychosocial areas. By maximizing available resources through outreach, education, and linkages, case management may be particularly cost effective.

Increase coordination between treatment programs and the criminal justice system

Focus group participants indicated that legal involvement actually facilitated treatment entry for them. It may be that greater coordination between the criminal justice system and treatment entities will assist incarcerated AIs with substance use problems to transition back to the community more successfully. In a study of AIs in remission from alcohol dependence, Feldstein, Venner, & May (2006) reported that the participants experienced significantly more alcohol-related

incarcerations than alcohol treatment episodes. Working together, the criminal justice system and the substance use treatment system could utilize their resources for mutual benefit. For example, funding treatment programs to provide intensive services within jail/prison facilities, even before release, could address a significant factor in the behaviors leading to incarceration, which may decrease recidivism in this population.

Define best practices for treating AI substance use treatment clients

Increasing knowledge of what treatment techniques and approaches are most effective with urban AI substance users in the Northern Plains will enable treatment providers to maximize existing funds. Although the availability of culturally congruent treatment elements was viewed positively by both providers and clients in this study, opinions varied as to which elements were most beneficial and whether elements of Native culture were necessary for successful treatment outcomes. Existing literature generally supports the use of cultural adaptations in treatment, but little is known as to what specific interventions result in improved outcomes for AIs in substance use treatment (Greenfield & Venner, 2012). To date, only two randomized controlled trials of interventions for Native substance users appear in the literature. In the first of these studies, O'Malley et al. (2008) found significantly improved treatment outcomes using culturally adapted assessment and counseling with oral naltrexone compared to placebo for alcohol dependence in an Alaska Native sample. In the second, Foley et al. (2010) examined an AI adaptation of a 12-hour job search-training program which was specifically designed for drug-dependent individuals and empirically-supported as efficacious in non-Native populations. The research team implemented this intervention, the Job Seekers Workshop, and the Job Interview Videos (JIV), a 40-minute two-part video, in an AI residential treatment program in order to compare outcomes on employment and substance use. The researchers found no difference between groups for employment outcomes. Further, although previous research had suggested that employment predicted successful functioning after substance use treatment in AI populations (Reynolds et al., 2000), Foley and his colleagues found no difference between groups for substance use outcomes. Additional comparative research is needed to further inform on which cultural adaptations increase efficacy and acceptability, as well as the extent to which interventions demonstrated effective in other populations might provide improved outcomes for AI clients.

Build collaborations between state, tribal, and IHS treatment providers

One way to both maximize resources and bridge cultural gaps is to develop strong collaborations between Native and non-Native treatment providers. Focus group members reported that, although previous attempts at collaboration had occurred, these large meetings and joint training efforts had been mostly unsuccessful. Given the lack of familiarity between the two treatment

systems, a more effective first step might involve simply assisting providers to learn more about each others' resources and processes. Regional AI organizations dedicated to integrated health initiatives (such as the Great Plains Tribal Chairmen's Health Board, a partner in the current project) may be uniquely positioned to facilitate such collaborations and serve as cultural consultants to urban, non-Native treatment providers.

Limitations

A number of limitations to the current study are noteworthy. First, data were collected at an urban, non-Native treatment program in a specific geographic area. Findings from the current study should not, therefore, be considered representative of urban AI substance users associated with culturally specific treatment programs, or of those in other areas of the U.S. Second, the clients in this study represent only those AI substance users who are engaged in the treatment process at some level. Presumably, they had already overcome many barriers to treatment; thus, their perspectives may be different from those of AI substance users who have yet to overcome such barriers. Next, significant differences exist between the intake questionnaire sample and the client focus groups. The intake questionnaire sample included all AIs seeking treatment services during the study timeframe, while the client focus groups were self-selected; small in number; and included only clients who had sought, entered, and remained in treatment for at least 90 days. Further, the client focus groups included an overrepresentation of females and persons legally mandated to treatment. Therefore, findings from the intake sample may not generalize to an AI treatment sample, nor will the focus group findings necessarily generalize to AIs prior to treatment or at treatment entry, or to treatment samples that differ in terms of gender proportions or legal status. Future research efforts on access to care for substance-using AIs should attempt to incorporate perspectives from a more diverse sample; it will be especially important to obtain such information from substance-using AIs who have not enrolled in treatment. Finally, the psychometric properties of the clinic's intake questionnaire are untested. Despite these limitations, the current study adds to the growing body of information available to non-Native treatment providers regarding barriers and provides recommendations for potential interventions to increase access to treatment for AI clients.

CONCLUSION

Studies report that AIs seeking services for substance use problems face numerous barriers to accessing treatment; however, factors associated with access to treatment may differ according to tribe, geographic region, and urban versus reservation location. As part of a larger project within the NIDA CTN, the study team utilized data from a clinic intake questionnaire, client focus groups,

and provider focus groups to identify and seek potential solutions for perceived access barriers for substance use treatment-seeking AIs in the Northern Plains. Resource barriers were prominently mentioned, particularly logistical issues associated with accessing care in this geographically dispersed region. Recommendations from the focus groups involved increasing resources for urban AIs and addressing cultural gaps. Specifically, focus group participants recommended expanding case management and assistance with transportation, along with outreach and education for patients' families, as methods of increasing resources for treatment access. To address cultural gaps, participants recommended incorporating elements of Native culture and spirituality into treatment through linkages to external resources and increasing the exchange of information among state-funded, tribal, and IHS programs at individual, institutional, and systemic levels. Implementing these recommendations in ways that maximize existing resources may help to improve access to substance use treatment for urban AIs in the Northern Plains.

REFERENCES

- Abbott, P. J. (2007). Co-morbid alcohol/other drug abuse/dependence and psychiatric disorders in adolescent American Indian and Alaska Natives. *Alcoholism Treatment Quarterly*, 24(4), 3-21. doi: 10.1300/J020v24n04_02
- Beals, J., Manson, S. M., Whitesell, N. R., Spicer, P., Novins, D. K., & Mitchell, C. M. (2005). Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. *Archives of General Psychiatry*, 62, 99-108. doi: 10.1176/appi.ajp.162.9.1713
- Call, K. T., McAlpine, D. D., Johnson, P. J., Beebe, T. J., McRae, J. A., & Song, Y. (2006). Barriers to care among American Indians in public health care programs. *Medical Care*, 44, 595-600. doi: 10.1097/01.mlr.0000215901.37144.94
- Centers for Disease Control and Prevention (CDC). (2011a). Binge drinking—United States, 2009. *Morbidity and Mortality Weekly Report*, 60(Suppl 01), 101-104. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6001a22.htm>
- CDC. (2011b). Cigarette smoking—United States, 1965-2008. *Morbidity and Mortality Weekly Report*, 60(Suppl 01), 109-113. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6001a24.htm>
- CDC (2011c). Drug-Induced Deaths—United States, 2003-2007. *Morbidity and Mortality Weekly Report*, 60(Suppl 01), 60-61. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6001a12.htm>
- Dennis, M. K., & Momper, S. L. (2012). "It's bad around here now": Tobacco, alcohol and other drug use among American Indians living on a rural reservation. *Journal of Ethnicity in Substance Abuse*, 11(2), 130-148. doi: 10.1080/15332640.2012.675244

- Dickerson, D. L., Spear, S., Marinelli-Casey, P., Rawson, R., Li, L., & Hser, Y. (2011). American Indians/Alaska Natives and substance abuse treatment outcomes: Positive signs and continuing challenges. *Journal of Addictive Diseases, 30*(1), 63-74. doi: 10.1080/10550887.2010.531665
- Duran, B., Oetzel, J., Lucero, J., Jiang, Y., Novins, D.K., Manson, S., & Beals, J. (2005). Obstacles for rural American Indians seeking alcohol, drug, or mental health treatment. *Journal of Consulting and Clinical Psychology, 73*(5), 819-829. doi: 10.1037/0022-006X.73.5.819
- Evans, E., Spear, S. E., Huang, Y. C., & Hser, Y. (2006). Outcomes of drug and alcohol treatment programs among American Indians in California. *American Journal of Public Health, 96*, 889-896. doi: 10.2105/AJPH.2004.055871
- Feldstein, S. W., Venner, K. L., & May, P. A. (2006). American Indian/Alaska Native alcohol-related incarceration and treatment. *American Indian and Alaska Native Mental Health Research, 13*(3), 1-22. doi: 10.5820/aian.1303.2006.1
- Foley, K., Pallas, D., Forcehimes, A. A., Houck, J. M., Bogenschutz, M. P., Keyser-Marcus, L., & Svikis, D. (2010). Effect of job-skills training on employment and job-seeking behaviors in an American Indian substance abuse treatment sample. *Journal of Vocational Rehabilitation, 33*(3), 181-192. doi: 10.3233/JVR-2010-0526
- Forcehimes, A. A., Venner, K. L., Bogenschutz, M. P., Foley, K., Davis, M. P., Houck, J. M.,... Begaye, P. (2011). American Indian methamphetamine and other drug use in the southwestern United States. *Cultural Diversity and Ethnic Minority Psychology, 17*(4), 366-376. doi: 10.1037/a0025431
- Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology: Research and Practice, 35*(1), 10-18. doi: 10.1037/0735-7028.35.1.10
- Goodkind, J. R., Ross-Toledo, K., John, S., Hall, J. L., Ross, L., Freeland, L.,... Lee, C. (2010). Promoting healing and restoring trust: Policy recommendations for improving behavioral health care for American Indian/Alaska Native adolescents. *American Journal of Community Psychology, 46*(3-4), 386-394. doi: 10.1007/s10464-010-9347-4
- Greenfield, B. L., & Venner, K. L. (2012). Review of substance use disorder treatment research in Indian country: Future directions to strive toward health equity. *The American Journal of Drug and Alcohol Abuse, 38*(5), 483-492. doi: 10.3109/00952990.2012.702170
- Guadagnolo, B. A., Cina, K., Helbig, P., Molloy, K., Reiner, M., Cook, E. F., & Petereit, D. G. (2009). Medical mistrust and less satisfaction with healthcare among Native Americans presenting for cancer treatment. *Journal of Healthcare for the Poor and Underserved, 20*(1), 210-226. doi: 10.1353/hpu.0.0108
- Herman-Stahl, M., & Chong, J. (2002). Substance abuse prevalence and treatment utilization among American Indians residing on-reservation. *American Indian and Alaska Native Mental Health Research, 10*(3), 1-23. doi: 10.5820/aian.1003.2002.1

- Indian Health Service. (2000). *Regional differences in Indian Health 1998-99*. Rockville, MD: Author. Retrieved from <http://www.ihs.gov/Publicinfo/Publications/trends98/region98.asp>
- Johnson, P. J., Carlson, K. F., & Hearst, M. O. (2010). Healthcare disparities for American Indian veterans in the United States. *Medical Care, 48*(6), 563-569. doi: 10.1097/MLR.0b013e3181d5f9e1
- Jones-Saumty, D., Thomas, B., Phillips, M. E., Tivis, R., & Nixon, S. J. (2003). Alcohol and health disparities in nonreservation American Indian communities. *Alcoholism: Clinical and Experimental Research, 27*(8), 1333-1336. doi: 10.1097/01.ALC.0000080343.90121.25
- Kidney, C. A., Alvarez, J., Jason, L. A., Ferrari, J. R., & Minich, L. (2011). Residents of mutual help recovery homes, characteristics and outcomes: Comparison of four US ethnic subgroups. *Drugs: Education and Prevention Policy, 18*(1), 32-39. doi: 10.3109/09687630903440022
- Kropp, F., Somoza, E., Lilleskov, M., Granados-Bad Moccasin, M., Moore, M., Lewis, D.,... Winhusen, T. (2013). Characteristics of Northern Plains American Indians seeking substance abuse treatment in an urban, non-tribal clinic: A descriptive study. *Community Mental Health Journal, 49*(6), 714-721. doi: 10.1007/s10597-012-9537-7
- Lau, M., Lin, H., & Flores, G. (2012). Racial/ethnic disparities in health and healthcare among U.S. adolescents. *HSR: Health Services Research, 47*(5), 2031-2059. doi: 10.1111/j.1475-6773.2012.01394.x
- May, P. A., Miller, J. H., Goodhart, K. A., Maestas, O. R., Buckley, D., Trujillo, P. M., & Gossage, J. P. (2008). Enhanced case management to prevent fetal alcohol spectrum disorders in Northern Plains communities. *Maternal and Child Health Journal, 12*, 747-759. doi: 10.1007/s10995-007-0304-2
- McFarland, B. H., Gabriel, R. M., Bigelow, D. A., & Walker, R. D. (2006). Organization and financing of alcohol and substance abuse programs for American Indians and Alaska Natives. *American Journal of Public Health, 96*(8), 1469-1477. doi: 10.2105/AJPH.2004.050575
- Moulton, P. L., Miller, M. E., Offutt, S. M., & Gibbens, B. P. (2007). Identifying rural healthcare needs using community conversations. *The Journal of Rural Health, 23*(1), 92-96. doi: 10.1111/j.1748-0361.2006.00074.x
- O'Malley, S. S., Robin, R. W., Levenson, A. I., Grey Wolf, I., Chance, L. E., Hodgkinson, C. A., ... Goldman, D. (2008). Naltrexone alone and with sertraline for the treatment of alcohol dependence in Alaska Natives and non-Natives residing in rural settings: A randomized controlled trial. *Alcoholism: Clinical and Experimental Research, 32*(7), 1271-1283. doi: 10.1111/j.1530-0277.2008.00682.x
- Radin, S. M., Banta-Green, C. J., Thomas, L. R., Kutz, S. H., & Donovan, D. M. (2012). Substance use, treatment admissions, and recovery trends in diverse Washington state tribal communities. *The American Journal of Drug and Alcohol Abuse, 38*(5), 511-517. doi: 10.3109/00952990.2012.694533

- Reynolds, G. L., Fisher, D. G., Estrada, A. L., & Trotter, R. (2000). Unemployment, drug use, and HIV risk among American Indian and Alaska Native drug users. *American Indian and Alaska Native Mental Health Research, 9*(1), 17-32. doi: 10.5820/aian.0901.2000.17
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. New York: Oxford University Press.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2012a). *Results from the 2011 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Author. Retrieved from <http://www.samhsa.gov/data/NSDUH/2011SummNatFindDetTables/NSDUH-DetTabsPDFWHTML2011/2k11DetailedTabs/Web/HTML/NSDUH-DetTabsTOC2011.htm>
- SAMHSA. (2012b). *Results from the 2011 National Survey on Drug Use and Health: Summary of national findings*. NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Author. Retrieved from <http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.htm>
- SAMHSA, Office of Applied Studies. (2009). *The N-SSATS report: Substance abuse treatment facilities serving American Indians and Alaska Natives*. Rockville, MD: Author. Retrieved from <http://www.oas.samhsa.gov/2k9/192a/192aTribalFac2k9.htm>
- Thomas, L. R., Rosa, C., Forcehimes, A., & Donovan, D. M. (2011). Research partnerships between academic institutions and American Indian and Alaska Native tribes and organizations: Effective strategies and lessons learned in a multisite CTN study. *American Journal of Drug and Alcohol Abuse, 37*, 333-338. doi: 10.3109/00952990.2011.596976
- Tripp-Reimer, T., Choi, E., Kelley, L. S., & Enslein, J. C. (2001). Cultural barriers to care: Inverting the problem. *Diabetes Spectrum, 14*(1), 13-22. doi: 10.2337/diaspect.14.1.13
- U.S. Department of Health and Human Services (US DHHS). (2006). *Barriers to American Indian, Alaska Native, and Native American access to HHS programs*. Retrieved from <http://aspe.hhs.gov/hsp/06/barriers2access>
- US DHHS. (2012). *Fiscal year 2013 budget in brief: Strengthening health and opportunity for all Americans*. Retrieved from <http://www.hhs.gov/budget/budget-brief-fy2013.pdf>
- Venner, K. L., Greenfield, B. L., Vicuña, B., Muñoz, R., Bhatt, S., & O'Keefe, V. (2012). "I'm not one of them": Barriers to help-seeking among American Indians with alcohol dependence. *Cultural Diversity and Ethnic Minority Psychology, 18*(4), 352-362. doi: 10.1037/a0029757
- Zuckerman, S., Haley, J., Roubideaux, Y., & Lillie-Blanton, M. (2004). Health service access, use, and insurance coverage among American Indians/Alaska Natives and Whites: What role does the Indian Health Service play? *American Journal of Public Health, 94*, 53-59. doi: 10.2105/AJPH.2005.063230

AUTHOR INFORMATION

Ms. Kropp is the CTN Ohio Valley Node Director of Clinical Trials Management at the Department of Psychiatry and Behavioral Neuroscience, University of Cincinnati College of Medicine. She is the corresponding author and can be reached at 3131 Harvey Avenue, Suite 104, Cincinnati, OH, 45229; kroppfb@ucmail.uc.edu; 513/585-8227.

Dr. Lilleskov is president of Xcel Research Consulting, Inc., PO Box 1365, Rapid City, SD, 57709.

Ms. Richards is a Senior Research Associate with the Center for American Indian Health, Bloomberg School College of Public Health, Johns Hopkins University, PO Box 857, Tuba City, AZ 86045.

Dr. Somoza is Professor Emeritus, Department of Psychiatry and Behavioral Neuroscience, University of Cincinnati College of Medicine, 3131 Harvey Avenue, Suite 104, Cincinnati, OH 45229.

This manuscript is dedicated to the memory of Dr. Duane Mackey and Terryl Blue-White Eyes.