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Content Analysis of Perceptions of Combined Pharmacobehavioral Treatment for American Indian People With Opioid Use Disorder

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Objective: Both opioid misuse and overdose mortality have disproportionately impacted the American Indian population. Although medications for opioid use disorder, such as buprenorphine (BUP-NX), are highly effective in reducing overdose mortality, questions have been raised about the cultural acceptability of Western medical approaches in this population. Understanding patients' desired recovery pathways can lead to more culturally appropriate, patient-centered, and effective approaches to opioid use disorder (OUD) treatment. In this qualitative study, we document experiences with combined pharmacobehavioral treatment for OUD and suggestions for enhancing it. **Method:** Participants ($N = 45$) were American Indian patients and community members impacted by OUD. They participated in one-time, 45- to 60-min, semistructured interviews. **Results:** Findings from conventional content analysis indicated participants were grateful for a Tribally run combined pharmacobehavioral OUD treatment program, which made treatment more financially and geographically accessible over a large, rural area. Participants expressed satisfaction with BUP-NX and the accompanying behavioral health programming but were interested in making it more accessible through telemedicine appointments and mailed prescriptions. Participants noted the importance of clear communication about this kind of programming, which tends to be less structured than other substance-use treatment programs, but also appreciated its tailored, compassionate, and holistic approach. Participants were interested in robust counseling options; a low-barrier, acceptance-based, and harm-reduction orientation; as well as more culturally aligned programming that honored their Native heritage and traditional medicine. **Conclusions:** Treatment providers, researchers, and policymakers should consider integration of more patient-driven, compassionate, and culturally aligned means of intervention for American Indian patients with OUD.

Public Health Significance Statement

This study summarizes important insights from American Indian patients and community members impacted by opioid use disorder that may make treatment more patient-centered, accessible, and culturally relevant.

Keywords: American Indian, Cherokee Nation, opioid use disorder, medication for opioid use disorder, qualitative analysis

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continued

The overdose mortality rate for American Indian and Alaska Native (AI/AN) people has accelerated beyond the national average, increasing nearly fivefold in 17 years (Tipps et al., 2018). Since the pandemic, there has been a sizable spike in overdose deaths in the general U.S. population, with AI/AN people experiencing both greater relative increases than non-Latinx Whites (33% vs. 11% increase, respectively) and higher overdose mortality rates (56.6 per 100,000) than all other races (Spencer et al., 2022). Considering these data, effective treatment options for opioid use disorder (OUD) that focus on reducing opioid-related harm are essential.

A group of medications for opioid use disorder (MOUD; e.g., methadone, buprenorphine-derived medications) is now considered the treatment gold standard. Among MOUD, buprenorphine + naloxone (BUP-NX), a partial opioid agonist treatment, is the most widely prescribed in the United States and is highly effective in reducing overdose mortality (Wakeman et al., 2020; Xu et al., 2022). Across studies, retention in MOUD is associated with $\geq 50\%$ decreases in overdose-related and all-cause mortality (Ma et al., 2019; Pearce et al., 2020; Santo et al., 2021).

Despite their increasing availability, opioid agonist treatments, such as BUP-NX, are less available in substance-use treatment programs serving AI/AN patients than in those serving the general population (22.39% vs. 27.60%; Krawczyk et al., 2021). The lower availability of BUP-NX in Native communities reflects larger health services inequities, a relative scarcity of waived physicians in rural areas (the need of waiving was still in place at the time of this research), and a perceived incompatibility of opioid agonist treatments with local treatment philosophies (Rieckmann et al., 2017; Venner et al., 2018).

A National Institute on Drug Abuse-supported panel of Native and non-Native researchers, providers, and community members sought to address issues surrounding MOUD in Native communities. In documenting this discussion, Venner et al. (2018) observed that researchers and providers could better leverage the relative strengths of both Indigenous and Western approaches by honoring the “AI/AN emphasis on spirituality, holistic healing and wellness” and using a “[community-based participatory research (CBPR)] approach based on the concept of ‘two-eyed seeing,’” in which both Indigenous healing traditions and Western medicine are included in a shared treatment vision.

Lonnie A. Nelson played a lead role in conceptualization, funding acquisition, investigation, project administration, resources, and software, a supporting role in writing—original draft, and an equal role in formal analysis, methodology, supervision, validation, and writing—review and editing. Susan E. Collins played a lead role in writing—original draft and an equal role in conceptualization, formal analysis, funding acquisition, methodology, project administration, supervision, and writing—review and editing. Emma Shinagawa played a supporting role in formal analysis, investigation, writing—original draft, and writing—review and editing. Sooyoun Park played a supporting role in formal analysis, writing—original draft, and writing—review and editing and an equal role in visualization. Vaishali Rajeev played a supporting role in formal analysis, project administration, and writing—original draft. Grace McPhail played a supporting role in formal analysis and writing—original draft. Sage Saplan played a supporting role in formal analysis and writing—original draft. Emily M. Taylor played a supporting role in formal analysis, validation, and writing—review and editing. Aaron T. Aguilar-Bonnette played a supporting role in formal analysis and writing—

review and editing. Sage Mednansky played a supporting role in formal analysis and writing—review and editing. Jessica Douthitt played a supporting role in writing—original draft. Roxanna J. King played a supporting role in formal analysis, validation, and writing—review and editing. Mark A. Taylor played a supporting role in resources, validation, and writing—review and editing and an equal role in funding acquisition, investigation, and project administration. Terrence K. Kominsky played a supporting role in investigation, methodology, project administration, and writing—review and editing and an equal role in conceptualization. Charity Green played a supporting role in validation and writing—review and editing. Andrew J. Saxon played a supporting role in supervision and writing—review and editing. Seema L. Clifasefi played a supporting role in conceptualization, project administration, and writing—review and editing.

Venner et al. (2018) further noted that areas of cultural misalignment and challenges to implementation of MOUD in AI/AN communities include the following: the lack of explicit integration of spirituality and culture in its implementation; the unacceptability of “evidence-based practice” in the absence of cultural adaptation; and the suggestion that MOUD may be needed long-term to maintain positive outcomes, which directly conflicts with some community members’ desire for abstinence from all drugs and medications. These observations have since been echoed by other researchers who have noted similar patterns across Native communities and assert that incorporating community-driven and culturally relevant treatment components and traditional healing methods is necessary to promote recovery and wellness across various key domains (i.e., spiritual, physical, emotional, mental; Blume, 2021; Mpofu et al., 2021; Zeledon et al., 2020).

In light of these suggestions, a team of researchers, community members, as well as staff, providers, and management at Cherokee Nation Health Services (CNHS), one of the first Tribally run “medication-assisted treatment (MAT)”¹ programs prescribing BUP-NX to bolster their preexisting behavioral health program for substance use disorder treatment, came together to document community perspectives to inform the enhancement of this program into the future. Collectively, our team deemed that a better understanding of community members’ and patients’ experiences with combined pharmacobehavioral OUD treatment programs as well as their desired future adaptations could help providers more effectively engage and retain patients and thus reduce the risk of opioid-related harm, including overdose-related deaths.

¹ “MAT” is the term used by CNHS management, staff, providers, and patients to describe their own program, where intentional pathways to MOUD were added to augment a more extensive behavioral health substance use disorder treatment program. We also acknowledge that, since these data were collected, the terms “medication-assisted treatment” and “MAT” have been flagged as terms that can convey negative bias or stigma in the treatment of people with substance-use disorder. In recognition, we have replaced these terms throughout the draft with “combined pharmacobehavioral treatment programming for OUD.” We have, however, opted to leave these terms in the article where they appear in interview prompts and were used by participants themselves, so as to accurately report on the project’s methods at the time they were implemented and to hew as closely as possible to participants’ own words, experiences, and treatment context.

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To this end, the present qualitative study features a conventional content analysis of interviews with community members with lived experience of OUD and patients at the CNHS's combined pharmacobehavioral OUD treatment program. The aim of this study was to describe participants' perceptions of this combined pharmacobehavioral OUD treatment program—its current strengths and challenges—and provide points for potential program enhancement that could improve retention, reduce substance-related harm, increase cultural connectedness, and more holistically improve quality of life.

Method

Study Design and Larger Context

These data were collected within the context of a larger, three-phase, community-based participatory research project. Community-based participatory research is a collaborative research approach that equitably involves community members, researchers, and other stakeholders in the research process with an aim of combining knowledge and action to create positive social change (Collins et al., 2018; Wallerstein et al., 2017). In this study more specifically, the research leadership and team included both university-based researchers and CNHS staff and clinic management, and the community advisory board included CNHS clinic staff, providers, and management as well as community members. In this three-phase model, we first elicit community perspectives on existing treatment and how to redesign it in the community's own vision. Second, we work with community advisory boards to shape these suggestions into manualized approaches. Third, we test the efficacy of these approaches in controlled trials. These data were collected in the context of the first of the above phases to (a) produce local findings that could be considered for their transferability to other communities and settings (Korstjens & Moser, 2018) and (b) inform the efforts of the local community advisory board in cocreating an enhanced version of the existing program (Collins et al., 2018).

Setting

This study was conducted largely within CNHS's combined pharmacobehavioral OUD treatment program, which was started in 2016. It currently has a panel of four providers prescribing BUP-NX as well as behavioral health counselors and staff serving 767 patients with OUD in a health care system comprising approximately 152,000 patients altogether. At the time of the interviews, the program featured MOUD and behavioral health support. Group treatment approaches were primarily abstinence-based and cognitive behaviorally oriented; however, counselors and family care managers worked to keep patients engaged within the program. At the time of these interviews, there were no culturally specific offerings through CNHS's combined pharmacobehavioral OUD treatment program; however, an outside group of community volunteers were available to meet with patients and offer connections to external cultural events to support recovery. Anecdotal reports from clinic staff at the time indicated that patients were primarily attending MOUD-related medical appointments and not frequently attending CNHS behavioral health groups or external cultural offerings extended through community volunteers.

Participants

Participants in this study were American Indian (AI) adults recruited via quota sampling as either patients in the CNHS combined pharmacobehavioral treatment program ("patient participants"; $n = 30$) or community members with lived experience of opioid use who were living in Cherokee Nation ("community participants"; $n = 15$). The importance of sampling from CNHS patients who had received services from their combined pharmacobehavioral OUD treatment program was a priority; however, the additional inclusion of community members with lived experience of opioid use who had not opted for formalized OUD treatment was considered an important aspect of improving outreach and engagement. The initial sample size was based on the research team's past experience regarding the necessary data to reach saturation in similar study designs; however, data collection continued until saturation was reached in a local evaluation of data adequacy (Vasileiou et al., 2018).

Measures

The Personal Information Questionnaire assessed age, sex assigned at birth, race, ethnicity, education level, and Tribal affiliation. This measure was used to describe the sample.

Open-ended *qualitative interview prompts* were developed by a study leadership team based on prior research and clinical experiences. Items used in the current analysis primarily comprised those that focused on (a) experiences with the CNHS program or other combined pharmacobehavioral OUD treatment or MOUD-only clinics and (b) preferred topics and protocols for future iterations of combined pharmacobehavioral OUD treatment programs. However, analyses included participants' responses to other interview prompts if they were relevant to the above topics. These additional prompts included discussion of substance use in the larger context of their lives, personal identification with and interest in Native cultural practices (e.g., healing circles, traditions, or other practices) integrated into substance-use treatment more broadly, preferred modes of communication (e.g., in person, phone, text, postal mail, email, video conferencing, online), perspectives on telehealth approaches, and concerns about the 2019 novel coronavirus disease (COVID-19) and how they felt the pandemic affected their substance use and treatment (see Supplemental Appendix A, for a complete list of qualitative prompts).

Procedure

All procedures were reviewed and approved by the Washington State University Institutional Review Board as well as the Cherokee Nation Institutional Review Board. Given its qualitative nature, this study was not preregistered. CNHS staff informed patients in the combined pharmacobehavioral OUD treatment program about the opportunity to participate in the study by showing them study flyers or by referring patients to the research team's email and/or telephone contact information. Flyers were also hung on bulletin boards in community gathering spaces, and online and print advertisements were placed in the local newspaper. When potential participants contacted the study team via email or phone, the study staff set up an initial information session at their convenience.

Initial information sessions aimed for maximal flexibility during the pandemic, so we offered that participants could use their own

phone or video conferencing capabilities or use those at prearranged study locations where tablets were set up with video conferencing capability. Later in the pandemic, as restrictions began to lift, some interviews were conducted in-person, one-on-one, and following all institutions' current COVID-19 guidelines.

Research staff (i.e., Native and Indigenous identifying medical and graduate-level students, PhD-level research coordinator, and coprincipal investigator) provided information about the study and an opportunity for prospective participants to have all their questions about participation answered. Those interested in participation provided verbal informed consent that was audio recorded and stored on secure servers at the primary research institution. Participants then shared their contact information to facilitate contact in case they were disconnected during the interview, to deliver the \$40 gift card, and upon completion of their interview, to allow for follow-up contact if they indicated interest in staying involved in subsequent stages of the larger research project.

Research staff administered the measures and interview prompts listed above and recorded the interviews verbally on secure recording devices as well as in REDCap (Harris et al., 2009), a secure, online, Health Information Portability and Accountability Act-compliant online data collection program. Following the interview, participants received a \$40 gift card via postal mail or electronically to honor their time.

Data Management and Analysis Plan

These program-specific data were part of a larger data collection at a single time point and have not been published elsewhere. Sessions were transcribed for qualitative analysis. Transcripts were stripped of identifying information prior to data coding. The goal was to provide a conventional content analysis of participants' previous experiences of programs offering MOUD, including but not limited to services at CNHS's combined pharmacobehavioral treatment program, and means of improving these services. Conventional content analysis is a qualitative research method used to interpret the content of text data through a systematic classification process involving coding and identifying themes (Hsieh & Shannon, 2005; Krippendorff, 2004). In conventional content analysis, the researcher does not start with preconceived, theory-based notions about what types or categories of codes will be identified. Instead, the researcher allows the data to drive the codes and categories (Hsieh & Shannon, 2005). While it is not the only qualitative approach that could address the current research question, conventional content analysis was deemed appropriate to preliminarily describe a lesser researched topic while staying close to participants' words and perspectives and to highlight potential points for program enhancement.

Qualitative data were managed in Dedoose (2014) and were independently coded using a constant comparative process (Charmaz, 2014; Miles & Huberman, 1994). The seven coders were Native- and non-Native-identifying medical students, master's and doctoral-level students in psychology and public health, and one of the coprincipal investigators. Initial coding was conducted using a line-by-line technique, whereby coders narrated the actions occurring in the interviews (Charmaz, 2014). Following independently conducted initial coding, we created a codebook during consensus meetings, wherein incident-by-incident codes were pooled and idiosyncratic or redundant codes were collapsed or removed. In the next coding phase, we used the codebook to independently double-code 10% of the

interviews until adequate intercoder consistency was established (Miles & Huberman, 1994; Shek et al., 2005). Any discrepancies and issues in coding were addressed during weekly coding meetings and resolved via consensus. Once adequate intercoder consistency was achieved (percent agreement: 79%), the remaining interviews were coded independently. (We acknowledge Krippendorff's α and Cohen's κ are additional means of conducting intercoder consistency, and we chose percent agreement for simplicity with multiple coders and a relatively high number of coding categories.) Independent coding was finalized with a round of thematic coding to synthesize focused codes and categories and reflect the complexity of participants' perceptions, values, and relationships to different topics (Charmaz, 2014). We reviewed primary findings with the study's community advisory board prior and subsequent to the drafting of this article, engaged in member checking, and took additional steps to ensure resonance (i.e., portraying an adequately complete picture of participants' experience), credibility (i.e., ensuring logic of and sufficient groundedness of codes and themes), and usefulness (i.e., offering interpretations that can further work in this field; Charmaz, 2014). Given the sensitive nature of qualitative data collected via long-form interviews, these data are not publicly available.

Results

Sample Description

Participants had a mean age of 40.43 years ($SD = 11.75$). They were 48.9% female sex assigned at birth ($n = 22/45$) and 51.1% male sex assigned at birth ($n = 23/45$). Of the overall sample, 40.0% ($n = 18$) self-identified as American Indian only and 60.0% ($n = 27$) as multiracial. Participants represented a range of Tribal affiliations including Cherokee, Osage, Chickasaw, Shawnee, Seminole, Choctaw, and Creek. Additionally, 11.1% ($n = 5$) of the sample identified as Hispanic/Latinx/Latine. Considering the highest level of education completed: 2.3% ($n = 1$) attended less than high school, 6.8% ($n = 3$) attended some high school, 27.3% ($n = 12$) completed high school or equivalent, 15.6% ($n = 7$) completed vocational school, 36.4% ($n = 16$) attended some college, 11.4% ($n = 5$) were college graduates, and 2.3% ($n = 1$) had an advanced degree. Nearly all participants gave interviews on the phone ($n = 41$); however, one participant was interviewed via videoconference, and three participants were interviewed in person.

Primary Analyses

Perceptions of Existing Programs to Date

Overall, participants generally expressed satisfaction with the current combined pharmacobehavioral OUD treatment program (e.g., "I'm pretty satisfied with it right now" [PAT6], "I think they pretty much got it down" [PAT20], and "I've been supported and encouraged and kind of given the tools I need to live life on my terms. I'm really grateful" [PAT27]). There were, however, a few concerns as well. In this section, we will share more specific themes that came up in participants' perceptions of combined pharmacobehavioral OUD treatment programs, including the role it fills meeting the community's health care needs, its counseling services, the medication prescribed through the program (i.e., BUP-NX), and structural barriers to program participation (see Table 1 for themes and their relative representation).

Table 1
Perceptions of Programming to Date and Suggestions for Its Enhancement

Theme/topic	N	%	Example
Perceptions of combined pharmacobehavioral programming to date			
Tribally run combined pharmacobehavioral programs can fill an important need in the community	4	9	"It was like kind of hard for us to find suboxone at first until we heard of Cherokee Nation." (PAT14)
Perceptions of medication for opioid use disorder (MOUD)			
Benefits of MOUD			
Appreciation for reduced craving and withdrawal	11	24	"That's like the main thing I use [suboxone] for is to control the cravings, you know. It helps a lot, it's really helpful with that." (PAT6)
Reduce temptation to use other illicit substances	5	11	"I don't go searching for it. I don't have to pay for nothing else. And just go through all the drama and stuff that it takes to get other drugs, you know?" (PAT17)
Pain management	4	9	"Been able to manage with the medicine, and I haven't had any pain medicine since I've started the program." (PAT29)
Improve overall functioning and health-related quality of life	2	4	"It makes you feel like you can get up and take care of your kid and, you know, go to work." (PAT7)
Concerns about MOUD			
Physical side effects	8	18	"It hurts my stomach a lot of the times." (COM11)
Having to take BUP-NX consistently to ensure positive effects, which felt like another form of dependence	5	11	"I'm living on another crutch and have lived on this crutch for 6 years now." (PAT5)
Perceptions of counseling			
Benefits			
General appreciation for the role of counseling and its support	12	27	"The counseling is good." (PAT1)
Compassion is key to good counseling	9	20	"[The counselors are] very caring and compassionate and, um, very down to earth. Not judgmental." (PAT26)
Concerns			
Interest in additional and/or more intensive counseling opportunities	3	7	"I think more counseling would be good." (PAT6)
Not feeling counseling is for everyone	3	7	"If you don't like counseling, I don't think it's ever gonna help you." (PAT18)
Structural barriers to accessing the program			
Confusion about timing and requirements of services	8	18	"At first [Cherokee Nation] became the Suboxone program-and they weren't helping anybody unless you had Hep C." (PAT24)
Long distances to programming	7	16	"It's a 2 hour drive." (PAT15).
Pharmacy wait times during the pandemic	7	16	"I sat in the parking lot for 5 hours waiting on 3 pills." (PAT16)
Concerns about lack of addressing pain and its overlap with OUD in the programming	3	7	"The Suboxone is being used every day more and more for chronic pain, so they need to have in the system with insurance and all that, that it is a chronic pain reliever, not just for heroin addicts or opiate addicts." (PAT9)
Suggestions for enhancing MAT programming			
Addressing medication choice and questions	4	9	"I would say more options. And what I mean by that is, uh, there's people that's been getting off opiates for a long time now, which is with Valium, and then they would take them off of it." (COM2)
Improving counseling			
Providing more extensive and tailored counseling	12	27	"To learn to cope with different stressors or whatever it may be." (COM4)
Having more robust group offerings	9	20	"Even more groups." (PAT2)
Ensuring counselors are nonjudgmental and relatable	5	11	"More love and compassion than judgment." (PAT30)
Lowering structural barriers to accessing the programming	2	4	"More locations." (PAT28)
Integrating more cultural practices and activities into substance-use treatment			
Incorporation of cultural activities	6	13	"The sweat lodge really. They thought it helped them to detoxify their bodies and it helps clear up their minds." (COM4)
Inclusion of traditional medicine practices	5	11	"It's kind of like a pyramid, a food pyramid, but it's a medicine wheel for good health." (PAT16)
Dissemination of cultural information and learning opportunities	4	9	"Someone may want to find out you know more about their culture, their background, or whatever. You know, that'd be cool to find out information like that." (PAT13)
Perceptions of harm-reduction approaches in treatment			
Positive perceptions of harm reduction	33	73	"Drug treatment would be something that anybody could come to no matter what point they're at." (PAT3)
Preference for abstinence-based treatment	4	9	"What good it would do? I mean, what kinda treatment is it if you don't have to be sober?" (COM12)

Note. N = 45. Denominators for all percentages were 45; however, not all participants provided quotes that were relevant for each category; thus, percentages within themes may not total to 100%. BUP-NX = buprenorphine; COM = community; OUD = opioid use disorder.

The CNHS Combined Pharmacobehavioral Treatment Program Fills an Important Need in the Community. The program offered by CNHS provides free services and medication to Tribal citizens, including BUP-NX, the cost of which was noted as a barrier in prior experiences (see Table 1 for relative representation). One participant appreciated the CNHS program because:

You don't have to pay for [BUP-NX], for one, cause it was very, very expensive to buy it yourself. And that's a lot of the problem, you know. I see with this issue right now is, the people like me back then that didn't have nowhere to go and to get the medication for free. Well, if you're already on drugs, and, you know, trying to help yourself, but you don't have anything to help yourself with, how're you gonna afford a \$400 to \$500 medicine? (PAT22)

Another individual indicated the CNHS program:

Was a lifesaver because, instead of the 90 pills I was supposed to take a month, I was lucky if I got 30. There were some months where I had 15 because that's all I could afford.... [Now] I don't pay anything for my medication—my pain medication, any of my medication actually—because I get it through the Cherokee Nation. (PAT9)

Participants View BUP-NX Positively, Even as They Perceive Side Effects. Positive perceptions of the sole MOUD prescribed by the CNHS program at the time of these interviews (i.e., BUP-NX) predominated. First and foremost, participants appreciated the fact that BUP-NX eases opioid craving and withdrawal (see Table 1 for relative representation). One participant noted, "I can agree that. ... I don't have any cravings at all for opioids" (PAT12). Another participant mentioned, "It made my sickness go away, it made my cravings go away" (PAT25).

Other individuals highlighted BUP-NX's helpful role in their pain management and lessening their prior dependence on other pain medications (see Table 1 for relative representation). One participant said they started BUP-NX "because it's a safer method, and it killed my pain to begin with" (PAT1). Another participant indicated that they had "been able to manage with the medicine, and I haven't had any pain medicine since I've started the program" (PAT29). Another recalled, "When they prescribed me, uh, BUP-NX, I thought it was the greatest thing in the world. Um, it, it took my desire away from pain pills" (PAT11).

Other participants indicated various ways in which BUP-NX had helped improve their overall functioning and health-related quality of life (see Table 1 for relative representation). One participant described BUP-NX as allowing them to "feel normal" (PAT3), and another stated "I've got my BUP-NX, and I mean I would say that I have, I have a life" (PAT16). Additionally, BUP-NX was credited with reducing the temptation to engage in illicit drug-seeking, thereby reducing harm (e.g., "I'm supplementing something legal instead of using a needle and possibly getting a disease or dying or putting something in my body that I don't know what it is" [PAT13]).

In noting its helpfulness, some participants also warned that it needed to be taken consistently to ensure the positive effects (see Table 1 for relative representation). This felt like its own kind of dependence:

The medicine really keeps you from having cravings. And, but like, it just, it makes you feel better. It makes you feel like you can get up and take care of your kid and, you know, go to work, but as soon as you don't have it, you're either want to either use or, you know, it's one or the other. (PAT7)

Further along these lines, a few participants worried that BUP-NX might be a "crutch" (PAT5) or constitute "swapping out one drug for another" (COM12).

Additional participants noted experiencing negative physical side effects of BUP-NX (see Table 1 for relative representation). One participant noted:

It made me really sick. Like, I was able, I was able to take it like to get high off of it, but then when I was taking it every day it was making me throw up like over half of the days of the week, and it was just really nasty. (PAT14)

Another participant indicated they walked a fine line between feeling over- or underdosed: "If I don't take just the perfect scientific amount for me, I'll get sick or I'll get high" (PAT5).

Participants Appreciated Positive Counseling Experiences but Wanted More Consistent Communication and More Counseling Options. Within the CNHS combined pharmacobehavioral OUD treatment program, participants mentioned having positive experiences with counseling more generally (e.g., "I like the counselors. ... We get to sit around in a group and ... everybody's in the same boat" [PAT11]), as well as with specific counselors and the strong therapeutic alliance they built (e.g., "I like my, my, um, my, uh, my counselor. I love her to death and we, um, you know, she, she's helped me a lot" [PAT1]). See Table 1 for relative representation.

Nonjudgmentality, compassion, and acceptance were mentioned repeatedly as aspects of the counseling approach that were appreciated (see Table 1 for relative representation). One participant stated, "[The counselors are] very caring and compassionate and, um, very down to earth. Not judgmental" (PAT26). Another participant indicated that "they've been very positive and encouraging and helpful and great" (PAT27). One person appreciated that "everybody's real nice, and, uh, pretty much, they pretty much won't kick us out for any reason. They may, like, discipline us, but they'll never fully kick us out. And I think that's pretty cool" (PAT20).

Whereas most participants cited positive counseling experiences at the CNHS combined pharmacobehavioral OUD treatment program, a few noted some challenges (see Table 1 for relative representation). One individual mentioned "not having a lot of success in counseling, and I don't know what the what's going on there. I'm going to change counselors." Eventually, this participant ascribed the difficulty in connecting with counseling as being due to "too many canned statements" and thought that "things got really repetitive" (PAT7). Another noted that their difficulties engaging with counseling was "not really [CNHS's] fault. ... I don't have good experiences with counselors and therapists and stuff" (PAT14). Another participant expressed wanting to engage with counseling but was unable to do so until further into the program:

I've been in, in the program a year, and I haven't had the counseling.... It really isn't their [CNHS's] fault. I would tell you if it was. I just happened to fall through all these little cracks that even they didn't see and managed to not get counseling, even though I'd called three times and tried to set it up. I got that lucky. So this time, um, I, I reached out again and, uh, they got back to me actually this morning, and I've got counseling set up, so that's great. (PAT30)

A few participants reported wanting more counseling opportunities (e.g., "More groups would be really helpful" [PAT6], "making sure there's more counseling" [PAT5]), and more

participation in groups, which were noted to comprise a small and inconsistent number of individuals (e.g., “I wish we had, we would’ve had more people in the group. We had 11 scheduled to show up and only two of us showed up.” [PAT11]). See Table 1 for relative representation.

Participants Encountered Structural Barriers to Accessing Programming.

Long Distances to the Program. Seven participants (15.6%) mentioned having to drive great distances to receive services, which impacted their ability to engage. One participant noted, “It’s a long drive to my doctor. It takes me about an hour and twenty minutes” (PAT28). Another shared, “It’s 150-mile round trip for me” (PAT16). One participant explicitly noted the physical distance as a barrier to service access: “Like I said, I live 45 minutes away, so it’s kind of hard to get down there for [the counseling sessions], so I kept missing the appointments” (PAT14). Without a vehicle of one’s own, these barriers can become insurmountable:

It’s a good 30-minute drive but if you have a vehicle, a vehicle is fine. I typically usually do but, um, my car’s motor blew up so it’s kind of—I’m looking for another car right now, but it’s going slow because I don’t have very many people to help me. (PAT12)

Pharmacy Wait Time During the Pandemic. Some participants mentioned having to wait a long time to get medication filled at the pharmacy during the height of the pandemic (see Table 1 for relative representation). When asked about the typical time it takes to get a prescription filled, one participant noted, “Oh, it’s anywhere from an hour to like, three or four hours. Yeah, that’s another thing I would change, the wait time” (PAT17). Other participants felt similarly. One noted this was an important consideration for program improvement: “The only thing I wish more of? Just I wish that pharmacy would be a little bit quicker” (PAT20). Another noted, “Sometimes you’re sitting there longer waiting for your medicines at the pharmacy than you are, you know, than your appointment is” (PAT29).

Confusion About Timing and Requirements of Services. Some participants reported that communications about services within the program were not always clear and straightforward (see Table 1 for relative representation). One participant noted that:

When I did call the MAT clinic yesterday, they told me, “Just show up and talk to my drug and alcohol counselor,” and then my refill would be ready. Well, that never happened, and then when I show up there, they told me to go to this morning, and then they still didn’t do what they said. I know their phone personnel or whoever’s running the MAT clinic desk and then the actual providers, they’re not passing notes to each other because half of them are just telling me to do this, and the other half didn’t know I was doing it. (PAT18)

Concerns About Addressing Pain and Its Overlap With OUD. A few participants alluded to the requirement that, in order to receive BUP-NX as part of this specific program or have it covered by insurance more generally, they needed to accept an OUD diagnosis and were often expected to join the combined pharmacobehavioral OUD treatment program. Participants found this stigmatizing when they did not necessarily identify as such:

For the insurance to approve it, I have to tell them, go on record with them, that I was an addict and that now my doctors ... my general doctor and my pain doctor knows that I’m not, but they—they understood, and it was my pain doctor that offered the [BUP-NX] to me, told me this is what I have to say. (PAT9)

Participants’ Suggestions for Enhancing Combined Pharmacobehavioral OUD Treatment Programming

Although participants expressed positive perceptions of the program overall, many participants were able to provide suggestions for improvement (see Table 1 for relative representation). Participants’ suggestions fell into a few primary categories, which emphasized the need for more communication about medications, inclusion of individual counseling and more robust group support, greater service accessibility and communication, and integration of cultural practices. When additionally asked about harm-reduction treatment and service provision, participants were largely supportive of such efforts.

Participants Wish to Address Medication Choice and Questions. A few participants indicated a desire for more medication “choice” (see Table 1 for relative representation). One participant requested flexibility in the program to “ease you off with the, whatever drug you’re using ... whether it be [BUP-NX] or methadone, and then slowly taper it down over, say, a six-month period or a year, however long they’ve been using” (COM4). Another participant requested other medication options, including medications that are not evidence-based for OUD treatment: “Add valium to it. Psychedelics, valium, uh, what’s the other one? Um, [BUP-NX] and methadone, yeah” (COM2).

In noting the contribution of opioid pain medications to the development of opioid-related harm, one participant offered:

You gotta have healthier remedies instead of just one or two or three [opioid pain medications], you know, to give ‘em for pain... You know, that’s where people overdose because they got a dang tolerance that’s so stinkin’ high ... have to take more to curb it and that’s when they die. (PAT9)

On the other hand, a community participant who takes opioids for pain indicated, after hearing about the program, “I’m not interested in anything to help me stop taking opioids. I can do that anyway. I’m interested in something that can end my pain” (COM8).

Participants Outlined Ways to Improve Counseling.

Tailored and Holistic Counseling Alongside BUP-NX Is Key. Participants indicated counseling could fulfill various needs for patients and thus that it should be tailored to patients’ goals and needs (see Table 1 for relative representation). One participant suggested to counselors: “I’d have to talk to the person and see how, see where they’re at, how long they’ve been in and what they’re willing to do” (COM2). Another said it should be “really individualized so that each person gets exactly what they need to support their recovery” (PAT15). Others indicated that learning about cognitive-behavioral strategies for managing craving and triggers would be helpful (e.g., “tips, tools, whatever, you know, for triggers, just coping in general... They’re there to help” [PAT26]).

Many participants also indicated the importance of counseling that is more holistic and encompassing than a narrower focus on substance-use treatment and recovery goals. For example, one participant said they were attending “not because I feel like I necessarily have to have it to stay on track ... more for just like personal peace of mind ...” and to talk through “things that are either intellectual or affecting people or affecting me, affecting my kids” (PAT12). Another noted, “You can have a counselor, not for just

being depressed but just to get through some tough points in your life or whatever is going on" (PAT9).

Counselor Characteristics Are Important. Counselor characteristics were noted as very important (see Table 1 for relative representation). One participant noted: "It's good to get a perspective from outside of the box.... It's just hard to talk your bullsh*t with strangers" (PAT26). Participants had various ideas how counselors could help build more trust. One suggestion was including counselors who have lived experience of substance-use disorder:

The number one thing would be to have someone that has, you know, years under their belt of being sober and clean going in with the doctor and talking to people ... 'cuz like I said, people that's been there understand people better than ones that haven't been there. (PAT22)

Most commonly, however, participants indicated that counselors should be inclusive, nonjudgmental, and able to meet patients where they are at. One participant wanted to see "more love and compassion than judgment" (PAT30). Another indicated that "people get judged at the bat of an eye.... So definitely more like, nonjudgmental, open kind of staff working that type of clinic" (COM7). When patients engaged in concurrent substance use, participants indicated it was important that providers "don't kick them out [of the program] just because they failed the drug test" (COM2).

Participants Wanted to See Robust Group Offerings. Group offerings, either group-based substance-use treatment or mutual-help groups (e.g., 12-step groups), were endorsed by participants (see Table 1 for relative representation). Even as one participant noted "there's always a group to go to," participants who spoke to the current group offerings added that "more groups would be really helpful" (PAT6). People indicated group support was helpful for a few reasons: They provided a sense of community (e.g., "family-oriented ... feel like you're a part of something" [PAT15]), they helped participants "with underlying issues that need to be dealt with" (PAT5), and they helped provide a sense of "accountability" (PAT13) by "making certain [patients] stay sober" (PAT20). Some participants went as far as to indicate groups should be required by the program (e.g., "I feel it should almost be a requirement to go to AA if you are on [BUP-NX]" [PAT7]). One participant noted, however, that they should not be "court ordered" (COM4).

Participants Suggested Lowering Structural Barriers to Accessing Services. Participants had suggestions for how to reduce barriers to accessing services (see Table 1 for relative representation). As previously discussed, distance to treatment centers was cited as a barrier but was one that could be overcome by providing services at "more locations" (PAT28) or by providing "gas vouchers for people driving up" (PAT16). Some participants indicated that long wait times ("2 to 3 hours") to get prescriptions filled were a barrier and suggested being able to receive medications during group support or via postal mail (PAT16), especially during the pandemic.

Similarly, some participants noted that telehealth options would be desirable (e.g., "It would all be done online" [PAT28]), both to remove the travel barrier for rural patients but also to destigmatize service-seeking (e.g., "And do it even by phone to where you don't have to go in the office because I know that's, sometimes that's a big, ugh, withdrawal or big turn off to a lot of people, especially proud people. And, uh, Indians are very proud people, for the most

part, so don't want people to know that they're seeing a psychiatrist or, you know, someone to talk to" [PAT9]).

When we asked participants about preferred service delivery options moving forward, 53.3% ($n = 24$) preferred an in-person visit, 24.4% ($n = 11$) preferred a phone visit, and 20.0% ($n = 9$) preferred video conference visits. For participants preferring in-person visits, reasons cited included (a) feeling comfortable with this long-standing norm (e.g., "I'm kinda old fashioned like that. You know, I wanna be there and talk with my doctor and have them, you know, with me in the room." [PAT5]); (b) being able to take care of multiple needs in one stop (i.e., "When I do go, because I go there for labs and anything else I need, um. ... I have foot issue that I'm going to have to have surgery on, so I see a doctor there for that. So I try to get everything that I need to do, or if I need to have an X-ray or any special thing, all on one day" [PAT9]); (c) having internet and cellular connectivity issues common to rural areas (e.g., "so, it's hard to kind of a get some of those telehealth options to work good for you without WiFi and stuff" [PAT22]); and (d) ensuring providers understand the patients' needs (e.g., "I'm hard to understand. If someone can look me, in my eyes, they're gonna understand me. Right. It's a little complicated over the phone to, like, get a real sense of what's happening" [COM30]).

Among participants who had used telehealth even once, however, there was a very high willingness to do it again. The advantages of telemedicine/telehealth as relayed by the participants were (a) its convenience (e.g., "She calls me at the prescribed time, and that's pretty easy. So, I can just be, be near my phone and, and then have a meeting with her, and that's good for me" [COM8]); (b) time and money savings for gas, parking, and otherwise lost wages (e.g., "It saves gas. It saves time, etc. It saves lives possibly. Who knows?" [PAT25]); and (c) ease and comfort of home for those with mental health and physical disabilities (e.g., "I like telephone interviews because I feel like I'm confident in my own home" [COM14], "I'm visually impaired. I can't just jump in a car and drive anywhere I want" [COM4]).

Integrating Cultural Practices and Activities Into Programming. When prompted, 18 participants (40.0%) expressed interest in the integration of cultural practices and activities into combined pharmacobehavioral OUD treatment programming as well as substance-use treatment and health care more broadly. (Of note, no participants spontaneously suggested the integration of cultural practices and activities into the programming.) General positive interest was expressed by eight participants (17.8%; e.g., "I think [that's] something that could be integrated into treatment more—as well as healthcare, too—because it could actually bring people together out of the same issues, and they could actually reflect on one another" [COM11]). Two of these participants (4.4%) felt cultural practices and activities should be available but also optional (e.g., "I wouldn't try to push it off on people, but I would definitely let them know that there is an option there for, you know, different sorts" [PAT26]). Although three participants (6.7%) were not sure what such additions might entail (e.g., "I'm thankful for whatever is out there, and if there's anything more. ... I don't know what that would be"), most ($n = 15$, 33.3%) participants had specific suggestions for cultural practices and activities.

The most common suggestions were cultural activities (see Table 1 for relative representation), including ceremonial practices (e.g., "sweat lodge"), cultural events (e.g., "Pow Wow, the dance, and the drum circles" [PAT 16]), traditional crafting (e.g., "basket weaving

and beading” [COM5]), and Cherokee games (e.g., chunky, stick ball).

Participants also expressed interest in programs that could support them in their connection to their heritage and histories via cultural learning opportunities. One participant suggested the program could include “a little bit more history ... just because I’m so fascinated with it. And ancestry” (COM7). Specific suggestions included courses on the Cherokee language (e.g., “I don’t speak but a few, very few words ... they do have a Cherokee language class that I would like to take” [COM5]) and traditional crafting (“bow-making skills, arrow-making skills” [PAT11]).

Participants also expressed specific interest in learning more about traditional medicine through their treatment services:

Maybe if there was something, uh, just to educate people or make people more aware or educate people a little more, um, about herbs that are available for, you know, certain uses. Or something that taught people how to prepare them correctly. Or what parts to use or something. (COM1)

Participants shared their interest in the use of specific plant medicines (e.g., “White willowbark is amazing for pain” [PAT30]), as well as more general practices, “like natural healing. You could maybe learn of different, you know, maybe natural ways to get healthier” (PAT29).

Four participants (8.9%) mentioned that the integration of cultural traditions and programming could build community and provide positive drug-free alternatives. One participant indicated:

When you quit doing drugs and drinking or whatever, your whole friends and your whole circle is gone. So yeah, if you could do traditional games or something like that, or metal making, basket making, something to occupy your time. (COM10)

Another participant stressed the overall importance of cultural inclusivity within treatment, noting that “just people getting back to their culture, you know, would help. Make them proud of their culture, and maybe that would help them to not want to do the drugs and alcohol” (COM5).

Participants Were Less Familiar With the Term “Harm Reduction” but Largely Appreciated Its Tenets. Because most participants indicated they were not familiar with the terms “harm reduction” or “harm-reduction treatment” ($n = 37, 82.2\%$), this approach was defined for them. For example, the interviewer would say:

Harm reduction is about meeting people where they are at in their use and recovery, such that, even if someone’s not ready, or able to stop using substances, harm reduction treatment could help them reduce the harm they experience when they use substances.

When defined as such, harm reduction as a treatment approach was perceived positively by the vast majority of participants (see Table 1 for relative representation).

Some participants thought that harm reduction would make a good start to treatment because it allows people to stay safer and healthier, even if they are not ready to quit. One participant noted, “It’s up to the person if they want to quit or not. But if you can give them a better way and a cleaner way and a safer way, yeah, cool. I’m for that” (COM2). One participant specifically noted that harm reduction could reduce the health risk of contracting a blood-borne infection:

I think in some instances it would be a good thing. And the only other thing I would also add to that is, like, people who use intravenous, I feel like if you don’t make a scene or that you’re being, you know, disruptive, that you should be able to trade in your [syringes] so that you don’t infect people with AIDS or disease. (COM3)

Other participants shared that a harm-reduction approach would provide a way for more people to engage with treatment. The underlying notion was that some people might turn away from abstinence-based treatment if they feel that they are being pushed toward abstinence when they are not ready, willing, or able for it. One participant stated:

I think, um, a lot of good things could come out of that because a lot of people, when they feel like they’re being pushed or made to do something, they’re gonna flee. They’re gonna run the other way, they’re gonna, you know, do it to the extreme, you know, um, that’s just human nature. You know, so if you get people, or if you make them think that they have options in this and that, I think it’s just a lot easier. (PAT26)

Based on their own experience, one participant felt:

It would definitely be worth trying. I think it would be, I mean, it’s certainly an option that I would, uh, uh, when I’ve had my- when I’m at my worst it’s certainly an option that I would more consider exploring than going, you know, to a straight rehab. (PAT28)

Two participants indicated that this approach would help people engage with treatment but hoped abstinence would be the long-term result:

I mean, it sounds like it could help, um, certain people, but I don’t think. ... I think the end goal is to, to get people off of the drugs or, I mean, I don’t, I, it sounds like it could work for some people. I, I don’t see that working great for everybody. (COM4)

A minority of participants ($n = 4, 8.9\%$) expressed a preference for abstinence-only treatment. For example, when asked what they thought about a treatment program that does not require sobriety, one participant indicated: “I don’t think that would be good. They’re gonna go back to using it still, you know what I mean? They don’t even require you to stay sober, so I don’t think there’s a point to this really, right?” (PAT21). Another participant posited that “if you were to get treatment, you should just go all out with it” (COM13).

Discussion

In this qualitative study’s documentation of perceptions of existing programming that offers MOUD and suggestions for its future enhancement, participants made clear that having a Tribally run combined pharmacobehavioral OUD treatment program fills an important need in the community. Prior to this program opening in 2016, participants reported having to locate physicians in private practice who would be willing to prescribe MOUD and paid hundreds of dollars out of pocket for treatment each month. Because they could not always consistently access or afford the medications, this piecemeal network often led to inconsistent dosing and frequent experience of opioid withdrawal. Considering that only 22% of substance-use treatment programs serving Native communities currently prescribe MOUD (Krawczyk et al., 2021), Tribally run programs can and do meet a vital need.

Overall, participants viewed BUP-NX positively. They noted it eased their opioid craving and withdrawal, helped with pain

management thereby lessening dependence on other pain medications, and improved their overall functioning and health-related quality of life. These findings correspond to other studies of participants' perceptions of MOUD in primary care, in which participants have likewise indicated MOUD has helped with stabilizing and improving housing, employment, and overall emotional well-being (Ling et al., 2019; Rawson et al., 2019). Even as they appreciated BUP-NX's effects, a few patients indicated they experienced withdrawal-like symptoms, particularly when they did not consistently dose, which made them feel dependent on the medication. This latter finding has likewise been documented in prior qualitative research studies (Hewell et al., 2017; Scorsone et al., 2020) and points to a need to ensure sufficient medication management to answer questions about the medication and ensure adequate dosing.

Participants largely indicated that their experience with counseling within the CNHS combined pharmacobehavioral OUD treatment program was positive. They noted that counselors were supportive and nonjudgmental, which are essential hallmarks of a strong therapeutic alliance and are associated with positive treatment effects (Hirschak et al., 2023; Nelson et al., 2023; Rawson et al., 2019). Although participants noted these factors were necessary for positive counseling experiences, they were not necessarily sufficient because participants also noted that group counseling sessions were sparsely attended. Other participants had difficulties in connecting with behavioral health, struggled to build secure therapeutic alliances with counselors, or found sessions to be rote or repetitive. These findings reflect common complaints about behavioral approaches to substance-use treatment (Nelson et al., 2023), in part because the stigma of substance-use disorder creates larger barriers to trust-building in treatment than experienced with other medical and psychiatric disorders (Fox et al., 2016).

Structural barriers to accessing the existing programming, which serves 6,950 square miles within Cherokee Nation, were predictably sizable. Participants reported having to travel long distances to access services, experiencing long pharmacy wait times (particularly noted during the height of the COVID-19 pandemic), and feeling confused about program requirements. These are important barriers for providers, especially in rural areas, to consider because the distances and time required to access services and medications can result in missing work, higher gas and transportation expenditures, and greater challenges for those with physical disabilities. These structural barriers are similar to those reported in other rural and reservation communities (Venner et al., 2018).

Participants' Suggestions for Enhancing Combined Pharmacobehavioral Programs for OUD

When asked how they would redesign combined pharmacobehavioral programming in their own vision, participants had important suggestions that echoed those found in prior studies and recommendations (Nelson et al., 2023; Novins et al., 2016; Venner et al., 2018). First, participants indicated there was a need to resolve patients' concerns and questions around MOUD, including addressing questions around the specific types of medications that are used, side effects, dosing, and potential tapering schedules. This finding aligns with those from a recent study conducted with urban AI/AN patients with alcohol use disorder, who likewise expressed interest in yet confusion and misunderstandings about medications in the context of substance-use treatment (Nelson et al., 2023).

Participants wanted more holistic, flexible, and tailored counseling experiences. They noted that counseling programs should honor the diversity of patient experiences and needs and meet patients where they are at in their values, communities, and motivation for change. Patients' preference for trust-building, nonjudgmental and compassionate counselors, as well as counselors with similar lived experience, are aligned with prior research findings outlining these as key factors for client-centered, culturally appropriate substance-use treatment in Native populations (Hirschak et al., 2023; Nelson et al., 2023; Zeledon et al., 2022).

Participants' suggestions went beyond the treatment content itself and invited providers to address structural barriers as a means of improving treatment accessibility and patients' overall experience. Specifically, participants suggested treatment centers bridge the distances by making available gas vouchers; mail-order prescriptions; and in-person, telehealth, and video conferencing appointment options. These suggestions converge with those from other communities seeking ways to improve accessibility of treatment services in rural areas and with marginalized populations (Aronowitz et al., 2021; Lockard et al., 2022; Sugarman et al., 2021). Participants' interest in more systemic and holistic solutions to treatment accessibility spilled over into treatment content as well. Namely, participants indicated that counseling should extend beyond a narrow focus on substance-use treatment goals to support other aspects of recovery, which echoes similar, recent findings among urban Native patients (Nelson et al., 2023).

It is of note that there were no spontaneous requests for cultural practices and activities to be integrated into treatment programming; however, when prompted, over one third of participants expressed interest in its integration into substance-use treatment and other health care services. Interest was particularly keen around incorporation of traditional medicine, cultural learning opportunities, and inclusion of cultural activities. There are various reasons why cultural practices and activities may not have been spontaneously suggested. First, at the time of this study, no cultural programming had been built into the behavioral offerings that participants had experienced. Thus, there may have been a seeming disconnect for participants, who may not have realized that integration of culturally grounded programming was an option in formal treatment settings where Western approaches often dominate. It is also possible that either acculturation or general satisfaction with other aspects of the Tribally run clinic (e.g., access to Native providers, a common sense of cultural identity, the option of connecting to external cultural events) played a role in its lack of initial mention.

However, the interest in such an integration upon prompting indicates an important role for cultural activities and practices in combined pharmacobehavioral programming for OUD. This finding is consistent with prior research showing (a) Native communities' interest in greater integration of cultural practices to honor patients' Native heritage and promote healing (Greenfield & Venner, 2012; Hirschak et al., 2023; Novins et al., 2016) and (b) the disconnects between Native cultural and healing traditions and Western substance-use treatment services (Hirschak et al., 2023; Venner et al., 2018; Zeledon et al., 2020). In hundreds of published studies, the importance of Indigenous ways of knowing and healing for Native communities has been documented (Redvers & Blondin, 2020). Additionally, existing research on the importance of the integration of cultural traditions with Western medicine approaches, like MOUD, shows promise. However, researchers have also

highlighted well-founded concerns with such an integration, including risks of cultural appropriation and assimilative practices of Western medicine and questions about the appropriateness of subjecting cultural practices to Western scientific review (Rowan et al., 2014; Wendt et al., 2022).

Contrary to some initial concerns in the literature about a potential clash between a community preference for abstinence-only over harm-reduction approaches (Venner et al., 2018), the vast majority of participants were supportive of MOUD and a harm-reduction approach to treatment, which does not require abstinence for treatment engagement and retention. Following from patients' interest in harm-reduction approaches, clinicians should address how patients can stay safer and healthier, even if they continue to use substances (Collins & Clifasefi, 2023). Relatedly, clinicians could move beyond more stringent program requirements by easing requirements for abstinence from other substances or negative urine toxicology tests. Other studies conducted in Native communities are converging on similar findings, indicating the importance of removing shame and stigma from OUD treatment and highlighting the need for flexible, nonjudgmental services provision (Hirschak et al., 2023; Nelson et al., 2023). That said, more comprehensive assessment of various stakeholders' perspectives is needed to better contextualize acceptance of and concerns about harm-reduction approaches across different AI communities.

Limitations

This study was carried out in a specific context with a self-selected group of participants. Also of note, programs experienced by participants were largely Western medicine-based, not directly involving the integration of cultural practices and activities. Participants were also patients in a very specific community: community members living in Cherokee Nation, impacted by OUD, most of whom were receiving treatment in the CNHS combined pharmacobehavioral OUD treatment program. Cherokee Nation exercises Tribal jurisdiction over a large reservation in rural northeastern Oklahoma. While findings may not be generalizable to other communities, the goal of qualitative research is to generate transferable data (Korstjens & Moser, 2018). Thus, the reader may decide whether these findings correspond to the needs of their own communities.

Also of note, participants' perspectives were documented during the height of the COVID-19 pandemic, which created challenges for health care systems globally as well as locally and for patients individually. It is thus possible that some of participants' responses may not transfer well to other eras of data collection. That said, some participant suggestions (e.g., mailed prescriptions, telehealth) may herald a more convenient, patient-centered era in substance-use treatment that may better integrate into patients' day-to-day lives, during the pandemic and beyond.

Finally, as noted throughout this article, the present study aim was to document perceptions of existing programming and suggestions for future program enhancement among patients in CNHS's combined pharmacobehavioral OUD treatment program and community members impacted by OUD. This scope is relatively broad, and analyses, as is required in conventional content analysis, hew closely to participants' own responses. Thus, future studies may be conducted that further home in on individual topics touched on in this broader study, such as participants' perceptions of the

acceptability of MOUD or the cultural acceptability of OUD treatment. Future articles are also planned to document participants' responses to areas adjacent to participants' experiences of OUD treatment programming (e.g., activities outside of treatment that build recovery capital).

Conclusions and Future Directions

Participants, who were AI patients and community members with lived experience of OUD, were grateful for the local Tribally run program, which made treatment more financially and geographically accessible over a large, rural area. They were largely satisfied with the BUP-NX and counseling services but suggested ways to make these services more accessible through telemedicine and mailed prescriptions. They also pointed out it is important to have clear communication about MOUD, specifically, and associated behavioral programming, more generally, which tends to be more flexible and tailored and thus less universally structured than traditional substance-use treatment programs. Participants were interested in a low-barrier, acceptance-based, and harm-reduction orientation as well as culturally aligned programming that honored their Native heritage and traditional medicine. These patient-driven perspectives indicate ways to enhance combined pharmacobehavioral treatment for AI people with OUD. These points should be considered by treatment and service providers to forge more compassionate, effective, and culturally relevant pathways to engagement, recovery, and healing for AI people with OUD.

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