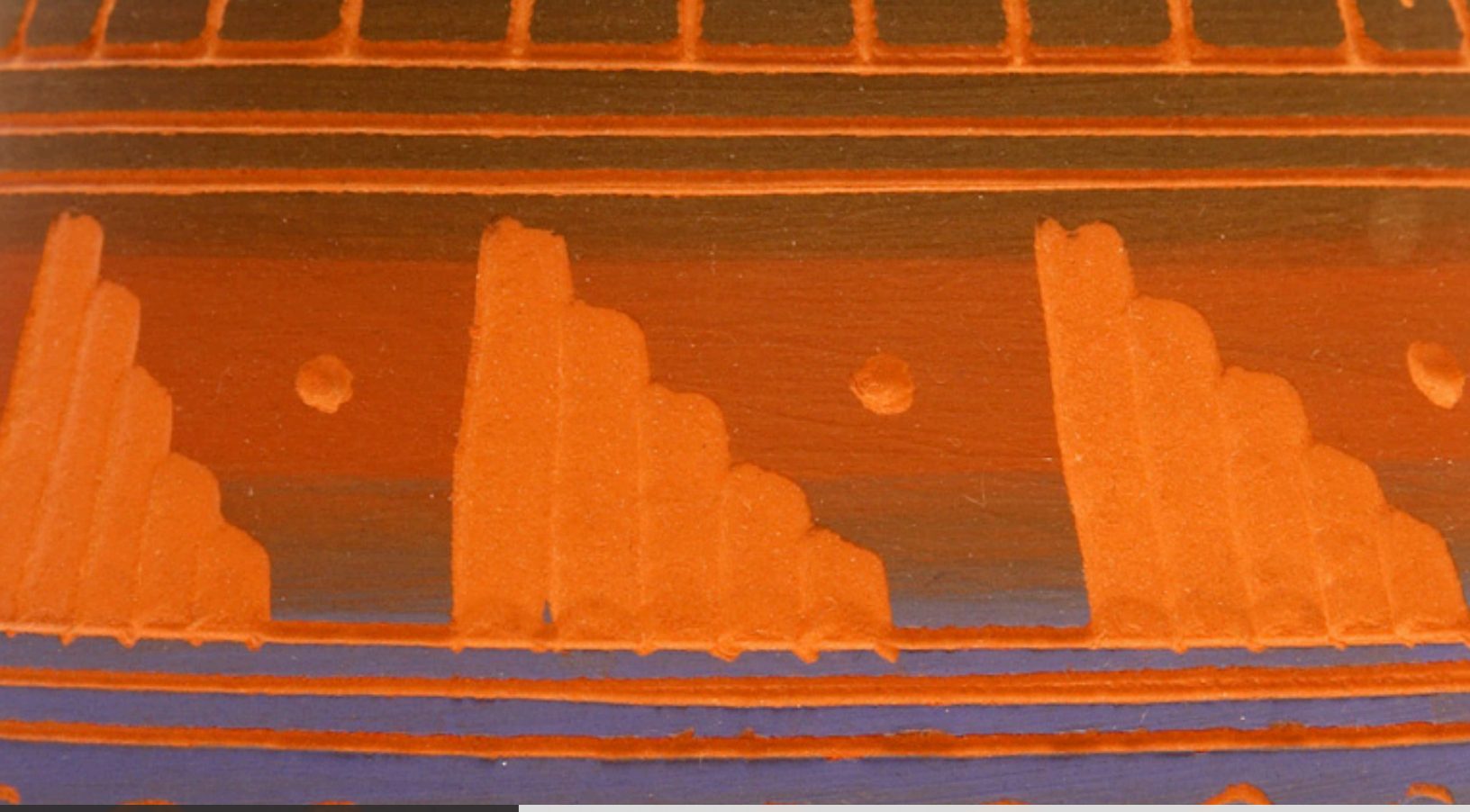
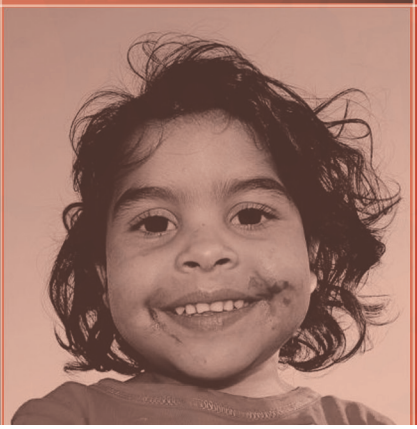


Urban Indian Health Institute
A Division of the Seattle Indian Health Board

Supporting Sobriety Among American Indians and Alaska Natives: A Literature Review

February 2014

The mission of the Urban Indian Health Institute is to support the health and well-being of urban Indian communities through information, scientific inquiry and technology.



ACKNOWLEDGEMENTS

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The Urban Indian Health Institute would like to thank the staff at the Urban Indian Health Organizations for the excellent work they do on behalf of their communities.

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A Division of the Seattle Indian Health Board

Please contact the Urban Indian Health Institute with your comments by e-mailing info@uihi.org, calling (206) 812-3030 or visiting us online at www.uihi.org.

EXECUTIVE SUMMARY

Introduction

The purpose of this report is to highlight and review literature, programs and activities focused on substance abuse in urban American Indian and Alaska Native (AI/AN) communities in the U.S. Throughout this report alcoholism and drug dependence and addiction are referred to collectively as substance abuse. In 2010 the Urban Indian Health Institute (UIHI) initiated its Health Equity Project to provide information and tools to address the health disparities affecting urban AI/AN communities. This report represents a synthesis of academic (articles in scholarly, typically peer-reviewed journals) and grey literature (from a variety of sources including websites, online documents, government reports and presentations). This combination of findings is uncommon in typical reviews of substance abuse among AI/ANs, which tend to focus on peer-reviewed academic literature.

This report covers a great deal of information. It is not meant to be read cover to cover but rather by either focusing on specific sections or program summaries based on your interests, or by searching for a specific topic using your PDF reader's search or "find" functions. The Background of this report describes substance abuse disorders, their prevalence among AI/ANs and standard treatments, as well as contextual information about co-occurring conditions, the consequences of substance abuse, data on risk and protective factors among AI/ANs and barriers to care. The procedures and inclusion criteria used in this literature review are detailed in the Methods section. Due to the limited availability of outcomes and evaluation information in the sources identified, the Results section does not present evidenced-based or best practices for substance abuse but rather the themes identified regarding implications for care as well as descriptions of programs in practice and useful resources. The Discussion summarizes the report's key elements and provides recommendations for future substance abuse research, programing and policies. For organizations serving urban AI/ANs, it is intended that this information be useful for program planning purposes and proposal development.

Background

Substance abuse, the use of alcohol and/or other drugs in a way that is harmful to oneself or others, poses serious health and social concerns for AI/AN individuals and families. Among current drinkers, AI/ANs had the highest rates of past year heavy daily drinking (over one drink per day for women and over two drinks per day for men) compared to all other races (21.9% vs. 15.7%); also AI/ANs had the highest rates of alcohol dependence and abuse (20.8% vs. 12.9%).[1] Compared to all races, AI/ANs had the highest past year prevalence of any alcohol use disorder (12.1% vs. 8.5%), any drug use disorder (4.9% vs. 2.0%) and comorbid (alcohol and drug use) disorders (3.5% vs. 1.1%).[2] Of all AI/AN deaths, 11.7% resulted from alcohol-attributable deaths (AAD) compared to 3.3% for the general population; AI/ANs lose more potential years of life (36.3 years) versus the general population (29.4 years) due to AADs.[3]

EXECUTIVE SUMMARY

Treatment for alcohol abuse is provided in different settings through a variety of approaches. Examples of standard care include counseling, cognitive-behavioral therapy, Motivational Interviewing, 12-step programs, relapse prevention and support, job training and life coping skills. However, the barriers AI/ANs face in accessing such treatments are multifaceted. Barriers range from personal to pragmatic to structural. In 2007, only 40% of all AI/AN substance abuse treatment facilities were located in urban areas (i.e., in counties the U.S. Census Bureau defined as Metropolitan Statistical Areas) despite 71% of the AI/AN population residing in urban areas.[4] Less than one fifth of alcohol and other drug abuse treatment programs nationwide offer specialized services for AI/ANs compared to about one third that offer these programs for African Americans and Hispanics.[5]

Methods

UIHI project staff developed search terms to obtain relevant and comprehensive search results. These search terms defined the population of interest (AI/ANs in the U.S.), the conditions of interest (alcohol and substance abuse) and the type of information sought (programs, activities and evaluations) as well as the locality (urban areas). In October 2012, UIHI project staff conducted initial searches of both academic and grey literature databases. The searches resulted in a high volume of sources, which staff then reviewed and eliminated systematically, based on previously determined inclusion criteria.

Results

Original academic and grey literature searches identified 2,543 sources; 1,152 were found through academic databases and 1,391 were found through grey source databases or search engines. An additional seven sources included in this report were referred to in the original searches. Of the 2,550 sources identified, 947 sources were excluded as duplicates, 1,470 sources were excluded based on review criteria and 19 were excluded because full text was unavailable. Two sources were excluded based on concerns about the published literature; this information came to our attention through external review of the summaries. A total of 112 sources are listed in this review.

The results of this literature review identified five common themes regarding implications for addressing substance abuse among AI/ANs. These themes included (1) cultural care, (2) client-centered care, (3) skills building, (4) community-support and (5) healing traumas for recovery.

Additionally, these results included program or activity descriptions. These program descriptions provided illustrations of the identified themes in practice. Lastly, the review identified resources for understanding, preventing and treating substance abuse in urban AI/AN communities. These resources are listed at the end of the Results section.

EXECUTIVE SUMMARY

Discussion

Considerations regarding the overall report are highlighted including limitations and recommendations. Key recommendations and items for consideration include:

- A pluralistic approach, embracing both Western scientific knowledge and indigenous ways of knowing, must be implemented not only in service delivery but also in program evaluation and effectiveness research.
- Best fit interventions require an understanding of the diversity within the urban AI/AN population with regards to acculturation, spirituality and Indian identity.
- Research into the cultural aspects of substance abuse prevention and treatment is needed and could inform policy changes that would better support and reimburse culturally-adapted services for prevention, early intervention and long-term treatment.
- Programming must be developed by AI/AN communities, building on assets and strengthening support networks and skills.
- Improvements to substance abuse prevention and treatment programming may be accomplished by strengthening screening practices (especially for co-occurring disorders), building programs through community inclusion, bolstering support networks and healing traumas.
- Physical, mental, spiritual and social services ought to be integrated to provide holistic care.
- Resolution of historical and lifetime traumas is fundamental to advancing well-being for AI/AN people.
- As the population continues to shift to urban centers, policy must also shift from tribal health tied to Contract Health Service Delivery Areas and enrollment in federally recognized tribes to an inclusive Indian health approach. Policy amendments should broaden eligibility for the full scope of services authorized by the Indian Health Service to ensure that all AI/ANs can access substance abuse services, regardless of enrollment status and geographic location – whether residing on a reservation or in a city.

Substance abuse has profoundly impacted all aspects of health and life for AI/AN people. Achieving health equity and overall wellness for AI/AN communities will require interdisciplinary and systems-level approaches based on collaboration, holism and community-specific knowledge and practices.

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INTRODUCTORY LETTER

The report that follows is a comprehensive and informative review of substance abuse prevention and treatment programs and resources that exist for urban American Indians/Alaska Natives (AI/ANs). Given that 71% of AI/ANs now reside in urban areas, this report is unique and timely in that it provides a review of services that has not been given its deserved attention. Some of the reasons for this are a significant shortage of comprehensive well-coordinated databases, limited research conducted in this area overall and limited funding allocated to address substance abuse prevention and treatment within this population.

One of the take home messages that is evident from reading and analyzing this report is that substance abuse programs that provide services to urban AI/ANs emphasize the need for traditional-based treatments, e.g., sweat lodge ceremonies, drumming, regalia making, etc. Another important theme among the findings included the provision of culturally-tailored care by many programs. Thus, these observations suggest that urban AI/ANs benefit from an integrated approach that allows for the provision of traditional-based practices, which indicates further justification for more funding and treatment to address this health-related disparity existing in the U.S. Furthermore, urban AI/AN leaders have identified an integrated approach as what is needed to meet the substance abuse prevention and treatment needs of this population. This report, rightly so, also supplies a policy component emphasizing the need for allowing for these services to be provided in order to ensure that culturally-relevant care is available to this population.

An interesting point to recognize in this report is that the data generated and analyzed were derived from many “grey-area” sources from the internet, etc. This suggests that there is a larger need for very valuable information, such as what is provided in this report, to be made available in more formalized reports, substance abuse/mental health journals and various government sources.

This report helps to further explain and clarify the effects associated with historical trauma that has continued to endure among AI/ANs for over 400 years. One of the significant effects of historical-based trauma is related to coercive assimilation into mainstream society in order to eradicate any “need” for providing healthcare services to this population through various treaties made between the U.S. and AI/ANs. However, because of the resilience of AI/AN people and in recognizing among themselves the importance of utilizing their own traditional-based practices even within a complex urban setting, this report was instigated and completed in a manner that is culturally-appropriate, informative and of benefit to urban AI/AN people.

It is also important to recognize due to the diversity that exists among AI/AN people, allowing for urban communities to design, evaluate and research their own programs is critical. Additionally, there is a need for urban AI/AN communities and programs to have opportunities to share their successes, challenges, and experiences together. This is what this report assists in doing. With publication of this report, it is hoped that further dissemination can then result whereby various urban AI/AN communities can enhance their programs, be encouraged to communicate with each other, in addition to providing a foundation for a policy platform in order to bring more attention to this significant health-related disparity that exists in the U.S.

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INTRODUCTION

The goal of this report is to provide a synopsis of efforts aimed at preventing, treating or managing chemical dependency and substance abuse among urban American Indians and Alaska Natives (AI/ANs). This report highlights findings from research, case studies and experts from the field. It is our hope that describing five themes for preventing and treating alcohol and substance abuse identified through this extensive review will support healthcare providers, policy makers and advocates in promoting useful substance abuse services for urban AI/ANs with the overall objective of achieving health equity for all AI/ANs.

Responding to the persistent inequities in health outcomes among urban AI/ANs, the Urban Indian Health Institute (UIHI) launched its Health Equity Project in 2010. With support from the U.S. Office of Minority Health, the project focuses on identifying and disseminating culturally appropriate models of care in urban AI/AN communities to prevent and reduce disease. The Health Equity Project provides tools, training, information and facilitates partnerships to support Urban Indian Health Organizations (UIHOs) in delivering high quality care to their clients. The Health Equity Project focuses on two diseases identified by Healthy People 2020 as critical focal areas for health improvement in urban AI/AN communities: cardiovascular disease and depression. In addition, UIHOs identified a third health topic, substance abuse, as a priority, which is the focus of this report.

Documenting and recognizing effective, culturally-appropriate efforts to reduce morbidity and mortality in minority communities is essential to achieve Healthy People 2020 goals and to realize health equity for all.

The critical health focus area of this report is substance use disorders (i.e., alcoholism and drug dependence and addiction, referred to hereafter collectively as substance abuse). Substance abuse can be described as the repeated, excessive or compulsive use of alcohol and/or other drugs (without medical need) that negatively impacts a person's ability to function, including fulfilling one's responsibilities at work, home or school, and can affect interpersonal relationships. While national surveys of drug and alcohol use indicate fewer AI/ANs are current alcohol drinkers than other races, other measures demonstrate issues of significant concern such as higher rates of binge drinking and drug use in the past month than the general population and the highest rates of heavy daily drinking, alcohol dependence and abuse compared to all other races.[1, 6] These factors illustrate the need to address this issue to improve the well-being of AI/AN people overall.

Socioeconomic status, social support, cultural preferences for care and historical traumas play a role in substance abuse as well as in the approach to restoring and maintaining sobriety. A Native concept of health traditionally embodies a holistic perspective in which all aspects of wellness are intertwined. Many of the programs developed and used by urban AI/AN communities in this report represent complementary care, incorporating both standard Western treatment and prevention approaches in tandem with AI/AN traditional approaches and activities.

INTRODUCTION

This report was developed by the UIHI primarily for the UIHOs and others serving the health needs of urban Indians in the U.S.

Urban American Indian and Alaska Natives

AI/ANs living in urban areas are a diverse and growing population. Over the past three decades, the population of AI/ANs has increased within urban areas, partly due to AI/ANs relocating from reservation and rural settings. Urban AI/ANs include members, or descendants of members, of many different tribes. For example, represented tribes may or may not be federally-recognized and individuals have varying degrees of ties to their AI/AN historical, cultural or spiritual backgrounds. The population as a whole is highly mobile; individuals may travel back and forth between their tribal communities or reservations on a regular basis. Generally, urban AI/ANs are spread out within the urban center rather than localized within one or two neighborhoods.[7] Thus they are often not easily seen or recognized by the wider U.S. population. This "invisible" Indian population makes up more than 71% of all AI/ANs living in the U.S.[8]

Health Care for American Indians and Alaska Natives

Numerous treaties, court cases, Executive Orders and laws, such as the Snyder Act of 1921 and the Indian Health Care Improvement Reauthorization and Extension Act of 2009, define and affirm the U.S. federal government's responsibility to provide healthcare services to members of federally-recognized Indian tribes and Native Entities of Alaska, regardless of whether they live in urban or reservation areas. This responsibility has been delegated to the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services. The IHS is divided into three distinct health delivery models characterized as the I/T/U. The "I" refers to hospitals and clinics run directly by the IHS. The "T" represents individual tribes or consortia of tribes that operate tribally-managed hospitals and clinics under Indian self-determination and self-governance. The "U" signifies a discrete program created to assist communities in improving access to health care for urban Indians. In 2012, urban Indian health programs received less than 1% of the IHS total program budget.[9] This funding shortfall contributes to a number of factors limiting AI/AN access to health services. Additionally, eligibility criteria for IHS and tribally-run services are more limiting than at urban facilities, often excluding urban AI/ANs who are either not enrolled in tribes or are members of tribes that are not recognized by the U.S. federal government, such as members of State-recognized tribes. Of note, non-tribal, non-IHS substance abuse treatment programs provided more services to AI/AN patients than tribal or IHS programs between 1997-2002 and half of AI/ANs admitted to treatment were at programs in urban areas.[10]

With the increased health insurance coverage and Medicaid expansion provided by the Affordable Care Act, access to substance abuse treatment services are expected to expand. However, it is unknown at the time of publication of this report who will be eligible to access the services, what specific reimbursable services will be available and what insurance networks will have the capacity to provide. In addition, access to services may be negatively impacted by the growing complexity of administrative burdens faced by providers, as well as increased demand resulting from utilization of newly covered substance abuse services.

INTRODUCTION

Urban Indian Health Organizations

UIHOs are private, non-profit corporations that serve AI/AN people in select cities by providing a range of health and social services, from outreach and referral to full ambulatory care. UIHOs are funded in part under Title V of the Indian Health Care Improvement Act and receive limited grants and contracts from the IHS. Located in 19 states, 33 UIHOs serve individuals in approximately 100 U.S. counties, in which over 1.2 million AI/ANs reside, according to the 2010 U.S. Census.[8] UIHOs provide traditional healthcare services and cultural activities in addition to being a culturally-appropriate place for urban AI/ANs to receive health care.

Urban Indian Health Institute

The UIHI was established as a division of the Seattle Indian Health Board to study and document the striking health disparities affecting the urban AI/AN population. The UIHI is one of 12 tribal epidemiology centers (TECs) and the only TEC providing surveillance, research and analysis of data focused on the nationwide urban AI/AN population. The UIHI provides data and technical assistance to all the UIHOs across the country. The mission of the UIHI is to support the health and well-being of urban Indian communities through information, scientific inquiry and technology.

In This Report

Beyond academic or peer-reviewed journals, there are many information sources regarding health promotion efforts, practices and lessons learned in AI/AN communities. Therefore the UIHI included both databases of academic literature as well as “grey” literature (online, open source, government reports, etc.) in its comprehensive review for this report. Innovative work in preventing and treating substance abuse among AI/ANs may not be captured in this report due to methodological limitations as well as limited dissemination of these novel efforts. The program and activities summaries are based solely on our review of the publically available sources identified. Any unpublished community-based knowledge about these programs is unknown to us and we apologize for any unintentional errors of omission or interpretation.

The remainder of this report is organized into several main sections. The Background provides context for the programs, activities and approaches presented by defining substance abuse and describing prevalence, risk and protective factors, historical traumas and barriers to care. The Methods section outlines the process and sources used for the literature review. The Results section consists of themes identified from expert opinions, research findings, activities and programs as well as brief descriptions of each program identified. The Discussion section reflects on the themes identified and provides recommendations for future research, practices and policies. This report covers a great deal of information. It is not meant to be read cover to cover but rather by either focusing on specific sections or program summaries based on your interests, or by searching for a specific topic using your PDF reader’s search or “find” functions. A companion report, titled *Supporting Wellness: Substance Abuse Services at Urban Indian Health Organizations*, describes the current work of UIHOs across the country and the critical role of the UIHOs in meeting the needs of the communities they serve in addressing substance abuse.

BACKGROUND

To contextualize our work, this Background section includes a description of alcohol and substance use disorders and the prevalence of these disorders among AI/ANs. Included in this summary are co-occurring conditions, the consequences of substance abuse and data on risk and protective factors among AI/ANs. The Background also provides a description of treatment for substance use disorders, including usual care and data on examinations of mainstream approaches, treatment utilization and barriers to care for AI/ANs.

Description and Definition of Alcohol and Substance Use Disorders

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)*[11] is the recognized source used by mental health professionals in the U.S. for classifying mental disorders. The DSM provides a common language and standard diagnostic criteria for the classification of alcohol and substance use disorders and is the basis for insurance reimbursement for services.

In the fifth edition of the DSM (DSM-V), a diagnosis of disordered substance use, which includes alcohol and other drugs, is no longer differentiated as either abuse or dependence as it was in the DSM-IV. Instead, a continuum of severity is outlined based on the number of symptoms experienced.[12] The 11 symptoms used as a criteria for determining the severity of the diagnosis are:

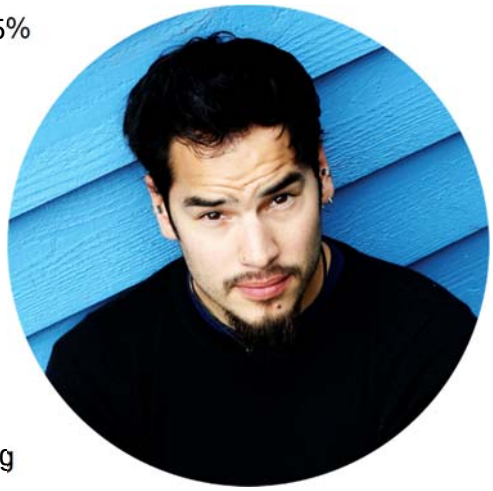
(1) "The substance is often taken in larger amounts or over a longer period than was intended.
(2) There is a persistent desire or unsuccessful efforts to cut down or control use of the substance.
(3) A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.
(4) Cravings, or a strong desire or urge to use the substance.
(5) Recurrent use of the substance resulting in a failure to fulfill major obligations at work, school, or home.
(6) Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
(7) Important social, occupational or recreational activities are given up or reduced because of use of the substance.
(8) Recurrent use of the substance in situations in which it is physically hazardous.
(9) Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
(10) Tolerance, as defined by either of the following:
    a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    b) A markedly diminished effect with continued use of the same amount of the substance.
(11) Withdrawal, as manifested by either of the following:
    a) The characteristic withdrawal syndrome for the substance.
    b) The substance (or closely related substance) is taken to relieve or avoid withdrawal symptoms."[13]

BACKGROUND

A patient with two to three of the above symptoms would qualify as having a mild disorder, four to five of the symptoms would qualify as a moderate disorder and six or more of the symptoms would qualify as a severe disorder.[12] The diagnostic criteria above are specified to the 10 classes of substances included in the DSM-V, although some classes do not include the withdrawal criteria.

Prevalence of Alcohol and Substance Use Disorders

Problematic alcohol and substance use pose serious health and social concerns for AI/AN individuals and families. While AI/ANs fare better than, or similar to, all races in some alcohol or other drug use behaviors, other indicators show AI/ANs have more problematic alcohol and substance abuse behaviors. Data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) indicate that compared to all races a lower percentage of AI/ANs are current drinkers (58.2% vs. 65.4%; one or more drinks in the past year). More AI/ANs report being former drinkers than all races (24.6% vs. 17.3%). Rates of lifetime alcohol abstinence are similar for AI/ANs and all races (17.1% vs. 17.3%).[1]



More AI/AN males than females are current drinkers (65.5% vs. 51.7%; one or more drinks in the past year). However, among current drinkers compared to all other races AI/ANs had the highest rates of past-year, heavy daily drinking (21.9% vs. 15.7%; over one drink per day for women and over two drinks per day for men); also AI/ANs had the highest rates of alcohol dependence and abuse (20.8% vs. 12.9%).[1] Similar percentages of AI/AN males and females reported heavy drinking in the past year (21.6% vs. 22.2%; more than two drinks/day for men and more than one drink/day for women), whereas rates of heavy drinking are lower among women (13.3%) than men (17.8%) of all races.[1]

Patterns of substance use in the past month from the National Survey on Drug Use and Health (NSDUH) 2004-2008 indicate that compared to all races, AI/AN reports of alcohol use were lower (43.9% vs. 55.2%), but higher for binge alcohol use on at least one day in the past 30 days (30.6% vs. 24.5%) and use of an illicit drug (11.2% vs. 7.9%).[14] Binge drinking is defined as raising blood alcohol concentrations to 0.08% or higher, which usually equates to drinking five or more drinks on the same occasion for men and four or more drinks for women.[15]

Among AI/ANs admitted to substance abuse treatment during 1998-2008, marijuana was the most frequently reported illicit substance for men (14%), followed by opiates (6%), methamphetamine and amphetamines (5%) and cocaine (3%).[16] For AI/AN women, marijuana and opiates were the most frequently reported illicit substances (12% each), followed by methamphetamine and amphetamines (10%) and cocaine (7%).[16]

Compared to other races, studies show higher rates of select alcohol and drug use behaviors among AI/AN youth. In an examination of 1997-2003 Youth Risk Behavior Survey data on high school students in urban areas, higher rates of AI/ANs than whites reported having drunk

alcohol before age 13 (40.5% vs. 28.1%) and drinking at school in the past month (8.3% vs. 4.4%), but no significant differences in lifetime or current alcohol use or heavy drinking was noted.[17] AI/AN students reported illegal drug use at rates more than twofold higher than that of white students, including having ever used heroin or injected illegal drugs, use of cocaine in the past month, use of marijuana before age 13 and use of marijuana in the past month at school.[17]

In addition to the national data, a review of AI/ANs in epidemiological studies of alcohol and substance use, abuse and dependence showed great variation across regions and tribal groups.[18] This variation highlights the importance of studying substance abuse behaviors, prevention and treatment in both national AI/AN population studies and local populations.

Co-occurring Conditions

National study findings reveal that many people with an alcohol use disorder (AUD) also have other psychiatric disorders, including other drug use disorders (DUD), mood disorders (e.g., major depression), anxiety disorders or personality disorders (e.g., antisocial personality disorder).[2] Compared to all races AI/ANs had the highest past year prevalence of any AUD (12.1% vs. 8.5%), any DUD (4.9% vs. 2.0%) and comorbid (AUD and DUD) disorders (3.5% vs. 1.1%) in the NESARC data.[2] Comorbidity has ramifications for diagnosis and treatment because people with comorbid disorders may respond less effectively to addiction treatment than those with only one disorder. Effective diagnosis and treatment of co-occurring addictive and psychiatric disorders requires varied treatment methods and staff trained in the treatment of both types of disorders.[2, 19]

Consequences of Alcohol and Substance Use

In a Centers for Disease Control and Prevention (CDC) analysis of death certificate data from 2001-2005, 11.7% of all AI/AN deaths resulted from alcohol-attributable deaths (AAD) compared to 3.3% for the general population. Results from this analysis also showed that AI/ANs lose more potential years of life (36.3 years) versus the general population (29.4 years) due to AADs. The leading acute cause of AAD was motor-vehicle traffic crashes and the leading chronic cause was alcoholic liver disease.[3]

The chronic liver disease and cirrhosis death rate in all UIHO service areas combined is 21.6 per 100,000 among AI/ANs, significantly higher than the rate of 9.2 per 100,000 people in the general population.[20] The alcohol-induced death rate among AI/ANs in all UIHO service areas combined (16.4 per 100,000) is also higher than the rate in the general population (5.9 per 100,000).[20]

In addition to alcohol related deaths, alcohol use among AI/ANs contributes to illness (morbidity) in many significant ways. For example, fetal alcohol syndrome and fetal alcohol spectrum disorders are more prevalent among AI/ANs than other race groups.[21] In a review of racial/ethnic disparities in alcohol use and related consequences, Chartier and Caetano (2010) cited several studies that indicated AI/ANs are at greater risk for alcohol-attributed violence and traumas, including intimate partner violence, rape and assault compared with other race groups.[22] In one study among Navajo Indians, alcohol dependence was an independent risk factor for experiencing and perpetrating physical domestic violence.[23] Studies on outcomes

associated with substance abuse for the general population describe a variety of health effects, injuries, birth complications, domestic violence, child abuse, family instability, lost economic opportunity, school underachievement and crime.[24]

Risk and Protective Factors

In a review of literature, Whitesell et al. (2012) described individual and community-level factors related to increased alcohol and substance use, some of which have been documented among AI/ANs.[18] Individual risk factors present among AI/ANs noted in the review included a family history of substance use disorders, psychiatric comorbidities, exposure to trauma and Post-traumatic Stress Disorder, social norms supporting alcohol use and exposure to problematic substance use behaviors.[18] One example includes NESARC data where a higher proportion of AI/ANs report a family history of alcoholism compared to all races (35.0% vs. 22.3%).[1]

In NSDUH data, compared to other racial/ethnic groups, AI/AN youth were more likely to perceive no risk from substance abuse or only moderate risk. AI/AN youth were also more likely to endorse the belief that all or most of the students in their school get drunk at least once a week.[6] Additionally, AI/AN youth compared to other racial/ethnic groups had lower rates of peer protective factors, such as participation in youth activities and religious services, and lower rates of family protective factors, including being less likely to perceive a strong parental disapproval of youth substance use.[6]

Community-level factors that are hypothesized to impact individual risk for alcohol and substance abuse include the culture and history of different tribes around alcohol and substance use, policies for and availability of alcohol and other substances and availability of healthcare services and treatment.[18] It is important to consider the impact of historical traumas on AI/AN communities and alcohol and substance use behaviors, for instance, traumas from colonization, forced assimilation, relocation and genocide. Historical traumas are part of the context for lifespan traumas and ongoing discrimination.[25] Responses to trauma include, use of alcohol and substances as a way to cope, as a fatalistic manifestation or self-destruction, to self-medicate, or even as self-improvement in cases of low self-esteem.[26-28] Validating the lifetime and historical traumas suffered is part of healing and recovery.[25] A shift to a strength-based approach that focuses on the majority of individuals who do not have a substance use problem would help identify the important factors that provide resilience.[18]

Treatment of Alcohol and Substance Use Disorders

Usual Care

Treatment for alcohol abuse is provided in different settings through a variety of approaches. Most treatment programs are delivered in health and social service settings, such as primary care clinics and mental health programs; there are also specialized treatment programs and

mutual aid support programs such as Alcoholics Anonymous (AA). While many studies identified the need for alcoholism treatment among AI/ANs, few have evaluated the quality, appropriateness and effectiveness of care for alcohol and substance use disorders among AI/ANs.[5]

There are a number of strategies to screen for alcohol abuse in primary care settings, including screening questions (e.g., AUDIT, CAGE, etc.), biochemical markers for harmful effects of alcohol use and collateral information (e.g., patient records and informants such as spouse, family, friends, parole and probation officers).[29] A large national study of the Substance Abuse and Mental Health Services Administration's recommended screening protocol for illicit drug and alcohol use – screening, brief interventions, and referral to treatment (SBIRT) – found that this model resulted in significant reductions in heavy alcohol use as well as any illicit drug use among AI/ANs comparing baseline data to six month follow-up.[30] Other tools examined and found to be useful among AI/AN populations included AUDIT and CAGE for adults, CRAFFT for adolescents and the SAQ for pregnant women.[31]

No studies that looked at biochemical markers or collateral screening questionnaires were located for AI/ANs. Family-based/collateral interventions have been utilized to motivate substance abusers into treatment. Authors of a literature review on this topic explained that there is a need for these questionnaires to be developed and validation studies conducted for AI/ANs as well as an integrated instrument to screen for drugs and alcohol in this population.[31]

The Institute of Medicine described broadly that specific types of care may be needed to adequately address the wide range of medical, psychological and social difficulties presented by persons with alcohol problems. These included a combination of inpatient hospital services, direct medical care, residential care in various sheltered environments, job training and placement assistance, counseling and aid in dealing with various life problems.[32] According to the 2009 National Survey on Substance Abuse Treatment Services the clinical or therapeutic treatment approaches that were being used *always or often* by a majority of substance abuse centers included substance abuse counseling (96%), relapse prevention (87%), cognitive-behavioral therapy (66%), 12-step facilitation (56%) and motivational interviewing (55%) (therapies are detailed later in the Results section of the report). Other treatment approaches, such as anger management (39%) or brief intervention (35%) were commonly used by over one-third of facilities.[33]

Findings from treatment outcome studies suggest that the appropriateness of mainstream approaches for AI/ANs needs further examination.[5] In a review of traditional and culturally-based interventions for substance abuse among AI/ANs, the authors described the need for systematic evaluation of the effectiveness of these approaches and determination of which clients would benefit from these interventions, noting that while difficult to implement, these evaluations would be critical to establishing "best practices."[34]

Treatment Availability and Utilization

Approximately 55% of all AI/ANs rely on Indian Health Service (IHS) or tribally-operated clinics and hospitals for health care, leaving a large proportion of the population to rely on other publicly- and privately-funded facilities.[4] In 2007, only 40% of all AI/AN substance abuse

treatment facilities were located in urban areas (i.e., in counties the U.S. Census Bureau defined as Metropolitan Statistical Areas) and 60% were located in rural areas (all other areas).[4] Furthermore, 62% of uninsured AI/ANs report they do not have access to IHS services.[35] Admission to treatment rates are higher among AI/AN men than among AI/AN women, which mirrors national trends.[36] Among AI/AN admissions, 71% of men and 56% of women entered treatment because of primary alcohol abuse.[16] A 2011 report on clinic data from 32 UIHOs noted that four percent of all patients used substance abuse services compared to eight percent of AI/AN patients who used these services.[37]

Barriers to Care

Differences between race groups in use of treatment services may result from underlying variations in barriers to care. In an analysis of data from the National Longitudinal Alcohol Epidemiologic Study researchers identified meaningful differences in the reasons why people fail to obtain needed care between patients of different ethnicities.[38] Authors noted specifically that beliefs about the appropriateness of alcoholism treatment and confidence in the treatment establishment are important factors in seeking help.[38] Less than one-fifth of alcohol and other drug abuse treatment programs nationwide offer specialized services for AI/ANs compared to about one third that offer these programs for African Americans and Hispanics.[5] The observed shortage of healthcare providers of AI/AN descent may similarly impact treatment seeking behaviors by AI/ANs.[39]

Incompatibility between the cultural perspective of an individual needing care, and that of available alcohol abuse/dependence treatment services may be a barrier to care for AI/ANs.[40] In a mixed methods study of 56 primarily non-reservation AIs with an AUD, participants described a number of barriers to treatment.[40] Barriers fell into the following categories: personal (belief they didn't have a problem, not wanting to stop drinking, stigma/embarrassment, etc.), pragmatic (cost, access, knowledge of services, transportation, child care, etc.), concerns about services (not thinking treatment will help, previous negative treatment experience, perception of poor quality care, concern about confidentiality, cultural appropriateness, prejudice, etc.) and social networks (negative social reinforcement for seeking treatment, positive reinforcement of alcohol use).

Similar barriers to substance abuse treatment were identified among 100 AI focus group participants in 10 non-reservation communities across the state of Oklahoma.[41] These barriers included lack of resources (e.g., insurance, money and transportation), prejudice (e.g., by service providers and institutions including the IHS, federal and state government programs), lack of awareness and family or tribal concerns.

This background provides the context to understand the nature of substance abuse and the importance of sharing substance abuse prevention and treatment approaches for AI/AN communities. In order to eliminate disparities in substance abuse prevalence, negative individual and community consequences of misuse and the barriers to care, tailored, comprehensive responses must be implemented. The remainder of this report explains the methods used to generate the literature review results, summarizes the findings of both academic and community-driven substance abuse programs involving urban AI/ANs and provides recommendations for future research, programming and policy.

METHODS

Process

Initial database searches (described below) were conducted in October 2012. The review process included several elimination rounds to narrow results to the most relevant findings according to the inclusion criteria (detailed later in this section). Project staff reviewed source content in the order below and eliminated non-relevant findings at each of the following steps:

(1) Review of all titles;
(2) Review of remaining abstracts or brief descriptions; then
(3) Review of remaining full articles, materials, project descriptions, reports, etc.

Terms

The project team developed a search strategy and search terms focusing on the population of interest, condition of interest and type of information sought. For the population component, the search terms included “American Indian” OR “Alaska Native” OR “Native American” OR appropriate PubMed MeSH[a] term: “Indians, North American” AND “Alaska Native.” The condition component search terms were “alcohol” OR “substance” OR “drug,” OR in PubMed, the MeSH term “Substance-Related Disorders.” Also, the condition search terms included “addict” OR “depend” OR “misuse” OR “abuse” OR “binge” OR “risky behavior” OR in PubMed staff used the MeSH terms: “Behavior, Addictive” OR “Dangerous Behavior” OR “Risk-Taking.” The time period of publication included sources published between 2003 and October 2012. For specifying the type of information, we used the search terms “prevention” OR “treatment” OR “management” OR “intervention” OR “evaluation.” Each of these search term families were connected by AND to ensure that results consisted of at least one key word from each of the components. These search terms provided the balance between focus and breadth to ensure results were both relevant and comprehensive. When available in a given database, advanced search techniques were used to optimize the key word search and the use of single or multiple wildcard operators were employed to allow for multiple versions of a word or word combinations with that root.

Inclusion and Exclusion Criteria

To be included in the review, project staff determined if each of the findings met the following criteria:

- Information available in English.
- Tailored for AI/ANs.
- Included an activity, task or materials for healthcare providers, patients and/or community members in an effort to prevent, treat or manage the topic areas.
- Addressed the topic areas specifically (i.e., substance abuse or chemical dependency are the focus of the finding not a sideline or minor mention). Holistic programs and activities that incorporate the topic areas along with other conditions were included.

[a] MeSH (Medical Subject Headings) is the vocabulary thesaurus used for indexing articles for PubMed.

METHODS

Sources were excluded for any of the following reasons:

- Information was a duplicate between databases of sources already identified in the search.
- Program, activity or study involved only non-urban AI/AN populations and settings (i.e., tribal or reservation studies, programs or interventions without any urban AI/AN population involvement).
- Program, activity or study was primarily focused on tobacco use or cessation (i.e., not tobacco in addition to or along with alcohol or substance use or abuse).
- Information was not available to the UIHI through an IHS library account or was not free of charge on the internet.
- Activity, task or material occurred outside the U.S.

Databases

Academic

Academic sources included those writings that were available in scholarly journals, most of which were reviewed by peer experts. A variety of databases provide access to academic articles. Project staff selected the following databases to conduct searches: PubMed, PsycINFO and Web of Science. Project staff utilized this combination of databases to provide the widest coverage with minimal overlap of findings.

Grey

Much of the innovative work being done in AI/AN communities is not available in academic sources due to a practice-based and service-delivery focus, rather than devoting time to the manuscript writing and publication process. Therefore, project staff also conducted searches for grey sources. Grey sources come in a number of forms including websites, online documents, working papers, government or technical reports, oral presentations and conference proceedings. The following are the databases searched for grey sources: the IHS, the Substance Abuse and Mental Health Services Administration and Google. Only the first 259 results in each grey source search were reviewed. This number represented the average number of results per database in the academic search after eliminating duplicates. This limit was set to prevent bias between grey and academic sources and to control for the disproportionally high number of results from Google.

Additional Sources

If a new reference was identified during review of the articles and materials through the process described above, project staff located the source document to review for inclusion.

RESULTS

Overview

The UIHI identified 2,543 sources; 1,152 were found through academic databases and 1,391 were found through grey source databases or search engines. An additional seven sources included in this report were referred to in the original search findings. Of the 2,550 sources identified, 19 sources were unattainable, 947 sources were excluded as duplicates and 1,470 sources were excluded based on review criteria. Two sources were excluded based on concerns about the published literature; this information came to our attention through external review of the summaries. A total of 112 sources are listed in this review.

This section synthesizes the findings of the UIHI's literature review of academic databases and grey sources, uncommon in typical reviews of alcohol and substance abuse prevention and recovery support among AI/ANs, which tend to focus on peer-reviewed academic literature.

Limited, if any, outcomes or evaluation information was available in many of the sources identified, a finding also noted by others.[39, 42, 43] Due to this limitation, our results do not present exclusively evidenced-based or best practices for alcohol and substance abuse programing but rather focus on two main categories of findings: (1) implications for care based on provider, key informant or researcher knowledge and perspectives on the needs and treatment preferences of AI/ANs, and (2) programs or activities describing study or program design, outcomes or lessons learned. Additionally, included in the Resources section of this review are materials on the prevention and treatment of, and recovery from, alcohol and substance abuse conditions for urban AI/AN communities. Our hope is that these results provide UIHOs and other urban AI/AN-serving organizations with valuable recommendations, programs that have been used in AI/AN communities and related resources for further investigation based on interests and needs.

Implications for Care

During the review, the recommendations of various professional, research and community experts who have experience or knowledge of substance abuse prevention and treatment strategies well-suited to AI/ANs emerged. These recommendations are grouped here under the category "Implications for Care." Rather than describing specific research, case studies or personal reflections, this section presents the themes that ran throughout the findings in this category. Using this approach, the UIHI hopes to minimize inappropriate generalization from findings of small studies and other limitations of these sources. Further investigation of these sources, found in the References section at the end of this report, is encouraged for more comprehensive coverage of the issues discussed.

While the findings in the Implications for Care category are diverse, all center on culturally-appropriate, community-supported and individualized approaches to preventing, healing and addressing substance abuse. Below, each of the themes are described with an emphasis on the implications for addressing substance abuse among urban AI/ANs.

RESULTS

Theme 1 – Cultural Care

A number of findings in this literature review highlighted the importance of the integration of cultural activities and practices into substance abuse prevention and treatment. One report concluded that cultural relevance and inclusion of traditional practices were elements of best practice for the treatment of substance abuse among AI/ANs.[44] The California Department of Alcohol and Drug Programs also recommended culturally-based prevention programs for AI youth to reduce the use of alcohol, tobacco and other drugs.[45] Many programs used evidence-based, conventional treatment methods with AI/AN traditional elements.[21, 46-52]

> "When they set foot into a Native organization where they feel comfortable, they start to heal. It's the cultural identity coming back."[53]

Focus groups and key informant interviews with 18 different AI/AN-serving treatment programs revealed two primary approaches to incorporate culture in care: specific traditional practices and the adaptation of Western models.[53] Examples of the specific cultural practices that programs typically offered included ceremonies; availability of Native staff, cultural directors and traditional healers; classes on cultural topics and use of Native languages; field trips to locations with cultural history or relevance and outdoor or community-based activities.[54] Examples of the adaption of Western treatment therapies included the use of the Wellbriety program (i.e., the combination of the AA 12-step program with AI/AN beliefs and teachings); "blended" treatment materials, which included cultural images and values such as the Medicine Wheel, totems or Native art graphics and informal (usually verbal) adaptations in the provider's interactions with clients such as talking about historical traumas or framing around Native concepts like the Medicine Wheel.[53]

> "It's not a homogenous population by any stretch…all different tribes, all different spiritual beliefs, all different ways of being. And, different levels of acculturation."[53]

The researchers identified foundational beliefs and values that lay the groundwork for all services. Foundational aspects featured across participating programs included emphasis on protective aspects of culture, recognition of the role of trauma and history and holistic care including spirituality. Challenges included the diversity of AI/AN populations, lack of resources (both availability of and funds to hire staff with traditional knowledge and expertise), funders' pressures to implement evidence-based interventions, billing for cultural practices, provider burnout and personal boundary violations.[53] One researcher highlighted the importance of political advocacy for traditional AI/AN healing practices to be recognized care practices in their own right, not just as complementary care.[55]

Another approach to incorporating community and individual cultures into care is through an ecological assessment that takes into consideration the relationship between contexts and individuals. The ecological assessment was recommended by Okamoto et al. (2006) to develop culturally-grounded interventions as a way to increase effectiveness, applicability and acceptability. For example, the *American Indian Youth Pilot project* in Phoenix used quantitative

and qualitative methods to learn about the relationships, contexts and circumstances most influencing AI youth substance use as well as the perceived effective drug refusal techniques. The findings of this study are being used to develop a school-based intervention.[56]

Traditional practices also play a role in building pride in AI/AN cultural identity and norms, including establishing AI/AN role models (both contemporary and historical) and acknowledging Native contributions to society.[57] Myhra (2011) recommended traditional practices – especially parenting practices – and restoration of traditional values as important for protecting future generations from substance abuse.[27] Kenyon and Hanson (2012) described the *Positive Youth Development (PYD)* framework as an approach for research and prevention efforts in AI/AN youth populations that places traditional activities and healing practices at the center, rather than as an add-on to a program. Examples of *PYD* in substance abuse prevention include *Project Venture* and *Daughters of Tradition* and *Sons of Tradition* from White Bison.[58]

Theme 2 – Client-Centered Care

Care and programming that is individualized, flexible and responsive to the values, preferences and needs of clients was a recurrent theme in our findings.[53, 59, 60] Encompassed within this theme is the notion of respecting and treating the whole person, rather than their addiction in isolation, as well as offering an open-door policy for providing services as needed by the client.[53] Blume and Escobedo (2005) also concluded that best practices for recovery programs would include flexibility to adapt to the diversity of AI/AN people such as addressing tribal and cultural diversity in urban settings, acculturation levels and gender differences.[44]

In addition to being flexible to needs and preferences, another presentation recommended (1) personalizing treatment to the client's level of acculturation and cultural identification, (2) engaging in traditional healing approaches with those who are more traditionally-oriented and (3) providing mainstream treatment options for more assimilated clients.[60] Venner et al. (2008) also supported this suggestion,[61] which serves to avoid stereotyping and allows services to be tailored to individual needs and preferences. Being flexible also means adjusting approaches to the gender and age of clients.[44, 57] One example included tailoring youth interventions for delaying substance initiation while focusing adult interventions on reducing actual use.[57]

Theme 3 – Skills Building

Policies, programs and interventions to increase a variety of skills – from coping and stress management to workforce and parenting – also emerged as a common recommendation to prevent and treat substance abuse.[57-59, 62-64] One study focused on identifying substance refusal preferences among AI/AN youth to develop a skills-building curriculum to delay initial, and reduce overall, substance use. This small qualitative study in the Phoenix area had somewhat contradictory findings with the authors indicating that urban Native youth had a preference for passive, non-confrontational drug and alcohol refusal techniques.[62]

However, the researchers found that more aggressive strategies, such as destroying the substance or setting boundaries, were preferred when the offer came from family members.[63] The authors concluded that a prevention program that taught respectful, simple ways for AI/AN youth to refuse substances is needed.[62] Similarly, Okamoto et al. (2006) found that youth prefer non-confrontational approaches to refusing substances.[56] Supporting bicultural competence – the ability to successfully and positively engage in both Native and mainstream values, identities and norms – and biculturally adapted life-skills training were also suggested as a way to minimize risks for substance abuse.[43, 57]

Positive socialization, relationship building with caring adults and structured activities that draw on youth and cultural strengths to create a safe environment are central to *PYD* and are used to increase the six C's: competence, confidence, connection, character, caring and contribution.[58]

Drawing on interviews conducted with AI women in treatment, Chong and Lopez (2008) suggested that increasing self-efficacy through coping skills to resist temptations, using cognitive and behavioral strategies and providing relationship building and management skills would assist AI women in recovery.[59]

Theme 4 – Community Supported Prevention, Treatment and Recovery Programs

The concepts of family and community appeared in two primary ways in the review. First, family and social support were included in the recovery process; second, including the family and/or community in the development of treatment plans and programming was valued.[27, 43, 53, 57, 65]

In a study at a residential substance abuse treatment program, Chong et al. found that active family participation and social support were significantly correlated with improved psychosocial functioning for women in recovery.[65] In a related study, Chong and Lopez (2008) found that poor family relations prior to treatment, associations with other substance users, family conflicts and negative life experiences were predictors of relapse,[59] indicating the importance of positive family relations for sustained recovery. In addition to providing support, another author noted that healthy family connections can also be a source of motivation for recovery.[27]

The second way community involvement emerged in this review was through involvement in the conceptualization and development of programming. Collaboration with the community in every stage of program development was discussed by a number of sources we reviewed.[39, 43, 52, 66-71] Reviewers of best practices noted that the best practices for AI/AN people include the community in a leadership role with professionals acting as consultants.[44] Another author suggested that community involvement could be especially helpful in the development of themes and messages for prevention campaigns.[57]

RESULTS

Theme 5 – Healing Traumas for Recovery

While the urban Indian community is diverse, a shared history of trauma exists. In addition to the historical and intergenerational traumas of human and cultural genocides, lifetime trauma is highly prevalent for AI/ANs through sexual and interpersonal violence, poverty and racism.[25, 28, 72-74] Authors have described various ways in which trauma is linked to substance abuse: as a way to cope, as a fatalistic manifestation or self-destruction, as a way to self-medicate or even as a means of self-improvement in cases of low self-esteem.[26, 27] A number of findings highlighted the importance of addressing and healing traumas as key to prevention and treatment of substance abuse.

One researcher, Myhra (2011), contended that naming historical trauma for those unfamiliar with it, but suffering from it, provides a safe space to discuss racism and discrimination, especially in group situations.[27] Myhra (2011) further suggested that broader education on historical trauma would aid in dispelling stereotypes of AI/ANs and contribute to the building of healthy cultural identities.[27]

Blume and Escobedo (2005) concluded that best practices of substance abuse treatment for AI/ANs will be strategies that confront both personal and community trauma, loss and exploitation.[44] Arundale (2006) argued for research into integrating traditional healing processes for traumas in community-led efforts for substance abuse treatment and prevention, including ongoing research on effectiveness.[26]

Approaches and Programs

Findings in the Approaches and Programs results category are organized into (1) descriptions of individual programs and approaches, and (2) resources. Many of these program descriptions provide examples of how the themes described above are implemented in practice. When available, information on evaluation results and efficacy is provided.

Individual Programs and Activities Descriptions

Access to American Indian Recovery Program (AAIR)

The *AAIR* program coordinates a network of community-based health providers in the provision of substance abuse treatment and recovery services across California. Programming provided at *AAIR* treatment centers include traditional Native healing practices such as sweat lodge ceremonies, drumming, talking circles and smudging that are integrated holistically with residential treatment programs.[75, 76]

Alaska Native Medical Center-South Central Foundation (ANMC-SCF)

The ANMC-SCF has integrated Western medicine with traditional AN culture and healing. With the understanding that many alcohol and substance abuse problems in the AN community are caused by deculturation and historical trauma, ANMC-SCF has embraced a return to community responsibility to heal and restore cultural pride to reduce the impact of substance abuse. Treatment approaches empower the client as instrumental in their own healing. Staff model

recovery and abstinence themselves; half of the staff members have a history of substance misuse or addiction and now live sober.[49]

Analenisgi

In Cherokee, Analenisgi means *'they are beginning' or 'they are starting out.'* The *Analenisgi program* is located in Cherokee, North Carolina, where wellness among families and individuals is encouraged through both conventional interventions and traditional AI/AN practices. Services include individual, group and family therapy; drop-in clinics; an intensive outpatient program; psychiatric evaluations; medication management and an adolescent recovery group.[77]

Brief Alcohol Screening and Intervention for College Students (BASICS)

BASICS uses a harm-reduction approach to prompt college students who have or are at risk for problematic alcohol behaviors to decrease their alcohol use. Designed to show the discord between the students' drinking behavior and their values and goals, *BASICS* uses the principles of Motivational Interviewing, delivered by a trained professional through two, one-hour interviews. The first session collects information about the student's alcohol use, beliefs about alcohol and directions for self-monitoring drinking. The student also completes an online assessment that informs the comparison between actual use and alcohol norms, personalized negative consequences and risk factors, and the perceived risks and benefits of drinking. The intervention is adaptable for young adults in environments outside of colleges. This program is listed on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-based Programs and Practices; the registry noted AI/ANs as one of the populations in which *BASICS* has been implemented.[78]

Best Drug Rehabilitation

Best Drug Rehabilitation is an addiction treatment center located in Manistee, MI that offers a range of addiction treatment methods, including an AI/AN treatment program. Approaches used include *Meditations with Native American Elders*, *The Medicine Wheel and 12 Steps* and *The Red Road to Wellbriety in the Native American Way*. (More about Wellbriety is discussed later in the results). Treatment programs, including a focus on customs and religion, group therapy, ceremony, confrontation of trauma and religious and spiritual recovery for a sober life, are led by licensed AI/AN counselors. Best Drug Rehabilitation believes in a holistic approach to wellness that addresses emotional, mental and spiritual well-being as well as physical health. Ongoing support for sober living after graduation includes *Wellbriety Circles* and *Movement* activities.[79]

Community Mobilization

Below are examples of two communities that developed and implemented community-wide initiatives to reduce substance abuse among AI/ANs regionally. In response to long-term, widespread substance abuse and alcohol-related deaths and associated unflattering media attention in the late 1980's, the McKinley County, NM community mobilized to take action with individual, policy and community-based efforts.[66] With support from the Robert Wood Johnson Foundation's *Fighting Back Program*, the community rallied behind several policy changes including establishing a local alcohol excise tax, banning alcohol sales on Sunday, lowering driving while intoxicated (DWI) thresholds and requiring jail time for those with repeat DWI convictions. Additionally, the "drunk tank" in the Gallup, NM facility was replaced with a 250-bed

substance abuse detoxification, short-term treatment and referral center known as the Na'nizhoozhi Center (NCI). NCI also offers a month long treatment program with Navajo and Zuni healing approaches. The community capacity to prevent and address alcohol and substance abuse was also increased through training of community leaders and education for hospitality workers about responsible alcohol service practices.

McKinley County successes included reduced rates of motor vehicle accident mortality (by 60%), suicide (by 59%), homicide (by 58%) and drug-induced causes of death (by 50%). These trends exceeded statewide and national declines over the same period from 1974 to 1995. Arrests associated with alcohol declined 42% in Gallup.[66]

Learning of the successes in McKinley County, tribal and community leaders in Fremont County, WY sought to develop their own community mobilization initiatives. Fremont County leaders organized a large group of community members into distinct task forces to develop and implement specific strategies. In addition to similar measures to reduce alcohol availability and alcohol-server training, Fremont County developed the Abate Substance Abuse Project and the Fremont County Alcohol Crisis Center, a detoxification, treatment and referral center. Adolescent programs included *Pathfinders*, an alternative high school, and the *KICK-IT* outpatient treatment program that emphasized addressing the statewide cultural acceptance of underage drinking.

Another keystone of the Fremont County initiative is an adult and juvenile drug court initiative offering treatment instead of incarceration as well as jail-based substance abuse treatment. The local media were actively engaged in substance abuse reduction activities through the generation of over 400 articles in five years.

Factors that contributed to successful mobilization efforts noted by both counties included developing community-based coalitions with both Indian and non-Indian leaders, significant media engagement and coverage both regarding the substance abuse problems and reduction efforts, use of local epidemiologic data to illustrate the scope of the problems to decision-makers and the public and monitoring progress in reduction efforts.[66]

Community-informed Behavioral Health Treatment Approach

In the summers of 2005 and 2006, Los Angeles County conducted focus groups and key informant interviews to design a community-informed behavioral health treatment approach for urban AI/AN youth. Sixty-seven people participated in nine focus groups, including parents, youth and service providers; 46 key informants highly involved in the AI/AN community in LA county participated in interviews.[39]

The most serious problems identified across all focus groups included (1) drug and alcohol abuse among AI/AN youth, (2) gang activity and violence and (3) negative stereotypes and racism. Identified community needs included outreach, youth and recreational services, child and family behavioral health and support services, cultural activities to promote cultural identity and address the feeling of invisibility, cultural competency training and more AI/AN service providers.[39]

RESULTS

A crucial feature of the resulting system of care developed for AI/AN youth with behavioral health needs was the individual's choice and responsibility in choosing their own treatment plan. Key elements were traditional crafts and cultural activities such as drumming, singing and dancing. A variety of evidence-based treatments were also available to choose from.[39]

The recommendation to improve outreach and build awareness of services was implemented through several avenues including flyers, monthly calendars, Facebook and the development of a youth and parent committee to inform future needs and treatment options. Lastly, transportation was made available for all cultural and youth/family activities.[39]

Contingency Management

An evidence-based treatment, *Contingency Management (CM)*, incentivizes alternatives to drug use, for example providing a voucher to purchase retail goods distributed after confirmation of a period of abstinence. Counselors found the incentives offered a tool to engage even resistant, disinterested clients because financially-based incentives have particular salience for clients with limited monetary resources. *CM* offers a hook to encourage initial participation in treatment while building internal motivation for change.[47]

Drum-Assisted Recovery Therapy for Native Americans (DARTNA)

Dickerson et al. (2012) conducted the first National Institutes of Health-funded research study on a substance abuse intervention utilizing AI/AN drumming as its core treatment component. Dickerson et al. conducted focus groups in Los Angeles with AI/ANs with current or past substance abuse disorders, AI/AN-serving substance abuse treatment providers and the *DARTNA* community advisory board to elicit feedback prior to testing and implementation. The focus group findings included four themes: (1) drumming benefits, including fostering cultural identity, building self-esteem and identifying with the "sacred medicine" of drumming; (2) value of a cultural focus; (3) discussing different gender roles in drumming and (4) establishing shared AI/AN drumming traditions.[68] *DARTNA* focuses on drumming but is also based on elements aligned with traditional healing concepts. Twice weekly sessions over 12 weeks consist of drumming, a talking circle and education about drumming and traditional concepts of wellness.[68]

To enable adaptation and flexibility for use according to the local or regional drumming practices, *DARTNA* treatment protocol does not specify one procedure for drumming. A cultural leader plays an important role in addressing issues of tribal diversity, gender roles and specific drumming activities.[68] A follow-up open trial (pre-test) conducted among 10 AI/ANs with histories of substance use disorders demonstrated promising results with significant improvement in medical status, psychiatric status, spirituality measures and physical and/or functioning outcomes.[80]

RESULTS

Family Effectiveness Training (FET)

FET combines three approaches: *Brief Strategic Family Therapy (BSFT)*, *Family Development* and *Bicultural Effectiveness Training* through a series of 13 family counseling sessions aimed at prevention and early intervention for children ages 6-12. The *FET* objectives are to strengthen families facing cultural and developmental challenges, increase resistance to substance abuse, improve family cohesiveness and bridge intergenerational and cultural divides between youth and parents. Originally developed for Latino families, *FET* has been adapted for AI/AN families and is recognized by SAMHSA as a culturally-competent, evidence-based practice.[81]

Gathering of Native Americans (GONA)

GONA is a program that has been adapted by hundreds of organizations across the country. Through storytelling, affirmation and ritual, the *GONA* process reflects the Native concept of the four levels of human development and responsibility. These levels are belonging (represents childhood; learning how to live and work comfortably and effectively), mastery (represents adolescence; empowerment, understanding communities, local contexts and partnerships), interdependence (represents adulthood; action and community leadership, connections with social networks and the environment) and generosity (represents elders; knowledge, teaching, responsibility to give back and share).[82]

One mixed methods evaluation of a four-day *GONA* event implemented by the Native American Health Center in the San Francisco Bay Area included 186 youth, ages 13-18, who participated in the event. While 46% (n=86) did not complete the six-month evaluation, the findings from completed evaluations showed statistically significant results. While perception of risk associated with marijuana and alcohol use increased (from 25% to 59% and 37% to 63% respectively), behaviors did not change. While ethnic identity, a protective factor, did not change significantly from baseline to follow-up, the authors suggested this may reflect recruitment strategies that were more likely to enroll youth who already had a strong Native identity. The authors suggested future evaluations of GONA examine other important outcomes such as community capacity, social capital and empowerment.[83] In another assessment of GONA, a survey of 29 youth (23 were Native) who participated in a 2004 *GONA* program showed that 83% had increased knowledge of AI/AN culture, 79% reported increased connection to AI/AN community, 55% reported improved drug refusal skills and 69% reported improved communication as a result of the *GONA* program.[84]

The California Department of Alcohol and Drug Programs also specifically recommends *GONA* as a program that emphasizes the role of community intervention rather than interventions implemented from hierarchal approaches like from federal agencies.[45]

Holistic System of Care - Native American Health Center (NAHC) in the San Francisco Bay Area and the Friendship House Association of American Indians (FH)

A strategic plan known as *Urban Trails*, originally developed as part of a Circles of Care planning grant in 1998, was implemented in 2003 through a six-year, Center for Mental Health Services-funded initiative. The goal of *Urban Trails* was to establish a holistic continuum of care system for AI/AN youth suffering from serious emotional disturbance. The system of care

includes early intervention, treatment, mental health, substance abuse treatment and medical and social services.[67]

Since then numerous partnerships, memoranda of understanding (MOUs) and links with county and state health departments along with other Native-serving non-profits in the Bay Area have been established. Funding restrictions have been overcome by establishing subcontracts from eligible agencies for funding streams which are not available to UIHOs like the NAHC.[67]

From the *Urban Trails* strategic plan, the Holistic System of Care for Native Americans in an Urban Environment (HSOC) was developed and expanded over time through the collaborative efforts of the NAHC and the FH. The HSOC provides integrated, culturally-competent services for the prevention, risk reduction and treatment of HIV/AIDS, substance abuse and mental health conditions among urban AIs.[50-52, 85] The holistic model aims to treat the whole person's needs for care including social and spiritual services as well as medical and emotional treatment.[84] The HSOC is a complex, interwoven care model that provides community and cultural activities. Outpatient and residential treatments include adolescent and adult screenings for alcohol and drug abuse, psychological assessment, peer support/role modeling as well as group, family and individual counseling. Education services provide information about substance abuse, health, life skills, nutrition, HIV/AIDS prevention, mental health promotion and medical care.[50-52] The HSOC incorporates evidence-based practices including *Positive Indian Parenting*, *GONA* and *MI*.[51] The HSOC has received numerous honors and is recognized by state, federal and national agencies as a best practice. The HSOC has also been adopted by other programs and included in national collaborations and initiatives.[52]

A ten-year review of data from multiple projects and peer-reviewed publications indicated statistically significant reductions in substance or alcohol use; stress, negative emotion or activities related to substance use in the last 30 days; as well as statistically significant reductions in high-risk HIV/AIDS behaviors and acting out behaviors among emotionally disturbed AI children.[52]

Additionally, in 2010 the NAHC entered into a three year contract with the California Department of Alcohol and Drug Programs to provide technical assistance and a statewide awareness campaign about alcohol and drug prevention, treatment and recovery for AI/ANs in California.[86]

Friendship House

Part of the HSOC, in partnership with the NAHC, the FH provides residential substance abuse treatment through a retraditionalization process that integrates traditional Native values with Western psychology. The six-month treatment program involves three months of residential care followed by three months of aftercare support.[87]

Through interviews with 12 AI/AN graduates of the FH program conducted between 1998-99, researchers identified three salient program elements: (1) the process of retraditionalization, (2) the recognition and healing of trauma and (3) the use of 12-step philosophy for treating addiction and supporting recovery.[87]

RESULTS

Women's Circle

Part of the HSOC, the *Women's Circle* was a joint endeavor of the NAHC and the FH that addressed substance abuse and mental health treatment as well as HIV prevention.[44, 88] As with other HSOC programs, the *Women's Circle* blended Western psychotherapy with cultural traditions and practices to meet the unique needs of urban AI/AN women, many of whom have experienced physical, sexual, emotional and historical abuses.[44, 88] Female staffing was important to ensure a safe, non-confrontational environment where women could heal from experiences impacting their substance abuse.[88] Participants were able to engage in a variety of cultural activities and treatment, including parenting skills. The "braiding together" of Western and Native healing practices was not usually part of the official process, but rather done by individual counselors, meeting the client at her level of readiness to engage in that treatment approach.[85, 88]

Youth Services Program

NAHC's *Youth Services Program* developed a substance abuse and HIV/AIDS prevention curriculum for AI/AN youth that combines cultural wellness education with life-skills training, school-based services and collaborative prevention activities. The *Youth Services Program* is based on traditional AI/AN wellness concepts including creating a balance among the four elements: spirit, thoughts, emotions and body. *Seventh Native American Generation Program (SNAG)* is a magazine publication written and edited by Native youth that empowers its creators to creatively express their experiences of growing up Native. The annual *SNAG* publication is celebrated with an in-person gathering that features both traditional and contemporary cultural activities.[84] In a 2003 survey of 34 youth (23 were Native) who participated in *SNAG*, 83% reported increased knowledge about the dangers of drug abuse/addiction and 88% reported an intent to participate in more community activities.[84]

Healthy Nations Initiative

Through the *Healthy Nations Initiative*, the Robert Wood Johnson Foundation funded 14 AI/AN communities, including three urban organizations, to implement creative, community-driven strategies to prevent, identify and treat substance abuse.[84, 89] This flexible funding mechanism allowed communities to increase the availability of programs and activities, spur policy changes addressing substance abuse and support infrastructure to institutionalize and sustain programs.[90] Successful programs were marked by effective leadership, culture as a foundation rather than an addiction, community ownership and collaboration, comprehensive methods stretching across systems (e.g., schools, families, peers, organizations) and entrepreneurial approaches.[90]

Integrated Spiritual and Western Treatment at Urban Native American Social Services Agency

Integrating traditional Native and spiritual practices with Western therapies, a social service agency serving AIs in a west coast urban setting provides a holistic outpatient substance abuse recovery program. A variety of staff, such as substance abuse treatment counselors, psychologists, social workers, Native traditional practitioners, employment specialists, case managers and administrators collaborate to provide services and a variety of wellness activities,

including AA and Narcotics Anonymous meetings, sweat and smudging ceremonies and vocational counseling.[48] The majority of staff are Native and have diverse tribal backgrounds.

Four themes emerged from interviews with providers at the agency about achieving wellness. First, staff members openly accept a bi-spiritual orientation among clients, supporting individuals' balancing of mainstream religious and traditional Native beliefs. The authors noted, "The clients' reconciliation of mainstream religious beliefs with traditional Native beliefs allows clients to function successfully in two very different worlds."[48] The second theme focused on accepting varying levels of acculturation. Third, staff noted the importance of spirituality and traditional practices in recovery and healing. Providers reported that spiritual and/or traditional activities assisted clients in achieving and maintaining sobriety by providing a foundation that provides support long after formal treatment has concluded. Such activities teach coping skills for dealing with stressors, moving toward wholeness, increasing a personal Native identity that assists with empowerment and being honest with one's self about the addiction experience and related behaviors. The fourth theme centered on staff goals for treatment. Some staff held the view that spiritual engagement is necessary to fully recover and maintain recovery (i.e., spiritual development is a primary goal). Other staff felt the primary goal was sobriety and stability of the client's life with spiritual development secondary to sobriety. However, the truly integrated therapies at the agency were demonstrated in the staff comments showing their unanimous commitment to using both Native and Western therapies.[48] As the researchers analyzing this project data observed, the small convenience sample limits the generalizability of findings as does the use of providers' input as proxies for client views.[48]

Keystone Treatment Center

The Keystone Treatment Center in Canton, SD offers a holistic treatment program for AI/ANs. A Native American Advisory Council with representatives from several tribal agencies provides guidance on culture, customs and history to inform the cultural activities (for instance, sweat lodge, talking circle, *Red Road*, *Wellbriety*, individual cultural assessment and advisor, song and prayer, lectures, encouragement and 12-step work) for both adults and adolescents. Additionally, there is a program to incorporate family member support into the patient's healing process.[91]

Matrix Model

The *Matrix Model* is a comprehensive, intensive outpatient program that uses multiple formats and therapeutic approaches to address stimulant abuse and dependence. Various educational and support groups help build knowledge, skills and social support for relapse-prevention. Education for family members is also included in the program. The relationship between the client and individual therapist is realistic, direct, and supports the individual's self-esteem, dignity and self-worth.[92]

This program was not originally developed for AI/AN communities, but adapted for AI/AN use by individual organizations.[47] Working together, the Matrix Institute and The Friendship House in San Francisco developed *Culturally Designed Client Handouts for American Indians and Alaskan Natives*.[93] The handouts include symbols, quotations, stories and ceremonial references from a variety of AI/AN tribes and communities. Further customization and adaptation of these materials are encouraged by the material developers.[47] SAMHSA lists the *Matrix Model* in its National Registry of Evidence-based Programs and Practices, although the studies listing positive outcomes data for treatment retention and completion did not specifically include AI/AN participants.[92]

Methamphetamine and Suicide Prevention Initiative

Since 2008 the *Methamphetamine and Suicide Prevention initiative* has funded over 130 entities, including 12 urban programs, to develop and implement activities to address these two critical issues. Funded sites have implemented a variety of diverse programming. Two years of initiative-wide data suggest that the programs have increased the number of meth-using patients who entered a treatment program, decreased the number of people with a meth disorder in AI/AN communities and increased the number of youth participating in prevention or intervention programs.[94]

Methamphetamine Treatment Project (MTP) and Treatment System Impact (TSI)

The multi-site, randomized controlled trial *MTP* of psychosocial treatments for methamphetamine dependence compared standard treatment to a 16-week outpatient *Matrix Model* of treatment (described earlier in this report) from 1999–2001. Sites included treatment centers, hospitals and community settings.[95] The *TSI* project recruited participants from 2003-2006 as part of a court-monitored option for non-violent drug offenders to choose treatment instead of incarceration or probation/parole without treatment.

Addiction Severity Scores improved for AI/ANs in all problem areas at 12 months (alcohol use, drug use, employment, family and social relationships, legal, medical and psychological); the comparison group scores improved in all areas except psychological. No significant difference in treatment outcomes at 12 month follow-up were found between AI/ANs and non-AI/ANs.

Several study limitations were noted including reliance on self-reported information; court-monitored treatment could have influenced retention and treatment completion and findings that are not generalizable to all AI/ANs.[95]

Miikanaake

The Fond du Lac Behavioral Health Department partners with three outpatient treatment programs in Minneapolis and St. Paul to provide services to AI/ANs living in this urban area. The program uses cutting-edge, non-invasive, relational electroencephalic (EEG) technology along with approaches like prayer and traditional medicine to help clients bring balance to brainwave activity. After an assessment with a certified practitioner, the patient undergoes once-daily EEG sessions and visualization exercises. Limited research exists about the effectiveness of this program but roughly 50% of 20 participants surveyed six months out of the program showed successful treatment results.[96]

RESULTS

Motivational Interviewing

Motivational Interviewing (MI) is a non-judgmental, flexible, respectful and client-centered intervention in which a provider reflects on the client's awareness of a problem behavior and the pros and cons of changing that behavior in order to support the client's transition to self-motivated change. The four principles of MI are (1) empathy, (2) recognition of the discrepancy between the consequences of problem behavior and the client's personal goals or values, (3) responding to resistance with flexibility and a reliance on the client to identify their own answers or solutions and (4) supporting the client's belief in their own ability to change. MI was developed for use with adults and has shown positive outcomes in studies.[97] MI has been adapted for AI/AN adult clients and is beginning to be used with youth, but has not yet been evaluated in studies of youth.[98] Several manuals have been developed on MI, including the following adapted for AI/AN populations (available free online):

- *Native American Motivational Interviewing: Weaving Native American and Western Practices. A Manual for Counselors in Native American Communities.* This manual drew upon focus groups of community members and Native mental health professionals to culturally adapt an MI manual for substance abuse interventions. The manual uses a conversational tone, and plain language, and incorporates discussion of community, cultural identification and spirituality.[61, 98]
- *Motivational Interviewing: Enhancing Motivation for Change-A Learner's Manual for the American Indian/Alaska Native Counselor.* This manual emphasizes cultural considerations and details the role of the Medicine Wheel in the healing process.[99]

A randomized control trial among a primarily AI sample in San Juan County, NM of incarcerated DWI first-time offenders found that those receiving a MI intervention, AI traditional treatments and incarceration had greater reductions in alcohol consumption (both number of drinks and number of drinking days) compared to the control group. The authors concluded that this treatment model holds promise to reduce the risk of future DWI incidents, arrests and accidents among first offenders.[97]

Native American Church (NAC)

The NAC is a religious faith that combines traditional Native rituals with Christian scripture to support members in living a lifestyle of wellness, healing and recovery. The NAC emphasizes love, faith, hope and charity and encourages members to live in harmony and well-being, practicing generosity and humility. The NAC fosters tolerance and willingness to accept foibles such as alcohol use, providing a safe, non-judgmental, healing environment for those struggling with problematic use. Since the NAC also includes wide networks of family and community members it is preventive as well as rehabilitative.[100]

According to NAC, the use of peyote allows participating members to achieve greater self-awareness, insight and empathy, connecting them not only to their community but also to their history through the traditional ceremony and use of peyote as medicine for healing. The NAC provides a faith structure for healing that is uniquely Native and positive.[100]

RESULTS

Native American Prevention Project Against AIDS and Substance Abuse (NAPPASA)

NAPPASA worked with residents and healthcare providers from an Arizona Indian reservation along with academic institutions to develop a culturally-competent curriculum for use with 8th and 9th graders to prevent HIV/AIDS and alcohol and other drug abuse.[44, 101] With an emphasis on AI ways of knowing, there are 11 educational interventions in this program: information, decision-making, values clarification, goal setting, stress management, self-esteem, resistance skills training, life-skills training, norm setting, persistent assistance and alternatives. Sessions consist of instructor lecturing, student activities and video clips.[101] The NAPPASA Curriculum Kit includes instructor manuals, youth manuals and videos.[101-103]

An evaluation of the 3,335 participants at one-year follow-up showed important impacts in behaviors in the intervention group compared to the control group. For example, among non-users at baseline the usual trend of increased drug or alcohol use with age progression was slowed significantly. Significantly more intervention students remained in, or changed to, lower-risk categories of alcohol or other drug use than control group students. Lastly, at the follow-up, intervention students had an increased number of factors known to be protective against risk behaviors.[44]

Native Health – Adult Intensive Outpatient Substance Abuse Program

Native Health, a UIHO in Phoenix, AZ provides a state licensed Adult Intensive Outpatient treatment and driving under the influence program, as well as a *Youth Substance Abuse Program*. The 12-14 week youth program is called *Strengthening the Journey*, which uses the *Adolescent Community Reinforcement Approach*. *Strengthening the Journey* focuses on communication and coping skills, individual counseling and family support, and pro-social activities.[104, 105]

Nokomis Endaad-Shki Bimaadzi Mikaana

Nokomis Endaad-Shki Bimaadzi Mikaana (Grandmother's House-Road to New Life) is a culturally infused healing and treatment program for women with a history of chemical dependency, mental health issues, sexual and cultural traumas. Located at the Minnesota Indian Women's Resource Center in partnership with Fond du Lac, Nokomis Endaad is a three phase outpatient program including up to 18 months of recovery support. Individualized treatment plans provide client-centered and culturally relevant approaches such as healing ceremonies. Also included are traditional practices with foods, art therapy and ways of releasing emotions. The Nokomis Endaad program components include education about substance abuse, Native and non-Native therapeutic approaches, life-skills training and physical activity along with familial and other support systems. At 31%, retention through the first phase of treatment was low, but all of the women who successfully completed Phase I completed Phase II, as well as four months of sobriety aftercare in Phase III.[46]

RESULTS

North American Indian Center of Boston/Tecumseh House

North American Indian Center of Boston/Tecumseh House in Roxbury, MA offers a multidisciplinary case management team to address the substance abuse and mental health needs of patients more fully. The aim of this IHS-recognized promising practice program is to reduce duplication of services and to predict a patient's future needs. The integrated care team includes substance abuse counselors, a licensed psychologist, a diabetes program nurse, a community health nurse and a community health advocate.[106]

The Path of Handsome Lake

In the late 1700's Iroquois leader, Handsome Lake, recognized the suffering caused by social change and the need for preserving traditions while simultaneously transforming them to function in a changing world. Based on the visions and recovery of Handsome Lake, researcher Walle (2004) created *The Path of Handsome Lake* by distilling six principles to supplement AA for AI/AN people: (1) embrace your tradition, (2) transform your tradition to keep it strong, (3) stop alcohol/substance use, (4) admit to errors made, (5) do not repeat errors of the past and (6) heritage is essential to recovery. Walle (2004) warned therapists or self-help group facilitators that *The Path of Handsome Lake* may not be appropriate for all AI/ANs.[107]

Positive Reinforcement in Drug Education (PRIDE)

PRIDE is a substance abuse education and prevention program in the Chief Leschi schools of the mostly urban Puyallup Tribal School system. This culturally-based program teaches personal and social skills to participants as part of the school's curriculum, policies and support services. The major components of the PRIDE curriculum include (1) building cultural identity and self-esteem; (2) zero tolerance of substance use or abuse and (3) drug testing, assessment, case management, referral, after-care services and inpatient and outpatient services. Program participants included 208 youth from pre-school through 12th grade from 50 tribes, 40% from the Puyallup tribe. Surveys revealed less excessive alcohol use among Chief Leschi high school students than students in a public school (22% of students drinking until drunk vs. 46% in a public school survey), increased school year completion rates, higher self-esteem, improved test scores and improved health measures.[44]

Project Venture

> "*Project Venture* builds a positive peer culture and helps middle-school youth to start thinking about their future and their value to culture and community, said *Project Venture* and *NLYP* founder McClellan Hall (Cherokee)."[108]

The Project Venture program is a substance-abuse prevention program created by the *National Indian Youth Leadership Project (NLYP)* that emphasizes values common to many AI/ANs including family, service, respect and spiritual awareness.[108] *Project Venture* is a school-based program for middle-school students. Through *Project Venture*, youth participate in outdoor activities, adventure camps and treks, as well as problem-solving, critical thinking, skill-building classroom activities and community-oriented service learning towards breaking the cycle of dependence.[108-110]

While not directly addressing substance abuse, *Project Venture* has shown a number of positive substance abuse prevention and risk reduction outcomes. Compared to a control group, program participants had decreased past 30-day alcohol and drug use and were less likely to

increase use of marijuana and alcohol. A number of organizations have recognized *Project Venture* as a model program including SAMHSA, First Nations Behavioral Health and the Office of Juvenile Justice and Delinquency Prevention.[108, 109]

Seventh Generation Program

The *Seventh Generation Program* is an alcohol prevention program designed for urban Indian youth in grades four through seven in Denver, CO. The *Seventh Generation Program* uses a life-skills approach to alcohol prevention by strengthening cultural and personal values counter to alcohol use and dispelling stereotypes about alcohol use in Native communities. The initial focus groups selected cultural values that reflect the concepts of the Medicine Wheel and the Navajo statement, Walk in Beauty.[70, 111] The initial 13 week program and five week booster session six months later promote self-esteem, good decision making, peer pressure resistance and personal commitment.[70, 111]

> "A child must remember the wisdom of their elders…when making decisions and they must also consider the impact of their decisions on those who will come after them."[70]

Six-month and one-year follow-ups showed promising, although not statistically different, results: improved decision making, fewer positive assumptions about using alcohol, less depression, greater school bonding, positive self-image and greater perception of social support.[70, 111] Only 5.6% of the intervention group reported drinking in the last 30 days, compared to 19.7% in the comparison group.[111] A noted limitation was a large loss to follow-up (51%) at one year. While the study authors' analysis suggested the impacts of attrition were neutral, selection bias in the one year results may persist.[70]

Substance Misuse Tele-behavioral Group

The Substance Misuse Tele-behavioral Group provides AI/AN youth with crisis intervention, consultations, education and behavioral health care through videoconferencing. The goal of the 12 weekly group sessions is to furnish holistic behavioral health care that incorporates traditional healing, spiritual values and cultural identification in order to increase participants' commitments to living sober. The group sessions also educate members about substance abuse risks and consequences, mediate misuse risk factors and seek to augment protective factors on all levels (individual, family, peer, community and societal).[112]

The curricula used to support the group are *Through the Diamond Threshold: Promoting Cultural Competency in Understanding American Indian Substance Misuse* training curriculum[113] and *Substance Abuse Prevention Activities: Just for the Health of It.*[114] In surveys participants reported the following: enjoying the topics discussed (88%), talking about reasons for using substances was helpful (88%), "learn[ing] a lot in group" (75%) and finding goal setting helpful (75%). Reported barriers included difficulty in synchronizing schedules across sites and difficulty ensuring privacy and confidentiality.[112]

Sweats or Sweat Lodge

Many tribes have historically used sweat lodges (also called sweats) for a variety of purposes, including ritual cleansing, transformations and healings to restore a sense of balance and harmony. Garrett et al. (2011) provided a history of the sweat, examples of sweat prayer and a

detailed description of a sweat itself. Drawing on the work of many researchers, the authors outlined the physiological, emotional, spiritual and behavioral benefits of participation in sweat therapy.[115]

The authors cautioned those interested in incorporating sweats into conventional therapy to be respectful of the sacred ceremony considering appropriate participants, leaders, locations and logistics; counselors should familiarize themselves with Native traditions and work in collaboration with a Native healer.[115]

Thunderbird Treatment Center

The Seattle Indian Health Board's (SIHB) Thunderbird Treatment Center is a residential treatment program with 24-hour patient supervision. Thunderbird Treatment Center services include group and individual therapy, interaction with family, a nutrition program and physical exercise. Culturally relevant healing practices and a traditional health liaison are available. In addition, clients at Thunderbird may access the full range of medical care and services at the SIHB clinic.[116]

Trauma Recovery and Empowerment Model (TREM)

Through group sessions, women in TREM develop coping skills and gain social support to heal from traumas such as physical and sexual abuse. The TREM manual is grounded in cognitive restructuring to change thought patterns. It includes pyschoeducational and skills training techniques to address the immediate and long-term impacts of trauma experiences, including substance abuse. This approach is listed on SAMHSA's National Registry of Evidence-based Programs and Practices.[117]

Village Sobriety Project

The Village Sobriety Project integrated traditional Yup'ik and Cup'ik practices of healing alongside Western treatment services for mental health and substance abuse. The Village Sobriety Project obtained Medicaid reimbursement for cultural activities such as tundra walks, hunting, berry picking, fishing, traditional arts and crafts, ceremonies and time with elders as a part of mental health and substance abuse treatment plans. Justification that these traditional practices related to treatment goals provided sufficient documentation to receive Medicaid reimbursement for services. The rationale relied on showing that if other services such as play and art therapies that are not strictly clinical are billable then traditional and cultural activities were equally valid treatment approaches for reimbursement. Traditional modalities are offered in tandem with Western treatment and can be used to the extent the patient chooses.[71]

Wellbriety Movement (White Bison)

Based on the teachings of Native elders, the White Bison organization and Wellbriety Movement is an umbrella of holistic treatment programming for AI/ANs struggling with substance abuse.[118-120] Since 1988, White Bison has provided resources about preventing addictions, recovery, sobriety and wellness tailored for AI/AN people.[121] The term Wellbriety conveys both sobriety and wellness.[118, 119]

RESULTS

White Bison's Wellbriety movement is a peer-based recovery system adapted from the 12 step AA model to reflect Native traditions, values, perceptions and spirituality including the Medicine Wheel, the Cycle of Life and the Four Laws of Change.[120] The four laws of change include (1) change comes from within, (2) development must be preceded by a vision (i.e., community visioning and self-determination), (3) a great learning must occur (including personal healing, self-knowledge and technical learning) and (4) a healing forest must be created.[69, 118, 119] Serving as both an inspiration for healing and a means of understanding the community healing process, the Healing Forest Model is an analogy for community where trees in the forest represent people with different states of health and sickness.[118, 119]

> "In the Healing Forest some trees are alcoholic, suffer from or cause abuse, are codependent or have dysfunctional relationships and other forms of suffering such as suicide, drug abuse, and gang membership. Below these manifestations of illness in the trees are the roots of anger, shame, guilt, all stemming from intergenerational trauma. All are connected by the roots. Healing comes from educating the members of the forest about the traditional, cultural ways in conjunction with contemporary life skills and perspectives, which combined exhibit health. To heal the forest, approaches such as vision, principles, traditional values, spirituality, unity, hope, and 'forgiving the unforgivable' are applied to the roots.[118] Healing the community (i.e., the Healing Forest) needs to be concurrent with the individual's recovery work to heal from alcohol, drug use, or other unhealthy behaviors."[119]

Another teaching from the elders incorporated into the Wellbriety movement is that of returning to the Red Road or "the right road – the right way of thinking" by following the traditional laws and teachings.[118, 120] Other authors referred to the book *The Red Road to Wellbriety: In The Native American Way* as a resource.[118, 122] Using talking circles, cyclical imagery of the Medicine Wheel, life mapping (mapping how the participant's life is now and how they want it to be) and peer-based recovery support (i.e., the *Firestarters*), Wellbriety allows for participants to share in a supportive environment where participants experience a decreased perception of judgment as the coaches are in recovery themselves.[120] Other Wellbriety resources include the "Wellbriety!" online newsletter as well as video presentations for both men and women at the White Bison website: http://www.whitebison.org/index.php.[123, 124]

Another Wellbriety initiative, *Journeys of the Sacred Hoop*, was a series of annual tours across the U.S. between 1999 to 2003 to provide the gifts of healing, hope, unity and the strength to forgive the unforgivable.[118]

In collaboration with White Bison, the University of the Pacific in Stockton, CA offers an online course for the Native American Wellbriety Certificate. The certificate program teaches the Wellbriety Movement philosophy and healing approaches for AI/AN communities.[125] In addition to these activities, many other Wellbriety activities have been developed. Learn more about Wellbriety and White Bison online at http://www.whitebison.org.[124]

RESULTS

Youth Regional Treatment Centers (YRTC)

The goal of YRTC is to address behavioral health issues among AI/AN youth and their families with a focus on substance abuse and co-occurring disorders. Tribal and federally-operated YRTC are funded by the IHS on a recurring basis.[126] The IHS Program Profiles lists IHS-Funded YRTC and eligibility criteria.[127] Other regional youth treatment programs include the *Phoenix Area Integrated Behavioral Health Programs*,[128] the *Shiprock Adolescent Treatment Center*[129] and the *Wemble Naalam T'at'sksni House*.[129]

These co-ed, youth inpatient treatment programs utilize a variety of holistic healing practices that incorporate traditional, spiritual and cultural methods into Western treatment modalities.[126, 128, 130-135] Many sites also offer skill building; education; aftercare support; and arts, crafts and music activities.[127-129, 131, 135, 136]

Conventional treatment approaches described by the programs included:

- *Trauma-Focused Cognitive Behavioral Therapy*[127]
- *Dialectical Behavioral Therapy*[127]
- *12-step Program*[133]
- *Relapse Prevention*[133]
- *Cognitive Behavioral Therapy*[127]
- *Motivational Interviewing*[127]
- *Teen Matrix Model*[127]
- *The Change Companies Journal and Moral Recognition Therapy*[127]
- *Relapse Prevention Therapy*[127]
- *Acceptance and Commitment Therapy*[127]
- *Practical Adolescent Dual Diagnosis Inventory*[127]

Traditional treatment approaches described by the programs included:

- *White Bison*[127]
- *Takoja Niwiciyape: Giving Life to the Grandchildren*[127]
- *Project Making Medicine*[127]
- *American Indian Life Skills*[127]
- *Voices: a Program of Self-discovery and Empowerment for Girls*[127]
- Spiritual counselors[127]
- *Red Road to Wellbriety*[127]
- *Project Venture National Indian Youth Leadership Project*[127]
- Wilderness-based components[137]

RESULTS

Resources

In addition to the programs and activities noted above, several other resources were identified through the literature review. These resources include:

American Indian/Alaska Native Behavioral Health Briefing Book

This IHS resource provides extensive background information about the IHS system of care and behavioral health practices.[96]

American Indian/Alaska Native/Native Hawaiian Resource Kit: Fetal Alcohol Spectrum Disorders (FASD)

This resource kit provides useful information about FASD in AI/AN and Native Hawaiian populations including statistics, strategies for prevention, education and outreach, as well as suggestions for collaboration among agencies and organizations. Also included in the resource kit are two posters and a CD.[64] This information is also available in a condensed format in the *Fetal alcohol spectrum disorders (FASD) - Community Health and Unity: Collaboration Strategies* pamphlet.[138]

Community Needs Assessments of Urban AI/AN Health Programs

Crofoot et al. (2008) provided a summary table of previous needs assessments for urban AI/AN populations in the western U.S. that focused on alcohol and substance abuse as well as mental health needs.[139] The authors noted that the needs assessments, and their own findings from focus groups and chart review, were not representative of epidemiological studies and did not assess community strengths and weaknesses. Instead, this work presented a spectrum of needs and priorities for comparison in different urban locations.[139]

CRAFFT Alcohol and Drug Risk Screening Tool

The CRAFFT screening tool screens for high risk drug and alcohol use and related risk behaviors in adolescents. In addition to being very brief, CRAFFT is one of the few screening tools that has been validated for use among AI/AN youth.[140, 141] More information and the screening tool are available online in multiple formats and languages for use through the Center for Adolescent Substance Abuse Research (CeASAR) at http://www.ceasar.org/CRAFFT/index.php.[142]

IHS Online Search, Consultation, and Reporting (OSCAR) System

The IHS OSCAR system allows viewers to search on best and promising practices by IHS Area, health indicators and key words.[143] Many of the programs described in earlier sections of this report were identified through the OSCAR System, available online at www.ihs.gov/oscar.

Indian Health Manual, Part 3 - Professional Services, Chapter 18 - Alcohol/Substance Abuse

This chapter of the *Indian Health Manual* provides information on the operation of, and guidelines for, the development of alcohol/substance abuse treatment and prevention services funded or administered by the IHS, including information on Youth Primary Residential Treatment Centers.[144]

RESULTS

'I Strengthen my Nation' Campaign

The multimedia campaign, *'I Strengthen my Nation,'* inspires drug and alcohol resistance among AI/AN youth and encourages parents to discuss drug and alcohol use with their children. Developed through a partnership between the Northwest Portland Area Indian Health Board and area tribes, the campaign materials are publically available online at http://www.ihs.gov/behavioral/.[145]

Native American Center for Excellence (NACE) - Now SAMHSA's Tribal Training and Technical Assistance Center

NACE services, originally a resource center providing information on substance abuse prevention programs for AI/ANs, are now incorporated under the Tribal Training and Technical Assistance Center.[146] The Service to Science model provided technical assistance and training on evaluation of prevention programs.[147]

NativeWeb

This online source maintains links to health resources for native people around the world. Several UIHOs are listed as well as other valuable health resources in the U.S. Where available, substance abuse programs are listed in the resource descriptions.[148]

Office of Indian Alcohol and Substance Abuse - "Prevention & Recovery Newsletter"

The Office of Indian Alcohol and Substance Abuse coordinates the "Prevention & Recovery Newsletter," a quarterly newsletter that shares funding opportunities, announcements and resources about alcohol and substance abuse from the Bureau of Indian Affairs, the Office of Justice Programs, Office of Tribal Justice and the IHS.[149]

One Sky Center

Funded by SAMHSA, the One Sky Center provides training, technical assistance, products and a searchable database in an effort to promote culturally appropriate prevention and treatment of substance abuse and mental health disorders in AI/AN communities.[110, 150]

WeRNative.org

Aimed primarily at AI/AN youth, the WeRNative.org website provides informational resources and blogs about various health and culture topics including alcohol and drugs. It is maintained by the Northwest Portland Area Indian Health Board.[151]

DISCUSSION

Review and Considerations

The high prevalence of substance abuse and dependence among AI/ANs has significantly and negatively impacted the well-being of AI/AN individuals and communities. Systemic barriers, such as inadequate funding for services and programs and a lack of culturally competent care, as well as personal barriers resulting from socioeconomic status, racism and housing challenges complicate care delivery and sustainable recovery. The prevalence of conditions co-occurring with substance abuse necessitates a complex, holistic response in the AI/AN community.

This literature review identified five themes running throughout the findings that highlight opportunities to enact substance abuse prevention, treatment and recovery. Briefly, these themes included (1) cultural care; (2) client-centered care; (3) skills building; (4) community-supported prevention, treatment and recovery programs and (5) healing trauma for recovery. Many of the specific programs and approaches identified and summarized in this report exemplified these themes, providing an illustration of practical application. Overall, the findings of this literature review indicate the need for:

- Further prevention and treatment effectiveness research in urban AI/AN populations as well as validation of practice-based evidence;
- Strengthened programing through community driven approaches and
- Policy changes leading to increased access to substance abuse prevention and treatment for all AI/ANs.

In contrast to the segmented Western research and treatment model, AI/AN care traditionally takes on a holistic and integrated approach. These disparate perspectives on treating substance abuse pose challenges for both paradigms.[52] For example, indigenous knowledge is a different “way of knowing” than randomized controlled trials, considered the gold standard of evaluating treatment outcomes.[152] Holistic and coordinated approaches, like the Holistic System of Care for Native Americans in an Urban Environment, address the problems caused by a fractured treatment system by integrating care. However, testing its effectiveness proves problematic because the system components cannot be independently tested in comparison groups.[52] Gone (2012) suggested adopting a pluralistic view that accepts both traditional knowledge and scientific knowledge as valuable approaches with their own specific strengths and allows for communication and coexistence between the two without expecting reconciliation of differences.[152] Findings in this report demonstrated both conventional Western and traditional approaches, often within the same programs.

DISCUSSION

Limitations

There are several limitations of this literature review of substance abuse prevention and treatment among urban AI/ANs. First, the intake period for searching for sources occurred in October 2012. Sources that may have been published or become publically available since that time were not incorporated. Second, our exclusion criteria may have eliminated some relevant sources due to a limited focus. Also, since this report focuses on providing information to organizations serving primarily urban AI/AN communities, exclusively tribal or reservation studies and programs or interventions without any urban AI/AN population involvement were excluded. (See the criteria detailed earlier in the Methods section.) Third, many of the programs and approaches identified provided limited or no outcome measurements or evaluations by which to assess their effectiveness. The dearth of evaluations is a limitation recognized by other researchers.[39, 42, 43, 153] Fourth, the summaries of the programs, activities and resources are based solely on our review of the publically available sources identified. Any unpublished community-based knowledge about these programs is unknown to us and we apologize for any unintentional errors of omission or interpretation.

Recommendations

Research

Further research, that includes evaluation of effectiveness, is needed in culturally relevant programming for urban AI/AN populations. Even though large national surveys now include ethnic minorities, comparisons between studies are difficult due to different survey instruments and study samples. Research increasingly needs to focus on ethnic minorities and racial/ethnic subpopulations.[22] Urban AI/AN populations are unique and programs that worked in reservation communities or other minority populations may not translate effectively in urban AI/AN settings. For example, alcohol/substance use prevention programs that have been developed for other ethnic populations like *keepin' it R.E.A.L,* have been shown to be less effective in AI/AN communities than other ethnic groups. For alcohol use participation the *keepin' it R.E.A.L.* intervention actually had a negative impact for AI/AN youth; hence the cultural matching needed to achieve acceptability, relevance and positive outcomes among AI/AN people is important to consider.[154] Understanding the diversity within the urban AI/AN population with regards to acculturation, spirituality and Indian identity may contribute to identifying a best fit intervention.[153]

Obstacles in obtaining reimbursement for traditional services and treatment from payers may make it infeasible for AI/AN-serving clinics to provide this culturally appropriate care. Limited published research exists on the effectiveness of traditional services. Our findings align with those of Moghaddam and Momper (2011); specifically, that traditional healing activities can provide coping skills, a stronger sense of AI/AN identity and empowerment and help individuals balance overall health and achieve life-long recovery after formal treatment.[48] Additional studies analyzing the effectiveness of traditional treatment services could provide the evidence needed to inform policy changes and influence insurers and other county/state/federal agencies involved in service reimbursement.[39, 68] Such research must be conducted with respect for the community and culture.

DISCUSSION

Research into several other cultural aspects of substance abuse prevention and treatment is needed. For instance, such research could include measuring and testing the cultural competency of programs[155] as well as identifying culturally appropriate means of resisting substance use offers from family members and friends.[62, 156] The hope is that such research will serve to support funding that recognizes indigenous evidence or ways of knowing and practice-based evidence developed within AI/AN communities utilizing a Community Based Participatory Research approach rather than solely evidence-based Western practices.

Prevention and Treatment Programming

Recommendations for the content of prevention and treatment programming include strengthening screening practices, building programs through community inclusion, bolstering support networks and healing trauma. Screening and assessment practices for alcohol and substance abuse disorders as well as co-occurring psychiatric disorders, especially by both mental health and alcohol/substance use providers, is essential for early intervention and harm mitigation. When issues are identified, integrated treatment services are needed to provide comprehensive care.[157] The Substance Abuse and Mental Health Services Administration screening protocol SBIRT is recommended for early intervention in varied medical settings and has been tested in a diverse, large scale population, including AI/AN patients.[30] Using scores from SBIRT, providers can do an initial severity assessment and provide appropriate follow-up.[95, 158]

Effective and culturally-grounded substance abuse prevention and treatment programs must be developed by AI/AN communities in both urban and reservation environments, reflecting local community and cultural expertise on what works.[18, 42] Also recommended are efforts that (1) strengthen family, support networks, communication skills and cultural identity; (2) offer mentoring for youth; (3) are designed for at-risk youth; (4) build bicultural competency or the ability to navigate both AI/AN and mainstream identities and societal pressures; (5) provide for the inclusion of traditional healing and AI/AN cultural activities and (6) promote assets associated with non-use of substances such as participation in religion-based activities, non-parental role models and peer-to-peer interventions.[72, 159, 160]

Integrated treatment programs for both mental health care and substance abuse disorders are needed.[161] Whitesell et al. (2012) advocated for the development of cross-discipline integrative theories that would support and inform combined interventions.[18]

In addition, addressing and healing trauma, frequently a contributor to substance misuse, is recommended by participating in traditional activities; deconstructing emotions and behavioral choices; reminding clients of their own reasons for choosing sobriety and achieving physical, mental, emotional and spiritual harmony.[25, 162] Edwards (2003) discussed how transformational healing experiences that allow for a free-flowing exchange of the full spectrum of feelings provide the most thorough resolution of childhood trauma.[87] Creative forms of personal expression, such as storytelling, making crafts, taking photographs or making digital stories are encouraged. Metaphoric interpretation through these forms of personal expression and reflection can uncover emotions, authenticate personal experiences and provide coping mechanisms that motivate behavior change and engender resilience.[163] Resolving historical trauma may establish protective factors to combat substance abuse and stop the passing on of

intergenerational trauma.[28] Recognizing and treating personal and historical trauma should be a critical component of substance abuse treatment programs for AI/AN people.[87]

Policy

Recommendations for policy development are focused on improvements in access and availability of services for substance abuse prevention and treatment. As the population continues to shift to urban centers, policy must also shift from tribal health tied to Contract Health Service Delivery Areas and enrollment in federally recognized tribes to an inclusive Indian health approach.

Of the approximately 1.2 million uninsured AI/ANs, 62% – many of whom reside in urban areas - report that they do not have access to IHS services.[35] Policy amendments should broaden eligibility for the full scope of IHS services to ensure that all AI/ANs can access substance abuse services, regardless of geographic location – whether residing on a reservation or in a city – and status (i.e., tribally enrolled, state recognized, non-enrolled, disenrolled, terminated, etc). Additionally, to support the feasibility of providing such services, all organizations caring for AI/ANs should receive the same reimbursement rate. The healthcare system for urban AI/ANs is inadequately funded to meet the needs of patients, especially regarding services for substance abuse treatment.[10, 42] An increase in advocacy and policy for early interventions, treatment programs providing culturally competent care and long-term treatment options is needed.[26]

While Medicaid expansion under the Affordable Care Act (ACA) will likely lead to greater insurance coverage, much is still unknown about the impact of ACA implementation on access to substance abuse services. Access may be hampered by the growing complexity of administrative burdens faced by providers as well as demand resulting from utilization of newly covered substance abuse services. These substance abuse services are now required to be covered with parity to other health conditions under the Mental Health and Addiction Equity Act.[164, 165] Marketplace insurance plans under the ACA are responsible for creating an adequate network of providers for addiction services, however the challenges of establishing this network and the consequences of non-compliance may create a barrier to care. Access to care will vary tremendously by state depending on how states choose to implement and enforce provisions of the ACA. It will be critical to assess gaps in access to substance abuse services with implementation of the ACA and allow waivers and bridge gaps in financing to meet the demand for care. AI/ANs living in urban areas should have the same access to, and quality of, care as they would be eligible for within the IHS and Tribal Health service delivery system.

Summary

The themes identified in this review and the program descriptions may offer inspiration to agencies considering changes or expansions to their substance abuse services. Sharing these successes and lessons learned across disciplines, organizations and communities is essential to strengthening programming and improving well-being. In addition, the original sources cited may prove useful for grant or proposal development.

Substance abuse in AI/AN communities has profound effects on all aspects of life from educational attainment, to interpersonal violence, overall health, employment and family cohesion. In order to reduce substance abuse and improve well-being in urban AI/AN

DISCUSSION

communities, systemic environmental, political and societal changes must be made. Simultaneous to system-wide changes, there must be an increase in investment in programmatic responses to the high prevalence of substance abuse among AI/AN as well as evaluation of such efforts. Eliminating disparities in substance abuse, and ultimately health equity, will require a multifaceted approach that embodies collaboration, holism and community-specific knowledge and practices.

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