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**BEST PRACTICES IN BEHAVIORAL HEALTH
SERVICES FOR AMERICAN INDIANS AND
ALASKA NATIVES**

EDITED BY:

ELIZABETH H. HAWKINS, PH.D., M.P.H.
&
R. DALE WALKER, M.D.

ONE SKY NATIONAL RESOURCE CENTER FOR
AMERICAN INDIAN AND ALASKA NATIVE
SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES



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Wado,

Elizabeth H. Hawkins, Ph.D., M.P.H.
R. Dale Walker, M.D.
One Sky National Resource Center
Oregon Health & Science University

CONTRIBUTORS

Britt K. Anderson, Ph.D.
NW Behavioral Solutions

Lisette Austin, M.A.
Addictive Behaviors Research Center
University of Washington

Douglas A. Bigelow, Ph.D.
One Sky National Resource Center
Oregon Health & Science University

Art W. Blume, Ph.D.
University of Texas at El Paso

Maria Yellow Horse Brave Heart, Ph.D.
The Takini Network &
University of Denver

Maria E. Burns, M.P.A.
National Diabetes Prevention Center
Centers for Disease Control and Prevention

Frank Canizales, M.S.W.
Indian Health Service

Roger Yellow Knife Cauthen
Spiritual Leader

Rose L. Clark, Ph.D.
United American Indian Involvement, Inc.

Carol Nice Conner, Ph.D.
Paradox Consulting L.L.C.

Joe L. Conner, Ph.D.
Paradox Consulting L.L.C.

Frances Cotter, M.A., M.P.H.
Center for Substance Abuse Treatment
Substance Abuse and Mental Health
Services Administration

Lemyra DeBruyn, Ph.D.
National Diabetes Prevention Center
Centers for Disease Control and Prevention

Crisol J. Escobedo
University of Texas at El Paso

Linda D. Frizzell, Ph.D.
One Sky National Resource Center
Oregon Health & Science University

George Gillette
Spiritual Leader

Joseph P. Gone, Ph.D.
University of Michigan

Barbara L. Graham, Ph.D.
Woodlands Wisdom Confederation
University of Minnesota

Jane Grover, M.S.
RMC Research Corporation

The Honorable Cheryl Kennedy
Grand Ronde Tribal Council

Pat D. Mail, M.P.H., Ph.D.
Addictive Behaviors Research Center
University of Washington

G. Alan Marlatt, Ph.D.
Addictive Behaviors Research Center
University of Washington

Philip A. May, Ph.D.
Center on Alcoholism, Substance Abuse &
Addictions (CASAA)
The University of New Mexico

James R. Moran, Ph.D.
University of Denver

Larry Murillo, Dr.PH.
One Sky National Resource Center
Oregon Health & Science University

Valerie Naquin, M.A.
Cook Inlet Tribal Council

Traci R. Rieckmann, Ph.D.
Oregon Health & Science University

Steven Schinke, Ph.D.
Intersystems, Inc. &
Columbia University

John Spence, Ph.D.
NW Indian Training Associates

Lisa R. Thomas, Ph.D.
Addictive Behaviors Research Center
University of Washington

Patricia Silk Walker, Ph.D.
One Sky National Resource Center
Oregon Health & Science University

Karina Walters, Ph.D.
Native Wellness Research Center
University of Washington

Joe Westermeyer, M.D., Ph.D.
University of Minnesota

Kalvin G. White, Ph.D.
Division of Dine' Education
Navajo Nation

Susan Yellow Horse, MSW, LCSW, CACIII
University of Denver

ABBREVIATIONS AND ACRONYMS

ACT	Assertive Community Treatment
ADHD	Attention-Deficit Hyperactivity Disorder
AI/AN	American Indian/Alaska Native
AOD	Alcohol and Other Drug
APA	American Psychological Association
ATOD	Alcohol, Tobacco, and Other Drug
CBT	Cognitive-Behavior Therapy
CDC	Center for Disease Control and Prevention
CMHS	Center for Mental Health Services
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DBT	Dialectical Behavior Therapy
DSM-IV	Diagnostic and Statistical Manual – Fourth Edition
EBP	Evidence-based practices
EBPP	Evidence-Based Practices Project
EMDR	Eye Movement Desensitization and Reprocessing
EST	Empirically Supported Treatments
ESTR	Empirically Supported Therapeutic Relationships
FARS	Fatal Accident Reporting System
FAS	Fetal Alcohol Syndrome
FFT	Functional Family Therapy
HPDP	Health Promotion/Disease Prevention
HTUG	Historical Trauma & Unresolved Grief Intervention
IHS	Indian Health Services
IOM	Institute of Medicine
IPT	Interpersonal Psychotherapy of Depression
JCP	Journal of Clinical Psychiatry

MST	Multisystemic Therapy
NHTSA	National Highway and Traffic Safety Administration
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NREPP	National Registry of Effective Prevention Programs or National Registry of Effective Programs and Practices
OEO	Office of Economic Opportunity
OSAP	Office Substance Abuse Prevention
PMT	Parent Management Training
PSST	Problem-Solving Skills Training
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Clinical Trials
SAMHSA	Substance Abuse and Mental Health Services Administration
SIT	Stress Inoculation Training
SUD	Substance Use Disorders
TCL	Training in Community Living
WestCAPT	Western Regional Center for the Application of Prevention Technologies

HISTORY AND CHALLENGES IN SUBSTANCE ABUSE PREVENTION AMONG AMERICAN INDIAN COMMUNITIES

PHILIP A. MAY, PH.D.

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Introduction

Alcohol and substance abuse programs were not specific, independent concerns of the Indian Health Service (IHS) prior to the early 1970's. There were major epidemics of infectious disease, frequently water born but also transmitted by other vectors and environments, that needed the full attention of the resources of the IHS from its beginning in 1955 through the late 1960's (Hawkins & Blume, 2002). Therefore, treatment and prevention of infectious diseases caused by various agents was the major emphasis. From a public health perspective the IHS did an excellent job of sanitizing and creating purified water supplies, isolating human waste, controlling pathogen as preventive measures, and dealing with outbreaks of infection through clinical care. However, the necessary emphasis on infectious disease left little room for dealing with behavioral health issues such as alcoholism, other substance abuse, and their sequela (Johnson & Rhoades, 2000).

The first alcoholism treatment programs were funded by the Office of Economic Opportunity (OEO) in the late 1960's as part of the war on poverty. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) also started an "Indian desk" in the early 1970's which funded some reservation-based treatment programs for up to 5 years. IHS agreed to assume responsibility for "mature" programs, defined as mature when a program had received 5 years of NIAAA funding (IHS, 1986). Upon completion of NIAAA funding, the programs were

transferred to IHS for administrative oversight and supervision. The first central office of alcoholism for IHS was staffed by a single director and was established in 1975 (IHS, 1986). The primary emphasis for the IHS at this time was developing and maintaining treatment programs for alcoholics. The majority of these programs were staffed by local, indigenous counselors with a minimum of training in addictions. Many of the programs emphasized the Alcoholics Anonymous approach to alcohol treatment and maintenance of sobriety.

The first major concern and organized effort for prevention programs in alcohol and substance abuse for a variety of tribes was centered around the prevention of fetal alcohol syndrome (FAS). FAS prevention programs in the IHS were started in 1982 and 1983. The approach was to provide primary prevention knowledge on FAS to all Indian communities served by IHS. Also in the middle 1970's, IHS started a more general approach to health promotion/disease prevention (HPDP) as a way of attacking a number of behavioral health issues. HPDP initiatives covered everything from tuberculosis checkups to weight reduction for diabetic care, to immunizations, to prevention of alcohol and substance abuse, and injury control. This was the dawn of large, organized prevention movements within Indian country. Many tribal communities were involved in these prevention initiatives and partnerships formed with IHS and other agencies to carry them out.

Barriers to Prevention in American Indian Populations

There have been many myths regarding drinking among American Indians since the first contact between American Indians and European populations. The "drunken Indian stereotype" (May, 1994; Westermeyer, 1974), or the "firewater myth" (Leland, 1976), held that American

Indians are overcome by horrendous changes for the worse when they consume alcohol. Alcohol was believed to affect American Indians in a more severe and negative fashion than it affects other populations. The drunken Indian stereotype held that Indians were not only different in terms of behavior when drinking, but that these changes were worse due to biological differences that Indians possessed. It was, and is still, believed by many people that most Native individuals and populations do not metabolize alcohol in the same manner as do Europeans, and that liver isoenzyme differences may be influential (Long, Mail, & Thomasson, 2002). In other words, Indians may metabolize alcohol more slowly and otherwise differently. Therefore, Indians are more affected by alcohol and its intoxicating effects than are other populations. The biological weakness or difference notion has been proven to be false from both the metabolism point of view and from genetic markers for liver isoenzymes (Bennion & Li, 1976; Long & Lorenz, 2000; Reed, Kalant, Griffins, Kapur, & Rankin, 1976). But the myth is still present and influential. For example, among the Navajo, 63% of a sample surveyed in the western portion of the reservation indicated that Indians have a physiological weakness to alcohol that non-Indians do not have (May & Smith, 1986), and over 40% of Plains Indians held this notion in the late 20th century (May & Gossage, 2001).

Mortality and Morbidity Reduction

In order for any program of prevention in health education to be successful in Indian Country, the beliefs regarding Indian drinking must be demystified before people begin to listen and take positive action (May, 1994; May, 1996). In fact, since most Indians process alcohol in the same manner and speed (in many cases slightly faster) as do most humans throughout the world, prevention programs that have been found to work elsewhere in the world can work well

with Indians (May, 1992). Another barrier which must be overcome prior to implementing prevention initiatives is expanding the population perspective on prevention. In many American Indian communities there is an almost exclusive emphasis on the disease model in Indian alcohol programs, and this model is held by a majority in the Indian population. Statements like "once an alcoholic always an alcoholic" and "once I start drinking I cannot stop" are quite common throughout Indian Country, and such beliefs are influential in shaping behavior. Because of the extreme emphasis on alcoholism as a disease concept, alcoholic behaviors are approached with fatalism by many. Furthermore, this perspective does not distinguish between chronic consumption and more sporadic, alcohol abusive behaviors. Therefore, the major effects of alcohol abuse on Indian populations have often been ignored (May, 1996). Because of this the mortality and morbidity from a variety of alcohol abusive behaviors continue to take a great toll in American Indian populations. For example, 24 to 33% of alcohol-specific deaths in Indian country are caused by chronic alcohol consumption or dependence behaviors, those referred to as "alcoholism deaths." On the other hand 67 to 75% of all alcohol-involved death could be classified as resulting from alcohol abuse (motor vehicle crashes, suicide, homicide, and other injury (May, 1992; May, 1996). But the vast majority of alcohol programs among Indians are directed to the former. Prevention must address both sporadic abuse of alcohol and chronic drinking problems.

There has been a historical lack of emphasis on using policy for universal and selective prevention, particularly for mortality reduction. Even though tribes have had the legal right to control the traffic, sales, and consumption of alcohol within reservation boundaries in the lower 48 states, there has been a lack of emphasis on using policy for improving public health through manipulation of alcohol policy (May, 1977; May, 1986; May, Lopez, & Landen, submitted)

Advantages for Pursuing Prevention in Indian Populations

Tribal councils in the lower 48 states have more power to regulate alcoholic beverages than do other communities in the United States. Federal law in 1953 that affected (what are now) the lower 48 states provided the opportunity for tribes to pass legislation, which was reviewed by the United States government. At that time tribal statutes could legalize the sale and control of all alcoholic beverages by tribal governments. However, by 1976 only 34% of all federally recognized tribes had legalized alcohol (May, 1977). Currently, some legalization has been attempted by less than 50% of all federally recognized tribes (May et al., submitted). Tribes in the lower 48 can allow alcohol on the reservation, can control the sale with their own business enterprises, and can set rules through tribal licensing and policy as to where, when, how, and why alcohol is to be sold. Furthermore, they can tax alcohol and utilize the revenue for a variety of purposes, including social and public health initiatives. If these tribes do nothing reservations remain under prohibition.

In Alaska, the laws are somewhat different. Alaska Native villages must adhere to state law and maintain legalized alcohol unless a majority of the inhabitants vote to prohibit alcohol in a special referendum. Approximately 45% of predominantly Native villages have voted to prohibit alcohol ("dry"), 5% prohibit sales ("damp"), but some (approximately 50%) allow possession, consumption and sale ("wet") of alcohol (Berman, Hull, & May, 2000). Two studies have found that prohibiting and restricted sales are associated with lower rates of sudden and violent death among Alaska Natives (Landen et al., 1997; Berman et al., 2000).

Because of a variety of preoccupations and other concerns, tribal councils and Alaska Native corporations and villages have not been as focused on alcohol policy as they might have

been. Tribal people may be more concerned with cultural and ethnic preservation, economic development, and other issues which take precedent in day-to-day activities. Therefore, the consideration and passage of alcohol legislation has frequently gone unnoticed. The real advantage to a focus on alcohol policy is that American Indian/Alaska Native communities are small and geographically circumscribed, so that any policy and laws passed could be uniformly enforced. Furthermore, there is often a solidarity of opinion around particular issues, such as legalization in many tribes (May & Gossage, 2001; May & Smith, 1986). For example, a vast majority of Navajos were against legalization of alcohol and have maintained prohibition for many years (May & Smith, 1986). Furthermore, many opinions held by reservation populations in the Plains and elsewhere tend to be very conservative. American Indian populations believe that alcohol laws and policy should be enforced strictly, including: driving while intoxicated, no sales to pregnant women, and that tribal council members should be alcohol and drug free (May & Gossage, 2001). A common theme voiced by tribal populations when expressing these conservative views about alcohol policy is that tribal and cultural preservation is a major motivation for controlling access to alcohol.

Prevention and Treatment of Alcohol and Substance Abuse among Indians-

Summative Literature

In reviewing the state of alcohol treatment in Indian Country, Silk-Walker, Walker, and Kivlahan (1988) stated: "our knowledge of treatment effectiveness is severely limited, and the extent of alcohol-related problems is widely recognized. Nevertheless, the focus on applied prevention research is slow to develop." In ending this review, the authors call for research on treatment outcome for programs serving Indians and new strategies of prevention that would

attack alcohol abuse in families.

In 1990, the Office Substance Abuse Prevention (OSAP) published a report entitled *Breaking New Ground for American Indian/Alaska Native Youth at Risk: Program Summaries*. This report concluded with optimism saying that a number of strategies based on sound theory have been employed for prevention programs for youth in Indian Country. However, there was also a strong conclusion that rigorous evaluation was needed for all programs in Indian Country, as it is difficult to ascertain which programs are efficacious and which are not. This recommendation has not been carried through well, as many reservation-based alcohol and drug abuse prevention programs remain completely unevaluated for either efficacy or effectiveness.

In 1986 the IHS published a report entitled *IHS Alcoholism/Substance Abuse Prevention Initiative*. In this report the history of alcoholism programs was reviewed, and goals and objectives for reducing the impact of alcohol and substance abuse on Indian populations were put forth (IHS, 1986). The two major goals stated were: that the alcoholism branch would attempt to lower the incidence and prevalence of alcohol abuse and alcoholism among American Indians to a level at or below that of the general population of the United States; and they would encourage and assist American Indian/Alaska Native groups to participate in community-based planning to establish effective programs of prevention, treatment, and rehabilitation. This document clearly identifies the need for prevention of alcohol and substance in Indian Country and establishes a groundwork for achieving such plans.

In 1987 IHS published another document called *Schools/Community-Based Alcoholism/Substance Abuse Prevention Survey*. This document concluded that positive efforts and initiatives were being made within schools and communities to prevent alcoholism and

substance abuse. Many prevention/intervention projects were aimed exclusively at Indian youth. Early intervention was emphasized in this publication, and it was stated that there were many prevention programs being employed that required careful analysis to evaluate the efficacy of these programs (IHS, 1987). While prevention was seen as far more effective to reduce the problems of alcoholism and substance abuse, there is a critical need to provide ongoing research and evaluation to determine whether prevention/intervention will work.

A number of general studies or papers by academics have been prepared in the past 20 years calling for prevention and careful evaluation of prevention programs. Two of these documents provided reviews of the literature and described and evaluated various programs that have been instituted in Indian country (May 1995b ; May & Moran,1995). As these documents make clear there have been a variety of programs instituted, but few evaluations of these programs have been carried out or published. Two other documents have been published which survey local populations as to their attitudes and opinions about alcohol abuse (May & Gossage, 2001; May & Smith, 1988). Generally, prevention is seen as a much needed and promising approach in Indian Country where there is a strong sentiment supporting prevention. However, with a number of prevention initiatives that have been instituted and gone unevaluated, it is impossible to tell what past success is and what the future of prevention is.

Next, in a special, invited commentary issue of the *Journal of American Indian and Alaska Native Mental Health Research*, an extensive review of the prevention literature, the promise of alcohol policy as a means for substance abuse prevention was presented (May, 1992). Commentary on this approach is provided by 12 scholars who also weigh in on the efficacy of policy-based prevention for tribes. This paper promotes the idea that carefully

tailored alcohol laws of legalization or prohibition that are supported by local norms can be efficacious for prevention of alcohol and substance abuse among tribes in the lower 48 states (May, 1992). In Alaska, recent literature has provided equally if not more persuasive data that indicates that policy, this case prohibition, lowers mortality from most forms of alcohol-related violent death (Landen et al., 1997; Berman et al., 2000).

Prevention of Suicide

Suicide has frequently been found to be alcohol-related in Indian Country, and has been frequently the focus of public health prevention programs. Middlebrook and colleagues (2001) reviewed the status of suicide prevention programs and found that these programs also lack strict evaluation to gauge efficacy. While more evaluation is needed in this area, there have been extensive literature reviews from which much program information can be drawn and used to design prevention initiatives (May, 1990; May & McCloskey, 1997). There are currently well over 300 published works and reports available on Indian and Alaska Native suicide in the U.S. and Canada (May & McCloskey, 1997).

Motor Vehicle Crashes

Another area in which alcohol-related morbidity and mortality plays a great role is motor vehicle crashes. While there have been a number of prevention initiatives regarding injury in Indian Country, there have been few evaluations of these initiatives. May (1989) reviewed the literature on motor vehicle crashes for the U.S. Surgeon General's office initiatives on drunk driving and found a small body of literature that would help in designing prevention programs for motor vehicle crashes. This article concluded, as have other literature reviews, that more

emphasis on prevention was certainly warranted and needed, in this case to prevent alcohol-related motor vehicle crashes. Since then there have been a large number of injury prevention initiatives in Indian communities, but few publications have resulted. As much injury is alcohol-related, this is a vital area of concern.

Prevention Initiatives among Youth

The first emphasis on alcohol and substance abuse prevention among Indians was on education among youth (IHS, 1987). The research base for examining the *causes* of alcohol and substance abuse among American Indian youth is the most extensive of any in the American Indian alcohol field. Oetting, Beauvais, and colleagues have published extensive quantitative data on the problem, and also review of the literature both looking particularly at etiology (Beauvais, 1995; Beauvais, 1998; Oetting & Beauvais, 1989; Oetting, Beauvais, & Edwards, 1988). The influence of peer groups, family, and individual psychological contributions to substance abuse among Indian youth has been documented well by this group of scholars and others (Winfree, 1985; Winfree & Griffiths, 1983; Winfree & Sellers, 1989). However, prevention programs in Indian Country rarely seem to take advantage of the extant literature and theory. Therefore, substantial academic information exists that would help define prevention programs for youth in Indian country, but rarely has been this information been specifically applied in the design and implementation of local youth programs. Furthermore, as has been pointed out earlier, the evaluation of prevention programs for youth has been all too rare.

In the 1990's a number of residential treatment programs were created for American Indian youth in all IHS areas. The literature regarding the implementation and success of these

programs has also been quite limited in the published literature.

Therefore, the prevention of substance abuse among American Indian youth remains an area which awaits further scrutiny as to its efficacy and promise.

Prevention of Fetal Alcohol Syndrome

One of the first major national initiatives for alcohol abuse prevention among Indians was fetal alcohol syndrome (FAS). In 1983, the National Indian Fetal Alcohol Syndrome Prevention Program was created by legislation initiated by the IHS and the Health Resources and Services Administration (May & Hymbaugh, 1983; May & Hymbaugh, 1989). Much of the impetus for this program had arisen from earlier successes in the epidemiologic study of FAS among southwestern tribes (May, Hymbaugh, Aase, & Samet, 1983). Furthermore, tribes recognized the importance of FAS prevention over other topics of substance abuse. FAS was in many ways found to be an effective “spark” topic that motivated communities and individuals to undertake prevention. In other words when other topics seem not to stimulate prevention initiatives, FAS was found to be one of importance and motivation for local Indian populations. Ostensibly, this motivation originates from a desire for protecting the innocent from alcohol, a major cause of developmental delay and a threat to tribal preservation.

There has been some evaluation of various programs of prevention of FAS in Indian Country. In Tuba City, Arizona, a hospital-based program of prevention was found to be effective in several ways (Masis & May, 1991). First, Indian women who entered the program when pregnant had a high degree of success at maintaining sobriety during their pregnancy. Second, a number of women who were considered very high risk for FAS births consented to birth control immediately postpartum. Overall in this study, about one-third of all women

defined as high risk were found to have adopted behavior (either drinking cessation or birth control) which would prevent future, alcohol-damaged pregnancies. Further, those defined as lower risk upon entry of the program were believed to be successful in maintaining abstinence from alcohol consumption in almost two-thirds of the cases (Masis & May, 1991).

Plaisier studied FAS prevention in American Indian communities of the Upper Peninsula of Michigan. She examined the knowledge, attitudes, and beliefs about FAS among American Indian women. Education about FAS was provided in each community, and the results indicated that FAS information was reaching many women. However, it was found that more must be done to help women who were at the greatest risk of having a FAS child (e.g. alcohol treatment and case management) because of their extreme alcohol abuse and dependence (Plaisier, 1989).

FAS is one of the few areas where there have been specifically targeted IHS initiatives of prevention of substance abuse. The National Indian FAS Prevention Program existed from 1983 through 1986. The emphasis of the program was to train trainers of FAS education and prevention, and to support their training with a variety of local groups via curricula, media materials (films, slides, pamphlets, posters, etc.), research, and evaluation. While this was limited to primary or universal prevention, knowledge gain and retention has been measured (May & Hymbaugh, 1989). In general, local indigenous trainers were found to be effective in implanting information in their local populations; this information was retained up to six months in many populations of both youth and adults. Whether this program resulted in behavioral change, however, was not measured.

A large NIAAA-funded comprehensive FAS prevention trial is underway in six Plains Indian communities at present. From 1995 to the present, baseline research on FAS

prevalence, knowledge, attitudes and beliefs, and intervention has been ongoing. This program is a controlled prevention trial where communities are phased into the prevention stage gradually, therefore providing the opportunity to compare communities with and without prevention over certain time periods. Summative results from this prevention initiative will be forthcoming in the next 5 years, but the trial is designed to: reduce the age-specific prevalence of FAS and Partial FAS, to raise awareness of alcohol-related problems in general, and to stimulate larger initiatives of alcohol abuse prevention.

Prevention and Evaluation of Alcohol-Related Injury and Motor Vehicle Crashes

Prevention of injury has been a major thrust of the IHS Environmental Health Program since the late 1980's. Training of IHS and tribal specialists/advocates in injury prevention has been ongoing in a rigorous manner through injury prevention institutes, workshops and conferences, and a network to support local initiatives. Much of their training emphasizes the link between alcohol and injury and also domestic violence and child abuse and neglect (DeBruyn, Lujan, & May, 1992). Some evaluation of these efforts has been done, but overall more documentation of efficacy is needed.

As has been shown in the literature, prevention of injury, particularly that related to alcohol abuse, is needed (Brody & May, 1983; Carr & Lee, 1978; May, 1989). Motor vehicle crash programs particularly have not received attention to evaluate them in the published literature; however, some data exists which would allow such evaluation (Bergdahl & May, 2002). Use of national data sets such as the National Highway and Traffic Safety Administration (NHTSA) Fatal Accident Reporting System (FARS) is a promising approach. State data systems can also be utilized.

The effectiveness of suicide prevention has been evaluated somewhat more than motor vehicle crashes, but not enough (Institute of Medicine, 2002; LaFromboise, 1996; LaFromboise & Howard-Pitney, 1995; May, 1987; May, Serna, Hurt, & Debruyn, in press; May et al., 2002; Serna, May, & Sitaker, 1998; Middlebrook, et al., 2001). The evaluation of injury control and suicide prevention holds promise. The dependent variable is more clear than in some other areas of prevention evaluation, and the knowledge and database regarding the epidemiology of both alcohol abuse (Beals et al., 2003; Spicer, Novins, Mitchell, & Beals, 2003; Spicer et al., 2003) and suicide among American Indians is improving (May et al., 2002; May et al., in press). Furthermore, data for evaluating programs and policies to effectively evaluate motor vehicle crash prevention exists in various states and the federal government statistical bases (Bergdahl & May, 2002; Guerin, 1998).

Changes in Alcohol Policy and Their Utility for General Alcohol Abuse Prevention

As mentioned above, alcohol policy has been used in Indian Country for alcohol abuse prevention, but very little prior to the late 1980's (Landen, 1997; May, 1977; May, 1992). In recent years, however, tribes have begun to utilize policy with a focus on public health improvements and alcohol abuse problems (May et al., submitted). Where such policy evaluation has been undertaken, it has been found that policy manipulation may be effective. For example, among American Indians of the Plains, alcohol legalization appeared to lower the rate of alcohol-related death from suicide, homicide, motor vehicle crashes, other injury and also substantially reduced alcohol-related arrests (May, 1975; May, 1976; May, 1986). However, some of the results of this legalization study could not be replicated by Landen in a similar study of the same reservations using a different methodology (Landen et al, 1997).

Berman attempted to evaluate the effectiveness of policy on alcohol-related death in Alaska, where the laws are substantially different. Looking at Native villages that had enacted wet, damp, and prohibition legislation, Berman found that prohibition (unlike in the lower 48 states where legalization was found to lower alcohol-related deaths) seemed to lower alcohol-related violence significantly (Berman, 2002; Berman et al., 2000).

From legalization to complete prohibition, to specific sales regulation (e.g. hours of sale, type of establishment), licensing, and server training, policy changes are promising modes of prevention. Unfortunately, these modes are underutilized and under evaluated by Indian communities to date.

The Healthy Nations Program for community-wide substance abuse prevention initiated by the Robert Wood Johnson Foundation was carried out in 14 communities in Indian Country from 1993 to 2001. However, it was not set up to be evaluated rigorously in a pre/post test fashion. Nevertheless, a qualitative evaluation with some reconstructed quantitative evaluation showed some positive effects (Moss, Taylor, & May, 2003). The major thrust of this prevention program was utilizing traditional tribal culture, community strengths, and integrated approaches to community awareness and mobilization to reduce substance abuse. A replication of this initiative would be very valuable, yet rigorous evaluation must be instituted from the start of this or any new program of prevention.

Overall, there has been a movement in Indian Country to begin to examine policy for prevention. A recent review of alcohol laws (May et al., submitted) indicates that tribal policies are becoming much more specific and focused towards prevention and intervention. In other words a trend towards public health applications for policy is evident in more recent legislation. Ironically, much of this legislation seems to be stimulated and motivated by tribal movement

into gaming enterprises.

Prevention Paradigms and Terminology to be Used in Prevention Applications and Research

There is a strong debate over community level prevention trials and how they should be implemented and evaluated. Much debate occurs over randomized community trials versus nonrandomized trials in public health evaluation (Murray, Varnell, & Blitstein, 2004; Victoria, Habricht, & Bryce, 2004). Randomizing communities for interventions in Indian Country is difficult and politically touchy, so non-random trials are more feasible, practical, and politically appropriate. Regardless of evaluation methods used, randomization versus nonrandomization, carefully selected control/comparison groups are best done either within or across Indian cultural groups. Whatever research prevention and evaluation methods are used, the TREND terminology should be used to clearly describe evidence-based outcomes (Des Jarlais et al., 2004).

The United States Institute of Medicine (IOM) has put forth clear and excellent paradigms for use in the prevention of substance abuse. Furthermore, these paradigms are useful for evaluation. At least five different IOM volumes have reviewed the literature in this area and laid out extensive public health theory to guide prevention initiatives and evaluation. The first book was entitled, *Broadening the Base of Treatment for Alcohol Problems* (IOM,1990). This book applied a public health approach to alcohol-related problems for new insights into the area of alcohol treatment and prevention. For the first time, a perspective outside of, or more encompassing than, clinical intervention was championed and laid out by this IOM committee of scholars. The implications of this work for prevention are substantial. A

second book is entitled, *Reducing Risk for Mental Disorders: Frontier for Preventive Intervention Research* (IOM, 1994). In this work on mental and co-occurring disorders, new prevention terminology was used which replaced the old primary, secondary, and tertiary scheme with new terminology which is described below. This new terminology helps define prevention more clearly and effectively to promote efficacy evaluations. The third volume of importance to prevention in Indian Country was entitled *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Treatment, and Prevention* (IOM, 1996). This volume examined FAS from its clinical diagnosis all the way to broad-based community prevention. It also applied the new terminology of universal, selective, and indicated prevention to FAS initiatives. A fourth book concerned mainly with substance abuse, was entitled *Bridging the Gap between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment* (IOM, 1998). This book outlines very clearly how communities, populations, and researchers can carry out theory-based research, measure the results objectively, and use the results to implement successful programs. The fifth and final work of relevance here is entitled *Reducing Suicide: A National Imperative* (IOM, 2002). In this work a population-based research and prevention approach is called for in order to understand the full spectrum of self-destructive behaviors in any one population. This is very important for American Indian populations, as self-destructive behaviors are often alcohol-related, and unlike most non-Indian communities, population-based prevention has been a common approach to suicide prevention in Indian communities.

The terminology that has been put forth by the IOM is an effective one for viewing the interrelated continuum of alcohol treatment to community-based prevention. In this terminology, the different levels of prevention (including treatment and after care) are clearly defined. *Universal prevention* attempts to promote the health and well being of all individuals

in a community by reducing problems with alcohol abuse. *Selective prevention* consists of interventions that are targeted to individuals or more particularly subgroups or aggregates of the population whose risk of developing a condition is significantly higher than others by virtue of belonging to that subgroup. Finally, *indicated prevention* uses methods that are targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms which foreshadow an alcohol abusive or alcohol dependent condition. While universal prevention is good for all people in the population, selective prevention targets high risk subgroups and aggregates, and indicated prevention is utilized in a therapeutic relationship or clinical setting which is frequently referred to as treatment (IOM, 1996).

Conclusion

In this brief review of substance abuse prevention literature among American Indians, it is obvious that there is a short history (approximately 20 years) of formal prevention programs for alcohol and substance abuse and related behaviors. American Indians and Alaska Natives have been subject of a number of prevention initiatives in the past two decades, but there is a vastly insufficient literature on methods, paradigms, and programs of prevention, the evaluation of their efficacy, and the effectiveness of these programs in general. However, as some literature indicates, there is great promise for prevention of alcohol and substance abuse among American Indian communities. The strengths of tribal communities, the conservative opinions of American Indian individuals regarding alcohol use, and the traditions of Native culture can be tapped for positive effects. Furthermore, there is a growing body of literature (both reviews/summaries and individual project descriptions) in both non-Indian and American Indian settings from which we can build. While prevention evaluation has been too rare in Indian

Country, there are works detailing both key etiological insights into programmatic approaches to problems of substance abuse.

A very promising area of prevention initiatives lies in the policy arena. Policy can be used more effectively to prevent alcohol and substance abuse and their sequela. Furthermore, the IOM paradigm of prevention provides a promising conceptual framework for prevention programs in Indian country and the promise of evaluating these programs effectively.

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SUBSTANCE ABUSE PREVENTION PROGRAMS FOR AMERICAN INDIAN YOUTH

JAMES R. MORAN, PH.D. & SUSAN YELLOW HORSE DAVIS, M.S.W.

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Introduction

The purpose of this paper is to provide an overview and analysis of typical substance abuse prevention efforts that have been conducted with American Indian youth. In addition we will identify common themes or best practices among them. Based primarily on the published literature, we provide a discussion of how prevention work is typically carried out in Indian youth programs. We use a general framework of cognitive / information dissemination, affective education, social influence, and personal and social skills training to examine programs. We also pay particular attention to how issues of culture are incorporated into the prevention programs. Finally, we identify principles that have been useful in carrying out successful prevention programs focused on Indian youth.

Typical Prevention Approaches with American Indian Youth

Because there are many Indian prevention efforts that do not find their way into the published literature, it is difficult to determine the range of Indian-focused prevention programs that may exist. To address this we searched several databases and the Western Regional Center for the Application of Prevention Technologies (WestCAPT) website to identify both published literature and unpublished reports. Based on this search, this section provides an

overview of common mainstream prevention strategies plus descriptions of several Indian focused prevention programs. We also focus on lessons that can be drawn from these programs.

It appears that many prevention efforts with American Indian youth have followed or been modifications of mainstream efforts. This is reflected in a recent Center for Substance Abuse Prevention (CSAP) report identifying effective and best practice programs that have been implemented with various tribal groups (Schinke, Brounstein, & Garner, 2002). The primary difference in most programs seems to be the addition of various cultural elements. Botvin (1995) provides a useful framework for examining prevention efforts. He describes four common strategies used in drug abuse prevention programs: (a) Cognitive / Information Dissemination, (b) Affective Education, (c) Social Influence, and (d) Personal and Social Skills Training.

The Cognitive/Information Dissemination approach focuses on teaching factual information about drugs and drug abuse. It is based on the concepts that people rationally decide to use drugs, and they do so because they are not aware of the negative consequences of this use. Given these concepts, individuals can be educated regarding the negative consequences of drug use, and, as a result, they will choose not to use drugs. Botvin (1995) states unequivocally that, based on the current literature, cognitive approaches are not effective in decreasing or preventing the use of tobacco, alcohol, or drug use. He further cautions that informational approaches may, in fact, precipitate increased drug use by stimulating curiosity.

Affective Education emphasizes the importance of personal and social development of the individual, and, unlike the cognitive approach, acknowledges the significance of psychosocial factors. Typical elements of the affective prevention strategy are decision-making,

effective communication, and assertiveness. Botvin (1995) states that results from studies utilizing this approach have been disappointing because of a focus on narrow and incomplete etiology, use of ineffective methods such as classroom games, rather than skills-training, lack of domain-specific information on drugs and drug use, and the presentation of "responsible-use" norms that may be counterproductive.

Social Influence (also called refusal skills or social resistance skills) focuses on the individual's resistance to social influences to use drugs and on skills training. This strategy is based on Bandura's social learning theory (Bandura, 1977) and a conceptual model that stresses the significance of social factors as precipitants of youth drug use. Components that are central to this approach include (a) teaching subjects to recognize situations in which they will likely encounter peer pressure to use drugs; (b) teaching ways to resist pressure to use; (c) correcting the perception by subjects that the majority of adolescents use drugs; (d) teaching subjects to recognize media influences to use, and how to resist those influences. According to Botvin (1995), results of studies using this approach indicate a 30-40% decrease in smoking among subjects with effects lasting up to 3 years. There have been fewer alcohol and marijuana studies, but results are similar.

Personal and Social Skills Training views the etiology of substance abuse as complex, comprising cognitive, attitudinal, social, personality, physiological and developmental factors. Proven cognitive-behavioral skills training is emphasized, as is the need to go beyond the social influences model. The underlying concept is that youth not only use drugs as a result of pressure to do so, but because they *want* to use drugs, to ease anxiety, combat low self-esteem, and for other reasons. Based on Bandura's social learning theory (Bandura, 1977) and Jessor's problem behavior theory (Jessor & Jessor, 1975), this model shares several features

with resistance skills models. It is different in its emphasis on teaching generic personal self-management skills and social skills that will have broad application, rather than teaching only resistance skills that are domain-specific, i.e., related to problems of drug use. These generic skills include (a) decision-making and problem-solving, (b) cognitive skills for resisting interpersonal and media influences, (c) skills for increasing self-esteem, goal-setting and self-directed behavior change methods, (d) adaptive coping strategies to deal with stress and anxiety, (e) general social skills, and, (f) general assertiveness skills. Methods used in this approach include a combination of instruction and demonstration, feedback, reinforcement, behavioral rehearsal, and extended practice. Botvin (1995) indicates that prevention outcomes using the personal and social skills training approach show a 40%-80% reduction in incidence and prevalence of drug use, and consistently demonstrate short-term effects of up to 3-4 years.

Program Reviews

To locate published reports we searched the following databases: (a) PsycInfo and Social Work abstracts, (b) Academic Index and the Health Reference Center Academic Index, and (c) National Library of Medicine Medline. To locate unpublished sources, we examined the "Best" and "Promising" practices on the Western Regional Center for the Application of Prevention Technologies website (www.open.org/~westcapt). Each WestCAPT program description includes an overview, population, risk factors, protective factors, CSAP strategy, type of strategy, method of evaluation, and research findings. WestCAPT states that the programs have all been evaluated with American Indian participants and have been shown to be effective. However, while all the programs include American Indian participants, many appear to have been developed for mainstream and/or multi-ethnic populations, rather than

designed specifically for American Indians. Additionally, not all program descriptions provide breakdowns for the percentage of American Indian participants involved in the studies, and none except those exclusively for American Indians provide research findings for American Indian participants alone.

Cognitive/Informational, Affective Education and Social Influence Skills

Among the prevention programs located in our search of the literature, only a few of them fall within combinations of the cognitive/informational, the affective education, and the social influence approaches. Conner and Conner (1992) report on a study that examined the effects of a summer camp experience on attitudes and alcohol and other drug (AOD) use with at-risk American Indian youth. Of the 102 participants, 74 were American Indian, representing northern New Mexico pueblo communities, rural non-reservation communities in north central Oklahoma, and a rural reservation in northern Wisconsin. Fifteen youth were of mixed American Indian and Hispanic or Anglo heritage, from New Mexico pueblo communities and rural Oklahoma, and five youth were Anglo. Mean age of participants was 13, 43.5% were female, and 95% were determined to be at or above moderate risk for AOD abuse.

In this single group quasi-experimental design, two major components served as the intervention, including an informational component that conforms to the cognitive approach, and a psychosocial component that parallels social influence skills. The intervention was delivered in the context of a one-time five-day camp experience. The cognitive component centered on single questions related to drinking and driving presented to participants on six different occasions prior to mealtimes. The psychosocial component involved participants observing a skit performed by peer participants in which a youth was pressured by peers to

drink, and refused to do so. Participants then discussed ways to refuse drinking, self-messages, and self-reward for refusal. According to the authors, this program also contained a cultural element that centered on collaboration among tribal, intertribal, federal mental health, AOD abuse, and health personnel to provide a culturally relevant program. The camp staff comprised a majority of American Indians who had several years of experience in providing psychological and counseling services to American Indian clients.

Participants completed questionnaires on the first and last days of camp. The pretest questionnaire included data on risk factors, demographic data, attitudes related to AOD use, and past alcohol use, alcohol intoxication, and other drug use. The posttest focused on expected future use. The authors report significant decreases between participants' self-reported past use and their expected frequency of future alcohol use and intoxication; no significant difference between expected post-camp use of other drugs and reported pre-camp use; significant improvement in attitudes regarding responsible driving and peer resistance; no significant improvement in attitude about participants' tendency to be positively affected by various negative outcomes on drinking and driving. While the camp context provides a creative backdrop to this study, the lack of a comparison group and the use of expected future AOD use, rather than follow-up test data, weaken the credibility of the results considerably. Additionally, although the authors note the importance of the collaboration in making the camp experience culturally relevant, they do not describe the essence of this collaboration or the resulting cultural content.

Parker (1990) reports on a pilot prevention study involving Rhode Island urban-based members of the Narragansett tribe. The project incorporated cultural traditions and alcohol and drug material as part of an employment-training program. The 14-19 year old participants

included nine American Indian youth in the intervention groups and 25 predominately Hispanic and Black youth in the comparison group. Although from different ethnic backgrounds, the youth in both the intervention and comparison groups were from similar income levels, lived in the same residential area, and were involved in similar employment-trainings programs.

Both the intervention and the comparison groups received an alcohol and drug intervention that was based on a commonly used curriculum called Project Charlie (Chemical Abuse Resolution Lies in Education). The major components of this curriculum were organized around self-awareness, relationships, decision-making skills, and chemical use in society. This intervention appears to combine the cognitive/informational and the affective education approaches. The intervention group also participated in several cultural sessions that included learning American Indian handicrafts such as beadwork and moccasin making, listening to traditional stories, and learning about traditional subsistence practices. In addition, the intervention youth were encouraged to explore their own identities as American Indians through visits to museums and archaeological sites.

The evaluation of this pilot program included both standardized instruments and ethnographic interviews. Quantitative data were collected on frequency of alcohol and other drug use, reasons for drug use, and self-esteem. The ethnographic interviews focused on the role and importance of culture as seen in knowledge of group/family traditions and participation in community activities. Parker indicates that there was a differential reduction in drug use between the two groups and that there was a significant correlation between increased cultural affiliation and decreased alcohol and drug use. No difference was found between the two groups on self-esteem. The ethnographic interviews produced general support for the inclusion of the cultural material in that the participants indicated that they enjoyed the activities and

that they gained an understanding of their heritage that they did not have prior to the program. While the author concludes that this study supports inclusion of cultural perspectives in prevention efforts with urban American Indians, the study actually gives us very little useful information. The intervention group was so small that the power to detect changes was virtually non-existent. Further, the use of a non-equivalent comparison group consisting of non-Indians essentially invalidates any use of the comparison group.

Personal and Social Skills Training

Most of the Indian specific programs we reviewed used the personal and social skills strategy in varying degrees. A good example of this approach is provided by a bicultural skills enhancement approach that was used in a substance abuse prevention program for American Indian youth in the Pacific Northwest (Gilchrist et al., 1987; Schinke et al., 1989; Schinke et al., 1988; Trimble, 1992). This study included noteworthy collaboration between prevention researchers and the American Indian community, involving substantial input from community members across all phases of the project, from initial planning onward. The 102 participants represented seven urban and rural areas, had a mean age of 11.34, and comprised 49% females. The program focused on the skills needed to manage internal and external influences that precipitate the use of alcohol, marijuana, tobacco, and inhalants.

Participants were randomly assigned by site to intervention and control groups, including three intervention sites (one urban and two rural) and four control sites (one urban and three rural). Youths at the intervention sites underwent ten skills enhancement-training sessions, each 60 minutes in length. Problem solving units were based on the commonly used SODAS model (Stop, Options, Decision, Act, Self-Praise) according to Trimble (1992). Cultural content

was integrated through (a) discussion of myths about Indian drinking and drug use, (b) information on factors that encourage drug use among Indians, (c) peer and adult/tribal speakers, and, (d) concepts such as “thinking like an elder” to maintain the *Indian Way*, as well as to resolve situations related to drugs and alcohol. Training sessions were delivered by a two-person team made up of one Indian research staff member and one indigenous community leader, all of who had received 10 hours of training prior to teaching the participants.

All subjects completed pretest, posttest and 6-month follow-up that measured the following variables: self-esteem, drug knowledge, attitudes toward drugs, and interpersonal behavior. Skills training outcomes revealed an increase in drug knowledge and interpersonal skills in the intervention group over the control group; no differences were found for self-esteem or for drug attitudes. Drug use outcomes indicated significantly fewer instances of alcohol, marijuana, and inhalant use by the intervention group than the control group at 6-month follow-up; and, intervention subjects were less likely to identify themselves as users of alcohol, marijuana, or inhalants. Positive changes in tobacco were found at posttest but were not evident at follow-up and there were no changes in participants' self-identification as tobacco users. Subjects assigned high scores (8-9 on a 10 point scale) for the program's sensitivity to American Indian culture, immediate applicability to their lives, and overall drug abuse prevention effectiveness. Seventy-five percent said they would advise their friends and siblings to participate in the program.

The authors indicate that they expected the intervention program to impact self-esteem scores. They state a likely reason for its failure to do so was that the self-esteem measure was too generic to pick up changes in self-efficacy and "substance abuse-specific" self-esteem that actually did occur. Authors were also surprised by the intervention's lack of lasting impact on

tobacco use, and surmise that tobacco use by Indian youths may be precipitated by different factors than those that affect the use of alcohol, marijuana, and inhalants. They note the need for further research on this topic. The authors conclude the results indicate a skills enhancement framework can be effectively tailored for American Indian youth in delaying the onset of substance abuse in some early adolescents. The strength of the empirical method utilized in this study lends credibility to those findings.

Trimble (1992) highlights a critical dimension of this program. He provides a detailed accounting of the cultural component and describes the involvement of Indian community members from the initial planning stages through the evaluation process. He describes the goals of the integration of cultural substance in this way: to determine the feasibility of blending social learning theory with local cultural *lifeways* and *thoughtways*, and assess the impact of the blended perspective. Trimble stresses the importance of the 12-member advisory committee, representing several Coast Salish reservations, that was formed at the outset of the program. This committee was an integral part of all aspects of the planning and implementation of the project. They also assisted in designing cultural elements of the training. Indian community members, including parents, tribal leaders, and paraprofessionals, facilitated the training sessions, after completing 16 weeks of training themselves.

Trimble outlines the four development stages of the bicultural training process as (a) establishing collaborative community relationships; (b) designing the intervention and curriculum to accommodate and incorporate local American Indian values, customs, and lifeways; (c) training local indigenous community paraprofessionals; and (d) conducting the intervention.

Dorpat (1994) reports on Positive Reinforcement in Drug Education (PRIDE), a

substance abuse education /intervention program in the Chief Leschi schools of the Puyallup Tribal School system in Tacoma, Washington. Participants were 208 pre-school through 12th grade students made up of 40% Puyallup tribal members and representing over 50 tribes. The reservation is primarily urban, and includes all or part of three municipalities. Puyallup Indians, non-Puyallup Indians, and non-Indians reside on the reservation.

Skills training corresponding to the personal and social skills training approach, combined with comprehensive support services, were couched within a strong cultural base. With the singular goal of "No Use," these components were infused into the schools' curriculum, policies, security and support departments in a systematic manner for all grade levels, pre-school through high school. The program was delivered by American Indian teachers and staff, and centered on four major elements: (a) the cultural aspect stressed the development of cultural identity and increased self-esteem, by infusing cultural content into regular academic courses, as well as through special classes, guest speakers, and cultural activities such as tribal dance and drumming; (b) the PRIDE curriculum was developed and produced by school staff (all schools were represented on the writing team) with consultation from Pierce College, tribal and public social service agencies; (c) building and program security emphasized zero tolerance of substance use (including cigarette smoking) by students and staff, and immediate action against offenders; and, (d) intervention/treatment included drug testing and assessment, inpatient and outpatient services, case management, referral and after-care services.

Formal process evaluation and a single student survey conducted in the spring term were used to evaluate the program. Findings included fewer incidents of drug or alcohol possession at the high school level, and a self-reported 22% of students drinking until drunk, contrasted with a public school survey (conducted independently of this study) which showed

46% self-report of high school juniors drinking once per month to get drunk. The author provided additional results of the student survey without indicating their comparison to previous years' findings or to other school systems. These included increases in school year completion, composite group achievement test scores, self-esteem and health (the latter two indicated by increased involvement in school functions and activities). While these findings reflect important changes, their power is significantly diminished by the lack of empirical method and measurement, including pre- and follow-up tests, and use of a comparison group.

Petoskey, Van Stelle, & DeJong (1998) report on a study with students in grades 4-12 at eight rural schools in northern Wisconsin and Minnesota, representing three different Ojibwe Indian reservations. While the goal for the youth was to reduce the prevalence of drugs and alcohol, a broader goal addressed the self-perception of personal and communal powerlessness of all residents of the American Indian communities involved in the study.

The theoretical approach used in the study was two-dimensional: (a) a cognitive-behavioral approach and (b) empowerment theory, based on psychological empowerment and community psychology theories, combined with the Freirian model of community empowerment (for the latter model, the researchers cite Paolo Freire's *Pedagogy of the Oppressed*, 1970). Comprehensive cultural components were incorporated into all aspects of the study. The structure was divided into the following four modules: (a) a culturally-based K-12 substance abuse curriculum that incorporated tribal legends and cooperative learning techniques and focused on building resiliency skills in students; (c) 24 hours of teacher training centered on curriculum materials, education and sensitization about the culture of their students, and substance abuse education; (3) 32 hours of training for five to seven community volunteers to serve as a leadership core group and facilitate training of the community curriculum; and, (d) a

community curriculum that included spiritual, cultural, and family perspectives on substance abuse, cooperation between tribal and non-tribal agencies to access resources, and comprehensive community-based planning. Each of these modules took two days to implement. The goal was to build the skills and confidence of community parents, grandparents, and others to help them develop a sense of ownership of community problems and become advocates and activists for change. Project staff trained both the schoolteachers and the community leaders.

This study used a pretest - posttest comparison group design, utilizing a school in another community as the comparison group. Quantitative results are based on self-report student surveys divided into grades 4-5, 6-8, and 9-12, and measured yearly over 3 years. Baseline scores showed steady increase across age groups for alcohol, cigarettes, and marijuana, and likelihood of accepting alcohol and marijuana if asked by friends; inhalant use flattened out in middle years, and stayed the same through high school. The intervention had a significant effect on slowing the rise in alcohol use, decreasing rates of marijuana use, and decreasing likelihood of accepting marijuana from friends over the comparison group. There was no significant difference in cigarette smoking or likelihood of accepting alcohol from friends. Qualitative findings regarding substance use included (a) an increase in the number of families involved in the community training who recognized family problems with substance use and took action to get help, (b) a political protest by local women elders at an establishment believed to sell drugs, and (c) a symbolic protest by youths who poured out liquor on the steps of the State Capitol. Qualitative results regarding community empowerment indicated an increase in social bonding and a gradual positive change in the relationship between the community and the school system.

The commitment to cultural involvement in the research process, evident in all phases of the study, is reflected in the author's accounting of the community becoming involved in the development of the measurement/evaluation tools. Initially, they were suspicious of an "aloof" evaluator who they determined did not have the cultural competence needed for the study. Community members took ownership in the evaluation process and developed tools that were more culturally appropriate. According to the author, that involvement was critical to the project's success.

Schinke, Tepavac, and Cole (2000) report on a 3-year prevention study with American Indian youth representing ten reservations in five states, including North and South Dakota, Idaho, Montana, and Oklahoma. The 1,396 subjects comprised third, fourth, and fifth grade students in 27 tribal and public schools located in socioeconomically comparable communities. With a mean age of 10.3, 49% of the participants were female, and 55.6% lived in two-parent households.

The study utilized a life skills model combined with bicultural competence training. Cultural tailoring of the training material to the youth participants was a strong element in the program. This tailoring addressed widely accepted American Indian values, regional and tribal traditions common to the participants, and material specific to individual communities. Community involvement, called "community mobilization intervention," was also incorporated into one arm of the intervention.

Schools were randomly assigned to one of three groups, two intervention groups and a control group. Both intervention groups participated in fifteen 50-minute weekly sessions during spring term of the school year. Each of these sessions contained instruction, modeling, and rehearsal in cognitive-behavioral skills associated with substance abuse prevention.

Participants were taught resistance skills to use both within their Native society and in the dominant society. Each session was culturally tailored through the inclusion of American Indian legends and stories, health and holistic concepts, and local traditions and beliefs. One of the intervention groups also participated in a community involvement component. The goals of this component were to raise awareness and to mobilize community members, such as participants' families, teachers, law enforcement officials, etc., to support prevention among youth. Methods included media releases, distribution of leaflets and posters, and informational meetings. The control group did not receive any intervention. Booster sessions were provided semiannually which paralleled initial sessions and added material that was developmentally appropriate to participants' age increase over the term of the study.

Measurement included pretest, posttest, 6-, 18-, 30-, and 42-month follow-up. Measurement tools comprised a self-report assessment battery on substance use, and self-collected saliva samples to increase report accuracy. Findings indicate significantly lower follow-up rates of smokeless tobacco, alcohol, and marijuana use in the skills group over the control group, no significant change in rates of cigarette use, and no significant effect of the community intervention on substance use rates. Authors explain the latter finding by suggesting that the community involvement components may have diluted the combined intervention and thus decreased its effectiveness. An added factor may be involved here. The community involvement described in this study appears to be markedly different than that reported by either Dorpat or Trimble, or even that of Conner and Conner. A major difference is that the involvement recounted here apparently takes place after the organization of the project, rather than as an integral part of it. Perhaps this later involvement of community members in the project is also a contributor to its ineffectiveness. Overall, however, this is an

important study. Results indicate the skills intervention positively influenced participants' substance use patterns for up to 3.5 years.

Moran (1998) reports on a study to develop and evaluate a culturally appropriate alcohol prevention program focused on urban Indian 4th - 7th graders in Denver. A quasi-experimental comparison group research design was used to assess the after-school program's impact on selected mediator variables and on alcohol use among urban American Indian youth. The conceptualization and structure of the program relied on the prevention research literature, and also involved the local Indian community through a process of community meetings and focus groups. The program used the following literature based approaches: (a) correcting inaccurate stereotypes that over-emphasize the amount of alcohol use; (b) enhancing personal and cultural values that are in conflict with alcohol use; (c) enhancing self-esteem; (d) teaching a structured way for making good decisions; (e) learning and practicing skills to resist peer pressure; and (f) making a personal commitment to not use alcohol. In other words, it utilized a life skills approach.

In order to address culture in a meaningful way, the local Indian community was systematically involved in identifying a unifying theme for the program. Meetings with various groups of Indian people were held to discuss what was needed in the community and to provide details about the study. This process resulted in a name for the project, the Seventh Generation. From an American Indian cultural perspective, this is more than just a name. Among the Lakota, who represent the majority of Indian people in Denver and the majority of the people involved in the meetings, the phrase refers to a time of healing, a time for Indian nations to come together. Today's Indian children are considered to be the seventh generation. Thus, using this name for an alcohol prevention program targeting American Indian youth was

assumed to carry a fundamental message within the community.

A second meaning of the term derives from placing the children in the center of seven generations. For many Indian people this conceptualization fits well with prevention efforts. Namely, children must remember the wisdom of their elders (parents, grandparents, and great grandparents) when making decisions, and they must also consider the impact of their decisions on those who will come after them (children, grand children, and great grandchildren). This multi-generational view fits well with the concept of responsible decision-making, and it became the focal point for much of the program.

In addition to the program's name, ideas expressed in the focus groups resulted in a plan to incorporate American Indian culture in a manner that might be meaningful to urban Indians. Over the course of several meetings an agreement emerged that a set of core values transcended tribal differences. After generating a list of over 20 values, the participants narrowed the list to seven: Harmony; Respect; Generosity; Courage; Wisdom; Humility; and Honesty. These values are reflected in American Indian cultural concepts such as the Medicine Wheel of the Northern Plains or the Navajo statement, Walk in Beauty. Thus, rather than utilizing cultural artifacts such as teaching children Indian arts and crafts, the Seventh Generation Program was developed in a manner that focused on cultural values. The program consisted of a 13-week intervention followed 6 months later by a 5-week booster. The after-school program was divided into seven main topical areas (such as enhancing Indian identity, decision making, making a meaningful commitment) and each of the 2-hour sessions focused on the particular topic for that week in addition to several of the seven core values.

Across three intervention periods a total of 257 fourth through seventh grade American Indian youth participated in the intervention and a total of 121 served as the comparison group.

Pretest, posttest, and 1-year follow-up data were collected on several mediator variables and on alcohol use (Moran, 2000). The intervention and comparison groups were not statistically different at either pretest or posttest; however, several significant differences were noted at the 1-year follow-up. At one year, the intervention group scored more favorably on measures of (a) structured decision making, (b) less positive beliefs about the impact of alcohol use, (c) less depression, (d) higher levels of school bonding, (e) positive self concept, and (f) higher levels of perceived social support. In addition, only 5.6% of the intervention group, compared to 19.7% of the comparison group, reported drinking in the past 30 days, $\text{Chi Sq. (1, } n=168) = 8.034, p=006$. The importance of these findings is supported by an examination of pretest scores for the comparison group and the subset of the intervention group with 1-year posttest data. The differences at pretest were minimal, with the intervention group scoring more favorably at a statistically significant level only on measures of decision-making and Indian identity. In other words, while there was some indication of selection bias, it appeared to be minimal.

Schinke (1999) reports on a study of alcohol prevention with 225 American Indian youth between 8 and 14 years of age. Participants were recruited through urban Indian centers located in New Haven, CT, Providence, RI, Boston, and New York City. Sites were randomly assigned to skills intervention, family-enhanced skills intervention, or the control condition. Skills intervention curricula consisted of 15 sessions that addressed knowledge about and patterns of alcohol use and abuse, attitudes towards alcohol abuse, behavior changes through culturally specific and other alcohol-free social activities, and skills for resisting or avoiding alcohol use. American Indian traditions that promote alcohol-free lifestyles were emphasized throughout the curricula.

Subjects assigned to family-enhanced skills intervention received the skills curricula and

also took part in six additional sessions with their parents and other interested family members. In daylong family sessions held once a month, leaders reviewed content delivered in the skills intervention and conducted role-plays with youths and their family members around alcohol abuse prevention content. Family-enhanced skills intervention sessions also included presentations by professional alcohol abuse prevention workers. American Indian cultural activities, such as storytelling or music, further reinforced alcohol abuse prevention content. Each family session culminated in a community-wide, alcohol-free social.

At pretest, posttest, and follow-up measurement occasions, data were collected regarding youth's current and previous (last 12 months) alcohol, tobacco, and drug use; knowledge of friends' alcohol and drug use; degree of willingness to keep friends from using alcohol or drugs and vice-versa; access to alcohol and drugs; and sensitivity to harmful effects of differing levels of alcohol and drug use. In addition, youth's attitudes about their family, friends, and school, self-perception, experience of physical abuse, and family participation in American Indian culture were measured. Outcome data revealed that the youth in both intervention conditions reported less drinking at follow-up than youth in the control condition. Compared to youth in the control condition, youth in each intervention condition reported less drinking over the last month and 12 months, were less likely to have gotten drunk in the last month and 12 months, and were more likely to report themselves as "nonusers" of alcohol.

Project Venture: National Indian Youth Leadership Project (WestCAPT, 2000) is a comprehensive prevention program serving Pueblo and Navajo youth in New Mexico. This study combined a leadership model, skills building analogous to personal and social skills training, and adjunctive cultural, school, community, and outdoor/ecological components. Drawing on outdoor skills training with team and leadership goals, followed by traditional rite of

passage ceremonies, and continuing into year-long outdoor activities, school and community projects involving families and teachers, the program indeed takes a "comprehensive" approach.

A 5 to 10 day summer camp experience produced the only fully certified search and rescue team in the United States comprising exclusively American Indian high school students. Following camp, participants are offered activities in their home communities throughout the year. These include regular meetings; outdoor activities such as canoeing, skiing, and climbing; youth service projects such as recycling and work with senior citizens; ecological projects; and serving as mentors. The program also provides training for parents and teachers.

The authors report that, while the program does not contain explicit anti-alcohol, tobacco, and other drug (ATOD) messages, it stresses personal and group wellness, involves non-abusing youth and adult role models. Despite the lack of substance abuse program content, the American Drug and Alcohol Survey (Oetting and Beauvais, 1990) was administered to 850 participants and comparison group members over three years. Results showed a decrease in risk status among participants, and a decrease in rates of ATOD abuse by participants in three of the four communities compared to a comparison group. Community acceptance was indicated by agreement for evaluators to test youth in the schools, and by community plans to continue the program after the funding period ended.

Diineegwahshii is a substance abuse program for Alaska Native girls (WestCAPT, 2000). Grounded in Native cultural values, it targets substance use, teen pregnancy, and school dropout rates. Of the 77 participants, ages 10 to 18, 80% were Athabaskan, and the remainder comprised other Alaska Natives or American Indians. Home visits are central to the program, and involve the teaching of life skills, cultural awareness, and family management skills to the

participants and their mothers. Assessment, case management, group training, field trips, success ceremonies, and family and community gatherings are also key elements. Research findings over the first four years of the program indicated the following: no pregnancies among the participants compared to a 20% pregnancy rate for Alaska Native girls 15 to 19 years of age; a 2.5% school dropout rate compared to the state dropout rate of 12.6%; significant decrease in substance abuse; and, the accomplishment of important personal goals by participants and their parents.

The Native American Prevention Project Against AIDS and Substance Abuse (NAPPASA) (WestCAPT, 2000) cooperated with schools in Arizona and Washington to develop, implement, and evaluate a culturally sensitive school curriculum for eighth and ninth graders on the prevention of HIV/AIDS and alcohol and other drugs (AOD). An education format, combined with skills training similar to the personal and social skills approach, were used in the program. These were buoyed by booster sessions consisting of activities, community meetings, videos and print media. Instructors of the curricula received 2 days of training prior to presenting the material to participants. Research on 3,335 participants indicated the following: significantly more participants remained in, or moved to, lower-risk AOD use at ninth and tenth follow-up compared to a non-intervention group; among baseline non-users, the normal developmental trend toward increased AOD use was slowed; delay in the initiation of being sexually active, and lower rates of risky sexual behavior among those who were sexually active; a decrease in the likelihood of sex while drunk or high among sexually active older youth; and, increased use by the intervention group of family, rules, laws, religion, traditional ways and community protective influences to avoid health-risk behaviors.

The Okiyapi - Devils Lake Sioux Community Partnership Project was a 5-year program to

reduce alcoholism (WestCAPT, 2000). The goals of the program were to establish Family Circle groups, create a networking organization and a comprehensive abuse prevention plan, and train and certify five American Indian addiction counselors. Tribal members were enlisted to assist in the design and implementation of the entire program. Workshops for community members of all ages addressed substance abuse prevention as well as depression, suicide, problematic parenting styles, abuse, and domestic violence. Professional program staff facilitated and supported decision-making by members of the Family Circle groups. Prior to program implementation, alcohol and drug use, high school dropout, poverty, and crime rates significantly exceeded national rates. Process and outcome evaluation measures indicated significant decreases in reported use of alcohol and related problems among youth, and alcohol related offenses community-wide, as well as changes in tribal law restricting availability of controlled substances. On-going legacies of this grassroots prevention program in rural North Dakota include the Mothers/Grandmothers Support Group and the UNITY Youth Group.

Summary of Program Reviews

Based on our review of the Indian focused youth prevention programs, most have been school-based initiatives that emphasize a personal and life skills approach. The consistent themes in school based substance abuse prevention programs are building bicultural competence (Gilchrist et al., 1987), increasing self-esteem and self-efficacy (IHS, 1987), improving resistance to peer pressure and overall discriminatory and judgment skills (Duryea & Matzek, 1990; Gilchrist et al., 1987, Schinke et al., 1989; Schinke et al., 1988;), and increasing the perception of the risk of alcohol and drug use (Bernstein & Woodall, 1987). The current literature supports these approaches if they are undertaken in combination. That is, building

self-esteem alone is not likely to reduce alcohol use, while building new perceptions, values, skills, and support systems along with increasing self-esteem may be beneficial. Newcomb and Bentler (1989) indicate that, in addition to single targets such as self-esteem, these programs must also affect the social and cultural aspects of life and mitigate the effects of abusive peer clusters in the lives of these youths. This can be accomplished by either direct or indirect influence, but the sociocultural aspects must be addressed in addition to the mental health and psychological issues (Oetting & Beauvais, 1989).

Cultural components in the prevention programs we reviewed focused on three major aspects, including (a) involvement of the Indian community (Conner & Conner, 1992; Dorpat, 1994; Gilchrist et al, 1987; Moran, 1995; Petoskey, Van Stelle, & De Jong, 1998; Schinke et al., 2000; Trimble, 1992); (b) incorporation of cultural content into the curriculum or program (Dorpat, 1994; Gilchrist et al., 1987; Moran, 1998; Parker, 1990; Petoskey et al, 1998; Schinke et al., 2000; WestCAPT, 2000); and, (c) program delivery by Indian trainers (Dorpat, 1994; Gilchrist et al, 1987; Moran, 1998; WestCAPT, 2000).

Degree of involvement by Indian community members differed from program to program, ranging from one-time attendance at program functions to participation in all aspects of planning and implementation. The literature supports the notion of strong involvement by the Indian community as a determining factor in the effectiveness of prevention programs for Indian youth. Consider the comprehensive involvement of tribal members across all phases of the projects reported by Trimble (1992) and Moran (1998). Edwards and colleagues (1995), Moran (1995), and Petoskey and colleagues (1998) also attest to the importance of strong community involvement in prevention programs.

The extent to which cultural content was incorporated into the curriculum of the

programs also differed along a continuum. The inclusion of traditional beadwork classes and museum visits in Parker's (1990) study represents the low end of that continuum, while the comprehensive infusion of cultural material into the curriculum of grades K-12 described by Petoskey and colleagues (1998) stands patently at the other extreme. While the literature substantiates the value of integrating cultural material into prevention programs for Indian youth, the specific tailoring of cultural content to participants' tribal heritage, cultural group, region, etc., is a key factor. There are excellent examples of this among the programs we reviewed, including Gilchrist and others' (1987) detailed attention to material appropriate to members of Coast Salish tribes, Dorpat's (1994) PRIDE program designed for the Puyallup Tribal School system, and Moran's (1998) focus on crosscutting tribal values in addressing prevention among urban American Indian youth.

The majority of studies addressed the importance of program delivery by Indian facilitators, again in different ways. Some, such as Dorpat (1994), Gilchrist and colleagues (1987), Moran (1998), and Petoskey and colleagues (1998), recruited and trained local community members as facilitators; others utilized Indian school teachers and staff already employed at sites selected for the study (Conner & Conner, 1992).

Gaining the Sanction and Involvement of the Indian Community

Without formal or informal sanction of the Indian community, researchers will always be seen as outsiders and hence be frustrated in any attempts to establish credibility. One of the first issues to consider in understanding the dynamics of carrying out prevention programs in Indian communities is that, like many other ethnic minority communities, Indian communities often have a historical distrust of the dominant society (Lockart, 1981). This distrust is based in

the historical nature of the relationship between the dominant culture and American Indians that includes a 500-year history of oppression and domination that approached genocide. When programs are seen as imposed from outside the community, this distrust is likely to escalate and form a significant barrier. In such situations, prevention programs are not likely to produce useful results. To overcome this we must find ways to make programs relevant to communities and we must demonstrate our commitment to the community. A key part of making programs relevant is to have them emerge out of the process of community involvement.

An example of involving the community is a research project that was conducted in the Denver urban Indian community (Moran, 1995), which involved research assistants like Susan Yellow Horse and others. The purpose was to examine barriers encountered by American Indians in their use of human service agencies. In designing the study, it was proposed that a sample of Indian people be interviewed concerning their experiences in attempting to obtain services. Following the procedures outlined above, this idea was proposed to a group of Indian people, including several formal and informal leaders from the community. The response was that *Indians have been studied enough! If you want to find out about agency barriers, go talk to the agencies.* Thus, sanction for the original proposal was not obtained from this community group and the study was modified to begin by interviewing a sample of agencies used as referral sources by the major Indian community agency. Endorsement for this new approach was obtained from the community group. The agencies identified several barriers such as lack of transportation, inadequate childcare, and limited resources. More importantly, once the general findings were reported to the community group, several individual Indian people agreed to provide input into the study. The key to carrying out this research was obtaining community support by asking for and accepting guidance from the community.

Several other authors outline specific methods to effectively involve members of the Indian community in research projects. Beauvais and LaBoueff (1985) present a model of community involvement that moves from a few interested people to a core group to a community task force. Each step includes more community members committed to the idea of prevention. Schinke and others (1986) propose a similar strategy for effective community collaboration. It entails early and ongoing involvement of community members, both lay and professional, which are integrated as full partners in all phases of project planning, implementation, and evaluation. In a similar vein, Edwards and others (1995) propose a model of a community approach for substance abuse prevention programs for American Indian youth. They describe a humanistic approach that assumes that people can find ways to solve their own unique problems through group and community efforts.

Another critical component in gaining the support of the Indian community is this: researchers and prevention workers need to be sensitive to the range of cultural differences that are present in Indian communities. In short, we must pay attention to the issue of cultural competency (Cardenas, 1989; Cross, 1988; Orlandi, 1992; Tello, 1985). Green (1982) clarifies this concept by pointing out that being culturally competent means conducting one's professional work in a way that is congruent with the behaviors and expectations that members of a cultural group recognize as appropriate among them. He indicates that it does not mean that researchers should attempt to conduct themselves as though they are members of the group. Rather, they must be able to engage the community and demonstrate acceptance of cultural difference in an open, genuine manner.

Finally, in order to gain the sanction of the Indian community, researchers must demonstrate their own commitment to the communities in which they wish to conduct research.

Simply responding to the stated needs that are defined by the process of community involvement, instead of having a set program that is defined by academic interests or by government or foundation announcements, is a strong statement to the community. Providing technical assistance that is needed in the community, even though it may not be funded directly by grants, also contributes to demonstrating a commitment. Perhaps most important, prevention workers need to be willing to stick around and deal with a problem for as long as it takes, even if that means moving beyond the original funding period. This might mean locating and securing additional funding in order to continue a program. In summary, working in Indian communities requires us to directly address issues of distrust by listening, and then responding in a committed manner, to community defined interests. To the extent that we fail to do this, at best we will have little constructive impact and at worst we will produce negative consequences.

There are no easy answers to the issues presented in this paper. However, to move ahead we must carry out our research and our prevention work in a culturally competent manner. And, part of the process of discovering how to deal with specific barriers is to involve the community in the actual process from start to finish (Davidson, 1988). This approach was undertaken in the Healthy Nations Initiative, funded by the Robert Wood Johnson Foundation. The intention was to provide funding to selected Indian communities to use their own cultural wisdom when addressing substance abuse issues (Noe, Fleming, & Manson, 2003). Likewise, Yellow Horse and Yellow Horse Brave Heart (2004), also recommend the need for more American Indian specific preventions programs that incorporate culturally grounded practice, theory, and evaluation including the use of focus groups, key informants, and consultants that come from the community. To every extent possible, community members should be employed

as part of the prevention team, in all areas of planning, intervention, and evaluation. This team should then meet as a group throughout the project to determine and monitor the specifics of implementation, explanations to the community, and reporting of evaluation results. This dual process of paying attention to cultural competence and involving the community offers the best hope of providing effective substance abuse prevention programs for American Indian youth.

Conclusion

In this paper we provided an overview of several Indian youth programs with a particular focus on how issues of culture are incorporated. We found that most of the programs used the personal and social skills approach. Finally, we emphasized the importance of cultural competence and community involvement in research projects conducted in Indian communities. While much has been accomplished in terms of serving American Indian youth, it is clear that more work remains if we are to add depth to our understanding of substance abuse prevention among this population.

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BEST PRACTICES IN SUBSTANCE ABUSE TREATMENT: ARE THEY USEFUL FOR EVERYONE?

LISA R. THOMAS, PH. D., LISETTE AUSTIN, M.A., & G. ALAN MARLATT, PH.D.

Evidence-based practices (EBPs) are the gold standard that we, as ethical treatment providers, strive to implement in our work with clients, families, and communities struggling with substance use issues. This paper is intended to present, and very briefly discuss, considerations regarding these “best-practice” treatment approaches. Following this, we offer a brief discussion of the current best, evidence-based practices available in the literature for the treatment of substance abuse. Additionally, we will discuss the potential limitations in current research, in particular issues concerning the inclusion and/or exclusion of ethnically and culturally diverse participants in substance abuse treatment research, and the effect this may have on the use of EBPs as the most appropriate treatment intervention for these populations.

Evidence-based treatments are generally understood to be those that consistently generate positive outcomes. Even so, treatment for substance abuse varies widely, with a lack of consensus among treatment providers regarding what is most effective or a “best practice” (DHHS, 2000). However, the National Institute on Drug Abuse (NIDA) has identified 13 specific components to be considered when evaluating effectiveness of treatment (NIDA, 1999). These are: (1) no single treatment is appropriate for all individuals (treatment matching is critical); (2) treatment needs to be readily available; (3) effective treatment attends to multiple needs of the individual, not just his or her drug use; (4) an individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs; (5) remaining in treatment for an adequate period of time is critical for

treatment effectiveness; (6) counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction; (7) medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies; (8) addicted or drug-abusing individuals with coexisting mental disorder should have both disorders treated in an integrated way; (9) medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use; (10) treatment does not need to be voluntary to be effective; (11) possible drug use during treatment must be monitored continuously; (12) treatment programs should provide assessment for HIV/AIDS, hepatitis diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection; and (13) recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment (NIDA, 1999, pp 3-5).

In other words, treatment for substance abuse may be considered a best practice if it includes one or more of these components, and has been demonstrated to result in positive outcomes. However, it is important to remember: (1) treatment efficacy may not necessarily mean treatment effectiveness (Carol & Rounsaville, 2003), (2) translation of empirically-supported treatment approaches into practices is not the status quo (Roy-Byrne et al., 2003); and (3) there is little evidence that current empirically-supported treatment approaches are relevant, appropriate and effective for ethnically and culturally diverse clients, including American Indian/Alaska Natives (AIAN) (Bernal & Scharron-del-Rio, 2001; Caetano, Clark, & Tam, 1998; DHHS, 2000; Galvan & Caetano, 2003; Hall, 1997; Mail, 2002; Mail & Heurtin-Roberts, 2002; Ozaki & Sue, 1996; Sue, 1999).

Therefore, there is little support in the literature to indicate that current treatment

strategies will be effective with ethnically and culturally diverse clients, families, and communities, including American Indian and Alaska Natives. Additionally, Moran (2002) emphasized that the diversity of the American Indian and Alaska Native population is so great that it is important to remember that there is not one intervention program that will be effective and appropriate for all Native people and communities. However, recent literature emphasizes that treatment programs may be modified to be more effective if they emerge from the community, are grounded in the community, have input at all phases from the community and provide feedback to the community throughout the process (Beauvais, 2001; Blum, et al., 1992; CNPAEEMI, 2000; Fisher et al., 2002; Hazel & Mohatt, 2001; Jumper-Thurman et al., 2001; Mail & Heurtin-Roberts, 2002; May & Moran, 1995; Mohatt et al., 2004; Moran, 2001; Moran, 2002; Moran & Reamon, 2002; Norton & Manson, 1996; Parker-Langley, 2002; Rolf, Nansel, Baldwin, Johnson, & Benally, 2002; Rowe, 1997; Sage, 2001; Trimble & Beauvais, 2001; Welty, 2002). Promising programs are emerging from the literature and Native communities and include programs that include traditional ceremonies and beliefs (Brave Heart & DeBruyn, 1998; Duran & Duran, 1995; Gray & Nye, 2001; Sage, 2001); bicultural skills training; and community readiness (Jumper-Thurman et al., 2001). In addition, many local, grass-roots programs are being implemented in Native communities around the U.S., but may never appear in the literature.

With the above in mind, we present a summary of the currently identified mainstream “best practice” treatment approaches to substance abuse as reported by NIDA (NIDA, 1999, pp. 35-47).

Scientifically Based Approaches to Drug Addiction Treatment

Relapse Prevention, a cognitive-behavioral therapy, was developed for the treatment of problem drinking and adapted later for other addictive behaviors. Cognitive-behavioral strategies are based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Individuals learn to identify and correct problematic behaviors. Relapse prevention encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.

As an example, the relapse prevention approach to the treatment of cocaine addiction consists of a collection of strategies intended to enhance self-control. Specific techniques include exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. A central element of this treatment is anticipating the problems patients are likely to meet and helping them develop effective coping strategies.

Research indicates that the skills individuals learn through relapse prevention therapy remain after the completion of treatment. In one study, most people receiving this cognitive-behavioral approach maintained the gains they made in treatment throughout the year following treatment.

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The Matrix Model provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention.

Treatment materials draw heavily on other tested treatment approaches. Thus, this approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain work sheets for individual sessions; other components include family educational groups, early recovery skills groups, relapse prevention groups, conjoint sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

A number of projects have demonstrated that participants treated with the Matrix model demonstrate statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission. These reports, along with evidence suggesting comparable treatment response for methamphetamine users and cocaine users and demonstrated efficacy in enhancing naltrexone

treatment of opiate addicts, provide a body of empirical support for the use of the model.

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Supportive-Expressive Psychotherapy is a time-limited, focused psychotherapy that has been adapted for heroin- and cocaine-addicted individuals. The therapy has two main components:

- Supportive techniques to help patients feel comfortable in discussing their personal experiences.
- Expressive techniques to help patients identify and work through interpersonal relationship issues.

Special attention is paid to the role of drugs in relation to problem feelings and behaviors, and how problems may be solved without recourse to drugs.

The efficacy of individual supportive-expressive psychotherapy has been tested with patients in methadone maintenance treatment who had psychiatric problems. In a comparison with patients receiving only drug counseling, both groups fared similarly with regard to opiate use, but the supportive-expressive psychotherapy group had lower cocaine use and required less methadone. Also, the patients who received supportive-expressive psychotherapy maintained many of the gains they had made. In an earlier study, supportive-expressive psychotherapy, when added to drug counseling, improved outcomes for opiate addicts in methadone treatment with moderately severe psychiatric problems.

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Individualized Drug Counseling focuses directly on reducing or stopping the addict's illicit drug use. It also addresses related areas of impaired functioning, such as employment status, illegal activity, family/social relations, as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence. The addiction counselor encourages 12-step participation and makes referrals for needed supplemental medical, psychiatric, employment, and other services. Individuals are encouraged to attend sessions one or two times per week.

In a study that compared opiate addicts receiving only methadone to those receiving methadone coupled with counseling, individuals who received only methadone showed minimal improvement in reducing opiate use. The addition of counseling produced significantly more improvement. The addition of onsite medical/psychiatric, employment, and family services further improved outcomes.

In another study with cocaine addicts, individualized drug counseling, together with group drug counseling, was quite effective in reducing cocaine use. Thus, it appears that this approach has great utility with both heroin and cocaine addicts in outpatient treatment.

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Motivational Enhancement Therapy is a client-centered counseling approach for initiating behavior change by helping clients to resolve ambivalence about engaging in treatment and stopping drug use. This approach employs strategies to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. The first treatment session focuses on providing feedback generated from the initial assessment battery to stimulate discussion regarding personal substance use and to elicit self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed with the client. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Clients are sometimes encouraged to bring a significant other to sessions. This approach has been used successfully with alcoholics and with

marijuana-dependent individuals.

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Behavioral Therapy for Adolescents incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, and recording and reviewing progress, with praise and privileges given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control:

- *Stimulus Control* helps patients avoid situations associated with drug use and learn to spend more time in activities incompatible with drug use.
- *Urge Control* helps patients recognize and change thoughts, feelings, and plans that lead to drug use.
- *Social Control* involves family members and other people important in helping patients avoid drugs. A parent or significant other attends treatment sessions when possible and assists with therapy assignments and reinforcing desired behavior.

According to research studies, this therapy helps adolescents become drug-free and

increases their ability to remain drug-free after treatment ends. Adolescents also show improvement in several other areas: employment/school attendance, family relationships, depression, institutionalization, and alcohol use. Such favorable results are attributed largely to including family members in therapy and rewarding drug abstinence as verified by urinalysis.

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Multidimensional Family Therapy (MDFT) for Adolescents is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decision-making, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child.

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Multisystemic Therapy (MST) addresses the factors associated with serious antisocial behavior in children and adolescents who abuse drugs. These factors include characteristics of the adolescent (for example, favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intense treatment in natural environments (homes, schools, and neighborhood settings) most youth and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Reduced numbers of incarcerations and out-of-home placements of juveniles offset the cost of providing this intensive service and maintaining the clinicians' low caseloads.

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Combined Behavioral and Nicotine Replacement Therapy for Nicotine Addiction consists of two main components:

- The transdermal nicotine patch or nicotine gum reduces symptoms of withdrawal, producing better initial abstinence.
- The behavioral component concurrently provides support and reinforcement of coping skills, yielding better long-term outcomes.

Through behavioral skills training, patients learn to avoid high-risk situations for smoking relapse early on and later to plan strategies to cope with such situations. Patients practice skills in treatment, social, and work settings. They learn other coping techniques, such as cigarette refusal skills, assertiveness, and time management. The combined treatment is based on the rationale that behavioral and pharmacological treatments operate by different yet complementary mechanisms that produce potentially additive effects.

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American Psychiatric Association. (1996). *Practice guideline for the treatment of patients with nicotine dependence*. American Psychiatric Association.

Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24-week outpatient therapy for treatment of cocaine addiction. The treatment goals are twofold:

- To achieve cocaine abstinence long enough for patients to learn new life skills that will help sustain abstinence.
- To reduce alcohol consumption for patients whose drinking is associated with

cocaine use.

Patients attend one or two individual counseling sessions per week, where they focus on improving family relations, learning a variety of skills to minimize drug use, receiving vocational counseling, and developing new recreational activities and social networks. Those who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy. Patients submit urine samples two or three times each week and receive vouchers for cocaine-negative samples. The value of the vouchers increases with consecutive clean samples. Patients may exchange vouchers for retail goods that are consistent with a cocaine-free lifestyle.

This approach facilitates patients' engagement in treatment and systematically aids them in gaining substantial periods of cocaine abstinence. The approach has been tested in urban and rural areas and used successfully in outpatient detoxification of opiate-addicted adults and with inner-city methadone maintenance patients who have high rates of intravenous cocaine abuse.

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Voucher-Based Reinforcement Therapy in Methadone Maintenance Treatment (also known as Contingency Management) helps patients achieve and maintain abstinence from illegal drugs by providing them with a voucher each time they provide a drug-free urine sample.

The voucher has monetary value and can be exchanged for goods and services consistent with the goals of treatment. Initially, the voucher values are low, but their value increases with the number of consecutive drug-free urine specimens the individual provides. Cocaine- or heroin-positive urine specimens reset the value of the vouchers to the initial low value. The contingency of escalating incentives is designed specifically to reinforce periods of sustained drug abstinence.

Studies show that patients receiving vouchers for drug-free urine samples achieved significantly more weeks of abstinence and significantly more weeks of sustained abstinence than patients who were given vouchers independent of urinalysis results. In another study, urinalyses positive for heroin decreased significantly when the voucher program was started and increased significantly when the program was stopped.

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Day Treatment With Abstinence Contingencies and Vouchers was developed to treat homeless crack addicts. For the first 2 months, participants must spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual assessment and goal setting, individual and group counseling, multiple psychoeducational groups (for example, didactic groups on community resources, housing, cocaine, and HIV/AIDS prevention; establishing and reviewing personal rehabilitation goals; relapse prevention; weekend planning), and patient-governed community meetings during

which patients review contract goals and provide support and encouragement to each other. Individual counseling occurs once a week, and group therapy sessions are held three times a week. After 2 months of day treatment and at least 2 weeks of abstinence, participants graduate to a 4-month work component that pays wages that can be used to rent inexpensive, drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

This innovative day treatment was compared with treatment consisting of twice-weekly individual counseling and 12-step groups, medical examinations and treatment, and referral to community resources for housing and vocational services. Innovative day treatment followed by work and housing dependent upon drug abstinence had a more positive effect on alcohol use, cocaine use, and days homeless.

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Conclusion

When considering the list of scientifically-based approaches to drug addiction treatment, several issues are important to keep in mind. As stated in the introduction, the extent to which these various treatment approaches are effective in ethnically and culturally diverse clients, including American Indian and Alaska Natives, remains to be determined. In addition, the following points are important to consider when selecting an appropriate intervention.

(1) EBPs are often manualized with the expectation that the treatment provider will follow the same intervention methods that were used in the outcome studies to evaluate treatment efficacy. Many providers object to the requirement that they follow a strict, manual-based intervention, unless they are allowed the flexibility of responding to individual client needs. The quality of the relationship between the client and provider (rapport, empathy, and continuity of contact over time) may be just as important toward a successful treatment outcome as the type of treatment employed.

(2) Many clients present with co-occurring or dual disorders, either with multiple substance use problems or other mental health/psychiatric disorders. There is a need to provide an integrated treatment approach instead of employing parallel or sequential EBPs for each disorder separately. There should be “no wrong door” for treatment entry when clients present with co-occurring disorders.

(3) In addition to treatment matching, in which providers attempt to match clients with the most promising EBP, clients can play an active role in selecting treatment programs on a “consumer choice” basis. Research shows that clients who select their own treatment goals and programs do better than a “one size fits all” approach. Clients could benefit from knowing about various interventions through a “treatment sampling” orientation at intake.

(4) Treatment approaches vary in terms of how they handle relapse or setbacks during and/or following the primary intervention. Clients need a supportive response to relapse management, if clients are unable to meet their initial treatment goal (e.g., abstinence). For clients who are unable to make a commitment to total abstinence at the start of treatment, an alternative harm-reduction intervention may be necessary to keep the client actively involved in the change process.

(5) Treatment approaches that are linked to the “stages of change” model (Prochaska & DiClemente, 1992) are recommended. For those in the ‘precontemplation’ or ‘contemplation’ stages, motivational enhancement may be the most effective approach. For those motivated and ready for change, selecting the appropriate EBP through treatment matching or consumer choice represents movement into the ‘action’ stage. During the ‘maintenance’ phase, relapse prevention is often the preferred approach.

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BEST PRACTICES FOR SUBSTANCE ABUSE TREATMENT AMONG AMERICAN INDIANS AND ALASKA NATIVES: REVIEW AND CRITIQUE

ARTHUR W. BLUME, PH.D., & CRISOL J. ESCOBEDO

Substance abuse is a major problem for many American Indian and Alaska Natives and contributes to numerous health consequences for Native communities. For example, liver diseases, often linked to substance abuse, were the sixth leading cause of death for Native peoples in the United States in 2001, a very striking statistic given that liver diseases were not listed in the top 10 causes of death in the United States for all races combined. When examining gender differences, liver diseases were the fourth leading cause of death for Native men (compared to the tenth leading cause for men of all races) and the seventh leading cause of death for Native women (liver diseases were not even in the top 10 causes of death for women of all races in the United States). Unintentional injuries and suicide, often linked to substance abuse, were the third and eighth leading cause of death respectively among Native Americans. Suicide was not even listed in the top 10 causes of death for all races in the United States (National Center for Injury Prevention and Control, 2004). In addition, the National Institute on Alcohol Abuse and Alcoholism (2001) has estimated that 75% of all unintentional injuries among American Indians are alcohol related.

Determining best practices to treat substance abuse becomes crucial to reduce the risk of substance abuse among Native communities and Native peoples. However, determining best practices is a complicated endeavor since many Native communities distrust researchers and practitioners from outside the community due to a history of neglect or abuse (e.g., Barrow

Alcohol Study; Foulks, 1989). In addition, data on treatment utilization suggests that Native Americans do not seek and receive treatment services at a rate consistent with projected population rates of substance abuse, although the reasons for this disparity are not fully understood (National Institute on Alcohol Abuse and Alcoholism, 2001; Substance Abuse and Mental Health Services Administration, 2004).

Best Practices for Treatment: Many Unknowns

Very little treatment research has been conducted among Alaska Natives and American Indians; in fact, no controlled trials of treatment modalities have been conducted, which hinders determining best practices for treatment (Abbott, 1998). Part of the difficulty in having controlled trials of therapy in Native communities has to do with a history in which some researchers have embarrassed elders or the community as a whole, have violated community norms during the conduct of research, and have not attempted to connect with community in any meaningful way, which includes not providing the community feedback from research data that would be helpful for its people. From the perspective of community-oriented culture, taking research data without giving back to the community is considered rude and abusive behavior. In addition, many community-oriented cultures often reject the use of no-treatment controls in studies because they feel that all community members should get the same level of care.

In the absence of controlled trials, what follows is a review of existing research literature and what it may suggest about best treatment practices, and perhaps most importantly, what may be the necessary next steps to determine what the best practices may be. Although it will not be reviewed exhaustively in this paper, the research literature for prevention methods among

Native communities also provides some clues for what therapeutic strategies may work. Future efforts to determine best practices will require researchers to work collaboratively with Native communities to develop treatment efficacy trials acceptable in design to those communities.

Minnesota Model 12 Step Treatment and Native Americans

Very little research has been conducted to investigate whether traditional Minnesota Model type treatment models are efficacious for the general population, not to mention whether they are efficacious for Native populations. There is evidence that treatment in general does help consumers, especially when abstinence is not the only criterion used for measuring success (Miller, Walters, & Bennett, 2001). Project MATCH found that the manualized 12 Step Facilitation Therapy did as well as Cognitive Behavioral Therapy and Motivational Enhancement Therapy. However, the MATCH sample did not include many Native Americans participants (Project MATCH Research Group, 1997; Tonigan, Connors, & Miller, 1998). In addition, methodological concerns about the study that may reduce its generalizability have been widely debated (e.g., Heather, 1999), including numerous research controls to promote adherence to the manualized therapies that would be uncommon in a typical clinical setting.

A recent review of the research literature evaluated substance abuse treatment for special populations and concluded that little was known about what constitutes effective treatment for American Indians and Alaska Natives, but that traditional 12 step treatment techniques did not seem to work very well for Native Americans. It also pointed out the vast differences across communities with concern to traditions and history and suggested that cultural adaptations of existing treatment methods are necessary (Gomberg, 2003). However, another review has suggested that making existing treatment culturally relevant must be done

carefully and then closely monitored for effectiveness (May & Moran, 1995).

One proxy for determining whether 12 step programs are helpful for American Indians and Alaska Natives is to investigate the membership of Alcoholics Anonymous and other 12 step programs to determine if Indians and Alaska Natives are adequately represented. Indeed, the membership survey of Alcoholics Anonymous provides evidence that Native Americans are underrepresented in the membership of that organization, constituting only 2% of the total membership in 2001 (Alcoholics Anonymous World Services, 2004). The reason for the low membership numbers in Alcoholics Anonymous is unknown, but it is reasonable to suspect that some American Indians and Alaska Natives will not find help in 12 step programs because of differences in worldviews. The 12 step philosophy was developed from the Judeo-Christian religious tradition and may not appeal to Natives who are more traditional in their spiritual beliefs.

Perhaps in response to this concern, some traditional 12 step programs have attempted to culturally enhance treatment with the introduction of traditional practices. For example, sweat lodges (e.g., Gossage, et al., 2003) and other traditional practices have been introduced into traditional treatment, especially those sponsored by the Indian Health Services or operated by tribal communities themselves, in an attempt to make 12 step treatment more culturally relevant to American Indian and Alaska Native participants. One research study found that the introduction of traditional practices into a 12 step facility was associated with longer involvement in treatment for Alaska Natives (Fisher, Lankford, & Galea, 1996). Some treatment programs in American Indian and Alaska Native communities that include the services of traditional religious leaders and healers to treat substance abuse have documented treatment success. However, other studies have found that stand-alone Native healing practices (without

traditional treatment) have been used to successfully treat substance abuse (e.g., Mail & Shelton, 2002), findings which beg the question of whether culturally-enhanced treatment offers more to participants than the use of traditional spiritual practices alone.

Cognitive Behavioral Therapy for Substance Abuse and Native Americans

Cognitive Behavioral Therapy (CBT) for substance abuse has been documented to be effective in controlled trials and some of its components have been suggested as the best practices known for treating substance abuse among the general population (e.g., Chambless & Ollendick, 2001). In addition, culturally relevant CBT skills training programs have been found to be effective for reducing substance misuse (Gilchrist, Schinke, Trimble, & Cvetkovich, 1987; Marlatt, et al., 2003; Schinke, Tepavac, & Cole, 2000). CBT also is being used in conjunction with relevant cultural practices in a limited number of treatment programs (e.g., Stewart-Sabin & Chaffin, 2003), but there is very limited data on how effective these interventions have been. One interesting treatment study trained family members to use strategies such as behavior modification and problem solving in conjunction with culturally traditional elements such as storytelling to influence the behavior of adolescents with problematic substance use. Adolescent participants in the intervention were found to have reduced number of days of substance use after treatment when compared with a treatment as usual group (Boyd-Ball, 2003).

Since American Indian and Alaska Native clients live in at least two cultures (the culture of the majority and their own culture), they may need to develop competence in both cultures to successfully overcome substance abuse. This particular model for coping, known as bicultural competence, suggests that different skill sets may be needed to cope with both

majority and traditional cultures (LaFramboise & Rowe, 1983). Many American Indians and Alaska Natives treatment programs use the model as a guide to culturally enhance their skills training components. Teaching bicultural competence to Native clients is intuitively appealing, but the efficacy of bicultural competence for treatment of substance abuse has not been tested under controlled conditions.

Other CBT therapies for treating substance abuse, such as cue exposure and expectancy challenge techniques, as well as relapse prevention, have not been empirically tested among American Indians and Alaska Natives. Expectancies are known to be a potent predictor of substance use behavior among the majority population (e.g., Jones, Corbin, & Fromme, 2001), but little is known about their ability to predict substance abuse in Native populations. Interestingly, there is evidence that substance use expectancies for Native Americans may be different than for Whites (Daisy, 1989), which may influence how expectancy challenges would be conducted with Native clients. More expectancy research is needed to determine if there are specific belief patterns that predict substance abuse and relapse among Native clients. Still another treatment unknown is whether lapses and relapses are experienced the same way for Native clients as has been modeled for Whites (Marlatt, 1985). More research on relapse would be helpful to determine if the relapse model for Native clients is consistent with has been found in majority population research samples, and relapse prevention can be adjusted according to those results.

Even though many aspects of CBT have not been tested for their efficacy among Native populations, research that supports CBT as best practices among the general population should not be ignored. CBT that can be easily used in family and community settings would likely offer the best of both worlds. In this way, therapy that is empirically validated in majority culture

can be used within culturally relevant social institutions in American Indian and Alaska Native communities. Some CBT easily lends itself to collective settings or to community needs and services, such as the community reinforcement approach (Miller, Meyers, & Hiller-Sturmhofel, 1999), relapse prevention which can involve families and community (Marlatt, 1985), and strategies designed to reduce the harmful consequences of substance use behavior that emphasize use of multiple community resources for health promotion (Daisy, Thomas, & Worley, 1998).

Cultural Considerations for Best Practices

Understanding the culture and history of an American Indian or Alaska Native community will be important to effectively treat substance abuse in that community. Many Native cultures place high value upon social relationships and social standing, family, and community. Effective treatment for Natives will need to respect these values. In addition, the history of many communities is quite rich but often filled with tragic events since the arrival of Europeans.

Individual and Community-wide Trauma

Trauma is a salient issue to discuss when addressing best practices for substance abuse treatment for American Indians and Alaska Natives. There are two sources of trauma that should potentially be considered. First, there are some data to support that individualized experiences of trauma, such as physical and sexual abuse, as well as confinement in boarding schools, may be predictive of substance dependence among some tribal groups (Koss, et al., 2003). In addition, being reared in foster care has been found to be associated with treatment

dropout in another study (Gutierrez, Russo, & Urbanski, 1994).

Second, there is the belief among many American Indians and Alaska Natives that trauma related to centuries of mistreatment by the conquering majority (e.g., as chronicled in Hawkins & Blume, 2002) may be transmitted intergenerationally (Gray & Nye, 2003; Jones-Saumty, 2002), and may constitute a “soul wound” that causes significant mental health issues for many Native Americans. Because of these concerns, effective substance abuse treatment will likely have to determine how and when to address these issues. However, since there is risk that therapists can unwittingly create false traumatic memories (Hyman & Loftus, 1997) and that debriefing about trauma in groups is not helpful for ameliorating traumatic stress (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002), the way that trauma should be addressed in treatment will require great caution. Research on empirically validated therapies for Posttraumatic Stress Disorder provides some clues on how to proceed (Chambless & Ollendick, 2001).

Psychiatric comorbidity in general is another related treatment issue that will have to be addressed effectively in order to improve treatment services to Native Americans. Ease of access to these services also will be important in order to effectively serve Native clients (Gray & Nye, 2003; Jones-Saumty, 2002; Walker, Lambert, Walker, & Kivlahan, 1992). The key will be to provide these services without falling into the trap of overpathologizing Native clients. Overpathologizing remains a risk when assessing and treating ethnic minority clients (e.g., Snowden, 2003).

Reservation versus Urban

Reservation and urban Native Americans live under vastly different conditions, which

may influence what kinds of treatment may be effective. For example, reservation based treatment facilities often face issues related to vast distances from homes to services and limited means of transportation. In order to address this issue, one treatment program piloted aftercare by phone, which showed some promise for aiding maintaining treatment gains (Chong & Herman-Stahl, 2003). Urban dwellers, on the other hand, sometimes face challenges because services can be scattered across vast metropolitan areas, which may make them difficult to find. To overcome this barrier, urban treatment centers can offer services for substance abuse, mental health, sexually transmitted diseases, and social services at one location in order to improve continuity of care (Nebelkopf & King, 2003).

Unfortunately, most of the research concerning treatment has been conducted with reservation based American Indians and Alaska Natives, even though a sizeable number of Native Americans live in urban areas. One of the unique challenges that an urban treatment center might face that a reservation center might not is to provide services to clients from literally dozens of different tribes or communities that come from radically different cultures and traditional practices. Creating culturally relevant treatment for such a diverse population is very challenging to accomplish.

Countering the Firewater Stereotype

Perhaps the most damaging stereotype that has been used against Native Americans is the firewater myth. The firewater myth suggests that American Indians and Alaska Natives are genetically incapable of “handling” alcohol when consumed in a controlled or rational manner. This stereotype has been used to perpetuate a belief that zero tolerance is the only safe course when addressing alcohol use among Native Americans and this stereotype has tended to thwart

discussion about using treatment in these communities which may include non-abstinent goals. However, recent studies have debunked this stereotype (e.g., Garcia-Andrade, Wall, & Ehlers, 1997; LaMarr, 2004). Treatment programs may want to challenge this stereotype among its Native American clients since it likely is not helpful to enhance self-efficacy for changing behavior or for preventing relapse. In addition, a natural history study conducted in Native American community found that 83% of the participants in the study who had stopped drinking alcohol over time did it without the aid of treatment (Leung, Kinzie, Boehnlein, & Shore, 1993). Determining best practices for treatment cannot begin with an assumption that all Native Americans should be treated similarly for substance abuse.

Acculturation Match between Client and Therapist

Researchers who have studied acculturation and its impact upon therapy have suggested that treatment matching to level of acculturation may be important for success. For instance, if a Native American client is not highly acculturated, interventions that assume a high level of acculturation (meaning a high level of familiarity with and skills in negotiating majority culture) may not be very effective. Ideally, acculturation levels should be matched between client and therapist, as well as between client and content of therapy (Sue & Sue, 2003). However, ethnic identity may be orthogonal (Oetting & Beauvais, 1991), suggesting that the level of identification with both cultures should be assessed to determine treatment and therapist matches.

Cultural Differences for Self-efficacy

Little is known about the relationship of self-efficacy with behavior change after

treatment among American Indians and Alaska Natives. Research in other domains suggests that the construct of self-efficacy may be different among people from ethnic-minority populations than it is for Whites (Earley, 1994; Earley, Gibson, & Chen, 1999). Although neither of these studies examined the relationship of self-efficacy with addictive behaviors, they do suggest that self-efficacy may develop differently among people who hold collectivistic worldviews.

Indeed, collective efficacy may be a more appropriate construct to consider regarding successful behavior change among people from collectivistic societies than self-efficacy. Collective efficacy can be thought of as the shared belief by a group of people in their ability to successfully organize and complete particular tasks in order to achieve specified goals (Bandura, 1997).

A great example of collective efficacy is the historical example of Alkali Lake (Ben, 1991), a Native community that worked together to rid itself of substance abuse. Indeed, many informed researchers have suggested that any effective treatment for substance abuse for American Indians and Alaska Natives will have to be developed through grassroots efforts and community empowerment (Beauvais & LaBoueff, 1985; May & Moran, 1995). An important part of community empowerment and collective efficacy seems to involve reconnections with traditional culture and values, and efforts toward redeveloping community-determination (as opposed to self-determination) and community identity (Beauvais & LaBoueff, 1985; May & Moran, 1995; McCormick, 2000; Spicer, 2001). Cultural efficacy can be enhanced through the community involvement in development of community treatment programs.

Gender Differences

Although the research is sparse, there may be significant gender differences in the pattern and consequences of substance abuse as well as motivation to change behavior. Such differences will need to be determined before best practices can be developed in a gender sensitive way. For example, one study found that concerns about children often motivate women to seek treatment, and that many Native women in treatment have been abused in some way (Peterson, Berkowitz, Cart, & Brindis, 2002). Findings like these may be used to improve treatment by making it gender relevant in addition to being culturally relevant.

Summary of Important Points to Developing Best Treatment Practices

Some Native clients find a home in traditional 12 step programs, but not all. Specific cognitive behavioral therapies that have been validated in the general population offer promise, especially those that would merge well with family and community models for recovery. Even though the research to determine best practices for substance abuse treatment is sparse and inconclusive, some important principles reviewed in this paper may help to define how best practices can be determined. For example, given the research findings, best practices for the treatment of substance abuse among Native Americans are likely to include the following elements: (1) community leadership and participation from inception to implementation, with professionals assuming a consultative role in the process; (2) the inclusion of traditional practices; (3) skills training for successfully negotiating with both traditional and majority cultures after treatment; (4) easily accessible and culturally relevant services for other co-occurring health and mental health problems; (5) development and use of empirically supported treatment strategies to address individual and community issues of trauma, loss, and

victimization; and (6) treatment flexible enough to be adapted to reservation and urban lifestyles, gender differences, and remarkably different cultures and communities. Because of the unique issues and challenges outlined in this paper, researchers may find that best practices for substance abuse treatment will vary according to the community being served.

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A SUMMARY OF BEST PRACTICES FOR MENTAL HEALTH TREATMENT

BRITT K. ANDERSON, PH.D.

Introduction

While some have previously asserted that the horse race is over and all models of psychotherapy are equally effective in treating people in general (Shapiro & Shapiro, 1982; Wampold et al., 1997), the need for both greater accountability by practitioners and more consistent guidelines for training and education within the field have led to a continued search for evidence-based evaluations of interventions. In fact, there is mounting evidence to suggest that treatments vary significantly in their successful treatment of individuals when interventions are evaluated in the context of treating specific problems or diagnoses. These differences also appear to be more pronounced when specific client factors, such as age and ethnic background, are considered. The term “best practice” refers to those that have been scientifically shown to be effective for the prevention or treatment of a mental health problem within designated populations. An alternative designation is “promising practice” in which the treatment appears to be effective but has not yet demonstrated adequate outcome data or replicated results to support the generalization of outcome findings.

As the amount and quality of empirical evidence supporting therapeutic interventions can vary widely, there has been a need to establish specific criteria to make these categorizations. Several groups have been involved with the process of identifying and evaluating empirically-supported treatments (ESTs) that encompass these domains. At the forefront of this effort has been the Task Force on Promotion and Dissemination of

Psychological Procedures of Division 12 (Clinical Psychology) of the American Psychological Association (APA) which has generated three reports (Chambless et al., 1996, 1998; Task Force, 1995) that established criteria for evaluating the efficacy of clinical interventions and specifying those interventions that they considered empirically validated (Chambless & Ollendick, 2001). As this initial effort largely addressed treatments designed for adults, a second task force was developed through Division 12 to assess ESTs and prevention programs specifically for children (Spirito, 1999). A more complete history of these task forces is detailed in a review of ESTs by Chambless and Ollendick (2001). Other evidence-based reviews of psychotherapy outcome research include *A Guide to Treatments That Work* (Nathan & Gorman, 1998) and a review by Kendall and Chambless (1998). Additionally, there have been specialized evaluations of evidence-based treatments for geriatric populations (Gatz et al., 1998), chronic pain patients (Wilson & Gil, 1996), and child physical and sexual abuse (Saunders, Berliner, & Hanson, 2004). Finally, international groups have made efforts to evaluate ESTs, such as the British National Health Service (Parry, 1996; Roth & Fonagy, 1996) and the Canadian Psychological Association (Hunsley et al, 1999).

There is great variability in the criteria used to determine whether mental health treatment protocols are evidence-based and efficacious. The APA's Task Force (1995) has delineated standards for the development, evaluation, and dissemination of ESTs and provided criteria for designating "well-established", "probably efficacious", and "experimental" treatments which are described below in Table 1. In addition, the Task Force is currently in the process of preparing a detailed manual to enhance reliability when reviewing treatment programs. While different groups vary in the specific criteria utilized for the determination of effective treatments, Chambless and Ollendick (2001) have noted in a review of several of these differing

approaches that they tend to come to consistent conclusions when evaluating the same treatments.

Thus, though there are certainly many other criteria-based systems for evaluating the scientific merit of therapeutic treatments, this paper will summarize those that most closely follow the APA's Task Force guidelines for well-established and probably efficacious treatments. Best practice guidelines for the following adult mental health diagnoses and/or problems will be addressed: depression, post-traumatic stress disorder, severe mental illness (bipolar disorder and schizophrenia), and suicide. An additional section addressing best practice guidelines for children diagnosed with depression, anxiety disorders, ADHD, and conduct disorder will be provided. Finally, empirically-validated practice guidelines for treating physically and sexually abused children and adult molesters will be summarized.

Major Depression

There are three therapeutic approaches that are considered well-established for the treatment of Major Depression by the APA task force standards: behavior therapy, cognitive therapy, and interpersonal therapy. A manualized behavioral therapy program for this diagnosis is The Coping with Depression Course developed by Dr. Lewinsohn and his colleagues (Antonuccio, 1998; Brown & Lewinsohn, 1984). The efficacy of this program has been validated in multiple studies with adults (Brown & Lewinsohn, 1984; Steinmetz, Lewinsohn & Antonuccio, 1983), adolescents (Lewinsohn, Clarke, Hopes, & Andrews, 1990), elderly patients (Teri, Logsdon, Uomoto & McCurry, 1997), and in prevention efforts (Clarke et al., 1990; Munoz et al., 1987). The course involves teaching coping strategies such as social skills, changing thought patterns, increasing pleasurable activities, and relaxation training in order to change

behavioral patterns and better manage life problems. The course for adults involves 12 two-hour group sessions conducted over 8 weeks but can also be successfully modified for individual treatment.

Cognitive therapy for depression involves teaching patients to monitor and write down negative thoughts and images and learn to identify the relationship between their thoughts, emotions, behavior, and physiological experiences (Butler & Beck, 1995). Therapists practicing this model of intervention typically guide patients to challenge their dysfunctional beliefs, increase activity level, self-monitor behavior and emotions, and complete regular task assignments. Many patients demonstrate improvement by eight individual sessions but a full course of treatment is 14-16 sessions. This clinical approach has demonstrated efficacy in several outcome studies and was found to be superior to pharmacotherapy, behavior therapy, “other” psychotherapies, and a wait-list condition in a meta-analysis of 28 controlled outcome studies of depression (Dobson, 1989).

Interpersonal Psychotherapy of Depression (IPT) was developed by Klerman, Weissman and their colleagues and stems from interpersonal psychology and theory regarding attachment and social roles (Cornes & Frank, 1994). This manualized approach involves an initial focus on a problem area such as delayed/incomplete grief, role transitions, role disputes, or interpersonal deficit (Klerman, Weissman, Rounseville, & Chevron, 1984). Through working on the problem area, patients are able to eliminate the symptoms of depression, improve interpersonal relationships, and anticipate the successful resolution of future difficulties. IPT has been found to be successful in both treating episodes of depression and minimizing the onset of future episodes in controlled clinical trials (Cornes & Frank, 1994).

Finally, brief dynamic therapy, self-control therapy, and social problem-solving therapy

are treatments that qualify as probably efficacious by APA task force standards. While there is some evidence suggesting their utility, they have not yet met the more stringent empirical standard of well-established. It is important to note that while medications are often helpful in the successful treatment of depression, they have not been included in this review.

Post-Traumatic Stress Disorder

According to the task force, no treatments evaluated for post-traumatic stress disorder (PTSD) met the criteria of well-established but several appear to be probably efficacious in the treatment of this disorder. These treatments include: EMDR, exposure therapy, and stress inoculation.

Eye Movement Desensitization and Reprocessing (EMDR) is an information processing therapy to help patients attend to previous and current experiences in brief doses while focusing on an external stimulus, such as eye movement (Shapiro, 2001; Shapiro, 2002). The patient then focuses on new material during this process of “dual attention” and repeats the procedure until any distress associated with targeted memories is eliminated. EMDR has demonstrated successful treatment of PTSD with civilians through several controlled studies in which it was compared to biofeedback, supportive counseling, relaxation, and various forms of exposure therapy (Davidson & Parker, 2001; Foa, Keane, & Friedman, 2000; Power, McGoldrick, Brown, et al., 2002).

Exposure therapy for PTSD, also known as imaginal flooding therapy, involves repeated exposure to imagined images of previous trauma (Keane & Kaloupek, 1982). The exposure is continued until the images cease to create anxiety exhibited through nightmares, flashbacks, concentration problems, fear, and/or irritability. Edna Foa and her colleagues have successfully

demonstrated effectiveness with a manualized approach to exposure treatment, often leading to immediate improvement of PTSD symptoms following completion (Foa, Rothbaum, Riggs, & Murdock, 1991; Foa & Meadows, 1997).

Stress Inoculation Training (SIT) has been used both to treat PTSD after exposure to trauma and to “inoculate” individuals to possible future stressors (Meichenbaum, 1996). This treatment is a form of cognitive-behavioral therapy that involves developing a strong, collaborative relationship between the client and therapist, educating clients about stress, teaching them to consider threats as problems-to-be-solved, and developing coping skills to better manage global stressors. Additionally, the treatment involves skills acquisition, rehearsal, and application of new skills across increasing levels of stressors. Typically, SIT involves 8-15 sessions provided over a 3-12 month period. This approach can be used effectively with individuals, couples, and groups. The APA task force acknowledged both SIT’s probable efficacy for treatment of PTSD (Foa et al., 1991; Meichenbaum, 1993; Vernon & Best, 1983) and demonstrated value as a well-established treatment for general symptoms of stress (Chambless & Ollendick, 2001).

Severe Mental Illness

Schizophrenia, bipolar disorder, and other severe mental illnesses have been effectively treated with a number of evidence-based psychological therapies. Empirical data suggest the importance of integrating pharmacological treatment, psychosocial treatments, and social support in treating individuals with schizophrenia. Psychosocial programs with well-established or probable efficacy for the treatment of schizophrenia include: behavior therapy and social learning/token economy programs, behavioral family therapy, social skills training, supportive

group therapy, and training in community living program.

Behavior therapy and social learning programs provide social and tangible reinforcers on a contingency basis to patients participating in hospital or day treatment programs. A token economy is formed when patients are reinforced for engaging in prosocial behavior (Kopelowicz, Liberman, & Zarate, 2002). Behavioral family therapy generally involves ongoing psychoeducation for the patient and family about the biology and treatment of schizophrenia, inclusion of the family on the treatment team, development of enhanced coping and communication skills among family members, and a focus on compliance with medication recommendations (Gingerich & Bellack, 1995). The treatment is long-term; often lasting at least 2 years.

Social skills training is a therapeutic approach that involves learning behavioral strategies to improve functioning in the community. For example, skills training may include learning how to manage medications, communicate effectively with health care providers, avoiding alcohol and illicit drugs, and developing conversation skills (Kopelowicz, Liberman, & Zarate, 2002). This therapy is usually provided through regular group sessions and conducted with outpatients who are stabilized on their medications and have the opportunity to utilize new skills in their community (Heinssen, Liberman, & Kopelowicz, 2000).

Supportive group therapy involves problem-solving and provision of practical advice with the support of a cohesive therapeutic relationship (Kopelowicz, Liberman, & Zarate, 2002). The focus of groups may include goal setting, learning coping strategies, discussing medication compliance, and socialization. This model of treatment is often used with patients living in the community who are seeking outpatient treatment.

The Training in Community Living (TCL) program is a form of case management that

involves the formation of multidisciplinary treatment teams that help patients function effectively in their natural environments (Scott & Dixon, 1995). This model of therapy is also known as Assertive Community Treatment (ACT) and provides support in medication management, adjusting the environment to be more supportive of the patient's needs, providing rehabilitation services, and assistance with employment. This comprehensive team approach has proven to be successful in reducing time spent in the hospital but is also costly and time-consuming to effectively administer (Mueser et al., 1998).

The empirically-supported treatments available for bipolar disorder include: psychoeducation and cognitive-behavioral therapy for medication adherence. Both of these approaches have been designated as probably efficacious according to APA task force guidelines (Chambless & Ollendick, 2001). Psychoeducation for bipolar patients is intended to provide information about the nature of the disorder and effective treatment. A key aspect of this education is providing a rationale for compliance with prescribed medications (Kopelowicz, Liberman, & Zarate, 2002). It appears that even a limited psychoeducational intervention, such as a 12-minute videotape and written handout, can be effective in improving adherence to medication protocols (Peet & Harvey, 1991).

Cognitive-behavioral therapy has also been effective at improving patient compliance with medications. This treatment approach addresses the cognitions and behaviors that may be interfering with individuals taking their medications. CBT programs for bipolar disorder typically involve challenging self-statements and core beliefs, increasing patient knowledge about the disorder, behavioral activation, and the teaching of relapse prevention strategies during a series of individual therapy sessions (Craighead, Miklowitz, Frank, & Vajk, 2002).

Finally, supported employment is an evidence-based treatment that is deemed probably

efficacious for the severely mentally ill. The goal of the program is to help individuals with mental illness find and retain competitive employment through the help of employment specialists. "Competitive employment" is defined as work that is available for anyone in the community and pays at least the minimum wage, rather than unpaid or sponsored work programs. The specialists work in concert with other treatment providers to integrate employment opportunities with mental health treatment, vocational assessment and support services (Kopelowicz, Liberman, & Zarate, 2002).

Suicide

While the APA task force and other reviewers cited by Chambless and Ollendick (2001) did not specify empirically-based treatments for the prevention of suicidal behavior, Dialectical Behavior Therapy (DBT) has been identified by researchers as probably efficacious for the treatment of Borderline Personality Disorder. Treatment of this disorder often involves the management and elimination of suicidal and/or parasuicidal behaviors (Linehan, 1993). Alternatively, the Evidence-Based Practices Project (EBPP) for Suicide Prevention is in the process of evaluating suicide prevention programs with criteria adapted from those established by the National Registry of Effective Prevention Programs (NREPP). An online directory of programs designated as promising, effective, or model will be available in the future. Information regarding this joint project of the Suicide Prevention Research Center and the American Foundation for Suicide Prevention is available at

<http://www.sprc.org/whatweoffer/ebp.asp>

Children

Evidence suggests that childhood depression and anxiety, including general anxiousness, separation anxiety, and avoidance, are effectively treated with cognitive-behavioral therapy (Chambless & Ollendick, 2001). CBT treatment typically involves identification of thoughts, feelings, and behavior that may be contributing to the symptoms of depression or anxiety. Psychoeducation and behavioral skills training are important components of this therapeutic approach.

Reviewers vary to the degree in which they endorse the efficacy of treatment programs for attention-deficit hyperactivity disorder (ADHD) (Chambless & Ollendick, 2001). Two approaches that have garnered some positive evaluation are behavioral parent training and behavior modification in the classroom. Behavior therapy programs for ADHD involve training parents in behavioral assessment, principles of reinforcement, and use of contingent punishments, such as time-outs. Teachers are similarly trained in methods of reinforcement, the need to modify expectancies regarding ADHD children, and environmental strategies, such as optimal classroom seating. However, there is some evidence to suggest that the use of medications in conjunction with or as an alternative to psychosocial interventions may be more beneficial in the long-term (Hinshaw, Klein, & Abikoff, 2002).

There are several treatments for conduct disorder and oppositional behavior that meet the APA task force guidelines for efficacious approaches including: CBT and cognitive problem-solving skills training, functional family therapy, multisystemic therapy, and parent management training. CBT for children has previously been described but essentially it entails the modification of thoughts and behaviors that may contribute to oppositional and defiant behavior and the development of more adaptive problem-solving skills. For example, aggressive

behavior is triggered by the attributions children make about an event in the environment. Children exhibiting oppositional behavior may be more likely to attribute hostile intent to others (Crick & Dodge, 1994). From a similar perspective, cognitive problem-solving skills training (PSST) involves deconstructing problems into manageable components and learning appropriate coping strategies through modeling and role-playing.

Functional Family Therapy (FFT) examines the function that problem behavior serves within the family system and for individuals themselves. Treatment involves developing more adaptive forms of communication and more supportive parent-child interactions. For example, therapists may emphasize a reduction in negative attributions and blaming behavior between the two parents and between each parent and their child (Kazdin, 2002). As the name suggests, multisystemic therapy (MST) addresses the overall systems within which the oppositional behavior exists, such as family, schools, peer groups, and the community at large (Kazdin, 2002). Treatment involves working with the family to improve communication skills, increase cohesion, and resolve any marital conflict that may be contributing to the behavior of the child. Additionally, treatment may address developing prosocial peer contacts through such resources as sports teams, community centers, and youth programs.

Parent management training (PMT) is based on principles of social learning and involves modifying parent-child interactions in positive ways (Feldman & Kazdin, 1995). Treatment includes psychoeducation, modeling of social learning techniques, and behavioral rehearsal of reinforcement and punishment techniques. Over the course of several sessions, therapists shape more effective skills with the parents and often provide between session phone contact to promote treatment compliance and successful implementation of strategies.

Physical and Sexual Abuse

In a cooperative effort, the National Crime Victims Research and Treatment Center at the Medical University of South Carolina, the Center for Sexual Assault and Traumatic Stress at the University of Washington, and the Office for Victims of Crime at the U.S. Department of Justice developed guidelines for the provision of evidence-based treatment for child physical and sexual abuse (Saunders, Berliner, & Hanson, 2004). Therapeutic programs were evaluated with a classification system similar to that used by the APA task force and other review groups. Two programs, one designed for abused children and one designed for adult molesters, met criteria for either well-supported or probably efficacious treatment. Trauma-focused cognitive-behavioral therapy has been proven effective for abused children by addressing attributions about the trauma, distorted cognitive thinking, and conditioned emotional experiencing. Graduated exposure techniques, cognitive reframing, parental involvement in treatment (for non-offending parents), and stress management techniques are integral to this treatment model (Deblinger & Heflin, 1996). Typically, children attend 12-16 therapy sessions which may be provided individually or in group settings. The adult child molester treatment program is based on principles of cognitive-behavioral therapy and involves replacing maladaptive thoughts and behaviors with "healthy thoughts" and skills. This approach utilizes several therapeutic strategies including: making environmental changes to reduce opportunity for relapse, modifying arousal patterns and dysfunctional beliefs, increasing personal accountability and motivation to change, providing relationship therapy and trauma therapy, and intervention for other problem areas (e.g. substance abuse, anger management) (ATSA, 2001). Typical duration for this treatment is one to two years of weekly individual and/or group sessions.

Conclusion

There may be helpful treatments available for the various mental health disorders and problems discussed that were not addressed by the APA task force or other reviews or that have not yet garnered adequate evidence to be considered. Additionally, it is important to note that the majority of treatment research literature evaluates efficacy rather than effectiveness. While efficacy allows for the study of therapeutic approaches with selected subjects in controlled settings, the results may have limited external validity in real-world settings represented by a full-range of patients and providers (Kopelowicz, Liberman, & Zarate, 2002). In particular, there is little information available on the successful treatment of older adults, people with co-occurring disorders, and ethnic or sexual minorities. As treatment research continues, the integration of effectiveness and efficacy research findings will likely illuminate our understanding of clinical best practice in the treatment of mental health across all populations.

Table 1: American Psychological Association’s Task Force on Promotion and Dissemination of Psychological Procedures Criteria for Identification of Empirically Supported Therapies (Chambless et al., 1998)

Well-Established Treatments:

- I. At least two good between-group design experiments must demonstrate efficacy in one or more of the following ways:
 - A. Superiority to pill or psychotherapy placebo, or to other treatment
 - B. Equivalence to already established treatment with adequate sample sizes
- OR
- II. A large series of single-case design experiments must demonstrate efficacy with
 - A. Use of good experimental design
 - B. Comparison of intervention to another treatment
- III. Experiments must be conducted with treatment manuals or equivalent clear description of treatment
- IV. Characteristics of samples must be specified
- V. Effects must be demonstrated by at least two different investigators or teams

Probably Efficacious Treatments:

- I. Two experiments must show that the treatment is superior to waiting-list control group
- OR
- II. One or more experiments must meet well-established criteria IA or IB, III, and IV above but V is not met
- OR
- III. A small series of single-case design experiments must meet well-established-treatment criteria

Experimental Treatments:

Treatment not yet tested in trials meeting task force criteria for methodology

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PRACTICE MAKES PERFECT? IDENTIFYING EFFECTIVE PSYCHOLOGICAL TREATMENTS FOR MENTAL HEALTH PROBLEMS IN INDIAN COUNTRY

JOSEPH P. GONE, PH.D. & CARMELA ALCANTARA

I think it basically boils down to pride. If people ain't proud of who they are, where they come from, and what they're doing, then they're gonna be doing these things: Alcohol. Drugs. And once you're into alcohol and drugs, you're gonna probably get into a depression and stuff. And you're gonna not feel worthy of being a human being. And you're gonna want to kill yourself.

--Winston (cited in Gone, 2004c)

As many Americans well know, this nation's tiny but diverse population of American Indians and Alaska Natives has endured centuries of colonial peril. Indeed, historical encounters of Native peoples with Euro-Americans in the U.S. frequently involved military conquest, reservation captivity, assimilation campaigns, resource theft, and numerous other dangers, both mortal and ideological (Jaimes, 1992). These experiences—some of which persist to this day—have collectively established and transformed the psychologies of contemporary tribal peoples, in many instances complicating, compromising, and confounding “mental health” in these communities (as testified to by the above quote from an elder on the first author's home reservation).

Although methodologically sophisticated research on the current incidence and prevalence of psychiatric distress or mental disorder in Indian country is difficult to come by (U.S. Department of Health & Human Services, 2001; Gone, 2003), anecdotal evidence suggests alarming rates of several kinds of psychological problems within this population, including mood disorders, substance use disorders, pathological reactions to violence and trauma, and suicide—recent evidence certainly attests to high levels of “frequent mental

distress” reported by Native respondents (Zahran, et al., 2004). Inasmuch as it remains an ethical and legal obligation of the U.S. federal government to provide health care services to citizens of federally recognized tribal nations (Pevar, 2004), the identification of state-of-the-art psychological treatments for mental health problems in Indian Country would seem crucial to ensuring that American Indians and Alaska Natives obtain reliably accessible and demonstrably effective therapeutic interventions in times of distress.

Unfortunately, the identification of “best practices” in the treatment of mental health problems for Native Americans is no simple endeavor. This chapter will canvass the scientific literature related to this effort, while simultaneously reviewing concepts and approaches that frame (and complicate) the worthy pursuit of best practices in Indian mental health service delivery.

Previewing “Best Practices”: Assumptions and Approaches

Clinical psychologists, psychiatrists, social workers and other allied mental health professionals are increasingly interested in incorporating “evidence-based practice” (or EBP) into their treatment of distressed clients (see McFall, 2000, for an exemplar from clinical psychology). Originating within professional medicine in the United Kingdom, EBP aspires to anchor clinical applications to the existing body of scientific evidence concerning therapeutic outcomes (Wampold & Bhati, 2004). For example, the American Psychological Association’s Division 12 (Society for Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures released a report in 1995 identifying “empirically validated” (or, in more contemporary parlance, “empirically supported”) treatments for a variety of psychological disorders based upon explicit evaluation criteria pertaining to the quality of the empirical

outcome literature associated with a given intervention (Chambless, et al., 1996). Treatments are considered “well established” if their therapeutic efficacy has been demonstrated to be superior to a placebo (or to be equivalent to an already supported treatment) in two or more randomized, controlled experiments undertaken by two or more research teams. Treatments are considered “probably efficacious” if their therapeutic efficacy has been demonstrated to be superior to a “waitlist” control group (instead of a placebo), or if only one experiment (instead of two or more) attested to its efficacy. The most recently published list of such treatments includes 108 well-established or probably efficacious treatments for adult psychological disorders and 37 for childhood disorders, including, for example, Exposure and Response Prevention for Obsessive Compulsive Disorder, or Interpersonal Therapy for Major Depressive Disorder (Chambless & Ollendick, 2001).

Not surprisingly, lists that are developed and disseminated by professional organizations such as this one have engendered fierce controversy because many mental health professionals have been accustomed to providing therapeutic services to their clients based *not* upon scientific evidence in support of their particular tools or techniques, but instead upon professional *conventions* that result from training, experience, intuition, and/or preference. Nevertheless, there is a compelling rationale for considering EBP as a superior alternative to these conventions. Allow us to clarify at the outset, however, that this rationale applies to professional interactions involving the “therapeutic triad,” in which *credentialed clinicians* provide *costly services* to *vulnerable clients* suffering from clinically significant psychological impairment or distress. The therapeutic triad recognizes that clinicians are *credentialed* (usually through Master’s or doctoral level training in accredited programs, plus professional licensure in the state in which they practice) precisely because they provide professional services that

presumably require expertise beyond the facility of the general public to evaluate independently—in such instances, the philosophy of “*caveat emptor*” is trumped by the quality control efforts of relevant civic and professional bodies. Furthermore, these expert professional services are understood to be relatively scarce and, therefore, *costly*—indeed, the majority of individuals experiencing diagnosable psychological distress in their lifetimes do not obtain specialized mental health treatment for their problems (Kessler, et al., 1994), owing in part to the limited availability and high cost of these services (U.S. Department of Health & Human Services, 1999). Finally, persons who obtain such services are typically contending with rather serious psychological disruptions in their lives and livelihoods—if ever we are in need of quality control and assurance to inspire our trust, bolster our confidence, and protect our interests, it is in these particularly *vulnerable* moments when sometimes even life and liberty are at stake. Thus, in instances properly characterized by the therapeutic triad, the professional obligation to provide the most effective therapeutic services available would seem beyond controversy or dispute.

Nevertheless, controversies and disputes arise because clinicians engaged in the active treatment of clients or patients (a) believe and proclaim that their services are in fact the “most effective” available (otherwise, they would not recommend them), and (b) disagree not infrequently with their colleagues about the treatment of choice for various psychological conditions or disorders (again, often based upon their professional training, experience, intuition, and/or preference). Obviously, in such circumstances some professionals—at least some of the time—are advancing erroneous claims on behalf of their “pet” therapies, approaches, or interventions (for provocative reviews, see Dawes, 1994; Garb, 1998; Lilienfeld, Lynn, & Lohr, 2003). The EBP movement in the mental health professions contends that

identification of the most effective therapeutic services available is a *scientific question* that should be answered through consideration of the results of experiments assessing the causal efficacy of mental health interventions. Readers who are less familiar with scientific approaches to mental health treatment may wonder what all the fuss is about: if we treat Patient X with Disorder Y using Intervention Z, and Patient X improves substantially over the course of treatment, isn't it obvious that Intervention Z was effective in curing Patient X of Disorder Y? Owing to a formidable array of cognitive biases, lapses, and limitations that routinely beset human inference (Dawes, 1994, 2001), the answer is, regrettably, no. Reliable attribution of cause and effect, especially in complex circumstances involving psychological experience, is extremely difficult (if not impossible) for humans to render casually or "off the tops of our heads."

For example, if Patient X is suffering from clinical depression (not transitory "depression" in the colloquial sense, but a constellation of signs and symptoms involving at least two weeks of significant disruption in affect, interest, and behavior), she may well improve over the course of therapy owing to changes that in fact occur independent of treatment (e.g., obtaining a better job, winning the lottery, ending an abusive relationship), or simply because individuals who often seek treatment when they are faring their worst could only be expected to improve over time, again independent of treatment (i.e., "regression toward the mean"). Worse yet, perhaps Patient X only supposes herself to have improved (despite contradictory evidence in her daily life that neither she nor her therapist fully recognize) because she wants desperately to believe that she is recovering, or to seem like a success story so as not to disappoint her therapist. In fact, the only way to be absolutely certain if Intervention Z cured Patient X of Disorder Y would be for an omniscient observer to travel back through time and withhold the

treatment (and *only* the treatment, ensuring not to alter anything else in the past) in order to determine whether Patient X this time around did not actually recover from Disorder Y. Absent this sort of fantastic impossibility, there is no definitive way to know whether Intervention Z cured Patient X—there are just too many *plausible competing explanations* for Patient X's recovery to afford clear and authoritative conclusions about the causal efficacy of the intervention in any given instance.

Instead, researchers seek to provide probabilistic accounts of whether treatments are “likely” to benefit individuals in distress by testing interventions on a group of patients and comparing their posttreatment results with the outcomes of a group of patients who did not receive the novel intervention. Throughout the history of medicine, professional debates about the causal efficacy of certain treatments—usually fueled by passionate references to training, experience, intuition, and/or personal preference—sometimes endured for centuries (e.g., the therapeutic advantages of wound debridement [reviewed briefly by Meehl, 1997]) before eventual resolution through this kind of scientific experimentation. For nearly two decades the use of streptokinase to treat myocardial infarction was professionally contested despite the fact that experimental evidence attesting to its efficacy was merely awaiting proper analysis to resolve the dispute definitively (Hunt, 1997, as cited in Wampold & Bhati, 2004). Had these data been properly appraised early on, countless lives might have been saved. In short, owing to the constraints of unassisted and undisciplined human cognition, the scientific experiment is the methodology of choice for reliably ascertaining causal relationships in the complex circumstances represented by therapeutic intervention in the health professions.

In the social and health sciences, the experiment is characterized by random assignment of research participants to either the designated treatment group or the comparison group that

does not obtain the treatment in question (but instead receives a different treatment or awaits treatment at the conclusion of the experiment). Random assignment is key to interpreting experimental outcomes because it alone ensures the “probabilistic equivalence” of the two groups, such that the only *systematic* differences among the participants that might account for post-experiment divergences in group outcome (assuming the experimental design remains intact) is the treatment itself (see Campbell & Stanley, 1963, for a classic discussion, and Kendell, Butcher, & Holmbeck, 1999, for a contemporary overview). Desirable indicators of treatment response, improvement, or recovery are specified in advance and measured as accurately as possible for each group both before and after the experiment. Between-group differences on these outcome measures are usually analyzed statistically to determine whether treatment effects were in fact identified according to prescribed research conventions.

Keep in mind, too, that in order to isolate the causal relationships involved in such outcome research, the conditions in randomized clinical trials (as these kinds of experiments are called) are often quite “artificial” compared to “real world” service delivery. For example, participants might be selected because they suffer only from the disorder of interest (while most patients suffer from additional “comorbid” disorders as well), or clinicians might be monitored for their adherence to the treatments being tested (while the practices of most licensed clinicians are not scrutinized at all), or psychological changes associated with treatment are rigorously assessed with objective tests and measures (while many therapists do not employ standardized outcome measures of any kind). Even though these decisions help to ensure that research results are interpretable by scientists relative to the causal relationships of interest, it is important to note that they also rearticulate the therapeutic encounter in ways that may or may not easily generalize to workaday professional practice.

In sum, having embraced the epistemological advantages of randomized clinical trials, the EBP movement aspires to relocate professional practice from the quicksand of clinical convention to the bedrock of incontrovertible evidence. Efforts such as the one undertaken by the Division 12 Task Force of the APA have specified evaluative criteria, reviewed the scientific literature, and published a list of empirically supported treatments for perusal and adoption by mental health professionals—similar evidence-based “effective practices,” “model programs,” and mental health “treatment guidelines” have been published by other government and professional organizations as well. Nevertheless, questions regarding the portability (or “generalizability” or “external validity”) of these interventions to workaday clinical settings have been raised (Garfield, 1996; Peterson, 1996), including their relevance for populations of color in the contemporary U.S. (Bernal & Scharron-Del-Rio, 2001; Coleman & Wampold, 2003). The principal goal of this chapter is to review the *Native-specific* literature on evidence-based “best practices” in mental health treatment for the most prevalent psychological disorders in Indian Country.

Reviewing “Best Practices”: Locating the Literature

From the outset of this endeavor, scientific literature describing Native-specific, evidence-based mental health interventions—deliberately excluding substance abuse treatments for separate coverage—promised to be an elusive quarry. For instance, in the most recent edition of the seminal *Handbook of Psychotherapy and Behavior Change*, Zane, Nagayama Hall, Sue, Young, and Nunez (2004) observed that:

Very few empirical studies have been conducted on the effectiveness of psychotherapy in the treatment of American Indians and Alaska Natives, and no research has

investigated the relative effectiveness of different therapeutic modalities. The need for outcome research is apparent given the proliferation and funding of a wide variety of treatment and prevention programs that have arisen to target the serious mental health needs of many American Indians and Alaska Natives. Given these efforts, the lack of research on outcome must be considered a serious problem. (p. 779)

Other recent overviews of Native American mental health issues have also attested to the dearth of published literature assessing therapeutic outcomes with this population (U.S. Department of Health & Human Services, 2001; Gone, 2003; Manson & Altschul, 2004).

Nevertheless, in order to ensure a systematic and comprehensive review of this literature, we undertook a series of on-line searches within four computerized bibliographic databases encompassing English-language citations of scholarly publications in the mental health field: PsycInfo, Medline, Social Work Abstracts, and the Social Sciences Citation Index. In order to accurately identify all of the Native-specific literature on “best practices,” the proxy descriptors “treatment,” “prevention,” and “intervention” were chosen since they were presumed to be inclusive of any associated terms used to catalog pertinent outcome studies. In addition, 12 descriptors of mental health problems were employed in the database searches based upon anecdotal evidence attesting to their prevalence in and relevance for Indian Country. More specifically, these problem descriptors included: mental disorders, depression, suicide, Posttraumatic Stress Disorder (PTSD), emotional trauma, child abuse, sexual abuse, Attention Deficit Hyperactivity Disorder (ADHD), antisocial behavior, conduct disorder, juvenile delinquency, and post colonial stress disorder. Finally, “Native American” and “American Indian” were the terms selected as racial group identifiers designed to limit search results to the Native-specific literature—use of these identifiers varied depending upon the database in

question (e.g., PsycInfo prescribed use of the latter rather than the former).

Searches employing the aforementioned descriptors within the respective databases (Computerized Database [4] x Practice Descriptor [3] x Problem Descriptor [12]) resulted in 144 searches, yielding 2,670 citations. These results were further supplemented by a manual search of the “Health and Mental Health Treatment and Prevention” section of a published bibliography of psychological abstracts pertaining to Native Americans (Trimble & Bagwell, 1995). Not surprisingly, many of these searches returned the same citations, all of which were meticulously checked for relevance to the task of identifying EBP in Indian country. Adoption of liberal (and, admittedly, somewhat subjective) inclusion criteria resulted in a corpus of 46 articles and chapters related to Native-specific mental health programs, interventions, and treatment approaches (see Appendix), excluding substance abuse treatment. This literature was classified as follows: (a) randomized controlled outcome studies ($n = 2$); (b) non-randomized and/or uncontrolled outcome studies ($n = 4$); (c) intervention descriptions ($n = 14$); (d) intervention overviews ($n = 2$); (e) clinical case studies ($n = 4$); and (f) intervention approaches ($n = 20$). By way of brief summary, this literature described prevention of maladaptive adolescent behaviors and suicide through the cultivation of coping skills and pro-social competencies; treatment of depression, trauma, and sexual abuse through both conventional and innovative therapeutic methods; application of extended family therapy, relaxation and assertiveness training, Eye Movement Desensitization and Reprocessing therapy, and stimulus fading procedures in single clinical cases; and implementation of innovative service delivery efforts within mental health treatment systems and settings in Indian Country.

Of particular relevance to the identification of EBP, of course, are the six outcome studies—the remainder of the citations may be interesting and useful from the perspective of

documenting programs or treatments that have been offered to Native American clients, enhancing therapeutic techniques presumably toward greater effectiveness in Indian Country, or designing novel and alternative helping interventions for mental health problems experienced by Native people, but none of these speaks to the question of scientifically-demonstrated therapeutic outcomes raised by the EBP movement. It is nevertheless interesting to note that the vast majority of these citations are not explicitly concerned with the assessment of therapeutic outcomes, and nearly half of them are observation or reflection pieces comprised of suggestions and recommendations for improving therapeutic services for Native Americans (with particular emphasis upon the cultural transactions implicated in mental health service delivery and the alternative community-based programs and organizational ecologies that might better suit Native American worldviews and cultural practices). In short, very few of these articles and chapters are *empirical reports*, and thus their value for identifying Native-specific, *evidence-based* mental health treatments is virtually nil.

Of the six outcome studies classified above, three (Centers for Disease Control and Prevention, 1998; Husted, Johnson, & Redwing, 1995; Kahn, Lewis, & Galvez, 1974) reported pre- and post-intervention results for a treatment group with no untreated group for comparison, thereby rendering valid inferences about the causal relationship of intervention to outcome in these instances nearly impossible (but see May, this volume, for an elaboration upon the suicide prevention effort described by the Centers for Disease Control and Prevention, 1998). In addition, one study reported outcomes related to the efficacy of a pharmacotherapy (methylphenidate) instead of a psychotherapy for comorbid ADHD and Fetal Alcohol Syndrome among Native children (Oesterheld, et al., 1998). Thus, the entire search for Native-specific, evidence-based mental health interventions yielded only two outcome studies with relevant,

interpretable results. Manson and Brenneman (1995) reported outcomes for an intervention undertaken to prevent clinical depression among older American Indians encountering health-related stressors in the Pacific Northwest. LaFromboise and Howard-Pitney (1995) reported outcomes for an intervention undertaken to prevent suicide among adolescent American Indians through life skills training in a school-based program in the American Southwest. Each of these preventive interventions is described in further detail below.

Manson and Brenneman (1995) adapted the mainstream, well established, and empirically supported Coping With Depression Course (Lewinsohn, Hoberman, & Clarke, 1989) for use with older Native American adults at risk for depressive symptomatology as a result of deteriorating health. Comprised of sixteen 2-hour weekly sessions, the adapted curriculum emphasized skills training toward progress in four areas: rehearsed relaxation, increased pleasurable activity, improved patterns of thinking, and cultivated social skills. In order to decrease the potential stigma of an intervention related to “mental health,” the Course was offered through a local tribal college for adult education credit—participants received tuition remission in the amount of \$10 per each session attended. Curricular resources included lectures, class activities, homework assignments, a textbook, and local community members who were trained as instructors—curricular materials were modified slightly for increased cultural relevance for this sample. Twenty-two participants (aged 45+, 19 females) from four Pacific Northwest reservations who reported moderate depressive symptoms and diagnoses of diabetes, arthritis, or coronary heart disease were randomly assigned to the treatment condition, while 26 participants comprised the wait-list control group—because the sampling strategy involved recruitment of only a subset of participants randomly assigned to the intervention condition, the design was quasi-experimental in nature. Participants were assessed

with a health-screening interview consisting of a host of relevant indicators (e.g., subjective health status, life satisfaction, depressive symptoms, etc.) pre- and post-treatment. Outcomes demonstrated that the Course participants experienced decreased depressive symptoms, decreased involvement in unpleasant events, and increased involvement in pleasant events (but did *not* report greater life satisfaction) in comparison to the wait-list control group, which evidenced statistically significant trends in the opposite direction for each of these indicators. Thus, despite the quasi-experimental nature of their research design and a relatively small sample size, Manson and Brenneman present reasonably compelling evidence in support of the efficacy of their adapted Coping With Depression Course for preventing depressive symptoms among older Native Americans confronted with chronic health problems.

LaFromboise and Howard-Pitney (1995) developed the Zuni Life Skills Development Curriculum for use with high school students at risk for suicide in the Zuni Pueblo in New Mexico. Comprised of close to 100 sessions offered three times weekly over the course of an academic year, the curriculum emphasized skills training toward progress in seven areas: identifying emotions, building self-esteem, increasing communication and problem-solving, eliminating self-destructive behavior, receiving suicide information, obtaining suicide intervention training, and setting goals. The curriculum—grounded in mainstream life skills training designed to prevent high-risk adolescent behaviors—was developed in close collaboration with community members to target risk factors for suicide and to ensure cultural relevance. Sixty-nine students in four classes were assigned to the treatment condition, while 59 students in four classes were assigned to the no-treatment control group—since neither students nor classes could be randomly assigned to these conditions (owing to institutional constraints), the design was quasi-experimental in nature. Participants were assessed with a

self-report survey consisting of a host of relevant indicators (e.g., suicide probability, feelings of hopelessness, depressive symptoms, etc.) pre- and post-treatment. Outcomes demonstrated that the Life Skills participants were less suicidal, less hopeless, and more skillful at suicide intervention and problem solving (but *not* less depressed or more self-efficacious) in comparison to the control group, though the attrition of roughly one-quarter of the original sample by the time of administration of the post-treatment assessment complicates the interpretation of these results. Nevertheless, LaFromboise and Howard-Pitney have achieved a remarkable degree of success in pioneering a collaborative and culturally grounded preventive intervention for over 100 Native adolescents in a reservation school system—their curriculum is publicly available (LaFromboise, 1996) and their intervention has been designated a “model program” (attesting to its status as an EBP) by the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services.

Two quasi-experimental prevention outcome studies notwithstanding, the results of our systematic bibliographic database searches attest to the rampant tendency of mental health professionals and researchers to critique conventional treatment modalities in order to recommend what are envisioned as more culturally relevant or sensitive—and therefore, presumably, more effective—service delivery options for Native American communities. In the absence of compelling empirical evidence indicating which treatments impart the most significant benefits to distressed Native people, however, the EBP movement insists upon caution and restraint in terms of professional endorsement of untested approaches and practices—no matter how promising or innovative—until rigorous evaluations are undertaken and reported in the literature. What then is the mental health practitioner to do when the press for adoption of EBP is frustrated by a scant empirical record; when, as Zane and colleagues

(2004) concluded, “it would be premature to try and address the question of the efficacy of mental health interventions” (p. 780) with this population because scientific research has yet to provide clear answers or precise guidelines regarding treatment outcomes for Native Americans with mental health problems?

Revisiting “Best Practices”: Reflections and Reconsiderations

During the planning meeting devoted to preparation of this monograph, a gathering of practitioners, researchers, and policy-makers with years of collective expertise in the arena of Indian mental health and substance abuse treatment discussed and debated the state of the professional knowledge base relative to EBP. One (usually implicit) point of contention was the epistemological status of evidence offered in support of claims about the efficacy of Native-specific interventions. Although nearly everyone agreed that mainstream, conventional mental health and substance abuse treatments required adaptation of one kind or another prior to implementation with Native clients or patients, consensus regarding the value and utility of scientific outcome assessments was more elusive. In the course of impressive presentations typically decrying the absence of empirical outcome evidence for Native-specific programs and therapies, some members of the workgroup asserted with escalating impatience, “We *already know* what works in these communities, it’s just a question of getting the federal funding agencies to recognize this expertise.” Clearly, these individuals believed that professional training, accumulated experience, clinical intuition, and personal preference are sufficient for inferring causal relationships between clinical intervention and therapeutic outcome. As a result, they considered the EBP movement—with its increasing control of mental health resources at all levels of health care service delivery—just one more example of Euro-American

arrogance and intrusion into the affairs of sovereign tribal Nations. In contrast, other participants in the gathering believed that the EBP movement facilitates greater accountability for claims of therapeutic efficacy and thereby provides a fundamental protection of vulnerable Native American clients in the context of the therapeutic triad.

The implications of these contrasting epistemological positions are indeed profound. If, on the one hand, professionals and researchers “already know” what works in Native communities, then the challenge before us is merely to persuade and/or compel those who control mental health resources either to abandon the EBP standards they have embraced or to afford exceptions to those standards for service delivery in Native American contexts—such an endeavor is *not* principally scientific but *political* in nature. On the other hand, if we remain fundamentally skeptical of our cognitive capacity to infer therapeutic cause and effect in the absence of compelling scientific controls, then the challenge before us is instead to determine how to most effectively conduct such inquiry and report such evidence so as to develop a corpus of Native-specific EBP in mental health and substance abuse treatment—for a variety of reasons, this endeavor is *both* scientific and political in nature, with the ultimate arbiter of decisions and recommendations being the quality and credibility of the science in question. As the authors of this chapter, we suspect that our own skepticism regarding the human cognitive capacity to render complex causal inferences is by now apparent and explains why we remain sympathetic to the EBP movement. We therefore recognize the pressing urgency to develop a robust empirical literature pertaining to intervention outcomes in the arena of Native American mental health. Nevertheless, we also believe there to be substantive reasons for reconsidering the call to EBP in Native American mental health.

We have already noted concerns among mental health professionals and researchers

regarding the external validity or generalizability of the outcomes of randomized clinical trials (RCTs) relative to actual clinical practice. These concerns seem intuitively legitimate in many instances, including those involving the transfer of treatments evaluated with middle-class Euro-American samples to working class or poor populations of color in the U.S. (though, as Manson and Brennenman [1995] have demonstrated, these concerns are not always substantiated—the cross-cultural portability of a given treatment is always an empirical question). At a minimum, then, the demonstration of positive therapeutic outcomes for an intervention through RCTs (i.e., the establishment of therapeutic “efficacy”) is only the *first phase* in identifying EBP; a second, crucial empirical endeavor is the establishment of parameters regarding the range of conditions and contexts in which the established causal relationship between intervention and outcome remains intact (i.e., the establishment of therapeutic “effectiveness” [see Lambert & Ogles, 2004]). Within the mental health EBP movement thus far this second phase has rarely been undertaken, particularly in regard to the portability of designated ESTs to U.S. ethnic minority clinical contexts.

A second, more substantive set of critiques and concerns addressed to the mental health EBP movement asserts that the designation of the RCT as the gold standard for the evaluation of pharmacological interventions in medicine cannot be meaningfully extended to the evaluation of psychotherapeutic interventions in the mental health professions (Peterson, 1996, 2004; Wampold & Bhati, 2004). The nuances of this debate are well beyond the scope of this chapter, but critics of the EST movement in professional psychology argue that the provision of psychotherapy to distressed clients differs substantially from the so-called “medical model” of physicians harnessing medical technologies for the treatment of their patients’ diseases in several ways. For one, there really is no psychotherapeutic equivalent to the placebo of

pharmacotherapy research since the psychological aspects of the client's experience, the presumed engine of the placebo effect, are precisely the targets of intervention in most circumstances—indeed, the “active ingredients” of a psychotherapeutic intervention have been difficult to isolate empirically. For another, the difficulties that motivate individuals to seek psychotherapeutic treatment may not best be conceptualized as diseases in the standard medical sense—indeed, effective intervention in mental health contexts may involve a great deal more than merely ameliorating “symptoms” of postulated psychiatric “illnesses.” Finally, critics have amassed a sizable body of empirical evidence to support their contention that specific treatment procedures or techniques employed by mental health professionals do not account for therapeutic change as much as the kind and quality of the *therapeutic relationship* (and other factors common to all psychotherapies) between clinicians and their clients (Norcross, 2002; Wampold, 2004). Rather than ESTs, these critics argue, mental health professionals should pursue EBP by prescribing ESTRs (empirically supported therapeutic relationships) instead of particular clinical techniques. In sum, according to these critics, the complexities of cause and effect in the context of psychotherapeutic intervention remain irreducible to overly simplistic technique-to-disorder outcomes (see Lambert, 2004, for an exhaustive review of these and related issues).

Finally, an even more radical perspective on Native-specific mental health intervention in particular would emphasize the current “postcolonial” political context of American Indian mental health service delivery (Gone, 2003, 2004a, 2004b, in press). More specifically, this perspective recognizes that the contemporary status of American Indian “mental health” remains significantly caught up in history, culture, identity, and (especially) spirituality, all in the political context of Euro-American colonialism. For example, Winston—the elder whose words

introduced this chapter (Gone, 2004a)—explained that drinking, depression, and other mental health problems on the Fort Belknap reservation are directly resultant from the loss of sacred custom and teaching due to the Euro-American “genocide” and forced “civilization” of Indian people. In such circumstances, the “medical model” for redressing the psychological problems of Native Americans seems even less relevant, given that epidemic rates of distress and dysfunction that afflict too many reservation communities clearly originated in the historical moment of U.S. colonial conquest and domination. A clear question thus arises: are the solutions to these seemingly *existential* exigencies properly formulated in terms of health care interventions? Certainly, Winston identified the solution *not* as more or better mental health services (which he skeptically dismissed as a modern form of neo-colonial “brainwashing”), but the return to sacred tradition and practice (from which a renewed sense of purpose, source of coherence, and semblance of continuity might be fashioned).

Within this radical reframing of contemporary Native American mental health problems, the role of EBP within the framework of the therapeutic triad is only of marginal relevance. Instead, mental health professionals dedicated to assisting American Indian communities might seek to embrace new kinds of roles and relationships to the citizens they seek to serve. Rappaport and Seidman (1983), who advocate a community psychology perspective (see also Rappaport & Seidman, 2000), have outlined several distinctions between traditional clinical services and community mental health and traced the implications of these distinctions along a continuum of mental health service delivery. For example, instead of extended psychotherapy, the strategy of service in community mental health is aimed at reaching large numbers of people through brief consultations and crisis intervention; instead of the clinician’s office, the location of intervention is practice in the community; instead of assuming an intrapsychic cause

of disorder, the etiological factors of interest are the environmental causes of maladaptation; instead of rehabilitative services or “treatments,” the type of service delivery is often preventative in nature; instead of professional control of mental health services, the locus of decision making is shared responsibility between professionals and community members; etc. Although the profound implications of an approach grounded in community psychology for Native American mental health service delivery are beyond the scope of this chapter (see Gone, 2003, for an extended discussion), they certainly suggest important alternatives in terms of professional roles and relationships that might render the current discourse of EBP much less salient even as they facilitate greater progress toward effectively redressing the postcolonial ills of contemporary Native American societies. As always, however, such progress will need to be charted through the rigorous scientific assessment of purported outcomes.

Conclusion

As the first author of this chapter has noted elsewhere, American Indian and Alaska Native communities require “a great deal more of the kinds of professional mental health services that do not yet exist” (Gone, 2003, p. 228). As our review has hopefully made clear, the EBP movement within the mental health professions has contributed much to clinical practice, providing therapists with scientific outcome evidence to substantiate their claims of efficacy for many state-of-the-art mental health interventions. A systematic survey of the scientific literature, however, indicates that treatment outcomes have not been empirically assessed or reported for Native American persons suffering many prevalent forms of debilitating psychological distress. What then are mental health professionals who are dedicated to service delivery with American Indian people to do? We have briefly discussed a variety of possibilities,

ranging from additional investment in efficacy and effectiveness studies of Native-specific clinical interventions to the professional adoption of alternative roles and relationships well outside of the framework provided by the therapeutic triad. In the end, these alternatives are together united by the scientific call for supporting professional claims through the empirical demonstration of positive therapeutic outcomes. To the extent that this epistemological commitment drives the EBP movement, its advocates and proponents have something important to contribute toward personal and communal healing and restoration in twenty-first-century Native America.

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Appendix: Native-Specific Mental Health Prevention/Intervention Outcome Citations (N=46)

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SUBSTANCE USE DISORDERS AND CO-OCCURRING DISORDERS: BEST PRACTICES FOR AMERICAN INDIAN/ALASKA NATIVE COMMUNITIES

JOE WESTERMEYER, M.D., PH.D. & BARBARA GRAHAM, PH.D.

State of the Art and Science

One of the earliest psychiatric practice guidelines addressed Substance Use Disorders (SUD) (Mirin et al., 1995). Published in 1995 and not since up-dated (McIntyre & Charles, 2002), it included a paragraph on comorbid psychiatric disorders among its 80 pages. A cogent half-page presents the challenges of discerning comorbid SUD and psychiatric disorders, since symptoms of both conditions commonly overlap. The guideline emphasizes the need to screen all psychiatric patients for SUD, and all SUD patients for comorbid psychiatric disorder. Ethnic and cultural aspects of diagnosis and treatment are absent.

Practice guidelines also cover many of the major psychiatric disorders. A group of them from the psychiatric literature includes Posttraumatic Stress Disorder (Foa, Davidson, & Frances, 1999), Bipolar Disorder (Hirschfeld, 2002), Eating Disorders (Yager, 2000), Delirium (Trzepacz, 1999), Borderline Personality Disorder (Oldham, 2001), Behavioral Emergencies (Allen, Currier, Hughes, Reyes-Hardi, & Docherty, 2001), and HIV/AIDS (McDaniel, 2000). These have been promulgated by several organizations, including the American Psychiatric Association (Hirschfeld et al., 2002; McDaniel et al., 2000; Mirin et al., 1995; Yager, 2001; Trzepacz, 1999; Oldham et al., 2001). The Journal of Clinical Psychiatry (JCP) (Foa et al., 1999; McEvoy, Scheifler, & Frances, 1999), and the Annenberg Center (Allen et al., 2001). Their methods vary, including more reliance on expert opinion and published research in the APA guidelines, to greater

reliance on clinicians' ratings in the JCP guidelines, to a combination of both in the Annenberg document. Regardless of source, method, or disorder, however, they contain minimal information and few guidelines about comorbid SUD treatment, and even less about the role of ethnicity or culture in assessment and care, as follows:

- *Posttraumatic Stress Disorder*: the importance of assessing PTSD patients for SUD is stressed, but it does not include methods for doing so; a few lines indicate clinicians' ratings of appropriate PTSD psychotherapies in the presence of SUD (Foa et al., 1999);
- *Bipolar Disorder*: a quarter-page documents the extremely high rate of SUD in Bipolar Disorder and emphasized the need for "concurrent treatment" (Hirschfeld et al., 2002);
- *Schizophrenia*: a few lines mention substance abuse in passing, as a possible indication for hospitalization and as a cause of hepatic dysfunction that might affect the pharmacotherapy of Schizophrenia (McEvoy et al., 1999);
- *Eating Disorders*: a single sentence documents that 30 to 37% of patients with Bulimia have a SUD, and 12 to 18% of patients with Anorexia have SUD; no mention of comorbidity in association with Obesity; a quarter-page on comorbid SUD calls attention to this high rate of comorbidity along with special problems in treatment, and calls for "concurrent treatment" of both the Eating Disorder and SUD, but does not further describe the nature of this concurrent treatment (Yager et al., 2000);
- *Delirium*: substance abuse is included in the differential diagnosis of Delirium, substances of abuse that cause delirium are listed, and it notes lab tests that can aid in diagnosis; management and care of SUD is not addressed (Trzepacz et al., 1999);
- *Borderline Personality Disorder*: half a page on presence of comorbid SUD and need for SUD treatment if present; recommendation that antidepressant medication or Buspirone

may less the need for “to resort to the use of alcohol or drugs” (Oldham et al., 2001);

- *Behavioral Emergencies*: three pages on the assessment and pharmacotherapy of acute intoxication; no information on differential diagnosis and care for withdrawal, overdose, or various complications (e.g., Korsakoff’s psychosis, drug-induced psychosis) (Allen et al., 2001);
- *HIV/AIDS*: SUD appears throughout this guideline as a risk factor for subsequent HIV/AIDS and as a common comorbid condition; risk reduction through preventing or treating SUD is emphasized; some details of SUD treatment are included (McDaniel et al., 2000).

An American Psychiatric Association practice guideline for the psychiatric evaluation of adults contains a paragraph on history-taking for SUD (Fogel et al., 1995). It contains no guidance regarding cultural or ethnic assessment, despite the earlier appearance of Appendix I in DSM-IV, describing a process for such evaluations.

Hundreds of research reports have addressed various combinations of SUD and comorbid psychiatric disorders, with only a few examples cited here (Arndt, Tyrrell, Flaum, & Andreasen, 1992; Biederman, Newcorn, & Sprich, 1991; George, Nutt, Dwyer, & Linnoila, 1990; Jordan, Davidson, Herman, & BootsMiller, 2002; Kessler et al., 1997; Kushner, Sher, & Beitman, 1990; Westermeyer & Eames, 1997; Westermeyer, Kopka, & Nugent, 1997; Westermeyer & Specker, 1999; Westermeyer & Tucker, 1995). Distilling this vast literature into practice guidelines is no simple task, especially since the available knowledge accumulates continuously. For example, one of us joined a team to prepare a text of comorbid Mood Disorder and SUD (Westermeyer, Weiss, & Ziedonis, 2002) due to the high prevalence of this particular comorbidity, the extent of research, and the paucity of publications for mental health

clinicians. This worthy effort required three years to complete.

The typical practice nowadays for comorbid disorders consists of extrapolating from two or three sets of guidelines in providing clinical care. For example, a patient with Alcohol Dependence, Major Depressive Disorder, and Social Phobia would need distinct treatment for all three disorders. A heavy dose of common sense is needed, as well. For example, a clinician would avoid use of benzodiazepines for the Social Phobia and utilize other approaches.

General Principles in the Care of Comorbid Disorders

At the current time certain general strategies for the SUD and its comorbidities are widely accepted in the health care field. The first of these (i.e., “concurrent care”) appears in a few of the practice guidelines cited above; the other strategies do not appear. These “best practices” have evolved over time. Some principles are the produce of common sense. Others are the result of hard-won experience, based on failures and successes in the care of patients with SUD and comorbid disorder.

Concurrent Care

For decades treatment for SUD and its common psychiatric comorbidities tended to occur in different settings. Moreover, different sets of clinicians usually provided the separate treatments. For example, a person developing psychosis or incapacitating mood disorder in an SUD treatment program would be referred to a psychiatric facility. Or a psychotic or suicidal patient noted to have SUD while being treated in a psychiatric facility might be referred to SUD program. This process was termed “sequential care,” as distinct from “concurrent care.”

At times sequential care managed to produce salutary outcomes. All too often,

however, serious, preventable problems ensued. The psychiatric facility may have lost sight of the patient's need for on-going sobriety, involvement in recovery activities, or the potentially addictive nature of certain psychotropic medications. Likewise, the SUD program may have ignored the psychiatric disorder with the result that the patient became over-stressed by the recovery program, or was induced to discontinue medications or psychotherapies needed for the comorbid disorder. These and other complications of some sequential care led to tragic outcomes, law suits, and disgruntled clinicians who avoided patients with "dual disorder" (i.e., comorbid SUD and other psychiatric disorder).

Remediating the blunders of sequential care resulted in a gradual switch to concurrent care for patients with dual disorders. Several factors accounted for this revolution in the care of the dual disordered patient. These changes included the following:

- SUD programs began to hire psychiatric consultants or staff members, who would evaluate patients presenting the SUD-related problems. In some settings, virtually all SUD patients had routine psychological or psychiatric evaluations. In these settings, SUD professionals would obtain consultation for special indications (e.g., development of suicidal ideas, repeated treatment failure, inability to engage in recovery activities).
- Psychiatric facilities established dual disorder programs and hired SUD professionals. Depending on the faculty, the SUD professional might routinely evaluate all patients, or only those patients identified as having a SUD.
- Health professionals trained in settings with "concurrent care" began to develop knowledge and skill in recognizing and treating both SUD and comorbid psychiatric disorders. Thus, beginning a few decades ago, a new generation of mental health clinicians eclipsed their mentors from two different, sometimes discordant fields.

- Formal programs appeared to train mental health professionals for competence in both types of disorders. Originally fostered by the NIH-sponsored Career Teacher Program, such programs now continue with diverse funding sources. Professional associations, new journals publishing on dual disorders, subspecialty training programs, and formal certification have provided a stable infrastructure for the care of dually disordered people.

Priority Setting

At times one or another of the comorbid disorders must be temporarily ignored while care focuses on only one of a few of all disorders present. One reason for doing so is that the condition is imminently life threatening or potentially disabling. For example, the acute care of a severely depressed patient in a hospital setting may involve minimal SUD care until the patient is sufficiently recovered from the depression. Or the acute care of Delirium Tremens may trump initiating care for a psychiatric condition.

There remains considerable confusion about priority setting in certain common combinations of dual disorder. The confusion results from an absence of research in the field or with research findings that are mutually conflicting. Examples include the following:

- Some evidence suggests that SUD patients with comorbid Nicotine Dependence should attempt total abstinence from all substances upon entering treatment (Joseph, Nichol, Willenbring, & Lysaght, 1990). Other evidence indicates that delaying care of Nicotine Dependence for a later time might be better.
- Many psychotherapists hold that psychotherapy during the first year of sobriety should be mainly supportive, since (1) brain recovery continues over several months

during early abstinence, and (2) therapy-induced stress may precipitate SUD relapse (Arif et al., 1988). Other therapists hold the early therapy for trauma-related disorders or certain Axis II Personality Disorders may foster sober recovery. Despite differences of opinion, most professionals in the field adhere to the notion of concurrent treatment. Differences in opinion mainly involve relative emphasis of various therapies or therapeutic approaches in the dual disordered patient.

Modifying Treatment

Concurrent care has changed both the SUD treatment field and the psychiatric treatment field from their former practices. This has resulted from greater appreciation of the morbidity induced by treatment under certain circumstances. When the two fields were separated by history, training, disciplines, and sites of care, they remained blissfully unaware of the morbid results that their ministrations could produce in selected patients. As they learned from one another, and as their trainees-in-common applied the lessons of both fields, these modifications became gradually accepted. For example, confrontation of an urgent, pressured type was widely practiced in the SUD field a few decades ago. Patients whose psychiatric conditions had severely undermined their self-esteem, confidence, and capacity to cope with stress either left SUD treatment, were made psychologically worse by such treatment, or both (Westermeyer, 1992).

Likewise, many psychiatrists prescribed benzodiazepine and other sedating medications for patients with comorbid SUD and certain anxiety disorders. Many of these patients then added these prescription drugs to those substances that they abused. This practice greatly complicated the SUD care of patients, who held that their psychiatric clinician had told them

they needed to take this medication.

These hard-won lessons taught clinicians that modified treatment could still be effective treatment. For example, the dual disordered patients may require and benefit from confrontation, but the timing and style of the confrontation can make a tremendous difference. Likewise, clinicians applying somatherapies for insomnia, pain, anxiety disorders, and other conditions can employ modalities that do not pose inherent risk of the patient's acquiring yet another addiction.

Early Recognition and Care as a "Best Practice"

Spontaneous Recovery

People can and do recover from SUD and other major psychiatric disorders without treatment (Ludwig, 1985; Stall, 1986). Experienced mental health professionals encounter patients who recovered from SUD or a depression earlier in life without formal treatment. A typical "spontaneous recovery" from SUD occurs when a person recognizes that he has serious problems associated with substance use and is able to successfully cease substance use. Some people seeking care for a mood disorder provide information of having an incapacitating mood disorder earlier in life that resolved after several months or a few years.

Several difficulties attend one's relying on "spontaneous recovery" as a route to renewed mental health. One problem is its relative infrequency, at least in regard to major disorders that are more than time-limited adjustment reactions to change or stress. For example, only 3% to 8% of people with SUD can achieve sobriety for a year or longer on their own.

A second problem is the duration of disability that often occurs. For example, patients recovering over time from Major Depressive Disorder are usually unable to work, to parent, or

to contribute to reciprocal relationships with relatives and friends. While waiting to recovery spontaneously (i.e., without treatment), people lose jobs, spouses and friends. If they have children, they are unavailable as supportive, responsible, and loving parents.

A third problem is that spontaneous recovery seldom leaves the sufferer with knowledge, skills, and experience to avoid a recurrence of the disorder. We learn about people's early experiences because they relapse and then cannot extricate themselves as they did earlier. In sum, relying on "self-help" or "spontaneous recovery" for major psychiatric disorders (e.g., SUD, Major Depressive Disorder, Panic Disorder, etc.) carries grave risk.

Comorbidity as Consequence of Delayed Treatment

Most major psychiatric disorders (excluding self-limited crises or adjustment problems) do not spontaneously resolve (Maser & Cloninger, 1990). One alternative is that the single disorder progresses in severity and disability. For example, a heavy drinker without problems becomes a problem drinker with an alcohol-related problem (e.g., a citation for driving under the influence), who in turn develops an Alcohol Use Disorder (with diverse, recurrent problems over time, along with inability to cease or moderate drinking). Or a person with a prolonged grief reaction goes on to develop insomnia, appetite and weight change, deteriorating memory and attention, inability to enjoy life, social withdrawal, and thoughts of death, perhaps later with suicide or psychosis.

Perhaps a more common scenario occurs when the untreated person with one psychiatric disorder develops a second disorder. The initial appearance of an Anxiety Disorder followed by a Mood Disorder is especially common (Maser & Cloninger, 1990). And if the second disorder remains untreated or treatment is delayed, a third or fourth disorder often

appears. The appearance of these additional disorders undermines the person's self-confidence, adds to the obstacles standing in the way of recovery, and makes treatment more difficult for the clinician.

Some disorders rarely present alone (i.e., without a comorbid disorder, in clinical settings). One example is Generalized Anxiety Disorder (Christian, Dufour, & Bertolucci, 1989; Kessler, DuPont, Berglund, & Wittchen, 1990), and another is Posttraumatic Stress Disorder. People seem able to cope with these disorders for a time by themselves. However, with time, an associated disorder develops either due to associated losses (e.g., Major Depressive Disorder), or attempts at self-treatment (e.g., SUD), or as a consequence of the first disorder (e.g., Panic Disorder, Social Phobia).

How Early is Early?

We all experience emotional, behavioral, and interpersonal vicissitudes in life. The death of a family member, a major occupational or academic failure, a divorce, a disabling physical condition, victimization or a natural disaster – these can cause distress that lasts months or even years. However, most people most of the time can resume usual responsibilities with weeks or a few months of such events. During this time, it may not be possible to identify those individuals who will bounce back from those who will not. However, it does become apparent with time – and usually within a month or two.

Persistence of incapacitating misery, anxiety, fear, or substance use beyond a few months warrants help seeking. If the patient or family is not sure that treatment is warranted, a single consultation can be helpful in providing information and reassurance. Or if the clinician is not sure that a disorder yet exists, a follow-up session can be conducted. Most clinicians do

not want to make an unsubstantiated diagnosis or initiate unneeded treatment.

Whose Responsibility?

It seems reasonable to expect that the individual should take responsibility for seeking care. However, many suffering people are not automatically aware that they have a treatable condition. Or perhaps they view their misery as part of their constitution, or their personality, or a punishment for past misdeeds. Of course, once the person has been informed that they have a particular condition and understand the need for and means of treatment, it is reasonable to expect them to be responsible for seeking care and complying with recommended treatment. Until that time, however, it often falls to others to foster early consultation.

Family members and friends are often key in motivating the suffering individual to seek care. Of course, this requires that friends and relatives manifest the following:

- an understanding of signs and symptoms that indicate the possible presence of a behavioral, emotional, or mental problem;
- knowledge of available resources that can conduct a skilled mental health assessment and facilitate appropriate care;
- the will and skills to discuss their concerns with the suffering person.

The *first need*, recognition of signs and symptoms, is a key element for a population to make maximum utilization of mental health services. An informed populace is more important than access to skilled clinicians. If the people are not knowledgeable and informed, skilled clinicians cannot perform their role effectively. Patients either do not come, or come so late that treatment may not remediate the accumulated problems. In Indian Country, this knowledge can be fostered through grade school and high school education, through local churches and

associations, and through local newsletters, posters, and radio programs.

Suffering individuals, friends, and relatives cannot by themselves make skilled mental health services available. That task falls to community leaders. This may not be a readily achieved goal in Indian Country. Rural mental health care for all segments of the American population is a challenge. Telepsychiatry services, telephone consultations-liaison, and circuit-riding consultants have greatly improved mental health care in rural areas.

Many American Indian communities have access to a local mental health counselor, primary care clinicians, and social workers, and clergy. With training and experience, these professionals can provide acute "crisis intervention" services, followed by referral to mental health services.

Am I My Brother's Keeper?

The *second need* involves the courage to intervene in the case of a suffering friend or relative, if he or she does not do so on their own. Many Americans have difficulty broaching the matter of another person's mental health needs. Individualism and the importance of autonomy and independence have impeded our acting as brother's keeper. Among some tribal groups, this value is extremely strong, based in a central belief in and respect for the individual and his or her decisions. The following case exemplifies the personal struggle that these strong values can engender.

Case Example. Mr. A. was the eldest of seven children, raised on a large, traditional reservation. The family had been a close-knit unit, with supportive parents. During a period of economic reversal, his father was laid off from work. During this time, the family fortunes took a turn for the worse. Mr. A, then just beginning his adolescence, took odd jobs to contribute to the family finances. His parents' drinking increased, as his mother joined his father in lengthy binges. Mr. A. become the functional parent, getting the children off to school, getting food from relatives, cooking and cleaning

house, making sure that his younger siblings got off to school. He hoped that by keeping the family together, his parents would get by this low point in their lives and resume their lives as responsible adults and parents. Over a weekend a crisis occurred when his mother took off with another man. His father, still hung over from the night before, sat in the front room one winter day, as the children studied, played, or listened to the radio. He got up slowly from the couch; Mr. A watched him carefully, since it was extremely cold outside and he wanted to ensure that his father might put on a hat, coat and gloves before going outside. To his horror, his father took down a shotgun and a shell, then went to his place back on the couch. The children continued playing at their activities, but Mr. A. watched, frozen, as his father practiced cocking the gun, putting the barrel in his mouth, and pushing the trigger home with his toe. Next his father slowly opened the chamber, inserted a shell, then repeated the process, dissolving his face in a morass of blood and amorphous flesh and blowing a large hole in his head. Following the father's death, the children were distributed to various relatives and foster homes; they never reconstituted as a family. Mr. A., in his first marriage, replicated the life of his father, marrying, having children, becoming unemployed, then alcoholic, followed by marital problems, his wife leaving him, and the loss of his children. He did not seek treatment on his own, but eventually had to be hospitalized with Delirium Tremens. Subsequently he went to live in an American Indian-run halfway house. A year later, while in training to become an alcoholism counselor, he sought timely treatment for an evolving depression. A major theme in his care was his growing doubt about his inaction at the time of his father's suicide. He knew that he was strong enough to grab the gun from his father, or to grab the shells, to run from the house, and sling them in a snow bank. But at the time, he knew that his father had made a decision and that he had to respect that decision. In retrospect, however, he saw that his father could be helped, that his decision was not the result of clear mind and rational thinking. Its devastating effect on Mr. A., his siblings, and his family was a tremendous price to pay. His personal grief and self-blame found resolution in the education of American Indian families to intervene in such cases, and to intervene early.

Culturally Competent Mental Health Care

A *third corner* of early care assumes the availability of and access to culturally competent mental health care. People in Indian Country may have special challenges in this regard. First, many states and even counties and cities are blind to the needs of American Indians. Even though they are taxpayers in these communities, many non-Indian community leaders view health services as being solely the province of American Indian people themselves, their employers, and the federal government. Second, some non-Indian professionals do not manifest cultural competence in the care of their American Indian patients. Third, the hand-off

from one clinician to another or one system to another may not be automatic, so that patients fall through the cracks.

Indian families and communities are harmed by delayed care. Mental health problems virtually never affect a single person. They affect that person's friends, brothers and sisters, children, spouse, relatives, neighbors and friends. The inability to help distressed or distressing friends and relatives can itself become a demoralizing experience. Each disabled family member robs the family and the community of a person whose efforts are needed to serve the family and community.

Types of Disorders and Comorbidities

SUD, depression, and anxiety disorders comprise the most prevalent psychiatric disorders. Each of them is eminently treatable. And each of them tends to progress or recur over time if left untreated. In addition, these disorders tend to co-occur over time if the original disorder is neglected.

Substance Use Disorder

Substance use Disorders are common in many American Indian communities. These include especially the Great Plains tribes and the urban areas to which they relocate (Christian et al., 1989). However, some tribal groups have rates that resemble those of the general American populations or are even lower. These include some of the southeastern groups, those in eastern Oklahoma, and in remote areas of the Navaho reservation where traditional life remains intact to a considerable extent (Kunitz et al., 1994). In some the latter settings, mood and anxiety disorders may be more common than SUD.

Major Depression and Anxiety Disorders

Major Depression and Anxiety Disorders vary greatly in various cultures around the world (Radford, 2004). Thus, it is not a foregone conclusion that American Indian groups will have rates of Mood and Anxiety Disorders like those of the general American population.

Depression may be less of a problem among some American Indian groups as compared to the general population. The evidence for this remains sparse, but consistent. This may not be atypical, since rates of depression range greatly around the world. Asian populations in particular have rates of depression that are a half or a third those of Europeans and others (Radford, 2004). In any event, depression is not rare among American Indian groups. However, it can lead to serious consequences if unrecognized and untreated.

Certain kinds of anxiety disorders may be more common in some tribal groups, as compared to the general American populations. Panic Disorder, Social Phobia, and PTSD are three of the anxiety disorders which some studies have suggested may be more common among American Indian people.

Psychoses

Two other disorders are relatively infrequent, affecting only about 1% of the total population, (i.e., Schizophrenia and Bipolar Disorder). Although these conditions are much less frequent than the main groups described above, they are notable for starting at a young age (teens or twenties), rapidly undermining the person's competence to function in society, rife with social and personal consequences if left untreated, and particularly demanding on the community and its resources (e.g., law enforcement, health services, social services). As with

the other disorders, SUD, depression, and anxiety disorders are especially apt to co-occur. Timely treatment, outreach, and support services are needed for optimal outcomes.

Associated Problems: Suicide & Violence

Certain syndromes, clinical presentations, or circumstances prevail in some American Indian communities. One of these is a high suicide death rate among adolescents and young adults, especially males. High death rates in close-knit extended families can produce prolonged periods of grief and loss, as one death follows another. “Grief binges” can undermine a stable recovery and create a family crisis.

Cultural Resources in American Indian communities

American Indian families and communities have a plethora of cultural resources that they can employ in coping with the problems described above. Although these resources are specific to tribes and communities, their general attributes and characteristics are found in all cultures (Weine, Ware, & Klebic, 2004).

A strong *ethnic identity* can foster self-esteem and confidence when facing behavioral, emotional, or mental problems. Many American Indian people have strong ethnic identity, reinforced by communal ceremonies (such as pow-wows), access to skill-based activities that enhance self-confidence (e.g., quilling, fishing, hunting, gardening, beading), an intact verbal tradition, and loyal extended families.

The Indian Health Services comprises an entitlement that only American Indian people can access. Although it has been heir to fiscal shortages and political machinations, it remains the rural health care system par excellence in the United States. Many rural non-Indians view

this resource enviously. It can comprise an at-hand resource for mental health acute care, triage, and referral. Once a mental health problem is stabilized, the IHS and other primary care clinics can provide the bulk of services.

Culturally and scientifically informed pharmacotherapy can facilitate recovery in some settings. For example, a common problem among those attempting to achieve sobriety at home in their own reservation or neighborhood is the social pressure to drink. Friends and relatives may view the refusal to drink as a personal rejection, accusing the newly abstinent person of “acting holier than thou” or “acting like a White man.” Disulfiram can provide an understandable excuse for passing up a drinking party, since most heavy drinkers are aware of the drug and its consequences should one be so imprudent as to drink while taking it. It also alerts the drinking party to the seriousness of the person’s problems with alcohol, and educates them regarding alcoholism as a disease and its treatment.

Increasingly, clinicians appreciate that the early phases of recovery involve bouts of insomnia, reduced pain threshold, anxiety, and loss of energy. Clinicians in the past, focusing solely on symptom relief rather than diagnosis and appropriate treatment, prescribed addictive drugs such as sedatives, opiate analgesics, and stimulants. This still occurs unfortunately, but less than in the past. Professional education, longer periods of training and supervision for primary care clinicians, and lawsuits have greatly reduced this problem in the last few decades.

Cultural Recovery

Cultural recovery is a significant part of stable recovery from SUD. Although it may not be feasible in the first few months or even years of sobriety, it is key to ultimate psychosocial recovery. Cultural recovery involves the following:

- engaging again in the activities of the community (e.g., attending ceremonial events);
- making peace with relatives, friends, and neighbors;
- making contributions to the community, perhaps by assisting others who are attempting to recover.

Some recovering individuals find that they cannot achieve recovery in their home community or a familiar culture. For some months or a few years, the “culture of recovery” may serve as their primary identity group, providing companionship, values, opportunities for service and achievement, and social support. During this time, friends and relatives should deed the recovering person the time and space to recover. This period is not meant as a denial or denigration of one’s culture, but more the need to set sobriety as an arching goal, the goal of one’s total existence – at least for a time.

A small percentage of recovering people will not want to return to their culture-of-origin. The reasons are as diverse as there are people. They may find another setting that suits them better. Or their culture-of-origin is too filled with disturbing memories. Or they marry into another group. Or they become highly successful in another setting, realizing the success that may have escaped them at an earlier phase of life. Relatives and friends can help by not perceiving this as a reflection of who and what they are. Rather it calls for respect of a highly individual decision, built certainly on bedrock of tears and joy, despair and hope, failures and successes.

Complementary-Alternative-Traditional Therapies

Indigenous rituals and ceremonies can prove highly effective in signaling a life change,

garnering support from friends and relatives, and seeking help in ways that are familiar and reassuring. Examples abound of American Indian people with SUD and comorbid disorders who have recovered from adherence to the Native American Church, a year-long preparation for a Spirit Quest or a Ghost Dance, or a rebirth ceremony following a period of sobriety and rehabilitation. These cultural resources can be powerful, healing events that affect not only the suffering individual but also the family and community who have suffered with (and sometimes by) the recovering individual.

By the same token, these cultural resources seldom act in a miraculous way, unattended by preparation and other efforts at sobriety. For example, it seldom works to refer an unwilling person to such indigenous therapies. Relying totally on these interventions is like relying totally on a self-help group, or on a medication, for a dual disorder. The following case exemplifies this situation.

Case Example. A 22-year-old American Indian man had dropped out of college three times as his drinking problems mounted. His parents, both alcoholism counselors, sought medical care for detoxification. They then planned to bring him to a healer in Canada who had been treating American Indian alcoholics. However, the son was adamant against going and instead insisted on maintaining contact with the clinician who had treated his withdrawal symptoms, asking for brief weekly visits. Within two weeks it became apparent that the young man had become severely depressed, with urgent suicidal impulses. Following treatment of his depression, he was able to continue with this recovery from alcoholism and continued his college education.

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BEST PRACTICES FOR CO-OCCURRING DISORDERS IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

MARIA YELLOW HORSE BRAVE HEART, PHD,

Introduction

GT is a 43-year old divorced full-blood American Indian male who has been in alcohol recovery for over 10 years. He has a history of physical abuse and neglect by alcoholic boarding school survivor parents. Although his father has been dead for a number of years, due to alcohol-related health problems, GT's mother died about six months before he sought treatment, also due to cirrhosis, despite her sobriety for one year before her death. GT came in for mental health services because he had been experiencing suicidal impulses, had been feeling depressed, and had been unable to cry. GT was placed on antidepressant medication but did not find it to be helpful in alleviating his symptoms and the suicidal thoughts persisted. GT dated the onset of his symptoms to four days after a traditional grief resolution ceremony; the ceremony was held prematurely by a relative who did not want him to suffer. Instead of observing the traditional time of one year after the death for the ceremony, which provided time for the bereaved to mourn, the ceremony was held at six months. GT felt that the ceremony worked in that he was no longer able to cry but that this was premature and hence his stunted grief expression turned into a depression.

GT was very involved in traditional spiritual practices ever since he became sober and found that traditional ceremonies helped him maintain his sobriety. GT decided that his sessions with the mental health therapist and the medication were not helping and arranged to have a healing ceremony. During the ceremony, GT was told that his mother's spirit was returning to take him out of his misery because she felt guilty about the pain she had caused him as an abusive alcoholic mother and she did not want him to suffer anymore. The traditional healer explained that the suicidal impulses were the impact of GT's mother's spirit trying to take him with her. In the ceremony, GT's mother was asked to leave him alone as he had more work to do on this earth and that he needed the freedom to grieve but would be fine. The spirit complied. After the ceremony, GT was again able to cry and work through his grief without the help of antidepressants, therapy, and with no signs of depression or suicidal thoughts. GT has had no symptoms of depression since the ceremony.

American Indian/Alaska Native concepts of best practices for co-occurring disorders may be divergent from the dominant cultural paradigm. Indigenous concepts frame Native experiences of practices as well as what criteria they may use to determine intervention effectiveness within a traditional Native cultural framework. For centuries, Natives have utilized

indigenous holistic healing interventions to ameliorate physical as well as spiritual, emotional, and mental problems. Consequently, the concept of co-occurring disorders, i.e. that substance abuse (including alcohol) and mental health disorders can exist simultaneously, is congruent with traditional Native thought. Indigenous views of illness include a holistic frame of reference, with disorders being seen as multi-determined. Illness is typically seen as a disruption in the balance among physical, spiritual, mental, and emotional realms of the person's existence and reality. Within Native frameworks, one could have a disorder with physical manifestations as well as emotional and mental impairment; questions would be generated regarding the person's spiritual health as a possible underlying cause. Traditional spiritual healing interventions address the whole person.

The case example described at the beginning of this paper illustrates indigenous explanations of depression and suicidal impulses in an individual with the co-occurring disorders of alcohol abuse in remission and acute major depression. Therapy and antidepressant medications, typically viewed as effective interventions, did not ameliorate the client's symptoms. Instead, a traditional healing ceremony was highly successful and resulted in a healthy resolution of the client's grief as well as his depression. In this example, an evidence-based non-Native practice was ineffective with this traditionally-oriented Native client, suggesting the need for Native-designed interventions for co-occurring disorders.

This paper addresses several issues regarding the development and evaluation of Native best practices for co-occurring disorders of mental illness and substance abuse. First, the paper provides an overview of some of the challenges Native programs face in evaluating and designating best practices. Then, the paper briefly discusses co-occurring disorders among Natives. Next, a cursory review of relevant literature on non-Native best practices is presented

and then challenges inherent in the process for becoming designated as a best practice are elucidated. A description of a few Native practices which address co-occurring disorders follows. The paper concludes with a discussion regarding the future of Native best practice research and recommendations for further action.

Overview of Issues in Developing and Evaluating Native Best Practices

Evaluation of Native practices is complicated. There are certain taboos about sharing information regarding the process and content of ceremonies which make evaluation of these practices challenging. Some tribal communities have been successful at conducting evaluations of interventions that include traditional healing components, selecting information to share without violating traditional cultural taboos and also respecting the sacredness of traditional healing. This author has been involved as a facilitator for the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Targeted Capacity Expansion Grant Native project evaluation. This group of grantees successfully designed a Native evaluation of substance abuse treatment effectiveness, using data elements that included a broad frame of "traditional cultural practices." The results were promising and indicated that the cultural practices were perceived as helpful in reducing substance abuse and the projects did, indeed, reflect data indicating a reduction in abuse. SAMHSA's Rural, Remote, and Culturally Distinct Native grantees also wrestled with the issue of evaluating project success while respecting the sacredness of traditional interventions. Gossage, Alexius, Monaghan-Geernaert, and May (2004) describe one of these tribes' efforts in utilizing traditional healing for substance abuse and their evaluation efforts. Qualitative and subjective measures revealed more positive outcomes than the quantitative scales, suggesting the need for tribes to develop and validate Native-specific

culture measurements.

Criteria for effective outcomes may also be different from the dominant cultural framework for best practices. Native concerns might include such things as the degree of the intervention's responsiveness to the community, inclusiveness of extended kinship networks in the healing process, accessibility of the intervention to the community, trust and confidentiality concerns, and the like. Current methods for determining which interventions are recognized as best practices are dominated by Western scientific models, ideas, and paradigms. The process for applying to become a best practice can be intimidating to Native project staff. Given the challenges of qualifying as a best practice and the dilemma of traditional cultural taboos which may restrict the examination of some intervention components, cultural sensitivity is critical as well as appropriate adaptation of best practice criteria and the process for designating Native best practices.

Evidence-based non-Native models are often alleged to be effective with Natives; these models are typically not culturally grounded nor sufficiently tested with the population (Yellow Horse & Brave Heart, 2004). Native communities are often required by funding agencies to utilize and culturally adapt models normed with non-Native populations and which emerge from a dominant cultural paradigm. Maintaining fidelity to these models may limit meaningful cultural modifications and instead cultural adaptation typically involves superficial changes such as substituting terms with Native words or using Native designs on intervention manuals. Consequently, the model remains inherently non-Native with non-Native values and worldviews. The efficacy of culturally grounded Native models most often have not been demonstrated, in part because of limited resources. Further, Native communities struggle with the legacy of insensitive non-Native researchers and are hesitant to subject their populations to more

research.

Native culturally grounded practices emerging from indigenous worldviews show great promise as they incorporate an understanding of Native values and norms for relationships and behavior and are often designed by Native communities for their own population (Yellow Horse & Brave Heart, 2004). Mental health in a traditional Native context may not be the same as defined in a dominant cultural paradigm. For example, mature, psychologically healthy Native behavior in a number of tribes includes generosity, interdependence, valuing the good of the community over oneself, humility, and respectful reserve in front of strangers, which could be misconstrued as dependency, masochism, passivity and withdrawn behavior, and depression by non-Native therapists (Brave Heart, 2001a; Brave Heart, 2001b). There is significant value in Native designed practices which utilize appropriate culturally informed assessment and intervention approaches. Native recipients of these interventions report perceptions that such Native models are effective. However, such practices often have never been sufficiently evaluated to advance them to the level of being promising or evidence-based.

Although there are a number of programs specifically addressing the mental health needs of American Indian children and families (Yellow Horse & Brave Heart, 2004), there are few that explicitly or specifically address co-occurring disorders for Native adults. Alaska Native focus groups defined best practices for co-occurring substance abuse and intergenerational trauma as those incorporating traditional customs and indigenous healing practices in concert with suitable non-Native healing approaches (Segal, 2003; Yellow Horse & Brave Heart, 2004). Although literature on traditional Native healing practices for mental health disorders is limited, studies on substance abuse treatment for Natives have established that cultural factors are important elements related to treatment outcome (Segal, 2001; Segal, 2003). Gutierrez, Russo,

and Urbanski (1994) found a higher substance abuse treatment completion rate among women practicing traditional Native culture.

Co-occurring Disorders among American Indians and Alaska Natives

Substance abuse and dependence may co-occur with Posttraumatic Stress Disorder (PTSD); the traumatized person attempts to numb their emotional pain with substances (Brave Heart, 2003; Segal, in press). PTSD is associated with an increase in marijuana and hard drug abuse in adolescents and the risk for substance abuse increased in adolescents who had been victimized through assault or who had witnessed violence; further, victimized youth began using substances at an earlier age (Kilpatrick et al., 2003). Traumatized adolescents such as victims of child sexual assault and first-degree relatives of PTSD trauma survivors have a higher prevalence of substance use disorders as well as anxiety and mood disorders (Yehuda, 1999). Children of substance abusers manifest signs of depression, with an increased prevalence of suicide attempts (Segal, in press). Childhood sexual abuse reported among boarding school survivors is a significant risk factor for substance abuse as well as depression, and/or anxiety disorders (Brave Heart, 1999a; Brave Heart, 1999b; Brave Heart, in press; Robin, Chester, & Goldman, 1996). Substance abuse and depression are correlated with PTSD (Brave Heart, 1999b; Brave Heart, in press; Robin et al., 1996) and high trauma exposure is significant among Natives (Manson et al., 1996). Common diagnoses for Natives at one urban clinic included mood, anxiety, substance induced, and substance abuse disorders (Duran & Yellow Horse-Davis, 1997, as cited in Brave Heart, 2001a).

Physical illnesses often co-occur with psychiatric and substance abuse disorders. Depression and PTSD often co-occur with heart disease, and Type II diabetes appears to be impacted by stress hormones such as cortisol which interferes with the body's use of insulin;

cortisol is elevated in traumatized individuals including those with PTSD (see Brave Heart, 1999b; Brave Heart, 2003; Brave Heart, in press). PTSD prevalence among Natives is 22% compared with 8% for the general population. Among Native veterans, PTSD rates are significantly higher than African Americans and the general population (Office of the Surgeon General, 2001). Oppression and racism exacerbate PTSD among African Americans (Allen, 1996). African Americans experience greater trauma exposure which increases with lower socioeconomic status and shorter life expectancy; darker skin color negatively impacts socioeconomic status (Brave Heart, 2003; Hughes & Hertel in Brave Heart, 1999b). Like African Americans, Natives have these similar risk factors for trauma exposure, including elevated mortality and substance abuse rates; the high degree of trauma exposure among American Indian youth has been documented by Manson and colleagues (1996). Additionally, Native community trauma exposure and PTSD were found to be elevated, with 82% of the sample having been exposed to at least one traumatic event and PTSD prevalence at 22% (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). One study in an urban area found high rates of trauma exposure among Native women being treated for substance abuse disorders; 69% of the women reported a history of sexual abuse and 86% reported physical abuse histories (Saylor & Daliparthi, 2004). Co-occurring mental health and physical illness is an emerging focus in some Native projects. The role of trauma in HIV/AIDS risk factors for American Indians in an urban area is being posited and research in this area is recommended (Clark & Stately, 2004).

Native communities are increasingly recognizing the role of underlying intergenerational trauma in co-occurring disorders and are increasingly making attempts to address what they view as the root cause of many of these disorders. The theory about an intergenerational

massive group trauma response, also referred to as *historical trauma*, evolved from clinical experience, observations, and Native-centric qualitative and quantitative research (Brave Heart, 1998; Brave Heart, 1999a; Brave Heart, 1999b; Brave Heart, 2001a; Brave Heart, 2003; Brave Heart, in press; Brave Heart & DeBruyn, 1998; Brave Heart-Jordan, 1995). Historical trauma theory responded to the deficiency in PTSD taxonomy, which inadequately represents generational and chronic Native trauma as well as the cultural influences on symptom presentation (Brave Heart, 1999a; Manson et al., 1996; Robin, et al., 1996). The “boarding school era” beginning in 1879 (see Brave Heart, 2001a; Brave Heart & DeBruyn, 1998; Tanner, 1982), included the forced removal of Native children under federal policy and their placement in residential schools, where they experienced physical and sexual abuse, starvation, incarceration, emotional deprivation and separation from family and tribal communities. The current generation of Native adults has descended from this legacy; many have themselves survived their own negative boarding school experiences.

The following case illustrates trauma across three generations and the application of the dominant cultural paradigm in the diagnosis of gender identity disorder for this Native boy with co-occurring substance use (Brave Heart, 2001b).

Joel, an 11-year-old full blood American Indian male with short dyed blonde hair and glasses, presented with exaggerated feminine behavior. Joel was referred because of problematic behavior, poor grades, and pregnancy fantasies which he shared with female peers with whom he associated exclusively. Joel abused alcohol and would attend late night parties. Joel boasted about his precocious escapades and gossiped about the latest reservation scandals.

Joel avoided discussing his neglectful alcoholic mother, whose current whereabouts were a mystery. He was being raised by his well-meaning but overwhelmed maternal grandmother, Mrs. A, who was a boarding school survivor. Two years ago, Joel was sexually abused by a gang of older boys at a BIA boarding school. Consequently, Mrs. A. brought Joel back to the reservation day school.

In boarding school, Mrs. A had been taught that she needed to abandon her Native culture, spirituality, and language through strappings. Mrs. A had

embraced Catholicism. She had consulted with the local priest who was admonishing her to send Joel to a Catholic boarding school to "straighten him out." However, Mrs. A's Native belief system remained with some tenacity; she felt that Joel may be special in a traditional way, a [transsexual]. Mrs. A was conflicted, part of her wanting to hold a ceremony for Joel to find out if he was a [transsexual]; in her Native tradition, this was a sacred and special role for Joel but could only be true if he had certain dreams and if a traditional healer could interpret this as the underlying reason for Joel's effeminate behavior and pregnancy fantasies. Joel's conflicts about his identity, without the affirmation of a ceremony and then acceptance of him as a transsexual by the traditional community, were acted out through substance abuse and other behavior problems. Joel's dyed blonde hair, which was not the style at that time, may have also reflected a rejection of or conflicts about his Native identity. Although Joel's history was consistent with a diagnosis of gender identity disorder -sexual abuse, abandonment and emotional unavailability of the mother, self-hatred, and generational trauma (Coates, 1992; Coates, Friedman, & Wolfe, 1991) - a traditional ceremony may have reduced stigma for Joel and provided a more socially acceptable outlet for Joel's developing transsexualism and his probable homosexuality (Brave Heart, 2001b).

Literature on Co-occurring Disorders and Implications for Native Practices

Native practices and Native clients are not typically included in the literature on co-occurring disorders and few Natives were included in studies aimed at developing evidence-based practices (Office of the Surgeon General, 2001). However, some research may provide implications for Native clients and practices. There are plans to develop a co-occurring disorders program for Native clients in New Mexico (Cline & Minkoff, 2002); although it is clear that the tribes will be consulted, it is unclear whether the project will truly be Native-designed. In a quantitative analysis of 15 empirical studies to determine intervention effectiveness with co-occurring disordered clients, the interventions demonstrating the most effectiveness were intensive case management and standard aftercare with psychoeducational treatment groups (Dumaine, 2003). Client characteristics such as unemployment and being Latino were statistically correlated with effect size. Although the author did not speculate on the meaning of this finding but did state that this merited further research, it does suggest that culture impacts

outcome and the effectiveness of an intervention. Evidence-based practices are defined as interventions with strong research demonstrating effectiveness for consumer outcomes (Mueser, Torrey, Lynde, Singer, & Drake, 2003). The highest standard for evidence-based practice designation involves numerous, repeated random clinical trials with different groups but in some cases, quasi-experimental designs are accepted when that may be the best available data. Currently, a project sponsored by CMHS and the Robert Wood Johnson Foundation is implementing evidence-based practices through the development of standardized implementation packages. The designated practices include collaborative psychopharmacology, assertive community treatment, family psychoeducation, supported employment, illness management, recovery skills, and integrated dual disorders treatment (Mueser et al., 2003). The most common co-occurring disorder for persons with severe mental illness is substance abuse. In a review of Native adolescents receiving substance abuse treatment, 67% of patients screened positive for at least one co-occurring psychiatric symptom (Novins, Beals, Shore, & Manson, 1996).

Challenges in the treatment of co-occurring disorders in the general population have been the compartmentalization of services to treat mental health and substance abuse separately. Native projects, while traditionally recognizing the value of holistic healing, are often restricted by compartmentalized funding agencies, which create challenges in developing effective systems of care for co-occurring disorders. In contrast to the past compartmentalization of interventions into separate programs treating mental health and substance abuse, integrated treatment focuses on treating substance abuse and mental disorders simultaneously. Controlled clinical trials to date show that most integrated treatment programs are effective, particularly in reducing substance abuse (Mueser et al., 2003). These

models include family intervention, case management, housing, vocational rehabilitation, and medication. *The Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit* includes a statement on cultural competence. The focus is on cultural sensitivity in a case-by-case basis, with examples, in utilizing the designated practices identified by Mueser and colleagues (2003) rather than facilitating Native communities to develop their own models which emerge from indigenous culture.

Literature on co-occurring disorders of substance abuse and non-psychotic conditions such as PTSD is less prevalent. There is a paucity of research and information on the incidence of psychiatric disorders among Natives. However, some research indicates that Natives with alcohol abuse disorders are more likely to also suffer from a psychiatric disorder (Office of the Surgeon General, 2001). There are studies indicating that Natives have high rates of mental distress at 13% compared with 9% for the general population. However, that distress may be expressed in ways that are inconsistent with DSM-IV categories and thereby are challenges for dominant culture-based interventions. Mental health services are limited for Natives. Utilization of traditional healers and ceremonies was prevalent, at approximately two-thirds of the populations examined, in both urban and reservation settings (Office of the Surgeon General, 2001). Although this may have more commonly been for physical problems, Natives tend to not distinguish between physical and mental problems as in the dominant culture. These findings suggest the need for Native interventions.

Challenges for Native Models: The Process of Becoming a Best Practice

Currently, there is an effort underway to identify best practices for co-occurring disorders. On the SAMHSA model programs website, there is an announcement asking for

submission of applicants for co-occurring best practice determination. At this time, the site includes primarily prevention models but it is useful to consider the criteria for best practice determination which implicitly will also be applied to applicants for co-occurring models. There are three levels of best practice determinations: Promising Practices, Effective Programs, and Model Programs. Promising Programs have been sufficiently evaluated and have demonstrated positive outcomes, but have not yet been shown to have sufficient scientific rigor and/or consistently positive outcomes required for Effective Program status. In order to advance to the next level, additional documentation must be submitted regarding program effectiveness. Effective Programs are well-evaluated programs that produce a consistently positive pattern of results. Model Programs are well-evaluated programs meeting the standards of rigorous research and their developers are working with SAMHSA to provide materials, training, and technical assistance nationally. There are 17 methodological criteria on the SAMHSA best practice/model programs website. These criteria include a strong theoretical and conceptual framework. If a Native model is based upon traditional cultural practices and beliefs, there may be challenges in articulating the framework in a way that reviewers will comprehend and in a way that does not compromise the cultural taboos surrounding sharing too much information about traditional ceremonies. Further, if the framework is traditional, it may not have support or any presence in the literature that could weaken the application. A second component for evaluating best practices is intervention fidelity. This could be a challenge for smaller tribes who cannot evaluate the model with large populations of the same tribal culture. Cultural diversity among different tribes is difficult for some non-Natives to comprehend; surviving indigenous peoples are descendants from over 500 different nations and while there are some shared values and beliefs, there are also differences that impact culturally congruent models,

definitions of mental illness and intervention delivery.

The scientific rigor of the research design, reviewed in evaluating candidates for best practice designation, might also be a challenge as the use of control groups again is an issue for smaller tribes and also presents some traditional ethical dilemmas for tribal communities. In tribal cultures, which are typically group-oriented and inclusive, delaying or withholding the intervention or components of the intervention for the sake of creating a controlled condition is incongruent with traditional cultural values of generosity, sharing, and inclusiveness. Tribes then have to struggle with research design strategies for developing control and/or comparison groups while not violating traditional cultural norms. Attrition, another review criterion that is also related to outreach and follow up evaluation, may be daunting for rural reservations with large land areas. Staff have to drive great distances in some instances to make one home visit. Outreach and follow up are complicated by the lack of telephone service in poor reservation homes and the ineffectiveness of cell phones in many reservation areas. Other challenges include inclement weather that prohibits easy travel for outreach. The quality of outcome measures is another area of concern for Native projects due to the limited number of culturally-normed and sensitive instruments for Native populations. An additional issue is how to measure the effectiveness of traditional spiritual healing ceremonies that may be a major component of the intervention and the need to not violate or disrespect the sacredness and privacy of spiritual customs. Replication and dissemination are also challenges for tribes who must replicate their models with other tribal groups, depending upon the size of the tribal population. Urban areas have the challenge of developing models for a multi-tribal community. Additionally, tribal programs are often understaffed, overworked, and underpaid. Tribes may be hard-pressed to find the time and resources to submit all the materials required for an application to become a

best practice.

Finally, there is a basic question: should Native models be evaluated utilizing a dominant cultural paradigm? Should Native Peoples instead be in charge of designating Native best practices? What about respecting traditional Native wisdom and traditional elders and healers as cultural experts and as experts in holistic healing and interventions? If there would be a Native-operated best practice effort, who should do this? One suggestion is that there could be a Native best practice initiative that would include a combination of grassroots Native community members, healers, and service providers as well as a diverse group of Native evaluators and researchers. This diverse group could facilitate a Native-driven process for determining effective Native-informed interventions.

Native Practices Addressing Co-occurring Disorders

Although there have been no studies regarding outcomes of standard mental health practices with Natives (Office of the Surgeon General, 2001) or rigorous, repeated clinical trials of co-occurring intervention models with American Indians and Alaska Natives, there are some Native practices which show promise and are being evaluated. Edwards (2002) conducted a qualitative evaluation of the experience of Native residential treatment for substance abuse in an urban area. The program included psychological treatment and incorporated two models of recovery: a trauma-resolution model and a self-esteem model which included a traditional Native spiritual foundation. There are a number of Native practices that incorporate holistic healing approaches which in essence support concepts in models addressing co-occurring disorders. Several of these practices are taking place in urban areas (see Nebelkopf & King, 2004). Literature on Alaska Native projects describes the effectiveness of incorporating

traditional healing in behavioral health interventions (Mills, 2004). Co-occurring mental health disorders with HIV/AIDS is the focus of attention in another urban project (Nelson, 2004). There are a number of best practices which, although they do not explicitly address co-occurring disorders, indirectly address underlying mental health and/or substance abuse problems in their design and the focus of attention. These models, targeting children and youth as well as parents, were reviewed by Yellow Horse & Brave Heart (2004).

Two additional projects are described here as examples of the type of work taking place in Native communities to address co-occurring disorders. The first project is based in a large urban area. The second model has been primarily reservation-based. These descriptions are presented with the understanding that there are other projects taking place; however, literature in refereed journals, describing these practices and reporting outcome evaluation results, is extremely limited.

The Women's Circle

The Women's Circle project (Saylor, 2003; Saylor & Daliparthi, 2004) has expanded from a substance abuse treatment and HIV prevention project to include mental health treatment. The project includes cultural elements including an emphasis on a holistic approach to physical and spiritual wellness and linking individual health to community health and that of the natural world. The project's clinical approach incorporates Western psychotherapy as well as traditional ceremonies and practices. Since the project operates in a multiracial urban setting, diverse healers from various tribes are brought in and opportunities for varied cultural traditions are provided. For example, there is prayer, smudging, drumming, purification lodges, and talking circles. In the individual modality, counselors work with clients to develop their sense of

spiritual and cultural identity. Outcome data has been collected over three years including changes over time in attitudes and behavior, including the incidence of self-reported substance abuse. There was a decrease in overall substance abuse after treatment and a decrease in women seeking inpatient mental health care. Although tribal identity was important to the women at intake (77%), at the end of treatment 100% of the women affirmed its importance.

The Historical Trauma & Unresolved Grief Intervention (HTUG)

Although this practice is not included on the SAMHSA Model Programs website, the *Historical Trauma and Unresolved Grief Intervention (HTUG)* was recognized as an exemplary model by SAMHSA's Center for Mental Health Services, under a minority initiative, through the award of a Lakota (Teton Sioux) Regional Community Action Grant on Historical Trauma to the Takini Network, a Native non-profit organization. This psychoeducational group model addresses the intergenerational impact of trauma and current lifespan trauma as well as the trauma response features. It recognizes that trauma responses, including complex trauma and PTSD, often co-occur with substance abuse and other disorders such as other anxiety disorders, depression, and personality disorders as well as stress-related physical conditions. HTUG has been utilized in training adult trainers who are themselves consumers, trauma survivors, and recovering substance abusers. It has also been incorporated in a parenting intervention to increase protective factors against substance abuse in offspring. HTUG has been evaluated through quasi-quantitative and qualitative research, documented in peer-reviewed journals as well as other publications (Brave Heart, 1995; Brave Heart, 1998; Brave Heart, 1999a; Brave Heart, 1999b; Brave Heart, 2000; Brave Heart, 2001a; Brave Heart, 2001b; Brave Heart, 2003; Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998). The theoretical constructs

underpinning HTUG are congruent with literature on American Indian trauma (Manson et al., 1996; Robin et al., 1996) which supports the need for specific culturally based trauma theory and intervention as well as general trauma literature (van der Kolk, McFarlane, & van der Hart, 1996). Historical trauma is defined as cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences; the historical trauma response is the constellation of features in reaction to this trauma (Brave Heart, 1998; Brave Heart, 1999a). This response, also described in Jewish Holocaust (Fogelman, 1988; Fogelman, 1991) and Japanese American internment camp literature (Nagata, 1991; Nagata, 1998), often includes self-destructive behavior, such as substance abuse as well as depression, suicidal thoughts and gestures, anger, anxiety, low self-esteem, and difficulty recognizing and expressing emotions (Brave Heart, 1998; Brave Heart, 1999).

HTUG has several components: (a) education about traumatic Native history and its impact upon current lifespan trauma; (b) utilization of videotapes and other visual stimuli to facilitate processing of that trauma through abreaction and catharsis; (c) fostering a re-connection to traditional cultural values as protective factors for mental health and against substance abuse; and (d) promoting group bonding, collectivity, and ego-enhancement as well as emotional containment thorough ceremonies such as a purification lodge which aids in that process (Brave Heart, 1998; Silver & Wilson, 1988; Yellow Horse & Brave Heart, 2004).

HTUG is intended to facilitate disclosure, cohesiveness, bonding and mutual identification, and provides opportunities for role modeling affect tolerance, self-regulation, and trauma mastery comparable to other group intervention models with PTSD clients, massive group trauma survivors and their descendants (Brave Heart, 1998; Fogelman & Savran, 1979; Yellow Horse & Brave Heart, 2004). HTUG is comparable to the Phase Oriented Treatment

strategies for PTSD (van der Kolk et al., 1996) utilizing (a) stabilization which includes education and identification of feelings, (b) reconditioning of traumatic responses and memories, (c) restructuring traumatic internal systems, (d) reestablishment of safe social connections and efficacy in relationships, and (e) amassing a collection of restorative emotional experiences (p. 426). Like other trauma treatment approaches, HTUG is intended to normalize symptoms (Koller, Marmar, & Kansas, 1992) and foster a healthy sense of connection with deceased ancestors rather than fixation to the trauma (Fogelman, 1991).

HTUG promises to positively impact parents, many who have been victims of punitive or “boarding school style discipline” which is perceived as negatively impacting interaction with children, contributing to poor mental health and substance abuse (Brave Heart, 1998; Brave Heart, 1999a). Parents traumatized as children are less likely to be emotionally present for their children. Parents raised in boarding schools often lack role models of healthy parenting, thereby being at risk for parental incompetence (see Brave Heart, 1995; Brave Heart, 1999a; Yellow Horse & Brave Heart, 2004). HTUG is also designed to address healing from traumatic history among American Indian parents, which includes an emphasis on parental competence and parental support.

The Future of Native Best Practice Research

In order for practices such as the Women’s Circle and HTUG to become designated as SAMHSA best practices, more rigorous research is needed. Research on the Women’s Circle and HTUG to date is promising but results for both projects are based in part on self-report measures and perceptions of Native participants. HTUG’s evaluation has included one projective measure, the Semantic Differential (Osgood & Succi, as cited in Brave Heart, 1998) which

captures unconscious meaning of concepts. This was utilized in a pre-test/post-test design to assess impact of the intervention and the results were strikingly significant despite the small sample size. However, more research is needed to assess impact over time. The concept of historical trauma itself is theoretical; while it is becoming increasingly popular among Native communities and there is an increasing demand for training in historical trauma and specifically in HTUG, additional research on both the core concept and the intervention is needed. Additional instruments measuring change in affect or behavior over time following the intervention are needed in order to meet the standards for best practice.

Both the Women's Circle and HTUG model developers recognize the limitations of their research to date, as do many of the current and former Native grantees under the CSAT Targeted Capacity Expansion Grant program who are working hard to develop research of their innovative, culturally grounded intervention models. One dilemma faced by Native researchers examining models like HTUG that focus on affective (emotional) experiences is the challenge of measuring internal emotional states which is typically of interest to practitioners in the trauma field. This is particularly difficult for examining the impact of generational massive group trauma and is similar to the challenges in Holocaust research (see Fogelman, 1998; Fogelman, 1991).

An emerging area of research in the intergenerational transfer of trauma is the work of Rachel Yehuda (1999) whose well-designed empirical study includes measuring cortisol levels of Holocaust offspring. Her findings support the theory behind HTUG. Yehuda (1999) found that adult children of survivors had a higher degree of cumulative lifetime stress (Brave Heart, 2003; Brave Heart, in press). Children of survivors having a parent living with chronic PTSD were more likely to develop PTSD in response to their own traumatic lifetime events. Further, the parental trauma symptoms are the critical risk factors for trauma responses among the children

of survivors. These important findings provide hope for advancing Native research on historical trauma and for informing effective interventions for Natives with trauma responses co-occurring with substance abuse.

Conclusion and Recommendations

Federal funding agencies as well as state and foundation resources can facilitate the development of and research on Native best practices for co-occurring disorders. Requiring Natives to take a dominant cultural model and then “culturally adapt” it is failing to recognize the depth and complexity of Native thought, values, and philosophies that are often diametrically opposed to the dominant cultural paradigm. Hence, true and meaningful cultural adaptation may be impossible. Rather than asking Native projects to utilize non-Native models framed in the dominant cultural paradigms, Native models that are already being developed which emerge from Native worldviews, philosophies, and behavioral norms, need resources to advance to the level of best practices. These culturally based, culturally congruent, and culturally grounded practices that emerge from Native communities should be supported, nurtured, and valued. There also needs to be a Native best practices team that will provide technical assistance to tribes and tribal communities seeking to develop Native best practice models. Most Native projects are still at the stage of knowledge development; SAMHSA’s noteworthy but yet unfunded initiative of Science to Service could be adapted to target specific outreach to Native projects for the development and refinement of best practice models for co-occurring disorders, particularly in trauma-related disorders and substance abuse. However, such an initiative needs funding support. Native evaluators could be involved in mentoring Native grantees in developing best practice research and evaluation strategies. A technical

assistance conference that addresses all stages in the process for developing and then evaluating Native best practices could be conducted with strategies for follow-up action steps. Natives should also develop their own best practice criteria as certain components may be weighed differently than in the dominant cultural framework; additional components may be added or elements eliminated regarding what constitutes a best practice in “Indian Country.” For example, Native practices might be concerned with the appropriate use of traditional ceremonies, utilizing legitimate healers, and accessibility to the extended family kinship network, if the intent of a best practice initiative is to protect Native clients and community members and to ensure that they receive the best help available for achieving the highest quality of outcomes. These are concerns that may have no relevance in a dominant cultural model.

Finally, a database of Native practices should be developed, initially casting a wide net, so as not to miss the grassroots, innovative work going on sometimes quietly and quite effectively in Indian Country. These models need to be supported, further developed, and then assisted in achieving best practice status but with Native-congruent criteria. The experience of Natives in delivering effective healing interventions for centuries needs to be respected. Traditional wisdom must be supported while attempting to translate and negotiate in the dominant culture. There are some evidence-based and promising practices that have the potential to be of help to Native populations and might be more readily adaptable, such as models with more multicultural application and frameworks that may be more congruent with Native cultures. Focus groups of Native community members, Native key informants, and Native consultants should be included in any Native best practice initiative. Then, culturally appropriate measurement instruments can be developed, respecting tribal diversity, perhaps designing

instruments that fit for each broad, regional tribal culture area.

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