TIP 61

BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES

Part 3: Literature Review

For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 3 of this **Treatment Improvement Protocol** describes the available literature on behavioral health services for adult American Indians and Alaska Natives. It examines epidemiological studies and culturally responsive adaptations to standard behavioral health services.

TIP Navigation

Executive Summary
For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives
For behavioral health service providers

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives
For behavioral health service providers, program administrators, and clinical supervisors

Appendix and Index

Part 3: Literature Review
For behavioral health service providers, program administrators, clinical supervisors, and researchers

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

PART 3: LITERATURE REVIEW

Part 3, Section 1: Literature Review 3
Introduction 3
The American Indian and Alaska Native Population and Their Behavioral Health Needs . . . 5
Large Epidemiological Studies on the Prevalence of Mental and Substance Use Disorders 5
Epidemiological Data on Mental Disorders From Other Studies 12
Epidemiological Data on Addictive Disorders From Other Studies 18
Substance Use and Misuse Patterns for American Indians and Alaska Natives 20
Epidemiological Data on CODs 29
Risk and Protective Factors for Mental and Substance Use Disorders 30
Differences in the Behavioral Health of American Indian and Alaska Native Subpopulations 54
Behavioral Health Services for American Indians and Alaska Natives 66
Motivation for Treatment and Access to Care 66
Retention and Outcomes 72
Screening and Assessment 73
Mental Health Promotion and Substance Misuse/Use Disorder Prevention 76
Adapting Standard Mental and Substance Use Disorder Treatment Modalities 80
Using Traditional Practices in Mental and Substance Use Disorder Treatment 87
Mutual Help 93
Relapse Prevention and Recovery Promotion 95
Systems Issues 99
Program Management and Sovereignty Issues 99
Community Involvement 99
Telephone- and Computer-Based Services 103
Vocational Training 105
Reference List 106

Part 3, Section 2: Links to Select Abstracts 133

Part 3, Section 3: General Bibliography 141

Exhibits

Exhibit 3.1. Lifetime Substance Use Disorders Among American Indians in the AI-SUPERPFP 10
Exhibit 3.2. Lifetime Rates of DSM-IV Mental Disorders Among American Indians in the AI-SUPERPFP 11
Exhibit 3.3. Lifetime Substance Use Among American Indians in the AI-SUPERPFP 23
Exhibit 3.4. Inter-Tribal Differences in Trauma Histories 42

Part 3, Section 1: Literature Review

Introduction

This Treatment Improvement Protocol (TIP) is concerned with behavioral health services for indigenous people whose ancestors lived in North and South America before the arrival of Europeans and thus includes American Indians and Alaska Natives. Although the term "American Indians and Alaska Natives" is used to describe people from a wide range of diverse tribal and cultural groups, these groups do share several things in common. They are all indigenous to North and South America; they have retained a traditional culture that varies significantly—in some ways—from White, mainstream American culture; and they have been displaced and oppressed to varying degrees during the process of colonization and its aftermath. Despite the limitations of using a single term to discuss this wide range of people, the authors believe that it provides the best working model for understanding shared concerns that affect mental and substance use disorders (SUDs) and their treatment. In instances where a given study identifies the population as either American Indian or Alaska Native, those terms are used.

Because various American Indian tribes and Alaska Native peoples also inhabit land in Canada, research from Canada is included in the review. This research uses the terms "First Nations" or "Aboriginal" peoples to identify Canadian Indian, Métis, or Inuit peoples, and those terms are used in relation to those studies.

TIP 59, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014b), is intended as a guide for clinicians and administrators to help them in fostering the provision of culturally responsive behavioral health services to a diverse group of clients. TIP 59 provides guidance on developing and implementing culturally responsive treatment and prevention services as well as specific guidelines on making services culturally responsive for members of diverse ethnic/cultural groups, including American Indians and Alaska Natives. Because cultural competence and responsiveness to clients' cultural backgrounds are discussed at length in that TIP, they are not covered in this TIP or its literature review in any detail.

According to the Census estimates released in 2018, 6.8 million people in the United States identified as Native American, either alone or in combination with another race, which was 2.1 percent of the U.S. population. Of those 6.8 million people, 4.1 million identified solely as American Indian and Alaska Native (1.3 percent of the population), and 2.7 million identified as American Indian and Alaska Native in combination with another race (Census Bureau, Population Division, 2018).

The American Indian and Alaska Native population is largely concentrated in certain areas of the country, and in 2010 there were 187 counties where American Indians and Alaska Natives made up 8 percent or more of the population (Norris, Vines, & Hoeffel, 2012). Most of these individuals did not reside in American Indian and Alaska Native areas, which include reservations, trust lands, tribal statistical areas, and Alaska Native villages; 67 percent of those who identified solely as American Indian and Alaska Native resided outside those areas, and 92 percent of those who identified as American Indian and Alaska Native in combination with another race resided outside those areas also. About one-third of American Indians and Alaska Natives migrate back and forth between urban and rural areas (Forquera, 2001).

Providing services to these individuals is further complicated by the fact that there are more than 560 federally recognized American Indian tribes and Alaska Native groups. Additionally, some tribes are recognized by states but not by the federal government, and more than 300 have petitioned for recognition but remain unrecognized (Bureau of Indian Affairs, 2010; National Conference of State

Legislatures, 2016). This group of tribes represents a diverse set of cultures, spiritual traditions, and histories, but many of them share commonalities with regard to the cultural and spiritual customs and historical factors. Providers should be aware of the cultures and practices of the specific tribe or tribes to which their clients belong. Wherever possible, this literature review identifies the region, not the tribe, from which a study draws its sample. The TIP honors tribal anonymity, as well as in personal anonymity, for participants.

The likelihood that a person will self-identify as American Indian and Alaska Native has been increasing since the 1960s at a faster rate than can be accounted for by normal demographic trends (Hack, Larrison, & Gone, 2013). For many, identifying as American Indian and Alaska Native is a decision based on genealogy and not cultural affiliation, and their American Indian and Alaska Native identity may have little relevance to their behavioral health needs (Hack, Larrison, & Gone, 2013). Gone and Trimble (2012) suggested that using self-identification as the means of determining American Indian and Alaska Native identity "threatens to undermine the meaningfulness of [American Indian and Alaska Native] identity relative to presumed commonalities in orientation, outlook, and experience" (p. 136). They suggested that research on American Indian and Alaska Native mental health and its treatment should instead focus on members of recognized American Indian tribes or Alaska Native peoples. This factor may also affect the accuracy of results from studies that rely on self-identification, such as the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC).

This review has attempted to be as comprehensive as possible, but because published research on American Indian and Alaska Native behavioral health is limited, it has relied on other types of literature, including dissertations, conference presentations, and government reports. In their review of mental health services for American Indians and Alaska Natives, Gone and Trimble (2012) noted that the published studies they located were "almost exclusively review, reflection, and advocacy pieces rather than systematic empirical investigations of therapeutic processes and practices with [American Indian and Alaska Native] participants" (p. 143). The review also includes a number of studies that are older than typically found in TIP reviews because more recent data are not available. It also sometimes refers to studies that combine data from some earlier yearly studies rather than referring to the most recent versions of those studies; the relatively small number of American Indian and Alaska Native participants in the new yearly studies makes it hard to draw significant conclusions.

Research on mental disorder and SUD treatment for American Indians and Alaska Natives is sparse in part because of the small number of American Indians and Alaska Natives included in national samples, faulty data reporting by providers serving American Indians and Alaska Natives, the failure of providers to identify American Indians and Alaska Natives, and a lack of interest in this population in some circles (Beauvais & LaBoueff, 1985; Moy, Smith, Johansson, & Andrews, 2006; Szlemko, Wood, & Jumper-Thurman, 2006). Some American Indian and Alaska Native communities may also be distrustful of researchers who have not shown respect or cultural competence in the past (Mohatt, Hazel, Allen, Stachelrodt, Hensel, & Faith, 2004). Hence, there are significant gaps in available data concerning health care in general for American Indian and Alaska Native peoples (Moy et al., 2006) and concerning the best behavioral health models for this population specifically. Other reasons for a lack of quality data for this population include a lack of cultural understanding or competence among researchers (Manson & Buchwald, 2007; Trimble, 2008), concerns about submitting data from American Indian and Alaska Native people who believe data may be misused (Beauvais & LaBoueff, 1985), unfamiliarity with research methods and data collection among program staff members (Moss, Taylor, & May, 2003), and frequent staff turnover that may disrupt the continuity of the research (Moss et al., 2003).

Although this TIP is primarily concerned with integrated behavioral health services, the research often focuses on SUDs or mental disorders only, and hence the two are sometimes discussed in separate sections. This is also an artifact of the origins of this TIP, which was intended to address

SUD treatment only but has since been expanded to cover prevention issues and treatment for mental disorders.

Finally, it should be noted that this TIP is concerned with behavioral health services for adult American Indians and Alaska Natives. When research on adults is not available, or when it is believed that research involving youth is also applicable to adults, studies concerning youth and adolescents may be mentioned.

The American Indian and Alaska Native Population and Their Behavioral Health Needs

Behavioral health service providers who work with American Indian and Alaska Native clients should understand as much as possible about the population they are going to serve. If working with a specific tribe or regional group of clients, providers should understand the cultures and practices of the specific tribe or tribes. However, in many areas (e.g., large urban areas), providers will encounter a more diverse group of American Indian and Alaska Native clients and thus may need to rely on more general information concerning the behavioral health of American Indian and Alaska Native peoples.

As noted above, quality data on the prevalence of mental disorders and SUDs in American Indian and Alaska Native populations are limited, and many large national studies have not included enough American Indian and Alaska Native participants to make accurate estimates possible. It is also worth noting that the methodology of some studies and the methods used to assess disorders may not be culturally appropriate for some American Indians and Alaska Natives, which can also result in inaccurate estimates (e.g., see discussion in Beals, Manson, Whitesell, Mitchell, et al., 2005).

The sections that follow begin with discussions of epidemiological studies that assessed a variety of mental disorders and SUDs and other large studies that included data on factors that are relevant to behavioral health (e.g., patterns of substance use, subjective ratings of health). Separate discussions of smaller studies are divided into investigations assessing addictive disorders and those assessing other mental disorders. In a few cases, the same study may be mentioned in both sections. Pathological gambling disorder is grouped with SUDs as an addictive disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association [APA], 2013), included under the heading "Epidemiological Data on Addictive Disorders From Other Studies," although the research included here has relied on earlier versions of the DSM.

Most of the literature addressed here does not use DSM-5 (APA, 2013) definitions for substance use and mental disorders. When the DSM-5 criteria were used, it is noted in the text. Also, some studies used the criteria in the third edition (DSM-III; APA, 1980) or the third edition, revised (DSM-III-R; APA, 1987); when that is the case, it is also noted in the text. Most of the research discussed herein uses the fourth edition (DSM-IV; APA, 1994) or DSM-IV-Text Revision ([DSM-IV-TR]; APA, 2000) diagnostic criteria; if not otherwise stated, it should be assumed that those criteria were used. The DSM-IV and DSM-IV-TR refer to "substance abuse" and "substance dependence disorders," a distinction that is no longer made in the DSM-5; we have used those terms when the source material found it important to distinguish between the two. The DSM-III and DSM-III-R refer to "substance abuse" and "substance dependence" without the word "disorder." When this TIP uses those terms, the text clearly indicates that they are from one of these earlier DSM editions.

Large Epidemiological Studies on the Prevalence of Mental and Substance Use Disorders

This section focuses on data from three large studies on mental disorders and SUDs that include a large enough sample of American Indians and Alaska Natives to make statistically sound estimates, at least when taken in the aggregate. These are: (1) NESARC sponsored by the National Institute on Alcohol Abuse and Alcoholism; (2) SAMHSA's yearly National Survey on Drug Use and Health (NSDUH) surveys; and (3) the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP)

funded by the National Institute of Mental Health (NIMH). The AI-SUPERPFP is the only large epidemiological study to date focused entirely on American Indian and Alaska Native behavioral health. Data from two other studies are also provided—the Behavioral Risk Factor Surveillance System (BRFSS) and the National Health Interview Survey (NHIS), conducted by the Centers for Disease Control and Prevention (CDC)—which do not diagnose mental disorders and SUDs but do provide information on mental disorder symptoms and behaviors that may relate to SUDs. This section concludes with information from the Canadian Community Health Study.

NESARC researchers conducted interviews in 2001–2002 with 43,093 individuals living in households or institutional housing; 701 of them identified as being in part or wholly American Indian and Alaska Native (Smith, Stinson, Dawson, Goldstein, Huang, & Grant, 2006). A second wave of interviews was conducted in 2004–2005 with 34,653 of those who had previously been interviewed and included assessments of certain disorders (e.g., borderline personality disorder [BPD]) that were not included in the first wave of interviews (Grant et al., 2009).

Although the number of American Indians and Alaska Natives included in NESARC was relatively small, it was large enough for researchers to make comparisons with members of other racial/ethnic groups (i.e., White Americans, African Americans, Asian Americans, Latinos) in regard to certain mental disorders. NESARC found high rates of many SUDs among American Indians and Alaska Natives, and NESARC researchers concluded that "in general, rates for [anxiety, mood, and substance use] disorders were greatest for American Indians and Alaska Natives" compared with all other racial/ethnic groups included in the study (Smith et al., 2006, p. 990).

According to Smith et al. (2006), NESARC found that in the year prior to their interview:

- 15.4 percent had a mood disorder.
- 15.3 percent had an anxiety disorder.
- 12.4 percent had major depression.
- 12.1 percent of American Indians and Alaska Natives had an alcohol use disorder (AUD).
- 8.2 percent had a specific phobia.
- 4.9 percent had a drug use disorder.
- 3.6 percent had social anxiety disorder (SAD).
- 3.5 percent had panic disorder without agoraphobia.
- 3 percent had dysthymia.
- 2.5 percent had mania.
- 2.5 percent had generalized anxiety disorder (GAD).
- 1.2 percent had panic disorder with agoraphobia.

The rates of AUDs, drug use disorders, major depression, dysthymia, and panic disorder without agoraphobia were all significantly higher than were found among any other racial/ethnic groups in NESARC.

There were, however, some demographic differences between American Indians and Alaska Natives and White Americans in NESARC that may affect comparisons. American Indians and Alaska Natives were significantly more likely to be in the lowest income bracket (i.e., $10,000 to $19,999 a year) and significantly less likely to be in the highest bracket (i.e., $70,000 or more a year); there were also significantly fewer male respondents among American Indians and Alaska Natives (Smith et al., 2006).

Because of the gender imbalance in the American Indian and Alaska Native sample in NESARC, the analysis of NESARC data conducted by Brave Heart et al. (2016) that looks at differences in rates of substance use and mental disorders and treatment seeking between American Indians and Alaska Natives and non-Latino White Americans by gender is important. The authors also adjusted rates for age, education, region, urbanicity, and individual and family income. In their adjusted model, they found that compared with White American men, American Indian and Alaska Native men were significantly more likely to have at some point during their lives a SUD (1.37 times more likely), a mood disorder (1.42 times more likely), a personality disorder (1.74 times), or some combination. American Indian and Alaska Native women were significantly more likely than White American women to have a lifetime mental or SUD diagnosis (1.51 times more likely), an Axis I

disorder (1.54 times), a SUD (1.58 times), an AUD (1.63 times), a drug use disorder (1.89 times), a mood disorder (1.58 times), an anxiety disorder (1.53 times), or a personality disorder (1.67 times). In terms of past-year disorders, American Indian and Alaska Native men were significantly more likely than non-Latino White American men to have had a mental or SUD (1.46 times), an SUD (1.44 times), or a mood disorder (1.58 times). Compared with White American women, American Indian and Alaska Native women were significantly more likely to have had a past-year mental or SUD (1.37 times), an Axis I disorder (1.39 times), or a drug use disorder (2.62 times). American Indian and Alaska Native women were significantly (2.21 times) more likely than White American women to have sought treatment for an anxiety disorder in the past year.

Some researchers using data from NESARC have looked more closely at specific disorders. For example, Grant et al. (2005) reported that American Indians and Alaska Natives had the highest past-year and lifetime rates of bipolar I disorder of any of the racial/ethnic groups in NESARC. Compared with White Americans, American Indians and Alaska Natives were 1.5 times more likely to have the disorder at some point during their lives; 6.2 percent of American Indians and Alaska Natives had the disorder at some point during their lives, compared with 3.3 percent of White Americans.

Grant et al. (2005) reported that American Indians and Alaska Natives had the highest rate of GAD of any of the racial/ethnic groups evaluated by NESARC both in the past year (2.6 percent of the sample had GAD) and during their lives (6.3 percent), and American Indians and Alaska Natives were 1.4 times more likely than White Americans to have GAD at some point during their lives.

Smith et al. (2006) reported that American Indians and Alaska Natives were more likely than members of other major racial/ethnic groups to have had SAD, but this percentage was only significantly higher than the percentage of African Americans, Asian Americans, or Latinos with the disorder (i.e., did not differ significantly from White Americans). Also, according to data from Wave 2 of NESARC, American Indians and Alaska Natives with SAD were significantly more likely than White Americans (1.24 times more likely) to have persistent, rather than remittent, SAD (Blanco, Xu, Schneier, Okuda, Liu, & Heimberg, 2011).

NESARC found high rates of AUDs in the American Indian and Alaska Native population (Gilman et al., 2008). A little more than 20 percent of American Indians and Alaska Natives in the study met criteria for a diagnosis of alcohol dependence at some point during their lives (for White Americans, who had the next highest level of alcohol dependence, the rate of lifetime alcohol dependence was 13.8 percent). After adjusting for age and sex of respondents, this means that American Indians and Alaska Natives were about 1.4 times more likely than White Americans to have a lifetime diagnosis of AUD.

Given that a large percentage of American Indians and Alaska Natives abstain from alcohol entirely and that there is a high percentage of lifetime abstainers (see discussion under "Abstinence Rates"), the rate of alcohol dependence is even higher if one only considers people who have used alcohol during their lives. Gilman et al. (2008) evaluated NESARC data only for those individuals who reported using alcohol during their lifetimes and who provided complete data on relevant parts of the survey (approximately 80 percent of the American Indian and Alaska Native sample was included). They found that the lifetime rate of alcohol dependence for American Indians and Alaska Natives included in their sample was 24.2 percent; by comparison, the rate for White Americans, the racial group with the next highest rate, was 15.9 percent. In a model that adjusted for age, gender, and age of first alcohol use, the odds of having alcohol dependence were 1.34 times higher for American Indians and Alaska Natives than for White Americans (a ratio that was not considerably different from that observed in the entire NESARC sample).

NESARC also found high rates of drug use disorders for American Indians and Alaska Natives, with 6.9 percent meeting criteria for a lifetime diagnosis of drug dependence and 2.6 percent meeting criteria for a current drug dependence diagnosis. By comparison, the next highest rate for

a lifetime diagnosis was among White Americans, 2.7 percent of whom had a lifetime drug dependence diagnosis (Compton, Thomas, Stinson, & Grant, 2007).

Lopez-Quintero et al. (2011) used data from both waves of NESARC to evaluate the risk involved in transitioning from use of substances (i.e., alcohol, cannabis, cocaine, or nicotine) to dependence on them. They found, in a model that controlled for other demographic and behavioral health factors, that American Indians and Alaska Natives were, along with Native Hawaiians and other Pacific Islanders, to be the most likely of all racial/ethnic groups evaluated to transition from tobacco use to dependence (they were 1.3 times more likely to do so than were White Americans) and were the most likely after Native Hawaiians and other Pacific Islanders to transition from cannabis use to dependence (1.91 times more likely to do so than were White Americans). The likelihood of transitioning from alcohol use to dependence was somewhat higher for American Indians and Alaska Natives than for African Americans or White Americans (they were 1.05 times more likely to do so than were White Americans) and slightly lower than for Latinos. The odds of transitioning to cocaine dependence after first use were lower for American Indians and Alaska Natives than for African Americans or Native Hawaiians and other Pacific Islanders but higher than for White Americans or Latinos. (American Indians and Alaska Natives were 1.79 times more likely to do so than were White Americans.)

In NESARC, pathological gambling was evaluated along with "problem gambling" (i.e., the presence of 3 or 4 DSM-IV [APA, 1994] criteria rather than the 5 required for the disorder), but researchers only presented data for American Indians and Alaska Natives combined with Asian Americans (Alegría et al., 2009). According to that combined data, 2.3 percent of Asian Americans and American Indians and Alaska Natives engaged in disordered gambling, a percentage comparable with that of African Americans (2.2 percent) and significantly higher than that of White Americans (1.2 percent).

NESARC also evaluated the prevalence of some personality disorders, although some (e.g., BPD) were only evaluated in Wave 2 because of the number of questions required for assessment. Of all the racial/ethnic groups included in the study, American Indians and Alaska Natives were the most likely to have avoidant, antisocial, obsessive–compulsive, paranoid, and schizoid personality disorders during the year prior to the survey (Grant et al., 2004). Compared with White Americans in a model that controlled for age and co-occurring disorders (CODs), American Indians and Alaska Natives were significantly more likely to have avoidant personality disorder (1.56 times more likely), schizoid personality disorder (2.35 times more likely), antisocial personality disorder ([ASPD]; 2.86 times more likely), and paranoid personality disorder (3.12 times more likely).

In a multivariate model that controlled for other demographic variables, American Indians and Alaska Natives in NESARC were 2.3 times more likely to have ASPD at some point during their lives and 1.4 times more likely to exhibit antisocial behavior in adulthood than were White Americans (Compton, Conway, Stinson, Colliver, & Grant, 2005). Among individuals with drug use disorders, American Indians and Alaska Natives were also significantly more likely to have ASPD than were White Americans (Goldstein et al., 2007).

Grant et al. (2008) found that 11.9 percent of American Indians and Alaska Natives in NESARC met criteria for BPD at some time during their lives (the highest of any racial/ethnic group in the study). Overall, American Indians and Alaska Natives had a significantly greater risk for BPD (1.8 times higher) than did White Americans, and much of that difference could be accounted for by the significantly higher rates of BPD in American Indian and Alaska Native men, who were 2.3 times more likely to have BPD than were White American men.

Each year, SAMHSA's NSDUH surveys individuals ages 12 and older and presents data according to race/ethnicity. Although the NSDUH evaluates the presence of SUDs, it typically does not assess specific mental disorders, opting instead to evaluate the presence of serious psychological distress based on the Kessler-6 instrument (K-6) and a measure of serious mental illness (SMI). The NSDUH also measures past-year major depressive episode (Center for Behavioral Health Statistics and Quality [CBHSQ], 2017b). Respondents were

defined as having SMI if, in the past year, they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities. To generate estimates of SMI in the United States, a subsample of adults was selected from the main NSDUH study to participate in the Mental Health Surveillance Study, which included a follow-up telephone interview that obtained a detailed mental health assessment administered by trained mental health clinicians. That is, the subsample was administered a clinical psychiatric diagnostic interview (Structured Clinical Interview for DSM-IV-TR Axis I Disorders [SCID]; SCID-I/Nonpatient Edition), in addition to a measure of functional impairment/symptom severity (i.e., Global Assessment of Functioning [GAF]). Adults who had at least one of the past-year mental disorders and who had a GAF score indicative of serious functional impairment (i.e., 50 or less) were classified as having past-year SMI. Based on these data, a predictive model was developed and cutpoints were established for the estimation of SMI using variables from the main NSDUH study. This statistical model was then applied to the full NSDUH adult sample to determine if each NSDUH respondent had SMI. The potential for misclassification exists in the NSDUH because determination of SMI among respondents is based on a prediction model.

CBHSQ (2017a) reported data from the 2016 NSDUH surveys. According to those data, rates of SMI in the past year were similar for American Indians and Alaska Natives (4.9 percent), compared with the national average (4.2 percent).

The 2016 NSDUH data also indicated that among individuals ages 12 and older, 9.2 percent of American Indians and Alaska Natives had an AUD in the year prior to the survey, while the national average was5.6 percent (CBHSQ, 2017a). Rates of illicit drug use disorders in the prior year were similar for American Indians and Alaska Natives who were 12 or older (4.1 percent) compared with the national average (2.7 percent).

In the 2016 NSDUH, 11.7 percent of all Native American respondents (again, those 12 and older) had an alcohol or illicit drug use disorder in the prior year (CBHSQ, 2017a); a rate significantly higher than the national average (7.5 percent). By comparison, 6.8 percent of Latinos, 7.8 percent of White Americans, 7.6 percent of African Americans, and 3.7 percent of Asians met criteria for a past-year SUD.

The 2016 NSDUH also provided data on heavy alcohol use, which is defined as consuming five or more drinks for males and four or more drinks for females on a single occasion on 5 or more days in the past 30 days (CBHSQ, 2017a). During that period, 5.7 percent of Native American respondents 12 or older engaged in heavy drinking in the month prior to the survey, a rate similar to the national average of 6.0 percent.

The AI-SUPERPFP is the largest study on American Indian behavioral health to date; it collected initial data from 3,084 American Indians ages 15–54 who were members of one of two related Northern Plains tribes or a Southwest tribe and who lived on or within 20 miles of their reservations. Later waves of data collection included a clinical re-interview (n = 335) and a series of ethnographic interviews (n = 90). The researchers specifically selected these two groups (i.e., Northern Plains and Southwest) because they had distinctly diverse cultures, histories, and languages, while sharing a similar history of confrontation and oppression (Mitchell, Beals, Novins, & Spicer, 2003).

According to the AI-SUPERPFP, 31.2 percent of American Indians from the total sample met criteria for a lifetime diagnosis of a SUD, and 13.4 percent met criteria for a past-year diagnosis according to DSM-IV criteria (Beals et al., 2006). The lifetime rates of SUDs were 42 percent for men from the southwestern sample, 14.9 percent for women from the Southwest, 43.1 percent for men from the Northern Plains sample, and 31 percent for women from the Northern Plains sample (Beals, Novins, et al., 2005). The rates of any SUD in the prior year were 18.8 percent for men from the southwestern sample, 4 percent for women from the Southwest, 22.0 percent for men from the Northern Plains sample, and 13.1 percent for women from the Northern Plains sample.

The AI-SUPERPFP also found high rates of AUDs among men in both populations (38.7 percent of men from the Southwest tribe met criteria for a lifetime disorder, as did 41.1 percent of men from

the Northern Plains tribes), but rates varied to a greater degree among women from these tribes (12.2 percent of women from the Southwest tribe met lifetime criteria compared with 28.8 percent of women in the Northern Plains tribes; Mitchell et al., 2003).

In terms of other SUDs, the most common among American Indians according to AI-SUPERPFP data were marijuana, cocaine, and other stimulants, roughly in that order (see Exhibit 3.1 for specific rates of lifetime diagnoses of SUDs for the diverse populations in the study).

The AI-SUPERPFP also assessed some mental disorders: major depression, dysthymia, GAD, panic disorder, and posttraumatic stress disorder (PTSD; Beals, Novins, et al., 2005). Psychotic disorders were not evaluated because of concerns about the cultural applicability of diagnostic criteria. Researchers found that 6.3 percent of men from the Southwest tribe had a depressive disorder (according to DSM-IV criteria) in the year prior to the study, as did 8.1 percent of Southwest women, 3.2 percent of men from the Northern Plains tribes, and 6.0 percent of Northern Plains women. Also, 6.5 percent of men from the Southwest sample had at least one anxiety disorder in the prior year, as did 9.0 percent of Southwest women, 5.3 percent of Northern Plains men, and 8.7 percent of Northern Plains women. Exhibit 3.2 gives lifetime prevalence rates of specific mood and anxiety disorders for different populations in the study.

The AI-SUPERPFP also evaluated the DSM-III-R (APA, 1987) diagnoses of disorders to make comparison with National Comorbidity Study (NCS) data; according to those comparisons, American Indians in the AI-SUPERPFP were, compared with NCS general population data, less likely to have

EXHIBIT 3.1. Lifetime Substance Use Disorders Among American Indians in the AI-SUPERPFP

DISORDER	SOUTHWEST MEN (%)	SOUTHWEST WOMEN (%)	NORTHERN PLAINS MEN (%)	NORTHERN PLAINS WOMEN (%)
Marijuana use disorder	12.2	4.5	14.1	9.4
Cocaine use disorder	2.3	1.1	2.3	2.1
Other stimulant use disorder	1.7	0.7	1.3	1.4
Inhalant use disorder	1.7	0.0	0.4	0.5
Hallucinogen use disorder	1.3	0.6	1.0	0.1
Opioid use disorder (heroin plus prescription opioids)	0.9	0.7	0.1	0.3
Sedative use disorder	0.7	0.0	0.5	0.4

Source: Mitchell et al., 2003. Adapted with permission.

EXHIBIT 3.2. Lifetime Rates of DSM-IV Mental Disorders Among American Indians in the AI-SUPERPFP

DISORDER	SOUTHWEST MEN (%)	SOUTHWEST WOMEN (%)	NORTHERN PLAINS MEN (%)	NORTHERN PLAINS WOMEN (%)
Major Depression	8.5	12.3	6.6	9.1
Dysthymic Disorder	3.0	3.9	1.7	3.0
GAD	2.4	4.1	1.5	1.8
Panic Disorder	3.6	5.2	1.7	3.1
PTSD*	11.7	19.5	8.9	19.2

*PTSD rates are calculated based on the three worst traumas the respondent had experienced rather than the single worst trauma, which is more often used in epidemiological studies (see Beals, Manson, et al., 2013).

Source: Beals, Manson, Whitesell, Spicer, et al., 2005. Adapted with permission.

depressive disorders (although only significantly less likely for women and Northern Plains men) and more likely to have anxiety disorders (significantly more so in the cases of Southwest men and women; Beals, Novins, et al., 2005).

In the AI-SUPERPFP, rates of PTSD according to DSM-III-R criteria were significantly higher for all populations compared with NCS: 12.8 percent of men in the Southwest sample and 11.5 percent of those in the Northern Plains sample met lifetime DSM-III-R criteria for PTSD, compared with 4.3 percent of men in the NCS; 22.5 percent of women in the Southwest sample, 20.2 percent of women in the Northern Plains sample, and 9.1 percent of women in the NCS also met criteria for PTSD (Beals, Novins, et al., 2005). Participants from the Northern Plains tribes as well as men from the Southwest sample were also significantly more likely to have developed PTSD if they had experienced interpersonal trauma rather than other varieties (Beals, Belcourt-Dittloff, et al., 2013).

Beals, Manson, et al. (2013) explored how rates of PTSD in the AI-SUPERPFP varied considerably when participants were asked about their responses to the three worst traumas they had experienced, instead of only the single worst trauma (the latter being standard practice in many epidemiological studies). The rates reported in Exhibit 3.2 reflect the three-trauma method, but when using the single-trauma method, the lifetime rate of PTSD (using DSM-IV criteria) was 8.4 percent for Southwest men, 5.9 percent for Northern Plains men, 14.8 percent for Southwest women, and 13.2 percent for Northern Plains women.

Beals, Manson, Whitesell, Spicer, et al. (2005) looked more closely at specific symptoms of major depression (according to DSM-III-R criteria) in the AI-SUPERPFP. The AI-SUPERPFP used less stringent criteria for evaluating major depression than did the NCS, based on focus group discussions about the cultural relevance of criteria. Notably, the AI-SUPERPFP did not require that multiple symptoms of depression occur at the same time. But the AI-SUPERPFP still found lower rates of major depression than were found in the NCS. The authors looked at the endorsement of specific symptoms and found that men from the Southwest sample were more likely to report each of the nine symptoms included than were men from the Northern Plains sample and were significantly more likely to state they had depressed mood, anhedonia, insomnia, hypersomnia, or some combination. At the same time, men from the Northern Plains sample were significantly less likely to report

each of the symptoms than were men in the NCS; men from the Southwest sample were significantly less likely to report fatigue or loss of energy and recurrent thoughts of death or suicide than were men in the NCS, but they were significantly more likely to report anhedonia. A similar pattern was observed for women in the studies, with women in the Southwest sample being significantly more likely to report anhedonia or depressed mood and more likely (but not significantly so) to endorse other symptoms than were women in the Northern Plains sample. Women from the Northern Plains sample were significantly less likely to report each of the symptoms than were women in the NCS, and women from the Southwest sample were significantly less likely to report six of the nine symptoms than were women in the NCS.

The Urban Indian Health Institute (UIHI, 2008) analyzed 5 years (i.e., 2001–2005) of health-related data derived from the BRFSS for American Indians and Alaska Natives living in counties serviced by urban Indian health organizations (n = 3,224) and compared those data with people who did not identify themselves as American Indian or Alaska Native from the same counties during the same period (n = 178,983). Although this survey did not evaluate SUDs, it did find that binge drinking was significantly more common among the American Indian and Alaska Native respondents, with 21.3 percent engaging in binge drinking in the prior 30 days compared with 15.8 percent of the rest of the sample; among American Indian and Alaska Native respondents who drank, 40.7 percent engaged in binge drinking, compared with 26.9 percent of the rest of the drinking sample.

BRFSS data from Alaska also indicate that Alaska Natives have high rates of mental distress (Alaska Department of Health and Social Services, 2011). According to age-adjusted data from the 2009 BRFSS for Alaska, 9.9 percent of American Indians and Alaska Natives in the state (who were largely Alaska Natives) reported frequent mental distress, which was defined as 14 or more days in the prior 30 during which the respondent perceived his or her mental health as poor. This was higher than the rate reported by White Americans in the state (i.e., 6.6 percent), but lower than the rate for African Americans (i.e., 13 percent).

Caron and Liu (2010) reported results from the Canadian Community Health Study that used the Kessler Psychological Distress Scale and the Composite International Diagnostic Interview (CIDI) to assess the behavioral health of 36,984 Canadians ages 15 and older. Aboriginal participants had the highest rates of psychological distress (i.e., Kessler 10 scores of greater than 9), with 29.2 percent reporting that level of distress, a significantly higher rate than found for White (i.e., 20.5 percent) or African American (i.e., 17.4 percent) Canadians. Aboriginal participants were also significantly more likely to have a mental or SUD, being 2 to 5 times more likely than members of other racial/ethnic groups.

Epidemiological Data on Mental Disorders From Other Studies

Several smaller studies reported epidemiological data on mental disorders for American Indians and Alaska Natives; some of these are discussed below. This section also contains data on suicidality for American Indians and Alaska Natives, which includes data from the AI-SUPERPFP in addition to other sources.

A multinational, cross-cultural study of college students (N = 1,150) that included an American Indian and Alaska Native sample (n = 353) in addition to White American, Argentine, and Japanese samples found that American Indians and Alaska Natives had significantly more severe depressive symptoms (assessed using the Center for Epidemiologic Studies-Depression Scale [CES-D]) than did White Americans or Argentines (Iwata & Buka, 2002). Specifically, American Indians and Alaska Natives were more likely to express depressive symptoms that indicate a negative feeling (e.g., "I feel lonely") and less likely to express symptoms that indicate the absence of positive affect (e.g., "I no longer enjoy life"). The authors also suggested that American Indians and Alaska Natives may tend to endorse somatic symptoms of depression more than affective symptoms.

Whitbeck, Hoyt, Johnson, and Chen (2006) assessed five DSM-III-R diagnoses (alcohol abuse disorder, alcohol dependence disorder, drug abuse disorder, major depression, and GAD) in a group of 861 American Indian or Canadian First

Nations parents or caregivers who resided on one of four reservations in the American Northern Midwest or one of five Canadian reserves. They found a past-year rate of major depression of 5.5 percent for men and 9.1 percent for women, and a lifetime rate of 9.3 percent for men and 20 percent for women. The past-year rate of GAD was 0.8 percent for men and 3.7 percent for women, and the lifetime rate was 1.7 percent for men and 5.6 percent for women. Data from this study on SUDs are presented below.

Rates of depression in some American Indian and Alaska Native samples may be confounded by the misuse of alcohol. Parks, Hesselbrock, Hesselbrock, and Segal (2001) evaluated the physical and behavioral health of 469 Alaska Natives admitted for AUD treatment to one of three programs. They found that 64.1 percent of women and 44.7 percent of men had a lifetime diagnosis of major depression, but when they considered only episodes of depression that were independent of heavy drinking or withdrawal from alcohol, the rates fell to 12.7 percent of women and 10.5 percent for men.

Dillard, Smith, Ferucci, and Lanier (2012) presented information from the Alaska Education and Research Toward Health study, which screened 3,771 Alaska Natives for recent depression (i.e., within 2 weeks of the screening) using the Patient Health Questionnaire-9 (PHQ-9). The study found that 20 percent of women and 13 percent of men likely had depression, based on having PHQ-9 scores of 10 or greater out of a possible 27. The authors also reported how frequently specific symptoms of depression were endorsed; the most often endorsed symptoms were insomnia or hypersomnia (endorsed by 50 percent of those with depression), decreased energy or tiredness (endorsed by 45 percent), and depressed mood (endorsed by 44 percent). Respondents of either gender were significantly more likely to have depression if they had one of several chronic physical conditions (e.g., arthritis, high blood pressure, asthma, glaucoma) or had lower incomes. Men were significantly more likely to screen positive for depression if they had *little or no* identification with their tribal culture, had less education, were unmarried, or some combination. Women were significantly more likely to have probable depression if they did have *greater* identification with their tribal culture, were ages 34 to 59 (rather than in other age groups), were current tobacco users, engaged in binge drinking, or some combination.

Aoun and Gregory (1998) assessed mental disorders for Alaska Natives who were seeking services at a community mental health center. They found high rates of mental disorders, with 58.6 percent of women and 30.4 percent of men meeting criteria for a current mood disorder, 13.6 percent of women and 24.4 percent of men having a psychotic disorder, 15.7 percent of women and 7.8 percent of men having an anxiety disorder, and 13.6 percent of women and 11.3 percent of men having a current personality disorder.

Canadian researchers evaluated anxiety and depression in an Arctic community that was 94 percent First Nations people, using English and Inuktitut versions of the Hospital Anxiety and Depression Scale (HADS), with a sample of 163 randomly selected individuals ages 14 to 85 (Chachamovich et al., 2000). They found that 29.4 percent of women and 21.8 percent of men screened positive as possibly having a mood disorder (i.e., had HADS depression scores of >8), and 21.4 percent of women and 15.1 percent of men screened as possibly having an anxiety disorder (i.e., had HADS anxiety scores of >10). Participants had significantly lower rates of anxiety disorders if they chose to have their screening conducted in Inuktitut (a possible indicator of acculturation), but their rate of depression was higher, although not significantly so.

Several studies have specifically evaluated the behavioral health of American Indian and Alaska Native women. For example, Duran, Sanders, et al. (2004) evaluated the mental health of 234 American Indian and Alaska Native women who were seeking primary care services (35 percent of whom had been screened as having poor general health using the General Health Questionnaire and would be expected to have worse mental health as well). Using the CIDI, they found that 23.1 percent of women had a mood disorder in the prior year, and 48.3 percent met criteria for a mood disorder at some point during their lives. Also, 51.3 percent had a past-year anxiety disorder, and 58 percent had an anxiety disorder during their lives. The most

common anxiety disorders were specific phobia (29.1 percent had one in the prior year) and PTSD (14.5 percent in the prior year).

A Canadian study assessed depression (using the University of Michigan version of the CIDI) among 769 First Nations women living on reservations in Ontario and compared results with those of 2,662 women who participated in the National Population Health Survey (NPHS), a large national study that used the same methodology (MacMillan et al., 2008). First Nations women in this study were twice as likely as women in the Canadian general population to have major depression in the prior year (with rates of 18.2 and 9.2 percent, respectively); 67.6 percent of First Nations women reported that psychological distress interfered with their lives at least a little, compared with 46.3 percent in the NPHS.

Wei, Greaver, Marson, Herndon, and Rogers (2008) assessed postpartum depression (using the Beck-Gable Postpartum Depression Screening Scale [PDSS]) for 586 new mothers (305 American Indian and Alaska Native) with low incomes using public health services in a North Carolina county. They found that American Indian and Alaska Native women had the highest rate of major depression (i.e., 18.1 percent) of any of the racial/ethnic groups evaluated but a medium rate of minor depression (i.e., 10.5 percent). These rates did not differ significantly from those of African American or White American women, but all three racial groups had significantly higher rates than did Latinas in the study.

Howard, Walker, Suchinsky, and Anderson (1996) evaluated the behavioral health records of 2,883 American Indian and Alaska Native veterans who had been inpatients at Department of Veterans Affairs (VA) hospitals (including psychiatric facilities) and were discharged in 1993 (1,351 of whom had been diagnosed with SUDs) and compared them with a total sample of 536,244 veterans. For those American Indian and Alaska Native veterans who did not have a co-occurring SUD, rates of most mental disorders were lower than in the total sample. The exception was PTSD; 3.9 percent of American Indian and Alaska Native veterans without co-occurring SUDs had that diagnosis compared with 1.9 percent of the total sample. Rates of mental disorders were higher for those with SUDs and are reported under "Epidemiological Data on CODs." The authors caution, however, that these data were derived from physicians' diagnoses and may reflect some bias.

Some studies have found higher rates of PTSD among American Indian and Alaska Native populations. For example, Ehlers, Hurst, et al. (2006) found that 13 percent of the 146 Southwest Indians they assessed met criteria for a current diagnosis of PTSD, although they also found that rates of alcohol dependence were not significantly higher for participants who had PTSD. Robin, Chester, Rasmussen, Jaranson, and Goldman (1997b) assessed a group of 247 members of a Southwest American Indian tribe and found that 21.9 percent met criteria for PTSD at some point during their lives.

Beals et al. (2002), in a study of 1,798 American Indian Vietnam veterans from two different tribes who were living on or near their reservations, found that those veterans were significantly more likely to have been diagnosed with PTSD than were other Vietnam veterans. Rates of lifetime PTSD were especially high for those from a Northern Plains tribe, of which 57 percent met criteria for PTSD at some point during their lives. By comparison, 45 percent of American Indians from a Southwest tribe had a lifetime PTSD diagnosis. A similar study was conducted 5 years earlier, in which 43 percent of African American, 24 percent of White, and 39 percent of Latino Vietnam veterans were found to have had PTSD. Among American Indians with PTSD, rates of co-occurring SUDs were also high, with 28.9 percent of the sample from the Southwest tribe and 30.8 percent from the Northern Plains tribe having co-occurring PTSD and SUDs. Of those who had PTSD and an AUD, more than 60 percent developed PTSD during their military service, and more than two-thirds developed PTSD at the same time or prior to developing the AUD. The authors considered a few possible reasons for these elevated rates of PTSD, including increased exposure to combat situations because of American Indian ethnicity and a strong identification with Vietnamese civilians and their plight.

Suicidality

In 2016, according to data collected by the CDC, there were 13.6 deaths from suicide per 100,000 American Indians and Alaska Natives—20.7 for men and 6.4 for women—which was less than that of the general population, for whom there were 13.9 suicide deaths per 100,000, with a rate of 21.8 for men and 6.2 for women (CDC, 2017). The suicide rate for American Indians and Alaska Natives was, however, second only to that of White Americans.

However, the CDC data provided above are derived from racial identifications made on death certificates and may undercount the number of American Indians and Alaska Natives (Department of Health and Human Services [HHS], Indian Health Service [IHS], 2015). IHS attempts to adjust death rate data for misreporting on death certificates, but the most recent years for which those adjusted data are available are from 2007 through 2009. During that period, the unadjusted suicide rate for American Indians and Alaska Natives was 16.6 per 100,000. By comparison, the rate of death by suicide in the general population in 2009 was 12.0 per 100,000 (Heron, 2012).

Suicide rates are even higher for Alaska Natives, as suicide rates in Alaska are more than twice as high as they are in the country as a whole (Allen, Levintova, & Mohatt, 2011; Herne, Bartholomew, & Weakhee, 2014). American Indians and Alaska Natives in the IHS Alaska service area had the highest rate of death by suicide of any IHS service area from 1999 to 2009, with an adjusted rate (adjusted for age and misreporting of race) of 42.5 per 100,000 (Herne et al., 2014). Suicide was the fourth leading cause of death for Alaska Natives between 2004 and 2008, and Alaska Natives had a suicide rate of 9.1 percent during those years, compared with a rate of 3.2 percent for White Americans in the United States as a whole (Day, Holck, & Provost, 2011). Another report on Alaska Native mortality indicates that between 1995 and 2006, Alaska Natives accounted for 39 percent of suicides in Alaska, in spite of only comprising 16 percent of the population (Alaska Injury Prevention Center, Critical Illness and Trauma Foundation, & American Society for Suicidology, 2007).

American Indians and Alaska Natives in Alaska (which includes American Indians residing in the state) are also significantly more likely to be hospitalized for a suicide attempt or other act of self-harm. Between 2002 and 2010, 26.8 out of every 10,000 American Indians and Alaska Natives were hospitalized for suicide attempts or self-harming behaviors, compared with 5.3 out of every 10,000 nonnative people in the state (Strayer, Craig, Assay, Haakenson, & Provost, 2014). The rate of such hospitalization was almost twice as high for American Indian and Alaska Native men (35 per 10,000) as for American Indian and Alaska Native women (18.4 per 10,000).

Herne et al. (2014) compared IHS-adjusted suicide rates for American Indians and Alaska Natives residing in counties that contained or were adjacent to federally recognized American Indian and Alaska Native tribal lands to rates for White Americans residing in the same counties, using data from 1999 to 2009. Thus, their comparisons more closely reflect specific regional factors that could affect suicide rates (e.g., weather, local economy). They found a wide variation in suicide rates according to region (regions they define in their article, and which necessarily reflect IHS service areas) and also found that although overall suicide rates were higher for American Indians and Alaska Natives, that was not always the case in given regions. Suicide rates were highest in Alaska counties, with a rate of 42.5 per 100,000 for American Indians and Alaska Natives (including American Indians residing in Alaska), compared with 12.6 for White Americans in the same counties, 65.4 for male American Indians and Alaska Natives (2.34 times higher than the rate for White American men), and 19.3 for female American Indians and Alaska Natives (2.88 times higher than the rate for White American women). The second-highest rate was for Northern Plains states (noting again that this included more states than are found in the IHS Northern Plains service area), where the overall suicide rate for American Indians and Alaska Natives was 26.2, with a rate of 41.6 for men and 11.9 for women (rates that were 1.77 times higher and 2.3 times higher than those for White American men and women, respectively). However, there were no significant differences in American Indian and Alaska Native and White

American suicide rates in counties in the Southern Plains area, and the suicide rate for American Indians and Alaska Natives in eastern states was actually significantly lower than the rate for White Americans in the same counties.

Given the Herne et al. (2014) study, it would be expected that suicide rates vary considerably among tribes (see also Leach, 2006). May (1987) reviewed several older studies on suicide and suicide risk for American Indian and Alaska Native adolescents and concluded that suicide rates were higher in tribes that have less social integration and a greater emphasis on individual autonomy and in tribes that are undergoing rapid change in social and economic conditions. IHS (2011) also called attention to the existence of suicide clusters in some American Indian and Alaska Native communities, where one suicide in the community or even an accidental death can contribute to multiple suicides or suicide attempts.

Pressure to acculturate to mainstream American culture also appears to increase suicide risk (Olson & Wahab, 2006). Leach (2006) reviewed a few studies that suggested that greater acculturation and lower income are associated with greater suicide risk, at least for members of some American Indian and Alaska Native tribes. Garroutte, Goldberg, Beals, Herrell, and Manson (2003), using AI-SUPERPFP data, determined that American Indians who were more oriented toward traditional spiritual beliefs (such as the belief that there is a balance and order to the universe) were significantly less likely to have attempted suicide.

Patterns of suicide risk for American Indians and Alaska Natives also vary somewhat from those seen in the general population. For example, rates of suicide among American Indians and Alaska Natives decrease with age (whereas for the general population, suicide rates are higher among younger and older people); this may reflect different cultural attitudes, which stress respect for elders, among American Indians and Alaska Natives (Leach, 2006).

American Indians and Alaska Natives also have higher rates of suicidal ideation, suicide planning, and suicide attempts than do members of other major ethnic/racial groups. In the 2016 NSDUH, 3.9 percent of American Indians and Alaska Natives ages 18 or older reported that they seriously thought of taking their own lives in the prior year, 1.4 percent made suicide plans, and 0.3 percent attempted to commit suicide (CBHSQ, 2017a). These percentages were similar to the national average for adults: 4.0 thought seriously about suicide, 1.1 percent made plans, and 0.5 percent attempted suicide.

In the AI-SUPERPFP, 6.6 percent of male and 10.7 percent of female respondents reported having made a suicide attempt during their lives (LeMaster, Beals, Novins, & Manson, 2004). Bolton et al. (2014) presented the AI-SUPERPFP data on suicidality along with general population data from the NCS for comparison. Compared with the NCS, the AI-SUPERPFP found relatively low rates of suicidal ideation, with 6.8 percent of Northern Plains Indians and 5 percent of those from the Southwest reporting suicidal ideation. By comparison, 12.9 percent of NCS participants reported suicidal ideation. Rates of suicide attempts were relatively high among American Indians from the Northern Plains, 8.7 percent of whom reported a previous suicide attempt, compared with 5 percent of those from the Southwest and 4.6 percent of those from the NCS. There were clear differences in how suicidality manifested between American Indians and Alaska Natives in the AI-SUPERPFP and the general U.S. population in the NCS. In American Indian and Alaska Native groups, suicide attempts without suicidal ideation were much more common than in the NCS. Of those who reported any form of suicidality, 39.8 percent of those in the Northern Plains sample and 32.6 percent of those in the Southwest sample had attempted suicide but did not report suicidal ideation, compared with only 2.4 percent of those in the NCS sample. The authors suggested that these differences reflect the fact that suicide attempts among American Indians and Alaska Natives, and more so for those from the Northern Plains tribes than the Southwest tribe, are impulsive and not preceded by contemplating or planning the act.

Bolton et al. (2014) also found that although men and women in the NCS and the Southwest tribe had significant differences in terms of rates of suicidal ideation (with women being more likely to

have suicidal ideation), there were no significant differences in terms of gender in the Northern Plains tribes, although women were still more likely than men to report suicidal ideation. There were also differences in the relationship of education to suicidal ideation for American Indians in the AI-SUPERPFP, compared with the NCS sample. In the NCS, suicidal ideation was less common among participants who completed high school than in those with less than 12 years of education, but in the Southwest sample, rates were the same regardless of educational attainment; in the Northern Plains sample, rates were actually somewhat higher (i.e., 7.1 percent) for those who completed high school than for those who did not (i.e., 6.6 percent).

Another publication from the AI-SUPERPFP evaluated the relationship of spiritual or religious beliefs and suicidality using measures of the strength of spiritual or religious commitment and of the degree to which the individual was oriented toward traditional cultural concepts of spirituality (Garroutte et al., 2003). These authors found that neither commitment to Christianity nor to traditional religious beliefs were significantly associated with suicide attempts, but that a stronger orientation toward traditional spiritual concepts (e.g., believing that there is a balance and order in the universe, believing oneself connected to other people) was associated with being significantly less likely to have attempted suicide.

As with other populations, suicidal acts and other suicidal behaviors among American Indians and Alaska Natives are even more common for those who have mental disorders and SUDs, although the degree to which such disorders affect suicidality may vary from tribe to tribe (Bolton et al., 2014; Leach, 2006; LeMaster et al., 2004; Olson & Wahab, 2006).

According to AI-SUPERPFP data, in a model that adjusted odds ratios for sociodemographic factors, having a diagnosis of a depressive disorder at some point during one's life was associated with a 9.11-fold increase in the odds of suicidal ideation for individuals from the Northern Plains tribes and a 5.78 times increase for those from the Southwest tribe (Bolton et al., 2014). Having an anxiety disorder during one's lifetime was associated with a 3.17 times increase in the odds of suicidal ideation in the Northern Plains sample and a 4.48 times increase in the Southwest sample. Having a SUD at some point was associated with a 5.4 times increase in the odds of suicidal ideation in the Northern Plains sample and a 3.54 times increase in the Southwest sample. In terms of the odds of having made a suicide attempt, a depressive disorder during one's lifetime was associated with a 5.15 times increase for those in the Northern Plains sample and a 4.63 times increase in the Southwest sample. Having an anxiety disorder during one's lifetime was associated with a 3.86 times increase in the odds of suicide attempts in the Northern Plains sample and a 3.25 times increase in the Southwest sample. Having a SUD at some point during one's lifetime was associated with a 4.03 times increase in the odds of having made a suicide attempt in the Northern Plains sample and a 5.11 times increase in the Southwest sample.

In terms of completed suicides, a case-controlled study of suicide among one First Nations tribe in Canada found that those individuals who died by suicide between 1982 and 1996 were significantly more likely than matched controls to have been diagnosed with one or more of the mental disorders evaluated (depressive disorders, personality disorders, and conduct disorder) or to have had contact with the behavioral health services system (Boothroyd, Kirmayer, Spreng, Malus, & Hodgins, 2001).

According to 2005–2006 data from 17 states, American Indians and Alaska Natives who died by suicide and who were tested for alcohol use were more likely than members of other racial/ethnic groups to have been drinking at the time of the suicide (45.5 percent of American Indians and Alaska Natives had been drinking, compared with 33.2 percent of the total sample of suicides) and more likely to have been intoxicated at or above the legal limit (37 percent of American Indians and Alaska Natives were compared with 24 percent for the total sample; CDC, 2009). Alcohol dependence was also suspected in coroners' reports for American Indian and Alaska Native suicides more often than for other racial/ethnic groups, with dependence suspected in 21 percent of the American Indian and Alaska Native cases, compared with

15.6 percent of the total sample. Another study, which looked at 2003 to 2009 data from the same reporting system, reached the same conclusions on the likelihood of drinking and alcohol intoxication at the time of death (Caetano et al., 2013).

Another study of suicide in aboriginal communities in Canada found that in 22 of the 30 cases, the individual was intoxicated at the time; in 23 cases, the person had a history of alcohol-related problems or illicit drug use; and in 6 of the cases, the individual had recently been diagnosed with a mental disorder (Laliberté & Tousignant, 2009).

Wexler, Silveira, and Bertone-Johnson (2012) analyzed data on Alaska Natives who either attempted suicide (n = 510) or died by suicide (n = 38) between 2001 and 2009 to evaluate differences between the two groups and between these groups and the general population in northwest Alaska in 2000. They found that Alaska Natives who had fatal or nonfatal suicidal behaviors were, compared with the total population of northwest Alaska, significantly less likely to be ages 14 or younger (5.4 percent of Alaska Natives with suicidal behavior in that age group were compared with 35 percent of the total population) or to be ages 60 and older (0.2 percent compared with 7.0 percent), but they were more likely to be ages 15 to 19 (33.8 percent compared with 10 percent) or ages 20 to 24 (24.7 percent compared with 7.0 percent). Compared with the total population with suicidal behavior in northwest Alaska, Alaska Natives with suicidal behavior were significantly less likely to be married (11.8 percent compared with 42 percent), employed (22.9 percent compared with 53 percent), to have a high school degree or greater level of education (49.8 percent compared with 72 percent), or some combination. Compared with Alaska Natives who attempted but did not complete suicide, those who died by suicide were significantly less likely to have had a known previous suicide attempt (15.8 percent versus 51.4 percent, although data were lacking for a larger percentage of Alaska Natives), to have displayed symptoms of depression (13.2 percent versus 32.6 percent), and to have used behavioral health services (32.2 percent versus 7.9 percent).

Studies involving Alaska Natives in the 1990s and 2000s found a history of misuse of alcohol or other substances significantly associated with completed suicides and suicide attempts and also found that a history of substance use/misuse was even more common among completers than attempters (Wexler, Hill, Bertone-Johnson, & Fenaughty, 2008; Wexler et al., 2012). However, data from 1995–2006 indicate that Alaska Natives who died by suicide were no more likely than other Alaskans who died by suicide during that period to do so while under the influence of alcohol or illicit drugs (72 percent of both groups tested positive for substances; Alaska Injury Prevention Center et al., 2007).

Among Alaska Native men, being suicidal has been associated with increased contact with healthcare service providers. Hill, Perkins, and Wexler (2007) found that Alaska Native men in northern Alaska who died by suicide were 2.75 times more likely than were matched controls to have had contact with medical staff members in the year prior to their suicide and 22.18 times more likely to have been treated for a problem involving or related to alcohol use. Boothroyd et al. (2001) also found, in their study of suicide among one First Nations tribe in Canada, that individuals who died by suicide had significantly more contact with the healthcare system as a whole than did matched controls who had not died by suicide.

Information on suicide prevention is presented under "Mental Health Promotion and Substance Misuse/Use Disorder Prevention."

Epidemiological Data on Addictive Disorders From Other Studies

Other, smaller studies with American Indian and Alaska Native samples have generally found high rates of lifetime AUDs, although rates of current AUDs vary more widely based on the age of the sample. For example, in a sample of 407 American Indians from six neighboring reservations in California, Ehlers, Wall, Betancourt, and Gilder (2004) found that 60 percent (n = 243) met DSM-III-R criteria for a diagnosis of alcohol dependence during their lifetime. Another study

that looked at illicit drug use of 460 American Indians from southwest Californian tribes found that 40 percent of the sample met criteria for a diagnosis of stimulant dependence at some point during their lives, 33 percent met criteria for marijuana dependence, 5 percent met criteria for opioid dependence, and 3 percent met criteria for inhalant dependence (Ehlers et al., 2007).

Rates of SUDs do vary considerably among tribes. Koss et al. (2003) evaluated 1,660 American Indians from seven different tribes and found that lifetime rates of alcohol dependence were high—ranging from 21 to 56 percent for men and 17 to 30 percent for women. In one tribe, rates were much lower than seen in the general population, with only 1 percent of men and 2 percent of women meeting criteria for alcohol dependence.

Young and Joe (2009) and Abbott (2008) reviewed several smaller studies, including ones that focused on the prevalence of SUDs in specific tribes. Abbott (2008) also included older studies, which have been excluded from this literature review because of their age.

Shore, Manson, and Buchwald (2002) sampled 754 American Indians and Alaska Natives who were primary care patients in an urban area. They found that 56 percent met criteria for a lifetime diagnosis of alcohol abuse disorder or alcohol dependence disorder, and 27 percent met criteria for a current diagnosis. They suggested that the high rate of AUDs found in their sample (compared with other studies) may be because urban American Indian and Alaska Native populations have higher rates of alcohol use than those living in rural areas, but there is no clear indication from other research that this is the case.

In a study of 234 American Indian and Alaska Native women receiving IHS primary care services, Duran, Sanders, et al. (2004) found that 15.6 percent had a past-year SUD, 14 percent had a past-year AUD, and 4.2 percent had a past-year drug use disorder. However, rates of lifetime disorders were considerably higher, with 62.3 percent meeting criteria for a SUD at some point during their lives, 57.9 percent meeting criteria for an AUD, and 29.8 percent meeting criteria for a drug use disorder.

In Whitbeck et al.'s (2006) study of 861 American Indian and Alaska Native parents or caregivers from the northern Midwest United States and closer parts of Canada, 54.7 percent had alcohol abuse disorder, 27.3 percent had alcohol dependence disorder, and 32.1 percent had an illicit drug use disorder at some point during their lives. The authors compared these rates to those found in the NCS and AI-SUPERPFP and observed that the rates of drug use disorders and alcohol abuse disorder were considerably higher than found for adults in the AI-SUPERPFP, although the rate of alcohol dependence is comparable. Rates were particularly higher for women. The authors were not able to conclude whether these differences reflected methodological differences or differences in the populations being evaluated.

In the study by Haggarty, Cernosvsky, Kermeen, and Merskey (2000) involving Canadian First Nations people, 23.2 percent of women and 42.3 percent of men had possible AUD as indicated by CAGE scores of greater than 1. However, in a sample of individuals convicted of driving while intoxicated in Bernalillo County, NM (N = 1,389), C'de Baca, Lapham, Skipper, and Hunt (2004) found that, after adjusting for age and other demographic differences, American Indian women in this group were significantly less likely to meet criteria for alcohol dependence than were non-Hispanic White women, and American Indian men were significantly less likely than non-Hispanic White men to have a drug dependence disorder.

Studies have also generally found rates of pathological gambling among American Indian and Alaska Native samples that are higher than in those of other populations. For example, Westermeyer, Canive, Garrard, Thuras, and Thompson (2005) surveyed 718 American Indian and 510 Latino veterans from the Southwest or North Central regions and found a significantly higher rate of pathological gambling in the former (a 10 percent lifetime rate) than in the latter (4 percent), according to DSM-IV criteria assessed using the Quick–Diagnostic Interview Schedule (DIS). However, research with another group of American Indian veterans in the North Central region (N = 557) found that a relatively low percentage of respondents (42 percent) had gambled five or more times during their lives (Westermeyer et al., 2008).

Volberg and Abbott (1997) surveyed 434 American Indians and Alaska Natives and 1,465 White Americans in North Dakota regarding gambling behaviors and found that American Indian and Alaska Native respondents were significantly more likely to have engaged in problem gambling (a score of 3 or 4 on the South Oaks Gambling Screen) or to have probable pathological gambling (scores of 5 or greater) than were White Americans. American Indians and Alaska Natives also spent significantly more (nearly three times as much) on gambling.

Zitzow (1996) compared problematic gambling behaviors for 109 American Indians living on or near a reservation and 102 individuals of other races who lived near the reservation. He found that American Indians were significantly more likely than non-American Indians to engage in each of the 14 problematic gambling behaviors evaluated and to be either problematic gamblers (i.e., to engage in three or more problematic behaviors but not meet criteria for pathological gambling disorder) or pathological gamblers (according to DSM-III-R criteria).

Substance Use and Misuse Patterns for American Indians and Alaska Natives

In addition to understanding rates of SUDs and related problems (e.g., binge drinking), it can help behavioral health services providers to have a better understanding of the types of substances misused, mortality related to SUDs and problematic use, rates of abstinence, and other factors. Providers should understand that as in other areas, these factors likely vary considerably according to tribe and region, and they should familiarize themselves with the patterns of substance use in the American Indian and Alaska Native populations they will be treating.

SAMHSA's Treatment Episode Data Set (TEDS) collects admission and discharge information about clients at SUD treatment programs that receive public funds but generally are not federal programs (although it does include some IHS-run programs); in a few states, some private programs are also included. Some states report on all clients in the facility; others report only those clients who receive public funding. Unless otherwise indicated, TEDS data are for individuals ages 12 and older. According to TEDS admission (TEDS-A) data for 2015, the primary substance used most often by American Indian or Alaska Native admissions entering these SUD treatment programs was alcohol (accounting for 55.8 percent of American Indian or Alaska Native admissions; SAMHSA, n.d.-a). In the 2015 TEDS, American Indian or Alaska Native admissions reported the following rates of primary substances:

- 17 percent of American Indians or Alaska Native admissions were admitted to treatment for primary use of opioids, compared with 39 percent of White admissions, 24 percent of Black or African American admissions, and 19 percent of Latinos of Mexican origin admissions.
- 12 percent of American Indian or Alaska Native admissions were admitted to treatment for primary use of marijuana, compared with 11 percent of White admissions, 25 percent of Black or African American admissions, and 20 percent of Latinos of Mexican origin admissions.
- 11 percent of American Indian or Alaska Native admissions were admitted to treatment for primary use of methamphetamine, compared with 9 percent of White admissions, 2 percent of Black or African American admissions, and 24 percent of Latinos of Mexican origin admissions.
- 2 percent of American Indian or Alaska Native admissions were admitted to treatment for primary use of cocaine, compared with 3 percent of White admissions, 13 percent of Black or African American admissions, and 2 percent of Latinos of Mexican origin admissions.

In the 2015 TEDS data set (SAMHSA, n.d.-a), American Indian or Alaska Native admissions reported the following rates of primary, secondary, or tertiary misuse:

- 6.0 percent of Alaska Native admissions and 7.3 percent of American Indian admissions reported using cocaine or crack as primary, secondary, or tertiary substances (compared with 14.3 percent of White admissions and 31.4 percent of Black or African American admissions).

- 8.8 percent of Alaska Native admissions and 13.5 percent of American Indian admissions reported using heroin (compared with 32.7 percent of White admissions and 23.8 percent of Black or African American admissions).
- 5.4 percent of Alaska Native admissions and 12.4 percent of American Indian admissions reported using other opioids (compared with 17.8 percent of White admissions and 5.2 percent of Black or African American admissions).
- 11.0 percent of Alaska Native admissions and 22.7 percent of American Indian admissions reported using methamphetamine (compared with 15.6 percent of White admissions and 3.3 percent of Black or African American admissions).
- 43.5 percent of Alaska Native admissions and 36.2 percent of American Indian admissions reported using marijuana (compared with 30.9 percent of White admissions and 42.3 percent of Black or African American admissions).

Combining Alaska Native and American Indian admissions, TEDS data showed that alcohol, opioids, marijuana, and methamphetamines were the substances primarily misused by those entering SUD treatment. According to collected data from 2015, 63.3 percent of American Indian or Alaska Native admissions for men and 44.4 percent of American Indian or Alaska Native admissions for women reported alcohol as the substance they primarily used most often (SAMHSA, n.d.-a). Opioids were the second most common primary substance for American Indian or Alaska Native admissions for men (12.9 percent) and women (22.5 percent). The third most common primary substance for American Indian or Alaska Native admissions for men was marijuana (12.8 percent), which was the fourth most common primary substance for American Indian or Alaska Native admission for women (11.5 percent). The third most common primary substance for American Indian or Alaska Native admissions for women was methamphetamines (16.5 percent), which was fourth for men (7.6 percent). The most common pattern of problem drinking among American Indians with AUD appears to be one of binge drinking followed by periods of abstinence (May & Gossage, 2001). A similar pattern is seen among Alaska Natives (Seale, Shellenberger, & Spence, 2006; Wells, 2004a). In the AI-SUPERPFP, individuals who lived on reservations were more likely to engage in binge drinking but also consumed alcohol less frequently than did people in general population samples used for comparison (O'Connell, Novins, Beals, & Spicer, 2005).

There are several reasons suggested for why such drinking patterns have developed for American Indians and Alaska Natives. Some see this pattern as reflecting the drinking patterns of early European settlers who first brought alcohol to many American Indian and Alaska Native tribes (see "Historical Oppression and Continuing Discrimination" for additional discussion). Other factors that may contribute to this pattern of binge drinking followed by periods of abstinence include the difficulty getting alcohol on dry reservations or isolated communities (French, 2004; Kunitz et al., 1994; Weaver, 2001); the lack of other, nonalcohol-related weekend activities because of geographic isolation and economic want (Adrian, Layne, & Williams, 1990; French, 2004); and the belief that weekend binges are acceptable and do not interfere with other responsibilities (Wardman & Quantz, 2005).

French (2000) identified this pattern of binge drinking, which he also recognized as typical of many American Indians and Alaska Natives with AUDs, as fitting Jellinek's category of "epsilon alcoholism." French noted that this pattern of drinking, in which individuals can go long periods without drinking but at the same time show many of the signs of alcohol dependence, is the least understood of the types of "alcoholism" Jellinek identified. Other evidence accumulated since the 1970s suggests that drinking patterns, social attitudes toward drinking, and the nature of abusive drinking differ for many American Indian tribes and groups from those seen among White Americans (Herman-Stahl & Chong, 2002; Kunitz et al., 1994; May & Gossage, 2001; Thatcher, 2004; Whittaker, 1979).

In a study of American Indians with major depression from three different tribes, Manson, Shore and Bloom (1985) found that binge drinking was common among those who did and did not meet diagnostic criteria for an AUD and that this pattern of drinking had negative repercussions regardless

of whether the individual had an AUD. Nearly one-third of the individuals in that study who did not have an AUD stated that others had objected to their drinking at some point.

Situations in which heavy drinking is considered acceptable will vary from tribe to tribe and may be carefully prescribed. For example, Everett (1980) observed six distinct situations in which it was acceptable for White Mountain Apache to drink. In each of those situations, there were also cultural rules about how drinking was to occur in the context of that event (e.g., at a dance, at a wake, when visiting another camp).

There are some indications that rates of alcohol use have decreased in at least some American Indian and Alaska Native communities since the 1960s, when significant research on the issue began (Henson et al., 2008). For example, Leung, Kinzie, Boehnlein, and Shore (1993) found that the prevalence of AUDs in a Pacific Northwest American Indian community decreased from 39 percent to 21 percent over the 19-year period of the study (decreasing from 52 percent to 36.4 percent for men and from 26 percent to 7 percent for women). McFarland, Gabriel, Bigelow, and Walker (2006) also found reductions in AUDs among American Indian and Alaska Native populations between 1997 and 2002.

However, a study comparing NSDUH data for 2004–2005 with that of data for 2007–2008 did not find any significant differences in past-month use of alcohol or past-month binge drinking for American Indians and Alaska Natives (SAMHSA, Office of Applied Studies [OAS], 2010). In a 20-year follow-up study with a Northern Plains tribe, Whittaker (1982) found that the percentage of youth and adults who drank regularly (at least three times per week) increased from 24 percent to 31 percent between 1960 and 1980. At the same time, the percentage of those who abstained from alcohol had also increased from 31 percent to 42 percent.

When it comes to the amount of alcohol used, American Indians do not appear to differ greatly from Whites. Data from the NSDUH (Cunningham, Solomon, & Muramoto, 2016) found generally comparable rates between American Indians and Whites in the number of alcoholic drinks consumed, with pronounced differences observable only at the lower ends of consumption. Specifically, 59.9 percent of American Indians versus 43.1 percent of Whites reported abstaining during the past month, and 14.5 percent of American Indians versus 32.7 percent of Whites reported drinking light/moderately only. These patterns were generally corroborated by analyses using data from the 2011–2013 BRFSS.

Patterns of illicit drug use by American Indians are not as different from those of other ethnic groups in the same geographic regions as are patterns of alcohol use. For example, Nixon, Phillips, and Tivis (2000) looked at a group of 522 American Indians entering treatment programs in Oklahoma and found "remarkable similarity" with members of other ethnic/racial groups in the state regarding patterns of substance use.

The AI-SUPERPFP also found that the most commonly used illicit drugs also varied somewhat according to tribe and gender (see Exhibit 3.3).

Whitesell et al. (2007) compared data from the AI-SUPERPFP to general population data from the NCS. Although the studies were conducted about 5 years apart, sampled different geographic areas, and used somewhat different measures, the authors found similar rates of lifetime drug dependence among the Southwest tribe, the Northern Plains tribes, and the general population sample. However, rates of drug use were somewhat higher for the American Indian samples than for the general population sample. Whitesell et al. (2007) also found that polySUDs were significantly lower for the AI-SUPERPFP sample than found in the NCS for the general U.S. population.

In an earlier article, Whitesell et al. (2006) compared AI-SUPERPFP data to the national data from SAMHSA's 1999 National Household Survey of Drug Abuse (NHSDA) to evaluate differences in patterns of alcohol and illicit drug use. They found that in the national sample, there was a broader array of substances being used during an individual's lifetime and a greater likelihood of a primary substance of misuse other than alcohol or marijuana. Based on this analysis, they categorized four basic patterns of substance use

EXHIBIT 3.3. Lifetime Substance Use Among American Indians in the AI-SUPERPFP

TYPE OF SUBSTANCE USE	SOUTHWEST MEN (%)	SOUTHWEST WOMEN (%)	NORTHERN PLAINS MEN (%)	NORTHERN PLAINS WOMEN (%)
Marijuana use	55.8	36.9	57.5	49.3
Hallucinogen use	15.6	3.3	13.9	6.4
Cocaine use	15.1	4.3	21.5	14.5
Other stimulant use	8.5	2.9	15.6	12.9
Inhalant use	13.3	3.6	17	10.6
Illicit prescription opioid use	6.9	5.1	11.3	6.9
Heroin use	1.4	0.5	0.6	0.3
Illicit sedative use	3.9	1.7	1.9	1.8

Source: Mitchell et al., 2003. Adapted with permission.

among American Indians from the two regions: (1) abstainers, (2) primary alcohol users, (3) primary alcohol and marijuana users, and (4) polysubstance users. Among those who used substances, the most common pattern of use was primarily alcohol use, followed by primarily alcohol and marijuana use, and then polysubstance use.

Among an urban treatment sample of Alaska Natives with alcohol dependence disorder (N = 582), most participants (56 percent) had two or more substance dependence disorders (Malcolm, Hesselbrock, & Segal, 2006). For men in the study, the most common co-occurring substance dependence disorder was marijuana dependence (for 68.5 percent of men in the study), and for women it was cocaine dependence (for 51.2 percent of women). Rates of co-occurring marijuana dependence were also high for women (46.5 percent), and co-occurring cocaine dependence was common for men (affecting 44.4 percent).

Methamphetamine use has been a particular concern for several American Indian and Alaska Native communities (IHS, 2011). According to a report from the National Congress of American Indians (NCAI), 74 percent of tribal police forces considered methamphetamine to be their greatest illicit drug threat (NCAI, 2006). One Southwest tribe in Arizona found that 30 percent of their tribal employees tested positive for methamphetamine use, and that number was believed to underestimate the extent of the problem. However, this trend may be changing. In the 2015 TEDS data, American Indians and Alaska Natives were more likely than White Americans (11 percent and 9 percent, respectively) to enter treatment primarily for a methamphetamine use disorder but were less likely to do so than Latinos of Mexican descent (24 percent) or Asian Americans (22 percent; SAMHSA, n.d.-a).

Methamphetamine use disorders may be an even greater problem for American Indians and Alaska Natives living in rural areas than for those living in most urban areas. In rural areas in 2004, American Indians and Alaska Natives made up 6 percent of all treatment admissions that indicated methamphetamine as the primary drug of misuse, compared with between 1 and 2 percent of cases in urban areas (OAS, 2006).

Data from 2000 through 2005 for Los Angeles suggested that methamphetamine was becoming the drug of choice for growing numbers of American Indians, especially women, entering treatment in that city (Spear, Crevecoeur, Rawson, & Clark, 2007). This may reflect a regional problem, as rates of stimulant use and stimulant use disorders were also high among American Indians on reservations in Southern California, according to research by Ehlers et al. (2007). They found that 55 percent of men (n = 105) and 62 percent of women (n = 168) in their sample of individuals from eight contiguous reservations in San Diego County had used stimulants (i.e., cocaine or methamphetamine), and 37 percent of men and 42 percent of women met criteria for a lifetime diagnosis of stimulant dependence. These authors also found that, for this population, stimulant use was more likely to develop into dependence than was use of other illicit drugs (use was associated with later dependence almost twice as often for stimulants as it was for opioids or marijuana).

Another growing concern in some American Indian and Alaska Native communities is the misuse of prescription opioids, such as OxyContin, which have become more readily available on many reservations (IHS, 2011; Momper, Delva, & Reed, 2011; Radin et al., 2015). The 2014 TEDS found that 4 percent of male and 9 percent of female American Indians and Alaska Natives indicated that opioids other than heroin were their primary substance of concern (SAMHSA, n.d.-b). According to 2016 NSDUH data, 3.9 percent of American Indians and Alaska Natives ages 12 or older misused painkillers in the past year, which was similar to the national average (4.3 percent). Rates of misuse among other racial groups were 3.9 percent for African Americans, 4.2 percent for Latino Americans, and 4.5 percent for White Americans (CBHSQ, 2017a).

In rural and frontier areas, patterns of substance use and misuse are affected by the limited availability of certain drugs. For instance, one study of "very rural" Native Alaskan villages found rates of alcohol, marijuana, and tobacco use that were high compared with those found in national surveys, but rates of other drug use were significantly lower than found in the nationwide samples (Stillner, Kraus, Leukefeld, & Hardenbergh, 1999). Many Alaska Native communities also either prohibit or restrict the importation and sale of alcohol in the community (Berman & Hull, 2001), but alcohol is still imported by bootleggers who can charge exorbitant amounts for their product (Barry, 2008). The lack of regular access to alcohol may also contribute to binge drinking (French, 2004; Kunitz et al., 1994; Weaver, 2001).

The relative isolation and poverty of some rural American Indian and Alaska Native communities may lead to less access to (and therefore less use of) costlier and more difficult-to-obtain illicit drugs but unfortunately may also encourage the use of chemical inhalants. Alcohol control policies may also inadvertently push people into using inhalants to replace alcohol (May, 1992). These substances tend to be used more often among people with lower socioeconomic status because of the ready availability and low cost of common household products like spray paint (National Institute on Drug Abuse, 2005). A few studies have found that American Indians and Alaska Natives are more likely than members of other racial/ethnic groups to use inhalants (Garland, Howard, Vaughn, & Perron, 2011).

Inhalant use is a significant problem among American Indian and Alaska Native youth, especially in rural communities, although use appears to have declined over the past decade (Beauvais, Wayman, Jumper-Thurman, Plested, & Helm, 2002; French, 2000; Garland et al., 2011). Inhalant use typically declines with age for American Indians and Alaska Natives, peaking around eighth grade (Miller, Stanley, & Beauvais, 2012), but there are also reports of inhalant use among older American Indian and Alaska Native men who, through years of such use, have serious cognitive deficits (Wallace & Green, 2009).

NSDUH data for 2016 indicated past-year use of inhalants by 0.5 percent of Native Americans ages 18 and older, similar to the national average of 0.1 percent (CBHSQ, 2017a).

Substance-related morbidity and mortality

Data also suggest that American Indians and Alaska Natives suffer disproportionately from ill health effects resulting from AUDs. In the early 1990s, the rate of death from "alcohol abuse" (as

defined by the National Center for Health Statistics (NCHS) and including deaths from liver disease or cirrhosis and other nontraumatic conditions caused by alcohol misuse) was seven times greater for American Indians than for the general population (Welty, 2002).

Similarly, the U.S. Burden of Disease and Injury study in 1996 found that alcohol use was the sixth greatest cause of years of life lost to mortality among American Indian men and the 13th greatest cause for American Indian women but was not listed among the top 20 causes for White men or women (Michaud et al., 2006). Most of the top six causes of life lost to mortality for American Indian and Alaska Native men in this study were potentially alcohol-related: (1) motor vehicle crashes, (2) ischemic heart disease, (3) self-inflicted injury, (4) homicide and violence, (5) cirrhosis of the liver, and (6) alcohol. For American Indian and Alaska Native women, the top six causes were: (1) motor vehicle crashes, (2) ischemic heart disease, (3) cirrhosis of the liver, (4) diabetes mellitus, (5) cerebrovascular diseases, and (6) breast cancer. According to data for age and mistakes in racial identification from 2007 to 2009, the rate of alcohol-related deaths for American Indians and Alaska Natives was more than six times higher than the rate for the U.S. general population in 2008 (HHS, IHS, 2015). Earlier data, from 2005 to 2007, indicated that the rate of alcohol-related deaths ranged from a low of 17 per 100,000 people in the Nashville service area to 83.4 per 100,000 people in the Billings service area, with a mean rate in all IHS service areas of 44.7 per 100,000, which can be compared with an unadjusted rate of 6.7 for the U.S. population as a whole during the same period (HHS, IHS, 2012).

Landen, Roeber, Naimi, Nielsen, and Sewell (2014) analyzed cause of death data from CDC's NCHS from 1999 to 2009 for 1,691 American Indians and Alaska Natives and 61,726 White Americans. They found that American Indians and Alaska Natives had a significantly higher rate of death from alcohol-related causes, and a larger percentage of American Indian and Alaska Native deaths were attributable to alcohol (10.3 percent of American Indian and Alaska Native deaths, compared with 2.6 percent of White American deaths). The authors also compared causes of death for American Indians and Alaska Natives with those for White Americans residing in counties where there were federally recognized tribal lands or that were adjacent to tribal lands for 2005 to 2009. According to this subset of data, American Indians and Alaska Natives were approximately 14.2 times more likely than White Americans to die of hypothermia, 7.6 times more likely to die of alcohol poisoning, 5 times more likely to die because of alcoholic psychosis, and 4.9 times more likely to die from alcoholic liver disease.

Shield et al. (2013) used data from NESARC and the Comparative Risk Assessment study to evaluate the contribution of alcohol to mortality for various demographic groups. Among all the races included in the study, American Indians and Alaska Natives had the greatest loss of years of life because of drinking. The authors used data on alcohol consumption and the relative contribution of alcohol to various causes of death (not just deaths that could be directly attributed to drinking) to determine the percentage of deaths that could be attributed to alcohol consumption, producing a higher rate than was found in studies that only looked at death certificates that attributed death to alcohol. They found that in 2005, for people ages 15 to 64, American Indians and Alaska Natives had the highest rate of potential years of life lost because of alcohol consumption (22.8 percent of years of life lost), a rate that was more than twice as high as the next highest (11.2 percent for White Americans). They also estimated that 20.5 percent of all American Indian and Alaska Native deaths could be attributed to alcohol consumption (25.8 percent for men and 11.6 percent for women), which was also more than twice as high as the rate observed in White Americans (9.3 percent for both genders).

Christian, Dufour, and Bertolucci (1989), in an analysis of alcohol-related deaths in Oklahoma between 1968 and 1978, found that alcohol-related death rates for American Indians were nearly three times as high as found for the racial group with the next highest rate (i.e., African Americans) and nearly four times as high as found among White Americans. However, there were also significant differences in alcohol-related deaths by tribal affiliation, with rates ranging from 1.9 percent to 29.7 percent.

In a review of data from NESARC and NSDUH, Delker, Brown, and Hasin (2016) found that, although the prevalence of current alcohol consumption was highest among Whites, the prevalence of past-year alcohol abuse or dependence was higher among American Indians than among members of any other racial/ethnic group. Analyses of racial/ethnic differences in the consequences of drinking identified American Indians as being at an increased risk of alcohol-related health outcomes compared with other groups. This included American Indians having the highest prevalence of self-reported drinking and driving, intoxication among drivers fatally injured in vehicle accidents, and alcohol use by suicide victims (particularly for American Indians ages 30 to 39 years and 20 to 29 years).

Alcohol is also a leading cause of death for Alaska Natives. According to data for 2004 through 2008, AUDs were the fifth leading cause of death for Alaska Natives, accounting for 4.4 percent of deaths, whereas it accounted for only 0.5 percent of deaths for White Americans in the general population during the same period (Day et al., 2011).

Abstinence rates

Rates of abstinence from alcohol and drugs are also high among American Indians and Alaska Natives compared with other racial/ethnic groups. The AI-SUPERPFP found that rates of lifetime abstinence from alcohol among the Northern Plains and Southwest tribes in the study were significantly higher than those found among the general population in the National Longitudinal Alcohol Epidemiologic Survey (NLAES), which used different researchers and research techniques and was conducted a few years earlier than the AI-SUPERPFP (Beals et al., 2003).

Whitesell et al. (2006), in another analysis of AI-SUPERPFP data, also found that past-year abstinence rates were higher in their American Indian samples, particularly among those from Southwest tribes, than among the general population in the 1999 NHSDA. Also, past-year abstinence rates were significantly higher among those American Indians who were not lifelong abstainers than among those in the general population who were not lifelong abstainers (and higher for those from the Southwest tribe compared with those from the Northern Plains tribes). The authors found that the proportion of American Indians from the AI-SUPERPFP that they classified as primarily alcohol users (i.e., not regular users of marijuana as well as alcohol or other polysubstance users) who had abstained from alcohol in the prior year was about three times higher than the proportion of primarily alcohol users in the NHSDA who had abstained in the past year. They concluded that this reflected the fact that American Indians who used alcohol and then attempted to change their drinking patterns are much more likely to become abstainers than are drinkers in the general population who attempt to do the same.

Other studies have found that a greater percentage of American Indians abstain from alcohol as compared with the general population (Ehlers et al., 2004; Heath, 1989; Herman-Stahl & Chong, 2002). Similarly, data on alcohol consumption for 2001 through 2003 showed that Alaska Natives are significantly more likely to abstain than are other Alaskans (Wells, 2004a).

Among urban American Indian and Alaska Native populations, abstinence rates are also high. In the UIHI's (2008) analysis of BRFSS data, 47.3 percent of urban-dwelling American Indians and Alaska Natives reported no alcohol use in the prior 30 days, compared with 40.9 percent of respondents who did not identify as American Indian and Alaska Native.

Similarly, Cunningham, Solomon, and Muramoto (2016) analyzed data from the NSDUH from 2009–2013 and found that, compared with Whites, American Indians were much more likely to have abstained from alcohol in the past month (59.9 percent versus 43.1 percent) or engaged in only light or moderate drinking (14.5 percent versus 32.7 percent). These patterns were generally replicated by data analyzed from the 2011–2013 BRFSS.

NESARC data, however, indicated that the rate of abstention from alcohol for American Indians and Alaska Natives, although higher than that of White Americans, was not higher than that for African Americans or Asian Americans and Pacific Islanders (Shield et al., 2013). Based on data from

both waves of NESARC, these authors estimated that in 2005, 14.1 percent of American Indian and Alaska Native men were lifelong abstainers, and 19.1 percent were former drinkers who currently abstained; 26.9 percent of American Indian and Alaska Native women were lifelong abstainers, and 21.2 percent were former drinkers who currently abstained.

In another publication using NESARC data, Falk, Yi, and Hiller-Sturmhöfel (2008) observed that in the first Wave of NESARC (2001–2002), 65.5 percent of American Indians and Alaska Natives reported using alcohol, and 10.8 percent reported some illicit drug use; in all, 32.7 percent of American Indians and Alaska Natives reported abstaining from alcohol and illicit drugs. By comparison, 25.2 percent of White Americans, 36.6 percent of African Americans, and 37.7 percent of Asian Americans and Pacific Islanders abstained from alcohol and drugs.

The fact that many tribes have traditional attitudes that value abstinence and condemn all alcohol intoxication may contribute to high rates of abstinence and heavy consumption or binge drinking among those who do drink (Coyhis & White, 2006; Thatcher, 2004).

Aging-out patterns

Although it is not specific to American Indians and Alaska Natives, the phenomena of "aging out" or "maturing out" from AUDs (i.e., stopping or limiting use of substances as one grows older) has been observed in American Indian populations and is worth considering when evaluating the overall course of SUDs in this population. Researchers such as Quintero (2000) and Kunitz et al. (1994), have observed that many American Indians, as they grow older and take on more responsibilities in the family and the community, become abstinent or significantly lower their level of alcohol use. However, data from both waves of NESARC indicated that there were no significant differences among races in the likelihood of maturing out from alcohol dependence (Vergés et al., 2012) or illicit drug use disorders (Vergés et al., 2013). NESARC found that across racial groups as individuals aged, there was a decline in the onset of new SUDs, a decrease in the recurrence of SUDs, and a less robust decrease in the persistence of SUDs that only manifested in the oldest age groups evaluated.

This pattern may be more common among American Indians and Alaska Natives who more closely identify with their traditional cultures. In one of the longest longitudinal studies on American Indian alcohol use done to date, Kunitz et al. (1994) looked at three different groups of Navajo Indians and observed that this aging-out pattern was much more common among members of those groups who had a stronger connection to a traditional Navajo way of life. They looked at samples from a Plateau group (who lived on the reservation in a lifestyle most in keeping with a traditional Navajo lifestyle), a South Tuba, AZ, group (who lived in or near the largest city on the reservation, which had a population of 8,225 in 2000, and who were somewhat less connected to traditional Navajo culture), and a Flagstaff, AZ, group (who lived in a large urban area outside the reservation with a population that was predominantly White and whose Navajo population had the least connection with their traditional way of life). Alcohol use patterns varied across these three communities, and the pattern of aging out was most apparent in the Plateau group and among rural dwelling men in the South Tuba group. Even though men in the Plateau group appeared to drink more heavily and scored higher on scales assessing preoccupation with alcohol than did men in the other two groups, they were also the most likely to have stopped drinking at the time of the restudy. In the Plateau group, 87 percent of men were abstinent, compared with 33 percent of the South Tuba group who lived in the city and 75 percent of the South Tuba group who lived in rural areas outside the city. Weibel-Orlando, Weisner, and Long (1984), in their comparison of urban and rural alcohol patterns in Southern California, also found that this aging-out process was more common among individuals living on reservations than among those living in the city.

Former drinkers whose AUDs are in remission will likely be older than active drinkers, but the age at which the recovery process begins may vary. May and Smith (1988) surveyed 174 Navajo living on the reservation or in nearby border towns and found that alcohol use peaked in the 20- to 29-year-old

age group and declined steadily thereafter. In Tan, Westermeyer, Thompson, Thuras, and Canive's (2008) research with 558 American Indian veterans living in the North Central region of the United States (half from rural areas and half from urban), the 41 percent (n = 82) who were in remission from SUDs for 1 year or more had a mean age of 47.2, compared with those with active SUDs (n = 117) who had a mean age of 43.4.

The pattern of aging out, however, is not unique to American Indians and Alaska Natives, and there are some indications that it may actually begin at a later age for American Indians and Alaska Natives than for members of other major racial/ethnic groups. Young and Joe (2009), in an analysis of NESARC data, found that although alcohol dependence among American Indians and Alaska Natives began to decrease as individuals (male and female) grew older, it did not decrease as much as it did for White Americans. Although American Indian and Alaska Native men, ages 18 to 29, were about as likely as White American men in that age group to have alcohol dependence, American Indian and Alaska Native men ages 45 to 64 were about twice as likely as White American men in the same age group to have alcohol dependence. American Indian and Alaska Native women ages 45 to 64 were 2.2 times as likely as White American women in that age group to have alcohol dependence, and American Indian and Alaska Native women ages 18 to 29 were 1.37 times more likely than White American women to have alcohol dependence. Rates of alcohol abuse disorder declined to a greater degree for American Indian and Alaska Native men than they did for White American men. In the 18 to 29 age group, American Indian and Alaska Native men were 1.41 times more likely than White American men to have alcohol abuse disorder, but in the 30 to 44 age group, American Indian and Alaska Native men were about 25 percent less likely than White American men to have a current alcohol abuse disorder (the ratio was similar in the 45 to 64 age group). Although with age, abstinence clearly increases and AUDs decrease, many American Indians and Alaska Natives continue to have AUDs even as they grow older (relative to White Americans, who are traditionally the racial group with the next highest rate of AUDs).

Barker and Kramer (1996) used a convenience sample from the late 1980s of 282 American Indians living in Los Angeles who were recognized as elders in their communities (participants had a mean age of 61.1, and individuals who were homeless were excluded). They found that the majority of these elders did not drink at all (73 percent were abstainers, and another 10 percent drank less than once per month), although many reported having drunk heavily when they were younger. Consistent with the idea that social and family responsibilities are motivators for abstinence among older American Indians and Alaska Natives, respondents in the study who lived in multigeneration households drank significantly less than did those who lived in single-generation households.

May and Gossage (2001) found that in their sample (N = 1,436), drawn from four tribes in the Northern United States, drinking was still common in individuals over the age of 50 (57.1 percent of men, and 43.8 percent of women drank) but not as common as among younger individuals (e.g., 86.2 percent of men and 72.8 percent of women ages 20 to 29 drank), and the amount consumed per occasion was substantially lower. Bezdek and Spicer (2006) also noted this phenomenon of aging out in their research with a Northern Plains tribe, although the focus of their work was on the reasons for this turn to abstinence. They interviewed 133 individuals who had been identified as having a lifetime history of alcohol dependence (according to DSM-III-R criteria) in research conducted 1 to 5 years earlier and found that 26.5 percent had been abstinent for at least 1 year, 56.1 percent had been abstinent for less than 1 year or had moderated their drinking (according to self-report), and 17.4 percent continued to drink at the same level.

Quintero (2000) found that although 77 percent of 112 men in a Southwest tribe qualified for a diagnosis of alcohol dependence at some point during their lives, 43 percent of them (n = 48) had achieved remission of alcohol dependence (defined as no use of alcohol or no DSM-III-R symptoms of dependence in the past 6 months) at the time of the study.

In a sample of 407 American Indians from six neighboring reservations in California, 61 percent of those who had met criteria for an alcohol

dependence disorder at a previous time in their lives were in remission (defined as at least 6 months without any symptoms of alcohol dependence) at the time of the survey (Ehlers et al., 2004).

Leung et al. (1993) studied alcohol use among members of an American Indian community in the Pacific Northwest, first in 1969 (n = 100) and again in 1988, among 131 adults, selecting participants who were age and gender matched with the community population. They found that individuals who had alcohol dependence had a 60.9 percent remission rate (defined as no drinking or symptoms of dependence for 6 months or more) over the course of the study, with the average period of remission being 8 years. Women had even higher remission rates than men (82 percent compared with 52 percent).

Refer to the literature review for the planned TIP, *Relapse Prevention and Recovery Promotion in Behavioral Health Services*, for more information on rates of remission and recovery in the general population (SAMHSA, planned).

Epidemiological Data on CODs

Alcohol and drug use disorders have been associated with higher rates of several different psychiatric disorders in American Indian and Alaska Native populations (e.g., Beals et al., 2002; Goldstein et al., 2007; Robin, Chester, & Goldman, 1996; Robin, Long, Rasmussen, Albaugh, & Goldman, 1998; Schneier et al., 2010; Tann, Yabiku, Okamoto, & Yanow, 2007; Westermeyer, 2001). Data from the 2015 TEDS-A also indicated that 33.7 percent of Alaska Natives and American Indians entering SUD treatment programs had psychiatric problems prior to admission in addition to their SUDs (SAMHSA, n.d.-a). The 2016 NDSUH found that 1.4 percent of American Indian and Alaska Native adults had past-year co-occurring SMI and SUDs; this percentage was higher than the national average of 1.1 percent (CBHSQ, 2017a).

Westermeyer (2001) and Beals et al. (2002) reviewed several earlier studies that provided epidemiological data on American Indians and Alaska Natives with CODs, which generally found high rates of CODs but which also often had flaws in their research design. Robin et al. (1996) also reviewed earlier research and concluded that there were elevated rates of CODs in many American Indian and Alaska Native communities, especially co-occurring depression and AUDs. Furthermore, Abbott (2008) reviewed regional studies (dating back to 1987) that evaluated rates of CODs among American Indians and Alaska Natives and noted that although comparisons to national samples cannot be accurately made, most research indicates that there is a high rate of co-occurring depression among American Indians and Alaska Natives with SUDs. Most of these reviewed studies, however, involved small samples, and a number were done with adolescents rather than adults or with very specific populations (e.g., male Vietnam veterans). As in other situations, rates of CODs are likely to vary by tribe, but more research is needed to assess these differences.

Hesselbrock, Segal, and Hesselbrock (2000) reported on co-occurring depressive, anxiety, and personality disorders among Alaska Native clients entering one of three public alcohol treatment programs in the Anchorage area. The authors noted that the rates of most of these disorders are comparable with those seen in other populations of people with alcohol dependence. They found that:

- 10.7 percent of men and 17.5 percent of women had a lifetime diagnosis of major depression.
- 1.9 percent of men and 6.2 percent of women had a lifetime diagnosis of panic disorder.
- 4.9 percent of men and 2.1 percent of women had agoraphobia.
- 8.7 percent of men and 5.2 percent of women had SAD.
- 49.5 percent of men and 21.6 percent of women had ASPD.
- 52.4 percent of men and 23.7 percent of women had had a conduct disorder in childhood.

Howard et al. (1996) reviewed VA inpatient medical records for 536,244 veterans (2,883 of whom were American Indians and Alaska Natives) who were discharged from VA medical centers. They compared rates of mental disorders for veterans with and without co-occurring substance dependence disorders and rates for American Indians

and Alaska Natives with rates for the entire sample. For American Indians and Alaska Natives who had substance dependence diagnoses in their VA records, 7.5 percent had co-occurring personality disorders, 9.3 percent had co-occurring major depression, 10.6 percent had co-occurring PTSD, 3.8 percent had co-occurring psychotic disorders, and 1.3 percent had co-occurring bipolar disorders. Rates of all CODs except PTSD were lower for American Indian and Alaska Native veterans with substance dependence (n = 1,351) than for those in the whole sample who had substance dependence (n = 123,495).

Several NESARC articles have looked at the co-occurrence of specific mental disorders with SUDs. For example, in NESARC, among individuals with AUDs, American Indians and Alaska Natives were significantly more likely than members of other racial/ethnic groups to have co-occurring SAD, and 2.6 percent of American Indians and Alaska Natives in the survey had co-occurring alcohol dependence and SAD (Schneier et al., 2010). Goldstein et al. (2007) observed that according to NESARC data, American Indians and Alaska Natives had higher rates of co-occurring drug use disorders and ASPD than most other racial/ethnic groups. NESARC did not, however, find a significantly greater likelihood of co-occurring alcohol dependence for American Indians and Alaska Natives with PTSD, compared with members of other racial/ethnic groups (Blanco et al., 2013).

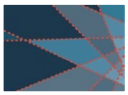
Psychiatric symptoms that do not meet diagnostic criteria for a disorder may also have an effect on drinking and other substance use. Seale et al. (2006) conducted focus-group discussions with Alaska Natives from a relatively small village above the Arctic Circle. The most common reasons given for drinking were in response to feelings of sadness and depression. For more information, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (Center for Substance Abuse Treatment [CSAT], 2008a). Information on the general assessment and treatment of CODs can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005b).

Risk and Protective Factors for Mental and Substance Use Disorders

Risk factors are things believed to increase the risk for mental disorders and SUDs, whereas protective factors are believed to reduce that risk. Risk factors are not causes per se, but rather personal or community factors that may contribute to the development or persistence of a disorder. Certain risk and protective factors affect whole communities of American Indians and Alaska Natives; factors such as historical trauma, poverty, and cultural beliefs operate at the individual and the community levels and are discussed in separate sections below.

Most of the research regarding risk and protective factors for American Indians and Alaska Natives focuses on those factors as they relate to SUDs, and those factors identified tend to be the same as they are for the general population (Hawkins, Cummins, & Marlatt, 2004; Schinke, Brounstein, & Gardner, 2002; Swaim, Oetting, Jumper-Thurman, Beauvais, & Edwards, 1993; Trimble & Beauvais, 2001). Much of this research is concerned with prevention, and thus has involved youth, but studies involving adult American Indians and Alaska Natives typically find the same basic risk and protective factors; most, if not all, of these factors should apply to adults as well.

Protective factors may directly address substance use behaviors or symptoms of mental disorders and may also work indirectly by reducing the effects of risk factors. For example, Yu and Stiffman (2010) investigated the role of two known protective factors (i.e., positive family relationships and religious involvement) in relation to symptoms of illicit drug use disorders in American Indian and Alaska Native adolescents (N = 401). They found that positive family relationships mitigated the effects that having family members with SUDs, being the victim of violence, and having a negative school environment had in increasing the risk for developing SUD symptoms. Having a stronger religious affiliation mitigated the effect that peers engaging in deviant activities (e.g., substance use, gang membership, criminal activity) had on reducing the benefit of positive family relationships.



SAMHSA's Center for the Application of Prevention Technologies (CAPT) conducted a literature review to identify risk and protective factors for mental disorders and SUDs identified through research conducted with American Indians and Alaska Natives (SAMHSA, CAPT, 2013). Although it did not give detailed information about the studies reviewed, it did provide the most comprehensive list of risk and protective factors for substance use and mental disorders in American Indians and Alaska Natives. According to the review, risk factors for developing SUDs and for their continuation after they have developed include:

- Conduct problems and delinquent behaviors and attitudes.
- Low self-worth.
- Physical or sexual abuse in childhood.
- Other violent victimization.
- Other forms of childhood adversity (e.g., witnessing violence, parental divorce).
- Concerns about historical loss and historical trauma.
- Substance use/misuse by parents or other family members.
- Substance use by peers.
- Low socioeconomic status of family.
- Having less education (high school degree or less).
- Unemployment.
- Pro-substance use attitudes from peers.
- Deviant behavior and misbehavior by peers.
- Feelings of alienation from family, community, or both.
- Greater involvement in traditional activities when they also involved alcohol use.

SAMHSA, CAPT (2013) identified protective factors that may help prevent SUDs or reduce the risk that they will continue; these factors include:

- Involvement in spiritual activities.
- Stronger religious or spiritual beliefs.
- Better family relationships, family communication, or both.
- Stronger parental attachment.
- Family sanctions against substance use.
- Having more educated parents.
- Having nonparental role models.
- Employment.
- Greater involvement in traditional activities or identification with American Indian and Alaska Native culture.

In addition, SAMHSA, CAPT (2013) identified risk factors for mental disorders, suicidality, or both, including:

- Physical health issues or greater concerns about health.
- Physical or sexual abuse in childhood.
- Stressful life events.
- Domestic violence.
- Experiencing other forms of assault or victimization.
- Experiencing more discrimination (according to self-perception).
- Gang involvement.
- Unsafe school or community environments.
- Financial strain (either current or in childhood).
- Concerns about historical loss and historical trauma.
- Maternal or paternal depression.
- Unstable (i.e., short-term) intimate relationships.
- History of suicide attempts in family or among friends.

SAMHSA, CAPT (2013) identified protective factors that may help prevent mental disorders, suicidality, or both, including:

- Positive mood.
- High self-esteem.
- Good physical health.
- Good communication with family and friends.
- Positive attention or caring from family.
- Prosocial behaviors.
- Greater attachment to school or sense of belonging at school.
- Support and caring from tribal leaders, school staff members, and other adults.
- Support by friends and other peers.
- Supplemental income to families.
- A greater sense of connectedness.

- Greater involvement in traditional activities or identification with American Indian and Alaska Native culture.

Hawkins et al. (2004) reviewed research on substance misuse/use disorder prevention for American Indian and Alaska Native youth and explored risk and protective factors identified in earlier literature. They noted that, in general, these risk and protective factors were similar to those identified in general population samples. The risk factors they identified from research conducted with American Indians and Alaska Natives included poverty, life stress, psychological distress, certain beliefs about substance use (e.g., positive expectancies about use), a lack of family sanctions against use, a lack of stability at home or in one's family, acculturation stress, and alienation from one's own culture or from the larger American culture. Protective factors identified included strong and supportive relationships with family, self-efficacy in social relations, bonding with conventional society, greater involvement in cultural activities, greater involvement in spiritual activities, and greater bicultural competence.

A review in Baldwin, Brown, Wayment, Nez, and Brelsford (2011) identified many of these same risk and protective factors based on research conducted with American Indians and Alaska Natives and explored some of them in detail. These authors observed that although some research has not found a relationship between social support and substance use for American Indian and Alaska Native youth, the preponderance of the research found that support from family is associated with decreased alcohol use, whereas pro-drinking influences from peers are associated with increased use. Research indicated that family sanctions against use are associated with decreased use of illicit drugs and with decreased drinking for women but not for men. Positive, nonparental role models are also associated with decreased risk for substance use. The authors also noted that research regarding the relationship of cultural identity to substance use among American Indian and Alaska Native youth is equivocal. However, a couple of studies have found that, when accompanied by a sense of social connectedness, a stronger cultural identity is protective against substance use.

A recent review from Henson et al. (2017) similarly suggests that certain socioecological and cultural factors may mitigate lower mental and emotional health in American Indian and Alaska Native adolescents. The authors identified individual, relationship-based, and community-based protective factors against a range of negative health outcomes including substance use, alcohol abuse, depression, and suicide attempts. They found nine factors with positive effects on these and other negative health outcomes: (1) current and future aspirations; (2) personal wellness; (3) positive self-image; (4) self-efficacy; (5) connectedness with nonfamily members; (6) family connectedness; (7) positive opportunities in the community (e.g., availability of extracurricular activities); (8) positive social norms (e.g., presence of a parent who models prosocial behavior); and (9) cultural connectedness (e.g., involvement in and identification with American Indian culture).

One reason that American Indians and Alaska Natives may have increased risk for SUDs is that they begin substance use at an earlier age. In a study involving 525 Southwest California American Indian adults, becoming intoxicated for the first time at an early age along with being male, not being married, having dropped out of high school, having a history of alcohol dependence among near relations, and having an externalizing disorder were all associated with a significantly higher risk for AUDs, as well as a shorter time before developing alcohol dependence (Ehlers, Slutske, Gilder, Lau, & Wilhelmsen, 2006). Other research confirmed that American Indians and Alaska Natives are more likely to be drinking prior to age 18 than are members of other ethnic/racial groups, and this plays a part in the development of AUDs among this population (Beauvais, 1998; OAS, 2007; Szlemko et al., 2006); they may also begin using illicit drugs, namely marijuana, at an early age, even prior to alcohol use (Whitesell et al., 2012).

Among Alaska Natives, protective factors against the development of AUDs included individual (e.g., self-efficacy, an awareness of the consequences of one's actions), family (e.g., caregivers who treated children as being special, family members who modeled sobriety), and communal factors (e.g., having role models who cared for the community's

children, having safe places in the community where children could go; Mohatt, Rasmus et al., 2004). For those who were lifetime abstainers, the latter two were more significant, whereas for those who drank but did not have problems with alcohol, individual factors were of greater significance.

Although research involving risk and protective factors for mental disorders in American Indians and Alaska Natives is more limited, those studies that are available have suggested that many of the same risk and protective factors that apply to SUDs also play a role in the development of mental disorders (see review in SAMHSA, CAPT, 2013).

Baldwin et al. (2011) conducted one of the few recent studies to evaluate the relationship of specific risk and protective factors to mental disorders and SUDs for American Indians and Alaska Natives. They assessed the relationship of selected risk and protective factors to depressed mood, substance use, and risky behaviors in a group of 221 American Indians and Alaska Natives ages 15 to 24 who were residing in off-reservation high-school dormitories. They found that stressful life events were significantly associated with increased substance use, more severe depressive symptoms, and greater engagement in risky or potentially antisocial behaviors.

Social support has been found in various studies with non-native samples to be protective against depression and general psychological distress (e.g., Lynch et al., 1999; Razurel, Kaiser, Sellenet, & Epiney, 2013; Sherman et al., 2006). As noted above, social supports are protective against substance use and mental disorders for American Indian and Alaska Native youth as well (see review in SAMHSA, CAPT, 2013), and although research conducted with adult American Indians and Alaska Natives is limited, it appears to confirm these findings.

For example, in a study involving 249 women (100 of whom were American Indian and Alaska Native), social support (measured with the Multidimensional Scale of Perceived Social Support) was associated with significantly lower levels of depressive symptoms (assessed using the CES-D), whereas increased social strain (measured with the Wake Forest Social Strain Scale) was associated with significantly higher levels (Sherman, Skrzypek, Bell, Tatum, & Paskett, 2011). Although the positive effects of social support did not vary significantly between White American and American Indian and Alaska Native women, the negative effects of social strain were significantly greater for American Indian and Alaska Native women. American Indian and Alaska Native women had lower mean levels of depressive symptoms than did White American women if they had low levels of social strain, but higher mean levels of depressive symptoms than did White American women if they had high levels of social strain.

Oetzel, Duran, Jiang, and Lucero (2007) conducted a similar study of the effects of social support (including emotional and instrumental support) and social undermining (measured as a combination of hurtful criticism from others and an individual's desire to isolate himself or herself from family and friends because of expressed negative affect) on a group of 169 American Indian women who were using primary care services at an IHS facility. Although they did not find that social support had a significant effect on mood or anxiety disorders, greater social support was associated with a significantly lower likelihood of SUDs. Different aspects of social undermining were associated with significantly increased risks of having an anxiety disorder (the isolation scale) and mood disorders (the critical appraisal scale), and both subscales of social undermining were associated with significantly higher rates of SUDs.

Historical oppression and continuing discrimination

Although American Indian and Alaska Native peoples come from many diverse tribes and cultures, they do share a common history of oppression at the hands of non-native people who came to settle and colonized their land. They were marginalized or actively persecuted and experienced considerable discrimination that continues to this day. This history is well documented (for review, see French, 2000; Hawkins & Blume, 2002). Because of this history, American Indians and Alaska Natives also face poverty and the various social ills (e.g., lack of infrastructure, unemployment, ill health) that accompany it (see "Poverty and Unemployment"). This history and

continuing discrimination may contribute to high levels of various mental disorders and SUDs among American Indians and Alaska Natives.

Specific historical factors relating to alcohol may continue to influence American Indian and Alaska Native drinking patterns and high rates of AUDs today. Contemporary American Indian and Alaska Native alcohol and substance use patterns are influenced by the patterns of substance use exhibited by those individuals who first introduced these substances to American Indians and Alaska Natives. Because most American Indian tribes lacked a cultural context for alcohol use, they were easily influenced by European settlers, trappers, and traders who introduced alcohol into their cultures (Frank, Moore, & Ames, 2000; Kunitz et al., 1994; Weaver, 2001). The use of alcohol as a trade good may have further exacerbated the harmful drinking patterns to which they were introduced, as American Indians were conditioned to see alcohol consumption as a mark of economic success (Frank et al., 2000).

Federally imposed prohibition of alcohol for American Indian and Alaska Native peoples, which continued past the repeal of the 18th Amendment, may have also negatively affected drinking patterns by encouraging rapid ingestion of alcohol and a distrust of authorities in relation to alcohol policy (French, 2000).

Traumatic events, such as the forced relocation of tribes (e.g., the Trail of Tears) and massacres of American Indians and Alaska Natives (e.g., Wounded Knee), continue to echo today, as do more recent sources of trauma such as the out-of-home placement of American Indians and Alaska Natives in boarding schools and ongoing land disputes that keep American Indian and Alaska Native people from their traditional lands (Brave Heart, 2003; Duran, Duran, & Brave Heart, 1998; Milbrodt, 2002).

"Historical trauma" is an important concept for understanding the effects that this history of colonization and accompanying oppression has had on American Indian and Alaska Native behavioral health. Historical trauma is the result of repeated violence directed against American Indian and Alaska Native peoples, which causes grief, shame, and anger that in turn contribute to mental disorders and SUDs and suicidality (Sotero, 2006). Historical trauma is understood to be intergenerational trauma, which in turn increases rates of depression, SUDs, and other mental disorders among American Indian and Alaska Native populations (Brave Heart, 2004; Brown-Rice, 2013; Cole, 2006; Duran et al., 1998; Evans-Campbell, 2008; French, 2000; Whitbeck, Adams, Hoyt, & Chen, 2004; Ross, Dion, Cantinotti, Collin-Vézina, & Paquette, 2015).

In support of this theory, Whitbeck, Chen, Hoyt, and Adams (2004) found, in their sample of 452 American Indian parents and caretakers from tribes in the upper Midwest United States, that thinking more often about different types of historical loss (e.g., loss of land, loss of language) was associated with increased rates of alcohol abuse (as defined by the DSM-III-R) among women, but not men. They also concluded that perceptions of historical loss served to mediate the effects of perceived discrimination on alcohol consumption by women. Whitbeck, Adams, et al. (2004), also found that American Indians and Alaska Natives often responded to thoughts about historical loss with responses that resembled symptoms of anxiety and depression, as well as with feelings of anger and distrust. More frequent thoughts about historical loss have also been found to be significantly associated with having more symptoms of depression among American Indian adolescents (Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009).

Concerns about historical loss may also affect other types of mental disorders and SUDs, although there is little research regarding it. Clark and Winterowd (2012) did find that more frequent feelings about historical loss along with more experiences of racism were significantly associated with binge-eating behaviors among American Indians (N = 269) from various tribes.

A few researchers have found that experiencing discrimination also appears to be related to mental health for American Indians and Alaska Natives. Whitbeck, McMorris, Hoyt, Stubben, and LaFromboise (2002) found a significant association between perceived discrimination (evaluated with their own 10-item scale) and symptoms of depression (assessed with the CES-D) in a group of 287 American Indians from the upper Midwest.

Canadian researchers also found a significant relationship between perceived discrimination (measured with a version of the Perceived Ethnic Discrimination Questionnaire) and depressive symptoms (measured with the Beck Depression Inventory [BDI]) in a group of 220 Aboriginal adults, even after controlling for demographic variables (Bombay, Matheson, & Anisman, 2010). This relationship was mediated by stronger feelings of in-group affect (i.e., pride in being Aboriginal) and for men, but not for women, by stronger connections with Aboriginal people. Experiences of discrimination in childhood have also been found to be associated with significantly greater odds of being involved in polydrug use and having significantly more symptoms of PTSD for American Indians and Alaska Natives (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015).

Cultural factors

Cultural factors may also play a role in the development of mental disorders and SUDs among American Indians and Alaska Natives, particularly in the development of SUDs. Stronger connections to traditional culture may protect against some mental disorders and SUDs.

The cultural context of alcohol use, which developed when American Indian and Alaska Native peoples were first introduced to alcohol, likely contributed to the development of problematic drinking patterns. Because the vast majority of American Indian and Alaska Native peoples had no exposure to alcohol prior to contact with European settlers, they lacked a cultural context for its use. As a result, they modeled their drinking behavior on that of early White hunters and traders with whom they came into contact, and those individuals typically engaged in binge drinking of large quantities of alcohol. Over time, the typical patterns of alcohol consumption among Whites changed, but in more isolated American Indian and Alaska Native communities, they remained the same, so the common patterns of alcohol consumption among American Indians and Alaska Natives are still very similar to those seen among White settlers and traders in 18th-century America (Frank et al., 2000; Kunitz et al., 1994; Weaver, 2001). The introduction of alcohol among Alaska Native communities followed a similar pattern and has also been a disruptive force in those cultures (Segal et al., 1999).

The fact that American Indian and Alaska Native cultures, for the most part, lacked traditional ways to deal with alcohol or most types of illicit drug use meant that the cultural mores around such use did not undergo a very long process of development and in many ways proved dysfunctional. In some American Indian and Alaska Native communities, dysfunctional and harmful patterns of alcohol use became the norm and were accepted, at least among some (Brady, 1995; O'Nell, 1992).

Some aspects of the culture surrounding drinking or drug use may contribute to increased rates of SUDs among American Indians and Alaska Natives. For example, Ehlers, Slutske et al. (2006) found that an early age of substance use among American Indians on reservations in Southern California contributed to elevated rates of SUDs in that population, and the causes for this early use were not genetic but cultural. Results from the 2014 NSDUH showed that American Indians and Alaska Natives tended to start using alcohol at an earlier age than did youths from other racial/ethnic groups, with 21.4 percent of American Indians and Alaska Natives reporting that they had their first drink by age 14 compared with 18.8 percent of White Americans, 14 percent of Latinos, and 12 percent of African Americans, but significance was not evaluated for these differences (CBHSQ, 2016). Similarly, American Indians and Alaska Natives who engage in binge drinking reported that this pattern of drinking is one that they learned from parents and other older individuals (Wardman & Quantz, 2005). Whitesell, Beals, Mitchell, Manson, and Turner (2009) found that early initiation of substance use mediated the relationship between childhood adversity (including childhood abuse) and the later development of SUDs.

American Indian and Alaska Native peoples have long been aware of the ill effects that alcohol has had on their communities (Coyhis & White, 2006; White, 2000a, 2000b). Coyhis and White (2006) presented a history of American Indian responses to alcohol use and alcohol-related problems showing that such interventions date back to the 18th century and, in fact, provided the first examples of mutual-help for AUDs in the

United States. These mutual-help movements were typically religious or spiritual in nature (e.g., Handsome Lake, who preached to the Iroquois a religion that promoted recovery from the "sickness" of AUDs), often involved an attempt to reconnect American Indians affected by alcohol misuse to their traditional culture and away from European cultural ways (e.g., the Delaware prophets who spoke against their people's adoption of European vices like drinking), and sometimes included legal or direct action to stem the flow of alcohol into American Indian communities (e.g., Miami Chief Meshekinoquah, who lobbied state legislatures around the country to try to stop the sale of alcohol to American Indians).

Researchers have also theorized for some time that the destruction of traditional American Indian cultures played a part in the development of high levels of AUDs in this population (e.g., Whittaker, 1963). Research suggests that having a strong connection to traditional culture may have a protective function against AUDs (Herman-Stahl, Spencer, & Duncan, 2003; Weaver, 2001; Whitbeck, Chen et al., 2004). Several authors have also speculated that the loss of such a connection increases rates of alcohol abuse and dependence (Choney, Berryhill-Paapke, & Robbins, 1995; Coyhis & White, 2006; French, 2000). Loss of traditional culture was one of the most often-cited explanations in focus-group discussions for why community members in rural Alaska Native communities drank (Seale et al., 2006).

Research has found that participation in traditional cultural events may also be protective against depression (Kaufman, Beals, Croy, Jiang, & Novins, 2013; Whitbeck et al., 2002). One study (Whitbeck et al., 2002) found a significant negative association between depressive symptoms and participation in native cultural events and activities. More recently, Kaufman et al. (2013) analyzed data from the AI-SUPERPFP, which indicated that individuals who engaged in activities that were not traditionally a part of their culture (i.e., hunting and fishing among participants from the Southwest, raising sheep or cattle for participants from the Northern Plains) were significantly more likely to have major depression, although participation in traditional activities did not have a significant relationship to depression.

The role of culture may also vary according to gender. In a study involving 3,771 Alaska Natives, having little or no identification with one's traditional culture was associated with increased risk of elevated depressive symptoms (assessed using the PHQ) for women but for men, it was associated with significantly lower risk for elevated depressive symptoms (Dillard et al., 2012). The strength of an individual's identification with non-native culture did not have a significant relationship to depressive symptoms for men or women.

A stronger cultural identity, stronger spiritual or religious beliefs (from either Christian or American Indian and Alaska Native spiritual practices), and a greater connection with tradition and traditional practices have all been identified as protective factors for SUDs in American Indians and Alaska Natives (Herman-Stahl et al., 2003; Kulis, Hodge, Ayers, Brown, & Marsiglia, 2012; Trimble & Beauvais, 2001; Walters, Simoni, & Evans-Campbell, 2002; Whitbeck, Chen, et al., 2004).

However, the relationship between the strength of an individual's connection to traditional culture and his or her substance use varies depending on context and in some cases, a stronger connection may be related to increased use of some substances. For example, Angstman, Harris, Golbeck, and Swaney (2009) found that among a sample of American Indians who were receiving services at an urban American Indian center, stronger identification with American Indian culture (as opposed to mainstream American culture) was associated with being more likely to smoke cigarettes. In a study evaluating a substance misuse/use disorder prevention program for American Indian and Alaska Native high school students, Petoskey, Van Stelle, and De Jong (1998) found that attendance at cultural events (e.g., pow wows) and participation in tribal ceremonies were associated with significantly greater use of marijuana and cigarettes, which could reflect greater opportunities to use those substances in social situations. Focus groups conducted with American Indian college students have also indicated that cultural events such as pow wows are often followed by parties during which heavy drinking occurs (Yu & Stiffman, 2007).

Herman-Stahl et al. (2003) found that being more strongly oriented toward American Indian

and Alaska Native culture was associated with significantly less heavy drinking among American Indian adults on reservations in South Dakota (according to an 8-point acculturation scale that asked about things such as how often one spoke one's American Indian and Alaska Native language, how often one participated in American Indian and Alaska Native cultural activities, and how often one thought about American Indian and Alaska Native culture). Research involving American Indian youth has also found that cultural pride and spirituality are associated with having significantly fewer symptoms of AUDs (Yu & Stiffman, 2007). In an unpublished study conducted with 600 Northern Plains American Indians, Eastman and Gray (2011) found that greater spirituality was associated with less likelihood of having an anxiety, depressive, or SUD. Adherence to traditional spiritual beliefs or practices was associated with a significantly lower risk for major depression among the Northern Plains American Indian samples, but not the Southwest American Indian samples in the AI-SUPERPFP (Kaufman et al., 2013).

The strength of cultural identification may also be more important than the object of that identification (i.e., traditional American Indian and Alaska Native culture, mainstream American culture). In Baldwin et al.'s (2011) study described above, a stronger cultural identity did not have a significant relationship to substance use, depressive symptoms, or engagement in risky behaviors. However, a stronger sense of identity with either American Indian and Alaska Native or White American cultures was associated with having significantly greater social support and more protective peer and family influences.

An issue related to cultural identity is "cultural continuity" in American Indian and Alaska Native communities, which has been studied by Canadian researchers in relation to suicidality (Chandler & Lalonde, 2008). These researchers identified six indicators of "greater cultural continuity," a term that involves political and cultural self-determination: (1) securing of traditional lands; (2) maintaining or taking back certain rights of self-government; (3) having community control over education, fire, police, and other essential services; (4) having cultural facilities to maintain and promote the culture; (5) providing services for children and families; and (6) involving women in governance (this last item was added to reflect the matrilineal traditions of the First Nations peoples of Canada's West Coast). The researchers found that communities with any one of these features had lower suicide rates than did communities where that feature was not present; the strongest relationship was with self-governance, as communities with no self-governance had suicide rates more than five times higher than communities that did have self-governance.

Poverty and unemployment

Poverty and unemployment may also contribute to mental disorders, or at least to their persistence and severity, according to research conducted with general population samples (e.g., Hudson, 2005; Jin, Shah & Svoboda, 1995; van der Waerden, Hoefnagels, Hosman, & Jansen, 2014; Wang, Schmitz, & Dewa, 2010). Specific studies conducted with American Indians and Alaska Natives also suggest that socioeconomic status has an effect on the development of SUDs (Herman-Stahl et al., 2003) and mental disorders (Costello, Compton, Keeler, & Angold, 2003; Costello, Erkanli, Copeland, & Angold, 2010; UIHI, 2008).

In 2017, 25.4 percent of American Indians and Alaska Natives who identified as belonging to a single race were living in poverty, which was the highest of any major ethnic/racial group; by comparison, 13.4 percent of the total population were living below the poverty line (Census Bureau, 2018). Census Bureau (2018) numbers also show that, in 2017, the median household income for American Indians and Alaska Natives who did not identify as belonging to another race as well was $41,882, compared with $60,336 for the United States population as a whole. Cumulative data from 2003 through 2005 also showed that American Indian and Alaska Native households were among the most economically deprived in the nation, with approximately 25.3 percent of households living under the poverty level; although this number was not statistically different from the rate of poverty in African American households, it was considerably higher than that found among all other major racial/ethnic groups (U.S. Commission on Civil Rights, 2003).

The gap in poverty rates between American Indians and Alaska Natives and non-native people is even larger for certain age groups, according to American Community Survey data from 2006 to 2010 (Pettit et al., 2014). During that period, 19.6 percent of American Indians and Alaska Natives ages 65 and older were living in poverty, compared with 9.5 percent of non-native people; 33.3 percent of American Indians and Alaska Natives under the age of 18 were living in poverty, compared with 19.1 percent of non-American Indians and Alaska Natives in that age group.

Poverty rates for American Indians and Alaska Natives are also higher in some states. According to 2010 data, 43–47 percent of American Indian and Alaska Native households in South Dakota, 32–36 percent in Montana, 31–33 percent in Arizona, 30–37 percent in Nebraska, and 30–33 percent in Minnesota have incomes below the poverty line (Department of the Interior [DOI], Office of the Assistant Secretary—Indian Affairs [OAS-IA], 2014).

Income and education levels are higher for urban American Indians than for those living on reservations, but American Indians and Alaska Natives in urban areas still tend to be poorer than their neighbors from other ethnic/racial groups (Henson et al., 2008). In the UIHI's 2008 report, using BRFSS data from 2001 through 2005, American Indian and Alaska Native respondents were twice as likely to be making less than $10,000 a year and more than 50 percent more likely to report incomes in the $10,000–$25,000 range. The unemployment rate for American Indians and Alaska Natives in the study was also twice as high as for the rest of the population.

The UIHI's 2008 analysis of BRFSS data for American Indians and Alaska Natives living in urban areas also showed that rates of binge drinking among American Indians and Alaska Natives in lower income brackets were comparable with those of other low-income people living in the same cities. However, among those with higher incomes (i.e., incomes more than 200 percent higher than the federal poverty level), binge drinking was significantly more common among American Indians and Alaska Natives than among non-native people: 46 percent of higher-income American Indians and Alaska Natives reported binge drinking in the past month, compared with 25.3 percent of others in the high-income group. This rate of binge drinking among American Indians and Alaska Natives with higher incomes was also greater than that of American Indians and Alaska Natives with lower incomes (35.7 percent of whom engaged in binge drinking), whereas the reverse was true for non-native respondents in the study. Also, although American Indians and Alaska Natives in the higher income group were less likely to report 1 or more days of worse mental health in the prior 30 days (42.1 percent did so) than were American Indians and Alaska Natives in the lower income group (45.8 percent of whom so reported), they were still more likely to report poor mental health than were non-native respondents in either the high- or low-income groups (36.1 percent and 41.6 percent of whom did so, respectively). These data suggested that poverty may not be as strongly associated with high levels of alcohol misuse among American Indians and Alaska Natives living in urban areas as it is for those in rural areas but other factors, such as the stress related to the need to acculturate to a non-native culture, may have a strong impact on urban populations (Johnson, Gryczynski, & Wiechelt, 2007).

Greene, Eitle, and Eitle (2014) analyzed data from the National Longitudinal Study of Adolescent Health regarding social roles and alcohol use for 927 American Indians and Alaska Natives who were followed for approximately 13 years after their first assessments in grade 7 to 12. The researchers found that transitioning to full-time work from being unemployed or only working part time was associated with a significantly greater chance of being a current drinker and with significantly more frequent binge drinking. Thus, increased income, at least for American Indian and Alaska Native young adults, may result in increased alcohol consumption.

Some have also argued that poverty and lack of opportunity contribute to high rates of AUDs among American Indians and Alaska Natives (e.g., Beauvais & LaBoueff, 1985). In support of such a view, Herman-Stahl and Chong (2002) cited their own research showing that of the three Arizona tribes they studied, the one with the highest average level of education and household

income also had the lowest levels of SUDs. On many American Indian reservations and in other American Indian and Alaska Native communities (urban and rural), there is significant poverty, and individuals face a lack of economic resources as well as the many problems that typically accompany such a situation (Beauvais, 1998; Beauvais & LaBoueff, 1985; Henson et al., 2008; Jervis, Spicer, Manson, & AI-SUPERPFP Team, 2003). Observational and self-reported evidence suggest that poverty contributes to mediating factors, such as boredom, that in turn fuel SUDs (Jervis et al., 2003).

There is also research indicating that growing up in a low-income family is associated with greater risk for mental disorders and SUDs later in life for American Indian and Alaska Native children. Costello et al. (2010) followed 1,420 children (349 of whom were American Indians from the same reservation) who were first assessed in 1993 at ages 9, 11, or 13 and who were reassessed regularly until age 21. During that period, a casino opened on the reservation included in the study, which resulted in increasing income supplements (rising from $500 to $9,000 a year per household) to tribal members living on the reservation but not to others living in the vicinity. The authors found that American Indians and Alaska Natives in the study were significantly less likely than non-native participants to have mental disorders and SUDs as adults and that this difference could largely be accounted for because of significantly lower rates of SUDs in general (especially alcohol and cannabis use disorders) among American Indians. American Indians in the youngest cohort, who would have been exposed to the effects of this increased income for more of their childhood, were significantly less likely than those in the other two cohorts to have a mental or SUD in adulthood (as well as being significantly less likely than non-American Indians in their own cohort to have a disorder in adulthood). Rates of conduct disorder, oppositional defiant disorder, ASPD, anxiety disorders, and depressive disorders did not differ significantly between American Indian and Alaska Native and non-American Indian and Alaska Native participants, but they were less common for American Indians and Alaska Natives in the youngest cohort, compared with non-American Indians and Alaska Natives in that cohort. This study also found that compared with participants in the older cohorts, American Indians in the youngest cohort attained higher levels of education and had less criminal justice involvement (Akee, Copeland, Keeler, Angold, & Costello, 2010).

In an earlier publication from this study, Costello et al. (2003) observed that during childhood, there was a significant negative correlation between family income and mental disorder and SUD diagnoses and the number of mental disorder and SUD symptoms identified that pertained to both the American Indian and non-American Indian children. In a response to Costello et al. (2010), Bullock and Bradley (2010) observed that in addition to the increases in family income, there were equal increases in social spending in this tribe for services such as mental disorder and SUD treatment, SUD prevention, and education, which also may have contributed to better behavioral health outcomes for American Indian children after income supplements began.

To understand how socioeconomic status may affect behavioral health, Businelle et al. (2013) analyzed data from NESARC indicating that although socioeconomic status at the time of the first wave of NESARC was significantly associated with mental health assessed during the second wave, that relationship was partially mediated by the number of stressors reported during the Wave 1 assessment. Thus, income may affect stress, which in turn may affect mental health. This study also observed that American Indians and Alaska Natives reported significantly more stressors than did White Americans, Asian Americans, and Latinos, which may partially explain studies that have found higher rates of mental disorders for American Indians and Alaska Natives with higher incomes compared with others with higher incomes (see discussion of UIHI, 2008).

Food insecurity (i.e., not having a sufficient nutritional and safe food supply) can be a consequence of poverty, and research conducted with Canadian First Nations members has found that those who do not have food security are more likely to report worse mental health (according to self-perception) and are more likely to be smokers (Willows, Veugelers, Raine, & Kuhle, 2011).

Studies also have found that unemployment is associated with an increased risk for alcohol misuse (Herman-Stahl et al., 2003) and illicit drug use (Reynolds, Fisher, Estrada, & Trotter, 2000) for American Indians and Alaska Natives.

In 2017, the unemployment rate for American Indians and Alaska Natives across the country was 7.8 percent compared with 3.8 percent for White Americans, and, 4 years earlier, the unemployment rate for American Indians and Alaska Natives had been above 10 percent for 5 consecutive years (Austin, 2013; Department of Labor, Bureau of Labor Statistics, 2017). Cumulative data from 2006 through 2010 showed that the mean unemployment rate for American Indians and Alaska Natives was 13.9 percent, but the rate of unemployment on reservations and other tribal areas was 15.9 percent (Pettit et al., 2014). According to those same data, American Indian and Alaska Native workers were less likely than non-American Indian and Alaska Native workers to be employed full-time (53 and 60 percent, respectively, were full-time employees).

The DOI, OAS-IA (2014) reported how many tribe members ages 16 and older in 2013 were employed in civilian jobs for each recognized tribe; for some tribes, that number was below 30 percent. Rates of unemployment were higher in some states and on some reservations. In 2010, there were at least 10 states (i.e., Alaska, Arizona, California, Maine, Minnesota, Montana, New Mexico, North Dakota, South Dakota, and Utah) where fewer than 50 percent of American Indians and Alaska Natives ages 16 and older living on or near reservations were employed.

Unemployment rates are even higher in populations seeking behavioral health services. According to the 2015 TEDS data set, only 19.6 percent of American Indians and 24 percent of Alaska Natives had full- or part-time employment at the time they entered treatment (SAMHSA, n.d.-a). By comparison, 26.8 percent of White Americans and 17 percent of African Americans were employed.

Other problems accompanying poverty include poor health, lack of infrastructure (including basic transportation and communications infrastructure, such as bus lines and phone lines), lack of cultural and entertainment opportunities, a sense of hopelessness, and boredom, all of which may contribute to the development or persistence of mental disorders and SUDs (Beauvais & LaBoueff, 1985; Jervis et al., 2003).

In recent years, casino gambling and other tribal businesses have made some tribes relatively wealthy, and members of those tribes have often benefited in terms of income, employment, and infrastructure (Taylor, Krepps, & Wang, 2000); such gains have been accompanied by improvements in behavioral health. However, the overall impact of casino gambling on American Indians and Alaska Natives' economic status is not as great as many people imagine it to be, and the benefit varies significantly by tribe and location (Henson et al., 2008; Taylor et al., 2000). Among tribes that have some form of gaming on their reservations, the per capita income in 2000 ranged from a low of $3,398 per person to a high of $146,000 (Henson et al., 2008).

According to Taylor and Kalt's (2005) study, economic conditions for American Indians generally improved during the 1990s at a greater pace than they did for the United States as whole. Increases in per capita and median household income were greater for tribes that had gaming (their per capita income increased 36 percent, and their median household income increased by 35 percent) than for those who did not have gaming (their per capita income increased 21 percent, and their median household income increased by 14 percent). Given that tribes both with and without gaming improved the economic conditions of their tribe members, Taylor and Kalt (2005) concluded that improvements are not driven so much by Indian gaming as they are by "a broader policy of Indian self-government" (p. xi).

A somewhat different view of the relationship of material conditions on American Indian reservations to high rates of AUD was proposed by Spillane and Smith (2007). They saw fewer material and community contingencies in effect for American Indians on reservations who were involved in heavy drinking, compared with the contingencies that occur in mainstream American culture (including for American Indians living in urban areas). As a result, there was less contingent motivation to stop heavy drinking in this population. For example,

they noted that some things that would promote less heavy drinking, such as education or quality jobs, were unavailable whether one drank heavily. Other reinforcers, such as housing and health care, continue to be available whether one drinks heavily. Even family support, which may be strong, often is not contingent on behaviors (such as heavy drinking). In their model, all of these factors helped explain why American Indians on reservations who did drink often drank heavily.

However, Kaufman et al. (2013) cautioned that economic factors alone (i.e., income, employment) do not capture the complexity of community differences in American Indian and Alaska Native cultures. The researchers analyzed rates of risk factors for depression among different communities (organized by census block groups) in the AI-SUPERPFP and found that economic differences only explained a small part of the variation in depression rates among different communities. Other factors, such as alternative or traditional economic activity (e.g., hunting, herding), endorsement of cultural or spiritual beliefs in a community, and perceptions of the community regarding such factors as substance use/misuse improved the ability of their model to explain differences in depression among people who belonged to the same tribe. Using this model, they demonstrated how certain communities could reduce the effects of risk factors for depression and enhance protective factors, whereas other communities appeared to intensify the effects of risk factors on depression.

Trauma exposure

Trauma is a risk factor for several mental disorders and SUDs and related problems beyond just the trauma-related disorders of PTSD and acute stress disorder (see discussion in the TIP 57, *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, 2014c]). Trauma exposure is a precondition for PTSD, and high rates of that disorder have been found in American Indian and Alaska Native samples (see discussion under "Large Epidemiological Studies on the Prevalence of Mental and Substance Use Disorders"). Certain types of trauma (particularly use disorder in childhood) have also been associated with significant increases in risk for SUDs, mood disorders, anxiety disorders, and ASPD in American Indians and Alaska Natives (Ehlers, Gizer, Gilder, & Yehuda, 2013; Libby et al., 2004; Libby, Orton, Novins, Beals, & Manson, 2005).

The relationship between PTSD and problematic alcohol use appears to be more notable among American Indians and Alaska Natives than among non-Hispanic Whites. Emerson, Moore, and Caetano (2017) analyzed data from the NESARC-III (N = 19,705) to examine lifetime PTSD and past-year AUD. Rates of lifetime PTSD were significantly higher among American Indians and Alaska Natives than among non-Hispanic Whites (22.9 percent versus 11.7 percent, respectively), as were rates of past-year AUD (20.2 percent versus 14.2 percent) and comorbid lifetime PTSD with past-year AUD (6.5 percent versus 2.4 percent). American Indian and Alaska Native men had more than three times the rates of PTSD and AUD seen in non-Hispanic White men, and American Indian and Alaska Native women had more than twice the rate of joint disorders seen in non-Hispanic White women. Compared with American Indians and Alaska Natives without lifetime PTSD, those with lifetime PTSD had 1.76 times greater odds of having AUD, controlling for age, sex, lifetime depression, and education; odds among non-Hispanic Whites were slightly lower at 1.56.

Many American Indians and Alaska Natives experience elevated exposure to certain types of trauma and may, because of cultural definitions, find certain events even more traumatic than do members of other cultural groups (Manson et al., 1996). Numerous studies have found high rates of trauma exposure in American Indian and Alaska Native populations (e.g., Beals, Belcourt-Dittloff, et al., 2013; Beals, Novins et al., 2005; Ehlers et al., 2013; Manson et al., 2005; Robin et al., 1997b). Trauma histories (personal and historical) are so common among American Indian and Alaska Native SUD treatment clients that Edwards (2003) recommended that "diagnosing and treating trauma, both childhood and historical, should become an integral part of ... treatment programs for American Indians and Alaska Natives" (p. 57).

Manson, Beals, Klein, Croy, and the AI-SUPERPFP Team (2005) compared trauma histories for American Indians from the Northern Plains and Southwest tribes and compared those data with

general population data from the NCS. They found that, as in other areas, trauma histories differed significantly among tribes in several respects (see Exhibit 3.4). In both regions, however, trauma histories were common, with 62.4 percent of Southwest men, 66.2 percent of Southwest women, 67.2 percent of Northern Plains men, and 69.8 percent of Northern Plains women reporting some trauma exposure. Additionally, there were some significant differences between these American Indian samples and the NCS sample, most notably regarding trauma exposure for women, which differed from exposure for men to a significantly greater degree in the NCS (where 63.3 percent of men and 53.5 percent of women reported some type of trauma exposure) than in the AI-SUPERPFP (where overall trauma exposure was similar for men and women in each region).

Even if an individual does not develop a trauma-related disorder (e.g., PTSD, acute stress disorder) because of trauma exposure, trauma exposure can negatively affect behavioral health (see discussion in TIP 57, *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, 2014c]). Certain types of trauma, particularly in childhood, have been associated with significant increases in risk for SUDs, mood disorders, anxiety disorders, and ASPD among American Indians and Alaska Natives (Ehlers et al., 2013; Libby et al., 2004, 2005).

For example, Ehlers et al. (2013) evaluated trauma exposure for 309 American Indians and Alaska Natives from eight different contiguous reservations and found that different types of trauma experiences were associated with significantly greater odds of several different mental disorders and SUDs. The odds of alcohol dependence were 2 times higher for individuals who were victims of sexual abuse, 3.6 times higher for those who experienced injury or assault, 2.3 times higher for those who were victims of crimes without injury, and 1.8 times higher for those who witnessed trauma to others. The odds of having a mood disorder were 2.8 times higher for those who were victims of sexual abuse, 2.6 times higher for injury or assault, and 1.8 times higher for victims of crime without injury. Rates of anxiety disorders were 2.8 times higher for victims of sexual abuse, 1.9 times higher for those who experienced natural disasters, and 2.9 times higher for those who witnessed trauma to others. Rates of other SUDs and ASPD were also elevated for those who had different trauma experiences. These associations do not establish causality—for example, individuals with SUDs are more likely to be involved in situations where injury or assault occurs.

Researchers who looked at trauma histories from a sample of adolescent and young adult American Indians included in the AI-SUPERPFP study (N = 432)

EXHIBIT 3.4. Inter-Tribal Differences in Trauma Histories

TRAUMA	SOUTHWEST MEN (%)	SOUTHWEST WOMEN (%)	NORTHERN PLAINS MEN (%)	NORTHERN PLAINS WOMEN (%)
Life-threatening accident	18.2	9.2	27.3	15.2
Physical attack	22.7	36.0	27.1	39.5
Sexual assault other than rape	2.6	8.0	1.6	7.6
Rape	2.4	12.8	1.4	14.4
Natural disaster	10.8	8.9	18.6	14.4

Source: Manson, S. M., Beals, J., Klein, S. A., Croy, C. D., & the AI-SUPERPFP Team. (2005). Social epidemiology of trauma among 2 American Indian reservation populations. American Journal of Public Health, 95, *851–859. Adapted with permission.*

found that not only was severe trauma associated with increased risk for AUDs, but also that there was a dose-dependent relationship between the number of traumas experienced and risk for AUDs (Boyd-Ball, Manson, Noonan, & Beals, 2006). Shore et al. (2002) also found, in their sample of 423 urban-dwelling American Indians who were using primary care services, a significant association between trauma histories and AUDs, although they suggested that this may be because drinkers are more likely to experience violent trauma.

Rates of some types of trauma (e.g., use disorder in childhood, intimate partner violence, violent crime, violent accidents) also have been found to be high for American Indians and Alaska Natives and are discussed separately, along with a discussion as to how specific types of trauma may affect behavioral health. The concept of historical trauma, which is important for understanding American Indian and Alaska Native behavioral health, and the relationship of trauma to PTSD for American Indians and Alaska Natives are also discussed under the section "Historical Trauma."

Childhood physical and sexual abuse

Physical and sexual abuse in childhood have been associated with increased SUD in the general population (see TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT, 2000b]) and in American Indian and Alaska Native samples (Duran, Malcoe, et al., 2004; Koss et al., 2003; Kunitz, Levy, McCloseky, & Gabriel, 1998; Libby et al., 2004; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997c; Zahnd, Klein, Holtby, & Bachman, 2002). Experiences of SUD in childhood have also been associated with significant increases in risk for several anxiety and mood disorders in both general population samples (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010) and American Indian and Alaska Native samples (Duran, Malcoe, et al., 2004; Libby et al., 2005). Research on child abuse and neglect among American Indians also shows a high correlation between these acts and later problems related to alcohol use (Libby et al., 2004; Zahnd et al., 2002), which in turn have been associated with higher rates of child abuse, thus perpetuating a cycle of substance abuse and child abuse (Kunitz et al., 1998). The Attorney General's Advisory Committee on American Indian and Alaska Native Children Exposed to Violence (Dorgan et al., 2014) concluded that "[American Indian and Alaska Native] children are exposed to multiple forms of violence at rates higher than any other race in the United States, resulting in increased rates of altered neurological development, worse physical and mental health, worse school performance, substance abuse, and overrepresentation in the juvenile justice system" (p. 36).

Libby et al. (2004), in an evaluation of AI-SUPERPFP data, found that the effects of childhood abuse varied somewhat by tribe or region. In a multivariate model that controlled for other trauma, other mental disorders and SUDs, demographic variables, and other stressors in adulthood or childhood, the authors found a large and significant effect from childhood physical abuse on all SUDs among the Northern Plains tribes, but only for drug and alcohol dependence disorders among the Southwest tribes. Childhood sexual abuse was significantly related to all drug use disorders and alcohol dependence disorder, but not alcohol abuse disorder, in the Northern Plains group. In the Southwest tribes, however, childhood sexual abuse had a significant relationship only with drug dependence disorder.

In another study that used AI-SUPERPFP data to evaluate the relationship of physical and sexual abuse in childhood to mood and anxiety disorders, Libby et al. (2005) found that in their multivariate model, physical abuse in childhood was associated with significant increases in the risk of mood disorders for men and women in the Southwest sample and for women in the Northern Plains sample, with PTSD in men and women in the Northern Plains sample and for men in the Southwest sample, and with other anxiety disorders for men in the Southwest sample. Childhood sexual abuse was associated with significant increases in risk for mood disorders for Southwest men and women, PTSD for all groups of participants, and other anxiety disorders for Southwest men and women.

Some data have suggested that American Indian and Alaska Native people experience physical abuse as children more frequently than members of many other racial groups (HHS, Administration for

Children and Families [ACF], Youth and Families, Children's Bureau [YFCB], 2017), but other data have indicated that rates of childhood sexual abuse are about the same (Libby et al., 2004). A few studies have found high rates (relative to the general population) for childhood physical and sexual abuse, at least among some tribes (Koss et al., 2003; Segal, 1999). In reviewing multiple sources, Earle and Cross (2001) also concluded that rates of child abuse varied greatly across tribes. Rates of neglect also appear to be higher for American Indian and Alaska Native children than for White children (Earle & Cross, 2001). Fox (2003), however, cautioned that state and national reporting (such as those sources Earle and Cross [2001] analyzed) likely undercounts the number of American Indian and Alaska Native children affected by abuse and neglect.

According to 2015 National Child Abuse and Neglect Data System data (which includes data collected by most states regarding *substantiated* incidents of reported child abuse or neglect), 13.8 American Indian and Alaska Native children per 100,000 were victims of abuse or neglect in that year (HHS, ACF, YFCB, 2017). By comparison, 8.1 White American children, 8.4 Latino children, and 14.5 African American children per 100,000 were victims of abuse or neglect. However, these data exclude some cases that occur on tribal lands and are thus not investigated by the State, so that the actual rate for American Indian and Alaska Native children may be higher.

Dakil, Cox, Lin, and Flores (2011) analyzed 2006 data from the National Child Abuse and Neglect Data System regarding specific forms of child abuse or neglect. They found that in that year, American Indian and Alaska Native children were significantly less likely than White American children to be victims of physical abuse (0.53 times less likely) as substantiated by investigators (about 20 percent of reported cases of physical abuse involving American Indian and Alaska Native children were substantiated, a rate comparable with most other major racial/ethnic groups). However, these same data indicated that American Indian and Alaska Native children were more likely than members of other racial/ethnic groups to die from abuse (0.21 percent of reported cases resulted in a fatality, compared with 0.15 percent of cases involving African American children and 0.12 percent of cases involving White American children).

Rates of physical and sexual abuse in childhood are even higher in some American Indian and Alaska Native samples, particularly those selected from behavioral health programs, and rates also vary considerably by tribe. In an evaluation of data from seven different tribes, Koss et al. (2003) found significant variation in rates of childhood sexual and physical abuse among tribes, with rates of childhood sexual abuse ranging from 4 to 40 percent for men and from 10 to 53 percent for women and rates of physical abuse ranging from 11 to 70 percent for men and 23 to 57 percent for women. They also found that histories of sexual abuse, if combined with physical abuse, increased the odds of having a lifetime diagnosis of alcohol dependence for men; for women, any type of childhood abuse or neglect significantly increased the odds of a lifetime diagnosis of alcohol dependence.

Robin et al. (1997c) evaluated rates of sexual abuse in childhood for 582 American Indians from a Southwest tribe and found that 63 percent of women and 20 percent of men reported childhood sexual abuse. Experiences of childhood sexual abuse were associated with significant increases in risk for ASPD, drug use disorders, mood disorders, and anxiety disorders.

In a sample of American Indian women receiving primary care services from an IHS facility in Albuquerque, NM, the percentages of women who had experienced physical abuse (41.5 percent) or sexual abuse (44.4 percent) in childhood were also high, as were the rates of severe physical abuse (17.5 percent) and severe sexual abuse (23.1 percent; Duran, Malcoe et al., 2004). In this sample, a history of childhood abuse or neglect was associated with increased rates of lifetime SUDs, PTSD, and mood disorders.

Peterson, Berkowitz, Cart, and Brindis (2002) investigated a sample of American Indian and Alaska Native women (urban and rural) who were seeking treatment for AUDs and found that 39 percent had been physically abused as children (in this case,

prior to age 18), 34 percent were sexually abused, and 23 percent were emotionally abused. In this sample, rates of abuse in adulthood were also high, with 61 percent having experienced physical abuse and 12 percent having been sexually abused. In another sample of 282 American Indian and Alaska Native women seeking SUD treatment at inpatient and outpatient treatment programs in the Oakland and San Francisco, CA, areas, Saylors and Daliparthy (2006) found that 63 percent had been physically abused in childhood, and 55.6 percent had been sexually abused.

Segal (1999) assessed trauma histories for 122 Alaska Native women who attended a Fairbanks, AK, SUD treatment program: 76 percent had been sexually abused, and 64 percent had been physically abused prior to age 13. The mean age of first physical abuse for women in the study was 7, and for sexual abuse, 16. Women who had been abused by their parents were six times more likely to have attempted suicide than those who had not been so abused, suggesting the long-term psychological harm of this abuse.

Rates of abuse may vary significantly depending on how abuse histories are defined and evaluated, and other studies have found lower rates of childhood abuse among American Indian and Alaska Native samples. Kunitz et al. (1998) found that 12.7 percent of their sample of men and women (n = 352) had experienced physical abuse in childhood and that 12.7 percent of the women and 2.4 percent of the men experienced sexual abuse in childhood. These authors found that childhood abuse (either physical or sexual) was a risk factor for conduct disorder, and that both conduct disorder and childhood physical abuse were risk factors for alcohol dependence. In turn, physical abuse in childhood and alcohol dependence were independent risk factors for being either a victim or perpetrator of domestic violence. These authors also found that those individuals who had experienced childhood abuse were significantly more likely to be involved (either as perpetrator or victim) in domestic violence, suggesting that childhood abuse contributes to a cycle of abuse.

According to data from the AI-SUPERPFP, the effects of child abuse on parenting skills among American Indians are often mediated by SUDs (Libby, Orton, Beals, Buchwald, & Manson, 2008). In other words, childhood abuse increases the likelihood that an individual will develop a SUD, and parents with SUDs are more likely to consider themselves worse parents (i.e., to indicate that they were not happy as parents or thought themselves irresponsible parents). The researchers concluded that by improving social support and treating SUDs, the intergenerational transmission of trauma can be reduced. Although a SUD was a mediating factor in leading to worse parenting for parents in both tribes in the study, it had a significantly stronger effect in the Northern Plains sample than among the Southwest sample.

Several recent studies have focused on the role of adverse childhood experiences (ACEs), which include childhood abuse and neglect as well as factors such as having a dysfunctional family, witnessing violence against others, and experiencing the untimely death of a significant other, rather than only abuse and neglect. Whitesell, Beals, Mitchell, et al. (2009) investigated the relationship of 30 different ACEs on the later development of SUDs for 2,927 American Indians enrolled in the AI-SUPERPFP study. They found that major childhood events (i.e., adverse events that did not involve violence but had a strong effect, such as parental divorce or a serious illness), childhood traumas, and witnessing violence to others were associated with significantly greater odds of having a SUD (as well as early age of initiation to substance use), whereas getting traumatic news and the death of a loved one were not.

More recently, Brockie et al. (2015) looked at the relationship of several ACEs (i.e., emotional neglect, emotional abuse, sexual abuse, physical abuse, physical neglect, witnessing violence committed toward one' mother, experiencing discrimination, and having thoughts and feelings associated with historical loss) to four negative outcomes (i.e., symptoms of depression, symptoms of PTSD, suicide attempts, and polydrug use) in a group of 288 adolescent and young adult

American Indians and Alaska Natives (ages 15 to 24). They found that most ACEs were significantly associated with one or more negative outcomes, the exception being sexual abuse in childhood, which did not have any significant associations, although it is possible the effects of such would not be noticeable until later in life. The strongest relationships to depressive symptoms were found with physical abuse, which was associated with an 8.85 times greater risk, physical neglect (7.09 times greater risk), and witnessing violence to one's mother (5.58 times greater). In terms of polydrug use (not limited to use disorders), the ACEs that had the strongest relationship were thoughts of historical loss (4.45 times greater), exposure to violence toward one's mother (4.05 times), emotional abuse (3.73 times), and discrimination (3.69 times). For PTSD symptoms, physical neglect (5.99 times) and thoughts/feelings of historical trauma (5.6 times) had the strongest relationship; whereas for suicide attempts, witnessing violence toward one's mother (3.1 times) and physical abuse (3.04 times) had the strongest relationship with those outcomes.

Kenney and Singh (2016) examined data from the 2011–2012 National Survey of Children's Health to compare prevalence rates and correlates of ACEs among non-Hispanic White children (n = 61,381) and American Indian and Alaska Native children (n = 1,453) ages 0 to 17 years. They found that American Indian and Alaska Native children experienced a greater accumulation of ACEs, including being 2 to 3 times more likely to:

- Have a parent who had been incarcerated.
- Observe domestic violence.
- Experience or witness neighborhood violence.
- Live with someone with a SUD.

American Indian and Alaska Native children were also 1.5 times more likely to live with a divorced or separated parent and to have a parent who died. They were significantly more likely to have experienced multiple ACEs across all frequency categories (2+, 3+, 4+, and 5+ ACEs) and were significantly less likely to have experienced no ACEs. Among American Indian and Alaska Native children with three or more ACEs, the prevalence rates of depression, anxiety, and ADHD were higher than in American Indian and Alaska Native children with fewer than two ACEs. Similarly, rates of taking prescribed medications, having increased healthcare service needs, experiencing functional limitations, and receiving needed counseling were 2.1 to 3.6 times greater among children with three or more ACEs than among those with fewer than two ACEs. Results from a logistic regression found that American Indian and Alaska Native children with two or more ACEs were approximately 10 times more likely to have parent-reported emotional, behavioral, or developmental problems than American Indian and Alaska Native children with fewer than two ACEs.

An important issue specific to American Indian populations is potential trauma caused by attendance at government-run boarding schools of large numbers of American Indians from the late 19th century onward (Colmant, 2000). Although the Indian Child Welfare Act of 1978 (P.L. 95-608) was intended to reverse the trend that removed American Indian children from their parents and their people, even today many American Indians and Alaska Natives are placed outside their own communities through foster care and adoption (Cross, 2000; Evans-Campbell, 2006). In Robin, Rasmussen, and Gonzalez-Santin's (1999) study of 580 members of a Southwest American Indian tribe, more than half the members had lived outside their home environments at some time during childhood or adolescence, with 49.5 percent of the sample attending boarding school and 11 percent having been in foster care. Rates of physical and sexual abuse at many of these boarding schools were high (Boyd-Ball et al., 2006; Colmant, 2000; Koss et al., 2003; Smith, 2003; Weaver & Brave Heart, 1999), and several studies have found various psychological problems resulting from boarding school attendance (see review in Colmant, 2000).

Some studies did not find a significant association between boarding school attendance and later AUDs (e.g., Henderson, Kunitz, Gabriel, McCright, & Levy, 1998). However, Koss et al. (2003), in the study cited above, after controlling for childhood abuse and neglect, did find such an association that was significant for women but not for men. On the other hand, Robin et al. (1999) found a significant association between boarding school attendance and drug use disorders for men and

not for women (and no significant associations for AUDs). For women, they found significant associations between boarding school attendance and anxiety disorders and ASPD.

Having been in a boarding school or an out-of-home placement may also be related to treatment outcomes. Gutierres, Russo, and Urbanski (1994) found that, in the sample of American Indians in treatment in the Phoenix, AZ, area (*N* = 58), having been in foster care for significant time was the only family-related factor (including physical, emotional, or sexual abuse in the family) that was significantly related to lower rates of treatment completion.

Canadian researchers interviewed 358 American Indians and Alaska Natives (Ross et al., 2015). More than one-quarter of their sample (28.5 percent) had attended residential schools, and those participants reported various problems occurring at those schools. Besides expected negative experiences, such as being isolated from one's family, community, and culture, individuals who had attended boarding schools were more likely than the overall sample to have experienced childhood physical abuse (61.9 percent versus 34.1 percent, respectively) and sexual abuse (46.9 percent versus 35.2 percent).

Violent crime

American Indians and Alaska Natives are more likely to be the victims of violent criminal acts than members of other racial/ethnic groups (Eichenberg, 2014; Harring, 2014). According to cumulative data covering 1992 through 2002, American Indians and Alaska Natives were more than twice as likely to be victims of violent crime than were African Americans, 2.5 times as likely as White Americans, and more than 4.5 times as likely as Asian Americans (Perry, 2004). These and other crime statistics may also underreport the problem as it is difficult to gather accurate data on crime on reservations (Henson et al., 2008). As in other areas, there is also a great deal of variation in crime rates among diverse tribes (Henson et al., 2008).

In addition to being more likely to be the victims of violent crime in general, American Indians and Alaska Natives are more likely than members of other racial or ethnic groups to be the victims of many specific types of violent crime. According to 1992–2002 cumulative data, American Indians and Alaska Natives were about twice as likely to be victims of rape or sexual assault than were members of the general population and more than twice as likely to be the victims of either simple or aggravated assault (Perry, 2004).

Justice Department data from 1994 through 2010 indicated that American Indian and Alaska Native women were more likely than members of other major races/ethnic groups to be victims of rape or sexual assault, although small numbers of cases in each of those years mean that statistical significance cannot be attributed to those differences (Planty, Langton, Krebs, Berzofsky, & Smiley-McDonald, 2013). However, the 2010 National Intimate Partner and Sexual Violence Survey oversampled American Indian and Alaska Native men and women to make more accurate estimates (Rosay, 2016). Although these rates clearly showed that rates of sexual violence against American Indian and Alaska Native women and men were higher, the relative risk was still not found to be significant. According to that year's survey, 14.4 percent of American Indian and Alaska Native women had experienced sexual violence in the prior year, compared with 5.4 percent of non-Latino White American women; 9.9 percent of American Indian and Alaska Native men had also experienced sexual violence in the prior year compared with 3.8 percent of non-Latino White American men. The difference in rates was even more pronounced when only rape was considered, as 35 percent of American Indian and Alaska Native women had been raped at some point during their lives, compared with 20.1 percent of non-Latino White American women; during their lifetimes, 10.8 percent of American Indian and Alaska Native men had been raped, compared with 5.1 percent of White American men.

American Indians and Alaska Natives who experienced violence were also more likely to be victimized by members of other racial/ethnic groups than were members of those other groups (Perry, 2004). When White Americans experienced violent acts, the perpetrators were White Americans in 70 percent of cases. When African Americans experienced violent acts, the perpetrators were African

American in 80 percent of the cases. However, when American Indians experienced violent acts, only 34 percent of the perpetrators were American Indian. The majority of violent crimes against American Indians were committed by White Americans, which was the case in 57 percent of those crimes. According to Perry (2004), American Indians were also more likely to be raped by a stranger (in 41 percent of the cases) or an acquaintance (in 34 percent of the cases) than by an intimate partner or family member (in 25 percent of the cases).

According to Rosay (2016), using data from the 2010 National Intimate Partner and Sexual Violence Survey, 96 percent of American Indian and Alaska Native women who had been victims of sexual violence during their lives had been victimized by a non-native perpetrator, as had 89 percent of American Indian and Alaska Native men who had been victims of sexual violence. By comparison, 32 percent of White American women and 27 percent of White American men who had been victims of sexual violence during their lives had been victimized by someone from another race.

Harrell (2012) also observed that, according to Justice Department data for 1993 through 2010, American Indians and Alaska Natives were more likely to experience violent crimes committed by strangers than were members of other major racial/ethnic groups. During each 6-year period in that 18-year span, American Indians and Alaska Natives were at least twice as likely and as much as four times as likely to experience violent crimes committed by strangers than were White Americans. It also should be noted that a greater percentage of the violent crimes committed against American Indians and Alaska Natives involved perpetrators who were under the influence of alcohol. In cases of violent crimes against American Indians and Alaska Natives where it was known whether the perpetrator used alcohol or drugs, 48 percent of the perpetrators were under the influence of alcohol (compared with 34 percent for crimes against Whites and 26 percent for crimes against African Americans); in 14 percent of the cases, the perpetrator was under the influence of alcohol and illicit drugs (compared with 9 percent for crimes against Whites and 9 percent for crimes against African Americans); and in 9 percent of the cases, the perpetrator was under the influence of illicit drugs only (compared with 9 percent for crimes against Whites and 11 percent for crimes against African Americans [Perry, 2004]).

Alcohol is also involved in many cases where American Indians and Alaska Natives are the perpetrators of violence. For example, Ehlers et al. (2004) compared American Indians from California with a general population sample from the state and found that it was significantly more common for American Indian respondents to state they had been in physical fights or had hit others when drinking.

Intimate partner and family violence

Rates of domestic or intimate partner violence are also high for American Indians and Alaska Natives: 1.6 percent of all victims of "family violence" (which includes domestic violence against adults and child abuse) between 1998 and 2002 were American Indians and Alaska Natives, although American Indians and Alaska Natives made up only 0.4 percent of the total population during that period (Durose et al., 2005). Earlier data showed that one unusual aspect surrounding domestic violence against American Indians and Alaska Natives is that it is largely committed by non-American Indian and Alaska Native partners. Between 1992 and 1996 in the United States as a whole, only 11 percent of the recorded cases in which an intimate partner committed a violent act were committed by someone of another race, but 75 percent of the intimate partner violence cases against American Indians and Alaska Natives were committed by a partner of another race (Greenfeld & Smith, 1999). Historical, legal, and jurisdictional issues also contribute to high rates of domestic violence for American Indians and Alaska Natives (see review in Finley, 2014).

Breiding, Chen, and Black (2014) reported findings from 9,970 women and 8,079 men interviewed in 2010 for the National Intimate Partner and Sexual Violence Survey. According to this survey, American Indian and Alaska Native men and women were more likely to be victims of intimate partner violence than were men and women from other major racial/ethnic groups, and American Indian

and Alaska Native women were significantly more likely to be victims of intimate partner violence than were White American women. According to this study, which oversampled American Indians and Alaska Natives to make more accurate estimates, 55.5 percent of American Indian and Alaska Native women and 43.2 percent of American Indian and Alaska Native men reported being victims of violence from an intimate partner at some point during their lives, and 8.6 percent and 5.6 percent, respectively, had been victimized in the prior year. By comparison, 34.5 percent of White American women and 30.5 percent of White American men reported being victims of intimate partner violence during their lives, and 4.1 and 4.5 percent, respectively, had been victimized in the previous year.

The BRFSS has also queried about intimate partner violence in some surveys. According to 2005 BRFSS data, 39 percent of American Indian and Alaska Native women and 18.6 percent of American Indian and Alaska Native men reported being victims of intimate partner violence at some point during their lives, the highest rate for women among major racial/ethnic groups and the second highest rate for men after African American men (CDC, 2008). This report also found that across all racial/ethnic groups, a history of intimate partner violence was associated with significant increases in the risk of smoking, binge drinking, and several physical ailments.

Rates of intimate partner violence are even higher among American Indian and Alaska Native women attending behavioral health programs. In Saylors and Daliparthy's (2006) sample of American Indian and Alaska Native women seeking SUD treatment in an urban area, 75 percent had been physically assaulted as adults. In 67 percent of those cases, the perpetrator was an intimate partner, and in 74 percent of the cases, alcohol or drug use were involved. In another study, 89 percent of the 122 Alaska Native women entering a women's SUD treatment program in Fairbanks, AK, reported having suffered domestic violence by a partner (Segal, 1999).

Zahnd et al. (2002) reviewed earlier research showing that domestic violence was significantly more common among American Indians and Alaska Natives who had problems with binge drinking than among those who did not, and domestic violence rates were lowest among alcohol abstainers. Oetzel and Duran (2004) also provided a review of earlier research regarding intimate partner violence among American Indians and Alaska Natives and noted that factors associated with increased risk for such violence include female gender, lower socioeconomic status, substance use (by either victim or partner), and age (being under 50 and, especially, in the 16 to 24 age group).

Duran et al. (2009) evaluated the behavioral health and histories of intimate partner violence for 234 American Indian and Alaska Native women who were using IHS primary care services in Albuquerque, NM (90 percent were members of Southwest tribes). They found that 43.6 percent of their sample had experienced severe intimate partner violence at some point during their lives, with severity assessed using the Revised Conflict Tactics Scales. In a model that adjusted for other mental disorders and SUDs, family histories of alcohol-related problems, family debt, and demographic variables, women who experienced severe intimate partner violence were significantly more likely to have a mood disorder and, if they also had family histories of alcohol-related problems, were also significantly more likely to have an anxiety disorder.

Although the common perception is that domestic violence is a problem that just affects women, men too can experience it (see TIP 56, *Addressing the Specific Behavioral Health Needs of Men* [SAMHSA, 2013a]). American Indian and Alaska Native men more frequently experience domestic violence than do members of other racial groups (Breiding et al., 2014). Robin, Chester, and Ramussen (1998) evaluated histories of intimate violence among men and women from a Southwest Indian tribe (N = 104). Fifty-one percent of women and 44 percent of men in the sample reported experiencing some type of domestic violence; 44 percent of women and 36 percent of men reported physical violence directed at them by their partner. Thirty percent of respondents reported initiating violence at some point (with men being about three times as likely to report initiating violence).

The Office of Justice Programs' publication, *Victim Services: Promising Practices in Indian Country* (Deer, Flies-Away, Garrow, Naswood, & Payne, 2004), describes some programs that have been found effective in helping American Indians who have experienced domestic violence, as well as American Indian children who have been abused.

Canadian researchers found that socioeconomic factors were a major contributing factor to higher rates of intimate partner violence for Aboriginal women compared with non-Aboriginal women (Daoud, Smylie, Urquia, Allan, & O'Campo, 2013). Another Canadian study concluded that younger age and greater use of coercive control by partners (e.g., preventing access to family income, damaging or destroying personal property, limiting contact with family and friends) were the major factors in explaining significantly higher levels of continued intimate partner violence for Aboriginal women who separated from their partners, compared with other women (Pedersen, Malcoe, & Pulkingham, 2013). Historical and intergenerational trauma may also contribute to intimate partner abuse among American Indians and Alaska Natives (IHS, 2011).

The physical abuse of elders is another domestic abuse situation that may occur and is often underreported. A review of the medical charts for 550 American Indian and Alaska Native older adults in the Seattle, Washington, area found that 10 percent had probably been physically abused as older adults and another 7 percent may have been abused as children (Buchwald et al., 2000). Earlier research by Brown (1989) involving 37 American Indians from the Southwest region ages 60 or older who were living on a reservation found that 16.2 percent had been physically abused as older adults. These percentages are high relative to rates of elder abuse found in earlier general population studies (i.e., from 2 to 10 percent; Pillemer & Finkelhor, 1988), but many of those earlier studies may have underreported the incidence of elder abuse (National Center on Elder Abuse, 1998).

Current alcohol use was associated with a significantly greater chance of having been abused for older American Indians and Alaska Natives. Nerenberg and Benson (2004) published a literature review on the problem of elder abuse in Indian Country and a guide to preventing and responding to such abuse. Witko, Martinez, and Milda (2006) discussed some of the causes of and treatment approaches for domestic violence in American Indian and Alaska Native communities. The Administration on Aging (2005) published a guide to *Elder Abuse Issues in Indian Country*, which reviewed the extent of the problem with examples and the practices and laws that address the problem.

Violent accidents

Rates of trauma and death resulting from accidents are about two and a half times higher for American Indians and Alaska Natives than for the U.S. general population (IHS, 2015). Rates of death from unintentional injury vary by geographic location, but in any given area, American Indians and Alaska Natives appear to be disproportionately affected. For example, in Alaska between 2002 and 2011, the rate of hospitalizations from unintentional injuries for American Indians and Alaska Natives was 109.2 per 10,000 people, which was significantly higher than the rate of 51.6 per 10,000 people for non-American Indians and Alaska Natives in the state during that period (Strayer et al., 2014). The rate of mortality from unintentional injuries is also high for Alaska Natives. According to 2004–2008 data, 13 percent of deaths among Alaska Natives were attributed to unintentional injury (17.3 percent of deaths for men and 7.8 percent for women); by comparison, 4.8 percent of deaths for White Americans in the U.S. population as a whole could be attributed to that cause during that period (Day et al., 2011). Death rates as a result of unintentional injury are often related to substance use, particularly alcohol use (see "Substance-Related Morbidity and Mortality").

Motor vehicle accidents and resulting fatalities are also more common for American Indians and Alaska Natives than for others. The rate of traffic fatalities is 1.5 times higher for American Indians and Alaska Natives than for White Americans or African Americans (CDC, National Center for Injury Prevention and Control, 2015). The disproportionate number of American Indians and Alaska Natives living in rural areas may affect this finding, but even in rural areas, American Indians and Alaska Natives appear to be more likely than White Americans to die from a traffic accident. In comparing traffic

fatalities for rural counties in Arizona that had either predominantly White or American Indian and Alaska Native populations, Kunitz et al. (1994) found that although a similar proportion of traffic fatalities in those counties were alcohol-related, the rates of traffic fatalities (whether alcohol-related) were substantially higher for American Indian than for White drivers, and the rate of alcohol-related traffic fatalities was nearly twice as high in the county that was predominately American Indian. They attributed the bulk of the difference in alcohol-related traffic fatalities to worse roads, fewer medical facilities, more unsafe or ill-maintained vehicles, and greater driving distances.

Historical trauma

In addition to personal trauma, American Indians and Alaska Natives may also be affected by historical trauma, the result of the cumulative oppression of and violence against their people. Grief, shame, sadness, anxiety, and anger over historical events, such as the massacres and the loss of land and culture appear to play a role in the development of a historical trauma response that in turn contributes to self-destructive behaviors, such as suicide or SUDs in American Indians and Alaska Natives (Brave Heart, 2004; Brave Heart, Chase, Elkins, & Altschul, 2011; Brave Heart & DeBruyn, 1998; Cole, 2006; Duran et al., 1998; Evans-Campbell, 2008; Morgan & Freeman, 2009; Sullivan & Brems, 1997; Szlemko et al., 2006).

The concept of historical trauma was originally developed to explain the psychological trauma of later generations descended from Jewish Holocaust survivors and the apparent way in which the trauma of their parents and grandparents continued to affect them (Brave Heart & DeBruyn, 1998; Duran et al., 1998). Clinicians who worked with American Indian and Alaska Native clients saw a similar pattern in their clients' reaction to genocide experienced by their ancestors (Brave Heart, 2004; Brave Heart & DeBruyn, 1998; Brave Heart et al., 2011; Duran et al., 1998).

There is some evidence that issues involving historical traumatic events continue to be of concern to American Indian and Alaska Native descendants of men and women who suffered through those events. Whitbeck, Adams, et al. (2004) assessed 143 American Indian parents and caretakers from tribes in the upper Midwest United States using the Historical Loss and the Historical Loss Associated Symptoms scales, which they developed. Historical loss and its effects were often on the minds of respondents, with 45.9 percent reporting they thought at least once a day about alcohol misuse and its effects on their communities; 33.7 percent thought about the loss of their traditional culture; 36.3 percent thought about the loss of their indigenous language in their communities; and 18.2 percent thought about the loss of traditional lands.

A greater preoccupation with historical loss has been associated with increased risk for a DSM-III-R diagnosis of alcohol abuse among female but not male American Indians and Alaska Natives (Whitbeck, Chen, et al., 2004); with greater feelings of anger and more responses that mirrored symptoms of anxiety or depression (Whitbeck, Adams, et al., 2004); and with a greater likelihood of binge eating behaviors (Clark & Winterowd, 2012). (See "Risk and Protective Factors for Mental and Substance Use Disorders.") American Indians and Alaska Natives with substance dependence were also more likely than those without a history of substance dependence to think about historical losses (Ehlers et al., 2013). Additionally, many clinicians who work regularly with American Indian and Alaska Native clients believe that historical trauma is an important issue that affects behavioral health and that needs to be addressed in treatment (Brave Heart & DeBruyn, 1998; Cole, 2006; Duran et al., 1998; Evans-Campbell, 2008; Morgan & Freeman, 2009; Walters et al., 2002).

Historical trauma is believed to affect American Indian and Alaska Native peoples at the cultural, familial, and community levels (Evans-Campbell, 2008; Robin et al., 1996). It may have repercussions that can negatively affect mental health (Whitbeck, Adams, et al., 2004), behaviors related to social and family interactions (Brave Heart, 1999; Libby et al., 2008), and physical health (Sotero, 2006). Key aspects of the American Indian and Alaska Native experience of historical trauma include the perpetration of a survivor's child complex, which involves a focus on the past and its trauma and a perceived obligation on the part of children to make up for their parents' trauma; disenfranchised grief that

results from the inability to openly mourn the trauma of the past; and an experience of transposition, which results in a preoccupation with past events and an inability to fully "live" in the present (Brave Heart, 2004; Brave Heart & DeBruyn, 1998; Evans-Campbell, 2008).

Sotero (2006) synthesized research on historical trauma conducted with several diverse populations to produce a model of how a mass trauma experience caused by deliberate perpetration continues to have repercussions in communities for years to come. She found that for the first generation experiencing the trauma, such events have material effects (e.g., the segregation or displacement of a population), psychological effects (e.g., PTSD), economic effects (e.g., loss of sources of income or sustenance), and cultural effects (e.g., loss of language, spiritual practices). The trauma and stress experienced by this first generation results in a physical response (e.g., malnutrition, infectious diseases, diabetes), a social response (e.g., increased domestic violence, child abuse, substance misuse, poverty), and a psychological response (e.g., PTSD, depression, anxiety), which in turn affect the next generation in a similar fashion. Thus, the original trauma is perpetuated for several subsequent generations.

Walters et al. (2002) proposed a similar model to explain American Indian and Alaska Native substance use patterns in the context of historical trauma while acknowledging the protective features of American Indian and Alaska Native cultures, identities, and families. In this stress-coping model, stress accumulating from historical trauma, contemporary violence and discrimination, unresolved grief, broken families, and lost cultural traditions are factors that increase SUDs, anxiety disorders, and mood disorders among American Indians and Alaska Natives.

Research supports aspects of these models to varying degrees. Libby et al. (2008) found that SUDs mediated the effects of child abuse, leading to worse self-perceived parenting (whereas depression had no such relationship to worse parenting) among American Indians in the Southwest and Northern Plains (see "Child Physical and Sexual Abuse.") The researchers noted that this likely reflected the ongoing effects of past traumatic experiences and that by addressing SUDs and improving social support, clinicians can reduce the effects of the intergenerational transmission of trauma.

Brave Heart (1999) similarly concluded that historical trauma perpetuates itself by negatively affecting parenting skills—for example, by increasing substance misuse and destroying traditional cultural practices related to child-rearing. Brave Heart (2004) also noted how historical trauma can be mitigated by reducing risk factors for further trauma (e.g., by treating SUDs) and increasing protective factors through improving parenting skills.

Whitbeck, Chen, et al. (2004) found that involvement in traditional cultural practices can assuage some of the negative effects associated with perceived discrimination and oppression (see "Risk and Protective Factors for Mental and Substance Use Disorders"). Traditional ceremonies that focus on mourning and coping with grief, such as the Wiping of the Tears and Releasing of the Spirits ceremonies, may benefit communities that are coping with the lasting effects of historical trauma (Brave Heart & DeBruyn, 1995).

Research by Brave Heart also has found that interventions to address historical trauma can improve parenting and thereby may reduce the intergenerational transmission of trauma (Brave Heart, 1999, 2004; Brave Heart & DeBruyn, 1998). Brave Heart and DeBruyn (1998) and Duran et al. (1998) recommended the use of group or family interventions to increase awareness about the effects of historical trauma, enable grieving about past events, and improve social support.

Brave Heart (1998, 1999) developed a culturally specific, psychoeducational intervention to teach the Lakota people the effects of historical trauma, their traditional childrearing practices, and parenting skills. This intervention, since called the Historical Trauma and Unresolved Grief Intervention (HTUG), targets parents specifically to break the intergenerational transmission of trauma through education about the trauma that the Lakota people have suffered and traditional Lakota

methods of child-rearing, as well as by providing a cathartic group experience that creates bonding and improves social support (Yellow Horse & Brave Heart, 2014). Although HTUG was developed specifically for Lakota people, it has been or is in the process of being adapted for other tribes. Brave Heart, Elkins, Tafoya, Bird, and Salvador (2012) also reported on historical trauma interventions aimed at American Indian and Alaska Native men and boys that address how historical trauma has affected male roles in American Indian and Alaska Native cultures.

HTUG has not yet been evaluated in published literature, but clients who participated in HTUG have reported reductions in shame and stigma (Brave Heart, 2004). Brave Heart (1999) also reported on the pilot testing of this intervention developed for the Lakota, which was delivered to 10 Lakota parents and 2 parent facilitators. Participants in this pilot program reported that the intervention helped them significantly in understanding their history and culture and had a positive effect on their parenting.

However, more research is needed to evaluate the specific effects of historical trauma on individuals, families, and communities, as well as on the effectiveness of specific interventions to address this problem (Evans-Campbell, 2008). In their discussion about the effects of cumulative trauma on American Indian communities, Robin et al. (1996) found that researchers needed to pursue three goals: (1) to better document the effects of long-term, repeated trauma on American Indian populations; (2) to examine how a single traumatic event may affect American Indians given the context of a history of cumulative, multigenerational trauma; and (3) to understand how traumatic events affect whole communities rather than just individuals.

Trauma and PTSD

Several studies have found high rates of PTSD in American Indian and Alaska Native populations (see "Large Epidemiological Studies on the Prevalence of Mental and Substance Use Disorders"). Some research conducted with Vietnam veterans (Beals et al., 2002) also concluded that American Indians and Alaska Natives were more likely than members of some other racial groups to develop PTSD as a result of trauma exposure.

Whether trauma exposure leads to PTSD may depend in part on cultural factors regarding the degree to which an event is considered traumatic by a culture and how a member of a given culture recognizes its effects and copes with it (Marsella, 2010; Marsella, Friedman, & Spain, 1996). Additionally, many material and social problems that American Indians and Alaska Natives have to contend with have been found to increase the risk of PTSD. Bonanno, Galea, Bucciarelli, and Vlahov (2007) assessed PTSD symptoms among New Yorkers (who did not necessarily meet diagnostic criteria for a disorder) after the September 11, 2001, terrorist attacks and found that minority status, lower levels of education, poverty, chronic health problems, recent stress, prior trauma, and lack of social support all independently increase the risk that a person will have elevated PTSD symptoms following exposure to trauma.

Some types of trauma may have a greater effect on American Indian and Alaska Native people and, in some cases, an event that is quite traumatic may not be recognized as such because of a lack of cultural sensitivity (Manson et al., 1996). After the Exxon Valdez disaster, researchers found that Alaska Natives exposed to the event had significantly higher rates of PTSD and GAD (apparently as a result of the event) than did White Americans who were also exposed (Palinkas, Downs, Patterson, & Russell, 1993). These elevated rates may reflect a different understanding of the disaster and its effects on the Alaska Natives' lives and culture. On the other hand, research with American Indian adolescents in boarding schools found relatively low levels of PTSD (1.6 percent) in spite of the fact that more than 60 percent had been exposed to trauma (Manson et al., 1996).

These differences may indicate that the concept of PTSD, coming from a Eurocentric model of trauma response, does not reflect the nature and extent of American Indian and Alaska Native reactions to trauma, especially to historical trauma, which may affect an entire people (Marsella, 2010; Robin et al., 1996).

Biological or genetic factors

The ideas that American Indians and Alaska Natives cannot drink without getting drunk or that they have an inborn craving for alcohol are myths that have developed out of prejudice toward native peoples and have no foundation in science (Coyhis & White, 2006).

People have theorized that there are genetic differences that may make American Indians and Alaska Natives more susceptible to SUDs, and several studies have been conducted to evaluate a possible genetic contribution to high levels of SUDs in this population. Ehlers and Gizer (2013) reviewed research published prior to 2012 that has identified genes that increase risk for SUDs and related factors, such as craving and tolerance in American Indian and Alaska Native populations, but none of the factors thus identified are unique to American Indians and Alaska Natives. Other research has found that some genetic variants that appear to protect against SUDs in East Asian and some African populations are lacking in most American Indians and Alaska Natives, but again, that is not unique to American Indian and Alaska Native populations. Most of the research reviewed has evaluated the contribution of genetic factors to AUDs, but studies have also identified genes that increase risk for other SUDs, including cannabis dependence (Ehlers, Gilder, Gizer, & Willhelmsen, 2009) and stimulant dependence (Ehlers, Gizer, Gilder, & Willhelmsen, 2011).

As with other racial groups, researchers also have found that genetic factors contribute to high rates of certain mental disorders in some American Indians and Alaska Natives, including ASPD (Ehlers, Gilder, Slutske, Lind, & Wilhelmsen, 2008) and PTSD (Ehlers et al., 2013). As with genes involved in SUDs, these genes are not unique to American Indians and Alaska Natives.

Differences in the Behavioral Health of American Indian and Alaska Native Subpopulations

Although there are many diverse American Indian and Alaska Native cultures, there also are other distinctions (e.g., whether the individuals live in a rural or urban area, the degree to which an individual is acculturated to mainstream American culture) that play a part in defining their behavioral health service needs. Information on some of the most salient (for behavioral health purposes) of these differences is discussed below.

Differences among rural, urban, and border town-dwelling American Indians and Alaska Natives

Most American Indians and Alaska Natives live in urban areas, but American Indians and Alaska Natives are more likely than members of other major racial/ethnic groups to reside in rural areas. According to the 2010 census, 71 percent of American Indians and Alaska Natives live in urban areas (UIHI, 2013), and only about 22 percent live on reservations or off-reservation trust lands (Census Bureau, 2011). This percentage is still smaller than the percentage of the country as a whole that was living in urban areas in 2010, which was 80.7 percent (U.S. Census Bureau, 2012b). When counties surrounding tribal areas are added to the equation, 6 out of 10 American Indian and Alaska Native households are either on tribal lands or in counties adjacent to those lands (Pettit et al., 2014).

Alaska Natives are also more likely than other Alaskans to live in rural areas, with almost 50 percent living in rural communities compared with 30 percent of non-Alaska Natives (Wells, 2004b). Many Alaska Native villages are very remote and not even accessible by road (Niven, 2007).

About one-third of the American Indians and Alaska Natives whose primary residence is on reservations, trust lands, or bordering rural areas migrate back and forth between cities and those rural areas (Forquera, 2001). Many of those whose primary residence is in an urban area still maintain close ties with family and cultural activities on reservations in rural areas.

Although the majority of American Indians and Alaska Natives enter behavioral health programs located in metropolitan areas, they are still less likely to enter an urban-based program than are members of other ethnic groups. According to data from multiple sources, the majority (66.8 percent) of American Indians and Alaska Natives admitted

to SUD treatment in 2002 entered programs that were in metropolitan areas but among the general population, a significantly larger percentage (83.2 percent) sought treatment in metropolitan areas in the same year (McFarland et al., 2006).

Rieckmann et al. (2012) compared client characteristics of American Indians and Alaska Natives receiving SUD treatment at either an urban- or reservation-based program. The researchers found that clients at the urban program were significantly more likely than were those at the reservation-based program to be female; to be regular amphetamine users or polysubstance users (i.e., use more than one substance per day); to be unemployed; and to have a history of physical, sexual, or emotional abuse. Clients at the rural program were significantly more likely than were those in the urban program to be regular users of hallucinogens, be married, report a violent temper, and have medical problems (indicated by more days of hospitalization and more days of self-reported medical problems).

Weibel-Orlando et al. (1984) compared alcohol use by urban (n = 155) and rural (n = 123) American Indians in Southern California and found little difference in drinking patterns except among two groups: the heaviest daily drinkers (i.e., those who consumed three or more drinks per day) and the heaviest drinkers per drinking occasion (i.e., those who consumed five or more drinks per drinking occasion). A significantly larger percentage of urban drinkers fell into the first category, and a significantly larger percentage of rural drinkers fell into the second category; the differences among more moderate drinkers were not significant. These drinking patterns may in part be dependent on factors such as the availability of alcohol and differences in income rather than on cultural differences. Weibel-Orlando et al. (1984) observed that, generally, urban American Indians and Alaska Natives in their survey indicated that their drinking patterns were established prior to their arrival in the city.

Abstinence patterns, however, may be different for rural and urban-dwelling American Indians and Alaska Natives. For example, in Kunitz et al.'s (1994) research, Navajo dwelling in rural areas were more likely to "age out" of their drinking and attain recovery than were those in an urban community (see "Aging Out Patterns"). This appears to be confirmed by data from the 2006 NSDUH, which found that a larger percentage of American Indians and Alaska Natives living in rural areas (36.9 percent) had gone 12 months or more without drinking, compared with those living in urban areas (20.2 percent); earlier NSDUH studies showed a similar pattern (OAS, 2007).

An evaluation of SUDs among a group of 171 American Indian women from rural and urban areas in California found few differences in rates of heavy or problem alcohol use between the two groups but did find that women in rural communities drank more per occasion of drinking. The study found that rates of illicit substance use in the prior year varied somewhat by location, with American Indian women in rural areas more likely to have used marijuana and methamphetamine and women in urban areas more likely to have used all other drugs (Zahnd & Klein, 1997). Evans (2006) also commented on the rise in methamphetamine use disorder in many rural American Indian communities. However, the 2014 NSDUH found that the rate of past-month methamphetamine use for American Indians and Alaska Natives in rural areas was about the same as the rate for American Indians and Alaska Natives in large metro areas, although the rate of past-year use was about twice as high for American Indians and Alaska Natives in rural areas, which may suggest more occasional but not regular use (CBHSQ, 2015).

The higher rate of methamphetamine use among rural, but not urban, American Indian women found in Zahnd and Klein's (1997) study may also not be accurate in all areas, because Spear et al. (2007) found a large increase in the number of American Indian women entering SUD treatment in Los Angeles between 2000 and 2005 who reported methamphetamine as their primary drug. Using data for 2,285 treatment admissions of American Indians and Alaska Natives (970 of whom were female) from the Los Angeles County Alcohol and Drug Program Administration reporting system, the research team found that the percentage of those listing methamphetamine as their primary drug increased from 24.8 percent in 2001 to 31 percent

in 2005. For women, this percentage increased from 31.7 percent to 40.3 percent at the same time the number of American Indian and Alaska Native women entering treatment also increased.

The phenomenon of "border towns," derogatively called "drunk towns" because of the binge drinking that occurs there, needs to be considered in relation to American Indian and Alaska Native drinking patterns (French, 2000). These towns, which border reservations that control alcohol sales on their lands, thrive economically on the sale of alcohol to individuals who travel from the reservation for that explicit purpose. Rates of alcohol and possibly illicit drug consumption will likely be elevated for American Indians and Alaska Natives living in and around these towns, as will be alcohol-related morbidity and mortality (Ellis, 2003). For example, in Kunitz et al.'s (1994) study of alcohol use, rates of death from cirrhosis were highest in those areas closest to these border towns.

Regional differences

Part of the reason studies have found high rates of SUDs in American Indian and Alaska Native samples (see epidemiological sections) may relate to the areas of the country in which most American Indians and Alaska Natives live. Kunitz et al. (1994), for example, cautioned that the tendency to see elevated levels of alcohol-related problems among American Indians may be skewed by comparing tribes with national general population samples. They found in their research that high levels of alcohol-related mortality observed among American Indians were not high, relative to those found among other ethnic groups in the same area. (For example, White Americans in the counties where American Indians primarily resided had higher rates of death by cirrhosis and suicide, comparable rates of death by homicide, but lower rates of death from motor vehicle accidents.)

As noted above, IHS reports significant differences in alcohol-related morbidity and mortality among American Indians and Alaska Natives in different regions (HHS, IHS, 2012). Other studies also have found regional differences in rates and patterns of alcohol use for American Indians and Alaska Natives. For example, in comparing data from multiple studies on American Indians, May and Gossage (2001) concluded that, "in general, Southwest tribes and the Plains tribes of Oklahoma appear to have lower prevalence rates of drinking than do northern Plains tribes" (p. 4).

Regional differences in rates of mental disorders are more difficult to do, but IHS data do show some variation in the frequency of hospitalizations and ambulatory care visits for mental disorder according to his service area (HHS, IHS, 2012).

To some extent, regional differences may really reflect tribal differences in behavioral health. Thus, it is difficult to determine the degree to which differences in mental health between the two samples in the AI-SUPERPFP (e.g., Beals, Novins, et al., 2005) reflect regional factors rather than tribal differences.

Differences among tribes

As noted, there are more than 560 federally recognized American Indian tribes and more than 300 that have petitioned for recognition but remain unrecognized (Bureau of Indian Affairs, 2010; National Conference of State Legislators, 2016). The category of Alaska Natives includes four recognized tribal groups: Alaskan Athabascan, Aleut, Eskimo (Inupiat and Yuit), and Tlingit-Haida and many more independent communities (Ogunwole, 2006). Providers should recognize that these tribes represent a wide variety of cultures that differ from one another in many ways (Duran, Jojola, Tsosie, & Wallerstein, 2007).

Several studies have found significant differences among tribes as well as among native peoples in different geographic regions on many different factors related to substance use and use disorders (e.g., Heath, 1989; Koss et al., 2003; Libby et al., 2004; May & Gossage, 2001; Whitesell et al., 2007). Even in the same state, patterns of substance use and use disorders or dependence can vary significantly among diverse tribes, as can the consequences of that use (Christian et al., 1989; Herman-Stahl & Chong, 2002; Kunitz et al., 1994).

Koss et al. (2003) compared rates of alcohol dependence (assessed using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV [AUDADIS]) among American Indians from seven different tribes and found rates of dependence

that varied from 56 percent of men and 30 percent of women in one tribe to 1 percent of men and 2 percent of women in another, with a mean of 30 percent of men and 18 percent of women for the total sample. The authors noted, however, that tribes that had members of their own tribe administer the AUDADIS found significantly lower rates of AUDs, and thus bias in reporting or administering the instrument may have affected findings.

Herman-Stahl and Chong (2002) compared three different American Indian tribes in Arizona and found that rates of SUDs differed significantly among tribes, with 53.3 percent of male respondents and 23.5 percent of female respondents from one tribe meeting screening criteria for a possible SUD, 45.3 percent of men and 24.9 percent of women in another tribe, and only 27.2 percent of men and 9 percent of women in the third tribe meeting those criteria.

Tribes have different levels of substance misuse and use disorders and diverse attitudes toward those behaviors, and those attitudes can have a significant impact on the course of SUDs as well as on their treatment. For example, Kunitz et al. (1994) noted that among the Navajo in the 1960s (when their study began), binge drinking by young men was tolerated, even if it was believed by most Navajo to be wrong (see May & Smith, 1988). Although the Navajo may have considered such drinking regrettable, they did not shun those who drank in this fashion. However, a neighboring tribe, during the same period, strongly believed that any alcohol use was unacceptable, and people who drank regularly were shunned or, in some cases, expelled from the community. As a result of these attitudes, the neighboring tribe's members who drank tended to drink alone or moved off their reservation to border towns where heavy alcohol use was common. The ostracism of individuals who drank apparently led to even greater levels of drinking, as there were much higher death rates from alcoholic cirrhosis among this tribe than among the Navajo. The authors concluded that intolerant attitudes toward drinking actually had a harmful effect on those who did drink.

At the same time, some individuals from tribes where heavy alcohol use is considered acceptable if not normal behavior may also feel that there is something wrong with them if they are unable to engage in such behavior (O'Nell, 1992). Beauvais and LaBoueff (1985) cautioned that if there is a prevailing attitude among a tribe or community that AUDs are inevitable and if it stems from factors over which individuals have no control (such as a genetic trait), then there may develop a "sense of fatalism that may defy treatment efforts" (p. 158). This fatalism can affect whole communities as well as individuals.

Differences according to level of acculturation

"Acculturation" is the process whereby an individual from one culture integrates elements of another culture into their own (Paniagua, 1998). For American Indian and Alaska Native clients, this refers to the degree to which they integrate the mainstream American culture into their own cultural practices and beliefs. Acculturation is a bidirectional model in which each culture may take something from the other, and to that extent it differs from models of "assimilation," which envision a process in which an individual loses the connection to his or her culture of origin while being absorbed into a dominant culture (LaFromboise, Coleman, & Gerton, 1993). "Biculturalism" is a term used to describe the situation in which an individual feels equally competent with both the mainstream American culture and his or her traditional American Indian and Alaska Native culture (LaFromboise et al., 1993); it differs from assimilation in that the individual does not lose the connection with his or her traditional culture. "Enculturation" is a term used to describe the process by which one learns about a culture and is often used in the literature on American Indian and Alaska Native behavioral health to describe an individual's knowledge of and connection with their traditional culture (Stone, Whitbeck, Chen, Johnson, & Olson, 2006). TIP 59, *Improving Cultural Competence* (SAMHSA, 2014b), contains more information on the process of acculturation and how it applies to behavioral health for American Indians and Alaska Natives and other populations.

Choney et al. (1995) posited five levels of acculturation: (1) a traditional orientation, (2) a transitional orientation (in which the individual is more oriented

toward traditional culture but has some familiarity with European American culture), (3) a bicultural orientation (in which the individual is equally comfortable with and knowledgeable about both cultures), (4) an assimilated orientation, and (5) a marginal orientation (in which the individual is not comfortable with either culture). They held that this model avoids many problems associated with earlier acculturation models (e.g., assuming a natural movement from a traditional orientation to being oriented toward majority culture, failing to account for multiple approaches to being in a bicultural environment) and that it acknowledges strengths associated with each level of acculturation without presenting the levels in any form of hierarchy.

There are a variety of other theories concerning acculturation and its various stages, and many of these were reviewed by LaFromboise et al. (1993). Many of these theories noted that the process of acculturation is often stressful and may have other repercussions (LaFromboise et al., 1993; Paniagua, 1998). However, there is a lack of specific research detailing the effects one's level of acculturation has on the behavioral health of American Indians and Alaska Natives.

The degree to which an American Indian or Alaska Native person is connected to his or her traditional culture or has been forced to acculturate to mainstream American culture may play a role in the development of mental disorders and SUDs (Choney et al., 1995). (See "Risk and Protective Factors for Mental and Substance Use Disorders: Cultural Factors.") Some studies have found that a stronger tie to one's traditional culture may protect American Indians and Alaska Natives against SUDs (Herman-Stahl et al., 2003; Whitbeck, Chen, et al., 2004) and depression (Kaufman et al., 2013, Whitbeck et al., 2002). However, this may not necessarily be the case, especially when SUDs are a community-wide problem (Westermeyer & Neider, 1986) or when involvement in traditional activities also increases exposure to substance use (Petoskey et al., 1998; Yu & Stiffman, 2007). Other research suggests that a strong connection to either American Indian and Alaska Native or White American culture can be protective against substance use and depression, as either connection may increase social support (Baldwin et al., 2011).

It is possible for American Indians and Alaska Natives to be competent and comfortable with both their traditional culture and the mainstream American culture—what such a bicultural identity consists of is explored at greater length by LaFromboise et al. (1993). Walters (1999) found that acculturation to mainstream culture among urban American Indians and Alaska Natives was compatible with self-identification as an American Indian or Alaska Native and was not related to having negative attitudes about being American Indian or Alaska Native.

People with physical health problems

Although health indicators have improved for American Indians and Alaska Natives over the past few decades (Henson et al., 2008), American Indians and Alaska Natives still suffer disproportionately from several physical illnesses including tuberculosis, diabetes, cardiovascular disease, and cervical cancer (Campbell, 2014; HHS, IHS, 2015; IHS, 2011; NCHS, 2016; Urban Indian Health Commission, 2007). American Indians and Alaska Natives are more likely than members of other major racial/ethnic groups to report their current health as being fair or poor; in the 2014 NHIS, 14.1 percent of American Indians and Alaska Natives reported this, compared with 8.3 percent of White Americans (NCHS, 2016). Among urban residents, American Indians and Alaska Natives were significantly more likely to report one or more days of worse physical health in the prior month (42 percent did) than were members of other major racial/ethnic groups (36 percent did; UIHI, 2008).

Many of the health problems faced by American Indians and Alaska Natives have a behavioral component (IHS, 2011). American Indians suffer disproportionately from alcohol-related morbidity and mortality (HHS, IHS, 2015), and many other health conditions may be exacerbated by alcohol or drug use, SUDs, or mental disorders. IHS (2011) noted that 7 of the 10 leading causes of death for American Indians and Alaska Natives have a behavioral component, such as lack of exercise, lower-quality diet and nutrition, tobacco use, alcohol use, or some combination of these, and this remains true according to more recent CDC data (Kochanek et al., 2016).

SUDs (especially AUDs) account for a large portion of increased mortality among American Indians and Alaska Natives (Day et al., 2011; HHS, IHS, 2015) and are also major contributors to poor physical health. Evaluating AI-SUPERPFP data, Shore, Beals, Orton, and Buchwald (2006) found that lifetime AUDs were significantly associated with increased rates of sprains and strains, hearing and vision problems, pneumonia or tuberculosis, head injuries, dental problems, liver problems, and pancreatitis among American Indians. The authors also found that having a greater number of medical conditions correlated with having an AUD.

Rates of diabetes are high for American Indians and Alaska Natives in general and particularly so for some American Indian tribes, and diabetes has been associated with high rates of SUDs and depression (Jiang, Beals, Whitesell, Roubideaux, & Manson, 2007; Tann et al., 2007). Using BRFSS data from 2002 through 2005, Sahmoun, Markland, and Helgerson (2007) found a significant association between having 2 or more weeks of poor mental health and diabetes in the general population; that association was stronger for American Indians and Alaska Natives than for White Americans. However, another study that compared the occurrence of depressive symptoms among older adults with diabetes who were American Indian and Alaska Native (n = 181), African American (n = 220), or White American (n = 295) did not find any significant differences in depressive symptoms among the three groups (Bell et al., 2005). Research involving American Indians and Alaska Natives living in Alaska who were screened for depression (n = 12,280) did not find any significant differences in rates of depression between those who did and did not have diabetes (Dillard et al., 2013).

Inadequate medical care may also exacerbate or fail to improve medical problems. Although many American Indians and Alaska Natives access health care through IHS, the expenditures by IHS are lower per capita than expenditures per user by Medicare, Medicaid, VA, or the federal employees' health plan, suggesting that those services may not meet the healthcare needs of at least some American Indians and Alaska Natives (Roubideaux, 2005; U.S. Commission on Civil Rights, 2003, 2004). For example, in 2013, IHS spending was under $4,000 per consumer; by comparison, VA spending was $6,980 per consumer, and the national average was $7,535 per consumer (NCAI, 2015).

Providers working with clients who have medical issues should also be aware that Eurocentric models of health that seek to separate physical and mental or behavioral health may be inappropriate for American Indian and Alaska Native populations and that American Indian and Alaska Native cultures practice a more holistic approach to health that sees mental, physical, and spiritual health as interrelated, as well as stressing the relationship between community and individual health (Duran, 2006; LaFromboise, Trimble, & Mohatt, 1990; Nebelkopf & King, 2003; Walters et al., 2002). Johnston (2002) provided a review on the use of traditional American Indian and Alaska Native healing practices for medical concerns.

People with HIV/AIDS

From 2010 through 2014 HIV rates for American Indians and Alaska Natives (along with those of Asian Americans) increased, whereas those of other major racial/ethnic groups either stayed the same or decreased (CDC, 2015). In 2014, the HIV rate for American Indians and Alaska Natives was 9.5 per 100,000 individuals, which was higher than found among White Americans (6.1) but lower than the rate for African Americans (49.4) or Latinos (18.4).

Several factors are associated with increased risk of HIV infection among American Indians and Alaska Natives, including unemployment (Reynolds et al., 2000), alcohol use (Baldwin, Maxwell, Fenaughty, Trotter, & Stevens, 2000), and some sexual behaviors (Fisher, Fenaughty, Paschane, & Cagle, 2000; Stevens, Estrada, & Estrada, 2000). Having experienced sexual assault has also been found to be associated with significantly more high-risk behavior for American Indian women in an urban sample (Simoni, Sehgal, & Walters, 2004), and being a victim of sexual abuse in childhood was associated with significantly higher HIV rates and riskier sexual behaviors for First Nations people in Canada who used illicit drugs (Cedar Project Partnership et al., 2008).

Focus groups and interviews with American Indians and Alaska Natives living in the Baltimore, MD, area suggest that the number of American Indians and Alaska Natives with HIV/AIDS may be under-counted and that pride, shame, poverty, lack of health insurance, and lack of awareness concerning free services are all barriers to HIV screening and treatment for this population (Johnson et al., 2007). Vernon (2001) presented many detailed case studies that describe the issues American Indians and Alaska Natives with HIV face in their communities and outside them.

Finally, Jim (2004) and Barney, Duran, and Rosenthal (2004) reported on programs that attempt to provide culturally responsive HIV/AIDS services to American Indian clients with mental or substance-related problems. Foley et al. (2005) used motivational interviewing (MI) to increase acceptance of HIV testing among clients at an American Indian SUD treatment facility.

Fetal alcohol spectrum disorders

Fetal alcohol spectrum disorders (FASDs) are a serious concern in many American Indian and Alaska Native communities (French, 2000; May, McCloskey, & Gossage, 2002; Segal et al., 1999). Although FASD rates among American Indians and Alaska Natives have varied considerably across studies, they are typically higher than found in the general population (Egeland et al., 1998; May et al., 2002). May et al. (2002) reviewed multiple studies and concluded that the rate of FASDs among American Indians was between 7.86 and 8.97 per 1,000 children—more than three times that found among White or African Americans. These relatively high rates of FASDs are likely related to a lack of information regarding the health effects of drinking on unborn children, and Kvinge et al. (2008) found that American Indian and Alaska Native women who had a child with a FASD significantly decreased drinking during subsequent pregnancies, with 80 percent of participants in one sample and 91 percent in another abstaining during subsequent pregnancies.

However, rates of FASDs may be lower for urban populations, where information on the dangers of drinking during pregnancy may be more readily available. Kaskutas (2000) surveyed 321 pregnant women (i.e., 102 American Indian, 34 White, and 185 African American) from cities in California. Although 21 percent of the American Indian women in the sample continued to drink during their pregnancy, this percentage was smaller than that of African American women (30 percent) or White women (32 percent). The percentage of American Indian women who reported daily alcohol consumption (14 percent of the total) was also less than that of African American women (33 percent) and slightly higher than that of White women (9 percent). Although this study did not evaluate FASDs in children after delivery, the frequency and amount of alcohol can be used to evaluate FASD risk.

Zahnd and Klein (1997) found that urban-dwelling American Indian women in their study who were pregnant or had children under the age of 12 were less likely to screen into the study by engaging in heavy or problematic alcohol or drug use than were similar women from rural communities (54 percent vs. 65 percent of American Indian women in rural areas). In that study, more women from rural areas also reported having five or more drinks on a single occasion in the past year (84 percent did) than did women from urban areas (68 percent). This also suggests that FASDs rates may be lower for American Indians and Alaska Natives in urban areas.

It should also be noted that prenatal exposure to other substances may be a problem in some American Indian and Alaska Native populations. For example, research involving women on a reservation in Canada found a high rate of prenatal exposure to oxycodone, which increased from 8.4 percent of births in the first half of 2009 to 17.2 percent of births in the first half of 2010 (Kelly et al., 2011). TIP 58, *Addressing Fetal Alcohol Syndrome Disorders* (SAMHSA, 2014a), discusses FASD prevention activities in behavioral health settings as well as behavioral health services for people with FASDs.

Women

In the general population, women have several mental disorders at higher rates than men, and the same seems true for many mental disorders in American Indian and Alaska Native communities.

To summarize findings discussed in greater detail above, several studies have found that, compared with American Indian and Alaska Native men, American Indian and Alaska Native women are significantly more likely to experience major depression (Beals, Manson, et al., 2005; Dillard et al., 2012; Hesselbrock et al., 2000; Whitbeck et al., 2006) and PTSD (Beals, Manson, et al., 2013; Beals et al., 2003). Some, but not all, research has found that rates of GAD are also significantly higher for American Indian and Alaska Native women than for men (e.g., Whitbeck et al., 2006). Sufficient data are lacking to make accurate claims about the relative rates of less common disorders, but some of these may also vary significantly by gender.

American Indian and Alaska Native women report high levels of trauma exposure in nonclinical (Duran, Malcoe, et al., 2004; Koss et al., 2003; Manson et al., 2005; Robin et al., 1997b) and clinical populations (Peterson et al., 2002; Saylors & Daliparthy, 2006; Segal, 1999). The amount of trauma exposure of American Indian and Alaska Native women in the AI-SUPERPFP was greater than American women as a whole in the NCS and was closer to the level of trauma exposure reported by American Indian and Alaska Native men than the relative exposure of men and women in the NCS (Manson et al., 2005). Thoughts of historical loss also appear to have a greater effect on the behavioral health of American Indian and Alaska Native women than on that of American Indian and Alaska Native men (Whitbeck, Chen et al., 2004).

As is the case in general population samples, rates of AUDs are lower for American Indian and Alaska Native women than for American Indian and Alaska Native men (Ehlers et al., 2004; Herman-Stahl et al., 2003; Whitesell et al., 2007). TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009b), contains more information on providing services for women. However, the size of that difference varies significantly among tribes (Heath, 1989; Herman-Stahl & Chong, 2002). In the AI-SUPERPFP study, women in the Northern Plains tribe, for example, had significantly higher rates of SUDs and were significantly more likely to have AUDs than were women in the Southwest tribes (Mitchell et al., 2003; Whitesell et al., 2007).

Rates of abstinence for women also vary by tribe and locale. In another analysis of AI-SUPERPFP data, which compared those data to national data from the NLAES, O'Connell et al. (2005) found that although men from the Northern Plains and Southwest tribes and women from the Southwest tribe were more likely to be abstinent than were men and women (respectively) in the general U.S. population according to data from the NLAES, women from the Northern Plains tribes were twice as likely to be current drinkers than were women in the general population.

Peterson et al. (2002) found that problems that may be indicative of AUDs (e.g., consequences from drinking) were consistent between American Indian and Alaska Native women seeking treatment and women from other ethnic groups entering treatment. The authors evaluated demographic factors from 164 American Indian and Alaska Native women who attended treatment for AUDs at one of nine IHS-funded treatment centers (both rural and urban). They found that 77 percent of these clients were unemployed, 89 percent had children, 45 percent had not graduated from high school, 39 percent had not gone beyond a high school education, and 80 percent had been arrested at some point prior to treatment. In their sample, 46 percent had previously been in SUD treatment, and the most common source for referral to treatment (in 40 percent of the cases) was the criminal justice system.

Binge drinking may be a more common problem among rural-dwelling women than among those who live in cities. Zahnd and Klein (1997) compared rural- and urban-dwelling American Indian women who were pregnant, current parents, and had been screened as at risk for heavy alcohol or drug use. They found women from rural areas were more likely to report occasions during the past year when they had five or more drinks (84 percent) than were women from urban areas (68 percent). In this study, women from rural areas also reported somewhat more frequent marijuana use but somewhat less use of "hard" drugs (e.g., cocaine, heroin). Women from rural areas also reported a greater need (compared with women from urban areas) for education and job training, job placement, financial assistance, housing, and transportation.

Parks et al. (2001) looked at gender differences for Alaska Natives entering treatment for AUDs. They found that although women were significantly more likely to have a lifetime major depression diagnosis, rates were high for both genders. Women began drinking and met criteria for alcohol dependence at significantly later ages than did men, but they were significantly more likely to also report cocaine dependence. Women were also significantly more likely to report their health status as fair or poor, to have pain complaints, and to use prescription medication for mood or anxiety disorder symptoms.

Parents

Mental disorders and SUDs negatively affect parenting in various ways, and parental mental disorders and SUDs are associated with mental disorders and SUDs in children (see discussion in the literature review for TIP 57, *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, 2014c]). SUDs, in particular, have been found to affect the parenting skills of American Indians and Alaska Natives negatively (Libby et al., 2008; Myhra & Wieling, 2014; Neault et al., 2012).

Parenting issues can also play a role in treatment seeking and recovery for men (see TIP 56, *Addressing the Specific Behavioral Health Needs of Men* [SAMHSA, 2013a]) and women (see TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* [CSAT, 2009b]).

Parental substance use and mental disorders increase the risk for child abuse and neglect (see "Childhood Physical and Sexual Abuse"). For clients in mental disorder and SUD treatment who have children, it may be helpful to the client and his or her children to address this relationship (see TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT, 2000b]). Because of a history of children being taken from their families and communities and the combined effects of SUDs and trauma, American Indian and Alaska Native parents with SUDs will often be very distrustful of child protective services (CPS) and may be reluctant to discuss issues involving their children (Horejsi, Heavy Runner Craig, & Pablo, 2008).

As in other areas, tribes are diverse and may have diverse parenting styles and practices, and parenting may be differently affected by SUDs as a result. Researchers, using data from the AI-SUPERPFP study, found that American Indian parents from the Northern Plains' tribes were about twice as likely to believe themselves to have been an irresponsible parent on one or more occasion (i.e., to report a parental role impairment) as were those from the Southwest tribe, although they were about as likely to report dissatisfaction with parenting (Libby et al., 2008). The study also found that SUDs, but not depression, mediated the relationship between having been abused as a child and reporting a parental role impairment for members of both tribal groups, but they only mediated the relationship between childhood abuse and parental satisfaction for members of the Northern Plains' tribes.

Having responsibility for children may hinder treatment entry for some clients who have concerns relating to childcare or child custody. Although this is often recognized for female clients, Parks, Hesselbrock, Hesselbrock, and Segal (2003) assessed 206 female and 263 male Alaska Natives admitted to one of three inpatient AUD treatment programs. They found that even though male Alaska Natives were significantly less likely than women to be acting as parents, those who did have such responsibilities delayed treatment entry significantly longer than other Alaska Native men who entered treatment for alcohol dependence. This was not the case for women with parenting responsibilities compared with women who were not custodial parents, although the authors cautioned that the lack of a significant difference may reflect the smaller number of women who were not parents (11 percent of all women in the study) included in the study.

Among participants in the AI-SUPERPFP who reported currently abstaining or drinking less than they had in the past, the response most commonly provided when asked what helped them to cut down on or stop drinking was childcare responsibilities, which was cited by 18.2 percent of participants (Bezdek, Croy, & Spicer, 2004). The response was the most commonly provided by women (who gave it 30.1 percent of the time) and the third most common response for men (who gave it 9.5 percent of the time). Other studies of American Indians and Alaska Natives in treatment or recovery

also find that the need to care for children is frequently cited as a reason for treatment entry or recovery, especially by women (Bezdek & Spicer, 2006; Mohatt, Rasmus, et al., 2004; Peterson et al., 2002).

Greene, Eitle, and Eitle (2014), in a study presented under "Poverty and Unemployment," found that for American Indians and Alaska Natives, becoming a parent was associated with being significantly less likely to be a current drinker, drinking significantly fewer drinks per occasion, and engaging in significantly less binge drinking. When individuals resided with their children, the odds of being a current drinker were about 60 percent lower.

A couple of interventions are available that have been found to improve parenting in American Indian and Alaska Native families. Barlow et al. (2013) evaluated the Family Spirit program (an early childhood intervention provided by paraprofessionals in clients' homes) with a group of 322 pregnant American Indian and Alaska Native teenagers who were assigned to receive the intervention in addition to usual services or to standard services alone. At assessments 12 months after the birth of the child, those who received the intervention had significantly more parenting knowledge, parenting-related self-efficacy, and better attitudes toward home safety. Among those mothers who used illicit substances (n = 285), those who received the intervention had children with significantly fewer externalizing and dysregulation problems and were significantly less likely to have their children evaluated as being clinically "at risk," compared with those in the control group. At a 3-year follow-up assessment, mothers who received the intervention continued to have significantly better outcomes in terms of better parenting knowledge and parental locus of control and fewer depressive symptoms, externalizing problems, and illicit drug use (Barlow et al., 2015). The children of mothers who received the intervention, compared with children in the control group, had significantly fewer externalizing, internalizing, and dysregulation problems.

Chaffin, Bard, Bigfoot, and Maher (2012) described and provided some outcome data on the SafeCare home-based intervention aimed at reducing repeat involvement with CPS. Although the intervention was not originally developed for American Indian and Alaska Native parents, it was well received by them with high ratings for cultural responsiveness, working alliances, quality of service, and benefits of the service. Participants also had less reinvolvement with CPS than did similar families from an earlier period when the intervention was not available.

Brave Heart's (1999) HTUG intervention is another parenting skills training that addresses historical trauma issues and their relation to parenting, which was originally developed for the Lakota but has since been adapted for other tribes.

The Rocky Mountain Quality Improvement Center (Lucero, 2007) has prepared a guide for CPS staff members who work with urban-dwelling American Indian and Alaska Native families in which there is both a SUD and child abuse. Although it is not intended for SUD treatment providers, it may be helpful for providers working with clients who are involved with CPS agencies. The Center has also published a report on the effectiveness of the Denver Indian Family Resource Center (Leake, 2007) and a replication guide for other locales interested in implementing a similar program (Lucero & Bussey, 2007). All of these documents are available from the American Humane Association's website.

People who are homeless

In general, rates of mental disorders, SUDs, and CODs are high for people who are homeless (see TIP 55, *Behavioral Health Services for People Who Are Homeless* [SAMHSA, 2013b], for more information on this and information on providing services to people who are homeless).

In spite of the fact that subsidized (and, in some cases, guaranteed) housing is available on some American Indian reservations (Spillane & Smith, 2007), large numbers of American Indians and Alaska Natives on reservations remain on waiting lists for housing, many are homeless, and overcrowding in the housing that does exist is very common (Henson et al., 2008; Pettit et al., 2014). According to 2006–2010 data, 8.1 percent of American Indian and Alaska Native households were overcrowded compared with 3.1 percent of households in the country as a whole, and for

American Indians and Alaska Natives in Alaska, 22 percent of households were overcrowded (Pettit et al., 2014). According to these same data, 2.9 percent of American Indian and Alaska Native households lacked complete plumbing (compared with 1.6 percent of households in the country as a whole), and 2.8 percent lacked kitchen facilities (also compared with 1.6 percent); in Alaska, 18 percent of American Indian and Alaska Native households lacked complete plumbing, and 15 percent lacked kitchen facilities.

In January 2015, approximately 2.7 percent of people who were homeless and 3.9 percent of those who were unsheltered were American Indians and Alaska Natives (Henry, Shivji, de Sousa, & Cohen, 2015), although they made up only 2.1 percent of the population in the most recent census estimates (Census Bureau, Population Division, 2018). Because American Indians and Alaska Natives who are homeless often avoid the service system and because service providers often misidentify American Indian and Alaska Native ethnicity, these numbers likely undercount the percentage of homeless people who are American Indian and Alaska Native (Zerger, 2004).

A report from the Alaska Housing Finance Corporation, using survey data collected in 2001, found that Alaska Natives made up about 40 percent of those who were homeless in the state and a similar percentage of those who were homeless in Anchorage specifically (Wiedle, 2001). This is significantly disproportionate to the number of Alaska Natives in the state. Recent research on Alaska Natives who are homeless is difficult to come by, but Travis (1991) observed that binge drinking and AUDs as well as discrimination contributed to the sense of isolation experienced by Alaska Natives, particularly in urban areas, thus leading to homelessness.

Ethnographic interviews with American Indians who were homeless in the Tucson, AZ, and San Francisco, CA, areas found that most faced episodic homelessness and not chronic homelessness (meaning that they experienced periods of homelessness interspersed with times spent living with friends or relatives, otherwise housed in the city or on the reservation, or institutionalized; Lobo & Vaughan, 2003). Health care for the Homeless has produced a guide for healthcare providers working with American Indian and Alaska Native clients who are homeless that will likely be of interest to behavioral health service providers as well (Zerger, 2004).

People involved with the criminal justice system

Perry (2004), looking at cumulative data from 1992 to 2001, found that arrests of American Indians and Alaska Natives for violent crime decreased steadily over that period, so that by 2001 the rate was comparable with that seen for the total U.S. population. According to national data from 2017, American Indian and Alaska Native arrest rates for most crimes continue to be comparable, given the size of the American Indian and Alaska Native population, with those seen for the general population (Department of Justice, Federal Bureau of Investigation, 2018).

Although national arrest rates do not appear to be out of sync with the size of the American Indian and Alaska Native population, studies in some parts of the country have found that a disproportionate number of American Indians and Alaska Natives are arrested and convicted of crimes (American Indian Policy Center, 2005; Poupart, Redhorse, Peterson-Hickey, & Hickey, 2005). This may be partially attributable to historical and social factors, including institutional racism (Harring, 2014).

Perry (2004) also found high arrest rates of American Indians and Alaska Natives for alcohol-related offenses (i.e., public drunkenness, violating liquor laws, driving under the influence [DUI])—rates that were double the national rate in 2001. Feldstein, Venner, and May's (2006) research confirmed high rates of alcohol-related arrests and incarceration for American Indian and Alaska Native men and women. SUDs among American Indian and Alaska Native inmates are also associated with increased rates of recidivism (Grobsmith & Dam, 1990).

Information is available on the number of American Indians and Alaska Natives incarcerated in federal facilities and in tribal jails, but the picture it provides

is distorted because of jurisdictional issues involving Indian lands and lack of information as to how people are identified as being American Indian and Alaska Native (Archambeault, 2014; Perry, 2004). Data from states and counties are even less accurate and harder to find.

In Alaska, where American Indians and Alaska Natives (either identifying as American Indian and Alaska Native alone or in combination with another race) made up 19.9 percent of the population in the 2016 census population estimates (Census Bureau, 2017). According to 2016 data, male Alaska Natives made up 34.6 percent of the male institutionalized population (i.e., including incarceration and placement in community residential centers) in the state, and female Alaska Natives made up 33.9 percent of the female institutionalized population (Alaska Department of Corrections, n.d.). In terms of incarceration for specific offenses, Alaska Natives made up 35.5 percent of those institutionalized for alcohol offenses, 38.0 percent of those institutionalized for offenses against people (excluding sexual offenses), 44.0 percent of those institutionalized for registerable sexual offenses, 27.7 percent of those institutionalized for property crimes, 34.9 percent of those institutionalized for public order offenses, and 39.2 percent of those institutionalized for parole violations. However, the percentage of Alaska Natives institutionalized for drug offenses (13.4 percent) was relatively low given the size of the population.

An Office of Justice Programs publication (Melton, Chino, May, & Gossage, 2000) described several promising but unevaluated treatment programs in state and local facilities for rural and urban American Indians and Alaska Natives, including programs aimed at people arrested for chronic public inebriation, DUI, underage drinking, and other offenses. White Bison (2004) has a relapse prevention program developed specifically for ex-offenders in recovery from SUDs, which focuses on building a support network that begins in prison and extends to the individual's home community. More general information on treatment for people with SUDs who are involved at various stages of the criminal justice system can be found in TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT, 2005a).

Veterans

According to data from the VA's most recent telephone survey of veterans, American Indian and Alaska Native veterans were the most likely of all racial/ethnic groups included to have served in combat (48.3 percent had); to have been exposed to dead, dying, or wounded people (48.4 percent); and to have been exposed to environmental hazards while on duty (37.9 percent; Westat, 2010). American Indian and Alaska Native veterans were the second least likely, after African American veterans, to report their health as good to excellent (59.2 and 58.6 percent, respectively, did so) and were the most likely to report they needed the assistance of another person for daily living activities (20.3 percent did).

American Indian and Alaska Native veterans disproportionately experience some mental disorders and SUDs. As noted in the epidemiological sections, Howard et al. (1996) found that American Indian and Alaska Native veterans had higher rates of SUDs and PTSD compared with the total veteran population (including American Indians and Alaska Natives), according to data for veterans discharged from the VA inpatient units in fiscal year 1993. Other research found that American Indian and Alaska Native Vietnam veterans were significantly more likely than other veterans to have PTSD (Beals et al., 2002) and that American Indian veterans were significantly more likely than Latino veterans to have pathological gambling disorder (Westermeyer et al., 2005).

Another study, which assessed 558 American Indian veterans living in the North Central region of the United States (half living in rural areas and half in urban), found that 36 percent (n = 199) met criteria for a SUD diagnosis at some point during their lifetimes (Tan et al., 2008). However, of those 199, 41 percent (n = 82) were in remission from those SUDs for 1 year or more.

Westermeyer et al. (2009) assessed the behavioral health of 362 American Indian veterans (only 28 female) from the North Central and Southwest regions of the country to make comparisons between male and female veterans. They found that compared with male veterans, women reported fewer PTSD symptoms, had lower mean

scores on the Michigan Alcoholism Screening Test modified to include drugs (MAST/AD), were less likely to use VA mental health services, and were more likely to seek mental health services if needed. However, there were no significant differences between genders in rates of anxiety disorders, mood disorders, tobacco dependence, ASPD, or pathological gambling. The authors also noted that some of the gender differences may reflect other demographic differences between the groups (e.g., the female sample was younger and had more education).

Behavioral Health Services for American Indians and Alaska Natives

Despite high rates of mental disorders and SUDs among American Indian and Alaska Native peoples, research evaluating particular treatment interventions for this population is limited (Gone & Trimble, 2012; Villanueva, Tonigan, & Miller, 2007). When possible, research is cited in the sections that follow, but opinion based on clinical practice is also included. The sections that follow address adaptations to standard behavioral health services to enhance treatment for American Indian and Alaska Native clients, including the incorporation of traditional American Indian and Alaska Native cultural and spiritual practices. These sections also address other important clinical issues, including motivation for treatment and treatment access, retention and outcomes, screening and assessment, and long-term recovery. As many of these clinical issues are relevant in the treatment of substance use and mental disorders, the sections discuss the two together, with subheadings delineating the two when appropriate (e.g., in the discussion of assessment).

Motivation for Treatment and Access to Care

The availability, accessibility, and acceptability of behavioral health services are all major barriers to treatment for American Indians and Alaska Natives (New Freedom Commission on Mental Health, 2003). Many American Indians and Alaska Natives may be suspicious of behavioral health services that do not recognize their cultural perspective on mental and physical health or are not provided by Native providers (Gone & Trimble, 2012; Grandbois, 2005; Martin, 2014; Olson & Wahab, 2006; Schmidt, 2000). Behavioral health services that are available for American Indians and Alaska Natives (such as IHS programs) are often underfunded and may not provide the same quality of services that are available to people with private insurance; many programs are also understaffed (Gone & Trimble, 2012; UIHI, 2012b).

Affordable (or no-cost) services, especially services tailored to the needs of specific populations (e.g., women with children, people with CODs), may not be available in every area, as rural and remote areas often lack treatment infrastructure because of either limited financial resources or irregular funding streams, and many urban areas are not served by IHS (Henson et al., 2008; McFarland et al., 2006; UIHI, 2012b). Treatment services may not be accessible because they may not be provided in an indigenous language, may not be delivered by a sufficient number of qualified staff members, and may not include outreach (Gone & Trimble, 2012; Weaver, 1999).

Treatment services that are available and accessible may still not be acceptable because they are not culturally responsive (Dixon & Iron, 2006; Gone & Trimble, 2012; Thatcher, 2004; Trimble, 2010). Many American Indians and Alaska Natives also understandably distrust organizations, especially government-run organizations, or, based on earlier systemic problems, believe that quality services are not available (Duran et al., 2005). Some behavioral health service providers who treat American Indians and Alaska Natives may lack cultural competence when dealing with them, and there is a dearth of behavioral health services provided by American Indian and Alaska Native providers (Gone & Trimble, 2012; Grandbois, 2005; Olson & Wahab, 2006), even though some research suggests that many American Indians and Alaska Natives prefer services provided by other American Indians and Alaska Natives (e.g., Haviland, Horswill, O'Connell, & Dynneson, 1983). However, a student who compared mental disorder treatment preferences of Alaska Native (n = 67) and White American (n = 105) college students in a psychology course (not individuals with identified mental disorders and SUDs) found that the former group was

significantly less likely than the latter to prefer providers with the same ethnicity/race (Stewart, Swift, Freitas-Murrell, & Whipple, 2013).

Behavioral health services also may not be acceptable because of the shame associated with treatment attendance, especially in small communities (Duran et al., 2005; IHS, 2011; Schmidt, 2000), or because American Indians and Alaska Natives have been discriminated against in the past when using such services (Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Gone & Trimble, 2012). One study that evaluated use of medical and mental health service use for a diverse group of Minnesota residents (*n* = 10,098; 203 of whom were American Indians) found that American Indians who frequently reported being the victims of discrimination were significantly less likely to have made use of mental health services than were those who did not perceive as much discrimination (Burgess et al., 2008).

Perceptions of prejudice, which may be greater in relation to mental disorders than SUDs, may affect the use of behavioral health services by American Indians and Alaska Natives (Grandbois, 2005; IHS, 2011). For example, Duran et al. (2005) found that treatment for AUDs was much more acceptable among American Indians at three different reservations in two different regions than treatment for mental illness, apparently because there was a greater perceived stigma associated with the latter.

Despite these barriers, most recent research indicates that Native American levels of use of SUD treatment services are as high or possibly higher than are found in the population as a whole, whereas the use of mental health services is comparable depending on the presenting problem and the type of service evaluated (Carragher, Adamson, Bunting, & McCann, 2010; Duran et al., 2005; Iza et al., 2013). Of course, as in other areas, there are likely to be considerable differences among tribes and regions in this regard, and issues such as the quality of available care and community attitudes toward treatment will play a large role in determining how willing individuals are to seek services.

In the 2016 NSDUH, 15.2 percent of American Indian and Alaska Native adult respondents reported receiving some form of mental health services in the prior year, but this was similar to the 14.4 percent national average (17.7 percent of White American adults, 8.4 percent of African American adults, and 8.5 percent of Latino adults; CBHSQ, 2017a). Receipt of inpatient mental health services in the prior year ranged from 1.9 percent for African American adults and 1.4 percent of American Indian or Alaska Native adults, to 0.3 percent for Asian adults.

In the AI-SUPERPFP study, 66.6 percent of individuals from the Southwest tribe who had anxiety or depressive disorders at some point during their lives but no co-occurring SUDs sought treatment, compared with 63.6 percent of those from the Northern Plains tribes (Beals, Manson et al., 2005). Rates were somewhat higher for those who had anxiety or depressive disorders co-occurring with SUDs: 73.7 percent from the Southwest tribe and 67.6 percent from the Northern Plains tribes had sought treatment. Unlike most general population studies, the AI-SUPERPFP did ask about seeking help from traditional or spiritual healers, and that was the most common type of help sought in many cases. For individuals from the Southwest tribe who had anxiety or depressive disorders alone, 34.6 percent had sought help from a mental health professional, 29.1 percent from a medical professional, and 48.9 percent from a traditional healer. For those from the Northern Plains tribes who had anxiety or depressive disorders alone, 40.1 percent had sought help from a mental health professional, 37.3 percent from a medical professional, and 33.7 percent from a traditional healer. For those with CODs, 42.7 percent of the Southwest sample sought help from a mental health professional, 35.4 percent from a medical professional, and 61 percent from a traditional healer. For those with CODs in the Northern Plains sample, 49.3 percent sought help from a mental health professional, 34.6 percent from a medical professional, and 37.4 percent from a traditional healer. Thus, individuals from the Southwest sample were significantly more likely than those from the Northern Plains sample to have sought help from traditional healers.

Another AI-SUPERPFP publication made comparisons between treatment seeking in that study and in the NCS, but it was limited in that the NCS did not inquire about seeking help from traditional

healers (Beals, Novins, et al., 2005). According to that analysis, 11.8 percent of men from the Southwest tribe who had lifetime diagnoses of anxiety or depressive disorders had sought help from a mental health professional, and 15.2 percent of those from the Northern Plains sample did so, compared with 29.4 percent of those in the general population sample of the NCS. For women with an anxiety or depressive disorder at some point in their lives, 27.5 percent of those from the Southwest tribe, 24.1 percent of those from the Northern Plains tribe, and 33 percent of the NCS sample sought treatment from a mental health professional. In terms of seeking helping from a medical provider for anxiety or depressive disorders, 16.4 percent of Southwest men, 18.9 percent of Northern Plains men, and 30.4 percent of men in the NCS sought help. Of women with anxiety or depressive disorders, 24.6 percent from the Southwest tribe, 23.6 percent of those from the Northern Plains tribe, and 42.5 percent of the NCS sample sought treatment from a medical provider. In the Southwest sample, but not the Northern Plains sample, individuals who used standard biomedical services (including behavioral health services) were significantly more likely to use traditional healers as well (Fortney et al., 2012).

Using data from both waves of NESARC, Iza et al. (2013) found that American Indians and Alaska Natives with anxiety disorders were as likely as White Americans with the same disorders to seek treatment. Depending on the specific disorder, American Indians and Alaska Natives were as likely or somewhat (but not significantly) more likely to seek treatment. Another study using NESARC data found that American Indians and Alaska Natives with major depression were as likely as White Americans with the disorder to consult a health professional or be prescribed medication for their depression and were slightly less likely (but not significantly so) to be hospitalized or visit an emergency room for depression (Carragher et al., 2010).

Duran et al. (2005) presented data from the AI-SUPERPFP concerning obstacles to seeking mental disorder or SUD treatment. From previous research and focus groups conducted with American Indians, the researchers derived a list of 16 potential barriers to treatment seeking that were grouped into four basic categories: (1) self-reliance concerns (e.g., wanting to solve problems on one's own), (2) privacy concerns (e.g., being concerned what others may think if one went to treatment), (3) quality of care issues (e.g., believing that treatment would likely not help), and (4) communication or trust issues (e.g., not trusting the staff). Respondents cited quality of care obstacles most frequently, followed by self-reliance obstacles. Participants were significantly more likely to have concerns about self-reliance if they lacked instrumental social support, believed providers would not be helpful, felt strongly that medical professionals would be helpful, or needed services for mental disorder rather than SUDs. Individuals were more likely to have concerns about privacy if they had anxiety disorders, were from the Southwest tribe rather than the Northern Plains tribes, needed services for mental disorders rather than for SUDs, or were seeking services from IHS or a tribal program rather than a private provider. Respondents were more likely to be concerned about quality of care if they were from the Southwest tribe rather than the Northern Plains tribes, had lower levels of social support, or had negative attitudes about providers. People were more likely to have concerns about communication or trust if they had anxiety disorders or had lower levels of social support.

AI-SUPERPFP data also indicated that geographic barriers (i.e., distance to providers, the need to cross reservation boundaries to reach providers, bad roads, differences in elevation between home and provider locations) did not have a significant effect on whether individuals with mental disorders and SUDs sought services for those problems (Fortney et al., 2012).

Several authors have commented that many American Indians and Alaska Natives may be suspicious of or doubt the efficacy of mental health services, which may in turn affect treatment use (e.g., Martin, 2014; Schmidt, 2000). However, Hunt et al. (2013), using data for 998 individuals with anxiety disorders (34 American Indian and Alaska Native) drawn from the Coordinated Anxiety Learning and Management study, failed to find that differences in American Indians and Alaska

Natives' beliefs about mental health services had a greater impact on the use of such services than it did for any other racial/ethnic group in the study. They did find that compared with White Americans, American Indians and Alaska Natives were significantly more likely to believe that people with mental disorders could get better without professional help and that money spent on therapy could be wasted, and they were significantly less likely to believe that therapy could help an individual learn new ways to cope with problems. At the same time, American Indians and Alaska Natives did not differ significantly from White Americans in terms of previous use of psychiatric medication (71 percent of American Indians and Alaska Natives reported use, compared with 70 percent of White Americans), prior use of counseling (47 percent of American Indians and Alaska Natives reported use, compared with 45 percent of White Americans), or overall satisfaction with mental health services (American Indians and Alaska Natives had a mean score of 3.3 on a scale where 5 was most satisfied compared with 3.2 for White Americans).

Givens, Houston, Van Voorhees, Ford, and Cooper (2007) evaluated attitudes toward treatment for depression by conducting a survey of 78,753 individuals (841 American Indian and Alaska Native) who used an online depression screening website and who had significant depressive symptoms (CES-D scores of 22 or higher). They found that attitudes of American Indians and Alaska Natives toward treatment for depression were most similar to those of White Americans (more so than those of African Americans, Asian Americans, or Latinos). American Indians and Alaska Natives and White Americans were the only racial groups who expressed a preference for medication over counseling. Also, comparable percentages of American Indians and Alaska Natives and White Americans reported having had prior counseling (10.1 and 10.3 percent, respectively) and prior use of psychiatric medications (47.3 and 44.6 percent, respectively).

When given the option, many American Indians and Alaska Natives may prefer traditional or cultural practices to standard behavioral health services. In the AI-SUPERPFP, individuals from the Southwest sample (but not the Northern Plains sample) were more likely to have sought help from a traditional healer for anxiety or depressive disorders than from a behavioral health professional (Beals, Novins et al., 2005).

Walls, Johnson, Whitbeck, and Hoyt (2006) found, in interviews with 865 American Indian parents and caretakers of children living in the northern Midwest, that the majority of respondents believed traditional cultural practices were more likely to be effective than standard behavioral health services and that services provided on the reservation would be more effective than the same types of services provided off the reservation. Respondents rated the following as most effective to help with mental disorders and SUDs: (1) talking with a family member (71.7 percent believed that would be effective), (2) talking to an elder (59 percent), (3) offering tobacco and praying (49.1 percent), (4) consulting a traditional healer (39.8 percent), and (5) using traditional ceremonies (37.7 percent). By comparison, 27.2 percent believed that IHS services would be effective, 27.5 percent believed that consulting a psychologist on the reservation would be effective, 23.6 percent believed consulting a psychologist off the reservation would be effective, and 20.7 percent believed that consulting a psychiatrist off the reservation would be effective.

Cost of services and lack of insurance may limit access to behavioral health services for some American Indians and Alaska Natives, particularly those living in urban areas who do not have access to IHS services nearby. The CDC's BRFSS provides some data on self-identified American Indians and Alaska Natives living in urban areas, and 2001–2005 data for that group has been analyzed by the UIHI (2008) and compared with data for non-American Indians and Alaska Natives living in the same areas. This report found that 29 percent of American Indians and Alaska Natives in urban areas had no health insurance, compared with 17.8 percent of non-American Indians and Alaska Natives, and 20.7 percent stated that they could not see a medical provider because of the cost (compared with 12.6 percent of non-American Indians and Alaska Natives).

Although it used data from 1997 to 2002, the McFarland et al. (2006) study still provides a good picture of SUD treatment settings and

services available to American Indian and Alaska Native clients. They found that 67 percent of American Indians and Alaska Natives entering SUD treatment in 2002 did so in urban areas, and most of the programs serving this population were not operated by IHS. According to their data, American Indians and Alaska Natives were somewhat more likely to enter a residential treatment program and stayed longer in residential treatment compared with the general treatment-seeking population. American Indian and Alaska Native clients were less likely to receive methadone maintenance. For 2002, approximately 19 percent of American Indian and Alaska Native clients entered residential treatment, compared with 16.1 percent of the total treatment-seeking population; 52.2 percent of American Indian and Alaska Native clients entered nonmethadone, outpatient programs, compared with 58.3 percent of the total treatment seeking population; and 23 percent entered detoxification programs, compared with 22.5 percent of the total treatment-seeking population.

Some American Indians and Alaska Natives may not feel that SUD treatment is important for recovery and thus be less motivated to enter a treatment program. For example, in Leung et al.'s (1993) study, only 17 percent of those who had stopped drinking (for at least 6 months) found SUD treatment had been helpful, whereas 83 percent had stopped without any treatment.

Data from the AI-SUPERPFP and other sources indicate that American Indians and Alaska Natives with SUDs are as likely or somewhat more likely to access SUD treatment as members of other ethnic/racial groups and that about one-third of American Indians and Alaska Natives with current use disorders will have had treatment in the past year (Beals et al., 2006; CBHSQ, 2015, 2017a; Duran et al., 2005; Herman-Stahl & Chong, 2002).

Whether these rates of treatment seeking are considered high or low depends on the perceived need of the population, the researcher's operational definition of treatment, and research methods. Herman-Stahl and Chong (2002) stressed that approximately two-thirds of the American Indians and Alaska Natives with substance-related problems, in their sample of 725 individuals from three different Arizona tribes, had not had treatment in the prior year. However, Beals et al.'s (2006) analysis of AI-SUPERPFP data, which accounts for individuals who sought help from mutual-help groups and traditional healers as well as behavioral health professionals, found that rates of treatment seeking for SUDs were higher in American Indian populations than in the general population according to NCS data. They found that 13 percent of all AI-SUPERPFP participants and 37.7 percent of those who met criteria for a SUD diagnosis in the past year had sought help during that year, with slightly more than 50 percent seeking treatment from a medical or behavioral health service provider and 42 percent seeking help from a traditional healer.

Beals, Novins, et al. (2005) observed that 19.1 percent of Southwest study participants and 21 percent of Northern Plains participants indicated that they had sought treatment for a SUD at some point during their lifetime (compared with 7.8 percent for the general population, as determined 5 years earlier by the NCS). At the same time, American Indians in the AI-SUPERPFP were somewhat less likely to seek assistance from a general medical provider for a SUD (14 percent of participants from the Southwest tribe had done so, and 12.7 percent of those from the Northern Plains tribes, compared with 18.6 percent of subjects in the NCS).

According to data from both waves of NESARC, American Indians and Alaska Natives were the only racial/ethnic group who were more likely than not to have received treatment for an AUD at the time of the second assessment if they had met criteria for alcohol abuse disorder (but not dependence disorder) or for risky drinking at the time of the Wave 1 assessment (Mulia, Tam, & Schmidt, 2014). Compared with White Americans who met these criteria, American Indians and Alaska Natives who did were almost twice as likely (1.96 times) to have received treatment during the 4-year period between Waves 1 and 2 of the study.

Other research has also found high rates of treatment seeking. For example, in a study of 582 American Indians from a Southwest tribe, Robin, Chester, Rasmussen, Jaranson, and Goldman (1997a) found that 41.1 percent of men and 18.8 percent of women in the total sample had undergone some form of SUD treatment during their lives.

However, tribal differences may also affect treatment-seeking behavior. Ehlers et al. (2004) compared data they collected from 407 American Indians from the Southwest with general population data collected at an earlier time using the same assessment instrument and found that American Indians were significantly less likely to have sought professional help with AUD.

Most data sources do not separate Alaska Natives and American Indians, but the TEDS publicly available data set indicates that in 2015, Alaska Native admissions made up 0.2 percent of admissions, and American Indian admissions made up 2.5 percent of admissions (SAMHSA, n.d.-a). In Alaska, Alaska Native admissions made up 43.7 percent of treatment entries in 2015, and American Indian admissions made up 1.7 percent. (By comparison, White Americans made up 33.8 percent of treatment admissions in Alaska in that year.)

TEDS data also indicate that sources of referral to SUD treatment for American Indian or Alaska Native admissions vary from those for other racial groups. According to the 2015 TEDS data set, American Indians were most likely to have been referred by the criminal justice system (41.0 percent, compared with 29.2 percent of White American admissions and 30.8 percent of African American admissions; SAMHSA, n.d.-a). They were also among the least likely to self-refer, with only 26.6 percent doing so, compared with 42.1 percent of White Americans and 40.5 percent of African Americans being admitted. Referral source patterns for Alaska Native admissions ranked in the middle compared with other races, with 33.1 percent entering treatment through the criminal justice system and 33.6 percent entering through self-referral.

To better understand why American Indians enter SUD treatment, Watts and Gutierres (1997) interviewed 58 American Indians who were in SUD treatment programs in the Phoenix, AZ, area. When asked about factors that helped them eventually deal with their SUD, most respondents noted the importance of a positive role model (most often a family member) who would tell them about the destructive effects of SUDs, encourage them to regain their self-esteem and autonomy, and sometimes connect them with a tribal healer or SUD treatment program. The need to reassert autonomy lost when the person began to misuse substances was another common theme.

Among American Indians and Alaska Natives, motivation for SUD treatment varies somewhat by gender (as it does in other ethnic groups). In Peterson et al.'s (2002) study of American Indian women at urban and rural his-funded treatment programs, the most common primary reason given for seeking treatment was for their children (28 percent), followed by a desire to change their lifestyle (25 percent), a desire to stop using (22 percent), a court order (17 percent), a need for help (8 percent), and pressure from family or friends (4 percent). The discussion in "Relapse Prevention and Recovery Promotion" includes more information on factors that motivate American Indians and Alaska Natives to enter recovery, but not necessarily treatment, although many of those reasons will also be potential motivators for treatment.

Many American Indians and Alaska Natives will enter recovery from SUDs without formal treatment. Venner and Feldstein (2006) interviewed 44 American Indians (from a variety of tribes) who had been alcohol dependent and had attained a significant period of recovery (with a mean of 10.47 years of abstinence). The vast majority of these respondents began efforts to change their drinking (e.g., by not drinking for a few days at a time, reading about AUDs, removing alcohol from their homes) prior to seeking any professional help. Eighty-four percent had never talked to a professional about their drinking, the same percentage went to one or more 12-Step meetings, and 50 percent had been in residential treatment. Most participants also realized by their late 20s that their drinking was a problem, although the mean age for beginning recovery or abstinence was 37.6. Most respondents' first recognition of a problem relating to their drinking was that it was hurting the people around them.

Quintero (2000) interviewed a community sample of 145 men from a Southwest tribe, 112 of whom met lifetime criteria for alcohol dependence and 48 of whom were in remission from alcohol dependence. He found that only 43 percent of subjects whose AUDs were in remission had been

in a formal treatment program, as had 44 percent of those who were still drinking.

To improve treatment participation among American Indians and Alaska Natives, providers may consider making greater outreach to other healthcare providers and to traditional American Indian and Alaska Native healers. Parks et al. (2003) found that most (96 percent) Alaska Natives who were in recovery in their study had sought help with their drinking from a healthcare professional before entering SUD treatment (Parks et al., 2003). Another study found that many individuals from a Southest tribe who sought assistance with health-related problems from a traditional healer or Christian church (including the American Indian and Alaska Native Church) met criteria for a SUD at some point during their lives. Rates of AUDs varied significantly according to the type of services sought, with 60 percent of those seeking help from the American Indian and Alaska Native Church, 38.7 percent of those seeking help from a healer, and 11.1 percent of those seeking help from another Christian church meeting criteria for alcohol dependence at some point during their lives.

Retention and Outcomes

A related issue to treatment entry is treatment retention. Data on retention for American Indian and Alaska Native clients, like data on treatment for this population in general, is hard to come by and focuses on SUD treatment or medical settings. A few older studies reported high dropout rates for American Indians and Alaska Natives in SUD treatment (e.g., Welty, 2002). Some authors speculated that this was because programs were not providing treatment that meets the specific needs of American Indian and Alaska Native clients or that was culturally relevant (LaFromboise et al., 1990; Thatcher, 2004).

However, researchers who compared SUD treatment retention and outcomes for 368 American Indians with that of a matched control group, all of whom attended inpatient or outpatient programs in California between 2000 and 2002, found that although the American Indian clients were retained for significantly fewer days in inpatient programs (a mean of 46 days compared with 66) than matched controls, they were actually retained for more days (although not significantly more) than controls when attending outpatient programs (a mean of 132 days compared with 121; Evans, Spear, Huang, & Hser, 2006). Both groups had similar improvements in outcomes at a 9-month follow-up and in terms of criminal justice involvement in the year following treatment.

National data (from the 2007 TEDS) also indicated that American Indians and Alaska Natives were significantly more likely to drop out of residential treatment but significantly less likely to drop out of intensive outpatient treatment than were White Americans attending the same programs; American Indians and Alaska Natives were also significantly more likely to drop out of non-intensive outpatient programs for alcohol but not for illicit drug use disorders (Saloner & Lê Cook, 2013). Across treatment settings, American Indians and Alaska Natives were, compared with White Americans, significantly more likely to drop out when treated for alcohol, marijuana, or opioid use disorders, but not for stimulant use disorders. In the authors' adjusted model (which controlled for treatment setting and level of need), the completion rate for AUD treatment programs was 56.6 for American Indians and Alaska Natives, compared with 62.4 percent for White Americans and 58.0 percent for African Americans. The adjusted rate of completion for drug use disorder treatment was 50.4 percent for American Indians and Alaska Natives, compared with 52.4 percent for White Americans and 46.3 percent for African Americans.

Research from the Treatment System Impact and Methamphetamine Treatment Projects also indicated that outcomes 1 year after treatment did not differ significantly for American Indian and Alaska Native participants (n = 279) from those of a matched comparison group of other study participants (Dickerson et al., 2011). American Indians and Alaska Natives, compared with matched controls, entered treatment with significantly more severe mental disorder symptoms (assessed with the psychiatric subscale of the Addiction Severity Index [ASI]), more chronic medical problems, and a greater likelihood of having been sexually abused. However, 1 year after treatment, both groups had similar ASI scores, similar legal outcomes, comparable rates of mental disorders, and similar housing situations.

Researchers evaluating retention for adolescents in the private SUD treatment program of a managed care provider found that American Indian and Alaska Native youth (n = 39) were significantly less likely to return to the program after intake than were White American youth (n = 206) and were more likely, but not significantly so, to drop out of treatment (Campbell, Weisner, & Sterling, 2006).

Some research suggests that the factors associated with treatment dropout for American Indian and Alaska Native clients are similar to those of SUD treatment clients in general. For example, Gutierres et al. (1994) looked at treatment factors for 58 American Indian clients who were in residential treatment programs in the Phoenix, AZ, area. They found that being divorced (rather than single or married); using cocaine, tranquilizers, or depressants; and having spent a significant amount of time in foster care as a child were all associated with higher rates of treatment dropout. Callaghan (2003) investigated reasons for dropout from a detoxification program for First Nations people in British Columbia and found that primarily misusing a substance other than alcohol and being self-admitted to the program were significant predictors of dropout.

In general, clients are more likely to remain in and complete treatment if they are satisfied with the services provided (Hser, Evans, Huang, & Anglin, 2004). Providing culturally relevant services is one way to increase satisfaction (see TIP 59, *Improving Cultural Competence* [SAMHSA, 2014b]), and improving cultural responsiveness by increasing access to culturally appropriate activities has been associated with significant improvements in retention for American Indians and Alaska Natives in a therapeutic community (TC; Fisher, Lankford, & Galea, 1996). Research involving a program to change behavior for people with diabetes conducted with American Indians and Alaska Natives found that program sites were better able to retain participants if the site had greater numbers of participants, had a mix of older and younger staff members, had a balance of male and female staff members, and had providers with higher professional credentials or degrees (Manson et al., 2011).

Programs may also benefit from having an organizational structure that reflects the traditional indigenous ideas about organization and hierarchy (Cornell & Kalt, 2003). Research on health care for American Indians and Alaska Natives has also found greater client satisfaction among those who attended programs controlled by tribes rather than those administered by outside entities (see review in Cornell & Kalt, 2003).

Screening and Assessment

The same issues that arise in counseling American Indians and Alaska Natives (discussed under "Adapting Standard Mental Health and Substance Use Disorder Treatment Modalities") also play a role in how screening and assessment of American Indian and Alaska Native clients should be conducted. These are discussed in the two sections that follow. Many clinicians who work with American Indian and Alaska Native clients express concerns that standard assessment instruments are not culturally appropriate for some or all American Indians and Alaska Natives (e.g., Manson et al., 1985); only 10 percent of such clinicians who participated in an online survey believe that instruments not specifically evaluated with American Indians and Alaska Natives should be used (Thomason, 2011). Unfortunately, very few instruments have been formally evaluated with American Indian and Alaska Native clients.

Several authors have suggested that behavioral health assessments of American Indian and Alaska Native clients should include an instrument to evaluate clients' comfort with and interest in their traditional culture as well as mainstream cultural practices that may play a part in their treatment (Garrett & Herring, 2001; Thomason, 2011; Weibel-Orlando, 1987). Reynolds, Quevillon, Boyd, and Mackey (2006) described one such instrument for evaluating cultural values and beliefs among Dakota/Nakota/Lakota peoples. TIP 59, *Improving Cultural Competence* (SAMHSA, 2014b) provides more information on instruments used to assess cultural orientation and acculturation, as well as information on providing a culturally responsive assessment.

Substance use disorder screening and assessment

Because many American Indian and Alaska Native cultures have attitudes toward substance use that vary from those of White American society, different criteria may need to be used to determine what constitutes problematic or dependent use. For example, Weaver (2001) found that when using screening and assessment instruments, the "quantity and frequency" of consumption were not as significant as whether drinking was seen as interfering "with social roles, norms, and expectations" when determining AUDs among American Indians (p. 88).

Gizer et al. (2013) compared DSM-IV cannabis abuse disorder and cannabis dependence disorder symptoms (assessed using the Semi-Structured Assessment for the Genetics of Alcoholism [SSAGA]) for a group of 406 American Indians living on eight contiguous reservations with a general population sample of 728. They found that withdrawal symptoms were significantly more common among the American Indian sample but also less severe, whereas three cannabis abuse disorder symptoms (i.e., role failure, hazardous use, social problems) were significantly less common among American Indians but more severe when they did occur.

In an evaluation of the oft-used Short Michigan Alcohol Screening Test (SMAST), Robin et al. (2004) found that significantly higher cutoff scores were required to demonstrate acceptable levels of specificity for men and women from Southwest and Northern Plains tribes. Subjects from these populations who scored at the standard cutoff score for the SMAST ($\geq$3) were actually less likely to be alcohol dependent (according to DSM-III-R criteria) than was the average person in the population. To make the instrument work better in these populations, a score of $\geq$5 was needed for members of the Southwest tribe of either gender, and scores of $\geq$8 and $\geq$6 were needed for men and women, respectively, from the Northern Plains tribe. The authors concluded that the need for such elevated cutoff scores brought into question the value of the SMAST as a screening tool for American Indians.

Saremi et al. (2001) evaluated the validity of the CAGE screening instrument, comparing it with assessments made with the Schedule for Affective Disorders and Schizophrenia-Lifetime Version (SADS-L), with 275 American Indians and Alaska Natives who were administered the instrument on two separate occasions. The authors concluded that the CAGE was a valid instrument with this population. It had a sensitivity of 68 percent in men and 62 percent in women and a specificity of 93 percent in men and 79 percent in women.

A more recent study evaluated the CAGE and the Alcohol Use Disorders Identification Test with a group of 50 Northern Plains American Indians who were receiving treatment for diabetes (Leonardson et al., 2005). These authors found that both instruments were reliable and had good concurrent and divergent validity.

Slinkey, Gray, and Carter (2013) administered the Substance Abuse Subtle Screening Inventory-3 (SASSI-3) to 600 American Indians from the Northern Plains. Although this conference abstract does not present detailed data regarding the properties of that instrument, the authors concluded that the SASSI-3 was not as reliable a screening instrument for SUDs for American Indians as it was for the general population.

In a review of earlier studies that evaluated assessment instruments using American Indian and Alaska Native populations, Manson, Walker, and Kivlahan (1987) observed that the Alcohol Use Inventory was evaluated in a few studies using American Indian and Alaska Native populations, and although it did appear to be valid, some of these studies found some differences in its reliability, validity, sensitivity, and specificity among tribal groups.

In evaluating the SADS-L, Manson, Shore, Bloom, Keepers, and Neligh (1989) found that the scales assessing AUDs were appropriate for an American Indian population, and they had perfect interrelater reliability when used to assess AUDs.

The ASI has also been adapted specifically for Northern Plains American Indians (Carise & McLellan, 1999) and is available from SAMHSA.

Mental disorder screening and assessment

Few mental disorder screening and assessment instruments have been evaluated with American Indian and Alaska Native samples (Thomason, 2011).

The Minnesota Multiphasic Personality Inventory (MMPI) was, at least at one time, in fairly wide use with American Indian and Alaska Native clients (Manson et al., 1987). Some reports, however, found problems with the instrument. For example, Pollack and Shore (1980) found little variation in MMPI scores among subgroups of American Indians and Alaska Natives (e.g., by age, gender, diagnosis) and also found that it was unable to distinguish certain diagnoses in that population (e.g., distinguishing nonpsychotic depression from schizophrenia). As a result, they suggested that the MMPI may not be appropriate for American Indians and Alaska Natives and may evaluate certain cultural beliefs as pathological or deviant.

Robin, Greene, Albaugh, Caldwell, and Goldman (2003) gave the MMPI-2 to 535 Southwest and 297 Northern Plains American Indian tribal members and compared results with a normative sample that was matched according to age, gender, and education (n = 512). They found significantly higher scores (typically considered as an indication of greater pathology) for the American Indian sample on several different subscales (e.g., ones measuring depression, antisocial attitudes or behaviors, misanthropic beliefs, hypochondriasis). However, in another article analyzing the empirical correlates of these MMPI-2 results, Greene, Robin, Albaugh, Caldwell, and Goldman (2003) concluded that differences in scores on MMPI-2 scales between American Indian and Alaska Native and general population samples reflected real differences in how American Indians and Alaska Natives experienced and reported psychological distress and were not the result of an inherent bias in the instrument.

Manson et al. (1987) reviewed findings from their own research conducted with American Indians and Alaska Natives regarding two structured diagnostic interviews: the NIMH DIS and the SADS-L. They noted that culturally appropriate revisions to these instruments improved their use with American Indians and Alaska Natives but also observed that both instruments were reliable with this population. Shore, Manson, Bloom, Keepers, and Neligh (1987) also provided information on the use of the SADS-L with American Indian clients.

Given that depression may be experienced, manifested, or expressed differently by American Indians and Alaska Natives (Kaufman et al., 2013; Manson et al., 1985; Shore et al., 1987; Somervell et al., 1992, 1993), instruments that screen or assess depression should be evaluated with American Indian and Alaska Native populations to assess their psychometric properties and, ideally, to establish American Indian and Alaska Native normative data; however, not many have been. In an unpublished study, Hill et al. (2011) examined the psychometric properties of the Beck Depression Inventory-II, CES-D, Tri-Ethnic Depression Scale, Beck Hopelessness Scale, Beck Anxiety Inventory, Symptom Checklist-90-Revised, Quality of Life Inventory, and Rumination Scale with a group of 600 American Indians and Alaska Natives. However, only limited findings are given in the presentation abstract.

Somervell et al. (1993) evaluated the CES-D with 120 American Indians from the Northwest. They found it had a sensitivity for major depression of 100 percent and a specificity of 82.1 percent, but sensitivity for evaluating all mood disorders (according to DSM-III-R criteria) was lower (77.8 percent). In a separate publication using the same research, Somervell et al. (1992, 1993) observed that somatic complaints and emotional distress were not differentiated well, which could represent a difference in how depression was expressed by American Indians. The authors also observed that there were problems with the CES-D's divergent validity and that CES-D scores were elevated by the presence of other disorders such as AUDs.

In a Canadian study involving 103 First Nations and Métis women, Clarke (2008) evaluated two screening instruments for postpartum depression (the PDSS and the Edinburgh Postnatal Depression Scale) and concluded the two were valid measures of postpartum depression for that population.

Few measures of anxiety have been evaluated with American Indian and Alaska Native samples. One exception is the ASI, which has been the subject of a couple of publications. Zvolensky, McNeil, Porter, and Stewart (2001) evaluated the ASI with a group of 292 American Indian college students from various tribes and found the three-factor structure validated in research with other populations applied to this population as well. They also found that the ASI had a high degree of internal consistency and good validity with this sample. This American Indian sample did have significantly higher ASI scores than found in general population samples, which could reflect greater anxiety sensitivity or cultural differences in how anxiety is experienced or expressed. However, Norton, De Coteau, Hope, and Anderson (2004), in an evaluation of the ASI with a homogenous sample of 146 individuals from a Midwest tribe, had somewhat different findings. Notably, they found a single-factor structure was the best fit for their sample and suggested this difference in findings may have resulted from the fact that they used a tribally homogenous sample.

Mental Health Promotion and Substance Misuse/Use Disorder Prevention

Prevention is an important component of behavioral health services, and that is especially true for many American Indian and Alaska Native communities, which often hold holistic views of SUD and mental illness that see prevention and treatment as different steps in the same process (Johnston, 2002; Trimble & Beauvais, 2001). The majority of prevention programs are aimed at youth, but some also include young adults or other adult populations, and some of the information from youth prevention programs are relevant for adults as well. With few exceptions, most prevention programs that have been evaluated with American Indians and Alaska Natives focus on substance misuse/use disorder prevention. An understanding of risk and protective factors (discussed under "Risk and Protective Factors for Mental and Substance Use Disorders") and resilience is important for understanding how prevention programs work.

Kirmayer, Dandeneau, Marshall, Phillips, and Williamson (2011) explore how standard concepts of resilience may need to be rethought to better address American Indian and Alaska Native cultures. They give examples of resilience as it relates to four Canadian Aboriginal peoples, including the Inuit and Mohawk, both of whom also reside in the United States. The authors observe that prevention activities for these populations need to consider culturally specific ideas about self, the importance of a tribe's history and traditions, and the relative importance of individual and collective agency.

Hawkins et al. (2004) reviewed a variety of different types of substance misuse/use disorder prevention programs that have been used with American Indian and Alaska Native youth. These include community empowerment approaches, such as the Parent, School and Community Partnership Program (Petoskey et al., 1998) and the Target Community Partnership Project (Rowe, 1997). Overall, these programs had some positive results, but either did not have an effect on primary outcomes or were evaluated in studies that did not include a comparison control group, thus making it difficult to evaluate results. These authors also reviewed older research on two types of prevention activities targeted at individuals rather than communities: peer-led interventions (e.g., Carpenter, Lyons, & Miller, 1985), which include skills training for things such as drinking self-control, and bicultural competence interventions (e.g., Schinke et al., 1988), which teach skills to help individuals negotiate the tension between mainstream and native cultures. Research on skills training, particularly bicultural competence skills training, supports its effectiveness in reducing SUDs for American Indian and Alaska Native youth.

A couple of studies conducted since Hawkins et al.'s (2004) review highlighted other promising programs for substance misuse/use disorder prevention delivered to American Indian and Alaska Native youth. Moran and Bussey (2006) evaluated the Seventh Generation Program, a skills training program that also seeks to build a positive American Indian and Alaska Native identity and promote traditional American Indian and Alaska Native values. They found that 1 year after the intervention, participants had, compared with a nonequivalent control group, significantly greater improvement in measures of locus of

control, depressive symptoms, and social support. Gathering of American Indians and Alaska Natives (GONA) is another substance misuse/use disorder prevention program developed for American Indian and Alaska Native youth, which uses skills training and community empowerment strategies for HIV and substance misuse/use disorder prevention (Aguilera & Plasencia, 2005). In the most recent evaluation of GONA, Nelson and Tom (2011) found that participants had significant pre- to postintervention improvements in knowledge and perceptions of risk, as well as sexual self-efficacy.

The Healthy Nations program was a large project funded by the Robert Wood Johnson Foundation that integrated substance misuse/use disorder prevention, screening, and treatment activities in American Indian and Alaska Native communities (Moss et al., 2003; Robert Wood Johnson Foundation, 2007). It was implemented at 14 sites around the country with diverse American Indian tribes. However, the evaluation of the project at seven sites found mixed results, suggesting that although the program appeared to reduce substance-related arrests at some sites and reduce the quantity of alcohol consumed (although not drinking frequency) at some sites, it did not have a consistent effect across sites and was even associated with worse outcomes at some sites.

In one of the few evaluations of a prevention program for adult American Indians that targeted a mental health outcome (depressive symptoms) as well as excessive drinking, Gray, Mays, Wolf, and Jirsak (2010) compared two different prevention interventions: a curriculum-based health promotion intervention and a cognitive–behavioral skills building intervention. They randomly assigned 268 adult women (ages 18 to 50) who were members of a Southwest American Indian tribe to receive one of the two interventions and conducted assessments at the conclusion of the intervention and 6 months afterwards. Although they found no significant differences at the 6-month follow-up between the two groups, participants in both groups had significant decreases in alcohol consumption and in symptoms of depression (measured with the BDI) and had significant increases in alcohol-related self-efficacy and self-esteem.

Trimble and Beauvais (2001) conducted a literature review on prevention programs for American Indian and Alaska Native youth. They looked at interventions that taught social skills, involved peer counselors, worked with families, addressed policy issues, and addressed use disorder and prevention on a community-wide level. Yellow Horse and Brave Heart (2014) reviewed literature on behavioral health services for American Indian and Alaska Native youth. They described several programs that have been implemented to provide prevention services to this population. An earlier review by May and Moran (1995) encompassed a wider range of substance misuse/use disorder prevention programs for American Indian and Alaska Native by including ones with a less rigorous research methodology and interventions aimed at secondary outcomes, such as preventing alcohol-related injuries and preventing FASD. Those authors stressed the importance of considering the wide variety of American Indian and Alaska Native cultures, shaping any prevention intervention to the specific local culture, and involving local assistance in planning and implementing such interventions.

There is limited evidence that prevention interventions that were not developed to be culturally relevant for American Indians and Alaska Natives will be less effective. A study conducted with a diverse group of urban youth in a Southwest city found that American Indian and Alaska Native youth who received a prevention intervention developed with youth from other cultural backgrounds (African American, Latino, and White American) experienced greater increases in alcohol and marijuana use following the intervention than did youth of other races who received the same intervention (Dixon et al., 2007).

Sanchez-Way and Johnson (2000) discussed the use of cultural practices in prevention programs for American Indian and Alaska Native youth, giving examples of prevention programs that involve cultural activities as well as reviewing how general prevention principles may apply in this context.

The community readiness model for substance misuse/use disorder prevention may be particularly useful in American Indian and Alaska Native communities (Jumper-Thurman, Plested,

Edwards, Oetting, & Helm, 2001). This model involves working with community members to assess community readiness to change substance use behaviors and then developing a prevention plan that addresses the specific needs of the community. Substance misuse/use disorder prevention activities in American Indian and Alaska Native communities may function not just to prevent new cases of SUD, but also to motivate recovery for individuals who have already developed SUDs. For example, the Chi-e-chee (Workers) program, funded by SAMHSA's Center for Substance Abuse Prevention, was instituted in a small, rural American Indian community and appeared to have a significant effect on reducing drug- and alcohol-related problem behaviors among adults as well as use by youth. Between 1992 and 1996, the period during which the program ran, the number of abstinent adults in that community increased from 25 percent of the population to 40 percent of the population (Rowe, 1997).

Walker, Bigelow, LePak, and Singer (2011) described the Indian Country Methamphetamine Initiative, a multi-tribal project that included prevention as well as treatment and law enforcement components. Another example of a prevention program for American Indians and Alaska Natives that targets adults is the Don't Forget Us Project, a promising program that works to prevent HIV/AIDS, hepatitis, illicit drug use, and excessive alcohol use among American Indians and Alaska Natives living in Baltimore, MD (Native American LifeLines & Friends Research Institute, 2008).

FASD prevention programs have targeted adult American Indian and Alaska Native women of childbearing age with the intention of reducing alcohol use and preventing FASD (see "Fetal alcohol spectrum disorders"). SAMHSA's Fetal Alcohol Spectrum Disorders Center for Excellence (2007) has published a report titled *Identifying Promising FASD Practices: Review and Assessment Report*, which may be of assistance to providers seeking to prevent FASD. It and other publications and information are available from the Fetal Alcohol Spectrum Disorders Center for Excellence website.

Montag, Clapp, Calac, Gorman, and Chambers (2012) reviewed several different FASD prevention interventions that have been implemented with American Indian and Alaska Native women but also observed methodological problems with some studies. They summarized key findings from these studies, which included recognizing the importance of having culturally tailored interventions, the value of incorporating traditional spiritual and cultural activities in interventions, the benefits of a community-oriented approach, and the potential value of medications (e.g., naltrexone, disulfiram) to help women maintain abstinence.

In a study included in this review, May et al. (2008) provided case management combined with MI to reduce FASD risk in Northern Plains American Indian communities. Of the 131 women who were referred to the study by criminal justice, social service, or healthcare providers and who agreed to participate, nearly one-third (31 percent) entered a SUD treatment program, and 38 percent reported complete abstinence from alcohol after 6 months in the program. The number of binge drinking episodes also decreased significantly, although the amount consumed per binge drinking episode remained about the same.

More recently, Hanson, Miller, Winberg, and Elliott (2013) evaluated a telephone-delivered preventive intervention for American Indian women of childbearing age who were members of one of three Northern Plains tribes (N = 231). They provided written materials and a telephone-delivered MI intervention to participants that included assessments every 3 months for 1 year following the baseline interview. They found that participants in the study had significant reductions in self-reported alcohol use at each assessment, so that the average number of drinks consumed per week went from 12.9 at baseline to 3.3 at the 1-year follow-up.

Along with telephone-delivered interventions, web-based interventions may also be effective for this population. Gorman et al. (2013) described the adaption of a web-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) intervention for use with American Indian and Alaska Native women of childbearing age. Based on focus group discussions and interviews, they derived five basic adaptations: (1) make the intervention more personal by including pictures and a story about a child affected by FASD, (2)

emphasize confidentiality, (3) involve family and the community in the intervention where possible, (4) make content specific to the tribe receiving the intervention, and (5) include more information about how a woman's alcohol use during pregnancy can affect her child's health. Web-based interventions for American Indians and Alaska Natives are discussed further under "Telephone- and Computer-Based Services."

However, a later assessment of this intervention, in which 247 women of childbearing age were randomly assigned to use the web-based program or to receive an assessment and standard medical treatment (in which printed materials on FASD were available), did not find any significant differences in risky and binge drinking during the 6 months following the intervention (Montag et al., 2015). Both groups, however, did reduce risky and binge drinking during that period.

Suicide prevention programs are another form of prevention that often targets adults as well as youth. Treatment providers should be aware of the increased risk for suicide of certain American Indian and Alaska Native populations and people, in general, who have mental disorders and SUDs (see discussion under "Suicidality"). General information on handling suicidal behaviors in SUD treatment settings can be found in TIP 51, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a). However, as Wexler and Gone (2012) observed, the meaning of suicide may be different in American Indian and Alaska Native cultures from how it is perceived in mainstream American culture; suicide may be understood as a "public expression of collective pain" rather than as a purely personal act (p. 802). They also discussed the implications of these differences for suicide prevention efforts (e.g., the need to develop interventions that address problems at a family and community level and are not just targeted at individuals).

For providers offering suicide prevention services, SAMHSA's publication on suicide prevention for American Indian and Alaska Native youth and young adults titled *To Live To See the Great Day That Dawns* includes a wealth of information, much of it applicable to adult populations (HHS, 2010). This publication discussed relevant risk and protective factors for American Indians and Alaska Natives, how to respond to suicide attempts in behavioral health settings, and community readiness and action. The One Sky Center has prepared a *Guide to Suicide Prevention for American Indian and Alaska Native Communities* (Walker, Loudon, Walker, & Frizzell, 2006), which is available online in draft form. In Canada, the Ajunnginiq Centre of the National Aboriginal Health Organization published a guide to suicide prevention for the Inuit people, which is also available online (Korhonen, 2006). Olson and Wahab (2006) reviewed information on suicide prevention for American Indians, and Brave Heart, Bird, Altschul, and Crisanti (2014) discussed suicide prevention specifically for American Indian and Alaska Native youth.

Methamphetamine is a contributing factor in many American Indian and Alaska Native suicides, and in response, IHS has developed the Methamphetamine and Suicide Prevention Initiative, which aims to prevent and treat methamphetamine use disorders and prevent suicide (IHS, 2015). The National Indian Health Board website contains information on specific programs that are part of the initiative, a project management toolkit, and quarterly newsletters.

Various other suicide prevention programs for American Indian and Alaska Native youth and adults have been developed and may be available for implementation. These include the Native Aspirations program funded by SAMHSA (see Running Wolf, 2005) and the Zuni Life Skills Development program (LaFromboise & Howard-Pitney, 1995), which has been implemented with members of other American Indian and Alaska Native tribes as the American Indian Life Skills Development program (LaFromboise & Lewis, 2008). Muehlenkamp, Marrone, Gray, and Brown (2009) described a suicide prevention program for American Indian college students and provided some data suggesting the program has been well-received by the first group of students to use the program.

Prevention programs, if they are to be successful in American Indian and Alaska Native communities, may benefit by acknowledging the ways in which information about behavioral health is communicated in those communities. According to research

conducted in Canada, face-to-face communication is particularly important among the Inuit; health information is often disseminated through storytelling, and elders' advice is often sought and accepted regarding healthcare decisions (Smylie, Kaplan-Myrth, & McShane, 2009). These authors also found that health-related messages could be disseminated quickly through Inuit communities once they were accepted by some community members.

A survey of 900 American Indians from the Midwest, however, found that the most trusted sources for health information were family members, followed by books and the Internet (Geana, Greiner, Cully, Talawyma, & Daley, 2012). Primary care providers from IHS or tribal clinics along with pharmacists were more trusted sources for such information than were hospital staff members, traditional healers, or friends.

Research that evaluated the reception of information on health risks with a group of American Indian college students (N = 489) found that graphic presentations of such information (e.g., bar graphs) resulted in better communication than presentations entirely in text (Sprague, Russo, Lavallie, & Buchwald, 2013).

Prevention programs also may benefit from designing and using interventions that leverage known protective factors associated with positive health. A review from Henson et al. (2017) suggested that certain socioecological and cultural factors may mitigate lower mental and emotional health in American Indian and Alaska Native adolescents. The authors identified individual, relationship-based, and community-based protective factors against a range of negative health outcomes including substance use, alcohol abuse, depression, and suicide attempts. Protective factors with positive effects on health included current and future aspirations, personal wellness, positive self-image, self-efficacy, connectedness with nonfamily members, family connectedness, positive opportunities in the community (e.g., availability of extracurricular activities), positive social norms (e.g., presence of a parent who models prosocial behavior), and cultural connectedness (e.g., involvement in and identification with American Indian culture).

The authors recommended that future research on health promotion and prevention programs actively involve American Indian and Alaska Native individuals in the design of interventions, as these individuals can help self-identify relevant protective factors best suited to serve as targets of change.

Adapting Standard Mental and Substance Use Disorder Treatment Modalities

Some conventional behavioral health interventions and services may not be appropriate for American Indian and Alaska Native clients without some adaptations, and American Indian and Alaska Native clients may have goals, values, and attitudes toward specific services that differ from those of clients from other ethnic groups (Aragon, 2006; Calabrese, 2008; De Coteau, Anderson, & Hope, 2006; Duran, 2006; Garrett & Herring, 2001; Paniagua, 1998; Prussing, 2008). However, many American Indians and Alaska Natives still receive standard or conventional behavioral health services, and those services could be improved by a better understanding of American Indian and Alaska Native cultures and treatment preferences (see discussion under "Motivation for Treatment and Access to Care").

Generally, American Indian and Alaska Native cultures have a view of physical and mental illnesses and their treatment that is more holistic and spiritual in its focus than European American treatment models (Calabrese, 2008; Garrett & Herring, 2001; LaFromboise et al., 1990; Nebelkopf & King, 2003). American Indian and Alaska Native models of health also place greater importance on family, community, and social harmony and harmony with nature, rather than competition and fulfilling individual goals (Duran, 2006; Garrett, 1999). Therapeutic interventions for American Indians and Alaska Natives may need to focus on helping each client reconnect with his or her community and cultural values instead of delineating and meeting personal goals (LaFromboise et al., 1990). These interventions may involve communal, rather than individual or even group, activities (Calabrese, 2008). They can be practices that are presented as spiritual rather than therapeutic in nature, with goals that are preventive (e.g., preventing further drinking) rather than

remedial (Calabrese, 2008). Therapeutic interventions may also need to be presented as activities that will help the individual achieve balance, gain wisdom, and transform suffering into healing (Duran, 2006; Williams & Ellison, 1996).

Research conducted with a general population sample (i.e., not individuals with diagnosed disorders) of American Indians from the northern Midwest found that respondents preferred more informal to more formalized behavioral health services and preferred services delivered on their reservations to those delivered elsewhere (Walls et al., 2006). They also tended to perceive services from traditional healers and the use of traditional cultural ceremonies as more effective than services provided by behavioral health professionals. Respondents were more likely to believe in the effectiveness of formal treatment services if they had more education, lived off the reservation, or had more perceived social support. However, not all American Indian peoples will be equally positive about the use of traditional healers. The AI-SUPERPFP found that individuals from the Southwest tribe were significantly more likely to seek help from traditional healers for mental disorders than were people from the Northern Plains tribes (Beals, Novins et al., 2005). Respondents from the Northern Plains tribes were more likely to have sought help for depression or anxiety from standard mental health service providers or medical providers than from a traditional healer, whereas the reverse was true for people from the Southwest tribe.

American Indian and Alaska Native indigenous recovery movements have typically viewed substance misuse in relation to cultural conflict between Native and Western cultures and considered alcohol and drugs as weapons in conflicts that caused a loss of traditions (Coyhis & White, 2006). So, SUD treatment for American Indians and Alaska Natives that wishes to be sensitive to client preferences may need to look at the spiritual and social harm done by SUDs in light of the greater context of European imperialism (Duran, 2006) and the loss of cultural traditions (Brady, 1995; Jilek, 1994). However, Brady (1995) cautioned that culture is complex and changing, and a return to the values of a traditional culture may not always be indicated.

Because most evidence-based practices and interventions will have been developed with other populations, implementing such practices in American Indian and Alaska Native communities presents certain challenges. Providers working with American Indians and Alaska Natives have expressed concern that such interventions may not be effective with this population or that methods that providers have found to be effective have been ignored by researchers (Echo-Hawk, 2011; Gone & Alcántara, 2007; Novins et al., 2011). Echo-Hawk (2011) and Gone and Alcántara (2007) discussed the need to find a balance between using interventions that have been demonstrated to be effective in research and those that behavioral health service providers working with American Indians and Alaska Natives have found to be effective.

Novins, Croy, Moore, and Rieckmann (2016) surveyed 192 SUD treatment programs that primarily served American Indian and Alaska Native clients regarding their use of evidence-based practices. The most commonly implemented interventions were cognitive–behavioral therapy (CBT), MI, and relapse prevention therapy. They also asked providers to consider whether specific interventions were culturally appropriate for American Indian and Alaska Native clients. The only two interventions considered culturally appropriate by most respondents were MI (which 55.9 percent said was culturally appropriate) and relapse prevention (which 58.1 percent recognized as culturally appropriate).

Walker, Whitener, Trupin, and Migliarini (2013) reported findings from a multi-tribal gathering in Washington State that focused on the development and implementation of behavioral health interventions for American Indian youth. From discussions in this meeting, which included tribal members and behavioral health staff members serving tribes in the state, the authors derived four overarching themes regarding the implementation of new behavioral health services: (1) respecting local traditions and values by ensuring that programs are in alignment with tribal values, (2) providing home-based services, (3) establishing credibility in the community, and (4) adjusting program schedules and timing to fit with

community norms and needs (e.g., understanding that tribal employment may be seasonal).

Given that many American Indians and Alaska Natives reside in rural or remote areas (see "Differences Among Rural, Urban, and Border Town-Dwelling American Indians and Alaska Natives"), providers may also need to take steps to bridge geographic distances as well as cultural ones. Providing in-home services is one method that has been recommended in the literature (Rohlfs, 2006; Walker et al., 2013). Schacht, Tafoya, and Mirabla (1989) described the process of providing home-based individual and family therapy in American Indian communities in New Mexico. Telephone and computer technology may also be useful in reaching clients in remote areas and programs using telephone or computer technology are discussed under "Telephone- and Computer-Based Services."

Individual counseling

Based on their clinical experience, LaFromboise et al. (1990), cautioned that the standard model for counseling used in many programs (based on neo-Rogerian concepts and the use of facilitative communication styles) is not well-suited for and, in fact, may be counterproductive with American Indian and Alaska Native clients. This is in spite of the fact that there are certain elements of this approach (such as priority placed on internal values and personal autonomy) that appear to be consistent with the values of many American Indian and Alaska Native cultures. American Indian and Alaska Native clients will often not respond well to a communication style that requires them to do a lot of talking, especially to reveal personal feelings. This style of therapy also may not place enough emphasis on family and community, factors that may be of great importance to many American Indian and Alaska Native clients.

To be most effective, interactions with American Indian and Alaska Native clients may need to rely to a greater degree on establishing an affinity with the client, and less on offering advice. LaFromboise (1992) had 43 American Indian and Alaska Native students evaluate three different types of responses to a client seeking behavioral health assistance: these responses expressed (1) affinity with the client, usually by disclosing personal information; (2) asking for clarification; or (3) helpful advice or suggestions for client behavior or actions. Student raters tended to find helpful statements dominant, mistrusting, or hostile. On the other hand, affinity and clarification responses were most often rated as agreeable and nurturing.

Calabrese (2008) similarly noted that traditional Western approaches to counseling may not be well-suited for clients coming from American Indian and Alaska Native cultures because such approaches expect self-disclosure to a professional who will likely be viewed as a stranger and expect self-disclosure in a limited time. Also, certain things—for example, the importance of dreams, rituals, and synchronous events—may have a different or greater relevance for American Indian and Alaska Native clients than Western psychology ascribes to them (Lewis, Duran, & Woodis, 1999).

Aragon (2006) recommended, based again on experience and not on research, the use of active listening and reflective responding and warned against interruption when practicing therapy with American Indian and Alaska Native clients. He also noted the value of psychoeducation for these clients. Similarly, Paniagua (1998) recommended not asking about personal or family matters unrelated to substance use without permission, avoiding excessive note taking, and being willing to accept input from traditional healers and community leaders who may even accompany the client to an initial session. Sutton and Broken Nose (2005), among others, recommended that clinicians understand the value of listening in American Indian and Alaska Native cultures and be prepared to accept extended silences as an important part of the therapeutic process.

Garrett (1999) provided a list of practical suggestions for counseling American Indian and Alaska Native clients. These seven basic recommendations are to (1) to greet clients with a gentle (rather than firm) handshake; (2) show hospitality (e.g., by offering food or beverages); (3) take some quiet time at the beginning of a session to show respect and allow the client to adjust to the situation; (4) assess the client's level of acculturation as well as tribal or cultural background before beginning counseling; (5) adjust to the level of eye contact

with which the client is comfortable (continual eye contact may be perceived as a sign of arrogance or aggression); (6) keep to your word and do what you say you will do; and (7) to offer suggestions, not directions (preferably more than one to allow for choice).

Williams and Ellison (1996) offered advice for social work with American Indians and Alaska Natives that is applicable in a variety of behavioral health settings: (1) Listen to clients to learn about American Indian and Alaska Native traditions. (2) Determine the relative importance of American Indian and Alaska Native culture and spirituality for the client. (3) Revise interventions so they are sensitive to the values of American Indian and Alaska Native and to those of European cultures. (4) Work on creating interventions that restore balance physically and spiritually. (5) Understand the client's definition of illness. (6) Consult with traditional healers and elders.

Gone (2010) explored the process of integrating traditional healing methods and psychotherapy in providing therapy to American Indian and Alaska Native clients and provided a review of earlier literature on the subject. He also warned about some of the ways in which traditional therapy may be problematic for American Indian and Alaska Native clients, noting that "modern psychotherapies—steeped as they are in Western assumptions regarding self, identity, personhood, social relations, communication, spirituality, and so forth—harbor the implicit potential for effecting ongoing Western cultural proselytization of vulnerable Indian clients" (p. 188).

Duran's (2006) book, *Healing the Soul Wound*, provided a lengthy discussion of how to negotiate differences between traditional American Indian and Alaska Native concepts of health and wellness and conventional American behavioral health services. The book also presented the author's views on how to conduct culturally responsive therapy with American Indian and Alaska Native clients.

Some believe that counseling that uses behavioral, cognitive–behavioral, or social learning approaches may be better suited for many American Indian and Alaska Native clients than psychoanalytic approaches. These approaches are often less culturally biased than those that have developed from a psychoanalytic model and are more similar to the learning styles, goals, and communication styles of many American Indian and Alaska Native cultures (Heilbron & Guttman, 2000; LaFromboise et al., 1990; Renfrey, 1998). Concepts such as the use of role-modeling techniques, an action-oriented approach, the idea that behaviors and beliefs are learned and can be relearned, and that personal responsibility is important in changing harmful behaviors are all in accordance with many American Indian and Alaska Native cultures' belief systems (Heilbron & Guttman, 2000; LaFromboise et al., 1990; McDonald & Gonzales, 2006; Thatcher, 2004). Korhonen (2004) observed that CBT may be useful in counseling Inuit clients, as the Inuit have a future orientation that is generally focused on problem-solving.

Jackson, Schmutzer, Wenzel, and Tyler (2006) gave the Cognitive Behavior Therapy Applicability Scale to a nonclinical sample of 41 American Indians and Alaska Natives and to a matched group of White Americans. The White American group had a more positive response to CBT's in-session behavior (e.g., its focus on uncovering the relationship between thoughts and feelings, its linear approach to problem-solving) and its level structure in the therapeutic relationship (e.g., the degree to which it required clients to be responsible for personal change, the set timing and regularity of sessions), but both groups had similar ratings of CBT's active stance (e.g., the level of client participation in treatment, the use of homework and scheduling). The authors suggested that CBT interventions for American Indians and Alaska Natives be modified so that the degree to which clients are encouraged to label thoughts and feelings in an abstract manner is limited; that linear cause-and-effect relationships between thoughts and feelings be deemphasized; that clinicians can be more flexible regarding the length and frequency of sessions, that treatment incorporate family and community when possible; and that the focus on personal autonomy in behavior change be reduced. However, they noted that CBT's focus on present problems, problem-solving, and skill building should be kept.

CBT approaches may also pose other problems for American Indian and Alaska Native clients, including a lack of attention to spirituality (Hays, 2006), and the clinician's assumption of competence in CBT may be perceived as a lack of humility by some American Indian and Alaska Native clients (De Coteau et al., 2006). CBT interventions will likely work best when integrated with culturally relevant interventions (McDonald & Gonzales, 2006).

When using CBT and behavioral interventions with American Indians and Alaska Natives, clients should be able to identify treatment goals and reinforcers that are culturally congruent, as otherwise the intervention may be perceived as imposing another culture's values (LaFromboise et al., 1990). For example, when adapting a community-reinforcement approach for Navajo clients with alcohol dependence, Miller, Meyers, and Hiller-Sturmhöfel (1999) made use of traditional clan ties to build a support network and Navajo cultural and spiritual practices to provide alternatives to reinforce positive change.

There is very little research evaluating behavioral or CBT interventions with American Indian and Alaska Native clients, and much of what exists is concerned with youth and not adults. Manson and Brenneman (1995) adapted a behavioral treatment for depression (the Coping with Depression intervention) for American Indian and Alaska Native older adults and found that compared with a waitlist control group, those who received the intervention had significant improvements in depressive symptoms. The Coping with Depression intervention has also been adapted for American Indian and Alaska Native youth, and its use was associated with significant reductions in depressive symptoms in a pilot study (Listug-Lunde, Vogeltanz-Holm, & Collins, 2013). Another CBT intervention for American Indian and Alaska Native youth with PTSD symptoms (the Cognitive Behavioral Intervention for Trauma in Schools) was also found to be promising in a pilot study (Goodkind, LaNoue, & Milford, 2010). However, the addition of a CBT skills training module to a culturally focused wellness intervention for American Indian and Alaska Native women was not associated with any greater improvements in anxiety and depressive symptoms and alcohol use in a nonclinical sample (Gray et al., 2010).

Motivational interviewing or motivational enhancement therapy (MET) is another treatment model that shows promise with American Indian and Alaska Native clients. In one of the only research studies that compares specific SUD treatment interventions for American Indian and Alaska Native clients, Villanueva et al. (2007) used data for 25 American Indians and Alaska Natives from the larger Project MATCH study to compare treatment outcomes for those who received MET, CBT, or 12-Step facilitation. Participants in all three interventions improved over the 15-month follow-up period in the percentage of days drinking and the number of drinks consumed per drinking day. Participants in MET also reported significantly fewer drinks per drinking day during the last (10- to 15-months posttreatment) follow-up period, suggesting that MET may have additional benefits.

Venner, Feldstein, and Tafoya (2006) have developed a manualized approach to MI with American Indians from the Southwest United States that they believe is applicable to all American Indian and Alaska Native populations (as well as to some indigenous peoples outside the United States).

Some authors have suggested that mindfulness-based interventions may be useful with at least some American Indian and Alaska Native populations (e.g., Mohatt et al., 2008). Mindfulness approaches to therapy derive certain central principles from Asian spiritual and philosophical traditions but integrate them into therapeutic approaches derived from CBT (Hoppes, 2006). Mohatt et al. (2008) observed that some Alaska Native peoples have belief systems that are compatible with the ideas of mindfulness meditation, and they recommended developing behavioral health approaches that integrate mindfulness. Witkiewitz, Greenfield, and Bowen (2013), in an article discussed under "Relapse Prevention and Recovery Promotion," found that mindfulness-based relapse prevention was more effective for a group of non-White women that included American Indian and Alaska Native women than was standard relapse prevention using a pure CBT approach.

Family therapy

Several authors have found family therapy to be a useful modality for American Indian and Alaska Native clients, especially when other social supports are lacking and when the focus of the therapy is on solving concrete problems (Attneave, 1969, 1982; Choney et al., 1995; De Coteau et al., 2006; Gorman et al., 2013; Jones-Saumty, 2002; LaFromboise et al., 1990; Manson et al., 1987; Sutton & Broken Nose, 2005). De Coteau et al. (2006) recommended involving extended family whenever possible in working with American Indians and Alaska Natives. American Indian and Alaska Native clients, who may otherwise be reluctant to talk in individual or group therapy, may be more motivated to do so in a family therapy setting (Choney et al., 1995).

Although family therapy may be a valuable treatment modality for American Indians and Alaska Natives in many behavioral health settings, providers should understand the diversity of American Indian and Alaska Native cultures and their varied understandings of family structure and roles (Sue & Sue, 2013; Sutton & Broken Nose, 2005). Limb and Hodge (2011) recommended spiritual ecograms, a method of diagramming spiritual connections, as a culturally appropriate way to "map out" the extended families and community connections of American Indian and Alaska Native clients.

Family and social support appear to have a significant impact on the course of mental disorder and SUD treatment for American Indian and Alaska Native clients (Paniagua, 1998; Spear, Crevecoeur-MacPhail, Denering, Dickerson, & Brecht, 2013; Sutton & Broken Nose, 2005). For example, in one study with 159 American Indian women, social support and active family involvement in SUD treatment were found to have a significant relation to better psychosocial functioning at discharge (Chong & Lopez, 2005). Jones-Saumty (2002) concluded that "substance use disorder treatment programs for American Indian clients must necessarily include members of their family and other close persons" as well as their communities (p. 275).

For many American Indians and Alaska Natives, family is not limited to the nuclear family and may include a large network of relatives and family friends (Paniagua, 1998). For this, among other reasons, Network Therapy, an approach that makes use of family as well as friends and other community members, appears to be promising for American Indian and Alaska Native clients. The model was originally developed for American Indian and Alaska Native clients living in urban communities but can be implemented in rural communities as well (Attneave, 1969; LaFromboise & Fleming, 1990). This model of therapy uses extended family and community in a way that approximates their use in many traditional American Indian and Alaska Native healing practices (LaFromboise et al., 1990).

Another model that involves clients' families (as well as their communities) in the process of SUD treatment is that of recovery management, which uses a systems approach and has a cultural and historical perspective on issues such as the intergenerational transmission of historical trauma and specific family and kinship patterns (White & Sanders, 2006).

In rural areas where actual treatment facilities may be lacking, providing services in clients' homes is an informal way of involving families in treatment, which if handled properly can complement treatment goals and strategies (Rohlfs, 2006; Schacht et al., 1989). Traditional American Indian and Alaska Native practices may also involve family members and have a therapeutic effect for clients in SUD treatment. One example of such a practice, the Navajo peacemaking ceremony, has been well-received by SUD treatment clients (Gossage, Alexius, Monaghan-Geernaert, & May, 2004).

Group therapy

Although at one time the accepted wisdom was that American Indian clients did not do well in group therapy, more recently authors have suggested that this need not be so as long as the group experience is properly structured (e.g., Garrett, 2004; Trimble & Jumper-Thurman, 2002). In fact, Garrett, Garrett, and Brotherton (2001) pointed out that American Indian and Alaska Native cultures have a long tradition of using group encounters to restore health and wellness, and they described an adaptation of American Indian and Alaska Native healing circles for a group therapy setting.

Paniagua (1998) recommended that providers running groups for American Indian clients first seek support or permission from tribal authorities and invite respected tribal members (such as traditional healers) to participate in the group, if group members consent. Mail and Shelton (2002) suggested that providers need to assess American Indian clients' levels of acculturation before placing them in group therapy and that those clients who are more acculturated to mainstream American culture tend to do better.

One alternative to group therapy, which may achieve similar ends, is the Talking Circle. In a Talking Circle, an object is passed, and each individual holds the object and may talk to the group but not comment on or discuss what others have said. Although many consider this more of a spiritual practice than a therapeutic intervention, it has been widely used in behavioral health programs for American Indians and Alaska Natives, where it has been successfully modified to have a more therapeutic focus (Mail & Shelton, 2002; Wright et al., 2011).

Therapeutic communities

Although there does not appear to be any published data on therapeutic communities (TCs) for American Indians, a couple of published studies have looked at Alaska Native participation in urban-based TCs and suggested ways in which the TCs can be adapted to incorporate Alaska Native ideas about community and culture.

The first study found that modifying the TC model to incorporate native cultural and spiritual practices and approaches significantly improved program retention rates for Alaska Native clients as well as for White and African American clients (Fisher et al., 1996). Prior to these modifications, retention rates for Alaska Natives in the program (Akeela House) were significantly lower than seen among African American or White American clients, but after the modifications were made, rates were comparable with those seen among those other ethnic groups. These modifications to the program included:

- Adding Spirit Groups, which were led by American Indian and Alaska Native providers and used a less confrontational approach than typically is used in TCs.
- Increasing the number of cultural awareness activities for Alaska Native clients, including activities conducted in Alaska Native languages; preparation of Alaska Native foods; hunting, fishing, trapping, and gathering ceremonies and activities; working on traditional Alaska Native crafts; and drumming and dancing.
- Providing ongoing education on how to acculturate to an urban environment as well as to life in a TC.
- Increasing the number of individual counseling during the first month of treatment.

Naquin, Trojan, O'Neil, and Manson (2006) reported on another modified TC program, designed for Alaska Native clients in an urban environment, that used an organizational model based on Alaska Native village life and includes traditional cultural ceremonies and activities. This program, the Therapeutic Village of Care, also had a vocational training component in which participants produce Alaska Native arts and crafts and work in a catering enterprise or gift shop. The program served a client population that in 2005 was 87 percent Alaska Native and 4 percent American Indian and had a 75-percent treatment completion rate. A preliminary assessment of 6-month posttreatment outcomes for clients showed that 80 percent had not used alcohol in the past 30 days and that 33.3 percent (up from 19.2 percent at intake) were employed full time.

SBIRT

Given the high rates of binge and at-risk drinking in some American Indian and Alaska Native populations, SBIRT interventions may be particularly useful for this population (Anderson, 2007; Patterson Silver Wolf, Duran, Dulmus, & Manning, 2014). Anderson (2007) explored factors that could affect implementation of such an intervention in Canadian Aboriginal communities, which also may be applicable to American Indian and Alaska Native communities.

Few studies evaluating SBIRT with American Indian and Alaska Native populations are available, but one major study that evaluated SBIRT at sites in six different states included one site where American Indians and Alaska Natives were in the majority, making up 93.7 percent of participants at that site (Madras et al., 2009). These researchers found

that at the majority American Indian and Alaska Native site and across all sites, American Indians and Alaska Natives who reported using illicit drugs at their initial assessment had significant decreases in self-reported use of marijuana, cocaine, methamphetamine, heroin, and other illicit drugs, as well as in heavy drinking after participation in the SBIRT intervention. American Indians and Alaska Natives did not differ from participants from other racial/ethnic groups in this regard. Members of all groups evaluated had significant reductions in use, but the evaluation does show that SBIRT can be as effective for American Indians and Alaska Natives as it is for others.

However, Montag et al. (2015) did not find any significant differences in drinking outcomes for American Indian and Alaska Native women who received a web-based SBIRIT intervention from those who received treatment as usual and assessment only (see discussion under "Mental Health Promotion and Substance Misuse/Use Disorder Prevention").

IHS has an Alcohol Screening and Brief Intervention program, which is available as a manualized intervention, that targets young American Indians and Alaska Natives who do not have substance dependence but enter IHS or tribal hospitals or clinics with an injury related to alcohol or drug use (Boyd, Milman, Stuart, Dekker, & Flaherty, 2008). Patterson et al. (2014) discussed general aspects of SBIRT and suggested instruments that may be used when conducting SBIRT with American Indian and Alaska Native clients.

Medication

American Indians and Alaska Natives with anxiety disorders or depression are about as likely to be prescribed psychoactive medications as are White Americans and are more likely to receive them than members of other ethnic/racial groups (Carragher et al., 2010; Givens et al., 2007; Hunt et al., 2013). (See "Motivation for Treatment and Access to Care.") American Indians and Alaska Natives are also about as likely as White Americans to express a preference for medication over counseling (Givens et al., 2007). However, data do not appear to be available regarding the relative effectiveness of psychiatric medications for American Indians and Alaska Natives.

One exception is a study by O'Malley et al. (2008) that found that naltrexone was as effective for American Indian and Alaska Native clients as it was for non-native clients, and for both, it significantly improved abstinence and reduced drinking-related consequences.

Using Traditional Practices in Mental and Substance Use Disorder Treatment

Many American Indian and Alaska Native clients and providers working with those clients believe that traditional American Indian and Alaska Native spiritual and cultural practices can help treat mental disorders and SUDs (e.g., Beals, Novins, et al., 2005; Gone, 2013; Hartmann & Gone, 2012; Niven, 2010; Walls et al., 2006). Gone (2013) observed that there are religious, political, and pragmatic reasons for using such practices in behavioral health settings. The spiritual perspective is that such practices can improve spiritual well-being and affect reality on a different level; the political perspective is that American Indian and Alaska Native cultural practices counteract the effects of colonization and reaffirm the value of American Indian and Alaska Native peoples; and the pragmatic view is that American Indians and Alaska Natives appear to benefit in several ways from participating in traditional practices, including improving their behavioral health.

American Indian and Alaska Native practices to address behavioral health will be culturally relevant in ways that mainstream practices are not. In general, American Indian and Alaska Native approaches to treatment take a more holistic approach to wellness. American Indian and Alaska Native approaches to treatment may integrate spiritual, psychological, and physical well-being; individual and group wellness; and treatment and prevention (Calabrese, 2008; Coyhis & White, 2006; Jilek, 1994; LaFromboise et al., 1990; Nebelkopf & King, 2003; Sage, 2001; UIHI, 2012a).

Although research data are lacking, some have suggested that strengthening clients' relationships with their traditional culture may help reduce depression for American Indians and Alaska Natives (see review in UIHI, 2012a). Some research discussed under "Risk and Protective Factors: Cultural Factors" also indicates that participation

in traditional cultural activities may protect against depression (Kaufman et al., 2013; Whitbeck et al., 2002). However, research (discussed under "Epidemiological Data on Mental Disorders From Other Studies") conducted with Alaska Natives found that greater identification with traditional culture was associated with greater risk for depression for women, but with decreased risk of depression for men, suggesting that gender may complicate the relationship of traditional cultural activities to depression (Dillard et al., 2012). A stronger commitment to spirituality (not necessarily traditional spirituality) has also been associated with having fewer anxiety and depressive symptoms for American Indians and Alaska Natives (Eastman & Gray, 2011).

Some other research mostly conducted with American Indian and Alaska Native youth (also discussed under "Risk and Protective Factors") suggested that involvement in traditional cultural practices can reduce suicide risk (Chandler & Lalonde, 2008; Howard et al., 1996; Yoder, Whitbeck, Hoyt, & LaFromboise, 2006), as can a stronger commitment to cultural spirituality (Garroutte et al., 2003).

A strong connection to traditional culture appears to have a protective function in relation to AUDs among American Indians and Alaska Natives. Several authors have also posited that involvement in traditional spiritual and cultural practices can improve outcomes related to abstinence (Hazel & Mohatt, 2001; Jilek, 1994; Spicer, 2001; Stone et al., 2006; Westermeyer & Neider, 1986). This idea is supported by research, such as that by Herman-Stahl et al. (2003), who found in a sample of American Indians living on reservations in South Dakota (N = 2,449) that reporting less involvement in American Indian culture (according to an 8-point acculturation scale) was associated with significantly greater levels of heavy drinking (according to self-report).

American Indians and Alaska Natives who are in or attempting to attain recovery from SUDs also often talk about cultural restoration as an important part of the recovery process (Milbrodt, 2002; Spicer, 2001), as do treatment staff members who work with American Indian and Alaska Native clients (Moss et al., 2003). In evaluating the effect of enculturation (i.e., the strength of an individual's connection with his or her traditional culture), Stone et al. (2006) found that participation in traditional cultural activities and involvement in traditional spirituality had significantly positive effects on alcohol cessation, but a third variable—strength of cultural identity—did not have a significant effect.

However, this does not mean necessarily that a stronger connection to native culture will result in improved SUD treatment outcomes. Venner and Feldstein (2006), in their study of 44 American Indians in recovery, did not find any significant differences in the recovery efforts or activities between those who were more acculturated to mainstream American culture and those who were more closely connected to their traditional cultures. Their research included participants from a variety of tribes, and other research reviewed in their article has indicated that there may be considerable intertribal differences in drinking patterns and the process of recovery, so cultural affiliation may play a greater role in some tribes than in others.

Another assessment of 77 American Indian and Alaska Native clients attending an urban SUD treatment program used primarily by American Indians and Alaska Natives in a Northern Plains urban area found no significant correlations between the level of client cultural engagement and substance use patterns or age of first use (Kropp et al., 2013).

Brady (1995) cautioned that people looking at this issue need to consider that culture is not a stagnant force and that in some American Indian and Alaska Native communities, alcohol or other substance use may have a central role in the current iteration of the local culture. She referred to Beauvais and LaBoueff (1985), who noted that, on some reservations, the misuse of alcohol "has come to be a valid expression of 'Indianness'" (p. 158).

Westermeyer and Neider (1986) found in their research with 45 American Indians in Minnesota that, at a 10-year posttreatment follow-up, clients who had attained abstinence had either no change in their level of cultural affiliation or a small shift away from affiliation (determined by changes in cultural affiliation scale scores) with their traditional

culture and community. Those clients who had worse outcomes had typically gained a stronger affiliation with their American Indian community. In their study, American Indians with AUDs were more successful in recovery if, at least for the first 1 or 2 years of abstinence, they affiliated less with the Indian community. However, after that period, increased affiliation was not related to worse outcomes. At the same time, all the individuals in their study who attained a period of abstinence increased the number of social contacts and activities with which they were involved. What may be an issue here is that individuals who had AUDs had to cut off contacts with the "people, places, and things" involved in their drinking, even if that meant separating themselves from their traditional communities to maintain recovery in the first 2 years following treatment. This research highlights the need for community networks that support recovery on reservations.

Integrating cultural activities and traditional healing into a behavioral health service setting is a complicated process, and there are several potential problems that may be encountered. Some authors (e.g., Kunitz et al., 1994) cautioned against attempts to bureaucratize or codify pieces of what is, in fact, an entire culture, noting that taking a specific cultural or spiritual practice out of context (as may be done in some programs) may do a disservice to the culture, the clients, and the program. LaFromboise et al. (1990) warned about "missionary zeal" among treatment providers who are not part of the culture or community they serve, which is an attitude toward a culture's practices that is "characterized by the counselor's overinterest or obsession with the minority's culture and customs" (p. 633). Moss et al. (2003) noted that culture and traditions should not be viewed as tools for intervention, but rather that the treatment provider should allow the cultural strengths of the community to be expressed in treatment settings by those American Indian and Alaska Native cultural or spiritual leaders. However, Niven (2010) has suggested that simple methods of incorporating cultural practices, such as practicing American Indian and Alaska Native crafts while engaging in therapy, can have benefits of their own, as well as making standard treatment more welcoming.

Programs that serve American Indian and Alaska Native populations from multiple tribes may also find that clients from one tribe will not want to participate in the cultural practices or traditions of another (Moss et al., 2003). Other individuals may prefer not to participate for spiritual/religious reasons or because they have a different understanding of the role of the traditional or cultural practice. Finally, some participants who are highly acculturated to European culture may see engaging in traditional cultural practices as threatening to their acceptance of that culture. Providers need to be sensitive to such preferences, be willing to alter plans to use more culturally neutral practices, and talk with clients to assuage their concerns.

Although not all treatment programs can make use of traditional practices and not all clients will be interested in using them, all programs should be aware of the cultural and spiritual practices of the population they serve. Young (1986) reviewed earlier literature on this subject and concluded that the most successful programs for American Indians and Alaska Natives will be ones that include a spiritual component appropriate to the beliefs of clients, have a concern for clients' culture(s) and values, and build clients' self-esteem. According to Young (1986), such a program will ideally present these values as part of a treatment model that draws from Western and American Indian and Alaska Native healing practices. Other authors have concurred with this basic recommendation (e.g., Edwards, 2004).

Indigenous interventions for behavioral health

A variety of traditional healing practices may be used to address problems that would be labeled as substance use or mental disorders by mainstream health services. Practices that are intended to promote health in general may also help improve behavioral health specifically. As noted above, American Indian and Alaska Native cultures generally have a holistic attitude toward health and wellness and understand mental disorders and SUDs (as well as physical disorders) in relation to mental, physical, spiritual, and community health, so that a practice intended to promote

health may address behavioral health indirectly (Calabrese, 2008; Csordas, Storck, & Strauss, 2008; LaFromboise et al., 1990; Nebelkopf & King, 2003; Powless, 2009; Storck, Csordas, & Strauss, 2000). Traditional healing practices also focus on maintaining and restoring wellness, so that prevention and treatment are often considered together (Johnston, 2002). Also, some cultural practices (e.g., the sweat lodge) may facilitate communication or connections between clients or between clients and staff members and thus have a further therapeutic function (Walkingstick & Larry-Osborne, 1995).

Many American Indians and Alaska Natives use traditional healing practices (Beals, Novins, et al., 2005; Walls et al., 2006), and many will value and trust traditional healers to a greater extent than mainstream behavioral health or medical providers (Beals, Novins, et al., 2005; Marbella, Harris, Diehr, Ignace, & Ignace, 1998). However, traditional and mainstream behavioral health services need not be opposed; in the AI-SUPERPFP, individuals from the Southwest sample who used traditional healers were also more likely to use mainstream behavioral health services (Fortney et al., 2012).

It is difficult to evaluate the effectiveness of American Indian and Alaska Native cultural and spiritual practices, and research on their value is sparse. Mail and Shelton (2002) reviewed much of the earlier literature on the use of "indigenous therapeutic interventions" for AUDs and suggested that several of these interventions have been of value to some American Indians. Other authors have concurred with this view (Coyhis & White, 2002; Jilek, 1994; White, 2000a, 2000b).

Even less information is available on the use of traditional healing to address mental disorders, but some anecdotal studies have suggested that it can be effective. For example, Storck et al. (2000) described three case study participants with major depression who used traditional healing, resulting in improvements in their depressive symptoms.

Determining which cultural practices to integrate into treatment is sometimes difficult, as many American Indian and Alaska Native cultures do not have practices specifically designed to address mental disorders and SUDs. For example, Kunitz et al. (1994) found that among one Southwest tribe, there were no indigenous rituals or practices that were intended to address SUDs, and some clients resented attempts to use their rituals in that context. Another study involving Navajo healers found that although they did not perceive anxiety and depressive disorders in the same way as mainstream behavioral health service providers, they were able to address symptoms related to those disorders as part of a holistic treatment (Csordas et al., 2008). Similarly, Powless (2009) found that traditional Oneida healers did not perceive symptoms of depression as illness, but instead they were able to address depressive symptoms as stemming from problems of physical and mental imbalance. Manson et al. (1985) looked at Hopi conceptions of behavioral health-related illnesses and the degree to which symptoms of those illnesses overlap with symptoms of depression.

As might be expected, traditional healing or medical practices will vary from tribe to tribe. Unfortunately, literature on this subject is limited and, when it is available, tends to focus on the practices of some of the larger known tribes, such as the Navajo and Lakota Sioux (Johnston, 2002). Johnston (2002) reviewed some of the anthropological and other literature on American Indian and Alaska Native traditional medicine.

Different programs have found different ways of incorporating traditional practices for American Indians (French, 2000; Mail & Shelton, 2002) and Alaska Natives (Mills, 2004). Traditional practices can be added to standard services, or standard services may be adapted to include some aspect of traditional culture or healing practice (Legha & Novins, 2012), such as by using the framework of a traditional healing ceremony to deliver a mainstream treatment like CBT (Heilbron & Guttman, 2000). Traditional practices that have been enlisted in healing substance use and mental disorders include the peyote ritual, sacred dances (e.g., the Sun Dance of the Plains Indians, the Gourd Dance of the Kiowa), the Four Circles (a way of conceptualizing a harmonious life), the Talking Circle, sweat lodges, and chants or songs (Abbott, 1998; Bucko, 1998; Hartmann & Gone, 2012; Jilek, 1994; Legha & Novins, 2012; Mail & Shelton, 2002; White, 2000a, 2000b).

One of the most common American Indian and Alaska Native practices used in SUD treatment programs is the sweat lodge, which has been widely implemented in treatment programs serving American Indians and Alaska Natives in the United States and Canada (Bucko, 1998; Jilek, 1994; Schiff & Moore, 2006). Although there is little research evaluating the effectiveness of sweat lodges for reducing substance use, Schiff and Moore (2006) found that participation in sweat lodges was associated with improvements in self-reported emotional and physical well-being. Similarly, Bezdek and Spicer (2006) found that some American Indians who practice abstinence used sweat lodges as a way of coping with stress. Bucko (1998) provided an extensive discussion on the Lakota's use of the sweat lodge, including participants' accounts of its effectiveness for various purposes.

Drumming is a common practice in many American Indian and Alaska Native cultures and has been incorporated into an intervention to address SUD called Drum-Assisted Recovery Therapy for American Indians and Alaska Natives (Dickerson, Robichaud, Teruya, Nagaran, & Hser, 2012). Focus groups conducted with American Indian and Alaska Native SUD treatment clients, community members, and providers indicated that it was culturally appropriate and was well-received.

Spirit camps are a cultural practice being used by some Alaska Native communities to help address problems associated with providing SUD treatment in a community where substance misuse is common while still working on improving clients' connections to their traditional culture (Jilek, 1994; Segal et al., 1999). In these camps, based on traditional summer fishing camps, Alaska Native elders and traditional healers teach clients about their culture and guide them as they participate in traditional fishing camp activities (e.g., building log houses, processing fish). The camps have been used for adolescents and families, as well as for adults who are undergoing detoxification or are engaged in treatment.

Hartmann and Gone (2012) conducted interviews with 26 urban-dwelling American Indians to gather information about how they believed American Indian and Alaska Native practices should be integrated into mental disorder and SUD treatment. From these interviews, they derived four basic principles that were endorsed by the majority of respondents: (1) include ceremonies (although some were hesitant to endorse the use of ceremonies that had overtly "supernatural" content); (2) include an educational component to teach people about traditional practices; (3) involve tribal elders or traditional healers; and (4) address the need to maintain community integrity and ensure the safety of community members.

Edwards (2003) described the process of reconnecting American Indian and Alaska Native clients with traditional culture (i.e., "retraditionalization") at Friendship House, a SUD treatment program in San Francisco for American Indians and Alaska Natives. Activities such as classes on American Indian and Alaska Native beliefs and values, participation in talking circles and sweat lodges, and conversations with American Indian and Alaska Native staff members and visiting Medicine people are recognized by clients as building self-esteem, empowerment, and a spiritual identity.

Gone (2011) described a behavioral health program on a Canadian reserve where mainstream behavioral health services and First Nations cultural practices are integrated. The program also has a holistic approach that combines prevention, treatment, recovery support, and community support.

Wright et al. (2011) described another behavioral health program implemented in a major American city that integrated prevention, treatment, and recovery promotion using culturally appropriate methods (e.g., talking circles, smudging, sweat lodges, spiritual healers). This approach was manualized; the authors found that its use was associated with significant improvements in several behavioral health outcomes, including self-reported substance use, full-time employment, participation in a school or training program, substance-related stress, serious depression, serious anxiety, and hallucinations.

Traditional healers

Some American Indians and Alaska Natives will seek help with mental disorders and SUDs from traditional healers (Beals, Novins, et al., 2005; Herman-Stahl & Chong, 2002; May & Gossage,

2001; Robin et al., 1997a; Walls, et al., 2006). American Indians and Alaska Natives with mental disorders and SUDs may also seek help from a traditional healer for another concern, which they may not recognize as related to their behavioral health (Csordas et al., 2008). In either case, it behooves behavioral health service providers to be aware of the traditional healers in their area that American Indian and Alaska Native clients may use and, if possible, to develop linkages or informal connections with those healers (LaFromboise et al., 1990; Weibel-Orlando, 1987).

Weibel-Orlando (1987) found that every rural SUD treatment center she visited did have access to such individuals. She also noted that although many clients did not avail themselves of traditional healing services, there were two types of clients with whom these services were popular: (1) those who were older and relatively unacculturated and had used traditional healers all their lives and (2) younger, more acculturated individuals who had repeatedly tried conventional treatments without success.

In the Robin et al. (1997a) study of treatment-seeking among a Southwest American Indian tribe, 17 percent of respondents had visited a traditional healer, and more than half of those sought help for substance use or mental disorders. In May and Gossage's (2001) sample of 1,436 American Indians and Alaska Natives from four different tribes in the northern United States, 17 percent of men and 12.8 percent of women indicated that they preferred help from a traditional healer when dealing with a mental disorder issue. Herman-Stahl and Chong (2002) found that 27.4 percent of their sample of American Indians with substance-related problems from three different Arizona tribes had used traditional healers or healing practices to address those problems. In interviews with a general population sample of American Indians from the northern Midwest (N = 865 individuals who were parents), Walls et al. (2006) found that respondents were more likely to believe traditional services (e.g., traditional healers, prayer, sweat lodges) were effective for substance use and mental disorders than they were to accept the effectiveness of more formalized services delivered by professional practitioners.

The AI-SUPERPFP found that substantial numbers of American Indians sought help from traditional healers for mental disorders and SUDs, with a greater use of such healers among participants from the Southwest sample than from the Northern Plains sample (Beals, Novins, et al., 2005, Beals et al., 2006).

When trying to involve traditional healers to address SUDs, treatment providers should also consider including Christian clergy, as Christian traditions among American Indians and Alaska Natives date back in some places more than 300 years (Weibel-Orlando, 1987). Among some tribes, traditional Christian churches or adaptations of Christianity (most notably the American Indian and Alaska Native Church) may be the primary religious tradition concerned with helping tribe members overcome SUDs because traditional healers may not have practices specifically developed to address that problem (Kunitz et al., 1994). For example, among the Navajo, traditional healers are generally opposed to alcohol use but note that their practices extend back before alcohol was introduced, so that the two major religious groups addressing AUDs have been the American Indian and Alaska Native Church and Pentecostal Christianity (Garrity, 2000).

Although Alaska Native spirituality or religion does not have a role for the same type of dedicated healers found in many American Indian tribes, Alaska Natives in recovery have stated in focus groups that talking to tribal elders to learn about their spiritual and cultural heritage was an important facet of the recovery process for them (Hazel & Mohatt, 2001).

Some authors have sought to understand why spiritual practices, such as the use of traditional healers, are effective for some American Indian and Alaska Native clients. Csordas (2011) reviewed earlier literature that found analogies between traditional ritual healing practices and psychotherapy and which argued that the two use similar techniques and are effective for similar reasons. Thomason (2010) proposed that American Indian and Alaska Native healing methods alter participants' consciousness, which in turn produces a spiritual transformation that can have lasting effects

on physical and behavioral health. Canadian researchers who evaluated improvements in physical and behavioral health associated with the use of traditional American Indian and Alaska Native healers for a self-selected group of 155 non-native people found that individuals who experienced a "sudden and powerful" spiritual experience as a result of that healing were significantly more likely to have improvements in their physical or behavioral health, according to self-report (Mainguy, Valenti, & Mehl-Madrona, 2013). These researchers found that the majority of participants who were seeking help for mental disorders and SUDs (n = 36) reported that symptoms were better or cured 5 years after the treatment.

Native American Church

A special word needs to be said about the Native American Church and its use of the hallucinogenic drug peyote. Although such a practice may seem contraindicated given traditional, Western conceptions of addiction, there is a body of research (much of it anecdotal because funding for such research is unlikely) that supports the value of the peyote ceremony in developing long-term abstinence from alcohol and drugs. At the same time, the Supreme Court has ruled that a SUD treatment program can fire staff members who participate in the peyote ritual if they see it as a violation of their abstinence policy for employees (Long, 2000). Programs and providers need to consider a client's potential involvement in this practice in the context of their own program's agenda and the best interests of the client.

Traditional practices involving the use of substances among Native American groups are very different from the patterns of illicit drug use. Even though peyote was introduced to many Native Americans relatively recently, its use follows traditional patterns, and the Native American Church has rules that are aimed at preserving the idea that peyote is a sacred substance and preventing its misuse (Beauvais & LaBoueff, 1985). Research on illicit peyote use among American Indian adolescents in a SUD treatment program showed that misuse of the substance was a relatively rare phenomenon, even among those who used illicit drugs (Fickenscher, Novins, & Manson, 2006).

In the context of the Native American Church, peyote use is ritualized and intended to be therapeutic, and, in fact, is used to help cure problems such as alcohol dependence (Calabrese, 2008; Coyhis & White, 2006; Kunitz et al., 1994; Mail & Shelton, 2002). Calabrese (2008) discussed at length how the Native American Church practice of the peyote ritual fits Native American ideas of healing in ways that Eurocentric interventions to treat SUDs do not. He contrasted the spiritual, communal, preventive, integrated, and ecstatic qualities of the peyote ritual to the secular, individual, remedial, separated, and rational qualities of Western psychological and medical interventions.

When used in the context of religious ceremony (i.e., not misused), peyote has not been associated with any long-term negative psychological or cognitive effects (Halpern, Sherwood, Hudson, Yurgelun-Todd, & Pope, 2005). Although there is a lack of data from large-scale, double-blind studies on the value of peyote and other Native American Church rituals in helping people with AUD attain abstinence, smaller studies and observational data have suggested that it is an effective method for addressing AUD, at least in the context of the Church (Coyhis & White, 2006; Kunitz et al., 1994; Mail & Shelton, 2002).

Mutual Help

Social support is an important factor in promoting recovery from SUDs for Native Americans and may play a positive role in recovery from other mental disorders and SUDs as well. Mutual-help groups are sources of social support that can positively affect recovery (for a general discussion, see the forthcoming TIP *Relapse Prevention and Recovery Promotion* [SAMHSA, planned]). Some studies also have found that mutual-help group attendance improves outcomes for American Indians and Alaska Natives in recovery from SUDs (Chong & Lopez, 2008; Spear et al., 2013; Tonigan, Martinez-Papponi, Hagler, Greenfield, & Venner, 2013).

In their study of American Indians and Alaska Natives who received SUD treatment in Los Angeles between 2004 and 2008, Spear et al. (2013) found that a high level of social support, a composite measure that included involvement in

mutual-help groups, and having family and friends who supported recovery, was, compared with a lower level, associated with significantly better odds of abstinence (2.61 times greater odds in their adjusted model).

Tonigan et al. (2013) evaluated 12-Step group attendance and substance-related outcomes for 63 urban-dwelling, self-identified American Indians and 133 White Americans. They found that for American Indian participants, 12-Step group attendance at a prior time was significantly predictive of abstinence from alcohol and decreased alcohol consumption at later assessments, but it did not have a significant relationship to illicit drug use (these findings were also true for White Americans). In terms of continued 12-Step group participation, the authors found that American Indians were significantly less likely to stop attending 12-Step groups than were White Americans.

Anecdotal evidence indicates that 12-Step groups such as Alcoholics Anonymous (AA) have been useful adjuncts to treatment for many American Indian and Alaska Native peoples, in some cases after being adapted to better address the belief systems of American Indians and Alaska Natives in recovery (Coyhis & White, 2006; French, 2000; Mail & Shelton, 2002; Willie, 1989). Adaptations have included the development of 12-Step literature for American Indians and Alaska Natives, American Indian and Alaska Native versions of the 12 Steps, changes to the meeting format and rituals to reflect American Indian and Alaska Native concepts and beliefs, and the creation of the American Indian and Alaska Native General Service Board of Alcoholics Anonymous (Coyhis & White, 2006).

Some American Indians and Alaska Natives may find aspects of the 12-Step approach off-putting and therefore may be leery of using such groups (Prussing, 2008; Young, 1986). For example, in one study of American Indians from Arizona tribes who had possible SUDs, only 14.3 percent of those who reported some form of help-seeking for their substance-related problems reported attending 12-Step groups at some point; by comparison, 27.4 percent used American Indian and Alaska Native healers for help (Herman-Stahl & Chong, 2002). However, this comparatively low rate may reflect a tribal or regional bias, and participation in 12-Step groups is much more common in some other tribes (e.g., Jilek-Aall, 1981).

Beals et al. (2006), using AI-SUPERPFP data, found that 39 percent of American Indians in that study with a past-year SUD who had sought help for that disorder did so from a 12-Step program (24 percent sought help from 12-Step programs only, 3 percent sought help from traditional healers, 7 percent sought help from biomedical providers, and 7 percent sought help from all three sources). The investigators also observed that rates of attendance varied considerably between the two groups in that study, with 47 percent of past-year help seekers in the Northern Plains tribe but only 28.8 percent of those in the Southwest tribe attending 12-Step meetings. Those individuals who attended 12-Step meetings were significantly less likely to have had a drink in the prior year, and if they did drink, they were significantly less likely to drink to intoxication, compared with those who sought help from other sources (i.e., traditional healers and mainstream biomedical providers, including behavioral health programs). Study participants were more likely to use 12-Step programs if they had more formal education, were more acculturated to White American culture, and described spirituality as more important to their lives.

Research with Alaska Natives in recovery found that 12-Step group participation was more common than participation in a formal SUD treatment program, but many individuals who were in recovery participated in neither (Mohatt et al., 2008). Hesselbrock, Hesselbrock, and Segal (2003) compared an inpatient SUD treatment sample of Alaska Natives with alcohol dependence (N = 650) with participants from other racial/ethnic groups who were alcohol dependent and participated in the Collaborative Study on the Genetics of Alcoholism (COGA). The researchers found that the Alaska Natives were somewhat less likely than members of other groups to have previously attended mutual-help groups: 77 percent of Alaska Native men and 73 percent of Alaska Native women had done so compared with the COGA sample, where 90 percent of White American men and 92 percent of White American women and 86 percent of African American men and women attended such groups.

Members of some American Indian and Alaska Native communities may be reluctant to attend 12-Step meetings because they do not feel that the structure and content are compatible with their culture (Jilek-Aall, 1981; Prussing, 2008) or because they are particularly concerned with confidentiality given the size of their community (Bezdek & Spicer, 2006). The most significant barrier to 12-Step group involvement for many American Indians and Alaska Natives is perhaps the importance of self-disclosure and confession in those programs, which runs counter to the beliefs of many American Indian and Alaska Native cultures. One exception is found among the Salish Indians, who have a tradition of public confessional speeches as a form of healing and have adapted well to the use of AA (Jilek-Aall, 1981; Young, 1986). This, again, makes clear the need to consider individual tribal and cultural differences wherever possible.

In some areas, there may be no core group of people already in recovery who are willing or able to start a mutual-help group. Niven (2007) suggested how, in remote Alaska Native communities, village-based providers or behavioral health aides who may provide services to multiple communities can start a mutual-help group and then turn leadership over to one or more group members. Another option in these areas are telephonic meetings, in which villagers call a toll-free conference call number at a set time. Online meetings are also available (see TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* [SAMHSA, 2015]).

Indigenous mutual-help movements, most notably the Wellbriety Movement, are widespread among American Indian and Alaska Native peoples. The Wellbriety Movement incorporates American Indian and Alaska Native cultural practices and spiritual beliefs into a mutual-help framework (Coyhis & White, 2006; White Bison, 2002). Wellbriety is a mutual-help movement that uses principles of traditional American Indian and Alaska Native cultures and of 12-Step groups to foster a model of recovery that goes beyond simple abstinence and also beyond the individual to improve American Indian and Alaska Native communities. It revises the 12 Steps to be more relevant to American Indian and Alaska Native people and conceives of the steps as a circle rather than a ladder (White Bison, 2002). In addition to book publications, White Bison, the organization that promotes the Wellbriety Movement, publishes a newsletter that is available on its website.

Relapse Prevention and Recovery Promotion

Relapse prevention and recovery promotion are extremely important behavioral health services, but there has been little research evaluating specific interventions in this area for American Indians and Alaska Natives, and what has been conducted focuses entirely on SUD treatment. (See the planned TIP, *Relapse Prevention and Recovery Promotion in Behavioral Health Services* [SAMHSA, planned].)

Some studies found a relatively low rate of long-term recovery for some populations of American Indians and Alaska Natives with AUDs. For example, for 10 years, Westermeyer and Peake (1983) followed 45 American Indians and Alaska Natives who were hospitalized for alcohol-related problems. They found that at the 10-year follow-up assessment, 7 participants (15.6 percent) had been abstinent for 2 or more years, 7 had problems with binge drinking and lives that were not substantially different from at the beginning of the study (i.e., had episodes of SUD treatment, employment problems, symptoms of AUDs), 19 were doing worse in terms of their drinking (i.e., increased mental or physical problems; increased social or family problems; less employment), 9 had died, and 3 were missing. As this was a hospitalized sample, it is expected that this sample would have severe alcohol problems to begin with, and the authors observed that those participants who were able to achieve at least 2 years of abstinence were ones who had more stable employment or marriages, stronger interpersonal relationships, and lower levels of depressive symptoms.

However, in NESARC, American Indians and Alaska Natives who had met criteria for one of four substance dependence disorders (i.e., alcohol, cannabis, cocaine, nicotine) at some point during their lives were about as likely as others in that situation to have attained remission from alcohol or cocaine dependence, but less likely to have

attained remission from cannabis or nicotine dependence (Lopez-Quintero, Hasin, et al., 2011). Compared with White Americans who met the same criteria, American Indians and Alaska Natives were slightly more likely (1.05 times) to attain remission from alcohol dependence and equally likely to attain remission from cocaine dependence, but they were 0.69 times as likely to attain remission from nicotine dependence and 0.64 times as likely to attain remission from cannabis dependence.

Social support has been identified as protective against SUD and some mental disorders for American Indians and Alaska Natives, and social strain has been identified as a factor that increases risk for mental disorders and SUDs in American Indians and Alaska Natives. Studies also have found that increasing social support and avoiding social strain are extremely important for recovery from SUDs for American Indians and Alaska Natives (Bezdek & Spicer, 2006; Chong & Lopez, 2008; Mohatt et al., 2008; Spear et al., 2013). The majority of these studies concern people in recovery from AUDs, but social support has also been identified as an important part of recovery from other SUDs for American Indians and Alaska Natives, including volatile substance misuse (Bone, Dell, Koskie, Kushniruk, & Shorting, 2011) and methamphetamine use disorder (Brown, 2010).

The role of co-occurring medical conditions in motivating American Indian and Alaska Native clients to enter SUD treatment appears to vary by tribe and community. For example, Quintero (2000) and Kunitz et al. (1994) found that ill health was often cited as a reason to stop drinking, at least among some groups. Stone et al. (2006) reported on a lagged sequential study involving a group of 980 American Indians and Alaska Natives from one of four upper Midwest American Indian reservations or five Canadian First Nation reservations who had consumed at least 12 drinks in 1 year at some point during their lives. They found that higher ratings of self-reported overall physical health correlated with a greater likelihood of having quit drinking.

Religion and spirituality may be powerful aids to or motivators for recovery from SUDs for American Indians and Alaska Natives, especially those living in more traditional communities. In Kunitz et al.'s (1994) research (described under "Aging-Out Patterns"), all of the men living in the Navajo Plateau group (i.e., the group that lived in the most traditional Navajo community) who attained abstinence said they stopped primarily for spiritual reasons. In 83 percent of the cases, this was because of membership in the American Indian and Alaska Native Church. However, none of the men who stopped drinking in the groups who lived in the border town of South Tuba, AZ, or in the large urban center of Flagstaff, AZ, cited religion or spiritual beliefs as their motivation for stopping drinking. In both groups, health problems were the reason most frequently given. In this study, reasons given for lessening alcohol consumption and stopping problem drinking were somewhat different. Treatment was cited as a reason to stop problem drinking but not to abstain entirely from alcohol use, and health problems were never given as a reason to stop problem drinking but only as a reason for abstaining entirely. Making the decision to stop was given as a reason to stop problem drinking but not to abstain entirely.

Gilder, Lau, Corey, and Ehlers (2008) assessed a nonclinical sample of 580 American Indians and Alaska Natives from eight contiguous reservations in California using the SSAGA and found that 254 met criteria for a lifetime diagnosis of alcohol dependence. However, in 59 percent of those cases, the alcohol dependence was in remission at the time of the assessment. In a multivariate model, being in remission from alcohol dependence was significantly associated with being older, being female, being married, having an earlier age of onset for alcohol dependence, reporting more symptoms of depression in relation to drinking, and not reporting or reporting few symptoms of anxiety in relation to drinking.

Chong and Lopez (2008) reported on factors associated with relapse and recovery for a group of American Indian and Alaska Native women who completed a 45-day residential treatment program and were re-interviewed 6 months (n = 186) and 12 months (n = 167) later. They found that these women were significantly less likely to relapse to alcohol use if they were older, experienced more positive life events in recovery, had fewer

interpersonal conflicts, had less craving for alcohol, spent less time around people who used substances, attended mutual-help meetings, had a father who warned the client about problems resulting from alcohol use, had better family relations, perceived their physical health as being good, or had greater abstinence-related self-efficacy. They were significantly less likely to relapse to drug use if they were older, had fewer conflicts with family, spent less time around people who used substances, had less drug craving, or had greater abstinence-related self-efficacy.

Spear et al. (2013) used administrative data to evaluate factors associated with abstinence from alcohol and drugs (according to self-report) at the time of discharge from SUD treatment programs for 811 American Indians and Alaska Natives who were treated in Los Angeles between 2004 and 2008. They found that the best predictors of abstinence were having recovery-oriented social support and not living in a situation where someone else was using substances or where there was family conflict.

Researchers from the People Awakening Project interviewed a convenience sample of 58 Alaska Natives in recovery from AUDs (who had at least 5 years of abstinence, with a mean of 14.1 years) and 43 who had never had problems related to drinking to determine the protective factors that help prevent the development of AUDs as well as factors that promote recovery (Mohatt et al., 2008; University of Alaska Fairbanks, 2004). Participants included members of all five Alaska Native groups, as well as some who would identify as bicultural. These researchers found a similar pattern leading to eventual recovery for respondents who had attained recovery after a history of alcohol-related problems, which began with a cognitive re-appraisal of their drinking, typically followed by multiple attempts to stop, and then a significant and painful event that provided a turning point that led to sustained recovery. Often, this turning point involved a recognition that the individual was failing in his or her responsibilities as a father, mother, or grandparent. It also often involved recognizing that some significant trauma of the past was being exacerbated by the individual's drinking. For a smaller number, rather than a painful event, the turning point was a profound spiritual experience. Among the 58 participants who were in recovery, 21 had not had any formal treatment or mutual-help participation, 19 used mutual-help (usually AA) alone, and 17 had participated in mutual-help groups and SUD treatment (Mohatt et al., 2008).

In a study of American Indian men described under "Motivation for Treatment and Access to Care," Quintero (2000) found that participants who had AUD in remission (n = 48) most commonly cited their reasons for becoming abstinent as the need to be responsible for their children, the effects drinking had on their health, and the importance of sobriety to their spiritual beliefs.

In the AI-SUPERPFP, participants who reported currently abstaining but were drinking in the past or who were drinking less than they had in the past were asked what factors helped them to cut down or stop drinking (Bezdek et al., 2004). The factors most often cited as helping individuals to stop or cut down were:

- Being responsible for caring for children (cited by 30.1 percent of women and 9.5 percent of men).
- Deciding to stop because they no longer wanted to drink or because of knowledge gained about alcohol and its effects on themselves or others (cited by 14.1 percent of women and 16.4 percent of men).
- Experiencing positive changes in relations with friends or family other than children or intimate partners, such as gaining support from parents (cited by 10.7 percent of women and 12.1 percent of men).
- Changing one's environment—for example, through a change in work or leaving school (cited by 7.3 percent of women and 8.3 percent of men).
- Having a physical or emotional health problem (cited by 6.0 percent of women and 6.3 percent of men).
- Feeling a need to do so because of religious or spiritual beliefs (cited by 3.8 percent of women and 7.2 percent of men).
- Experiencing positive changes in relations with intimate partners or marriage partners (cited by 3.0 percent of women and 7.5 percent of men).

Bezdek and Spicer (2006) conducted interviews with 133 American Indians from a Northern Plains tribe who had been identified in a previous study as having met criteria for alcohol dependence at some point during their lives. Among those who were abstinent for a year or more (*n* = 35), religion or spirituality was a significant factor for 17 of them. Other motivations cited for abstinence included having a family or children and discovering new activities that helped overcome boredom and loneliness. Although these were the most often cited reasons for being able to maintain abstinence, the authors noted that what emerged from interviews was that these individuals were able to develop several different ways of coping with problems without using alcohol, which then led them to a new sense of possibilities and choices in their lives. Bezdek and Spicer (2006) found that the two tasks that appeared most essential for maintaining abstinence were (1) being able to respond to former drinking associates who did not support their abstinence and (2) finding new ways to deal with boredom and feelings they had avoided through their drinking. Individuals who were able to surmount these obstacles generally built a new social support system and, through that process, developed new strategies to cope with feelings and problems.

Similarly, research from the People Awakening Project conducted with Alaska Natives found that several active coping responses were important for recovery, including (1) distancing oneself from friends or family who drank heavily, (2) becoming more involved in church, (3) doing community service, and (4) praying. At a certain point, all respondents began to recognize that they were no longer fighting relapse, but rather, they were living their lives as they "were meant to" (Mohatt et al., 2008; University of Alaska Fairbanks, 2004). Although Alaska Native spirituality or religion does not have the same role for dedicated healers, focus group discussions with Alaska Natives in recovery have identified talking to tribal elders to learn about spiritual and cultural heritage as an important facet of the recovery process (Hazel & Mohatt, 2001).

In Venner and Feldstein's (2006) research, respondents who had achieved a significant period of recovery reported using a wide variety of strategies to attain abstinence or begin recovery:

- 100 percent of the respondents said that before entering recovery, they realized that their drinking was hurting others and decided to stop drinking.
- 96 percent prayed about their drinking.
- 96 percent realized that their drinking was hurting themselves.
- 89 percent avoided situations in which drinking occurred.
- 86 percent quit for a few days at a time before resuming drinking.
- 84 percent went to 12-Step meetings.
- 84 percent talked to a professional about their drinking.
- 82 percent focused on keeping busy with nondrinking activities.
- 77 percent admitted defeat.
- 75 percent tried to cut down their drinking.
- 71 percent made it a point to avoid heavy drinkers.
- 68 percent read about AUDs.
- 66 percent promised others that they would change their drinking behaviors.
- 50 percent had undergone residential SUD treatment.
- 46 percent participated in sweat lodges or similar traditional interventions.

Little information is available on use of specific relapse prevention and recovery promotion interventions with American Indians and Alaska Natives. Mindfulness-based approaches have been recommended for American Indian and Alaska Native clients (e.g., see Mohatt et al., 2008). Witkiewitz, Greenfield, and Bowen (2013) evaluated a mindfulness-based relapse prevention intervention for SUDs with a group of 105 women (13 percent of whom were American Indian and Alaska Native). Although they did not report outcomes specifically for American Indian and Alaska Native women in the study, they did find that that non-White women had significantly fewer days of drug use and significantly less severe addiction severity (according to ASI scores) during the follow-up period if they received mindfulness-based relapse prevention rather than standard relapse prevention.

Skinstad (2013) observed that the recovery-oriented systems of care model (see Whitter, Hillman, & Powers, 2010) is well-suited for American Indians and Alaska Natives and has elements that are in line with American Indian and Alaska Native beliefs (e.g., the community focus, the holistic approach to recovery); that model has also been successfully implemented on several reservations.

White and Sanders (2006) described a similar model of recovery support, which they called recovery management, which was developed for historically disempowered people (including American Indians and Alaska Natives). This model prioritizes creating a space in the community where recovery is promoted and people in recovery are supported. The model, which recognizes the healing potential of the community, works to start up or expand local community resources for recovery, educate communities about recovery, and introduce clients and their families to those resources, among other related activities. This model also makes room for incorporating traditional healers and cultural practices to support recovery.

Systems Issues

Providers working with American Indian and Alaska Native client populations will face challenges in implementing effective behavioral health programs that can meet the needs of this population. Some of these challenges will result from structural problems, such as the remoteness of many American Indian and Alaska Native communities. In small, remote communities, a provider may face several issues, such as problems with maintaining confidentiality, difficulties in limiting relationships with clients to a professional capacity, expectations that one will fulfill multiple roles in the community, and a lack of access to supervision or support from other professionals (Roberts, Battaglia, & Epstein, 1999; University of Alaska Fairbanks, 2002). Some other systems-related concerns such as sovereignty issues, staff training, community relations, and the use of computer and telephone technologies are also discussed below.

Program Management and Sovereignty Issues

Significant jurisdictional and sovereignty issues are involved in delivering SUD treatment services to American Indians and Alaska Natives—particularly on reservations—that do not apply in other situations (Henson et al., 2008). On American Indian reservations, state civil laws and regulations may not apply, and programs will need instead to follow the regulations and civil law of the local tribe. These regulations may affect a whole host of issues relevant to program management, from taxation to legal recourse and liability.

Because tribal governments may directly manage health care (including behavioral health services), either with or without IHS funds, those governmental entities may also take an active role in program management. Changes in tribal government can result in changes in program priorities, allocation of resources, treatment staff members, and program goals (Moss et al., 2003).

Community Involvement

Communities have an important role in improving the nation's ability to provide behavioral health services (Hoge et al., 2007), but their role may be even more critical for American Indian and Alaska Native communities, where healing is expected to take place in the community and not just as an individual enterprise (Giordano et al., 2009; Hartmann & Gone, 2012; Jiwa, Kelly, & St. Pierre-Hansen, 2008).

One of the most common critiques of standard behavioral health services in Hartmann and Gone's (2012) interviews with American Indians and Alaska Natives (see description under "Using Traditional Practices in Mental and Substance Use Disorder Treatment") was that Western medical and behavioral health services focused too much on the individual at the expense of addressing the community's needs. American Indian and Alaska Native cultures have a more communal orientation than European cultures and typically perceive illness and healing in a communal context (Calabrese, 2008; LaFromboise et al., 1990).

In many American Indian and Alaska Native cultures, problems such as SUDs or depression are believed to have communal effects and social causes, rather than just individual ones, and thus appropriate treatment is expected to heal the community as well as the individual (Jiwa et al., 2008; Powless, 2009). Duran and Duran (1995), among others, have argued that American Indian and Alaska Native perspectives on behavioral health should address communities, not just individuals. The importance of interventions that help heal the community as well as the individual is also recognized by American Indians and Alaska Natives with mental disorders and SUDs (Milbrodt, 2002) and by behavioral health service providers who work with this population (Hartmann & Gone, 2012).

SUDs, in particular, often have been addressed at a community level by providers working in American Indian and Alaska Native communities. Jiwa et al. (2008) reviewed 32 years of research regarding community-wide substance misuse/use disorder prevention and treatment. They discussed several different models for providing such services, including community mobile treatment programs that have had some success in Canada, the use of alcohol and drug control policies, and the use of partnerships and integrated prevention and treatment programs. From their review of these studies, these authors identified four important aspects of successful community interventions: (1) strong leadership, (2) strong community engagement in the effort, (3) paid positions for programming and organizing the intervention, and (4) commitment of resources to develop infrastructure and promote long-term sustainability.

SUDs in culturally and geographically isolated communities that are also facing poverty and a loss of traditional culture can take the form of an epidemic and therefore may require an intervention at the community level to be successfully treated (Abbott, 1998; LaFromboise et al., 1990). Without an intervention at this level, trying to provide treatment services "in a culturally, socially, and spiritually 'broken' community may be a hopeless task" (Abbott, 1998, p. 2632).

Some authors have argued that the most effective SUD treatment interventions are ones that seek to shift the attitudes and accepted behaviors of the entire community (Beauvais & LaBoueff, 1985; Thatcher, 2004). Everett (1980) observed that among the White Mountain Apache, treatment programs that followed a typical American model and focused on promoting individual change without also considering the individual's involvement in his or her community appeared to meet with failure. The primary goal of SUD interventions that are aimed at the entire community is, according to Beauvais and LaBoueff (1985), "to create an observable ethic which encompasses the community's stance on drug and alcohol use … [and] make(s) clear what the acceptable options are for the individual in the community" (p. 159).

One of the best-known cases of an intervention that successfully changed substance use/misuse patterns in an American Indian or Alaska Native community is that of Alkali Lake in British Columbia, Canada. This small, rural Shuswap Indian community (population of about 400) achieved a 95-percent rate of recovery from AUDs through a community-wide approach that made use of 12-Step groups, changes in alcohol policy and enforcement, and a reconnection with traditional customs and practices (Ben, Dereshiwsky, & Lansing, 1992; Mail & Shelton, 2002; Willie, 1989).

Wiebe and Huebert (1996) described the use of mobile SUD treatment teams in Canada who are able to provide services to American Indian and Alaska Native communities that may be isolated from other service providers. These teams mobilize communities to address SUDs and provide an intensive SUD treatment program for clients and their families. They observed that implementing this type of community mobilization is a long-term process and can take up to 2 years to develop appropriate interventions for the community, but the authors reported that it has been highly successful in several American Indian and Alaska Native communities.

Although less information is available on community-wide interventions to address mental disorders, suicide prevention programs in American Indian and Alaska Native communities have tried to mobilize the community to assist in prevention activities (HHS, 2010).

Freeman, Iron Cloud-Two Dogs, Novins, and LeMaster (2004) described the planning and development of the Circles of Care initiative, which was designed to address the behavioral health of youth in American Indian and Alaska Native communities using a systems of care approach. Even though it is concerned specifically with youth, the program assessment and planning activities may be adaptable to programs that are intended to provide services to adults.

Beauvais and LaBoueff (1985) outlined a standard pattern of development for effective SUD interventions with American Indian communities. To be effective, community-based interventions must stem from the will of the community, not from an outside influence. Community members must believe the values being promoted are the values of at least the majority of community members, even if the majority has failed to follow those values. Community interventions typically do not begin with a community-wide movement, but rather, with one or a few concerned individuals who take the initiative to create awareness of the issue and its extent in the community. From there, a core group is developed that may collect data on the problem, further define it, increase awareness, and perhaps produce some report that can be used to leverage assistance. At this point, it is common to develop an actual taskforce that can expand support from the community, contact service providers and appropriate agencies for assistance, raise funds, and work on leveraging community support for the initiative.

Duran, Wallerstein, and Miller (2007) provided another model for understanding how to address problems using a community-wide approach. Their model included five different aspects of change efforts (i.e., problem identification, assumptions and information from research literature, project objectives, program strategies, and anticipated outcomes) that operate at four different levels (i.e., individual, peer, school or other smaller institution, community). The authors also discussed how to operationalize an intervention developed in another context for American Indian and Alaska Native communities by looking at how different components of the theory or intervention may be interpreted by members of the community.

The article also discussed evaluation issues in community-wide interventions for American Indians and Alaska Natives.

Edwards and Egbert-Edwards (1998) provided some further ideas on community development among American Indians and Alaska Natives, again stressing the importance of community approaches for this population. The authors outlined a number of process and outcome goals for those doing community development work, which broadly fall under the tasks of (1) identify community problems and resources; (2) include everyone; and (3) emphasize cultural values, beliefs, and traditions.

Although it is focused on prevention efforts, the framework Jumper-Thurman et al. (2001) provide for assessing community readiness to address substance use, substance misuse, and SUD issues will also be helpful for those who are developing community-oriented treatment models.

Noe, Fleming, and Manson (2004) analyzed the results of community-based intervention developed as part of the Robert Wood Johnson Foundation's Healthy Nations initiative (see the section titled "Behavioral Health Programs' Involvement in Community Activities"). The researchers proposed a hierarchy of results to evaluate such efforts that move from a basic "generating interest" through engagement of key people in the community, which enhances the capacity of individuals and groups in the community to address SUDs and produces specific behavioral changes in the community (which they called outcomes) to the greatest level of results involving changes in social indicators of problems resulting from SUDs (which they call impacts). Using this model of evaluation, they discussed the variety of beneficial outcomes resulting from the Healthy Nations initiative that fell short of the level of creating an impact on the community but still resulted in some degree of improvement.

Providers interested in developing and sustaining a community-based program to address substance misuse among American Indians and Alaska Natives may also benefit from the information provided in CSAT's (2008b) *Sustaining Grassroots Community-Based Programs: A Toolkit for Community- and Faith-Based Service Providers*,

which, although not aimed specifically at American Indian and Alaska Native programs, addressed topics such as organization assessment and readiness, effective marketing, financial management, fund raising, and evaluation.

Publications concerning how to involve American Indian and Alaska Native communities in research activities may also provide some ideas for involving those communities in treatment. Several authors described the work of researchers who undertook "tribal participatory research" that involves American Indian and Alaska Native communities in planning and carrying out research activities (Davis & Reid, 1999; Fisher & Ball, 2003; Loppie, 2007; Thomas, Donovan, & Sigo, 2010).

Another useful tool for programs wishing to address sustainability is the *Sustainability Strategic Planning Template* within the American Indian/Alaska Native Sustainability Self-Assessment Tool produced by the Center for Mental Health Services (2003), which is available online at the Technical Assistance Partnership for Child and Family Mental Health website. This template can help programs consider key indicators for program success and strategies to reach those goals. It also lists the personnel needed to accomplish the task and outlines areas where programs can affect positive change.

Engaging American Indian and Alaska Native communities in urban areas

Involving communities in treatment and recovery in urban areas poses particular problems for American Indian and Alaska Native clients. In many cities, the American Indian and Alaska Native community encompasses multiple tribes and is often geographically dispersed, rather than concentrated in a single part of the city or surrounding area (Lobo, 2003). That said, it is still possible to develop a holistic, community-oriented approach to treatment in such an environment. Nebelkopf and King (2003) give an example of this process, which was done for a program that addressed mental illness, SUDs, HIV/AIDS, and other social service needs for American Indians and Alaska Natives living in the San Francisco area.

Urban American Indian community centers also play an important role in the lives of many American Indians and Alaska Natives living in urban areas, and a number of these centers provide health services in addition to cultural activities, educational programs, and employment assistance (Henson et al., 2008).

Other possibilities for organizing American Indian and Alaska Native communities in urban areas include working with elders and community activists, such as the women that Lobo (2003) labeled as "urban clan mothers." These women, who play a part in many cities that have large American Indian and Alaska Native populations, are well-respected older women who typically own their own homes and often are involved in American Indian and Alaska Native community service organizations. Such women's homes become unofficial gathering places for what is otherwise an often transient and mobile population.

Behavioral health programs' involvement in community activities

Behavioral health programs treating American Indian and Alaska Native clients should be aware that involving the community in treatment may also require that the program become more involved in the community and, as a result, programs may need to provide a broader range of services to assist clients as well as their families and communities. On reservations and in other rural American Indian and Alaska Native communities, behavioral health programs may be expected to provide services for clients and their families that include transportation for clients and visitors, childcare for women in treatment, community education and prevention services, assistance with obtaining emergency aid for families who have members in treatment, and employment opportunities for community members (Mail & Shelton, 2002).

A program's involvement in the community may extend beyond what is normally considered treatment practice into things such as prevention, law and policy issues, or the provision of community recreational and cultural activities (Sage, 2001; Trimble & Beauvais, 2001). Because of the importance of cultural affiliation for mental disorder and SUD treatment outcomes, community-based cultural activities for American Indians and Alaska Natives need to be considered

as potentially "enhancing health and reducing social and behavioral problems" (Westermeyer & Neider, 1986, p. 187).

A publication from the Office of Justice Programs (Melton et al., 2000) on promising programs to reduce substance misuse and SUDs among American Indians and Alaska Natives described a number of legal measures tribes have taken to address substance misuse in their communities, including the creation of drug courts, initiatives to limit or tax alcohol sales, highway safety programs, other public education programs, and prevention activities. The Navajo Nation has had success using Peacemaker's Courts for cases involving substance misuse and domestic violence (among other things); these courts use traditional methods of adjudication and focus on reconciliation and compromise, rather than on punishment (French, 2000). Tribal Healing to Wellness Courts are another similar criminal justice intervention and have been described in detail in a series of publications and conference or training reports from the Tribal Law and Policy Institute (available on its website). The paper titled *Healing to Wellness Courts: A Preliminary Overview of Tribal Drug Courts* (Tribal Law & Policy Institute, 1999) introduces the topic, with other papers going into more detail about treatment guidelines, program development, operations, and other topics.

More than 60 percent of federally recognized American Indian reservations have policies prohibiting the sale or distribution of alcohol (Kovas, McFarland, Landen, Lopez, & May, 2008). Kovas et al. (2008) surveyed American Indian alcohol control laws and discussed how they have changed from 1975 to 2006. In considering changes to alcohol policy, tribal governments should be aware that legalization of alcohol after a period of prohibition has been followed by lower crime rates and lower alcohol-related mortality on some reservations in the continental United States (Melton et al., 2000). At the same time, new prohibition policies in Alaska Native communities have been associated with reductions in levels of injury, violence, and crime (Berman, Hull, & May, 2000; Wood & Gruenewald, 2006). Therefore, decisions to change alcohol policy need to be studied carefully to evaluate potential positive and negative effects.

Reservations that do have policies prohibiting alcohol sales often still have high rates of alcohol abuse disorder and alcohol dependence disorder, and some have cautioned that tight restrictions on alcohol may lead to increased use of other substances such as inhalants (May, 1992).

May (1992) discussed a range of measures that can be implemented by tribal governments to limit consumption of alcohol, which include complete prohibition of the sale of alcohol, limitations on advertising, stricter enforcement of drunk driving laws, education programs, and taxation. He noted that a wide variety of measures can be implemented and that in some ways, trying to control the use of alcohol rather than prohibit its use may give tribal governments a greater number of options to address the problem.

Because of the existence of "border towns," American Indian and Alaska Native communities that seek to reduce alcohol use among their members may need to extend their influence beyond the borders of the reservation to nearby towns or even surrounding counties and states. Initiatives begun by rural American Indian and Alaska Native communities located on reservations in McKinley County, NM, and Fremont County, WY, have had a good deal of success in changing policy and attitudes in their respective counties and states (Ellis, 2003). In these counties, concerned American Indian community leaders (in both cases representing more than one tribe) used local and statewide media to educate and push for policy change, gathered data to influence policymakers and track progress, and lobbied against vested interests (e.g., the alcohol industry) to affect policy change. These efforts are described in more depth by Ellis (2003).

Telephone- and Computer-Based Services

Given that many American Indians and Alaska Natives live in rural or remote areas, telephone- and computer-based interventions (sometimes referred to in the literature as telemental services) may be a valuable addition to behavioral health services, and access to such services can bestow a number of benefits, such as treatment provided by speakers of American Indian and Alaska Native languages or the enabling of greater disclosure

to clinicians who are more physically distant from clients (see review in Gibson et al., 2011). The research on these types of interventions conducted with American Indians and Alaska Natives is limited and discussed below. However, studies with other samples indicate that interventions using telephones or computers can improve behavioral health and improve access for clients who may not otherwise receive treatment. That research is described in the literature review for TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (SAMHSA, 2015).

Canadian researchers interviewed 59 members of rural First Nations communities about the potential benefits of and problems with telemental services, particularly those using videoconferencing technology (Gibson et al., 2011). Respondents commonly noted that potential benefits of such technology were that it could improve access to services, reduce travel costs and time, and increase client comfort and willingness to disclose. Respondents' major concerns were that such interventions would remove the human contact that some saw as essential for behavioral health healing, could present problems with privacy or security, would increase safety concerns given that providers would not be on site, could limit capacity-building in the community if such interventions were adapted in place of onsite services, and could malfunction.

Shore et al. (2008) found that a PTSD intervention from the VA that used videoconferencing technology was ranked about as satisfactory as in-person patient–psychiatrist exchanges by a group of 53 American Indian and Alaska Native Vietnam veterans. Participants received both kinds of interventions and rated the interactions on a number of domains; although in-person therapy received somewhat higher ratings, the differences between ratings were not significant. Overall, a greater percentage of participants (45 percent) preferred live interactions to the video interactions (20 percent), with 34 percent expressing no preference. However, 94 percent of respondents stated they had a positive experience with the videoconferencing. The same group of researchers also found that psychiatric assessments for American Indian veterans can be conducted as accurately by using live, interactive videoconferencing as in person (Shore, Savin, Orton, Beals, & Manson, 2007). Shore, Kaufmann, et al. (2012) described these VA PTSD services in greater detail and also reviewed other studies that provide some insight into the use of telemental services by and benefits for American Indian and Alaska Native veterans.

Computerized behavioral health services may reach clients who would not otherwise receive treatment and, through that engagement, may improve use of other behavioral health services. In another evaluation of the VA's videoconferencing PTSD intervention, Shore, Brooks, et al. (2012) reviewed medical records for American Indians and Alaska Natives who received the intervention. They found that after beginning to receive these services, American Indian and Alaska Native veterans were significantly more likely to be receiving other VA health services (both behavioral and physical health services) and significantly more likely to be prescribed psychotropic medications.

Chong and Herman-Stahl (2003) reported some preliminary success with a telephone-based SUD continuing care program for American Indians living on reservations that provided graduated monthly contacts by phone for a 6-month period.

Niven (2007) noted that an Alaskan regional healthcare center had previously arranged for telephone-based mutual-help meetings for Alaska Natives in remote villages and suggested that such a model be implemented again. Several studies evaluating phone- or web-based prevention efforts are also described under "Mental Health Promotion and Substance Misuse/Use Disorder Prevention."

On some American Indian reservations, people may not have telephones in their homes or cell phones (Jervis et al., 2003), and broadband Internet access may be limited (Department of Commerce [DOC], National Telecommunications and Information Administration [NTIA], & Economics and Statistics Administration [ESA], 2016; HHS, Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy, 2006). In 2015, approximately 70.2 percent of American Indians and Alaska Natives had Internet access at some location (less than the percentage of White Americans or Asian Americans but more than that

of African Americans or Latinos), but only 59.9 percent access at home (the smallest percentage of any major racial/ethnic groups; DOC, NTIA, & ESA, 2016). An older study that surveyed 196 American Indians and Alaska Natives found that a higher percentage of respondents owned computers (i.e., 90 percent) and that 86.3 percent of respondents had accessed the Internet on the day prior to completing the survey (Morris & Meinrath, 2009). Data on American Indian and Alaska Natives' Internet access through smart phones appear to be unavailable, but some type of Internet access is seen with other racial groups and may indicate that American Indians and Alaska Natives also have access through smartphones (File, 2013). Behavioral health service providers will need to determine the reach and quality of phone and Internet access in the area (e.g., broadband service may be necessary for videoconferencing) to determine whether this type of intervention will be beneficial.

Vocational Training

American Indians and Alaska Natives have one of the lowest, and in some states the lowest, employment rates of any major ethnic/racial group in the United States. Research has also linked unemployment to mental disorders and SUDs for American Indians and Alaska Natives (Costello et al., 2003; Costello et al., 2010; Herman-Stahl et al., 2003). Thus, vocational training may be a key service in promoting recovery for many American Indians and Alaska Natives.

Tribes may be able to qualify for vocational rehabilitation funds and may also be able to work with state vocational rehabilitation programs to get assistance in developing a vocational program or using existing resources (Hitchen, 2001). The American Indian Vocational Rehabilitation Services program, administered by the Department of Education, also provides money for vocational rehabilitation services for American Indians and Alaska Natives with disabilities (Vocational Rehabilitation Service Projects for American Indians with Disabilities, 2010).

Hassin (1996) described a program in Oregon that was developed to link American Indian and Alaska Native clients from SUD treatment facilities to vocational rehabilitation services as part of an intensive continuing care approach. The program included educational workshops, regular mutual-support group sessions focused on coping with life problems in recovery, attendance at vocational rehabilitation group sessions, and opportunities for participants to train as new teachers for the intervention. Participants in the first round of the intervention had low relapse rates (only 18 percent relapsed in the 18 months following the intervention) and reported increases in self-esteem and self-empowerment following the intervention. Of the 14 individuals who completed the training (out of the initial 22), 3 were still receiving vocational rehabilitation, and 9 were employed full-time at follow up.

The American Indian Rehabilitation Research and Training Center has prepared a training manual to teach SUD treatment providers how to improve employment outcomes for American Indian and Alaska Native clients, which is available online (Schacht, Sargent, & Mitchell, 2003).

TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT, 2000a), contains more information on providing vocational training services within an SUD treatment setting.

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Part 3, Section 2: Links to Select Abstracts

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Purpose: To offer guidance on the use of cognitive–behavioral therapy (CBT) with Alaska Native clients.

Conclusions: CBT can be a very useful approach to therapy with Alaska Native clients, but should be applied with culturally specific knowledge.

Methodology: The author draws on her own clinical experience and selected background literature to make recommendations on how to use CBT with Alaska Native clients.

Summary of Results: The chapter begins with some cultural and historical background information about Alaska Natives. The author discusses cognitive–behavioral assessment as part of a comprehensive assessment for Alaska Native clients. She then elaborates on the pros and cons of using CBT with this population, noting that its strengths include a focus on problem solving, emphasis on empowerment and client strengths, and attention to the client's environment and its effects on thinking and mental health. The disadvantages of CBT with this population include an emphasis on logic and rationality (particularly as defined by the dominant culture), a lack of attention to spirituality, and the importance of verbal expression (which can hinder individuals whose first language is not English if therapy is conducted in English). The author discusses some basic principles for therapy with Alaska Natives and how they can be applied when using CBT—these include how to establish a relationship, how to clarify problems and strengths, and how to explain CBT. She then provides a case study and discusses how techniques involving problem solving and cognitive restructuring can be applied in such a case.

Henson, E. C., Taylor, J. B., Curtis, C., Cornell, S., Grant, K. W., Jorgensen, M., … Lee, A. J. (2008). *The state of the Native nations: Conditions under U.S. policies of self-determination: The Harvard Project on American Indian Economic Development.* New York, NY: Oxford University Press.

Purpose: To provide current information about the political, economic, social, and cultural realities of Native American nations.

Conclusions: The authors note improvements in many areas for Native Americans living on reservations, but because of the magnitude of the problems faced by native nations, those residents continue to have significantly greater problems in many domains (e.g., poverty, employment, housing, health care) than people in the country as a whole.

Methodology: The authors drew on a variety of political, social, and economic research conducted over the years by the Harvard Project on American Indian Economic Development (the leading national institute devoted to these issues). They also reviewed research from other sources on these topics. In addition to the work of Project members, the book contains essays from Native American community/tribal leaders on topics such as Native American sovereignty, self-determination, education, natural resources, health care, law, and art.

Summary of Results: The book presents a wide range of findings concerning the diverse group of tribal governments often characterized as "Indian Country." It provides historical background concerning the

reassertion of tribal sovereignty and self-determination, and the central importance they play in defining the lives of Native Americans today. Although the federal government has shifted its policy since the 1970s to accept greater tribal self-determination and sovereignty, the rights of tribal governments are still in dispute and federal courts continue to make rulings affecting those rights. Federal policies and economic problems have caused many Native American nations to lose territory or control over lands that belonged to them, but that process is being reversed and many native nations are expanding the land they own and their control over that land. Issues of economic development are also highlighted. Per capita income for Native American nations (both those with and without casino gaming) increased during the 1990s at a rate two to three times higher than in the United States as a whole (an increase of 30 percent for tribes that did not have gaming and 36 percent for those that did), but, as of 2000, the average individual income for people living on native lands was still half that of the United States as a whole. So, despite improvements having been made, there is still a great deal of poverty among Native American nations; Native Americans living on reservations had a poverty rate of nearly 40 percent in 1999 (among Native Americans living off reservations, the rate was 26 percent—about the same as African Americans and nearly three times as high as White Americans). Overall, native unemployment remains about four times as high as in the country as a whole. Native American nations are also increasing their control over natural resources, education, health care, family services, housing, and public safety. In some of these areas, there are still significant problems. In terms of health and health care, for example, Native Americans face a significantly greater burden from various problems, including diabetes, depression, and alcohol use disorders, than is seen among other major ethnic/racial groups, and the Indian Health Service (IHS) has been unable to sufficiently address these health disparities. Per capita spending for clients who receive IHS services remains at half of that received by federal prisoners or Medicaid recipients and one-third of that received by Medicare recipients. Thus, many native nations are taking over the administration of their healthcare systems from IHS and, as a result, are able to offer more flexible and culturally appropriate services. Although most of the book is concerned with American Indian nations, it concludes with chapters on Alaska Natives and Native Hawaiians.

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Kunitz, S. J., Levy, J. E., Andrews, T., DuPuy, C., Gabriel, K. R., & Russell, S. (1994). *Drinking careers: A twenty-five-year study of three Navajo populations*. New Haven, CT: Yale University Press.

Purpose: To evaluate patterns of alcohol use among Navajo people from different locales over a 25-year period.

Conclusions: Heavy drinking and binge drinking among Navajo men is related to cultural values involving the testing of individual strength, the show of group solidarity, and the importance of demonstrating economic standing. This behavior tends to diminish or cease as individuals grow older, especially among those leading a more traditional Navajo way of life.

Methodology: The authors conducted a 25-year longitudinal study of alcohol use among different groups of Navajo. In the original assessment, four groups were included: (1) a Plateau group of related adults who lived a traditional Navajo lifestyle (n = 46); (2) a randomly sampled group of adults living in the border town of South Tuba (n = 40); (3) a group of patients who had been referred to an Indian hospital in South Tuba for alcohol abuse (n = 35); and (4) a group of Navajo adults who had lived for 10 years or more in the city of Flagstaff, AZ (n = 48). The percentage of women in each sample varied, but slightly more women than men were included in the study overall. For this book, the authors focused on the 112 individuals from the first three groups who were alive in 1966, as follow-up was more difficult with the urban sample. Participants were interviewed in 1966 and regularly thereafter until 1990. Additional information on alcohol-related mortality (including motor vehicle

accidents, homicides, suicides, and alcoholic cirrhosis) among the Navajo was retrieved from the state, area counties, the Navajo Nation, and the United States Census.

Summary of Results: In the initial assessment in 1966 or 1967 (depending on the group), 37.5 percent of women in the Plateau group were lifelong abstainers (*n* = 9), 58.3 percent had stopped drinking (*n* = 14), and 4.2 percent were currently drinking (*n* = 1). Of men in the Plateau group, 5 percent (*n* = 1) were lifelong abstainers, 60 percent (*n* = 12) had stopped drinking, and 35 percent (*n* = 7) were currently drinking. Among women in the South Tuba group, 64.3 percent (*n* = 9) were abstainers, 28.6 percent (*n* = 4) had stopped drinking, and 7.1 percent (*n* = 1) were currently drinking. Of men in the South Tuba group, none were lifelong abstainers, 31.6 percent (*n* = 6) had stopped drinking, and 68.4 percent (*n* = 13) were currently drinking. All the individuals in the hospital group (30 men and 5 women) were currently in treatment for alcohol use disorders and were prescribed Antabuse, and thus were believed to be currently abstaining. At the time of the last follow-up assessment (or the time of death), 87 percent of men in the Plateau group and 53 percent of those in the South Tuba group were abstinent. In the hospital group, 33 percent of those who were residing in South Tuba and 75 percent of those who were living in rural areas were abstinent. For women, only one of those in the Plateau group and six of those in the South Tuba group were drinking at the last assessment or time of death. Overall, the authors note, these findings support the existence of an "aging out" pattern among the Navajo; they observe that this pattern is more common among those residing in rural areas (who are also leading a more traditional Navajo way of life) than those residing in urban communities. Men in the Plateau group were also significantly more likely to have only drunk socially (and not alone) than those in South Tuba. In both groups, drinking typically led to problems for men; 74 percent of social drinkers and 77 percent of those who, at least some of the time, drank alone reported that drinking caused them problems at some point during their lives. However, for women, being at least an occasional solitary drinker was associated with a significantly greater chance of believing one's drinking resulted in problems (all female solitary drinkers believed so, but only about one-third of social drinkers did). The majority of male participants who did drink began to do so as a result of peer pressure, whereas the majority of female participants did so at home with their families or when out with their husbands. The authors observe that there are cultural values that affect drinking and patterns of drinking, which may result in a greater likelihood of binge drinking. These include the importance of testing individual strength, showing of group solidarity, and demonstrating economic standing. The authors found significant differences relating to location and cultural orientation in the reasons participants stated for being able to obtain abstinence. The most common reason given by men in the Plateau group was that they stopped drinking for religious reasons and, in five instances, because of participation in the Native American Church. On the other hand, no men in the South Tuba or hospital groups said they stopped drinking for religious reasons. Men in those groups were most likely to state that they stopped drinking for health reasons (nine men in both of those groups stated this compared with one man in the Plateau group). Women gave similar reasons for stopping drinking, following the same pattern.

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Purpose: To compile and synthesize research and clinical information on the use of CBT with American Indian clients.

Conclusions: CBT is an appropriate treatment intervention for American Indian clients when used as part of an integrated treatment program that also addresses cultural orientation and provides culturally appropriate services.

Methodology: The authors compile and synthesize research and clinical literature as well as draw on their own clinical experience to provide information on CBT for American Indian clients.

Summary of Results: Despite differences, CBT and American Indian ideas about healing and health share some similarities, and, although research is lacking, many clinicians believe that it is an appropriate treatment for this population, especially when integrated with culturally relevant practices. The authors provide some introductory information on American Indian cultural identification/acculturation, American Indian mental health care, and American Indian belief systems and how they relate to Western concepts of mental health. They then give a case study of an American Indian man who has posttraumatic

stress disorder and a substance use disorder, explaining in detailed, session-by-session notes how he can be treated using CBT. The case study highlights how cultural orientation must be considered in decisions to use CBT.

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Purpose: To describe a substance abuse treatment initiative for Yup'ik and Cup'ik Alaska Natives.

Conclusions: Programs can develop culturally appropriate interventions for substance abuse for Alaska Native clients in such a way as to make them Medicaid reimbursable.

Methodology: The author describes the Village Sobriety Project (VSP), a program developed under a grant from the Center for Substance Abuse Treatment to provide culturally appropriate substance abuse treatment services to Yup'ik and Cup'ik people in three villages. VSP developed out of another program that used focus groups to identify appropriate cultural activities that could be incorporated into a substance abuse treatment program (e.g., berry picking, fishing, chopping wood, traditional arts and crafts). Local wellness counselors were also interviewed to determine how traditional healing activities may fall under rubrics used for Medicaid billing.

Summary of Results: VSP incorporated 27 cultural activities that were traditional for the Yup'ik and Cup'ik people. In addition to making traditional cultural activities part of treatment, the program also tried to consider culture in treatment planning. All participants answered questions about their commitment to traditional Yup'ik/Cup'ik culture and about their interest in learning about and using such activities. These cultural assessments were used to guide the choice of activities and to justify their use for Medicaid reimbursement. Traditional activities were perceived as having a traditional and a therapeutic function, and each activity was tied to a specific treatment goal. For example, tundra walks were used as a time of reflection and also (traditionally) as a way of orienting oneself in the landscape for times when there may be whiteout conditions. The program also used standard substance abuse treatment modalities. Counselors were certified for substance abuse treatment and use of traditional cultural activities.

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Purpose: To describe ethnocultural factors that may affect substance abuse treatment for Native American clients.

Conclusions: Although various strategies have been used to good effect with Native Americans in substance abuse treatment, more research and clinical documentation is needed to inform practice.

Methodology: The authors draw upon their clinical experience and a wide range of literature to present background information about, and some recommendations for, treating Native American clients.

Summary of Results: The authors provide some historical and demographic information about Native Americans. They then discuss ideas, drawn from a variety of sources, for mental health and substance abuse treatment for this population. They note the importance of understanding Native American cultures, the central role of community in those cultures, the need to address community as part of a comprehensive approach to treatment, the problem of historical trauma, and the difficulties involved in developing a cross-cultural model for treating Native Americans who, in fact, come from many distinct cultures. This is followed by a discussion of counselor characteristics and the role counselors can play in treatment, which touches, among other things, on how Native American cultures view those who take on the role of healers and the characteristics these cultures typically value in their healers. Similarly, the authors investigate client characteristics and considerations that may affect treatment, such as acculturation and cultural affiliation, culturally specific responses to stress, and native value systems that may vary from those of treatment providers. Based on the background information they provide at the beginning of the chapter, the authors use the second part of the chapter, for the most part, to suggest some counseling approaches that may be useful with Native American clients (e.g., accepting silence, using a directive counseling style, involving family and community in treatment, modifying group therapy to be acceptable to Native American clients, recognizing the importance of humor and storytelling, involving traditional healers and healing practices). The authors conclude the chapter with a short literature review that summarizes published information on counseling Native American clients.

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