



NATIVE AMERICAN CENTER FOR EXCELLENCE

ENVIRONMENTAL SCAN SUMMARY REPORT

NOVEMBER 2008

"We've seen the definition of prevention change. We now work with a definition that focuses on positive cultural attributes, that promotes the well being of our people. Previously we talked about stopping something before it got worse."

- Key Informant Interview Participant

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INTRODUCTION

Native American Center for Excellence (NACE)

In September 2007, the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Native American Center for Excellence (NACE), a national technical assistance, training, and resource center for Native American substance abuse prevention. The center was created in response to the well documented and overwhelming need to address substance abuse in Native American communities. With a focus on prevention, NACE supports tribal and other Native American prevention efforts through the provision of culturally appropriate training and technical assistance services. It also functions as a hub for Native American prevention information resources. The NACE website, designed specifically for Native audiences, will be launched in Fall 2008.

About this Report

The purpose of this report is to present basic information on Native American substance abuse prevention trends, issues, challenges, and strengths for NACE planners and decision makers regarding future programming. The information will be used to inform the development and implementation of the NACE training and technical assistance plan, as well as other NACE activities. It does not make recommendations for the field of Native American substance abuse prevention or offer in-depth analysis on the topics presented. Instead, it summarizes NACE environmental scan research to paint a general picture of prevention in Native American communities and across the U.S.

The first half of this report covers American Indian and Alaska Native (AI/AN) substance abuse trends and compiles research on risk and protective factors. The second half describes AI/AN prevention system challenges and strengths, and summarizes findings from a series of key informant interviews. A list of sample Native American prevention programs, policies, and initiatives is also included to give examples of different Native American prevention efforts currently in action. The following table lists each section and its sources.

Report Section and Data Source	National Data Sets (SAMHSA, CDC, Census)	Literature Review	Prevention Research	Internet Scan of Prevention Efforts	NACE Expert Panel Focus Group	Key Informant Interviews *
Substance Abuse Trends	✓	✓	✓			
Risk and Protective Factors		✓	✓			
Prevention System Challenges		✓	✓		✓	✓
Prevention System Strengths		✓	✓		✓	✓
Asking the Experts					✓	✓
AI/AN Prevention Efforts		✓	✓	✓	✓	✓

* Key informant interviews were conducted with 23 individuals with expertise in Native American substance abuse prevention including six federal officials.

Acknowledging Tribal Differences

There are 561 federally recognized tribal nations and Alaska Native villages and corporations in the U.S.¹ Each of these tribes has unique governments, cultural traditions, modern-day customs, and belief systems. They vary in population, geographic location, historical events, and in their relationships with outside governments, Native and non-Native alike. Approximately 60% of AI/AN people live in urban settings² and do not necessarily affiliate with other tribal members in those settings.

These differences are significant and should be emphasized in the context of substance abuse prevention for two reasons. First, substance use and abuse patterns vary by tribe and geographic region.³ What works for prevention in a remote Alaska Native village may not work in an urban setting. Therefore, effective prevention interventions must not only address AI/AN cultural considerations, but also the unique characteristics and needs of the tribal or village community in which they are implemented. Second, AI/AN differences affect how information is collected and simultaneously are affected by the limited data currently available. There are a number of challenges with collecting community- and tribal-level data which have created a gap resulting in generalizations and in some cases, distortions. The missing data should be kept in mind, particularly for the next section, *Substance Abuse Trends*. This report addresses tribal differences by limiting generalizing statements and providing information at both the national and community levels.

SUBSTANCE ABUSE TRENDS

Substance use and abuse trends among AI/AN populations are provided for the following substances: alcohol, tobacco, and illicit and other drugs. Methamphetamine is included as a separate category because of its severe consequences in AI/AN communities. These categories of substances

were chosen based on the availability of data from national sources. In looking at the figures below, it is important to distinguish figures on alcohol or illicit drug use from use disorders, dependence, or abuse.

Alcohol

Alcohol is the most commonly used drug among AI/ANs, which is one of the reasons why it receives so much attention in the context of AI/AN substance abuse. However, AI/ANs have lower rates of alcohol use than whites, persons with two or more races, Hispanics, and African Americans,⁴ an often overlooked, but not insignificant fact. The “alcohol problem” is based on high rates of binge drinking and alcohol abuse among AI/ANs; its negative social consequences for individuals, families, and communities; and its short- and long-term health risks including unintentional injuries, violence, neurological problems, heart disease, depression, and other psychiatric problems, cancer, gastrointestinal problems, and liver disease.⁵ There are different patterns of AI/AN alcohol use depending on the age group, the geographic location, and the tribal culture. One of the most alarming alcohol statistics is that more than one fifth of AI/AN young adults have alcohol use disorders.⁶

- AI/ANs have lower rates of alcohol use than other racial groups, including Whites.^{7,8} However, AI/ANs have higher rates of alcohol use disorders compared with other racial groups – 10.7% versus 7.6%.⁹ AI/AN females have lower rates of alcohol use and alcohol use disorders than AI/AN males.¹⁰
- The rate of AI/AN past-month alcohol use increased from 21.7% in 2005 to 31.3% in 2006. The 2006 rate for Whites was 32.3%.¹¹
- Among AI/AN youth and young adults, 8.5% of 12 to 17 year olds and 20.8% of 18 to 25 year olds have an alcohol use disorder.¹²
- The 2006 rate of alcohol dependence or abuse among AI/ANs ages 12 and older is the highest compared to other racial groups at 15.1%, but decreased from 18.3% in 2005.¹³
- In urban settings, of the 53% of AI/ANs who drink alcohol, 41% binge drink compared to 27% of the non-AI/ANs who drink alcohol.¹⁴
- 23.6% of AI/ANs age 12 to 20 binge drink, up from 18.1% the previous year.¹⁵
- Chronic liver disease and cirrhosis rank sixth in the top 10 leading causes of death for AI/AN populations.¹⁶
- AI/AN men have the second-highest self-reported rates of driving under the influence compared to men from other racial and ethnic groups.¹⁷

Tobacco

AI/AN adults and youth have the highest smoking rates of all racial and ethnic groups in the U.S. Smoking causes 3 of the top 10 leading causes of death among AI/AN populations: heart disease, cancer, and respiratory disease.¹⁸ It is also associated with stroke, vascular disease, low bone density among post-menopausal women, and reproductive problems including SIDS and low birth weight babies.¹⁹

- AI/ANs have the highest smoking rate of any other racial group: 32.4% of AI/ANs smoke compared to 23% of blacks, 21.9% of whites, 15.2% of Hispanics, and 10.4% of Asians.²⁰
- In 2006, past-month cigarette use among AI/AN youth age 12 to 17 increased from 2005 rates of 18% to 21.2%. It is the highest rate compared to youth in other racial groups.²¹
- 18.2% of AI/AN women smoke during pregnancy.²²
- In Southwest area reservations and urban locations, 59% of American Indian youth use tobacco outside of traditional ceremonies.²³ In Alaska, 44% of Alaska Native high school students smoke, compared to 12% of non-Alaska Native students. However, smoking rates among Alaska Native students decreased from 62% to 44% between 1995 and 2003.²⁴
- In urban settings, more AI/ANs smoke than non-AI/ANs.²⁵

Methamphetamine

In the last several years, methamphetamine has received growing attention nationally and in AI/AN communities because of its destructive effects on users and their communities. Compared to alcohol and illicit drugs, methamphetamine use among AI/ANs appears low. However, methamphetamine use presents unique problems associated with sale, distribution, environmental, legal, and child welfare issues, requiring the development of drug-specific prevention and treatment systems by tribal governments, urban Native organizations, states, and federal agencies.

- AI/AN methamphetamine use estimates vary from 1.7%²⁶ to 12.8%, and are up to four times higher than estimates among whites.²⁷ Of all substance abuse inpatient admissions, 9.4% are for primary methamphetamine abuse.²⁸
- For women there is an association between methamphetamine use, drug sales, and high-risk sexual behavior.²⁹
- Most people who use crystal methamphetamine are occasional users.³⁰
- Native communities are targeted for methamphetamine sales and distribution for complex reasons, including criminal jurisdiction problems and chronic underfunding and understaffing of tribal police forces.³¹ Nearly 75% of tribal law enforcement agencies identify methamphetamine as the greatest threat to their communities.³²

Illicit and Other Drugs

Illicit drugs refer to marijuana, cocaine, inhalants, hallucinogens, heroin, and prescription drugs used non-medically.

- Compared to other racial groups, AI/ANs ages 12 and over have higher rates of past-month illicit drug use: 13.7% of AI/ANs compared to 9.8% of African Americans (second highest). The AI/AN rate increased from 12.8% in 2005 to 13.7% in 2006.³³
- AI/AN youth ages 12 to 17 have the highest rate of past-month illicit drug use compared to other racial groups—18.7% of AI/AN youth compared to 10.2% of African American youth (second highest). However, the 2006 AI/AN rate decreased from 19.2% to 18.7%³⁴ since 2005.

- Compared to other racial groups, AI/AN youth have higher rates of illicit drug use disorders.³⁵
- 8.2% of AI/AN youth age 12 to 17 and 8.9% of AI/AN young people age 18 to-25 have illicit drug use disorders, compared to 5.1% and 8.1% from other racial groups, respectively.³⁶
- A greater percent of AI/AN adolescents admitted for drug treatment reported inhalant use than not,³⁷ and nearly half of all substance abuse treatment admissions reporting inhalant use were adolescents.³⁸

RISK AND PROTECTIVE FACTORS

Risk and protective factors increase or decrease a person's likelihood of engaging in risky behavior. In substance abuse, they occur in individual, family, peer, school, and community contexts. Prevention interventions often aim to enhance protective factors and/or reduce or eliminate risk factors, particularly among youth. Among AI/AN youth, risk and protective factors are comparable to those for youth in other racial and ethnic groups.³⁹ However, compared to their non-AI/AN counterparts, the occurrence of most protective factors is lower, and of risk factors is higher.⁴⁰ Risk and protective factors are critical considerations in designing effective and sustainable prevention strategies. As described below, a growing body of literature documents the protective qualities of culture on AI/AN populations. For this and other reasons, it is critical to incorporate culturally appropriate elements into any intervention targeting AI/AN populations.

Youth-Specific Risk and Protective Factors

Family dynamics and parent behavior play an important role in determining a youth's risk for substance abuse. Family history of alcohol use⁴¹ and adult models of substance abuse⁴² can be risk or protective factors depending on the positive or negative behavior of the parent and family. Stable and supportive relationships with parents,⁴³ perceived strong parental disapproval of youth substance use,⁴⁴ parental monitoring,⁴⁵ speaking with at-least one parent about the dangers of substance use,⁴⁶ and parental encouragement⁴⁷ are protective factors. The absence of these conditions, that is, lack of parental involvement, are risk factors. In tobacco use reduction, parental sanctions and modeling are more important protective factors among AI/AN youth than school and legal sanctions.⁴⁸ Family composition is also a factor in determining risk. Substance use is a risk factor among AI/AN youth who don't live in two-parent homes,⁴⁹ and living with an original two-parent home may act as a protective factor.⁵⁰ However, because extended family plays an important role in AI/AN culture, one-parent families that incorporate extended family into the family unit may also act as a protective factor.

Age can influence the degree to which risk and protective factors are present in AI/AN youth substance abuse. Age of initial alcohol use is a common prevention measure and it is well

documented that early age of initial alcohol use is a risk factor for future alcohol abuse.⁵¹ For younger youth, parental monitoring and discipline have a greater effect on drinking. For older teens, parental drinking habits have a greater effect.⁵²

Risk and protective factors also relate to a youth's involvement in, and connection to, school and other organized activities. Risk factors in this category include poor school performance⁵³ and antisocial peer associations.⁵⁴ Protective factors include participation in youth and other organized group activities,⁵⁵ the importance of religious beliefs,⁵⁶ and self-efficacy in social relations.⁵⁷

A final category of AI/AN youth risk and protective factors involves individual skills, perceptions, and peer attitudes. Risk factors include a low perceived risk in using substances;⁵⁸ positive expectancies of alcohol's effects;⁵⁹ a belief that the majority of peers are using cigarettes, alcohol, or illicit drugs;⁶⁰ and peer approval of substance use.⁶¹ Protective factors include self-efficacy and refusal skills, which stem from school bonding, peer social skills, and parent support and involvement.⁶²

Mental Health

Poor mental health is a risk factor for substance abuse and drug use initiation among young adults.⁶³ Life stress and developing potentially harmful methods for coping can also lead to poor mental health and place a person at risk for substance abuse.⁶⁴ In AI/AN communities, high rates of mental health issues may compound other risk factors described in this section. For example, among AI/AN adolescents and young adults, suicide is the second leading cause of death, and suicide rates are almost double those of the national average for non-AI/ANs in the same age group.⁶⁵ Among young adults, AI/ANs have the second highest rates of a past-year major depressive episode⁶⁶ and in urban settings, 43% of AI/ANs report poorer mental health compared to 37% of non-AI/ANs.⁶⁷ High rates of mental health disorders in AI/AN communities, and the role of poor mental health as a substance abuse risk factor, are two important reasons to include mental health promotion in planning effective substance abuse prevention strategies.

Mental health is also an issue for veterans and active duty members of the armed forces. There are nearly 140,000 AI/ANs enlisted in the U.S. armed forces⁶⁸ and 169,000 AI/AN veterans.⁶⁹ Unlike past wars, there is raised awareness about the prevalence of mental health and substance abuse issues among military personnel serving in Iraq and Afghanistan. Serious psychological distress is found in 20.9% of all veterans age 18 to 25 and 11.2% of veterans age 26 to 54.⁷⁰ In addition, 25% of veterans age 18 to 25 and 11.3% of veterans age 26 to 54 have a substance use disorder.⁷¹ Although AI/AN-specific data is unavailable, these figures illustrate the link between mental health and substance abuse among members of the military. They also provide an indication of the current and future needs among active and veteran AI/AN military for substance abuse and mental health prevention and treatment.

Violence

Violence, though not specifically identified as a substance abuse risk factor, is a pervasive and chronic issue among AI/AN people that compounds mental health issues,^{72,73} and is closely tied to current and historical trauma (discussed below). AI/ANs are victims of violent crime at more than 2.5 times the rate of the overall population,⁷⁴ and more than one third of AI/AN women will be raped in their lifetime (a significant percentage of perpetrators are non-Native).⁷⁵ At the Friendship House, a non-profit urban prevention and treatment center serving AI/AN populations in San Francisco, 50% of clients have endured some form of physical abuse prior to receiving services.⁷⁶

Cultural Identity

Building and reinforcing an AI/AN person's identity with one's traditional Native culture is an important element of many AI/AN prevention models today. At the same time, there are a number of risk and protective factors that relate to the ability of an AI/AN person to live in harmony with Native and non-Native identities. This set of positive coping skills is termed bicultural competence by LaFromboise, Coleman, and Gerton⁷⁷ or self-actualization by Sydney Brown of the Denver Indian Family Resource Center. Bicultural competence,⁷⁸ cultural involvement,⁷⁹ bonding to conventional society,⁸⁰ and acculturation⁸¹ are all protective factors, whereas discrimination,⁸² ethnic dislocation,⁸³ acculturation stress,⁸⁴ and alienation from the larger culture are risk factors.⁸⁵

Community Norms

Community norms reinforce community-wide beliefs, attitudes, and behaviors regarding what is considered acceptable substance use behavior. They represent a set of risk and protective factors discussed earlier, such as adult models of substance abuse or peer approval of substance use, in a community-wide application. For example, some tribal communities view alcohol initiation among youth as a rite of passage. Others strongly discourage any alcohol use among its members.

In a study on suicide among Native communities in Canada, those with certain factors present, such as self-government, women in government, education, child protection, health, and land claims, had lower suicides per 100,000 than those without.⁸⁶ The higher the number of factors present, the lower the rate of suicide.⁸⁷ These factors function as community-wide protective factors and represent positive community norms. Although presented in the context of suicide prevention, these factors could have the same influence on substance abuse and invite further investigation. Researchers Chandler and Lanlonde describe communities with these variables present as ones that are “more or less successful in reconstructing their cultural past, and gaining future control over their evolving civic lives.”

Recent and Historical Trauma

Trauma is a substance abuse risk factor occurring in different forms in AI/AN communities⁸⁸ including single events (accident/rape); prolonged experience (historical events); cumulative effects (high rates and exposure to violence); personal events impacting several generations; violent deaths;

multiple victimization;⁸⁹ and distressing life events of death and loss.⁹⁰ For children, exposure to multiple traumas increases the degree of risk.⁹¹

Historical trauma is a form of trauma unique to AI/AN communities. Maria Yellow Horse Brave Heart defines it as cumulative trauma – collective and compounding emotional and psychic wounding – both over the life span and across generations.⁹² It comes from shared historic experiences by AI/AN people of genocide, colonial oppression, displacement, forced assimilation, broken treaties, resource restrictions, suppression of language and culture, and boarding schools. Its effects are compounded by continued experiences into modern times of discrimination and poverty. Historical trauma is considered a risk factor for substance abuse and other social problems like suicide and depression, and is increasingly gaining legitimacy as an intervening variable for substance abuse that can effectively be addressed with culture-based prevention.

Boarding school practices in the first half of the 20th century are among the more recent events contributing to historical trauma affecting AI/AN students, their parents, communities, and subsequent generations. One study describes boarding school experiences among former Alaska Native students in terms of individual and community outcomes.⁹³ Individual outcomes include post traumatic stress disorder, social phobias, contemplation of suicide, damage to sense of identity and well-being, alcohol abuse, emotional scars, difficulty integrating back into family and community, loss of culture, loss of language, feeling like strangers in their home, and failure to learn parenting skills. Community outcomes include increased substance abuse by parents upon loss of children, increased substance abuse among students who returned to villages, and unprepared local education systems once schools re-opened.⁹⁴

Another study of families from upper Midwestern U.S. reservations and Canadian reserves in Ontario, assesses historical trauma according to thoughts and emotional responses pertaining to historical loss. It demonstrates that historical events and traumas continue to impact current generations of AI/ANs. In the study, parents of school age children reported thinking about the following losses daily or weekly: language (43%), traditional spiritual ways (47%), culture (40%), respect by children for elders (56%), loss of people through early death (46%), loss of respect by children for traditional ways (43%), and losses from the effects of alcoholism on Native people (30% daily and 18% weekly).⁹⁵ They also identified the following feelings, always or often, associated with historical loss: sadness or depression (16%); anger (24%); discomfort around white people when thinking of these losses (21%); and fearful or distrusting of the intentions of white people (16%).⁹⁶ These thoughts are associated with symptoms of emotional distress including anger/avoidance and anxiety/depression.⁹⁷

Both studies show the link between the effects of historical trauma and a number of substance abuse risk factors, particularly those described under mental health, violence, and cultural identity.

Other Factors

Other indirect factors such as inadequate health care, poverty, and homelessness are also associated with increased risk of substance abuse and in many cases, affect an AI/AN person's ability to get needed prevention or treatment services. A few examples are listed below:

- 24% of AI/ANs are uninsured compared to 16% of the U.S. population,⁹⁸ and 29% of AI/ANs living in urban settings are uninsured compared to 18% of urban non-AI/ANs.
- 16% of AI/AN children are uninsured compared to 6% of White children.⁹⁹
- In urban settings where nearly two thirds of the AI/AN population resides, 50% of AI/ANs have incomes under 200% of the federal poverty limit, compared to 27% of non-AI/ANs.

PREVENTION SYSTEM CHALLENGES AND STRENGTHS

This section presents strengths and challenges in the current AI/AN prevention system, starting with challenges. The information was produced through a combination of literature reviews, consultations with tribal prevention programs, and assessment exercises with national experts. Topics under both categories may be used to identify target areas for training and technical assistance and should be validated through an assessment with AI/AN prevention providers. Questions to ask include: how can challenges be approached, and how can strengths be a foundation for further action?

CHALLENGES

Workforce

There is a gap in the AI/AN prevention field in trained, culturally competent program planners, prevention specialists, community educators, and program evaluators. Tribal communities, villages, and councils often rely on one or two prevention specialists to administer, evaluate, and sustain prevention programs. In addition, prevention is a specialized field with state-specific certification requirements.

AI/AN Prevention Models

Of the 91 prevention programs included in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), only two target AI/AN populations, and only one of these is specifically designed to prevent substance abuse. Although there are potentially hundreds of prevention programs serving AI/AN audiences, the NREPP database is one indication that very few are culture-based and ready for effective replication.

Funding

A lack of resources is a common challenge in most prevention efforts, but AI/AN communities face an additional set of challenges. These include a high need for prevention services; limited funding

from state and local governments due to block grant limitations; limited funding from tribal governments particularly in poorer AI/AN communities; ineligibility of culture-based programs for monies requiring documented evidence of effectiveness; a lack of awareness among foundation funders about the need; geographic isolation in some tribal communities; and competing needs in AI/AN communities such as health care, education, transportation, and safety. There is also a lack of awareness among private philanthropic foundations of AI/AN funding needs.

Community Capacity and Coalition Building

Today's prevention field is looking to entire communities to implement local prevention strategies via the coalition. In many smaller Native communities, the formation of a coalition is a natural occurrence because the community is accustomed to coming together around important community issues. This dynamic is a strength. However, it also presents challenges because active and engaged community members often wear many hats and cannot always fulfill the multiple, diverse roles needed for effective coalition work. In some Native communities, a lack of education about substance abuse prevention and/or negative community norms can prevent key stakeholders from becoming involved. Other communities lack private non-profit sectors which inhibits coalition efforts and sustainability. Lastly, as one Native American prevention specialist from the Southwest region of the U.S. said, "prevention specialists are trained to do prevention, not facilitate community coalitions, but in tribal communities they are the people identified to do coalition work." Tribes need resources and training to effectively coordinate coalitions.

Data

There are substantial gaps in data on AI/AN substance abuse trends and risk factors, as well as research documenting AI/AN prevention program outcomes. Although the field has produced comprehensive one-time reports like the Indian Health Service, University of Minnesota, and Robert Wood Johnson Foundation-supported health survey of 14,000 Native adolescents in 1992,¹⁰⁰ the lack of follow-up reporting makes comparisons difficult. National efforts like the National Institutes of Health *Monitoring the Future Survey*, or the Centers for Disease Control and Prevention's *Youth Risk Behavior Surveillance Survey* are conducted annually and semi-annually and provide comparison data. However, they do not include sufficient Native American samples to provide useful insights about Native substance use and abuse behavior change. The U.S. Department of Health and Human Services, Office of Human Services Policy, commissioned a report titled, *Gaps and Strategies for Improving AI/AN/NA Data* in 2007. The report is a helpful guide which documents data-collection challenges and makes recommendations to improve data collection efforts for AI/AN populations.

Discrimination

Discrimination, dominance of western or European prevention techniques, and a need for cultural competence training, are three related issues that combined, create a barrier to establishing a strong AI/AN prevention system. This plays out in a number of ways including: a lack of recognition by state and federal funding systems that culture-based programs are effective and require the

development of alternative measures to demonstrate effectiveness; a lack of cultural competency training; barriers to building relationships between tribal and public officials which limit opportunities – funding, programmatic, technical assistance, or otherwise – that typically arise from this type of relationship; and the need for AI/AN people in dominant leadership positions.

Other Challenges and Needs

- A lack of programs in urban settings where two-thirds of the AI/AN population resides, and prevention interventions targeting multi-tribal urban youth.¹⁰¹
- More AI/AN programs in the private sector, that is non-profit organizations, to attract more private foundation funding.
- Insufficient coordination with related prevention fields such as violence, suicide, bullying, and mental health.
- Insufficient tribal-sponsored treatment for methamphetamine.¹⁰²
- A lack of drug courts.
- A need for greater involvement by tribal leadership involvement, and a need for sober leadership.

STRENGTHS

Many of the AI/AN prevention system strengths described below occur in the context of challenges discussed above. Resiliency, a protective factor and a common thread woven through AI/AN culture, allows these strengths to take place in the context of otherwise overwhelming challenges.

Culture

The integration of culture into AI/AN prevention is a great strength because it can be easily accessed in Native communities. Closely knit multigenerational families and tight communities are examples of cultural strengths that works as a protective factor when positive substance use behavior is modeled. A 2001 Office of Juvenile Justice and Delinquency Prevention report concludes that culture is “one of the stronger allies in the battle to enforce underage drinking laws.”¹⁰³

Evidence-Based Progress

Although more thought is needed regarding how to define evidence for culture-based programs, there are indications that both AI/AN prevention systems and traditional Western systems are taking steps to accommodate each others’ approach. For example, SAMHSA’s Strategic Prevention Framework includes in its definition of evidence-based interventions “elders or other respected leaders within indigenous cultures” as an acceptable group of informed experts who can assert an intervention’s effectiveness based on a combination of theory, research, and practice. In another example, Project Venture, a Native-specific substance abuse prevention program opted to conduct rigorous evaluation and apply for a review by SAMHSA’s NREPP.

Holistic Worldview

Another commonality among Native cultures is a holistic worldview in which all elements of life – at the individual, community, natural, and spiritual levels – are interconnected. Increasingly, research shows that single-sector approaches to prevention are not as effective as those that reach across and involve an entire community.^{104,105} As the broader prevention field moves in a more holistic direction, the holistic worldview is an asset because many Native communities are already practicing a form of prevention that aligns with the community-based approach promoted by SAMHSA and other national-level funders.

Response to Methamphetamine

A number of community, tribal, and national level initiatives have developed in response to the methamphetamine crisis. Nationally, these initiatives include SAMHSA's Office of Minority Health Indian Country Methamphetamine Initiative; National Congress of American Indian National Indian Country Tribal Meth Initiative Task Force; and the White House Indian Country Federal Meth Initiative Task Force. Locally, tribes have established programs and responses to methamphetamine, including banishment for methamphetamine dealers; "Meth Walks;" Cherokee Children's Marbles Game promoting the message "Use Your Marbles, Don't Use Methamphetamine;" student art competitions illustrating the dangers of methamphetamine; and cultural immersion in lieu of punishment. Tribal policies include anti-meth criminal codes; tribal employee drug testing; cooperative tribal criminal jurisdiction agreements; and inter-jurisdictional task forces.¹⁰⁶

Other Strengths and Opportunities

- The development of tribal-state collaborations: for example, 26 recognized tribes in Nevada and the state of Nevada partnered to form a Statewide Native American Coalition, recognized by SAMHSA as a notable practice.
- A resurgence of national level prevention-focused funding opportunities are open to tribes, including Indian Country Methamphetamine Initiative, Drug-Free Communities, Strategic Prevention Framework-State Incentive Grants, and the federal Medicaid encounter rate.
- Increased recognition among tribal leaders that their substance use behaviors shape community norms and influence youth substance use.
- New mediums for reaching youth with prevention messages (e.g., comic books).
- Increased tribal empowerment to address problems,¹⁰⁷ for example, a positive relationship between self-governance and substance abuse outcomes.¹⁰⁸
- A network of urban Native American health organizations serving the health and prevention needs of urban AI/AN populations.
- A sense of hope; learning and healing from tragedy.
- The use of bi-cultural interventions and life skills training to fit the bi-cultural world of Native American adolescents.¹⁰⁹
- Tobacco control initiatives.

- The development of AI/AN-specific screening tools assessing youth alcohol and drug risk¹¹⁰ and use.¹¹¹
- The development of historical and recent trauma assessments among or by AI/AN providers.

ASKING THE EXPERTS: FINDINGS FROM KEY INFORMANT INTERVIEWS AND A FOCUS GROUP OF THE NACE EXPERT PANEL

Between February and May 2008, NACE convened the NACE Expert Panel in a focus group and also interviewed 23 national experts, including six federal officials, to gather qualitative information on Native American substance abuse prevention. Individuals were asked to share their views on trends, gaps, strengths, and solutions. This query generated a collection of meaningful insight into the numerous and complex issues surrounding AI/AN substance abuse prevention. The five most common themes from participant responses centered around community, culture, family dynamics, youth, and understanding the problem.

Community was the most frequently referenced AI/AN substance abuse prevention theme among interview and Expert Panel respondents. Views on community and culture often went hand in hand. A lack of both community and culture were viewed as AI/AN substance abuse risk factors. Participants also described some communities as toxic. They cited the combination of toxic communities and unhealthy social norms as contemporary causes of the substance abuse problem. A loss of traditional culture and spiritual values was also described as a cause. Examples of this loss included a lack of healthy coping skills, a lack of culturally competent interventions, a loss of cultural identity, and the need for a wellness-focused approach.

Participants paid equal attention to community and culture in their descriptions of strengths and solutions. For example, the allegiance to community commonly found in Native culture is a strength, as is comprehensive community involvement in prevention efforts. Key components of any sustainable prevention effort should be creating community awareness of the problem, particularly among tribal leaders, and changing community norms around substance abuse behavior. Prevention efforts based in traditional cultural and spiritual practices, such as language lessons and dance, were also critical ingredients of any successful prevention effort. Cultural revitalization, especially among younger AI/AN populations, was credited by many participants as the key ingredient for interventions that work.

Family, both nuclear and extended, was also a frequently cited variable related to AI/AN substance abuse issues. Unhealthy family dynamics contribute to substance abuse. These include the absence of teaching by the community, or learning by the parents, of responsible parenting; all forms of family violence; the lack of healthy parent-child interaction; and family disorganization. Solutions

included increasing family-related protective factors; involving multiple generations of family in prevention efforts; addressing and reducing trauma exposure, particularly related to family violence; and strengthening parenting skills.

Related to family, but also distinct, was the need to emphasize and involve youth in the solution. Participants commended those substance abuse prevention programs that already do this. There was a strong belief that nurturing young people's contemporary culture and simultaneously supporting their reclamation of traditional culture, leads to successful prevention. This belief is reinforced by the number of successful youth-centered prevention interventions that combine traditional and modern cultural approaches.

It was felt that families, communities, tribal leaders, and non-AI/AN institutions need a better understanding of the problem to make long-term gains in substance abuse prevention. Understanding the problem means youth are educated about physical and other harmful effects of using alcohol and other substances; families reinforce this education through modeling and expectations; communities have collective knowledge about community-wide issues associated with substance abuse, such as traffic fatalities, disease, and family violence; and tribal leaders are actively engaged in and committed to addressing the problem. A better understanding of the problem at all levels of an AI/AN community also promotes education of non-AI/AN institutions, like states, federal agencies, and educational organizations.

To fully understand the problem, many participants noted that historical trauma or multi-generational trauma must be acknowledged. Youth need to understand how traumatic historical events, such as relocation and boarding schools, led to the problems their communities currently face. Families and communities need to acknowledge and grieve historical losses that occurred, and understand the effect those losses had on the collective good. The underlying message from participants: understanding the role historical trauma plays in substance abuse will make our prevention efforts more likely to succeed.

Not surprisingly, insufficient funding was another common issue raised by participants in relation to AI/AN substance abuse prevention. This plays out through a lack of access to culturally competent treatment, economic challenges among tribes, institutional racism, too few employment options for adults, and funding limitations specifically for prevention. Prevention funding limitations include scarce tribal resources, evidence-based requirements, short-term grant cycles, and eligibility restrictions for foundation grants. Some participants noted that communities with casino funds are becoming more empowered to address broader social and economic issues that link with the prevention of substance abuse. They also identified volunteerism and the "wearing of many hats" among community members as factors that offset severe funding challenges.

Key informants and Expert Panel members discussed five additional issues addressed earlier in this report. These are: 1) the need for professional development and professional capacity building in the AI/AN prevention field; 2) a shift toward wellness promotion as an over-arching principle of AI/AN substance abuse prevention; 3) the view that alcohol remains the most significant substance abuse problem in AI/AN communities; 4) the relationship between substance abuse and poverty; and 5) the need to pursue prevention independent of treatment and yet also integrate it in all cycles of addiction including abuse, treatment, recovery, and relapse prevention.

AI/AN PREVENTION EFFORTS

This table provides information on a small sample of AI/AN substance abuse prevention practices, programs, and policies. It illustrates the range of approaches in use today.

Name	Description	Population	Organization
Anti-Meth Campaign for American Indians/Alaska Natives	The first anti-meth public service campaign targeting AI/AN populations, created through the Office of National Drug Control Policy, the Department of Health and Human Services, the Bureau of Indian Affairs, the Partnership for a Drug-Free America, and the National Congress of American Indians. The campaign is a free public service featuring print and radio ads, trainings, technical assistance, information, funding announcements, and events, available on the MethResources.gov website.	American Indians/Alaska Natives	Office of National Drug Control Policy
Fatherhood is Sacred	Curriculum for Native American fathers to enhance the responsible involvement of fathers to become more actively involved in the lives of their children, families, and communities.	Native American fathers	Native American Fatherhood and Families Association
Journeys of the Circle	Canoe Journey, Life's Journey uses a life skills/harm-reduction approach to prevention. The curriculum involves a life skills course using aspects of the canoe journey and other Native symbols.	Urban Native adolescents	University of Washington Addictive Behaviors Research Center and Seattle Indian Health Board
The Native American Tobacco Coalition of Montana	The Native American Tobacco Coalition of Montana is a network of diverse groups working to preserve, teach, and practice the respect for ceremonial, spiritual, and cultural use of traditional tobacco. The coalition promotes the responsible use of sacred, ceremonial tobacco to ensure family and community health. Their website provides culturally based resources and information.	Native Americans living in Montana	Native American Tobacco Coalition of Montana
Nevada's Statewide	Nevada's Statewide Native American Coalition works through the tribal chief system to develop	Native American	Statewide Native American Coalition

Native American Coalition	alcohol, tobacco, and other drugs (ATOD) prevention policies that can be implemented at local and tribal community levels. The coalition includes all 26 recognized tribes in Nevada and urban Native Americans and was recognized by SAMHSA as a “notable practice.” A successful data collection effort of local Native American data resulted in data-based decision-making by the tribal chief system to guide ATOD prevention policy.	residents living in Nevada	
Project Venture	Project Venture is a prevention program comprised of a set of key components adapted for high-risk Native American youth in tribal, alternative, and public schools. The major intervention strategies include summer skill-building leadership camps and outdoor adventure activities, followed by school- and community-based programs for youth. These strategies are designed to develop skills, self-confidence, teamwork, cooperation, and trust. All activities and strategies are chosen because they connect with both traditional Native cultural activities, as well as appropriate learning styles of the focus population.	Project Venture is currently being replicated or adapted in over 50 sites, in 16 states because of its appeal as a culturally appropriate prevention program.	National Indian Youth Leadership Project, Inc., Gallup, New Mexico
Protecting You, Protecting Me (PYPM)	PYPM is a model alcohol abuse prevention curriculum targeting Hopi and Navajo elementary school students. The program develops healthy attitudes around alcohol use and helps students make decisions which reduce the risk of alcohol use/abuse and vehicle related injury. Hopi and Navajo high school juniors and seniors are trained to mentor first through fifth elementary grade students.	Hopi and Navajo high school students and 250-300 Hopi elementary students	Protecting You, Protecting Me and Hopi Reservation schools
Red Cliff Wellness Curriculum	The Red Cliff Wellness Curriculum is a culturally-focused, comprehensive, manual driven education and training curriculum with three components: a K-12 school-based prevention program, a community change curriculum, and a family wellness kit.	Native American students, families, and communities.	First American Prevention Center
Wellbriety Curriculum	White Bison, Inc. is an American Indian nonprofit organization that brings Native American communities into wellness through its Wellbriety curriculum. The curriculum is available in different forms including trainings, workshops, materials, and conferences. Wellbriety includes sobriety, recovery, addictions prevention, and wellness.	Native American individuals, groups, and communities	White Bison, Inc.

CONCLUSION

Substance abuse is a complex problem that is intensified across AI/AN communities, who must grapple with disproportionate rates of poverty, death, and disease, on top of the psycho-social effects of historical or multi-generational trauma. Therefore, implementing effective AI/AN substance abuse prevention efforts and finding resources to sustain them is a monumental task. Despite these challenges, the AI/AN prevention landscape is filling in, and sustainable culture-based approaches are taking hold.

This report represents the first phase of an ongoing effort to make current information available on AI/AN prevention through NACE. In the coming months, NACE will offer additional informational resources through its website, reports, and the provision of training and technical assistance to AI/AN substance abuse prevention organizations and programs.

Although this report is not designed to make recommendations, the research conducted to produce this report highlighted several common AI/AN substance abuse prevention issues that warrant further consideration. These are listed below:

- Addressing AI/AN data collection challenges;
- Conducting further analysis regarding AI/AN alcohol consumption, specifically the low use rates juxtaposed with high abuse rates compared to other racial groups;
- Documenting how the effects of historical trauma can be applied as substance abuse risk factors;
- Establishing a common framework for evaluating culture-based practices;
- Expanding the pool of prevention interventions for AI/AN populations, particularly for those living in urban, non-tribal settings; and
- Establishing an AI/AN definition of prevention where substance abuse is one indicator of a broader set of socioeconomic issues, and where prevention strategy funding supports a comprehensive approach.

Acknowledgements

This report was prepared by Kauffman & Associates, Inc. for SAMHSA's Center for Substance Abuse Prevention and the Native American Center for Excellence. July 2008. Spokane, Washington.

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