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Treatment of American Indians with Alcohol Problems: Annotated Bibliography

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Abstract
This paper provides detailed summaries of the best articles in the professional literature on the treatment of American Indians with alcohol problems published between 1980 and 1995.
Prevention Models and Programs


Curriculums:
Red Cliff Alcohol and Drug Curriculum Project, designed for Indian children in grades K-9. Focuses on information, self-awareness, peer and family relations.

Being Free: prevention curriculum. K-12, divided into age groups. Focuses on attitudes, feelings, families, choices, information, etc.

"Here's Looking at You, 2000" - has been used successfully with Indian children, provides information, self-esteem, decision making skills, K-12.

Project Charlie: has been used successfully in some Indian communities. Self-esteem, decision making, peer relationships, and info.


(This program has a secondary school component. Focuses on the "social context" of children, not on the children themselves. Programs need to look at all areas of influence in a child's life, school is a place to start, but must be complemented by programs in the community. Their goal is to prevent any use and abuse of alcohol by children. Renewing Traditions uses different aspects of the following prevention models: Information, Psycho-Social, Public Health, Social Pressures. The program is "long-range, comprehensive, has genuine commitment, and genuine collaboration between school, community, teacher, parents and children." (p. 19).

Focus on teachers: goal is to encourage and allow "safe disclosure" (p. 24) about alcohol in the classroom. Give several suggestions on how to accomplish this.

Community change is discussed. Community itself, through facilitation needs to think about problem, diagnose causes, suggest solutions and plan for action. This can be accomplished through a core group. Looks at long-term social change in the community. Part of this is defining, finding and using traditions in the community.

Lists on-going preventive strategies for teacher and parents. Teachers: guide, influence, role model, help children feel significant, and teach decision-making skills. Parents: Share family activities, discuss alcohol use, role model, encourage children to find their own solutions.


Tulsa Indian Council on Alcohol and Drug Abuse (TICADA) uses performing arts as a model for prevention. Target group is at-risk children ages 8 to 18. Goal is to get kids involved in theater, so that they will continue to be involved in Indian programs or school theater groups. Another goal is to raise self-esteem and awareness. Program provides families with drug and alcohol information and referrals. Has guitar, ballet, drama, creative writing, photography, flute making, and traditional dance. Small education groups happen throughout the week, informally. Has a spiritual base, pipe ceremony every week and a sweat twice a month.

Upon entering program kids take a pretest, measuring self-esteem, and a drug use inventory. They take the same tests when they leave. Have a control group, results not accumulated yet.


A practical, clearly-written (not in academic style) report for laypersons regarding this issue. Suggests many ideas.
1) youth need a clear message against drugs from peers, parents and schools.
2) working with parents: collect data on size of problem, then they can’t ignore it.
invite parents to a special meeting, to build awareness, provide information and give parents a way of responding to drug use. Parents should be helped to realize that they should talk openly to their kids about drugs.

3) working with students: Honest, factual information with an emphasis on long term dangers. Main focus should be on values and attitudes. Need to build group values against drug use. Need to help teens find own values through clarification and assertiveness training. Teach good leadership roles. Have teens be responsible for younger kids in community.

4) School staff: Have a training program on the extent of substance use and factual info. re: drugs. Need to make school positive for all students, make them feel successful. School needs to control use of drugs in and around schools - have parents help make these rules.

5) Hospitals and Courts: IHS people need education, should cut down on prescription tranquilizers. Tribal police and judges need training too. Not all drug users are delinquents and should be dealt with differently.

6) Role Models needed: Older people, grandparent types of programs. Community sports or activities where adults volunteer.

7) Cultural Activities: A wide range can be used. Teens with strong Indian values use fewer drugs, according to research. Values have to become an important part of teen life. Most important is entire community involvement.


Four principles of dealing with drug and alcohol abuse. 1) The solution must come from within the native communities. 2) Native people must rediscover their traditional values. 3) Need to educate people from the very beginning of their life. 4) Individual healing, and that of the community must be integrated.

Need to eliminate the context of substance abuse in the community. Emphasis is on holistic human development. Immediate steps to take as a community begins the project. 1. Make media materials available, which address native identity and value as they relate to substance abuse prevention. 2. Support and assist and current substance abuse programs, through workshops and technical support. 3. Need to establish a core group of people interested in the process. 4. Establish a communication system for native communities to consult with each other.


A curriculum that focuses on the impact of alcohol and drugs on the body, and how to get high naturally, from the viewpoint of the American Indian lifestyle. (Summary from Lobb and Watts (1989). Do not have actual article on file.


Taught responsible drinking to 30 AI students at risk for problem drinking. Decreases were would in quantity and frequency of drinking, and of BAC. Maintained at 4,9,12 months. Self-report, with breath tests and official records. Both minimal and full program interventions had the same effects. Teenagers are already drinking and do not respond to programs encouraging abstinence 2) program had specific guidelines, important for teenagers where “normative standards for drinking are lack.” (p.307). Teaches how to achieve tools and self-control. Peer counselors must be trained adequately. Confidentiality must be ensured. Community must be considered and support program.


Describes Positive Reinforcement in Drug education (PRIDE) preschool through high school program of Puyallup Tribe in Washington. The four components are: cultural identity, curriculum development, building and program security, and intervention and social service access. Program evaluation is discussed. (Have ordered article through ILL)

Program for youth ages 11-17. Seeks to reduce excess morbidity and mortality. Empowerment education and problem-posing. Students volunteer to become involved in three weekly 4-hour facilitated visits to an emergency-trauma center and one 2-hour visit to a county detention facility.

This program is an integration of the following models: social influence, which uses peer-led training in social skills; Botvin's Life Skills Training, emphasizing problem solving, decision-making, cognitive skills, self-control and assertive skills; and Jessor's problem-Behavior Theory, looking at personality, perceived environment, behavioral systems, and the interaction of these.

Models are aimed at individual responsibility and change. ASAP Model is Listening, Dialogue, and Action. Students interview, ask questions, and listen. They share reactions to patient and inmate interviews. Stresses the complexity of problems. Action is strategies for positive change.

Results of a recent study with 12-13 year olds found that, using a repeated measure design at 8 month post-program, perceived riskiness of drinking under the influence continued to increase for "participant " group while control group perception decreased. Qualitative evaluations are being conducted, difficult to attribute direct changes to effects of ASAP.


Changing attitudes are: that there is a choice, abstinence is an option, non-drinkers need not be isolated, the community is responsible. and must act. Need to utilize the changing attitudes. Need to provide dry activities. Indian people need to network their strategies and accomplishments.


Risk factors for Native youth are low self-esteem, post-traumatic stress, and culture conflict. Many tribal programs seek improvements in self-esteem through tribal cultural participation, chapters of national youth organizations, physical challenge programs, and peer support groups.

Sample approaches to intervention and prevention are: all of the above, plus any activities that emphasize tribal involvement.


Culturally-tailored 10 sessions skills enhancement program was delivered in reservation and nonreservation settings to 129 youth. Had a control group and an intervention group. Skills covered problem-solving, and communication skills, and sessions were led by American Indian social workers. At 6 month follow-up, intervention subjects had better knowledge, better interpersonal skills, and lower rates of alcohol, marijuana, and inhalant use. Behavioral skills training is promising. the study found some support for the efficacy of a prevention intervention Program


Reviews nativistic movements (NA church, peyote.), evangelistic religions, medical model (AA, which has been successful with acculturated NAs) and NA group-oriented efforts. Argues for prevention model based on instilling self-esteem at a very young age, through peer-tutoring. Says that education and dissemination are not very useful.

There is the assumption that a positive self-concept is a basic preventive strategy. However, there is the question of what constitutes a positive self-concept in American Indian children, and how to assess it. "A primary preventive task is the development of modes of accommodation not only with the dominant culture, but within the group itself." (p. 84). Basic need is to develop a secure identity about where one stands in the world.


Family and societal involvement are necessary to consider in counseling. Success in treatment should look at, "support, understanding, and reinforcement of positive helpful behaviors." (p. 47) Rehab counselors also need to consider preventive activities as part of their work.


Programs designed for one tribe may not be very relevant for another tribe. Need for definition of problem in populations and sub-populations in order to develop interventions.

Primary prevention: Need to keep youth alive and healthy during experimental stages of alcohol and drug use, so they can develop a nonabuse style of life. Need to address motor vehicle accident prevention, and the physical consequences of alcohol use. Also need social, recreational and economic alternatives. Need to consider legalizing alcohol on reservations. Studies have shown long-term reductions in cirrhosis of liver, motor vehicle accidents, suicide and homicide.

Community-based preventive education should provide information about alcohol and drug misuse. For youth, should emphasize a social learning model, self-esteem, coping, and peer groups. Train bartenders in border towns and Indian bars.


Did an extensive review of the literature from 1982-1994. Conclusions: programs need to account for within group differences and address both heavy drinking and the problems that relate to alcohol misuse. Cultural relevance must be planned for, local community must be involved, the drunken Indian stereotype should be addressed, and community empowerment be a goal.

Secondary level prevention: early detection and intervention to correct or minimize alcohol misuse. Articles describing this often carry this out in the context of mental health programs. The many possibilities include, stabilization of at-risk families, social detoxification centers and halfway houses. One article (Shore and Kofoed) advocates drunk driver identification and diversion programs, as well as public inebriate programs and outpatient social detox. Majority of school based programs emphasize information about effects and consequences of alcohol abuse. May identifies the following themes "building bicultural competence, increasing self-esteem and self-efficacy, improving peer pressure resistance, and overall discriminatory and judgment skills, and increasing the perception of the riskiness of alcohol and drug use." (p.293). Emphasizes that the programs must take place in the proper context, and need to address sociocultural aspects.

Primary level prevention: Articles reviewed call for community change, social policy, environmental change, comprehensive prevention, and that prevention programs need to come from communities themselves. Other authors consider community mobilization and empowerment through volunteers, as well as a five level integrated model that looks at socioeconomic conditions. Another level of primary prevention is alcohol related injury control. These efforts include social and economic improvement, public education, new alcohol policies, laws, norms, etc. Lastly the article considers changes in community policies re: alcohol, and a change in norms.

Summary, review seems to indicate that secondary prevention programs are most common and successful. Also, primary prevention programs that use comprehensive community approaches are
becoming more common. However all approaches must be considered successful only in a preliminary sense. Need to approach interventions as a package, and have more evaluation.


Indigenously created primary prevention program. created and managed by the youth. Prevention of alcohol and drug abuse is not the only goal, it is to provide recreational opportunities. No formal membership, all youth are considered members. Economic functions, bingo, basketball, many community service. Educational functions, Youth Conferences, with outside speakers. Also, Alcoholism Awareness day. Increases competence of youth, reduce stress, offer communal alternatives, increases community self-esteem, increases youth responsibility. How effective in prevention is it? Cannot really say. While it may not have decreased incidence, it has prevented a significant increase.


Cited Carpenter’s study and Lyon’s follow up of positive outcomes after a year. States that controlled drinking strategies, and behavioral self-control are supported by research as being effective. Especially effective with early stage problem drinkers, who are not receptive to abstinence models. Seems to be effective with tertiary prevention and initially with secondary prevention. Primary applications have not yet been proved.


Have not yet developed a strong theoretical risk assessment model for targeting youth in danger for substance use. Less is know about protective factors. Bicultural competence: "Preventive interventions must more sensitively address acculturation issues if they are to be successful within this population." (p. 409).


Primary prevention programs for Indians. Major problems are accessing the population and disseminating information. Other major problem is lack of moderate drinking norms in the community. Guiding principles of prevention program must come from the Indians in the community. Secondary prevention: Need detox facilities and medical centers on reservations. Need to educate about withdrawal and how to manage it. Should have DWI classes. Using the mass media for Indian population is underdeveloped. Most prevention is aimed at children as are alternatives to drinking. Limiting access, prohibition may actually encourage consumption.


Cultural identification, while a positive force, and bicultural youth may be more resistant to alcohol involvement, cultural identification is an "underlying characteristic, and its effects are indirect. . . few or no direct links extend from cultural identification to alcohol involvement. " (p.263).

Peer cluster theory and its implications for programs: programs that try to change individual attitudes not like to be effective. Need to be run by youth, and encourage peers to encourage each other, within peer clusters to avoid alcohol. Strong families may influence kids to join non-use peer groups. Can also have other good effects. May need direct intervention with peer clusters.

Need to recognize that many factors underlying alcohol abuse are the same in both Indian and non-Indian populations. Their study, along with other research, supports the theory that alcohol use is not very related to personality or emotional variables. Study finds that socializing and alcohol are linked, and that alternative type programs must clearly be alcohol free. If so, these programs may work. Spirituality is important to many Indian youth, and this can help prevent alcohol use. Any programs must address peer clusters and need to impact the norms. "Don't turn your sister on" program might be useful. Prevention should strengthen the family, identify weak families and provide alternatives. Cultural programs alone are unlikely to be very successful unless they prevent the forming of alcohol using groups. School adjustment help can be useful. Prevention programs need to be high impact and reach significant groups. Successful programs focus on family strength, school adjustment, hope for future, changing peer clusters.


Report lists prevention materials that have been reviewed for scientific accuracy, appropriateness for audience, and conformance to public health principles.

Self-Instructional:

Curricula: Renewing Traditions
- Sacred Tree Curriculum Guide: school-based. Uses visual imagery and ethnic heritage. Students are taught positive steps to take and community involvement is used.


Suggests that prevention focus on very early prevention of use or exposure to drugs or alcohol and that programming focus on reducing the initiation of use, rather than on reduction. this is applied to Native American youth age of initiation of use and experimentation is between 10-13.


Prevention program for teenagers used an existing prevention curriculum ("Project CHARLIE") and supplemented it with a cultural awareness curriculum. Outcome data indicate that teaching cultural traditions can help reduce alcohol abuse among Native American teenagers. Supportive data were the retention of all participants and a correlation between increased cultural affiliation and decreased alcohol and drug use. Too soon to tell if these outcomes will be sustained over time. Problem was a non-equivalent comparison group, also differences in attention paid to both groups. To succeed a prevention program must influence students enough that they can withstand social and peer pressure. "The findings of this study suggest that prevention lesson can affect actual choices about alcohol and drug use if a transformation occurs in the individual's perception of being the prevention provider, rather than solely a target of the prevention effort." (p.116). Students in program acted as role models for grade school children.


Just gives the results of her dissertation. States that the teaching of cultural traditions suggests that it was appealing enough to prevent any dropouts. Almost half of the participants in the comparison group dropped out.

Two important aspects of prevention. Community involvement and stake building. Stake building implies that "substance use must become a disadvantageous behavior pattern that if followed will lead to lost rather than reward." (p.276). Need to educate and build awareness of traditions. "Community education in traditions through organized social events will build awareness of the traditions on the one hand, but will also build interdependence through allocation of roles in these activities." (p.276)


Did a survey of school and community prevention activities among Indian communities, 1986-1987. Many schools are using curriculums that emphasize values, attitude clarification, decision-making, and education regarding effects of alcohol abuse. These programs prompt referrals of students for counseling. Community based programs provide education and build self-esteem, coping skills, decision-making family enrichment and parenting. Also media presentations are being used in communities. Lots of information and programs (large numbers of people involved), but no analysis of relative benefit. Curriculums: Here's Looking at You 2000, Project Charlie, BABES. Community Programs: TRAILS, Circle of Life, Children Are People.


Though this curriculum is designed for grades K-8, there are several recommendations in the report that are relevant in the implementation and evaluation of prevention curriculums. A curriculum that has the confidence of school staff should continue to be used. Curriculum must be used for a long period of time before a complete evaluation can be made, and a long term evaluation plan should be developed. There is a need for adequate curriculum resources and it should be integrated with other curricula. Finally it was recommended that alliances be developed with the community, and legal issues clarified, as some teachers believed that the curriculum was too "religious" and did not give equal time to other religions.


Data from the study gives modest support to a bicultural competence skills intervention approach. Test group showed more improvement in knowledge attitudes, and interactive abilities. Caution about generalizing and more research before widespread implementation.


Emphasis on understanding drug-taking behavior in its meaning within an ethnic group. Need to understand the social and cultural interactions with drug-taking behavior within different cultural groups. (p.309). Prevention: should address cultural factor, only then will they be influential. Instead of trying to change attitudes, prevention should focus on changing factors in the environment that promote drug-taking behavior.

In a study of drinking attitudes and patterns, the authors’ conclusion is that community norms affect drinking behavior, and that those interested in prevention should concentrate on developing community norms which promote moderation. Study gives support to the influence of friends in the decision to drink, as well as siblings.


Uses participatory research, in which people affected by a problem develop the information to support action. Examples include brainstorming, researching alcohol effects, surveys and developing a local resource guide.

Cultural journalism: contributes to understanding by looking at causes and cures of substance abuse, through written histories, private reflection, group discussion, oral history interviews, and putting the story in written form. Brings cultural heritage into the classroom.

Experiential writing: encourages students to express own experiences and supports the generation of ideas. Focuses on the individual.


Prevention can be specific, to reduce problem behaviors, and nonspecific, which attempts to change variable such as self-image communication and problem-solving. Need more American Indians trained in mental health work. Most prevention strategies focus on specific and emphasize educational content. Many researchers do not think this is a feasible strategy. Some efforts are expanding into social and cultural realms, with alternative activities. Exemplary efforts involve: 1) a non-academic setting, collaboration with local community, putting project under direction of lay persons or paraprofessionals and blending knowledge with traditional Indian orientations.


Just what it says it is. Ordered from ILL.


Prevention project was located in Baltimore, was only a summer and worked with young people. Project wished to create a climate where youth could seek help. Goals were to help youth become aware that they are high-risk, uncover myths of alcohol abuse, make aware of early warning signs, teach them to teach other youths about alcohol abuse, make aware of resources, and teach that alcoholism is a disease. Results prove that knowledge can increase and self worth can change. Suggests a year round project, and state that volunteers are an integral part.


Comprehensive review of the literature and of prevention programs past and present. Though OSAP found that much of the literature was broad recommendations, they did find approximately 60 articles that mentioned specific programs. The interventions are organized in the report based on the type of activities mentioned, and the references are cited by author and year in the body of the report. The report summarizes articles published as of 1988. I will list here only those articles specific to alcohol abuse prevention (and that are current), using OSAP’s headings. Some of the programs address risk factors for alcohol abuse, but do not address alcohol specifically (These are mentioned if relevant or not cited elsewhere in this lit review).
Programs with Historic Significance: Native American Indian Church, Indian Shaker Church, Prohibition, legalization of alcohol sales and consumption, Sweat Lodge, Sun Dance, Alaskan Village Spirit Committees, Alcoholics Anonymous.

Programs Targeting Indian Boarding School and Public School Populations:
Preventive Mental Health Program for Indian Boarding School (alcohol abuse counseling and education, and peer counseling)
Toyei Dormitory Model (used Navajo houseparents in a high ratio of parents to children), Chemawa Indian Boarding School Recreational Therapy Program (outdoor adventure to reduce use of alcohol)
St. Mary's Boarding School (combined traditional Eskimo values with religious and western ideals)
First-Offender Program for Alcohol and Drug-Abusing Adolescents and their Parents (First offenders and parents were required to participate in 10 family therapy sessions with a Native counselor.),
Adolescent Indian Therapy Group (secondary prevention, an elective course in a high school which acted as a therapy group),
Assertiveness Skills Training for Bicultural Competence (small group setting),
Life Skills Training with Adolescents (10-12 sessions using cognitive-behavioral techniques),
• Peer Managed Self-Control Prevention Program (responsible consumption through education and peer counseling), See Carpenter article.

Community-Based Programs for Youth:
Mt. Edgecumbe Comprehensive Alcohol Program (MECAP) - peer counselors available weekend nights
• Chevak Village Youth Association (group process and achievement), See McDiarmid article
The Acoma-Canoncito-Laguna Teen Center (counseling, workshops, recreation),
DARE (Ute- emphasized skills such as decision-making, assertiveness )

Residential Programs for Youth:
Fort Hall Medical Detoxification Center for Adolescents (medical holding facility on reservation, crisis counseling and referrals)
Youth Chemical dependency center at North Dakota State Hospital - 4-6 week residential program using reality therapy

Cultural Enhancement for Youth in the Community:
Mescalero and Hopi Health Fairs,
Miccosukee Culture Program (overnight trips by children to an ancestral campsite),
Tiospaye Project (spiritual advisors and traditional healers were involved in promoting community development projects to reduce pathology),
WIDO-AKO-DA-DE-WIN (helped to form a support group and integrate activities into existing family systems. Also adopted a school-based program),
Project Nak-nu-we-sha (formally a child abuse/neglect program, and a counseling program directed at adolescents with alcohol problems, using Native counselors),
Multidimensional Prevention and Intervention Program on the Manitoulin Island Indian Reserve School and community based, Rainbow Lodge Recovery center, residential treatment facility, Youth at risk were trained to perform residential facility jobs. Local tribal members were trained as mental health workers

Programs Within Behavioral Health Clinics:
Papago Community Mental Health Clinic (alcohol abuse was targeted through education),
USET Program--Seminole Tribe (community prevention with major emphasis on alcoholism - comprehensive approach),
Cultural Therapy Program (informal structured Cherokee cultural sessions to increase clients' social integration back into community).

Intervention Program Planning:
Reservation Improvement Model (prevention programming with a focus on the community, promoting tribal identity),
Navajo Alcohol Abuse and Education Project (tertiary, detox, residential, group homes, outpatient and day centers),
National Association for Native American Children of Alcoholics (primary - network for Indian COAs, educate, national conference, inform policy makers about needs),
• Four Worlds Development Project - see Bopp article
Summary: 60 actual programs were considered and reviewed. 55% promotional; 68% primary, 13% secondary, and 35% tertiary.
Promotional - most activities were education/training, and more than half of these had a sociocultural component. 27% provided recreational opportunities.
Primary: Mostly individual counseling and psychotherapy services (49%) and education and/or training (44%). About 25% included culturally relevant experiences and large groups had a special facility (24%) and group treatment (22%).
Secondary: Over 50% offered individual counseling and more and 1/3 had group treatment. And 25% provided a referral service or special facility for individuals in early stages of abuse. Secondary is the least used strategy.
Tertiary: Counseling in almost half, and 52% had group treatment. 43% had a social-cultural component, and over 1/3 provided a special facility.
Few evaluations have been done on these programs.

Next section summarizes grant programs funded by OSAP. Describes programs and then does a summary analysis.

Rural Alaska Community Action Program (for high risk youth): Promotive activities include a resident alcohol resource person for each village, consultation leading to a needs assessment, community workshops and development of a curriculum (preschool-12). Primary intervention: month-long workshops targeting high-risk people. Case-finding and referrals were made. Tertiary - individual and group therapy, and self-help groups.

Tanana Chiefs Conference, Inc. (for high-risk youth): Elders helped with needs assessment and in the selection and modification of youth organizations. Activities were designed to develop personal and social skills. Youth participated in economic development activities and an annual youth conference. Primary prevention in leadership training given to adults and to youth leaders. Leaders could then better identify peers for referral.

Kodiak Council on Alcoholism, Inc. (adolescent alcohol abuse): Focuses on early identification of students and families (through school system) for interventions. Youth caught using or selling are suspended and attend a day treatment program. During program, child is assessed, continues with academics, participates in workshops, AA and NA, family counseling, Alaska Native counseling, and recreation. Workshops and support groups for families as well. Group home is available, as is aftercare.

North Olympic Alcohol and Drug Abuse Program (Student Assistance Program): Education and training are available, as are classes for both students and parents. Parent support groups. Natural Helpers, a peer counseling program, helps with early case-finding. Intervention plans are established by a team and are coordinated with many different agencies.

Shoshone-Bannock Tribal School (school based for jr. and sr. high): Primary prevention includes, a formal alcohol abuse curriculum and classes on Native American Studies. Counselors are available for individual and family sessions. Alateen. Screening and assessment of high-risk youth. Parental sessions and a summer family campout.

Confederated Salish and Kootenai Tribal Health Department of the Flathead Reservation (Blue Bay Project): Formal substance abuse curricula in all the schools, chemical-free activities for youth and adults. Did much training of staff and providers, which created a network of recovering role models in the community. Support groups for ACOA and an EAP program within tribal personnel. Drop-in youth centers and support groups.

Chippewa Cree Tribal Business Committee (school and community based): After school resources learning center, for youth and families, curriculum, training sessions, recreational activities, cultural activities. Coordination of substance abuse resources is important. Also provides career counseling to students.

Sac and Fox Tribe of Indians of Oklahoma (School and Community-based, ages 3-21). Training in the community on substance abuse, communication and parenting skills. Youth receive information on substance abuse and life skills training. Peer counselors act as resources. Individual and group counseling are available. Screening, referral, transportation, outpatient and after care are all available.

Indian Health Board of Minneapolis, Inc. (community-based program for children 3-20 and their families): Social center and services are available to all Indian families in Minneapolis. Offer classes, recreational activities, community service projects for youth. Youth are identified and referred if necessary.

Fond du Lac Reservation - group home for 12 Indian youth, ages 8-18. Primary prevention in the form of substance abuse and life skills education, library materials, recreation, support groups and
Many opportunities to learn about Indian culture. Offers a work-study program, so youth can contribute to the community.

**Bad River Band of Lake Superior Ojibwa** (community based program for youth, ages 1-18 and their families): Workshops on Indian culture. Formal curriculum based on advisory board of educators and elders. Offer recreational activities and workshops.

**Cherokee Center for Family Services** (early intervention for youth ages 10-18 who are already substance abusers): This is a court diversion program, which includes education, recreational opportunities (emphasize adventure, education and service) and formation of youth clans.

**Summary:** Most of these interventions are primary. Social action, education training, and cultural enhancements were predominately promotional activities. Most secondary programs offered assessment and referrals, individual and group therapy and self-help groups. Tertiary interventions were group and individual treatment.

Most projects use multiple approaches, with cultural activities being prominent. Most programs rated them themselves between 5-7, on a scale from not effective (1) to extremely effective (7). Major barriers were a need for more time to educate community leaders, and employing qualified Native providers. Most projects did not have specific outcome evaluation plans, but did know what they wanted to measure. That major outcome variable was number of clients to complete project.

**Prevention and Treatment**


The authors advocate a community based approach which aims at creating a community ethic regarding alcohol use and abuse. Also the community must make clear what acceptable behavior is.

Steps: Need to form a core group to define problem and gather data regarding the extent of it. A report should be generated and local resources to deal with problem assessed. Task force can generate specific strategies, must be developed locally. The visibility of the task force is important in getting community ethic across.

Schools are important as well, as they can be the focus of the community. Police and courts should work in conjunction with the community task force, so that their work can collaborate with task force interventions. Community-based approach needs cohesiveness, may not work everywhere.


Community approach is crucial in order to provide services for treatment and prevention. Important to include every agency or unit in community that can contribute to substance abuse problems. Representatives from alcohol and drug-related agencies need to be leaders. Prevention program in Ignacio, Colorado: Indian Youth "Drug Busters" has an annual run, monthly meetings, movie trips, drug-free parties and dances, a teen center. Entire community benefits.

Family focus:

- Involve as many members as possible in interventions.
- Provide families with factual information re: problem drinking
- Avoid labeling people as alcoholics
- Work with individual through appropriate family or clan members.
- Help family become aware of community resources.
- Do not give up easily.
- Deal more with behavior than feelings.

Contracting: a written contract between teen and parents re: alcohol use.

Community Recommendations

- American Indian elders can be helpful as role models and support.
- First offenders program, where teens and parents are referred for counseling.
- High school programs with counseling offered.
- Identify at-risk teens who are leaders in school and who participate in activities, may be pressured to use.
Train teens to act as models and volunteers with younger children or elders. Seek out employment opportunities for youth.


Maintain “relatively higher” rates of alcohol abuse and alcoholism than the general population. Prevention programs should address strengths of community rather than pathology. Describes briefly a longitudinal study they conducted. Recidivism was the rule, with successful outcome the exception. Successfully recovering clients were “younger, more educated, more stably employed, more involved with their family and social support system, and more occupied with cultural activities and traditions.” (p.59). They are now focusing on adolescents; identifying risk and protective factors, and trying to develop a screening battery for early identification.

Indian Health Service. (1985). Indian Health Service Alcoholism/Substance Abuse Prevention Initiative.

Women are underserved by the IHS in alcoholism programs. A major differing factor in programs specifically for women is the provision of child care. Another factor is the elimination of male/female role expectations.

Prevention: establish the desired outcome threshold and then do post-testing only.

Dr. Walker emphasized the need to do outreach, motivating patients into treatment, and then follow-up services. Need to link alcohol programs with other programs. Need to be selective about matching treatment to patients. (p.53). Dr. May: prevention: 1) identify modifiable behavior 2) develop program that can motivate people 3) enhance optimism. Focus should be on alcohol abusive behaviors rather than alcoholism. Program needs to identify something in the community that is “antithetical to alcohol abuse and reinforce that antithetical component.” (p.56)

Prevention Special Session: Learn by Doing, young Indians work on health-related projects, are paid and recognized. Dance groups, intergenerational mentoring programs, keep elder active and needed. The Colville Tribe wants families to take more responsibility for their children. If child gets in trouble parents should be involved in the therapy. Noted that prevention has many forms: Big Brother/Sisters, scouts, Outward Bound, survival schools, parental support, career development traditional arts, refusal skills, 4-H, performing arts, rodeo school, aerobics, etc.


Need to recognize that there have been interventions and prevention for psychological problems inherent in American Indian culture. Need to blend these with conventional approaches. Any intervention must be changed to fit local customs. By itself, cognitive-behavioral approach not effective, needs to be integrated into the community, and local people must be involved in modifying the program to fit their needs.

Treatment

Treatment models: 1) Kakawis Center: A family development center that emphasizes cultural and traditional teaching. Native families (eight at a time) reside in apartment for six-week stay. “highly successful” (p.45). Family is the entire focus, sobriety targeted first, then family healing and development. Kakawis staff facilitate growth and clients are responsible for their own progress. Extensive evaluation has been done of this program. (Results not presented.) 2) Half-way houses and Continuum of Care. Little aftercare, etc. in order to aid in transition back to home community.

Recommendations need to emphasize community and family based treatment, at the village level. Communities need large amount of discretion as to how to utilize substance abuse treatment funds. Funds should go directing to Alaska Native organization and village councils, rather than government agencies.
Peyote suitable as a treatment for the social and psychological problems of alcoholics. Ceremony is pan-Indian and is held in high regard. Has strict rule of no drinking 24 hours before program. Participants are encouraged to express feeling and support and empathy is provided by the group. Philosophy of the NAC is good because it reduces isolation of the alcoholic and allows expression of inner feelings, as well as the development of a sense of identity.

American Indian Eagle Lodge, Long Beach, CA. Program brochure.

Treatment approach: structured, comprehensive. Focus is on three areas; 1) Delayed Gratification, 2) Self-Discipline, and 3) Responsibility. Use cognitive therapy to recognize "identity conflict, cultural shock and self dehumanizing behaviors."


Four factors central to alcohol abuse and their implications for treatment using this model.
1) Rapid consumption of alcohol: drinking rate control training can be useful, especially in a group setting in order to generalize to natural drinking situations. Also, BAC discrimination training helps individual to be aware of intoxication. Self-recording of drinks can slow rate.
2) Outmoded models of prolonged intoxication: behavior therapy can establish the skills needed to maintain a model for controlled drinking. Also, abusive drinking can be identified as not a part of traditional Indian values.
3) Non-responsibility for Intoxicated behavior: this can be controlled directly by behavior therapy. Client can learn to use social situations for the maintenance of controlled drinking, rather than having the social situation control them.
4) The Peer Drinking Group: any treatment needs to address this directly. Stimulus control can be used so client can recognize social situations that could lead to excessive drinking. Also, interpersonal effectiveness can help resist social pressure.


Interventions need to be impactful and pervasive. They need to produce positive affects, facilitate social interactions and help the adolescent to cope with negative affective states. Interventions should include group and individual activities, social skills training and opportunities, training to deal with anxiety and anger and support systems. Interventions will need the combined efforts of community resources. (This article has been lost - I have re-ordered from ILL).


Examines case histories of recovery from substance abuse using peyote ritual.


In recent study (Coleman and Davis, 1978) found that 93% of 2012 agencies with drug-abusing clients included family or marital therapy. Yet, racial-ethnic minorities were less likely to receive family therapy. On Navajo Nation drug workers were concerned about damage which was occurring to the family structure. Difficulty was that Navajo parents refused to come to an agency for therapy. So counselor went to family home accompanied by a respected local clergyman. If parents were receptive they would meet the counselor outside the house and discuss their child's drug problem. Each agency
needs to adapt family therapy to the cultural norms of the treatment population. In these agencies, the family was considered the most important factor in the recovery process.


Describes Seattle Indian Alcoholism Program, and the contributions of anthropology to program evaluation. Has both inpatient and halfway house. Directed and staffed by Native Americans. Has three different phases, initial orientation, which is restricted, second phase, begin to explore future, and third phase, resident are given referrals for vocation and academic training. Maintains an office near downtown where patients can go for counseling, meetings and drop in. Philosophy is that alcoholism has no cure, but can be handled through sobriety. Promotes a sense of community, has an outreach program. Counselors keep in touch with former patients. In 1981 were conducting a 2 year longitudinal study of program. Ethnographic study, baseline and follow-up interviews, and forming a normative sample of Indians who do not misuse alcohol, to get a better understanding of misuse and its measurement.


Presents a new theoretical approach to Native American alcoholism, called "invasion reaction". This approach recognizes the history and physical, sociocultural, emotional, and spiritual aspects of Native life. (Ordered article from ILL).


This approach is a long-term intensive case management intervention suitable for severely disabled chronic alcoholics. Goals are to stabilize clients' lives by assisting with financial aid and housing, and then to help reduce or cease alcohol consumption. Preliminary results from 6 month follow-up indicate relative success for the case management intervention.


Criticizes research that makes culture responsible for the drinking problems, as a result of parental and community attitudes etc. Cites much of the literature regarding what has been done. States that prevention efforts are not consistent with the etiology. "What is not recognized is that alcohol use and even suicide may be a functional behavioral adaptation within a hostile and hopeless social context." (p.75).

Need to strengthen those mechanisms that sanction or control deviant behavior. This supports autonomy and revitalization of traditional culture. Describes this with the Alkali Lake tribe. "Most prevention projects are suspect in that how can prevention be a rational process when the community is already inundated in alcoholism and substance abuse?" (p.78)

Talks about showing respect for the forces of alcohol, in a spiritual sense. Has clients appease the spirit of alcohol, and talk to it. Eventually client can be more offensive. Can perform purification rituals. Therapist should be able to refer client to healthy social activities. Need integration of new lifestyle.

Inpatient-treatment, group therapy, working with unconscious. Obtain analytical tools. These are all in addition to other therapeutic strategies.


Author's hypothesis was that those with a stake in society would respond better to treatment program than those who did not. Those with a stake in either traditional or both traditional and modern had longest-term success. Stake was defined as "a consistent investment of time, skill, and other resources in the context of society with expectation of reward." (p.75)

Describes community development approach, which stresses a healing process to break generational cycle. The paper focuses on the results of 2 external evaluations, one which was a survey of client satisfaction and community awareness, and one which was based on 12 key informant interviews. (Waiting for article from ILL, biblio summary is from Psych Lit abstract.)


Disparity in values one reason why so few Native American alcoholics remain in treatment. Needs to be further explored. This study supports the poor recovery rates for NA alcoholics. If similarity in values is an important component of psychotherapy than it is not surprising that the success rate for NA alcoholics is so low. Also need to explore if group differences are due to alcoholism.


Used the St. Paul, MN "Red Schoolhouse" model or philosophy. Development of an identity of "Indianness" was important, and should include a tribal-specific base if possible. The kids need to learn via participation. The program operated for 10 years (1977-87). All prevention and intervention strategies were culturally specific and contributed to a send of identity. The cultural therapy program used the craft skills of traditional girls who were at-risk for alcohol abuse. They had a new role as teachers with the children. Out of a small sample of only 9 girls, only one has shown any alcohol related problems.


Therapy: should focus on "enhancing the client's 'Indianism'”. (p.161) Once this objective has been met, need to help client find strategies to survive in the world. French calls this ‘multicultural integration’. The counselor is responsible for cultural empathy, but should feel comfortable with own cultural identity. Need to help client manage in both worlds. Uses behavioral cognitive therapy, focusing on self, reality and the immediate future. Multicultural integration consists of "didactic and problem solving techniques.” (p.161) Didactic component should pair Indian language or perspective with English or U.S. majority culture. Problem solving can be learned in individual, family and group counseling.

With chronic adult Indian alcoholics, paradoxical interventions can be helpful. Uses a videotape of client while drunk. Elder participates to help prevent depression and shame when this is used.

Two rules. 1) need to foster positive self image during cultural counseling stage and 2) prepare for problem solving within own culture and larger society (multicultural integration).


Salish-Kootenai people. 1) looked at problem, who is being hurt and how. 2) Assessed tribal values. 3) Identified four healing principles that would address problem in a way that supported our tribal values. 5) Looked at resources 6) made plan and implemented it 7) evaluated. (Similar to the community development approach advocated by many.

Healing principles: Solution must come from the community 2) Must discover life-enhancing values in culture and build these 3) Need an ongoing learning process 4) individual and community healing must go together - these are all based on Four World project.

Resources: Lost of healthy people would be role models. Renewal of traditions.

action Plan: Foster personal recovery for high risk individuals. Help youngsters choose not to abuse. Intervene in the generational cycle of substance abuse. Healing center would be community based, use traditional Salish-Kootenai system, be a visible expression of tribal unity and pride. Blue Bay Center: Upon return from residential treatment, family meets there. Together they learn about alcoholism and
how it affects everyone. Lean to have fun, Indian traditions, communication and resources. Predictable routine, meals and space are provided. Hosts support groups. Positive atmosphere. Dances, hiking, swimming etc.


Program was completely initiated by members of that community. All actions were completed without involvement by external people or institutions. Social support network was formed. Educational objectives were clear. Wanted to provide skills in order to add jobs and reduce poverty. Leader addressed alcoholism as a community program and created norms that no longer tolerated it at an individual level.


Did extensive outreach activities with schools, churches, courts and other referral sources. Treatment outcome was discouraging, most clients left without finishing program. Research needs: would rewards for completing program help impoverished clients? 2) would traditional healing practices appeal and help urban Indian clients? 3) Need to better define treatment goals, are those of clinic and those of client the same? 4) need to clarify which treatments have good outcome, from eclectic mix employed here.


Sweat lodge - pan-Indian movement. Produces a strong physical and emotional reactions. Can be used as a supplement because it is a ritual, not a formal organization. In a study done, there was no relationship between having a sweat lodge and the type of alcohol treatment program offered. This is evidence of the sweat lodge's flexibility as a treatment modality.

Use of these indigenous practices requires more than sensitivity, it requires a belief and trust in another way of healing, and another philosophy. Sweats can integrate alcoholics into the wider community. this can help maintain sobriety.

Remarks on integration of Western and Native practices. "Particularly striking in the interviews was the ability of personnel to integrate contemporary psychological concepts and skills, ... with traditional arts and beliefs. " (p. 175).


78% of NA 12-17 have tried alcohol, compared with 53% of population, by age 11 years, nearly 1/3 have tried it. 42% of NA male teens are problem drinkers, as compared with 34% of Anglo male teens. More frequent substance use because NA teens have significantly more risk factors. Basic risk factors: ethnic dislocation, lack of familial sanctions, and peer pressure. Mentions bicultural competence and focusing prevention on family and community rather than individual, as well as early intervention. School and community cooperation as well as ethnic and tribal appropriateness. Basically a review of the literature.

Reviews implications of increasing quantity and quality of professionals. Need to learn integration between conventional and traditional interventions. Collaboration with elders, medicine people. Need to pay attention to spirituality.


Support for family systems approach. 1. Past efforts have been ineffective. 2. Treating individual and returning to same environment perpetuates process, 3. Family members need treatment.
4. Treatment seems to be more effective when whole family participates. 5. Native peoples view alcoholism as a community problem in need of a community solution. This author looks at it from a biopsychosocial perspective. Need to look at family in context of acculturation, values and cultural variation in drinking styles. It appears that the drinking style is maintained by entire families and not by individuals, and in a sociocultural context, is viewed as a social response that is culturally relative.” (p.257). Most important in treatment and prevention are psychological factors. "It is possible that sociocultural factors that are specific to each cultural area, or specific tribe, are more important determinants of alcoholism than is the family.” (p.260).

Framework needs to consider physiological, sociological, and psychological factors. Once the framework is built, one can develop appropriate treatment and prevention strategies.


Having studied personality differences, authors offer suggestions. NA women may resist making confessions of weakness. Could use confrontation techniques such as Reality Therapy. Counselors should consider relaxation training, self-concept building and rational-emotive therapy. NA women were average or above on extroversion. Seek out group and family support systems. NA women scored high on toughmindedness and resistance to authority. Should incorporate cultural traditions and practitioners to avoid any perception of external authority.


Educational programs are appropriate for children because: Indian youths are socialized to accept concepts in that manner, these programs are accessible, etc. Positive results are obtained from programs that build affective skills, and involve parents and peers produce more positive and lasting effects. There is also a positive relationship between intensity of program and effectiveness.

A demonstration program which was successful used a Teen Advisory Group. Did skits, peer-targeted health newsletter, videotapes, presented workshops at other schools.

Teachers roles: empathy, socialization, exercise, survival skills, education about drugs, non judgmental, understanding parents, anonymity, self-image.

School-based content: most frequently, programs include decision making, peer pressure, values clarification, education re:: alcohol effects, self-awareness and cultural issues.

School activities: most frequent: counseling referral, psych. enrichment, workshops, peer group counseling, self-help.

Criticism: study does not pinpoint which activities actually work. Only 7% of school programs indicated a positive outcome of reduced alcohol-related incidence and reduced abuse.

Community-based programs: States that promotion of health and wellness are now a supported concept among Indian people, especially at local tribal level. (p. 63). Intervention should focus on targeted groups, rather than individuals.


Treatment approaches: include both individual and family. Need to address "Bio-psychosocial-spiritual antecedents, influences, and effects associated with the patient's dependence." (p.1) Treatment outcome is improved when exposed to full range of services. Focus is on assertiveness, independence and balance. Services include, 12 steps, addictive process, physiological and psychological affects of alcohol, acculturation, communication, problem solving. Use individual, group, gender-specific groups, family, marital spirituality, educational, lectures, films, skill practice, recreational therapy, nutrition, physical fitness, etc. This program requires aftercare services.


Discusses how AA has been integrated into the cultural framework of the tribe, and how they have adapted traditional AA concepts to better fit their cultural values.

Fifty urban American Indians followed through 2 years. Averaged 44.6 detox admissions and had not sig. change in number of annual detox admissions. Recommend social setting detoxification: a nonmedical approach with three goals: supportive counseling with safe withdrawal, referral to further treatment, and cost-effectiveness. Patients more likely to continue in rehab after social setting detox. than after med. detox. Their study reflects the revolving door of detox.


Women without traditional centers of support seem to be at higher risk for alcohol abuse. Suggestions for programs to serve AI women:

- Early education programs for children.
- Acknowledge of cultural traditions.
- Integrate mental health services, drug and alcohol programs, and include traditional healers.
- Respect spirituality.
- Be flexible in "where, when and how services are provided." (p.28).
- Include family in treatment, hire Indian women as providers, increase research.

Connections between alcoholism, education and unemployment are strong. Employ women as teachers and use elders as role models. Use vocational training programs.

"Indian women are in a unique position to provide a network of support and education to their communities and their children." (p. 30)


Therapist Barbara-Helen Hill, former program director of Weendahmagen alcohol and Drug Treatment Center in Thunder Bay, Ontario. Has an unusual and controversial treatment program. Does lots of ceremonials, said it was effective. The condolence ceremony. Urges her clients to face ACOA issues early in recovery. Her plan includes: awareness of issues, abstinence, nutritional support, avoidance of substituting compulsive behaviors and exercise.


An ethnographic interview fulfills two functions: can help identify issues of cultural relevance in treatment, and can give a broad base of knowledge with which to compare individual behavior. Interview can identify the meaning that people give to alcohol in their life.

Review of other literature: United Tribes of All Nations Foundation developed a puppet show to teach Indian Children different skills to cope with alcohol use and abuse. Research setting, Puyallup Tribal Treatment Center which integrates Western and traditional treatments. Sweat lodge, individual and group counseling, classes in alcohol, poetry, nutrition.

Results: participants identified the need for more familial support and affiliation in order for them to stay sober. Significant numbers needed support of other alcoholics, steady work, and a stable environment in order to maintain sobriety.

Implications for treatment: therapist needs to be accepted and respected by American Indian community, and be comfortable within client’s social framework. Therapist should not emphasize professional role. Group work can be appropriate, provided therapist is subtle and indirect. Therapist should work within the influence of the extended family, make no cultural assumptions, and should have client and family identify issues.

The early efforts toward treatment of Native Americans focused on the AA model, though reports have raised objectives about it lack of appeal. AA appears to be successful where it has been "Nativized". Western psychiatric approaches have not been adequate and there have been reports of lack of understanding and discrimination by White staff towards Native American clients. There are only a few reports of non-Native American program which appear to help, there include integrated programs, education about prescribing tranquilizers, and Christianity.

The use of Disulfiram receives enthusiastic support in the early literature, as it appears to be effective against peer pressure to drink. Review discusses the trend towards adapting treatment approaches to Native American culture and that these programs seem to be helpful. Much of the literature calls for Native Americans to staff their own alcohol programs as counselors.

Leland reports that studies have shown how practical approaches and services are developed to serve not only the drinker, but those who are affected by it. These include alternative activities, transportation, and emergency aid.

The transfer of programs from NIAAA to IHS is discussed, and the implications that this may have. The main problem with the treatment literature is the lack of evaluations.

One treatment approach which has been suggested, but not tried is that of mobilizing wives in the fight against drinking. This also involves coping styles. Another approach would be to teach controlled drinking, which does not appear to have been tried. This would require behavior modification techniques.

Prevention programs have been called for since 1964, but little appears in the literature at the date of this review.


Literature review: (1) nativistic 2) conversion to evangelistic religions, 3) individual aids provided by psychotherapy and AA, 4) AI group-oriented programs. Suggests a "cultural 'bias' toward the medical model, even though it has been suggested that Indians who possess a different world view will not respond in a constructive manner." (p. 322). Also suggests that because these types of programs have access to journals, it is difficult for new innovative programs to be implemented. AA helpful only to highly acculturated Indians (shouldn’t they decide?)

Most promising include Indians in programs. limited by federal funding requirements.


Recognition that treatment needed to take cultural heritage and values into consideration. Staff would be accessible 24 hours a day, on a rotating basis, would live in the target community, would emphasize education and prevention as well as treatment. Treatment should use a community approach and would involve excessive, moderate and even potential drinkers. Projects should be administered by the tribal council. Did community survey to identify needs. Those needs were education (meetings, medical testimony, youth advisory group,) prevention (encouraging abstinence, reducing consumption, socially acceptable drinking habits) treatment (counseling, referrals, guidance, follow-up. Tried to provide formal training for community residents, had a resident attend a two week introductory training workshop on alcoholism.


Need to address women and alcohol. why do most women not abuse alcohol? Need more research into Indian social drinkers, as well as those who are sober and abstinent. Advocates community-wide therapy. Nothing to lose, and should try innovative different approaches. Four Worlds Project should be applied in the U.S., not just Canada. Pan-Indian traditions, sweat lodge, ceremonial drumming and the sun dance. Some culture better than none. AA and Children of Alcoholics.

Manson (Ed.), New Directions in Prevention among American Indian and Alaska Native Communities. Oregon Health Sciences University.

Little research on effectiveness of strategies for chronic alcoholics, the kind of community support that is needed, or on how to create and maintain that support. Harvey, Gazay, and Samuels (1976) described a program that was student-run regarding alcohol. Six student were sent to an institute on student-run alcohol programs and returned as leaders in a new program with peer-counseling and detox.

Methodology and definitions of alcoholism and problem drinking are very problematic in the literature.


Does overview of treatment literature in the areas of 1) therapeutic functions of indigenous healing practices, 2) differences in cultural values and implication for counseling 3) psychoanalytic elements 4) legitimacy of traditional healers 5) structure and evolution of formal delivery systems. Also mentions psychoanalytic techniques, group therapy and family network interventions. Discusses a family system model by Redhorse. Also reviews prevention literature, and some work on general prevention techniques.


While not a scholarly article or book, this collection of interviews with Native American recovering alcoholics and addicts is very recent, relevant to treatment and prevention, and personal. It is worth taking a look at, if only for your own knowledge.


Ethnographic observation is essential to understanding the experiences of alcoholism, achievement and maintenance of sobriety, and strategies for coping in Indian people. Among the Sioux, "intervention and behavior modification, which is the crux of sobriety, are self-induced and constructed in such a manner as to withstand the pervasive, calculated an continuous pressure of a peer group . . ." (p. 206). Sun dance for therapeutic reason, to seek aid to eliminate dependence, a new change in the ritual. Yuwipi ceremony, may be held specifically for a person with a drinking problems. Ask for help from the spirits. A person seeking aid from an Indian spiritualists or counselor is not given specific direction. Strong emphasis on autonomy and will to change.


Describes Urban Indian Child Resource Center in San Francisco. Organized foster families into the Family Support Network. Takes on the same role as the extended family or clan did in traditional society. Provides support, advice and caring. "Much of the work of the Center takes place in and around events such as potlucks, powwows, feasts, and recreation programs.” (p.186). Families are expected to be interdependent, not encouraged to go on own, but to ask for help if necessary. (While this article is not specific to alcoholism, it addresses the issue of community, the integration into which is very important for recovering and maintaining sobriety.)


Advocates exclusive use of the biogenic paradigm for alcoholism. Under this paradigm treatment is consists of professional treatment only during, "acute detoxification and the troublesome early weeks of recovery." In order to bring the patient back to sanity use medical management, directive counseling, appropriate nutritional therapy, regulated rest, moderate exercise, and complete reeducation.
to the neurological origin of alcoholism. With this, the syndrome and craving will subside. 4 week inpatient. No attempt to do therapy with the "fading, counterfeit self.". After they stabilize, go into 12 step program for long term maintenance and self-realization.


Little research has done regarding the effectiveness of alcoholism counselors and how to attain sobriety among Native Americans. Did a study of 277 American Indian counselors, in an attempt to define factors which were most beneficial in their own achievement of sobriety. Acceptance of drinking as a problem was the first and most important step. AA was most helpful program by far, as was voluntary participation in a recovery program. Being engaged in meaningful activities was beneficial in maintaining sobriety. Vocational training was appreciated as much as educational programs. Spirituality was considered helpful, as were avoidance of old drinking relationships and emotional support. Forced participation was considered the least helpful intervention. Interestingly, less than half of the former drinkers considered Indian pride and education helpful in maintaining sobriety. Internal factors were the most helpful.

Therapeutic Interventions: Competent, trained and committed personnel. Supportive Antabuse therapy could be important. Atmosphere should be positive, time for contemplative thinking, meaningful activities should be scheduled. Medicine men should be accessible and visitors and family members welcome. AA programs should be sanctioned by leaders in the community. Physical needs should be addressed. Involvement in cultural and social activities. Need to help deal with emotions. Daily spiritual awareness program can be helpful. As clients gain sobriety, educational programs can be helpful, to meet long-term goal of enhancement of self-esteem. Employment readiness programs, have people in recovery organize community activities. But, number one priority should be helping clients "become aware of and accept responsibility for their drinking behavior." (p.95).


Handbook describes how to implement family systems approach to recovery. This approach was developed through primary and secondary research in treatment centers, Native communities and other institutions. This model does not exclude current approaches, but adds a new way of thinking about the issues involved. Model covers family systems theory, family of origin, genograms, the family life cycle, the alcoholic family, the healing process, working with families in treatment. Covers important considerations when counseling Native families. An appendix in the handbook summarizes interviews with staff from Native Substance Abuse Treatment Resources. Cultural and traditional practices were the most emphasized. Majority of the staff saw a need for more inclusion of the family in treatment. Describes the Kakawis program, which has a six-week program for families, with separate components for spouses, youth and children. Has an on-site school and day care center.


Found little difference in etiology between white and NA youth patients, but at 6 months follow-up, outcome data were much stronger for White patients. Treatment program was 4-6 weeks, reality therapy. Though all of the Indian patients were using some kind of alcohol or drug at 7 month, there was a reduction in number of drugs.


Advocated a task-centered group approach for culturally marginal American Indians. Offers guidelines for setting up a group structure. Profile, recognize alcohol use as problematic. Homogeneity of group members is encouraged, those who identify with both tribal and non-Indian cultures. This approach fits in with the traditional sense of responsibility to family and tribe. Task-centered treatment seems promising, organized around specific tasks to manage sobriety, especially dealing with situations
of conflicting values. Emphasizes a pragmatic style of actions, emphasizes client autonomy and tasks value putting the group welfare first, which is a traditional value. Gives guidelines for structuring the group and tasks.


Draws analogies between the peyote ritual and individual psychotherapy, group process, family systems theory, etc. Also compares it to AA, as far as introspection and awakening. The drug-altered state is used to facilitate insight and communication. Similar to Western individuals reliance on a psychotherapist. Could be useful within the ritual meetings for certain Indian alcoholics. Promotes self-actualization and spiritual consciousness. This is what is missing in most treatment centers.


Early stages of alcoholism, introduce individual to the sweat lodge, can make a difference. Yet explaining these methods to funding agencies is difficult. Need to satisfy both Indian and non-Indian concepts. Need to use non-Indian concepts that can be useful, such as money management. Need to have Indian counselors, to promote trust and a better relationship. More sensitive to Indian values and needs. Treatment setting may be the only place an alcoholic can feel like they belong, try to keep them moving into more complex communities as they progress.

Prevention: youth activities, cultural, sports, and social. Used media; TV, radio, newspapers to get message across.


Native Americans tend to be treated in two different networks: alcohol treatment and community mental health. Alcohol treatment emphasizes detox. Designed to treat an immediate problem. Community aims as uncovering causes of behavior. Study data suggest the need for a treatment system that can respond immediately. Should also include services such as legal advocacy, shelter, food and clothes. Efforts should be concentrated on female Native American drug user. Should target services to a group with Native Americans as defined by their drug-using behavior. Tribal difference impeded unified NA treatment approach.


Describes model programs and recommendation. Waiting for article from ILL.


Literature on treatment is mostly speculative. Most articles call for cultural sensitivity, but there are few actual models that specify how to proceed. There is also a lack of evaluation and follow-up studies to determine success of interventions. Need for further research in treatment and prevention. Value differences may be one reason AI patients drop out of treatment. Treatment should consider client's meaning of spirituality. Also, some say treatment should empower individuals to be bi-cultural.


For Native American women in the early stages of recovery, research suggests that it may be helpful to have counselor of same ethnicity. Sensitivity to spiritual issues is important for therapists. Some argue that cultural sensitivity is not as important in first stage of recovery. Study of NA alcoholics
found top three factors in obtaining sobriety; 1) recognition of problem 2) awareness of reasons for drinking 3) motivation to refrain from drinking.” p.43)  Treatment should have main emphasis on “actual drinking factors.” p.44). AA meetings are helpful, as long as they are adapted for the local culture.


Describes a drug and alcohol treatment program in San Francisco which caters to Native Americans. Counselor help clients reconnect with their culture through spiritual foundation building. A major tool is the reintegration of traditional rituals into daily life of the community. (Still waiting for article from ILL).


Most common overall treatment orientation was AA/NA (71%). The literature "suggests a need to find out which parts of AA are commonly utilized, and which are de-emphasized.” (p.18).

Top five treatment orientations were AA/NA, outpatient treatment programs (generic), outpatient drug free programs, 28-day Hazelden or Minnesota model inpatient treatment programs, and Native American traditional healing. When asked to estimate percentage of clients who were "successfully rehabilitated", responses ranged from 1% to 95%, with an average of 45%. Treatment orientations were not correlated with successful rehabilitation. Over half the programs reported family of clients involved with client in counseling, through Al-Anon, and with other families in counseling sessions.

Top five elements in treatment plans, in order of importance were: 1) promotion of abstinence, 2) encouragement to become responsible for one’s own life 3) individual and group counseling, 4) recognizing/admitting addiction, and 5) physical, emotional, and spiritual effects of alcohol and substance abuse.

Discusses the stages of change and that the counselor may have the opportunity to move clients into the action stage, which may improve chances of success. No suggestions are given about how to move clients toward this.


Common characteristics of programs: 1) evolved from within the community 2) coordinated with the IHS 3) practiced intensive social casework and rehab, employing nondrinking Indian alcoholics as caseworkers 4) used principles of AA, 5) used court referrals 6) respected cultural characteristics.


IHS programs have little direction or philosophy of treatment and very little evaluation. Currently most programs are established locally and use many different treatment approaches. Most have some affiliation with AA, as well as with traditional religion and cultural activities.

Treatment outcome: success is the exception, and much focus has been on chronic users, programs for which are described as "custodial." Aftercare can contribute to successful outcome. Relapse prevention techniques are needed. Suggest treating and following-up with entire drinking group at once.

Antabuse and Antidepressants: need more evaluation of this alone, and with other treatment modalities. Tricyclics show promise. Detox: Alone has been criticized. Should research "mobile assistance patrols, drop-in facilities, sleeping-off places and 'dry hotels'." (p.78)

Interpersonal skills may be related to outcome, and research should also look at controlled drinking, vocational rehab. and patient attitudes and motivation. Skills training, and family intervention strategies. Could use family therapy for when alcoholic moves into sobriety.

Focuses on the similarities between these two organizations and how the Shaker Church has been influential in helping its members maintain sobriety.


IHS physicians attended a workshop at the Hazelden treatment and training center. Participated and interacted personally with patients. Implemented a training program. Three day workshops, self-study materials to be made available in libraries, and community education materials for providers to use in schools, tribal councils and meetings.


Native American Rehabilitation Association (NARA) In Portland OR. Out-patient clinic, in-patient treatment, and one for women and children. During mothers' sessions (6 hours a day, 5 days/weeks), child care is provided, which is very critical, so mothers can focus on treatment. In treatment help clients re-establish relationships with family and friends. Focus on four areas, relationships with creator, spouse or partner, children, community. This is a very important area. Self-actualization treatment, four different generations in four areas of life. Spiritual-religious, social-recreation, training-education, family-self. Treatment plans follow cultural orientation. Important to resolve conflicts. Self-actualization is realized when individuals can 1) freely choose preferences; 2) be non-judgmental towards other lifestyles and values; and 3) can function between two worlds, being aware of the proper conduct in each.


Purpose: to "improve and enhance the possible outcome indicators which substantiates our ability to reduce the rate of alcoholism and alcohol abuse within the Native American population which we serve." (p.2) Program claims good results, between 39 and 70 percent of clients complete the treatment program. By classifying clients according to "generation", treatment staff can direct planning and goal setting more accurately. Counselor and client together determine current "generation." Have added a requirement that clients resolve at least one cultural conflict before discharge. Resolution of conflicts is necessary for Indian clients to maintain sobriety, because "the success of maintaining sobriety lies in part with conflict management." (p. 12). This process enables clients to live in both worlds.


Outlines dimensions of cross-cultural treatment: medical, psychological, socioeconomic, and cultural-historical. Medical, can set limits on treatment choice. Psychological: provides a picture of client's ability to experience psychological growth. Socioeconomic: position client occupies in community, and degree to with community can meet their needs. Cultural-historical: long-term practices and beliefs of cultural group. Therapist need to be familiar with this and understand what it means for the client to participate in daily life.

Treatment: medical intervention: need to stabilize problems. psychotherapy: using verbal interaction to help client grow, understand and resolve conflicts. cultural-historical dimension of this is very important when client and therapist are from different backgrounds. Need to consider this when behavioral directives are employed. Environmental intervention: therapist does something to help change client's environment, which will reduce stress in client. Controversial, but in many places lack of knowledge of social services make it clear that therapist should consider this role.
Treating Navajo "alcoholics": treatment biased toward medical or cultural-historical not likely to be successful. Need to consider different treatment for clients with more severe psychological disorders. Treatment cannot be limited to the patient.


Report deals with different treatment settings and therapeutic interventions, as well as preventive and promotive activities. However it does not specify which would be appropriate for alcohol abuse, just mental health in general. For adolescents in particular this report advocates the use of mental health services in or adjacent to schools, as well as therapeutic group homes and home-based interventions. The report goes over all the different types of interventions that are available to use, but mentions that systematic evaluation of such processes are rare. The most commonly used interventions with Indian clients appear to be supportive and client-centered psychotherapy, group psychotherapies, single issue groups, and self-help groups. Family therapy, network therapy and recreation therapy are all mentioned. Traditional Indian interventions that are highlighted is the four circles, the talking circle, and the sweat lodge. The report advocated approaches integrating traditional and western techniques, mentioning in particular the Salish-Kootenai program in Montana, which has a strong clinical component, a cultural program and coordination with other community programs.


Re: outreach and identification of women (American Indian Women). Barriers include, the disproportionate number of unemployed women, Lack of sensitivity to culture, the use of stereotypes can be a basis for assessment, geographic isolation, poverty, cultural differences may preclude the women from accepting or seeking help. Another barrier is identifying women in urban areas. A simple strategy is for treatment programs to establish relationships with existing American Indian programs.

Treatment considerations are minimizing isolation from AI community, by involving family, and leaders. Need to be aware of cultural definitions of health, illness, and substance abuse, and how these can be used as the foundation for treatment. Services should be provided in native language if possible. Agency should arrange for transportation for clients and families, if appropriate. Program must acknowledge and promote spiritual beliefs and practices. Should collaborate with AI programs and allow for adaptation of treatment modalities. These show respect for AI culture. AI women should, if possible be referred to AI agencies, etc., when outside resources are used.


Explores the possibility of collaboration between a counselor who works with the alcoholic patient and the ethnographer who works with that person as an alcoholic informant.


Need to realize when you are treating clients from your own tribal viewpoint. Be aware of this, as it can threaten patient. Need to recognize acculturation level of individual, and recognize value differences. Tries to go from most specific to general to find out where client is having difficulties. Works outward from the individual. Need to look for positives in individual. First concern should be to establish self-esteem. Need to ask yourself all the question you ask your client.


Written contract is important in committing to treatment. Often used in parole plans. “The contract specifies a certain period of time in which they will not drink at all.” (p. 839) Usually less than
twenty-four hours. An outside individual can impose this contract, which the alcoholic can feel is greater than their addiction. Clients also need to commit to not using any drugs, it makes them too comfortable to enter treatment. Need to have at least a ninety day program, so that people can learn about and control their "biorhythms, cycles of twenty-eight to thirty days." (p.841) AA is the most common therapy. Physical recovery: megavitamin therapy, should have a physical exam to determine extent of damage. Antabuse. Social Recovery - restructuring life so that it doesn't involve drinking. Spiritual recovery: counselor should base treatment around any spiritual beliefs. Need to consider physical, psychological, social and spiritual. Most Indian programs are not successful because they have too narrow an orientation. A successful program "has the public identity of its clients." (p.843).


Draws an analogy between alcohol recovery programs and a traditional rite of passage. Separation, transition, and re-incorporation. This is the ideal, how treatment is supposed to function. Often however, time in treatment center is just a phase in a drinking cycle, there is little motivation to learn and accept the new social status of being sober.

Approaches: create a dry social network for reincorporation of alcoholics. Church involvement, traditional activities, and involvement in a recover program as a counselor are all social contexts that foster abstinence. Another option is halfway houses that use treatment centers as support are an alternative.

Need to broaden treatment to reach the segment of urban Indians who drink abusively, but not yet chronically. Mid level interventions could be designed, and these people might have a better prognosis for reduction of drinking to appropriate levels, or abstinence.


Implications for Treatment: Range of treatment modals
medical model, disease theory, influenced by AA
socio-psychoanalytic orientation: identification and resolution of psychosocial problems. Help develop more positive coping strategies.
assimilative: al Indian, but use essentially Western medical or psychosocial interventions.
culture-sensitive: modifies treatment in recognition of client background.
syncretic: incorporates Indian values and practices into standard interventions. Encourage involvement in spiritual quests.
traditional: relies on assistance of traditional healer.
Most programs were culture-sensitive or assimilative
"Indian alcoholism intervention programs with the highest rates of sustained client sobriety are those that integrate a variety of spiritual elements and activities into their treatment strategies." (p.223)


Same description of the different treatment models. States that there is reluctance to combine conventional and traditional modalities, even when there is evidence that some indigenous model are effective. Cultural heterogeneity is a problem for most programs. Suggests a wider adaptation of Stone’s self-actualization model. Could match clients “according to their life experiences, attitudes and world views with the most appropriate alcoholism intervention strategy. (p.278). In this way all available therapies, from sweat lodge to gestalt therapy to AA could be utilized. Success with conventional treatment has been associated with age, level of education and lack of serious involvement in Native American traditional culture.

In order to accomplish this, there would need to be open communication between IHS, detox, mental health clinics, health services in the same areas.
Most projects have inadequate evaluation procedures. This study attempted to find some answers about treatment programs. Findings: Most programs had either all or mostly Indian staff. The consensus is that it makes more sense for Indians to counsel Indians. Most had some affiliation with AA. Seems to be consensus that this approach is efficacious. Most programs considered initial and ongoing training of staff to be important. Treatment modality was either psychosocial or eclectic (which gave equal time to indigenous practices.) Most programs made some accommodation to Indian culture. Traditional healers had a very small role in most programs (these were federally funded.) Another reason is that some medicine men did not believe that traditional practices had a place in urban settings and formal treatment centers. No directors could provide anything more than anecdotal evidence for abstinence after treatment completion. No one knows what works consistently.

Conclusions: healing community is important, those who healed themselves should help others along the way, which will help the healers stay in balance and healthy.


Looks at the different ways in which anthropologists can contribute to alcoholism treatment and prevention. These include follow-up and evaluation of intervention programs, building models for drug-free social alternatives, and systematic observation of the efficacy of indigenous curing strategies. Interventions that the author has observed as being viable included the following characteristics: self-generated, and charismatic role model initiators, involved recovering clients as both clients and healers, saw themselves as a social entity.


Only 7 out of 42 clients were improved. Treatment had ranged from Indian-run and Anglo-run centers, detox, hospitals, and halfway house. The 7 who were doing better (sober for more than 2 years) had stable employment, good living conditions, strong relationships and little depression. One factor in low success rate is most likely low employment rate at original admissions.

Also published article in 1984 in Alcoholism: Clinical and Experimental Research. (same info.)


Need to be aware of one’s own ethnicity. Self preparation, need to first learn about chemical dependency within own ethnic group. Need to work with the patient’s group, and use their resources.

Clinical skills: build rapport. Facilitate during interview to give patients time to tell their story. Use clarification to understand patient’s differing viewpoint. Use probing carefully. Confrontation can be effective when working with a patient’s family. Treat problem as a family problem. An informed family can take the initiative for confrontation, with physician’s support. Has found it effective with NA alcoholics in MN and WA.

Accommodate folk healing practices. To avoid bias in treatment institutions, have a variety of clans or tribes on the full-time staff, or on advisory board. Others hire a director of a related ethnic group, commonly used by majority institutions.


A project in Minneapolis, MN that uses an intensive case management system for the chronic public inebriate. Program was found feasible, but problems were staff turnover and resistance, stigmatization of the clientele, and a shortage of low-income housing.

Describes the important different steps in the recovery process. 1) Forming of a core group in the community. Important factor was that this group believed in themselves. 2) "Moral persuasion" (p.170) techniques. 3) Andy was elected Chief of the tribe, where he could be more directive and even coercive. 4) spiritual aspects. It, and traditional customs became an alternative to drinking. Chief encouraged people to embrace any religion, as long as they had some kind of spirituality. 5) "Caring for your fellow human being." (p. 171). This was community aftercare, on the level of the people, not from formal therapists.


In summarizing the available literature, Young concludes that a treatment program should include a spiritual component and a concern for Native values that includes the development of self-esteem. The ideal model would incorporate both traditional and Western practices. States that AA and Antabuse are the most widely used western strategies. Describes how AA has been modified by some tribes. Emphasizes the necessity for Native peer counselors and discusses the need for training programs for such counselors. Does not cite any statistics regarding prevalence, citing problems with data. Addresses the need for better evaluation procedures.


Describes a clinic at Mass. General Hospital in Boston that serves American Indians. Goal is to cut through bureaucracy, help patients receive medical care and follow-up and alcohol and drug counseling and placement. Social workers serve as advocates, provide counseling and deal responsibly to crises. Engage in outreach, did follow-up visits in the community. Clients were welcome in the offices anytime. In response to cultural values, a goal of the clinic is to eliminate impersonality. The clinic does not make appointment, except in the case of court-referred cases. Patients do not need a medical complaint to come to the clinic. Patients are welcomed, whether they are sober or not, out of respect for the person. Author advocates individual counseling rather than group. Staff members attend Indian community social events, to keep in contact. Feedback from Indian patients and community focuses on four factors 1) feeling by patients that they are accepted as whole human beings 2) a sense that services are offered out of sincere interest 3) knowledge that patients can be seen sober or not 4) the fact that patients are welcome to come by and do not need appointments.

Statistics


Alcohol: Deaths and Disorders

During 1980s decade, alcohol mortality rate of Native was three and one-half times that of non-Natives(4.1/10,000 Natives, and 1.2/10,000 non-Natives). The rate at which alcohol is an underlying or contributing cause of injury death among Alaska Natives is nearly triple that among non-Natives. Seventy-nine percent of all Native suicide victims have detectable levels of blood alcohol.


"The overall rate of alcoholism is two to three times the national average (Yates 1987:1136)." Does a review of the literature, focusing on prevention. Looks at skills training for bicultural competence, the social-learning model, the need to build community sanctions and support, and focusing efforts on the family, the community and children at a very early age.

For youth, from 1981-1987, rate of alcohol use has declined slightly to 81%. (From 1975-1981 it increased from 76%-85%). There was a similar pattern of decline in non-Indian youth. Studies have shown that after controlling for SES, Indian and non-Indian groups show similar pattern. This suggests common influences. However Indian females use drugs (doesn’t say if alcohol is included in this) at the same high rate as Indian males, which is not true for non-Indian females.


For period 1980-1987 via IHS. Estimated prevalence of an alcohol-related disorder was, for males 48.87 per 1,000 population and estimated rate for females was 24.06 per 1,000 population. The northern areas, of Aberdeen, Bemidji, Billings, and Alaska have both higher overall and gender-specific prevalence rates, when compared to the southwestern areas of Phoenix, Albuquerque, and Tucson. Primary limitation is that it underestimates the prevalence of alcoholism/alcohol abuse for the AI/AN served by the IHS. Reported rates are only for those individuals who were hospitalized. There were also problems with accuracy.


In 1988, age-adjusted alcoholism death rate was 33.9 per 100,000 population, or 5.4 times the U.S. All Races rate of 6.3.


Need more research on women, especially women of color. "Native American women ages 15-34 have a cirrhosis death rate 36 times that of White women.” (p. 11)


States that "alcohol-related mortality is a major problem among Native Americans, with cirrhosis of the liver the fourth leading cause of death. Accidents are the leading cause, and the contribution of alcohol to fatal mishaps is substantial. Death rates attributable to major alcohol-related causes of death . . . are about eight times greater among Native Americans."


Cites statistics from the literature. "alcohol and other drugs were implicated in 5 of the 10 leading causes of American Indian death. . . . (May, 1986). "Young also reported that "perhaps the single most disturbing statistic is that 75 percent of all Native American deaths can be traced to alcohol in some way." (p.26).

Research needs:


Argues that research findings are rejected by treatment programs if they did not fit the current treatment ideologies, of if they are seen as threatening the economic functions of programs. Calls for
more basic as well as innovative evaluation research. (Cannot locate this article at NAU, bibliographic summary comes from Lobb and Watts (1989).


Regarding treatment strategies, Rebach writes, "...there is a shortage of actual models that operationally specify how clinicians or prevention staff should proceed and a shortage of follow-up studies that indicate the relative success of interventions." (p. 34-35)


Research Recommendations on Alcohol Abuse: Need research that leads to "alternative prevention, mid-level intervention, and treatment modalities." (p.348) Need to communicate findings to the staff who will make use of them in treatment facilities and recovery homes. Especially need more information about American Indian women's drinking, treatment and recovery.

Cut list:


Discusses drug abuse prevention strategies, influences of society and culture, condition which contribute to drug abuse, role of an Indian community, suggested process and procedure for community involvement. (Summary is from Lobb and Watts. Waiting for article from ILL.)


Same as Gilchrist (1986) article.

Trimble, J.E.

Very little prevention research has been conducted re: alcohol abuse. "We are somewhat limited in our understanding of culturally appropriate schemes for drug and alcohol prevention." (p. 28)

This article lists many research questions that remain to be answered regarding the different levels of prevention among Native Americans.


Tule reservation, prevention program focuses on girls 11-19. Teaches women's health, traditional midwifery, decision making, and how to be a traditional woman today. Have strong positive messages about natural highs.


Mentions the four factors of prevention advocated by Oetting. Intervention programs need to be based on general knowledge. Article is based on review of the literature.

Covers the implementation of youth prevention programs. Need to emphasize the whole community, but can start with the school and the individual. Approaches include providing support to existing alcoholism programs, implementing prevention activities in school via the spontaneous approach or the subject area integration approach, and developing a community-based prevention project.


Prevention: we need to foster a new attitude towards alcohol, especially for youth. Treatment must be integrated into culture and community support secured, otherwise treatment will fail. Detox and urban recovery centers are not very effective, just a way to get benefits. Current methods, Indian-oriented AA, medicine men encourage pride in culture, some use indigenous method similar to Antabuse. Peyote ceremony in Native American Church.

NIAAA Alcohol and American Indians Alcohol topics In Brief - 1980

Indian-run alcoholism treatment programs may attract a higher number of Indians. Lack of program evaluation is a significant problem. Some advocate for adult education about alcohol, and then having parents pass that along to their children, leaving the schools out of that. Most Indian people obtain alcohol information from the mass media. Indian leaders however learn more from formal meetings. Direct instruction and information may be more effective.

Martin, R. The Myth & Reality of Indian Alcoholism. Rocky Mountain Magazine

Difficult obstacle is lack of guilt in many communities for alcohol abuse. Most programs suggest that it is counterproductive and that sobriety is easier and better. Spiritual approaches, Native American church, and Christian denominations. As well as native ceremonies. Some say legalize alcohol on reservations.


Recipients of OSAP grants have used funds for cultural enhancement activities, considered crucial to prevention. Cherokee Challenge Early Intervention Project, ages 10-18. Similar to Outward Bound. Other programs establish links between elders and high-risk youth. Secondary prevention should be located in the community to serve those youths who dropout of school. Natural Helpers, attempts to change peer behavior. Need to have more employee assistance programs, and those in the workplace.


Important to look at significant aspects of adolescents' life: parent, peers, and school. These are related to alcohol abuse. Higher rates of broken homes, lower grades and a strong peer group influence among drug users.

Treatment and intervention: there have been many efforts made to make these programs relevant and consistent with Indian values and culture, but implementation has met with conflict within the tribes and with the funding agencies. "Substance abuse programs for Indians have suffered as a result of the artificial boundaries that divide mental health, drug abuse and alcoholism into distinct federal
agency entities . . . there must be a willingness to cross traditional boundaries and develop and fund programs to provide a breadth of services to meet the needs of the Indian communities." (p.489-490)

Keltner, B.R.
Native American Children and Adolescents: Cultural Distinctiveness and Mental Health Needs

Need to consider resources in home environment and travel to keep appointments. Should ask if recommendations can be incorporated into lifestyle and recognize family members for their contributions to therapy. Interventions for alcohol abuse: (Inouye, 1988; 1993)
1. Strengthen family ties.
2. Provide access to mental health services and integrate these into the schools
3. Address stress and depression and enhance natural coping mechanisms in the culture
4. Target school age children to prevent alcohol abuse
5. Build on Indian culture and traditions
6. Involve teenagers in starting health projects and serving as peer helpers.

Albaugh, B.J.
Ethnic Therapy with American Indian Alcoholics as an Antidote to Anomie
Paper - 1973
Therapy: native healing ceremonies and Indian counseling. Reduces rootlessness, and isolation, which are common in marginal peoples. Can lead to a support community which may result in less destructive behavior, such as alcoholism.

Weibel-Orlando, J.C.
Warriors and Shakers: Alcoholism Intervention in Our Own Terms
The parallel between the Indian Shaker Church and AA rituals and peer group support systems. (May need to find this reference)
Phil Underbaggage uses the Warrior Society to explain concepts "such as sobriety, testimony, pride in accomplishment, and honor to his Indian clients." (p.11) This strategy can have translational problems.
Program attempt to translate AA 12 steps into Lakota. Putting extra-cultural concepts into culturally acceptable terms.


Study done at an American Indian boarding school. Life stress was a major influence on rates of substance use, levels of family support and depression. However, social support was not as great a mediating factor for Indians as it was for non-Indian teenagers. Further research should be done on the "nature and importance of family and friend support to Indian adolescents." (p. 265)


Should therapy be different for gregarious vs. solo drinkers? Group therapy for Native Americans has not always been successful. May need to try non-traditional group therapies. More disruptive effects of alcohol abuse for Native Americans, and dominant vulture programs may not meet their needs. Showed greatest disruption in areas of social, vocational, and economic adjustment.
Treatment needs may be different in these areas. Findings suggest that treatment should focus on social-role adjustment for Native Americans. Findings support specialized treatment approaches, structured programs, transitional living situations, vocational counseling and "change with respect to antisocial and antilegal behavior." Social-role learning model and advocacy is suggested. Should have specially trained staff and peer group counselors. Clients need to work through conflicts with peer drinking group.

Literature review of some major perspectives. Some debate whether Indian alcohol/drug abuse is unique to Indians and thus demands specific treatment. Yes, however, counseling and community work are often the same in sub-groups and many of the problems are the same. Need clear thinking and evaluation, and avoid simplistic solutions.


States that the questions we should be asking are "how much is Indian identity associated with the use of chemicals?" and "What are you asking people to give up by being chemically free?". (p.35). Recover needs to include the same aspects of a chemical life-style, such as a social support system. Native traditions of social support can form the bases for recovery programs.


Complex problem, needs to include community, family, involvement and leadership, as well as economic development. Still need more research focusing on the Native people and their lives as part of tribal and family communities. Programs have replaced the roles of elders, and tribes have thus lost out on valuable resources, as the expense of federal grants.


States: National estimates are that around half the adult Indian population is chemically dependent. In MN, 45% of Indians are considered dependent.

Treatment Programs: Confrontation therapy not always useful, should be carefully considered before using with Indian clients. Recommends a drop-in program where there is a non-alcohol environment, for socializing, support, services and referrals.

Suggestions by clients for better treatment programs: More Indian counselors, spiritual activities, cultural activities, more follow-up and aftercare, more family involvement, more sober Indians involved with treatment centers.


Need positive Indian role models that alcoholics can identify. Antabuse can be effective. Mentions that some IHS providers over prescrib minor tranquilizers. Legalize alcohol on reservations.

Alcohol and Native Americans. Alcohol Topics: Research Review.

Need creativity in funding, to allow for flexibility. Basically a review of the literature. Cites Lewis (1982) who believes that alternative to drinking would be helpful. Recreation, cultural activities and work programs. Need more Indians trained in the health care professions.


Reported some statistics, divided by tribe, dated. Indians who are integrated in both traditional and modern cultures are at the lowest risk for misuse. Describes the typologies of alcohol treatment programs. No one knows what kind of modality works best with NA clients. Little evaluation has been done. Healing community is key.


not very helpful.

Calls for methodologies that would (establish respect and trust relationships 2) renew group solidarity and belonging 3) reduce alienation through identity and cultural pride 4) knowledge to choose between cultural alternatives.


Did a survey to determine Navajo knowledge about consequences of alcohol abuse, their opinions about abuse, the etiology of abuse and alcohol legalization. Indications are that the Navajo are knowledgeable about adverse consequences, 52% drink at all, and generally view an alcohol consumption as negative. 63% agree with the "drunken Indian" stereotype and the majority are opposed to legalization on the res. Recommends more education on the diverse policies of intervention and prevention. Policy options should be made available and discussed openly.


Found a 44% improvement rate in a study of 83 AI men in inpatient program. Compares favorably, as it involved difficult cases. Doesn't really describe program.


Describes the National UNITY Council, which is committed to a national anti-alcoholism program. Local youth councils provide leadership opportunities for Native youth, and keep activities substance-free.


Study of 460 adult Lumbee men. Treatment implications Rural programs need not be as complicated in terms of organization, because of the community cohesiveness that already existed. This just needs to be strengthened. Support cooperation in community social activities Urban programs are more complicated, because you must try to duplicate the community which is in the rural area. Observed difficulties in setting where Lumbee and other minorities were together.

Indian Rehabilitation, Inc. ( ). Guiding Star Lodge Program Description.

Comprehensive, holistic. Combines therapeutic approaches with cultural and spiritual approaches to healing. Uses Sweat Lodge and Talking Circle. Self understanding through fellowship.


Beauvais and LaBoueff (1985) and May (1986) provide thorough literature reviews. Beauvais concluded that external solutions will not work and that community action and support are the answer. May looks at reduction of mortality and morbidity, increased education and increased resources and use of rehab programs. See booklet to cross-check with articles to order.