1996

Evaluating the Effectiveness of Alcohol and Substance Abuse Services for American Indian/Alaska Native Women

Indian Health Service, Office of Public Health, Staff Office of Planning, Evaluation and Research
University of California, San Francisco, Institute for Health Policy Studies

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Evaluating the Effectiveness of Alcohol and Substance Abuse Services for American Indian/Alaska Native Women

Phase 2 Final Report

Executive Summary

DHHS Contract Number 282-92-0048
Delivery Order Number 5

Center for Reproductive Health Policy Research
Institute for Health Policy Studies
University of California, San Francisco

December, 1995
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Submitted to
The Indian Health Service

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Introduction

Alcohol and substance abuse are serious problems among American Indian and Alaska Native people. Research has demonstrated much higher levels of morbidity and mortality from such alcohol and substance use-related conditions as cirrhosis and cancer among Native populations as compared with the national population. Alcohol and alcohol abuse are responsible for 25% of all deaths for All AN women (Leland, 1984), and hospital discharge rates for alcohol-related diagnoses are approximately three times greater than national rates. American Indian/Alaska Native (AI/AN) women also appear to be at greater risk of dying from alcohol-related problems than non-AI/AN women, or AI/AN men, who tend to drink more than females and are more likely to die from alcohol-induced accidents (Hisnanick and Erickson, 1993). In 1993 Trends In Indian Health, the Indian Health Service published alarmingly different alcoholism death rates between AI/AN women and women in the general population. Estimates of the potential years of life lost due to causes of death directly associated with alcohol use are as high as 22 years for AI/AN women; if such indirect causes as accidents are included this rate might be even higher (Christian et al., 1989; Dufour et al., 1989; Hisnanick and Erickson, 1993).

The impact of substance use extends beyond its influence on morbidity and mortality rates; pronounced negative consequences are also felt by the family and the larger community. Fetal Alcohol Syndrome (FAS), child abuse, and domestic violence are all related to alcohol and other substance use. Alcohol and other drug (AOD) use also contributes to – and is influenced by – family dissolution, unemployment, and poverty. One study reported that between 85% and 93% of all child neglect cases on an AI/AN reservation involved alcohol abuse (DeBruyn et al., 1992).

Despite the enormity of the issue, substance abuse treatment services for AI/AN women (as well as programs for non-Native women) have only recently received much attention in this country, and AOD treatment services for AI/AN women have been targeted by the Indian Health Service (IHS) as a critical area requiring additional resources. Significant barriers to treatment exist for American Indian/Alaska Native women, who face institutional, economic, psychological, and informational obstacles, including restrictions on bringing their children to treat-
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ment. Increasingly, however, AOD treatment programs serving AI/AN populations have begun to adopt Indian-focused interventions that either include women or that are designed exclusively for women. This is important because the treatment needs of women are in many ways very different from men; not only do women often have child care responsibilities, but they exhibit different addiction patterns as well.

Because research is virtually nonexistent on the scope of the problem of AOD use among AI/AN women, as well as the effectiveness of treatment for this population, the evaluation study described in this report was undertaken to examine the needs of women receiving treatment services through IHS-funded programs. It is the intent of this evaluation to provide useful information about the needs of AI/AN women by describing their demographic, social, behavioral and health characteristics and their attempts at recovery. However, substantial and continued research is still needed to further advance effective treatment strategies, including large-scale epidemiologic studies about the prevalence of substance abuse, AOD-related morbidity and mortality, and trends in substance use and its health implications for both AI/AN women and men, as well as youth.

Description of the Evaluation

In order to promote the health and well-being of American Indian/Alaska Native women, their families, and their communities, it is critical to 1) adequately understand the life conditions of the women who are currently receiving treatment through IHS-funded centers, 2) assess the long-term outcomes of treatment, and 3) evaluate the centers themselves in order to relate participant outcomes to the AOD treatment and recovery services that women have received. However, descriptive and outcome data for both AI/AN and non-AI/AN women in treatment remain very limited. There is also little empirical evidence about the effectiveness of AOD treatment centers for chemically dependent AI/AN women.

In light of this lack of current information, the Office of the Assistant Secretary of Health (OASH) and the Indian Health Service (IHS) requested a multi-phase evaluation of alcohol and substance abuse services for adult AI/AN women in AOD treatment centers that are fully or partially funded by the IHS. The overall, long-term goal of the evaluation is to contribute up-to-date information that can be used to help improve the health of AI/AN women, and through doing so, help promote the growth of tribal communities.

The evaluation study incorporates four phases. During Phase 1, the evaluation design for the entire project was completed, a Technical Advisory Committee (TAC) was convened, and a number of consultants were hired to assist in designing and implementing the evaluation study. An extensive review of the literature was also conducted during Phase 1. During Phase 2, descriptive information was collected about women currently in treatment in centers that are either fully or par-
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tially IHS-funded. A prospective client outcomes study will comprise the evaluation activity for Phase 3, and Phase 4 will consist of an evaluation of the efficacy of IHS-funded treatment centers. It is hoped that the findings from the entire four-phase evaluation will be used to improve access to, the descriptions, availability and effectiveness of alcohol and substance abuse services for adult AI/AN women. In addition, the results of this evaluation will contribute to the literature by validating or refuting findings from other studies, by improving the understanding of substance use and abuse among women, and by describing the strategies for promoting the recovery of women, their families, and their communities.

Description of Study Participants

The major goal of Phase 2 was to collect and analyze much-needed descriptive, demographic, social, cultural, and clinical information about women receiving treatment in alcohol and substance abuse treatment centers funded in whole or in part by IHS. This information will provide critically necessary data about the women who are participating in IHS-funded treatment centers, and serve as the foundation for assessing the long-term impact of current models of treatment. The information derived from Phase 2 should also prove useful for further focusing and fine-tuning subsequent phases of the evaluation.

Evaluation Questions

Phase 2 evaluation activity was directed towards answering the following research questions:

1. Characteristics of women using IHS-funded treatment centers:

• What are the demographic, social, behavioral, and health characteristics of the women who receive IHS-funded treatment services (such as age, marital status, family composition, level of education, employment status, drug/alcohol use, and history of sexual abuse)?

• What proportion of these women have mental health problems?

• What proportion of these women are pregnant and/or are parents?

• What are the social and behavioral strengths of these women, as well as social and behavioral deficits?

• What are the patterns of substance abuse and AOD-related problems of women in treatment?

• What are the health and medical conditions of these women?
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- What are their cultural and spiritual orientations?

- Is there family and community support to help women seek treatment (e.g., child care)?

- Are there family or community influences that inhibit women from seeking treatment?

2. Treatment utilization characteristics:

- What are the sources of referral to treatment for these women?

- What are the service needs of these women, both apart from and related to, AOD use?

- Which factors influence the treatment-seeking behavior of these women?

- Which factors influence their retention in treatment?

Methodology

To assemble a comprehensive profile of American Indian/Alaska Native women participants in treatment at a sample of IHS centers that provide services to women, a combination of different data collection approaches was used for Phase 2 of this evaluation study. A multi-method approach was adopted in order to integrate multiple perspectives through different types of evaluation approaches, to augment and illuminate data collected by more conventional means, and to overcome the limitations of any single method. This coordinated employment of multiple data-collection strategies enables the evaluators to draw an enhanced range of inferences about meaning, causes, and effects.

To provide a comprehensive profile of a sample of AI/AN women in treatment at the nine IHS treatment centers participating in the study, four data-collection approaches were used:

1) Focus groups of 60 study participants were conducted at a selected sample of nine treatment centers that serve women. Focus group participants were asked about both their history of AOD use and their current use, the role played by their family and community in their AOD use, their experience with AOD treatment centers, and the perceived benefits of participating in their current treatment program.

2) Information was abstracted from 172 participant treatment records by members of the evaluation team, using investigator-developed chart abstract forms
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to systematically retrieve the desired information in a uniform and consistent manner. This information consisted of basic demographic data (age, marital status, education, employment, living partners, number of children), history of drug/alcohol use, social and behavioral risk factors, and duration of treatment.

3) Group interviews were conducted with 52 treatment center staff members to acquire important descriptive information on IHS-funded treatment centers that provide services to women, including strategies that have been adopted to promote the recovery of AI/AN women.

4) Individual interviews with 9 treatment center administrators were conducted to acquire important descriptive information on IHS-funded treatment centers that provide services to women, including characteristics of the treatment center, its staff, and strategies that have been adopted to promote the recovery of AI/AN women.

Nine IHS-funded treatment centers, and one alternate that was included as a pilot site, were invited to participate in the evaluation study; these included both female-only and co-gender centers that serve American Indians and Alaska Native women. With input from the Delivery Order Officer, the Technical Advisor, and the Technical Advisory Committee, the centers were chosen according to specific criteria; the information derived from this phase may thus not be generalizable to all treatment centers. Efforts were made, however, to ensure that the treatment centers would be as representative as possible of the complete range of IHS-funded treatment centers.

Findings: Themes and Variations

One challenge of the multi-method evaluation approach chosen for this study was to synthesize the findings from each of the different data collection strategies. Overall, there was remarkable consistency in the findings across the different data sources. The themes and variations that emerged are summarized below according to the following sections: the life conditions of the participants; their initiation into and progression of AOD use; pathways into treatment; perceptions about AOD treatment centers; the availability of women-centered approaches to AOD treatment; implications for further study; the role of the community in reducing AOD use; and individual and community resiliency. The findings from each data collection strategy are summarized in separate chapters in the full report.
Life Conditions of Women Participants

The life conditions of the women about whom information was gathered are extreme, and for many women, adverse or abusive childhood experiences and conditions have carried through to adulthood. As adults women experienced many of the same patterns with their own children, including single parenthood, children residing in out-of-home placements, unemployment, poverty, abusive relationships, potential and real child abuse, and continued AOD use.

The vast majority of women were exposed to various types of abuses, such as physical, sexual, and emotional abuse, from childhood to adulthood, as shown in the table below. Evidence regarding such abuse was provided in the chart review. The review of 172 AOD treatment record charts of women participating in IHS-funded treatment centers depicts a profile of American Indian/Alaska Native women who have experienced abuse, neglect, and hardship throughout their lives. A large percentage of participants were physically abused (44%), sexually abused as children (43%), or emotionally abused (29%). In many cases staff reported that this abuse was combined with abandonment and neglect by parents or caretakers. Nearly two-thirds (63%) reported that they had been separated from at least one of their parents as a child.

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any type</td>
<td>117</td>
<td>81%</td>
</tr>
<tr>
<td>Physical</td>
<td>50</td>
<td>44%</td>
</tr>
<tr>
<td>Sexual</td>
<td>49</td>
<td>43%</td>
</tr>
<tr>
<td>Emotional</td>
<td>33</td>
<td>29%</td>
</tr>
<tr>
<td>Neglect/Other</td>
<td>10</td>
<td>9%</td>
</tr>
</tbody>
</table>

Note: More than one type of abuse could be documented for each participant.

Over three-quarters of the participants (78%) experienced abuse as an adult; 80% were physically abused, 16% were sexually abused, 12% were emotionally abused, and 4% experienced other abuse, as shown in the following table. The women in the focus groups most often reported abuse at the hands of their fathers,
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uncles, siblings, or male partners. Seventy-six percent of the participants reported domestic violence in their lives.

Types of Abuse Experienced by Participants as Adults

(N=172)

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any type</td>
<td>105</td>
<td>78%</td>
</tr>
<tr>
<td>Physical</td>
<td>82</td>
<td>80%</td>
</tr>
<tr>
<td>Sexual</td>
<td>16</td>
<td>16%</td>
</tr>
<tr>
<td>Emotional</td>
<td>12</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4%</td>
</tr>
</tbody>
</table>

Note: More than one type of abuse could be documented for each participant.

The women suffered from poor physical and mental health. Sixty-five participants (49%) reported an underlying health condition at enrollment to treatment. The prevalence of mental health problems was also a recurring theme. Perceived prevalence rates by staff varied, from an estimated low of 30% of participants to a high of 90-100%. Based on the chart review, 38% of participants had received mental health treatment prior to entry in the treatment program.

The social support systems of these women are often fragile and volatile. Nearly half reported that their relationships with family members were estranged, although almost one-fifth of were reported to have positive family relations. The majority of participants (75%) reported that they were involved in a negative or stressful relationship.

As observed by staff, poverty, homelessness and social isolation were common among women AOD treatment participants from childhood through adulthood. Death among close family members and friends was common, accompanied by strong feelings of loss and grief. In addition, other personal hardships were common, such as lack of education and social supports, and discrimination by race and gender.
Initiation into and Progression of AOD Use

In general, the women participants of the nine IHS-funded treatment centers can be characterized by early exposure to alcohol and other drugs. Most of the women grew up in environments of high levels of AOD use by family members, friends, and communities. Among them, alcohol and other drug use is common, and has been in their immediate living environment. Thirty-nine percent of women participants responded that their friends use AOD and some indicated that they therefore felt pressured to use alcohol or other drugs themselves, based on the chart review. Relationships with family and friends influenced and are influenced by prevalent AOD use. The high prevalence of AOD use in the environment made it difficult to refrain from use early in life, to abstain later on, and made recovery difficult, based on the experiences of women in the focus groups.

Most women began using substances at an early age, usually beginning with alcohol. The mean age at first AOD use was 14 (s.d.=3.4) with some participants reporting first use as young as age 6, based on the chart review. Seventy-nine percent of women reported alcohol as the first substance they used. Among the women whose charts were reviewed, AOD use was high among friends and family, and peers pressured them into using alcohol or other drugs. Personal or family problems, depression, recreational use, and death were other factors influencing initial AOD use.

Alcohol was the primary substance of choice. However, most women, at some point in their lives, have been polysubstance users, substantiated by the chart review, participant focus groups, and staff interviews. The three most commonly reported substances used by enrolled participants were alcohol, marijuana, and crack cocaine or crank. Injection drug use appeared to be uncommon.

Women in the focus groups consistently described a progression of use from alcohol and inhalants to other substances, such as marijuana, methamphetamines and cocaine, while a few women also progressed to opiates, such as heroin. However, for the majority of women, alcohol was the primary substance of choice during their substance-using periods, although polysubstance use was predominant.

Among women who had ever been pregnant, some discontinued substance use when they discovered they were pregnant, some stopped using later during their pregnancy, and others did not quit at all, based on the charts reviewed. Five of the nine treatment sites reported that 100% of their female participants used alcohol or other drugs while pregnant, while the others estimated that between 45% and 90% of participants had used AOD during their pregnancy. Based on the chart review, 73% of participants used alcohol or other drugs during a previous pregnancy.

The women in the focus groups described a recurring cycle predicated on long-standing emotional problems that had never been resolved, and low self-esteem that seemed to preclude overcoming them or their addiction. Nearly all the
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women described using alcohol and/or drugs in attempts to suppress such emotional difficulties as grief, self-pity, and loneliness. Among the women who started using alcohol and/or drugs later, in their 20s, initiation into substance use was often triggered by a tragedy or major life transition. Many said the death of a close family member, a divorce, or the end of an important relationship was the impetus for their initiation into regular and heavy AOD use. The most frequently reported triggers to AOD use were depression, loss, stress, and anger.

Some women indicated that they accepted the alcohol when it was offered to them because they wanted to please their parents. One woman said: “I drank with my mother to get to know her; she was cold to me when she was sober.” Another said that her father was a bootlegger who gave her her first drink, home-brew. Often these women drank with their siblings or cousins. One participant said, “When my parents went out fishing, I was left in the care of my older siblings, who drank.”

Another way the women were commonly introduced to AOD was through their peers. Most said they drank with friends at parties in high school, at local bars, or with gang members. Many of the woman said that their boyfriends introduced them to alcohol and drugs, and many indicated that they drank alcohol, smoked marijuana, or inhaled substances (such as paint) to be accepted by their peers, or “to be cool.” One woman in her early 20s said that she drank because she was too shy to be part of the crowd, and when she was intoxicated she felt more self-confident in a social gathering.

Pathways into Treatment

Women entered treatment through a variety of ways, as shown in the following table. Those who were mandated tended to enter treatment as an alternative to incarceration because of repeated criminal offenses such as driving while intoxicated or other AOD use-related charges, or as a condition of family reunification or family maintenance. Women hear about the availability of services through the court system, word-of-mouth, or through a community or AI/AN social service agency.
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Motivation for Treatment

<table>
<thead>
<tr>
<th>Motivations Listed in Charts*</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children/parenting issues</td>
<td>44</td>
<td>28%</td>
</tr>
<tr>
<td>To change lifestyle</td>
<td>39</td>
<td>25%</td>
</tr>
<tr>
<td>To stop using alcohol/other drugs</td>
<td>34</td>
<td>22%</td>
</tr>
<tr>
<td>Court ordered</td>
<td>27</td>
<td>17%</td>
</tr>
<tr>
<td>Need/want help</td>
<td>13</td>
<td>8%</td>
</tr>
<tr>
<td>Family/friends pressure</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>4%</td>
</tr>
</tbody>
</table>

* More than one motivation could be documented per chart; these data are based on responses from 158 participant charts. Frequency unavailable = 14.

In the focus groups it was commonly mentioned that the strongest treatment motivation was the participant's desire to keep her children or to regain custody. Many were in treatment because of a court mandate. Another important factor was the women's personal motivation to be clean and sober and to change the direction of her life.

Encouragement from family members or friends was also an important source of referral to treatment. Other women were self-referred to treatment, having "hit bottom" in many aspects of their lives. According to staff, once enrolled in treatment, women remain for diverse reasons, depending on their ability to accept their addiction, and their willingness to make the changes needed to sustain recovery. Staff also pointed out that many of the participants stay in treatment to avoid less palatable alternatives. Generally, staff believed that women complete treatment in large part because they want to prove their worth to themselves, to their peers, and to their families, and/or family reunification with children in out-of-home placements. The most common responses the staff offered as obstacles to recovery was involvement with an unsupportive partner, and having to return to communities where substance abuse may be widespread.

Perceptions about AOD Treatment Centers

Clearly, the emphasis that the nine participating treatment centers place on American Indian and Alaska Native culture and traditions is important to the
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women participants, as shown in the following table. Women in the focus groups tended to select their current AOD treatment program over alternatives because of its focus on AI/AN tradition and culture. In fact, the aspects of the treatment centers that were most frequently mentioned as beneficial were their AI/AN focus and their supportive environments. Moreover, women derived support from other Native American women, and this support encouraged their efforts to stay sober.

**Characteristics of the Current AOD Treatment Program**

**Compared to Previous Treatment Experiences**

<table>
<thead>
<tr>
<th>• Focus on American Indian/Alaska Native culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Less structure and fewer rules</td>
</tr>
<tr>
<td>• Less confrontational approach</td>
</tr>
<tr>
<td>• More of a family atmosphere</td>
</tr>
</tbody>
</table>

Programs have adopted a variety of strategies to make their center's services culturally appropriate. On an administrative level, the programs make special efforts to recruit and hire AI/AN staff, particularly those who are knowledgeable about their culture and history. For all, incorporating traditional activities and beliefs is an integral part of the treatment program. Cultural and spiritual activities employed by the treatment centers include the Red Road to Recovery Series, talking circles, sweat lodges, playing tribal music, learning Native crafts, cooking and eating traditional food, attending pow-wows and peyote meetings, learning about their culture and history, beadwork, focusing on personal spirituality, and employing traditional symbols such as feathers, sage and drums with the AOD treatment curriculum. Spiritual leaders, such as medicine people and tribal elders, are often invited to meet with the participants during the recovery process. The curriculum at many of the programs is Indian-focused and incorporates traditional elements such as the medicine wheel and the "Indian Belief System."

The women and staff also espoused the benefits of the family-like environment that the treatment centers promoted. Staff characteristics such as professional qualifications, dedication to recovery, strong interpersonal skills, and their ability to work together as a recovery team were highlighted as conducive to achieving a therapeutic environment. It also appeared important that a high proportion of staff were in recovery themselves. However, women also cited several unfavorable program aspects. Those most frequently mentioned concerned the amount and type of program rules, and barriers encountered to entering and continuing treatment among women with children.
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Predominantly, the treatment centers have adopted a holistic approach to treatment. Such an approach incorporates the mental, emotional, physical, social and cultural components in the treatment process.

Availability of Women-Centered Approaches to Treatment

The availability of women-centered, family-focused approaches to AOD treatment is severely limited in the U.S. In most cases, the nine participating treatment centers are the only facilities in their geographic area which offer AOD treatment services for AI/AN women. Where other programs do exist, they are not specifically for American Indian/Native Alaskan clients, do not allow children to accompany their mothers to treatment, or do not offer residential services.

Several barriers to services for potential participants exist. The leading obstacle for parenting women is the lack of child care for their children while in treatment. Transportation is also a major barrier to treatment for many women who live either in rural, isolated areas far from a treatment center or in cities with inadequate public transportation systems. Another problem is that many of the women face resistance from partners who do not want them to enter treatment. Many women are hesitant to seek out treatment services because of confidentiality concerns.

Overwhelmingly, staff felt lack of funding was the major factor hampering the success of their AOD treatment centers. Insufficient funds resulted in limited facility space, inadequate staffing, and caseload limitations. Other services such as child care and transitional housing, which require supplemental funding, are needed to support women in treatment, particularly those with children.

Nonetheless, most program administrators expressed great hopes and plans for the future of their programs. Many indicated plans to move to a new facility or expand their current facility. Increasing the number of beds, expanding services for women, and providing transitional housing for clients were the plans most frequently mentioned. Also noted were plans to stabilize funding, expand outreach efforts, and to increase AOD prevention activities in the community.

It is important that the efforts of such treatment centers be sustained. Without the availability of a comprehensive array of services that can help to 1) initially engage a woman (the pre-treatment phase), 2) provide multidimensional support during the course of drug treatment, and 3) link the woman to a range of needed services after she has completed treatment (the aftercare period), long-term success for most individuals will continue to be elusive. For their long-term viability and effectiveness, treatment centers will need to address all of these issues.
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Implications for Further Study

The present evaluation leaves many questions unanswered, and raises many new ones. This evaluation provides both qualitative and quantitative information about a group of women that have been traditionally under-represented in research. Thus, the information derived from this study can be used as the foundation for further research about the experiences of AI/AN women, and the models of AOD treatment that are available to them. While the findings presented here are based on a small sample of women, they may not be representative of all American Indian and Alaska Native women. Therefore, there is a need for large-scale, epidemiological studies about the prevalence of substance abuse, AOD-related morbidity and mortality, and trends in substance use and its health implications, not only by women, but males, and youth as well. In addition, both qualitative and quantitative research is needed to better understand the precursors to and consequences of substance abuse among all American Indian/Alaska Native people. More information is needed about AOD use patterns, treatment-seeking behaviors, and short- and long-term treatment-related outcomes. Because of the tremendous diversity among American Indian/Alaska Native people, such studies need to include a wide range of tribal representation, geographic diversity, and cultural diversity.

While this evaluation provides extensive information about the components and effectiveness of a select number of treatment centers, there are many treatment approaches, modalities, components that need to be explored in greater detail. For example, testimonies from the women participants and treatment center staff advocate for a comprehensive continuum of AOD treatment centers. It will be important to evaluate the effectiveness of such a continuum in comparison to other approaches to recovery. Evaluation findings also highlight the importance of culturally-specific approaches in the treatment process. Future efforts should include the gathering of more information about the efficacy of such approaches. Additionally, successful community-level interventions, such as the community acceptance of sobriety achieved at Alkali Lake, where a community that was once dominated by alcoholism achieved a 95% sobriety rate fifteen years later, and what happened to that community many years after that, deserve greater exploration so that there can be a better understanding of not only the outcomes achieved, but the processes that contributed to their overall success.

While there is a need for further study in many areas, it is also important that such investigative endeavors be sensitive to local conditions. From the perspective of the treatment centers, although they are frequently asked to participate in research activity, they rarely receive the research reports, and are unlikely to benefit from research effort. Researchers need to establish positive working relationships with the tribal communities in which the investigation is to be conducted, the staff and participants within the treatment centers themselves, and with the Indian Health Service. By establishing such rapport, the research design, data-gathering approaches, and the information derived from the research will have greater legiti-
macy and validity, both nationally and within the communities where it is located. Operating principles should include being respectful of local practices in the scheduling and conduct of research activities; being responsive and adaptable to the needs of the community; and using culturally appropriate measures whenever possible.

The Role of the Community in Reducing AOD Use

It was strongly emphasized that a woman's recovery was dependent on three key factors: herself, her social networks, and her community. Overwhelmingly there appears to be tremendous community support for such women-focused AOD treatment centers. These centers are respected by the local community, and are regarded as leaders toward positive reform in the American Indian/Alaska Native community. Overall, most programs reported receiving ample respect and support from their communities. Some programs, however, continue to encounter opposition, both from their tribal communities as well as from non-tribal communities. There is still skepticism attached to AOD treatment in some communities, and chemically dependent women may also be stigmatized.

While communities can support the recovery process, they can also hamper the success of treatment programs. Within the past decade, staff have observed an increase in polysubstance use among women, earlier onset of abusive AOD use, and increased prevalence of mental illness. The rise in polysubstance use and violence in both AI/AN and non-Native communities have likely affected the demand for treatment services as well.

Some staff felt that the recent surge in the development of casinos can be a strong counterforce to recovery from alcohol and other drugs. While they may provide additional employment to tribal members, with their low-cost drinks and gambling atmosphere, they may also encourage substance use. In addition, controversy over distribution of casino profits exists. Some treatment staff suggest using some of the casino profits for AOD treatment, education, and other social services.

On the positive side, there appears to be a reduction in tobacco use among women, based on staff's observations. There is a perception that there has been a shift in attitudes towards drinking in AI/AN communities, and that sobriety is gaining appeal. Most of the women cited recent alcohol-free community events, including pow-wows. Together, these positive changes in their environment and in themselves will facilitate the long-term recovery of these women, and may also encourage AI/AN people to return to their tribal communities. As often quoted of late, and repeated by more that one staff member, "It takes a village to raise a child."

Concrete examples of community change are evident. One recent example of such responsiveness is among the Blackfeet Nation People. The abuse of alcohol, tobacco, and other drugs has become recognized as one of the most injurious health
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and social ills on the Blackfeet Reservation. In addition to the toll exacted by sub­
stance abuse on the individual’s physical and mental well-being, drugs and drug-re­
lated crimes, and inter-generational substance abuse have devastated the social fab­
ric of the reservation, affecting generations of young Blackfeet families. Chemically
dependent women who have children, often single head of households, cannot en­
ter AOD treatment for lack of child care for their young children. The children of
these families are at the highest risk for poor health and social outcomes, yet ser­
vices for substance-affected children are severely lacking.

In response, a demonstration project was conceived by the Blackfeet commu­
nity to develop and implement an innovative approach to AOD use for pregnant
and parenting Blackfeet Nation American Indian women. Named the Pikuni
Family Healing Center (PFHC), it represents an historic development in responding
to the needs of chemically dependent Blackfeet Nation women. This demonstration
project is funded through SAMHSA, Women and Children’s Bureau, and CSAT. The
contract is through the Blackfeet Tribal Business Council and the Tribal Health,
Education and Social Service Committee of the Council, the Blackfeet Tribal Health
Administration. The Pikuni Family Healing Center is the first residential treatment
program on the Blackfeet Reservation that is designed to provide comprehensive,
holistic, family-focused AOD treatment for chemically dependent women and their
children. Courageous efforts among other American Indian and Alaska Native
communities, like the Blackfeet Nation, should be encouraged.

Individual and Community Resiliency

One of the strongest impressions that has been derived from this evaluation
is that the women who have participated in these AOD treatment programs are,
overall, a strong cadre of women. Despite all of the difficult conditions these
women have faced during their lives, they are clearly survivors — survivors of
abuse, neglect, and institutional barriers to recovery. Each has developed mecha­
nisms, both healthy and unhealthy, to cope with these highly stressful environmen­
tal conditions. Many, though not all, are equipped with strong coping skills and a
determination to improve the quality of their lives, with strong spiritual and emo­
tional potential.

In spite of facing major barriers to accessing AOD treatment, they are moti­
vated enough to attempt formal treatment, often several times. The majority of
women have made multiple attempts to recover from AOD use, in spite of the con­
tions to the contrary. The average length of treatment participation was 86 days
among the women whose charts were reviewed. An astounding 80% completed the
treatment program, according to the individual treatment program’s criteria for
completion, which varied by center, and sometimes were based on individual client
needs. They strive to become better mothers. And most important, they still have
hope for a better life ahead for themselves, and for their children. Looking towards
the future, most women in the focus groups were hopeful, but also somewhat skepti­
tical, about their ability to remain clean and sober, yet they continue to work towards cultivating a promising future. To support their efforts, communities must respond in-kind through economic and social development, so that women will feel confident about returning to their communities after leaving the AOD treatment programs.

Resiliency may be the key to long-term recovery, and this is founded on the strengths, protective factors, and determination of individual women, and their communities. At the individual level, success is dependent upon their inner strength and their ability to face their childhood and adult life conditions and experiences. Family support, particularly from family members who do not use alcohol or other drugs, is also a key element in promoting their recovery. The strength and support that women derive from their communities, and their Indian culture and tradition, are of paramount importance.

To ultimately achieve the goal of this evaluation, which is to contribute to the improvement of the health of American Indian/Alaska Native women, recovery needs to be understood not only as recovery from alcohol and drug use itself, but from poverty and homelessness, abusive relationships, low self-esteem, and negative patterns that have been entrenched over generations. The process of recovery needs to be understood as a lengthy, slow, complex, and often unpredictable process comprised of small steps, and sometimes bouts of relapse, that occur over time. Individuals, families, friends, communities, service providers, researchers, and policymakers must maintain this conceptualization in their response to chemical dependency. It is important to pay attention to the voices of the women themselves in developing treatment and service policies for AI/AN substance-using women. As the data from the participant focus groups attest, and data from the chart review and staff interviews support, their experiences and needs are best articulated by the women themselves.

It is hoped that the information derived from the first two phases of the this four-phase evaluation will provide the foundation for the conceptualization and implementation of subsequent phases of this research. More important, it is also hoped that these findings will be directly useful for policymakers, planners, service providers, and American Indian and Alaskan Native people.
Executive Summary

References:


I. Overview of the Evaluation
Introduction

Alcohol and substance abuse are serious problems among American Indian and Alaska Native people. The roots of substance abuse in this population can be traced back to the influence of American and European settlers and the displacement or disaffection of Native populations from their lands and cultures. Attempts to assimilate Native populations have led to forced resettlement to urban areas or less productive land, sending children to boarding schools, and subsequently to isolation, high unemployment and poverty. Although these problems are pervasive throughout the Native population, tribal differences such as religious beliefs, socioeconomic status, cultural practices, and geographical location have led to different patterns of substance abuse throughout the United States and Canada.

Research has demonstrated much higher levels of morbidity and mortality from such alcohol and substance use-related conditions as cirrhosis and cancer among Native populations as compared with the national population. Alcohol and alcohol abuse are responsible for 25% of all deaths for AI/AN women (Leland, 1984), and hospital discharge rates for alcohol-related diagnoses are approximately three times greater than national rates. American Indian/Alaska Native (AI/AN) women also appear to be at greater risk of dying from alcohol-related problems than non-AI/AN women, or AI/AN men, who tend to drink more than females and are more likely to die from alcohol-induced accidents (Hisnanick and Erickson, 1993). In 1993 Trends In Indian Health, the Indian Health Service published alarmingly different alcoholism death rates between AI/AN women and women in the general population. Estimates of the potential years of life lost due to causes of death directly associated with alcohol use are as high as 22 years for AI/AN women; if such indirect causes as accidents are included this rate might be even higher (Christian et al., 1989; Dufour et al., 1989; Hisnanick and Erickson, 1993).
I. Overview

Table 1.1
Female Alcoholism Death Rates Per 100,000 (1987-89)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>AI/AN All Races</th>
<th>U.S. All Races</th>
<th>Ratio AI/AN to U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-34</td>
<td>21.2</td>
<td>1.6</td>
<td>13.25</td>
</tr>
<tr>
<td>34-44</td>
<td>39.7</td>
<td>4.7</td>
<td>8.45</td>
</tr>
<tr>
<td>45-54</td>
<td>68.0</td>
<td>8.7</td>
<td>7.82</td>
</tr>
</tbody>
</table>


The impact of substance use extends beyond its influence on morbidity and mortality rates; pronounced negative consequences are also felt by the family and the larger community. Fetal Alcohol Syndrome (FAS), child abuse, and domestic violence are all related to alcohol and other substance use. Alcohol and other drug (AOD) use also contributes to – and is influenced by – family dissolution, unemployment, and poverty. One study reported that between 85% and 93% of all child neglect cases on an AI/AN reservation involved alcohol abuse (DeBruyn et al., 1992).

Despite the enormity of the issue, substance abuse treatment services for AI/AN women (as well as programs for non-Native women) have only recently received much attention in this country, and AOD treatment services for AI/AN women have been targeted by the Indian Health Service (IHS) as a critical area requiring additional resources. The Indian Health Care Improvement Act (Public Law 102-573, Section 703), as amended, requires the Indian Health Service (IHS) to develop and implement comprehensive alcohol and substance abuse prevention, intervention, treatment, and relapse prevention services that specifically address the cultural, historical, social, and child care needs of Indian women, regardless of age.

Significant barriers to treatment exist for American Indian/Alaska Native women, who face institutional, economic, psychological, and informational obstacles, including restrictions on bringing their children to treatment. In general, for both the AI/AN population and the general population throughout the county, most AOD treatment programs have been designed for men, and primarily for Caucasian men (Fleming and Manson, 1990). Increasingly, however, AOD treatment programs serving
AI/AN populations have begun to adopt Indian-focused interventions that either include women or that are designed exclusively for women. This is important because the treatment needs of women are in many ways very different from men; not only do women often have child care responsibilities, but they exhibit different addiction patterns as well.

The importance of implementing treatment programs which take into consideration the special psychological, cultural, medical and social needs of women and their families has been increasingly recognized in recent years. This has included incorporating traditional and cultural beliefs into the recovery model. Many programs hire recovering AI/AN staff and employ culturally relevant treatment approaches. For those AI/AN women who do receive treatment services, the effectiveness of AGO programs has not been well documented thus far. It is widely believed, however, that participation in a recovery program can instill hope and optimism in an addicted woman, and that her chances of recovery are increased when counseling and an array of such ancillary services as child care and transitional housing are provided.

Because research is virtually nonexistent on the scope of the problem of AOD use among AI/AN women, as well as the effectiveness of treatment for this population, the evaluation study described in this report was undertaken to examine the needs of women receiving treatment services through IHS-funded programs. It is the intent of this evaluation to provide useful information about the needs of AI/AN women by describing their demographic, social, behavioral and health characteristics and their attempts at recovery. However, substantial and continued research is still needed to further advance effective treatment strategies, including large-scale epidemiologic studies about the prevalence of substance abuse, AOD-related morbidity and mortality, and trends in substance use and its health implications for both AI/AN women and men, as well as youth.

Description of the Evaluation

In order to promote the health and well-being of American Indian/Alaska Native women, their families, and their communities, it is critical to 1) adequately understand the life conditions of the women who are currently receiving treatment through IHS-funded centers, 2) assess the long-term outcomes of treatment, and 3)
1. Overview

evaluate the centers themselves in order to relate participant outcomes to the AOD treatment and recovery services that women have received. However, descriptive and outcome data for both AI/AN and non-AI/AN women in treatment remain very limited. There is also little empirical evidence about the effectiveness of AOD treatment centers for chemically dependent AI/AN women.

In light of this lack of current information, the Office of the Assistant Secretary of Health (OASH) and the Indian Health Service (IHS) requested a multi-phase evaluation of alcohol and substance abuse services for adult AI/AN women in AOD treatment centers that are fully or partially funded by the IHS. The overall, long-term goal of the evaluation is to contribute up-to-date information that can be used to help improve the health of AI/AN women, and through doing so, help promote the growth of tribal communities.

The evaluation study incorporates four phases. During Phase 1, the evaluation design for the entire project was completed, a Technical Advisory Committee (TAC) was convened, and a number of consultants were hired to assist in designing and implementing the evaluation study. An extensive review of the literature was also conducted during Phase 1. During Phase 2, descriptive information was collected about women currently in treatment in centers that are either fully or partially IHS-funded. A prospective client outcomes study will comprise the evaluation activity for Phase 3, and Phase 4 will consist of an evaluation of the efficacy of IHS-funded treatment centers (the evaluation design for this multi-phase project is included in Appendix A). It is hoped that the findings from the entire four-phase evaluation will be used to improve descriptions of, access to and the availability and effectiveness of alcohol and substance abuse services for adult AI/AN women. In addition, the results of this evaluation will contribute to the literature by validating or refuting findings from other studies, by improving the understanding of substance use and abuse among women, and by describing the strategies for promoting the recovery of women, their families, and their communities.

Evaluation Guiding Principles

Because of the potential importance and utility of this evaluation study, it was important that the evaluation team establish positive working relationships with the tribal communities in which the evaluation was to be conducted, with treatment center
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staff and participants, and with Indian Health Service personnel. Positive rapport was
demed essential to establishing the legitimacy of the evaluation study at the tribal
community level and ultimately its validity for policymakers and within the field of
AOD treatment and recovery. Toward this goal, the following evaluation principles
were established to guide the evaluation team and its consultants:

• Be respectful of local customs in the scheduling and conduct of evaluation activities,
such as protocols for addressing tribal councils.

• Seek the support of the communities within which the evaluation is conducted.

• Encourage the active participation of the community and its representatives in the
evaluation process.

• Be responsive and adaptable to the particular needs of each tribal community.

• Make all evaluation materials available to the tribal communities and to the IHS, in­
cluding the evaluation design, literature review, data collection instruments, and
findings as they become available.

• Prior to actual data-gathering, share data-collection tools with representatives of
tribal communities, solicit their comments, and revise these tools based on their sug­
gestions.

• To the extent possible, be available to respond to concerns by the IHS and tribal
communities relating to any aspect of the evaluation.

• Obtain approval (by attending community meetings when possible and appropri­
ate), either verbally or in writing, from the tribal communities before proceeding
with data-gathering activities.

• Employ culturally appropriate methods whenever possible.

• Respect the integrity and confidentiality of all evaluation study participants.

The Roles of the Technical Advisory Committee and Special Consultants

To ensure that the evaluation would be both scientifically sound and culturally
appropriate, a Technical Advisory Committee (TAC) was convened and four consul­
tants were selected (the TAC membership roster is included in Appendix B). These ex­
erts brought to the project their expertise in substance abuse problems, treatment cen­
ters, and evaluative research among AI/AN women. They represented AI/AN sub-
stance abuse treatment centers, IHS Area Alcoholism and Substance Abuse Coordinators, IHS Headquarters staff, women's treatment centers, and research centers. The role of the TAC was to provide expertise and overall guidance to this process so that the evaluation design and the data collection instruments and procedures were as thoroughly thought out and appropriate to the study population as possible. The consultants also reviewed the evaluation design, and were given the additional responsibility of participating in site visits to the AOD treatment centers included in the study. During these site visits, the consultants facilitated the participant focus groups, conducted some of the staff interviews, and helped review the records of the women in treatment.

**Evaluation Phase 1: Evaluation Design, Literature Review, and Convening the Technical Advisory Committee**

Numerous issues must be considered when assessing the prevalence of chemical dependency among AI/AN women and its impact at the individual, family, community and national levels. To aid in the conceptualization of the evaluation, a comprehensive review of the literature was conducted at the beginning of Phase 1 (see Appendix C). This review focused on chemical dependency among AI/AN women and its impact at the individual, family, and community levels, and the effectiveness of existing alcohol and drug treatment and recovery centers serving AI/AN women. The purpose of the literature review was to 1) summarize the issues related to chemical dependency among AI/AN women, and 2) describe prior programmatic efforts in the field. Covering what is currently known about the prevalence of AI/AN AOD use, its health impacts, the interventions that have been employed to promote recovery among women, as well as a historical perspective and the life experiences of AI/AN women, this information was useful in the selection of data-gathering methods and appropriate variables to study. The knowledge base encapsulated in the literature review served as a foundation for the evaluation design. A comprehensive evaluation design was developed to gather the necessary information needed to answer a variety of evaluation questions. This evaluation plan specified the research questions for each of the evaluation's four phases, the variables of interest and data collection strategies, and plans for data analysis. Phase 1 was initiated September 30, 1994 and was completed by March, 1995.
2. Evaluation Phase 2: Description of Study Participants

At the beginning of Phase 2 (January, 1995) a brief, self-administered survey was sent to the director of each participating treatment center. This survey requested information that would help the evaluators become familiar with each of the participating centers. Information was requested about the length of time the center had been in operation, the AOD treatment modalities it provided, the number and composition of its staff, the target groups the center tried to reach, its outreach strategies, and eligibility criteria, and the number of treatment slots available for women. The survey also requested information about the range of services offered by the center in addition to AOD treatment.

The major goal of Phase 2 was to collect and analyze much-needed descriptive, demographic, social, cultural, and clinical information about women receiving treatment in alcohol and substance abuse treatment centers funded in whole or in part by IHS. This information will provide critically necessary data about the women who are participating in IHS-funded treatment centers, and serve as the foundation for assessing the long-term impact of current models of treatment. Findings from this evaluation should furnish AOD treatment providers, program planners and policymakers with information about service configurations and resource allocation that will help them effectively promote the recovery of AOD-using American Indian and Alaska Native women. The information derived from Phase 2 should also prove useful for further focusing and fine-tuning subsequent phases of the evaluation.

Evaluation Questions

Phase 2 evaluation activities were directed towards answering the following research questions:

a. Characteristics of women using IHS-funded treatment centers:

• What are the demographic, social, behavioral, and health characteristics of the women who receive IHS-funded treatment services (such as age, marital status, family composition, level of education, employment status, drug/alcohol use, and history of sexual abuse)?

• What proportion of these women have mental health problems?
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- What proportion of these women are pregnant and/or are parents?
- What are the social and behavioral strengths of these women as well as social and behavioral deficits?
- What are the patterns of substance abuse and AOD-related problems of women in treatment?
- What are the health and medical conditions of these women?
- What are their cultural and spiritual orientations?
- Is there family and community support to help women seek treatment (e.g., child care)?
- Are there family or community influences that inhibit women from seeking treatment?

b. Treatment utilization characteristics:

- What are the sources of referral to treatment for these women?
- What are the service needs of these women, both apart from and related to, AOD use?
- Which factors influence the treatment-seeking behavior of these women?
- Which factors influence their retention in treatment?

As we have stated, Phase 2 of the four-phase evaluation was conducted to provide descriptive information about the AI/AN women receiving AOD treatment at programs which are either fully or partially funded by the IHS. This report summarizes the findings from Phase 2 of the evaluation.
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The Multi-Method Evaluation Approach

To assemble a comprehensive profile of American Indian/Alaska Native women participants in treatment at a sample of IHS centers that provide services to women, a combination of different data collection approaches was used for Phase 2 of this evaluation study. Compared to a single-method approach, there are several reasons why a multi-method approach is advantageous. First, integrating multiple perspectives through different types of evaluation approaches can be used to augment and illuminate data collected by more conventional means, and can also be used to overcome the limitations of any single method. Information gathered by means of a single method may be limited in its explanatory powers, whereas the coordinated employment of multiple data-collection strategies enables the evaluators to draw an enhanced range of inferences about meaning, causes, and effects. For example, in the effort to describe women who use IHS-funded treatment centers, rather than relying on one source of information (such as treatment records), the evaluators asked the AOD treatment staff to describe the women who use their centers; to gather information from another perspective, the women who were in treatment were queried during focus groups about their views on the treatment center and to talk about their histories and life experiences. The responses from these group staff interviews and participant focus groups were used to support or refute findings from other sources of information about women receiving treatment. In circumstances where data inconsistencies arose, the differing responses were compared and further clarification was sought.

To provide a comprehensive profile of a sample of AI/AN women in treatment at the nine IHS treatment centers participating in the study, four data-collection approaches were used:

1) Focus groups of study participants were conducted at a selected sample of nine treatment centers that serve women. Focus group participants were asked about both their history of AOD use and their current use, the role played by their family and community in their AOD use, their experience with AOD treatment centers, and the perceived benefits of participating in their current treatment program.
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2) Information was abstracted from participant treatment records by members of the evaluation team, using investigator-developed chart abstract forms to systematically retrieve the desired information in a uniform and consistent manner. This information consisted of basic demographic data (age, marital status, education, employment, living partners, number of children), history of drug/alcohol use, social and behavioral risk factors, and duration of treatment.

3) Group interviews were conducted with treatment center staff to acquire important descriptive information on IHS-funded treatment centers that provide services to women, including strategies that have been adopted to promote the recovery of AI/AN women.

4) Individual interviews with treatment center administrators were conducted to acquire important descriptive information on IHS-funded treatment centers that provide services to women, including characteristics of the treatment center, its staff, and strategies that have been adopted to promote the recovery of AI/AN women.

These qualitative data collection methods were used in an exploratory manner to learn (for example) more about the life conditions of the participants and the configuration of services provided by the treatment center, and to elucidate the perspectives and values of the staff and the participants. Quantitative methods were used when a standardized and numeric format for the acquisition and analysis of information was available, e.g., standardized IHS-required reporting forms that all IHS-funded centers complete on a regular basis. Data collection approaches, particularly qualitative methods, were selected that were culturally relevant and appropriate to the needs of the tribal communities as well as to the evaluation. Like the data-gathering approaches employed for this evaluation, a variety of data-analysis methods were used so that the evaluators could explore many variables from several perspectives simultaneously.

Institutional Approvals

Throughout the Phase 2 data-collection process, participant and staff confidentiality were strictly maintained. All necessary institutional review board and tribal council approvals were obtained prior to the commencement of data collection, including a Certificate of Confidentiality from the National Institute of Alcohol Abuse and Alcoholism (NIAAA) (see Appendix D). However, the original Delivery Order for this study did not include provisions for the complicated and lengthy processes required to obtain institutional approvals. Institutions that required approvals included the
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University of California at San Francisco, the Indian Health Service, two of the nine participating IHS Area Offices, and every tribal council that represented the nine participating treatment centers. The entire process of obtaining these institutional approaches took approximately three months, and the beginning of data collection was thus delayed well beyond the original target date.

Sample Selection

Nine IHS-funded treatment centers, and one alternate that was included as a pilot site, were invited to participate in the evaluation study; these included both female-only and co-gender centers that serve American Indians and Alaska Native women. With input from the Delivery Order Officer, the Technical Advisor, and the Technical Advisory Committee, the centers were chosen according to specific criteria; the information derived from this phase may thus not be generalizable to all treatment centers. Efforts were made, however, to ensure that the treatment centers would be as representative as possible of the complete range of IHS-funded treatment centers. The criteria for selecting the centers for the study were as follows:

1) The length of time the center had been in operation and providing services to women;
2) The capacity or census of the center (a mix of high-, moderate- and low-volume centers was studied);
3) The geographic location of the center (a mix of geographic areas was represented, including both urban and rural centers);
4) Gender diversity (i.e., both women-only and co-gender centers);
5) Diversity of treatment modalities (i.e., outpatient, intensive day, or residential treatment);
6) The availability and accessibility of information on participants (including children and families if possible); and
7) A maximization of evaluation resources (e.g., if two treatment centers that serve women were located within the same geographic location, both were visited if possible).

Table 2.1 lists the IHS treatment centers that were selected to participate in the study. The Technical Advisor was instrumental in identifying treatment centers, and
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contacted each to explain the purpose of the evaluation and invite their participation. The evaluators then convened a meeting of representatives from the ten selected treatment centers, all of whom agreed to participate. With only two exceptions, a representative of each treatment center attended the meeting in San Francisco in early April, 1995 (the meeting was audiotaped for those who could not attend). Federal Office of Management and Budget (OMB) regulations regarding the maximum number of participants about whom information could be collected without obtaining OMB approval were followed.

Table 2.1
Phase 2 Participating Treatment Centers

<table>
<thead>
<tr>
<th>Location</th>
<th>Center Name</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco, CA</td>
<td>Friendship House</td>
<td>Helen Waukazoo</td>
</tr>
<tr>
<td>Oakland, CA</td>
<td>American Indian Family Health Center</td>
<td>Kathleen Richards</td>
</tr>
<tr>
<td>Portland, OR</td>
<td>Native American Rehabilitation Association</td>
<td>Alex McCloud</td>
</tr>
<tr>
<td>Phoenix, AZ</td>
<td>Indian Rehabilitation/Guiding Star Lodge</td>
<td>Diana Yazzie</td>
</tr>
<tr>
<td>Anchorage, AK</td>
<td>Dena A Coy</td>
<td>Lorraine Namyniuk</td>
</tr>
<tr>
<td>Anchorage, AK</td>
<td>Alaska Native Alcoholism Recovery Center</td>
<td>Ernie Turner</td>
</tr>
<tr>
<td>Browning, MT</td>
<td>Blackfeet Alcoholism Program</td>
<td>Pat Calf Looking</td>
</tr>
<tr>
<td>Gresham, WI</td>
<td>Maehnowesekiyah</td>
<td>Sylvia Wilbur</td>
</tr>
<tr>
<td>Allen, OK</td>
<td>Kullihoma Treatment Center</td>
<td>Shirley Byrd Lydia Harrison</td>
</tr>
<tr>
<td>Winnebago, NE</td>
<td>IHS Drug Dependency Unit</td>
<td>Bob Hollowell</td>
</tr>
</tbody>
</table>

* The alternate site was later designated as one of the nine study sites because one of the selected centers withdrew from the study.
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Data Collection

With assistance from several consultants to the project, the evaluation team worked with individual treatment center staff to develop the data collection protocol. The participation of both treatment staff and the women in treatment was voluntary, and all information derived from the evaluation was kept confidential. No names were written on any of the recording forms, and no personal identifiers were affixed to the chart abstract forms that recorded data obtained from participant treatment records at the centers. The three Phase 2 data-collection activities are described below; examples of all data-collection instruments are included in Appendix E.

Review of Participant Treatment Records

The review of participant treatment records drew upon a central source of information about AI/AN women participating in IHS-funded treatment centers. This chart review was used to collect information in several areas, including:

- Basic demographic data (age, marital status, education, employment, living situation, number of children);
- History of AOD use;
- Social and behavioral risk factors; and
- Duration of treatment.

Investigator-developed chart abstract forms were designed to systematically retrieve information from the participant treatment records. All records for women who had exited treatment within the preceding year were eligible to be reviewed, from which a random sample of up to 30 charts were selected. All information was abstracted from participant treatment records by members of the evaluation team.

To develop the chart abstract form used to record this information, a feasibility assessment was conducted on a sample of charts at one IHS-funded treatment center to determine the quantity and quality of the data available from participant treatment records. The forms used at each treatment center to record participant data were examined to determine the type of information each center collected, and the format used to record that information. Following this process, a core set of variables common across all the treatment centers was isolated. In addition to this cross-site standardization process, all treatment record forms at each participating treatment center were individually
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reviewed in order to derive a set of indicators that were unique to each center. It should be noted that the use of these forms was not consistent across the treatment centers. Similarly, inconsistencies were observed in the completion of standard forms within each treatment center.

The potential for using information available through existing IHS AOD reporting systems was also explored. The most widely used system within the Indian Health Service is the Chemical Dependency Management Information System (CDMIS). However, because of inconsistencies among the treatment centers participating in the evaluation study in terms of comprehensiveness of participant information, it was decided not to use the CDMIS records as a source of data.

The use of information abstracted from participant treatment records is permitted through federal regulation 42 CFR 2.52. This regulation allows research to be conducted on participant records without participant consent if certain conditions are present. However, at no time was information from the participant treatment records linked to other sources of participant information, such as records of focus group discussions. To maintain confidentiality, no names were recorded on the chart abstract forms, which were distinguishable only by means of a unique but non-personal participant identifier code. Furthermore, participant information from the Phase 2 chart review will not be used to select or identify study participants for Phases 3 or 4 of the evaluation. Phase 2, and its subjects, will be kept completely separate from any subsequent research activities.

A total of 172 participant treatment records were reviewed; each chart review took from 20 minutes to an hour to complete. The type and amount of information that was recorded in the participant treatment records across the nine centers varied widely. However, most of the data variables of interest to the evaluation team were available from the majority of treatment records.

**Participant Focus Groups**

Participant focus groups at all nine sites were used to provide contextual data to supplement the largely quantitative data derived from the chart review. A focus group guide was developed by the evaluation team to elicit information in several important areas: history of AOD use; precursors and consequences of the participant’s AOD use; the role of family, friends and community in the participant’s AOD use; the participant’s experience and degree of satisfaction with previous AOD treatment centers; benefits
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derived from participation in the current treatment center; and plans for the future, in­
cluding aftercare involvement.

Per OMB regulations, up to nine women were permitted to participate in the fo­
cus groups at each center. At virtually all the treatment centers, nine or fewer women 
were currently in the active phase of treatment, and thus no woman who wished to 
participate was refused. Treatment center staff were asked to select a convenient date 
and time to conduct the groups, and to invite the women to attend. Consent forms and 
information sheets explaining the evaluation study were distributed to focus group par­
ticipants and read aloud to the group (see Appendix F). Individual consent forms were 
signed by each participant before the session began. All participants were assured that 
they were free to decline participation in the focus groups, free to decline to answer 
specific questions, and free to leave the focus group at any time during the session. The 
women were also assured that neither their decision to participate nor any of their re­
 sponses would affect the services they were currently receiving or would receive in the 
future. The group facilitators and the evaluators also vowed they would never share 
individual information or reveal the personal identity of any participants to anyone.

A total of 60 women participated in the nine focus groups. The sessions lasted no 
longer than two hours and were facilitated by a consultant who was highly experienced 
in working with AI/AN women. One member of the evaluation team attended each 
group to record observations. Refreshments were provided by the evaluation team. In 
addition, in appreciation for their time and contribution to the study, a non-monetary 
incentive was given to each participant following completion of the session. Incentives 
included gift certificates to local stores, souvenir T-shirts, and bath accessories.

Interviews with Treatment Center Administrators and Staff

Treatment center administrators were asked to participate in an interview covering 
aspects of the treatment centers they manage, and their perceptions of the needs of 
the women participating in their AOD treatment program. In addition, group inter­
views with substance abuse counselors were conducted at each location. The purpose 
of these interviews was to gather essential contextual information about the treatment 
centers, as well as administrator and staff impressions about the centers, observations of 
trends and significant issues related to women's treatment needs, and the experiences 
and needs of women seeking treatment. Consistent with the protocol for the participant 
focus groups, fewer than ten administrators and staff were interviewed at each center.
II. Methodology

The group staff interviews lasted approximately two hours. In a process similar to that followed in the focus groups, consent forms were required for participation, and staff members were each given an information sheet that described the overall purpose of the evaluation and the purpose of the staff interview. They were assured that they were free to decline participation in the group interview, to answer any questions they did not wish to answer, and free to leave the interview at any time during the session. The information derived from the staff interviews was kept confidential; no names were written on any of the recording forms. Staff participants were also told that their names would not be connected in any way with their answers, and that their names would never be used in any report or publication from this study. The security of all information obtained through these means was strictly maintained. In addition, a Certificate of Confidentiality through the National Institute on Alcohol Abuse and Alcoholism was obtained. A total of 52 staff persons participated in these interviews, including supervisors, counselors, and administrative and support staff.

Plan for Data Analysis

The data analysis plan included strategies for synthesizing both quantitative and qualitative descriptive and comparative information to assemble a comprehensive profile of women in treatment at IHS-funded centers. Findings from one center were not compared to another as a measure of effectiveness; rather, results were aggregated across all nine AOD treatment programs.

After all the focus groups had been completed, the observations recorded by the observers were aggregated and analyzed using appropriate computer software and analytic techniques. For the quantitative data recorded on the chart abstract forms, the frequency distributions of all response categories for each relevant indicator, and the total number responding, were computed. A second stage of analysis included cross-tabulation by selected variables, including analyses of correlations and variations among selected variables. For example, the geographic characteristics (i.e., reservation, rural, or urban) were compared with participant AOD use characteristics. A third level of analysis examined similarities and differences across centers. Appropriate statistical tests were applied based on the mode of inquiry and format of the data.
III. Description of the Participating Treatment Centers
III. Description of the Participating Treatment Centers

This chapter provides an overview of the nine Indian Health Service-funded treatment centers that participated in Phase 2 of this evaluation. These centers include both female-only and co-gender centers that serve American Indian and Alaska Native women. With input from the Delivery Order Officer, the Technical Advisor, and the Technical Advisory Committee, the centers were chosen according to specific criteria; the information derived from this phase may thus not be generalizable to all treatment centers. Efforts were made, however, to ensure that the treatment centers would be as representative as possible of the complete range of IHS-funded treatment centers. The criteria for selecting the centers for the study were as follows:

1) The length of time the center had been in operation and providing services to women;

2) The capacity or census of the center (a mix of high-, moderate- and low-volume centers was studied);

3) The geographic location of the center (a mix of geographic areas was represented, including both urban and rural centers);

4) Gender diversity (i.e., both women-only and co-gender centers);

5) Diversity of treatment modalities (i.e., outpatient, intensive day, or residential treatment);

6) The availability and accessibility of information on participants (including children and families if possible); and

7) A maximization of evaluation resources (e.g., if two treatment centers that serve women were located within the same geographic location, both were visited if possible).

The information presented here was derived from a self-administered survey sent to the program managers of each participating treatment center, and from subsequent in-person interviews conducted later with these administrators during site visits. Each participating AOD treatment center was observed individually; one cen-
Profiles of the Nine Participating Treatment Centers

Each of the nine participating IHS-funded treatment centers is briefly described below with regard to programmatic philosophy, goals, activities, staffing, and provision of services for American Indian/Alaska Native women.

**Indian Rehabilitation/Guiding Star Lodge**
Phoenix, Arizona

Program Overview

The Guiding Star Lodge is an AOD treatment program that provides residential and outpatient services for men, women, and children from several Southwestern tribes. The program was established in 1972 and has been offering services to women since 1989. Outpatient and day treatment services are offered eight hours per day, five days per week. An intensive outpatient program is offered three days a week, three hours per night, for a 12-week period. Guiding Star's primary funding sources include the federal and state governments, the Indian Health Service, and tribal contracts.

Program Philosophy

Guiding Star Lodge's program philosophy is that alcoholism and drug addiction are treatable diseases. It has embraced a holistic approach that seeks to address the healing of the mind, body and spirit of program participants. The primary focus of the program is to resolve addiction primarily through the identification of the participant's feelings and underlying emotions, followed by life skills development. The highest priority goals of Guiding Star Lodge are for the participants to achieve sobriety and to be effective parents. In this program model, children who accom-
pany their mothers into treatment are also considered program participants.

**Program Services**

Twenty treatment slots are currently available for women (although this number is being reduced due to decreased funding) and twenty slots are available for children. A variety of treatment services are offered, including individual and group counseling, AA and NA groups, and alcohol education. Referrals to other facilities are made for detoxification (urban areas only) and methadone maintenance. Social support services offered that are part of the core service package include help with enrollment in government assistance, and transportation. Referrals to services in the community are also made for housing assistance, job training, educational programs, child welfare assistance, and limited assistance with utility expenses. Limited counseling and substance abuse treatment services are available for the family as well, as are a variety of children’s services, such as child care, child therapy, and recreational activities. In addition, referrals to services in the community are made for children’s immunizations, medical care, and educational programs. Aftercare services include 12-step meetings and counseling. Spiritual, tribal, and cultural activities include the Sweat Lodge and the Talking Circle.

**Outreach and Eligibility**

Community outreach strategies used by the program include formal outreach to community organizations, hospital delivery referrals, referrals from the criminal justice system, word-of-mouth, advertising, brochures, tribal organizations, and detoxification centers. To be eligible for enrollment in the program the participant must be an adult or emancipated youth with substance abuse as a primary problem. Participants must be capable of self-care, present no danger to themselves or to others, and be medically stable. Guiding Star Lodge makes a special effort to enroll pregnant and parenting American Indian women, including substance-exposed or affected infants and children. Other targeted groups include chemically dependent women with mental illness, and incarcerated women. Children up to age 12 are allowed in the program. On occasion, teenage women are admitted.

**Staff Profile**

The staff at Guiding Star Lodge is comprised of 28 FTE (full-time equivalent) direct service providers, three program administrators, seven support staff (e.g., cooks, transportation, and maintenance staff) and six administrative support staff (e.g., secretaries, data and accounting staff). Thirty-six of the 44-person staff (82%) are
American Indian or Alaska Native and 34 (77%) are women. Seven are graduates of the treatment program who must have sustained sobriety for a minimum of one year to work in non-direct services, or two years to work as a house manager or in direct participant services.

Alaska Native Alcoholism Recovery Center
Anchorage, Alaska

Program Overview
The Alaska Native Alcoholism Recovery Center (ANARC) provides an organized therapeutic environment for both men and women. The program was established in 1988 and is affiliated with the Alaska Native Cook Inlet Tribal Council. In addition to residential services, day treatment, outpatient treatment, aftercare, and follow-up are offered at ANARC. The outpatient services are offered three hours per day, three days a week; day treatment is available seven hours per day, five days per week. The aftercare treatment component consists of one-hour sessions, two nights per week. ANARC's primary funding sources include the federal and state governments, the Indian Health Service, private donations, and participant fees.

Program Philosophy
The mission of ANARC is to identify and treat adult men and women who are chemically dependent, and to help participants achieve physical, emotional, mental and spiritual health, economic security, employment, positive social and family interdependence, and positive cultural identity. ANARC defines alcoholism and chemical dependency as a treatable disease that contributes to physiological, psychological, spiritual, and socio-cultural problems. The ANARC philosophy acknowledges the scientific evidence that alcoholism is hereditary and therefore a physical addiction. It maintains that the effects on the individual from taking a mind-altering substance, like alcohol or other drugs, depend on the physiology of the individual. ANARC recognizes that alcohol consumption and drug use are
well-established and acceptable behavior for the major segment of the Alaska Native people. It is the substance abuse which causes impairment and death that primarily concerns ANARC.

**Program Services**

Eleven inpatient slots are available for women; outpatient treatment slots are unlimited. Services are not available for children. Alcohol education, individual counseling, group counseling, and AA or NA groups are part of the core package of services offered on-site. ANARC also offers transportation services and provides referrals for job training, education, enrollment in government assistance, housing assistance and child welfare. Referrals to services in the community are available for counseling and a variety of children's services.

**Outreach and Eligibility**

ANARC makes a special effort to reach chronic alcoholics with psychosis, chemically dependent women with children, the partners of these women, and chemically dependent women with public or private insurance. Participants must be American Indian or Alaska Native to enter the program. Community outreach strategies include formal outreach to community organizations, word-of-mouth, advertising, brochures, the criminal justice system, and tribal organizations.

**Staff Profile**

ANARC is staffed by 16 people; 15 (94%) are American Indian or Alaska Native, 10 (63%) are females, and 9 (56%) are female American Indian/Alaska Natives. Six of the staff are graduates of ANARC.

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**The Chickasaw Nation Kullihoma Alcohol/Drug Treatment Center**

**Allen, Oklahoma**

**Program Overview**

The Chickasaw Nation Kullihoma Alcohol/Drug Treatment Center was es-
III. Description of Participating Treatment Centers

tablished in 1980 and is affiliated with the Chickasaw Nation. The program has provided services for women for 6 years. All AOD treatment is provided in a 24-hour residential setting. Kullihoma Alcohol/Drug Treatment Center’s funding source is the Indian Health Service.

Program Philosophy

The program philosophy of the Kullihoma Alcohol/Drug Treatment Center is based on Rational Emotive Therapy. Both the importance of humor and the family are emphasized in AOD treatment. The program has prioritized the need to help women achieve sobriety, to support women in improving their self-esteem, and to help rebuild family relationships.

Program Services

Four residential treatment slots are available for women. Services are available for children ages 4 through 18, although there are no slots for younger children in the program. A wide range of on-site services are available at the treatment center. Participant counseling services include individual counseling, group counseling, and AA or NA groups. The program aids participants with enrollment in government and housing assistance as part of their on-site social support services. Detoxification and alcohol education are also part of the core package of services offered. The program provides extensive aftercare services, including 12-step meetings, counseling, job training, educational referrals, and housing assistance. Family members may also receive counseling services at the center. Referrals for services not provided through the program include transportation, child welfare services, assistance with utility expenses, methadone maintenance, drug treatment for family members, and children’s services (child therapy, immunizations, medical care, and educational programs). Some children’s services (child care, recreational activities, and food/snacks) are available on-site, but are not a part of the program’s core services.

Outreach and Eligibility

Kullihoma Treatment Center makes a special effort to reach chemically dependent women with mental illness, adolescents, incarcerated women, and partners of women participants. To be eligible for treatment, participants must be over 18 years old, must have documentation that s/he is an American Indian or Alaska Native, that they have an existing problem with AOD, and have received a complete physical examination. Community outreach strategies include formal out-
III. Description of Participating Treatment Centers

reach to community organizations, word-of-mouth, brochures, hospital obstetrical departments, the criminal justice system, and tribal organizations.

**Staff Profile**

The Treatment Center has eleven staff, 5 of whom (45%) are women. All of the women are American Indian or Alaska Native. One of the staff is a graduate of the program.

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**Dena A Coy**

Anchorage, Alaska

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**Program Overview**

Dena A Coy is a comprehensive treatment program for substance-using pregnant women that was established in 1991. Dena A Coy provides residential services, outpatient/day treatment services, and transitional services. The program is designed to allow women to remain in treatment throughout the duration of their pregnancies, and six weeks postpartum. The center’s primary funding sources include the federal and state governments, the Indian Health Service, private donations, in-kind donations, and Medicare.

**Program Philosophy**

The philosophy of AOD treatment at Dena A Coy is one that integrates the major theoretical models of drug and alcohol dependency, including social, medical, and biopsychosocial models, to assist participants in understanding their dependency issues, maintain abstinence, and work toward long-term sobriety. Dena A Coy’s treatment philosophy is to help the women discover their own strength. A combination of treatment models are presented to the participants through the development of their individual treatment plans. It has been the experience of Dena A Coy that a confrontational style of treatment is not always effective for pregnant women. The highest priority goals of the program are to create a respectful envi-
III. Description of Participating Treatment Centers

Program Services

Sixteen treatment slots are available for pregnant women. Six slots are available for children, from birth to age three. While in treatment, Dena A Coy participants receive education, support, counseling, and therapy to help them attain the goals they have identified. Services are modified according to individual participant needs. In addition to spiritual, tribal and cultural activities, Dena A Coy offers extensive counseling services, social support services, alcohol education, aftercare activities, family counseling, child care, and recreational services for children. Referrals are available for detoxification, methadone maintenance, family counseling and drug treatment, and additional children’s services.

The six-week postpartum phase is designed to assist women who have recently given birth to promote maternal bonding and attachment. In addition, the program promotes maternal physical and psychological self-care. Coordination of participant activities and services are monitored by a case manager to ensure that all aspects of treatment and aftercare planning have been addressed.

Outreach and Eligibility

Eligibility criteria for enrollment require that a participant be pregnant and at risk for using drugs or alcohol. In addition to pregnant women, the program makes a special effort to reach chemically dependent women with mental disorders, adolescents, incarcerated women, other members of the participant’s family, and substance-exposed or affected infants and children. Community outreach strategies used by Dena A Coy include formal outreach to community organizations, word-of-mouth, advertising, brochures, community street outreach, schools, hospital delivery referrals, the criminal justice system, the foster care system, and tribal organizations.

Staff Profile

The staff is comprised of 15 FTE direct service staff members and one program administrator. All of the staff are women, and all but one are American Indian or Alaska Native.
III. Description of Participating Treatment Centers

Drug Dependency Unit
Winnebago, Nebraska

Program Overview
The Drug Dependency Unit (DDU) is a component of the Indian Health Service Winnebago Hospital. The DDU is a hospital-based alcohol and drug treatment program which offers services to all adult male and female American Indians and Alaska Natives who reside in the United States. The DDU is a 12-bed co-ed facility with 24-hour coverage seven days a week. Individuals are admitted at eight different intervals throughout the year for six weeks of comprehensive and intensive treatment. DDU's primary funding source is the Indian Health Service.

Program Philosophy
DDU tries to significantly reduce the negative impact of substance use among American Indian/Alaska Native people, and to develop the most appropriate model of treatment for AI/AN people. Their philosophy is to provide treatment in a patient-centered and compassionate manner, to assist individuals attain and then maintain a lifestyle that is free from the effects of chemical dependency. This is accomplished by utilizing a comprehensive, habilitative approach that focuses on the physical, mental, emotional, social, spiritual, cultural, and familial aspects of human development. The structured treatment approach is designed to motivate patients towards problem recognition and self-awareness. Emphasis is also placed on encouraging and supporting healthy lifestyle adjustments and changes that are necessary to prevent relapse.

Program Services
Six treatment slots are available for women. Treatment methods include the AA philosophy, individual/group counseling, gender-specific counseling, marital counseling, counseling on issues related to family violence, counseling for STDs/HIV, health care counseling, perinatal care, medical care, and educational lecture presentations and films. Referrals are available for aftercare, including 12-step meetings, counseling, transitional living skills, enrollment in government assis-
III. Description of Participating Treatment Centers

tance, job training, and educational programs. Although services are not available for children, referrals are made for a variety of children’s services, including child care, child therapy, medical care and recreational activities.

**Outreach and Eligibility**

To be eligible for enrollment the participant must be 18 or older, and an American Indian or Alaska Native affiliated with a federally recognized tribe. Six treatment slots are available for women. In addition to women, DDU makes a special effort to reach chemically dependent persons with mental illness, incarcerated participants, participants with children, the participant’s partner, other members of the participant’s family, and individuals with diabetes and alcoholism. The program uses several community outreach strategies to bring participants to the program, including formal outreach to community organizations, word-of-mouth, brochures, hospital delivery referrals, the justice system, the foster care system, and tribal organizations.

**Staff Profile**

The staff is comprised of seven employees who provide direct services to participants, one program administrator, and one secretary. All staff are American Indian or Alaska Native, of whom 6 are women; one staff member is a program graduate.

Native American Rehabilitation Association of the Northwest
Portland, Oregon

**Program Overview**

The Native American Rehabilitation Association of the Northwest (NARA) was established in 1970 and is affiliated with all Northwest tribes and some tribes from Arizona and Alaska. NARA began providing treatment for women 14 years ago, but has expanded to include the children of women participants in the past two
years. Services are offered in both a 24-hour residential and an outpatient treatment setting. Outpatient services are offered ten hours day, five days a week. NARA's primary funding sources include federal, state and local governments and the Indian Health Service.

Program Philosophy

The NARA treatment philosophy is evolving towards a comprehensive model focused on total wellness. The program is building a multi-disciplinary treatment plan that integrates different modalities, including primary care, AOD treatment, and aftercare. The primary focus of NARA is to help women achieve a substance-free lifestyle through a family-centered approach to treatment. The program espouses a treatment model predicated on the inclusion of family members in the treatment and recovery process.

Program Services

Thirty treatment slots are available for women, with 25 slots for children up to the age of 8. NARA offers a variety of on-site treatment services. Cultural activities include sweat lodges, circle talks and pow-wows. Individual and group counseling services are part of the core package of services. Alcohol and drug education, AA or NA groups are also offered on-site. The program provides help with enrolling participants in government and housing assistance, transportation, and child welfare services. Consistent with NARA's family-focused philosophy, a wide range of services are offered to family members and children, including counseling and drug treatment for adults, child care, family therapy, recreational activities, and educational programs for children. Referrals are made for immunizations and medical care for children. Aftercare services include 12-step meetings, counseling and discharge planning.

Outreach and Eligibility

NARA gives admission priority to pregnant women, women with children, and participants with a third party insurance payer. Eligibility criteria include affiliation with an AI/AN tribe, a recent physical with a TB test, and a 72-hour period of sobriety. In addition to women, NARA makes a special effort to reach participants with children and substance-exposed or affected infants and children. Community outreach strategies include word-of-mouth, brochures, the criminal justice system, the foster care system, and tribal organizations.
III. Description of Participating Treatment Centers

Staff Profile

NARA's staff is comprised of 55 FTE positions for direct services to participants and 14 program administrators. Eighty-five percent of the staff are American Indians or Alaska Natives, and 70% are women. NARA employs 20 program graduates.

American Indian Family Healing Center
Oakland, California

Program Overview

The American Indian Family Healing Center is a residential alcohol and drug treatment program which has been offering services to both men and women since 1971. Its primary funding sources are the federal and state governments, the Indian Health Service, and private and in-kind donations.

Program Philosophy

The program philosophy of the American Indian Family Healing Center is focused on healing the participant through spirit, mind and body to prepare her to return to society sober and healthy. The program believes that the individual woman is linked to her community and that the key to success is the incorporation of family and community support in the recovery process. The program's highest priority goal is to help communities recover from the devastation of AOD abuse. Towards this goal, the program encourages graduates to be active in their communities by pursuing leadership roles, starting AA groups, and encouraging others to work towards sobriety.

Program Services

The American Indian Family Healing Center enrolls up to 10 women and 8 children at a time. The program offers several cultural activities, including sweat lodge ceremonies, prayer ceremonies, spiritual gatherings, and talking circles.
III. Description of Participating Treatment Centers

also held on-site. Services for family members include counseling and AOD treatment. Alcohol education is offered on-site and referrals are made for detoxification and methadone maintenance. Social support services, including help with enrollment in government and housing assistance, and child services, are available through referrals; transportation assistance and help with utility expenses are offered directly through Friendship House. A strong on-site aftercare program is offered as part of a core package of services, including 12-step meetings, counseling, transition to the community, and job training. Job training and educational and housing assistance are available through referral.

**Outreach and Eligibility**

Friendship House recruits chemically dependent women and makes a special effort to reach chemically dependent women with mental illness, incarcerated women, and the participants' partners. Children are not allowed in the program. Outreach strategies include formal outreach to community organizations, word-of-mouth, advertising, brochures, the criminal justice system, and tribal organizations. The primary requirement for admission is that the individual demonstrate a sincere desire to stop drinking and/or abusing drugs. Clients must be clean and sober for 72 hours prior to admission. Friendship House refers individuals who do not meet these requirements to a detoxification facility where s/he must remain for three days before being admitted to the program.

**Staff Profile**

Friendship House is staffed by 6 FTE employees who provide direct services to clients, 5 FTE program administrators, 2 half-time consultants, and 3 volunteers. Seven of the staff (64%) are American Indian/Alaska Native. Two program graduates are currently employed by Friendship House.
III. Description of Participating Treatment Centers

Blackfeet Chemical Dependency Program
Browning, Montana

Program Overview

The Blackfeet Chemical Dependency Program (BCDP) offers residential, outpatient, day treatment and aftercare services to clients from the Blackfeet Nation and other tribes in Montana and outlying areas. The center was established as part of an inpatient hospital program in 1989 and was accredited by the state in 1992. The primary funding sources are the Indian Health Service, and the county in which BCDP is located.

Program Philosophy

The program philosophy of the Blackfeet Chemical Dependency Program is that chemical addiction is a treatable but not curable disease. The participants must demonstrate a willingness to engage in the recovery process for treatment to be effective. The treatment approach uses an integrated, holistic model based on the Pikuni (the Indian word for Blackfeet) model of health, incorporating the tenets of the Indian Medicine Wheel. The highest priority goals of the program are to treat pregnant women and disadvantaged women who have been referred to them through the courts. BCDP is trying to change the living environment on the reservation towards one that espouses sobriety by instilling the message that there is hope for recovery. The center seeks to de-stigmatize alcohol and drug abuse on the reservation so that Blackfeet tribal members will be more inclined to seek AOD treatment.

Program Services

In addition to AA or NA group meetings, BCDP provides on-site individual group and family counseling services as part of a core package of services. Alcohol and substance use education is available for participants and is offered to family members on a limited basis. The aftercare program includes 12-step meetings, counseling, transitional living assistance, educational referrals, and housing assistance. Referrals to other community organizations are also available for these services.
III. Description of Participating Treatment Centers

Outreach and Eligibility

Fourteen treatment slots are available to women. To enroll, the participant must be affiliated with a federally recognized tribe or the descendant of an affiliated member, and the participant must be chemically dependent. The program provides outreach to chemically dependent women and makes a special effort to reach chemically dependent women with mental illness, adolescents, incarcerated women, clients with children, and other members of the client's family. BCDP utilizes several outreach strategies to contact potential participants, including formal outreach to community organizations, the criminal justice system, the foster care system, brochures, community street outreach, schools, and tribal organizations.

Staff Profile

BCDP is staffed by 12 FTE employees who provide direct services to clients, 4 FTE program administrators, and 14 employees who provide assistance with other duties such as cooking and maintenance. Twenty-nine of the staff (97%) are AI/AN and 17 (57%) are AI/AN women. Three program graduates are employed by the center.

Cross-Site Program Description

The following section summarizes the individual site information presented above across the nine treatment centers participating in the evaluation study. The information is organized in four categories: treatment center organization and services; staffing patterns; outreach and eligibility; and community involvement. In the discussion that follows, the names of the nine treatment centers have been replaced with alphabetical identifiers ("A" through "I"). However, to maintain essential anonymity, there is no correspondence at all between the order in which the treatment centers have been presented and described in the first section of this chapter and the order in which they are alphabetically identified and presented in the cross-site analyses that follow.
Treatment Center Organization and Services

*Primary AOD Treatment Modality*

As Table 3.1 indicates, eight programs provide residential treatment and one offers inpatient hospital-based treatment. Five offer outpatient treatment services, ranging from 3 hours a day, 3 times a week, to 24 hours a day, 7 days a week. Four programs provide day treatment services, from 7 hours a day, 5 days a week to 24 hours a day, 7 days a week.

Table 3.1

<table>
<thead>
<tr>
<th>Site</th>
<th>Residential Treatment</th>
<th>Outpatient Treatment</th>
<th>Day Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Yes</td>
<td>10 hrs/5 days</td>
<td>No</td>
</tr>
<tr>
<td>B</td>
<td>Yes</td>
<td>8 hrs/5 days</td>
<td>No</td>
</tr>
<tr>
<td>C</td>
<td>Yes</td>
<td>8 hrs/5 days</td>
<td>8 hrs/5 days</td>
</tr>
<tr>
<td>D</td>
<td>Yes</td>
<td>24 hrs/7 days</td>
<td>24 hrs/7 days</td>
</tr>
<tr>
<td>E</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>F</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>G</td>
<td>Yes</td>
<td>3 hrs/3 days</td>
<td>7 hrs/5 days</td>
</tr>
<tr>
<td>H</td>
<td>Yes</td>
<td>No</td>
<td>8 hrs/5 days</td>
</tr>
<tr>
<td>I</td>
<td>No*</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

* In-patient hospital services

Table 3.2 shows that five centers have been providing services for at least 20 years, while the others have been in existence from 4 to 15 years. Four of the programs have been offering services to women from the year they were established,
III. Description of Participating Treatment Centers

while the others began enrolling female participants several years after opening.

Table 3.2
Number of Years of Service

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Years Providing Services</th>
<th>Number of Years Serving Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>25 years</td>
<td>14 years</td>
</tr>
<tr>
<td>B</td>
<td>32 years</td>
<td>25 years</td>
</tr>
<tr>
<td>C</td>
<td>23 years</td>
<td>6 years</td>
</tr>
<tr>
<td>D</td>
<td>6 years</td>
<td>1 years</td>
</tr>
<tr>
<td>E</td>
<td>15 years</td>
<td>6 years</td>
</tr>
<tr>
<td>F</td>
<td>24 years</td>
<td>24 years</td>
</tr>
<tr>
<td>G</td>
<td>7 years</td>
<td>7 years</td>
</tr>
<tr>
<td>H</td>
<td>4 years</td>
<td>4 years</td>
</tr>
<tr>
<td>I</td>
<td>20 years</td>
<td>20 years</td>
</tr>
</tbody>
</table>

Accreditation

The program administrators at the nine centers were asked to indicate which accreditations or licenses their program had received. Six are accredited by either the Committee on Accreditation of Rehabilitation Facility (CARF) or by the Joint Commission on the Accreditation of Health Care Organizations. Two are licensed through their states and one has applied for accreditation.
III. Description of Participating Treatment Centers

**Funding Sources**

Most of the programs are funded through a variety of sources, and all receive financial support from the Indian Health Service. The majority receive state and federal funding; 67% receive both federal and state government support, and 33% receive local government funding. Private contributions help fund 44% of the sites, and 33% receive in-kind donations. Only two of the programs collect fees from clients. Other sources of income include tribal funds and Medicaid.

**Program Services**

Table 3.3 shows the availability of AOD treatment services across the nine centers participating in the evaluation study. A specific service is considered a "core" service if it is included within a package of services received by all participants at the center. A service is considered an ancillary service if it is offered only on an as-needed basis. (Note: a treatment center may offer a service as both a core service and an ancillary service; percentages therefore may total more than 100%.)

All nine centers offer alcohol education on-site either as a core service (89%) or as an ancillary service (22%). Some (11%) also offer outside referrals for alcohol education. Almost half (44%) provide referrals for detoxification, and one-third (33%) offer methadone maintenance referrals to participants. Few of the centers (22%) provide detoxification on-site, and none offer on-site methadone maintenance.

**Table 3.3**

<table>
<thead>
<tr>
<th></th>
<th>On-Site Core Service</th>
<th>On-Site Ancillary Service</th>
<th>Referrals Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Detoxification</td>
<td>2</td>
<td>22%</td>
<td>-</td>
</tr>
<tr>
<td>Alcohol education</td>
<td>8</td>
<td>89%</td>
<td>2</td>
</tr>
<tr>
<td>Methadone maintenance</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Note: Services may total more than 100%.
III. Description of Participating Treatment Centers

All programs offer on-site individual and group counseling as part of their core package of services, and some (22%) also offer outside referrals for individual counseling. All sites sponsor on-site AA or NA meetings either as a core service (89%) or as an ancillary service (33%), and some (22%) also offer outside referrals for 12-step meetings. Table 3.4 shows the types of counseling services offered by the nine treatment programs.

Table 3.4  
Provision of Counseling Services

<table>
<thead>
<tr>
<th>Service</th>
<th>On-Site Core Service</th>
<th>On-Site Ancillary Service</th>
<th>Referrals Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Counseling</td>
<td>9 100%</td>
<td>2  22%</td>
<td>2  22%</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>9 100%</td>
<td>2  22%</td>
<td>--</td>
</tr>
<tr>
<td>AA or NA Meetings</td>
<td>8  89%</td>
<td>3  33%</td>
<td>2  22%</td>
</tr>
</tbody>
</table>

Note: Services may total more than 100%.
III. Description of Participating Treatment Centers

As shown in Table 3.5, the nine programs offer varying arrays of support services. Nearly half (44%) help enroll participants in government assistance as part of their core package of services, 11% offer this service on-site but as an ancillary service, and 44% provide this service through referrals. Two of the programs offer on-site housing assistance as a core service, another 22% provide this service on-site as an ancillary service, and over half (56%) of the centers report that they offer outside referrals for housing assistance. Transportation assistance is provided as a core service by over half (56%) of the programs, as an ancillary service by 22%, and through referrals by 44% of the sites. Child welfare services are offered on-site as a core service by one-third (33%) of the programs, on-site as ancillary service by 11%, and 44% offer referrals for this service. Help with utility expenses is offered by only 11% of the programs on-site, and 11% provide referrals to agencies that can assist them with utility expenses.

Table 3.5
Percent of AOD Treatment Programs Offering Various Support Services

<table>
<thead>
<tr>
<th>Service</th>
<th>On-Site Core Service</th>
<th>On-Site Ancillary Service</th>
<th>Referrals Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment in government assistance</td>
<td>4 4%</td>
<td>1 11%</td>
<td>4 44%</td>
</tr>
<tr>
<td>Housing assistance</td>
<td>2 22%</td>
<td>2 22%</td>
<td>5 56%</td>
</tr>
<tr>
<td>Transportation</td>
<td>5 6%</td>
<td>2 22%</td>
<td>1 11%</td>
</tr>
<tr>
<td>Child welfare</td>
<td>3 33%</td>
<td>1 11%</td>
<td>4 44%</td>
</tr>
<tr>
<td>Utility expenses</td>
<td>1 11%</td>
<td>–</td>
<td>1 11%</td>
</tr>
</tbody>
</table>

Note: Services may total more than 100%.
Table 3.6 displays the variety of aftercare services provided by the programs, either on-site or through referrals to outside agencies. Nearly all offer on-site 12-step meetings and counseling services, either as a core service (78%) or as an ancillary service (11%). Approximately two-thirds (67%) of the sites also provide referrals for off-site 12-step meetings. One-third of the programs (33%) offer on-site job training, education referrals, and housing assistance as part of their core service package, and more than half (56%) provide these services through referrals.

Table 3.6  
AOD Treatment Programs Offering Aftercare Services

<table>
<thead>
<tr>
<th>Service</th>
<th>On-Site Core Service</th>
<th>On-Site Ancillary Service</th>
<th>Referrals Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-Step meetings</td>
<td>7 78%</td>
<td>1 11%</td>
<td>6 67%</td>
</tr>
<tr>
<td>Counseling</td>
<td>7 78%</td>
<td>2 22%</td>
<td>4 44%</td>
</tr>
<tr>
<td>Transition to community</td>
<td>6 67%</td>
<td>1 11%</td>
<td>4 44%</td>
</tr>
<tr>
<td>Job training</td>
<td>3 33%</td>
<td>-</td>
<td>5 56%</td>
</tr>
<tr>
<td>Education referrals</td>
<td>3 33%</td>
<td>1 11%</td>
<td>6 67%</td>
</tr>
<tr>
<td>Housing assistance</td>
<td>3 33%</td>
<td>1 11%</td>
<td>5 56%</td>
</tr>
</tbody>
</table>

Note: Services may total more than 100%.
III. Description of Participating Treatment Centers

All nine programs provide family counseling services on-site, and one-third (33%) also offer referrals to outside agencies, as shown in Table 3.7. Most sites offer AOD education services to family members as a core service (67%), or as an ancillary service (11%), or through referrals (44%).

Table 3.7
AOD Treatment Programs Offering Services for Family Members

<table>
<thead>
<tr>
<th>Service</th>
<th>On-Site Core Service</th>
<th>On-Site Ancillary Service</th>
<th>Referrals Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>n  9 100%</td>
<td>n  2 22%</td>
<td>n  3 33%</td>
</tr>
<tr>
<td>AOD education or treatment</td>
<td>n  6 67%</td>
<td>n  1 11%</td>
<td>n  4 44%</td>
</tr>
</tbody>
</table>

Note: Services may total more than 100%.
III. Description of Participating Treatment Centers

As Table 3.8 shows, six of the programs had designated a certain number of slots for the children of participants. The eligibility criteria based on age varied considerably among the nine centers; some programs admit toddlers but not older children, and others exclude young children, ages birth to three years.

Table 3.8
Availability of Children Services

<table>
<thead>
<tr>
<th>Site</th>
<th>Children Allowed in Program</th>
<th>Number of Slots</th>
<th>No. Children Allowed per Client</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>yes</td>
<td>25</td>
<td>5</td>
<td>0-8</td>
</tr>
<tr>
<td>B</td>
<td>no</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>C</td>
<td>yes</td>
<td>20</td>
<td>4</td>
<td>0-12</td>
</tr>
<tr>
<td>D</td>
<td>yes</td>
<td>0</td>
<td>1</td>
<td>9-18</td>
</tr>
<tr>
<td>E</td>
<td>no</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td>F</td>
<td>yes</td>
<td>8</td>
<td>2</td>
<td>0-5</td>
</tr>
<tr>
<td>G</td>
<td>no</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>H</td>
<td>yes</td>
<td>6</td>
<td>1</td>
<td>0-3</td>
</tr>
<tr>
<td>I</td>
<td>no</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
III. Description of Participating Treatment Centers

Table 3.9 displays the types of children's services available at the nine sites. Over half provided child care as a core service (44%) or as an ancillary service (11%), and one-third (33%) offered referrals to child care. Child therapy is offered by one-third (33%) of the programs as a core service and almost half (44%) provide referrals for child care. Recreational activities and snacks are available to children in 44% of the sites. A small proportion (22%) offer on-site medical care or immunizations to children, while the other centers provide referrals for these services.

<table>
<thead>
<tr>
<th>Service</th>
<th>On-Site Core Service</th>
<th>On-Site Ancillary Service</th>
<th>Referrals Available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n %</td>
<td>n %</td>
<td>n %</td>
</tr>
<tr>
<td>Child care</td>
<td>4 44%</td>
<td>1 11%</td>
<td>3 33%</td>
</tr>
<tr>
<td>Child therapy</td>
<td>3 33%</td>
<td>N/A</td>
<td>4 44%</td>
</tr>
<tr>
<td>Recreational activities</td>
<td>4 44%</td>
<td>1 11%</td>
<td>2 22%</td>
</tr>
<tr>
<td>Food/snacks</td>
<td>4 44%</td>
<td>2 22%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immunizations</td>
<td>N/A</td>
<td>N/A</td>
<td>7 78%</td>
</tr>
<tr>
<td>Medical care</td>
<td>N/A</td>
<td>N/A</td>
<td>7 78%</td>
</tr>
<tr>
<td>Educational programs</td>
<td>2 22%</td>
<td>N/A</td>
<td>4 44%</td>
</tr>
</tbody>
</table>

Note: N/A indicates that this service is not available.

Culturally Appropriate Strategies

The program administrators were asked to describe strategies they have used to make their center's services culturally appropriate. All responded that incorporating traditional activities and beliefs is an integral part of their center's treatment
III. Description of Participating Treatment Centers

The programs make special efforts to recruit and hire AI/AN staff, particularly those who are knowledgeable about their culture and history. Three of the administrators said that they invite spiritual leaders, such as medicine people and tribal elders, to regularly meet with the participants during the recovery process.

As Table 3.10 indicates, many traditional activities are included in the AOD treatment curriculums at these centers. One-third (33%) of the programs offer the talking circle as a core service, and 22% as an ancillary service. Sweat lodges are available on-site at 22% of the centers, at 11% as an ancillary services, and 11% offer referrals elsewhere. Eleven percent of the centers offer the Red Road to Recovery Series as a core service. Other traditional activities described by the program administrators include playing tribal music, learning Native crafts, and cooking and eating traditional food. Finally, the curriculum at many of the programs is Indian-focused and incorporates traditional elements such as the medicine wheel and the "Indian Belief System."

<table>
<thead>
<tr>
<th>Service</th>
<th>On-Site Core Service</th>
<th>On-site Ancillary Service</th>
<th>Referrals Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking circle</td>
<td>3 33%</td>
<td>2 22%</td>
<td>N/A</td>
</tr>
<tr>
<td>Red Road to Recovery</td>
<td>1 11%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sweat lodge</td>
<td>2 22%</td>
<td>2 22%</td>
<td>1 11%</td>
</tr>
<tr>
<td>Pow-wows</td>
<td>N/A</td>
<td>1 11%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note: N/A indicates that the service was not available.
Relapse Policies

The Program Administrators were also asked to describe their Center's relapse policies. Three sites do not have a declared policy and work with participants who relapse on an individual basis to determine the most appropriate action. Three programs do not discharge participants who relapse, but require that they begin the program over. The other three sites discharge participants who relapse, refer them to outpatient or detoxification services elsewhere, and then re-evaluate their needs and abilities before re-admitting them to the program. Overall, the program administrators consider relapse as a part of the recovery process for many individuals in treatment that must be acknowledged and planned for in the AOD treatment plan through ongoing support and services during and after such periods.

Staffing Patterns

Description of Staff

As Table 3.11 (next page) shows, the number of FTE direct service provider positions among the nine centers ranges from 6 to 55, and the number of FTE program administrators from one to seven. Other staff employed in the treatment centers include secretarial staff, cooks, maintenance staff, administrative support staff, and various specialty consultants. Table 3.12 (page 48) shows that majority of staff are American Indian/Alaska Native, and the proportion who are female varies from one-third to 100%. Most of the programs employ at least one program graduate. The average caseload per counselor is approximately seven, which counselors feel is an ideal ratio.
### Table 3.11
AOD Treatment Program Staff

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Direct Service Providers (FTE)</th>
<th>Number of Administrators (FTE)</th>
<th>Number of Other Staff (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>55</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>C</td>
<td>28</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>D</td>
<td>12</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>E</td>
<td>8</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>F</td>
<td>8</td>
<td>2</td>
<td>.5</td>
</tr>
<tr>
<td>G</td>
<td>12</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>H</td>
<td>15</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
III. Description of Participating Treatment Centers

Table 3.12
AOD Treatment Program Staff Profile

<table>
<thead>
<tr>
<th>Site</th>
<th>Percent AI/NA</th>
<th>Percent Women</th>
<th>Percent AI/NA Women</th>
<th>Number of Employed Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>85%</td>
<td>70%</td>
<td>68%</td>
<td>20</td>
</tr>
<tr>
<td>B</td>
<td>58%</td>
<td>33%</td>
<td>58%</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>82%</td>
<td>77%</td>
<td>66%</td>
<td>7</td>
</tr>
<tr>
<td>D</td>
<td>97%</td>
<td>57%</td>
<td>57%</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>100%</td>
<td>45%</td>
<td>45%</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>80%</td>
<td>50%</td>
<td>45%</td>
<td>6</td>
</tr>
<tr>
<td>H</td>
<td>94%</td>
<td>100%</td>
<td>94%</td>
<td>0</td>
</tr>
<tr>
<td>I</td>
<td>100%</td>
<td>67%</td>
<td>67%</td>
<td>1</td>
</tr>
</tbody>
</table>

Staff Orientation and Training

Staff orientation at the centers generally includes an overall program orientation that includes general substance abuse prevention and treatment education and outlines staff roles and responsibilities. Specific subjects covered include American Indian/Alaska Native issues, FAS/FAE risks, sexual abuse education, dual diagnosis issues, patient rights, AIDS education, and First Aid/CPR. Specific training in other areas are held at the request of staff.

Staff Recruitment and Turnover

The program administrators were asked to describe their staffing, recruitment, and turnover experiences. All administrators emphasized the importance of treating staff with respect, offering good salaries and benefits, hiring former clients,
III. Description of Participating Treatment Centers

and motivating staff to perform at a high level. Three of the program administra-
tors reported that staff turnover was low, and that they actually had more qualified
people requesting employment than they could hire. Six administrators reported
that they suffer from high staff turnover due to “burnout” and low pay and benefits.
Some bemoaned the lack of qualified staff with clinical experience, particularly
AI/AN staff. One administrator said that the isolated location of the center presents
another difficulty in recruiting staff.

Outreach and Eligibility

Eligibility Criteria

Eligibility criteria to enter treatment varied across the centers, as shown in
Table 3.13 (next page). Four of the programs require a medical examination to prove
that the woman is free of such communicable diseases as tuberculosis. Four pro-
grams require that participants prove their affiliation with an American
Indian/Alaska Native tribe. Other criteria include a 72-hour period of sobriety prior
to enrollment and that the participants demonstrate that they are capable of self-
care. Finally, AOD use, as opposed to an underlying mental illness, must be the
primary problem of the prospective participant.
Table 3.13
Eligibility Criteria

<table>
<thead>
<tr>
<th>Site</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>• 72 hrs sober</td>
</tr>
<tr>
<td></td>
<td>• TB test</td>
</tr>
<tr>
<td></td>
<td>• Physical exam</td>
</tr>
<tr>
<td>B</td>
<td>• 72 hrs sober</td>
</tr>
<tr>
<td></td>
<td>• Desire to be clean</td>
</tr>
<tr>
<td>C</td>
<td>• Over 18 years of age</td>
</tr>
<tr>
<td></td>
<td>• AOD as primary problem</td>
</tr>
<tr>
<td></td>
<td>• Medically stable</td>
</tr>
<tr>
<td></td>
<td>• Capable of self-care</td>
</tr>
<tr>
<td>D</td>
<td>• Enrolled member of tribe</td>
</tr>
<tr>
<td></td>
<td>• Chemically dependent</td>
</tr>
<tr>
<td>E</td>
<td>• Over 18</td>
</tr>
<tr>
<td></td>
<td>• Physical exam</td>
</tr>
<tr>
<td></td>
<td>• AOD problem</td>
</tr>
<tr>
<td>F</td>
<td>• 72 hrs sober</td>
</tr>
<tr>
<td></td>
<td>• No communicable disease</td>
</tr>
<tr>
<td>G</td>
<td>• AI/AN</td>
</tr>
<tr>
<td></td>
<td>• Priority given to pregnant women</td>
</tr>
<tr>
<td>H</td>
<td>• Pregnant</td>
</tr>
<tr>
<td></td>
<td>• Female</td>
</tr>
<tr>
<td></td>
<td>• Risk for AOD use</td>
</tr>
<tr>
<td>I</td>
<td>• Over 18</td>
</tr>
<tr>
<td></td>
<td>• Proof of tribal affiliation</td>
</tr>
</tbody>
</table>
Extensive individual and group counseling services are offered, including AA and NA groups. Support services are also available to participants, such as help with enrollment in government assistance, transportation, and child welfare. Referrals are available for housing assistance. Alcohol education is offered and referrals are made for detoxification. The aftercare program includes 12-step meetings, counseling and help with the transition to living in the community.

Family counseling services and parenting classes are available on-site; drug treatment services for family members are available through referrals in the community. Children's services include child care, child therapy, recreational activities, food/snacks, and educational programs. Children are referred to outside agencies for immunizations and medical care.

Outreach and Eligibility

The American Indian Family Healing Center makes a special effort to reach women with children or who are at a high risk of pregnancy. They also target chemically dependent women with mental illness, incarcerated participants, participants with children, children of participants, other family members of participants, and other people from the tribal community. To enroll, participants must be sober for 72 hours immediately prior to entering the program, and have proof that they are free of communicable diseases. Community outreach strategies include word-of-mouth, brochures, schools, the criminal justice system, the foster care system, tribal organizations, and media campaigns.

Staff Profile

The staff is comprised of 8.4 FTE employees who provide direct services to participants, 1.8 FTE program administrators, and a .4 FTE position for a tribal elder. Nearly all of the staff (99%) are American Indians or Alaska Natives and all are women. No program graduates are currently employed as staff in the program.
III. Description of Participating Treatment Centers

Friendship House Association of American Indians
San Francisco, California

Program Overview
The Friendship House Association of American Indians is a residential and outpatient substance abuse treatment program that was originally created in 1963 as a meeting center for urban American Indians. In 1973, Friendship House instituted a treatment program to serve people from all tribal groups. Outpatient services are currently offered 8 hours per day, 5 days a week. The program is located in an urban setting, although many participants come to the program from rural areas and reservations. Primary funding sources are the federal and state governments, the Indian Health Service, foundations, private and in-kind donations, and client fees.

Program Philosophy
The program philosophy of Friendship House is that alcohol and drug addiction are treatable. The treatment approach is to include a variety of people in the healing process, including medicine people, social workers, and family and friends to help participants reclaim the life that had been lost to AOD use. Through a family-like atmosphere the program places a strong emphasis on self-acceptance and acceptance of others. In the belief that traditional Indian practices can help participants overcome life-long problems, the program also incorporates cultural elements. To begin the healing process, the program tries to help participants learn about themselves and better understand the role of AOD use in their lives. Eventually it is hoped that participants will be able to help others in similar situations and become active members in their respective communities.

Program Services
Friendship House has been serving men and women for the past 25 years, and currently offers eight treatment slots for women. Tribal or cultural activities offered on-site include talking circles, the Red Road to Recovery Series, drumming, beadwork, and sweat lodges. As part of its core package of services Friendship House provides individual, group and family counseling. AA or NA group meetings are
III. Description of Participating Treatment Centers

**Availability of Treatment for Women**

The majority of participating AOD treatment programs are co-gender facilities, and only one of the programs excludes men from treatment as shown in Table 3.14. The number of treatment slots for female participants ranges from 4 to 30, depending on the size of the program. Five programs reported that 100% of their slots for women are usually filled, and the other four reported that most of these slots are usually filled. All programs maintain waiting lists when they are operating at full capacity.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Treatment Slots for Women</th>
<th>Percent Slots for Women Usually Filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>30</td>
<td>80%</td>
</tr>
<tr>
<td>B</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>C</td>
<td>20</td>
<td>100%</td>
</tr>
<tr>
<td>D</td>
<td>14</td>
<td>71%</td>
</tr>
<tr>
<td>E</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>F</td>
<td>10</td>
<td>70%</td>
</tr>
<tr>
<td>G</td>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td>H</td>
<td>16</td>
<td>75%</td>
</tr>
<tr>
<td>I</td>
<td>6</td>
<td>100%</td>
</tr>
</tbody>
</table>
III. Description of Participating Treatment Centers

Special Outreach Efforts to Targeted Groups

Many of the programs engage in special outreach efforts to enroll specific groups into their programs. Seven programs made special efforts to reach chemically dependent women with mental illness, incarcerated women, women with children, and partners of women. Five sites employ special outreach efforts for women with young children, particularly those who have been substance-affected. Four sites also attempt to bring other family members of participants into AOD treatment, two programs make a special effort to engage adolescents in treatment.

Community Involvement

An important program component at these treatment centers is community outreach to educate the public and local institutions, and inform potential clients about the availability of AOD services. All programs rely on word-of-mouth to publicize their programs, seven use formal outreach through linkages with community agencies, and one site advertises through the media. Other important strategies involve informing community institutions about the availability of services at the treatment center. All the centers approach the courts and probation officers about their programs, six distribute information to the foster care system, and four provide local hospitals with program information.

Summary

Although Phase 2 of this evaluation study focuses on women in treatment at these nine centers, it is also important to describe the programs themselves, and the strategies that have been developed to respond to the multiple needs of the clients they serve. This summary of the nine participating AOD treatment programs documents the range of services, program philosophies, and treatment strategies that are currently available in a number of communities across the country. The sample of sites selected for the study, while not randomly selected from the pool of IHS-funded treatment centers, represents the continuum of women-centered, AI/AN-focused approaches to AOD treatment and recovery currently in operation.