RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR URBAN AMERICAN INDIANS AND ALASKA NATIVES

PART I: SERVICES AND STAFF

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Abstract: Although residential substance abuse treatment is utilized extensively by urban American Indians and Alaska Natives (AI/ANs), there are few detailed descriptions of this care. This study delineated services provided by and interviewed staff working at residential programs designed for chemically dependent urban AI/ANs. Study agencies were compared to national data from residential programs serving general population clients. Study agencies delivered arrays of services substantially broader than those provided by general population programs. As well as culturally specific programs tailored for AI/ANs plus so-called "mainstream" substance abuse treatments, study facilities provided numerous ancillary services, such as care for clients' children.

INTRODUCTION

Substance misuse is a major component of health disparities for urban American Indians and Alaska Natives (AI/ANs; Castor et al., 2006; Johnson, Bartgis, Worley, Hellman, & Burkhart, 2010; Urban Indian Health Institute [UIHI], Seattle Indian Health Board [SIHB], 2011). For example, during the 1990s, alcohol-related death rates were 28 per 100,000 among AI/ANs in 34 metropolitan areas, versus 10 for the general population (Castor et al., 2006). UIHI and SIHB (2011) examined health conditions related to alcohol among people living in 34 metropolitan areas during the late 2000s and found that 20% of AI/AN adults reported binge drinking in the previous month, versus 16% for all races. Similarly, the AI/AN annual liver cirrhosis death rate in these urban areas was 22 per 100,000, versus an all-races rate of 9 (UIHI, SIHB, 2011).

These findings reflect health disparities related to chemical dependency problems experienced by AI/ANs nationwide (Beauvais, 1998; Frank, Moore, & Ames, 2000; Gray & Nye, 2001; Greenfield & Venner, 2012; Spicer, 2001; Wright et al., 2011). For example, looking at both urban and rural areas, Castor et al. (2006) found annual alcohol-related death rates of 27 per 100,000 for AI/ANs nationally, versus 7 for the general population. Thus, treatment intended to help people with chemical dependency is especially important for urban AI/ANs (Dickerson, Brown, Johnson, Schweigman, & D'Amico, 2016). More recently, the Urban Indian Health Program (a component of the Indian Health Service) reported to Congress that "alcohol-induced death rates are 2.8 times greater for urban AI/AN people than all races in urban areas" (U.S. Department of Health and Human Services, 2015, p. 8).

Agencies providing substance treatment services for urban AI/ANs face a dilemma. As Hartmann and Gone (2012) noted, "On one hand, many of these (urban) agencies wish to provide both standard Western and traditional healing services, but on the other hand, they lack concrete guidance for the design and integration of such services" (p. 543). Moreover, Legha et al. (2014) pointed out that chemical dependency treatment programs for AI/ANs must deal with "pressure to use Evidence-Based Treatments (EBTs)" (p. 7). However, in a recent survey of chiefly rural substance abuse treatment programs for AI/ANs, Novins et al. (2016) found that "only two of the commonly implemented psychosocial EBTs (Motivational Interviewing and Relapse Prevention Therapy) were endorsed as culturally appropriate by a majority of programs that had implemented them" (p. 214).

Consequently, "the fundamental challenge becomes how to accommodate substantive cultural divergences in psychosocial experience using narrowly prescriptive clinical practices and approaches without trivializing either professional knowledge or cultural difference" (Gone, 2015, p. 139). Indeed, as stated by Moghaddam and Momper (2011), "providing effective substance user treatment that incorporates both Western and traditional Native healing is challenging" (p. 1431).

And, adding to the challenges, "detailed descriptions of approaches for making traditional healing available for urban AI communities do not exist in the literature" (Hartmann & Gone, 2012, p. 542). Consequently, Hartmann and Gone (2012) noted that these information deficiencies "invite the development of urban-specific guidelines for making traditional healing available for these AI populations" (p. 543).

In addition to lack of information about services, few (if any) data are available about staff members at substance abuse treatment programs designed for urban AI/ANs. National substance abuse treatment workforce survey participants described substantial concerns, including staff recruitment and retention (Ryan, Murphy, & Krom, 2012). But there appear to be no comparable data pertaining to providers of chemical dependency services for urban AI/ANs. And, speaking about treatment providers in general, the authors of the national Action Plan for Behavioral Health Workforce Development noted "the paucity of available data about workforce characteristics" (Hoge et al., 2009, p. 885).

This project addressed these issues by obtaining data on services and staff at substance abuse treatment programs designed for urban AI/ANs.

When examining specialty substance abuse treatment services, it is helpful to distinguish between residential versus outpatient care. By definition, residential clients spend nights at a treatment facility, whereas outpatient clients do not (Reif et al., 2014). Residential substance abuse treatment is a key service setting for AI/ANs (McFarland, Gabriel, Bigelow, & Walker, 2006), especially for those who live in urban areas. For example, the nationwide 2012 Treatment Episode Data Set compiled by the Substance Abuse and Mental Health Services Administration (as analyzed by the authors) showed that residential care accounted for 27% of some 31,729 chemical dependency admissions for AI/AN clients served by either outpatient or nonhospital inpatient (i.e., residential) rehabilitation programs. Conversely, for non-Natives, residential care represented only 22% of 1,296,650 rehabilitation admissions. And in urban areas, residential treatment accounted for 28% of AI/AN chemical dependency rehabilitation admissions, versus only 24% for non-Natives.

It should be noted that AI/AN residential admissions in urban areas need not be to programs that focus on this population. Indeed, the (admittedly limited) California data on program characteristics reported by Evans, Spear, Huang, and Hser (2006) suggest that most AI/AN substance abuse treatment admissions are to agencies designed to serve the general population.

Along these lines, in a review examining effectiveness of residential services, Reif et al. (2014) stated that "implementing effective and culturally responsive care is essential," recommended that researchers "analyze the role of culture-specific approaches," and suggested that "studies should examine the components of residential treatment that might relate to

effectiveness, such as types of clinical staff" (p. 310). To facilitate such an examination, it is helpful to distinguish Indigenous/traditional (Gone, 2012) culturally specific healing approaches (see Wright et al., 2011, for examples) from what might be called *mainstream* (Moore, Arons, Davis, & Novins, 2015) or *conventional* substance abuse treatment services (such as cognitive-behavioral therapy) as described by the National Institute on Drug Abuse (2012). It is also useful to differentiate staff members who deliver culturally specific services from providers of conventional substance abuse treatment (such as licensed chemical dependency counselors).

Studies have addressed the value of traditional healing activities (such as sweat lodges) for urban AI/ANs with substance abuse problems. Edwards (2003) asked clients of an AI/AN residential treatment program in San Francisco to list transformational experiences and found that traditional values were mentioned frequently. Moghaddam and Momper (2011) reported that providers at an urban AI/AN outpatient substance abuse treatment program emphasized the importance of traditional activities for healing. And in their qualitative work with both urban and reservation providers, Legha and Novins (2012) found that clinicians often mentioned ceremonies and rituals as key aspects of treatment for AI/ANs with substance abuse problems. Dickerson et al. (2012) reported similar findings. Unfortunately, data about programs aimed at urban AI/ANs are limited because national information systems that describe substance abuse treatment do not identify culturally specific services and no longer describe client race or ethnicity (McFarland et al., 2006).

Indeed, very few data are available about the services delivered at, or the providers of, residential substance abuse care for urban AI/ANs. There have been reports on AI/AN clients of urban residential substance abuse treatment programs, including those in Anchorage (Hesselbrock, Segal, & Hesselbrock, 2000; Parks, Hesselbrock, Hesselbrock, & Segal, 2001), Los Angeles (Spear, Crèvecoeur, Rawson, & Clark, 2007), Phoenix (Chong & Lopez, 2005, 2007), and the San Francisco Bay Area (Edwards, 2003; Nebelkopf & King, 2003; Nebelkopf & Penagos, 2005; Saylors, 2003; Wright et al., 2011). Rieckmann et al. (2012) described AI/AN clients of an urban treatment center that included a residential program. Saylors (2003) described services provided to AI/AN clients of residential programs in Oakland and San Francisco. And Wright et al. (2011) discussed services (especially traditional healing programs) for outpatient and residential clients of an agency in Oakland that focuses on AI/ANs.

However, there have been few (if any) comparisons of services and staff between agencies focusing on AI/ANs and mainstream treatment programs. Dickerson et al. (2011) and Evans et al. (2006) compared outcomes for AI/ANs versus non-Natives who received substance abuse treatment in California. But concerns have been raised about loss to follow up in the California studies (Greenfield & Venner, 2012) which, in any event, did not address traditional healing services or staff composition. Indeed, Evans et al. (2006) called for investigation of culturally specific components of treatment. And Novins et al. (2011) stated that "there are no reliable surveillance data regarding the nature and scope of substance abuse services for AI/ANs" (p. 4). Similarly, Wright et al. (2011) emphasized that "research must address appropriate cultural practices among this population (urban AI/ANs obtaining treatment for substance misuse)" (p. 1428). Put differently, a key question is: How can residential treatment agencies serving urban AI/ANs deliver both traditional and what has been called "comprehensive" (Ducharme, Mello, Roman, Knudsen, & Johnson, 2007) care?

Therefore, the purposes of this project were to 1) describe two residential substance abuse treatment programs focused on urban AI/ANs, 2) discuss the services delivered by the agencies, 3) delineate the providers of care, and 4) compare the study facilities with information from general population programs. The hypotheses to be tested were: 1) the AI/AN agencies would provide more varied mixtures of services than mainstream urban residential treatment programs, and 2) study agency staff would be more heterogeneous than those in conventional facilities. In addition, this study provides background for findings on treatment costs, which are presented in a companion paper ("Residential substance abuse treatment for urban American Indians and Alaska Natives Part II: Costs," in this issue).

METHODS

Selection of Study Sites

Agencies to be studied were selected based on the following criteria: 1) chiefly serving urban AI/ANs, 2) providing residential substance abuse treatment, and 3) offering short-term and/or long-term residential programs. In this context, "urban" refers to metropolitan areas (also known as Core Based Statistical Areas; i.e., cities), as defined by the U.S. Census Bureau. Residential substance abuse treatment, as defined by the Substance Abuse and Mental Health

Services Administration (SAMHSA, 2007), is a nonhospital, nondetoxification rehabilitation program whose clients stay overnight at the facility. Short-term programs typically have 30-day (or less) planned lengths of stay, according to SAMHSA, whereas long-term programs have planned lengths of stay greater than 30 days. Given resource constraints, the sample was limited to two study agencies. Data were obtained for study years 2006 through 2008.

Locations

The project took place in two cities in the western U.S. that had populations of approximately 500,000 (within metropolitan areas of roughly 1 to 2 million each, and state populations of 3 million and 7 million, respectively). As shown in Table 1, AI/ANs comprised approximately 1% of each study city's population. Table 1 also shows that fewer than two thirds of the AI/ANs were employed and approximately one quarter were below the poverty level. Moreover, AI/AN per capita personal incomes were less than $20,000 annually (compared with some $40,000 annually in the general population). Substance abuse treatment admissions were frequent for AI/ANs in the study cities—roughly 20 per 100 population (vs. 3 per 100 in the general population). Residential (vs. outpatient) treatment was provided for 24% of AI/AN admissions, compared with 12% of the general population admissions.

Table 1
American Indian and Alaska Native (AI/AN) Populations

	City A	City B
N	5,418	5,645
Female	50%	48%
Age 18 and over	88%	91%
Employed	63%	55%
High school or more	80%	77%
Below poverty level	23%	29%
Per capita income	$14,788	$16,738
Substance abuse treatment admits per hundred	16	23
Residential substance abuse treatment	14%	33%

Sources: Census 2000 (U.S. Bureau of the Census); Treatment Episode Data Set for 2000 (Substance Abuse and Mental Health Services Administration)

Overview of Study Agencies

The two study agencies largely serve urban AI/ANs, are closely connected with general medical care, provide numerous treatment modalities for individuals with substance abuse problems, and include culturally specific services. While the focus is AI/ANs, the agencies provide services to all racial and ethnic groups. Both agencies are private not-for-profit entities founded in1970, and both are funded by numerous entities, including the Indian Health Service (IHS) and Medicaid.

Agency A Overview

According to its website, the mission of Agency A is "to provide education, physical and mental health services, and substance abuse treatment that are culturally appropriate to AI/ANs and other vulnerable people." The agency's vision "is to achieve the highest level of physical, mental, and spiritual well-being for (AI/AN) people."

In 1970, a group of AI/AN men recovering from substance abuse established Agency A as an all-male residential treatment center for clients with alcohol and drug problems. They wrote a grant to provide AI/AN treatment services and purchased a large house in City A, now known to the community as Totem Lodge, which was the original home of the residential treatment program. Eventually Agency A also established a women's treatment center in City A. The men's program remained at Totem Lodge. In 1989 Agency A established a family treatment program using a cultural approach to the Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) 12 steps. The residential program moved to its current location on the outskirts of City A in 1994.

Agency A now serves both genders and operates a residential family substance abuse treatment program, an outpatient chemical dependency treatment program, and a primary health care clinic that provides physical examinations, prenatal care, immunizations, women's health care, nutritional counseling, sexually transmitted disease diagnosis and treatment, family planning, well-baby checks, and mental health services. Note that for both study Agency A and for study Agency B substance abuse treatment is another term for chemical dependency treatment.

The health clinic emphasizes early intervention services in pediatrics, women's health, and mental health services. The Agency A outpatient treatment center provides outpatient

substance abuse treatment, relapse prevention counseling, a "parents as teachers" program, and community outreach linking clients with resources for housing, transportation, child care, and other social services. The health clinic and outpatient programs serve the five counties of the City A metropolitan area. Agency A depends on Medicaid for approximately half of its revenue, with IHS providing the remainder.

Agency A also operates a family wellness program (a culturally based service designed to give support to parents, grandparents, aunts, and uncles in their roles as caregivers of children). Agency A has several grant-funded programs such as tobacco cessation and wraparound services. These projects are located at three different facilities in City A.

Agency B Overview

Summarizing its website, Agency B is a private not-for-profit multiservice community health center chartered in 1970 to serve the health care needs of AI/ANs living in the greater City B region. The agency is governed by a 15-member board of directors, at least 51% of whom are of AI/AN heritage. The mission of Agency B is to assist AI/ANs in achieving the highest possible physical, mental, emotional, social, and spiritual well-being through the provision of culturally appropriate services and to advocate for AI/AN people, especially the most vulnerable members of the community.

Services at Agency B are divided into four functional areas: 1) physical health, which operates the medical, dental, laboratory, pharmacy, and nutrition programs; 2) community and behavioral health, which operates community education, case management, outpatient mental health, and outpatient substance abuse treatment programs; 3) the residential treatment center, which is a chemical dependency facility for both adults and adolescents; and 4) drug and alcohol prevention programs, which have included the Healthy Nations project (sponsored by the Robert Wood Johnson Foundation). Special programs are available for adolescents and for people with HIV/AIDS.

In addition to substance abuse treatment, Agency B offers primary medical care; general practice dental care; mental health services; domestic violence services; traditional health liaison services; Women, Infants, and Children (WIC) programs; nutrition services; laboratory services; and pharmacy services. Agency B is nationally accredited and licensed through the state. Services are provided at an outpatient substance abuse treatment clinic near the administrative

building, at the clinical center across the street from the administrative building, and at the residential treatment center.

The Agency B residential treatment center is the largest treatment center in the nation focusing on urban AI/ANs. It was established in 1973 as a recovery house with a loosely knit treatment program, which became more formalized over time. The residential treatment center moved to its current location in 1986 when Agency B purchased the property, which consists of several cottages that provide housing for residents, a cafeteria, and medical services situated on four acres in a quiet residential area of City B.

Quantitative Measures

Agency staff members were asked to complete a questionnaire regarding demographics, education, and professional certification. The instrument included the Transcultural Self-efficacy Scale (described below). In addition, AI/AN staff members were asked to complete the Adult Biographical Questionnaire (described subsequently). Only one staff member at each agency declined to complete the surveys. Thus, the staff response rates were 97% at both Agency A and Agency B.

Transcultural Self-efficacy Scale (TSET)

This instrument is designed to measure health care providers' comfort and confidence in working with individuals from many cultures. The questionnaire was developed and validated chiefly with nursing students. Sample prompts and items include "Rate your degree of confidence or certainty for each of the following interview topics. Please use the scale below and mark your response accordingly"

- …Interview clients of different cultural backgrounds about
    - …meaning of nonverbal behaviors
    - …folk medicine tradition & use.

and "Please rate YOUR degree of confidence or certainty for each of the following items. Use the scale below and mark your response accordingly"

- …Among clients of different cultural backgrounds you are AWARE OF
    - …traditional caring behaviors
    - …comfort and discomfort when entering a culturally different world?"

Responses range from 1 (*not confident*) through 10 (*totally confident*). The scale has several factors, such as "recognition," which explained 36% of variance, and "kinship and social," which explained 8% of variance (Jeffreys & Smodlaka, 1998). The questionnaire has good test-retest reliability, with subscales showing correlations of .63 to .75 for measures completed at an interval of 2 weeks (Jeffreys, 2000). A test of known groups validity was also favorable in that advanced nursing students showed higher scores than novices. There are three subscales addressing cognitive, practical, and affective aspects of self-efficacy. Advanced nursing student subscale scores averaged 7 through 8 (Jeffreys & Smodlaka, 1999). Among staff participants at the study agencies, the subscales were highly reliable, with Chronbach's alpha scores of 0.97, 0.99, and 0.95 for cognitive, practical, and affective, respectively.

Adult Biographical Questionnaire (ABQ)

This instrument collects extensive cultural information and includes the Orthogonal Cultural Identification Scale (Oetting & Beauvais, 1990-1991). Owing to missing data on items pertaining to family activities or children, this project used a 4-item version of the scale. These items pertained to personal ethnic identity (How do you see yourself?/What is your ethnic identity?), family tradition (How many of these special activities or traditions does your family have that are based on American Indian culture?), ways family lives by (Does your family live by or follow the American Indian way of life?), and personal (Do you live by or follow the American Indian way of life?). Response options range from 0 (*not at all*) through 3 (*all or nearly all*). These 4 items showed excellent reliability, with Cronbach's alpha exceeding 0.76 for 21 AI/AN staff respondents. As with the original scale (Oetting & Beauvais, 1990-1991), total scores greater than 7 were considered evidence of "high" American Indian cultural identification.

National Comparison Data

National data sets were used to provide comparisons. This information was accessed online via the Substance Abuse and Mental Health Data Archive, then at the Inter-University Consortium for Political and Social Research maintained by the University of Michigan. For the national data sets, "urban" admissions, discharges, and agencies, respectively, were defined as those within Core Based Statistical Areas.

The SAMHSA-supported Treatment Episode Data Set (TEDS) compiles information about admissions to and discharges from virtually all publicly funded substance abuse treatment programs in the U.S. (Albrecht, Lindsay, & Terplan, 2011; Mutter, Ali, Smith, & Strashny, 2015;

Stahler, Mennis, & DuCette, 2016; Terplan, Smith, Kozloski, & Pollack, 2010). Both study agencies provide data to this system. Consequently, variables in the national data (such as a client's primary substance of abuse) match variables describing the study agencies. The unit of analysis is generally the admission (or the discharge), so that a given person may be represented more than once.

Data were examined pertaining to discharges during 2006 of AI/ANs from residential rehabilitation programs located in Core Based Statistical Areas. There were 2,075 discharges from short-term programs and 2,668 discharges from long-term programs.

Another data set provided by SAMHSA is the National Survey of Substance Abuse Treatment Services (NSSATS). This mail, telephone, and Internet survey encompasses the overwhelming majority of publicly funded chemical dependency treatment agencies (with a response rate above 95%). Both study agencies contribute data to this system. Therefore, variables in the national data (such as numbers of admissions) match data describing the study agencies. Data from the survey are used to populate the online Substance Abuse Treatment Facility Locator. The survey includes a checklist where respondents indicate which services are provided by their agencies. In addition, the survey asks respondents about numbers of admissions, current census, and numbers of residential treatment beds. However, client demographic data (such as race and ethnicity) are not included. Data from the 2006 survey were obtained pertaining to 3,539 agencies in Core Based Statistical Areas that offered either short- or long-term residential (nonhospital) treatment services. For convenience, agencies responding to the national survey will be referred to as "mainstream" programs.

Nationwide staff data were obtained from an older project supported by SAMHSA. The Alcohol and Drug Services Study (ADSS) was a national examination of publicly funded substance abuse treatment agencies conducted from 1996 through 1999 (Reif, Horgan, & Ritter, 2011; Woodward, Das, Raskin, & Morgan-Lopez, 2006; Woodward, Raskin, & Blacklow, 2008). Briefly, the study included a stratified random sample of substance abuse treatment agencies (with a response rate of 91%). Analyses focused on the "nonhospital residential-only" stratum. There were 366 urban nonhospital residential-only programs whose census on the survey date averaged 27 clients (with median of 24). Facility administrators responding to "phase one" telephone interviews in 1996 provided information about the agency (such as number of clients in residence on the survey date) and about staff members, including numbers of

employees, education, and credentials. These responses appear to be the most recent nationally representative data about urban residential treatment center staff. A more recent substance abuse treatment workforce survey (Ryan et al., 2012) did not distinguish between outpatient and residential facilities. Also, variables in the ADSS project that describe program staff correspond approximately to educational backgrounds, credentials, and job titles of staff at the study agencies. The national ADSS data pertaining to full-time staff were analyzed using the facility "phase one" final sampling weight.

Procedures

Both qualitative and quantitative approaches were employed to describe services and staff at the study agencies. Study agencies were selected to represent programs focusing on urban AI/ANs. The researchers had worked for several years with staff at both study agencies. The work was motivated in part by concerns at both study agencies regarding requests by payors for documentation of service provision. Building on study agency concerns regarding documentation of service provision, the researchers approached study agency leaders to suggest the project.

The project began with extensive discussions between agency staff (including senior leaders) and members of the research team, leading to agreement on the study protocol.

In addition, the meetings served to introduce the project to agency staff members. Each agency hired a Native researcher (a masters-level individual who had years of experience collecting quantitative data from publicly funded substance abuse treatment programs) who facilitated quantitative data acquisition. In addition, the directors of the study agencies served as consultants to the project. Additional qualitative information came from agency websites and documents. State substance abuse agency data in both study states were also reviewed.

Qualitative approaches were then employed to obtain detailed descriptions of services provided by the study agencies. The work involved triangulation, defined by Cohen and Crabtree (2008) as "using multiple data sources in an investigation to produce understanding" (p. 334). Information collected via qualitative means included referral sources, histories of the two agencies, treatment practices, counselor activities, treatment staff, employee evaluation procedures, and residential funding. The Native researcher interviewed staff members at the residential treatment program to collect this information. Table 2 shows the training and experience of the interviewees.

Table 2
Substance Abuse Treatment Staff Interviewees

	Agency A			Agency B		
	Demographics	Training	Experience	Demographics	Training	Experience
Treatment director	46 / m / Am Ind	College / CADC-II	14 / 14	56 / m / white	College / CDP	16 / 10
Clinical supervisor	57 / f / Am Ind	College / CADC-II	28 / 7	62 / f / white	BA / CADC	6 / 11
Counselor	49 / f / Am Ind	BS / CADC-II	9 / 9	37 / f / Am Ind	BA / CDP	4 / 4
Counselor	49 / f / Am Ind	College / CADC-I	1 / 1	65 / f / Am Ind	NA / CDP	15 / 1
Cultural advisor	65 / m / Am Ind	NA	NA	57 / m / Am Ind	BA / NA	12 / 12

Demographics = age / gender / race
Training = education / certification
Experience = years in field / years with agency

BA = Bachelor of Arts
BS = Bachelor of Science
College = some college education
CADC = certified alcohol and drug counselor
CDP = chemical dependency professional
NA = not applicable / not available

The Native qualitative researcher visited the Agency A residential treatment center on July 19-20, 2006. The researcher interviewed the treatment director, the clinical supervisor, and two AI/AN counselors; attended two treatment groups, one on grief and the second on alcohol and drug education; and conducted additional interviews with the cultural director and the early childhood education program director.

The Native qualitative researcher visited the Agency B residential treatment center on July 27-28, 2006. The researcher interviewed the treatment director, the clinical supervisor, two AI/AN counselors, and the cultural teacher; attended an alcohol education group; and visited the outpatient treatment facility to talk with a longtime counselor.

The authors reviewed notes (including quotations) compiled by the qualitative researcher. Themes were identified from the notes (Marshall & Rossman, 2015; Perakyla & Ruusuvuori, 2011). The qualitative data were then summarized according to the themes.

The investigators conducted multiple regression analyses with TSET scores as dependent variables using site, age, gender, race, and counselor status as predictors.

The researchers also conducted multiple regression analyses using AI/AN staff members' Orthogonal Cultural Identification Scale scores as dependent variable with age and gender as predictors.

Study years were 2004 through 2010. The project was approved and overseen by the Oregon Health & Science University Institutional Review Board. Data analysis used SPSS version 20.

RESULTS

It will be helpful to understand the flow of clients to and through the study agencies. Therefore, the following sections describe study agency referral sources, intake procedures, arrays of outpatient and residential services available, and client treatment schedules. Detailed descriptions of residential services are then provided. The last sub-section describes characteristics of residential staff.

Referral Sources for Residential Substance Abuse Treatment

Both agencies served members of numerous tribes and, as shown in Table 3, received referrals from several sources (including self or family, reservations, courts, welfare agencies, and detoxification programs). Sources for Agency A referrals included tribes, county and state facilities, the justice and court systems, family members, caregivers, tribal members acting individually (rather than for the tribe as a whole) for themselves and-or their families, and private individuals. In addition, clients were referred by human services agencies (especially a family involvement team), tribes (often at the tribal government level), a detoxification center, hospitals, and other treatment programs, including Agency A's outpatient component.

Every county in State B has its own assessment center which refers people to treatment. Referrals to Agency B also came from legal systems, hospitals (including Veterans Affairs), outreach programs at community locations (for example, at cultural events), family members, and self-referral. The Agency B residential treatment center also worked with tribes (both within and out of state) who referred clients. Agency B was one of the few treatment programs in the state serving people with co-occurring disorders.

Table 3
Urban Substance Abuse Treatment Processes and Programs

	United States [a]	Agency A	Agency B
Referral sources			
Self		Yes	Yes
Family		Yes	Yes
Reservation		Yes	Yes
Courts		Yes	Yes
Welfare		Yes	Yes
Detoxification programs		Yes	Yes
Intake procedures			
ASAM patient placement criteria [b]		Yes	Yes
Detoxification		Offsite	Offsite
Outpatient program			
Groups		4 / week	3 / week
Individual		4-8 hrs / month	1 hr / month
Drunk driving rehabilitation	11%	Yes	No
Residential program			
Capacity	33	54 adult beds	76 adult beds
Occupancy	84%	100%	72-86%
Blackout period		7 days	No
Residential treatment components			
Individual therapy	94%	Yes	Yes
Addiction physiology	94%	Yes	Yes
Group therapy	93%	Yes	Yes
Discharge planning	92%	Yes	Yes
Relapse prevention	91%	Yes	Yes
Self-help groups	78%	Yes	Yes
Life skills	77%	Yes	Yes
Aftercare	74%	Yes	Yes
Family stabilization	73%	Yes	Yes
Housing assistance	68%	Yes	Yes
Women's groups	57%	Yes	Yes
Job readiness	56%	Yes	Yes
Mental health services	42%	Yes	Offsite
Modified twelve step		Yes	Yes
Motivational enhancement		Yes	Yes
Sobriety coping		Yes	Yes
Cognitive behavioral		Starting [c]	Starting [c]

continued on next page

Table 3, Continued
Urban Substance Abuse Treatment Processes and Programs

	United States [a]	Agency A	Agency B
Culture-specific services in residential programs			
Treatment work book		No	Yes
Talking circle		Yes	Yes
Native crafts		Yes	Yes
Sweat lodge		Yes	Offsite
Flute playing		Yes	No
Drumming		Yes	No
Fire ceremony		Yes	No
Beds for clients' children	16%	Yes	No
Adolescents accepted	80%	No	Yes

[a] National Survey of Substance Abuse Treatment Services 2006 urban residential facilities. [b] ASAM = American Society of Addiction Medicine. [c] as of 2002.

Assessment, Triage, and Residential Intake Procedures

Agency A has never advertised its services, although it does have a website. People telephoned the Agency A residential center for information, and the intake team sent an intake packet. Once the intake, including a physical examination and tuberculosis (TB) test, was completed, a client could be admitted.

During the study years, a client referred to Agency A was assessed at the agency's outpatient facility utilizing the American Society of Addiction Medicine (ASAM, 2001) patient placement criteria, as required by the state. Based on the assessment, clients were typically referred to Agency A's outpatient program or, in more severe cases of addiction, to Agency A's residential facility. From residential treatment, clients moved to Agency A's outpatient follow up and aftercare services.

No records were kept regarding the numbers and sources of referrals, but Agency A intake files remained open for 6 months. If a client had not enrolled in the program within 6 months, the file was destroyed. The Agency A residential program was not able to admit someone with a violent background as determined by self-report or by information from the referral source (such as the criminal justice system) because of the presence of women and children in the facility.

Clients arriving at the Agency A residential center went to the admissions office, where their bags were checked for contraband, and they were given needed paperwork and release

forms. They were then connected with a counselor or peer leader who gave them a tour of the facility and introduced them to other clients and staff. They then went for a medical intake. During the first two days, clients rested, became acquainted with their schedules, and began group sessions addressing topics such as the physiology of addiction, family issues, the 12 steps, and relapse prevention. Clients had their initial meeting with their counselors during the first day or two. Clients were under a "blackout" for the first seven days, allowed no visitors or trips to attend outside A.A. meetings, and not able to attend sweat lodge ceremonies.

Individuals presenting at Agency B were evaluated by clinicians using the ASAM patient placement criteria, as required by the state. Treatment options included detoxification (almost always provided at an offsite facility), residential care, and an outpatient program at the clinic. On average, clients addicted to drugs other than heroin remained in the detoxification facility for 24-48 hours. Clients addicted to heroin typically stayed in detoxification for a week or more.

Clients arriving for Agency B residential treatment underwent an intake interview at the reception area where they were given registration forms, case management forms, and a consent-to-treatment form; they also read and signed the rules of the center. Clients then went to the medical building for a brief medical history and physical examination. From the medical building, they were taken to their cottage where the residential assistant welcomed them. The residential assistant went over the rules and expectations and gave the clients their daily schedules. Clients saw a counselor for a one-on-one session within 24-48 hours of arrival. In the meantime, clients started attending group sessions, such as a morning men's or women's group, followed by an education group dealing with the physiology of addiction, family issues, the 12 steps, and relapse prevention.

The first session with the Agency B counselor was devoted to an interview in which the counselor asked about addiction history, number of times in treatment, and mental health history. The counselor kept a written document of all sessions. During the initial session, the counselor determined the client's motivational level and, in consultation with the client, devised an individualized treatment plan. Thereafter, clients generally had weekly one-on-one sessions with their counselors.

Substance Abuse Treatment Services at the Study Agencies

Reviews of the agencies' websites and documents, as well as discussions with staff, indicated that both study agencies provided several mainstream services (as well as numerous ancillary or wraparound programs), including individual and group therapy, substance abuse education (incorporating addiction physiology), relapse prevention, discharge planning, case management, self-help groups, life skills and social skills training, sobriety coping instruction, aftercare counseling, family counseling and stabilization training, social services, housing assistance, peer support, general health education, special groups for men and women, transportation assistance, job readiness preparation, employment assistance, mental health care, and domestic violence programs for women (Table 3). Both agencies facilitated self-help programs, including A.A. and N.A. The agencies had residential and outpatient programs but referred clients to offsite detoxification facilities. Both programs provided mental health care but Agency B did so offsite.

As shown in Table 3, the agencies also offered comprehensive, culturally specific treatment programs, chiefly via groups; including a sweat lodge (described below). In addition, the agencies had adapted for AI/ANs and incorporated into their treatment programs standardized therapies, including Motivational Enhancement and cognitive-behavioral treatment.

The Agency A substance abuse program also included HIV/AIDS prevention and education, TB and hepatitis C virus testing, routine urine screens, medical treatment, recreational activities, diet and nutritional advice, personal budgeting education, a child development center (CDC), early intervention services, preschool program (ages 0-4 years), school-age program (ages 5-8 years), fetal alcohol syndrome education, child care, and parenting classes.

The Agency B outpatient substance abuse treatment facility employed a 12-step recovery program modified to include cultural activities. In keeping with Agency B's commitment to providing a continuum of care in the recovery process, outpatient treatment typically consisted of group sessions in which parenting, anger management, budgeting, and job search skill training, were addressed. Agency B outpatient services also included group therapy, family involvement, physical exercise, and nutritional assessments and regimens.

If deemed necessary by the treatment counselor or team, Agency B outpatients could be given up to three group sessions per week. Patients typically had 1 hour of one-on-one

counseling for every 20 hours of group work, which generally amounted to about 1 hour per month. The Agency B outpatient facility had an average caseload of 50 clients.

Table 3 shows that Agency A provided more outpatient groups per week than Agency B and offered more individual treatment. The programs also differed in that Agency A had residential beds for clients' children and provided outpatient driving while intoxicated programs.

Schedules of Residential Substance Abuse Treatment at the Study Agencies

The residential treatment schedules shown in Table 4 summarize the programs. Notice that Table 4 provides both short- and long-term schedules for Agency B, whereas Agency A has only a long-term program. However, the Agency A schedule included parenting programs and parent-child group activities.

Table 4
Residential Substance Abuse Treatment Schedules 2006

	Agency A	Agency B	
		Short Term	Long Term
Monday AM	Men and women process group	Men meditation Women meditation Chemical dependency and family Stress management	Meditation Education/computer
Monday PM	Relapse prevention group Alcohol and drug education	Men study period Women study period Computer class Men intensive process group Women intensive process group Cottage meeting	Beginning computer Education Cottage meeting
Tuesday AM	Alcohol and drug process group Domestic violence for women group	Men meditation Women meditation Educational/vocational presentation Smoking cessation	Meditation Education
Tuesday PM	Men and women process group Coin ceremony	Arts and crafts Men intensive process group Women intensive process group Life skills Narcotics Anonymous	Arts and crafts Education Computer Narcotics Anonymous
Wednesday AM	Parenting group Parenting process group Men process group	Men meditation Women meditation Alcohol and drug education	Meditation Employment basics Nutrition group

continued on next page

Table 4, Continued
Residential Substance Abuse Treatment Schedules 2006

	Agency A	Agency B	
		Short Term	Long Term
Wednesday PM	Socialization group Alcohol and drug education Parent child play group	Men study period Women study period Computer class Alcohol and drug presentation Speakers meeting	Beginning computer Alcohol and drug video Education
Thursday AM	Men process group Women process group	Men meditation Women meditation Twelve step education	Meditation Education/vocational guidance Housing resources
Thursday PM	Case management groups	Talking circle or spirituality pathways Men intensive process group Women intensive process group Alcoholics Anonymous	Talking circle or spirituality pathways Alcoholics Anonymous
Friday AM	Alcohol and drug education	Men meditation Women meditation Men clothing run Women domestic violence group	Meditation Men clothing run
Friday PM	Men process group Women process group Cultural education	Community meeting Women clothing run Hepatitis C presentation Men intensive process group Women intensive process group	Community meeting Women clothing run
Saturday AM	Medical sessions Mental health group	Meditation Relapse prevention	
Saturday PM	House meeting Cultural film Arts and crafts Sweat lodge		
Sunday AM	Big Book Family group Alcohol and drug education	Education group	
Sunday PM	Visiting Cultural film	Visitors (except blackout) Women Narcotic Anonymous Men Narcotic Anonymous	Women Narcotic Anonymous Men Narcotic Anonymous

Specifics of Agency A Residential Substance Abuse Treatment

The Agency A residential center is a regional resource serving 44 tribes as well as the urban AI/AN population, comprised of individuals from more than 150 tribes. The Agency A

residential facility could house up to 54 clients and was typically full to capacity (Table 3). The residential program served adults ages 17 years and older. Parents were able to bring infants and children up to 5 years of age with them to treatment.

The Agency A facility is a former school building, located on 11 acres of land. The area is bordered by trees on one side and homes on the other sides. There are two sweat lodges (men's and women's), a fire circle, an outdoor track, and a small gymnasium which also serves as a dining hall and a location for cultural activities, including graduations. The Agency A facility is handicap accessible, with elevator access between the lower floor, where the gym is located, and the upper floor, which has approximately 60 treatment beds, offices, a large meeting room, and the CDC.

Agency A incorporated AI/AN cultural practices such as talking circles, flute playing, drumming, and bead work into the residential treatment program. In addition to alcohol and drug treatment, Agency A had mental health therapists on staff and during the study years began working toward a cohesive dual diagnosis approach to alcohol/drug and mental health treatment.

Clients at Agency A participated in three process group sessions and one small group session per week during the day. Groups were also offered throughout the week for parenting skills, relapse prevention, life skills, alcohol and drug education, and meditation, along with medical and/or health lectures. Mixed group sessions typically had women sitting on one side of the room and men on the other. Some smaller group sessions, such as process groups, featured separate sessions for men and for women. Agency A also provided gender-specific groups addressing mental health issues as well as grief and loss groups.

At the Agency A residential program, A.A. and N.A. meetings were held four nights per week, with one evening devoted to Big Book study. Other evenings were devoted to AI/AN traditional talking circles and guest speaker meetings. Pregnant women were encouraged to attend the parenting group and to work with the marriage and family counselor. Residential clients also participated in culturally relevant activities, including sweat lodge ceremonies (defined below), talking circles, flute playing, arts and crafts, singing and drumming, and fire ceremonies. Near the end of treatment the counselor or case manager assisted clients in finding housing and employment. Clients were required to have at least a temporary A.A. sponsor to provide support in the early days after treatment. Residential clients often went to the Agency A outpatient program for aftercare.

Agency A provided mental health services onsite at the residential program seven days per week (Table 3), with a psychiatrist available two days per week. Dialectical behavioral therapy and dual diagnosis groups were held weekly, facilitated by a consulting psychologist. Substance abuse treatment staff and mental health counselors worked side by side to provide integrated treatment.

Agency B Residential Treatment

The residential program at Agency B is one of the largest residential treatment centers operated by an AI/AN not-for-profit health care agency in the U.S. During the study years, Agency B had approximately 90 patient beds (Table 3) and offered 3 levels of care: 1) a 30-day intensive inpatient program for stabilization and education involving 4 hours per day of group sessions followed by written homework, 2) long-term care, defined as a 60-day transition phase following the 30-day program, and 3) long-term treatment of 180 days for clients covered by a special State B program (described below) followed by 90 days of outpatient treatment.

The residential program at Agency B typically had 76 adult beds and 10 adolescent beds (Table 3). Four large cottages housed adults and a special wing in the main administration building housed adolescents. During 2002, the residential occupancy rate ranged from 72% to 86% (Table 3). Length of stay varied depending on individual needs.

Treatment programs at the Agency B residential program typically focused on group therapy, cultural and spiritual needs, nutritional regimens, one-on-one therapy, physical exercise, family involvement, and 24-hour supervision. Combined alcohol-drug dependence was treated when necessary. Residents had full access to comprehensive health services.

Culturally relevant practices were important at Agency B; a traditional health liaison person was on staff. In addition, Agency B residential clients completed a culturally specific workbook.

The Agency B residential treatment program offered intensive recovery programs, cultural activities, long-term recovery stays, a family-oriented treatment approach, individual and group treatment, and access to comprehensive health services, including mental health counseling. Transportation was provided for residential clients to the Agency B clinic for mental health services and to a general hospital for medical services. Every effort was made for patients to stay with their existing health care providers while in treatment.

Agency B substance abuse treatment patients also received wraparound and support services, including job training, resume writing, GED preparation, and computer laboratory access. The Agency B residential center provided clients with educational services through a specialist employed for that purpose. In-house A.A. and N.A. meetings were available to all residential treatment clients wishing to attend. Agency B encouraged continuity of care for those in recovery. Residential clients could seek outpatient counseling at the Agency B clinical center, where many outpatient services were located.

Study Agency Sweat Lodges

Both agencies provided sweat lodge programs for residential clients. A sweat lodge is a low windowless structure made of woven ash branches. Tarps or blankets are placed on top of the branches to keep out the light and prevent the heat from escaping. The floor is made of hardened earth with a pit in the center into which hot rocks are placed. Participants enter the lodge on their hands and knees and crawl around the outside of the pit, seating themselves on the ground. The fire keeper brings in a certain number of hot rocks. Herbs such as cedar, sage, or sweet grass are sprinkled on the rocks, then the door to the lodge is closed and water is poured on the rocks to create steam. Some ceremonies offer four rounds of prayers. The door is opened between rounds and additional hot rocks are brought in. During each round, participants pray for certain purposes, such as general prayers, prayers for women and for mother earth, prayers for veterans and the ancient ones, and prayers to thank the Creator.

Study Agency Services Compared to National Urban Residential Programs

As shown in Table 3 (left column), according to the 2006 National Survey on Substance Abuse Treatment Services, over 90% of urban residential treatment programs provided individual and group therapy, substance abuse education, relapse prevention, and discharge planning. Over 80% offered case management and special programs for adolescents, and over 70% provided or facilitated self-help groups, social skills training, aftercare counseling, and family counseling. At least 60% of national survey respondents offered social services, housing assistance, peer support, HIV/AIDS education, and general health education. Approximately half the programs offered special groups for men and women, transportation assistance, and employment assistance.

On the other hand, fewer than half the national survey respondents provided mental health services, domestic violence programs, special programs for pregnant or postpartum women, or services focused on criminal justice clients. And only a handful of agencies (less than 20%) offered residential beds for clients' children, child care, or driving while intoxicated programs.

Themes from Qualitative Research

Prominent themes identified in the interviews and document reviews included cultural considerations, family involvement, and staff activities. The themes are presented here via quotations, interview summaries, and descriptions of agency staff activities.

Cultural Considerations

The Agency A treatment director said, "Whatever decisions are made here consider culture and the clients first. I believe this is foundational to Agency A." He said that approximately 80% of the clients (including many non-Natives) attend culturally specific services. Agency A did not bill insurance sources for cultural services, although these are part of the agency budget.

The Agency A clinical supervisor said that, to Native people, cultural services are incredibly important and the lack of such services in other treatment agencies is one reason why they may not do as well in treatment elsewhere.

Indeed, all Agency A interviewees agreed that the role of culture in treatment is very important. Accordingly, traditional AI/AN culture and spirituality have always been an integral part of Agency A's services. In recognition of its services to AI/ANs, Agency A has been honored by tribes with a sacred pipe, a totem pole, a drum, and an eagle staff.

The Agency A residential program regularly offered sweat lodge ceremonies, the Winto fire ceremony (a ceremony of the Northern California Winto tribe given to Agency A by tribal elders), talking circles, and cultural education. Many people also used the purification practice of "smudging" themselves with smoke from a receptacle containing burning leaves such as sweet grass, sage, and/or cedar in connection with prayer and ceremony.

The Agency A cultural advisor and assistants explained how the 12 steps are related to AI/AN cultures. One of the terms used to describe cultural practices in treatment is "walking the Red Road." The Red Road has many meanings. As a recovery movement, it refers to combining

ancient spiritual wisdom and modern substance abuse treatment practices. The cultural materials included a quotation from the late Sacramento, California Yurok artist David Ipina (deceased 1998) who said of the Red Road:

> "Being Indian is mainly in your heart. It's a way of walking with the earth instead of upon it. A lot of the history books talk about us Indians in the past tense, but we don't plan on going anywhere... We have lost so much, but the thing that holds us together is that we all belong to and are protectors of the earth; that's the reason for us being here. Mother Earth is not a resource, she is an heirloom."

Because Agency A served AI/ANs from over 150 different tribes with many different cultures, the cultural advisor and his staff met with clients from traditional backgrounds to explore what cultural practices they needed and tried to arrange for those to be provided.

Guest speakers and elders provided stories and information from various tribal traditions. For example, a guest from a distant reservation held a Washat service at Agency A. Washat traditions are significant to the tribes of the Columbia River area. Members of the Native American Shaker Church also provided services, and the family wellness teacher carried out a cradleboard-making project with parents, while teaching traditional parenting values.

A key event at Agency A was the "Coin Ceremony," which honored clients completing the residential program. Family members and friends of the graduating clients were encouraged to attend. Agency A also sponsored several community events each year. Two of these in particular brought together treatment program graduates: the New Year's Eve Sobriety Powwow and the Alumni Picnic. The treatment director said that he frequently heard present and past Agency A residential clients talk about "the Agency A way" which means "stay clean, stay on the Red Road, don't get in trouble, and stay out of jail." The use of this term illustrated the extent to which clients experienced a sense of community in residential treatment that stayed with them after they left.

Similarly, all of the Agency B residential staff interviewees stressed the importance of cultural activities. One counselor said, "It is 100% vital. When it is available and used there can be no price on it. It restores their sense of self. Natives will tell you if they are 'using' they are losing their spirituality. Traditional practices are a way of experiencing life."

One Agency B counselor said that AI/AN clients are very aware of the AI/AN staff, watch them, and know they are there. She said that some AI/AN clients come with their own culture, while others are not raised in their cultures and want to have some cultural experiences.

The Agency B clinical supervisor said that the spiritual component is important because so many AI/ANs either never had it or had lost it. She said, "It's a gentle way to get them back on a spiritual road." She went on to say that residential staff thinks the cultural activities are more important than do some of the AI/AN clients, who are out of touch with and disconnected from their cultures. Several Agency B staff mentioned that reasons for disconnection from cultures included homelessness as well as frequent geographic moves.

Another Agency B counselor remarked that the clients in residential programs interacted well with each other despite all the different cultural backgrounds they came from. He said, "We see all ethnicities and peace is generally maintained." Another said that the treatment program was the beginning of healing for each patient. She said, "Residential has Native American cultural themes, yet it still encompasses all the people served."

The Agency B treatment director said that AI/ANs did not have many options for residential treatment. Usually approximately 40% of residential clients at Agency B were AI/AN, and he said they tended to require a higher level of care than non-Native clients.

The weekly men's sweat lodge ceremonies provided by Agency B were conducted by a Makah Indian who moved to City B in 1959. The cultural services provider said that, when he first became interested in the sweat lodge ceremony, he began helping with the fire used to heat the stones and generate heat in the lodge at a cultural center. He said that a well-known Native cultural expert taught him the sweat lodge ceremony and that he still worked with the expert.

The ceremonies at Agency B offered four rounds of prayers; the door was opened between rounds and additional hot rocks were brought in.

At one time, Agency B offered sweats for both men and women; however, some traditions do not permit "mixed sweats," so they discontinued the practice and were only able to offer the ceremony to men during the study years. The clinical supervisor said that women could go to a nearby reservation or to another tribal location for women's sweats. Typically, women rode with someone who came to the residential center to participate in evening A.A. meetings.

The Agency B cultural services provider held men's and women's talking circles every week. Talking circles began with the purification practice of "washing" each person with smoke

from a receptacle containing burning leaves such as sweet grass, sage, and/or cedar, a practice often used in connection with prayer and ceremony. An eagle feather or other sacred object was then passed around the circle. The person holding the feather could speak without interruption or comment until finished and then passed the feather to the next speaker until everyone wishing to speak had done so. This opportunity to share one's heart in a sacred manner was a meaningful and healing spiritual practice for many people. The cultural services provider also worked regularly with residential clients in arts and crafts, teaching them to make dream catchers and god's eyes. He said most clients lacked eyesight or patience to do beadwork.

Family Involvement

Regarding family involvement in treatment, the Agency A clinical supervisor said that families were not involved as much in treatment as she would like. She said that it was difficult to involve families when clients came from a distance or were homeless or estranged from their relatives. A mental health counselor offered a Sunday afternoon group meeting for those families who visited clients in treatment, to help them understand and support their treatment and healing process. Counselors were also beginning to involve clients, along with their significant relatives, in discharge planning.

The CDC was considered very important to AI/AN families in treatment at Agency A. The treatment director said, "Sometimes the children arrive in worse shape than their parent, and in a sense, they are also in treatment. Seeing the process of the family getting healthy, the kids setting boundaries, and parents' engagement in parenting sessions through the CDC is my favorite thing at Agency A." Agency A had recently added a residential children's case manager who could follow families to outpatient care and help address children's needs; the agency also had received a grant focused on assisting children from families affected by methamphetamine addiction.

In summary, all Agency A services are centered on the family. It is the agency's philosophy that "without the family circle there will be no future."

Conversely, the Agency B clinical supervisor said that the majority of patients were not in contact with their family members. The counselors supported clients in getting back in touch with relatives, where possible, and helped mothers who had lost custody of their children to have visits with them. Clients were most likely to have had visits from brothers or sisters who were open to supporting their recovery, but many only saw their social workers or their A.A./N.A.

sponsors during visiting hours (Sunday afternoons from 1 to 4 p.m.). For clients who had family contacts, friends, relatives, and significant others could gather with them in the family room, picnic area, horseshoe pit, or on the lawn.

In addition, the Agency B residential center had an alumni barbecue that was free of charge. Typically around 400 former clients, A.A. participants, and others attended the event. To many, the residential center became like their family.

Counselor Activities

Overall, each study agency had approximately 15 residential and/or outpatient counselors (Table 4) and employed non-Native as well as AI/AN counselors. At Agency A, counselors reported that they worked 40 or more hours per week. For example, each week the Agency A lead counselor spent approximately 14 hours in one-on-one sessions with clients, 14 hours conducting group sessions, 12 to 15 hours on paperwork, and 9 hours in meetings. She said it was hard to fit all her activities into 40 hours. Regarding paperwork, she said that, for every 2½-hour process group, she had 1 to 1½ hours of documentation. There were 20-25 people in the group, and documentation required notes about each individual. The groups with which she worked included alcohol and drug education, relapse prevention, and a process group consisting of a client circle in which people checked in, raised any healing issues of concern, and were taught content from a women-focused A.A. workbook (Covington, 2000) regarding self, relationships, sexuality, and spirituality. She also allowed 30-60 minutes after each group for clients to speak with her individually about questions raised. She said she had a caseload of 10-14 clients.

The alcohol and drug evaluation for every new client at Agency A consisted of a 3-hour interview and a 1-hour written survey. Counselors spent approximately 1 hour writing up each evaluation, using ASAM criteria for placement and American Psychiatric Association Diagnostic and Statistical Manual criteria for dependence (substance use disorder). When they suspected a client had co-occurring mental health issues, they referred him/her to the mental health counselor onsite.

Each client's treatment plan at Agency A was based on his/her evaluation and was developed jointly with the client. It was reviewed every 30 days in an individual session. All clients had random urine analyses (UAs) for substance abuse. If a client was involved with the legal system, UAs were required once each week. Otherwise UAs usually were scheduled after

clients had been off campus with a group trip. If a client's UA indicated alcohol or drug use, it was addressed on an individual basis—usually with a warning for the first occurrence. Continuing "dirty" UAs resulted in a client having to leave Agency A residential treatment. Usually such clients had the opportunity to reapply for the program. Other behaviors, such as violence, abuse (emotional as well as physical) of a child or elder, or acting out in a sexually explicit way, resulted in a person being expelled from treatment.

When Agency A counselors recognized that a client was not making progress with his/her treatment plan, they usually held a "staffing" with the client and all counselors who worked with him/her. The purpose of the staffing was to discover what the client needed to be successful and how the counselors could support him/her. If the person was on probation or otherwise involved with the criminal justice system, the probation officer could also become involved in the staffing.

The Agency A substance abuse treatment counselors were trained in motivational interviewing, which they used as much as possible, and in client-centered treatment, and all were experienced with and respectful toward the role of culture in treatment. Agency A had no required curriculum (e.g., completion of the 12 steps was not mandated), although the lead counselor said that Agency A has been 12 step-based from the beginning. The treatment director believed that counselors needed total flexibility to develop a client's treatment plan in consultation with the client. For example, video- and audiotapes and oral (rather than written) homework were used for clients who did not read well. The Agency A clinical supervisor indicated that flexibility was important to gear treatment to the needs of each client and that the counselors usually made clinical decisions as a team. She said that all therapeutic work was done within a framework of respect, safety, and professional conduct. She said, "Our mental health people are very much a part of the treatment team."

The Agency A lead counselor mentioned that some clients were third-generation sufferers from fetal alcohol spectrum disorder. They had difficulty concentrating and needed special assistance, such as tape-recorded reading assignments, to carry out their homework. She had noticed that they could concentrate well when participating in singing, drumming, and ceremonies and believed that the cultural services were integral to the healing process for these clients.

The Agency A clinical supervisor said that she provided supervision "all day long." She had an open door for the staff and clients. She spent approximately 40% of her time with counselors discussing issues such as treatment planning, intervention with clients, and group dynamics. There was a weekly clinical staff meeting at which she provided education for counselors related to cultural issues, motivational interviewing, and other topics. She worked to ensure that all staff members kept in mind the importance of supporting the treatment mission and client needs as the first priority.

The treatment director had been with Agency A since 1992 and had served as an intern, a counselor, and an administrator. The clinical supervisor had been at Agency A for 7 years, first as a treatment counselor. The lead counselor (who had worked at Agency A for 9 years) said that there was a wonderful team dynamic between counselors and other residential treatment staff. "This results in a multidisciplinary approach to helping the clients succeed in treatment." She said the cultural, mental health, and CDC staff members were all part of the team as well. The counselor who had been at Agency A for 1 year said that she had personal experience with methamphetamine abuse and believed this knowledge to be one of her gifts to the treatment team.

The human resources department at Agency A had initiated annual evaluations using a standardized form. Newly hired counselors also were also evaluated within the first 6 months. Evaluations addressed specific criteria, including productivity, attendance, and relationships with co-workers. Areas of improvement and specific steps to take also were included.

Counselors at Agency B worked 40 hours per week, spending 15-20 hours per week in face-to-face counseling and 12 hours per week in groups. They spent about 2 hours per day on case management for clients. The Agency B clinical supervisor checked in with each counselor for 15 to 30 minutes every day. Counselors prepared notes on each client's participation in each group for the clinical supervisor to review. These notes helped them decide, for example, whether changes needed to be made in group membership. One of the counselors interviewed facilitated small process groups of 10-12 clients, educational groups of 50-55 clients, and also worked with groups on topics of family, self-esteem, relapse prevention, and pharmacology.

The Agency B counselors had to follow the required schedule for group sessions and show the clinical supervisor what curriculum they were using. Counselors had added, for example, some stress management to their group sessions. Counselors and the clinical supervisor

collaborated on expanding group sessions to include topics in stress management such as progressive muscle relaxation. They also used dialectical behavioral therapy with some clients. Clients did not engage in trauma work in early recovery; counselors instead sought to involve patients in a support system.

According to the clinical supervisor, Agency B did not have a primary treatment theory that all counselors had to use. The Agency B counselors provided services according to the individual needs of their patients. There were many young men coming to treatment at Agency B needing cognitive behavioral therapy, anger management, and coping skills, and counselors spent considerable time arranging and coordinating services to ensure that these needs were met.

Agency B counselors conducted evaluations of every client they served. Clients came into treatment with completed ASAM and American Psychiatric Association Diagnostic and Statistical Manual assessments (which were conducted by residential counselors prior to start of formal treatment), and then the counselors did a complete 1- to 2-hour biopsychosocial evaluation. Counselors wrote up the evaluations as they went along.

Each client worked together with a counselor to develop an individualized treatment plan and addressed the plan every week in one-on-one sessions. One Agency B counselor said that he constantly thought of each client in terms of ASAM criteria. If a client stayed beyond the initial intensive treatment phase for long-term treatment, he developed a new treatment plan with the client.

The Agency B residential center worked on a random UA system. Counselors had a weekly UA list. If a blood test was required, they sent clients to the clinic. If the counselors identified someone in need of a mental health assessment, they discussed it with the client and then sent him/her to mental health services.

When an Agency B counselor recognized that a client was not working to meet his/her treatment goals and objectives, the counselor had a thorough discussion with the client to find out what the issue was. Sometimes counselors addressed such issues in weekly staff meetings, where clients were not present. If a client broke the rules (e.g., using substances, leaving the facility without permission), the counselors tried to give him/her the benefit of the doubt and learn what was going on. While procedures were tailored specifically for each client, in general clients were given several chances. Usually counselors and clients developed behavioral contracts to address the issue.

The Agency B clinical supervisor said she felt the program was going well. She would like to continue to have 6-7 counselors and raise their salaries to stay competitive. The salary level had been lower than other agencies' for years; as a result, there had been considerable staff turnover. She believed that problem had been addressed and that the current staff was very effective and had high standards for their work. She also said that they were innovative and current in their treatment practices.

Counselors were formally evaluated annually using a form provided by Agency B's human services department. The Agency B clinical supervisor said that she observed both group and one-on-one sessions, depending on the needs of the counselors. The kinds of interventions counselors used with clients told her about their skills. She had been meeting with counselors twice a week but was planning to do so less often as the counselors kept her informed about any work issues they were facing, such as clients needing to be moved into different groups.

Residential Staff Characteristics

Table 5 presents characteristics of residential staff nationally (left column) and at the study agencies (right columns). Both study agencies had notably large (above the 80th percentile) staffs compared to programs nationally. Specifically, information from ADSS showed that urban residential treatment centers had, on average, approximately 14 full-time staff members (median of 12), of whom 6 were counselors (median of 5). While the numbers fluctuated, during the study period, there were roughly 6 residential, 7 outpatient, and 2 youth substance abuse treatment counselors. Agency B typically employed approximately 8 residential counselors and 4 outpatient counselors. Again, there was fluctuation such that, during the study period, there were, on average, roughly 7 residential substance abuse treatment counselors.

Agency A required that staff must model nondrinking, nonusing behaviors on and off the job and must understand the importance of culture and its impact on client recovery. Counselors must, at minimum, hold a Certified Alcohol and Drug Counselor Level One (CADC-I) certificate and have one year of on-the-job experience, although Agency A considered other experience, such as a practicum, when hiring. All alcohol and drug counselors at Agency A were state certified.

Training for new Agency A clinical staff included an orientation with human resources personnel and a 2-week introductory period (before beginning full job responsibilities) when they usually spent time with experienced clinical staff and toured all Agency A facilities. The

executive director and the cultural director provided annual cultural competency training for all staff and provided opportunities for staff members to attend culturally based treatment conferences, such as those offered by White Bison, Inc. Staff members who needed a particular kind of training could arrange for it, and those who had cultural questions usually consulted the cultural director or one of his assistants.

All certified counselors at Agency A were required to have 20 hours of continuing education credit per year and to maintain their certification. Agency A provided numerous onsite trainings for staff to earn required continuing education units. An AI/AN consultant provided ongoing training in a culturally appropriate manner in topics such as ethics, toxicology, and addiction in families in a culturally appropriate manner.

Agency B counselors had to be certified Chemical Dependency Professionals (CDP), which involves two years of study and a certification exam. State B required 40 hours of continuing education every two years to maintain certification.

As shown in Table 5 (right columns), study agency residential staff members were mostly female and in middle life. Overall, AI/AN staff were in the minority at the study sites, especially at Agency B. Staff members with college degrees were also in the minority. Approximately one third of staff members had been at their study agencies less than 1 year. On the other hand, another third of staff had been with their study agencies for more than 5 years. Nearly all study agency staff members were full-time employees working 40 hours per week. Unfortunately, national data on staff demographics (such as gender, age, and ethnicity) were not available.

There were numerous job titles at the study agencies, with *substance abuse treatment counselor* and *residential aide* being the most common. Several staff members reported more than one job title. For example, some administrators were also substance abuse counselors or cultural staff. It is useful to define substance abuse counselors, residential aides, child development staff, cultural staff, mental health staff, and health clinic staff as direct contact (with clients) personnel. At both study agencies, direct contact staff represented approximately 70% of the job titles. Inconveniently, national comparisons are not available because ADSS lumped many direct contact personnel into an “all other” category that included administrative staff.

At the study agencies, substance abuse treatment counselors represented less than one third (26%) of staff members. Conversely, treatment counselors comprised half of the full-time staff in the national data (average 54%; median 50%). Virtually all study agency substance abuse

treatment counselors were certified as chemical dependency professionals. Thus, certified counselors represented roughly one fifth to one third of study agency staff (22% at Agency A and 29% at Agency B), which is slightly less than the analogous national data (mean, 32%; median, 22%).

At the study agencies, 39% of counselors did not have college degrees. Conversely, half of counselors nationwide lacked college degrees (mean and median were 50%). Moreover, at the study agencies, some 44% of counselors had masters or doctoral degrees. Nationally, the average percentage of counselors with a masters or doctoral degree was 20% (median of 17%).

The study agency substance abuse treatment counselors generally reported caseloads of 10-20 clients. Conversely, the national data suggested that counselor caseloads were mostly under 10.

The lower rows of Table 5 show that TSET scores for study agency staff members were generally in the ranges reported by clinicians who have considerable confidence in their cognitive, practical, and affective capabilities to work with people of diverse cultural backgrounds. Stated differently, the scores were typically in the "advanced" or expert range (Jeffreys, 2000) and were approximately Gaussian (bell-shaped curve) in distribution. Multiple regression analyses (with site, age, gender, race, and counselor status as predictors) showed that substance abuse treatment counselors were slightly more confident than were other staff on the practical scale ($p = 0.05$) and that women were somewhat more confident than men on the affective scale ($p = 0.05$). There were no statistically significant predictors for confidence on the cognitive scale. Interestingly, race (i.e., AI/AN vs. non-Native) was not a statistically significant predictor for any of the scales.

Approximately half the Native staff at each agency had Indian blood quantum of half or greater. The vast majority of AI/AN staff at each agency were enrolled tribal members from a variety of tribes. For example, AI/AN staff at Agency A came from 15 different tribes and included five individuals with mixed (i.e., multiple) tribal backgrounds. At Agency B, five tribes were represented, and there were two individuals with mixed (i.e., multiple) tribal heritage.

On the four Orthogonal Cultural Identification Scale items included in the ABQ, most AI/AN staff scored in the "high" range with respect to AI/AN cultural identification (right columns at bottom of Table 5). The scale was roughly Gaussian (bell-shaped curve) in

distribution. Age and gender were not statistically significant predictors of scores among the AI/AN staff members.

Comparing the two agencies, residential staff members were similar with regard to gender, age, education, certification, and workload. There were no statistically significant differences by agency on any of the TSET score, and agency was not a statistically significant predictor of TSET scores in multiple regression analyses. The Orthogonal Cultural Identification Scale scores of AI/AN staff did not differ between the agencies.

On the other hand, the agencies did differ with regard to AI/AN representation among staff members. Approximately half of Agency A staff members were AI/AN, whereas, at Agency B, only one quarter of staff identified themselves as AI/AN.

The agencies also differed with regard to staff roles. For example, the Agency A residential program had several onsite staff members who specialized in cultural consultation, mental health, or child development. Conversely, Agency B residential staff members were overwhelmingly either substance abuse treatment counselors or residential aides. Moreover, approximately half the staff members at Agency A were clinicians (i.e., counselors, child development staff, mental health clinicians, or health clinic personnel) whereas only one third of staff at Agency B were clinicians.

Table 5
Urban Residential Substance Abuse Treatment Staff

	United States [a]	Agency A	Agency B
N	13.8 (12)	37	31
Female		65%	58%
Age			
20-29		6%	0%
30-39		26%	20%
40-49		35%	23%
50+		32%	57%
American Indian or Alaska Native		47%	26%
Education			
No academic degree		3%	6%
General Educational Development (GED)		19%	16%
High school		19%	29%
Associate		16%	19%
Bachelor		27%	10%
Master or doctor		11%	10%
Professional		5%	10%

continued on next page

Table 5 Continued
Urban Residential Substance Abuse Treatment Staff

At agency	United States [a]	Agency A	Agency B
Less than a year		35%	32%
Five or more years		38%	32%
Forty hours per week		79%	90%
Job title [b]			
Substance abuse treatment counselor	54% (50%)	22%	32%
Residential aide		16%	35%
Child development staff		14%	0%
Cultural staff		8%	0%
Mental health staff		8%	0%
Health clinic staff		5%	3%
Administrator		22%	13%
Admissions		8%	6%
Office staff		8%	10%
Kitchen staff		8%	6%
Maintenance staff		5%	0%
Other job title		5%	13%
Certified alcohol drug counselor	32% (22%)	22%	29%
Substance abuse treatment counselor		Yes	Yes
N	6.0 (5)	8	10
No college degree	50% (50%)	38%	40%
Master or doctor	20% (17%)	50%	30%
Substance abuse treatment counselor caseload			
Under ten	87% [c]	29%	44%
Ten to twenty	11% [c]	71%	56%
Transcultural Self-Efficacy Scale [d]			
Cognitive		6.2 (2.2)	7.0 (1.6)
Practical		6.5 (1.9)	7.2 (1.9)
Affective		8.2 (1.1)	8.2 (1.0)
American Indian or Alaska Native		16	5
Blood quantum ½ or more		55%	50%
Enrolled tribal member		71%	100%
Mixed (multiple tribes) tribal heritage		31%	40%
Orthogonal Cultural Identification Scale [e]		7.6 (2.5)	9.2 (1.9)
High American Indian identification [f]		50%	80%

[a] Alcohol and Drug Services Study 1996 phase one urban residential (N = 366) weighted mean (median). [b] More than one job title could be selected at study agencies. [c] Estimate based on numbers of current clients divided by numbers of full-time substance abuse treatment counselors. [d] Mean and standard deviation. Scales can range from one through ten. [e] Four-item measure mean and standard deviation. Scale can range from zero through twelve. [f] Scores above seven on the four-item Orthogonal Cultural Identification Scale indicate "high" American Indian identification.

CONCLUSIONS

As hypothesized, the study agencies delivered treatment services that were notably more varied than those provided by mainstream residential programs in urban areas. Both study agencies provided conventional services, such as alcohol and drug education. And, as expected, both agencies delivered numerous culturally specific programs, such as sweat lodges. But in addition to traditional healing, the study agencies offered programs, such as mental health care, domestic violence services, and residential beds for clients' children, that were rarely provided by mainstream residential treatment facilities.

Thus, the "menus" of services found at the study agencies were much more comprehensive than those delivered by conventional programs (as reported in national data sets). This broad-based approach is especially pertinent for AI/ANs who often live in adverse environments (Manson, Beals, Klein, Croy, & The AI-SUPERPFP team, 2005). Indeed, given the social determinants of health (Friel & Marmot, 2011; Lillie-Blanton & Roubideaux, 2005; Roubideaux, 2002), it may well be appropriate for all substance abuse treatment programs serving urban AI/ANs to consider delivering the extensive arrays of services described here.

Comprehensive services are particularly pertinent for urban AI/ANs because these individuals experience substantial health disparity when compared with non-Natives (Crofoot et al., 2007; Johnson et al., 2010; Urban Indian Health Commission [UIHC], 2007). For example, Castor et al. (2006) found that one quarter of AI/ANs in 34 metropolitan areas were disabled in 2000, versus only one fifth of the general population in those cities. And, based on nationwide data, Castor et al. (2006) reported that AI/ANs had a disability prevalence rate of 24%, versus 20% for the general population. Thus, this group warrants provision of broad service arrays.

The hypothesis regarding staff composition was also confirmed. Namely, the study agencies employed staff members who were more heterogeneous than expected from national data. As expected, the study agencies had staff members who focused on provision of culturally specific services. However, they also had personnel such as child development specialists or residential aides. Perhaps in consequence, substance abuse treatment counselors represented a minority of staff at the study agencies but were the majority in the national data. Interestingly, more counselors at the study agencies had college education and advanced degrees than would be expected from national data.

Looking within the study agencies, staff members scored in the expert range on measures pertaining to provision of services to people with assorted cultural backgrounds. Interestingly, AI/AN and non-Native staff at the study agencies scored about the same on these measures. As expected for urban programs (Nebelkopf & King, 2003; Wright et al., 2011), AI/AN staff at the study agencies came from numerous tribes.

Strengths and Limitations

Strengths and limitations of the study should be recognized. The study's strengths include detailed descriptions (obtained via both qualitative and quantitative procedures) of urban agency treatments, particularly culturally specific services. This information complements rural data provided by the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP) project (Beals, Manson et al., 2005; Beals, Novins, et al., 2005; Manson et al., 2005), which focused on two reservations.

On the other hand, the project was limited to two urban AI/AN treatment programs. The study agencies may or may not be representative of other facilities focused on this population.

However, by design, the two study facilities illustrate variations among programs offering residential treatment.

For example, Agency A began as a chemical dependency treatment program and subsequently developed a primary health care component. Conversely, Agency B is a primary health care program that has expanded to offer residential and outpatient alcohol and drug treatment services. And Agency B was the larger residential program but was not necessarily full at all times, in contrast to Agency A. Also, residential clients at Agency A had a mandatory blackout week not required at Agency B.

In addition, the residential programs differed in treatment structure. Residential treatment at Agency A was a long-term program with a component focused on women and families that provided housing and services for children of clients. Not surprisingly, female AI/AN clients were well represented at the Agency A residential program. Conversely, residential care at Agency B was a short-term intensive program with an extended care component into which clients needing additional treatment were "readmitted" when discharged from the short-term section. There were few AI/AN women at Agency B's residential program. Interestingly, most

residential clients of Agency B were not AI/AN. Similarly, there were few AI/AN counselors at Agency B, in contrast to Agency A.

Another limitation is that the present report, also by design, focused on services and staff. Thus, client data (including treatment outcomes) are not provided here but will be described elsewhere. However, other projects have examined treatment results for AI/ANs with substance abuse problems. For example, Evans et al. (2006), studying administrative data, found similar reductions in problem severity one year after treatment entry for AI/AN versus non-Native clients in California. Importantly, Evans et al. (2006) recognized the limitations of these data and called for investigation of culturally specific components of treatment.

These limitations notwithstanding, the present project showed that urban AI/ANs who have substance abuse problems can be served by comprehensive and culturally specific residential treatment programs. These results are important because urban AI/ANs are a large and rapidly growing population (Castor et al., 2006; Novins et al., 2011; UIHC, 2007; UIHI, SIHB, 2009). For example, during the last three decades of the 20th century, more than 1 million AI/ANs moved to cities (UIHC, 2007) so that fewer than one quarter of AI/ANs now live on reservations or in other rural tribal areas (U.S. Census Bureau, 2012).

To summarize, the study agencies offered the overwhelming majority of services provided by mainstream urban residential treatment programs, as well as numerous additional services, including culturally specific programs. Moreover, treatments were delivered by notably diverse staff members.

In the words of Lillie-Blanton and Roubideaux (2005), these findings address “an important but often overlooked public policy issue—how to more effectively address the health care needs of this nation’s first citizens” (p. 759). The results are especially pertinent for substance abuse treatment program developers and managers who recognize that “efforts to improve health care for American Indians and Alaska Natives need to be more culturally appropriate and community based and must help build community capacity” (Lillie-Blanton & Roubideaux, 2005, p. 760). In addition, this study provides background for findings on treatment costs presented in a companion paper, “Residential substance abuse treatment for urban American Indians and Alaska Natives Part II: Costs,” in this issue.

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