# SUBSTANCE ABUSE AMONG AMERICAN INDIANS IN AN URBAN TREATMENT PROGRAM

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*Abstract: Chart reviews were used to describe demographic and clinical characteristics of 68 urban American Indian people attending an Indian-oriented outpatient substance-abuse treatment program in Denver, Colorado, and to describe program staff's assessment of client's response to treatment. Alcohol and marijuana were the drugs abused most frequently. The program admitted about equal numbers of males and females; age averaged 24 years. Although Colorado has only Ute reservations, 49% of clients were Sioux, while none were Ute. Moreover, 87% of clients were not active in Indian religion and culture. Clients had low educational achievement and very low income. Few were in stable marriages. In comparison to counselors, clients underestimated the severity of their problems. By counselors' assessment, 78% of clients did not finish the program, and only two fully achieved the treatment goals. Areas for further clinical research are suggested.*

Reliable data on extent and patterns of drug (including alcohol) use among American Indians have been scarce. Information often is anecdotal and based only on observer impressions. Health reporting systems on reservations are inefficient, and a primary diagnosis of alcoholism or drug abuse may go undocumented. Conducting research among American Indians, whether on remote reservations or in urban areas, is difficult. Especially for non-Indian researchers, secrecy, deception, and distrust of researchers may preclude research access to social functions, clinics, schools, or individuals.

Drug abuse has presented problems for American Indians for many years, and even though there is a recent slight decrease in lifetime prevalence, the rate is still much higher than that for non-Indian people (Beauvais & LeBoueff, 1985). Brod (1975) found that alcoholism death rates for American Indians have ranged from 4.3 to 5.5 times the national average. He also found the Indian alcohol arrest rate to be 12 times the national average, with the rate for urban Indians 38 times greater than the rural Indian rate. Many Indian suicides and homicides may be attributed to alcohol abuse (Snake, Hawkins, & LeBoueff, 1976). Average education is low (9th grade), and unemployment is as high as 80% on some reserva-

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tions. Snake and associates concluded that "the use of alcohol and drugs causes 80 to 90 percent of the problems of Indian people."

Although the use of alcohol and other substances by American Indians has received considerable attention, empirical studies of substance abuse prevalence are few and rural-focused. About half of Indians now live in cities away from reservations (Sorkin, 1978). Few data are available on substance abuse problems among these urban Indians.

An outpatient clinic was established to treat drug (including alcohol) abuse among Indian youth and young adults in the Denver metropolitan area. We examined records from the first 68 of these urban, substance-abusing admissions for psychosocial, vocational, legal, sociocultural, and drug factors, and report counselors' assessments of treatment outcome.

## Methods

### The Treatment Program

This Indian-staffed outpatient substance-abuse treatment program was part of a larger Indian-directed medical, social, and mental health service agency. It offered Indian Child Welfare services, primary health care, and a food-clothing bank. The substance abuse program offered very active outreach and patient recruitment, medical examinations and treatment, and individual, group, or family counseling. It emphasized Alcoholics Anonymous, Narcotics Anonymous, and disulfiram. The most common treatments were individual or group supportive counseling. Some patients were contacted through education outreach groups in schools with larger proportions of Indian students. Another off-site group was located in another Indian community program in a heavily Indian neighborhood. Clinical consultation was provided by a University substance abuse treatment program. Clients generally were referred by family and friends, courts, clinicians, and self-referrals. The program was developed under a grant from the Indian Health Service to provide care to adolescent and young adult American Indian substance abusers (and their families) in the Denver area.

### The Clients, Materials and Procedures

Records from 68 consecutively admitted male and female American Indian clients seen for substance abuse problems were studied. Cross-employment of staff by the research and clinical organizations, qualified service agreements between them, and the fact that only retrospective reviews of existing chart data were performed removed the need for client consent for the research.

An admission log book was used to identify these clients. Client files were checked for American Indian ethnicity. We then extracted information from clinical record forms required by funding agencies;

Colorado's Drug/Alcohol Coordinated Data System form and the Alcoholism Treatment Guidance System form of the Indian Health Service had been completed by the patients' counselors, who provided supplemental information as needed. Data were analyzed with the Statistical Analysis System (SAS User's Guide, 1985).

## Results

### Demographic Characteristics

Of the 68 clients reviewed here, 62 were seen in relation to their own substance abuse, five primarily in relation to substance abuse among family members, and one did not have specific substance-abuse complaints in self or family. However, we have included all of these clients, since all sough evaluation or treatment in the substance abuse program. These 68 clients included 32 females, while one client's sex was not reported. The clients' mean age was 24 years (range 13-62). Among the 67 clients for whom a birth year was clearly recorded, 72% were 17 years of age or older.

Of this group, 38% were living with parents, 20% with a spouse, and 9% with children. Sixteen percent were considered at admission to be "transient loners," were living alone, or were in a group living situation. Only 23% of clients were employed at admission. Thirty-two percent said that their usual occupation was "student," while homemaker and laborer each were reported as usual occupation by 13%; 16 clients said that they had no usual occupation.

Of the 67 clients for whom martial status information was available, 11 stated that they were married, 5 lived in common-law marriages, 2 were separated, 5 were divorced, 1 was widowed, and 43 reported never having been married.

Sixty-seven clients classified themselves as American Indian, and 45 of the clients said that they were of at least one-half Indian descent. Half were Sioux and 12% were Navajo. Although only Ute tribal reservations are located in Colorado, no clients were Ute. Only 21 of these clients had been raised in an Indian community. Few participated in Indian cultural activities: 47 clients reported that they did not participate, one reported regular participation, and the others fell between these extremes. Similarly, 59 clients reported no participation in traditional Indian religious activities, and only one reported regular participation.

The mean educational achievement for all clients was 10.2 years, with a range of 0 to 13 years. For those 17 years of age or older, the mean was 10.7 years.

Thirty-four percent of the group said that they were supported by family or friends. Twenty-two percent reported that they supported themselves with jobs, 21% through public assistance, and 15% had no income. Pension and illegal sources of income were each reported by one client,

and four said that they had "other" sources. Forty-one of these clients said that they had no annual income; of the 72% of clients 17 years of age or older, the mean reported annual income was $3,154. The highest income, $13,000 per year, was reported by two clients.

It is very striking that only two clients reported alcohol abuse among their fathers, and only one reported alcohol abuse by the mother. Moreover, only three clients reported alcohol abuse among siblings, although they averaged 0.56 siblings per client (range 0 - 6).

## Referral Sources

Referrals for treatment were from social and community service agencies (31% of clients), relatives (24%), self (12%), probation agencies (10%), and various other services (24%). Reasons for referral included alcohol problems (39%), alcohol and drug problems (35%), and family problems (12%).

## Legal Status

These clients reported a median of 0 and a mean of 2.7 for lifetime arrests (range 0-90). The numerous and extensive client-tracking forms required by the program's funding agencies ask about arrests in several different places. Although 39 clients reported no arrests on one form, 58 reported no arrests on another form. Sixty-four clients stated that they had never had an arrest for Driving Under the Influence (DUI) or Driving While Intoxicated (DWI). Two clients reported one such arrest, one reported two such arrests, and one reported 10. In another form, all 68 clients denied any DWI arrests. Seventy-one percent of clients said they had never spent any days in jail, so the median was zero jail days. However, 8 clients reported spending from 3 to 167 months in jail.

## Admissions Assessments

At admission the counselors considered alcohol the primary or secondary drug of abuse for 90% of clients; marijuana was listed as primary or secondary for 62%. One of these two drugs was primary in all but three cases, in which cocaine, inhalants, or "tranquilizers," respectively, were listed as primary. The primary drug was reported to have been abused a mean of 6.4 years (range 1-30 years). Forty-four percent of clients were considered to have no secondary drug of abuse. For 31%, alcohol constituted a secondary drug of abuse, and for 21% marijuana was a secondary drug. Barbiturates, anti-anxiety drugs, or heroin were the secondary drug problem for each of three patients respectively.

Fifty-nine percent of clients reported no prior alcoholism treatment experience, and 27% had been in alcoholism treatment only once previously. Ten clients had experienced 2 to 12 prior alcohol treatment

episodes. Ninety percent had received no prior treatment for abusing other drugs.

At admission, 22% of clients already were taking disulfiram. None of the others were using drugs commonly prescribed to substance-abusing patients, including methadone, naltrexone, neuroleptics, benzodiazepines, or tricyclic antidepressants.

At admission, 65 clients had never had a blood test for Human Immunodeficiency Virus (HIV). Three had been tested but results were not available to us. All clients denied that they ever had shared hypodermic needles, and only one admitted to prostitution. In a list of signs and symptoms of AIDS or AIDS-Related Complex, only one client complained of fatigue, and one other complained of dry cough. Thus, the risk of drug-related HIV infection in this sample appeared to be low. Similarly, all 68 clients denied that they ever had a history of tuberculosis.

At admission, both clients and interviewers were asked to rate problem severity in several different areas on a 0 (no problems) to 3 (severe problem) scale. Table 1 shows that interviewers rated the problems as more severe than did clients.

Table 1
Mean (±SD) Rating of Problems by Client and Interviewer at Admissions

| | Client | Interviewer |
|---|---|---|
| Health | .35 ( .79) | .90 (1.04) |
| Family | 1.50 (1.22) | 2.54 ( .74) |
| Friends | .94 (1.10) | 2.00 ( .99) |
| Employment or School | 1.10 (1.16) | 2.16 (1.06) |
| Legal | 1.59 (2.02) | 1.71 (1.23) |

Of the 65 clients for whom data were available, 40% reported at admission that they had no current legal problem, and 25% reported severe current legal problems. The others fell between these extremes. The admission interviewers' assessments were that 28% of clients had no legal problems and that 37% had severe problems. None of these outpatients had current commitments under Colorado's Alcohol Commitment Act.

## Treatments and Discharges

At the time of our chart review, 79% of the clients had been discharged and the rest still were registered. On the discharge forms, counselors reported that services used most frequently in treatment were group counseling (43% of clients), individual counseling (35%), and family

counseling (11%). Disulfiram was prescribed for 22%. Discharged clients had received an average of 11.7 hours of services.

Discharge records were somewhat confused because some patients formally had been discharged, others no longer were attending treatment but had not yet been formally discharged, and still others remained active in treatment. However, relative counts of the counselors' stated reasons for discharge remain interesting. Seventy-eight percent of admitted clients had dropped out of treatment; notations included "refused services," "moved away," "left before completed," and "needs not met in treatment." Only two clients were considered to have fully attained the treatment goals, and nine others partially attained those goals.

At discharge, clients were rated on the Indian Health Service (IHS) 9-point scale of alcohol/substance dependence. The scale ranged from Stage 1 ("in withdrawal") to Stage 9 ("{sobriety is a way of life or no problem for one year or more"). Of the 60 clients for whom we had ratings (some provided by counselors after our initial chart review), 73% ranged at discharge from Stage 2 ("compulsive drinking or drug use") to Stage 5 ("some problems related to alcohol or drugs, or building up to abuse"). Twenty-seven percent ranged from Stage 6 ("has a plan for maintaining sobriety but still needs a supportive environment") to Stage 9 ("sobriety is a way of life or no problem for one year or more").

In the IHS scale, Stage 4 is "activities centered on alcohol or drugs, or admits use causing problems." The mean admission rating for the entire group of 68 clients was 4.1 (±1.8 S.D.). The mean discharge rating for the 60 clients so rated was only 4.7 (± SD 1.7).

Counselors' ratings of 1 (severely impaired) to 9 (problem-free for at least one year) were made on IHS forms at admission and discharge not only for alcohol/drug problems, but also for physical, emotional, cultural-social, and "spiritual" problems. The mean across all factors at admission for the 68 clients was 3.76, while the mean for the discharged 60 clients was 3.72.

## Discussion

This report of an effort to provide substance abuse treatment for a group of urban American Indians has obvious weaknesses. The treatment organizations were also the investigators. The data were assessments by counselors who provided the treatment. The method involved retrospective chart reviews. The many forms required by funding agencies resulted in some questions being asked more than once, and discrepancies in answers certainly suggest unreliability in data collection. The extremely infrequent reports of substance abuse in first-degree relatives of these substance-abusing clients are especially suspect.

On the other hand, there are almost no data describing American Indian substance abusers who live in cities. Accordingly, this report may

have heuristic value for formulating future hypotheses about substance abuse among urban American Indians. Some of the factors which appeared to stand out in our data, and which may merit further research, are discussed here.

Difficult Population

Attracting and treating this group was very difficult. The counselors did extensive outreach activities with schools, churches, courts, and other potential referral sources.

The assembled clients were not well equipped for success in the majority society. They were young, of a minority group, desperately poor, poorly educated, medically indigent, and largely unemployed. In addition, many members of the group had criminal involvement.

Moreover, these clients seemed to have little attachment to Indian culture or values. Most had not been raised in Indian communities and did not participate in Indian cultural or religious activities. Most also were at some distance from their own reservations; the group included no representatives of tribes with reservations in Colorado.

With an average age of 24 years, this was a group of mostly younger persons. The clinic was supported by a grant which specified attention to a younger population, and that may have influenced the age distribution. Surprisingly, males and females were about equally represented; in the American general population alcoholism is about four times more prevalent among males than among females (Robbins et al., 1984). The reasons for the unusual distribution here are unclear.

In substance abuse treatment, employment, education, income, and marriage are all considered prognostic factors. By those standards, this was an exceedingly difficult population, with low educational and occupational achievement, extremely low income, and few clients in stable marriages. Moreover, more than 40% of the clients were referrals from social service or probation agencies. These clients infrequently reported prior substance abuse treatment. Although the reasons are unclear, we can conclude that these clients had not actively sought much treatment previously. In addition, in comparison to estimates of the counselors, the clients underestimated the severity of their problems at the time of admission; problems perceived as minor do not effectively motivate change.

We conclude that clients in this clinic were a particularly difficult group to treat. As might be expected, treatment outcome as assessed by counselors was discouraging. Most clients left without completing treatment, and only two were considered to have attained their treatment goals fully. It may be argued that counselors had set unrealistically high goals for this admittedly difficult population, but the high rate of early drop-outs also suggests that, as originally structured, this treatment program had limited beneficial effect.

## Cultural Considerations

Alcohol and marijuana overwhelmingly were the drugs abused by this group. It may be that drug choice is influenced by urban-rural differences, since other investigators have emphasized the extensive use of inhalants by younger American Indians in on-urban settings (Cockerham, 1977; May, 1982; Young, 1988; Cohen, 1977; Young & Lawson, 1986). Moreover, cocaine abuse was spreading through other impoverished minority groups at the time that this study was underway, but cocaine rarely was abused by these clients.

This clinic, with consultation from University substance abuse specialists, was directed and staffed by Indian personnel, so it was very sensitive to these clients' cultural issues. However, few clients had strong ties to Indian culture, and very few practiced Indian religions.

## Research Needs

It would be helpful if future clinical research with substance-abusing American Indians could address the following issues:

First, this program experienced considerable difficulty in attracting clients into treatment. Counselors had to perform extensive community outreach to get referrals; meanwhile, the grant paid for treatment, not outreach. Communication networks, usual forms of media advertising, and other familiar methods for attracting clients had limited value in this project. Moreover, retaining clients was a major problem. Families and social agencies generally were not very effective in maintaining pressure to keep clients in treatment. Clients had shown little previous motivation to enter treatment, and tended to drop-out well before treatment had achieved much.

The need for extensive outreach activities, coupled with many early drop-outs, may indicate that outpatient treatment of the kind offered here is not very attractive to these clients. Novel methods may be needed to draw them into treatment and to hold them there. In other contexts (Crowley, Andrews, Cheney, Zerbe, & Petty, in press) we have paid patients to enter treatment and to modify their drug-using behavior, and such approaches might be appropriate with these impoverished clients. Perhaps future research could examine the hypothesis that these clients would have better outcomes if they were rewarded with food, social services, social activities, or even money for participating in and improving in treatment.

Several factors may be related to the high drop-out rates. One may be the enormous paperwork burden imposed upon the treatment process by funding agencies. The required detailed records were useful in preparing this report, but intruded into the client-counselor relationship; clients come to a clinic to get help and not to fill out forms. Perhaps the collection of such data could cease until those who require its collection have analyzed and published that which now is in their possession.

Second, many programs aimed at American Indian clients emphasize traditional healing practices, including the Sweat Lodge, traditional religious activities, etc. However, most of these urban clients had very little attachment to traditional Indian culture and religion. The effort of having programs staffed by Indians and offering traditional healing practices deserves further research. Some might argue that greater cultural emphasis would improve outcome, while others may suggest that traditional practices would be perceived as irrelevant by urbanized Indians; the issue warrants empirical testing.

Third, it will be important to examine what treatment goals are reasonable for these clients, given their bleak prognostic indicators. In retrospect, clients' individual goals were probably not well defined. Some may have come only because of pressure from an agency, while others may have sought food or shelter, to avoid domestic violence, or simply to associate with a counselor respected in the community. Staff often assumed that the client's goal was, "I want to stop drinking." However, this may not always have been a major motivation. When counselors set goals that cannot be achieved, they become frustrated and clients are not well served. Our review of this program suggests that modest initial goals may be appropriate for such clients. For example, if initial clinic goals were that most patients would stay in treatment for six months, would usually take Antabuse, and would decrease drinking days by 50% during the six-month period, counselors and clients more often might feel successful, and that might contribute to later work on more extensive goals. The value of using such concrete, modest initial goals is empirically testable. Such goals, of course, must be individualized in consideration of patients' different age, tribe, urban/rural residences, etc.

Fourth, future research should focus on the merit of well-defined treatment interventions for this very difficult group. An eclectic mix of behavioral, pharmacologic, counseling, and traditional medicine treatments, together with strong exhortations regarding Alcoholics Anonymous, were employed here (and in many other programs). However, improving outcome will depend upon clarifying the merit of these various components; that requires research with an experimental group which receives the component and a control group which does not.

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