A SURVEY OF VOCATIONAL REHABILITATION COUNSELORS CONCERNING AMERICAN INDIAN AND ALASKA NATIVE CLIENTS WITH ALCOHOL AND OTHER DRUG ABUSE DISORDERS

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Abstract: Vocational rehabilitation (VR) counselors in states where many American Indians reside were questioned about the characteristics of their American Indian clients with alcoholism or drug abuse problems, and the kinds of services that were provided to them. A total of 124 counselors from 14 states responded to the survey. Twenty-seven of these respondents were employed in tribally operated VR projects in nine states.

Alcohol and substance abuse are often viewed as one of the most, if not the most, widespread and severe health problems among American Indians. These health problems contribute significantly to and greatly exacerbate almost every other of their most serious problems (Apodaca, 1984). As a group, American Indians also have a higher alcohol consumption than other ethnic groups or subgroups in the United States (Weisner, Weibel-Orlando, & Long, 1984). The extent of these problems has been reported in detail by many others (Kunitz & Levy, 1994; Vanderwagen, Mason, & Owan, 1986).

A major source of data on this problem is the Indian Health Service. May (1994) reported that an analysis of IHS data from 1986 to 1988 ". . . indicates that 17.0% to 19.0% of all Indian deaths are probably alcohol-related . . . [which is] substantially higher than the general U.S. average of 4.7%" (p.122). This is especially true for the young adults (age 15–34), for whom the death rate due to alcoholism (i.e., alcohol dependence, alcohol psychoses, and chronic liver disease and cirrhosis) is eight times that of the general population (May, 1994, Table 3). Another study showed that alcohol-related diagnoses (ARD) accounted for an overall estimated per annum rate of 13.7% of the adult inpatient days at 43 IHS facilities. IHS discharge rates for ARD over the period of study were three times greater than reported ARD discharge rates for the U.S. civilian population (Hisnanick & Erickson, 1993).

There may also be differences in alcohol metabolism between American Indians and other ethnic groups, though recent reviews of the literature do not support this hypothesis (May, 1989; 1994). Work on the genetics of alcohol metabolism, using different methodologies (e.g., Bower, 1991), have not yet been able to demonstrate any differences among ethnic groups and are concentrating instead on metabolic variations controlled by specific genes in alcoholics vs. nonalcoholics without regard to ethnicity. This work may eventually prove relevant, but the genetic link for alcoholism remains tentative.

In order to avoid the "drunken Indian" stereotype (May, 1989; 1994; Westermeyer, 1974), it is crucial to understand that American Indians are not a homogeneous group and that there are differences both within and between tribes in rates of alcoholism and substance abuse (Stratton, Zeiner, & Paredes, 1978; Young, 1988). Even if there are genetic factors involved, these may vary in frequency within and between groups as well as between Indians and non-Indians. For example, there is considerable variation between IHS areas in the frequency of Alcohol Dependence, Alcohol Psychosis, and Alcoholic Liver Damage diagnoses, from above 6% in the Aberdeen and Albuquerque areas to less than 2% in Oklahoma (Morgan, Hodge, & Weinmann, 1987). Wiesner, Weibel-Orlando, and Long (1984) provided evidence that there is an association between lifelong drinking styles and tribal origin. However, they find that the reasons for this association are complex and that the best predictors of drinking level are sex, age, the models of drinking behavior provided by the family of origin, and psychological stress. They point out that:

> Given the high rates of alcohol consumption and related sequelae in Indians as a group, it is often overlooked that substantial numbers of them do not drink at all or drink in moderation. How do these Indians differ from the heavier drinkers? We are not asking why one tribe drinks more than another or why Indians as a group drink more than non-Indians but rather what characterizes intratribal differences in drinking levels. (p. 237)

It is also true that a number of tribes have given special recognition to some of these problems among their members. For example, alcoholism has been identified by the Health and Human Services Committee of the Navajo Tribal Council as "the leading health problem" among Navajos (Morgan, Hodge, & Weinmann, 1987, p. 80). It has also been cited by the Alaska Native Health Board as "the most serious health hazard" facing Natives and non-Natives in rural Alaska (quoted in Morgan, Hodge, & Weinmann, 1987, p. 91).

Vocational Rehabilitation

Alcoholism poses a problem for the field of vocational rehabilitation (VR). The ratio of American Indians accepted into Rehabilitation Services Administration (RSA) caseloads for alcohol abuse during 1980–1982

was almost 19%, 3.34 times higher than for U.S. general population clients (Morgan, Hodge, & Weinmann, 1987). This does not include cases where alcoholism is considered a contributing, but not the primary disability.

The VR system recognizes alcoholism and substance abuse as disabilities (e.g., codes 520, 521). However, in the Rehabilitation Act, as amended in 1992, an important part of the definition of "individual with a disability" is that it excludes "any individual who is an alcoholic whose current use of alcohol prevents such individual from performing the duties of the job in question" (29 U.S.C. § 706(8)(C)(v), U.S.G.P.O. 1993). In other words, the only clients of this sort who might be eligible for VR services are abstinent alcoholics, and for those reasons find it difficult to get or keep a job. Elsewhere in the Act, specifically subparagraph (C) (ii), the following also are deemed ineligible: alcoholics or drug users for whom their substance abuse has been a substantial impediment to employment (e.g., they were fired from their last job for this reason) who are participating in or have successfully completed a supervised drug rehabilitation program, but have not yet been able to find employment.

Vocational rehabilitation counselors provide numerous services, but *treatment* for alcoholism or drug abuse is not among them. If a client needs such treatment, s/he must be referred to another program. This makes VR counseling different from other kinds of alcohol and rehabilitation counseling. However, VR counselors can provide support, encouragement, and other general counseling services. The main purpose of VR counseling is to determine the barrier(s) to a client's employment, to help the client deal with those barriers, and to assist the client in getting a job. If the barrier is the client's *present* alcoholism, and that is the client's only disability, the legislation appears to preclude his/her eligibility for VR services. If the client is receiving services for another disability and the VR counselor discovers that the client is abusing alcohol or drugs, VR services may be terminated, or suspended, or the client may be referred to an alcohol or drug treatment facility. Meanwhile, the VR counselor *can* support the client's recovery process. If the client has difficulty finding employment because of their *past* alcoholism, the VR counselor can support the client's efforts to maintain sobriety while helping them to find a job. But, again, the VR counselor may not provide "treatment" for alcoholism or drug abuse.

Alcoholism clearly constitutes a substantial barrier to employment. In 1986, a survey of the needs of 117 persons with disabilities living within the Pueblos of New Mexico was conducted by the Native American Research and Training Center, Northern Arizona University. Because of the sensitivity of issues relating to the use of alcohol, the questions had to be worded carefully (Martin & O'Connell, 1986, Appendix E). Nevertheless, the second most frequent reported disability (14%) was alcoholism. Alcoholism programs had been used by 29% of the respondents. Of these, 73% reported having used this resource during the past year. In

most cases (84%), this service was obtained on the reservation. Each respondent was asked to list what they were doing now to help with their disabilities. Ten (10) of the 117 respondents reported going to Alcoholics Anonymous meetings.

A survey of State VR and Blind Service agency administrators in the 27 states with the largest American Indian/Alaska Native populations was conducted in 1987. One of the questions asked (White, 1987) was:

> It is the legislative intent that "the State shall provide VR services to handicapped American Indians residing in the State to the same extent as the State provides such services to other significant segments of the population of individuals with handicaps residing in the State." Section 101(20). What problems or barriers do you foresee in accomplishing this? (p. 156)

Substance abuse was mentioned by all respondents as both a barrier to serving American Indians and as an obstacle to successful rehabilitation (White, 1987).

A multistate survey of 332 vocational rehabilitation counselors subsequently was conducted to assess rehabilitation counselors' perceptions related to working with American Indians with disabilities (Martin, Frank, Minkler, & Johnson, 1988). This survey reported that one-third of the counselors found chemical dependency among their clients was "seldom" to "almost never" manageable during the vocational rehabilitation process. The counselors were also asked to rank which agency personnel were the most important to work closely with in order to provide effective services to American Indian clients. From a list of 22 service providers, the category of chemical dependency counselors was ranked first, as the most important provider (summarized in Marshall, Martin, & Johnson, 1990). The results of this survey indicate the importance of alcohol abuse and dependence in rehabilitation (see also Young, 1986). Moreover, they point to a need for follow-up to provide more information about whether available rehabilitation services adequately meet the needs of these clients.

Methods

Design

The purpose of this study was to determine the perceptions of VR counselors who work with American Indians/Alaska Natives about the magnitude of alcoholism and substance abuse as a problem for their American Indian/Alaska Native clients; how seriously they think it affects rehabilitation outcome; and what, if anything, they think VR should do that can be done under current legislative mandates.

The target population was vocational rehabilitation counselors who work with American Indians or Alaska Natives suffering from alcoholism or

substance abuse as a diagnosed disability. Though national in scope, the study focused mainly on areas of high concentrations of American Indians and Alaska Natives. Data were collected via mail survey. The questions were grouped into six sections: (a) respondent characteristics, (b) special [cultural] issues, (c) caseload characteristics, (d) training background and needs, (e) treatment programs, and (f) aftercare or maintenance therapy. A variety of question types was employed, including open-ended responses, Likert-scaled responses, and various fixed-response formats.

Procedures

To develop the survey instrument, an advisory committee was established consisting of four American Indian VR counselors, four VR program directors, an RSA district program manager, and the superintendent of an American Indian school district who had a background in the treatment of alcoholism. Nine of these were American Indians/Alaska Natives. The authors and the American Indian Rehabilitation Research and Training Center director developed initial drafts of the questionnaire, which was then sent to advisory board members for review, corrections, and comments. The resulting questionnaire was then pilot-tested with four VR counselors (three in-state, one out-of-state). After discussion with these counselors, additional changes were made, and the questionnaire finalized.

Administrators of RSA and Section 130 tribal VR programs were contacted to enlist their support for the survey. If they agreed to participate, they were asked to name a liaison person who would identify appropriate VR counselors to send the survey to. With the assistance of the liaisons, about 300 questionnaires were distributed to VR counselors. In most cases, the liaison person identified only those counselors known to have American Indian or Alaska Native clients with alcoholism or substance abuse as a disability. In some cases, however, questionnaires were sent to a wider range of VR counselors. In these cases, the counselors were expected to decide whether or not they had worked with enough American Indians/Alaska Natives to respond. A cover letter asked them to respond if appropriate. Sometimes follow-up calls were made to the liaison person in order to expedite responses. Counselors were asked in the questionnaire if we could contact them with any follow-up questions. This proved valuable, as some responses were incomplete or unclear. All responses were voluntary, and no payments were made.

Completed questionnaires were entered into a database on an IBM PC using Symantec Corporation's "Q&A" software. The analysis was conducted using this software.

Results

A total of 124 VR counselors from 14 different states responded to the survey, a response rate of about 40%. These included 39 who were American Indians or Alaska Natives, representing about 20 different tribes. Fifty-three (53) of the counselors had more than 12 American Indians/Alaska Natives with alcoholism or substance abuse disabilities (primary, secondary, or tertiary) on their case load. Although it is impossible to be sure why 60% of those who were sent questionnaires did not respond, the most likely reasons were (a) they hadn't worked with enough American Indians or Alaska Natives who had alcoholism or substance abuse disabilities, (b) they didn't have time to complete the questionnaire, (c) some of the questions were too difficult, or (d) they thought their time was better spent working with clients rather than answering questionnaires. The biggest limitation of this data is that about half of the sample had worked with only a few (less than 10) American Indians or Alaska Natives who had alcoholism or substance abuse disabilities. Their inclusion reflects the reality that American Indians with alcoholism or drug abuse problems are often assigned to VR counselors who have little experience with this population.

Casework

Respondents were asked to rate aspects of their relationships with clients who have alcoholism/substance abuse problems. The ratings were on a Likert scale from 1 = Always to 5 = Never. Their responses are presented in Table 1.

Respondents were asked about the minimum amount of time they required that a client be detoxified or abstinent before beginning to implement VR services. Their responses are tabulated in Table 2. About one-third (34%) said there was no minimum period. Almost as many (29%) indicated one week to at least two months; virtually the same number (29%) indicated at least 3 to 6 months. Another 9% indicated that it would depend on various other factors.

Respondents were then asked what VR services their clients with alcoholism/substance abuse usually received for this disability while a client of their agency, and how these services were funded (Table 3). These services are standard categories used by VR counselors and defined by the Rehabilitation Services Administration pursuant to Title I of the Rehabilitation Act of 1973, as amended through 1992 (see 29 U.S.C. 723). The services most often received were Counseling and Guidance, and Assessment. Counseling and Guidance was the service most likely to be provided directly; Assessment was the most likely to be purchased, and Assessment and Restoration were the services most likely to be received as a similar benefit. "Similar benefits" are those benefits or services not

Table 1
Relationship With Clients

Item	Total n	Mean Rating	Mode	Standard Deviation
Honesty & directness	123	1.41	1 (Always)	0.66
Encourage client to be more responsible, productive and self-reliant	123	1.46	1 (Always)	0.71
Being a "sober" model, a "straight" authority figure	121	1.67	1 (Always)	1.01
Awareness of information & other services which can be useful to the client	123	1.70	2 (Usually)	0.67
Personal warmth & empathy, along with firmness	122	1.73	2 (Usually)	0.72
An evaluation of the client Communicating a reality-based, ordered	121	1.78	1 (Always)	0.88
disciplined & responsible way of life	120	1.81	1 (Always)	0.85
Ability to set limits	122	1.81	2 (Usually)	0.69
The ability to listen without judging	124	1.84	2 (Usually)	0.79
Ability to confront potentially destructive thinking or behavior	123	1.85	2 (Usually)	0.74
Educated & informed compassion & emotional support (without "enabling")	119	1.86	2 (Usually)	0.68
Awareness of choices that the client may not see	121	1.88	2 (Usually)	0.71
Time and availability	122	1.90	2 (Usually)	0.92
Interpreting evaluations of others for client	120	2.32	2 (Usually)	1.10
Family therapy	123	2.85	2 (Usually)	1.18
Native healing or diagnosis	117	3.84	5 (Never)	1.15

Table 2
Minimum Period of Sobriety Before Implementing Services

Minimum period	N	%
No minimum	40	34%
At least one week	2	2%
At least one month	21	18%
At least two months	10	9%
At least three months	23	20%
At least six months	10	9%
Depends	10	9%
TOTAL	116	

Table 3
VR Services

VR Service	Provided directly	Purchased	Similar benefit	Total
Counseling & Guidance	2.72	1.13	1.36	1.99
Assessment	2.14	1.92	1.72	1.93
Adjustment counseling	2.09	1.28	1.40	1.64
Job referral	2.03	1.32	1.29	1.63
Job placement	1.70	1.39	1.24	1.48
Transportation	1.49	1.32	1.	1.48
Restoration	0.87	1.23	1.77	1.34
Business/Vocational training	0.82	1.43	1.46	1.30
College/University	0.64	1.36	1.48	1.24
On-the-job training	1.02	1.26	1.40	1.23
Maintenance	1.34	0.86	1.38	1.20
Miscellaneous training	0.98	1.20	1.17	1.13
Independent Living	0.89	0.76	1.15	0.93

Response format employed the following alternatives:

3 = always; 2 = often; 1 = sometimes; 0 = never

administered by the VR Program for which VR clients are eligible and which are either available from sources other than the VR Program, or are similar to, or the same, as VR Program services. These are services which would be provided by the VR Program if not otherwise available. Responses were scored on a three-point scale from "Always" (3) to "Never" (0). Table 3 depicts the mean response in each cell.

Training Background and Needs

Most (85%) of the respondents had training in alcohol or substance abuse counseling, but one-third (38, 31% of the total) wanted more training. The areas of training of greatest interest were, in order of descending importance:

1. Legal issues relating to the disability status of American Indian/ Alaska Natives who have problems with alcoholism/substance abuse, under the Rehabilitation Act of 1973 as amended (77%).
2. Use of supportive services in IWRP development to improve chances for successful rehabilitation (65%).

3. Learn how to identify and counsel clients who have functional limitations affecting employment, with alcoholism/substance abuse as a secondary or "hidden" disability (64%).

4. Evaluate whether or not their applicant or client can benefit from treatment programs in their area (58%).

The most popular media for reviewing such information were workshops (81%) and videotapes (52%). Other media considered useful were newsletters (31%), manuals (28%), brochures (22%), and audiotapes (14%).

Treatment Modalities

Most VR counselors (101, 81%) thought that treatment modalities for American Indians and Alaska Natives who abuse alcohol and other substances sometimes need to be different from treatment modalities for other clients. The most highly rated treatment models are indicated in Table 4. All were rated either excellent or good by most of the respondents who had some knowledge of these treatment modalities. (Ratings were based on a four point scale ranging from A = excellent = 4 to D = Poor = 1). However, the two most highly rated treatment modalities were much less well-known than AA/NA, which was mentioned by 94 (76%) of the counselors, compared with 65 (52%) who were able to rate 28-day

Table 4
Rating of Treatment Models

Treatment Model	Total n	Other*	Mean rating	Mode	St. Dev.
Native American traditional healing	37	34	2.84	3 (Good)	.82
28-day Hazelden/Minnesota/AA	65	20	2.82	3 (Good)	.76
Outpatient: AA/NA	94	8	2.77	3 (Good)	.76
Residential therapy program	53	21	2.72	3 (Good)	.79
Native American Church	28	37	2.64	3 (Good)	.81
Spiritual or religious programs	46	23	2.61	2 (Fair)	.82
Outpatient employee assist. prog.	43	30	2.54	3 (Good)	.82
Psychiatric/Psychological models	66	12	2.49	3 (Good)	.72
Behavioral approaches	34	33	2.47	2 (Fair)	.92
Outpatient drug-free program	57	21	2.46	2 (Fair)	.68
Outpatient:Methadone	40	31	1.98	2 (Fair)	.88

*Some mark (e.g., a comment) other than a rating was written.

Table 5
Elements of Treatment

Elements of Treatment	Total	Other*	Mean rating	St. Dev.
Encouraging responsibility	98	14	3.051	.84
Individual sessions	96	18	3.000	.75
New support networks	90	22	2.856	.89
Group sessions	91	21	2.824	.87
Support regarding relationships	94	19	2.819	.81
Suggesting healthier choices	98	15	2.806	.83
Confrontation	94	19	2.766	.82
Drug education	94	19	2.745	.89
Family counseling	90	23	2.744	.94
Encouragement regarding feelings	99	14	2.737	.89
Promotion of abstinence	98	15	2.735	.95

*Some mark other than a rating was written.

Hazelden or Minnesota model inpatient treatment programs and 37 (30%) who were able to rate Native American traditional healing methods. The lowest rating was given to Methadone maintenance programs, which were rated fair to poor by 73% of the counselors who had some experience with them.

VR counselors were then asked to rate 11 elements of treatment for American Indians and Alaska Natives who had alcoholism or substance abuse disabilities (see Table 5). The rating scale was based on A = Excellent = 4, B = Good = 3, C = Fair = 2, D = Poor = 1. An "X" was used rather than a rating if "you didn't know, or have no experience with a particular element of treatment." These responses are recorded in the "other" column. This question likely reflects the perceived value of such elements clients might receive in an alcoholism or drug abuse treatment center, rather than the counselors' own work with clients. However, some counselors may have interpreted the question in terms of their own counseling experiences with clients. In either case, it is likely that clients receive multiple elements of treatment. The counselors were not asked about multiple forms of intervention or combinations of elements of treatment.

Most counselors (n = 85, 69%) indicated that there was a program within a 100 mile radius of their office that is specifically designed to serve the needs of American Indians and Alaska Natives who have alcoholism or substance abuse as a disability, but less than half (44%) were satisfied with these programs. Nevertheless, when asked if they knew of a "good" treatment program for these clients, the names and addresses of about 50 treatment programs were offered, although few were mentioned by more than one respondent.

Aftercare

When asked what aftercare programs were most important in helping a client maintain sobriety and/or abstinence, the most common answer was Alcoholics Anonymous (n = 34), which received a "good" rating (mean = 2.77, max = 4.00). However, there was a wide variety of responses to this open-ended question.

Discussion

A diverse sample of 124 VR counselors from 14 states responded to the survey. About one-third were American Indians, representing 20 different tribes. Fifty-three (53) of the counselors had more than 12 American Indians/Alaska Natives with alcoholism or substance abuse disabilities (primary, secondary, or tertiary) on their case load. In their relationship with these clients (Table 1), the dominant attitude of these counselors was "honesty and directness." The primary methods of dealing with these clients, given their history of addictive behavior, was to "encourage client to be more responsible, productive and self reliant," and "being a 'sober' model, a 'straight' authority figure." However, "using family therapy", or "Native healing or diagnosis", ranked lowest among the 16 aspects of counseling which they were asked about.

These counselors were also asked to rate eleven (11) treatment elements (see Table 5). All received favorable ratings, and had been used by at least 72% of the counselors. The highest rating was given to "encouraging responsibility," consistent with their relationship with their clients. Individual sessions were rated more highly than group sessions, but not by much ($t[178] = 1.48$, $p = 0.14$). In general, differences in mean ratings were small. More significant is that all treatment elements received favorable ratings, on the average, by those who had used them. Conversely, treatment elements were not rated by a significant number of counselors (20–30%)—either because they hadn't used them, or because they felt they could not rate them for some reason. This *may* indicate a need by some counselors for training in these areas.

Respondents were asked to what extent "family therapy or counseling" characterized their relationship with their clients, and also about family counseling as an element of treatment. The relatively low rankings may suggest that counselors need to know more about the benefits of family counseling for such clients. However, it may also be that alcoholic family members are regarded as part of the problem, and a case beyond the scope of the counselor's duties, especially if the family member is in denial about his/her drinking problem.

When asked about the minimum amount of time they required that a client be detoxified or abstinent before beginning to implement VR services, about a third said they require no minimum amount of time. The time periods required showed a multi-modal distribution, with 20% requiring at

least three months, and 18% requiring at least one month. About 9% of the counselors responded that the minimum time they would require "depends" on other factors. Given that federal legislation appears to require that potential VR clients need to be at least in treatment, if not abstinent, before being eligible for VR services, this finding is evidence of a high degree of variation in practice. Perhaps for this reason, the greatest interest in additional training was with respect to legal issues relating to the disability status of American Indians and Alaska Natives who have problems with alcoholism or substance abuse, under the Rehabilitation Act of 1973, as amended.

VR Services

Results summarized in Table 3 suggest that American Indians/Alaska Natives with alcoholism/substance abuse disabilities may not be receiving all of the support services they need. For example, maintenance services tend to be provided only "sometimes," whereas the odds of rehabilitation might be substantially improved if these services were provided "often." On-the-job training also seems underutilized. In addition, some funding options appear to be underutilized. For example, college/university training and business/vocational training are rarely "provided directly."

From the viewpoint of rehabilitation counselors, the question is often one of how best to use scarce service dollars. The reality is that for most, their performance will be evaluated on the basis of how many cases they successfully close. This sometimes means that clients whose recovery from drug or alcohol abuse has not stabilized may be seen as less likely to benefit from VR services than other clients. Consequently, VR agencies are loathe to serve such clients. However, if it can be shown that certain ways of providing services to these clients result in the same chance of successful closure as other clients, then more American Indian clients with alcohol or drug abuse problems could benefit from VR services.

Treatment Modalities

Most (81%) of the VR counselors thought that treatment modalities for American Indians and Alaska Natives who abuse alcohol or other substances sometimes need to be different from treatment modalities for other clients. But VR counselors cannot themselves provide treatment for alcoholism or drug abuse. Instead, if the VR client is not already in treatment, the VR counselor can refer a client for treatment elsewhere. Thus, the list of VR services provided in Table 3 does *not* include alcoholism or drug treatment modalities. The most highly rated treatment modality was familiar to less than one-third of the counselors: Native American traditional healing (30% of counselors). Thus, a major need is to make sure

VR counselors who work with American Indians suffering from alcohol or drug abuse disorders are aware of American Indian/ Alaska Native traditional healing programs in their area. The second most highly rated treatment modality was that provided by the 28 day Hazelden or Minnesota model inpatient treatment program (52% of counselors). The AA/NA program, really a support group rather than a "treatment" program, was the most widely familiar (76% of counselors); it received the third best rating.

Such differences in familiarity may be primarily due to availability: as a grass-roots support group, AA/NA requires a minimum of expense, and is available wherever at least two confessing drug abusers wish to meet. Consequently, AA or NA groups exist in virtually every community. The Hazelden or Minnesota model inpatient program, however, requires facilities, staff, funding, etc., so are fewer in number and not always close at hand. Even less well known are programs based on Native traditional healing. They are probably less well known because they do not advertise themselves or the methods used in ways likely to come to the attention of VR counselors. This points to a need for better information about what "traditional healing" means for American Indians and Alaska Natives who have problems with alcohol or drug abuse, and where such options are located, admission and eligibility requirements, etc. Furthermore, this information needs to be packaged in a form useful for VR counselors.

Conclusions

Although the available literature on the vocational rehabilitation of American Indians who have alcohol or drug abuse as a disability is not extensive, it is clear that counselors are very sensitive to the importance of this issue, but often feel ill-equipped to deal with it. Furthermore, except for Alcoholics Anonymous, they have little idea of where to turn for help. Alcoholics Anonymous is cited more often because it is well known than because of evidence of its effectiveness with this special population. AA is not a treatment program, but a support group whose principle of anonymity limits its usefulness as a treatment program. For example, there are no records kept which a counselor can obtain to certify treatment—or even attendance. Some counselors try to compensate for this by asking their client to identify their AA sponsor, and then solicit progress updates from the sponsor. However, this practice violates the AA principle of anonymity. Although there are hundreds of treatment centers for American Indians, little research has been conducted which identifies successful approaches to treatment of American Indians in a way which meets scientific standards.

This survey is consistent with Guyette's (1982) finding that a majority of the treatment population preferred a combination of Native healing practices and Western treatment strategies. That is, although there was widespread support for the AA model, the highest-rated (but

less well-known) treatment model was Native traditional healing. In addition, most counselors thought that treatment modalities for American Indians/Alaska Natives who had alcoholism and other substance abuse problems sometimes need to be different from treatment modalities for other clients. This is similar to Duran's approach (1990), and to Weibel-Orlando's (1989) "Syncretic Model," in which:

> Indian values and ceremonial curing practices are incorporated into standard alcoholism intervention strategies. Western treatment programs such as Alcoholics Anonymous are stressed although certain structural or substantive changes may be made so as to make the meetings "more Indian." Non-Indian treatment strategies are employed in conjunction with traditional Indian spiritual guests, curing rituals, and reidentification with one's tribal origins and beliefs (Weibel-Orlando, 1989, p. 134).

Finally, the state of the vocational rehabilitation of American Indians for alcoholism or drug abuse problems is revealed in the kind of training counselors desire. Although most respondents had training in alcohol or substance abuse counseling, one-third of them (n = 38, 31% of the total) wanted more. Conversely, about two-thirds of them were either satisfied with the training they had, or were not optimistic that additional training would help. In view of the notorious difficulty of vocational rehabilitation with these clients (documented in the introduction), the latter seems more likely. The extent to which counselor frustration and cynicism constitute barriers to rehabilitation has not been resolved and deserves further inquiry.

Recommendations

As a result of these considerations, a number of recommendations can be based on the results and the discussion:

1. *Design training workshops in areas of expressed interest.* Workshops could be videotaped for further distribution, since a majority of respondents indicated some interest in this training medium. In addition to the four areas of training identified previously, the following might be offered: (a) effective utilization of maintenance and on-the-job training services for the VR of American Indians/Alaska Natives with alcoholism/substance abuse, and (b) relevance and value of college and university training and business and vocational training to American Indians/Alaska Natives recovering from alcoholism/substance abuse.
2. *Identify and publish information about exemplary treatment programs of the "Syncretic" type.* This type of treatment program was identified in an earlier study of urban treatment programs as the type preferred by urban clients (Guyette, 1982). It also fits the profile

of treatment programs that the respondents in the present survey rank most highly.

3. *Alternatives to the requirement for three months' abstinence before implementing VR services are needed.* Too often this requirement screens out applicants who seek help. Legal issues can be a factor here, but as long as the applicant is *in recovery*, he or she can receive services. No 90-day waiting period is required. Counselors may need guidance on how to deal with this issue. When embarking on abstinence, an applicant needs support and reinforcement. Support in the form of career counseling, family healing therapy, etc., can motivate the client to remain abstinent and to prepare him or her for success with other VR services.

4. *VR counselors with expertise should be given specialty caseload responsibilities.* That is, counselors with special training, knowledge, and interest in substance abuse and knowledge of how to work with American Indian/Alaska Native clients should be encouraged to specialize in working with American Indians/Alaska Natives with alcoholism/substance abuse. The underlying cultural, psychological, social, and economic factors require special expertise that is usually needed for dealing with these clients.

Future Research

Much remains to be done with the data collected for this paper. For example, does counselor caseload experience, or ethnicity, influence the results? We intend to examine these and other issues with the present data.

Using the treatment centers identified by counselors in this survey as exemplary for the treatment of American Indians and Alaska Natives, we have conducted a follow-up survey of these treatment centers, and are preparing a report on the results. The purpose of this survey was to try to identify factors which promote success in treatment. Also, since so many treatment centers describe their methodology as "based on" AA, we hope to reveal what that means.

Lastly, we have sent a follow-up survey to the same counselors, focusing on counselor/client interaction. The purpose of this survey is to identify barriers in counselor-client interaction, and to explore ways to improve the interaction to promote successful and cost-effective rehabilitation.

Finally, a methodological analysis of alcoholism treatment approaches (Hester & Miller, 1995), published after this study was conducted, has suggested that a radical rethinking of conventional treatment is needed. They found that ". . . a number of treatment methods were consistently supported by controlled scientific research. On the other hand,

we were dismayed to realize that virtually none of these treatment methods was in common use within alcohol treatment programs in the United States." However, ". . . there is no single treatment approach for alcohol problems that is superior to all the others" (p. xi). Furthermore, "without a single exception, the studies failed to show any advantage for the more intensive, longer, or residential approaches over less intensive and less expensive alternatives" (p. xii). The success of AA modalities, partly as a consequence of anonymity factors, cannot be effectively evaluated at this time because of the lack of adequately controlled trials (Miller et al., 1995, p. 31). The most successful treatment methods, as measured by their "cumulative evidence scores," were (Miller et al., 1995, p. 18):

1. Behavioral Intervention
2. Social Skills Training
3. Motivational Enhancement
4. Community Reinforcement Approach
5. Behavior Contracting.

However, these ratings were for treatment methods in general, and not specifically for American Indians. Future studies should investigate the use and effectiveness of these methods with American indians, along with finding a way to evaluate the effectiveness of AA, or its various elements ("steps").

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