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Exploring Culturally Based Treatment Options for Opioid Use Disorders Among American Indian and Alaska Native Adults in California

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ABSTRACT. Objective: American Indian and Alaska Native (AIAN) communities have been severely affected by the opioid epidemic, resulting in high opioid overdose death rates and disrupted community life. An added complexity is the diversity of AIAN communities throughout California, with regional differences, resources, infrastructure, and economic opportunities. This study examined the perspective of 163 AIANs in California to assess culturally based or traditional healing treatment modalities to treat opioid/substance use disorder. **Method:** A total of 21 adult focus groups were conducted throughout 10 counties in California reaching 20 urban and tribal communities. Eight of these focus groups were conducted in recovery centers and 13 focus groups were conducted in tribal and urban organizations. Interviews were transcribed and coded using NVivo software utilizing an iterative coding approach with a priori domains. **Results:** Participants emphasized building a sense of belonging, connecting with their culture, and having awareness of substance use disorder and treatment as protective factors. **Conclusions:** Findings indicate that medications for opioid use disorder programs serving AIAN communities should include cultural components that resonate with urban and tribal communities. (*J. Stud. Alcohol Drugs, 83,* 613–620, 2022)

AMERICAN INDIAN AND ALASKA NATIVE (AIAN) populations are disproportionately impacted by the opioid epidemic, with higher overdose death rates than other racial and ethnic groups in the United States. From 1999 to 2013, AIAN opioid overdose-related deaths had a four-fold consistent increase (Tipps et al., 2018; Zeledon et al., 2020). Between 2013 and 2015, AIAN communities suffered an overdose death rate 2.7 times higher than White Americans and experienced higher rates of mortality from polysubstance abuse (Calcaterra et al., 2013; Planalp & Lahr, 2017). In California, AIAN populations have the highest age-adjusted rate for opioid-related overdose deaths in the state (11.57 per 100,000 residents) compared with other racial/ethnic groups (Joshi et al., 2018). There are a number of contributing risk factors to the disproportionately high rates of substance use among the AIAN population. These include and are not limited to family history of drug or alcohol use, experiencing high levels of stress, comorbid mental disorders, discrimination, living in poverty, inadequate healthcare, and historical and intergenerational trauma (Ehlers et al., 2020; Mitton et al., 2020; Skewes & Blume, 2019).

Resiliency factors of California AIAN communities

California is home to more than 700,000 AIAN residents living within 109 federally recognized tribes, 45 tribal communities, and in urban areas (State of California, 2022). California AIAN communities face unique historical trauma from the widespread disease, discrimination, genocide, dispossession of lands, relocation, forced removal of children into Indian boarding schools, and destruction of traditional ways of life occurring since initial European contact (Dickerson et al., 2021a; Guenzel & Struwe, 2020). The cumulative effects of historical trauma have led to adverse responses that persist through individuals, family systems, and community members across generations and a disruption of traditional and cultural values within AIAN communities (Evans-Campbell, 2008; Walters et al., 2011).

Despite these pervasive stressors, studies have found that AIAN people with higher levels of cultural connectedness (variedly operationalized) had better mental health outcomes that did those with lower levels of connectedness (Kading et al., 2015; Snowshoe et al., 2015, 2017). AIAN cultural tra-

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ditions prioritize holistic approaches to healing where wellness is an alignment of emotion, mind, body, and spirit and where AIAN cultural traditions are embedded with lessons of character strength, resiliency, reciprocity, and connection with the community (Gone et al., 2017; Isaacson et al., 2018; Wendt & Gone, 2016). For adolescent youth, studies have found enculturation (cultural connectedness), spirituality, and a sense of belonging to be protective factors (Hilton et al., 2018; Masotti et al., 2020; Wexler et al., 2015). Studies using cultural interventions in the treatment of addiction have validated the feasibility of these interventions, and preliminary outcomes show favorable results in reducing or eliminating substance use problems (Gone, 2010; Gone & Calf Looking, 2015; Henson et al., 2017; Masotti et al., 2020; Rowan et al., 2014; Wexler et al., 2015).

Integration of cultural and Western treatment modalities for medications for opioid use disorder

Current U.S. Food and Drug Administration–approved medication-based treatments for opioid use disorder (OUD) include methadone, buprenorphine, and naltrexone. Medications for opioid use disorder (MOUD) decrease overdose events and overdose mortality by 50% (Bart, 2012; Bell & Strang, 2020; Chou et al., 2016; Winograd et al., 2019). The standard of care for treating complex MOUD cases is a combination of pharmacology and behavioral health treatments (Sofuoglu et al., 2019). Studies have found that evidenced-based behavioral health treatment modalities can increase motivation in the early phases of MOUD treatment (e.g., motivational interviewing modalities) and assist with building coping skills to remain in treatment (e.g., cognitive behavioral therapy), which in turn increases both retention in treatment and abstinence rates (Amrhein et al., 2003; Carroll & Weiss, 2017; Copenhaver et al., 2007; Dickerson et al., 2018; Veilleux et al., 2010).

Strategies reported in the literature to successfully integrate AIAN culture alongside Western treatment modalities include implementing specific cultural practices, culturally adapting existing treatments, or designing services that are imbued with AIAN foundational beliefs and values (Legha & Novins, 2012; Zeledon et al., 2020). Current culturally integrated interventions for OUD treatment include holistic approaches that package MOUD with cultural practices (e.g., talking circles, smudging, drumming, ceremonies) and culturally centered behavioral health services (e.g., cognitive behavioral therapy, motivational interviewing, or 12-step programs) facilitated by AIAN community members (Dickerson et al., 2018; Mpofu et al., 2021). Although there are limited randomized control trials studying the outcomes of these integrated interventions, initial studies found that culturally adapted MOUD treatments yielded improvements in psychosocial distress, increased substance abstinence, and increased adherence to MOUD treatment at 6-month follow-up (Dickerson et al., 2021b; Forcehimes et al., 2011; Klein & Seppala, 2019; Moore & Coyhis, 2010; Novins et al., 2011; Rieckmann et al., 2016; Venner et al., 2018).

Purpose of the study

The purpose of this study was to examine the perspective of California Tribal and Urban Indian populations, both in active recovery and in the community to assess (a) resiliency factors, (b) services available for OUD treatment, and (c) recommendations to integrate Western and cultural treatment modalities. Exploratory differences among urban and tribal communities were also examined.

Method

Research design

Our study methods used a participatory action research approach design and implementation process to ensure the engagement of AIAN community members and agency partners in all aspects of the research process. The needs assessment team included members from two academic organizations and four community-based organizations. Weekly meetings were held from June 2018 to December 2018 to create and pilot the needs assessment tool, recruit, and collect data from various AIAN communities throughout California (see Appendix Table 1). Additional information including demographic information, focus group instrument and tables of findings are available in the Appendix. A total of 15 organizations across California, including community-based organizations and Indian Health Services programs, were engaged for active recruitment of focus group participants. The research design used talking circles as a culturally informed focus group format to create a safe space and establish trust among participants and facilitators (Bohanon, 2000). All scripts, semistructured interview tools, surveys, protocols, and procedures were approved by the University of Southern California Institutional Review Board.

Participants

Focus groups were conducted among adults (18–65 years) who met the selection criteria of (a) self-identifying as American Indian or Alaska Native, (b) either being impacted by OUD in their community or actively being in OUD recovery, and (c) residing in a local AIAN community (e.g., Tribal Land) or being affiliated with one of the 15 AIAN partner organizations. These 15 AIAN community organization partners located in tribal areas and urban settings were the initial thread of snowball sampling. Participants resided across 12 California counties: Alameda, Fresno, Humboldt, Inyo, Lake, Los Angeles, Mendocino, Riverside, Sacramento, San Diego, Sonoma, and Tulare. A total of 21 adult focus

groups (N = 163) were conducted. Eight of the focus groups were conducted within recovery centers (e.g., residential treatment or sober living homes) and 13 focus groups were among community members who experienced the impact of OUD. A total of 55% (n = 89) of participants self-reported as in active recovery. Forty-seven percent of participants reported as male and 45% reported female. The majority of participants (87%) reported identifying as AIAN, 5% did not report their AIAN identity, and 14% selected "other" in the focus group survey. However, we decided to include the data from all participants regardless of survey AIAN self-identification because these participants clearly identified with the target community and were affiliated with AIAN organizations that provided services only to those who self-identified as AIAN (Appendix Table 2). For the privacy of participants, the organizations, tribes, and rancherias (small tracts of California Indian land under federal trust that is home to members of in-state and out-of-state AIANs) that participated in this study are blinded.

Procedure

In collaboration with our community-based partners, we drafted an initial focus group semistructured guide that was modified and finalized through feedback received from a pilot study. The focus group guide included the following a priori domains: (a) resiliency factors, (b) OUD services available, (c) acceptability of services, (d) barriers to accessing services, (e) risk factors, and (f) cultural service needs. Facilitators were either AIAN study staff members or partners from local organizations trained in focus group facilitation. A notetaker accompanied the facilitator to capture field notes. Based on the participant's request, each focus group was initiated with an icebreaker and/or a prayer using sage or cleansing with a local traditional smudge.

Participants completed a survey of demographic information (e.g., age, sex, gender, sexual identity, substance use, active recovery from substance use, and geographic location). All participants signed consent forms and were awarded a $30 gift card incentive for participation.

Data analysis

Focus groups were audio recorded and transcribed using a professional transcription service. Transcripts were validated to ensure accuracy. Data were analyzed using NVivo software (QSR International, Chadstone, VIC, Australia). A codebook was created based on a priori domains and, within each domain, an inductive approach was used to analyze emerging themes. The preliminary codebook was created by a team of five researchers. To refine and finalize the codebook, two researchers coded a sample of five focus group transcripts. Then, weekly coder meetings were held to discuss codes and reach consensus until 90% reliability was established. The inclusion criteria for key themes included either high frequency (i.e., reported in three or more focus groups) or high significance (i.e., low frequency but deemed impactful by the research team), and saturation of themes was discussed and established. Because of the robustness of the data, this study focuses on resiliency factors, OUD services available, and cultural service needs, including recommendations for integrating Western and cultural services (see Appendix Table 3). Each focus group was categorized by their recruitment setting (either active recovery or community based). Then, we used the NVivo Comparison Diagram functionality to compare the differences and similarities in emergent themes between the two groups.

Results

Resiliency

The resiliency a priori domain identified protective factors to prevent OUD or support OUD recovery. Participants consistently discussed (a) building community and increasing connection, (b) returning to cultural values, and (c) increasing community awareness of OUD for prevention and to assist in recovery (Appendix Table 4).

Building community and connectedness. Participants in both urban and tribal settings expressed the importance of being connected and engaged in their community as a preventative factor for substance use initiation. Building community was defined as maintaining interpersonal relationships outside of the family circle and participating in community-based organizations or events and was referenced in 64 passages across all focus groups.

Participants in active recovery shared the importance of interpersonal relationships that fostered feelings of connection and bonding with community members. The feelings of familiarity among community members were viewed as protective. Participants described that community interconnectedness provided additional support outside of the family circle. This support included positive role models, advice, and tangible or emotional assistance during the recovery journey. In regard to positive role models, a participant in active recovery described their desire to participate in substance use prevention for younger youth as follows:

> For me to look some kid in the eye and say, "I was just like you at your age, and I made these choices because I did these things," it would give him a thought in the future when that situation ever occurred, that they would know to make the right choice or whatever. You know, they, they at least think about it and have the choice to make . . . . (Active Recovery FG2)

Emphasizing cultural values. An important component of community building included reinforcing and returning to cultural values. Even though participants acknowledged that cultural traditions among AIAN tribes varied across

regions, a unifying theme throughout the focus groups was that Native traditions contained embedded, beneficial life lessons and values. Most participants regarded AIAN values as wholesome, emphasizing sobriety, connection to and stewardship of the land and AIAN people. Most participants agreed that AIAN communities needed reconnecting with their spirituality and cultural values, or, in the case of youth, they needed to be introduced to the history, traditions, and stories of their ancestors.

Cultural values were reported in 33 passages across all focus groups as protective against substance use disorders by (a) promoting a sober and connected way of life (to creator, land, and others), (b) providing alternative activities to overcome addiction, (c) creating a support system rooted in their community, (d) increasing self-awareness, (e) bolstering identity, and (f) serving as therapeutic modalities (e.g., drumming or dancing).

Participants described the importance of culture in active recovery as follows:

> I think having our culture plays a major role in our recovery because it gives us something to turn to when we're down and when we're hopeless. It gives us the strength and the ability to know that we are capable of beating this illness or at least making it another day. I know myself I [didn't] practice my culture for a major part of my life. I had nothing. I felt like I was lost. That's one thing I've been hoping to regain here [. . .] Here's something you turn to. So I won't feel so alone out there. Like I said, for me, it's a major factor, it's a major role in my progress and recovery. (Active Recovery FG 4)

Community awareness of OUD. Another protective factor for OUD reported by participants included community awareness of (a) services available to prevent or treat substance use disorders, (b) knowledge of substance use disorder as a disease, and (c) how to best help an individual with a substance use disorder. Participants suggested increasing the visibility of substance use treatment or prevention programs available in the community, either through word of mouth, flyers, brochures, or active advertisement. A key to decreasing stigma, as reported by participants, involved community awareness, knowledge, or understanding of substance use disorder as a physical disease and building understanding of how OUD can be passed down generationally, create family dysfunction, and strategies to best support a loved one in recovery.

Participants advocated for substance use disorder education as follows:

> A lot of people [are] not getting treatment for mental health and then just substituting [it with substances] because of not having the understanding or even a diagnosis of what's going on with them. I'm not saying that they need to be on [prescribed medications], but to understand what's going on with them inside and outside. Education and treatment, and it doesn't always necessarily have to be medicated [pharmaceutical] treatment. [FG 4]

OUD services available

Participants were asked about services available in their community to treat substance use disorders. Although access and quality of services varied, most focus group participants reported assorted access to the following services: (a) Western and culturally adapted 12-step programs, (b) pharmacotherapy, specifically MOUD, (c) behavioral health treatment centers, (d) Native treatment centers, (e) counseling services and programs, (f) inpatient or residential treatment, (g) sober homes, (h) traditional services, and (i) parenting classes. Ancillary programs were reported as pivotal in aiding recovery. These included parenting classes and community-based programs. Many community-based programs offered a safe space to organize gatherings and the opportunity to participate in culturally centered activities, such as making regalia, beading, and drumming (see Appendix Table 5).

Participants described the importance of culturally centered activities as follows:

> You know, ceremonial classes where we sit and really just talk about ceremony, what it's about, how it works, why it exists and, and things like that. We get a little bit of that here, but I don't feel like it's enough. [FG 2]

Motivation to engage in recovery services. An important theme that emerged when discussing services and their access revolved around an individual's motivation to engage in those treatment and recovery services. Participants with previous substance use disorders shared how negative consequences of substance use disorders, especially when it led to family disruption, motivated them to seek recovery services. Many participants discussed the concept of readiness—for many this was a "rock bottom" experience, a concerned family member or friend that provided compassion and accountability, or an internal desire to change their circumstance. Some described entering recovery services through the judicial system or without their ability to feel "ready." This resulted in not benefiting as much from the services and/or not being able to complete treatment.

One participant described this "readiness" as follows:

> You got to, you got to want it more than anything, whatever you're doing . . . it's a big thing for me to wake up every morning to go to my job and do anything, you know. It's just most people don't have that opportunity, or they don't think they do, and so they're just going to stay at home and not try to get help. [FG 10]

A majority of participants reported that feeling "ready" to engage in care was the starting point to seek out recovery services and that recovery was a very individualized experience. To address this, many participants recommended providing multiple opportunities to engage with recovery services.

Relapse management and maintenance. Similarly, to the concept of readiness, many participants reported that treatment adherence was an individual process with relapses occurring along the way. Participants in active recovery

discussed strategies to manage relapses, including entering sober living homes, removing themselves physically from family members with substance use disorder or areas with prevalent substance use, and creating a strong sober support group. At a system level, participants reported the need for more sober living spaces to support sobriety and the need for nonpunitive services that allow multiple opportunities to engage in recovery services.

Recommendations for integrated cultural and Western treatment modalities of care

Participants were asked about their participation in both Western and culturally centered treatments to understand their perceptions of different treatment modalities. Most participants saw Western treatment modalities as complementary to cultural treatments. Rehabilitation programs that were considered most successful included both components in tandem. Providing cultural treatments was more than having cultural awareness, either by having AIAN practitioners or culturally centered materials. It involved legitimizing cultural practices as therapeutic components equivalent to Western modalities.

A participant described a Native Center treatment as follows:

> I was at [Recovery Center- Name Redacted]. And they are actually, one of the counselors there, she's from South Dakota and she runs a spiritual program. I believe that no matter where I'm at, like if I carry it with me, I can spread it. And just because I'm around people who aren't Native American, there still can be—like everyone can use this program, you know what I mean? And I've noticed that when I walk on my Red Road that like other people see me, and not just in my community, but in recovery. You know what I mean? So I know [Recovery Center] isn't Native American–based, but they do have someone coming in once a week and teaching Wellbriety. And they do have a counselor that meets one-on-one. Like she met one-on-one with me and went over the Red Road with me.

Two of the most common strategies reported to integrate cultural and Western treatment modalities were (a) culturally adapted programs and (b) active provision of cultural services. The most commonly reported culturally adapted program was White Bison. Examples of cultural services actively practiced in some treatment centers included traditional healing (healing ceremonies), sweat lodges, drum-assisted recovery therapy, and ceremonial dances.

Exploratory comparisons between recovery focus and general population

Both focus groups—those that took place at recovery centers and those that surveyed the general population—discussed risk factors, community description of substance use, and cultural services. Risk factors that were reported by both groups included peer pressure to initiate using a substance, mental health issues, social normalization of substance use, economic stressors and lack of employment opportunities, historical trauma, intergenerational trauma, disconnection, lack of social support, and lack of awareness about substance use disorders. Both groups discussed the similar trends of substance use that they viewed in their community: (a) younger initiation age and more substance options and availability, (b) substance use can be chronic and pervasive among family units, and (c) the high frequency of overdose experiences occurring within the community. The cultural services that were reported and discussed by both groups were Wellbriety, local Native Treatment Centers, and Powwows. Themes that were unique to those in active recovery included (a) returning to cultural values as part of their recovery, (b) seeking and becoming positive role models, (c) searching for spirituality, (d) discussing how recovery requires "motivation" or a readiness to want a change, (e) experiencing and discussing the negative consequences of OUD, (f) discussing the use of behavioral health services, (g) the need for more traditional healers to be incorporated in treatment, (h) the perceived lack of education on OUD, and (i) discussing transportation as a barrier to accessing services. The focus groups with the general population uniquely discussed (a) their perceptions of people with an OUD, (b) the lack of awareness of OUD, (c) a lack of trust in nonnative health providers, and (d) the need to socially integrate those who are undergoing substance use disorder.

Discussion

Participants identified significant community and cultural resiliencies that could be leveraged to address OUD risks and barriers to treatment. Resilience factors included community connection, return to cultural values, and community awareness of OUD. Discussions on community connection were inextricably linked to a desire to celebrate and preserve their AIAN cultural practices, celebrations, and values. A key difference when analyzing recovery-based focus groups from those of the general AIAN community was their relationship to culture. Although both groups spoke of the importance of actively cultivating culture in their community, participants in recovery-based focus groups emphasized their need to return to cultural values in order to heal. In the literature, concepts such as Wellbriety (a culturally centered 12-step program) or traditional practices (such as drumming, dancing, or traditional ceremonies) are actively incorporated alongside Western behavioral health strategies (i.e., cognitive behavioral therapy, counseling, etc.) with positive outcomes (Dickerson et al., 2021b; Gone, 2010; Rieckmann et al., 2016). Participants in these focus groups reiterated the importance of reintegrating their foundational AIAN cultural

values and traditions in active recovery and introducing their AIAN culture to youth as a method for OUD prevention (Moore & Coyhis, 2010; Rowan et al., 2014; Stewart, 2008).

Participants provided innovative and creative ideas about what future integrated and culturally centered OUD treatment and services models might look like. For example, they advocated for the use of Western modalities in tandem with traditional practices, such as the use of traditional healers, therapeutic cultural traditions (e.g., sweat lodges, drumming, and cultural dances), and active learning of AIAN traditional values (i.e., medicine wheel). They discussed the need to invest in retaining cultural values within their communities by actively coordinating and planning community events that engage and teach AIAN cultural traditions. Given the importance of functional family systems to prevent substance use disorder and, for those undergoing treatment, to remain engaged in care, an emphasis should be placed on creating interventions that integrate family dynamics. For youth OUD prevention, interventions can incorporate strategies to increase family communication and connectedness and bolster family resiliency. These findings are aligned with previous literature citing community-based organizations as the preferable setting for the delivery of mental health and family services (J. Allen et al., 2018; M. L. Allen et al., 2016; West et al., 2021).

At a systems level, participants agreed that it was difficult to find, access, and remain in OUD treatment. A recommendation made by the California Department of Health Care Services 2019 report was to use a system of care model where a case manager would oversee the treatment plan of patients and help individuals navigate the complexities of patient care treatment plans by advocating for services that are tailored for each individual. This high-touch, patient-centered, and fully integrated approach will reduce barriers to accessing services. If possible, facilities such as Federally Qualified Health Centers that offer OUD treatment should incorporate components of treatment (behavioral therapy, primary care physician, laboratory testing, and MOUD waivered providers) within their primary facility to avoid delays in treatment caused by referrals or piecemeal services (Soto et. al., 2019). Participants in active recovery discussed the difficult path to recovery, with setbacks and relapses. To assist in the recovery process, participants suggested increasing awareness of OUD from a biological perspective, providing multiple opportunities to enter recovery services, and sensitizing support systems of individuals under recovery to know how to approach and encourage an individual during a relapse. In the health behavior literature, the increased knowledge of the biological effects of substances have supported the disease model of addiction (Bell & Strang, 2020; Chou et al., 2016; Volkow, 2018).

Future directions in understanding the intersection of OUD Western and traditional services include the systematic data collection of mental and health outcomes of treatment components and, whenever possible, conducting randomized control trials of behavioral health and traditional modalities. Research and its implementation must acknowledge the geographic diversity of the AIAN populations and provide targeted, community-based approaches that are comprehensive, integrated, and individualized.

Limitations

As qualitative research, this study has methodological limitations, including subjective interpretations of research questions by participants and of research analysts. Snowball sampling can lead to an unrepresentative sample of participants sharing similar characteristics. Findings are limited to the experiences of those who were recruited and able to participate in this study, which could lead to self-selection bias. This study is not representative of the entire AIAN adult population in California, as participants were not sampled from all the existing recognized tribes within California, and these findings may not be generalizable to other AIAN communities outside of California.

References

Allen, J., Rasmus, S. M., Fok, C. C. T., Charles, B., & Henry, D., & the Qungasvik Team. (2018). Multi-level cultural intervention for the prevention of suicide and alcohol use risk with Alaska Native youth: A nonrandomized comparison of treatment intensity. *Prevention Science, 19,* 174–185. doi:10.1007/s11121-017-0798-9

Allen, M. L., Garcia-Huidobro, D., Porta, C., Curran, D., Patel, R., Miller, J., & Borowsky, I. (2016). Effective parenting interventions to reduce youth substance use: A systematic review. *Pediatrics, 138,* e20154425. doi:10.1542/peds.2015-4425

Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology, 71,* 862–878. doi:10.1037/0022-006X.71.5.862

Bart, G. (2012). Maintenance medication for opiate addiction: The foundation of recovery. *Journal of Addictive Diseases, 31,* 207–225. doi:10.1080/10550887.2012.694598

Bell, J., & Strang, J. (2020). Medication treatment of opioid use disorder. *Biological Psychiatry, 87,* 82–88. doi:10.1016/j.biopsych.2019.06.020

Bohanon, J. P. (2000). *The Talking Circle: A perspective in culturally appropriate group work with Indigenous peoples.* Retrieved from https://www.se.edu/international-student/wp-content/uploads/sites/85/2019/09/Proceedings-2005-Bohanon.pdf

Calcaterra, S., Glanz, J., & Binswanger, I. A. (2013). National trends in pharmaceutical opioid related overdose deaths compared to other substance related overdose deaths: 1999-2009. *Drug and Alcohol Dependence, 131,* 263–270. doi:10.1016/j.drugalcdep.2012.11.018

Carroll, K. M., & Weiss, R. D. (2017). The role of behavioral interventions in buprenorphine maintenance treatment: A review. *American Journal of Psychiatry, 174,* 738–747. doi:10.1176/appi.ajp.2016.16070792

Chou, R., Korthuis, P. T., Weimer, M., Bougatsos, C., Blazina, I., Zakher, B., . . . McCarty, D. (2016). Medication-assisted treatment models of care for opioid use disorder in primary care settings. *AHRQ Comparative Effectiveness Technical Briefs, 28.*

Copenhaver, M. M., Bruce, R. D., & Altice, F. L. (2007). Behavioral counseling content for optimizing the use of buprenorphine for treatment of opioid dependence in community-based settings: A review of the

empirical evidence. *American Journal of Drug and Alcohol Abuse, 33,* 643–654. doi:10.1080/00952990701522674

Dickerson, D. L., D'Amico, E. J., Klein, D. J., Johnson, C. L., Hale, B., & Ye, F. (2021a). Mental health, physical health, and cultural characteristics among American Indians/Alaska Natives seeking substance use treatment in an urban setting: A descriptive study. *Community Mental Health Journal, 57,* 937–947. doi 10.1007/s10597-020-00688-3

Dickerson, D. L., D'Amico, E. J., Klein, D. J., Johnson, C. L., Hale, B., Ye, F., & Dominguez, B. X. (2021b). Drum-Assisted Recovery Therapy for Native Americans (DARTNA): Results from a feasibility randomized controlled trial. *Journal of Substance Abuse Treatment, 126,* 108439. doi:10.1016/j.jsat.2021.108439

Dickerson, D., Moore, L. A., Rieckmann, T., Croy, C. D., Venner, K., Moghaddam, J., . . . Novins, D. K. (2018). Correlates of motivational interviewing use among substance use treatment programs serving American Indians/Alaska Natives. *Journal of Behavioral Health Services & Research, 45,* 31–45. doi:10.1007/s11414-016-9549-0

Ehlers, C. L., Geisler, J. R., Luna, J. A., Gilder, D. A., Calac, D., Lee, J. P., & Moore, R. S. (2020). Community awareness of outreach efforts to reduce underage drinking on California Indian reservations. *American Indian and Alaska Native Mental Health Research, 27,* 21–41. doi:10.5820/aian.2701.2020.21

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence, 23,* 316–338. doi:10.1177/0886260507312290

Forcehimes, A. A., Venner, K. L., Bogenschutz, M. P., Foley, K., Davis, M. P., Houck, J. M., . . . Begaye, P. (2011). American Indian methamphetamine and other drug use in the Southwestern United States. *Cultural Diversity & Ethnic Minority Psychology, 17,* 366–376. doi:10.1037/a0025431

Gone, J. P. (2010). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist, 38,* 166–235. doi:10.1177/0011000008330831

Gone, J. P., Blumstein, K. P., Dominic, D., Fox, N., Jacobs, J., Lynn, R. S., . . . Tuomi, A. (2017). Teaching tradition: Diverse perspectives on the pilot Urban American Indian Traditional Spirituality Program. *American Journal of Community Psychology, 59,* 382–389. doi:10.1002/ajcp.12144

Gone, J. P., & Calf Looking, P. E. (2015). The Blackfeet Indian culture camp: Auditioning an alternative indigenous treatment for substance use disorders. *Psychological Services, 12,* 83–91. doi:10.1037/ser0000013

Guenzel, N., & Struwe, L. (2020). Historical trauma, ethnic experience, and mental health in a sample of urban American Indians. *Journal of the American Psychiatric Nurses Association, 26,* 145–156. doi:10.1177/1078390319888266

Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native Adolescents: A literature review. *Journal of Primary Prevention, 38,* 5–26. doi:10.1007/s10935-016-0455-2

Hilton, B. T., Betancourt, H., Morrell, H. E. R., Lee, H., & Doegey, J. A. (2018). Substance abuse among American Indians and Alaska Natives: An integrative cultural framework for advancing research. *International Journal of Mental Health and Addiction, 16,* 507–523. doi:10.1007/s11469-017-9869-1

Isaacson, M. J., Bott-Knutson, R., Fishbeck, M. B., Varnum, A., & Brandenburger, S. (2018). Native elder and youth perspectives on mental well-being, the value of the horse, and navigating two worlds. *Online Journal of Rural Nursing and Health Care, 18.* doi:10.14574/ojrnhc.v18i2.542

Joshi, S., Weiser, T., & Warren-Mears, V. (2018). Drug, opioid-involved, and heroin-involved overdose deaths among American Indians and Alaska Natives — Washington, 1999–2015. *Morbidity and Mortality Weekly Report, 67,* 1384–1387. doi:10.15585/mmwr.mm6750a2

Kading, M. L., Hautala, D. S., Palombi, L. C., Aronson, B. D., Smith, R. C., & Walls, M. L. (2015). Flourishing: American Indian positive mental health. *Society and Mental Health, 5,* 203–217. doi:10.1177/2156869315570480

Klein, A. A., & Seppala, M. D. (2019). Medication-assisted treatment for opioid use disorder within a 12-step based treatment center: Feasibility and initial results. *Journal of Substance Abuse Treatment, 104,* 51–63. doi:10.1016/j.jsat.2019.06.009

Legha, R. K., & Novins, D. (2012). The role of culture in substance abuse treatment programs for American Indian and Alaska Native communities. *Psychiatric Services, 63,* 686–692. doi:10.1176/appi.ps.201100399

Masotti, P., Dennem, J., Hadani, S., Banuelos, K., King, J., Linton, J., . . . Patel, C. (2020). The Culture Is Prevention Project: Measuring culture as a social determinant of mental health for native/indigenous peoples. *American Indian and Alaska Native Mental Health Research, 27,* 86–111. doi:10.5820/aian.2701.2020.86

Mitton, J. A., Jackson, S., Ho, J. J., & Tobey, M. (2020). Opioid and amphetamine treatment trends among American Indians in the Great Plains. *Journal of Addiction Medicine, 14,* e100–e102. doi:10.1097/ADM.0000000000000594

Moore, D., & Coyhis, D. (2010). The multicultural Wellbriety peer recovery support program: Two decades of community-based recovery. *Alcoholism Treatment Quarterly, 28,* 273–292. doi:10.1080/07347324.2010.488530

Mpofu, E., Ingman, S., Matthews-Juarez, P., Rivera-Torres, S., & Juarez, P. D. (2021). Trending the evidence on opioid use disorder (OUD) continuum of care among rural American Indian/Alaskan Native (AI/AN) tribes: A systematic scoping review. *Addictive Behaviors, 114,* 106743. doi:10.1016/j.addbeh.2020.106743

Novins, D. K., Aarons, G. A., Conti, S. G., Dahlke, D., Daw, R., Fickenscher, A., . . . Spicer, P., & the Centers for American Indian and Alaska Native Health's Substance Abuse Treatment Advisory Board. (2011). Use of the evidence base in substance abuse treatment programs for American Indians and Alaska Natives: Pursuing quality in the crucible of practice and policy. *Implementation Science, 6,* Article no. 63. doi:10.1186/1748-5908-6-63

Planalp, C., & Lahr, M. (2017). *The opioid epidemic: National trends in opioid-related overdose deaths from 2000 to 2015.* State Health Access Data Assistance Center, June, 1–8. Retrieved from http://www.shadac.org/sites/default/files/publications/US opioid brief 2017 web.pdf

Rieckmann, T., Moore, L. A., Croy, C. D., Novins, D. K., & Aarons, G. (2016). A national study of American Indian and Alaska Native substance abuse treatment: Provider and program characteristics. *Journal of Substance Abuse Treatment, 68,* 46–56. doi:10.1016/j.jsat.2016.05.007

Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., . . . Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy, 9,* Article no. 34. doi:10.1186/1747-597X-9-34

Skewes, M. C., & Blume, A. W. (2019). Understanding the link between racial trauma and substance use among American Indians. *The American Psychologist, 74,* 88–100. doi:10.1037/amp0000331

Snowshoe, A., Crooks, C. V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a cultural connectedness scale for First Nations youth. *Psychological Assessment, 27,* 249–259. doi:10.1037/a0037867

Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for First Nations youth. *Journal of Primary Prevention, 38,* 67–86. doi:10.1007/s10935-016-0454-3

Sofuoglu, M., DeVito, E. E., & Carroll, K. M. (2019). Pharmacological and behavioral treatment of opioid use disorder. *Psychiatric Research & Clinical Practice, 1,* 4–15. doi:10.1176/appi.prcp.20180006

Soto, C. Unger, J., Miller, K., Zeledon, I., Telles, V. M., Henderson, B., ... Moerner, L. (2019). *Addressing the opioid crisis in American Indian & Alaska Native communities in California: A statewide needs assess-*

ment. Retrieved from https://ipr.usc.edu/wp-content/uploads/2019/11/USC_AI_Report.pdf

State of California. (2022). *Digital atlas of California Native Americans.* NAHC Digital Atlas. Retrieved from https://nahc.ca.gov/cp

Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. International Journal of Health Promotion and Education, 46, 49–56. doi:10.1080/14635240.2008.10708129

Tipps, R. T., Buzzard, G. T., & McDougall, J. A. (2018). The opioid epidemic in Indian Country. *The Journal of Law, Medicine & Ethics, 46,* 422–436. doi:10.1177/1073110518782950

Veilleux, J. C., Colvin, P. J., Anderson, J., York, C., & Heinz, A. J. (2010). A review of opioid dependence treatment: Pharmacological and psychosocial interventions to treat opioid addiction. *Clinical Psychology Review, 30,* 155–166. doi:10.1016/j.cpr.2009.10.006

Venner, K. L., Donovan, D. M., Campbell, A. N. C., Wendt, D. C., Rieckmann, T., Radin, S. M., . . . Rosa, C. L. (2018). Future directions for medication assisted treatment for opioid use disorder with American Indian/Alaska Natives. *Addictive Behaviors, 86,* 111–117. doi:10.1016/j.addbeh.2018.05.017

Volkow, N. D. (2018). Medications for opioid use disorder: Bridging the gap in care. *The Lancet, 391,* 285–287. doi:10.1016/S0140-6736(17)32893-3

Walters, K. L., Mohammed, S. A., Evans-Campbell, T., Beltrán, R. E., Chae, D. H., & Duran, B. (2011). Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives. *Du Bois Review: Social Science Research on Race, 8,* 179–189. doi:10.1017/S1742058X1100018X

Wendt, D. C., & Gone, J. P. (2016). Integrating professional and Indigenous therapies: An urban American Indian narrative clinical case study. *The Counseling Psychologist, 44,* 695–729. doi:10.1177/0011000016638741

West, A. E., Telles, V., Antony, V., Zeledon, I., Moerner, L., & Soto, C. (2021). An opioid and substance use disorder needs assessment study for American Indian and Alaska Native youth in California. *Psychology of Addictive Behaviors.* Advance online publication. doi:10.1037/adb0000664

Wexler, L., Chandler, M., Gone, J. P., Cwik, M., Kirmayer, L. J., LaFromboise, T., . . . Allen, J. (2015). Advancing suicide prevention research with rural American Indian and Alaska Native populations. *American Journal of Public Health, 105,* 891–899. doi:10.2105/AJPH.2014.302517

Winograd, R. P., Presnall, N., Stringfellow, E., Wood, C., Horn, P., Duello, A., . . . Rudder, T. (2019). The case for a medication first approach to the treatment of opioid use disorder. *American Journal of Drug and Alcohol Abuse, 45,* 333–340. doi:10.1080/00952990.2019.1605372

Zeledon, I., West, A., Antony, V., Telles, V., Begay, C., Henderson, B., . . . Soto, C. (2020). Statewide collaborative partnerships among American Indian and Alaska Native (AI/AN) communities in California to target the opioid epidemic: Preliminary results of the Tribal Medication Assisted Treatment (MAT) key informant needs assessment. *Journal of Substance Abuse Treatment, 108,* 9–19. doi:10.1016/j.jsat.2019.04.003