

Recommendations for the Effective Treatment of Methamphetamine Addiction With Native
American Cultural Specificity

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Recommendations for the Effective Treatment of Methamphetamine Addiction With Native
American Cultural Specificity

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Abstract

The usage of methamphetamine in Native American communities has continued to climb throughout the last few decades. Increased usage of methamphetamines has had a disastrous effect upon the tribal communities. The modern form of this methamphetamine is nearly 1000 times the dose of that which was used during World War II. The availability of Methamphetamine has significantly increased in Wisconsin with tribal addiction represented in a disproportionately high quantity to the general population. Treatment options and programs for methamphetamines are lacking for a Native American population. This research examines first, the physical, psychological, and economic effects of methamphetamine drug abuse among Native American communities. Second, it examines methamphetamine drug abuse among Native American Communities, rural and urban, in comparison to other communities in America. Thirdly, current treatment program methodology theory is looked at, the stress process model, Primary Socialization Model, and Dialectical Behavior theory. It is recommended that dialectical behavior therapy be used in addition to cultural traditions and spiritual beliefs and integration of spiritual and western treatment to develop new programs for treatment of Methamphetamine addiction. Treatment barriers are examined, such as psychosocial and practical barriers, for those who are seeking access to treatment. This research recommends implementation of a Native American cultural methamphetamine treatment program based upon an identified set of theoretical framework and in acknowledgment of current established programs. It is recommended that any new start program will incorporate western medicine, Native American cultural beliefs and spiritual practices, be based upon evidence based medicine, and aspects of consideration must be addressed for a program to be effective in this unique population.

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Recommendations for the Effective Treatment of Methamphetamine Addiction With Native American Cultural Specificity

I. Introduction

A. Statement of the problem: lack of methamphetamine treatment programs for native communities

The usage of methamphetamine in Native American communities has continued to climb, and many families are being destroyed by its presence. According to Dickerson, Spear, Marinelli-Casey, Rawson, Li, and Hser (2010) the use and abuse of methamphetamines had continued to rise in the Native American ethnic group across the decade preceding their study. The increased usage of methamphetamines has had a disastrous effect upon the tribal communities, for example, leading to the Ho-Chunk Nation to declare a state of emergency in 2016. The Ho-Chunk Nation declared a State of Emergency that was related to drug addiction and the illegal use of drugs, especially affecting the Nation's Youth and Families (The Ho-Chunk Nation, 2017). The Child Welfare League of America (CWLA) reported that the survey data on drug use in tribal communities show that 1.7% of the American Indian/Alaska Native population reported meth use in 2005. This makes it the second highest racial group rate according to the Substance Abuse and Mental Health Services Administration (SAMHSA) (CWLA, 2016). For comparison less than 1% of the white population reported using meth in 2005.

The research problem this paper will address, in response to this disproportional use rate, is the lack of drug treatment programs for Native American Communities, specifically methamphetamine treatment programs. A major concern for treatment is the lack of facilities focusing on methamphetamine (Cumming, Troeung, Young, Kelty, and Preen, 2016). This

creates a significant disparity in care between the general population and the disproportionately affected Native American population (Reickmann, Moore, Croy, Novins, and Aarons, 2016). In addition to a lack of programs, those that do exist do not generally run long enough to reduce the relapse rate (2016 Wisconsin Methamphetamine Study, 2016).

B. Brief History of Methamphetamines

Methamphetamine is a synthetic chemical which acts on receptors in the brain that stimulates the release of the neurotransmitter dopamine. Dopamine has many functions in the brain but, it enhances mood, pleasure, and energy levels. Unlike heroin or cocaine, it is a long lasting high of up to 12 hours. However, when the user comes down the effects are extremely hard on the body and mind. The come down from meth has been associated with depression, mood swings, exhaustion, and even violent and erratic behavior (Chamberlain, 2015).

The methamphetamine that exists today can be traced back to amphetamine type stimulants (ATS) that were first developed in the 1890's. The first ATS was developed by a Japanese chemist named Nagai Nagayoshi in 1893 during his research on extracting ephedrine from a plant named man hung, the resulting process being called the Nagai method. This process was refined by one of his students in 1919 resulting in the creation of the first crystal meth. In 1934 the pharmaceutical company Smith Kline and French purchased the patent for amphetamine, discovered by Gordon Alles in 1929, and began research on its uses eventually coming up with the drug Benzedrine. Benzedrine was used as an antidepressant and as a tool by the British and American armies in World War II. The allies gave their soldiers Benzedrine to increase confidence, decrease appetite, and reduce fatigue. The use created addiction that followed the troops home after the war (2016 Wisconsin Methamphetamine Study, 2016).

Heavy legal use during the 1950's and 1960's led to the classification of Methamphetamine as a schedule II drug in the 1970 Comprehensive Drug Abuse Prevention and Control Act, which was an amendment to the Public Health Service Act (Gabay, 2013). One of the consequences of its listing as a now controlled substance is that the ready supply for many people already addicted was cut off and this created a demand which was filled by illegal meth labs. While initially the province of motorcycle gangs during the early 1980's the publication of a book by a Wisconsin chemist, Steve Preisler, detailing the recipe and manufacture of 6 different recipes for methamphetamine using legal ingredients led to the expansion of home manufacture. This led to continued crackdowns by the DEA and classifications of precursor ingredients into controlled substances in an effort to reduce manufacture. This eventually led to the passing of the 2005 Combat Methamphetamine Act leading to the regulation of pseudoephedrine, the main used precursor for methamphetamine. One of the main effects of this is that many small meth labs have been closed and home production has diminished significantly. Unfortunately, the Majority of Meth Production has relocated to Mexico and super labs that produce and supply methamphetamine to the USA. The modern form of this meth is nearly 1000 times the dose of that which was used by our World War II soldiers (2016 Wisconsin Methamphetamine Study, 2016).

C. Methamphetamines in Wisconsin

The availability of Methamphetamine has significantly increased in Wisconsin, data shows that from 2011 to 2016 availability increased between 250 and 300 percent and was predicted to continue to climb since then (2016 Wisconsin Methamphetamine Study, 2016). According to the Wisconsin Department of Health Services meth usage in Wisconsin has increased by 462% between 2010 and 2017 (Wisconsin DHS, 2019). That data is accompanied

by a fact sheet stating the increase in usage of individuals receiving substance use disorder treatment for methamphetamines showing the increase from 2010 of 331 individuals to 2015 level of 706 individuals. This was only tracked of people using treatment by paid county funding, but what can clearly be seen is a direct yearly increase. (Wisconsin DHS, 2017). Law enforcement reporting states that the drug is coming into the U.S. and Wisconsin from Mexico and is being produced by drug cartels. The drug is entering Wisconsin primarily from the Twin Cities, which has been identified as the largest distribution center and enters over the highway system. Secondly the drug enters the state from California via the United States Postal system, UPS, or FedEx (2016 Wisconsin Methamphetamine Study, 2016).

D. Methods

This paper will be done through secondary research and critical analysis of published scholarly literature. The literature search will focus on Native American addiction studies with a focus on Methamphetamines. Primary source of literature will be gathered from PubMed and EBSCOhost databases. Secondary sources will be current Native focused treatment program websites. These websites will provide data on program components and statistics on treatment success and failure. No original data will be collected for this study.

E. Purpose and Significance of the study

The purpose of this research paper is to first look at general information on methamphetamines to show the effects it has on a person, both physical and psychological through repeated exposure (Eitle, and Eitle, 2013). The research will look at the continued rise of usage in Native American population and its effects (Dickerson, Spear, Marinelli-Casey, Rawson, Li, and Hser, 2010). The paper will examine treatment options and programs for

methamphetamines in general and show why they are lacking for a Native American population (Rieckmann, Moore, Croy, Novins, and Aarons, 2016). The research will address treatment outcomes for Native populations looking at both the positive outcomes and continued challenges (Dickerson, Spear, Marinelli-Casey, Rawson, Li, and Hser, 2010). This study will look at effective drug treatment programs, at the foundational principles that make a program successful. By looking at programs which have been effective in other states a recommendation for a program specific to our tribal community can be created based upon the research. Analysis and comparing and contrasting of multiple treatment programs such as the Keystone Treatment Center in South Dakota, Juel Fairbanks in Minnesota, the Anishnaabek Healing Circle, Access to Recovery Program (ATR) which works with the Grand Traverse Band of Ottawa and Chippewa Indians Behavioral Health Services in Michigan, and Bear River Health at Walloon Lake Michigan, will provide recommendations for effective components of an ideal treatment program for Native American communities.

In an effort to address the lack of effective methamphetamine treatment programs for Native communities this paper will; first, examine the physical, psychological, and economic effects of methamphetamine drug abuse among Native American communities. Second, this research will look at methamphetamine drug abuse among Native American Communities, rural and urban, in comparison to other communities in America. Thirdly, this research will look at current treatment program methodology theory and specific cultural based programs, to determine best practices. Fourth, the stress process model, Primary Socialization Model, and Dialectical Behavior theory will serve as the theoretical framework for a cultural specific treatment program for Native communities. Recommendations for dialectical behavior therapy with cultural traditions and spiritual beliefs and integration of spiritual and western treatment in a

Native Treatment Program will be offered in hopes to provide a best practice guidance for Native communities struggling with Methamphetamine addiction.

II. Literature Review

A. Physical, Psychological, and Economic Effects of Methamphetamine Drug Abuse among Native American Communities

Methamphetamines are a schedule 2 controlled substance (Gabay, 2013). It does have approved medical uses such as treating attention deficit hyperactive disorder, narcolepsy, and obesity. The drug acts upon the central nervous system as a stimulant causing various physical and psychological manifestations. Methamphetamine use causes the brain to release increased amounts of dopamine, norepinephrine, and serotonin. The effects upon the body at a normal clinical relevant dose are a state of arousal or higher energy, lowered fatigue, enhanced mood, euphoria, increased heart rate and blood pressure, increased body temperature, decreased appetite, short term improvement in mental acuity, and a decrease in inhibitions. However, when used at high doses the drug can have disastrous effects such as psychotic symptoms, agitation, aggressive and violent behavior, chest pain, heart, liver and kidney failure.

Methamphetamines are commonly taken in by smoking or injection, have rapid onset of euphoria, and last in the body for 10 to 12 hours (2016 Wisconsin Methamphetamine Study, 2016). The long term effects of use can lead to impairment of the monoamine systems of the brain, in particular sites which work with dopamine. The effects of this are a degradation of memory ability, attention loss, and lowered cognitive abilities particularly in areas of decision making. Reduction of the dopamine system, the chemical directly related to happiness, also leads to long term depression. While some improvement occurs over recovery it is slow and often incomplete (McGuinness and Pollack, 2007).

The effects of methamphetamines extend beyond the physical and psychological manifestations. These have been reported to include job loss, crime, car accidents, depression, and higher incidence of violence and abuse. Methamphetamine use creates environmental hazards in the home and community such as needles, waste chemicals, and lighters, and used glassware with chemical residuals (Chamberlain, 2015). It is reported that for every one pound of methamphetamine produced up to five pounds of toxic waste are generated. As this waste is often disposed of in illegal and unsafe manners in backyards, parks or roadsides the environmental concerns to a community are staggering (Messina, Jeter, Marinelli-Casey, West, and Rawson 2007). This creates a huge economic loss on the community to repair damages caused by waste dumping (2016 Wisconsin Methamphetamine Study, 2016).

The effect upon families is particularly disastrous, more than one third of children living in meth houses test positive for exposure. Children exposed to methamphetamine use by parents are a particular concern for Native communities that frequently have multigenerational households. Some effects upon children include disturbed sleep, nightmares, flat affect, fear of the police and worry for parents, developmental delays, grief, hopelessness, respiratory problems, congenital deformities, and low school attendance just to name a few. Also, a major concern is the effect upon communities when methamphetamine using parents go to jail as the children are often put into foster care (Chamberlin, 2015). This issue is of particular importance for Native families whose history of child removal from communities has already caused multigenerational trauma (Fast and Collin -Vézina, 2019). Another concern particularly in rural communities is the growth of a distinct drug culture, being spread from parent to child characterized by antisocial beliefs and practices. These practices include, lying, stealing, drug use and violence, neglect abuse, loss and isolation (Haight, Jacobsen, Black, Kingery, Sheridan,

and Mulder, 2004). While this is a significant concern in non-native communities as it is, in Native communities where individuals already feel isolated and removed from society, this additional level of disassociation is even more damaging.

The overall economic impact of methamphetamine use is potentially staggering. It is hard to create a clear estimate due to the variety of factors, such as individual health, family stability, child health in short and long term, effect on the community and the environment. In 2005 a RAND Corporation study was commissioned to look at estimating the costs associated with Methamphetamine use. The data is outdated, but still useful as a guide to the overall impact. The study broke down cost categories as follows: drug treatment, health care, intangibles/premature death, productivity, crime and criminal justice, child endangerment, production/environment. The economic impact for Wisconsin in 2005 was estimated to be 424 million dollars, which adjusted for inflation would be roughly 560 million dollars in 2020 (2016 Wisconsin Methamphetamine Study, 2016).

B. Statistics on Methamphetamine Drug Abuse among Native American Communities in compares to other communities in America (Methamphetamine Usage in Tribal Communities, Rural and Urban Native Communities)

The Child Welfare League of America (CWLA) reported that the survey data on drug use in tribal communities show that 1.7% of the American Indian/Alaska Native population reported meth use in 2005. This makes it the second highest racial group rate according to the Substance Abuse and Mental Health Services Administration (SAMHSA) (CWLA, 2016). For comparison less than 1% of the white population reported using meth in 2005. More recent studies cite Native Americans as having the highest risk rate of methamphetamine use and abuse. In particular Native youth have a 4.2 odds ratio of heightened use compared to non-Hispanic whites. In addition, Native American teens are at greatest risk of substance abuse regardless of

living on a reservation or integrated into mainstream society (Eitle and McNulty Eitle, 2013). An analysis of data from the National Longitudinal Study of adolescent Health showed a huge disparity of 12.8% of Native American youth using methamphetamine in the past year compared to 7.6% of White, African American, Hispanic, and Asian races combined. Data from the National Survey on Drug Use and Health Reports showed across all age groups for 2002-2006 overall past year usage rates of 1.4% for American Indian/Alaskan Native compared to 0.6% for all other (Forcehimes, Venner, Bogenschutz, Foley, Davis, Houck, Willie, and Begaye, 2011).

Stimulant Dependence (SD) has been shown to be significantly higher in Native communities. It is associated with lower income, lower education, and earlier onset of first use, all issue found to be associated with tribe/reservation living. One study found from 1997 to 2004 the number of Indian Health Service outpatient visits rates for SD increased by 30 times. This study looking at participants from eight different reservations in the United States found an overall SD rate of 33%, roughly equal between men and women (Gilder, Gizer, Lau, and Ehlers, 2014). The impact of methamphetamines on the Tribal population cannot be overstated enough. One report from the San Carlos Apache reservation showed twenty-five percent of babies born on the reservation as addicted to methamphetamine. This report also stated that a survey of Tribal government employees on the White Mountain Apache reservation found thirty percent testing positive for methamphetamine usage (Chaney, 2007).

Epidemiological data has shown that substance use among AI/AN populations varies greatly by tribe, gender, age, and region. This makes it difficult to make a clear estimate of the impact on any specific tribal community (Forcehimes et al., 2011). There is significant regional variation in usage. Individuals in the Northern Plains and Great lakes have higher substance use in general while those living in the Southwest have higher usage rates of Methamphetamines

(Miller, Stanley and Beauvais, 2012). However, one can look at specific state data to gather insight into the effect on a tribe integrated within that population.

A source of data to provide a clear view of the growth of meth in Wisconsin can be seen from the State of Wisconsin Department of Justice Crime Lab. Between 2011 and 2015 the number of meth cases analyzed grew by 349% in comparison during this same time period the number of heroin cases only grew by 97%. From the data the 10 counties with the largest increase were Ashland, Rock, Oneida, Price, Trempealeau, Fond Du Lac, Wood, Calumet, and Jackson. The numbers also are seen in a rise in Department of Corrections inmates. The DOC showed an increase in inmates for meth possession charges of 371% over the 2011 to 2015 time period. Law enforcement data also shows an increase in meth related arrests during this time period of 225% (2016 Wisconsin Methamphetamine Study, 2016).

C. Current treatment program methodology for substance use disorders and methamphetamines

Current treatment for substance use disorder, and methamphetamine addiction in specific, has focused on the use of either intensive inpatient residential therapy or outpatient community based therapy. The choice of which is based upon availability, client resources, and insurance among other factors. Regardless of the choice of residential or outpatient there are multiple psychological and pharmacological treatment options available in the provider toolkit. In addition to treatment regimen Evidence Based Practices then guide the application of the chosen therapy throughout the treatment process.

Residential versus Outpatient Therapy

Treatment options for SD and methamphetamine usage involve either inpatient residential treatment programs or outpatient therapy. One study looked at 2 inpatient programs 6

months in length, comparing conventional stimulant dependence therapy with methamphetamine specific therapy and found no benefit for the specific methamphetamine dependence therapy. The study found similar treatment success from both cohorts, showing reduction in depression, craving, and psychiatric symptoms at completion of treatment. The study did find a dropout rate of roughly 40% primarily due to relapse (Kamp, Proebstl, Hager, Schreiber, Rienschlager, Numann, Straif, Schacht-Jablonowsky, Manz, Soyka, and Koller, 2019). A study of outpatient treatment patients showed substantial reduction in symptoms following completion of therapy at 2-5 years. An Australian study compared community based outpatient and residential programs finding that the residential group had superior abstinence at follow-up, although abstinence rates declined severely as time following treatment elapsed (Manning, Best, Garfield, Allsop, Berends, and Lubman, 2016).

In contrast to the study by Kamp et al. the meta-analysis by Cumming et al. found that traditional therapy for SD and opioid dependence was insufficient for methamphetamine users and a tailored therapy was required for greater success. This was complicated however by that fact that the majority of methamphetamine users were poly-substance abusers (Cumming, Troeung, Young, Kelty, and Preen, 2016). The study data does suggest that a residential program is superior to outpatient treatment, however limited space and resources preclude all patients from engaging in residential programs (Kamp et al., 2019). Benefit has been shown however from program completion for all patients regardless of inpatient/outpatient nature with multiple studies stating that treatment cost is worth the investment (Manning et al, 2016).

Psychological and Pharmacological Treatment options

Research indicates that psychosocial treatment is the primary effective means of treatment for methamphetamine users. Included are Cognitive Behavioral Therapy, counseling, residential rehabilitation, and contingency management. There are four main goals of psychosocial interventions: 1) to engage users, 2) to retain patients in treatment process, 3) to encourage compliance, and 4) to provide relapse prevention support. There have been many pharmacotherapy's tried however the findings have not been beneficial or evidence supported. The main successful therapies focus has been to reduce cravings in users. Other drug therapies from monoamine agonists such as sertraline and paroxetine, Dopamine agonists, such as bupropion, monoamine antagonists such as haloperidol, GABA receptor agonists such as topiramate, and use of provigil have all been tried and tested with limited success (Ciketic, Hayatbakhsh, Doran, Najman, and McKetin, 2012).

Evidence Based Practices for Addiction Therapy

Implementation of successful treatment programs requires the use of evidence based practices (EBP) also known as evidence based treatments (EBT). Study data has show that programs based on EBP are money well spent, with the highest chance of patients remaining sober and having positive outcomes following treatment (Manning et al, 2016). Examples of current EBP used in the field of addiction medicine are motivational interviewing, cognitive-behavioral therapy, adolescent community reinforcement approach, and assertive community treatment. Of these EBP's CBT as type of counseling therapy or as part of a residential rehabilitation treatment program has been the most successful in promoting abstinence (Ciketic et al, 2012). However even when these EBP programs are used the implementation of them can

make or break a program's effectiveness. There are multiple factors which can determine the success or failure of implementation of these EBP. Examples are structure and consistency, flexibility, clinical supervision, and organizational input. Sites with the highest rates of successful program implementation have been shown to have strong program leadership, a skilled well trained staff, and an organizational culture which supports change and continued development (Amodeo, Lundgren, Belrame, Chassler, Cohen, and D'Lppolito, 2013).

Based on the data presented the highest rates of success occur with residential inpatient therapy. Pharmacological treatment has shown limited success, and of the psychological treatments the EBP of CBT has shown the most promise in promoting abstinence. Implementation of the residential program using this EBP requires strong leadership, organizational support and programmatic flexibility.

C. Native American cultural treatment programs

Providing effective treatment for methamphetamine addiction is a difficult proposition. Some of the factors involved in this are the increasing quantity of available drug, the increasing purity and potency, the physiological changes leading to dependence and addiction, the lack of available programs of sufficient length and specificity, the difficulty of successful implementation of evidence based practices (2016 Wisconsin Methamphetamine Study, 2016). For the Native American population there are even further layers of complications that exist beyond those just listed. These include the providing of culturally appropriate clinical services, challenges with infrastructure of treatment programs, and issues associated with the greater service/treatment system itself. Challenges in the clinical setting are numerous, involving sociodemographic barriers as well as cultural barriers to treatment engagement and process such

as complex historical trauma. Infrastructural challenges involve frontline worker fatigue and burnout but also a lack of program and treatment resources. The challenges with the treatment system itself involve appropriate aftercare, culturally appropriate and validated EBP and federal program oversight requiring high amounts of paperwork that can interfere with clinical care (Legha, Raleigh-Cohn, Fickenscher, and Novins, 2014). On top of these challenges there is also well documented mistrust of the research community, fear of exploitation, and an overall negative attitude toward EBP by the Native Community (Larios, Wright, Jernstorm, Lebron, and Sorensen, 2016).

The task of creating an effective treatment program that can address the needs of the Native American Population, of integrating Western treatment modalities and cultural appropriate treatment allowing for spiritual practices, is daunting but necessary (Moghaddam and Momper, 2011). A major concern for treatment is the lack of facilities focusing on methamphetamine. In addition to a lack of programs, those that do exist do not generally run long enough to reduce the relapse rate (2016 Wisconsin Methamphetamine Study, 2016). There have been numerous treatment barriers listed for methamphetamine users who are seeking access to treatment. Primary barriers that exist are psychosocial: embarrassment or stigma, belief that treatment was unnecessary, preferring to withdraw alone, and concerns over privacy. The study also identified a number of other practical barriers, namely insufficient places, high waiting times, and affordability and cost (Cumming et al., 2016).

Historical Trauma

In addition the impact of disparities in healthcare and client resources makes it necessary that mental health concerns also be addressed in any Native focused treatment, looking at not

only substance abuse but also victimization and suicide as well as historical trauma (Kropp, Somoza, Lilleskov, Granados-Bad Moccasin, Moore, Lewis, Boetel, Smith, Winhusen, 2012). It has been argued that the Native history of oppression and cultural eradication is a direct cause of the current levels of alcohol and substance abuse (Legha and Novins, 2012). Historical Trauma is at its nature the intergenerational accumulation of risk for increased poor mental health status due to colonial subjugation, and ethnocidal policies and practices. These policies led to widespread loss of Native language, culture, ceremony and identity, along with multigenerational disruption of family and parenting practices through Native child removal, all have led to a increased level of disability and decreased behavioral health for contemporary Native peoples (Gone, 2013).

Indigenous Heritage, Identity, Spirituality

With the focus of use of EBP, and mandates from insurers for their use in treatment to assure payment, concern has grown in the Native community about applicability (Larios et al, 2011). It has been stated that EBP were not developed or validated with inclusion of the Native American Tribal population, as such they may be in conflict with traditional beliefs and practices (Skinstad, Walker, Richards, and Bear, 2015). Not only have they not been validated, but EMP may not be able to incorporate traditional beliefs at all due to lack of flexibility. To effectively work with the AI/AN population it is critical that an EBP be adaptable enough to allow cultural beliefs and traditional practices while maintaining fidelity to the EBP manual and program (Beckstead, Lambert, DuBose, and Linehan, 2015). Taking a step back, even at the basic level there is low levels of cultural sensitivity and awareness in most clinic settings. The focus on Western medicine techniques can be interpreted as belittling the cultures traditional beliefs and practices (Larios et al, 2011). A major disconnect with the Native population can be seen in the

very aim of the EPB, western treatment patterns focus on the individual, while Native patterns of healing need to focus on emphasizing connections with others. Western models of treatment work by isolating the individual from social, physical, and spiritual environments and following treatment will re-introduce them slowly. Traditional Native healing practice works through establishing interconnectedness and establishing balance between emotional, physical, spiritual and psychological aspects of the patient, their community, environment and the world in general (Moghaddam and Momper, 2011). To complicate matters even further, while studies have shown that an ethnic match between provider and patient has improved outcomes, few NA/AI providers are available in the practice setting (Larios et al, 2011). In addition to a lack of tribal providers, the varied nature of the many separate tribal identities also complicates matters. Even if integrative EBP programs are implemented with inclusion of sweat ceremonies, talking circles, prayers, smudging, and sessions with spiritual leaders in combination with western practice such as group therapy, the complex variation of individual tribes practices may come into conflict (Moghaddam and Momper, 2011). The danger exists of trying to homogenize Native culture and traditional practices in order to create a one size fits all program with universal applicability, there is great concern that too much adaption can compromise validity (Larios et al, 2011). There have been some successful main stream programs such as the RedRoad or Wellbriety, that are used to treat alcohol dependence, combining AI/AN cultural beliefs and practices from Alcoholics Anonymous. This program takes a more holistic approach to sobriety (Legha and Novins, 2012). While it is not aimed specifically at methamphetamine treatment it could have useful applications in developing a treatment model.

Therefore, the goal of this research, based upon reviewed scholarly literature, is to address the lack of effective methamphetamine treatment programs for Native communities.

Recognizing the limitations created by the physical, psychological, and economic effects of methamphetamine drug abuse, the divergent needs of rural and urban Native communities, the established current best practice guidelines of treatment methodology, and attempting to incorporate Native identity, heritage and spirituality. Thusly generate recommendations for implementation of a Native American cultural methamphetamine treatment program based upon an identified set of theoretical framework and in acknowledgment of current established programs.

III. Theoretical framework for methamphetamine addiction therapy

The theoretical framework for addressing the formation of a Native American specific methamphetamine treatment program can be built upon three core idea sets. These are the Stress Process Model (SPM), Primary Socialization Theory (PST), and Dialectical Behavior Therapy (DBT). The stress process model looks at stress and stress buffering factors within the native community. Primary socialization theory looks d family, school and peer networks which develop self efficacy and drug refusal skills. DBT builds upon these other theories and is an evidence based therapy which teaches mindfulness and can incorporate a Native American specific component encompassing traditional and spiritual practices. These three together form the bases of an effective treatment program which can be targeted to Native American communities specifically.

A. Stress Process Model

The stress process model looks at health disparities that arise due to differences in social stress exposure. The level of health disparities have a large impact in terms of disproportionate levels of suffering, social, and economic costs. The stress process model makes it clear that there

is a significant racial component in the level of availability, usage of, and effectiveness of medical care (Turner, Avison, Aneshensel, Schieman, and Wheaton, 2010). The stress process model is a theoretical approach created by Leonard Pearlin in his paper *The Sociological Study of Stress*. His idea was that the stress process is a convergence of primary and secondary stressors from life events and chronic strain which are mediated by coping skills and social supports (Pearlin, 1989). In the context of this paper the relevance to Native population is that the SPM gives a basis for understanding that race and place in society social structure are associated with stress exposure and resource availability. Studies have demonstrated, as has been previously noted, that Native American race places individuals at heightened risk of stress exposure (Eitle and Eitle, 2013). Eitle and Eitle argue that the stress process framework gives a fundamental explanation toward the increase of substance abuse within the Native American Population. They argue that race, life events, Historical trauma, and family usage all have a direct relation to increased substance usage. While mediating factors such as family social support and self esteem have a preventative influence upon substance abuse levels.

The importance of this model to our purpose is that it provides the framework to build upon. SPM shows that any treatment program must acknowledge that Historical Trauma, life stressor events, and chronic stressors such as societal place created by Native Race must be acknowledged and anticipated in program users. It also shows that for the Native Population treatment cannot exist in a vacuum, community and family involvement must be part of the program. The Native population gets a moderating influence on behavior based upon a strong social support structure. Also important is the idea of self esteem and racial identification as a Native American which is strengthened by incorporation of Native traditions and cultural norms (Eitle and Eitle, 2013).

B. Primary Socialization Theory

The second theoretical framework for this paper is primary socialization theory. This concept is based upon the idea that behavior is based upon peer influence from family, schools and peer-networks. The idea is that normal and deviant behaviors are actually learned behaviors that are acquired through social interactions. Study data suggest that peers have the highest role in formation of delinquent behavior (Higgins, Ricketts, Marcum, and Mahoney, 2010). In relation to Native American population PST provides evidence that positive family relationships and strong levels of family support predict lower levels of substance abuse. Conversely, familial history of substance abuse led to a lower level of, and unhealthy manners of coping skills (Galliher, Evans, and Weiser, 2007).

For the purpose of this paper the importance of PST is that it identifies areas of influence and development over an individual's life. PST data identifies that strong pro-social and cultural bonds were identified as helping to develop self efficacy and drug refusal skills. In relation to a treatment program strong community and social bonding is again highlighted. Cultural conditions such as those of family sanctions against drug usage help to strengthen individuals ability to withstand peer pressure and subsequent usage of illicit substances. Of importance to the Native American population is the broader idea of family that is created with the cultural norm. Traditional western family structure provides minimal support due to smaller more nuclear family concept as opposed to the broader family concept in Native populations. PST shows the importance of family and community involvement within the treatment paradigm. What this implies is that the treatment not only must address the individual but also the family environment. In particular the treatment program must reconnect the individual with the community if it is to be successful (Galliher, Evans, and Weiser, 2007).

C. Dialectical Behavior Therapy

The third and final theoretical concept is Dialectical Behavior Therapy (DBT). DBT is a form of cognitive behavioral treatment that is based upon the ideas of mindfulness found in Zen Buddhism. The target behaviors of DBT therapy as it pertains to substance abuse is four fold; it first addresses behaviors that are seen as life threatening, second, it addresses behaviors that would interfere with treatment, third it targets behaviors that interfere with quality of life, and fourth, it targets behavior skills (Beckstead, Lambert, Dubose, and Linehan, 2015). The process that is followed to target these four areas is broken down into four components. These four primary components of DBT are; one, weekly structured individual therapy. Two, group skills training that works on four major skill areas which are mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Three, coaching between group sessions to work on an individual bases to assist with skill development. Four, weekly treatment team meetings focusing on DBT, peer support, and supervision. DBT is not a short term therapy design. It is intended to be worked on for at least a year of therapy (Walsh, Eaton, and Barent, 2014).

DBT is the primary recommended form of therapy recommended by the research for incorporation into a Native American methamphetamine treatment program. As one of the main goals of a Native American focused program is incorporation of culturally specific aspects into treatment DBT provides an access point for this. Mindfulness teachings allow for incorporation of traditional and spiritual practices. Ways to incorporate this are inclusion of tribal leaders on a programs governing body, bringing in a local medicine man, use of a sweat lodge, smudging ceremonies, and talking circles. The incorporation of a medicine man, who would receive training in DBT and mindfulness, allows for the spiritual leader to explain and tie mindfulness

practices to those in therapy as they relate to traditional beliefs (Beckstead, Lambert, Dubose, and Linehan, 2015).

The three theoretical frameworks looked at in this section provide the basis of the treatment paradigm. The SPM shows that Historical Trauma, life stressor events, and chronic stressors such as societal place created by Native Race must be acknowledged and anticipated in program. Also, that community and family involvement must be part of the program. The Native population gets a moderating influence on behavior based upon a strong social support structure. PST shows that cultural conditions like family sanctions against drug usage help to strengthen individuals ability to withstand peer pressure and subsequent usage of illicit substances. In order to incorporate PST concepts treatment must address the individual but also the family environment, building on the Native American concepts of expanded family structures incorporating non direct relations and community as a whole. To be able to bring these two frameworks together in practical application DBT is used to incorporate not only community by engaging tribal elders as part of the treatment team but also incorporating traditional and spiritual components into the mindfulness teachings. This is done by bringing in a local medicine man to train in DBT, use of a sweat lodge, smudging ceremonies, and talking circles. The incorporation of these frameworks and therapy concepts will provide a Native American culturally specific treatment program.

IV. Current Treatment Programs with Native American Cultural Focus

Four treatment programs were identified that either were run by or provided specialty services to a Native American population. These treatment programs are the Keystone Treatment Center in South Dakota, Juel Fairbanks in Minnesota, the Anishnaabek Healing Circle, Access to

Recovery Program (ATR) which works with the Grand Traverse Band of Ottawa and Chippewa Indians Behavioral Health Services in Michigan, and Bear River Health at Walloon Lake Michigan. Attempts were made through multiple avenues to contact these programs for detailed information and statistics however no responses were received from the programs or their representatives. This may have been complicated by the COVID 19 pandemic occurring during the time of this research project. Information was taken from publicly available program websites. While this does not provide statistical information for the sites it does provide information on the programs themselves and their target populations as well as information on culturally specific practices for each program.

A. Keystone Treatment Center

The Keystone treatment center is located in Canton, South Dakota. Their mission is to provide quality treatment to people battling chemical dependency, people who are struggling with compulsive gambling, and to people with addiction and mental health disorders, as well as to their families. The centers treatment philosophy is that each person possesses the right be treated with dignity, regardless of creed, gender, race, age, sexual orientation, or ethnic origin. That each person is a unique and holistic creation with right to life, dignity, and worth as a person and as a member of society. That each person has an inherent potential for change and growth and need not be bound by past learning history, but can respond to both present and future expectations. That each person has the ability to continually adapt to a changing environment; an environment which, on a daily basis, challenges the balance between disease and health. That successful recovery encompasses improvements in self-esteem, interpersonal relationships, positive family interaction, vocational productivity, the establishment and attainment of realistic life goals, and a healthy lifestyle adjustment.

Type of programs offered: Adult Residential, Young Adult Residential, Adolescent Residential, Drug and Alcohol Detox, Family Therapy, Outpatient treatment, Continuing care, and Native American Addiction Program.

Native American Addiction Program: culturally-sensitive services, that reflect the traditions and practices of the Native American culture, and that addresses the traditional values of their Native American patients. Staff at Keystone includes Native American counselors, as well as Native American Cultural and Spiritual Advisors, and full-time cultural coordinator who provides guidance for their Native American patients. Keystone has certified Native American chemical dependency counselors who provide treatment in both the adolescent and adult programs. Examples of activities that incorporate cultural specificity: Inipi/purification ceremonies are held weekly at an onsite Sweat Lodge. Individual assessments are provided for patients with the cultural coordinator. Honoring ceremonies are held as requested. Traditional songs and prayers are offered to address death or loss. The site uses the Red Road Walk, and discussion with patients on how to incorporate it into the 12-Step Recovery Model. Spiritual advising is offered on various traditions. Smudging and prayers are offered using sage, sweet grass, or cedar. The site also uses a Talking Circle model for peer support.

Keystone has a focused methamphetamine addiction treatment program using:

Medically monitored detoxification: Non hospital-based, medically monitored, with around-the-clock nursing care, and meetings with physicians.

Medication management: for those patients suffering from symptoms of a mental health condition in addition to a meth addiction, psychotropic medications may be prescribed.

Psychiatrists meet with patients on an as-needed basis.

Individual therapy: a minimum of two individual therapy sessions each week. Topics include: understanding of how patients behaviors impact major aspects of their lives. The individual sessions have a goal of developing more efficient and effective coping mechanisms.

Family therapy: family therapy sessions are led by a licensed family therapist and are offered on an as-needed basis. Weekly Family Program is also available to patients and their family members which includes one hour of psycho-educational programming. Day-long programming is also offered for family with the family therapist.

Group therapy sessions are led by licensed or certified counselors. During these sessions patients work together to identify problems that they are facing. Adult patients take part in three group therapy sessions each day, adolescent patients take part in three to five sessions per day. Adult patients topics include: Topics Group, Men's Topic Group, Women's Topic Group, Young Adult Topic Group, Interactive Sharing Therapy Group, Relaxation Group, 12-Step Group Meetings, Skills Training Groups, Community Group, Gambling Group, Spirituality Groups. Adolescent patients topics include: Relaxation Group, Topics Group, Interactive Sharing Therapy Group, 12-Step Group Meetings, Skills Training Groups, Spirituality Groups, Exercise Group, Experiential Growth Groups, Recovery Skills Group, Community Group

Experiential therapy is offered for all patients on a daily basis. This is based on each patient's treatment plan. Topics include Recreational therapy, Bibliotherapy, Social training, Arts and crafts, Ropes course, Cultural activities, or Pastoral care (Keystone Treatment Center, 2020).

B. Juel Fairbanks

The Juel Fairbanks program is located in St. Paul Minnesota. Type of programs offered are residential treatment, outpatient treatment, housing support, and cultural services. Cultural

services based on the plans of the program founder, an Ojibwe tribe member. The intention of the cultural component is enhancing the recovery process for other Native Americans. The program has different culturally specific offerings including: Smudging, Pipe ceremonies, Red Road, Talking Circle, and Wellbreity.

The Residential Treatment program is a Minnesota state licensed facility with 24 beds. It is a 90 day, medium intensity residential treatment program. Licensed alcohol and drug counselors provide individual counseling, group counseling, and Native American cultural services. Individual counseling focuses on treatment planning and aftercare coordination. Group services are offered in the following topics: Helping Men Recover, Moods and Feelings, Living Skills, Co-Occurring Education, Extended Care, Relationships, Men's Health, Anger Management, Recovery maintenance. The program patients attend daily group meetings and individual sessions for a minimum of 15 hours of group per week. The inpatient program also uses recreational therapy, daily meditation, and AA/NA meetings.

The Outpatient Treatment program for men is based on a 12-step program. It is designed for adult patients who need frequent contact and structure. The program consists of group sessions and weekly individual sessions. Group counseling sessions topics include: Co-occurring Treatment Services, Positive Mental Health, Who am I Sober?, Moral Compass, Colorful Meditation, Men's Health, Living Skills. Patients attend for a total of 150 hours, Patients also do weekly individual sessions with counselor for a total of 15 weeks (Juel Fairbanks Recovery Services: St. Paul, Minnesota, 2019).

C. Anishnaabek Healing Circle, Access to Recovery Program (atr)

The Anishnaabek Healing Circle, Access to Recovery Program is run by Inter-Tribal Council of Michigan, and is located in Sault Ste. Marie, MI. The programs mission is to reflect the values and recommendations expressed in the National Tribal Behavioral Health Agenda (TBHA) developed by SAMHSA, the Indian Health Services and the National Indian Health Board. To integrate authentic cultural interventions and culturally tailored evidence-based practices into existing tribal programs as a means for reestablishing Tribal spiritual conditions of physical, mental, and spiritual health. To create and implement long-term, community wide engagement and mobilization strategies that emphasize community ownership. To respect diverse pathways to healing and the diversity of tribal spiritual beliefs and health practices.

Type of programs offered are Medication assisted treatment (MAT), State Targeted Response Treatment and Recovery Services (STR), Peer recovery support (SOR), and Tribal Opioid Prevention (TOP). The medication assisted treatment (MAT) is the use of medications, along with counseling and behavioral therapies, to treat substance use disorders. The State Targeted Response Treatment and Recovery Services (STR) consists of two components, the Tribal Opioid Treatment and Recovery Initiative (TOTR) and the Tribal Opioid Use Disorder Prevention Initiative (TOP).

The TOTR goal is treatment and recovery support services for underinsured or uninsured American Indian/Alaskan Natives with an opioid use disorder. Participants must 12 years old or older, and live in service areas of the twelve tribes in Michigan. The project is a grouping of clinical and recovery support providers. The providers use culturally influenced evidence based practices, such as cognitive behavioral therapy, and motivational interviewing. Native American

healing services are also available at some tribal sites. Detox, outpatient and residential treatment are available along with recovery support services. The second component is the Tribal Opioid Prevention (TOP) program. The TOP initiative generates services such as culturally competent evidence based primary prevention services, media campaigns, policy change, alternative pain management, and overdose prevention.

The final program offered by the Anishnaabek Healing Circle, Access to Recovery Program is the peer recovery support (SOR) which is a trauma informed, evidence based, and culturally responsive peer recovery support system for American Indian/Alaskan Natives. Program participants must be at least 18 and live in the service area of one of the twelve tribes in Michigan. Peer support workers assist with engagement in the recovery process and reduce the likelihood of relapse. Peer support services are able to extend treatment beyond the clinical setting and bring it into everyday life helping create a sustained recovery process (Grand Traverse Band of Ottawa and Chippewa Indians, n.d.).

D. Bear River Health

The Bear River Health program is located in Walloon Lake Northern Michigan. The vision statement of the program is that drug and alcohol addiction as a chronic and progressive medical disease that affects the physical, mental, and spiritual well-being of individuals and their families. The program is based upon evidence based practice protocols established by SAMHSA (Substance Abuse and Mental Health Services Administration). It provides aftercare planning that works with patients to ensure sustainable recovery. The types of programs offered: Drug & Alcohol Detox Program, Residential Program, Outpatient Program, Intensive Outpatient (IOP) Program.

Bear River Health includes a family program. The program believes that odds of successful, sustained recovery from addiction is higher when family is involved in treatment. The program states that drug and alcohol addiction often have genetic components. In addition, family dynamics also play a role. Sustained recovery is shown to be improved when family understands the changes necessary following treatment.

The Bear River Health clinical program uses the Living in Balance curriculum. This program includes twelve core sessions that address issues patients in recovery typically encounter. Sessions topics include drug education, triggers and cravings, relapse prevention, self-help programs, mental and physical health, emotional and social wellness, sexual and spiritual health, daily living skills, and vocational and educational development. Additional topics include self-help and Twelve Step programs, physical issues, social and family issues, sexual abuse and compulsive sexual behaviors, grief and loss, money management, nutrition and exercise, medication-assisted treatment, chronic pain and opioids, strategies for older adults, and advanced relapse prevention. Partial Hospitalization (PHP) and Intensive Outpatient Programs (IOP) are also available, maintaining the core curriculum through allowing more client flexibility (Bear River Health, 2019).

The four programs reviewed, the Keystone Treatment Center in South Dakota, Juel Fairbanks in Minnesota, the Anishnaabek Healing Circle, Access to Recovery Program (ATR) in Michigan, and Bear River Health in Michigan all had similar components however were very different. Programs were specific to some tribes, or sex, or region. They all included forms of cultural components to embrace Native heritage. Only the Keystone Program had a methamphetamine specific program although all incorporated some form of 12 step program.

V. Recommendations for Implementation of a Native American Cultural Methamphetamine Treatment Program

The formation of an entire addiction and recovery program is a complex multidiscipline process, as such it is beyond the scope of this research project. The aim of this section is to provide some considerations garnered from the research presented within this paper for the implementation of a methamphetamine treatment program that will incorporate western medicine, Native American cultural beliefs and spiritual practices, and be based upon evidence based medicine. Research had identified many universally applicable issue with the treatment systems in place such as a clients socioeconomic needs, insufficient qualified staff, inadequate program resources, limited aftercare options, inability to address medical/psychiatric co morbidities, overwhelming paperwork demands, and siloed care resulting in lack of integration. In addition American Indian/Alaskan Native specific issues are layered upon this, an increased need for substance abuse treatments, provider mistrust, social stigma, limited resources and even the question of applicability of approved evidence based therapy (Legha, Raleigh-Cohn, Fickenscher, and Novins, 2014). All these aspects must be considered and addressed for a program to be effective in this unique population.

A. Considerations When Implementing a New Program

As identified in the above paragraph many considerations must be addressed when implementing a program for a Native population. These challenges can be broken down into three categories for ease of discussion. Challenges associated with providing clinical services, challenges related to the treatment setting and support framework, and challenges related to the treatment system itself. The following discussion is not meant to be an exhaustive list but a starting point for brainstorming of potential issues when implementing a new program.

When looking at providing clinical services to the Native population a treatment program must consider possible barriers to seeking treatment and those hindering program engagement. Some problem areas that must be considered are: housing status or homelessness of the client, availability of transportation, legal issues and integration with the courts and local police, levels of relapse rates and successful completion, levels of employment and ability for payment. When considering barriers to treatment engagement a program would need to consider history of trauma, complex patient diversity (Moghaddam and Momper, 2011)., cultural integration, and treatment stigma (Larios et al, 2011).

In consideration of the treatment setting and support services a program would need to look at two categories, the frontline workers and program and treatment resources. Issue of worker fatigue and burnout are prime considerations. Staff become invested with patients on a personal and emotional level. There is the issue of high caseloads, paperwork and administrative requirements, establishing professional boundaries, and the overall shortage of trained, qualified staff. There is the issue of location, and adequate facility space not only for patient needs but also for the staff. And there is the issue of supplies and funding. This deals with the logistical considerations for a program, where it will be, how it is staffed, and how it will be paid for. What is clear is there is more need than ability to provide and any program will quickly find itself overwhelmed and with more requests for need than it will be able to provide. Clear guidelines need to be created in the beginning as to the service population and what to do for people that must be turned away.

Final consideration must be given to challenges associated with the treatment system itself. This area requires consideration of barriers to providing aftercare such as housing, transportation, and continued treatment plans. Appropriate treatment services are a

consideration as there is pressure from many outside sources and payers to use specific evidence based practices in order to receive reimbursement. As has been stated, many of these were not studied or validated with the native population (Skinstad, Walker, Richards, and Bear, 2015). Applicability of these programs to a Native population is in question however in order to secure funding it may be required (Larios et al, 2011). Finally, in this area regulatory consideration and paperwork requirements must be thought about. Clinical measures must be studied and tracked and reported on to prove validity of treatment. Also interfacing with many state and federal programs will be required on multiple levels. Staff requirements for licensure and certifications must be looked at as well.

B. Dialectical Behavior Therapy

As identified above in the general considerations choice of appropriate evidence based therapy is a major factor in programmatic success. There have been some successful main stream programs such as the RedRoad or Wellbriety, that are used to treat alcohol dependence, combining AI/AN cultural beliefs and practices from Alcoholics Anonymous based upon a 12 step program. Programs like these take a more holistic approach to sobriety (Legha and Novins, 2012). While they are not aimed specifically at methamphetamine treatment, they could have useful applications in developing a treatment model through integration into the therapy process.

The form of evidence based therapy identified earlier in this paper as fitting the need for use in the Native population is Dialectical Behavior Therapy (DBT) a form of cognitive behavioral treatment that is based upon the ideas of mindfulness found in Zen Buddhism. As stated, target behaviors of DBT therapy as it pertains to substance abuse is four fold; it first addresses behaviors that are seen as life threatening, second, it addresses behaviors that would

interfere with treatment, third it targets behaviors that interfere with quality of life, and fourth, it targets behavior skills (Beckstead, Lambert, Dubose, and Linehan, 2015). When instituting this process consideration must be given toward the needs of the program.

DBT is based upon a four part structure that will need to be scheduled along with other programmatic components. These are: one, weekly structured individual therapy. Two, group skills training that works on four major skill areas which are mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Three, coaching between group sessions to work on an individual bases to assist with skill development. Four, weekly treatment team meetings focusing on DBT, peer support, and supervision. DBT is not a short term therapy design. It is intended to be worked on for at least a year of therapy (Walsh, Eaton, and Barent, 2014). This last statement is particularly important for program development. This form of EBT is designed for long term treatment and will require a year of continued therapy to be effective. This creates the question of length of total program treatment time and how long the individual programs need to be inpatient versus outpatient continuation of therapy. As seen in the Keystone treatment Center, which has a dedicated methamphetamine program, a new program may need to start with medical monitored detox program through inpatient services and then transition into outpatient maintenance services (Keystone Treatment Center, 2020).

C. Integration of Spiritual and Western Treatment in a Native Treatment Program

Integration of spiritual treatment and Native culture into a western treatment modality is difficult because of a lack of empirically studied options within a Native framework (Skinstad, Walker, Richards, and Bear, 2015). However, research has shown that the most successful treatment programs for Native Americans incorporates traditional healing and cultural practices

(Moghaddam, and Momper, 2011). One of the main goals of a Native American focused program is incorporation of culturally specific aspects into treatment, DBT provides an access point for this through the use of mindfulness.

Mindfulness teachings, that the DBT system is based upon, allow for incorporation of traditional and spiritual practices. Some potential ways to incorporate this are: inclusion of tribal leaders on a programs governing body, bringing in a local medicine man, use of a sweat lodge, smudging ceremonies, and talking circles (Beckstead, Lambert, Dubose, and Linehan, 2015). Other forms are seen in the Jules Fairbank program: Pipe ceremonies, Red Road, and Wellbreity (Juel Fairbanks Recovery Services: St. Paul, Minnesota, 2019). Additional considerations from the Keystone program include: honoring ceremonies, use of traditional songs and prayers, and individualized counseling with a spiritual leader and cultural advisor (Keystone Treatment Center, 2020). The incorporation of a medicine man, who would receive training in DBT and mindfulness, allows for the spiritual leader to explain and tie mindfulness practices to those in therapy as they relate to traditional beliefs (Beckstead, Lambert, Dubose, and Linehan, 2015).

Beyond the choice of EBT and inclusion of mindfulness components is the need for community connectivity. This is an area where Western medical treatment and Native American needs differ. Western medicine is based on the idea of patient isolation the reintroduction, a Native American based program needs to consider the concept of interconnectedness with the community as part of the healing process (Moghaddam, and Momper, 2011). It is particularly important, as seen in the facility programs reviewed, that Native American staff are included on the team (Legha et al., 2014). A final note is that not only is it important that Native members e included on the team, but they receive training on all practices of EBT so that they are fully able to participate at all levels of the process.

VI. Summary and Conclusions

This paper has shown that the usage of methamphetamine in Native American communities has continued to climb throughout the last few decades, and because of this increase many families and communities are being destroyed by its presence. According to Dickerson, Spear, Marinelli-Casey, Rawson, Li, and Hser (2010) the use and abuse of methamphetamines had continued to rise in the Native American ethnic group. The increased usage of methamphetamines has had a disastrous effect upon the tribal communities. Methamphetamine, a synthetic chemical, acts on receptors in the brain that stimulates the release of the neurotransmitter dopamine, creating a euphoric high. When the user comes down the effects are extremely hard on the body and mind. This has been associated with depression, mood swings, exhaustion, and even violent and erratic behavior (Chamberlain, 2015). The methamphetamine that exists today can be traced back to amphetamine type stimulants (ATS) that were first developed in the 1890's. The modern form of this meth is nearly 1000 times the dose of that which was used by our World War II soldiers (2016 Wisconsin Methamphetamine Study, 2016). The availability of Methamphetamine has significantly increased in Wisconsin, data shows that from 2011 to 2016 availability increased between 250 and 300 percent and was predicted to continue to climb since then. Methamphetamine is entering Wisconsin primarily from the Twin Cities, which has been identified as the largest distribution center (2016 Wisconsin Methamphetamine Study, 2016).

This research paper looked first at general information on methamphetamines to show the effects it has on a person, both physical and psychological through repeated exposure (Eitle, and Eitle, 2013). Then looked at the continued rise of usage in Native American population and its effects (Dickerson, Spear, Marinelli-Casey, Rawson, Li, and Hser, 2010). Then examined

treatment options and programs for methamphetamines and showed that they are lacking for a Native American population (Rieckmann, Moore, Croy, Novins, and Aarons, 2016). Then looked at the treatment programs run by Keystone Treatment Center in South Dakota, Juel Fairbanks in Minnesota, the Anishnaabek Healing Circle, Access to Recovery Program (ATR) which works with the Grand Traverse Band of Ottawa and Chippewa Indians Behavioral Health Services in Michigan, and Bear River Health at Walloon Lake Michigan. In an effort to address the lack of effective methamphetamine treatment programs for Native communities this paper examined first, the physical, psychological, and economic effects of methamphetamine drug abuse among Native American communities. Second, this methamphetamine drug abuse among Native American Communities, rural and urban, in comparison to other communities in America. Thirdly, current treatment program methodology theory, the stress process model, Primary Socialization Model, and Dialectical Behavior theory. Based upon this research it is recommended that dialectical behavior therapy be used in addition to cultural traditions and spiritual beliefs and integration of spiritual and western treatment to develop new programs for treatment of Methamphetamine addiction.

The task of creating an effective treatment program is complex. This can be seen in the considerations section, the needs of the Native American Population, of integrating Western treatment modalities and cultural appropriate treatment, and allowing for spiritual practices, is all a part of the process (Moghaddam and Momper, 2011). A major concern for treatment as a whole, is the lack of facilities focusing on methamphetamine treatment. In addition to a lack of programs, those that do exist do not generally run long enough to reduce the relapse rate (2016 Wisconsin Methamphetamine Study, 2016). The recommendation, based upon this research, is a

minimum of one year of therapy. There have been numerous treatment barriers listed for methamphetamine users who are seeking access to treatment. Primary barriers that exist are psychosocial: embarrassment or stigma, belief that treatment was unnecessary, preferring to withdraw alone, and concerns over privacy. In addition, practical barriers exist such as insufficient locations, high waiting times, and affordability and cost (Cumming et al., 2016). Recognizing the limitations created by the physical, psychological, and economic effects of methamphetamine drug abuse, the divergent needs of rural and urban Native communities, the established current best practice guidelines of treatment methodology, and attempting to incorporate Native identity, heritage and spirituality. This research recommends implementation of a Native American cultural methamphetamine treatment program based upon an identified set of theoretical framework and in acknowledgment of current established programs.

Three core idea sets are recommended for incorporation into a new treatment program. These are the Stress Process Model (SPM), Primary Socialization Theory (PST), and Dialectical Behavior Therapy (DBT). DBT is used to incorporate not only community, by engaging tribal elders as part of the treatment team, but also incorporating traditional and spiritual components into the mindfulness teachings. Examples of how this can be done have been shown such as by bringing in a local medicine man to train in DBT, use of a sweat lodge, smudging ceremonies, and talking circles. The incorporation of these frameworks and therapy concepts will provide a Native American culturally specific treatment program.

Four treatment programs were identified, to provide examples of current therapy, that either were run by or provided specialty services to a Native American population. These treatment programs are the Keystone Treatment Center in South Dakota, Juel Fairbanks in Minnesota, the Anishnaabek Healing Circle, Access to Recovery Program (ATR) in Michigan,

and Bear River Health at Walloon Lake Michigan. The programs shared similarities, however had very different overall scope. Programs were specific to some tribes, or sex, or region. They all included forms of cultural components to embrace Native heritage. Only the Keystone Program had a methamphetamine specific program although all incorporated some form of 12 step program. The formation of an entire new addiction and recovery program is a complex multidiscipline process, as such it is beyond the scope of this research project. However, some considerations are presented, garnered from the research presented within this paper, for the implementation of a methamphetamine treatment program.

It is recommended that any new start program will incorporate western medicine, Native American cultural beliefs and spiritual practices, and be based upon evidence based medicine. This research had identified many universally applicable issues with the treatment systems in place such as a clients socioeconomic needs, insufficient qualified staff, inadequate program resources, limited aftercare options, inability to address medical/psychiatric co morbidities, overwhelming paperwork demands, and siloed care resulting in lack of integration. Additionally, American Indian/Alaskan Native specific issues are presented such as, an increased need for substance abuse treatments, provider mistrust, social stigma, limited resources and even the question of applicability of approved evidence based therapy. Any new program that hopes to turn the tide of methamphetamine addiction with the Native American tribal communities must address these complicated aspects to be effective in this unique population.

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