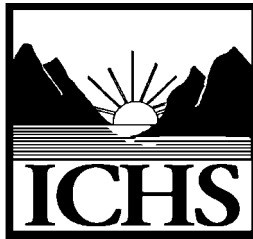


**Evaluation of the
Chemical Misuse Treatment and Recovery Services
(CMTRS) Program**



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I. INTRODUCTION

A. BACKGROUND

The Rural, Remote, and Culturally Distinct (RRCD) Populations program of the U. S. Department of Health & Human Services' Center for Substance Abuse Treatment (CSAT) awarded funds for projects designed to improve the availability, accessibility, and effectiveness of services to individuals with culturally distinct characteristics who reside in rural, remote, and geographically isolated areas.

The State of Alaska, the Yukon-Kuskokwim Health Corporation (YKHC), and CSAT signed a cooperative agreement in 1993 for a special substance abuse treatment and recovery services project with YKHC as the primary provider. The purpose of the RRCD grant funding the project was to create a decentralized substance abuse treatment program in the Yukon-Kuskokwim Delta that would provide culturally appropriate outpatient recovery services to Alaska Natives in three villages. A detailed review of the literature on cross-cultural research issues regarding substance abuse program evaluations is provided in Appendix A.

The project became known as the Chemical Misuse and Treatment Recovery Services (CMTRS) program. This was the first example of a collaborative effort between YKHC, the State of Alaska, and CSAT in joining forces to create a new way of providing services to culturally distinct populations in the Yukon-Kuskokwim area. The goal was for local village members, trained in substance abuse, to provide successful, village-based interventions and treatment services, making maximum use of local Alaska Native cultural traditions and language. CMTRS thus sought to incorporate the wisdom, beliefs, and knowledge of the indigenous Yup'ik and Cup'ik people. Over the course of five years, many innovative approaches in the program were developed to achieve this goal.

B. SETTING

The CMTRS program involved the villages of Scammon Bay, Chevak, and Hooper Bay, located on the isolated western region of Alaska along the Bering Sea Coast. The combined population of the villages is approximately 2,000. Most residents of the villages still speak their indigenous languages, Yup'ik and Cup'ik, and most of their food is obtained through subsistence activities. Their customs are greatly different from Western ways, and few service providers in the past have understood these differences and appreciated their significance.

The three villages are part of the sub-Arctic Yukon Kuskokwim Delta, one of the poorest economic regions in Alaska, with virtually no roads or land-based communications systems linking the villages. Bethel, the largest community in the region, with a population of 4,700, is more than 150 air miles away from the nearest participating CMTRS village, making it inaccessible to the people of these three villages, especially in the winter. The only means of transportation in or out of the villages is by airplane (weather permitting), boats in the summer, and snow machines or dogsleds in the winter.

The residents of all three villages thus depend largely on a subsistence lifestyle of hunting, fishing, berry picking, and trapping to provide food for the entire year. Due to the severe climate, a limited amount of sunlight during the winter, and long hours of sunlight during the summer, the subsistence activities are subject to seasonal peaks: berries in the spring and fish before winter. Subsistence practices teach planning, self-value, responsibility, and caring for

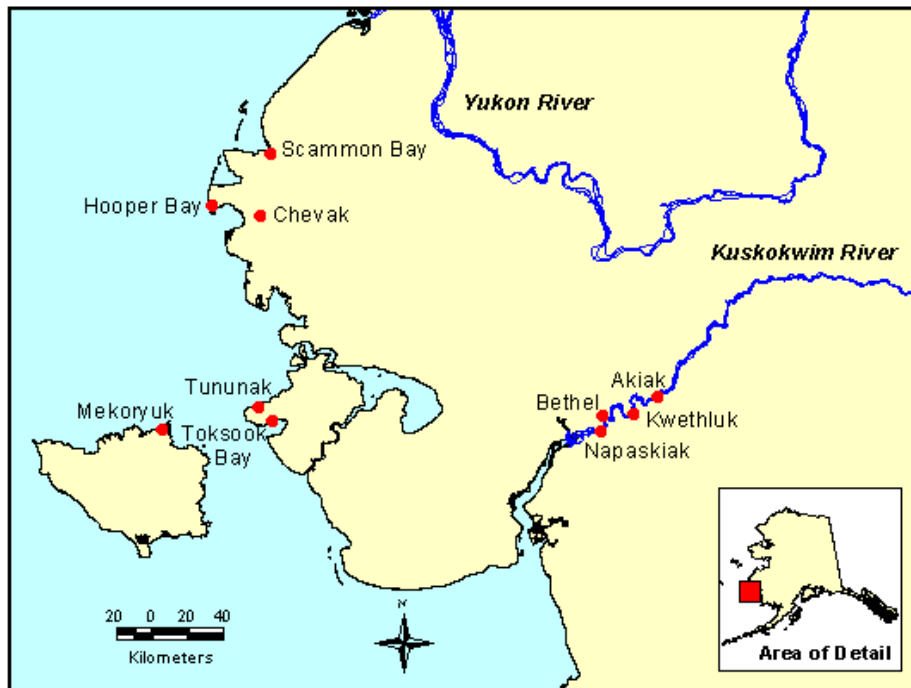
others. To survive, the village members must plan far into the future for the consumption needs of their family and community as well as for any potential winter guests.

People in the villages strongly believe that the process of taking food from the wilderness must be done in a sacred and respectful manner because of the inherent spirituality of all things. The act of separating or discounting objects and people upsets the balance of the world. One Yup'ik community member described the spirituality of subsistence living this way, "I belong to the whole, and therefore I help provide for the betterment of the whole." The village members believe that the intrinsic value they place on nature is not shared by their Western neighbors. Tension has developed between traditional and modern cultures.

C. DESCRIPTION OF VILLAGES

The following section provides individual descriptions of the three CMTRS villages and the six VAEC villages used in the comparison study, as well as a description of the hub city of Bethel¹. A map of these villages is shown below.

Figure 1: CMTRS Demonstration and Comparison Villages



1. CMTRS Villages

Chevak is a Cup'ik Eskimo village of 763 people located on the north bank of the Niglikfak River in the Yukon-Kuskokwim Delta. Temperatures range from -25 to 79. Snowfall averages 60 inches per year. 93% of the population in Chevak are Alaska Natives.

¹ Community information for villages provided by the Alaska Department of Community and Regional Affairs

In 1990, the official unemployment rate was 17.8%. The median household income was \$17,222, and 27% of residents were living below the poverty level. Construction and BLM fire fighting provide summer employment. Commercial fishing and subsistence activities are an important part of the local culture. The sale or importation of alcohol is banned in the village.

A gravel airstrip is available for travel, and floatplanes can land on Chevak Lake and Niglikfak River. A barge landing is available for cargo off-loading. Skiffs are used for local travel on the river in the summer, and snowmachines are used in the winter.

Hooper Bay (population 1,028) is a traditional Yup'ik Eskimo village located 25 miles south of Scammon Bay in the Yukon-Kuskokwim Delta. The mean annual snowfall is 75 inches, with a total precipitation of 16 inches. Temperatures range between -25 and 79. 96% of the population are Alaska Natives.

In 1990, the official unemployment rate was 41.7%. The median household income was \$18,125, and 43.5% of residents were living below the poverty level. Most employment in Hooper Bay is seasonal with peak economic activity in the summer. Commercial fishing and subsistence activities are the primary means of support. The sale or importation of alcohol is banned in the village.

Residents of Hooper Bay rely on air and water transportation. Barge lines deliver shipments of fuel and other bulk supplies throughout the summer. Skiffs are used during summer for local transportation.

Scammon Bay (population 484) is a Yup'ik Eskimo village on the south bank of the Kun River, one mile from the Bering Sea. Temperatures range between -25 and 79. Annual precipitation is 14 inches, with 65 inches of snowfall. 96.5% of the population are Alaska Natives.

In 1990, the official unemployment rate was 18.4%. The median household income was \$15,179, and 40.7% of residents were living below the poverty level. Employment is focused on commercial fishing. Fire fighting for BLM, construction projects, and handicrafts also provide seasonal income. Subsistence activities are an important part of the local culture. The sale, importation, or possession of alcohol is banned in the village.

A gravel airstrip and seaplane base on the Kun River serve air traffic. Barges bring in bulk supplies each summer. Winter trails connect Scammon Bay with Hooper Bay. Snowmachines and skiffs are the primary means of local transportation.

2. VAEC Comparison Villages

Akiak (population 338) is located on the west bank of the Kuskokwim River, 42 air miles northeast of Bethel. Precipitation averages 16 inches in this area, with snowfall of 50 inches. Temperatures range between -2 and 62. 97.2% of the population are Alaska Natives.

In 1990, the official unemployment rate was 16%. The median household income was \$13,571, and 33.9% of residents were living below the poverty level. The majority of the employment in Akiak is with the City, schools, or other public services. Commercial fishing or BLM fire fighting also provides seasonal income. Akiak residents rely on subsistence and fishing activities. The sale or importation of alcohol is banned in the village.

A gravel airstrip provides chartered or private air access year-round. Snow machines, ATVs, and skiffs are used extensively for local transportation to nearby villages.

Kwethluk (population 714) is a Yup'ik community located 12 air miles east of Bethel at the junction of the Kwethluk and Kuskokwim River. Kwethluk's precipitation averages 16 inches, with snowfall of 50 inches. Temperatures range between -2 and 62. 96.4% of the population are Alaska Natives.

In 1990, the official unemployment rate was 11.8%. The median household income was \$16,000, and 38.7% of residents were living below the poverty level. The largest employers are the school district, City, village corporation, store, and health clinic. Subsistence activities play a central role in the lifestyle. The sale or importation of alcohol is banned in the village.

A gravel airstrip and seaplane base are available for air transportation. Barge services deliver cargo during the summer. Snowmachines, ATVs, and skiffs are used for local travel.

Napaskiak (population 406) is a Yup'ik Eskimo village located on the east bank of the Kuskokwim River, 7 miles southeast of Bethel. Average annual precipitation is 16 inches, with 50 inches of snowfall. Temperatures range between -2 and 62. 94.8% of the population are Alaska Natives.

In 1990, the official unemployment rate was 22.7%. The median household income was \$18,750, and 34.3% of residents were living below the poverty level. The school, local businesses, and some commercial fishing provide employment. Napaskiak is a traditional Eskimo village dependent upon fishing and subsistence activities. The sale or importation of alcohol is banned in the village.

A gravel airstrip and seaplane landing area provide aviation access year-round. Fishing boats and skiffs are used in the summer for subsistence fishing and travel to nearby villages. Snow machines and ATVs are used in winter. Barges deliver goods during the summer months.

Mekoryuk (population 193) is a traditional Cup'ik Eskimo village located on the north shore of Nunivak Island. Average precipitation is 15 inches; annual snowfall is 57 inches. Temperatures range between 4 and 54. 99.4% of the population are Alaska Natives.

In 1990, the official unemployment rate was 16.7%. The median household income was \$14,792, and 31.5% of residents were living below the poverty level. Employment by the school, city, village corporation, commercial fishing, construction projects, and services prevails. Trapping and crafts provide income to families. This village maintains reindeer and musk ox herds, and almost all families engage in subsistence activities. The sale, importation, or possession of alcohol is banned in the village.

Mekoryuk relies heavily on air transportation for passenger, mail, and cargo service. A gravel runway allows year-round access. Barges deliver goods from Bethel once or twice each summer. Boats, snowmachines, and ATVs are used for travel within the community.

Toksook Bay (population 513) is a traditional Yup'ik Eskimo community located on Nelson Island, which lies 115 miles northwest of Bethel. Precipitation averages 22 inches, with 43 inches of snowfall annually. Temperatures range between 6 and 57. 95.5% of the population are Alaska Natives.

In 1990, the official unemployment rate was 25.5%. The median household income was \$21,875, and 39.2% of residents were living below the poverty level. Commercial fishing, the school, and the City are the primary income producers. Subsistence activities supplement income and provide essential food sources. The sale or importation of alcohol is banned in the village.

A gravel airstrip provides service year-round. Fishing boats, skiffs, snow machines, and ATVs are used by residents for local travel. Barges deliver goods during the summer months.

Tununak (population 331) is a traditional Cup'ik Eskimo village located in a small bay on the northeast coast of Nelson Island, 115 miles northwest of Bethel. Average precipitation is 17 inches, with annual snowfall of 28 inches. Temperatures range between 2 and 59. 96.2% of the population are Alaska Natives.

In 1990, the official unemployment rate was 14%. The median household income was \$18,750, and 26.3% of residents were living below the poverty level. Employment is primarily with the school district, village corporation, stores, and commercial fishing. Trapping and Native crafts also generate cash for many families, and subsistence activities are an important contributor to village members' diets. The sale or importation of alcohol is banned in the village.

Tununak relies heavily on air transportation for passengers, mail, and cargo service. A gravel airstrip is available. Barges deliver goods two to four times each summer. Boats, snow machines, and ATVs are used extensively for local travel.

3. Village Hub City

Bethel (population 5,471) serves as the regional "hub" center for the surrounding villages in the Yukon-Kuskokwim Delta. It provides a higher level of behavioral services than the villages, including facility-based substance abuse and mental health services and intensive outpatient services. Bethel is a Yup'ik Eskimo community located at the mouth of the Kuskokwim River, 40 miles inland from the Bering Sea. Precipitation averages 16 inches a year, with snowfall of 50 inches. Temperatures range between -2 and 62. 63.9% of the population are Alaska Natives.

In 1990, the official unemployment rate was 9%. The median household income was \$42,232, and 12.2% of residents were living below the poverty level. 50% of the jobs in Bethel are in government positions. Commercial fishing is an important source of income. Subsistence activities contribute substantially to village member's diets. The sale of alcohol is banned in the community, although importation or possession is allowed.

The Bethel Airport is the regional transportation center, with two major passenger airlines, two cargo carriers, and numerous air taxi services. Two float plane bases are nearby. River travel is the primary means of local transportation in the summer, and it becomes a 150-mile ice road to surrounding villages in the winter. A barge service based in Bethel provides goods to the Kuskokwim villages.

D. PROGRAM DESCRIPTION

1. Initial Program Vision

In applying for the RRCD grant, YKHC was interested in finding a funding source that would recognize the ability of villages to better manage their own services. The concept of self-determination was embodied in Public Law 93-638 that began the transfer of management responsibility to the local level. YKHC, the Native Regional Health Corporation that administers health and human services on behalf of Alaska Natives, exists through resolutions from villages within the region. This project was initially devised to continue this shift in self-determination to the village level to revitalize and empower the villages to use appropriate ways to handle their problems.

This change in policy responsibility signaled the final stage in switching from health and human service management administered by the Federal government to health and human services managed by local people at the village level. This paradigm shift was considered a bold move on the part of the State of Alaska and the Federal government. It was markedly different from the typical way of doing business, which is based on a “command and control” mode of administration from the Federal government. This shift in administrative and governance philosophy required that the levels of governance above the village level give up some of this control².

The shift to village-level administration and management was considered especially important in the area of substance abuse. YKHC’s CEO had been disappointed with the lack of success of existing programs and believed that greater involvement of village members in managing their own programs could improve the health status of villages. The RRCD Program met the needs of YKHC. Local policy advice became a major focus of the CMTRS program. Advice was sought and obtained from community leaders, IRA and city government representatives, the Elders, and key health and human service providers.

a. Local Policy Steering Committees

A key component of the CMTRS program thus became the establishment of a Policy Steering Committee (PSC) in each of the three villages. The PSCs were composed of Elders, leaders and service providers. Their role was to provide primary guidance and direction in program design, and to select and guide local staff in a continuing oversight of the program.

The PSC’s potential ability to make the program a success was undeniable. It was the village members who possessed the knowledge, skills, and experience inherent in the local decision-making process. The village members were thoroughly familiar with the people in their village and the most effective ways of addressing the village’s problems. They could make the best use of modern, Western ways, and of traditional culture and beliefs.

A principal issue to be explored in the evaluation of the effectiveness of the Policy Steering Committee, is the clear delineation of their role in CMTRS program management. The Policy Steering Committee Bylaws (see Appendix C) state that the purpose of the Policy Steering Committee is to “advise, provide [name of community] CMTRS project oversight, make recommendations, guide and review policies that will result in systematic change that will improve the delivery, accessibility, and effectiveness of addiction treatment and recovery services.” This responsibility could be implemented in two different ways:

- **Consultative:** In this system of governance, the body must be consulted prior to a decision being made. It can veto a decision, modify it as it deems appropriate, or recommend program actions. In health planning terms, this role is called a “review and approval or disapproval.” Boards with this role have a strong management authority and are major players in the decision-making process.
- **Advisory:** Advisory policy-making bodies provide, review, and comment. They may review proposed decisions or give advice, but they have no veto power. Or they can merely be informed of the decision after it is made. These bodies have less decision-making power than those that are organized around the “review and approval or disapproval” model.

² This idea of centrally managed alcohol policy is explored in greater detail in Appendix B.

Recommendations made by a Policy Steering Committee with review and comment authority may be ignored or rejected or modified by the sponsoring organization.

The Bylaws of the CMTRS Policy Steering Committees are unclear about the extent of their decision-making responsibility. A subsequent chapter in this evaluation discusses the effects of this lack of clear delineation of decision-making authority.

b. Local Providers

A second key component of the program was the use of local providers. Each of the three villages selected and hired two, local full time counselors who received training to become State-certified Level I Substance Abuse Counselors. In consultation with the village leaders and Elders, these counselors provided local treatment services using both traditional and Western methods.

This too represented a paradigm shift in the way treatment was provided in the villages. In the past, counselors from outside of the village who had neither the knowledge of nor the continuity in villages, made occasional visits. Otherwise, treatment was available on an in-patient basis in distant towns or cities (e.g., Bethel, Anchorage, or Fairbanks).

Travelling outside the village was very costly, and not staying within one's family and community while getting help had its own cost. For the most part, treatment programs were Western in orientation, and the returning patient had no trained support person to guide early days of sobriety.

Having local village members select other local village members to become CMTRS counselors had the potential to greatly enhance the success of the program, since the persons selected had won the respect and backing of the local community. Having grown up in the village, these individuals knew the people and traditional ways that could help bring sobriety and self-esteem back to those in need. Further, those getting help did not have to leave the village, and could receive the support of the community throughout their recovery process.

c. Traditional Treatment Modalities

The third major component of the CMTRS program was to use traditional Yup'ik/Cup'ik treatment modalities as part of an outpatient care program, which also included group activities such as 12-step programs. Cultural activities were provided, along with individual one-to-one counseling sessions, family counseling sessions, education, and outside referrals when needed.

Cultural activities were used as part of the therapeutic process in the CMTRS treatment and recovery program. Historically, the Yup'ik/Cup'ik people practiced many traditional activities that promoted positive methods of addressing problems an individual might experience in daily life. Due to the rapid acculturation of the Yup'ik/Cup'ik populations, many youths (and others) suffered from loss of identity and self-esteem, complicated by drug and alcohol factors. An emphasis on findings one's bearings or balance through traditional cultural activities was believed to be critical to developing self esteem and a sense of purpose that would replace feelings of ennui, or hopelessness and loss. See Appendix D for a list of traditional treatment modalities.

2. Program Values

The overall goal of the CMTRS Program was to improve individual, family, and community wellbeing in the three selected villages in the Yukon Kuskokwim Delta.³ This was achieved by providing locally staffed and managed substance abuse, mental health, and other human service counseling and support services that were consistent with traditional Yup'ik and Cup'ik cultural values, thereby ensuring cultural integrity and enhancing recovery.

Cultural integrity was defined as the positive manner in which a person's family, community, values, lifestyle, foods, ceremonies or rituals, spirituality, dress, and beliefs were respected, validated, affirmed, and celebrated. Cultural integrity implies a set of ethical standards by which one conducts him/herself in relation to a culture or cultures. When cultural integrity was utilized by a program, it promoted, facilitated, and catalyzed the community or village at many levels. Statements of core Yup'ik/Cup'ik values are shown below:

1. Develop individual and communal positive identity and self-concept.
2. Promote indigenous language preservation and continuity.
3. Promote respect and appreciation for Elders and their wisdom.
4. Promote respect for skills, knowledge, and experience regarding collective action.
5. Promote and appreciate the wisdom of the cultural tradition of the individual and community.
6. Promote a vision of the future that is congruent and in harmony with its past.
7. Promote respect for the environmental and ecological concerns.
8. Build a system for maintenance of tradition, change, and survival.
9. Acknowledge and appreciate feminine and masculine balance.
10. Balance the positive with the negative, the strengths with the weaknesses, and the old with the new in terms of community action.

E. EVOLUTION OF CMTRS

Lessons have been learned, and growth continues (see *Guidelines for Developing Substance Abuse Programs for Native Americans: Lessons Learned from the Chemical Misuse Treatment and Recovery Program, Southwest Alaska*). Overall, the CMTRS program demonstrated the effectiveness of locally selected counselors, acting with input from the village-based Policy Steering Committees in providing culturally acceptable behavioral health treatment services to its target population.

In essence, the CMTRS program evolved to include the following key elements:

- Establishing a Policy Steering Committee (PSC) in each of the three villages composed of Elders, leaders, and service providers who provided guidance and direction to both the program and local staff;
- Hiring two, local, full time counselors in each of the three villages selected who received training to be State-certified Level I Substance Abuse Counselors and who, with input from the PSC and other village Elders, provided local treatment services using both traditional and Western methods;

³ Specific objectives and tasks of the CMTRS program are shown in Appendix E, and are referred to throughout this evaluation report.

- Identifying and using culturally-based treatment modalities that included traditional activities such as hunting, story telling, and berry picking as part of the treatment plan; and
- Promoting village-wide awareness, support, and involvement in locally based treatment and prevention activities.

Further, the CMTRS program evolved to encompass a holistic approach to recovery from addiction. The CMTRS program worked with numerous individuals and organizations in addressing the needs of its clients. It recognized the critical importance of addressing the patient and the village in a holistic manner. The program developed a multi-disciplinary approach to treatment. The counselors were trained to assess the patients' social, biological, and spiritual needs, to refer them to appropriate services, and to provide traditional and Western methods of treatment. If a patient needed more intense treatment, the counselor could contact mental health workers, Community Health Aides (CHAs), and village police safety officers, or make direct referrals. If a client was referred to a residential treatment facility, the village counselor maintained contact with residential program staff. The CMTRS counselor made an appointment with the patient before he or she left residential treatment. The patient knew the CMTRS counselor would provide counseling when the patient returned home.

Traditional Treatment Modalities were put together by the PSC, Elders, counselors, and other interested people in the community. The counselors learned from the PSC and other village Elders the traditional Yup'ik and Cup'ik treatments of addictive behavior. The treatment included activities that had meaning, value, and utility, which a healthy individual would perform in the Yup'ik/Cup'ik communities.

In contrast, single-focused counseling only deals with the patient and the patient's substance abuse problem, and may not address underlying issues that can contribute to relapse. The single system of treatment also may not include the input and wisdom of Elders. CMTRS staff learned that the client could not be treated alone; the family and community needed to be included because they were affected by the client's addiction. The client may have many issues that must be dealt with in order to maintain lasting sobriety. Once a client was admitted into treatment, he/she must identify a support system within the community, such as an Elder, a cleric, sober friends, and family members. They were also encouraged to attend AA meetings and other weekly support groups, as well as participate in cultural activities. The cultural activities were the traditional Yup'ik/ Cup'ik Treatment Modalities.

CMTRS counselors interacted with Elders and many other agencies in providing services to patients and their families. While patients were in residential treatment, the CMTRS counselors provided counseling services to the patients' families in their villages as well. Family healing ceremonies were conducted with the patient and the patient's family. Recovery and healing were viewed as a physical, emotional, and spiritual experience.

F. SERVICES

1. Western Substance Abuse Treatment

Western models of substance abuse treatment are typically based on the 12-step Alcoholics Anonymous program. This program, used by the VAEC counselors to a large extent, stresses the critical importance of total abstinence "one day at a time," and begins with the person's

acknowledgement of a profound desire to stop drinking, followed by the admission that one is "powerless" to stop drinking on one's own.

In these anonymous meetings, the individual must acknowledge that he or she is an "alcoholic." After admitting being powerless over alcohol, and that life is unmanageable, he/she is directed to Step Two: coming "to believe that a Power greater than myself could restore me to sanity."

The individual is then guided by a sponsor or program director toward working through the rest of the 12 steps as outlined in "The Big Book" of AA, written in 1934. A great deal of the program's success relates to attending meetings. In an urban area such as Anchorage, there are literally hundreds of meetings scheduled year round in different locations and at all hours of the day and night.

For Native people living in villages, reliance on this program alone may make recovery difficult for a number of reasons. For one, the term "alcoholic" may be difficult to define, given cultural and language differences. Second, Step Two suggests that the person's behavior has been, relatively speaking, "insane," another concept that may be difficult for the Native village member. Third, in a relatively short period of time in a treatment facility, one rarely 'works' through anything more than the first several steps of the AA Program. Upon returning to the villages, the individual may find there are no meetings to attend and no sponsor to guide him/her through the rest of the steps. Finally, the language and stories contained in the AA program's "The Big Book" may be difficult at best for a village person to relate to.

There is no doubt, however, that AA has had more success than any other program on a global basis and within the region. When adapted to local language and culture, it has proven to be helpful to recovering addicts and alcoholics in the villages. In the CMTRS program, the 12-steps were adapted and, with local service providers living in the village to provide support, further enhanced the possibility of long-term recovery.

As noted above, other Western treatment modalities used in the CMTRS program included individual one-to-one counseling sessions, family counseling sessions, education, and outside referrals when needed. However, what made CMTRS so unique was the use of traditional treatment modalities.

2. Traditional Treatment Modalities

Although treatment for the Yup'ik/Cup'ik clients in the CMTRS program included Western treatment methods, it also built upon traditional practices that were a successful part of the people's way of life for centuries. These traditional activities were used in treatment planning and in data reporting. Use of traditional activities was a means of returning to successful traditional healing practices and in validating the Yup'ik/Cup'ik cultures and histories.

The CMTRS Program incorporated traditional treatment modalities into treatment protocols. Modalities are any therapeutic agent or activity, such as attending a fish camp, that can be employed in the treatment of substance abuse. For the most part, treatment protocols were related to Western substance abuse methods and have been recognized throughout Alaska as an important contribution to culture-based substance abuse treatment. The CMTRS Traditional Treatment Modalities are described in ED, and a comparison between Western and traditional Yup'ik/Cup'ik treatment modalities are shown in Appendix F.

3. Local Hiring

A key component of the CMTRS program was the use of local staff, selected by village leaders from each of the three communities. Providing health and human services was labor intensive. This was especially true with clients suffering from addictions. Providers needed to be familiar with the language and customs of their clients, be well trained, be available at any hour, and be on location when clients needed them.

At the outset of the project, it was important to make contact with the local tribal entity to advertise the counselors' positions in the villages. Once the Policy Steering Committees were established, they were able to make recommendations on staffing. It was decided that there should be both women and men on the counselor team to accommodate the clinical needs of the patient population.

G. TRAINING

The CMTRS program was intended to follow a holistic behavioral health model in addressing the chemical misuse needs of the selected villages. To accomplish this, an aggressive training program was established that went beyond the level of training commonly experienced by other substance abuse programs within the region.

The grant called for CMTRS training to be more richly funded than other service programs within the region. Counselors were expected to rapidly reach basic alcohol counselor certification standards, which often required substantial periods of time away from the provision of direct services. Counselors received training on a wide variety of topics not typically required of other counselors. In addition to the routine substance abuse training available to most counselors, CMTRS counselors were trained in social and mental health issues such as suicide prevention and child abuse prevention.

The training program also included counselor self-development and self-awareness, which was intended to help counselors separate their own issues from those of their clients. This training was held away from the villages so counselors did not feel awkward about sharing personal issues that might get back to the village members in treatment.

As a unique program, CMTRS required a strong team approach to program implementation. Teambuilding was an essential part of this process. Although some occasionally saw this process as taking away from direct service time or other clinical training time, teambuilding was a critical component to the program's success. Teambuilding began as soon as the counselors were hired, and before counselors felt the need to request teambuilding retreats. Information and a common vision were shared, since the observations of one counselor might be of value to others. Trust was essential among the staff.

Staff orientation occurred as soon after hire as possible. Transitions appeared to be smooth, and the overlap period was typically long enough to train the incoming staff member in the history and skills required of the position.

The network of providers, both in Bethel and within the villages, created a source of referrals to the CMTRS Program. The Bethel network of providers was promoted and maintained by the founding director during the early phase of the program. Eventually, local village-based providers were able to maintain the provider network with Bethel agencies on their own. This greatly expanded the scope of behavioral problems that the CMTRS providers were able to

address. These networks must be maintained because they were essential to sustaining the holistic nature of the program, and were one of the CMTRS program's greatest contributors in fostering local self-determination.

H. GOVERNANCE

CMTRS had a multi-layered system of governance that contained traditional Yup'ik and Cup'ik characteristics as well as Western bureaucratic characteristics. The program relied on the interaction of policy advice and formulation from the local, regional, state, and Federal levels. The following briefly describes the governance responsibilities at each of these levels.

1. YKHC Board of Directors

The Yukon Kuskokwim Health Corporation (YKHC) is the regional non-profit corporation responsible for providing health and human services to Alaska Native residents of the region. Established under P.L. 93-638, YKHC operates by resolution of the 56 villages within its catchment area. YKHC is governed by a Board of Directors.

The State, aware of the shortage of available substance abuse treatment services in the YK region, learned of the RRCD grant and alerted YKHC. YKHC agreed to participate in the grant and, in partnership with the State, submitted the application. As the program sponsor on record, YKHC assumed primary administrative responsibility for effective and efficient program operations. These were assigned to the RSAS. The CMTRS administrative functions were located in Bethel, and included the Office of the Director, an Itinerant Counselor, a Clinical Supervisor, and Management Information Systems technical support. Timely filing of grant reports and programmatic data were the responsibility of YKHC. The Board of Directors received routine reports on CMTRS progress.

2. CMTRS Policy Steering Committees

Policy Steering Committees (PSC) were formed within each of the three communities served by the program. While the number of PSC members varied from community to community, the PSCs were peopled with a balanced group representing community leaders, IRA and city government representatives, Elders, and key health and human service providers. Their role was to assist the CMTRS Counselors in identifying community needs, to represent the program to other members of the community, and to provide policy leadership and advice to units of local government, the YKHC Board, and senior administration. This intense local involvement was expected to result in more responsive and credible behavioral health programs. It was also more consistent with Yup'ik and Cup'ik forms of governance (see Appendix C for a description of the Policy Steering Committee bylaws).

3. Mental Health and Substance Abuse Advisory Board

Policy advice for the VAEC program was furnished by the YKHC Mental Health's Alcohol and Drug Abuse Advisory Board. This Board met quarterly and provided policy advice through the YKHC Board of Directors. Consistency and continuity of policy advice was assured through the interlocking membership of the Advisory Board and the YKHC Board of Directors. Occasionally, CMTRS program managers presented progress reports to this Advisory Board, which were for informational purposes only. Therefore, the policy advice they developed was focused on the VAEC program; it was not directed at a specific community but rather at a regional level.

I. ADMINISTRATION

1. Center for Substance Abuse Treatment RRCD Program

The Center for Substance Abuse Treatment (CSAT) program, funded under the Rural, Remote, and Culturally Distinct Programs (RRCD), was a unique initiative developed by CSAT. The overall program objective was to find new ways of providing effective substance abuse services to rural, remote, and culturally distinct populations. The RRCD program was managed through a cooperative grant arrangement with the State of Alaska Division of Alcohol and Drug Abuse. Federal program managers had responsibility and accountability for budget expenditures at the program level. The oversight was based on documentation received from the State of Alaska, and developed by the CMTRS financial system.

2. Regional Substance Abuse Treatment System

The CMTRS administrative apparatus was headquartered in Bethel within the YKHC Regional Substance Abuse System (RSAS). The RSAS operates a centrally coordinated regional system of outpatient services and aftercare within the villages, staffed by Village Alcohol Education Counselors (VAECs), as well as an accredited residential alcohol treatment program.

The CMTRS program philosophy, emphasizing local policy input and the use of traditional treatment modalities, was inconsistent with centralized control and decision-making. The RSAS, as part of the cooperative agreement between the State of Alaska, the Federal Center for Substance Abuse Treatment (CSAT), and the YKHC, employed its flexibility in the use of program funding and design.

CSAT had multiple responsibilities in policy development and implementation. There were data requirements of all participating programs that were communicated to both ADA and YKHC. There were also routine direct communications with the RSAS and the CMTRS program administrators. The policy directives from CSAT were, in part, contained in Federal law and regulation. The grant was a cooperative venture and thus allowed much flexibility and cooperation.

3. State of Alaska Division of Alcoholism and Drug Abuse

The cooperative grant was administered by the State of Alaska Division of Alcohol and Drug Abuse (ADA). As a state agency within the Alaska Department of Health and Social Services, ADA applied the same state regulations and reporting requirements to the CMTRS program as it would to any other substance abuse program funded by the State of Alaska.

CSAT information and data requests were coordinated through ADA, giving ADA an important and visible role in program management and operations. The Federal government held ADA accountable for timely filing of programmatic and financial reports, and the ADA Program Coordinator participated in all CSAT RRCD conferences. These responsibilities for administrative functions often placed ADA in between CSAT, YKHC, RSAS, and CMTRS.

4. Summary

The multilevel system of governance in the CMTRS program occasionally resulted in conflicting demands on program operations and often conflicting policy direction. Through the designation as a cooperative agreement, the amount of negotiation and cooperation was beyond that typically experienced by Federal grantees. Nonetheless, complete local governance was not possible within the administrative and governance structures associated with the program. Much of this could not have been avoided; each level of the administrative and policy structure retained its individual mission and corporate goals, and was required to abide by a set of regulations and standards.

II. EVALUATION DESIGN

The CMTRS project was one of six demonstration projects funded throughout the country to investigate methods of strengthening substance abuse treatment services among indigenous people. An evaluation component was considered essential to these demonstration projects. Initial funding reviews of the projects included substantial attention to the evaluation plans included by the proposer.

The responsibility for the evaluation shifted three times during the early phase of the project. The first evaluator was selected by the Division of Alcohol and Drug Abuse left soon after the project was initiated. A second evaluator was then retained by the Division of Alcohol and Drug Abuse, an arrangement that was not satisfactory to the program sponsors. One reason was the apparent conflict of interest between a state employee evaluating a program supported through a state cooperative agreement. The evaluation responsibilities were subsequently shifted to the University of Alaska Anchorage, Institute for Circumpolar Health Studies, which was responsible for the on-going evaluation and production of the final report.

A. EVALUATION QUESTIONS

The evaluation questions were those initially included in the evaluation plan. These questions are addressed in various parts of this report. However, the report is not structured according to each individual question asked. The evaluation plan was designed to answer the following questions, which have been reordered and grouped for clarity:

Treatment components

1. What are the components of effective treatment in this rural, remote, and culturally distinct setting?
2. What are the culturally sensitive and gender sensitive components of this treatment program?

Barriers

3. How has the program reduced barriers to accessing treatment?
4. What successes and difficulties were encountered in establishing and operating the project? How can program successes be implemented and difficulties alleviated if the program were to be replicated elsewhere?

Program impacts on patients

5. How many patients or participants were there in the program and what was their level of participation?
6. How has the program increased the number of village residents who now seek treatment locally as compared to the number who have historically sought and received treatment outside the community?
7. As a result of the CMTRS program, to what extent has the level of functioning of the patients increased?
8. How has the level of functioning of the patient's family been impacted by the patient's involvement with this program?

Community gains

9. How has the community changed as a result of the CMTRS project?
10. In what ways does the community feel the CMTRS program was beneficial in impacting substance abuse related problems?
11. Have medical, safety, criminal justice, and social problems in the target villages related to substance abuse been reduced?
12. How was the health status of the village residents impacted by this project?
13. How do CMTRS communities' perception of their program compare to other communities' perceptions of programs that provide similar substance abuse services?

Cost Impacts

14. Are there any measurable changes in the cost of substance abuse treatment?
15. Have alcohol-related costs, including the cost of DFYS placements, community productivity (the value of substance), and childcare, changed as a result of the program?

B. COMPARISON GROUPS

Many research projects include a reference group that has not been given the same level or type of service as the group in the demonstration project. The comparison groups, to the extent possible, are selected because of their similarity to the demonstration project group. For this demonstration project, the CMTRS communities were compared with those served by Village Alcohol Education Counselors (VAECs).

Comparison groups were required to control for the impact of extraneous variables on the measurement of CMTRS program effectiveness. For this reason, villages within the Yukon Kuskokwim region with substance abuse counseling services were selected as a comparison group. Specific villages were included in the comparison group because they were highly similar to the CMTRS villages in many respects, except for their programmatic approach. The effectiveness of CMTRS programs could be better measured by comparing them to the Village Alcoholism Education Counselors (VAEC) programs practicing in other communities in the YK Region. The overall goal of this expanded evaluation was to prepare for the possible integration of the CMTRS and VAEC programs by identifying the strengths of each.

The communities included in the comparison group were two clusters of three villages each. The villages in the first cluster were Mekoryuk, Toksook Bay, and Tununak, located on the southwest coast of Alaska, within the Bethel region. An additional cluster of three villages nearer to the hub community of Bethel was also included within the comparison group. Those villages were Napaskiak, Kwethluk, and Akiak.

The demographic and ethnic characteristics of these villages were very similar to those served by the CMTRS program.

The comparison communities received substance abuse prevention and aftercare services from the (VAEC). The VAECs were part of a larger Regional Substance Abuse System (RSAS) sponsored by the Yukon Kuskokwim Health Corporation (YKHC), and headquartered in the regional offices in Bethel, Alaska. Clinical and programmatic supervision were provided through the central YKHC RSAS office. There were no Policy Steering Committees; therefore,

all governance was also from the central office and the mental health and substance abuse advisory board of YKHC.

The population data from 1992 to 1999 show that the size of the clusters of villages were similar (Table 1). The total size of both groups was under 5,000 people.

Table 1: Community Population Data

	1992	1993	1994	1995	1996	1997	1998
Chevak	622	655	664	680	699	716	743
Hooper Bay	906	920	949	982	993	1015	1032
Scammon Bay	377	415	433	436	423	455	452
CMTRS	1905	1990	2046	2098	2115	2186	2227
Akiak	313	299	307	317	327	327	319
Kwethluk	593	581	613	644	630	664	669
Napaskiak	356	359	401	398	406	395	392
Comparison Area 1	1262	1239	1321	1359	1363	1386	1380
Mekoryuk	181	202	205	210	201	192	192
Toksook Bay	463	462	485	487	485	500	508
Tununak*	325	333	339	353	326	329	325
Comparison Area 2	969	997	1029	1050	1012	1021	1025
Total	4136	4226	4396	4507	4490	4593	4632

Source: Alaska Department of Labor, Research and Analysis Section, Demographics Unit.

*Alaska Population Overview (1998) shows that Tununak was dissolved as a village entity in 1997 (p.109).

Counselors hired under the CMTRS program were often able to address the needs of clients with multiple problems. This holistic approach was considered by local Policy Steering Committees to be a major advantage of the CMTRS program. It was largely the result of extensive training in a wide range of behavioral health interventions, including alcohol and substance abuse, mental health, suicide, youth protective services, social welfare, domestic violence, and other related problems. In addition, the skills of the CMTRS counselors were often well known and highly regarded in the hub city of Bethel. This enhanced their ability to obtain needed referrals for locally provided behavioral services.

VAEC counselors, on the other hand, were focused on substance abuse treatment services. Most of the patients they encountered were seeking drug or alcohol services or were referred by other agencies for aftercare. Most of the patients they saw had the presenting problem of alcohol or substance abuse. Referring providers in the villages and in the hub city of Bethel acknowledged the expertise of the VAEC in providing substance abuse services. Their close working relationship with the regional substance abuse services system ensured easy flow of clinical data between various levels of care. Typically, village residents and regional providers held the VAECs' clinical skills in high regard.

The evaluation compared and contrasted villages on the actual and perceived effectiveness of various substance abuse treatment approaches. Table 2 shows the principal differences between the CMTRS and the VAEC comparison communities.

Table 2: Comparison of CMTRS and VAEC Communities

Area	CMTRS	VAEC
Clients	Individuals and family units	Mostly individuals
Services	A broad array of behavioral health services	Services limited to prevention, aftercare, and some outpatient counseling
Provider Selection	Selected by Policy Steering Committees	Selected by RSAS central office in consultation with traditional government
Coverage	2 counselors per village	1 counselor for 2-3 villages
Hours of operation per village	80 hours/week	15 hours/week
Treatment Modalities	Western substance abuse treatment plus traditional treatment modalities	Focuses on Western prevention and AA services
Referrals	Referrals from many referral agencies located in Bethel (mental health, family and youth services, courts, RSAS, and self referrals)	Most referrals from RSAS and court system and self referrals
Clinical supervision	1 clinical supervisor for 6 counselors	1 clinical supervisor for 9-18 counselors
Governance	Policy Steering Committees	Central office mental health, alcohol, and drug advisory board, and YKHC governing board
Facility costs	Included CMTRS budgets	Donated by village government (variable by village)

C. SELECTION OF QUANTITATIVE AND QUALITATIVE TECHNIQUES

1. Initial Effort of Using Quantitative Data

The CSAT evaluations often encourage the use of quantitative evaluation techniques. Although the use of qualitative evaluation is noted, the emphasis is clearly on quantitative measures of program outcome. Despite this emphasis, quantitative evaluation techniques may be less important than qualitative evaluation techniques to assess program performance during the project's early stages. In addition, qualitative evaluation techniques may be more culturally appropriate than quantitative techniques.

Initially, the first evaluator designed and pilot tested a community survey prior to leaving. A final review of the data and survey administration was not done until ICHS had assumed the evaluation responsibilities. ICHS identified these problems:

- Many questions were too broad and unrelated to program goals and objectives.
- The survey was too long and complex and difficult to translate for Yup'ik and Cup'ik speakers.

The evaluator and CMTRS staff determined that more culturally suitable evaluation techniques that valued the oral and communal character of the Yup'ik and Cup'ik cultures were needed (Saylor, Booker, et. al, 1996). A new qualitative evaluation plan was designed to respond to the above concerns.

2. Decision to Incorporate Qualitative Evaluation

Shortly after the Institute for Circumpolar Health Studies (ICHS) took over the evaluation contract in 1996, it consulted with the CMTRS staff asking their opinions about what should be evaluated, and how it should be done. Staff were assured that a new plan was needed that would be more responsive to the program and community needs. It was suggested at that time to shift emphasis from quantitative to qualitative techniques and consider holding focus groups and videotaping key informant interviews.

a. Conditions Influencing the Decision to Use Qualitative Methods

Before describing the qualitative evaluation process, the conditions that predisposed the selection of this evaluation technique and working principles that were critical to its successful completion must be noted.

First, the goal of the evaluation was to document the story of the CMTRS program and to do this in a culturally appropriate way. Second, as described above, there were poor responses and resistance in the villages to the use of written processes—whether they were surveys or program statistics. So evaluation techniques that used and relied on the spoken rather than written feedback appeared more suitable.

Third, the use and viewing of video by other educational, service, and religious programs in the region have been well received in the villages. Fourth, video technology was both available and used in each of the program sites. Hi-8 camcorders, VCRs, and televisions had been purchased for each village program to use in documenting and viewing local applications of the traditional healing modalities and other therapy presentations.

In addition to the above predisposing conditions, central to the process was a commitment to collaboration and consultation by all principal players throughout the evaluation process. Specifically, those players included the CMTRS administration and staff, the evaluation team, and each of the three village-based PSCs. Each of these groups had its own perspective. Yet, regular consultation, information sharing, and problem-solving sustained and promoted the level of trust and cooperation that was needed to successfully complete each step of the process.

b. Evaluation Plan Revisions

At the administrative level, this process led to several revisions and exchanges of proposals over what key informant questions best responded to both content and cultural needs. At the village level, the process led to the willingness of Elders to candidly talk in front of the camcorder about how substance abuse had affected their families. While the predisposed

conditions provided the opportunity, the collaborative efforts took the opportunity step by step to completion.

A new evaluation plan was submitted to the CMTRS administration that included the following qualitative study components: (1) conducting a series of focus groups with local residents in each of the three villages and service providers in the regional center of Bethel; (2) videotaping key informant interviews in each of the three villages and in Bethel; and (3) doing a comparative cost analysis. By late spring of 1996, the plan was formally approved by CSAT, the federal funding agency.

Upon receiving approval of the plan, ICHS hired a field research assistant as the focus group recorder and videographer, and contracted for video editing services. Additionally, a focus group instrument was designed and approved by CMTRS staff and village PSCs; focus group members were selected; and a schedule was finalized. By July 1996, six focus groups were completed in the villages and one was completed in Bethel with regional service providers.

Within the next month, focus group reports were completed and an analysis had begun to identify “themes” for the key informant interviews. The specific steps included: (1) the recorder submitted a summary of focus group responses for each focus group relying on written notes and an audio recording of each focus group; (2) following content approval by CMTRS staff and village PSCs, an analyst at ICHS consolidated each focus group report by “themes,” grouping and summarizing similar responses; (3) after review and analysis of the focus group “themes,” the evaluation team composed and submitted the key informant interview draft instrument to the CMTRS staff and village PSCs for review, revision, and approval; (4) the evaluation team submitted a preliminary list of key informants to CMTRS staff and village PSCs for review, revision, and approval; (5) the evaluation team, together with the CMTRS staff, scheduled the selected key informant interviews and procured the necessary audio/video equipment.

These action steps illustrate how the focus group and interview components of the evaluation process interacted. Specifically, the focus group exercises facilitated the informant interviews in both content and process. By conducting a “thematic content analysis,” the focus group data was synthesized into a series of summary statements. This summary was instrumental in generating, first, the topic areas and, second, the final questions used in the key informant interviews.

Earlier “formative” parts of the CMTRS evaluation used data gained from this qualitative evaluation. The impressions, perceptions, and values of village members, counselors, and administrators were considered to be a more valid and reliable indicator of the progress and acceptability of the program than quantitative programmatic data.

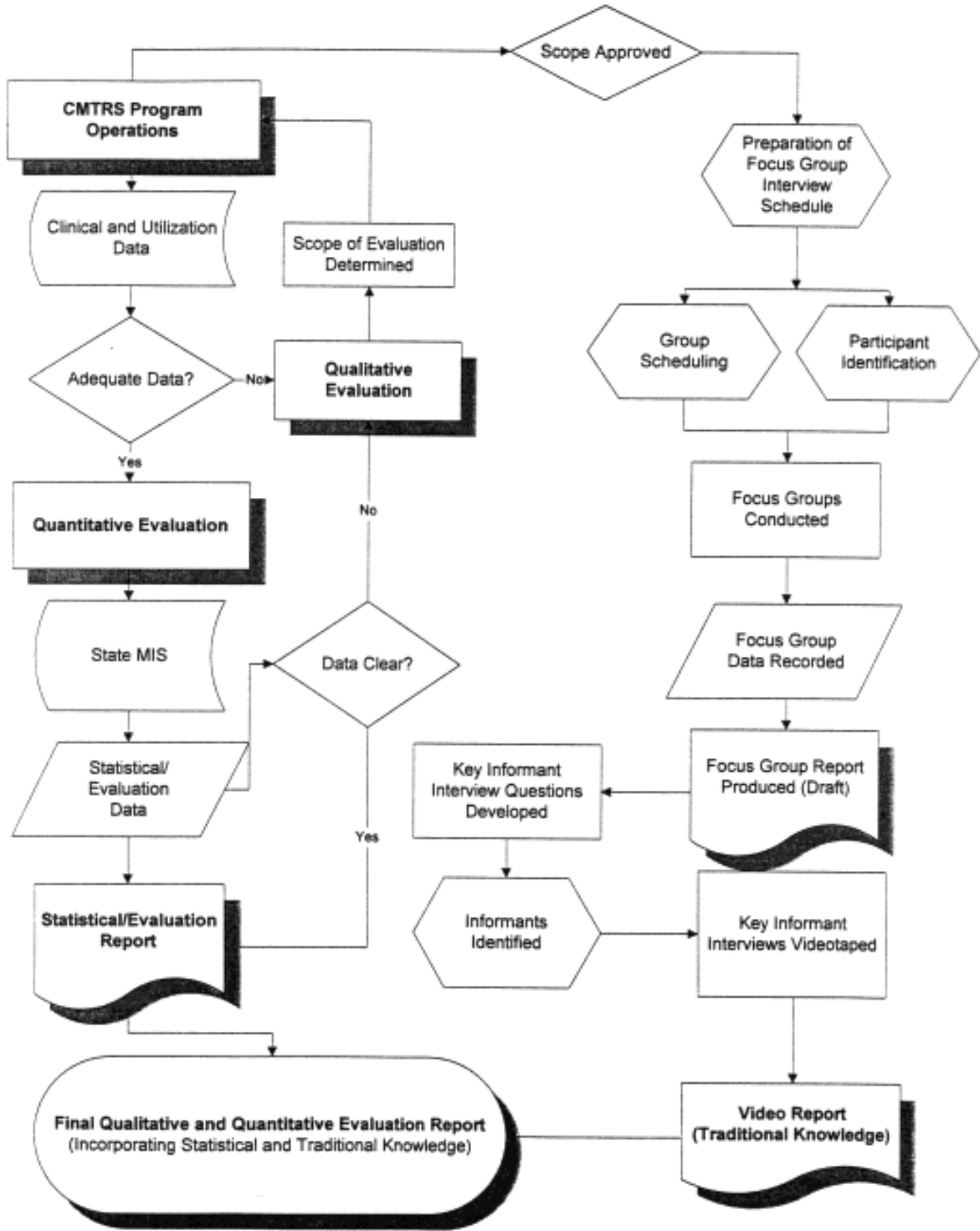
c. Summary

Qualitative data were used in the evaluation of the CMTRS program because the quantitative programmatic data systems were not well developed, nor were there sufficient numbers of clients receiving services in the program to conclusively demonstrate program impacts. The results of the formative phases of the evaluation were reviewed with program sponsors and policy advisors to help improve program performance. This is consistent with the “fourth generation” evaluation approach.

However, as more and more clients used CMTRS services, there were sufficient data to shift the focus from a qualitative, formative evaluation to a quantitative, summative evaluation. This reduced the reliance on fieldwork required to collect and analyze qualitative data, and increased the use of quantitative programmatic data. In the following section, a flow chart describes the steps taken in the evaluation process.

3. Flow chart on choice of Evaluation Method

Figure 2
CMTRS Evaluation Plan Flow Chart



III. QUALITATIVE FINDINGS

In order to gain an in-depth assessment and understanding of the CMTRS program's successes and weaknesses, the emphasis of the evaluation was shifted from a quantitative to a qualitative evaluation technique. This approach was deemed more culturally responsive, as well as believed to generate better information in the early stages of the program (Saylor, Booker, et. al, 1996).

The qualitative evaluation plan included a two step approach. The first step employed focus groups "to obtain major 'themes' or ideas common to all participating villages that address the strengths and weaknesses of the new substance abuse treatment program approach" (Saylor, Kehoe, and Smith, 1996). The second step was to produce a video using the major "themes" from the focus group feedback to build a "storyboard" or script that could "guide the video taping of key informant interviews" (Saylor, Booker, et. al, 1996). The two steps were interdependent evaluation techniques intended to elicit in depth program information and feedback using culturally compatible communication methods.

An important aspect of the qualitative evaluation was the incorporation of feedback from the CMTRS staff and community members, since program participants or observers may have valid opinions about the strengths and weaknesses of their village treatment services. In addition, the CMTRS Policy Steering Committees (PSCs) in each village have many village Elders as members. In keeping with cultural values and the village-based philosophy of the program, their review and approval was critical for each aspect of the focus group and key informant video taped evaluation.

Both focus group and key informant interviews were intended to solicit the opinions of all of those involved. Occasionally, the views, opinions, and perceptions of people associated with program were not an entirely accurate, reliable, or factual statement of program activities. Subsequent reviews of focus group data occasionally yielded discrepancies between information and focus group reports and programmatic information obtained from program administrators. These discrepancies do not invalidate the focus group data, but show additional issues in the knowledge of community members and Policy Steering Committees in their understanding of program operations.

A. FOCUS GROUPS

Since local program participants and community members often see program results and benefits that escape capture during a quantitative programmatic evaluation, focus groups were the chosen technique for collecting this data. The expectation was that a sufficient number of focus groups could be conducted to obtain major "themes" or ideas common to all participating villages that addressed the strengths and weaknesses of the new substance abuse treatment program approach.

The use of focus groups is based on the premise that individual attitudes and perceptions are not developed in isolation, but through interaction with other people. For this reason, the data obtained in focus groups, while reflecting the views of the individual members, are very different from the participant's narrative obtained through interviews (Morse and Field, 1995; Saylor, Booker, et al., 1996). In a cross-cultural research setting, Rolf (1995) noted how focus group use increased local trust levels and credibility in the process by portraying the research team as "good listeners' and people who could be trusted to seek local impute, to value it, and to keep seeking more of it" (168).

A focus group is typically composed of seven to ten members selected because of their knowledge or relationship to a topic. During focus group meetings, the leader creates a permissive, non-threatening environment where individuals can feel free to discuss areas of interest. In this study, focus groups were determined to be the most efficient method for obtaining community perceptions about the strengths and weaknesses of the CMTRS program because of the oral and communal character of the Yup'ik and Cup'ik cultures.

The use of focus groups originated among businesses whose goal was to obtain a wide range of opinions to enhance marketing strategies (Kruger, 1994). Focus group techniques have expanded beyond their traditional use in corporate marketing analysis, and have become more common for assessing needs in health services (Kruger, 1994). In Alaska, focus groups have been used extensively (Burhman, 1996 and Pearson, 1996).

Focus groups promote a safe environment that encourages discussion of sensitive topics. The leader guides participants through an in-depth discussion using a prearranged schedule of probing questions. Experience shows that participants are more forth-coming in expressing their opinions and feelings than they might otherwise be in family groups or office staff settings. The information collected during focus group discussions is often richer, and provides more in-depth information than might be achieved through a public opinion survey. In addition, focus group data can provide more "objective" information than might be obtained through key informant interviews.

All focus groups were conducted using a consistent interview schedule, except for the provider focus group in Bethel, which was slightly modified. The basic interview schedule is shown in Appendix G.

1. CMTRS Focus Groups

a. Introduction

Detailed reports from seven focus groups were used to prepare the following summary, or "thematic content analysis," addressing the problems, strengths, and opportunities of the CMTRS Program. A member of the evaluation team who did not attend the focus groups developed a series of basic themes and presented the focus group comments that supported each theme. The assistant focus group leader and the focus group leader then reviewed and edited the draft thematic content analysis. Village counselors and Policy Steering Committee members also reviewed the draft themes to assure their accuracy. The major themes are presented below.

b. Thematic Analysis

Substance abuse is a major problem in participating villages.

Participants reported seeing substance abuse around them every day-- among friends who smoked marijuana or binged on alcohol, and among young people who were often listless and unmotivated. They reported loud and abusive language on the VHF in the evening and graffiti in the village, revealing anger, hurt, and the rejection of the traditional value of property.

Substance abuse reportedly contributed to accidents, suicide, and the disruption of the family unit. Participants expressed great concern over how alcohol and drugs affect families and children. Many reported a high level of protective custody. When parents drank, their children were often neglected and went hungry. Child neglect and abuse cases in the village were

almost always alcohol/drug related, and children were often removed from their home. One participant said, *“One hundred percent of the families involved with the Protective Service system have some type of alcohol abuse as their reason for involvement with that agency.”* State child protection sees substance abuse treatment as “the major issue of every family undergoing family treatment.”

Participants talked extensively about the risks of substance abuse to children. They said young people were exposed to and used alcohol and drugs in their homes, which was tolerated by parents and older brothers and sisters. One participant said, *“Teens won’t change until parents change.”* Others said young people acquired bad habits from outlying villages. *“Like disease, young people bring it back to our village.”* In addition, participants said juveniles involved in the legal system were there due to personal or family related substance abuse issues.

Eroding traditional values contribute to the increase in substance abuse problems.

Most participants felt that getting back in touch with traditional ways was important for combating substance abuse. *“If we returned to our traditional ways, we would be much happier.”*

Participants suggested renewing cultural values that promote subsistence living and caring for one's self, family, and community. They urged people to stop by and visit an Elder, invite people to dinner, and share with others. One participant encouraged people to work together, back each other up, and take time. *“The best things in life are things that take time.”* In addition, participants said all village members, young and old, should have a job or role in the family to increase a sense of self worth. *“If all are given value, one would not have to look for value in the bottle.”*

Participants encouraged village members to wean away from modern technologies that promote an instant and disposable “microwave” mentality. One member said, in the past people died of old age; today people are eating canned food and dying young from sickness. *“Get back to traditional values, back to subsistence lifestyle.”*

Decreased reliance on Elders has contributed to the increase of substance abuse problems.

In the past, village members relied on one another, and their lives were interwoven. *“Today someone else will take care of it.”* Participants encouraged individuals to deepen traditional values by using more Native sayings, traditions, and rules of the past, and by incorporating more “celebration of life” activities, such as “1st catch” and “passages of life” celebrations. They urged building a community steam house, going to fish camps, and holding public recognitions and celebrations of yearly sobriety anniversaries. One participant suggested having wood gatherings. *“Just when that saw hits the wood, something happens in my heart.”*

Elders are seen as a great strength, with the knowledge to advise people with problems. *“Elders don’t correct you, but tell you to sit down and think about it a second time.”* Many felt Elders needed to be promoted and helped to speak out so they could “regain their place” as role models. *“If a person who was abusing was spoken to, they would change.”* Many felt it was especially difficult to get young people to listen to family Elders who wished to pass on values. *“How can we help youth think straight again?”* Participants said an Elder/Youth Meeting could be a first step toward restoring the spiritual meaning of life to young people.

Local control of substance abuse programs can help make programs more effective.

Group participants expressed a strong desire for local involvement and control in their community. *“The whole community must be involved in the solution.”* They encouraged villages to hold community meetings, identify purpose, set goals, and use local knowledge that would eliminate outside dependency. One participant suggested increasing efforts to gain village “self-sufficiency” and heal at the community level (Alkali Lake model).

Participants said village leaders who knew what was “best for all” could better meet community needs. Reportedly, some community leaders have gotten involved in substance abuse issues by confronting village members through letters or a meeting. Participants said each community leader needs to be energetic, as well as a strong model for sober and healthy living in the community.

Participants reported that many people have begun looking at ways they can improve programs in their village--without depending on outside sources. *“Outside ways become a crutch and takes pride away and makes us feel empty.”* They said villages that retain some sense of local community control are often less tolerant of substance abuse, as opposed to villages with little community control. A regional provider who worked closely with the CMTRS Program said, *“We are onto something here that seems to be community based and is working.”*

The use of local resources can enhance substance abuse prevention and treatment.

Participants discussed the need for greater coordination of effort in their community, saying that there were too many factions and variations in agendas. Many saw strength in continuing and encouraging partnerships among local resources that support sobriety, such as mental health workers, Community Health Aides, schools, and church ministers and priests. They listed other available resources, including parents, friends, Elders, and the Traditional Council, which now intervenes and directs individual to treatment or to Tribal Court. One participant said, *“I’m so glad Traditional Council chose to intervene and help her stop...”*

Many participants considered individuals who are recovering from alcohol and substance abuse as important resources and models for others. Even *“neighbors are taking the courage to confront when needed.”* One participant said, *it is important to “know someone is caring about them and their children.”*

More vigorous local law enforcement on the sale and distribution of alcohol and other illegal substances can help reduce the impact of substance abuse.

Participants reported that alcohol was abundant in the villages due to home brewing and bootlegging. Most felt laws needed to be enforced more strictly in the villages, particularly relating to the importing of alcohol and drugs. They suggested checking bags and “pat searching” people at the airport, and enforcing postal service laws that forbid mailing of alcohol and drugs. Others suggested enforcing the \$25 fine for public drunkenness. One participant said, *if Bethel did not have liquor and bootleggers, it would help the villages because local people did not self-police.*

Many participants felt that since the CMTRS program began, they have seen increased police protection, and more patrolling and confiscating of alcohol and drugs. They reported less public drinking because offenders were sent to CMTRS for counseling. Participants listed many of the stiffer local ordinances against alcohol and drug-related crimes, for which offenders were currently being court-ordered for treatment.

CMTRS has allowed village members to receive substance abuse services in their own communities.

Prior to the CMTRS program, individuals were sent out of town for treatment, which they often could not afford. Today CMTRS provides a local alternative so clients do not have to leave their family and community. *“Counseling doesn’t work when people go outside.”* Participants reported that CMTRS was the first village based program that successfully followed up on clients when they returned from outside treatment programs. *“Clients feel hopeless and immobilized when they return to their village and find no local, follow-up services available.”* Participants reported that now these individuals feel more hopeful about returning to their village where the CMTRS program has a locally based program.

Many participants expressed concern over the future of the CMTRS program. One individual said, *if CMTRS ends, the village will fall back because no local counseling will be available.* Apparently, other villages were aware of the program and actively requesting use of the CMTRS model. However, as the initial funding decreases, a transition plan is needed to retain and continue the CMTRS program and model.

CMTRS is credited with reducing the impact of substance abuse in the villages.

Evidence of the CMTRS program’s success was widely cited by the focus group members. One participant said there were *“dramatic changes in the village...today substance abuse is not as visible.”* Others reported seeing less partying, drinking, and fighting, and more people attending church and talking about substance abuse issues. Participants said holidays were more positive. *“This is the first, mostly sober Christmas we have had.”*

Local program governance through Policy Steering Committees has helped to make CMTRS services more responsive and effective.

Participants viewed the CMTRS program as a strong and important part of their community that increased substance abuse awareness, drew on local strengths and partnerships, incorporated cultural values, provided resources to kids, strengthened laws, and provided professional and stable counselors to village members struggling with substance abuse. They discussed the impact the CMTRS program has had as a locally based service, saying that because local people were invited to take “ownership” for the program, it had become *“part of the fabric and structure of the village.”*

The CMTRS program works as a community partnership, drawing together the strengths and wisdom of local Elders, clients, and staff. “Organizational committee” meetings are held regularly to discuss and problem-solve village concerns. *“They mean business!”*

The selection and training of local counselors has contributed to the effectiveness of CMTRS.

Group participants spoke highly of CMTRS counselors, saying the workers were doing a good job sharing, teaching, and making the village healthier. CMTRS counselors were trained to respond to village problems and were available daily. One participant said, *“Since they are there every day, you get an immediate response.”*

CMTRS counselors provide ongoing and follow-up treatment plans that move people toward wellness. *“Other locally based counselors are not ‘wellness’ oriented.”* One participant stated that unlike other YKHC counselors, CMTRS counselors can make their own decisions regarding the program and specific treatment needs. With two counselors per village, they are also able to respond to substance abuse problems as a “team.” Many participants appreciated

that CMTRS counselors were able to respond to all people regardless of their level of substance abuse.

The use of “traditional healing modalities” based on traditional practices are effective methods of treating substance abuse in the village.

Generally, cultural values have been ignored in substance abuse treatment plans. However, group participants felt the CMTRS program incorporated traditional values and practices in their treatment plan. They said CMTRS counselors were trained and capable in both Western and traditional counseling practices, and used cultural knowledge (treatment modalities) to work on problems. *“The Yup’ik treatment modalities are unique and make the program work.”* CMTRS has also helped groups of Elders speak at school. *“There have been good and remarkable results in three years.”*

CMTRS has helped increase community awareness of the effects of substance abuse in the villages.

Group participants reported that the CMTRS program has successfully increased substance abuse awareness in their village. *“If we start with one family and they change, everyone notices.”* Participants said the CMTRS program needs to continue what it is doing, so people will continue to hear about the negative effects of alcohol and drug abuse, and eventually want to change. Reportedly, more families have come forward, and the referrals made by the Traditional Council have decreased because most people with problems are already in the system.

Professionals serving the region see the CMTRS Program as effective because it decreases their caseloads and assists with aftercare and follow-up.

Service providers in the “hub city” of Bethel reported that the CMTRS program has helped reduce the number of referrals made to them from the three target villages. They said the ability to work with CMTRS providers has reduced the need for state and outside agency interventions.

Providers encouraged the expansion of programs based on the CMTRS model. One said, *“This is the first time in 8 years I have seen a group of service providers agree on a service delivery model that is working well in the villages.”*

c. Conclusion

The CMTRS program was credited with increasing substance abuse awareness in the villages, providing services based on traditional healing modalities, and providing accessible treatment that enables individuals to remain in their village. Keys to the program’s success are:

- The use of providers who are residents of the village.
- Program governance at the local level.
- Treatment practices that are consistent with the traditional culture and lifestyle.

Results showed that the CMTRS program was effective in providing local, culturally-based substance abuse services to the three Alaska communities targeted in the demonstration project. It is our belief that this program could be replicated in other traditional Alaska communities, and perhaps in other remote and culturally distinct communities across the nation.

2. VAEC Focus Groups

a. Introduction

This section summarizes the results of focus groups held in six villages (Kwethluk, Napaskiak, Akiak, Mekoryuk, Toksook Bay, and Tununak) served by Village Alcohol Education Counselors (VAECs). The questions asked were the same as those asked during the focus group project in CMTRS communities. An additional group was also held for Bethel-based providers. The objective of this project was to produce data that would offer a comparison of public perceptions of CMTRS and VAEC substance abuse treatment services. VAEC focus groups were held with both teen members and adult members. Originally, the evaluators questioned whether the ideas expressed by teens might differ from those expressed by adults. However, a separate analysis of teen and adult focus groups revealed little differences between the two. The following thematic analysis includes both teen and adult focus groups combined.

b. Thematic Analysis

Overview of VAEC services

Bethel participants discussed how the VAEC program works. Most agreed that completion of some kind of treatment program seems to help keep legal offenders from returning to jail. *“Of the 320 on probation out here in the Delta, only 15 to 20 are in jail. MR/DD staff convene local village meetings and expect the VAECs to participate and become part of the local “safety net” for the returning client. “We need someone like the VAECs to provide client support in the village.”*

Usually court-ordered substance abusers are mandated by the court to receive an assessment and treatment up to a maximum of 45 days. *“Counselors attempt to ‘convince’ clients to go beyond the 45 day treatment period and remain in ‘aftercare’.”* However, the Department of Corrections cannot legally mandate client substance abuse treatment beyond the court-ordered sentence. *“Clients usually do not pursue any ‘aftercare’ treatment beyond their mandatory sentence.”* If the court-recommended residential treatment does not occur immediately after release from jail and the client returns to their village, the client often cannot afford the plane trip to Bethel for residential treatment.

Process of Referrals between Bethel providers and local VAECs

Bethel participants discussed the referral process that takes place for substance abuse treatment in the villages. In Akiak, for example, referrals come from both the tribal council and the community. Referrals must come from appropriate agencies and channels. *“Sometimes an IRA member will ask the VAEC to go take care of that person who is drunk. That is not an appropriate approach.”*

When appropriate, VAECs refer clients to Bethel for residential treatment. After completing treatment, the client is referred back to the local VAEC with a written “aftercare” treatment plan for the VAEC to follow. (The VAEC participant indicated that they are not involved in developing this treatment plan.) MR/DD adults who undergo substance abuse treatment in Bethel are also referred back to the VAEC in hopes that the VAEC will become a primary resource for supporting and assisting these clients who return to the village. Two types of clients are referred to the VAECs: (1) assessed clients who enter a 12-month, local out-patient and aftercare program, and (2) those receiving a “DWI” citation. “DWI” referrals complete an 8-hour correspondence course in the village. *“ASAP and other deferred sentences or deferred*

prosecution programs expect VAECs to provide an assessment and local aftercare to these referrals.” Local out-patient care uses the “12-step program” for 3 months, followed by aftercare” treatment the remaining 9 months.

However, mental health clients with a substance abuse problem are only referred to the local VAEC if the client wants to work on his/her substance abuse problem. If the client is not interested, no referrals are made. All clients are court referrals for either “aftercare” counseling and/or community service. There are no self-referred clients.

VAECs can also provide treatment to Community Health Aides with substance abuse problems. *“It’s a ‘hope’ more than an ‘expectation’ that the health aide will seek out the local VAEC for treatment services.”* In the last year, the YKHC Community Health Aide Program developed an employee assistance program process with PATC, VAEC, and CMTRS staff for Community Health Aides with substance abuse problems. *“[They] designed an employee referral system specific to Health Aides.”* However, when a health aide is attempting to receive substance abuse treatment, there are 4 to 6 week gaps between the initial review and assessment, and when the treatment can begin. During this time local support or follow-up is needed, but often not available. One participant said, *“We have a long way to go.”*

Substance abuse has decreased over the years in some villages.

Some participants felt substance abuse had decreased in the villages over the years. They said the VAEC program provided people with a local option for treatment and follow-up. Many agreed, however, that the amount of substance abuse goes up and down in the villages. *“It changes rapidly—people sober up, then relapse.”*

Substance abuse continues to be a major problem in VAEC villages.

Participants see substance abuse as a significant problem that needs to be addressed in their village. *“[I see] a lot of it—people staggering. It happens anytime of the year.”* As evidence of a problem, participants reported seeing drunk people speeding on snow machines, starting fights, talking on the VHF, and shooting their guns erratically. *“They walk around with guns and scare people.”* Participants associated increased drinking with the fishing season, weekends, holidays, and after people got paid (from work, commercial fishing, public assistance, longevity or permanent fund, etc.). One participant gave the following response to seeing drunk individuals on the street: *“They must have just gotten paid.”*

Many participants expressed concern over the magnitude of the problem, and the difficulty of treating substance abuse. *“No one wants to pay attention to it—the problem is too big.”* They said people drink to get drunk, and can’t admit they have a problem. *“It’s seen as acceptable.”* Participants agreed that *“it can be hard to change.”* One said the village started an Alcoholics Anonymous meeting, but not many attended. Substance abuse affects everyone, from children to Elders. One Elder said when he was a young man no one used alcohol and drugs, but today it was in the village and *“leads to problems with families.”* Participants discussed how alcohol impacts families through Fetal Alcohol Syndrome and violence. They said parents who drink often get into fights, exposing their young children to this behavior. *“These parents often think it is okay to do this.”*

Although participants agreed that substance abuse was a significant problem that needed to be addressed, opinions varied as to whether it had increased or decreased over the past few years. Some felt substance abuse had decreased, reporting less public drunkenness, fewer custody cases and abuse complaints to VPSOs, and growth in public awareness. *“[Alcohol use] has gone down a little. You used to see it every day, but now you don’t see it as often.”* Others, however, felt the problem had either remained the same or differed depending on the

age group. A Napaskiak participant said, *“The problem has stayed about the same for adults, but less teens are in trouble.”* Participants from Akiak also felt substance abuse had remained about the same. In Mekoryuk, participants said substance abuse was a major problem before the village members elected to make it a “dry” village in 1981. *“It was so bad that I was thinking of moving out of the village.”* Since then, Mekoryuk has cleaned up and, although alcohol and drugs are still present, it is less of a problem than in other villages. *“It doesn’t get as crazy here as in other villages.”*

Marijuana use has increased in the villages.

Participants reported an increase in marijuana use in the VAEC villages. They said it was easier to get and use marijuana than alcohol. *“[It’s] common—you can see it around town.”* Some reported that the leadership in the village smoked marijuana. *“This is a bad influence on the kids.”* Others said their own teens were using marijuana and may be addicted to it. Participants discussed the problem of marijuana being illegally imported into the villages. One suggested that YKHC fund a dog to “sniff out drugs” at the airport. *“[Marijuana is] hard to trace when it is coming in by mail.”*

Tobacco use among youth is a major problem in villages.

Participants see reducing the use of tobacco, particularly among youth, as a significant and important challenge for the villages. Many felt tobacco use was higher than ever, and most of the teen participants said they have smoked cigarettes, and/or chewed tobacco and “ikmik” (homemade chew). Some said they have been using smokeless tobacco since they were 3 or 4 years old.

Inhalant use is a problem in some villages.

Participants reported that inhalant use was a problem in some villages, but not in others. In Akiak and Bethel, they said inhalant use happened regularly. *“Having limited financial resources, ‘gas sniffing’ is the biggest area of abuse.”* Participants from Tununak said that although gas sniffing still occurred among young people in their village, it happened less than it used to. *“It’s a cheap high,”* and *“...it’s free.”* Participants from Kwethluk and Napaskiak reported that few if any used inhalants anymore, and those from Toksook Bay and Mekoryuk said inhalant abuse was not a problem for their village. *“Very young people were experimenting, but they were sat down and told it was dangerous.”*

Bingo takes money and quality time away from families.

Many participants felt bingo was a significant problem in their village, and that eliminating it would create more family time. *“If they didn’t play bingo, parents would spend more time with families.”* In Mekoryuk, all village organizations collectively decided not to sponsor bingo, and participants said they wanted to continue keeping bingo out of the village because it was addictive and took money away from the poor. Some suggested using the “saved money” or profits from bingo to install a drinking water and sewage system.

Many village members feel it is essential to maximize local resources for developing a successful substance abuse treatment program.

Reestablishing and maximizing local control in the villages was an important topic of discussion, particularly for participants from Akiak. *“We have the knowledge to operate on our own, instead of using outside help.”* Many felt outside influence and control worked against

them, and that they needed to be provided with the technical assistance to allow them to craft their own program. *“We can do it on our own!”*

Currently, all programs are regionally administered (what has been done in the village has been funded from outside the village—YKHC or the State of Alaska). Participants said that if the program direction and a larger part of AVCP and YKHC dollars were transferred to the village there would be a better chance of local control. Many felt they could do a better job than outside organizations if the village could get all the dollars contractually. *“It has to come from the village to work.”*

Bethel focus group participants also stressed the importance of local control. *“Active involvement locally needs to be stressed and promoted.”* They said if positive changes were to occur, each village would need to decide locally and act on these decisions. *“Each village and individual needs to pursue their own health.”* Many also wanted to see more local control by tribal councils. They said, as members understood the program and its referral process, the local council could become a major referral resource to the VAEC. *“As the local councils learn their roles, they can become a local force to encourage and keep clients in the program.”*

Participants also emphasized the importance of local training and jobs in the villages. They stressed making an effort to utilize “local talents” and to hire people locally instead of from outside the village. *“Today local counselors are picking up more local work versus outsiders doing it.”* They suggested finding ways to increase local experience, education, and vocational training to help local residents secure jobs. *“Establish more local training and openings for work.”*

Many village members want to see local law enforcement strengthened, especially against bootlegging.

One of the single most mentioned concerns expressed by the focus group participants was the need for increased law enforcement for combating substance abuse in the villages. *“We have no specific tribal laws enacted to enforce.”* Many felt laws were either not enforced, or when enforced, took too long before the arrest and prosecution. Participants also said minor problems were often enforced but major problems ignored. *“They stress curfew instead of alcohol enforcement.”* Others complained that law enforcement officials “played favorites” in their village. *“They are afraid to tell on locals, because of fear of friends and family—they’re often related.”*

Participants reported a high volume of bootlegging out of boats, on the river, and out of Bethel, particularly during the commercial fishing season. *“Liquor is too close, too easy to get. Young people chip in together at \$50 a bottle.”* Although most of the VAEC villages are “dry” villages, participants said individuals could easily get booze from Bethel, which impacts the smaller villages. Some felt that when Bethel residents voted on issues such as the legalized sale of alcohol, the surrounding villages should also be allowed to vote. Participants offered a number of suggestions for increasing law enforcement in their community:

- Searching luggage coming into the village
- Patrolling fish camps where people drink
- Making sales of alcohol illegal in all villages in the region
- Increasing consequences for offenses (stiffer fines, community service, and jail time)
- Getting funding to hire more VPOs and VPSOs
- Allowing VPSOs to enter a house when they think someone is drinking (VPSOs need a warrant to enter a house)
- Increasing local law enforcement authority (only state troopers who live outside the village can respond to felonies)

- Getting a local magistrate to take care of local crimes
- Getting a federal marshal to replace state troopers in arresting bootleggers (participants felt that in the past the federal marshals were more effective—before state troopers took their place)

Many village members recognize the need for strong leadership.

Participants from the villages of Mekoryuk, Toksook Bay, and Tununak stressed the importance of strong, sober leadership in their villages. Several said they were ashamed when leaders spoke at conferences and meetings while drunk. *“We need to promote sober leadership.”* In Mekoryuk, participants said the VAEC’s advocacy for “sober leadership” has helped the City Council and other local organizations see this as a priority. Participants from Toksook Bay reported that Elder leaders today support various prevention programs that promote sobriety, such as the Suicide Prevention And Recreation Coordinator (SPARC) program and the COPS (Community Oriented Policing Services) program. They also said that village leaders have pushed for village-wide involvement, recognizing the need to work with young people who are their “future leaders.”

Reestablishing traditional values can help make villages healthy.

Participants from Tununak and Toksook Bay, in particular, discussed the need to strengthen traditional values, including parenting, family values, and land values. Some said difficulties regarding substance abuse were a result of the clash of two cultures. *“Boarding schools, religion, and alcohol have been sources of current problems.”* Participants also discussed how the loss of traditional cultures has led to anger, frustration, low self-esteem, and suicide in young people. *“Drugs are taken to feel better.”*

Elders have begun focusing on teaching the traditional ways of life, rather than stressing the “negatives” of substance abuse. In Toksook Bay, efforts have been made to incorporate speakers at dances, discussing topics like how to travel safely in the winter. Elder speakers have also shared traditional ideas and experiences on how they *“lived in the past.”* Participants said their village has begun to consider ways to combine traditional Yup’ik and Western ways into substance abuse prevention. *“The Yup’ik approach would give a person more of a chance helping to sustain a person’s esteem.”*

Bethel participants also felt that in order to be effective in the villages, a service provider should have substance abuse and mental health training, instruction in the Yup’ik language, and cultural knowledge and skills. Most agreed that the challenge of a local counselor is to identify how and when to use Western and traditional therapy methods. *“It takes time to find out what works.”* Training standards are slowly becoming more inclusive of traditional Yup’ik healing methods and traditions. *“We have had in-service training where the village Elders came and told their stories. These had more impact on them than the Western training.”*

Local judges may be open to inclusion of traditional therapy approaches. *“After prescribing ‘Eskimo dancing’ as a therapy, a suicidal teen in Bethel has shown significant improvement in both her school work and personal attitude at home.”* Other examples offered where sex offenders are being successfully counseled locally by village Elders. *“Elder counselors in two villages have an added advantage and are looked up to for guidance and advice.”*

Many felt state systems were also becoming more accepting of use of traditional knowledge and counseling methods. *“Funders are beginning to consider a more holistic approach--blend of both traditional and Western methods.”* A court approved plan coordinated by MR/DD, Vocational Rehabilitation, and CMTRS has initiated a village-based “vocational subsistence” program for an MR/DD client as an alternative to jail or PATC. *“A local person is working with*

the client doing subsistence activities in the village.” In the VAEC Program, the “12-Step” Program has been conducted orally in Yup’ik in deference to Elder clients who have limited English writing and speaking skills. Current training goals are to certify all VAECs both at a minimum “Level 1” rating and secondly as state recognized “traditional counselors.” *“Elder coordinators are invited regularly, as presenters to the VAEC trainings.”*

Elders should be involved in substance abuse programs.

Several focus groups addressed the need to involve Elders in substance abuse programs and treatment plans. *“I wish there was a way to get Elders back involved.”* They spoke about ways Elders were involved in the past. For example, when someone was drinking in a village, Elders pulled their boat onto land or disabled their snow machine until they sobered up. *“Elders gathered regularly and talked in a caring way to young persons with problems.”* Participants from Mekoryuk said 6 or 7 years ago the village used the “hot seat” approach where several Elders talked to an abusing individual. Once or twice a family that continued abusing was banished from the village.

Participants suggested ways to increase Elder-youth communication, and to reinstate “Elder interventions.” An Elder-youth conference was held in Bethel the previous three years, which helped students talk about substance abuse. *“We did a skit—it helped others open up.”* In the old days, local Elders taught regularly and did counseling in the sod house. They suggested using Elders to help teach and guide the VAEC. *“Let the VAEC listen to and learn from the Elders, and pass on these teachings.”* Participants said Elders support ongoing inclusion of traditional and Western approaches, and that they talk to families in an attempt to solve substance abuse problems locally through tribal court and referrals to the local VAEC.

Providing more education about the dangers of substance abuse can help locals deal with these issues.

Participants discussed the need to educate kids and adults about the dangers of alcohol, drugs, and inhalants. Individuals from Toksook Bay said the VAEC should be talking monthly with the school kids about alcohol and drug abuse, and suggested that YKHC provide them with additional help to do this. Other participants suggested alternative teaching methods and environments, away from distractions like TV and Nintendo. Suggestions included: steam baths, basketball games, and hunting and fishing in the tundra. They also suggested providing education to adults and school-age children in both Western and Yup’ik traditions. *“Start with elementary students.”* One participant from Akiak said that less than 1% of public dollars were for local children’s services in substance abuse prevention. Participants encouraged VAECs to continue working with the school and local community on “public awareness” projects, such as with the state and regional “sobriety movement.” *“The key is individual and group awareness.”*

More activities can help make villages healthy.

Most participants felt it was important to have plenty of activities available to families and young people, since boredom can lead to substance abuse. A VAEC who spoke at the schools also reported that, *“Kids said that there is no activity in the village—nor in Nightmute.”* Apparently, Toksook Bay used to have a pool hall for games and “hanging out,” but the community closed it down because some individuals were selling and using drugs. Participants from villages that already had a teen center suggested extending activities, supervision, and hours. *“[It’s] open only 2 or 3 hours a day.”*

Participants also suggested increasing other community activities, such as dances (especially Eskimo dancing), summer camps for young people, and conferences that include “everyone”

(youth, Elders, and presenters). “[We need] more gatherings—community festivals.” Others suggested improving gym facilities and having more open gym time in the summer and winter. “Open gym--not just for boys and adults, but girls as well.” Some reported that their community recently responded with more activities, such as basketball, Native Youth Olympics, cross-country running, sober dances (suicide prevention fund-raisers), puppet troupe, Eskimo dancing, live band concerts, and potlatches.

Some village members identify strong local groups that continue to help in the effort to combat substance abuse.

Participants mentioned a number of local groups that currently respond to substance abuse problems in the villages. In Mekoryuk, these primary groups include the IRA, the city government, and the City Council, which works with the IRA Council and Native Corporation promoting village activities and helping to “dry up” the community. Many felt substance abuse diminished significantly after the City Council drafted and enforced village ordinances. Other local groups that have helped address substance abuse are: VPSOs, local tribal court, and school conferences and programs, such as the “natural helper” program (a peer counselor program). Participants also reported several ways the following local groups have supported local solutions: the City, IRA, and Traditional Council made an \$800 annual donation for New Year’s activities, the Native Corporation store removed products related to substance abuse (yeast, hair spray, shaving lotion and cologne), and organizations established local video arcades for young people.

Participants from Toksook Bay reported having strong local groups that respond to the problem of substance abuse. Once a month all leadership groups meet for 4 to 5 hours to problem-solve and work through various community issues and concerns. The City Council’s initiation of the COPS Program has helped put the entire village “on notice” since anyone can report substance abuse activities. The program involves the general community, State Troopers, National Guard, and the airlines in Bethel. Through the COPS Program, local consequences have been established for substance abusers. These include: (1) exclusion from community activities, and (2) the possibility of being “kicked out of the village” with a majority of village signatures. VPSOs also visit and inform individuals of their involvement in substance abuse (and the consequences if they continue), and commend those who have ceased importing alcohol. Many agreed that community policing has “slowed down alcohol in the village.”

In the past, the City Council in Mekoryuk had a joint agreement with AVCP and the State Troopers regarding the VPSOs, but today the City Council does not have any formal supervisory responsibility over the VPSOs, who are not required to formally report their activities to the City Council. “The City Council can only invite but not insist on regular VPSO reporting.”

People can improve the quality of life in their villages by talking with people and involving them in local solutions.

Participants felt that getting rid of alcohol and drugs was one of the best ways to improve the quality of life in their community, “[so] people are sober and drug free.” Some suggested involving local churches more directly in the community. In the past, when 2 local accidental deaths involving alcohol occurred in Akiak, the local Moravian pastor gathered and talked to all the men, which seemed to work. Participants also said people could get help or help others by talking with someone they trust. They suggested the following additional ways they could improve their village:

- Installing indoor plumbing and sewage systems
- Cleaning up garbage and tearing down old buildings
- Building more roads
- Starting an AA group
- Returning to more subsistence activities
- Having more private businesses
- Installing cable TV
- Educating young people
- *“Wanting the best for our children—physically, emotionally, and spiritually.”*

Consolidating the efforts of local programs can help improve the delivery of services.

Many participants felt the VAEC needed to consolidate efforts with other programs to improve service delivery. It appears that with so many different providers in the villages, there is often confusion over who should be called to deliver a service. Participants said any type of local consolidation would be most helpful.

Some participants also felt the City Council needed to be more involved with the VAECs. *“It was very good when it happened.”* Apparently, the City Council used to advise the VAEC about substance abuse problems, but that had decreased. Participants said that as the village grew, the VAEC program changed; home visits stopped, and fewer Elders intervened. *“No one seems to be listening right now to Elders.”* Providers from Bethel said, overall, local team efforts with mental health clients have been “noticed and experienced” more in CMTRS staffed villages than in VAEC staffed villages.

Some participants spoke favorably of the VAEC’s collaborative efforts. In Toksook Bay, the VAEC works cooperatively with VPSOs, Community Health Aides, City Council, Traditional Council, and Bethel agencies. In Mekoryuk, the VAEC also works closely with the City Council by reporting monthly about program activities, and by receiving feedback and guidance regularly. Although participants on the Community Council admitted that though it was difficult to work with relatives in the village, the combined use of education and the “tough love” approach was working. *“It breaks the cycle of denial, and enables our people.”*

Participants from Akiak also said consolidation efforts were occurring. The VAEC apparently works closely with a recently hired part time Mental Health counselor. *“They work together whenever possible.”* The VAEC and Mental Health counselor respond as a team to “aftercare” referrals whenever possible. *“If the client gives permission, information can be shared with other local counselors.”*

Some village members see the local VAEC as a strength in their community, but others say they need to make more changes to improve program effectiveness.

Traditional councils are involved in hiring the VAECs and health aides by selecting and referring three local finalists to the Bethel office. A participant from Bethel said, *“We have had mixed results on local hiring recommendations--some good and some not so good.”* Once VAECs are hired, they are expected to meet regularly with the local leadership groups (i.e. traditional councils, city councils, etc.).

Currently, the villages of Kwethluk, Napaskiak, and Akiak each share a VAEC with another village. Participants from Akiak said in the past *“the VAEC was stuck with three other villages.”* Many participants felt that even two villages per VAEC was too much. *“The VAEC has too many clients, is alone and powerless, and needs additional assistance from the council.”*

Participants suggested increasing staffing in order to reduce workload, and to increase service availability and follow-up care. *“Use two people to counsel—as in the past.”*

Participants discussed barriers relating to the location of the VAEC’s office. Some felt the public location and formal atmosphere turned people away. They suggested providing better office space that was separate from public buildings, assuring privacy and confidentiality. *“The VAEC office is too public and very small with no windows.”* Many felt clients would be more willing to talk informally away from the office, and suggested doing “coffee and donut” visits. *“Just stop by and let people know [you are] available to talk.”* Still others were concerned about whether VAECs and VPOs could stay “neutral” when dealing with family members. They suggested having the VAEC come from another village (so he or she would not be working directly with relatives).

Many, however, felt the local VAECs were finding ways to reduce substance abuse in the villages. They said the VAECs were learning how to face the challenges of dealing with families, friends, and neighbors in the village. *“They are learning how to put aside local politics, divisions, and family relationships.”* Participants also stressed that the VAECs could only do so much. They said some people with substance abuse problems seek counseling from the VAEC, but others do not. *“If they want help, they have to want to get help”*

VAECs provide community awareness on the dangers of substance abuse.

Group participants said the VAEC program is successful in providing the communities with substance abuse awareness. In Kwethluk, the VAEC meets, plans, and works as part of a local team responding specifically to substance abuse problems of clients in the village. In Akiak, the VAEC has had meetings with teens in the school about substance abuse. *“[The VAEC] worked with the school, and talked to each class.”* Today, the VAEC in Toksook Bay talks to students about alcohol and drug abuse, and has helped students quit smoking and drinking. The VAEC also conducts weekly meetings, individual counseling, and receives referrals from the City Council, the Traditional Council, and service positions and organizations.

Participants from Toksook Bay said there has been an ongoing desire and openness to listen and consider outside programs and expertise that might assist sobriety and health in the village. In Mekoryuk, participants said the local VAEC went to the school and made presentations about alcohol abuse and pregnancy prevention, and posted public notices informing the village of programs and activities. They said the VAEC’s “personal testimony” presentations have been effective with groups and individuals. *“Kids have found out that it gets them into trouble—so they do not get into substance abuse.”* Participants said the VAEC has provided community awareness through the following ways:

- Co-sponsoring the *“Youth, Parents, and Elders Conference—Achieving Tribal Sovereignty, SOBER”*
- Sponsoring an “Elder-youth conference” that gathered around 100 Elders and youth from several villages
- Responding to referrals from the state and local tribal court
- Coordinating AA meetings
- Participating in local substance abuse public awareness activities
- Securing donations and assistance from the City Council and other local village groups
- Making “personal” presentations whenever possible

In a “healthy village,” people are open, trusting, supportive, and free of substances.

Many participants envisioned a “healthy village” as one that was free of alcohol. “[It is] being a dry village all the time.” They also said ongoing communication was a major key to being healthy, and that families and community members should be able to share their feelings, trust one another, and be allowed to overcome mistakes. One participant said a healthy village was a “happy” village: “friendly...having respect...no crime...no graffiti or vandalism...no gambling or bingo...listening to our parents and Elders.”

In particular, participants felt it was important for community members and leadership groups to work together to develop healthy models for everyone to see, especially young people. They said people should have lots of healthy relationships and refrain from talking about one another. “There’s a lot of gossiping—not just in high school.” Many felt individuals should be able to encourage and get support from others, such as from family and friends. “[It is about] respect for self and others.”

Bethel providers want more feedback from local VAECs.

Providers from Bethel felt the communication and feedback between Bethel and the VAEC villages needed to be improved. After referrals to the local VAEC of MR/DD clients, they often received no feedback. “Never get feedback from the villages.” State Corrections referrals are made by the regional facility to the local VAEC. “Need more communication on what follow up services are available in each village.” Despite these difficulties, Bethel providers stressed the importance of the VAECs. “We get many letters from villages on the importance of retaining the VAECs.”

c. Conclusion

The VAEC program was credited with increasing community awareness and providing village members with a local treatment option. Keys to developing a successful treatment program include:

- Maximizing local resources
- Strengthening traditional values, leadership, and Elder involvement
- Providing more education and local activities
- Consolidating service delivery

Results show that the VAEC program had some degree of impact on the reduction of substance abuse in the villages, but is in further need of improvement, particularly in the areas listed above.

3. Comparison of CMTRS and VAEC Focus Groups

a. Introduction

Focus groups were held in villages served by the CMTRS program and villages served by the VAEC program to discuss the major issues of substance abuse. Individual reports for each focus group were reviewed and edited and used to prepare a “thematic content analysis” for each of the two programs. In the following, these analyses are being compared to gain a qualitative understanding of the success of these programs, as well as to compare problems, strengths, and opportunities.

b. Thematic Analysis

Substance abuse continues to be a major problem for both CMTRS and VAEC villages.

Participants from all focus groups wanted to see a reduction in substance abuse. “[I see] a lot of it--people staggering. It happens anytime of the year.” As evidence to a problem, they reported seeing drunk people speeding on snow machines, starting fights, talking on the VHF, and shooting their guns erratically. “They walk around with guns and scare people.”

In particular, participants from the CMTRS villages discussed how substance abuse impacts families and children, reporting a high level of protective custody. “One hundred percent of the families involved with the Protective Service system give some type of alcohol abuse as their reason for involvement with that agency.” Participants from the VAEC villages expressed an especially high concern for an increase in marijuana use, which they said was easier to get and use than alcohol. “[It’s] common—you can see it around town.”

CMTRS and VAEC villages feel Elder involvement in substance abuse treatment plans is important to program success.

CMTRS and VAEC village focus groups discussed the importance of involving Elders in treatment services, program policy decisions, and local problem solving. Participants from CMTRS villages talked about ways Elders had been involved in the community in the past, and ways Elders were being involved now (such as through Elder-youth conferences).

Participants from the VAEC villages also stressed the importance of Elders as guides and role models in substance abuse treatment plans, but had fewer examples of how this was currently being done. “I wish there was a way to get Elders back involved.”

CMTRS and VAEC villages stress the importance of incorporating traditional healing methods into substance abuse treatment plans.

Participants felt the CMTRS program, in particular, has made successful efforts to incorporate traditional and Western methods into treatment plans. “If we returned to our traditional ways, we would be much happier.” They reported that CMTRS counselors were trained and capable in both Western and traditional counseling practices, and used cultural knowledge (treatment modalities) to work on problems.

Participants from the VAEC villages also stressed the need to incorporate traditional methods into substance abuse treatment plans, giving examples of ways this can be done. “The Yup’ik approach would give a person more of a chance helping to sustain a person’s esteem.” Some VAEC villages have made steps to incorporate Elders and traditional methods into their programs.

Utilizing local resources and maximizing local control are essential to developing a successful substance abuse treatment program. CMTRS villages have made strong steps toward this goal.

Many focus group participants felt villages should have the power to create and build a substance abuse treatment program that works for them (rather than having it crafted by outsiders). Participants from CMTRS villages said those villages that retained some sense of local control were often less tolerant of substance abuse. A regional provider who worked closely with the CMTRS Program said, “We are onto something here that seems to be community based and is working.” Participants reported that local program governance

through Policy Steering Committees has helped make CMTRS services more responsive and effective.

Reestablishing and maximizing local control was an important topic in VAEC villages as well. Currently, programs in many of these villages are regionally administered, and local programs are funded from outside the village (YKHC or the State of Alaska). In some villages, participants felt there needed to be more opportunities for hiring and training people locally. They also said the City Council needed to become more involved in the VAEC program. Others, however, reported that their community has made significant strides toward local involvement and collaboration. For example, in the village of Toksook Bay, the City Council initiated a community policing program called the COPS Program, involving the general community, State Troopers, National Guard, and the airlines in Bethel.

Participants from CMTRS and VAEC villages want to see improvements in local law enforcement, but some report recent improvements in CMTRS villages.

Participants from VAEC and CMTRS villages were concerned about the lack of law enforcement for bootlegging, substance use, and drug and alcohol sales. Participants from CMTRS villages, however, reported an improvement in law enforcement since the program began—in increased police protection, patrolling, and confiscating of alcohol and drugs. These participants listed many of the stiffer local ordinances against alcohol and drug-related crimes, for which offenders were currently being court-ordered for treatment.

Many participants from the VAEC villages felt laws were not enforced, or when enforced, took too long to get to the arrest and prosecution. They also said minor problems were often enforced, while major problems were ignored. *“They stress curfew instead of alcohol enforcement.”* However, in some villages participants felt there have been improvements in law enforcement, citing efforts such as the COPS Program.

Most individuals in the CMTRS villages can get the services they need without leaving their village, but some individuals from VAEC villages encounter service barriers.

CMTRS and VAEC have enabled village members to receive substance abuse services in their own communities. Prior to the CMTRS program, individuals were sent out of town for treatment, which they often could not afford. Today CMTRS provides a local alternative so clients do not have to leave their family and community. *“Counseling doesn’t work when people go outside.”* Participants reported that CMTRS was the first village based program that successfully followed up on clients when they returned from outside treatment programs. *“Clients feel hopeless and immobilized when they return to their village and find no local, follow-up services available.”*

Participants from some of the VAEC villages reported that individuals sometimes could not get the substance abuse services they needed, due to waiting lists and travel costs to Bethel. In other villages, participants said the VAEC program successfully provided people with a local option for treatment, as well as follow-up treatment.

The CMTRS program has had better results than the VAEC program in hiring and training local counselors.

The selection and training of local counselors has contributed to the effectiveness of the CMTRS program. CMTRS counselors, unlike other YKHC counselors, can make their own decisions regarding the program and specific treatment needs. They also said that with two counselors per village, they are able to respond to substance abuse problems as a “team.” *“Since they are there every day, you get an immediate response.”*

Participants from the VAEC villages, however, reported varying success with local hiring of VAECs. *“We have had mixed results on local hiring recommendations--some good and some not so good.”* Some questioned the locally-hired VAEC’s ability to stay “neutral” when dealing with family members. Still others were concerned about the VAEC’s ability to relate to teens.

Participants also felt the VAECs were spread too thin. *“The VAEC has too many clients, is alone and powerless, and needs additional assistance from the council.”* They suggested increasing staffing to help reduce workload and to increase service availability and follow-up care. *“Use two people to counsel—as in the past.”* Currently, the villages of Kwethluk, Napaskiak, and Akiak each share a VAEC with another village. Participants from Akiak said that in the past *“the VAEC was stuck with three other villages.”* Many participants felt that even two villages per VAEC was too much.

Efforts toward coordinating services has been “noticed and experienced” more in CMTRS villages than in VAEC villages.

Providers from Bethel reported a higher level of service coordination in CMTRS villages than in VAEC villages. Many other participants saw strength in continuing and encouraging partnerships among local resources that support sobriety, such as mental health workers, Community Health Aides, schools, and church ministers and priests.

A number of participants from the VAEC villages reported problems in service coordination, saying that, with so many different providers in the villages, there was often confusion over who should be called to deliver a service. However, participants from several of the VAEC villages reported some ways coordination efforts are being made. In Mekoryuk, the City Council works with the IRA Council and Native Corporation to promote village activities and to help “dry up” the village. Also, in Toksook Bay, the VAEC works cooperatively with VPSOs, health aides, City Council, Traditional Council, and Bethel agencies.

CMTRS and VAEC programs are credited with increasing substance abuse awareness in the villages they serve.

CMTRS has helped increase community awareness regarding the dangers of substance abuse in the villages. Participants said the CMTRS program needed to continue what it was doing, so people would continue to hear about the negative effects of alcohol and drug abuse, and eventually want to change. Reportedly, more families have come forward, and the referrals made by the Traditional Council have decreased because most people with problems are already in the system.

Participants also credited the VAECs with providing community awareness through the following ways: making presentations and providing “personal” testimonies, talking to kids in school, sponsoring an “Elder-youth conference,” responding to referrals from the state and local tribal court, coordinating AA meetings, participating in local substance abuse public awareness activities, and securing donations and assistance from the City Council and other local village groups.

Professionals in the region see the CMTRS and VAEC programs as helpful to them in several ways, but some see ways the VAEC program could be more helpful.

Professionals see the CMTRS program as effective because it decreases their caseload and assists with aftercare and follow-up. Several reported that the ability to work with CMTRS providers has reduced the need for state and outside agency interventions. Professionals from VAEC villages also see the program as helpful, although some said they needed to receive more feedback from VAECs, and to see greater collaboration between providers.

The CMTRS program is credited with having a greater impact on substance abuse than the VAEC program.

The CMTRS program's success in reducing the impact of substance abuse in the villages is seen through the following ways: increasing awareness, providing accessible treatment that enables individuals to remain in their village, using providers who are residents of the village, utilizing program governance at the local level, and offering treatment practices that are consistent with the traditional culture and lifestyle. Providers encouraged an expansion of programs based on the CMTRS model. *"This is the first time in 8 years I have seen a group of service providers agree on a service delivery model that is working well in the villages."*

The VAEC program is also credited with having an impact on substance abuse, particularly through increasing substance abuse awareness and providing individuals with a local option for treating substance abuse, including follow-up. Although some participants said the VAEC program had a good start toward successfully treating substance abuse problems, many felt it still had a ways to go.

c. Conclusion

The priorities and goals expressed by participants from the CMTRS villages and the VAEC villages in regards to substance abuse treatment were quite similar. All wanted to see a greater reduction in substance abuse. Participants from both groups felt a reduction could be attained through increased decision-making and governance at the local level, and through incorporating Elders and traditional methods into the treatment plans.

Overall, CMTRS villages were credited with greater success at reducing substance abuse through the following ways:

- Utilizing local resources and local control,
- Increasing local law enforcement,
- Consolidating services,
- Reducing case loads for other professionals in the hub community by referring them to village-based treatment, and
- Providing substance abuse services in a more holistic integrated manner.

B. VIDEO TAPED KEY INFORMANT INTERVIEWS

1. Introduction

The video taped key informant interview component of the evaluation process was tightly linked to the outcome of the focus group process. Summary statements derived from the thematic content analysis of the focus groups were instrumental in establishing 1) the interview topic areas and 2) the final questions used in the key informant interviews. The following describes the process and methods of the videotape component of the evaluation, but does not include a description of the findings. These are represented in the videotapes themselves. A complete literature review on video use in social research among indigenous peoples is presented in Appendix H.

2. The Key Informant Interview Evaluation Process

One of the most common methods of collecting qualitative information is the use of key informants (Morse and Field, 1995). Key informants are typically members of the social or cultural group in the research context who provide information and assistance with the

interpretation of the setting. Specifically, the key informant can speak to information that the interviewer cannot or has not experienced, and can further explain events witnessed by the observer (Patton, 1990). While key informant interviews can provide valuable information in a qualitative program evaluation, the evaluator must guard against biases from both the informant and the evaluator/recorder of the interview. This concern is heightened when the evaluation, first, is studying a new and developing social service program where there is potentially divergent views and, secondly, is occurring in a culturally distinct setting where English is a second language for a majority of its participants (Saylor, Booker, et al, 1996).

Aware of these potential biases, the program staff and village leaders collaboratively selected an age and gender-balanced mix of key informants in each community who were articulate and candid in their opinions regarding the strengths and weaknesses of the program. When needed, Yup'ik and Cup'ik translators were used in the interview process. Secondly, potential interviewer/recorder bias was overcome through the use of videotape recording as the primary recording and reporting document. In the case of Yup'ik or Cup'ik responses, a team of local translators provided English voice over translations that were edited into the final version of the video report. By taking the above steps, potential biases were minimized and the final, forty-five minute version entitled *Strength from Our Elders* (1996) became the final product of the key informal interviews. The VAEC video counterpart used a similar methodology and is called *Protecting Our People* (1999).

3. Planning, Instrument Design, and Execution

Focus group exercises impacted the process by establishing local trust and credibility in the evaluation team and process itself. The focus group exercises also alerted the evaluation team to potential key informants and topic areas where they had made notable contributions. For instance, in every village there were Elders who spoke insightfully of village history regarding substance use and abuse. These observations by the evaluation team contributed significantly to a purposeful and informed selection process of key informants and the specific questions they were asked in their interview. While other factors affected the selection of key informants, a majority of those interviewed were selected from their focus group participation. Lastly, as illustrated in the "Video Interview Questions" grid (see Appendix I), each key informant was associated with a specific cluster of questions, as no one individual was expected to knowledgeably respond to all questions. It was also a useful guide for the evaluation team member who later conducted the interview.

After the previously described planning steps were complete, the key informant interviews were conducted and videotaped. Of the thirty-four scheduled key informants, twenty-five were completed with a mix of nineteen village informants and six service providers in Bethel, yielding approximately fourteen hours of videotaped interview material. An additional two hours of footage recorded a variety of indoor and outdoor scenes of local activity and surroundings of each village. Prior to each interview, the informant's written consent for videotaping and televising was obtained. All interviews were recorded using one Hi-8 camcorder and a cordless lapel microphone system for the audio.

The Bethel interviews, the first cluster completed, were conducted by two members of the evaluation team--one acting as the interviewer and other as videographer. All Bethel interviews occurred at the person's place of employment and were conducted in English. A week later, village interviews were conducted by one evaluator acting both as the interviewer and videographer. One or more CMTRS staff was available in each village to assist the

evaluator with translation as needed. Of the nineteen village interviews, eight required a Yup'ik or Cup'ik translator during the interview process.

Upon completing the interview process, the videographer reviewed all footage and constructed a detailed, written log of each interview. This is a standard practice that assists in the editing process. The sixteen hours of footage were reduced to a fifty-five minute first draft. The draft copies were extensively reviewed by CSAT staff and consultants, CMTRS staff, the Policy Steering Committees, and the evaluation team. After incorporating all suggestions, a forty-five minute video entitled *Strength from Our Elders* (1996) was submitted as the final report of the key informant interviews.

Some guiding principles in the filming and editing of the report are worth mentioning. One primary goal of this process was to provide an evaluation reporting methodology that would let those directly effected by the program to “tell their own story from their own point of view” regarding the strengths and weaknesses of the CMTRS program. This goal was met in a variety of ways throughout the process. First, a pre-production decision was made to use only the words of the key informants in the video. This was accomplished by not using any post-production narration, and by editing out all evaluator questions and dialogue recorded during each interview. Second, to assure an accurate translation of the Yup'ik and Cup'ik languages spoken by some informants, the English voice-over was produced and dubbed into the final version. Finally, by inviting careful review of the first draft by all stakeholders, the editing process had maximum feedback in developing the final version of the video report.

The final revision of the CMTRS video report was distributed to all stakeholders locally, the State of Alaska, and CSAT. Additionally, the video was aired on ARCS, the statewide satellite television network. CSAT also shared it with other federal officials in Washington, D.C.

In a separate contractual arrangement with YKHC, the evaluators prepared a companion videotape for CMTRS villages. Following the CMTRS qualitative evaluation design, the VAEC questions were derived from a series of focus groups conducted with clients, teens, Elders, and Policy Steering Committee members of VAEC villages. The resulting videotape, entitled “Protecting Our People: the Village Alcohol Education Counselors (VAEC) Program in Southwest Alaska,” was edited from approximately 16 hours of key informant interviews. As with the CMTRS video project, the VAEC report was reviewed by VAEC administrative staff and evaluation staff prior to its final production.

In summary, the key reasons this particular process was successful included, first, a genuine cooperation between all the stakeholders. There was a willingness to risk honest feedback since each step of the way was developed to safeguard the Yup'ik and Cup'ik cultural perspectives. In particular, the candor and honesty of the CMTRS staff with the evaluation team was critical in designing workable and culturally appropriate instruments used in the focus groups, key informant interviews, and the video report design. In addition, the CSAT program officers provided their support and encouragement for this new and innovative approach to evaluation research. Finally, the local cooperation, involvement, and honest feedback by staff and participants in each of the villages provided the content sought by the evaluation team.

4. Conclusion

The comments of the key informants were captured on videotape and edited into a videotaped evaluation report. There were two video reports produced for this project. The first contained

information from counselors, Policy Steering Committee members, and clients involved with the CMTRS program. The second was a similar report from the perspective of the VAEC communities.

These two reports were viewed extensively by people within the region. The CMTRS report was aired numerous times on Alaska Rural Television Networks. The final VAEC video report, produced toward the end of the grand period, received less circulation. The video titles are shown in the knowledge development section of this report and are available upon request.

With the current user friendly video technology available today, even in remote settings, social scientists have a powerful tool to translate local policy study findings using the felt experiences of policy recipients. In addition to the technology, collaborative research methods are at hand (Kehoe, 1996; Saylor, Kehoe, Smith, 1996) to assist researchers and local indigenous communities effectively plan and develop strategies to implement video reporting in various policy study areas. Our experience has demonstrated that evaluation research can benefit from this approach. The CMTRS project has generated requests for similar products from other indigenous communities.

IV. USE OF YUP'IK/CUP'IK TRADITIONAL MODALITIES

A. INTRODUCTION

This section provides a description of key factors on how to manage the implementation of Yup'ik traditional modalities to reduce alcohol and substance abuse.

Constructing a fish net or a harpoon teaches patience, diligence, discipline, refined thinking, and incorporates cultural technology. The processes involved are intricate and complex. They help produce cultural meaning, competency, and identity. They play an important part in village survival and subsistence. They are critical activities that eventually link to a community's self-concept, identity, and sense of accomplishment. These activities--and hundreds of others--eventually combine to produce community-level celebration and sharing.

Berry picking has similar benefits that affect the individual and, collectively, the community in positive ways. Berry picking is a seasonal, communal, and family activity that is very enjoyable and physically, emotionally, spiritually, and mentally healthy because it takes one outdoors into the beauty of the natural world. Blueberries, blackberries, and salmon berries provide nourishment and are a true delicacy for many people in the community or village. One can visit with others or become engaged in deep thoughts and memories while berry picking. Berry picking is a process that results in a chain of competencies involving food preparation, song, prayerfulness, celebration, patience, and thanksgiving.

CMTRS and YKHC leadership, under the guidance of Yup'ik Elders and villagers, indicated these modalities as having very healthy and healing cultural and therapeutic content and process. They reasoned that the modalities were relevant to the clinical treatment process. They also reasoned that these modalities, in fact, were more relevant than many western clinical theories and practices.

Today, this belief persists among village Elders and alcohol counselors partly because of the realization that the modern world cannot address fundamental Yup'ik needs for harmony and balance the same way the happiness of berry picking season can produce a sense of harmony and balance. It is like saying "only Yup'ik culture can heal Yup'ik people."

Yup'ik language and experience are the only language and experience that can express what is most accurately Yup'ik. Yup'ik Elders already know how to produce a sense of joy, happiness, and competence that only the Yup'ik understand. They know about hurt, pain, and grief as experienced by the Yup'ik people. Only the Yup'ik language and experience can describe what it means and feels like to hunt or fish--or to produce dance masks that sing, embody, and connect with the natural world. Having thousands of years of experience and knowledge, only the Yup'ik can truly understand the Yup'ik at their most basic need level, or in relation to their most basic meaning.

What is also unique about the Yup'ik traditional modality effort is the Yup'ik villagers' view that traditional Yup'ik culture can be empowered and once again made meaningful in the Yup'ik sense, even in the so-called "clinical" treatment process. The Yup'ik traditional modalities are meant to incorporate contemporary Yup'ik needs for reliance on "old and traditional" wisdom. In doing so, long term Yup'ik cultural survival would be assured.

This section focuses on how to bridge gaps between the "traditional world" and the "modern world" and all its assumptions on progress, science, use of technology, religion, culture, and

language. This section can assist program managers and developers in planning, implementing, and evaluating programs that have goals relating to cultural relevance.

One must read this report knowing that a report such as this one cannot really describe what is "out there" in the natural world. It cannot describe the intensity of wayfinding in an ocean full of danger or "wayfinding through miles of snow under dark star-filled skies." It cannot really describe the sense of pride and fulfillment of sitting down with family and friends to partake in delicious foods and long stories of the hunt, or to embody the friendly conversation and laughter during its preparation. The song of Yup'ik human cultural experience is really the essence of this section.

B. IMPLEMENTATION OF TRADITIONAL MODALITIES

This section is intended to serve as an alcohol and substance abuse program implementation guide for Yup'ik villagers, YKHC service providers, state and federal officials, and other indigenous peoples. It is intended for those interested in indigenous peoples' cultural empowerment, the use of Native traditional knowledge, and modalities for healing within or despite a modern world context. Hopefully, this information will speak to the village Elder, alcohol worker, clinician, program administrator, evaluator, and policy maker in a supportive and validating way.

1. Mission Statement

There is a need for YKHC Behavioral Health staff to provide leadership regarding the implementation of Yup'ik traditional modalities. At a March 2000 workshop, certain YKHC Behavioral Health staff drafted the following statement. This statement is included as an example of how various staff (e.g., field supervisors and clinical supervisors) can address the issue of leadership.

We are committed to preserve the integrity of our original way of life through the use of traditional modalities in our wellness programs. We use four (4) original Yup'ik values as guides to promote a healthy way of life for our people:

- Yuya'raq - the way of life, stressing cooperation, love for others, respect for the land.
- Aler'qutet - the rules of the people that emphasize accountability to self, respect for Elders, helping one another and sharing.
- Picir'yarat - traditional ways which stress the responsibility to monitor and carry out traditions and customs.
- Kanru'yutet - oral instructions for the purpose of cultural continuity.

2. Basic Assumptions

The following are the basic assumptions regarding the use of traditional modalities at the program level or service provider level:

- Yup'ik traditional modalities have been fixed in time and have a non-changing dimension particularly in terms of its perennial wisdom.
- There is no need to change Yup'ik traditional modalities in terms of their original teachings, relevance, and applicability to contemporary Yup'ik life.
- Traditional and western "treatment" modalities are different. Sometimes they can be mutually exclusive. Other times they can be likened to "oil and water." Definite differences can be described.

- Traditional and western modalities can be similar, and at times compatible, but they are not identical.
- Western style intervention historically has been dominant in treatment programs serving Native people.
- Traditional style intervention is perceived by Native people, such as Elders or traditional counselors, as the potentially more relevant and efficient way to reduce the incidence of alcoholism and/or drug abuse.
- Eventually, there can be a balance achieved between traditional and western intervention in terms of service provision, service availability, or access to services. However, it will take a lot of legislative, managerial, fiscal, and government support and collaboration if this is to happen.
- Eventually, traditional intervention will become more predominant if Native self-determination is acknowledged and catalyzed.
- The YKHC Mission Statement is essential to the success of traditional modality usage.
- Elders are essential to this process, and their involvement should not be compromised or overlooked.
- Each village is unique--in that each village potentially has its own way of addressing alcohol problems.
- At the basis of each traditional modality is the opportunity for the client to gain a sense of positive Yup'ik cultural identity, a sense of Yup'ik community, a sense of belonging, and a sense of Yup'ik self-sufficiency.
- Great care must be taken when institutionalizing the traditional modalities within a service provider paradigm, and planners must accept the fact that at times things traditional and modern just won't fit or work together.

3. Traditional Modalities for Wellness Goals and Outcomes

Traditional modalities are activities, methods, or processes embedded in Yup'ik subsistence activities (e.g., hunting, fishing, food preparation, berry picking, wood gathering), Yup'ik dance, crafts, Yup'ik ceremony and other activities reflecting traditional Yup'ik lifestyle. These modalities have the potential to heal or cause wellness because of their therapeutic effect. These modalities have withstood the test of time and are non-changing and fixed because of their capacity to ensure Yup'ik long range cultural survival.

Traditional modalities are an organized set of activities which, when linked together, form a whole meaning or teaching. A traditional modality is holistic and ongoing. At one level, a traditional modality results in "food on the table" or a successful hunt. At another level, a traditional modality results in a feeling of competency and meaning. All the various activities contained in fishing expedition (e.g., planning, implementing, and evaluating an activity) are potential traditional modalities if those activities are traditional, reflect traditional knowledge, and can be applied to goals of wellness in the Yup'ik sense.

C. YUP'IK/CUP'IK STANDARDS OF CARE

1. Definition of Standards

Standards can be the accepted and established as norms of a culture because they have been proven over the ages to be effective, for example, in managing society or ensuring balance in a community.

Standards can be cultural if that society so wishes (e.g., via self-determination); standards can be specific to a culture and language group. They can be cultural in order to preserve culture and language. Standards are expectations, and are most useful when focused on a smaller set or core of useful norms or ideas that will cause effectiveness. Standards are also a way of creating accountability: professional, organizational, or system standards.

Each Native culture has a purpose. Native cultures do not exist as museum artifacts. Native cultures are living processes that embody wholeness, completion, being sacred and kind, or being acutely aware of human's potential for hurt, pain, anger, or murder. A set of standards is implied when one answers the question "What is the purpose of Yup'ik culture?"

Standards are guides, criteria, markers, or benchmarks that govern individual or group behavior, decision-making, or governance within a cultural context. They provide a model or models for comparison and evaluation concerning individual and/or group performance within a cultural context. By defining Yup'ik standards side by side with western standards, one creates a more practical view of Yup'ik contemporary realities. This reality reflects a bicultural and bilingual world.

Standards are written in two languages (e.g., Yup'ik and English) so that one can inform the other. But primarily, the issue of language relates to the patient's need to understand all the implications of intervention in a language she/he can understand. This relates to a patient's right to informed consent. Yup'ik standards of care emanate from the Yup'ik language--not any other language. English may serve to assist in defying or bridging Yup'ik contexts, processes, content, concepts, principles, competencies, and meanings into the English speaking and western world.

Yup'ik standards can "draw the line" on the issue of compromise. For example, many Native Americans have said that they have been allowing modern practices to come into community or tribal life. While promoters of modern practices may have good intention, they can also marginalize non-modern ways of the Yup'ik. For example, traditional activities relating to arts and crafts may find themselves marginalized in favor of watching television or excessive consumerism.

2. Yup'ik Standards and Alcohol Programs

Yup'ik/traditional standards provide real and authentic cultural guidelines to monitor or evaluate programs and intervention. They are useful in the following ways:

- Assessment - to help determine the degree of assimilation away from Yup'ik life; to help determine the amount and degree of cultural intervention necessary; to help determine what modalities might be best for intervention.
- Diagnosis - to provide an additional perspective to a western (e.g., DSM-4) diagnosis; to help determine the best traditional modality for intervention.
- Intervention and treatment - to serve as a guide to determine what constitutes a Yup'ik wellness outcome; to serve as a guide to assess treatment itself.
- Discharge and aftercare - to serve as a guide to assess continued wellness at the individual and/or village level.

At the community or village level, Yup'ik standards become critically important because of the issue of relapse. If a village was collaborating to reclaim Yup'ik culture through the use of a

traditional modalities approach, and if that village was experiencing success, the likelihood of relapse would decrease for the individual.

3. The Need for Yup'ik Standards of Care

- Standards that are used in health care for Native people and for service providers who serve Native people are often western in orientation. Western standards may, for example, emphasize individuality over group intervention, may be very minutely time and cost benefit oriented, or may tend to be pathologically based as opposed to strengths based. Yup'ik culture, on the other hand, may emphasize very different or opposite values.
- Defining one's own standards is a way to align the macro to the micro (e.g., the culture to tribal government to the community) in society. Defining one's own standards can be a means of reclaiming cultural identity.
- Yup'ik standards will tend to be the most relevant and appropriate to Yup'ik experience. If properly managed, Yup'ik standards will lead to more efficient program management.
- Using culturally relevant standards implies the ability to provide culturally and linguistically sensitive services to address the special needs of clients.
- Culturally relevant standards require the use of sensitive materials, discussions that incorporate cultural needs of patients, and policies that address issues of cultural difference and cultural integrity.
- Double standards (e.g., traditional and modern) can be confusing. In the experience of Native people, double standards usually mean the Native is to follow the standards of the dominant culture while suppressing or making his/her own standards subordinate.

4. How Standards are Developed

There must be a need. People must see the need for services that are culturally appropriate. There must be a discussion about the Yup'ik "stakeholders," values, and vision. There must be a plan that states the vision, definition of Yup'ik standards, purposes and goals, the means to achieve the goals, the resources needed, the cost and benefit to the people, and some form of a time line.

In addition, there must be the development of a theoretical framework, as well as the development of actual standards. There must be a way to allow the standards to grow and manifest in a Yup'ik manner, and there must be a means to assess performance or content of work performed using the standards.

There could be the development of a task force to review all related information and models that could be used in this process, and there could be a field testing of the standards phase. This could be done by stakeholders, practitioners, program managers, etc. The YKHC Board could do preliminary approvals to allow further testing and implementation of standards.

There must be an implementation phase when the plan gets put into action, and a revision process developed to accommodate change. There must be a way to evaluate the planning and implementation process and the standards themselves.

5. Yup'ik Standards and Treatment Planning and Clinical Supervision

Standards directly influence treatment planning and clinical supervision. If the standards were western based, then the evaluation of treatment through a clinical supervision process would

be western as well. While western standards are ethically developed, many times they fall short of incorporating non-western standards.

It can be difficult and confusing to use non-Yup'ik standards to evaluate the effectiveness of Yup'ik cultural activities. Not only does the English language (sometimes called the language of modern science and inquiry) not suffice, it can cause much confusion, especially to village level peoples who cannot understand the English language very well. Appropriate treatment planning and clinical supervision models must be developed to account for Yup'ik traditional knowledge.

6. Ethical Considerations in Standards

Ethics plays an important role in any standard, or in the development of any standard. Ethics implies a "walk your talk" criteria. Standards and ethics go hand in hand because both concepts relate to the human condition. Developing Yup'ik cultural standards implies working with many hundreds of years of Yup'ik tradition. At certain levels, it means working with the experiences of ancestors. It can mean working at the spiritual level, the emotional level, the intellectual level, and the physical level of meaning. Thus, it becomes important to remember the ancestors and their connection to present day existence and meaning.

D. ISSUES IN TREATING NATIVE PEOPLES

The following is based on observations made of CMTRS Counselors while performing as counselors. They have an excellent grasp of the traditional modalities but need further experience bridging the modalities into clinical contexts. Counselors exhibit much wisdom in their use and understanding of the traditional modalities. A client has much to gain in participating in a traditional modality activity.

The paperwork involved in treatment planning does not do much justice to the expansiveness and meaning of a traditional modality activity. A Traditional Modality activity is a whole set of activities simultaneously carried out. There is a global and cultural context for each activity, which must never be forgotten. When client needs and problems are identified, and there is an attempt to address client problems in an isolated piecemeal fashion using a traditional modality, this does not work well for the client. A Traditional Modality is a communal activity, demanding much work, openness, and willingness on the part of the client to be part of a communal system. For the most part, Traditional Modalities and subsistence are one and the same thing.

There are key issues in using traditional modalities in a clinical treatment setting. In discussing traditional modalities, the Yup'ik/Cup'ik traditions occupy the center, while western or modern modalities are marginalized. This model of treatment is different because, typically, it is reversed in Native people's programs.

The following issues should be considered when addressing Native Traditional Counseling:

- There is a need for a working definition to address issues of cultural difference between modern and Native traditional healing practices.
- There are cultural differences, particularly between the modern/contemporary world view and Native tradition, regarding what counseling is.
- In western clinical psychological practice, there is a need to incorporate Native traditional healing practices and vice versa.

- In Native traditional healing practices, there is what may be called a counselor or counseling component which can be likened somewhat to western counseling practice.
- All Native people today live in a bicultural and bilingual world and in many cases a multicultural world. As such, traditional counseling can take on a multicultural dimension.

1. Choice

Up until recently, Native clients seeking services had no choice when it came to non-western treatment or intervention modalities. When a Native client sought services, it was assumed that intervention or treatment was going to be western or modern in orientation. With the introduction of the traditional modalities framework comes a new choice in service provision. However, this new choice is very old, in that its origin is in non-modern traditional knowledge and experience. It is just that clinicians and others have realized that western oriented modalities have limitations and that wisdom traditions, like the Yup'ik, have much to offer in terms of relevance and appropriateness of service. Informed Consent is necessary. This is simply informing the client of the implications of a traditional modality in the same manner one would explain the implications of western intervention process.

2. Confidentiality

An area of concern that may need special attention is the Yup'ik concept of community vs. the legal definition of confidentiality in more modern contexts.

3. Cultural Competency

The idea embodies the concept that an employee or member of an organization must be aware of his/her bias and prejudice in order to minimize employee conflict and promote racial, ethnic, gender, and sexual preference harmony amongst people. Cultural competency is seen at two levels: individual and institutional. When it is defined at the institutional level, the issue of policy must be examined.

4. Cultural Adaptation Skills

It is critical skill to possess cultural adaptation skills, whether the individual staff member is Yup'ik or non-Yup'ik.

5. Recontextualization

This is defined as the skill and process of defining a context and being able and flexible to redefine that same context in order to see things differently. The recontextualization process implies a willingness to adapt to new situations or contexts. It implies an understanding that such a process is necessary in a culturally diverse world.

6. Translation

Translation is defined as the skill and process of defining one system, and the ability to clarify, depict, or interpret the phenomena of one system and its relationship or non-relationship to another system.

7. Bridging

Bridging is defined as the skill and process of constructing a means to translate or interpret one system to another in terms of their similarity or dissimilarity, function, structure, context, content, or operation.

8. Defining "Clinical"

What does "clinical" mean in traditional contexts? If the word "clinical" means to observe a situation or event under carefully guided conditions based on specific criteria, then it might be possible to use Yup'ik measures and criteria to "carefully observe a specific event or situation" in order to assess its effectiveness. The use of Yup'ik measures is implied. One question will be that of "whose measures or criteria" will be important to use and under what conditions?

9. Clinical Supervision

Clinical supervision relates to assessment and diagnosis, intervention and treatment, and discharge and aftercare. Clinical supervision that involves Yup'ik traditional modalities implies that the supervisor at best or ideally should be bicultural and bilingual (Yup'ik/English; Yup'ik/American) and have the multi-cultural competency skills of bridging, translating, and recontextualization across cultures--presumably Yup'ik to American and vice versa.

Specifically, this might mean a clinical supervisor is able to work simultaneously with two or more standards of care, one of which embodies indigenous traditional knowledge and process. This may mean that the clinical supervisor be "required" and willing to marginalize the non-Yup'ik system in favor of the Yup'ik cultural empowerment where and when appropriate.

10. Spirituality

Since spirituality in the indigenous way is not to be compromised, then clinical supervision must find ways to embrace and support this practice. As the reader may know, indigenous systems of care hold spirituality as a core value.

E. RESEARCH AND EVALUATION OF TRADITIONAL MODALITIES

The issue of research and evaluation of traditional modalities is a vast one, requiring much ethical thought and sensitivity regarding culture, language, spirituality, method, and theory. In Native country, it is typically thought that qualitative methods are preferred over quantitative methods in conducting research and evaluating Native programs. Emancipatory and action research approaches may fare the best if it is participatory, empowerment-centered, and promote community or tribal ownership and self-determination over the research process.

Additionally, approaches that embrace and understand the politics of cultural difference are worthy of note because of the willingness of the researcher to look at such factors as oppression, racism, inequity, colonialism, or cultural trauma as critical factors in understanding contemporary tribal society.

Another issue relates to the questions: Can certain metaphysical, sacred activities be measured? Should they be measured? These questions must be considered during a program's planning and evaluation design, and they must be answered primarily by Native people.

It is generally understood that a certain amount of quantitative measures are necessary. For example, these mainly relate to demographic information. These measures may indicate a lowering of alcohol use and behaviors, socioeconomic measures, accidents caused by alcohol use, diseases caused by alcoholism, domestic violence incidence caused by drinking, drug or alcohol socialization characteristics, or incidence of incarcerations due to alcohol usage.

Another issue is western bias (e.g., the bias in western modernism's approaches and world view which typically discriminates against non-modern traditional cultures), which use Eurocentric or Anglo American questions, assumptions, and methods that include instrumentation and assessment theory. Because of "white privilege" systems, such research gets published and receives financial support.

F. TRADITIONAL PROVIDERS AND COUNSELORS

The RRCD Program reflects a growing interest in enhancing the participation of indigenous people in the services that they receive part of this involvement includes use of local traditions and customs in the development of services. However, there are some concerns which must be addressed as these traditional treatment approaches become integrated into the "mainstream" service array.

1. Provider Concerns

The following are key concepts, issues, and concerns identified by Yup'ik counselors regarding the use of traditional treatment modalities:

- Elders must be involved in all phases of intervention and treatment.
- The goal of policy making should always be towards the empowerment and validation of Yup'ik traditional knowledge and modalities.
- Spirituality is implied in all intervention phases.
- The use of traditional modalities is not meant to discriminate against anyone.
- Despite the use and implementation of traditional modalities, clients still have a choice not to use traditional modalities as part of their healing process.
- All accreditation and certification processes must acknowledge and recognize Yup'ik traditional knowledge and modalities as fundamental and basic to Yup'ik service provision. As such, all accreditation and certification processes must not marginalize Yup'ik traditional knowledge.
- Regarding personnel issues, Yup'ik traditional modalities and knowledge competencies are important and critical to Yup'ik cultural services. This may affect job descriptions, recruitment, hiring, and firing of YKHC personnel.
- Because of the need to maintain and respect the Yup'ik language, we recommend the use of bilingual translators at meetings where any traditional knowledge is used. We recommend YKHC build in-house capacity to provide such services.
- Quality Assurance shall be guided at least by the four core Yup'ik values. Traditional modalities should be an essential part of the assessment of each client's folder.
- In treatment planning, we recommend that recognized Elders may sign off on the client's treatment plan.
- YKHC might consider passing a general blanket policy regarding traditional modalities and their usage throughout the YKHC corporate system.
- Elders' input and signatures are needed in key places within the clinical supervision area.
- Quality assurance processes should be guided by the four (4) values contained in Yup'ik standards of care, and in any traditional modality.

- When there is a clear use of a traditional modality, a recognized Elder may sign off on a treatment plan.
- Any paperwork reduction or streamlining of bureaucratic process should be towards ends of cultural empowerment and continuity.
- Elders are a key component in the use of traditional modalities. As such, we recommend their employment in this effort. They can be helpful in clinical oversight, trainers, guides, and cultural resources. An effort should be made to compensate the Elders well, and to use both male and female Elders.
- YKHC should allow time for Elders themselves to address the issue of ethics, and to include various issues from western programs in their discussions (e.g., conflict of interest, professionalism, keepers of knowledge and skills, etc.). YKHC should also allow Elders to consult with staff people about specific issues that need to be included and addressed.

2. Defining the Native Traditional Counselor

Listed below are some possible qualities, responsibilities, and duties of a Native Traditional Counselor:

1. Have a primary responsibility to understand Native traditional knowledge in its various forms, processes, content, and context.
2. Have responsibility to know and understand key words and concepts embodied in the Native language. These key words and concepts relate to understanding the nature of that tribe's healing process. A Native traditional counselor need not be fluent in his/her language. However, Native language fluency is a definite asset to traditional counseling.
3. Have experience and training in Native traditional knowledge forms, processes, content, and contexts that relate to skills and competencies in the following areas of contemporary tribal life:
 - Ceremony, which includes song, dance, and prayer.
 - Creation stories, which contain means for addressing various forms of imbalance, disharmony, chaos, and disorder in one's life.
 - Vocation which includes tribal work and productivity within a cultural context.
 - Identity, which tends to answer the question *Who am I?* within a tribal context.
 - Culture, which is defined as a process of transmitting a people's knowledge, experience, and skills, and which pertains to activities like ceremony, song, dance, prayerfulness, story telling, traditional food, traditional dress, arts, and other traditional lifestyles.
 - Language usage and value, since tribal language embodies the core of the meaning of tribal life.
 - Community or group mindedness, since tribal life is predicated on communal action that is inclusive of individuality as well.
 - Place or a sense of meaning attached to earth, water, plants, animals, water beings, air, light, fire and other important elements in life.
 - Kinship, which pertains to the interdependent relationships among all life forms. This includes the human sense of family, clan, tribe, community, and nation.
 - Tribal sovereignty, particularly when it pertains to one's right to one's pre-modern, pre-American culture, language, spirituality, self-governance, self-determination, and aboriginal land rights.

- Tribal self-determination.
4. Have an understanding of life in the modern world from a traditional knowledge point of view.

The following are some important examples of issues and concerns that the Traditional Counselor works with in the counseling process:

1. Understands how such issues as colonialism, racism, sexism, inequity, power, and privilege have undermined Native identity, culture, and language.
2. Understands colonialism effects on community, family, extended family, and individuality.
3. Understands colonialism's effects on the sacred earth and sky and all the various life forms on this earth.
4. Understands compassionate responses, mediated via the tribe's sense of ceremony, song, dance and prayerfulness, to the effects of unresolved colonialism, racism, sexism, inequity, power, and privilege.
5. Is an educator. The Traditional Counselor educates the relative (client or patient) about Native culture and language and how that culture and language views the healing process.
6. Is a facilitator, collaborator, and community organizer. The Traditional Counselor works with the community at large and works to cause collaboration among community members.
7. Is an advocate for the client.
8. Opens the door to insight, and acts as a midwife to the acquisition of knowledge in terms of what that culture sees as meaningful, purposeful, useful, and traditional.
9. Understands western psychological theory and practice (as defined in western theory) that pertains to his/her relative's needs (e.g., alcohol recovery, anger management, sexual abuse, emotional disturbances, etc.).
10. Understands the likelihood that western psychological theory and indigenous ceremony will have strong differences as well as similarities. However, the Traditional Counselor takes the initiative to personally explore:
 - How, when, where, and why the two systems relate or don't relate,
 - How, when, where, and why the two systems can live side by side with one another (e.g., bilingualism and biculturalism), and
 - How, when, where, and why the two systems should be viewed as two separate and distinct systems on behalf of the relative and his/her perceptions of the two systems.
11. Understands his/her own woundedness as a healer and how his/her actions affect the client and the larger context of community and global responsibilities.
12. Seeks to develop his/her own theory and practice of counseling that will result in individual, community, and cultural transformation in a post-colonial fashion.

G. STRENGTHENING TRADITIONAL TREATMENT MODALITIES

The initial need is to develop a program plan that anticipates the validity of the Yup'ik cultural perspective. It would be a mistake to presume that non-Yup'ik planning processes are all that is needed to make a program work. There is also a need for cultural integrity and the appreciation of the uniqueness of Yup'ik tradition in program management.

In addition, there needs to be cultural democracy and tolerance for cultural and linguistic differences. There also needs to be, for the person being treated, an opportunity to reclaim Yup'ik cultural identity and to build in what one loves and knows into one's work, an important facet of Yup'ik existence.

There needs to be positive Yup'ik cultural affirmation and respect for the wisdom traditions of this world. There is also the need to appreciate what one knows best because it survived the test of time. Then too, there is the need to work on learning potential, strengths, and resiliency capacities of people, avoiding excessive diagnosing and pathologizing of people.

There is the need to do what one does best because it has survived the test of time. There is also need to survive in two worlds: traditional and modern, and there is the need to do what is most comfortable and makes common sense.

There is the need to feel love, happiness, competency, and community, and the need to heal in a way that addresses racism, oppression and colonization, the unresolved effects of multigenerational trauma, cultural differences, and western privilege.

What must be done externally, environmentally, and institutionally to make things work so Yup'ik traditional modalities have a real presence in the alcohol and drug abuse treatment process? Quality standards must reflect Yup'ik traditions of community, competency, meaning, integrity, innocence, and wisdom. Adequate funding needs to be invested for one to efficiently achieve cultural awareness, identity, and wellness competence.

Institutional policies and procedures need to allow for cultural integrity and empowerment in all phases of the program, including the following:

- Using and hiring local people to address problems;
- Finding a means for local village level self-determination and action to resolve local problems with means to utilize outside resources effectively;
- Accommodating the need to address oppression, colonization, the unresolved effects of multigenerational trauma;
- Finding a means to deal with cultural difference; and
- Becoming completely reliant on the culture and people as a means to respond to a problem.

There needs to be self-determination within a tribal or community context through such entities as a local policy steering committee. There needs to be assessment, diagnosis, treatment, and aftercare processes that are documented in a way that can satisfy western needs for data, standards, policy, and procedures that build bridges (i.e., appropriate models, processes) between the traditional and modern world. There needs to be collaboration designs which respect cultural differences, tribal self-determination and sovereignty, local autonomy, and decision making rights, while at the same time promoting diversity, equity, democracy, and due process.

There needs to be evaluation designs, models, and processes that indicate understanding and respect of cultural differences, indigenous thinking and process, and western and Native traditional issues. There needs to be research and evaluation models in which local people feel a sense of local ownership over important questions, hypothesis, theory, design, and outcomes, while at the same time meeting data needs of western and scientifically oriented institutions.

There needs to be a means to train or re-train all staff persons at all levels--professional and paraprofessional--in such areas as culture, language, cultural competency, issues in maintenance and empowerment of traditional knowledge and wisdom, and models that build bridges between the traditional and modern world. One assumption is that western-oriented educational institutions tend to ignore important issues.

There needs to be 1) a great overall vision, plan, and design that encompasses the nature of institutional and bureaucratic behavior in a traditional and modern context, 2) a quality clinical treatment program model and design that incorporates Yup'ik cultural process, content, and context, 3) quality counselors who are competent in what they do--in what villagers have always done for centuries--while at the same time have knowledge and skills to function as counselors in the western sense.

There needs to be quality leadership from Elders who embody Yup'ik tradition of community, competency, integrity, innocence and wisdom, as well as quality training program and process that accomplishes the following goals: Treat Yup'ik counselors, Elders, and others as the experts regarding their own condition, and as experts regarding generating, implementing, and evaluating solutions that use Elders as trainers, and provides for English/Yup'ik language translation.

Training needs to be provided to achieve Yup'ik goals to implement non-modern and non-western modalities, while still accounting for cross cultural adaptation needs of clients. This can be done by incorporating the following ideals:

- Use cultural empowerment as a basis for training;
- Allow participants to frame and construct their own knowledge about issues they consider relevant to their existence;
- Incorporate the need for participants to deal with their own healing needs and strengths;
- Allow participants to do their own designing and thinking;
- Avoid using outside experts who bring outside answers that are sometimes irrelevant.

H. GLOSSARY OF IMPORTANT TERMS AND CONCEPTS

Traditional. Since the advent of modernism, this term has become necessary to distinguish between two world views: traditional and modern/contemporary. Some writers and advocates of traditional knowledge have seen the need to define "tradition" in contrast to modernism because of the eclipse of traditional knowledge by modern knowledge systems.

According to one traditional knowledge scholar, "Tradition means truths or principles of a divine origin revealed or unveiled to mankind and, in fact, a whole cosmic sector through various figures envisaged as messengers, prophets, avatras, the Logos and other transmitting agencies, along with all the ramifications and applications of these principles in different

realms including law and social structure, art, symbolism, the sciences, and embracing Supreme Knowledge along with the means for its attainment."

Traditional Modalities. CMTRS described these as "cultural activities" which have therapeutic value and application to chemical misuse. Historically, the Yup'ik/Cup'ik people practiced many traditional activities that promoted positive methods to address problems an individual may experience in day to day life. Due to rapid acculturation of the Yup'ik/Cup'ik population, many youths are suffering the loss of identity and self-esteem complicated by drug/alcohol factors. Treatment for the Yup'ik/Cup'ik patients should include methods that build upon traditional practices, which have for centuries been a successful part of their way of life.

Examples of traditional modalities include hunting, berry picking, fishing, feasting and ceremony, trap making, story telling, mending nets, clam gathering, spending time with Elders, dancing, wood gathering, chopping wood, tundra walks, gathering medicinal and edible plants, steam bathes, arts and crafts, food preparation, teaching the skinning of fish and animals, summer fish camp, winter camps, sports, sewing, and various forms of community service.

Traditional knowledge. Traditional knowledge is the knowledge, experience, and competencies of cultures and languages that can be classified as pre-modern or non-modern in practice. The term "primordial tradition" has also been used to identify certain traditions that have origins in non-modern or pre-modern times. Also, the term "wisdom tradition" has been applied to this group possessing traditional knowledge.

Reclaiming cultural identity. The fact that one has a feeling or need to reclaim his/her cultural identity implies that it has been lost by some means. In Native peoples' history, major causes of this loss stem from cultural genocidal practices, racism, colonialism, and other inequitable treatment. Often, the idea of reclaiming one's cultural identity typically involves much pain and grief because of the loss involved. On the other hand, the reclamation process can result in a positive sense of one's inner beauty, meaning, and competency.

Culture. Culture is the content, process, and context in which a group of people or society endows and transmits meaning to their lives over the course of time.

Elders. In many non-modern cultures, a central goal of one's life, beginning at childhood, is to grow old, to mature, to be competent in the culture and to gain wisdom. As such, there is much respect afforded to the Elders for their capacity to teach, to provide both wise hindsight and foresight, to be open and honest, and to offer the traditional knowledge and means to achieve a social, political, or economic end.

Bridge building between traditional and modern worlds. This is a difficult process of forming comparisons and relationships between two often very different world views. Many Native people view the two worlds as separate systems, while others view them as compatible. Still others say there must be two-way bridges built between both cultures to allow for relevance between the two systems.

Use of "outside experts." Many times this orientation presumes there are no real experts inside the group or that the inside experts have slightly or grossly irrelevant knowledge. Sometimes this is because of the negative influence of modernism on traditional knowledge systems (e.g., modernist privilege).

Western. Often, Native people use the term "western" to describe "non-Native" systems, processes, or knowledge. The term "non-Native" is usually applied to white peoples, who it is presumed are all or mostly Eurocentric or western European in world view.

Knowledge construction. This is the process of building or rebuilding knowledge for oneself or by a community or group of people. This process applies to the pedagogy of an individual, a group (e.g., a culture or community) or a whole society.

Modernism. Modernism includes anything that is not "traditional." Some assumptions about modernism from Native people are that modernism can be both beneficial and traumatic to one's culture, tradition, identity, language, sense of community and/or sense of decision-making. Native people have always experienced trauma as a result of modern knowledge. Thus, from the Native traditional point of view, modernism is not always something that should be greeted with blind faith in its process, content or context.

Local policy steering committee. In the CMTRS experience, the local policy steering committee was a body of local Native people who were seen as Elders, leaders, and cultural authorities--to the extent that without their guidance, there would be irrelevant service provision.

Tribal self-determination. This concept refers to both individual and communal self-determination. The concept should not be restricted to refer only to the individual dimension.

Diversity. Diversity refers to the mix of ethnicities in the United States today. It includes diversity of language, culture, spiritual practice, religion, sexuality, gender, and tribal self-governance.

Equity. Equity refers to the notion of equality, equal opportunity, equal access, and/or equal treatment. This term becomes necessary when inequality is felt or experienced caused by such things as oppression, unequal power relations, or subordination.

Cultural democracy. Cultural democracy refers to the notion that cultures--as opposed to just individuals--can dominate and oppress one another. Inequity can and does exist amongst cultures. Consequently, some writers have proposed the need for a macro level democracy between cultures as a means to address issues of cultural diversity, multiculturalism, or cultural pluralism.

Clinical treatment. This term is typically assumed to mean "clinical" in the western scientific sense. However, it is possible to construe this term in an indigenous Yup'ik sense as well. The word "clinical" connotes structured observation using a particular method or set of methods and criteria or variables. It is possible for Yup'ik culture to function as such. It is assumed that differences between Yup'ik "clinical" and western "clinical" would sometimes be in terms of process, content, and context. A possible difference would surface regarding empirical research as defined in western terms. Empirical research might at times threaten Yup'ik holistic world views and narrow the focus of inquiry, such as only to the physical realm.

Cultural difference. The notion of cultural difference is not limited to just differences in dress, foods, lifestyles, world views, architecture, and spirituality. Cultural difference theory also embraces the idea that cultural difference can result from conditions of subordination, discrimination, racism, colonialism, and other forms of oppression. As a result, this can affect one's cultural identity, cultural consciousness, and one's notions of class, ideology, and

colonialism. An "oppositional consciousness" (the ability to read situations of power, and the ability to resist negative power) can develop as well.

Unresolved multigenerational trauma. This theory relates to the notion that one generation of people (e.g., within a culture group) can pass on various patterns of unhealthy behaviors, ideas, and practices from one generation to the next. This may include what has been called "dysfunctional behaviors and beliefs." This may also include unresolved grief, shame, and loss. If not dealt with, the same behaviors and practices roll forward in an intergenerational or multigenerational continuum

Yup'ik. The word "Cup'ik" is also included whenever the word "Yup'ik" is used in this report.

Note: Several Native service providers, such as the Na'nizhoozhi Center, Inc. (NCI), in Gallup, NM, choose not to use the label "client" or "patient" when referring to community members. Instead, they prefer to use appropriate labels or words that emanate from that culture's own concepts and notions of relationships. Therefore, NCI uses an English equivalent word meaning "relative" in addition to the Navajo word k' along with the various clanship relations such as "father," "mother," "grandfather," "grandmother," "uncle," "auntie," and so on.

I. CASE STUDIES

CMTRS clinical staff provided information on the use of traditional treatment modalities on selected clients. The following case studies, while reflecting actual patient outcomes, have been altered to protect the privacy of those involved.

There was strong anecdotal evidence that the CMTRS programs were of significant value to the communities involved. For example, in Scammon Bay, Community Health Aides reported that they were seeing fewer patients with alcohol-related injuries since the CMTRS program began. The CHAs also reported that the overall health status in the village was improving. There appeared to be fewer trauma calls that required CHAs to work late nights and early morning hours due to alcohol-related medical emergencies.

Village Public Safety Officers (VPSOs) reported similar results, saying there were fewer people in jail during holiday seasons. In the past, jails were crowded with individuals incarcerated for alcohol-related offenses, such as disturbing the peace, assault, domestic violence, and possession of alcohol.

These reports suggest that the presence of the CMTRS program in the villages had a positive effect, as it was the single most visible change in the human service delivery capability in the villages. CMTRS Program staff also reported positive results. For example, three families who entered the CMTRS Program for treatment in Scammon Bay have remained sober and are maintaining a healthier lifestyle. The parents in these families have jobs now, whereas they were not employed before receiving treatment through CMTRS. These successes appeared to be the combined results of CMTRS services, including traditional treatment modalities, as well as other services offered through the RSAS system. CMTRS worked affective coordination with other services. Some people who were known in the community as heavy drinkers before the CMTRS Program began are now drinking less and are remaining sober for longer periods of time. The Mayor of Scammon Bay, also a member of the Policy Steering Committee, confirms these observations. He stated that families are functioning better as families, children are being cared for, homes are cleaner, and men and women are fulfilling their roles in the home.

V. QUANTITATIVE FINDINGS OR PROGRAM IMPACTS

A. INTRODUCTION

An accurate comparison between the CMTRS villages and the control group VAEC villages required a uniform programmatic data source. For this reason, the evaluators and program sponsors decided at the beginning of the project to use existing data sets wherever possible. This would ensure:

- Comparability of data
- Consistency in data collection methods
- Consistency in variable and value definitions
- Similar time frames for data collection compilation and analysis

The data sets used included programmatic information from the State of Alaska Division of Alcohol and Drug Abuse Management Information System, health care data from the Community Health Aides, the Alaska Public Safety Information Network, the State of Alaska Division of Family and Youth Services data system, and other data sources which could be used to compare the experimental and control programs over time.

This section presents the results of the quantitative data analysis. Each section begins with a review of the purpose and use of the data in addressing evaluation research questions or measuring the attainment of goals and objectives contained in the initial project grant. Next, the source of the data is described. Quantitative findings are presented in both narrative and graphic form where possible.

B. SERVICE UTILIZATION DATA

1. Introduction

The characteristics of clients and the type and extent of services provided were the most important part of this quantitative evaluation. As a start-up program, it was important to see if the initial expectations of the program were realized--specifically, if the demographic characteristics of the clients were different from similar programs, if the presenting problems of clients were broader, and if the service delivery differences, especially the use of traditional treatment modalities, had any effect on the successful completion of treatment.

2. Data Source: State ADA MIS

All programs that receive financial support from the State of Alaska Division of Alcohol and Drug Abuse are required to submit periodic programmatic reports to the State Management Information System. These reports contain information about the program, program staff training, admission, and discharge information for all clients served, and information about the specific services provided by staff.

State data for all programs financed by the Division of Alcohol and Drug Abuse were transported to the Institute for Circumpolar Health Studies in a flat ASCII format. Data on admissions, client transfers, and staff activity bonds were all independently formatted. Client data from admissions forms and client transfer forms were merged together to develop an episode of illness file with the following matching variables:

- Client number,
- Client suffix,
- Service site, and
- Component.

The original data set contained records for the years 1992 through 1997, while the recent data set contained data for the years 1988 through early 1999. This recent data set was more comprehensive than the data initially received from the State of Alaska. The total number of accurate records was increased from 937 to over 1,242 records, including complete information on over 935 clients.

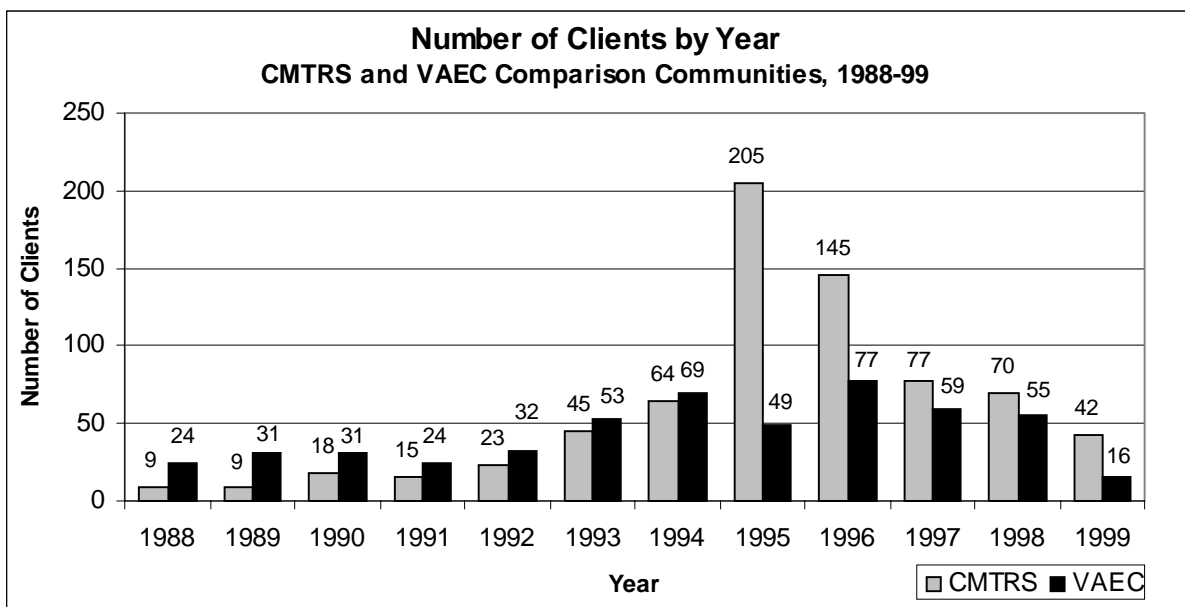
Additional activities were required to map the staff activity logs to give an accurate portrayal of direct service and administrative functions. This allowed for an evaluation of the distribution of staff time, especially the type of direct services provided to patients. A description of the data process is provided in Appendix J.

3. Findings

a. Overall Use of Services

Figure 3 describes the overall use of services in CMTRS and VAEC comparison communities for calendar years 1988 through October 1999. As expected, the data show relatively low use of services for CMTRS communities during the 1988 – 1994 period. CMTRS program operations began in 1995 and had a dramatic enrollment of 205 clients during that calendar year. Although enrollment fell off substantially since then, it appeared to continue at a higher level than the comparison VAEC communities. The two groups had approximately the same number of individuals in the community (see Table 1) and one fifth the number of counseling hours available (see Table 2). This suggests a higher output of VAEC counselors than CMTRS counselors. However, in every instance, the number of admissions to CMTRS communities continued to exceed the number of VAEC admissions.

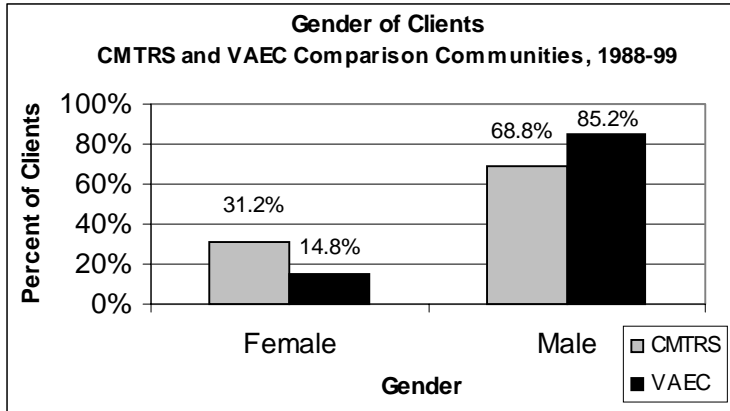
Figure 3



b. Client Characteristics

This section describes the demographic and social characteristics of clients seen by the two programs.

Figure 4



Gender of Clients: Figure 4 shows that CMTRS programs had a significantly higher proportion of female clients than their VAEC counterparts ($\chi^2 = 43.9$ Significance = .000). This may have been because the CMTRS communities insisted that there be at least one female counselor on the two counselor staff.

An additional analysis was completed to test the hypothesis that the gender of the counselor by itself was a sufficient explanation for the higher proportion of female clients in the CMTRS programs. The village of Napaskiak was selected as the comparison village because it had a female counselor. A review of the gender of clients admitted from 1988 – 1998 showed the same distribution as that for all other VAEC villages. This suggests that the CMTRS communities emphasized attracting and retaining female clients that went beyond the mere presence of a female counselor. This also suggests that CMTRS programs had a successful outreach effort to attract and retain female clients.

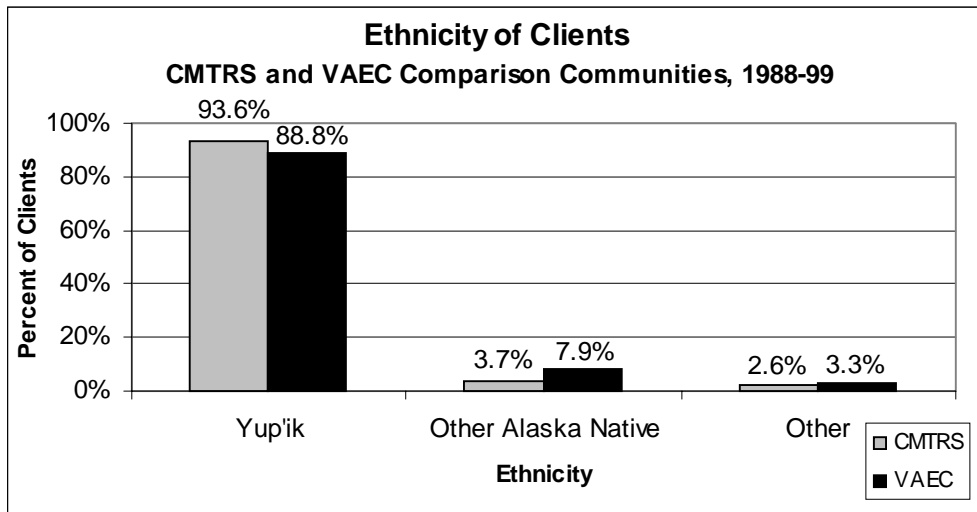
Age and Family Income: Table 3 shows the mean age and family income of clients admitted to CMTRS and VAEC comparison communities. The ages for both groups were virtually identical. Both had a mean client age of approximately 33 years. There was no significant difference between the CMTRS and the comparison groups. Table 3 shows significant differences in the family income between the two groups ($t = -1.99$ Significance = .047). The CMTRS client family income was substantially lower than that of their VAEC counterparts (\$5,624 vs. \$6,864 respectively). While this difference was significant, it may not have had a material affect on the ability of clients to pay or received benefits for services rendered. The difference between the two villages, for example, would not affect welfare eligibility and the accompanying eligibility for Medicaid. It could, however, support the differences found in the gender distribution of clients. It may be reasoned that an increased proportion of female clients could have the affect of reducing the annual family income.

Table 3: Client's Mean Age and Income

	Mean Age	Sig.	Mean Family Income	Sig.
CMTRS	32.81	.958	\$5,624.39	.047
VAEC	32.78		\$6,863.58	

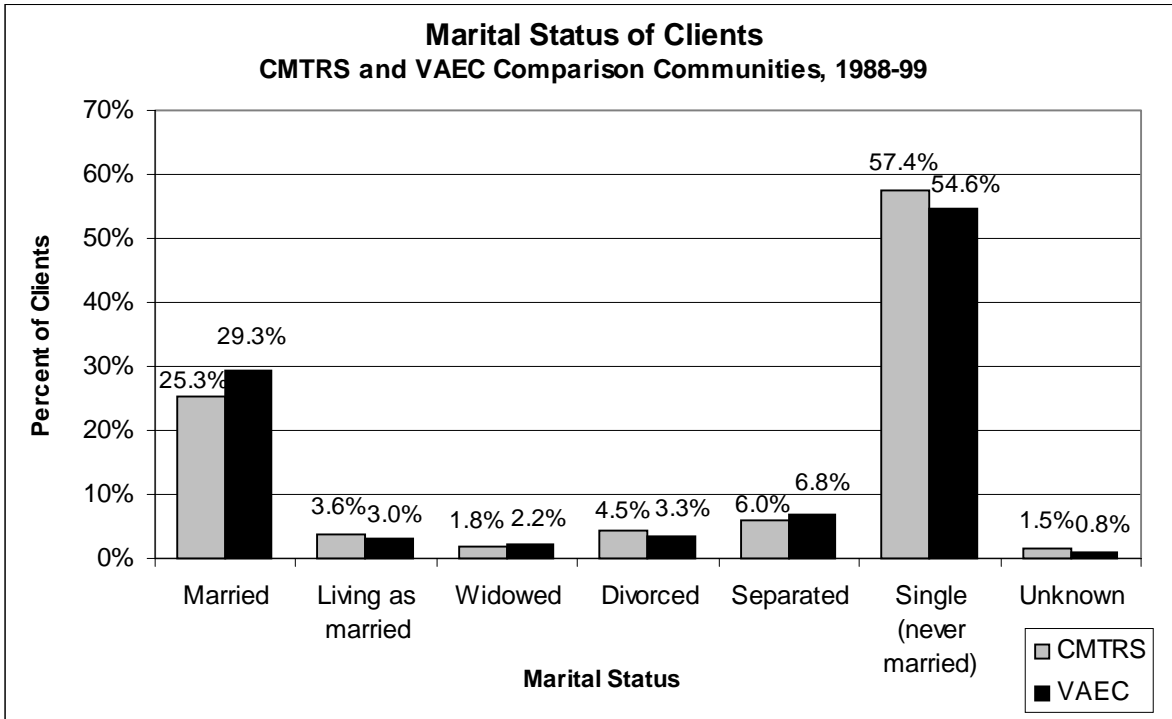
Ethnicity: Figure 5 shows a comparison of the ethnicity of clients in CMTRS and VAEC communities. While the differences in the ethnic composition of the two groups appears to be significant, it may not be material. The CMTRS villages were over 90% Yup'ik, whereas the comparison VAEC villages were slightly under 90%. The VAEC villages also had a slightly higher proportion of other Alaska Native groups, and a slightly higher proportion of non-Native clients.

Figure 5



Client Marital Status: While missing data made a comparison of marital status between CMTRS and VAEC communities difficult, the marital status of clients served by the two programs appeared to be the same (Figure 6).

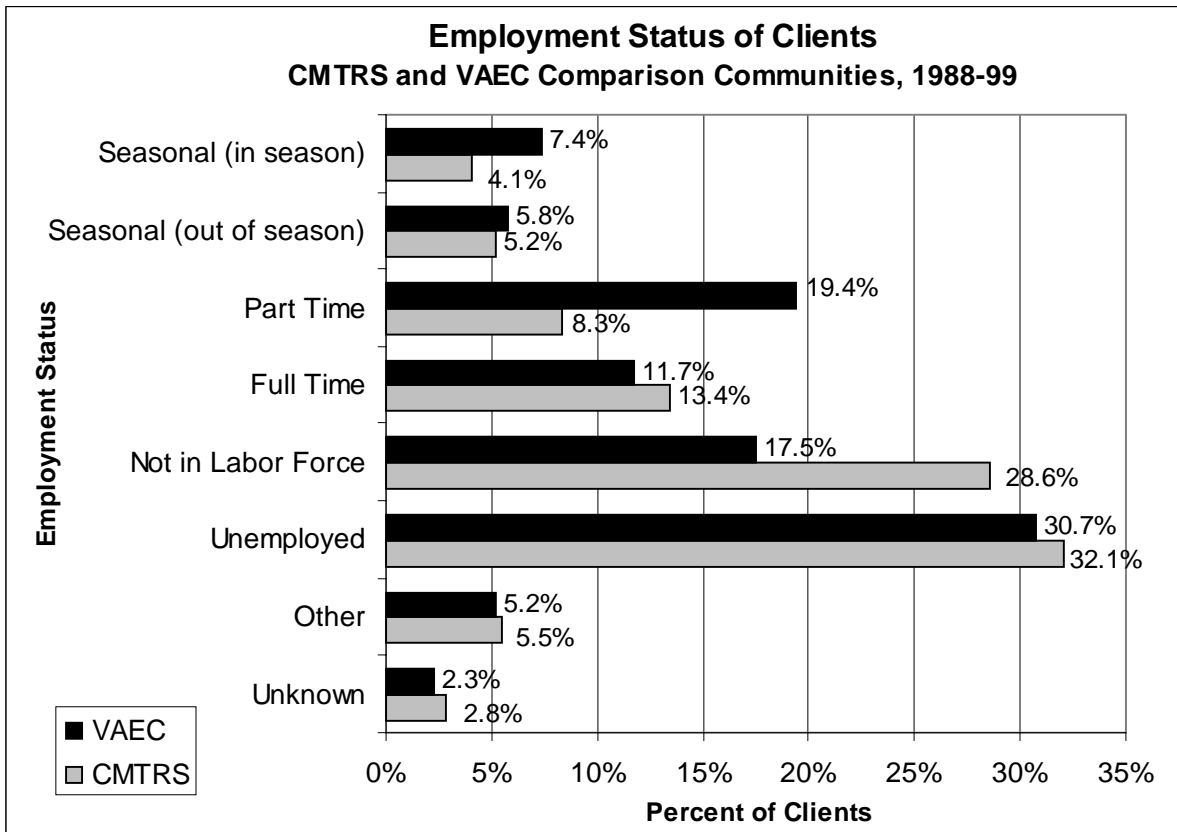
Figure 6



The CMTRS program emphasized treatment of both families and individuals (see Table 2). However, the distribution of the marital status of clients did not reflect this emphasis. The marital status of CMTRS and VAEC communities appeared to be identical in structure. One would expect that the CMTRS program, with its emphasis on the treatment of families, would have had a higher proportion of married clients and a lower proportion of single clients. The reverse, however, was true. One possible explanation for the lack of file closure could be the Yup'ik belief that people may feel slighted if they are no longer recognized as clients after making the effort to receive treatment. Another possible explanation is the Yup'ik people's reluctance to sever relationships that have grown over time. One would expect, however, that similar Yup'ik values would predominate as well in VAEC comparison communities, because the ethnic distribution of these communities is virtually identical. A third possible explanation is the nature of clinical supervision for the CMTRS programs as compared with the VAEC programs. The VAEC clinical supervisor insisted on the timely closure of the records, whereas the CMTRS clinical supervisor was less aggressive about closing client files.

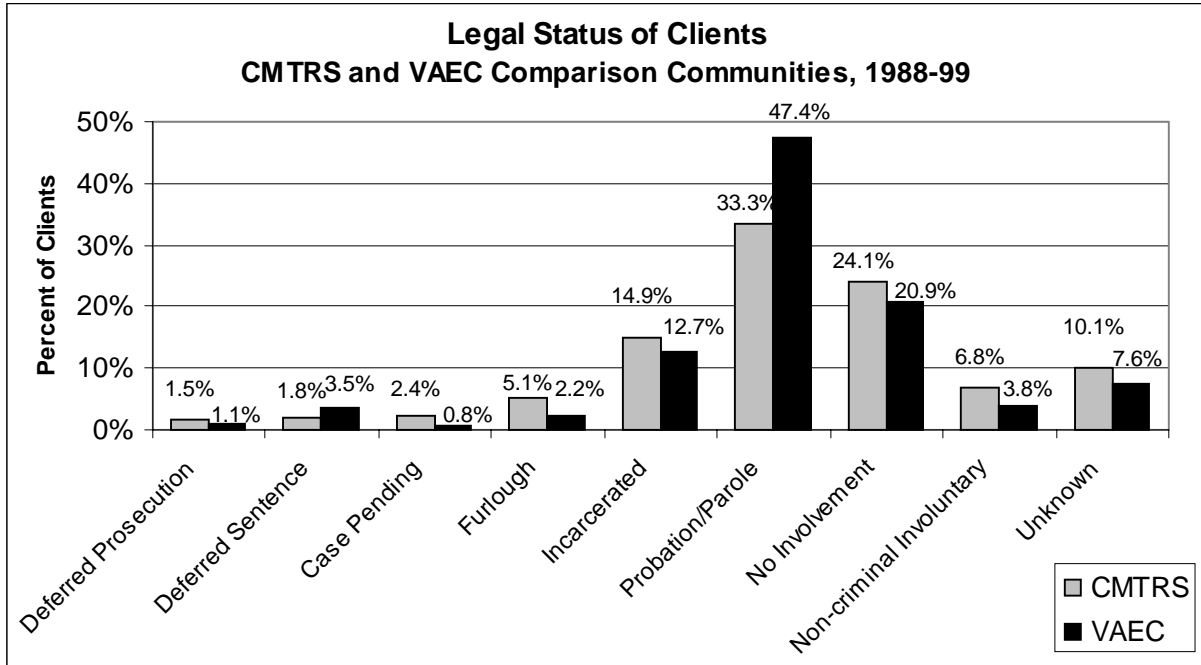
Employment Status: Figure 7 compares the employment status of clients from CMTRS with clients from VAEC communities. The data was difficult to interpret because of the large proportion of cases with missing data or codes that were unknown to the evaluators. In CMTRS, 60% of the clients had unknown or missing data. In the comparison VAEC communities, 43% of employment information was unknown. For those clients who provided reliable employment information, the most significant difference was the proportion of clients who had part-time employment within communities served by VAECs – over twice the proportion of similar clients in CMTRS communities. There appeared to be a slightly higher proportion of individuals who had full time employment in CMTRS communities. This may be attributable to the development of Community Development Quotas (CDQs) in CMTRS villages. The three CMTRS areas are in a relatively poor census tract (Wade Hampton), this accounting for the higher proportion of clients not in the labor force. Other proportions were roughly identical.

Figure 7



Legal Status: Figure 8 compares the legal status of CMTRS and VAEC communities. As with the employment data, this information was difficult to interpret because of the high proportion of missing data (53% missing from CMTRS and 29% missing from VAEC communities).

Figure 8



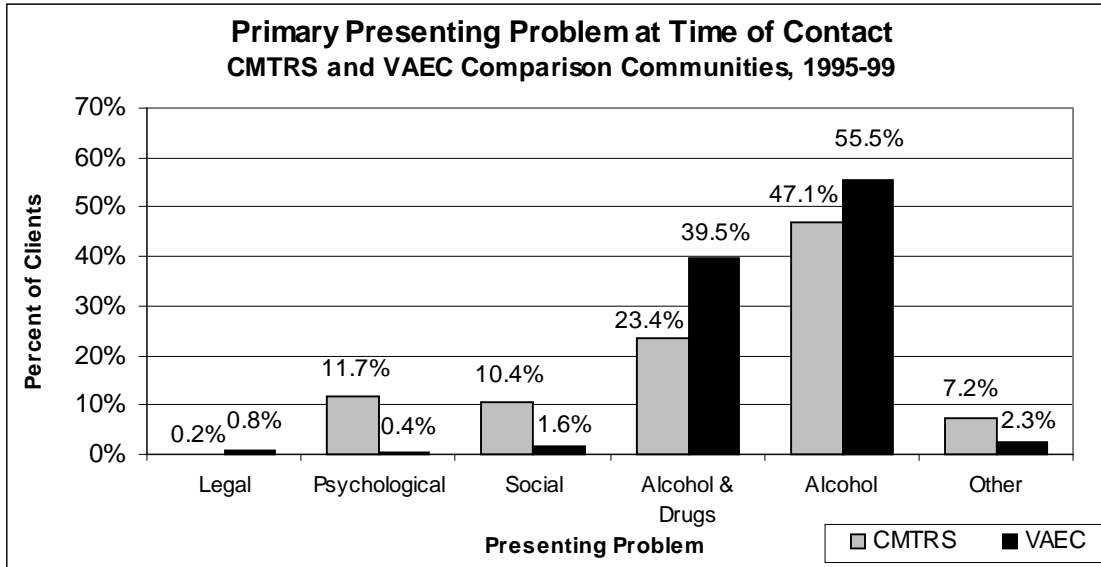
Of particular interest was the difference in the proportion between CMTRS and VAEC clients who were on probation and parole. VAEC communities have a higher referral rate from the criminal justice system and therefore would have been assigned to the cases of clients who were on probation or parole. CMTRS had a substantially lower proportion of clients with this legal status. The VAEC communities also had a lower proportion of clients with no involvement in the criminal justice system at all, again reflecting the closer relationship of VAEC counselors with the criminal justice system.

c. Clinical Characteristics of Clients

This section presents a comparison of the clinical characteristics of clients admitted to CMTRS and VAEC programs between 1995-1999. Earlier historical data were eliminated to allow greater accuracy in the comparison of clients admitted during the operation of the CMTRS program.

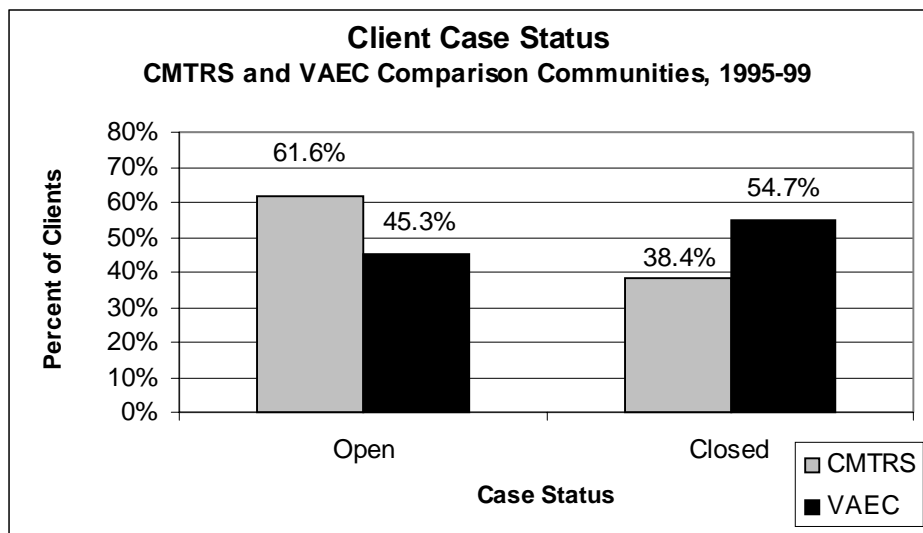
Primary Presenting Problem at Time of Contact: CMTRS programs appeared to see a broader range of clients than their VAEC counterparts (Figure 9). VAECs focused mainly on clients with alcohol and drug problems, whereas CMTRS clients saw clients with a wider array of behavioral and social problems (chi sq.= 72.54, significance = .001).

Figure 9



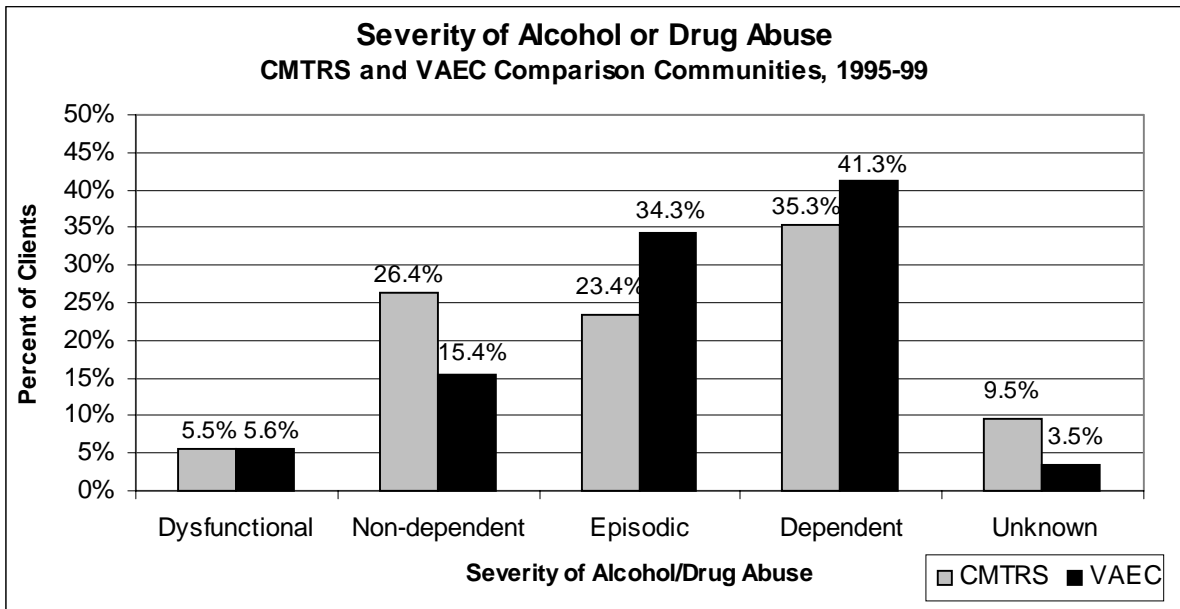
Client Case Status: CMTRS clients were expected to be transferred to the VAEC project effective June 1999. A description of the procedure for transferring CMTRS clients and contacts to other programs is shown in Appendix K. Therefore, one would expect that all CMTRS client files should be closed. We found, however, that this was not the case. The final proportions of open and closed cases within CMTRS ranged between 60% and 70% throughout the duration of the program. There was no appreciable change in the 1999 year when all cases were expected to be closed (Figure 10). This reflects the continued problems with the accuracy and reliability of programmatic data collected by CMTRS counselors.

Figure 10



Severity of Alcohol and Drug Use: Figure 11 compares the severity of the problems that clients experienced in CMTRS and VAEC comparison villages. The differences between the two groups are significant ($\chi^2 = 13.2$ Significance = .01). The major differences are in the proportions of people who were not alcohol dependent. Within CMTRS villages, the proportion of people in this category was substantially higher. VAEC counselors, on the other hand, had a higher proportion of people who were considered episodic drinkers, often called “binge” drinkers. This information suggests that CMTRS counselors were able to engage people into treatment before they became substance dependent. It is also consistent with data that suggest that the CMTRS outreach efforts were fairly well developed.

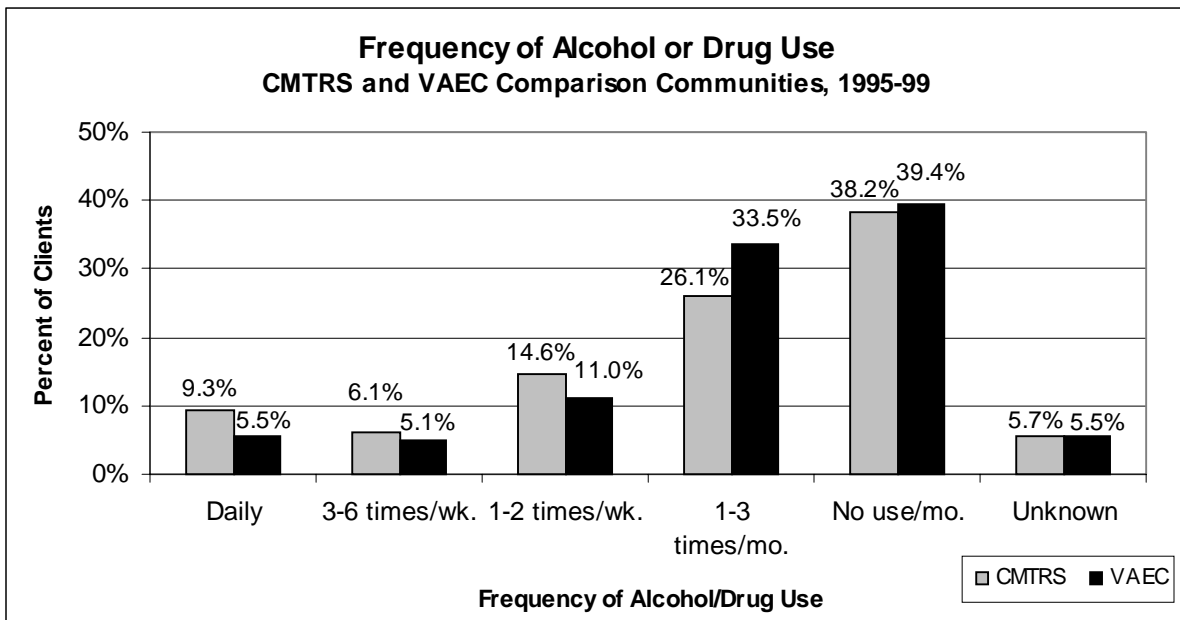
Figure 11



As with other parts of this analysis, the high proportion of missing data (44% VAEC and 63% CMTRS) make an analysis of the severity information problematic.

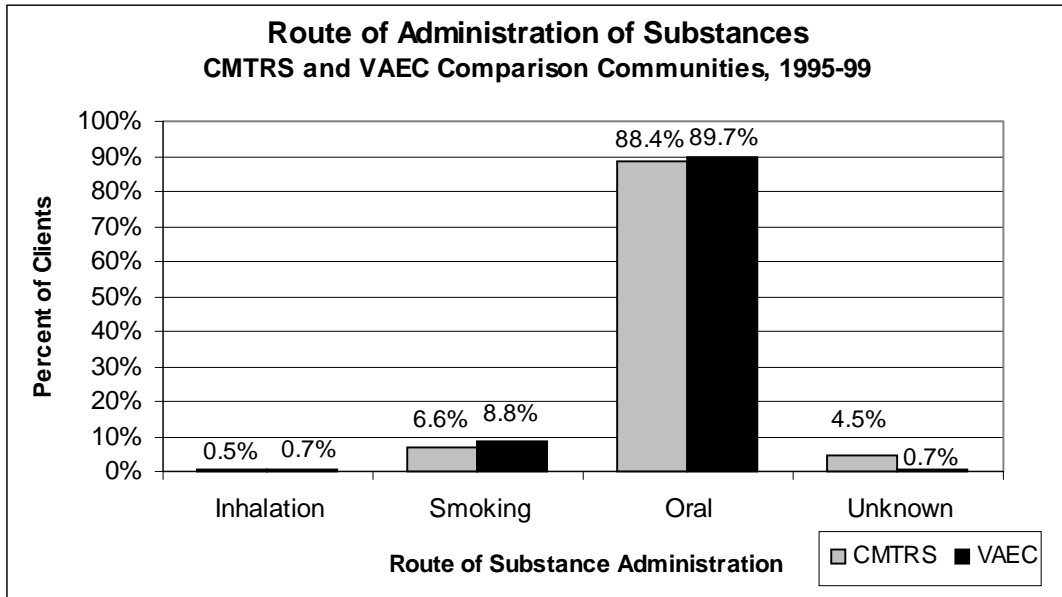
Frequency of Alcohol Use: Figure 12 compares the frequency of alcohol or drug use among clients in CMTRS and VAEC comparison communities between 1995 – 1999. The information does not show any material difference between the two client groups. Most people enrolled in both CMTRS and VAEC villages had not used alcohol or drugs within the past month. This was consistent with the emphasis on aftercare of patients who already went through treatment and who were attempting to maintain sobriety. However, the CMTRS clients appear to have had slightly higher intense use (from 3 to 7 times per week), which is typical of clients who are just beginning to engage in alcohol treatment. This information suggests that both CMTRS and VAEC villages emphasized aftercare, but a higher proportion of CMTRS clients were in the early stages of the disease characterized by frequent alcohol and drug use.

Figure 12



Route of Administration of Substances: Figure 13 compares the route of administration of substances for CMTRS and VAEC clients. As expected, the largest proportion of clients were drinkers, as demonstrated by the number and proportion of clients who took their drug of choice orally (mostly alcohol). Smaller proportions of clients were smoking or inhaling their substances. There were no significant differences between VAEC and CMTRS communities in this regard.

Figure 13

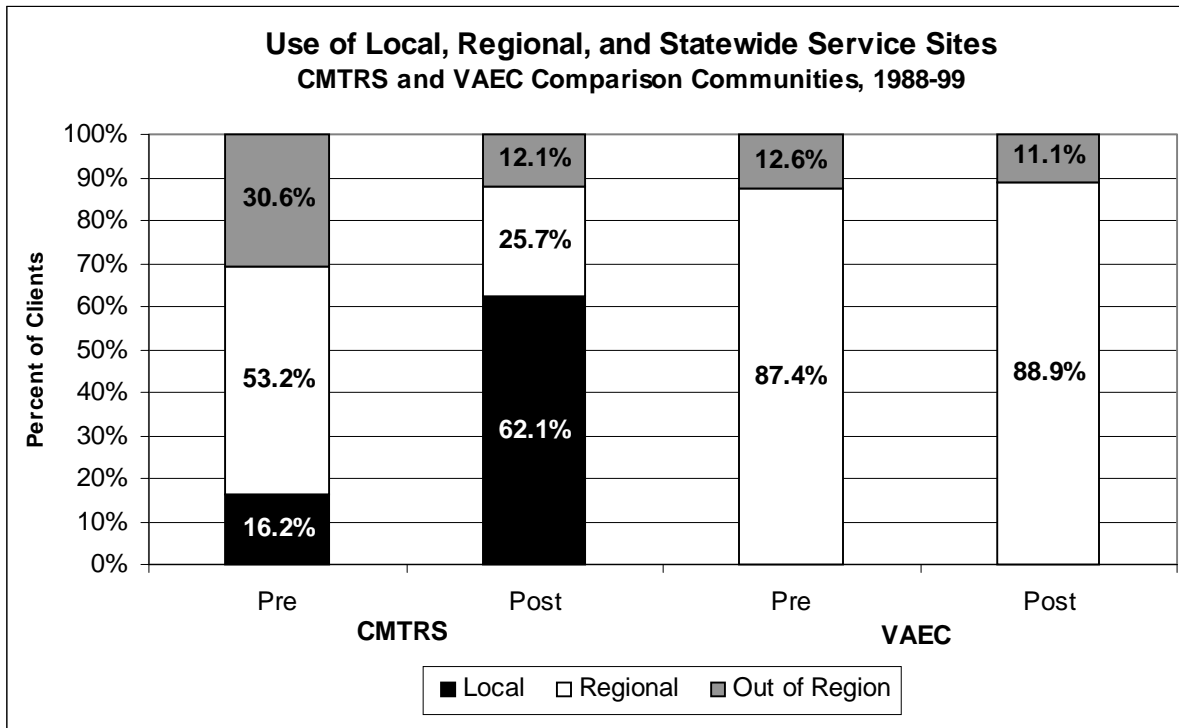


d. Characteristics of Treatment

This section analyzes the characteristics of treatment between CMTRS communities and VAEC communities, comparing the periods 1988 through 1994 (before CMTRS implementation), and the period 1995 through 1999 (after the implementation of CMTRS).

Use of Local Services: Figure 14 shows the changes in the use of local, regional, and statewide services between CMTRS and VAEC communities. The low proportion of missing data allows more confidence in the interpretation of these results.

Figure 14



The proportion of VAEC clients who were served outside of the region in the period before CMTRS implementation was about 13%. Before CMTRS implementation, there were no services within the communities of Hooper Bay, Scammon Bay, and Chevak, thus obligating most clients to seek services outside of their region. This resulted in a 31% referral rate to services outside of the YK region. These figures took a dramatic change after the implementation of CMTRS. While the VAEC villages referred approximately the same proportion of clients out of the region, CMTRS referrals to services outside of the region plunged to 12% of all clients seen. On the other hand, the proportion of clients seen within the villages increased from 16% to 62%.

e. Length of Stay

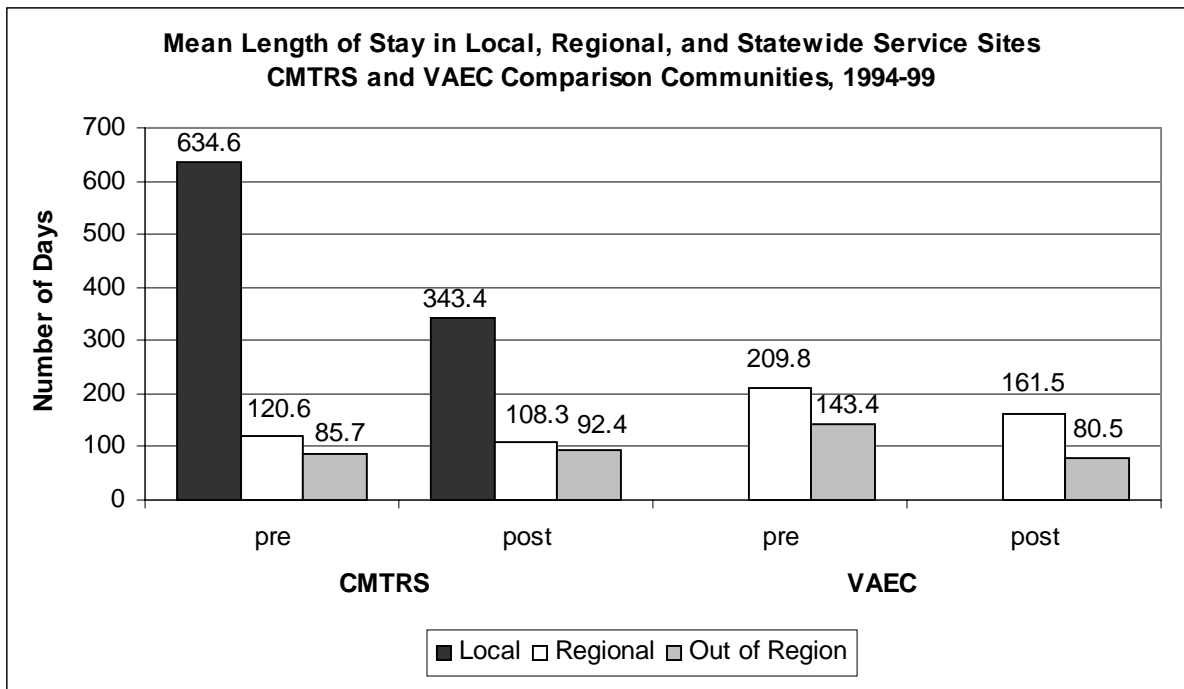
Table 4 shows the length of treatment for clients in CMTRS and VAEC villages seen at local, regional, and out-of-region service sites. There appears to be no significant difference between CMTRS and VAEC villages over the 10 year time period of this study (1988 to 1999).

Table 4: Comparison of Overall Length of Treatment, 1988-1999.

Program	Length of Treatment	Significance
CMTRS	173	.814
VAEC	178	

Figure 15 highlights the differences between CMTRS and VAEC Programs for the pre and post CMTRS implementation periods. After the implementation of the CMTRS program, the length of treatment in the village was reduced from over 634 days to 343 days. The proportion of referrals outside the village-based treatment setting went up, but the length of treatment decreased, suggesting that there were some efficiencies realized from village-based treatment. The slightly increased length of treatment out-of-region may also be attributable to increased efficiencies, and that only greatly impaired people with severe problems were referred out of the region for care. The increase in severity may have accounted for the increased length of treatment. During the same periods, the VAEC programs showed a decrease in length of regional treatment and a decrease in the length of stay in out-of-region treatment facilities. This also suggests a greater sophistication of RASA services.

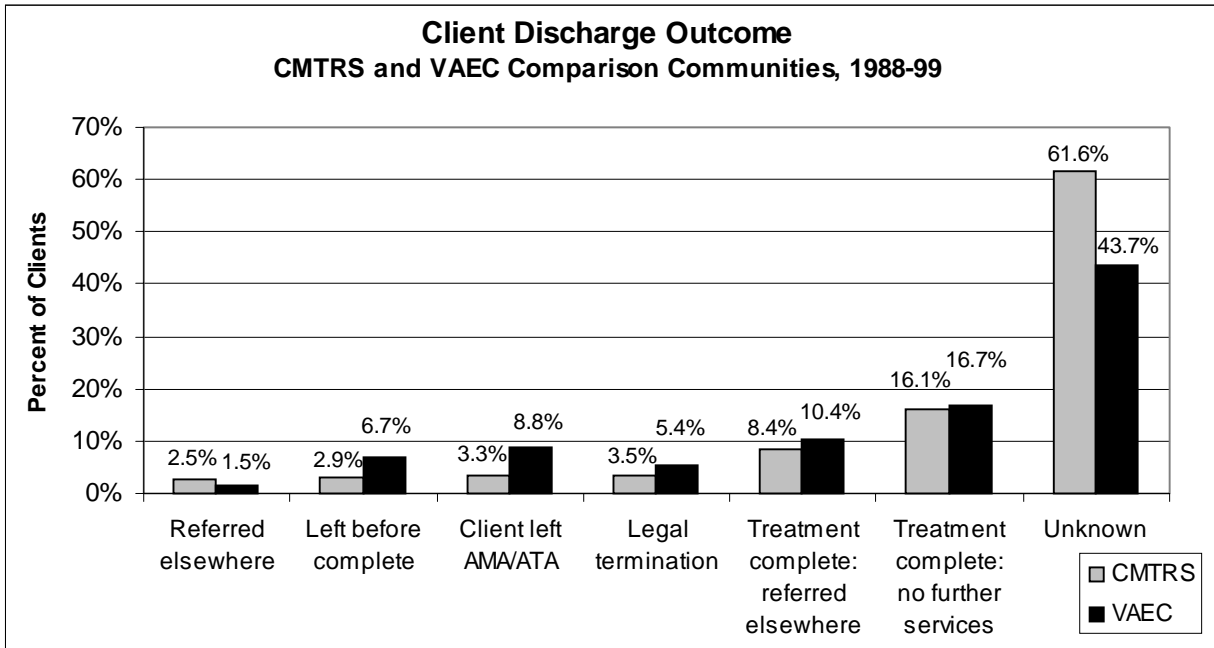
Figure 15



f. Treatment Completion

One of the most stable and reliable measures of the success of treatment is treatment completion. Figure 16 shows data on treatment completion. The data, however, were difficult to interpret because of the high proportion of cases with unknown discharge outcomes or missing data.

Figure 16



Between 1988 and 1999, CMTRS and VAEC services appeared to have the same completion rates. Approximately 16 to 17 percent of clients completed treatment. The discharge categories that describe why a treatment was not completed suggest that CMTRS programs had more success in preventing people from leaving their treatment protocols before treatment was complete than their VAEC counterparts.

An additional analysis was performed comparing changes in the discharge outcomes before and after the implementation of the CMTRS program. The results show that completion rates for both VAEC and CMTRS communities dropped from the “pre” period (1989-1994) to the “post” period (1995-1999). However, the drop appeared in both CMTRS and VAEC communities and in approximately equal amounts. The reason for this drop is unknown (see Table 5). Missing data was much higher in the post-periods in both groups.

Table 5: Proportion of Discharges in Selected Categories
CMTRS and VAEC Communities, 1989-1999

Disposition	CMTRS		VAEC	
	Pre	Post	Pre	Post
Treatment Complete	30.6	11.1	24.6	8.6
Complete, Referred Elsewhere	19.1	4.8	16.3	4.3
Client Left AMA/ATA	9.3	1.3	14.8	2.7
Missing/Unknown	16.9	76.8	12.9	75.4

4. Summary

The programmatic data from the State MIS that compared CMTRS and VAEC communities shows that the services provided by the CMTRS counselors had been used since their implementation in 1995. Further, these services were being used with increasing frequency by women and people with problems other than substance abuse. This reflects the holistic nature of the project and the value of its emphasis on a behavioral health model.

CMTRS services appeared to capture clients with more severe substance abuse problems than their VAEC counterparts, as measured by the frequency of substance use. CMTRS programs also appeared to capture clients earlier in their course of growing addiction to alcohol. Although the duration of the resulting treatment appeared to be the same between the CMTRS and the VAEC communities, there seemed to be more efficient use of services in CMTRS communities, as evidenced by the longer lengths of stay for a reduced proportion of clients referred outside the village. This suggests that more severely impaired people were being appropriately referred outside the village for treatment.

C. PUBLIC SAFETY DATA

1. Introduction

One of the objectives of the CMTRS project was to reduce the target communities' involvement with the criminal justice system. A review of criminal justice data strongly suggests that the CMTRS program helped moderate or reduce alcohol-related crime, thus improving the public safety and welfare of target villages when contrasted with villages in the comparison group.

It has long been believed that substance abuse is a significant contributor to major and minor crimes in most Alaska villages. One of the expected outcomes of the CMTRS program was the

reduction in alcohol related crimes in the three villages served by the demonstration program. This section presents a preliminary review of existing data on the actions taken by public safety personnel in CMTRS villages.

2. Data Source: APSIN

The Alaska Public Safety Information Network: Criminal Justice Data from the Alaska Public Safety Information Network (APSIN) was used to develop trend data for selected criminal offenses. Data from CMTRS villages that participate in the APSIN system were contrasted with similar data from comparison communities.

APSIN contains over 8,000,000 records and 650 separate programs, and is the largest on-line data processing system in the State of Alaska. Agencies across the state routinely enter data into the system. These agencies include: local police agencies, the Division of Motor Vehicles, the Department of Corrections, the US Customs Bureau, the FBI, and many other Alaska agencies involved with public safety.

Data has been consistently collected since May 1984, and is stored on a main frame computer in Anchorage. Public Safety has expressed confidence in its system and has published the annual report "Crime in Alaska" since 1983. The system has also been used to prepare the federal uniform crime reporting statistical programs for the federal government.

In this analysis, data was extracted from APSIN regarding actions taken by public safety officers in the CMTRS villages of Hooper Bay, Scammon Bay, and Chevak, and from the comparison VAEC communities of Kwethluk, Napaskiak, Akiak, Mekoryuk, Toksook Bay, and Tununak from 1989 to 1999.

The following information was collected:

- Violation code - Four digit national crime information center (NCIC) offense codes were used to identify violations or suspected violations. These codes are often used in reporting crime at the national level. Those activities, which do not correspond to NCIC codes but are violations of state statutes, were coded separately by the researcher.
- Offense date - The year, month, and day of each offense was extracted from the APSIN system.
- Location - The location of the offenses or suspected offenses were Scammon Bay, Hooper Bay, and Chevak. The agency responding may have been located in a village or a town outside these three villages. However, for the purposes of this study, the location of the crime, not the agency that responded to it, was of major importance.
- Alcohol or drug related - The APSIN system requires full reports of offenses to contain information on whether the offense was alcohol or drug related. Many times, however, this information was not completed by those filling out the record.
- Action - Although over 4,000 records of various actions were recorded in the APSIN system for the three villages from 1989 to 1997, only 12% actually generated any formal record of an offense. The remaining records contained logged actions, where a public safety officer visited the village and observed the alleged activity, but filed no formal report on those actions. In these cases, a NCIC record is not available.

Reliability: The quality of APSIN data is variable. Occasionally, Village Public Safety Officers (VPSOs) do not complete the APSIN forms, and some villages do not contribute data to the system. The 1995 Uniform Crime Report indicates that Hooper Bay may not routinely contribute information to the APSIN system.

APSIN data were grouped for the CMTRS and the comparison VAEC villages. Contacts with the public safety system were categorized using the NCIC codes. Data on only alcohol-related offenses was used. This information is collected by the arresting officer at the time of the incident and, therefore, is believed to be an accurate representation of alcohol involvement in the offense. Arrest records were then subset into those that occurred before 1995 (the beginning of the CMTRS program) and after 1995. This set up a pre-post comparison of alcohol-related offenses.

3. Methods

The frequency of the contacts with the public safety system in CMTRS and VAEC communities were plotted over a ten year period from 1989 to 1999. The data was analyzed using a control chart technique applied by business statistician William Edwards Deming.

The control chart provides references for data points over time based on data averages as well as upper and lower control limits. In this analysis, the data points represent the average occurrence of alcohol-related public safety contacts per year. The control limits indicate a range in which data will fall if no unusual occurrences have occurred. The control limits are a function of the consistency of the data and total number of cases represented within each time interval. The control chart is a useful tool for 1) identifying time intervals that fall outside of the control limits and 2) determining the consistency of a process.

The control limits are determined by calculating the standard deviation of the data using statistical formulas. The standard deviation indicates the degree of variability in the data. Two standard deviations can be added and subtracted from the average to provide control limits within which 99 percent of the data should fall (Becker-Reems, 1995). Deming advises that quality improvements through the reduction of variation in organized systems can be graphically demonstrated in control charts (Deming, 1982).

There are two kinds of variation. The first is variation results from many small causes that demonstrate a lack of system control. These minor variations in the system are often linked to the inability to clarify procedures, inappropriate processes, or the limitations of machinery and equipment. Management can only change these common causes. Other causes of variability are called "special causes." They show up on control charts as points outside the confidence limits (Walton, 1986) and are commonly referred to as "outliers."

Continuous improvements in a community's approach to public safety issues can be shown over time by the ever-narrowing upper and lower confidence limits in public safety contacts. The more finely tuned the process, the less variation will be seen in the data, and data points will begin to hover around the average.

4. Findings

The control charts for public safety contacts in the VAEC communities showed greater variation than similar data from the CMTRS communities (see Figures 17 and 18). Further, there were more points outside the upper and lower confidence bounds, suggesting that there

may have been more “common causes” of variation in the VAEC communities. Lastly, the range between the upper and lower confidence bounds for the CMTRS communities appeared to be narrowing over time, while those for the VAEC communities did not. This suggests that CMTRS communities were having an effect on controlling the variation in the detection, adjudication, and treatment of alcohol related public offenses.

Figure 17

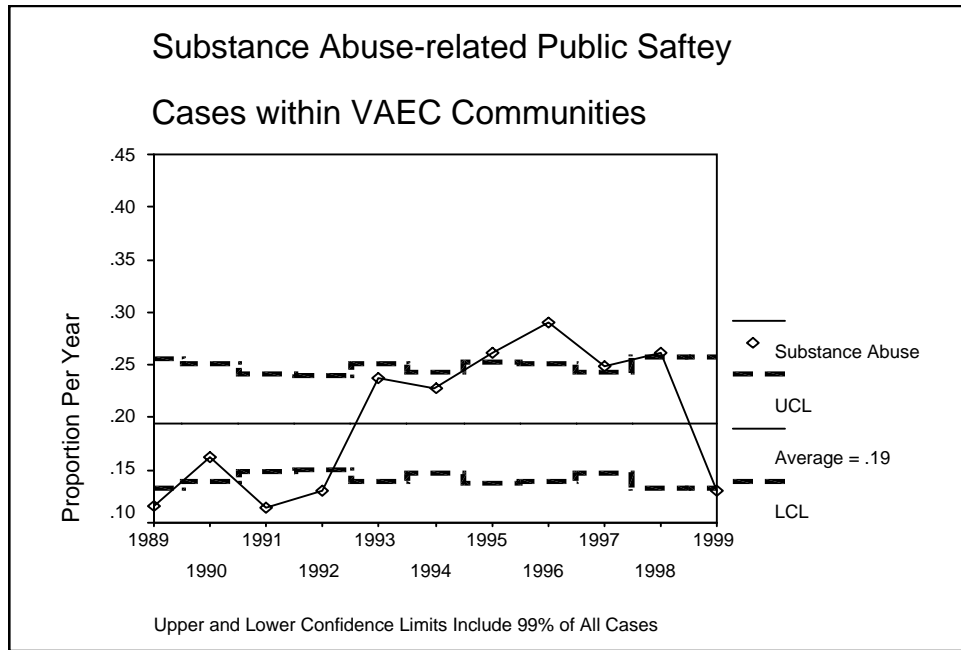
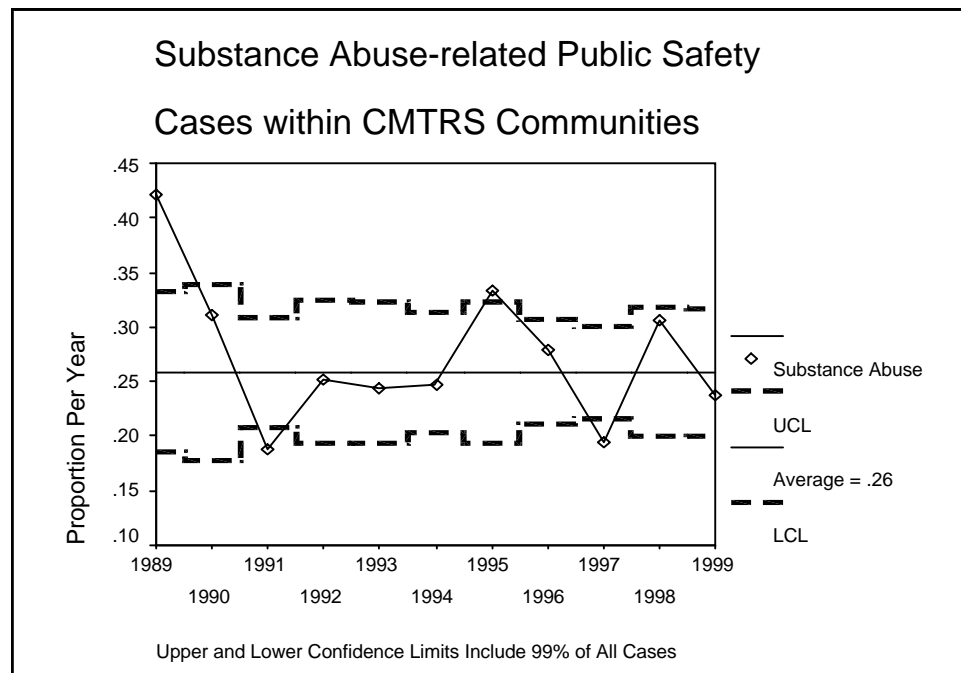


Figure 18



Analysis of Substance Abuse-Related Arrests: While the mean proportion of alcohol-related offenses in CMTRS communities was higher than that in the comparison VAEC communities, the upper and lower 99% confidence limits appeared to be growing closer together. This suggested that, while the proportion of alcohol-related offenses was higher in CMTRS villages, those villages appeared to be getting more control over alcohol-related behavior. The next stage of the analysis attempted to understand the specific reasons for this decrease in variation.

A proportional analysis was used for the remainder of this study. This analysis compares the proportion of alcohol-related offenses for selected NCIC codes for VAEC and CMTRS villages for the pre-1995 period and the post-1995 period. Because changes in the proportion of alcohol-related offense between the pre and post periods were the unit of analysis, the actual number of occurrences and the duration of the pre and post periods were adjusted.

There appeared to be a significant increase in the proportion of alcohol-related charges involving the “business” of alcohol (Table 6). These charges involved alcohol manufacturing (home brew), as well as the transportation, sale, and distribution of alcohol. These may be considered methods of directly addressing the local option laws in “dry” communities.

Table 6. Proportional Changes in Alcohol “Business” Arrests
CMTRS and VAEC Villages, 1989-1999

NCIC Code	N	CMTRS		VAEC		Significance*
		Pre 1995	Post 1995	Pre 1995	Post 1995	
Liquor Offenses**	186	38.6	61.4	52.9	47.1	.05
Dangerous Drugs***	77	16.7	83.3	39.1	60.9	.033

*Pearson chi-square

**Includes Alcohol manufacture, sales, possession and transport

***Includes heroin and marijuana

There appeared to be no change in charges that involved crimes against people (Table 7), including sex offenses, sexual assault, and family offenses. The only category of offense that showed a significant difference was assault. This may have been because the number of cases was high, thus showing a significant, but not a material effect

Table 7. Proportional Changes in Arrests for Substance Abuse-Related Crimes Against People
CMTRS and VAEC Villages, 1989-1999

NCIC Code	N	CMTRS		VAEC		Significance*
		Pre 1995	Post 1995	Pre 1995	Post 1995	
Sexual Assault	128	36.8	63.2	51.9	48.1	.09
Assault	681	55.1	44.9	46.8	53.2	.035
Sex Offenses	100	62.5	37.5	69.4	30.6	.485
Family Offenses	17	60.0	40.0	57.1	42.9	.91

*Pearson chi-square

There was no significant change in crimes against property, such as weapons offenses, disturbing the public peace, traffic arrests, invasion of privacy, burglary, and property damage (Table 8).

Table 8. Proportional Changes in Arrests for Substance Abuse-Related Crimes Against Property
CMTRS and VAEC Villages, 1989-1999

NCIC Code	N	CMTRS		VAEC		Significance*
		Pre 1995	Post 1995	Pre 1995	Post 1995	
Disturbing the Peace	113	35.4	64.6	35.3	64.7	.99
Weapons Offenses	113	61.8	38.2	51.1	48.9	.26
Traffic Offenses	244	45.5	54.5	50.5	49.5	.44
Invasion of Privacy	60	77.4	22.6	62.1	37.9	.19
Property Damage	75	54.5	45.5	61.9	38.1	.52
Burglary	66	50.0	50.0	50.0	50.0	1.00
Larceny	32	45.0	55.0	50.0	50.0	.78

*Pearson chi-square

These findings suggest that most of the change in the community's response to alcohol-related behaviors that were outside the realm of acceptable behavior appeared to be related to

the effective implementation of existing laws regarding the sale, distribution, and consumption of illegal substances. Of particular interest was the increasing proportion of alcohol-related arrests involved with the enforcement of local option laws. It did not appear that the community reached the same level of response yet. There continued to be roughly similar proportions of alcohol-related offenses for crimes of a violent nature and those of a less violent nature.

5. Summary

The Public Safety data showed that the variation of alcohol-related arrests over time continued to decrease within CMTRS communities. A similar pattern was not seen with the comparison VAEC villages. This finding suggests that predictability increased in the systems for addressing alcohol-related public safety issues.

An analysis of the reasons for this decrease in variation appears to relate to the enhanced enforcement of violations of laws prohibiting the importation, sale, distribution, and manufacture of alcoholic beverages. These were all aspects of the CMTRS community decision to exercise their local option to become alcohol-free communities.

However, there did not appear to be a significant reduction in the proportion of either personal or property crimes.

D. HEALTH CARE DATA

1. Introduction

The initial CMTRS goals and objectives highlighted the relationship between receiving substance abuse treatment (and changes in physical health status) and the use of medical services. Specifically, the objectives stated that the target CMTRS population would have reductions in:

- The utilization of acute general health care services and
- A reduction in the spread of infectious diseases.

While the development of the CMTRS program appears to have impacted the health and welfare of the populations of the target communities, evaluators have been unable to detect changes in the use of primary health services.

This section summarizes a review of the clinical literature that supports the hypothesis that substance abuse treatment can lead to substantial improvements in the health of populations and a reduction in the use of physical health services. Much of this research is grouped under the category of “medical care offset,” and focuses on the relationship between the receipt of alcohol treatment services and a reduction in medical care utilization. A complete discussion is shown in Appendix L.

2. Measurement Concerns

Improvements in the health status of the population was difficult to measure using health service utilization data. Community Health Aides record their data using the patient encounter forms. It was initially expected that the box indicating whether the admission or encounter was alcohol-related would be a good indicator of changes in the alcohol-related health status of the village. However, it was found early in the process that Community Health Aides did not routinely enter data into this box. This made it impossible to directly measure alcohol-related outpatient visits to Community Health Aide clinics.

An alternative approach was attempted where the number of Community Health Aide visits per person/per month would be used to measure changes in outpatient use over time. This information, however, could not be used to conclusively demonstrate changes in physical health status.

Researchers argued that a decrease in the number of Community Health Aide visits per person/per month would show an increase in the village health status. It could be argued that a decrease in the prevalence of alcohol use within the village would accompany a decrease in the number of alcohol-related Community Health Aide visits. Thus, the reduction would be a measure of the success of the CMTRS program in improving village health status. On the other hand, it could be argued that as people become more aware of their own physical health needs, and the physical health needs of their families, as they begin to control their chemical misuse and the number of Community Health Aide visits per person/per month would increase. Thus, the increase could be both interpreted as a programmatic success or failure. Therefore, the evaluators were unable to develop a consistent interpretation of the data on Community Health Aide patient encounters per person/per month.

Two other measures were also considered. First was the use of inpatient care by residents of the CMTRS villages compared with residents of non-CMTRS villages. Changes in the hospital admission rates for alcohol-related diagnoses were initially thought to be available from the RPMS inpatient data set, but were found to be difficult to obtain and interpret.

The second was the assessment of the reduction of infectious diseases. Data is kept only on vaccine-preventable diseases by the State Section of Epidemiology. In addition to the methodological problems, the number of occurrences of vaccine-preventable infectious diseases was too small to develop statistically significant findings over a brief period of time. Therefore, this measure was rejected.

3. Impact of Substance Abuse Treatment

Clinical literature clearly shows that people with substance abuse problems generate higher health care costs than those without such problems. Early studies within Alaska (see Kelso, 1975) show a substantial increase in health care costs in Alaska generated by individuals with alcohol problems.

Recent research in medical care cost reductions, attributable to successful substance abuse treatment, suggests that the range of decreased cost can be between 23% and 55%. In addition to the decreased medical care costs, there are decreased social costs of recovering individuals. These include reduced domestic violence, child abuse, and the number of contacts with the criminal justice system. A complete analysis of the medical care offset literature is shown in Appendix L.

4. Summary

A number of alternative methods were considered to assess changes in the health status of the population. They included:

- A change in the number of Community Health Aide visits;
- A change in the number of alcohol-related inpatient admissions; and
- A change in the number of vaccine-preventable infectious diseases.

In all instances, the data were insufficient to measure these changes.

E. SOCIAL WELFARE DATA

1. Introduction

This section presents the data on three indicators for three villages. The indicators include "accidental deaths and suicides," "offenses leading to incarceration," and "out-of-home placements." The villages and dates that the CMTRS centers opened were: Chevak (1994), Hooper Bay (1995), and Scammon Bay (1994). Previously, crime data were to be included, but the data for this indicator were not available.

2. Analysis

Data for all three indicators were analyzed in two ways. First, "time" was used to discern temporal changes resulting from the start-up of the treatment programs and centers. With all three indicators, the baseline was several years before program start-up. However, due to problems in accessing the data, there was limited information for comparison *after* start-up. The second analysis provides a comparison of the CMTRS communities with the surrounding communities.

Time: Two different time periods were employed in this analysis. For two of the three indicators ("accidental deaths and suicides" and "offences leading to incarcerations"), the period included 1986 through 1995. 1986 was selected as a period long enough before the centers were started to provide a reasonable "temporal" baseline. The year 1995 was the latest year for which the data were available for these two indicators. For the third indicator ("out-of-home placements"), the period only included 1990 through 1995; data for prior years were not available.

These time-periods were the basis for observing changes in the indicators for the three villages. However, if changes occurred after the CMTRS programs started, it would still be questionable whether they occurred because of the CMTRS program or for other reasons. There could be contributing factors in the three CMTRS villages that caused changes in the indicators that were independent of the treatment centers.

Comparison Communities: If communities without CMTRS programs also had "before" and "after" differences similar to the differences in the three CMTRS communities, this would suggest that it was not the CMTRS programs that caused the differences. For example, "accidental deaths and suicides" rates might show the same increases and decreases in both the CMTRS study group and the non-CMTRS study group. Thus, these changes in rates could be part of a broader trend not yet changed by the new centers. However, if the trend in "accidental deaths and suicides" in the CMTRS villages was less

than in the non-CMTRS villages, this could suggest that the centers were influencing such deaths. To assess this possibility, the three CMTRS villages were compared with other villages.

The three villages under study included Chevak, Scammon Bay, and Hooper Bay. Sixteen other Alaska Native villages surrounding the CMTRS villages were employed as the comparison group. These 16 villages did not have substance abuse treatment centers.

3. Findings

The data in this report did not show that the CMTRS program in the three villages under study reduced the levels of "accidental deaths and suicides," "offenses leading to incarceration," and "out-of-home placements." In actuality, in the CMTRS villages, the rate of "accidental deaths and suicides" climbed in 1994 and 1995, after the treatment programs were established (see Figure 19). "Offenses leading to incarceration" also rose in the CMTRS villages in 1994, to a level previously reached in 1987 (after a long decline since 1987), and then declined slightly in 1995 (Figure 20). "Out-of-home placements" showed different trends in the CMTRS study group, depending on the placement. Child protective placements continued to decline in 1994 and 1995, following a continuous decline since 1990 (Figure 22). By contrast, youth corrections placements rose precipitously in 1994, and then declined slightly in 1995 to the level last reached in 1991 (Figure 23).

Small numbers made the search for patterns difficult. First, in Chevak, two accidental deaths occurred in 1994 and two suicides in 1995 (after no accidental deaths or suicides in 1993), which accounted for the rapid rise in these rates for the entire study group. Hooper Bay and Scammon Bay had no accidental deaths in 1994 or 1995 (Scammon Bay had none since 1986). Hooper Bay and Scammon Bay had no suicides in 1994 and one suicide each in 1995. These small numbers were difficult to attribute to any single variable, such as the CMTRS program.

Second, the increase in "offenses leading to incarceration" in the CMTRS study group reflected trends in one village; in Chevak, offenses (misdemeanors especially) doubled from 27 in 1993 to 42 in 1994, and remained high (at 45) in 1995, similar to the levels in the late 1980s. In Scammon Bay, offenses were slightly less in 1994 and 1995 than in 1993—yet too small a reduction to attribute to the CMTRS program in that village.

Third, in 1994 and 1995, the CMTRS group saw a reduction in "out-of-home placements" in the category of child protective services, which appeared to be a continuation in a downward trend since 1990—rather than a new trend from the advent of the CMTRS program. However, the numbers here too were small (a reduction from 33 in 1993 to 25 in 1994 and to 22 in 1995). Hooper Bay accounted for the biggest increase in the category of youth corrections in 1994, which had only two cases in 1993, but 15 cases in 1994, as compared with no cases in 1994 in Chevak or in Scammon Bay.

4. Indicators

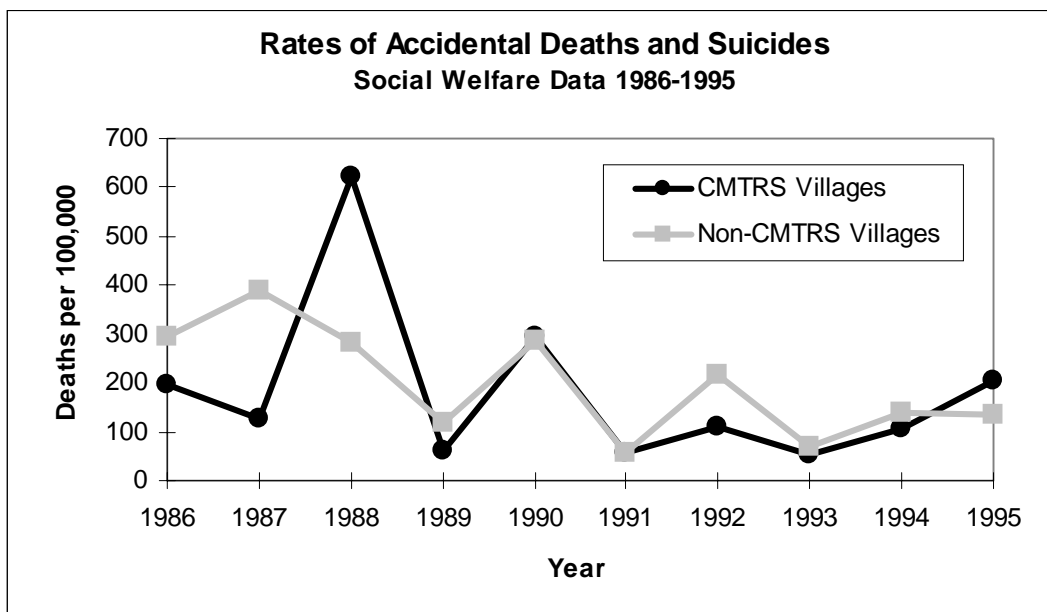
Alaska Native "Accidental Deaths and Suicides": The following compares the CMTRS villages with the 16 other non-CMTRS villages for the period 1986-1995. The most striking feature was that few deaths occurred—134 "accidental deaths and suicides" over the 10-year period, for an average of 13 annually in a total Alaska Native population of 7,000. However, wide fluctuations occurred from year to year. A small number of deaths, along with large

fluctuations, meant the rates changed dramatically over time. Thus, the rates should be interpreted cautiously when looking for trends.

It is important to note that accidental deaths dominated these numbers, accounting for two-thirds (83 out of 134) of the deaths. Thus, these numbers reflect the rates of accidental death more than the rates of suicide.

Figure 19 shows that the annual average rate of "accidental deaths and suicides," as a whole, was slightly less in the three CMTRS villages (179 per 100,000) than in the non-CMTRS villages (194 per 100,000). However, contrary to what one might expect, the rate of "accidental deaths and suicides" in CMTRS villages increased in 1994 and 1995 after the centers were introduced.

Figure 19



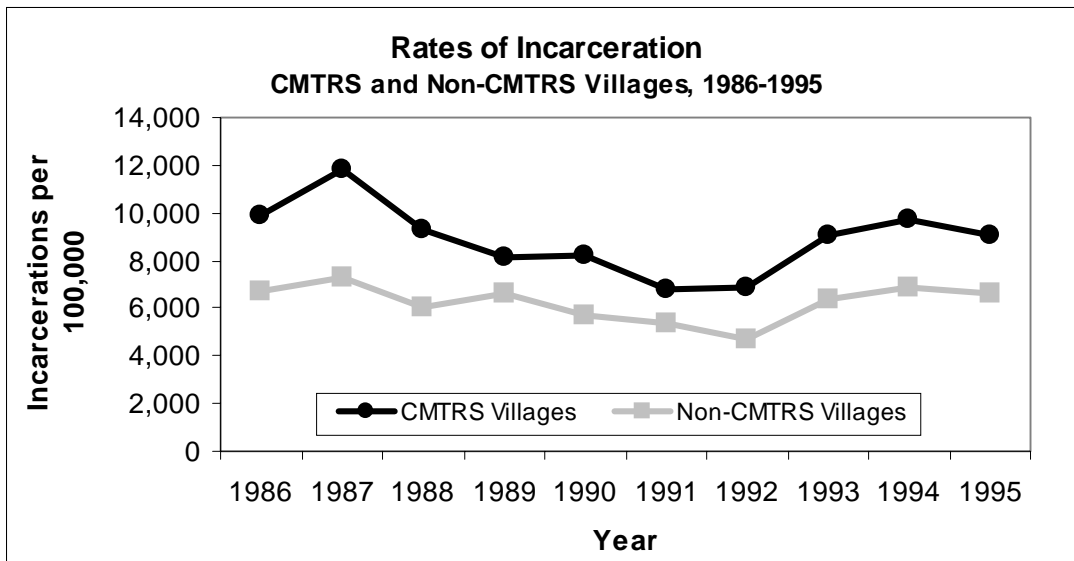
In short, the data do not show that the centers had a detectable impact on the rate of Alaska Native accidental deaths and suicides in the CMTRS villages—either over time or by comparison with other villages without treatment centers. This is not surprising, for two reasons. First, it takes time for such centers to change long-held attitudes towards alcohol. Second, rates change dramatically from year to year because they involve small populations (a single death in a small village can cause a big change in its rate). In general, data for a comparison are needed for a longer period of time, such as a decade prior to and a decade after the centers are started, to obtain more reliable results. This is a reminder that these small numbers may point to changes, anomalies, and discrepancies—an understanding of which must be sought in a detailed investigation of the circumstances surrounding the deaths.

Suicides in many Alaskan communities often occur in clusters. One individual, typically a young Alaska Native, commits suicide and, for a variety of reasons, other individuals within the victims cohort group decide to commit suicide as well. These clusters of suicides often mask the suicide rates from one year to the next. Since this data was collected, there was a rash of suicides in CMTRS villages, most notably in Hooper Bay. It is not known whether this will change the aggregate suicide rate over time.

Alaska Native "Offenses Leading to Incarceration": The data on incarceration included the annual number of offenses in the form of felonies, misdemeanors, and violations committed by individuals who were incarcerated that year. Most individuals committed more than one offense during the year they were incarcerated.

Figure 20 shows that over the period 1986-1995, the CMTRS villages experienced substantially higher rates of offenses than the non-CMTRS villages. In addition, rates in both the CMTRS and non-CMTRS study groups increased since lows in 1992. These two facts suggest that the treatment centers did not had a detectable effect on offenses in the communities that led to incarceration.

Figure 20



The consistent increase in rates during the 1990s in the CMTRS and non-CMTRS study groups could be part of a random pattern of short-term volatility, or a reflection of increased public sensitivity to crime in the villages (i.e. an increase in reporting of offenses). Interviews in the villages are needed to shed light on changing sensitivity.

In the CMTRS villages over the period 1986-1995 there were 784 misdemeanors whose perpetrators were incarcerated, as compared with 510 violations and 236 felonies. (Note: the same individual may have been incarcerated for different offenses at different times during this period.) In the non-CMTRS villages, there were 1,756 misdemeanors, as compared with 905 violations and 633 felonies. Misdemeanors represented the largest number of offenses, except for 1987 and 1988 in the CMTRS villages, when violations were slightly higher.

Figure 21A shows the number of incarcerations by type of offense in the CMTRS villages over the period 1986-1995. A modest reduction occurred in the number of violations, while the number of felonies remained steady (with a slight increase in the 1990s). The number of misdemeanors remained steady in the 1980s, followed by an abrupt increase in the 1990s. In the non-CMTRS villages, Figure 21B shows that the number of felonies and violations decreased over the period, with misdemeanors increasing in the 1990s.

Figure 21A

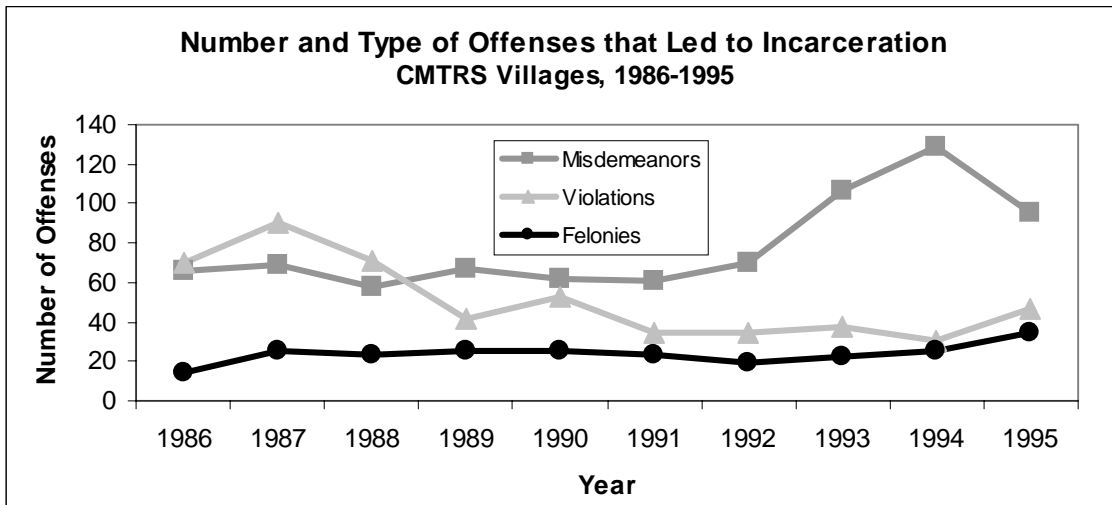
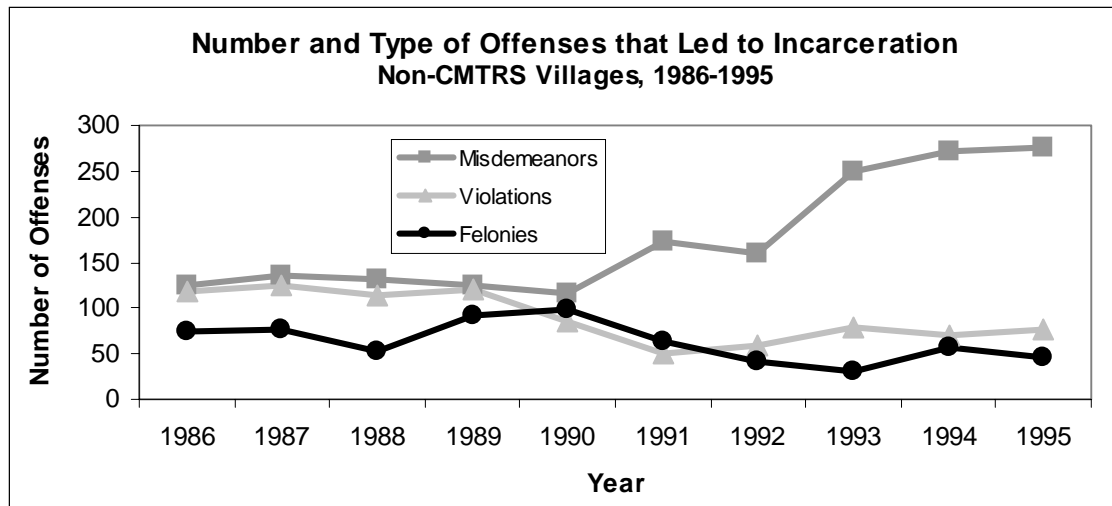


Figure 21B

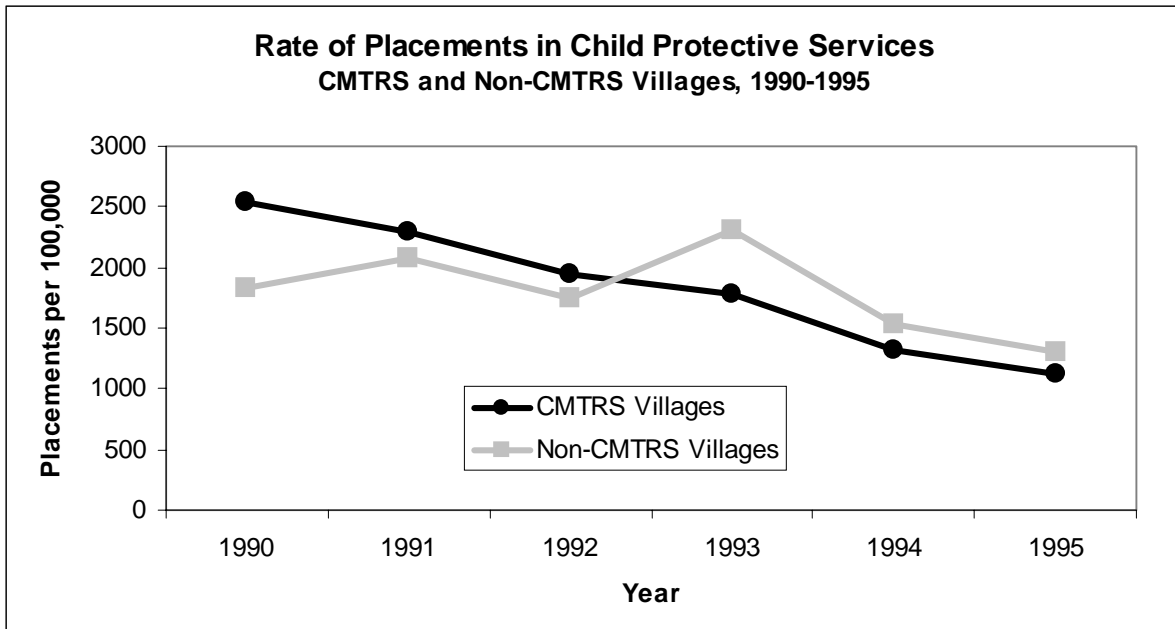


"Out-of-Home Placements": Child Protective Services (CPS) and Youth Corrections (YC):
 The Alaska Department of Health and Social Service's Division of Family and Youth Services (DFYS) has two programs that provide for the option of "out-of-home placement": Child Protective Services (CPS) and Youth Corrections (YC). These data were for Alaska Natives and non-Natives combined; there was no breakdown by ethnicity.

For both programs, the numbers used were not first occurrences, but total occurrences. For example, an individual may have been placed in several homes during a year in search of a more suitable home. In general, total occurrences outnumbered first occurrences by three or four to one. First occurrences were arguably a more important indicator of dysfunction than total occurrences. Yet, the number of both CPS and YC cases was so small that using first occurrences alone would have precluded the search for patterns. Even the use of total occurrences did not appear to reveal detectable patterns that could be linked to the presence of a treatment program in the three CMTRS villages under study.

1. Child Protective Services (CPS): Figure 22 shows the rate of placements in child protective services, comparing CMTRS villages with non-CMTRS villages. In the CMTRS villages, the number of cases fell during the period 1990-1995. This rate declined every year since 1990—from reductions in all three villages, but with an upward trend in Hooper Bay since its low in 1992. This may suggest the influence of the new treatment centers in at least two of the three CMTRS villages. But the numbers are not completely convincing, because there was also a reduction in child protective services in the non-CMTRS villages. This too reflected different patterns in the villages within it: big reductions in Alakanuk and Sheldon’s Point, but big increases in Emmonak after a low in 1992.

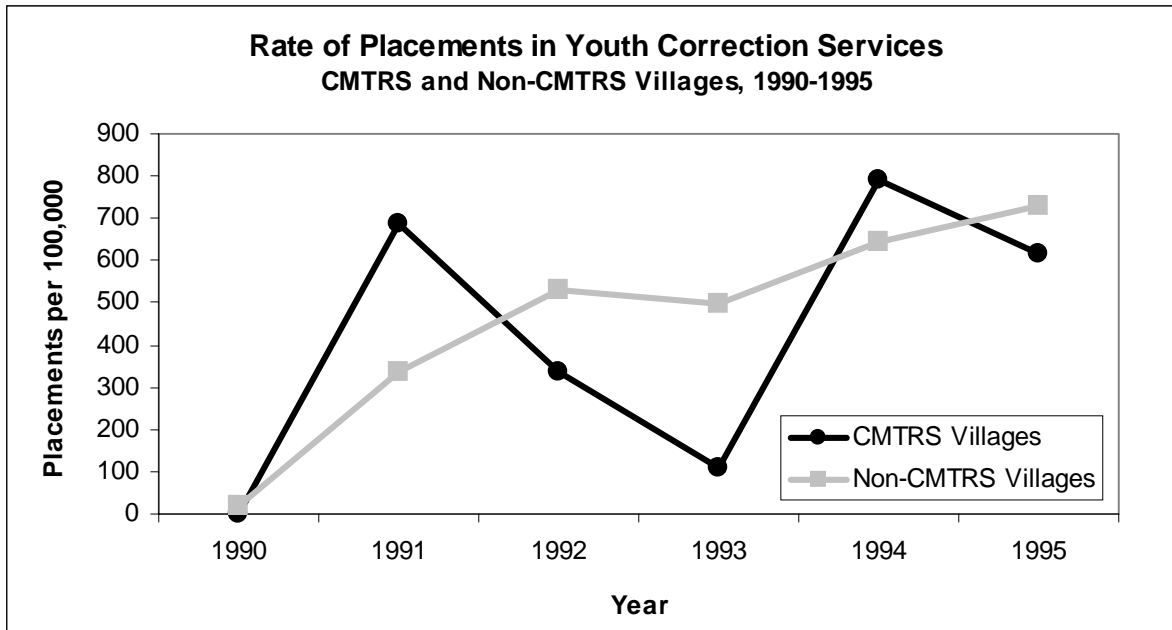
Figure 22



2. Youth Corrections (YC): An analysis of youth corrections is awkward because the number of cases was small, even smaller than the other variables. This suggests any interpretation of patterns, especially since the time periods varied: the six-year period 1990-1995 as compared to a decade of numbers for the other variables.

Figure 23 shows a downward trend in the rates of youth corrections in the CMTRS villages since the advent of the CMTRS programs in 1994. The non-CMTRS villages show a steady upward trend during the study period.

Figure 23



5. Summary

This analysis of possible changes in social indicators, attributable to the implementation of CMTRS program, provides an appropriate baseline measure for subsequent evaluation. The study relied on the use of long-term and stable available programmatic data from a variety of sources. The latest years for which data were available and compiled were before the implementation of CMTRS. Therefore, this analysis does not provide any evidence that these social indicators have changed over time. However, subsequent evaluations can use this data to assess changes.

Specific indicators that appeared to be stable and reliable measures of social change were accidental deaths and suicides, offenses leading to incarceration, and out-of-home placements in child protective services and youth corrections.

VI. ADMINISTRATIVE PROCESSES

A. GOVERNANCE OBSERVATIONS

The CMTRS project was unique in its effort to change the focus of policy accountability from the federal or state level to the village level. It was understandable that the evolution of this major transition would create some challenging administrative problems. Among those were: 1) definition of authority, 2) levels of policy advice, 3) staff discipline, and 4) stability of local policy-making bodies.

1. Definition of Authority

The extent of the decision-making roles of the Policy Steering Committees was never clearly defined. While CMTRS central administration promoted the local authority of the Policy Steering Committees, the larger YKHC administrative policy and performance was inconsistent in supporting or affirming the “local control concept,” especially in the areas of personnel, budgeting, and staff performance.

While the federal CSAT RRCD staff appeared to endorse the consultative model (review and approval or disapproval), the YKHC central office appeared to favor the advisory model (review and comment).

Further confusing this lack of clarity was the change in the reporting relationship between the CMTRS Executive Director and the different levels of governance. In some cases, the CMTRS director reported directly to the YKHC Board of Directors, bypassing the traditional administrative reporting structure. In other instances, the reporting structure was rigidly adhered to and the Executive Director was told by YK administrative personnel to reduce her interactions with the Board.

These inherent conflicts were shown in the policies and procedures of the CMTRS program. Section B of those procedures (Organizational Management) clearly established the CMTRS director's line of authority to the regional substance abuse service director. It also directed the CMTRS director to attend all meetings of the YKHC mental health substance abuse committee meetings and the YK Board of Directors. While this policy clearly placed the CMTRS director within the YKHC organizational hierarchy, it also directed the executive director to consult with the village-based Policy Steering Committees on a regular basis (see CMTRS Policies and Procedures Manual, Pg. 6).

The authority of the PSCs and the Executive Director was not clarified by the final transfer of administrative responsibility to the village level through the village-based program coordinator. It was the stated intent of YKHC to transfer administrative responsibilities from the YKHC headquarters in Bethel to one of the villages, thus further strengthening the local governance and self-determination. Although toward the end of the demonstration project a village-based coordinator was hired and stationed in one of the three target communities, the specific decision-making authority of the village-based coordinator in concert with the Policy Steering Committees remained unclear.

2. Levels of Policy Advice and Governance

The Regional Substance Abuse System and YKHC, the State Alcohol and Drug Agency (ADA), and the Federal government each had responsibility for setting and enforcing clinical

and administrative policy. The degree that each level of government relinquished its policy and gave responsibilities to the CMTRS program had an effect on the conduct of local CMTRS programs and their responsiveness to local needs as determined by the PSCs. Some of these requirements at the state level included:

- a. Clinical Policy: The State of Alaska sets clinical policy through regulation and administrative policy. Important sources of policy direction included:
 - Outpatient, aftercare, and residential facility accreditation requirements of the Joint Commission on Accreditation of Health Care Organizations.
 - Laws and regulations emphasizing abstinence and discouraging “moderation” treatment modalities.
 - Reimbursement regulations allowing payment for some services and not for others.
- b. Administrative Policy: External sources of administrative policy included:
 - Data reporting requirements using State ADA Management Information System.
 - Facility standards contained in accreditation standards.
 - Restriction on eligible applicants for state funds.

Over the five-year period of the demonstration project, CMTRS worked with government agency staff to facilitate greater success in meeting the overall program goal of local accountability and management of the CMTRS program. This was not an easy task, since turnover of staff, not only in the villages but also at YKHC in Bethel, affected the program.

The Policy Steering Committees were largely absent from provision of regulatory and accreditation policy advice and governance. Their activities, on the other hand, were largely in making sure that services provided in CMTRS villages were consistent with local customs, and acceptable to the communities and the clients they served. It appears as if this function was appropriate and sufficient in regard to involving the Policy Steering Committees in technical accreditation issues, which may have diluted their valuable contributions in assuring acceptability of services at the local level.

3. Staff Discipline

Although Policy Steering Committees were formed in each of the villages, they did not have the kind of leverage usually enjoyed by a hiring body. In the case of CMTRS, the Yukon Kuskokwim Health Corporation continued to pay all CMTRS counselors. Therefore, counselors were more accountable to YK than they were to their local Policy Steering Committees.

The involvement of the Policy Steering Committees may have interfered with effective supervision of some counselors. Repeated instances of incomplete clinical records, staff work attendance, and clinical production were of concern to the central office in Bethel. However, until recently, there were few consequences to staff for these kinds of activities. Policy steering committees were typically not involved in any disciplinary functions. This split in accountability to both the YKHC and the Policy Steering Committees may have had the unintended effect of making staff immune to on-going clinical and production standards.

Another example of the complexity of the arrangement between the Federal government, the state government, the Yukon Kuskokwim Regional Health Corporation, and the Policy Steering Committees was seen in the discharge of the Executive Director. The Yukon Kuskokwim Regional Health Corporation, which had the responsibility for program operations, decided to

change its leadership in hopes of making some changes in the direction of the program. The state government was neutral on the subject. However, the Policy Steering Committees and the federal government were opposed to such a management change. This created a significant controversy that highlighted the struggle between various levels of government, insuring local control.

4. Stability of Policy Steering Committees

The actual involvement of Policy Steering Committees in governance of CMTRS activities was unclear. Although there were copies of steering committee meeting minutes, these meetings were not routinely held, and the active involvement of the Policy Steering Committees in overseeing program operations was difficult to ascertain. This could be attributable to the unique character of the program and its lack of institutional history. Policy steering committee membership appeared to be fluid. There were few formal rules for quorums or replacements of steering committee members, nor were there any direct responsibilities for staff supervision or financial management.

5. Summary

Alaska Native villages have long called for increased involvement in providing oversight to programs that affect the residents of their villages. The use of Policy Steering Committees by CMTRS villages was an example of the successful implementation of this idea. The Policy Steering Committees did not appear to get involved in technical issues of accreditation, or in setting of regulatory standards. However, they were valuable in assuring that services were acceptable to the local community and consistent with local customs, traditions, and cultures.

The role of the Policy Steering Committees, however, could have been better defined. It appeared there were examples where the role of the committee was unclear, particularly in areas of staff supervision. Multiple layers of accountability from the regional corporation to the federal government further confused some of these issues.

The Policy Steering Committees may become more formalized as time goes by. Their relatively new positions within the community, together with their evolving roles and responsibilities, suggests that basic procedural issues in their development should receive more attention.

B. STAFF TURNOVER

1. Introduction

Staff turnover occurs when an employee leaves an organization and has to be replaced. A high turnover rate within a clinical organization means that individual treatment plans will be interrupted and continuity of care will be compromised. High administrative turnover can result in changes in program direction and weak leadership.

The turnover rate for an organization can be calculated using the following formula from the US Department of Labor:

$$\text{(Number of employees during the month/Total employees at mid month x 100)}$$

For the calculation of the CMTRS turnover rates, this formula was altered to span an entire year, rather than just one month.

2. Findings

The following table shows the number of employees each year, the number of terminations, and the resulting turnover rate.

Table 9. CMTRS Turnover Rates, 1995-1998

Employee Category	Total Employees	Separations			
		1995	1996	1997	1998
Counselors	6	0	0	1	2
Administrators	4	0	1	2	1
Total	10	0	1	3	3
Turnover rate		0%	10%	30%	30%

Many industries experience turnover rates between 2% and 30% (Mathis and Jackson, 1988). Using this standard, the CMTRS turnover rate appeared to be common.

The reasons for turnover can be attributed to external factors, work-related factors, or personal characteristics of the employee. A description of these factors is shown in Table 10.

Table 10. Factors Associated with Turnover

Type of Factor	External Factors	Work-related factors	Personal Characteristics
Reasons	<ul style="list-style-type: none"> • Other job alternatives available • No union • Low unemployment rate 	<ul style="list-style-type: none"> • Low pay • Low job satisfaction • Low job performance • Unclear job expectations 	<ul style="list-style-type: none"> • Young age • New employee • High education level • Few dependents • Elder dependents

While the real reason for employee separation may not be known, CMTRS employees appeared to leave for all three reasons. Some moved to better paying jobs within the same field and within the region. One left to take care of an elderly family member. Others may have left because of low job satisfaction or unclear job expectations.

3. Summary

CMTRS turnover rates ranged between 10% and 30% over the duration of the project. These are commonly seen in work situations throughout the country. On the local level, one of the counselors in each village transferred to another program of similar mission within the village. This will help preserve the lessons learned during the development and refinement of the

CMTRS program. The administrative staff, however, completely turned over. No individuals who started with the CMTRS program remained with its successor.

C. TRAINING

The CMTRS program was intended to be an integrated behavioral health model. To accomplish this, CMTRS counselors had to provide outpatient counseling services in mental health and substance abuse, as well as prevention and after care services provided by their VAEC counterparts. The CMTRS program budgets allocated substantially more money to these training efforts than budgets of comparison communities.

1. Training Resources

This section reviews training data for CMTRS counseling and administrative staff from 1995 to 1998. The data is analyzed by topic, function, and the time within the program's operation.

Training resources were largely spent for a wide range of behavioral health training for counselors providing direct services. Although a high portion (46%) of the expenditures were for alcohol and substance abuse-related training, a significant proportion was devoted to training in mental health, program management, and cultural/community development (Table 11).

Table 11. Number and Distribution of Training Sessions for CMTRS Staff

Training Categories	Director	Clinical Supervisor	Bethel Staff	Field Counselor	Total Trainings	%
Alcohol, Other Drugs	21	15	15	104	155	46
Mental Health/Counseling	9	7	6	37	60	18
Family/child/abuse	5	2	1	13	21	6
State Certification	0	0	0	12	12	4
Program Management	10	12	11	28	61	18
Cultural/Community Development	4	4	3	15	26	8
Percent of Training	14.6%	12%	10.8%	62.6%	100%	
Total Training Sessions	49	40	36	209	334	100

As expected, field counselors participated in the greatest number of training sessions (62.6%). Because they represented just over half of the CMTRS staff (8 of the 15 employed between 1994 and mid-1999), it was more appropriate to look at the training hours per person and staff position. As Table 12 indicates, field counselors engaged in the greatest number of training hours per person (776.38 hrs).

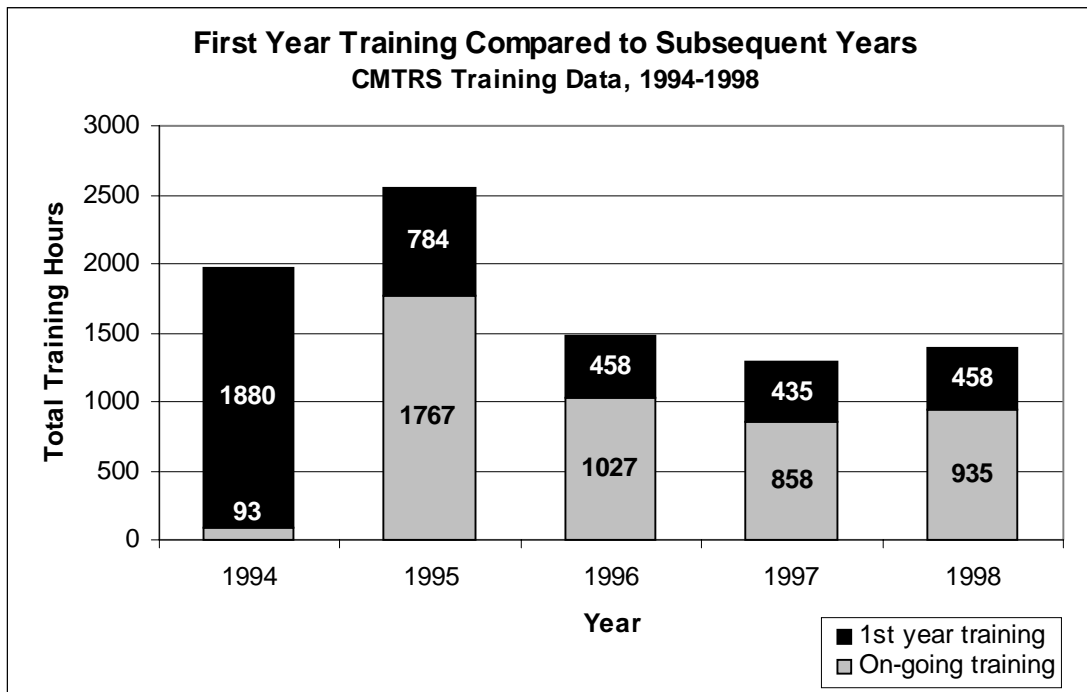
Table 12: Distribution of Training for Staff

Position	Staff	Training Sessions	Mean Sessions	Training Hours (sum)	Hours/ Training	Hours/ Person
Field Counselors	8	209	26.13	6211	29.7	776.38
Director	2	49	24.5	989	20.1	494.50
Clinical Supervisors	3	40	13.33	865	21.6	288.33
Bethel Staff	2	36	18.00	869	24.1	434.50

2. First Year versus Ongoing Training

Staff turnover impacted the volume of training needed. If one assumes that a new staff member's first year of training is intended to bring him/her up to speed on CMTRS services, the staff person's first year of training may be compared to subsequent years. Figure 24 compares the number of training hours expended on an annual basis for staff in their first 12 months of employment to subsequent months.

Figure 24

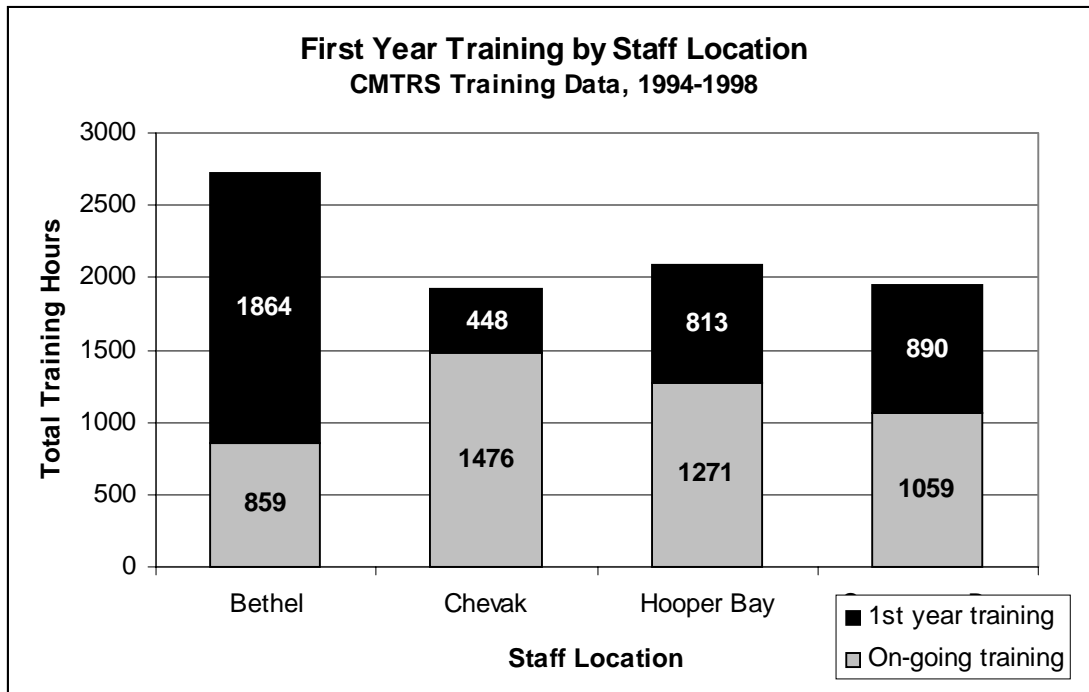


An analysis of training by staff location, type, and year provides additional insights to its implementation. Data were most complete for 1994 through 1998, in hours, and were thus the unit of measure for this secondary analysis.

As expected, most staff started in 1994, and the majority of training hours may be categorized as general training to perform the job. However, this “first year” training remained relatively high during the next four years and averaged between 30.7% (1995) and 33.6% (1997) of total training hours. This corresponds to staff turnover of 30.7%. It is thus reasonable to say that about one third of training hours and training costs may have been averted if there had been no staff turnover.

Figure 25 shows the same phenomenon by site. Bethel experienced the greatest proportion of “first year” training hours. Turnover at that site was 50%, and first year training hours were 68.5%. Chevak experienced no turnover and had by far the lowest staff training of 23.3%. Hooper Bay had a 33.3% turnover and 39% of their training hours may be categorized as “first year.” Scammon Bay shows different results in this analysis: the CMTRS site experienced no turnover, yet “first year” training hours represented 45.6% of their total training hours. Closer analysis of annual training hours for Scammon Bay suggests a substantial reduction in overall training after 1995, which contributes to the disproportion of training hours over time.

Figure 25



3. Clinical and Operational Training

Training was already broken into six categories. Re-breaking training into clinical and operational categories provided a larger sample size for new analyses. In this classification, alcohol, mental health, and family/child abuse were all related to direct clinical service delivery and were classified as “clinical.” State certification, program management, and cultural/community development related to the administration and operation of CMTRS, and were classified as “operations.”

Figure 26 compares clinical and operational training by year. As would be expected, operational training diminished over time and was nearly non-existent in the last programmatic year. Presumably, staff members understood how CMTRS functioned, and training hours were devoted to clinical continuing education and staying abreast in their respective fields.

Figure 26

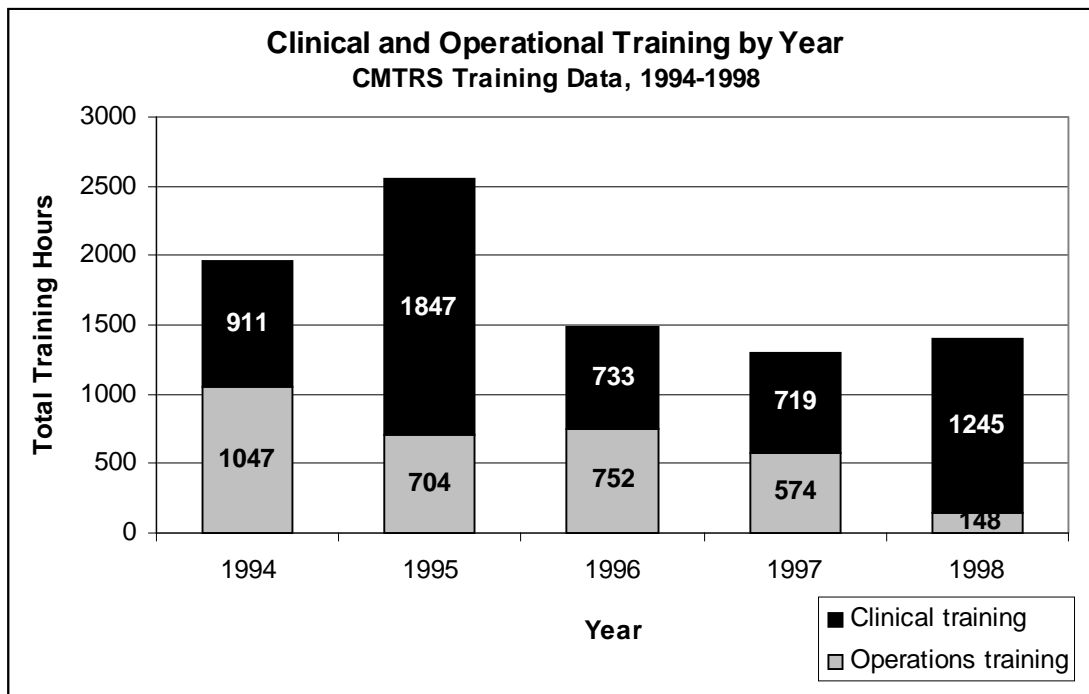
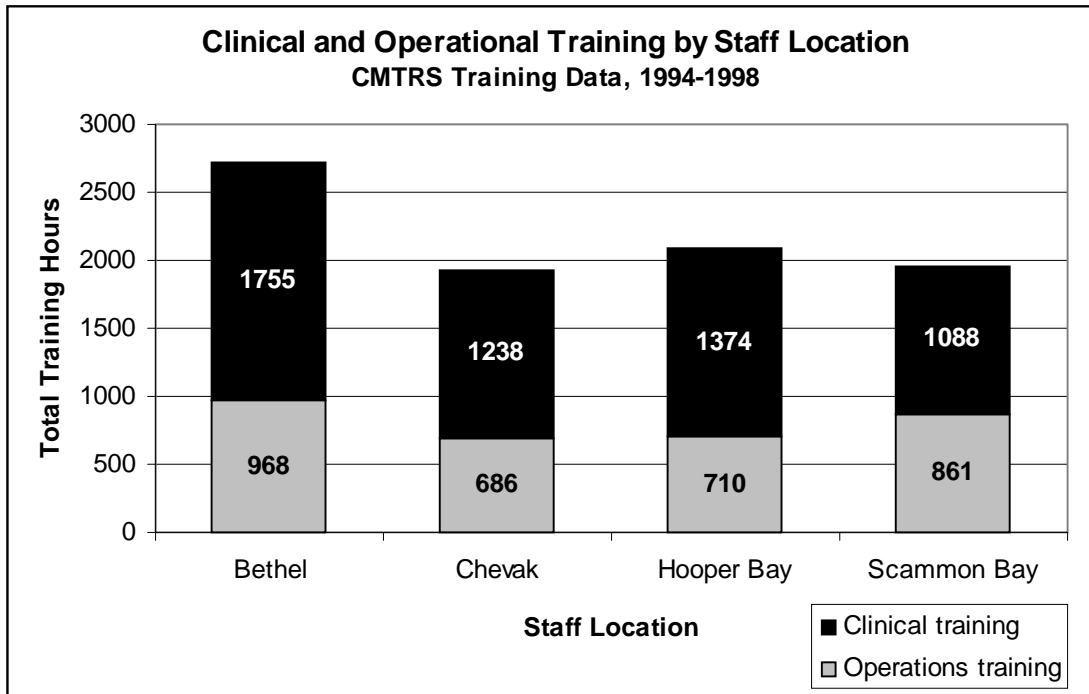


Figure 27 sheds more light on the distribution of clinical and operational training. Training was not obviously segregated by staff position. Bethel staff performed primarily administrative and managerial roles (program director, clinical supervisor, central administration, and MIS coordinator). The remaining three sites had field counselors only who were responsible for direct service delivery.

Figure 27



One would expect Bethel staff to have engaged in demonstrably more “operational” training than the other sites. This was not the case. Staff in Bethel, Chevak, and Hooper Bay all spent 64% to 66% of their training hours in “operations” training, with the remaining one-third in clinical training. Scammon Bay was different again, with 55.8% of training hours directed into operations, and the remaining 44.2% in clinical training. For all sites, a greater proportion of training was undertaken for administrative and operational subjects than clinical delivery. No explanation for this occurrence can be gleaned from the available data.

4. Training Costs

Due to changes in the YKHC computer system during the CMTRS implementation, and complicated by staff turnover, a complete cost-benefit analysis of training costs was not feasible. However, a descriptive analysis, with its own caveats, reflects trends in the training of CMTRS staff.

The training costs for travel and tuition were available for 1997, 1998, and part of 1999. The cost of staff time for attendance at these events was available for 1994 through 1998. 1997 and 1998 data suggested that training costs increased as the volume of training hours increased – as would be expected. Some variation certainly existed due to the location of training (travel costs) and differences in tuition rates. However, based on these 1997 and 1998

costs, a blended rate of \$35.84 per training hour was not unreasonable. Thus, a reasonable estimate of training costs may be calculated by multiplying training hours by \$35.84. This compares to \$25 per hour training costs for VAECs, as estimated by RSAS administration. Unfortunately, further analysis by category of training or the year in which it occurred was not possible.

5. Summary

The broad training provided to CMTRS counselors supported a wider range of clinical activities than those of their VAEC counterparts. The differences in the scope of practice are shown in detail in Section V. In summary, there was a higher proportion of patients with presenting problems, including social service issues, mental health, domestic violence, and other behavioral health problems. The increased scope of practice appeared to be related in part to the training received by CMTRS counselors, and also by the perceptions of Bethel providers of counselor capabilities. The increased scope of practice and training also enhanced the confidence of CMTRS providers to maintain contact with regional health and human service resources.

Further, the training analysis suggested that the volume of training hours undertaken was directly correlated to the rate of staff turnover. Thus, training and training costs could have been reduced if there had been more stability in staffing. The analysis also suggested no correlation between staff position and the type of training undertaken. With the exception of field counselors in Scammon Bay, all other sites directed approximately 65% of their training hours to administrative and operational topics. Even in Scammon Bay, over half of the training hours (55.8%) may be attributed to operational topics. The remaining 33-44% of training hours may be classified into clinical delivery topics.

D. GOAL AND OBJECTIVE ATTAINMENT

The goals and objectives for the original CMTRS grant laid out an ambitious plan for reducing barriers to the receipt of substance abuse services for the selected CMTRS villages. This section summarizes the accomplishments of the CMTRS program over the past five years. The information used to develop the final status of the goals and objectives was taken from various sections of this evaluation report and the impressions of the evaluators.

GOAL 1: THE PROGRAM'S EVALUATION EFFORTS SHALL IDENTIFY BARRIERS FOR VILLAGE RESIDENTS AND THEIR FAMILIES TO ENTER AND ACCEPT SUBSTANCE ABUSE TREATMENT.

Objective 1: Management Information System (MIS) data will report a 50% increase above baseline, in the number of admissions to treatment from the target villages. This data shall be analyzed to identify barriers to treatment, and the impact of the program on this targeted increase. It shall be reported twice annually beginning 9/1/95.

Final Status: This objective has been met. In 1995, there were 205 clients seen by the CMTRS program, as compared with 64 the previous year. This was a 320% increase above baseline. However, as seen in Figure 3, the number of admissions has steadily declined in the subsequent four years of the program, down to a level more closely matching the VAEC comparison counterparts.

Objective 2: MIS data will report that an average of 21 patients, 42 contacts, and 2,000 participants annually will have utilized services of the program in the three targeted villages. Progress on this targeted level of program activity shall be reported twice annually beginning 9/1/95.

Final Status: This objective has not been met. While there were more than 21 patients seen in CMTRS communities, the number of contacts and participants have been far more difficult to measure. In addition, the objective of seeing 2000 participants annually was very close to the total number of all individuals in the target villages.

Objective 3: MIS data will report that patients will have received at least an average of 30 hours of program services during treatment. At least 40% of patients will be listed in the MIS as having treatment plan outcomes complete at discharge. Data shall be analyzed to identify factors that ensure treatment completion and the elimination of barriers to treatment, and progress on these targeted levels of service shall be reported twice annually beginning 9/1/95.

Final Status: This objective has been partially met. It requires an average duration of treatment of 30 hours, 40% of the patients having a successful discharge, and the identification of barriers to the receipt of treatment. CMTRS client treatment is not measured by the State MIS system in the number of hours of treatment, but in the duration of treatment. The data shown in Table 4 suggest that the average CMTRS client received 173 hours of treatment, roughly the identical number required by VAEC clients. If a client were seen two hours per week, the goal would have easily been met. However, only 24.5% of the patients discharged from CMTRS had a completed treatment plan (see Figure 16: "Treatment Complete, Referred Elsewhere" and "Treatment Complete, No Further Services Required"). The CMTRS program has been successful in reducing the barriers to the receipt of care. In particular, it has increased the proportion of women in treatment and has made services more acceptable to the community through the use of traditional treatment modalities.

GOAL 2: THE PROGRAM'S EVALUATION SHALL IDENTIFY EFFECTIVE CULTURALLY APPROPRIATE PROGRAM COMPONENTS.

Objective 1: Cultural components shall be identified by CMTRS staff and integrated into the MIS by ADA staff by 9/1/95. Twice annual evaluation reports beginning 4/1/96 shall reflect that at least 25% of hours of services provided to patients will be these cultural activities.

Final Status: This objective has been met. The traditional treatment modalities for the CMTRS program have been widely adopted throughout the region as the preferred method of providing substance abuse and other behavioral health treatment. However, it is unclear if at least 25% of the hours of service to patients were attributed to cultural activities. The staff activity logs where this information is routinely collected, are incomplete, and do not allow an accurate calculation of the proportion of staff time devoted to traditional treatment modalities.

Objective 2: In the Patient Program Evaluation, patients will report at least a 3.5 score on a scale of 5 regarding the level of satisfaction with these cultural components, and their relevancy to their recovery while in treatment.

Final Status: This objective has been met, although it has been difficult to quantify. Qualitative evaluation reports suggest high satisfaction with services rendered. However,

there was no satisfactory way of administering clients satisfaction studies on a routine basis to obtain the required 3.5 score.

Objective 3: Gender sensitive components shall be identified by CMTRS staff and integrated into the MIS by ADA staff by 9/1/95. Twice annual evaluation reports beginning 4/1/96 shall reflect that at least 10% of hours of services to patients will be these gender sensitive activities.

Final Status: This objective has been met. The CMTRS counselors see twice as many female clients as do their VAEC counterparts. This is three times the proportion required in this objective (see Figure 4).

Objective 4: In the Patient Program Evaluation, patients will report at least a 3.5 score on a scale of 5 regarding the level of satisfaction with these gender sensitive components, and their relevancy to their recovery while in treatment.

Final Status: As with objective 3, this objective has been difficult to measure. There are currently no client satisfaction instruments that were found to be valid and reliable for this population. Qualitative data, on the other had, strongly suggest that the objective has been met.

Objective 5: Twice annual evaluation reports beginning 9/1/95 shall identify successes and difficulties encountered in establishing and operating the project. This data shall be gathered via structured interviews with all CMTRS staff, key Policy Steering Committee (PSC) members, and key YKHC staff and Board members. The feasibility of replication of successful components of the program shall be an important point of analysis.

Final Status: This object has been met. Success and difficulties in evaluating the program have been identified on a regular basis through a constant interaction between the program sponsors, program management, and the evaluators. Records of these efforts are shown in routine qualitative and quantitative reports, which are compiled in the working papers section of this report (Knowledge Development and Dissemination).

GOAL 3: THE PROJECT EVALUATION SHALL PROVIDE PROGRAM GUIDANCE INFORMATION THAT WILL AID IN INCREASING PROGRAM EFFECTIVENESS AND MEASURE THE IMPACT OF THE PROGRAM ON THE PATIENTS AND COMMUNITIES.

Objective 1: MIS data will report that an increase of an average of at least 2.0 points in level of patient functioning over the duration of treatment as measured on the IHS staging tool. Progress on this targeted level of functioning shall be analyzed to identify key factors to patient progress and will be reported twice annually beginning 4/1/96.

Final Status: This objective has not been met. The client staging tool included in the MIS was expected to yield valuable information about improved client outcomes; however, data was sporadically collected by CMTRS counselors, thus making the staging tool an unreliable source of data for this measure. However, qualitative reports show high patient satisfaction.

Objective 2: As reported in continuing care contact with patients, at 6, 12, and 24 months, patient shall identify at least two major areas of improvement in the level of functioning of the patient's family. Progress on this targeted improvement shall be analyzed to identify key causal factors and will be reported twice annually.

Final Status: While this objective appears to have been met, there is no empirical documentation of objective attainment. Follow up studies at 6, 12, and 18 months have not been accomplished by CMTRS personnel. However, qualitative evaluations suggest that the enhanced aftercare services and support services within the CMTRS village have greatly improved the probability of continued recovery of people with chemical misuse problems.

Objective 3: Respondents to the community survey and key informant questionnaire, conducted every other year, will report reductions in perceived drug/alcohol use and abuse over the project period. Progress on this targeted improvement shall be analyzed to identify key causal factors, and a baseline report will be generated by 4/1/96.

Final Status: This objective has been met. The reports of periodic qualitative analyses are shown in this report.

Objective 4: Village Community Health Aide (CHA) reports throughout the life of the project will identify a reduction in the number of alcohol/drug related illnesses and injuries. Progress on this targeted improvement shall be analyzed and a baseline report will be generated by 4/1/96.

Final Status: This objective has been very difficult to measure. Community Health Aide data was collected using patient encounter forms (PEFs), which have a separate check box for determining whether or not the encounter was alcohol related. Data quality assessments early in this process confirmed that Community Health Aides do not routinely collect this data. In addition, the evaluators found it difficult to determine the measure of success. On one hand, if the number of Community Health Aide visits went up, it could be seen as a sign of failure, in that, many of the Community Health Aide visits were hypothesized to be alcohol related. On the other hand, a similar trend could be interpreted as a success because people who were previously insensitive to their physical health treatment requirements or for similar requirements of their family, would tend to use more Community Health Aide visits. (See Section V. D.)

Objective 5: Village Public Safety Officer reports gathered over the life of the project will identify a reduction in the number of alcohol/drug related illnesses and injuries. Progress on this targeted improvement shall be analyzed and a baseline report will be generated by 4/1/96.

Final Status: This objective has been met. While the proportion of alcohol related criminal justice contacts with all contacts was higher in CMTRS communities, the distribution appears to be tightening using a Deming control chart approach. One could conclude that there is more predictability in the community systems for addressing alcohol-related criminal justice problems. Most of the variability is explained in the reduced proportion of arrests related to the "business of substance abuse." (See Section V. C.)

Objective 6: Data from medical, safety, criminal justice, and social services sources will be tracked during the life of the project and analyzed for correlation with the impact of the CMTRS program. This analysis will be included in the twice-yearly report beginning 9/1/95.

Final Status: Evaluators have been unable to determine the attainment of this objective. Data on suicides, child protective services, and youth incarcerations were measured over time for CMTRS and comparison villages. Data were only available through 1995 from

existing state systems. Therefore, although a conclusion cannot be made regarding the effectiveness of CMTRS services, there is a substantial body of baseline data that can be used in the evaluation of subsequent programs.

GOAL 4: THE PROJECT EVALUATION WILL BE INDEPENDENT AND THOROUGH.

Objective 1: To ensure an independent, unbiased, and thorough evaluative effort, ADA will establish a contract with the University of Alaska by 9/1/95, for oversight of the finalization and implementation of the evaluation plan, for twice yearly evaluation reports, and for the final report.

Final Status: This objective has been met. Evidence of this has been shown in this report.

Although not all goals and objectives have been met, there is a substantial body of evidence that strongly suggests that the CMTRS approach has been successful. First, the use of traditional treatment modalities have been developed and adopted by other parts of the Yukon Kuskokwim Health Corporation Behavioral Health Division. The information developed during this project has been transferred to other YKHC behavioral health programs. Second, YKHC and state and federal officials have recognized the importance of local policy advice. While the Policy Steering Committee roles and relationship with YKHC and administration have yet to be defined, it is clear that enhanced community involvement has strengthened the program. Last, locally selected counselors appear to strengthen the program's ability to adjust to the local customs and social structures within each village. It is unclear about the number of counselors required. Perhaps two counselors in each village may be more than the system can absorb.

VII. KNOWLEDGE DEVELOPMENT AND DISSEMINATION

Numerous reports have been produced in the evaluation of the CMTRS project. The policy agreed to by the CMTRS program and the evaluation team at ICHS stated that no products would be published without the consent of the Policy Steering Committees and the Yukon Kuskokwim Health Corporation. For this reason, presentations at national conferences have been made frequently, but no published material has appeared in the peer reviewed scientific literature.

A. LIST OF PRODUCTS

This section lists those specific products and reports that were produced during the five years of this project. It is hoped that many of these will be summarized in future scientific publications to be developed jointly with the Yukon Kuskokwim Health Corporation.

Program Description

Hamilton J., Saylor B. "The Development of a Cultured-Based Substance Abuse Treatment Program in the Kuskokwim Delta, Alaska." Proceedings of the 10th Congress on Circumpolar Health, Anchorage, Alaska, May 1996.

Methodology

Kehoe, B., Saylor, B., Hamilton, J., Smith, S. "Video Use in Social Research Among Indigenous Populations," CMTRS Evaluation Series, ICHS, January 1998, and accepted for publication, National Rural Institute on Alcohol and Drug Abuse.

Saylor B., Booker J., Hamilton J., Klose, K. "Methodological Issues in Evaluating a Culture-Based Substance Abuse Treatment Program In The Yukon-Kuskokwim Delta, Alaska." Proceedings of the 10th Congress on Circumpolar Health, Anchorage, Alaska, May 1996.

Kehoe, B. "Cross-cultural Research Issues Regarding Alcohol and other Drug Program Evaluations in American Indian and Alaska Native Settings." November 1996.

Saylor, B. "New Ways of Evaluating the Effectiveness of Rural Health Services for Indigenous Peoples of the Arctic." Presented at the 6th Circumpolar Universities Cooperation Conference, University of Aberdeen, Scotland, June 24-27, 1999.

Saylor, B. "Evaluation Methods for Remote Community Substance Abuse Services." Presented at the Northwest Health Policy Research Conference, Seattle, WA, June 1997.

Evaluation Working Papers

Saylor, B., Kehoe, B., Smith S. "Community Perceptions of the Culture-based Chemical Misuse Treatment and Recovery Services Program in Southwest Alaska." CMTRS Evaluation Series, ICHS October 1996. (Focus Group Report from Yup'ik communities).

Saylor, B., Kehoe, B., Smith, S. "Community Perceptions of the Village Alcohol Education Counselors (VAEC) Program in Southwest Alaska." CMTRS Evaluation Series. Institute for Circumpolar Health Studies. June 1997.

Marshall, D., Saylor, B., Smith, S. "Comparison of Local and Non-Local Substance Abuse Treatment Costs: Analytical Framework and Data." Institute for Circumpolar Health Studies. December 1996.

Saylor, B., Kehoe, B., Smith S. "Community Perceptions of the Culture-based Chemical Misuse Treatment and Recovery Services Program in Southwest Alaska." Institute for Circumpolar Health Studies. October 1996.

Saylor, B., Smith, S. "Public Safety Data in Villages Served by the CMTRS Program." Institute for Circumpolar Health Studies. June 1997.

Saylor, B., Kehoe, B., Smith, S. "Comparing Substance Abuse Treatment Services in CMTRS and VAEC Villages." Institute for Circumpolar Health Studies. June 1997.

Saylor, B., Smith, S. "Community Health Aide/Practitioner Patient Encounters, 1989-1996." Institute for Circumpolar Health Studies. May 1997.

Abraham, A, et al. "*Guidelines for Developing Substance Abuse Programs for Native Americans: Lessons Learned from the Chemical Misuse Treatment and Recovery Program, Southwest Alaska.*" Institute for Circumpolar Health Studies. July 1999.

Video Productions

"Strength from our Elders: CMTRS- Village-Based Substance Abuse Treatment," a 45 minute videotape, Pacific Productions; Robert Pond, Editor; Brad Kehoe, Videographer; Brian Saylor, Producer, 1996.

"Protecting Our People, Strength from our Elders: The Village Alcohol Education Counselors (VAEC) Program in Southwest Alaska," a 45 minute videotape, Pacific Productions, Robert Pond: Editor, Brad Kehoe: Videographer, Brian Saylor: Producer, 1999.

In addition to specific products, the CMTRS study gave the evaluation researchers the opportunity to map and analyze the quality of the data included in the State Alcohol and Drug Abuse Management Information System. The data has historically been maintained in a COBOL relational database format, making it extremely difficult to use for analytic purposes. ICHS staff had some success in downloading, mapping, formatting, and using the data for this particular analysis. Although the exercise showed that there were some substantial limitations in the quality of the data, our experience has demonstrated that the data quality can be significantly improved and the accessibility to existing records enhanced through aggressive data formatting for analytic purposes.

B. AUTOMATION OF FORMS

As noted in Section V, there were numerous problems in collecting accurate and timely programmatic data. Many of these problems resulted from the reluctance of CMTRS counselors to record admission, treatment, and discharge data for their clients on a timely basis. Repeated attempts were made by CMTRS administration to motivate and train the counselors. These met with limited success.

An alternative method of collecting and storing programmatic and client data was devised by RRCD consultants and CMTRS counselors to better address the problems of data quality. This project, called the “Automation of Forms Project,” used some commonly available database tools to facilitate data entry.

While the automated forms were developed and praised by CMTRS counselors and the federal government, they did not appear to have had a significant impact on improving the accuracy and timeliness of programmatic data collection. A detailed set of protocols for the automated forms are shown in Appendix M.

VIII. CONCLUSIONS

- Solutions that were generated at the local level could have a greater impact on community substance abuse problems than those generated from outside the community. The CMTRS program was developed to test the idea that strong local input into ways of combating substance abuse could increase the effectiveness of treatment and reduce the impact of substance abuse in villages. This idea appears to work. The presence of the CMTRS program in the villages is having a positive effect, as it is the single most visible change in the human service delivery system in the villages. It appears also that CMTRS counselors were able to engage people into treatment before they became substance dependent and were also able to attract clients who were in more severe substance abuse stages. The lessons learned from the CMTRS program have already been adopted by the local sponsoring organization, YKHC.
- Solutions that emphasized community involvement were more effective than those based on individual treatment alone in addressing substance abuse problems. In the early phase of the evaluation, it became clear that measures of a successful substance abuse program were community-based rather than based on individual treatment successes alone. The single system of treatment focused on the individual patient, which may not address underlying issues that can contribute to relapse. The family and community needs to be included, because they are affected by the client's addiction. This is consistent with the values of the Yup'ik/Cup'ik cultures.
- Traditional treatment modalities provided an effective alternative for treating substance abuse problems among Yup'ik/Cup'ik people. The traditional treatment modalities link substance abuse treatment protocols to Yup'ik/Cup'ik customs, events, and activities that are more appropriate to the culture of the clients served. There were insufficient data to show a direct comparison of their effectiveness with other methods in resolving alcohol treatment issues. Therefore, one cannot say that traditional treatment modalities are more or less effective than standard Western substance abuse treatment protocols. However, case studies show that the use of traditional Yup'ik/Cup'ik treatment modalities, especially in addition to adaptations of Western methods, can be effective means of resolving substance abuse problems in certain individuals. They have received wide support throughout the region and throughout Alaska.
- The local governance needed time to mature. All villages within the region have some kind of local governments. Many villages have well developed tribal and city administrative structures. Policy Steering Committees, on the other hand, are still in the early developmental stages and are not yet mature. There appears to be a value in the use of Policy Steering Committees to help make programs more responsive to local needs and consistent with local values. However, it may take some time to bring local programmatic policy governance to the level of sophistication of their city and tribal government counterparts. Their relatively new positions within the community, together with their evolving roles and responsibilities, suggest that basic procedural issues in their development should receive more attention.
- The behavioral health model appeared to be appropriate for small rural Alaska communities. The enhanced training CMTRS staff received resulted in a broader array of behavioral health services at the village level and represented a more holistic approach to problem behaviors. The CMTRS behavioral health provider was able to provide mental

health, substance abuse, and family counseling services. The behavioral health model better addressed the multiple problems and diagnoses presented by clients with behavioral health problems. It also explained the increase in the referrals from providers of services other than substance abuse from the hub community of Bethel. Other programs sponsored by YKHC have already employed the behavioral health model.

- Changes in health status of program villages were difficult to measure. An initial project objective was to improve the health status of individuals in CMTRS villages. Early attempts to assess the change in the rate of visits to Community Health Aides showed mixed results. The evaluators were unable to interpret these results. The use of inpatient services was likewise difficult to measure because of the low admission rate and the small sample size within participating villages.
- Data collection continued to be a significant problem. The CMTRS villages were expected to provide substantial amounts of accurate and timely programmatic data for the State of Alaska and for the RRCD program which provided the initial funding for this demonstration project. The program encountered difficulties in developing and maintaining accurate programmatic data. These difficulties may reflect, in part, the low value that community members placed on statistical reports. Numerous efforts were made to enhance data collection efforts, including threats of personnel termination and the development of alternative data collection hardware and software. None of these efforts was entirely successful.
- Qualitative evaluation research methods were useful in evaluation human service programs in rural Alaska. During the early phases of the CMTRS program, the amount of data that could be collected was insufficient to support any detailed quantitative program analysis. Therefore, qualitative techniques were employed to learn more about early phases of program implementation. These qualitative techniques provided reliable information on community perceptions of program strengths and weaknesses throughout the project.
- Videotaped program evaluation reports were well received by program participants and sponsoring agencies. Videotaped key informant interviews were edited into evaluation reports. These videotapes recorded the statements by participating village members of their perceptions of the CMTRS program's effectiveness. The videotapes were widely viewed and broadcast throughout the region. This stakeholders' support strongly suggests increased use of videotapes as a reasonable alternative to printed evaluation research reports.
- The CMTRS project explored ground in the development of culture-based substance abuse treatment. The long-term effects of this demonstration project are already being seen in the Yukon Kuskokwim delta. YKHC Behavioral Health Services implemented two programs based on the CMTRS model, even before the production of this final summative evaluation report. The Village Sobriety Project, funded under the Targeted Capacity Expansion CSAT funding mechanism, was intended to expand the knowledge gained during the CMTRS project. The CMTRS model is also being implemented in "People Working Together," a project addressing the clinical needs of severely emotionally disturbed children in YK villages. These children will be served by paraprofessionals using culture-based treatment approaches similar to those developed by CMTRS.

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