found relationships between methamphetamine use and suicidal behaviors among 8th and 11th grade students (Embry, Hankins, Biglan, & Boles, 2009).

Methamphetamine in Urban Communities

Understanding the patterns and rates of methamphetamine use within the Urban Indian population is challenging for the same reasons as understanding suicide. In addition to the major gaps in health research and epidemiology tracking within Urban Indian communities, there are also problems with racial misclassification of AI/AN people who are living in urban settings (Urban Indian Health Commission, 2007).

Gaining an understanding of the current methamphetamine use rates and patterns of use is critical for developing programs and services for prevention and treatment. Although epidemiology data on methamphetamine use in Urban Indian communities is limited, some data on the admissions to treatment for substance abuse is available through the Treatment Episode Data Set as reported through DASIS, a data set collected by the Substance Abuse and Mental Health Administration. The reports suggest that the majority of all American Indian and Alaska AI/AN admissions to treatment (40 percent) come from people living in Small Metro Areas (i.e., less than 1 million people) as compared to rural areas or larger metropolitan cities (DASIS, 2003). It is important to note that this data examines rates of treatment admission for all substances and is not methamphetamine specific.

In 2006, DASIS issued a report on the methamphetamine treatment admissions for urban and rural areas. This report sheds some light on the treatment admission rates specific to methamphetamine use (primary, secondary, or tertiary) in an Urban Indian sample. The data indicate that treatment admission for methamphetamine abuse is still substantial within a Small Metro area (three percent of all submissions to treatment were AI/AN). However, the methamphetamine treatment admission rates for AI/AN people in very rural settings were twice as high.

The most relevant research article on methamphetamine use among Urban Indians was conducted in Los Angeles (Spear et al., 2007). The study used data from the Los Angeles (LA) County Participant Reporting System Admission and Discharge Questionnaire and examined the changes in reporting of AI/AN patients between 2001 and 2005. The sample over the 5 years included a total of 2,285 treatment admissions of AI/AN people. The study brings to light a number of important findings for the AI/AN population in LA:

- Over the entire 5 years of data, the majority of treatment admissions of AI/AN people in LA County were for alcohol use (29.8 percent) but methamphetamine use was a very close second (25.7 percent).
- In 2004 and 2005, methamphetamine replaced alcohol as the primary reason for entering treatment among AI/AN patients.

- In 2001, significantly more AI/AN women reported entering treatment for methamphetamine than AI/AN men in LA County (31.7 percent vs. 17.5 percent, respectively).
- By 2005, the rate of AI/AN women entering treatment for primary methamphetamine problem increased to 40.3 percent.

Service Implementation

This section reviews the available literature as well as the protective factors and cultural vulnerabilities involved in the implementation and evaluation of these practices.

With the increased prevalence of suicide and methamphetamine abuse among AI/AN people it is critical to have culturally competent options for prevention and treatment. Most of the academic research has focused on describing the psychosocial implications and associated risks for suicide of AI/AN youth. This section will review Evidence-Based-Practices as defined by SAMHSA as well as culturally based practices that have demonstrated positive outcomes for both methamphetamine and suicide prevention and intervention.

Events, including U.S. policies that were in opposition to the worldview and culture in which Indian people lived, have significantly contributed to how services are implemented in Indian Country. Additionally, as with the general population, stigma also impacts AI/AN communities and there are specific culturally-based beliefs that are important to consider. Understanding these commonalities and community factors are critical for developing effective and culturally competent models of prevention, treatment, and recovery support.

Historical Commonalities

The worldviews of AI/AN people are similar to, yet very distinct from, many other cultures. Cohen (2006) describes an indigenous model of healing that highlights the difference between an indigenous worldview and the worldview from western medicine perspective. The major defining features of the indigenous worldview include:

- **Holistic:** The belief that disease is complex and must be assessed and treated in a holistic way. Disease is not bound to one cause and holistic assessment examines the larger context and multiple factors of disease in the spiritual, physical, emotional, social, and environmental realms. Each of these may need to be targeted in a prevention or treatment plan for an AI/AN person.
- **Strength-Based:** Focus on health and healing of the person and community instead of the pathology and curing of disease. This includes the health care provider as a counselor and advisor that works to empower a person to build the necessary skills to take charge

of their own health vs. a western provider which fosters dependence upon medication and technology.

- **Relational:** Balance and harmony with our relations promote health and wellness. This means that families and oftentimes, entire communities are important for healing to occur. Engaging all relations in the healing process in a harmonious way also provides sustainable community wellness.

Second, as citizens of Tribal Nations, Indian people have a unique political status, in that, the United States has a trust responsibility to the health and welfare of those people regardless of where they live. The Snyder Act of 1921 was the principle legislation authorizing federal funds for health services to Tribes (Snyder Act, 1921). Over the past 300 hundred years, AI/AN Tribes have ceded over 400 million acres to the federal government in exchange for benefits to guarantee the survival and integrity of their Tribes, including health care. In 1803, the federal government assigned the responsibility for AI/AN health to the Office of Indian Affairs in the War Department. Tribes are "domestic dependant nations" as Chief Justice John Marshall termed in 1832, "distinct independent political communities retaining their original natural rights as the undisputed possessors of the soil" (Cherokee Nation v. Georgia, 30 U.S. 1, 1831). In 1849, the health care duties were transferred to the Department of the Interior and renamed Bureau of Indian Affairs (BIA), which administered funding for health care programs provided by Congress. As such, they constitute the only minority group with government agencies, the Bureau of Indian Affairs and Indian Health Service, specifically devoted to their well being. Unfortunately, in spite of the US governmental responsibilities and federal resources devoted to Indian people, AI/AN remain at the bottom in almost every measurable economic and health indicator. A review of the Indian Health care system will be discussed later in this section.

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Third, AI/AN people are united by the strong and rich Tribal cultures and histories. In spite of all the cultural loss and genocide that has occurred for Indian people, the culture is still alive and thriving. Although the cultures are different from Tribe to Tribe, family to family, clan to clan and region to region, the importance of culture for health is universal. Some of the most effective prevention and treatment programs for Indian youth and families are built upon a strong culturally-based models that matches the local community beliefs, practices and norms (LaFromboise, & Howard-Pitney, (1994), LaFromboise et al., (2007), Pucci, (2009), Carter, Straits, & Hall, (2007). Culture is prevention in many Tribal communities and is critical for building successful service programs.

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It is clear to see the vast difference in worldview and how that might create obstacles and challenges when western medicine model collides with indigenous perspectives on health and wellness (Duran & Duran, 1995). Two competing views of health and wellness could interpret the epidemic of suicide in very different ways. Healers of competing worldviews could pathologize an incorrect symptom or disease, prescribe an ill informed remedy, and engage in culturally inappropriate service that proves to be more detrimental than helpful. It is critical that

world view be a foundation to prevention and treatment. An indigenous, or holistic prevention/treatment plan, can engage a network of support built on family relationships, community interaction, spiritual values, emotional balance, physical health, and connection to the environment.

Stigma in Indian Country

Stigma has been defined as a "mark of disgrace" and represents negative beliefs regarding specific characteristics of an individual. These beliefs can lead that can lead to negative actions from that individual or the larger society in which they live. For a person who is addicted to substances, the stigma around substance addiction may lead them to hide their use, fail to seek appropriate treatment, or even result in family maltreatment from the stigma. In mainstream society, there is incredible stigma related to behavioral health conditions (DHHS, 2009). However, the concept of mental illness, and certainly substance abuse, was foreign within many indigenous societies during pre-colonial times (Walker & Ladue, 1986). Even within more recent years, the concept of mental illness was difficult to express for many Tribal communities. When attempting to define "Serious Emotional Disturbance" not one of the Tribal Circles of Care grantee cohorts funded from the Substance Abuse and Mental Health Services Administration even used this term to define their youth (Simmons, Novins, & Allen, 2004). Instead these communities referred to these youth as "sacred," as "Unci Maka Ta Cinca [Grandmother Earth's Children]," as having "temporary disharmony," or as being "unable to maintain balance." However, after centuries of colonization, AI/AN communities have internalized concepts of mental illness and the related stigma (DHHS, 2001; Grandbois, 2005).

Many AI/AN people experienced personal effects of being labeled mentally ill from a society that did not understand tribal ceremonies, languages, relationships, and other cultural rituals (Grandbois, 2005). In fact, the first federal mental hospital for AI/AN populations, the Hiawatha Asylum for Insane Indians established in 1889, hospitalized AI/AN people for practicing spiritual/religious ceremonies and rituals that were punishable by federal law (Yellow Bird, 2001). The policy of the Asylum was to sterilize "defective" AI/AN people so they could not procreate. Given that the superintendent of the Asylum did not know how to conduct sexual sterilizations, inmates stayed incarcerated until death. Yellow Bird (2001) reports that 9 of the 10 average discharges each year were due to death. Additionally, AI/AN youth that were forced into Christian Boarding Schools were often spiritually, physically, sexually, and emotionally abused likely resulting in mental illness with limited recovery support. Throughout the years of colonization of Indian people the development of mental illness and the classification of cultural ways as mental illness has had a lasting effect (DHHS, 2001).

There are some culturally specific factors within AI/AN communities that can impact stigma and even treatment for this population. It is important to remember that great diversity that exists among AI/AN people and the Tribes they represent and that these concepts may not be

generalizable to every AI/AN person or Tribe. For many indigenous communities mental illness is viewed as either a form of supernatural possession, an imbalance or disharmony with self and the world, or the expression of a special gift (Thompson et al., 1993). If an AI/AN person believes that a supernatural possession or an imbalance with the natural world is the cause for their symptoms, it is easy to see how a western practice like Cognitive Behavioral Therapy that focuses on changing individual thought patterns might seem irrelevant. Similarly, if an AI/AN person believes that their symptoms are really the expression of a special gift, telling the person they had "distorted" or "irrational thoughts" might also seem incongruent.

Finally, there is a commonly held belief among many indigenous societies that thinking or speaking about a negative force brings energy to it and can actually cause a negative event to happen. This is incredibly important for both prevention and treatment efforts. In fact, the only evidence-based-practice that exists for suicide prevention in Indian Country required adaptation because of this belief (LaFromboise & Howard-Pitney, 1995). Further, IHS reports that many Alaska Native people have the belief that if one talks about suicide it will cause an attempt even with no prior history of suicidal thoughts (IHS, 2009).

Within the general population the stigma associated with mental illness and substance addiction often results in both limited access of treatment and even discrimination of people with these illnesses. The US Surgeon General reports that stigma is the most "formidable obstacle" to the future of mental health (DHHS, 1999). People with mental illness often internalize the stigmas about their illness, become embarrassed or ashamed, and hide symptoms or fail to seek treatment as a result (Wall, 1999). In as study of 1300 mental health consumers, individuals with mental illness completed a survey about their experience of stigma and discrimination. A second phase of the study involved interviews with 100 randomly selected participant of the survey. It is important to note that no AI/AN participants were included in this sample. Seventy percent of respondents reported that they had experienced being treated as less competent by others (at least sometimes) once their illness was exposed. For one-third of the participants, these experiences occurred "often" to "very often." One in four survey participants reported that they were often being told to lower their expectations regarding education and employment. More than one-half of participants reported that they have had experiences where they were "shunned" or "avoided" and ¼ reported frequent rejection. Nearly three-quarters of the participants in the sample reported that they have avoided telling others about their illness but often remained fearful of being discovered. Over fifty percent reported that they were worried "often" or "very often" that someone would view them negatively as a result of their mental illness.

In AI/AN communities, stigma around mental illness and substance abuse is no less impactful. In rural Alaska Native communities, stigma around suicide has been reported to result in harsh judgments by community members with subsequent feeling of shame for the person who is at risk for suicide. Reports also suggest that, although a screening tool is available for village health care providers, it is rarely used (IHS, 2009). Within many remote and rural AI/AN communities, concerns of stigma are intensified due to issues related to limited confidentiality (i.e., being seen