Peer Recovery Support in American Indian Communities: A Qualitative Intrinsic Case-Study Approach

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Abstract:

Peer recovery support (PRS) offers significant benefits for individuals in recovery from substance abuse disorders. This research describes the experiences of the first 12 months of a tribally led, American Indian community-based PRS project in two American Indian communities. An intrinsic qualitative case-study design was used to answer the research question, "What are some considerations for implementing PRS services in an American Indian reservation community?" Results showed PRS services fill a much-needed gap in American Indian communities where recovery support resources are limited and substance abuse is pervasive.

Keywords: peer recovery support | substance abuse | American Indian community | reservation | medicine wheel framework

Article:

Background

Culturally relevant community-based peer recovery support (PRS) services are needed to address high rates of substance abuse and recidivism in American Indian communities. PRS is peer-based mentoring and education provided by individuals in recovery from substance use disorders to individuals with substance use disorders or co-occurring substance use and mental disorders (Reif et al., 2014). This nonclinical service aims to decrease substance abuse and increase the quality of life of individuals involved in PRS through education and coaching (Reif et al., 2014). The theoretical basis for peer support comes from the fields of psychology and sociology (White, 2009) where the emphasis is placed on social support, empathy, and therapeutic relationships. Unlike other peer-based programs, PRS focuses on the reciprocal benefits of support offered by

an individual in sustained recovery (peer coach) to another individual in recovery (peer). PRS often focuses on adults with alcohol- and drug-related substance abuse disorders, and services may occur before, after, or in lieu of treatment. The setting in which PRS services are offered varies based on what is most convenient for the peer coaches and peers involved.

There are numerous benefits of PRS, yet building an evidence base for PRS is difficult because the contexts and approaches used to implement PRS vary; therefore, isolating the mechanisms of PRS that lead to recovery is difficult to achieve. To begin, few data sources exist that document the mechanisms by which successful recovery occurs, and in American Indian populations, data are even more limited. Yet most funding agencies and insurance providers require treatment and recovery programs that are evidence-based (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.). A strong evidence base for PRS is not available; however, several authors have reported significant benefits (Reif et al., 2014; Solomon, 2004). American Indian communities are addressing the limited evidence base by developing strategies and best practices to promote PRS based on their own experiences, culture, values, and definition of what works (evidence). Although the National Registry of Evidence-Based Programs and Practices (NREPP) is often viewed as more desirable and effective by funding agencies because it rates the quality of the research approach used to reach intervention outcomes (SAMHSA, n.d.), American Indian communities are creating their own path for PRS opportunities. Notably, the very nature of PRS projects requires flexibility and subjectivity that may not meet stringent NREPP requirements, and therefore, such approaches are not included in the NREPP list. For example, a search in the NREPP using the search criteria "substance abuse prevention," "treatment," "co-occurring disorders," "alcohol," "drugs," "treatment/recovery," "American Indian or Alaska Native," and "tribal" resulted in 13 interventions. Of these, only 1, the *Community Trials Intervention to Reduce High-Risk Drinking*, was an approach that uses community-based strategies to prevent alcohol use, but it does not utilize PRS services (SAMHSA, n.d.). Also, a meta-analysis of PRS studies conducted by Reif and colleagues (2014) revealed two randomized control trials, four quasiexperimental studies, and four pre/post studies—with a moderate evidence base. The moderate evidence for PRS demonstrated reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience. However, the authors called for additional studies to isolate the effects of PRS from other peer-based services while establishing a place for PRS within the current substance use treatment continuum (Reif et al., 2014). This present study answers this call by adding to the literature considerations for implementing PRS and the adaptability of PRS in diverse and distinct cultures.

This study examines the experiences and activities that occurred during the first 12 months of a PRS pilot program in two rural American Indian reservations in two Northern States. The purpose of this review was to answer the research question, "What are some considerations for implementing PRS services in an American Indian reservation community?" Results may be helpful and instructive for other communities as they build effective PRS programs and for funding agencies and policymakers as they work with tribes, community-based chemical dependency programs, treatment centers, and recovery support services. To begin, this process requires one to recognize epistemological differences between American Indian and non-American Indian communities and recovery. There are fundamental differences in how American Indian communities view recovery compared with funding agency guidelines or Western treatment standards. For example, this PRS project defined recovery as follows:

> A commitment and choice of every 'unique' and 'sacred' individual to make a personal change in their life through self or supported services in response to maintaining a 'holistic' healthy and productive lifestyle. This is ultimately accomplished through a life style that is balanced through mental, physical, social, emotional, and spiritual well-being in harmony with one's chosen culture and identity. (Transitional Recovery and Culture Project Definition of Recovery, 2015)

In contrast, the funding agency defines recovery as "A process of change through which individuals improve their health and wellness, live a selfdirected life, and strive to reach their full potential" (SAMHSA, 2015, para. 3). Different definitions of recovery lead to different PRS implementation approaches and outcomes that complicate efforts to document effectiveness. With this in mind, the next section describes an American Indian approach to recovery through a culturally based PRS approach.

American Indian PRS Approaches

Within PRS services, there are key characteristics of peer coaches that differentiate PRS from other mutual-aid group service work—for example, Alcoholics Anonymous. Peer coaches are not sponsors, counselors, priests, or physicians—they are individuals with lived experiences in recovery. Peer coaches provide four types of recovery support services: emotional, informational, instrumental, and companionship.

Within American Indian communities, the characteristics and support of PRS differ from those in non-American Indian communities. To begin, effective PRS approaches in American Indian communities require a deep understanding of the culture, values, norms, and healing practices (LaFromboise & Lewis, 2008; Wexler & Gone, 2012). When these considerations are incorporated into the PRS approach, it is often more desirable and effective than evidence-based programs that have undergone scientific review (i.e., NREPP). Another distinction of PRS approaches in American Indian communities includes the wisdom of elders, ceremonial leaders, and families—many of these people have experienced recovery or have supported family members in recovery. In non-American Indian communities, PRS approaches often rely more on Western treatment standards, Western concepts of recovery, and more traditional recovery supports—for example, Alcoholics Anonymous. An American Indian PRS approach may view the problem (substance abuse) and solution (strategies/PRS services) based on what they experience, feel, or intuitively know, whereas non-American Indian community-based PRS approaches may view recovery based on normative assumptions and the medicalization of substance abuse problems where Western chemical treatment programs/techniques are used. PRS in American Indian communities requires intuitive knowledge of the people, cultures, histories, and services that exist in the community that might help individuals sustain recovery. With these differences in mind, this PRS approach acknowledges the community context and setting, commitment of team members, program goals and objectives, the analysis process, and importance of sharing results.

Methods

Community Context and Setting

The American Indian reservation communities are located in a rural Northern state. According to the 2010 U.S. Census (U.S. Census Bureau, 2010), tribal membership of the participating American Indian reservation communities combined is 11,005 people. Both reservation areas are considered to be medically underserved areas, and marked health disparities exist among tribal members including higher rates of death from unintentional injuries, cancer, heart disease, stroke, infant mortality, and diabetes (Holm, Vogeltanz-Holm, Poltavski, & McDonald, 2010). These communities suffer from substance abuse usage that could be alleviated through effective PRS services.

The Team

The strategies and experiences described represent the efforts of an ambitious team with enduring commitments to recovery and American Indian culture. The PRS program director, coordinator, chemical dependency program directors, staff, program consultants, and various program partners started working with the lead tribal consortium on the project in October 2013. Most team members live in the communities and are enrolled tribal members. Others live off the reservation and have established long-term relationships with community members.
The lead author of this study is an independent evaluator, contracted by the tribal consortium for the 3-year project with no ties to the funding agency and does not have a vested interest in PRS programs. The second author is the PRS program director, and the third author is the PRS program coordinator.

Caps in Service and Support

This tribally led PRS approach was conceptualized in August 2012 after tribal leaders voiced concerns about substance abuse and the need for recovery supports. Tribal resources are limited by a lack of tribal and personal funds that results in limited support for people in recovery. Tribal leaders identified the following high-need areas: (a) inadequate resources for recovery support, (b) lack of employment assistance for those completing recovery, (c) lack of adequate counseling and recovery support, (d) lack of sufficient culturally resonant treatment and recovery support services, and (e) limited social and community understanding of the recovery process and how to support it. With these five high-need areas identified, the tribal consortium submitted a grant proposal that was successfully funded by the SAMHSA Center for Substance Abuse and Treatment. This 3-year funded program is administered by a tribal consortium with direct ties to the participating communities' tribal health and chemical dependency programs. Peer navigators (coaches) on location at each reservation serve in various capacities including: mentors, cultural leaders, elders, and natural helpers.

Program Goals

The goals of this 3-year PRS program are as follows: improve sobriety rates on each reservation, increase community awareness of substance abuse problems and the need for supporting recovery, and increase community support for efforts to create sober communities. Program objectives were designed to cover a wide range of topics relevant to PRS and increasing

community awareness based on the unique contextual and cultural factors in reservation communities.

Culturally Appropriate Qualitative Method

The team selected an intrinsic qualitative case-study approach because they were interested in exploring the phenomenon of PRS using a variety of data sources bounded by time, location, and activity (Stake, 1995)—in this case, the first 12 months of a pilot PRS project in two American Indian reservation communities. Community members and stakeholders felt the intrinsic case-study approach was a valid and culturally appropriate qualitative research method because it seeks to understand the considerations of implementing PRS in American Indian communities rather than explaining PRS using quantitative methods. Intrinsic case-study designs require data that are both holistic and in-depth and that allow the reader to get a picture of the phenomenon (PRS) under study (Stake, 1995) using multiple sources of information, including observations, interviews, and documents. Also, this approach allowed the team to maintain confidentiality of the program and participants—which is critical because the PRS project is still being implemented in the two reservation communities.

Table 1 Data Collection Matrix: Type of Information by Source

Information/Source	Interviews	Observations	Documents	Audio-Visual Materials
Community members	x	x		x
Chemical Dependency Program	x	x	x	
Tribal Leaders	x	x	x	
Funding Agency			x	
PRS Staff	x	x	x	x
Individual in Recovery	x			
Traditional Person	x	x		
Elder	x	x		
Technical Assistance Provider			x	

Note. PRS = peer recovery support.

Data Sources

With these intrinsic qualitative case-study guidelines in mind, this study utilized program data compiled monthly throughout the first 12 months of the project. Data included monthly reports, unstructured open-ended interviews and notes, site visit summaries, funding agency reports, tribal program reports, meeting minutes, observations, and evaluation summaries from weekly and monthly community-based events and various communications (Table 1).
Seven interviews served as the primary data source to answer the research question and were conducted in the first 12 months of the program. Purposive selection criteria were used to select individuals to interview. The program director identified people based on their involvement in the program. These individuals also represented various perspectives and values of the community including a tribal leader, mental health provider, social services provider, peer

navigator, chemical dependency program director, individual in recovery, and a community member. The evaluator developed a semistructured interview guide for the interviews and asked the program director and coordinator to review it to ensure the questions were culturally and contextually appropriate. All interviews started with the evaluator introducing herself, explaining the purpose of the interviews, and gaining verbal consent of the interviewee. Then the evaluator asked the interviewees to describe their experience with the PRS project in the previous year. Next, interviewees were asked how the program helps address substance abuse in the community and the community views of substance abuse and recovery. Last, interviewees were asked to talk about the challenges and strengths of implementing PRS in their communities. All interviews (N = 7) and data were collected and analyzed following local tribal protocols and ethical standards of research with the population. Their age, gender, tribal affiliation, and substance abuse history were not collected in the present study because these attributes were not considered essential in answering the primary research question. The PRS study was submitted and approved by the designated institutional review board of record for the tribes involved; tribal leaders supported PRS via written letters of support and tribal resolutions.

Data Analysis and Considerations

This analysis process required several steps. The first step was to devise a coding framework based on the medicine wheel domains of spiritual, mental, emotional, and physical (Atlantic Council for International Cooperation [ACIC], n.d.). Coding included examining the similarities and differences in the texts, and this involved a reiterative, inductive, and reductive process that organized the data (Walker & Myrick, 2006). Through this coding process, 12 categories emerged. Categories were refined based on consensus and review of the authors and program personnel and were then examined to find meaning between categories and form more complex connections (Clark & Creswell, 2014).

To answer the question, "What are some considerations for implementing PRS services in American Indian communities?" the evaluator developed a conceptual framework to identify who and what would be included in the study (Denzin & Lincoln, 2008), to describe relationships, and to gain insight on general constructs related to PRS (Baxter & Jack, 2008). This framework guided the first examination of program data where multiple data sources (see Table 1) were examined, transcribed in the case of interviews, and analyzed by the lead author. Following the recommendations of Stake (1995), the evaluator categorized events and statements in the data to find meaningful information about PRS that would answer the research question. The evaluator also looked for patterns in the data, where the correspondence between two or more categories emerged (Stake, 1995)—for example, increased community awareness and training needs were corresponding categories. After this initial analysis process from the first five interviews, the evaluator began to develop considerations (or themes) from categories in the data. Next, program data in the form of monthly progress reports, minutes from team conference calls, and activity reports were further examined. Based on the emerging categories, the lead author conducted two additional interviews. Saturation was reached after the seventh interview, and no new ideas or insights emerged from the data that would answer the research question. The lead author uploaded all data into Atlas.ti (Muhr & Friese, 2004) to ensure the categories illustrated were supported by the text and to see how they were related (Attride-Stirling, 2001). The authors, community members, and program personnel then reviewed categories and

resultant considerations to ensure they represented the actual activities, experiences, and perceptions of the previous 12 months.

In the last step of the analytic process, the evaluator organized the categories based on medicine wheel domains and subcategories as they related to considerations for developing PRS services in American Indian community settings. These considerations reflect generations of knowledge, extensive time spent in the community, and a participatory paradigm influenced by indigenous ways of knowing and sovereignty (Denzin & Lincoln, 2008). Although these results are not generalizable to other populations, findings can be related, transferred (Guba & Lincoln, 1994), or recontextualized (Morse, 1999) to other similar contexts—in this case, PRS programs and American Indian recovery support strategies.

Results

Considerations from the analysis process were then organized into conceptual domains using the medicine wheel framework (ACIC, n.d.) as follows: (a) the spiritual domain related to the increase in spiritual activities available through PRS services, transformation, and connectedness; (b) the mental domain related to increasing community awareness for sobriety, personal growth in the Transitional Recovery and Culture Project (TRAC) team, and leadership; (c) the emotional domain related to relationships established through PRS, the history of substance abuse, and various feelings related to recovery and substance abuse; and (d) the physical domain related to the American Indian community setting and the unique cultural and contextual differences of PRS implementation, existing services available, organizations, training, logistics, funding, and tangible support for PRS. These conceptual domains, their categories, and their subcategories are outlined in Table 2.

Table 2 Domains, Categories, and Subcategories of PRS Recommendations

Domain	Category	Subcategories
Spiritual	Spiritual Activities	Increase in sweats and talking circles.
	Connectedness	Increase in community events, trust.
	Transformation	Individual and community reports of change.
Mental	Community Awareness	Increase in knowledge, PRS, and recovery supports.
	Personal Growth	Reports of positive change, sustained recovery, training increasing skills.
	Leadership	Direction and guidance of project honored.
Emotional	Relationships	Increase in PRS relationships.
	History	Recognition of substance abuse usage/traumas.
	Feelings	Need for new approaches to support recovery. Readiness for change.
Physical	Community Setting	Acknowledge rural, limited recovery resources, close-knit, connected.
	Organizations	Partner programs increase success and referral networks.

Logistics	Funding, transportation, and communication barriers.

Spiritual

Themes related to the spiritual domain included participation and facilitation of spiritual activities, community events that promoted trust and connectedness, and individual reports of transformation—in the participants' lives or in the lives of others involved in PRS activities. One peer navigator reported, "I have people that come for spiritual help, you know. I became sober through my spirituality and that is how come I try to promote it (the program) and sweats and sundances."

Mental

Themes related to the mental domain included community awareness of PRS and recovery support available, reports of sustained recovery in peer navigators and increased PRS skills. Leadership was also an area mentioned and highlighted in the data, where several people acknowledged the strong leadership of the project and the respect they had for the individuals directing the program.

Emotional

Several data sources highlighted the importance of recognizing the history of substance abuse usage in American Indian communities and the historical and ongoing trauma resulting from substance abuse. This finding was supported in the data by statements and actions of stakeholders, where their readiness for change but feelings that it was not happening were noted. One tribal leader interviewed said, "I don't know, it's just um a real dismal situation. I think with more people fully engaged and fully involved, [a] real caring, compassionate, outgoing, generous person could make it work, but right now we don't have that person." Another category related to the emotional domain was the importance of relationships, and throughout the 12-month project, there was an increase in the number of people and programs involved; in addition, the project strengthened relationships between the facilitating organization and the American Indian communities.

Physical

Many challenges were noted related to the physical domain, where individuals often reported a lack of recovery resources available, limited funding, and challenges with administering the project. A major challenge reported by peer navigators related to payment for services and transportation to provide PRS services. One peer navigator said, "My car is in the garage; I thought I could run around today, touch base with the partner programs to let them know that I am not going be giving up there."

These four medicine wheel domains contextualize the data in a culturally appropriate manner that may be useful for PRS programs in American Indian reservation community-based settings (Figure 1).

Considerations

Four considerations emerged from the analysis process and were supported by significant statements made by key informants and program data as described. These may be useful for other tribes, funding agencies, policymakers, and communities interested in PRS.

Consideration 1

Understand and promote the critical components of PRS based on the unique cultural traditions, community context, and history while acknowledging the limited programmatic and financial resources available. Examples from interviews that support this recommendation included:

Alcoholism is a serious problem as well as drug abuse in our community.

There is nothing here. No place for them to go.

Peer mentoring is about people who are ready for recovery support services rather than treatment. Referral sources need to be educated on ... mentoring versus treatment differences.

When people come home from treatment, when they come back to the reservation and everything is the same. The same people, same pitfalls—there just does not seem to be enough. There doesn't seem to be the people here ready to catch them before they fall.

We developed a training curriculum for PRS. Peer navigators use our curriculum as a resource when working with peers—this helps peer navigators do their work more effectively.

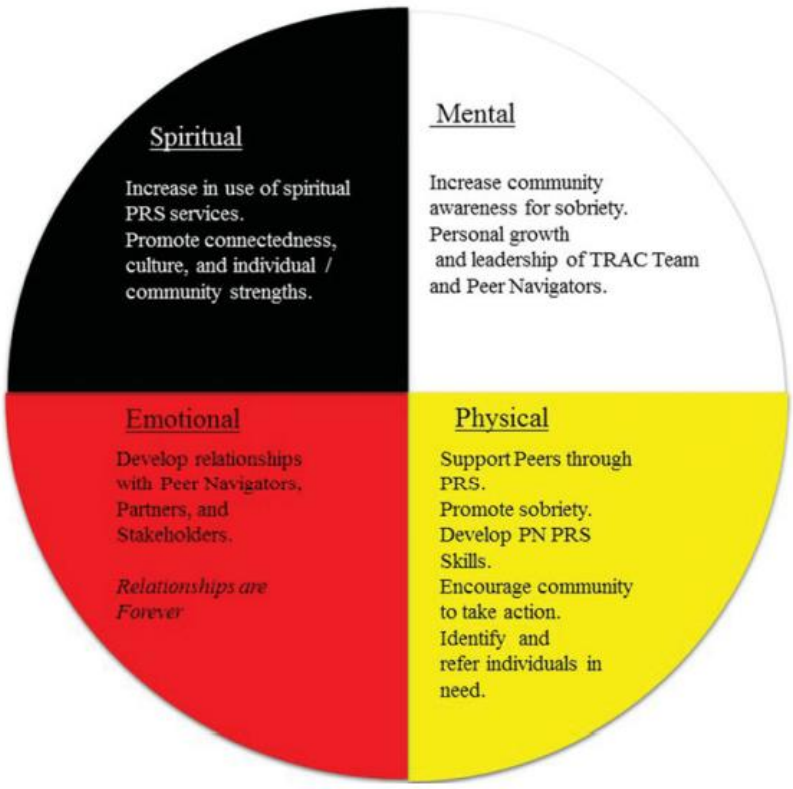

Figure 1 PRS Medicine Wheel Domains. Note. PN = peer navigator, PRS = peer recovery support.

Considerations begin with promoting critical components of PRS services in an American Indian community-based setting. In the first 12 months of the program, critical components of PRS were identified and promoted. Documenting the need for PRS and, in this case, the statement that alcoholism and drug abuse is a serious problem is the first step toward promoting and acknowledging the critical components of PRS. Next, building and sustaining relationships in the community while acknowledging limited resources available is necessary to begin building PRS resource components. Often this requires a constant presence in the community, ongoing training and experiential learning, understanding of the unique community context (strengths and challenges), adequate funding to implement the program, administrative support and management of the program activities, and addressing resource needs and program logistics. These components may be different for each tribal or non-reservation-based community, and therefore PRS services, policies, and funding agencies must seek to understand how PRS services support existing chemical dependency programs and recovery supports rather than create new standalone programs. When these components are promoted through PRS services, people receive support to *catch them if they fall*.

Consideration 2

Community members, tribal leaders, programs, and people in recovery must believe and trust in the PRS approach. This includes developing relationships based on leadership, trust, and

community values. Participants described some of the conditions related to this consideration, including the following:

You have to have the community behind you, you know, and the people.

> We have overcome challenges by spending more time in the communities and developing solid relationships with the CD [chemical dependency] programs, councils, social service programs, peer navigators, and community members.
>
> I think the leadership is real positive. I think it's a good pilot project.
>
> I like [the project team]. They are very good to me. I recommend that anyone who needs help to see them or see me.
>
> Your program helps by coming and helping those people in recovery.

The team promotes PRS as an effective, culturally based approach to recovery in the community by spending time in the community and sharing knowledge and resources with the community members. The strong relationships developed between the team and tribal leaders, peers, peer navigators, and program directors are based on community values like generosity, honesty, humility, and respect. By modeling these values, the team and community promote conditions that allow the community to trust and believe in the PRS process.

Consideration 3

Flexibility in the PRS approach is necessary based on the tribal community setting, traditions, language, culture, and individual. Participant responses underscore the need for flexibility and include the following:

Everybody is different.

We need someone who is aware of different people's make up and can do the counseling and find out where people are at and what they need ... and offer help.

Flexibility in the program approach is needed, and this must be communicated to the funding agency, tribal leaders, stakeholders, and program team. Community and individual recovery needs vary and require PRS programs to be creative in the delivery of PRS services and program implementation. For example, in one American Indian community, the chemical dependency program subcontracted with the facilitating organization to implement the project, and in the other American Indian community, the facilitating organization implemented the project from 180 miles away. Although this was not what was originally planned, the team continued to support PRS services, training needs, and communicated these changes to the funding agency.

Consideration 4

Tribal communities are very small and people watch and observe others, their actions, and helping spirit. The individuals who make up PRS programs in tribal communities are motivators, and they believe in helping people in recovery. Participant responses included the following:

I always say if you are going to help somebody you have all these other people coming to help you like a big round dance. That will motivate other people to see that is where the help is. That is where everything falls in place because you are there trying to help somebody.

I think that anyone who has had a problem is more sympathetic and caring than someone who hasn't.

I have heard people say that they have had problems for years and years. They made up their minds to quit [and did]. Other people struggle and struggle and struggle.

When implementing PRS in American Indian community-based settings, it is important to focus on their capacity and strengths. In this program, the training and outreach focused on building knowledge and skills of community members in recovery to become peer navigators. This training was appropriate for the cultural and linguistic needs of the population and increased the community's capacity to support PRS in the future. A strength of PRS in American Indian communities is the multiple roles of peer navigators (e.g., traditional/cultural leader, parent, educator, health provider). Due to the limited number of recovery support resources available, peer navigators provide multiple services and resources within the reservation-based community. For example, many of the peer navigators also serve as group facilitators for the chemical dependency program or offer sweats, or link peers to existing sweats in their communities. Peer Navigators also offer traditional healing and sobriety servces. At the same time, the capacity, knowledge, and strengths are different in every community and are often influenced by different factors at various times such as changes in tribal council, program staffing, funding, access to technology such as e-mail, voicemail, and computers, department leadership, and access to traditionally based cultural helpers and healers.

Aspects of the project that are facilitating success include strong partner support, trust in the project leadership, and the need for PRS in communities to address high rates of substance abuse usage and limited recovery support resources. Barriers included the following: distance of the facilitating organization, limited funding to implement the project as designed, difficulties with Government Performance Results Act (GPRA) administration, ongoing training needs, and delays in payments for services provided. Several aspects of the project demonstrate that PRS is an effective and culturally relevant recovery support service, but at the same time, barriers may impact the potential for success.

In summary, these considerations add to the existing PRS literature and provide insight for communities, policymakers, and funding agencies when working with American Indian reservation communities to implement PRS programs. The experiences and recommendations reported in this article are consistent with those in previous publications related to PRS; however, this article extends understanding and adds a unique perspective based on experiences in two American Indian reservation communities as they work toward implementing programs that address high rates of substance abuse. Considerations reinforce the need for culturally tailored, community-based recovery approaches that utilize peer navigators and American Indian traditional knowledge, cultural teachings, and holistic approaches to health and wellness.

Ultimately, such approaches reinforce the cultural identity of individuals and communities and the importance of family and community values—all of which support recovery.
These considerations may help further the field of PRS in American Indian communities; however, they fail to address the underlying challenge of building an empirical evidence base for PRS. In American Indian communities, increasing the evidence base for PRS may not lead to sobriety and sustained recovery because the evidence often fails to acknowledge the unique aspects or mechanisms of American Indian communities, their strengths, knowledge, histories, and capacities. Many would say that the concept of PRS services has always been a part of American Indian communities, their histories, and ultimately, their survival. Because of this history, it may be difficult to isolate the effects of PRS from other traditional or value-based support services in American Indian communities. Future PRS in American Indian communities must acknowledge this and focus on what is known—the holistic spiritual, mental, physical, and emotional domains of PRS as described in this article.

Conclusions

In the team's opinion, this article adds to the evidence base for implementation of PRS services in American Indian community settings. Considerations draw from the first 12 months of an American Indian PRS service program and show how adaptable PRS is for diverse and distinct cultures and communities. The team described domains, categories, and subcategories as they relate to the medicine wheel framework and used these to develop considerations about PRS services in American Indian reservation communities. The task of implementing PRS services requires consideration of the issues most important to the community and acknowledging the history of substance abuse in American Indian communities (White, 2009). Ultimately, PRS programs have the potential to support individuals on the road to recovery through unique spiritual and traditional practices. The process of designing and implementing PRS in American Indian communities begins with an understanding that PRS is not a new concept to American Indian communities but is rather a way of being and helping, passed on for many healthy sober generations. Future PRS efforts must focus on balancing requirements of PRS services in American Indian communities and the reality of what will work based on lived experiences and knowledge of individuals in recovery.

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