Photo by Antonia Gonzales

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Urban American Indians and Alaska Natives Experiencing Homelessness in California: Strategies for Addressing Housing Insecurities and Substance Use Disorder

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INTRODUCTION

The California Department of Health Care Services (DHCS) funded the USC Keck School of Medicine, a Tribal Medication-Assisted Treatment (MAT) Project partner, to lead a unique opportunity to conduct a statewide needs assessment among urban and rural American Indian and Alaska Native communities (AIAN) experiencing homelessness in California. This project stemmed from a recommendation highlighted in the statewide needs assessment report titled, "Addressing the Opioid Crisis in American Indian & Alaska Native Communities in California: A Statewide Needs Assessment" which can be found here: https://ipr.usc.edu/index.php/aian-needs-assessment/. This report includes information from community interviews and focus groups among adult key informants (n=33), Native youth (n=84) and Native adults (n=163). The goal of this project was to provide an assessment among AIANs experiencing homelessness with the overall goal of reducing overdose-related deaths by identifying gaps in prevention, treatment, and recovery services.

THIS REPORT INCLUDES PERSPECTIVES FROM INDIVIDUAL INTERVIEWS WITH 19 AIAN ADULTS EXPERIENCING HOMELESSNESS WHO HAVE BEEN IMPACTED BY SUBSTANCE USE DISORDER (SUD) AND/OR OPIOID USE DISORDER (OUD) IN LOS ANGELES, SAN FRANCISCO, OAKLAND, SACRAMENTO, AND SAN DIEGO.

HOMELESSNESS AMONG AIAN IN CALIFORNIA

American Indian and Alaska Natives (AIAN) account for 1.3% of the United States' total population, yet make up 3.6% of the nation's homelessness population.[1,2] California is home to the largest population of AIAN with approximately 720,000 which represents 14% of national AIAN population.[3] In 2019, California harbored one-third of the nation's total homeless population and more than 50% of the nation's unsheltered homeless.[2]

Of the total California homeless population reported in 2019, approximately 4.5% were AIAN.[4] Sixty percent of the 109 California Tribes acknowledge challenges with homelessness, accessibility of stable housing, and reported extremely high rates (80%) of overcrowding in their communities.[5]

HISTORY OF DISPLACEMENT

US government policies have contributed to the continued displacement of Native peoples, historical trauma, and attempted erasure of traditional culture. Policies such as the Indian Removal Act, Indian Boarding School era, and the Indian Relocation Act of 1956 have all contributed to modern day AIAN homelessness.

AIAN communities, Tribes, and cultures are unique and diverse, and share commonalities in how they were affected by the US government policies. An example of US policy that has led to the displacement of Native people is **The Indian Removal Act of 1830** that was signed into law by President Andrew Jackson; this led to the military forcibly removing multiple Tribes from their lands which is commonly referred to as the **"Trail of Tears"**. Another historical tactic was **The Indian Relocation Act of 1956** also known as the Urban Indian Relocation Program. During World War II, the federal government cut the Bureau of Indian Affairs (BIA) budget to meet the wartime demands. Due to these cuts, the average American Indian male living on the reservation made 5 times less than all males. Rather than reinvesting resources in Tribal communities and Tribal lands, the BIA created the Urban Indian Relocation Program. Unfortunately, the relocation program led to overcrowded housing units with unsanitary living conditions. Being strategically placed to prevent racial enclaves of American Indians, and it was not uncommon that Natives who participated in the program were left in a city without any support system. These policies have left AIAN with disproportionate rates of health disparities, socio-economic inequities, loss of culture, and trauma.

1828 - 1887
Indian Removal Act, Trail of Tears, Treaty Period

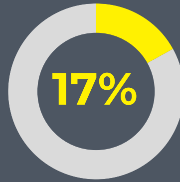
1924
All Native Americans are granted US Citizenship

1950 - 1960
Indian Relocation Act of 1956

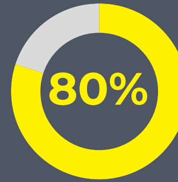
1979- PRESENT
Indian Self-Determination Act

1869 - 1960s
Indian Boarding School Era

SUBSTANCE USE AND ATTITUDES ABOUT SERVICE SEEKING



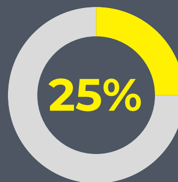
struggle with chronic substance use



living in unsheltered conditions

People who experience homelessness are at a greater risk of substance use disorders (SUDs).[6] Among the total homeless population in California, approximately 17% (26,410/151,278) struggle with chronic substance abuse with almost all of these individuals living in unsheltered conditions (21,381/26,410 = 80%), followed by emergency shelters and transitional housing.[4]

With the growing number of urban AIANs experiencing homelessness, a deeper understanding of the associations between SUD and homelessness in California urban settings is necessary. Limited research on community knowledge about AIAN homelessness exists.



of people who need substance use treatment access it

Nationally, less than 25% of people who need substance abuse treatment access it, and the deficit is higher among individuals experiencing homelessness. More than half of adults experiencing homelessness who use alcohol have no intention to quit or seek ways to quit within the next 6 months.[8] It is unclear for those with SUD. Furthermore, abstinence-based approaches to SUD treatment are not generally desired among individuals experiencing homelessness and other routes to recovery should be considered as identified by the community and those experiencing homelessness and SUD.[9]

METHODS

As an extension of the broader statewide needs assessment report, *Addressing the Opioid Crisis in American Indian & Alaska Native Communities*, this component of the study utilized a participatory action research/community-based participatory research approach (PAR/CBPR) for the research design. Development of the interview guide was a collaborative process including researchers from the University of Southern California (USC) and partners from community-based organizations serving AIANs.

DATA WAS COLLECTED FROM OCTOBER 2019 TO AUGUST 2020 ACROSS FIVE DIFFERENT CITIES IN CALIFORNIA: LOS ANGELES, SACRAMENTO, SAN FRANCISCO, OAKLAND, AND SAN DIEGO.

Participants were eligible for the study if they were 18 years of age or older, self-identified as American Indian or Alaska Native, and currently experiencing homelessness or unstable housing. Those who had experience with OUD/SUD were preferred, but it was not a requirement to participate. Participants were recruited for the study through community partners and community-based organizations. The study included participants completing a demographic survey and participating in a semi-structured interview. The demographic survey collected information such as age, gender identity, substance use, recovery status, and service utilization.

Each participant signed a consent form and received a $30 gift card incentive for their time. Each interview was guided by a Native trained facilitator and a note taker. Interviews were audio recorded and transcribed using a professional transcription service.

Survey and interview data (quantitative and qualitative) were analyzed by a team of researchers at USC (one of whom identifies as AIAN). Members of the research team developed a codebook consisting of seven main themes and met weekly to discuss any emerging sub-themes from the interview data. After data analysis was complete, the research team discussed the interpretation of the data with other AIAN researchers and AI community members to understand the codes in context and ensure validity from an AIAN community perspective.

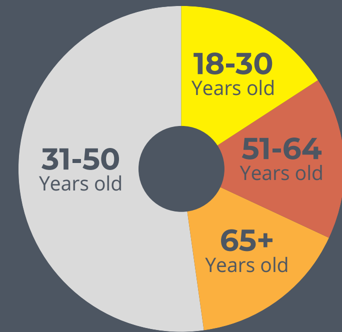
OUTCOMES

This section includes demographic information about the 19 participants and the main outcomes. There are seven common themes that provide a narrative of the outcomes with relevant quotes for each theme. Quotes from the interviews are de-identified out of respect for the participants.

Gender	N=19	Percent (%)
Male	9	47
Female	9	47
Prefer not to answer	1	6
Age		
18-30	3	16
31-40	5	26
41-50	5	26
51-64	3	16
65+	3	16
City		
Los Angeles	7	37
San Francisco	3	16
Oakland	2	11
Sacramento	6	32
San Diego	1	4
First Substance Ever Used		
Alcohol	2	11
Tobacco	11	58
Marijuana	1	5
Polysubstance	5	26
Age of First Substance Use		
8-12	4	22
13-17	5	26
18-25	5	26
Prefer not to answer	5	26
In Active SUD Recovery		
Yes	8	8
No	6	32
Prefer not to answer	5	26
Time in SUD Recovery (Range)	1 week to 21 years	

DEMOGRAPHIC INFORMATION

Nineteen participants completed the brief demographic survey before their interview. Seven were from Los Angeles, 3 from San Francisco, 2 from Oakland, 6 from Sacramento, and 1 from San Diego.



Nine participants identified as female, 9 as male, and 1 participant preferred not to answer. About half of participants were between the ages of 31-50 years old. Most participants indicated tobacco was the first substance they used followed by multiple substances at first use (which included a combination of alcohol, tobacco, and/or marijuana).

Fourteen of 19 participants are in active recovery ranging from 1 week to 21 years of recovery time.

COMMUNITY SUBSTANCE USE DESCRIPTION

In the interviews, participants were asked to describe their perspective about the community's most used substances, access to substances, and availability of substances.

SUBSTANCE USE

Participants stated a wide range of substances being used in the community: alcohol, opiates, heroin, crack, marijuana, and methamphetamine. Methamphetamine was identified as the substance with the most harmful consequences to the community. Those who had early experiences with substance use discussed their continued use of that substance, which also led to using other substances once that one was no longer accessible. In addition, participants believed that substance use is higher among the homeless community.

SUBSTANCE ACCESS

All participants expressed that substances including, but not limited to, alcohol, marijuana, heroin, opioids, and methamphetamines were easily accessible. Substances were accessible from family members, friends, elders with prescribed opioids, and people in the community. Fourteen out of 19 participants said opioids can be easily accessed through a doctor's prescription. Geography was identified as a risk factor for substance use and access because certain cities/areas normalized substance use much more than where they relocated from.

"I SEE A LOT OF PEOPLE DOING DRUGS, JUST RIGHT OUT ON THE STREET. AND IT'S LIKE, WHEN YOU GO DOWN TO SKID ROW, THEY'RE LIKE LITERALLY SELLING IT LIKE THEY'RE PAPER BOYS OR SOMETHING."

- MALE PARTICIPANT

OVERDOSE

Fifteen out of 19 participants had witnessed an overdose related to substance use. When asked about how participants intervene while witnessing an overdose, one participant stated they took a training course to help people during an overdose. Another participant mentioned they are trained to administer naloxone (NARCAN). When responding to an overdose, two participants mentioned fear of arrest.

"BUT WE'RE ALWAYS TOO SCARED TO GO TO THE HOSPITAL, BECAUSE LIKE I HAVE THIS FEAR, LIKE, IF YOU GET REALLY SICK OFF OF DRUGS OR ALCOHOL, THEY'RE GOING TO ARREST YOU. SO THERE'S A FEAR OF GETTING THAT KIND OF HELP, BECAUSE YOU DON'T WANT TO BE IN TROUBLE WITH THE PERSON."

- MALE PARTICIPANT

"AND I [WAS] REALLY WORRIED. AND I FOUND OUT LATER, NOBODY WANTED TO HELP AN OVERDOSE, BECAUSE YOU COULD BE RESPONSIBLE AND CHARGED WITH THEIR DEATH IF YOU'RE THERE. THAT'S WHY NOBODY AT THE RAVE WANTED TO HELP ME."

- MALE PARTICIPANT

RISK FACTORS

Participants were asked to identify potential risk factors for substance use among their community. Common themes identified were homelessness, trauma, family stressors and loss, mental health disparities, and peer influence.

HOMELESSNESS

Participants spoke directly about the experience of having unstable housing or experiencing homelessness and how that is connected to the potential risk of SUD. One participant mentioned that they began using substances to ensure their safety while living in their car.

OVERALL, 11 OUT OF 19 PARTICIPANTS DISCUSSED HOMELESSNESS AND SUBSTANCE USE DISORDER AS A BIDIRECTIONAL RELATIONSHIP.

“THEN ALSO, LIKE I KNOW FOR ME, PERSONALLY, A LOT OF TIMES I USED IT BECAUSE I WAS LIVING IN MY CAR, SO I COULD FEEL SAFE. I WAS AFRAID PEOPLE WOULD TRY TO BREAK INTO MY CAR AND STUFF.”

- FEMALE PARTICIPANT

In addition to safety, hopelessness was another major risk factor for substance use disorder. Hopelessness, combined with loneliness and a lack of a social support network, was a major risk factor for SUD. Geographic isolation and disconnection can be common for members of the community who move between their reservation and urban cities.

“HOPELESSNESS. I MEAN, THAT’S PRETTY MUCH ROCK BOTTOM. I THINK THAT IF YOU HAVE A PLAN, STRONG BACKING, AND A SENSE OF PURPOSE, YOU WILL STEER CLEAR OF THOSE THINGS. BUT IF YOU DON’T, YOU WILL FALL PREY TO MAKING BAD DECISIONS.”

- MALE PARTICIPANT

TRAUMA AND LOSS

Intergenerational trauma was a common theme among participants. Boarding school was identified as a main factor for intergenerational trauma among their parents which led to substance use in the household growing up and subsequently their own substance use. Some participants mentioned they were raised by relatives because their parents were unable due to their substance use.

Eight out of 19 participants attributed their substance use to experiencing trauma in the form of family separation or loss. A specific challenge among female participants with children was navigating child protective services, losing custody of their children, and coping with these life changing and traumatic situations. In addition, participants mentioned coping with family loss such as death or separation. One participant mentioned drinking to cope with their mother’s passing.

"I'D LIKE TO SEE MORE TARGETING, LIKE GETTING MOTHERS AND FATHERS BACK WITH THEIR CHILDREN...YOU SEE NOT ONLY A MOTHER GOING THROUGH HER STRUGGLE OF WHAT SHE'S GOING THROUGH, BUT THEN SHE ALSO HAS TO WORRY ABOUT HER CHILD. I THINK IT WOULD BE MORE INTERESTING TO SEE STUFF LIKE THAT, INSTEAD OF JUST TAKING THEM COMPLETELY OUT OF THE SYSTEM OR TAKING THEM OUT OF EACH OTHER'S LIVES."

- MALE PARTICIPANT

MENTAL HEALTH

Eleven of the 19 participants discussed mental health illness and using substances to cope as risk factors for SUD. Participants mentioned lack of access to adequate mental health services, general stress, and undiagnosed mental health conditions as precursors to self-medicating for their mental health.

"AND IT'S JUST, SAME REASON I DID, I GUESS, BECAUSE OF STRESS, SCHOOL, LIFE, BILLS, PAYMENTS, KIDS, WHATEVER YOU HAVE. AND IT JUST TAKES THAT ONE TIME TO BE PRESSED ENOUGH TO BE LIKE, 'OKAY, THAT'S IT. I'M GOING TO TRY IT.' AND ONCE YOU TRY IT, [YOU'RE] MORE THAN LIKELY GOING TO BE HOOKED."

- MALE PARTICIPANT

PEER INFLUENCE

Early onset of substance use was attributed to peers who used or sold substances. Experimenting with different substances was mentioned among those who used substances at an early age to cope with their mental health and for recreational curiosity. Participants also mentioned peers who may be experiencing similar hardships, such as homelessness, were more likely to use substances with those peers.

ACCEPTABILITY OF EXISTING SERVICES

Discussions in the participant interview covered the perception of services currently available revealed information on provider competency, quality of service, and provider sensitivity to patient needs.

QUALITY OF SERVICES

The most commonly mentioned services were those of the Indian Health Service (IHS) clinics such as the United American Indian Involvement (UAII), the Sacramento Native American Health Center (SNAHC), Friendship House, and American Indian Changing Spirits. Eight out of 19 participants identified IHS specific services such as Wellbriety's Red Road workshops, Gathering of Native Americans (GONA), and other culturally specific services the clinics offered.

"IF WE'RE LOOKING AT NATIVE COMMUNITIES ONLY [FOR CULTURALLY TAILORED SUBSTANCE USE DISORDER TREATMENT]...THEN THAT'S KIND OF WHERE MY STORY BEGAN."

- MALE PARTICIPANT

ACCESS TO SERVICES

Participants mentioned multiple barriers to accessing the services currently available to them, including the lack of accessible clinics for SUD treatment. Two primary concerns regarding accessibility mentioned were they did not know the services were available and the difficulties faced when navigating these systems. The amount of prior knowledge needed to understand how to traverse the SUD care system is overwhelming for many individuals, especially when they are experiencing homelessness and focused on ensuring their physical safety. One participant described their experience of being unable to receive treatment due to a facility's operating hours. These waiting times were of great concern to many participants, as they felt reaching out for services was a last resort.

"BECAUSE I DIDN'T HAVE NOWHERE ELSE TO TURN. I DIDN'T HAVE NOWHERE ELSE TO CALL. SO I CAME TO THE NATIVES, YOU KNOW WHAT I MEAN? I'M JUST LIKE, 'I NEED HELP. WHEN IS THIS PLACE GOING TO OPEN? I NEED TO DO SOMETHING. I'M GOING TO LOSE MY KID. I'M GOING TO LOSE MY LIFE', YOU KNOW."

- FEMALE PARTICIPANT

The variety and amount of services available were not issues to those interviewed but rather positive attributes of the services currently in place. However, the lack of individual resources, such as beds at inpatient programs, made it difficult for people dealing with SUD to access these services.

"BUT THEY HAVE A DIRECTORY OF PLACES THAT THEY CALL. AND, LIKE I SAID, IT'S NOT INSTANTANEOUS. IT'S LIKE, I'M CALLING YOU. IT'S TAKING EVERYTHING IN MY BEING TO CALL YOU, BECAUSE I NEED HELP NOW. NOT, 'OKAY, IT'S GOING TO TAKE TWO WEEKS TO GET YOU IN HERE.' IN TWO WEEKS THAT PERSON COULD EITHER BE DEAD, OR YOU KNOW, THEY'RE LIKE, 'WELL, THE HELP IS REALLY INACCESSIBLE.' AND THEY JUST USE ANYWAYS, YOU KNOW."

- MALE PARTICIPANT

"SO EVERYTHING IS A WAITING LIST. IT'S ALL A WAITING LIST. THAT'S WHY I KIND OF STAYED AWAY FROM [THE PROGRAM], I WAS GOING THROUGH—TRYING TO GET INTO THE [OUTPATIENT] GROUPS. AND AT FIRST IT WAS A THREE-WEEK. THREE WEEKS GO BY. THEN I'M TOLD IT'S FOUR. AND THE NEXT THING IT'S FIVE, SIX. AND CONTINUOUSLY, THE WAIT LIST SEEMS TO GET LONGER AND LONGER. AND IT'S JUST LIKE, 'JUST COME BACK. KEEP COMING BACK.' AND IT'S LIKE, WELL DAMN. WHAT ELSE AM I SUPPOSED TO DO? I'M HERE FOR FOUR CONTINUOUS WEEKS. I'M SHOWING YOU THAT I WANT THIS. WHAT MORE IS IT THAT YOU CAN DO? AND IT'S LIKE, YOU'RE JUST NOT PART OF THEIR INNER RING, I GUESS."

- MALE PARTICIPANT

CULTURAL SUPPORTIVE SERVICES

To determine whether existing supportive services were adequately sensitive to cultural values, participants were asked to discuss the use of traditional healing and integration of traditional values into mental health services. Participants frequently mentioned that feeling connected to their community helped with their recovery and strengthened their cultural identity. Cultural services mentioned included sweat lodges, Wellbriety's Red Road curriculum, traditional healers, drumming groups, Gathering of Native Americans (GONA), and Native specific residential treatment centers.

Of the 19 participants, 13 stated that cultural services were valued and needed in the AIAN community. Participants also mentioned that staff who self-identify as AIAN or have extensive experience working with AIAN communities increased a sense of community and a feeling of belonging.

“WE HAVE [THE PROGRAM] ‘CULTURE IS PREVENTION’. IT TEACHES A LOT OF STUFF THERE. IT’S MORE ENGAGED IN YOUR CULTURE THAN ANYTHING ELSE, YOU KNOW? MORE THINGS THAT NATIVE PEOPLE CAN DO TO LEARN ABOUT THEIR CULTURE AND PROBABLY PREVENT THEM FROM DOING WHAT THEY’RE DOING OUT THERE IN THE STREETS, AND SHOWING THEM YEAH, IT DOES REALLY WORK.”

- FEMALE PARTICIPANT

“I STILL REMEMBER THE FIRST TIME I WENT INTO THE SWEAT...AND THEN I REMEMBER THE FIRST TIME I WENT IN WITH MY UNCLE, WHEN I WAS TRYING TO STAY SOBER. AND I’LL NEVER FORGET THAT EXPERIENCE, BECAUSE IT WAS LIKE, THIS WAS WHAT WAS MISSING. THIS WAS WHAT THEY MEANT. THIS WAS WHAT SHE MEANT BY, YOU’RE MISSING THE SPIRITUAL ASPECT. YOU’RE NOT BALANCED YET. AND I MEAN SHE AS IN MY SECOND COUNSELOR.”

- MALE PARTICIPANT

BARRIERS

Participants were asked about internal and external barriers to accessing services. Major themes discussed were desire to seek services, hierarchy of needs, stigmatization of homelessness, proximity to care, and eligibility requirements.

DESIRE TO SEEK SERVICES

Eleven out of 19 participants reported that lack of personal motivation was the primary internal barrier to seeking services for SUD. Participants also stated that they thought people were often in denial about needing help or being dependent on substances, and consequently, they did not see a need for help. In addition, some participants stated they enjoy the effect of using substances and had no desire to seek treatment.

HIERARCHY OF NEEDS

Other participants expressed that people with SUD are often in a situation where they are unable to plan for the future due to trying to get their basic needs met, such as their next meal or where they are going to sleep. Thus, making plans for future recovery may be continuously put off or avoided. Other participants considered that the desire to recover from SUD was something that would come with time, or after experiencing a traumatic event such as an overdose. One participant described the process of change and seeking recovery.

"...BECAUSE LIKE I SAID, BE IT A DRUG PROBLEM OR BE IT A MENTAL PROBLEM, THEY'VE STOPPED GROWING MENTALLY. THEY DON'T KNOW HOW TO INTERACT WITH WHAT WE WOULD CALL 'NORMAL PEOPLE.' YOU KNOW. AND IT'S HARD. IT'S AN ADJUSTMENT. AND IT TAKES TIME. AND FOR SOME PEOPLE, IT TAKES A LOT OF TIME...BUT LIKE I SAID, IT'S A PROCESS. IT'S A JOURNEY. IT'S EXHAUSTING EMOTIONALLY AND PHYSICALLY AT TIMES."

- MALE PARTICIPANT

STIGMATIZATION OF HOMELESSNESS

Although the desire to seek recovery may be an individual choice, there are still considerable barriers for seeking help. An example is the shame that people feel as a result of experiencing homelessness and the fear of being looked down on while seeking services. Participants specifically cited not having access to showers or clean clothes to look presentable to case workers. Some felt that, due to their appearance, social service professionals are not welcoming and set discouraging rules, such as requiring that they leave their belongings on the street when they come in for services.

GEOGRAPHIC PROXIMITY TO SERVICES

External barriers involved geographical distance and lack of transportation to recovery services. Eight of 19 participants described transportation as a barrier to accessing services. Participants stated that some services were located in different counties and were too far from where they lived. The inability to pay for extended public transportation, as well as concerns about leaving behind personal belongings, were additional barriers that impeded service access. Moreover, participants described that culturally-sensitive services were too geographically dispersed compared to services such as Alcoholics or Narcotics Anonymous. This was unfortunate as many participants expressed a preference for culturally-sensitive services because Alcoholics and Narcotics Anonymous did not always align with their beliefs and practices, and consequently, they would not access these types of services.

ELIGIBILITY REQUIREMENTS

Participants also mentioned that many agencies required complete sobriety to participate in services, which was often difficult to achieve. For people experiencing homelessness, not having an address or a stable place where they could receive mail or be contacted was also a significant barrier to care. Participants described that treatment facilities are often restrictive regarding whom they can serve and what services they offer, complicating the search for services even further.

"JUST FOR PEOPLE LIKE ME WHO ARE ENROLLED TECHNICALLY, BUT TECHNICALLY I'M NOT ENROLLED. MY GRANDMOTHER'S GOT HER ROLL NUMBERS, BUT I HAVE TO GO TO MISSISSIPPI TO GET MY TRIBAL CARD. IT'S TOO MUCH DRAMA...I DON'T WANT TO BOTHER DOING ALL THAT."

- MALE PARTICIPANT

An additional barrier discussed was the length of time people had to wait to receive services, which ranged from a few days to several weeks before they were offered any type of support. One participant shared their experience about the intake process.

"AND IT'S A LONG PROCESS. I MEAN WHEN I WAS TRYING TO GET INTO MY REHAB, IT TOOK 90 DAYS...AND ALSO, NOT PUTTING A LIMITATION (ON WHO CAN BE SERVED). THEY NEED TO MAKE IT COMFORTABLE FOR YOU. AND IF THEY HAVE QUESTIONS, HAVE SOMEBODY ON THE OTHER END THAT THEY CAN CALL, AND NOT HAVE TO GO THROUGH A HUGE PHONE SYSTEM, AND PRESS 15 DIFFERENT EXTENSIONS JUST TO TALK TO A PERSON. A DIRECT LINE, YOU KNOW. AND THAT'S, IN MY MIND, WHY PEOPLE ARE, LIKE I AM, PUTTING IN TOO MUCH WORK GETTING NOWHERE."

- MALE PARTICIPANT

SERVICE SYSTEM NEEDS

Participants were asked to provide advice or recommendations for future services and to identify any service system needs.

AWARENESS

Seven out of 19 participants expressed a lack of awareness about existing services. In addition, multiple participants described difficulties navigating the system and knowing where to begin. Additionally, some participants were not raised within the Native community and had difficulty navigating culturally tailored services until they came in close contact with another Native community member.

The most common need mentioned was increasing outreach to community members outside of the organization and/or clinic. Participants mentioned that people experiencing homelessness are often unaware of services, especially if they are new to the area and the only way they are able to learn about services is through word of mouth. In addition to outreach, participants mentioned general workshops about SUD treatment to increase awareness among community members so information sharing can happen at a grassroots level.

"I THINK MORE AWARENESS OF WHAT THEY ARE, AND MAYBE THE AWARENESS OF WHERE WE CAN GET THE HELP IF WE DIDN'T KNOW. LIKE I DIDN'T KNOW ANYTHING ABOUT THE INDIAN CENTER, UAII, UNTIL I DATED SOMEBODY NATIVE. LIKE I WAS ADOPTED. I WAS TAKEN AWAY FROM MY MOM, BECAUSE OF SUBSTANCE USE AND ALL OF THAT. AND I WAS PLACED IN A WHITE FOSTER HOME."

-FEMALE PARTICIPANT

INDIVIDUALIZED CARE AND CONTINUUM OF CARE

Participants mentioned gaps in services during the SUD treatment process. Wraparound services including medical and mental health evaluation, additional SUD treatment options, housing, and assistance with child protective services were mentioned.

"SOMEONE NEEDS TO HOLD YOUR HAND THROUGH THE WHOLE THING. YOU NEED TO WORK WITH THE SAME PERSON, AND BUILD THAT RAPPORT FOR A LONG TIME. WHAT I'VE NOTICED AT PLACES I'VE GONE TO, IS YOU KNOW, PEOPLE ARE COMING IN FOR THEIR TRAINING, OR WHATEVER, OR WORKING ON THEIR DEGREE. AND THEY COME IN AND DO LIKE A SIX-MONTH STAY, AND THEN LEAVE. AND THEN, LIKE, WELL THAT PERSON JUST OPENED UP TO THAT PERSON. IT TOOK A LOT TO OPEN UP TO THAT INDIVIDUAL PERSON, AND NOW THEY'RE GONE. NOW THEY HAVE TO START ALL OVER WITH A NEW PERSON, JUST TO TRY TO GET THEM TO UNDERSTAND WHERE THEY'RE COMING FROM AGAIN."

- MALE PARTICIPANT

INCREASE AVAILABLE SERVICES IN URBAN SETTINGS

More culturally tailored substance use treatment options including treatment centers, support groups, and safe community spaces were identified by participants. Participants mentioned that community spaces are needed for community members to share information with one another and increase awareness. Some female participants specifically mentioned more female specific residential treatment centers are needed—there is only 1 female AIAN residential treatment center in California.

Services beyond SUD treatment were discussed among participants. Housing was identified as a top need behind increased access to showers and bathrooms. Participants expressed that if people were able to meet their basic needs, there would be a greater likelihood individuals would seek services for SUD treatment.

“I THINK THEY NEED TO HAVE MORE SERVICES FOR SUBSTANCE ABUSE TREATMENT THROUGHOUT CALIFORNIA, ACTUALLY. THEY NEED MORE RED ROAD PROGRAMS BECAUSE A LOT OF NATIVE PEOPLE WON’T GO TO AA OR NA OR ANYTHING LIKE THAT BECAUSE THEY’RE NOT COMFORTABLE. AND WITH THE NATIVE COMMUNITY, YOU’RE COMFORTABLE WITH OTHERS LIKE THAT. YOU’RE COMFORTABLE WITH OTHER NATIVES BECAUSE THEY FEEL THE SAME WAY YOU DO, AND THEY’VE BEEN THROUGH THE SAME HISTORICAL TRAUMA THAT WE ALL HAVE IN OUR FAMILIES, YOU KNOW?”

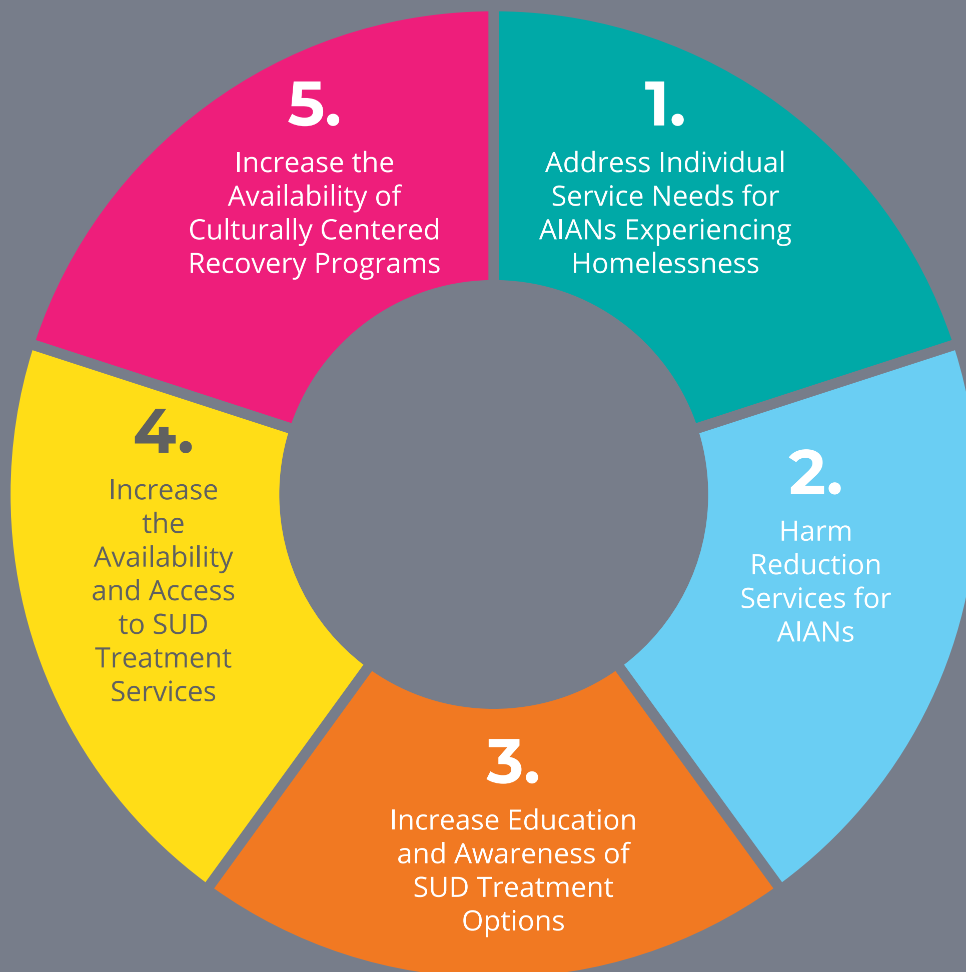
- MALE PARTICIPANT

"MORE SERVICES. MORE SERVICES FOR NATIVE PEOPLE BECAUSE THERE'S NOT A LOT OUT HERE. NOT A LOT OF NATIVE SERVICES OUT HERE. I KNOW YOU KNOW THERE'S RESERVATIONS AND STUFF OUT HERE, BUT THAT'S FOR MOSTLY THE CALIFORNIA INDIANS HERE. THEY NEED MORE SERVICES FOR THEIR OTHER TRIBES ALSO, NOT JUST CALIFORNIA TRIBES BECAUSE WE HAVE A LOT OF TRIBES HERE THAT ARE DIFFERENT FROM DIFFERENT STATES. BUT WE JUST NEED MORE OF IT, MORE SPIRITUALLY-BASED PROGRAMS LIKE THE RED ROAD AND IN MORE PLACES, OFFER IT IN MORE PLACES SO THEY DON'T HAVE TO TRAVEL."

-MALE PARTICIPANT

RECOMMENDATIONS

The following recommendations are based on the voices of the AIAN participants experiencing homelessness who currently reside in California urban areas. Based on these perspectives, these recommendations can assist this population in major urban cities in California, policy makers, and other stakeholders to strategize and address the SUD disparities and inequities for this community.



1. ADDRESSING INDIVIDUAL NEEDS FOR AIAN EXPERIENCING HOMELESSNESS

1a. **California AIAN Housing First—**Housing First is a homeless assistance approach that prioritizes permanent housing solutions for individuals experiencing homelessness and provides a foundation of all service delivery and recovery efforts. Many of the barriers to accessing services found in this report can be traced directly to a lack of permanent housing for AIANs. Creating a California AIAN Housing First Program would guarantee permanent housing to all AIANs experiencing homelessness and form the foundation of addressing other needs such as job placement, SUD treatment, and recovery.

1b. **AIAN housing education and home ownership programs—**Funding and development of housing security and homelessness prevention must include education of homeownership as it applies to AIANs in California. Education centered around financial literacy and qualifications for homeownership should be made available to Tribal and Urban Indian communities through local county or statewide agencies.

1c. **Housing cash assistance programs for AIANs—**Increased funding should be made available for direct cash assistance for AIANs experiencing homelessness or at risk of becoming homeless as a result of financial hardship or SUD. Increased funding for current programs for cash assistance should include AIAN specific financial resources that are made available to both urban and hard to reach rural/Tribal communities.

1d. **Affordable housing programs for CA AIANs**—Increase funding for affordable housing projects available to AIANs in Tribal communities and urban Indian communities. Due to the long-standing issues of relocation and the Indian Removal Act referenced in the report findings, municipalities should adopt ordinances targeting housing programs for AIANs and their families. Increasing funding for community housing organizations and Tribal governments would increase the availability of housing stock for AIANs in California.

1e. **Meal programs for homeless AIAN—**Meal programs provide vital nourishment and an opportunity for service delivery and outreach for individuals experiencing homelessness. Increasing funding to AIAN-serving organizations that provide nutritional support services will provide needed access to meal voucher programs and other nutritional services and ensure direct access to AIANs by engaging programs that are currently serving these populations.

1f. **Hotel voucher program for AIANs—**Increased funding and availability of a hotel voucher program should be made available to AIANs in CA. Hotel vouchers should be made available at the county level through local homelessness resource organizations and AIAN serving organizations across all CA counties.

1g. **Employment placement programs for AIANs experiencing homelessness—**Job placement and training are critical for the long term success of addressing homelessness and SUD for AIANs in California. Employments and job skill programs should be made available through urban Indian and Tribal agencies to ensure adequate access and availability of services.

1h. **Emergency shelters—**Funding for emergency shelters should be increased to ensure access and availability of shelter services in both rural and urban settings. Existing emergency shelters should offer guaranteed access to all AIANs in California. Additionally, a critical component of continued services should be the availability of storage and temporary addresses for AIANs in order to receive mail and be eligible for services that require an address.

2. HARM REDUCTION SERVICES FOR AIANS

Harm reduction is an approach to public health programming aimed at reducing the risks and harmful effects associated with substance use and addictive behaviors for the individual or community. It is a pragmatic, humane, and evidence based approach to address issues of substance use and homelessness with demonstrated efficacy in AIAN communities. As opposed to prioritizing abstinence as the only treatment for SUD, harm reduction focuses on caring for individuals regardless of substance use behaviors as those individuals progress through phases of treatment. Some harm reduction strategies that would support AIANs experiencing homelessness include:

- On-site and mobile equipment supply distribution programs such as needle exchanges, safe use kits, safer sex supplies, and biohazard containers for the purpose of limiting injury and the transmission of disease.
- Safe injection and consumption sites, and overdose prevention and treatment that is culturally informed.
- Providing appropriate information on the amount of alcohol in a standard serving of wine, beer, and spirits in order to help individuals make decisions about what and how much they can safely drink.
- Offer AIAN centered motivational interviewing, a special counselling technique to support change in small increments, over time that includes a cultural component.

3. INCREASE EDUCATION AND AWARENESS OF SUD TREATMENT OPTIONS

3a. **Services guide for AIANs experiencing homelessness—**As evidenced in the report findings, AIANs requested better availability of information regarding access to services to address SUD and homelessness. A resource guide detailing local and statewide resources for AIANs experiencing homelessness should be made available and distributed through the county system. Agencies that work with homeless AIANs would have information regarding local AIAN serving agencies and recovery services.

3b. **Mentorship programs—**AIANs in California who have recovered from homelessness and SUD are often the best advocates for those who are currently in the recovery process. Connecting AIANs to community leaders, healers, and trained counselors can provide a powerful motivation for recovery. Statewide and local funding should be made available for mentorship services connecting AIANs experiencing homelessness to AIAN recovery professionals for ongoing and immediate recovery needs.

4. INCREASE THE AVAILABILITY AND ACCESS TO SUD TREATMENT SERVICES

4a. **Availability of SUD treatment services—**Simplifying the intake and application process for community members could increase participation. Strict requirements for proper identification, dealing with uncaring professionals, and the complex steps associated with securing services were some of the challenges that deter one from seeking assistance and support.

- Simplifying communication with agency staff and limiting the number of requirements may make the process less daunting for people experiencing homelessness.
- Creating a more welcoming environment and kinder approach to helping individuals with SUD could make a difference.
- Offering staff training on the challenges that people with SUD experience as well as the difficulties and dangers of experiencing homelessness could cultivate a more empathetic climate and help individuals provide better services.
- Providing case workers with cultural sensitivity and trauma informed training.

4b. **Transportation—**Transportation is a considerable barrier that could be addressed in most, but not all cases by providing bus or train passes to people experiencing homelessness and allowing them to bring a few of their personal items on board.

- Some mental health agencies provide such passes for their clients, but expanding this assistance could be of greater service.
- Providing a shuttle that can transport individuals to and from services could help individuals avoid the hurdles associated with understanding and taking public transportation.
- Provide transportation vouchers for clients seeking services.

5. INCREASE THE AVAILABILITY OF CULTURALLY CENTERED RECOVERY PROGRAMS

5a. **Increase program outreach capacities to target homeless AIAN individuals—**While the disparities of homeless AIANs far outpace other racial groups in California and nationally, the availability of culturally centered resources has not yet reached parity. This report demonstrates the need for increased funding and development of outreach to homeless and housing insecure AIAN individuals in need of recovery services. Outreach workers should connect individuals with local and statewide resources to address their needs and unique housing situation.

5b. **Culturally centered detox programs for CA AIANs—**An issue referenced in the report is the availability of detox services that meet the cultural needs of AIANs in California. AIANs experiencing homelessness in California rely on city and county detox services. These services often lack a cultural component that is responsive to AIAN needs. Additionally, these detox centers often lack coordination with local and statewide AIAN residential treatment centers and Urban Indian Health Programs or Tribal Health Centers to refer AIANs for continued care.

CONCLUSIONS

The goal of this project was to provide an understanding of Native Americans experiencing homelessness who have been impacted by substance use disorder (SUD) and/or opioid use disorder (OUD) in five CA urban cities (Los Angeles, San Francisco, Oakland, Sacramento, and San Diego). Nineteen interviews with AIAN adults experiencing homelessness provided a unique perspective to understand the availability and gaps in substance use support services, mental health services, and treatment programs for this population. It is clear that services with cultural integration must continue and more of these types of services are crucial to meet the needs of this population. Funding to support treatment services and resources for this population are imperative to reduce unstable housing, substance and opioid use, opioid overdoses, and mental health disparities. Continuum of care must include wraparound services that include medical and mental health evaluation and services, additional SUD treatment options, housing options, and assistance with child protective services.

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Photo by Antonia Gonzales