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Aligning Three Substance Use Disorder Interventions among a Tribe in the Southwest United States: Pilot Feasibility for Cultural Re-Centering, Dissemination, and Implementation

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Abstract

In this article we describe cultural re-centering, dissemination, and implementation activities in partnership between an American Indian reservation community and a university in the Southwest United States. We offer examples of cultural adaptation and implementation of evidence-based treatments (e.g., Motivational Interviewing, Community Reinforcement Approach and the Community Reinforcement and Family Training) using the Interactive Systems Framework. Facilitators and barriers are described within each study including recruitment strategies, training, and sustainability of counselors in the community. Through this Tribal-university partnership, we offer insight on the cultural adaptation and implementation process that will be translatable and clinically meaningful to other rural and reservation communities.

Keywords

Community Reinforcement and Family Training; American Indian adults; dissemination and implementation; Twelve step facilitation; substance use disorder treatment; family treatment engagement

Introduction

Dissemination and Implementation Science Among Tribal Communities

It takes nearly two decades for a fraction of evidence-based treatments (EBTs) to reach applied settings (Glasgow & Emmons, 2007; Morris, Wooding, & Grant, 2011; Proctor et al., 2009). This is particularly true in under-resourced and underserved communities that are impacted by the glaring gap in translation (Alvidrez & Stinson, 2019). The field of alcohol

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and substance use treatment is no exception (Glasner-Edwards, & Rawson, 2010). There is relatively modest adoption of EBTs for alcohol and substance use disorders (AUDs and SUDs, respectively) in privately funded treatment agencies (Knudsen, Johnson, Roman, & Oser, 2003). Practitioners face challenges adopting and implementing EBTs in real-world settings because often the evidence being translated does not address the intricacy of implementation at the community level (Glasgow & Emmons, 2007).

Similarly, attempts to improve implementation efforts in community settings outside of the research environment (where efficient dissemination of information is key) have been less successful, in part because they focus too heavily on individual risk factors rather than community level factors that can lead to improved health outcomes (e.g., empowerment and advocacy strategies; Chinman et al., 2012). Not only is this approach less effective generally, it is particularly ineffective for Tribal communities due in part to centuries of systemic oppression and structural inequities that American Indian (AI) communities continue to experience. Understandably, AI communities are hesitant to adopt a majority culture approach to healthcare. Thus, more research is needed into tools that can be developed and utilized to better address these issues when implementing interventions among Tribal communities.

Community-Based Participatory Research (CBPR) and Dissemination and Implementation (D&I) Science in Tribal Communities

In line with a more strengths-based approach, recent research has emphasized the evaluation of the implementation process as an area of importance for Tribal-university research partnerships conducting community-engaged work (e.g., Crump et al., 2017; Jernigan et al., 2018; Meyers, Durlak, & Wandersman, 2012; Pearson, Smartlowit-Briggs, Belcourt, Bedard-Gilligan, & Kaysen, 2019; Rycroft-Malone et al., 2004; Stetler, Damschroder, Helfrich & Hagedorn, 2011; Sorensen & Kosten, 2011; Tabak, Khoong, Chambers & Brownson, 2012; Wallerstein et al., 2019). CBPR partnerships provide the foundation for research to honor the interconnectedness of Tribal communities, traditional Indigenous knowledge, and the complexity of interacting Tribal systems (LaVeaux & Christopher, 2009). Clearly, CBPR is an important framework to use when implementing interventions among Tribal communities and is complementary to D&I research. However, the science of D&I among AI communities is still an emerging research area (Jernigan, D'Amico, Duran & Buchwald, 2018; Jernigan, D'Amico, & Keawe'aimoku Kaholokula, 2018b; Rasmus, Whitesell, Mousseau & Allen, 2019).

In response to the pressing need for D&I efforts to address health outcomes, various frameworks have been utilized to enhance implementation success (e.g., Chinman et al., 2012; Rycroft-Malone et al., 2004; Stetler, Damschroder, Helfrich & Hagedorn 2011; Sorensen & Kosten, 2011; Tabak, Khoong, Chambers & Brownson, 2012) in both community and academic settings. The Interactive Systems Framework (ISF; Wandersman et al., 2008) is an evaluative, systems approach to assist in the translation of science into practice. It does so by building infrastructure and bolstering the multiple levels involved in service delivery via three interrelated systems. Each system is responsible for its own role within the implementation process: implementing and evaluating, training and technical

support, and a broader support network tasked with "distilling information" to enhance the disseminability of emerging scientific evidence. The ISF aligns well with CBPR and a community-engaged approach among Tribal communities, as it supports the complexity of Tribal research, allowing for the various and intersecting moving parts within the community (Belone et al., *in press*). Therefore, implementation frameworks, like the ISF, provide a rubric in which practitioner and program-level capacity can be evaluated throughout the implementation process.

Present Study

The present study describes the adaptation and implementation process of two academic-community partnerships with one rural reservation community in the Southwest to culturally adapt three evidence-based treatments for AUD and SUD (Venner et al., 2016; Venner et al., *under review*). The Tribal-university collaboration resulted in two culturally adapted interventions: 1) a combination of Motivational Interviewing and the Community Reinforcement Approach (MICRA), and the current, on-going project, 2) the Community Reinforcement and Family Training-American Indian (CRAFT-AI) study. Although previous research has demonstrated the effectiveness of SUD EBTs among Tribal communities (e.g., Komro et al., 2017), of the published randomized control trials of psychosocial interventions for SUD among adults (Foley et al., 2010; O'Malley et al., 2008; Villanueva, Tonigan & Miller, 2007; Woodall et al., 2007), none of the studies described the cultural adaptation or implementation process to inform future D&I research. In this paper we therefore identify a potential process template for other communities and researchers seeking to enhance their adaptation and implementation activities with Tribal partners by describing our implementation process for three SUD treatment interventions using an ISF lens.

Case Study 1 Methods

Early Partnership: Motivational Interviewing and Community Reinforcement Approach (MICRA) Project

Intervention.: Over ten years ago researchers from the university team partnered with a rural reservation community on a federally funded grant to culturally tailor two EBTs: Motivational Interviewing (MI; Miller & Rollnick, 2013) and the Community Reinforcement Approach (CRA; see Venner et al., 2016) and conduct a small pilot of MICRA to be followed with a larger RCT of MICRA versus treatment as usual (TAU). At the time, neither EBT had been culturally adapted or thoroughly tested among AI adults. However, there was evidence to suggest that MI, a client-centered counseling method that assists clients with resolving ambivalence and making positive changes in behavior, was an acceptable and effective intervention for ethnic minority individuals (Hettema, Steele, & Miller, 2005). Additionally, there was preliminary evidence to suggest that CRA might improve substance use outcomes in AI adults when cultural healing practices were incorporated (Miller, Meyers, & Hiller-Sturmhöfel, 1999).

Cultural adaptations.: Prior to the implementation of the intervention, university researchers and community partners conducted a one-day meeting with various community stakeholders. The university researchers presented the top EBTs and elicited preferences for

Tribal communities and MI and CRA rose to the top. The community partner was not interested in implementing an existing version of treatment that was not culturally adapted and believed that culturally adapting the treatment was essential to making the treatment more culturally congruent. The two interventions were combined to create the MICRA Project. As described previously (see Venner et al., 2016), cultural adaptations to the treatment included identifying clan and building kinship ties between the client and the counselor, including spirituality and the spiritual aspect of social interactions within each session, and utilizing counselors who were Tribal members, able to speak their Native language fluently, to deliver the treatment. CRA was delivered with inclusion of spirituality, extended family, and traditional activities as part of assessing happiness and conducting a functional analysis of drinking. Tribal members were hired as full-time counselors and a Research Assistant to coordinate the combined intervention in their community and this greatly contributed to the success of the project.

Case Study 1 Results

Reflections on D&I of the MICRA Project.—In the first phase of this grant, a pilot study was conducted (n=8) to assess treatment outcomes among those receiving the culturally adapted version of 16–20 MICRA sessions. Even with high rates of abstinence at baseline, the intervention demonstrated significant and positive outcomes for the culturally adapted treatment in reducing alcohol and substance use among Tribal members (alcohol, Hedge's g = 0.56; cannabis, g=0.60) (Venner et al., 2016). In addition, as evidence for enhancing engagement and implementation success, adapting the intervention to the local reservation community resulted in high rates of retention at the 8-month follow-up (94%). After the initial pilot, the second phase of this grant involved a full randomized controlled trial (*n*=79; Table 1). This consisted of AI adults receiving both MICRA and TAU. In the forthcoming outcome article, the authors reported that the adapted version of MICRA performed equally to the control condition, with both groups demonstrating increased abstinence rates compared to baseline. Future research is needed to test whether culturally tailored EBTs are equal to TAU in other Tribal communities.

Several aspects of the MICRA intervention implementation were unique and have applications for other communities. The ISF framework retrospectively applied to highlight the success of the project focuses on the prevention, feedback and synthesis of information with the partnering community and these are directly tied to the cultural adaption, implementation and the evaluation of the interventions within the prevention, feedback and translation systems (Table 2 adapted from Chinman et al., 2012). As previously described, MICRA was delivered by counselors who were fluent in their Native language and allowed for strengthening of kinship relationships between the client and the counselor. Although TAU was administered through the outpatient facility located on the reservation, MICRA services were provided at offices located at the Tribal office building nearby. This was thought to have increased participation, reduced contamination effects, and reduced potential stigma around receiving treatment services.

Additional facilitators of implementation were the study staff. The Research Coordinator that supervised the day-to-day operations of the study was a Tribal member fluent in the

Native language and well respected in the community, with many good working relationships with other organizations. On the opposite end, a barrier to implementation was fidelity monitoring. Recordings of the sessions were provided to and coded by the expert MI and CRA trainers to ensure the certification of the counselors initially and on-going coding of recordings and coaching calls continued. Unfortunately, the fidelity coding sheets were not submitted, and the recordings were erroneously deleted to ensure confidentiality precluding random fidelity coding of the tapes by another expert. Another MI expert rated the last 30 MI tapes and found average global ratings of MI to be above the threshold for proficiency but the reflections to ratio were below and the majority had MI in adherent statements. Relatively low fidelity is not uncommon in effectiveness trials (e.g., McCambridge et al., 2011). Despite this, monitoring fidelity of a treatment intervention at all within an AI treatment setting is novel and deserves noting.

In addition, the forms to track the exact procedures used in the TAU were not completed by the counselors and thus remain unknown. Unfortunately, this makes it impossible to identify common factors that may have led to similar treatment outcomes between MICRA and treatment-as-usual. Despite these identified barriers, the MICRA intervention was implemented successfully, was associated with improved treatment outcomes among participants and was well regarded within the community. Research on the use of the ISF has previously demonstrated the innovative specific capacity building that occurs, and this was also confirmed here (Chinman et al., 2012). For example, the counselors were unfamiliar and wary of randomization but appreciative of their improved understanding of such research concepts due to training along the way. Furthermore, after the success of MICRA, the university research team assisted the program and Tribal council with identifying an appropriate EBT chosen for cultural relevance and goodness of fit that was more family focused. Therefore, the MICRA project laid the foundation for the development of the subsequent and currently on-going research project described in detail below.

Case Study 2 Methods

Current Partnership: Community Reinforcement and Family Training-American Indians (CRAFT-AI) Project

Intervention.: Family members and romantic partners of individuals with SUD face significant negative consequences such as financial difficulties, legal, medical, and psychological problems and substance-related violence and psychological abuse (Calabria, Clifford, Shakeshaft, & Doran, 2012; Orfod, Krishnan, & Velleman, 2003). Despite the high risk of psychological and physical distress that family members of those with an SUD suffer, there are few interventions available to assist them in their own right (Copello, Velleman, & Templeton, 2005; Orford, Velleman, & Natera, 2013). Community reinforcement and family training (CRAFT) represents such an intervention (Dutcher et al., 2009; Manuel et al., 2012; Smith & Meyers, 2007).

The culturally adapted version of CRAFT for AI adults, CRAFT-AI, is the first funded SUD treatment study with an AI sample that emphasized the well-being and mental health functioning of the family member or concerned significant other (CSO) rather than the person with an SUD, the identified patient (IP). CRAFT-AI is potentially culturally

congruent and has a good theoretical fit with AI culture and values due to the importance placed on the well-being, cohesion, and the health of family and extended family (Calabria, Clifford, & Shakeshaft, 2012). After previous collaborations and conversations with the partnering community, we chose to compare the culturally adapted CRAFT (CRAFT-AI) with un-adapted Twelve Step Facilitation-Concerned Significant Other (TSF-CSO) based on the Al-Anon and Nar-Anon programs. The community determined that they would not approve an un-adapted version of CRAFT but accepted the unadapted TSF-CSO because an Al-Anon group already existed on the reservation

The CRAFT-AI and TSF-CSO interventions are both delivered in individual counseling for up to 12 sessions. CRAFT-AI aims to influence the IP to enter SUD treatment, and in this adapted version, traditional healing. CRAFT is an ideal treatment for AI people because of its culturally consistent focus on family interactions, use of positive reinforcement and communication styles, and the specified skills designed to enhance CSO functioning and increase IP treatment engagement. Typically, CRAFT counselors and CSOs complete a functional analysis of the IP's substance use that identifies the negative behavior, triggers for the behavior and both positive and negative consequences of use. In the TSF-CSO control condition, the counselor works with the CSO to focus on acceptance, surrender and active involvement in Al-Anon 12-step work.

Cultural adaptations.: The ADAPT-ITT (Assessment, Decision making, Adaptation, Production, Topical Experts, Integration, Training facilitators, Testing) methodology was identified to standardize the adaptation process (Wingood & DiClemente, 2008). ISF includes opportunities to provide feedback to the various stakeholders of the project (e.g., the prevention, synthesis systems). ADAPT-ITT fits nicely into this feedback mechanism because it offers clear steps for adapting an EBT and then piloting the adapted intervention with considerations for fidelity and diffusion within the organization.

The ADAPT-ITT model includes 8 steps. Step 1) assesses the target population and institutional capacity for implementing intervention; step 2) an evidence-based treatment (EBT) is selected for implementation and adaptation. The research team had previously successfully partnered with the Tribal community, so the first 2 steps had already been accomplished. The first step for the current study was to qualitatively evaluate the agency's ability to implement the intervention. In Step 2, an appropriate EBT was chosen for cultural relevance and goodness of fit. Therefore, this study began at Step 3: adapting CRAFT with behavioral health providers and community members who were potential CSOs. The academic-community partners began adapting CRAFT with behavioral health providers and community members who were potential CSOs. This step included two day-long patient and provider focus groups with didactics on the CRAFT modules conducted by the PI, research assistants, and developers of CRAFT followed by two day-long focus groups with the PI and research assistants.

Both the behavioral health providers and potential CSOs provided qualitative feedback as to cultural relevance and ways to adapt CRAFT procedures. A common adaptation suggested was to use the Tribal language when possible to help explain concepts. When the Tribal language is used, the person speaking is taken more seriously, and the respondent is more

respectful. Culturally appropriate reinforcers that were suggested included giving items to help individuals reconnect with traditions, such as providing traditional regalia. Whether traditional healing would be appropriate (and able to be confirmed) as a primary outcome comparable to the IP engaging in Western SUD treatment was controversial among providers and respondents, so more discussions may be needed.

Step 4 involved hosting four focus groups to identify themes and important areas for cultural adaptation. Interestingly, after the focus groups were completed, one of the counselors told the PI that the counselors realized they should culturally tailor their program-based interventions. Given they have cultural educators on staff, it seems they have compartmentalized SUD treatment from cultural education and healing. It may be difficult for counselors and community members to both learn about a new EBT and offer ways to culturally tailor that EBT. The next step for cultural adaptations will be individual interviews with the counselors to see if more ideas have arisen over time and to see if more ideas will be shared individually as opposed to in a group format. The CRAFT-AI manual is drafted and will be critiqued by CRAFT and tribal experts using both rating scales and qualitative questions to assess acceptability and confidence in the cultural adaptations once the pilot is complete.

Step 5 involved engaging topical experts (i.e., CRAFT experts and PI) to help with modifying the adapted manual, forms, and protocols while balancing fidelity to CRAFT with cultural adaptations. Step 6 integrated the expert and community adaptations. Step 7 included training counselors in the adapted CRAFT and certification during the pilot, which will culminate in Step 8, the RCT of the adapted CRAFT-AI and TSF-CSO.

Case Study 2 Results

Reflections on the D&I of CRAFT-AI.—As a hybrid adaptation, implementation, and effectiveness clinical trial (Carroll & Rounsaville, 2003), other Tribal communities planning to adapt and implement behavioral interventions to improve the health and well-being of families struggling with an SUD may assess specific facilitators and barriers to our adaptation and use of CRAFT-AI (Table 2, adapted from Chinman et al., 2012). CRAFT-AI may also be useful to Tribal communities who prefer culturally congruent, strength-based interventions. Spirituality has been identified in AI research as one area to be integrated into the measures and the process, thus reinforcing cultural resilience (Greenfield, et al., 2015). Additionally, moving forward, we will deliver a more nuanced CRAFT-AI that allows the counselor to calibrate the level of cultural adaption appropriate to the individual client. We will continue to query other ways to culturally adapt the modules through language, images, traditional stories that are appropriate to share, considerations of discrimination as potential stressors that may impact substance use, and community-oriented concepts and values (Hulen, et al., 2019). These adaptations include delivering the intervention in the Native language (which was successfully applied in the MICRA Project) or in the future may include using traditional communication, including cultural activities such as dancing, traditional roles and responsibilities in the community as part of the functional analysis, or identifying additional reinforcers that encourage cultural identity and revitalization.

There have been opportunities for reflection and strengthening implementation activities leading up to the adaptation and implementation of the pilot CRAFT-AI. The Tribal partnership has guided the researchers in obtaining Tribal approvals of the research, data-sharing agreements, and university IRBs, enhancing trust. Those involved in the research on the reservation are respected members of the community, also ensuring a community-engaged approach. Despite this, there also have been many implementation strategies to consider. In addition to weekly calls, the university team including the PI, post-doctoral fellow, and research assistants have traveled to the reservation at least monthly during the academic year and 2–4 times each month during the summer to increase staff morale, aid in research procedures, and increase recruitment.

Training counselors to reach fidelity in the CRAFT and TSF-CSO conditions was a lengthy process (taking over a year to complete), as was recruiting for, and completing the focus groups. Many staff members are not familiar with technology such as digital audio recording and encrypting counseling sessions and uploading them to a secure location for the expert trainers to code them and provide feedback. Staff members also are not accustomed to such close oversight of their services, so anxiety about being evaluated with specific feedback was also a concern to address. A contributing factor to the difficulty in achieving fidelity may also lie in the level of R34 funding for the CRAFT-AI study being significantly less than the R01 funding for the previous MICRA study. Thus, the counselors' time is divided between the research and usual clinical duties and the program is currently understaffed. Nonetheless, three counselors are working toward certification in the CRAFT-AI and TSF-CSO interventions, which will increase the sustainability of the intervention in the community and assist with obtaining additional future research and programmatic funding. We are closely tracking the completion of fidelity monitoring forms for CRAFT-AI and saving the encrypted audio recordings for future independent coding of at least 20% of sessions to examine fidelity. Success and strengths may lie in the capacity building of the counselors who are community members.

Additionally, turnover and recruitment have been problematic. A turnover in Tribal Council, two new acting directors in a row and a recent new director had to be oriented to this research project to help direct the counselors and research assistant. The hiring of a full-time research assistant on site was also delayed by Tribal finance and human resource procedures. After one year, there was additional turnover and a new RA was hired and is currently undergoing training. Recruitment for the pilot has provided opportunities for strategizing. Family members of individuals with an SUD have been hard to reach, especially recruiting through an outpatient treatment facility where stigma may be a concern for CSOs and staff were more likely to come into contact with individuals seeking treatment for themselves. As recruitment for the pilot is on-going, questions remain around additional capacity to roll-out the full RCT and feasibility to continue in a setting that primarily works with those in need of direct treatment services and not necessarily their family members. To address this, the intervention can now also be offered in other program locations, and more focus was placed on recruitment visibility throughout the community and building relationships with organizations that would have contact with families, such as Indian Health Service and social service programs.

Discussion

This research offers the first D&I process integrating ADAPT-ITT, ISF and CBPR in a Southwest, rural, reservation AI community. This is a case study of the partnership, adaptation, and process required to implement culturally tailored SUD behavioral EBTs (e.g., MICRA, CRAFT-AI) in a Tribal community. The work contributes to refining research strategies and methods among Tribal communities to address health disparities and improve treatment outcomes more effectively. Previous studies have highlighted the challenges and successes related to conducting D&I among heterogeneous populations (e.g., Black and Latinx communities) on a range of health outcomes including cancer screening (Rabin, Glasgow, Kerner, Klump, & Brownson, 2010; Tinkle, Kimball, Haozous, Shuster, & Meize-Grochowski, 2013), HIV/STIs (Collins & Sapiano, 2016), and tobacco control (Boyd et al., 1998; Marin & Pérez-Stable, 1995). Barriers and facilitators to implementation are consistent across communities, with unique opportunities among Tribal communities. There is a continued need to develop buy-in and enhance the intervention components to appeal to the ethnically diverse partners by utilizing appropriate research methods. Obstacles occur when researchers are not cognizant of factors that impact uptake (e.g., history of distrust, marginalization and thus conscious non-participation by potential participants). Other factors may include when the intervention setting is under-resourced with lack of necessary infrastructure and trained staff and geographical and neighborhood factors that may impede implementation (Yancey, Glenn, Ford & Bell-Lewis, 2017).

Therefore, this study adds to the literature on next steps in D&I research that calls for identifying the process, strategies and sequences to optimize this research and sought to address previous obstacles among diverse communities generally (Yancey, Glenn, Ford & Bell-Lewis, 2017) and AI/AN communities specifically (Rasmus, Whitesell, Mousseau, & Allen 2019). The ISF can be re-centered and integrated with a CBPR approach to improve D&I research with Tribal Nations because it accounts for the necessary uptake, cultural acceptance and sustainably of evidence-based interventions among these communities (Belone et al., *in press*). Through the application of ADAPT-ITT and ISF, we identified implementation barriers and facilitators, as well as the foundation for the future development of a process template to assist other Tribal and university researchers with successfully implementing alcohol and SUD projects to strengthen the science and the healthy functioning of families residing on reservations.

Conclusions and Future Directions

Importantly, the results of these randomized trials will have clinical and research implications for future D&I science, as appropriate D&I strategies of SUD treatments among AI families have yet to be fully explored. Due to the success of MICRA and CRAFT-AI projects, as examples, findings from those studies informed a new research project currently underway in which the university research team aims to culturally adapt medication for addiction treatment for opioid use disorder and implement this intervention in four programs across different AI/AN communities. In addition to cultural considerations, there remain concerns for rural participants around the potential stigmatization of participating in SUD treatments (Hirchak et al., 2019; Venner et al., 2016). Research should

therefore continue to address how perspectives around stigmatization impacts engagement and outcomes of AI treatment-seeking adults. Although there have been many successes between the research partnership of the reservation community and the academic institution over the last decade, opportunities for improvement remain in the adaptation and use of existing implementation strategies. Future AI/AN treatment research should therefore continue to utilize CBPR and adapt and develop D&I tools, such as ISF, that can be translated to AI/AN communities to improve D&I science and test SUD interventions to achieve health equity.

Acknowledgements:

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Table 1.

Demographic Characteristics of MICRA Participants (n=79)

	MICRA (n = 38)	TAU (n = 41)	p-value
Age[a]	32.16 (9.86)	33.61 (10.46)	.528
Gender[b]			
Male	66.0%	71.0%	.637
Education[a,b]	11.39 (0.95)	11.56 (0.84)	.410
Marital Status[b]			
Single	34.2%	48.7%	.540
Married	42.1%	34.1%	
Other	23.6%	17.0%	
Employment Pattern Over Last Three Years[c]			.466
Full-Time	18.0%	17.0%	
Part-Time	7.8%	21.9%	
Self-Employed	45.0%	41.4%	
Unemployed	8.0%	9.7%	
Tribal Enrollment[b]	100.0%	95.0%	.168

Note:

[a] t-test,

[b] total number of years,

[c] $\chi 2$

Table 2.

MICRA and CRAFT-AI reservation community and academic partners' completed activities in the ISF system

ISF Systems	Completed Activities	Facilitators	Barriers
Prevention delivery system	Identify community need, community meetings, meetings with organizations to address substance misuse in the community, plan, implement and evaluate intervention	MICRA/CRAFT-AI	
Provide feedback to support system	Focus groups to adapt intervention	CRAFT-AI	
	Quality improvement survey completed by counselors/participants at 6-week and 3-month	CRAFT-AI	
Prevention support system	Training and booster sessions for counselors to become certified in the intervention and maintain fidelity to adapted version of the intervention	MICRA/CRAFT-AI	
	Bi-monthly in-person meetings in the reservation community	CRAFT-AI	CRAFT-AI
	Provide on-going support to counselors	MICRA/CRAFT-AI	
Provides feedback to synthesis and translation system	Weekly TA from university staff on research activities	CRAFT-AI	CRAFT-AI
Prevention synthesis and translation system	Treatment manuals created with adaptations and tips for providers on implementation strategies	MICRA/CRAFT-AI	
	Monthly presentations to community with university partners	CRAFT-AI	
Provides feedback to support and delivery systems	Weekly conference calls with community intervention staff/academic partners	CRAFT-AI	CRAFT-AI
	Presentations to Tribal Council and the Governor on research and for publication/presentation approvals	MICRA/CRAFT-AI	