



Study Protocol and Statistical Analysis Plan

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Study Title: Motivational Interviewing and Culture for Urban Native American Youth
(MICUNAY)



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Abbreviations

AI/AN	American Indian/Alaska Native
CWG	Community Wellness Gatherings
AOD	Alcohol and other drug
MICUNAY	Motivational Interviewing and Culture for Urban Native American Youth
SPIWC	Sacred Path Indigenous Wellness Center
MI	motivational interviewing
RSE	Resistance self-efficacy
MEIM	Multigroup Ethnic Identity Measure
RCT	Randomized Controlled Trial
IRINAH	Intervention Research to Improve Native American Health
EBP	Evidence-based Practice

Study Protocol

Objectives

The goal of the study was to compare six-month outcomes for urban AI/AN teens who only received a culturally appropriate community event to those who received this community event plus three AOD workshops that integrated the evidence-based practice of motivational interviewing (MI) with traditional AI/AN practices.

Design

This study's primary purpose is prevention. It is a randomized, unmasked, 2-arm parallel intervention model. In Native American research, it is typical that both groups receive some degree of an intervention. In this study, participants either received a Community Wellness Gather (CWG) or a CWG plus MICUNAY. CWGs were culturally focused, and featured Native foods and entertainment (e.g., Native comedians, hoop dancing, lectures, storytellers, and talking circles).

Methods

From 2014 to 2017, we worked closely with our community partner, Sacred Path Indigenous Wellness Center (SPIWC), to recruit AI/AN adolescents from large cities in northern, central, and southern California. SPIWC is led by Dr. Carrie Johnson (Wahpeton Dakota) and is a non-profit organization that provides AOD and mental health services for AI/ANs, and consultation to help ensure that research and services are provided in a culturally appropriate manner. All procedures were approved by the institution's review board and by the communities with whom we collaborated on the project. We also had a community Elder Advisory Board and a Teen Advisory Board, and we collaborated with AI/AN community organizations in every city to determine how to best engage the community in our project and recruit AI/AN families and adolescents. For example, each recruitment flyer used images relevant to the particular community (e.g., in one community, we used a picture of a known landmark that community members recognized in a park where culturally-related events were often held), and we worked closely with leaders in each community to provide events tailored to the needs of that particular community (Jernigan, D'Amico, & Kaholokula, 2018). We held information meetings, attended Pow Wows and other community events, posted information on AI/AN email listservs and on Facebook, and hired AI/AN recruiters in each community to discuss the project with AI/AN families. Interested parents and adolescents could call our 1–800 project number or provide contact information to one of our recruiters at these events and be called by our staff. Eligibility criteria required that adolescents be 14–18 years old (inclusive), and either verbally self-identify as AI/AN or be identified as AI/AN by a parent or community member. Eligible adolescents were then scheduled to complete a baseline survey at a time and place that was convenient to them. They were paid \$25. At that time, teens were randomly assigned by block randomization to either Community Wellness Gathering (CWG) only or MICUNAY + CWG. Teens had a three-month period to complete all three MICUNAY workshops, which rotated weekly, and to complete one CWG, which occurred once per month. After completion of MICUNAY and/or the CWG, teens then completed a three and six month follow up interview, for which they were paid \$50 and \$75, respectively. We also reimbursed for transportation to the MICUNAY workshops, and adolescents were provided a \$5 gift card or free movie pass at each workshop.

Over the course of the project, 334 adolescents provided consent to contact. Forty-one of these youth were not eligible, 9 declined participation, and 69 were not able to be contacted within the field period. Thus, 215 adolescents screened in as eligible to be in the project (see Fig. 1). Of these adolescents, 30 did not

complete their baseline assessment within the field period or hand unreliable contact information. This yielded a final enrolled sample of 185 adolescents who completed a baseline survey.

Measures

Demographics—Initially, adolescents had to either verbally self-identify as AI/AN or be identified as AI/AN by a parent or community member to participate in the project (D’Amico et al., 2019). In a subsequent self-report survey using categories established by NIH, participants checked “all that apply” for the following categories: AI/AN, Hispanic or Latino/Latina, Asian or Asian American, Native Hawaiian or Pacific Islander, black or African American, white or Caucasian, and other. Adolescents reported their age, gender, and level of education for each parent or guardian.

AOD use—We assessed substance use with the well-established Monitoring the Future items (Miech, Johnston, O’Malley, Bachman, & Schulenberg, 2016). Adolescents reported past 3-month use for cigarettes, alcohol, and marijuana. For this study, we created a dichotomous indicator of whether adolescents reported any use of these substances. This is because AOD use rates are typically lower in younger adolescents, leading to highly skewed distributions in continuous variables (D’Amico et al., 2016).

Consequences of alcohol and marijuana use—Adolescents reported on the consequences they had experienced in past three months. Consequences are based on DSM- IV criteria with 7 items for alcohol (e.g., missed school or work) and 5 for marijuana (e.g., had difficulty concentrating) (D’Amico et al., 2016). Both scales have been used extensively with adolescents and were reliable with teens in this study ($\alpha = 0.77$ for marijuana and $\alpha = 0.94$ for alcohol). For this analysis we created dichotomous indicators of whether adolescents reported any consequences from alcohol or any consequences from marijuana.

Intentions to use AOD—Three separate items assessed whether adolescents believed they would drink any alcohol, use any marijuana, or smoke a cigarette in the next six months (1=“definitely yes” to 4=“definitely no”) (Ellickson, McCaffrey, Ghosh-Dastidar, & Longshore, 2003).

Resistance self-efficacy (RSE): (D’Amico et al., 2012) for alcohol was defined as the average of four items rated from “I would definitely use” to “I would definitely not use” based on different situations (e.g., if my best friend were using; you were bored at party; your friend gives you a drink). RSE ranged from 1 to 4; higher scores indicated greater RSE ($\alpha = 0.94$).

Peer influence—Three separate items assessed how often adolescents spend time around teens who drink, use marijuana, or smoke cigarettes (1 = “never” to 4 = “often”) (D’Amico, Miles, Stern, & Meredith, 2008).

Intentions to participate in traditional practices—Adolescents reported how likely they were to participate in >20 different traditional practices (e.g., going to Pow Wows, prayer, playing Native hand or stick games) in the next six months (1=“definitely yes” to 4=“definitely no”). Items were based upon extensive research conducted with AI/AN adolescents, parents, and community partners ($\alpha = 0.97$) (Kaufman et al., 2014).

Cultural pride and belonging—We assessed adolescents’ AI/AN cultural pride and sense of belonging with the Multigroup Ethnic Identity Measure (MEIM), which has twelve items ($\alpha = 0.94$). Respondents are asked the degree to which they agree with statements such as, “I have a clear sense of my ethnic background and what it means to me” on a scale from 1 = “strongly disagree” to 5 = “strongly agree” (Phinney & Ong, 2007; Ponterotto, Gretchen, Utsey, Stracuzzi, & Saya, 2003). Given that our prior focus group work (Brown et al., 2016) indicated that many adolescents were of mixed ethnicity, and our focus was on AI/AN identity, we modified these items to focus on AI/AN heritage (e.g., “I have clear sense of my AI/AN identity and what it means to me”).

Spirituality/happiness—Spirituality and happiness were measured using a subset of ten items from the 12-item Functional Assessment of Chronic Illness Therapy- Fatigue-Spiritual Questions instrument, or FACIT-SP 12 (Peterman, Fitchet, Brady, Hernandez, & Cella, 2002). Adolescents reported agreement with statements such as “I find comfort in my faith or spiritual beliefs” and “I feel a sense of harmony within myself.” Two items that referred specifically to chronic illness were removed from the scale as they were not relevant for this study. Response options, which ranged from 1=“not at all” to 5=“very much,” were averaged ($\alpha = 0.83$), with negative statements reversed such that higher scores indicated greater spirituality and happiness.

Statistical Analysis Plan (SAP)

Introduction

The goal of this study is to develop a community informed, culturally appropriate group intervention for Native American youth that integrates traditional healing approaches with motivational interviewing (MI). We will conduct a multilevel intervention and intervene at both the individual adolescent level with a group intervention and community level by utilizing Community Wellness Gatherings (CWG) that occur monthly in the community. We will compare three- and six-month outcomes for MICUNAY only adolescents and MICUNAY plus CWG adolescents.

This statistical analysis plan will provide more detailed descriptions of the endpoints in the study and the corresponding analyses.

Detailed study design

We worked closely with communities and our Elder Advisory Board over the first year of the project to design the two interventions and determine how to best implement the RCT in these urban communities. Intervening at the community level, we offered monthly CWGs for all adolescents at each study site, with a focus on traditional practices and living a healthy life, which included making healthy choices around AOD use. Half of the youth were also randomized to attend three 2-h group workshops that addressed traditional practices, including beading, prayer, and Native cooking. Upon completion of the six-month follow up, every adolescent in the CWG only group was offered an opportunity to participate in the three MICUNAY workshops.

Community wellness gatherings—Every youth that participated in the study was assigned to attend a CWG. These two-hour events were held monthly in each community, typically in the evening. Many communities often had these types of gatherings already scheduled. When this occurred, we would provide the food, and compensate the people who conducted the gathering (e.g., the Elder who conducted the beading workshop). When a gathering was not already scheduled, we worked with each community to have someone from the community conduct the CWG. Some examples of CWGs included beading workshops, hoop dancing, drumming and singing, and storytelling. Each CWG began with a prayer and discussion of the importance of making healthy choices. CWGs also focused on the importance of traditional practices and discussed ways that youth could connect with their culture.

MICUNAY—We developed MICUNAY (Motivational Interviewing and Culture for Urban Native American Youth) to address the gap in culturally-appropriate evidence-based interventions targeting AOD use among urban AI/AN teens (Dickerson et al., 2015). Our team was one of the first groups funded as part of the IRINAH initiative, and we are the only research group to date to conduct culturally centered prevention intervention work with

AI/AN adolescents in urban settings (Dickerson, Moore, et al., 2018). To help design MICUNAY, we conducted qualitative research with AI/AN adolescents, parents, providers, and Elders in two large urban cities in California (Dickerson et al., 2015). Findings highlighted that urban AI/AN adolescents struggle with cultural disconnection, mixed identity, and racial-ethnic discrimination. We also found that cultural identity and participation in traditional practices is protective for AI/AN youth (Brown et al., 2016; Brown et al., In press; Dickerson et al., 2015). In addition to utilizing traditional practices, our work (Dickerson et al., 2015; Dickerson, Moore, et al., 2018) and the work of others has emphasized the usefulness of MI with AI/ANs (Tomlin, Walker, Grover, Arquette, & Stewart, 2014; Venner et al., 2007). MI is one of the most

widely-used EBPs for AOD use in the U.S (SAMHSA National Registry of Evidence-based Programs and Practices (NREPP), 2014). Many studies have shown the acceptability (Feldstein Ewing, Wray, Mead, & Adams, 2012; Gilder et al., 2011; Venner et al., 2007) and efficacy of MI with non-white youth (D’Amico et al., 2018; Gil, Wagner, & Tubman, 2004; Gilder et al., 2011; Naar-King et al., 2010; Schmiede, Broaddus, Levin, & Bryan, 2009).

Half of the teens in the study were randomized to three 2-h MICUNAY workshops in addition to the CWG to test the added benefit of the workshops. One hour of the workshop focused on AOD use and making healthy choices using MI, and 1 h focused on a traditional Native American practice. MICUNAY workshop content was developed with extensive input from the community (Dickerson et al., 2015), and the AOD information was taken, in part, from previous MI intervention development and evaluation work with adolescents (D’Amico et al., 2015; D’Amico, Hunter, Miles, Ewing, & Osilla, 2013; D’Amico et al., 2018). One of the unique elements of the MICUNAY workshops was to ensure that the MI component and traditional practice component connected to ensure cohesiveness, deliverability and cultural relevance (Dickerson et al., 2015). For each traditional component, we provided guidelines for the facilitators on the overarching topic, but encouraged them to discuss the traditional practice in a way that fit best for their community. Based on our focus groups (Brown et al., 2016), and given that these urban AI/AN adolescents came from over 60 tribes (Brown et al., In press), the focus of the cultural component of the workshop was on “pan-Indian” identity (being AI/AN in general) while empowering youth to learn about their own tribal-specific roots (Dickerson et al., 2015). Workshops were tailored to each participant’s experience and cultural background so that all felt welcome (Jernigan, D’Amico, Duran, & Buchwald, 2018).

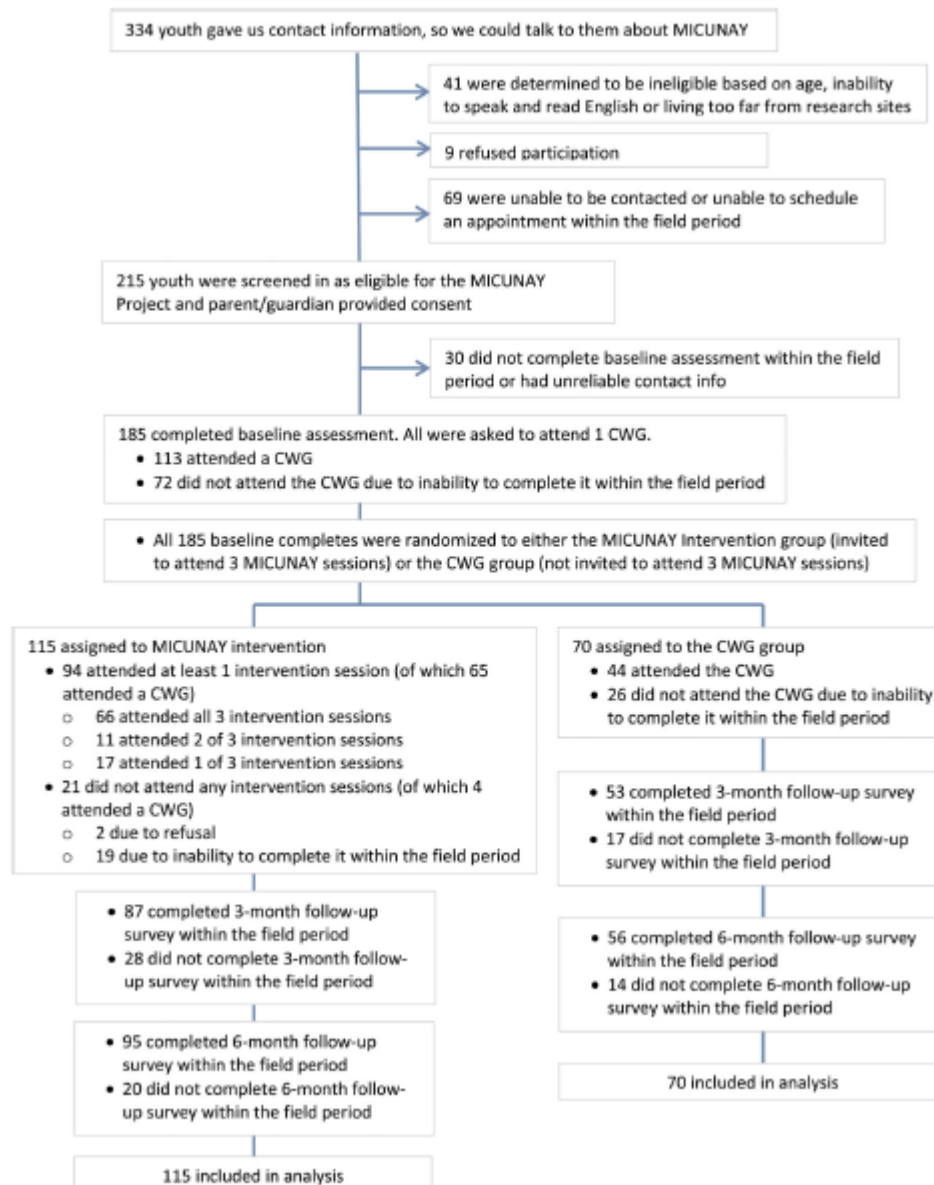
The cultural component of every session began with a discussion of the Medicine Wheel. As there are many versions of the Medicine Wheel, facilitators were encouraged to discuss the Medicine Wheel in ways that were most locally appropriate. Each workshop addressed a different aspect of the Medicine Wheel (Fig. 2). Every workshop was interactive and delivered using MI strategies, such as open-ended questions and reflections throughout both the cultural and MI portions of the session. Session 1 addressed “Making Healthy Choices for My Brain,” and started with a beading workshop for 1 h, after which youth could continue beading during the discussion of how AOD use can affect the brain. This interactive discussion encouraged teens to think about how AOD use may affect their brain and behavior, how and whether the brain recovers from AOD use, and how thinking about this information could affect their own personal use of substances. Session 2 addressed “Making Healthy Choices for my Body” which focused first on discussing the pros and cons of AOD use, how AOD use can affect one’s life, and alternative life paths to AOD use. The facilitator also used willingness and confidence rulers to discuss with teens where they were at in terms of potentially changing their AOD use, and how confident they were in making a change if they were ready. The second part of Session 2 addressed healthy food choices, focusing on Native American foods and traditions.

Facilitators were instructed to discuss topics that were locally appropriate and interesting to youth. Some example topics were discussions of hunting and fishing, watching portions of the documentary, Good Meat, origins of the bow and arrow, and utilizing local tools and ingredients to make recipes, such as Three Sister Stew (https://en.wikibooks.org/wiki/Cookbook:Three_Sisters_Stew). Teens then had an opportunity to taste different foods, such as buffalo stew, grilled salmon, acorn squash, and Three Sister Stew. Session 3 addressed “Making Healthy Choices for My Spirit,” which first focused on different risky situations that may occur because of AOD use, as well as ways to make healthy life choices to avoid these risks. Teens were encouraged to discuss the pros and cons of substance use with two specific examples: impaired driving and having sex without a condom. Discussion revolved around how to make a healthy choice in these situations by planning ahead. Based on the strategies discussed, the facilitator then used the willingness and confidence rulers to help teens evaluate whether they felt that they could use these strategies to make a

change if they were ready.

The second part of Session 3 addressed spiritual life and ways of praying. Facilitators could use a YouTube video called, “Picking sage and great advice from an Elder” to generate discussion or discuss local traditions for praying.

Figure 1. Flowchart of screening and inclusion process



Primary analysis

We first tested whether teens in the MICUNAY + CWG and CWG only groups differed at baseline with Fisher's exact tests for categorical characteristics and t-tests for continuous characteristics. We used intention-to-treat analyses to assess all intervention effects. Intervention efficacy was estimated with a series

of longitudinal linear and logistic regression models. The models included an indicator for being randomized to the intervention group and the following covariates: baseline value of the outcome and demographics (age, gender, and race/ethnicity [self-identification as Hispanic, multi-racial, or other vs. AI/AN]). Because follow-up surveys were administered over a somewhat wide timespan from the intended 3-month and 6-month time points (the interquartile range was 80–158 days for administration of the 3-month survey and 170–243 days for the 6-month survey), models additionally adjust for the number of days between the end of the treatment period and the follow-up survey date, as well as which follow-up survey the response is from. Because each adolescent contributed two records (3- and 6-month follow up) to this analysis, standard errors were adjusted for clustering on individuals with SAS Proc SURVEYREG and SURVEYLOGISTIC. Among the intervention group only, a similar set of regressions was fit to estimate the effect of each intervention session.

Missing data

All analyses of responses to follow-up surveys were based on imputed data. SAS Proc MI was used to generate 40 imputed datasets for all variables used in the analysis at all time points, including for completely missing follow-up surveys. Imputed values were truncated to their original minima and maxima. SAS Proc MIANALYZE was used post-analysis to compile results across the 40 imputed datasets.

Descriptive statistics

Means at follow-up were calculated as the mean of the means from each of the 40 imputed data sets. Standard deviations were calculated using standard rules for multiple imputation (Rubin, 2004), which estimates the overall variance as the average within-imputation variance plus the product of the between-imputation variance and $1 + (1/m)$ where m = the number of imputations (40).

Loss to follow-up

Although we imputed data for those lost to follow-up, we also assessed the degree to which those lost to follow-up were different from those for whom we had complete data. Differential loss to follow-up was assessed by comparing adolescents who responded to either the 3- or 6-month follow-up survey to adolescents who did not respond to either survey on a variety of baseline characteristics. Statistical significance was assessed with t-tests for continuous characteristics or Fisher's exact tests for binary characteristics. t-Tests and Fisher's exact tests were similarly used to compare means and percentages reported for the control (CWG only) group versus the intervention (MICUNAY + CWG) group at baseline.

Baseline differences and attrition

There were 115 adolescents in the MICUNAY + CWG group and 70 adolescents in the CWG-only group. As noted, to be part of the project, all teens had to either verbally self-identify as AI/AN or be identified as AI/AN by a parent or community member. Adolescents also self-reported race/ethnicity on baseline surveys, marking “all that apply.” Based on this self-report, 81% of the overall sample identified as AI/AN (35 youth did not mark AI/AN on the survey), 45% as Hispanic/Latino, and 17% White/Caucasian. Female participants made up 51% of the sample; 14- and 15-year-olds comprised 49% of the sample. In the 3 months prior to baseline, 15% of participants reported tobacco use, 23% reported drinking alcohol, 28% used marijuana, and 13% had 5 or more drinks in a row. Sixteen percent of the sample reported experiencing consequences from drinking alcohol in the past 3 months, and 15% reported experiencing consequences from marijuana use.

The only statistically significant difference between the two intervention groups at baseline was in terms of gender, where females made up 69% of the CWG only group and 41% of the MICUNAY + CWG group ($p < 0.001$). The MICUNAY + CWG group reported marginally more alcohol resistance self-efficacy (average score of 3.43) than the CWG group (average 3.18, $p = 0.06$), and also had a marginally higher score for the

spirituality and happiness scale (3.71 vs. 3.51, $p = 0.08$).

Among the 185 adolescents who were included in the study, we were able to reach 76% for follow-up surveys at 3 months, and 82% at 6 months. Adolescents who completed at least one of the two follow-up surveys (89% of the 185) differed from those who did not on several baseline characteristics. On demographics, they were more likely to be female (54% vs. 29%, $p = 0.04$), younger ($p = 0.01$), and have mothers who were more likely to have a high school degree (84% vs. 40%, $p < 0.001$). For substance use outcomes, those who completed follow up were less likely to report tobacco use (12% vs. 43%, $p = 0.001$) or heavy drinking (11% vs. 29%, $p = 0.04$) at baseline. Those who completed a follow-up survey also had lower intentions to smoke marijuana (scale mean 1.67 vs. 2.29, $p = 0.01$), were with other teens smoking cigarettes less often (1.53 vs 2.14, $p = 0.05$), and scored lower on the spirituality/happiness scale (3.58 vs. 4.08, $p = 0.004$) at baseline. There was not a significant difference in follow-up rates between the intervention groups at 3 months (75.7% for MICUNAY +CWG vs. 75.7% for CWG only, $p = 1.00$ per Fisher's exact test) or 6 months (82.6% MICUNAY +CWG vs. 80.0% CWG only, $p = 0.70$).

Outcomes

For outcomes, we found that the estimated added benefit of MICUNAY + CWG compared to CWG-only was small on the 16 outcomes we measured, with most effect sizes estimated to be <0.1 in magnitude, and confidence intervals including both positive and negative values. The largest estimated effect size was -0.18 for consequences from using marijuana in the past 3 months, corresponding to an odds ratio of 0.72; however, the 95% confidence interval includes strong odds ratios in both directions (0.35–1.48, $p = 0.37$).

Rates of use for the overall sample remained fairly stable over time, with 23% of the sample reporting alcohol use in the past 3 months at baseline, and 30% of the sample reporting use at 6 months. Similarly, for marijuana, 28% of the sample reported use in the past three months at baseline, and 29% reported use in the past three months at the six month follow up. Intentions to drink and use marijuana were also stable for the overall sample over the course of the study, as was the time that teens spent with peers who used alcohol, tobacco, and marijuana. Of note, tobacco use for the overall sample appeared to increase over time, as did the number of teens reporting consequences from drinking or marijuana. Among those who were randomized to the MICUNAY + CWG group, 21 (18%) attended no workshops, 17 (15%) attended one workshop, 11 (10%) attended two workshops, and 66 (57%) attended all three MICUNAY workshops. The effect of each additional session of MICUNAY attended in this group was small, with an estimated effect size of about 0.15 or less in magnitude for each outcome. Three outcomes had moderately sized associations and marginal p - values: intentions to drink alcohol, alcohol resistance self- efficacy, and intentions to participate in cultural activities. For example, for each MICUNAY session attended, the average alcohol resistance self-efficacy response was estimated to be 0.19 higher, with an effect size of 0.17 and a p -value of 0.04. However, the confidence interval for this effect is large, and after adjusting for performing tests on all 16 outcomes, the Bonferroni-adjusted p -value was 0.64. Although the Bonferroni adjustment is likely conservative, we conclude that there is not strong evidence in favor of a treatment effect for MICUNAY + CWG on these outcomes.

Primary outcomes

- a) Alcohol Use -- this is a Standard Question Used in Monitoring the Future. [Time Frame: change from baseline to 6 months]
- b) Marijuana Use--this is a Standard Question Used in Monitoring the Future. [Time Frame: change from baseline to 6 months]

Secondary outcomes

- a) Consequences of Alcohol Use - [Time Frame: change from baseline to 6 months]
- b) Consequences of Marijuana Use - [Time Frame: change from baseline to 6 months]
- c) Intentions to Use - Alcohol [Time Frame: change from baseline to 6 months]
- d) Intentions to Use - Cigarettes [Time Frame: change from baseline to 6 months]
- e) Intentions to Use - Marijuana [Time Frame: change from baseline to 6 months]
- f) Alcohol Resistance Self-efficacy [Time Frame: change from baseline to 6 months]
- g) Peer Influence - Alcohol [Time Frame: change from baseline to 6 months]
- h) Peer Influence - Marijuana [Time Frame: change from baseline to 6 months]
- i) Peer Influence - Cigarettes [Time Frame: change from baseline to 6 months]
- j) Intentions to Participate in Traditional Practices [Time Frame: change from baseline to 6 months]
- k) Cultural Identification [Time Frame: change from baseline to 6 months]
- l) Spirituality/Happiness [Time Frame: change from baseline to 6 months]

Risk factors

Unique risk factors may predispose urban AI/ANs to initiate AOD use during adolescence. For example, experiences of acculturative stress directly and indirectly associated with historical trauma experienced by AI/ANs throughout U.S. history have been shown to result in poor mental health outcomes. Among urban AI/AN youth, acculturative stress may also play a role in AOD use as identity issues among urban AI/AN adolescents have been postulated to contribute to lower self-worth, which is associated with the genesis and maintenance of AOD problems. In addition, a variety of psychosocial and environmental risk factors, such as witnessing domestic violence, physical/sexual/emotional abuse, issues associated with stigma, and family histories of mental health and substance abuse may increase AOD use among urban AI/AN youth. Thus, these stressors may increase the potential for AOD use due to issues associated with cultural identity, decreased spiritual base, and lack of community cohesion. Providing an AOD program that incorporates traditional healing activities, promotes community involvement, and encourages healthy notions of AI/AN identity may increase wellbeing and other healthy behaviors by addressing sources of stress linked to cultural identity, stigma, and community connections. However, few evidenced-based programs have been successfully developed and implemented among urban AI/AN youth that integrate such important cultural elements.

Surveys and scales

All youth will complete surveys at baseline, 3- and 6-months that will focus on behaviors of AI/AN

participants as they relate to AOD use.

Scale names

For the secondary measures, “Intentions to Participate in Traditional Practices” and “Cultural Identification,” we used the Multigroup Ethnic Identity Measure (MEIM), which has twelve items ($\alpha = 0.94$). Respondents are asked the degree to which they agree with statements such as, “I have a clear sense of my ethnic background and what it means to me” on a scale from 1 = “strongly disagree” to 5 = “strongly agree”. Given that our prior focus group work indicated that many adolescents were of mixed ethnicity, and our focus was on AI/AN identity, we modified these items to focus on AI/AN heritage (e.g., “I have clear sense of my AI/AN identity and what it means to me”).

For the secondary measure, “Spirituality/Happiness,” we used a subset of ten items from the 12-item Functional Assessment of Chronic Illness Therapy-Fatigue-Spiritual Questions instrument, or FACIT-SP 12. Adolescents reported agreement with statements such as “I find comfort in my faith or spiritual beliefs” and “I feel a sense of harmony within myself.” Two items that referred specifically to chronic illness were removed from the scale as they were not relevant for this study. Response options, which ranged from 1=“not at all” to 5=“very much,” were averaged ($\alpha = 0.83$), with negative statements reversed such that higher scores indicated greater spirituality and happiness.

Safety outcomes

Adverse event reporting policy

The current study involves Elders, providers, parents, and AI/AN youth aged 14-18 as participants. It is unlikely that focus group participation, completing questionnaires or participation in CWG or MICUNAY will cause participants to experience an —adverse event!; however, trained staff will be conducting the focus groups, surveys, and MICUNAY, and overseeing the CWGs to ensure that participants are stable enough to participate in this study and to address any potential crises. Co-Investigators Dickerson and Brown will be present at every focus group to lead these groups and oversee the process. We will also have at least one of our staff attend each CWG to ensure that things run smoothly and to handle any issues should they arise. All MICUNAY facilitators on the project will have received extensive training on the community, MI, the MICUNAY protocol, and how to handle adverse events, should they arise. In addition, D’Amico and Dickerson will conduct weekly supervision throughout the duration of MICUNAY implementation to address any issues. Furthermore, all digital recordings will be reviewed and coded each week by research assistants for adherence to MI and fidelity so recordings that are high in non-adherence to MI or are low in fidelity to the protocol will be flagged immediately and brought to the attention of D’Amico and Dickerson. Finally, D’Amico and Dickerson will be available during the intervention implementation times so that if a crisis arises, the facilitator can call them immediately. As clinicians, D’Amico and Dickerson have extensive experience conducting and supervising interventions. Should any adverse events occur during the study, we will use standard IRB and NIH procedures for reporting these events.

No adverse events occurred during the course of the clinical trial.