Behavioral Health Services for American Indians and Alaska Natives

For Behavioral Health Service Providers, Administrators, and Supervisors

TREATMENT IMPROVEMENT PROTOCOL

TIP 61

SAMHSA
Substance Abuse and Mental Health Services Administration

Please share your thoughts about this publication by completing a brief online survey at: https://www.surveymonkey.com/r/KAPPFS

The survey takes about 7 minutes to complete and is anonymous. Your feedback will help SAMHSA develop future products.

TIP 61

BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES

Executive Summary

For Behavioral Health Service Providers, Program Administrators, Clinical Supervisors, and Researchers

The Executive Summary of this **Treatment Improvement Protocol** summarizes substance use and mental illness among American Indians and Alaska Natives and discusses the importance of delivering culturally responsive, evidence-based services to address these behavioral health challenges.

TIP Navigation

Executive Summary
For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives
For behavioral health service providers

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives
For behavioral health service providers, program administrators, and clinical supervisors

Appendix and Index

Part 3: Literature Review
For behavioral health service providers, program administrators, clinical supervisors, and researchers

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

EXECUTIVE SUMMARY

Foreword iii
Introduction v
Overall Key Messages. vi
Content Overview viii
Terminology x
TIP Development Participants xiii
Publication Information. xvi

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission by providing science-based best-practice guidance to the behavioral health field. TIPs reflect careful consideration of all relevant clinical and health service research, demonstrated experience, and implementation requirements. Select nonfederal clinical researchers, service providers, program administrators, and client advocates comprising each TIP's consensus panel discuss these factors, offering input on the TIP's specific topic in their areas of expertise to reach consensus on best practices. Field reviewers then assess draft content.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
SAMHSA

This page intentionally left blank.

Executive Summary

This Treatment Improvement Protocol (TIP) serves as a primer for working with individuals who identify with American Indian and Alaska Native cultures. It aims to help behavioral health service providers improve their cultural competence and provide culturally responsive, engaging, holistic, trauma-informed services to American Indian and Alaska Native clients. The TIP presents culturally adapted approaches for the prevention and treatment of addiction and mental illness, as well as counselor competencies for providing behavioral health services to American Indians and Alaska Natives.

Introduction

American Indians and Alaska Natives have consistently experienced disparities in access to healthcare services, funding, and resources; quality and quantity of services; treatment outcomes; and health education and prevention services. Availability, accessibility, and acceptability of behavioral health services are major barriers to recovery for American Indians and Alaska Natives. Common factors that influence engagement and participation in services include availability of transportation and child care, treatment infrastructure, level of social support, perceived provider effectiveness, cultural responsiveness of services, treatment settings, geographic locations, and tribal affiliations.

In response to existing behavioral health disparities, this TIP illustrates strategies for facilitating American Indian and Alaska Native individuals' access to and engagement in behavioral health services. It outlines promising practices for providers to apply in working with American Indians and Alaska Natives, and it includes tools and strategies that will help program administrators facilitate implementation of these practices.

Through this TIP, behavioral health workers will learn to identify how and to what extent a client's cultural background affects his or her behavioral health needs and concerns. It offers practical ideas and methods for addressing the realities of service delivery to American Indian and Alaska Native clients and communities, and it provides programmatic guidance for working with their communities to implement culturally responsive services. Throughout, the TIP emphasizes the importance of inclusivity, collaboration, and incorporation of traditional and alternative approaches to treatment and recovery support when working with American Indian and Alaska Native clients.

This TIP was developed through a consensus-based process that reflected intensive collaboration with American Indian and Alaska Native professionals. These professionals, who represented diverse tribes and native cultures, carefully considered all relevant clinical and research findings, traditional and culturally adapted best practices, and implementation strategies. American Indian and Alaska Native contributors shared their behavioral health-related experiences and stories throughout the process, thereby greatly enriching this important resource.

Audience

This TIP can serve as a resource to both native and non-native behavioral health professionals who wish to provide culturally appropriate and responsive services. This TIP is for:

- Addiction treatment/prevention professionals.
- Mental health service providers.
- Peer support specialists.
- Behavioral health program managers and administrators.
- Clinical supervisors.

- Traditional healers.
- Tribal leaders of governance.
- Other behavioral health professionals (e.g., social workers, psychologists).
- Researchers and policymakers.

Objectives

Addiction and mental health professionals will improve their understanding of:

- American Indian and Alaska Native demographics, history, and behavioral health.
- The importance of cultural awareness, cultural identity, and culture-specific knowledge when working with clients from diverse American Indian and Alaska Native communities.
- The role of native culture in health beliefs, help-seeking behavior, and healing practices.
- Prevention and treatment interventions based on culturally adapted, evidence-based best practices.
- Methods for achieving program-level cultural responsiveness, such as incorporating American Indian and Alaska Native beliefs and heritage in program design, environment, and staff development.

Overall Key Messages

Importance of historical trauma. Providers should learn about, acknowledge, and address the effects of historical trauma when working with American Indian and Alaska Native clients. Most American Indians and Alaska Natives believe that historical trauma, including the loss of culture, lies at the heart of substance use and mental illness within their communities.

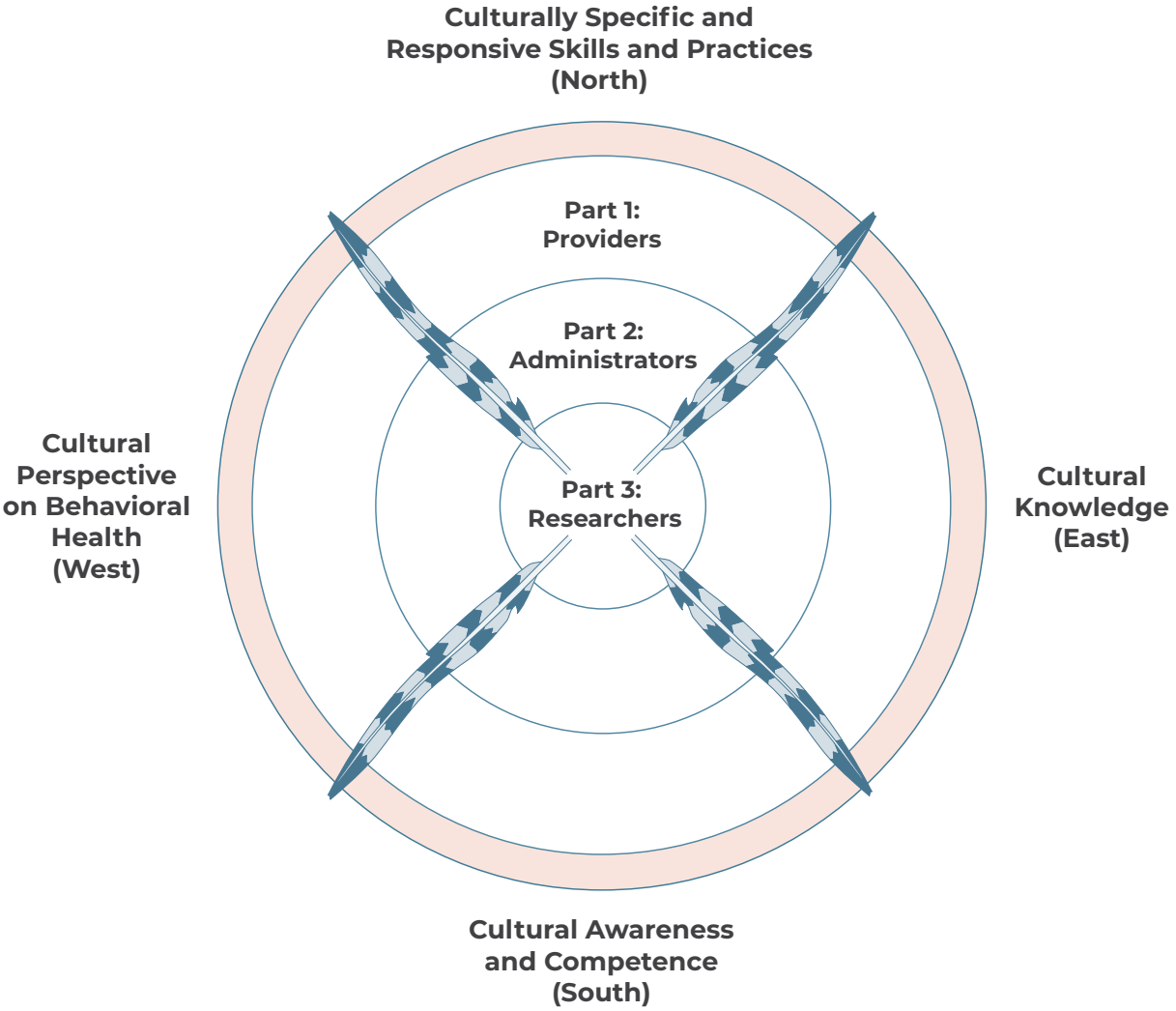
Acceptance of a holistic view of behavioral health. Among many American Indian and Alaska Native cultures, substance use and mental illness are not defined as diseases, diagnoses, or moral maladies, nor are they viewed as physical or character flaws. Instead, they are seen as symptoms of imbalance in the individual's relationship with the world. Thus, healing and treatment approaches must be inclusive of all aspects of life—spiritual, emotional, physical, social, behavioral, and cognitive.

Role of culture and cultural identity. Providers need to understand how clients perceive their own cultural identity and how they view the role of traditional practices in treatment. Not all American Indian and Alaska Native clients recognize the importance of culture or perceive a need for traditional practices in their recovery. Nonetheless, providers and administrators must be ready to address their clients' cultural identity and related needs. Helping clients maintain ties to their native cultures can help prevent and treat substance use and mental disorders. Through reconnection to American Indian and Alaska Native communities and traditional healing practices, an individual may reclaim the strengths inherent in traditional teachings, practices, and beliefs and begin to walk in balance and harmony.

Recognition of sovereignty. Tribal governments are sovereign nations. Each nation adopts its own tribal codes and has a unique history with the U.S. federal government. Providers in native and non-native programs need to understand the role of tribal sovereignty and governance systems in treatment referrals, planning, cooperative agreements, and program development.

Significance of community. American Indian and Alaska Native clients and their communities must be given opportunities to offer input on the types of services they need and how they receive them. Such input helps match services to clients, increase community use of services, and use agency and tribal financial resources efficiently. Providers must involve themselves in native community events and encourage native community involvement in treatment services.

Value of cultural awareness. If providers are aware of their own cultural backgrounds, they will be more likely to acknowledge and explore how culture affects their interactions, particularly their relationships with clients of all backgrounds. Without cultural awareness, providers may discount the influence of their own cultural contexts—including beliefs, values, and attitudes—on their initial and diagnostic impressions of clients and selection of healing interventions.



Commitment to culturally responsive services. Organizations have an obligation to deliver high-quality, culturally responsive care across the behavioral health service continuum at all levels—individual, programmatic, and organizational. Not all American Indian or Alaska Native clients identify or want to connect with their cultures, but culturally responsive services offer those who do a chance to explore the impact of culture, history (including historical trauma), acculturation, discrimination, and bias on their behavioral health.

Significance of the environment. An environment that reflects American Indian and Alaska Native culture is more engaging for, and shows respect to, clients who identify with this culture. Programs can create a more culturally responsive ethos through adapted business practices, such as using native community vendors, hiring a workforce that reflects local diversity, and offering professional development activities (e.g., supervision, training) that highlight culturally specific American Indian and Alaska Native client and community needs.

Respect for many paths. There is no one right way. Providing direction on how something should be done is not a comfortable or customary practice for American Indians and Alaska Natives. For them, healing is often intuitive; it is interconnected with others and comes from within, from ancestry, from stories, and from the environment. There are many paths to healing.

Content Overview

Through this TIP, providers can explore how they interact with American Indian and Alaska Native clients and how they can incorporate culturally responsive ways of healing into their work. First, the TIP explores the basic elements of American Indian and Alaska Native cultures. Second, it emphasizes the importance of becoming aware of and identifying cultural differences between providers and clients. Third, it highlights native cultural beliefs about illness, help seeking, and health. Fourth, it offers culturally adapted, practice-based approaches and activities informed by science and the restorative power of native traditions, healers, and recovery groups.

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives

Part 1 is for behavioral health service providers who work with American Indian and Alaska Native clients and communities to support their mental health and drug and alcohol recovery.

Part 1 consists of two chapters. Part 1, Chapter 1, explains the background and context for Chapter 2, so it is strongly recommended that readers examine it first. Part 1, Chapter 1, includes:

- A summary of American Indian and Alaska Native history, historical trauma, and critical cultural perspectives on such key topics as health beliefs and help-seeking behaviors.
- An overview of American Indian and Alaska Native demographics, social challenges, and behavioral health issues.
- Strategies to expand providers' cultural awareness/competence and culture-specific knowledge.
- Specific treatment interventions, including traditional American Indian and Alaska Native interventions and cultural adaptations of standard treatment/prevention strategies.

Part 1, Chapter 2, content provides:

- Several case histories in the form of story-based vignettes that demonstrate specific knowledge and clinical skills necessary for providing effective counseling to American Indians and Alaska Natives across behavioral health settings.
- For each vignette, an outline of the client's presenting concerns and treatment needs, provider–client dialog, and master provider notes.
- Practical suggestions and guidance for key stages in the provider–client relationship.

In Part 1, readers will learn that:

- Not all native cultures are the same. Similarities across native nations exist, but not all American Indian and Alaska Native people have the same beliefs or traditions.
- The use of diagnostic terminology in clinical work with American Indian and Alaska Native clients can be problematic, because the process of "naming" can have significant spiritual meaning and may influence individual and community beliefs about outcome.
- For hundreds of years and into the present, American Indians and Alaska Natives have endured traumatic events resulting from colonization. They and their communities continue to experience repercussions (i.e., historical trauma) from these events.
- American Indian and Alaska Native clients experience grief for unique reasons, such as loss of their communities, freedom, land, life, self-determination, traditional cultural and religious practices, and native languages, as well as the removal of American Indian and Alaska Native children from their families.
- Among American Indians and Alaska Natives, historical loss is associated with greater risk for substance abuse and depressive symptoms.
- Genes that increase risk of substance misuse and related factors (e.g., tolerance, craving) are no more common in American Indians and Alaska Natives than in White Americans.
- Alcohol is the most misused substance among American Indians and Alaska Natives, as well as among the general population. Many American Indians and Alaska Natives do not drink at all, but binge drinking and alcohol use disorder occur among native populations at relatively high rates.
- American Indians and Alaska Natives start drinking and using other substances at a younger age than do members of other major racial or ethnic groups. Early use of substances has been linked with greater risk for developing substance use disorders.

- Health is viewed holistically. American Indian and Alaska Native cultures rarely make a distinction among physical, mental, emotional, and spiritual health. One aspect of health is believed to affect the others.
- Illness affects an American Indian or Alaska Native individual's community as well as the individual. A health problem that affects one person will have effects on a family, community, tribe, and other individuals as well. This also means that healing the community can positively affect individual health.
- American Indian and Alaska Native clients' ideas about behavioral health interventions will likely reflect traditional healing, mainstream treatment services, and mutual-help groups.
- American Indians and Alaska Natives use behavioral health services at a rate second only to White Americans; they may be even more likely to use addiction treatment services.

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives

Part 2 is an implementation guide directed specifically to administrators, program managers, and clinical and other supervisors. This part can also help providers who are interested in program development. Both chapters address programmatic features that can help foster culturally responsive treatment practices for American Indian and Alaska Native clients. Specific topic areas include workforce development, culturally specific considerations in program and professional development, and culturally responsive program policies and procedures.

Part 2 consists of two chapters. Part 2, Chapter 1, content includes:

- Approaches to fostering a culturally responsive organization and workforce, as well as programmatic policies and procedures that benefit American Indian and Alaska Native populations.
- Overviews of administrative challenges and paths toward solutions.
- Methods for staff training, along with supporting content on American Indian and Alaska Native history and culture.
- Suggestions for supporting cross-cultural supervisor–supervisee relationships.
- Criteria for evidence-based tribal behavioral health practices.
- Provider competencies in attitudes, beliefs, knowledge, and skills related to working with American Indians and Alaska Natives.

Part 2, Chapter 2, content includes organizational tools to help administrators and program managers better serve American Indian and Alaska Native clients. The chapter offers tools for:

- Developing a culturally competent and responsive workforce.
- Developing culturally adapted and evidence-based practices.
- Integrating care to include traditional practices in behavioral health services.
- Creating sustainability.

In Part 2, readers will learn that:

- Facing serious health disparities has led to poorer behavioral health outcomes among American Indians and Alaska Natives compared with the general population.
- Working with American Indian and Alaska Native populations can pose challenges to implementing effective programs in remote communities where clients have difficulty accessing services because of a lack of service awareness, transportation, phone or Internet services, child care, or insurance or healthcare financing.
- Engaging and establishing a positive relationship with local native leaders and communities can help alleviate initial feelings of mistrust among American Indian and Alaska Native clients and can strengthen your program's effectiveness.
- Requesting programmatic input from tribal partners can help administrators identify potential obstacles early and develop culturally appropriate ways to overcome challenges.
- Engaging with American Indian and Alaska Native communities as partners helps programs identify and make use of tribal resources and strengths, such as family ties, large community networks, physical resources, intergenerational knowledge and wisdom, and community resilience.

- Incorporating cultural adaptations into effective evidence-based practices is essential to avoid the perception among American Indians and Alaska Natives that these practices are mainstream, thus ignoring or failing to honor native practices, knowledge, and culture.
- Training efforts should be specific to the tribe(s) a program serves and should function within the constraints of the geographic region in which the program operates.
- Fostering culturally informed professional development creates ripple effects. Staff members see such education as beneficial; training improves organizational functioning; clients have better treatment experiences and outcomes; acceptance of and respect for programs increase among native communities; thus, more American Indian and Alaska Natives seek services from such programs.
- Providing cultural training and developing cultural competence form a main pathway in reducing health inequalities. We know that understanding tribal history and culture results in better healthcare communications with American Indian and Alaska Native clients and communities and improves outcomes.

Part 3: Literature Review

Part 3 content includes:

- A literature review, intended for use by clinical supervisors, researchers, and interested providers and program administrators. It provides an indepth review of the literature relevant to behavioral health services for American Indians and Alaska Natives.
- Links to selected abstracts, along with annotated bibliographic entries for resources that had no existing abstract available.
- A general bibliography.

Parts 1 and 2 are available in print and online in both PDF and HTML formats. Part 3 is available only online in PDF and HTML formats; you can access digital versions at https://store.samhsa.gov.

Terminology

Before you read Part 1, Chapter 1, you will want to be familiar with the terms this TIP uses, along with explanations for why they are used. Of course, different people have different preferences; some people will prefer different terms. The intent and usage of these key terms are explained below. Clinical diagnostic terms (e.g., "substance use disorder," "social anxiety disorder," "major depressive disorder") are used in accordance with definitions in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013).

American Indians and Alaska Natives. This TIP uses the term "American Indians and Alaska Natives" to refer to the indigenous peoples from the regions of North America now encompassed by the continental United States and Alaska. The term includes a large number of distinct tribes, pueblos, villages, and communities, as well as a number of diverse ethnic groups. On occasion, "native" or "Native American" is used for the sake of brevity, and this usage is not meant to demean the distinct heterogeneity of American Indian and Alaska Native people. The Native American peoples of the continental United States are known as American Indians, and those from Alaska are known as Alaska Natives. American Indians and Alaska Natives are considered distinct racial groups. In the U.S. Census, for example, the federal government considers American Indian and Alaska Native to be racial categories. However, this TIP is concerned with the cultural identity of American Indian and Alaska Native people. A person may have

USE OF DIAGNOSES WITH AMERICAN INDIAN AND ALASKA NATIVE CLIENTS

Some providers working with American Indian and Alaska Native clients find diagnostic terminology in clinical work to be problematic because the process of "naming" can have spiritual significance and may have negative consequences for the individual, family, and community. For those reasons, providers should be careful when using such terminology with clients, although the use of such terminology may be essential in other clinical contexts.

American Indian and Alaska Native ancestry but very little cultural identification with it, or he or she may have a large percentage of non-native American ancestors but still identify as a member of his or her native culture. A number of other terms used to describe American Indian and Alaska Native people are not used in this TIP, including "Amerindians," "Amerinds," "Indian," "Indigenous People,""Aboriginal People," and "First Nations" (the last two are commonly used in Canada). This TIP sometimes refers to people from other racial or ethnic groups as "non-native" for brevity's sake.

Behavioral health. The term "behavioral health" is used throughout this TIP. Behavioral health refers to a state of mental/emotional being and choices and actions that affect wellness. Behavioral health problems include substance use disorders, serious psychological distress, suicide, and mental illness. Such problems range from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders, substance use and related problems; treatments and services for mental and substance use disorders; and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in the United States, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America's communities, such as those described in this TIP, will help achieve nationwide improvements in health.

Cultural competence. This TIP uses the term "cultural competence" to describe the process in which services are delivered that are sensitive and responsive to the needs of the cultural group being served. Cultural competence is an ongoing process that involves developing an awareness of culture, cultural differences, and the role that culture plays in many different aspects of life, including behavioral health. TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a), contains more information on cultural competence in a general sense, whereas this TIP discusses how to provide culturally responsive treatment to American Indians and Alaska Natives specifically. It is worth noting that there is no single Native American culture, but rather many hundreds of diverse cultures with their own languages, traditions, beliefs, and practices, and providers must try to understand the cultures of all the clients they serve.

Culture. The term "culture" is defined in this TIP as the product of a shared history and includes shared values, beliefs, customs, traditions, institutions, patterns of relationships, styles of communication, and similar factors (Castro, 1998). An individual may belong to more than one culture or cultural subgroup and may not accept all the values and beliefs of his or her primary culture, but culture will play a role in defining the individual's basic values and beliefs. TIP 59 (SAMHSA, 2014a) has more information on how cultures work and their importance in behavioral health services.

Indian Country. The term "Indian Country" is often narrowly defined in legal terms. In this context, the term includes reservations, native communities, Indian allotments located inside or outside reservations, towns incorporated by non-native people if they fall within the boundaries of an Indian reservation, and trust lands. This includes lands held by federal, state, or local (nontribal) governments, such as wildlife refuges, as well as sacred sites that are not on tribal lands. Many American Indians and Alaska Natives use the term more broadly to include any native community, independent of land designation, this TIP uses the term in that sense.

Medicine versus healing practices. Traditional healers may be referred to as "medicine men" and "medicine women," but to avoid confusion among different meanings of "medicine," this TIP refers to American Indian and Alaska Native healing practices rather than to medicine.

Provider and client. The TIP refers to someone who provides behavioral health services as a "provider" and someone who receives them as a "client." These terms are not intended to be pejorative in any way or to reduce the relationship between the two to a purely business relationship; they are merely intended to highlight the fact that a client is someone seeking a service from a provider and that the provider has a responsibility

to provide the service that the client requests. The consensus panel invested considerable energy in selecting the most appropriate terminology when referring to providers and clients. Members gave voice to traditions and beliefs surrounding healing, as well as some traditions established within behavioral health programs. Different programs may use different terms, and different terms may be used for providers with different roles (e.g., "psychiatrist," "counselor," "prevention specialist"). Certain programs refer to individuals as "relative," "family," or "cousin," regardless of whether they are the provider or client. Some American Indian and Alaska Native programs use the term "participant" rather than "client" and "counselor" rather than "provider." This TIP generally uses the term "provider" rather than "counselor," except in specific examples where "counselor" is appropriate. As you read the document, recognize that there are certain phrases in the English language that would or could be perceived as paternalistic. For example, the term "your client" occurs a few times. This phrase is not meant to denote ownership or to reinforce paternalistic attitudes, but rather to reference the specific clients that the provider is working with in the healing process.

Substance abuse. The term "substance abuse" is used to refer to both substance abuse and substance dependence. This term was chosen partly because it is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances. In this TIP, the term refers to use of alcohol as well as other substances of abuse. Readers should note the context in which the term occurs to determine its meanings. In most cases, however, the term will refer to all varieties of substance use disorders described by DSM-5 (APA, 2013). The term "addictive disorders" is used to describe other mental disorders that are now classified under the category "Substance-Related and Addictive Disorders" in DSM-5 (APA, 2013), including tobacco use disorder and gambling disorder.

Traditional versus mainstream. When referring to American Indian and Alaska Native cultures, this TIP uses the adjective "traditional," which is widely used by native people to refer to their own cultures. The term is not intended to imply that such cultures are static or out of date, but merely that American Indian and Alaska Native traditions reside in those cultures. This TIP uses the term "mainstream" to refer to the American culture that is endorsed by the majority of Americans. American society is pluralistic, and many diverse cultures contribute to that mainstream culture (including American Indian and Alaska Native cultures); for this reason, the TIP avoids terms like "European culture." The term "mainstream" also avoids the hierarchy implied by terms such as "dominant culture."

TIP Development Participants

Consensus Panel

Each Treatment Improvement Protocol's (TIP's) consensus panel is a group of primarily nonfederal behavioral health-focused clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Knowledge Application Program (KAP) team, they develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel's expertise and combined wealth of experience.

Consensus Panel Chair

Pamela Jumper Thurman, Ph.D.
Western Cherokee
Senior Research Scientist/Director
Commitment to Action for 7th Generation Awareness and Education
National Center for Community Readiness
Colorado State University
Fort Collins, CO

Part 1 Consensus Panelists

Raymond Daw, M.A.
Navajo
Gamerco, NM

Elaine Mzhickteno Barr, LMSW, CADC
Prairie Band Potawatomi
Alcohol and Drug Counselor
Prairie Band Potawatomi Nation Health Clinic
Mayetta, KS

Shannon Sommer
Koyukon Athabascan
Director, Recovery Services
Cook Inlet Tribal Council
Anchorage, AK

Sandra Stroud
Choctaw Nation of Oklahoma
Assistant Director
Chi Hullo Li Treatment Center
Talihina, OK

Kamilah L. Venner, Ph.D.
Athabascan
Assistant Professor
Department of Psychology
Research Assistant Professor
Center on Alcoholism, Substance Abuse and Addictions
University of New Mexico
Albuquerque, NM

Raymond Watson
Yup'ik Eskimo
Director of Adult Rehabilitative Services
Yukon Kuskokwim Health Corporation
Bethel, AK

Don Wetzel, Jr., M.A.
Blackfeet
Director
Planting Seeds of HOPE/IT
Montana–Wyoming Tribal Leaders Council
Billings, MT

Part 2 Consensus Panelists

Mary Helen Deer, RN
Kiowa Tribe of Oklahoma and Muscogee Creek Nation
Health Consultant
Oklahoma City, OK

Victor Joseph
Tanana Chiefs Conference (TCC)
TCC Health Services Director
Fairbanks, AK

Duane H. Mackey, Ed.D.
Santee Sioux Tribe of Nebraska
Assistant Professor and PATTC-SD Coordinator
University of South Dakota
Vermillion, SD

Eva L. Petoskey, M.S.
Grand Traverse Band of Ottawa and Chippewa Indians
Director
Anishnaabek Access to Recovery
Inter-Tribal Council of Michigan
Sault St. Marie, MI

Stakeholders Meeting Participants

Stakeholders represent a cross-section of key audiences with a deep interest in a TIP's subject matter. Stakeholders review and comment on the draft outline and supporting materials for the TIP to ensure that its focus is clear, its stated purpose meets an urgent need in the field, and it will not duplicate existing resources produced by the federal government or other entities.

Chair

Pamela Jumper Thurman, Ph.D.
Western Cherokee
Senior Research Scientist/Director
Commitment to Action for 7th Generation Awareness and Education
National Center for Community Readiness
Colorado State University
Fort Collins, CO

Stakeholders Meeting Participants

Christina Currier
Government Project Officer
Knowledge Application Program
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Dorothy A. Dupree
Director of Tribal Affairs
Office of External Affairs
Centers for Medicare and Medicaid Services
Baltimore, MD

Ginny Gorman-Gipp
Senior Advisor for Tribal Affairs
Office of the Administrator
Substance Abuse and Mental Health Services Administration
Rockville, MD

Jaime Hale
Assistant for Legislation and Policy
National Indian Health Board
Washington, DC

Richard Kopanda, M.A.
Deputy Director
Substance Abuse and Mental Health Services Administration
Rockville, MD

Jack Stein, Ph.D., M.S.W.
Director
Office of Science Policy and Communications
National Institute on Drug Abuse
Rockville, MD

Wilbur Woodis
Management Analyst
Indian Health Service
Rockville, MD

Brenda Woods-Francis
Public Health Analyst
Health Resources and Services Administration
HIV/AIDS Bureau
Division of Training and Technical Assistance
Rockville, MD

Michael Yesenko
Public Health Advisor
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
Rockville, MD

Field Reviewers

Field reviewers represent each TIP's intended target audiences. They work in addiction, mental health, primary care, and adjacent fields. Their direct front-line experience related to the TIP's topic allows them to provide valuable input on a TIP's relevance, utility, accuracy, and accessibility.

Sean Bear, CADC
Meskwaki Tribal Nation
Senior Behavioral Health and Training Coordinator
National American Indian and Alaska Native Addiction Technology Transfer Center
University of Iowa
Iowa City, IA

Elaine Mzhickteno Barr, LMSW, CADC
Prairie Band Potawatomi
Alcohol and Drug Counselor
Prairie Band Potawatomi Nation Health Clinic
Mayetta, KS

Raymond Daw, M.A.
Navajo
Behavioral Health Administrator
Yukon-Kuskokwim Healthcare Corporation
Bethel, AK

Teresa Evans-Campbell, Ph.D., M.S.W.
Snohomish Tribe of Indians Associate
Associate Professor, School of Social Work
Indigenous Wellness Research Institute
University of Washington
Seattle, WA

Delores Ann Jimerson, M.S.W., LCSW
Seneca, Bear Clan
Integrated Care Mental Health Counselor
Yellowhawk Circles of Hope Suicide Prevention Project
Pendleton, OR

Billie Jo Kipp, Ph.D.
Blackfeet
President
Blackfeet Community College
Browning, MT

CAPT Cheryl A. LaPointe, M.A., M.P.H. (Ret.)
Rosebud Sioux Tribe
Lead Evaluator
Tiwahe Glu Kini Pi 'Bringing the Family Back to Life' System of Care Project
Sinte Gleska University
Mission, SD

Laura Fenster Rothschild, Psy.D.
Director, Education and Training
Rutgers University, Center of Alcohol Studies
New Brunswick, NJ

Anne Helene Skinstad, Ph.D.
Program Director
National American Indian and Alaska Native Addiction Technology Transfer Center
University of Iowa, College of Public Health
Iowa City, IA

Sharon Tomah, LCSW
Passamaquoddy: A Wabanaki Tribe of Eastern Maine
Executive Director
Wabanaki Health Wellness, NPC
Bangor, ME

Kamilla Venner, Ph.D.
Athabascan
Assistant Professor of Psychology
University of New Mexico
Albuquerque, NM

Keja Nokomis Whiteman
Turtle Mountain Band of Chippewa Indians
Executive Director
Alaska Native Village Corporation Association
Anchorage, AK

Publication Information

Acknowledgments

This publication was prepared under contract numbers 270-04-7049, 270-09-0307, and 270-14-0445 by the Knowledge Application Program (KAP) for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Christina Currier and Suzanne Wise served as the Contracting Officer's Representatives, and Candi Byrne served as KAP Project Coordinator.

Special thanks go to Pamela Jumper Thurman (Western Cherokee), TIP Chair and content contributor; Betty Poitra (Turtle Mountain Band of Chippewa) and Stephanie Autumn (Hopi Tribe), content contributors; Kauffman and Associates, content contributors; and the many consensus panelists and other American Indian and Alaska Native people from various tribes who contributed stories, ideas, and feedback during the development of this TIP.

Disclaimer

The views, opinions, and content expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA or HHS. No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described is intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

Public Domain Notice

All materials appearing in this volume except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA or the authors. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access and Copies of Publication

This publication may be ordered or downloaded from SAMHSA's Publications Ordering webpage at https://store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration. *Behavioral Health Services for American Indians and Alaska Natives.* Treatment Improvement Protocol (TIP) Series 61. HHS Publication No. (SMA) 18-5070EXSUMM. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Originating Office

Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

Nondiscrimination Notice

SAMHSA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SAMHSA cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, o sexo.

TIP 61

BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives

For Behavioral Health Service Providers

Part 1 of this **Treatment Improvement Protocol** addresses historical trauma among American Indians and Alaska Natives. It describes native perspectives on help-seeking behaviors. It also presents culturally adapted strategies for the prevention and treatment of addiction and mental illness.

TIP Navigation

Executive Summary
For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives
For behavioral health service providers

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives
For behavioral health service providers, program administrators, and clinical supervisors

Appendix and Index

Part 3: Literature Review
For behavioral health service providers, program administrators, clinical supervisors, and researchers

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

PART 1: GUIDE FOR PROVIDERS SERVING AMERICAN INDIANS AND ALASKA NATIVES

Part 1, Chapter 1 5
Introduction 5
Choosing a Path for Your Learning Journey. 11
Beginning in the East: The Direction of Cultural Knowledge 13
Moving to the South: The Direction of Cultural Awareness and Competence 34
Continuing West: Cultural Perspective on Behavioral Health 42
Arriving in the North: The Direction of Culturally Specific and Responsive Skills and Practices. 49

Part 1, Chapter 2 69
Introduction 69
Vignette 1—Vicki: Establishing Relationships, Acknowledging the Past, and Choosing Treatment 74
Vignette 2—Joe: Addressing Methamphetamine Dependence, Reconnecting With Family, and Recovering on the Reservation. 86
Vignette 3—Marlene: Facilitating Support, Creating Family Connections, Honoring Traditional Ways, and Recovering in Remote Alaska Villages. 96
Vignette 4—Philip: Making Connections Between Losses and Alcohol Use, Using One-Stop Outreach and Case Management Services for Homelessness and Treatment Service Needs, and Building Relationships Using Traditional Practices in Recovery 110

Exhibits

Exhibit 1.1-1. Timeline of Significant Events in Native American History 17
Exhibit 1.1-2. Cycle of Historical Trauma 21
Exhibit 1.1-3. Cycle of Assimilation and Reconnection 30
Exhibit 1.1-4. Traditional American Indian and Alaska Native Values and Beliefs 37
Exhibit 1.1-5. Examples of Culturally Adapted Treatment Approaches 61
Exhibit 1.2-1. Vignette Summary Table. 71
Exhibit 1.2-2. The Stages of Change Model 93

This page intentionally left blank.

This page intentionally left blank.

Part 1, Chapter 1

Introduction

This Treatment Improvement Protocol (TIP) is designed to assist you, the provider or program administrator, in working with and providing culturally responsive services to American Indian and Alaska Native clients in behavioral health service settings. This manual is addressed to all kinds of behavioral health service providers—counselors, outreach workers, prevention specialists, healthcare professionals, psychologists, program managers, and administrators—whose work is directly or indirectly concerned with supporting American Indian and Alaska Native clients and communities in recovery from mental illness and substance abuse.

This manual, using guidance from consensus panels, weaves together practice-based experience with available published resources and research relevant to behavioral health in American Indians and Alaska Natives. A group of respected American Indian and Alaska Native behavioral health service providers, clinical directors, researchers, and administrators from across Indian Country formed the clinical- and administrative-focused consensus panels; their contributions shaped the development and content of this TIP.

This TIP begins with a demographic, historical, and cultural overview of American Indians and Alaska Natives, laying the necessary groundwork that supports the dialog, suggestions, and resources that follow. This TIP can serve as a resource to both native and non-native providers in providing culturally appropriate and responsive services. By emphasizing the strengths of native cultures and reinforcing the importance of a holistic perspective in the etiology and treatment of substance use and mental disorders, it will help dispel the myths and stereotypes about American Indians and Alaska Natives.

This TIP Is for You, the Behavioral Health Services Provider

If you want to reflect on your work and enhance your cultural competence in relationships with your American Indian and Alaska Native clients, this TIP is for you. If you are new to working with American Indian and Alaska Native clients, or if you find that your usual approaches to providing treatment services just do not seem to work as well with these clients, you are also the person for whom this TIP has been developed.

You know your work, and you are likely good at it. You may assume that your clients see you as credible because you have earned your position; you have credentials that speak to your skill in helping people recover from mental and substance use disorders and maintain that recovery. Much of the time, this is sufficient for your clients to trust you enough to benefit from the help you offer them.

Yet, somehow, you may sense that this is not enough for many of your American Indian and Alaska Native clients. Your credentials seem less important to them than their assessment of you and of your ability to help them. The fact that you have opened this TIP says that you care about their perceptions. You want to help your clients, and if there are things you can learn that will help you earn the trust of your clients, you want to learn them.

Providing behavioral health services to members of a culture that is different from your own is not easy to do well. Grasping the nuances of another culture requires cultural self-awareness and the patience to learn, understand, and respect the expressions of the culture that you see and hear. Your curiosity about what you could do differently to be more effective with American Indian and Alaska Native

clients in a way that works for them is a genuine asset. What is different about these clients that you need to better understand? How can developing your understanding help you provide more effective support, counseling, and treatment? This TIP will explore several responses to these questions.

Why a TIP on Working With American Indian and Alaska Native Clients in Behavioral Health?

American Indians and Alaska Natives have persistently experienced serious health disparities in access to care, funding, and resources for health services. They face disparities in the quality and quantity of services, treatment outcomes, and health education and prevention services. The availability, accessibility, and acceptability of services are all major barriers to substance abuse and mental health services for American Indian and Alaska Native people. Rural and remote areas often lack treatment infrastructure, and American Indian or Alaska Native individuals will sometimes delay seeking available care in part because they do not trust organizations. Other factors that influence participation include transportation, level of social support, perceived provider effectiveness, type of treatment setting, geographic location, and tribal affiliation.

In response to existing behavioral healthcare disparities, this TIP illustrates strategies for facilitating access to and engagement in treatment and describes promising practices for working with American Indians and Alaska Natives. It also provides tools and strategies for administrators to facilitate implementation of these practices. This TIP helps behavioral health service providers identify how and to what extent an individual's cultural background can affect his or her needs and concerns. It gives providers and administrators practical ideas and methods to deal with the realities of service delivery to American Indian and Alaska Native clients and communities.

Culturally responsive treatment requires establishing a standard of respect, focusing on strengths, and addressing underlying personal and historical trauma issues as appropriate (see definition on pages 20–21). Traditional interventions (both client centered and community centered) and care that are integrated with mainstream treatment methods are recognized as best practices for native communities.

Did You Know?

- Practicing many cultural traditions was illegal for American Indians and Alaska Natives from 1878 until 1978, often resulting in imprisonment and fines for those who broke the law. Today, many tribes are working to restore important and protective cultural practices in their communities. These cultural practices are a pathway to prevention and healing.
- Although some professionals have suspected that genetic factors play a part in the high rates of substance abuse among American Indians and Alaska Natives who use alcohol or drugs, this is incorrect. There are no genetic factors unique to Native Americans that are associated with high rates of substance use.
- Suicide and suicide attempts are a significant problem in many American Indian and Alaska Native communities, especially among young men ages 15–24, who account for nearly 40 percent of all suicide deaths among natives. Native youth have a much higher suicide rate than youth or adults of other races. Suicide rates for Alaska Natives are more than double those for the U.S. population as a whole.
- American Indians and Alaska Natives are less likely to drink than White Americans; however, those who do drink are more likely to binge drink and to have a higher rate of past-year alcohol use disorder than other racial and ethnic groups.

- American Indians and Alaska Natives are more likely than White Americans or Latinos to abstain from alcohol and drugs. Among people who have been drinkers, American Indians and Alaska Natives are about three times more likely to have become abstainers than are former drinkers in the general population.
- American Indians and Alaska Natives experience some mental disorders at a higher rate than other Americans (e.g., anxiety disorders). Although results vary, some research has found that Native Americans are less likely to have other disorders (e.g., major depression).
- American Indians and Alaska Natives seek mental health services at a rate second only to that of White Americans and may be even more likely than White Americans to seek help, if one takes into account that many consult traditional healers for such problems. American Indians and Alaska Natives appear to be more likely than all other major racial and ethnic groups to seek substance abuse treatment services.
- Likely reasons for today's high rates of substance use, suicide, violence, and domestic abuse among American Indians and Alaska Natives lie in the fact that their communities are exposed to a greater degree to the same risk factors that are predictors of problems for everyone, such as poverty, unemployment, and trauma (including historical trauma), as well as loss of cultural traditions.
- Many American Indians and Alaska Natives report experiencing at least one traumatic event in their lifetimes, and all Native Americans have been affected by historical trauma across generations (sometimes referred to as "intergenerational trauma").
- American Indian and Alaska Native women report higher rates of victimization than women from any other racial or ethnic group in the United States. For example, American Indian and Alaska Native women are nearly twice as likely to be raped or sexually assaulted than are White or African American women. Nearly 80 percent of sexual assaults against Native American women are committed by non-native men (see Amnesty International, 2007; Bachman, Zaykowski, Kallmyer, Poteyeva, & Lanier, 2008; Tjaden & Thoennes, 2006).
- Although more than 70 percent of American Indians live in urban areas, many maintain strong ties to their home reservations, making frequent visits and moving back and forth from cities to tribal lands.

Native American individuals have historical cause to wonder whether behavioral health service providers will recognize them for who they are, respect them, and offer assistance in walking their life path. History has taught tribes that it is dangerous to trust outsiders. Their people's lives—the lives of their parents and grandparents—have been taken or forever altered by outsiders.

Before You Begin

This TIP addresses the more common treatment needs of American Indians and Alaska Natives with behavioral health issues. However, the treatment concerns and pathways to healing presented in this manual will not—and cannot—equally and effectively represent all American Indian or Alaska Native individuals, communities, and tribes. There is simply much more diversity among American Indian and Alaska Native people than can be fairly represented here. Instead, the material can serve as a starting place, and you can adapt it to meet the unique attributes of each client and each client's cultural identity, treatment setting, community, and culture.

There are many distinct Native American cultures, and recognizing the diversity among tribes is important. Although clear similarities across native nations exist, especially when compared with mainstream American culture, not all American Indians and Alaska Natives hold the same beliefs or practice the same traditions. This also holds true for views on substance use and mental health, attitudes toward and beliefs about help-seeking, and treatment for mental and substance use disorders. Therefore, you as a provider must first

invest in learning about and understanding the population and culture that you serve prior to selecting and adapting the material presented in this manual.

Some providers working with American Indian and Alaska Native clients find the use of diagnostic terminology in clinical work problematic, because the process of "naming" can have spiritual significance and may influence what is thus named. Providers should be careful when using such terminology with clients, although it may be essential in other clinical contexts.

The consensus panels expressed concern about the possible misuse of sacred ceremonies and traditional practices; therefore, to preserve and respect native ceremonies and heritage, no specific ceremonies are cited in detail. Without forethought, non-native providers may exploit native healing modalities by practicing traditional healing methods with clients. To avoid misuse of native healing modalities, native and non-native providers should rely on the community and native tribal council (governance) to guide the selection of traditional practitioners and the integration of traditional healing practices across the continuum of care. The consensus panels also agreed that identifying tribal affiliations for specific client case studies or examples could increase the risk of mistaken identification of individuals from a smaller tribe or a misrepresentation of tribal values and ways.

A thorough online literature review in Part 3 supports the manual. Parts 1 and 2 of this TIP use minimal citations to produce a user-friendly document, yet we recommend that you read the literature review. If you are interested in references associated with the presenting topics, please consult the literature review at https://store.samhsa.gov. To complement the materials presented in this TIP, the consensus panel suggests that providers, including counselors, other clinical staff members, program directors, and administrators, read TIP 59, *Improving Cultural Competence* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a).

Consensus Panel Perspectives

Throughout the consensus process, several themes emerged from many conversations, as well as shared experiences and stories among panel members. As you read and reflect on the material presented in this manual, keep these core concepts at the center of your attention and let them guide your practice.

Importance of historical trauma. As a provider, you should recognize, acknowledge, and address the effects of historical trauma in the treatment process (see the section in Part 1, Chapter 1, titled "The Importance of History for American Indian and Alaska Native Behavioral Health"). Although native people across North America share similar experiences of loss and trauma, each tribe has its own story of contact with Europeans. Most American Indians and Alaska Natives believe that historical trauma, including the loss of culture, lies at the heart of substance use and mental disorders within their communities. Typically, providers consider it important to obtain clients' psychosocial history prior to any medical or psychological treatment and place less emphasis on addressing the history and role of trauma. However, in treatment for American Indians and Alaska Natives, it is critical to incorporate the role of historical trauma in assessments, in developing treatment plans, and in implementing healing strategies.

Acceptance of a holistic view of behavioral health. The view of substance use and mental disorders—their definition and nature—among American Indian and Alaska Native people is markedly different from mainstream beliefs. Among many Native Americans, substance use and mental disorders are not defined as diseases, diagnoses, or moral maladies; they are not physical or character flaws. Instead, substance abuse is seen as a symptom, reflecting an imbalance in the individual's relationship with the world. Keeping with this holistic worldview, healing and treatment approaches need to be inclusive of all aspects of life—both seen and unseen—incorporating the spiritual, emotional, physical, social, behavioral, and cognitive. No one aspect is separate from the others, and all provide a path to recovery, with room to embrace traditional healing and mainstream treatment practices along the way.

Role of culture and cultural identity. Mental and substance use disorders are frequently seen as the consequences of culture loss among American Indian and Alaska Native communities. Maintaining ties to one's culture can help to prevent and treat substance use and mental disorders; thus, healing can come from reconnecting. Through reconnection to native communities and traditional healing practices, an individual may reclaim the strengths inherent in traditional teachings, practices, and beliefs and begin to walk in balance and harmony. In translating this belief into practice, initial interviews and assessments need to be culturally responsive (e.g., inquiring about the client's involvement in traditional and healing practices).

Providers need to understand how clients perceive their own cultural identity and how they view the role of traditional practices in treatment. Providers need to adapt treatment planning to match clients' needs and treatment preferences. Not all American Indian and Alaska Native clients recognize the importance of culture or perceive a need for traditional practices in their recovery. Nonetheless, providers and treatment programs must be flexible to match their clients' needs, rather than expecting the client to adapt to match the treatment program, regardless of whether it is native or non-native.

Recognition of sovereignty. Tribal governments are sovereign nations. Each nation adopts its own tribal codes and has a unique history with the federal government. Providers in native and non-native programs need to understand the role of tribal sovereignty and governance systems in treatment referrals, planning, cooperative agreements, and program development.

Significance of community. Creating culturally responsive services requires the participation of the native community, including leaders (formal and informal), councils, clients, potential clients, and client families. Even though it may appear less time consuming, complex, and expensive to avoid community participation, doing so represents an example of paternalism, in which the administrators or providers assume that they inherently know what is best for the program, client, staff, and community.

Instead, clients and the community should have an opportunity to provide input on the type of services needed and how those services are rendered. Without this information, services may be poorly matched to clients and underused by the community, and may further drain the agency's and tribe's financial resources. For example, providers may overlook that the program location offers minimal privacy for clients seeking help, especially in rural and reservation settings. Unbeknownst to providers, clients may be reluctant to drive and park at the building for fear of being seen. With community involvement, providers are more likely to learn of potential obstacles and plan accordingly.

Additionally, American Indian and Alaska Native beliefs revolve around the value of connectedness and the importance of relationships. If providers do not build relationships or demonstrate interests in the community, the native community may be less accepting of the services offered. Providers need to take time to be involved in community events and to create ways to encourage community involvement in treatment services.

Value of cultural awareness. Providers who have a general understanding of how culture affects their own worldview (as well as that of their clients) will be able to work more effectively and be better equipped to respect clients who have diverse belief systems. If providers are cognizant of their own cultural backgrounds, they will be more likely to acknowledge and explore how culture affects their interactions, particularly their relationships with clients.

Without cultural awareness, providers may offer counseling that ignores or does not address issues that relate specifically to race, ethnic heritage, and culture. This lack of awareness can also lead to discounting the importance of how their own cultural backgrounds—including beliefs, values, and attitudes—influence their initial and diagnostic impressions of clients. Providers may unwittingly use their own cultural experiences as a template to prejudge and assess clients' experiences and clinical presentations. They might struggle to see the cultural uniqueness of clients, assuming that they understand clients' life experiences and backgrounds better than they really do. With

cultural awareness, providers examine how their own beliefs, experiences, and biases influence their definitions of normal and abnormal behavior, illness, and healing.

Commitment to culturally responsive services. Organizations have an obligation to ensure high-quality care and the cultural competence of all personnel. The first aim is to protect the welfare of clients. Cultural competence is important at all levels of operation in behavioral health services: individual, programmatic, and organizational. It is also important in all activities and at every treatment phase—outreach, initial contact, screening, assessment, placement, treatment, continuing care, and recovery services—as well as with research, prevention, and education. Culturally responsive practice recognizes the fundamental importance of language and the right to language accessibility, including translation and interpreter services.

Culturally responsive services will likely provide clients with a greater sense of safety, supporting the belief that culture is essential to healing. Although not all clients identify or want to connect with their cultures, culturally responsive services offer clients a chance to explore the impact of culture, history (including historical trauma), acculturation, discrimination, and bias and how these relate to their behavioral health.

Significance of the environment. An environment that reflects American Indian and Alaska Native culture will be more engaging to clients and set a tone that indicates respect. The program should take specific steps to make the facility more accessible and culturally appropriate. In addition, the organization should work to create a more culturally reflective environment—not only within the facility, but also through business practices, such as using local and community vendors when possible.

Respect for many paths. There is no one right way. Providing direction on how something should be done is not a comfortable or customary practice for American Indians and Alaska Natives; the consensus panel expressed this sentiment while discussing treatment approaches. Most data on evidence-based practices (EBPs) are not based on native participation. Evidence- or science-based practices are practices that have emerged from mainstream culture. Although EBPs have value, practice-based approaches and traditional healing practices play a significant role in Indian Country. Inherently, introducing the necessity of using EBPs suggests that there is one right way of doing things. This approach can be seen as an attempt by mainstream treatment providers to impose specific treatment methods on native communities while devaluing traditional healing practices and beliefs. To American Indians and Alaska Natives, healing is intuitive; is interconnected with others; and comes from within, from ancestry, from stories, and from the environment. Instead of one right way, there are many paths to healing.

You Can Do This!

You are likely aware that people who grow up in cultures different from your own may think differently than you do about many things. They have had different experiences than you might have had and generally have attitudes and beliefs about many things that are at least slightly different—if not very different—from yours. You may know this instinctively when you visit a foreign country, an Alaskan Native village, or an American Indian reservation. Things are different, and these differences go far beyond the difficulty of reading signs in another language or finding familiar food on a menu. You observe that people have created a way of life that is grounded in their land and language and expressed in their beliefs, customs, communication styles, and relationships—their lives have a different rhythm or pace from yours. As you proceed in your work, remember you are the visitor, the guest, the "different" one. Take time to observe, learn, and participate.

You already have plenty of knowledge and skills in your field of practice. You know about mental health and substance abuse and how to carry out your own role in the continuum of prevention, assessment, intervention, treatment, and recovery. You have developed interpersonal, clinical, and psychoeducational skills that work well in connecting you to many of your clients. You are likely caring as well as competent. You are also interested in improving your ability to help your clients—in this case, your American Indian and Alaska Native clients. Pursuing this learning is as much personal as it is professional. You may learn new things about your own perspectives on life as you come to understand those of others. It can be a rich journey.

Choosing a Path for Your Learning Journey

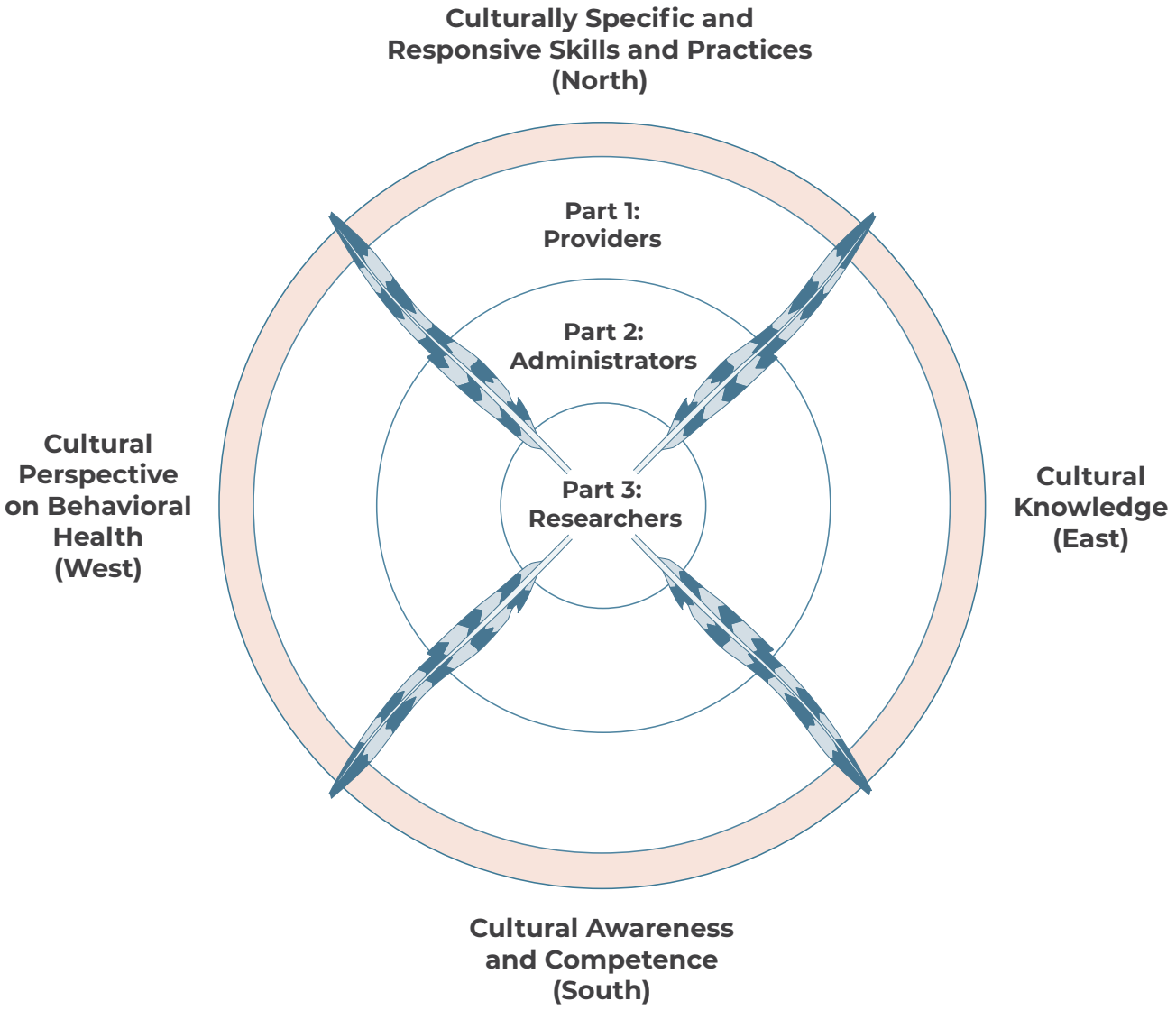
In this publication, you will explore how you interact with your clients and adapt culturally responsive ways of healing. To this end, the TIP emphasizes four main content areas. First, it explores the basic elements of American Indian and Alaska Native cultures; more knowledge prepares you to listen in a new way, tuning in more carefully to your American Indian and Alaska Native clients. Second, the manual emphasizes the importance of becoming aware of and identifying cultural differences between you and your clients, whether you are a native or non-native provider. By avoiding assumptions of similarity and taking the time to understand your clients' unique cultural identities and perspectives, these attitudes and actions can lead to a stronger and more trusting relationship. Third, the TIP highlights cultural beliefs about illness, help-seeking, and health. Fourth, it offers practice-based approaches and activities informed by science and the healing power available through native traditions, healers, and recovery groups.

A circle is the best image to organize the information that you will need to work competently with American Indian and Alaska Native clients. The circle is a widely shared symbol among native cultures; all of life, seen and unseen, moves in circles and cycles. The circle symbolizes a key philosophy for understanding the relationship of people to everything in their environment and represents many things to American Indians and Alaska Natives. It represents the circle of life, the seasons, unity and harmony among all creation, and the importance of striving for balance and harmony. One lesson that the circle teaches is that there is no right or wrong within the circle, merely different viewpoints and pathways that are influenced by life experience, family, community, and environment (Cruickshank-Penkin & Davidson, 1998).

The circle graphic on the next page models the key elements for providing culturally responsive care for American Indians and Alaska Natives in behavioral health services. The concentric circles highlight the primary audience for each part of the TIP: providers, administrators, and researchers. The outermost shaded band symbolizes the importance of cultural, environmental, and historical factors that influence the effectiveness of services across the continuum of care. Each quadrant of the circle represents an essential ingredient in supporting culturally responsive services for American Indians and Alaska Natives. Adapting Sue and Sue's (2013) multidimensional model of cultural competence, the four ingredients (beginning in the East) are cultural knowledge, cultural awareness and competence, cultural perspective on behavioral health, and culturally specific and responsive skills and practices.

To your American Indian and Alaska Native clients, you are the embodiment of your message; they expect that you are an expert at what you do. What will they encounter when they are with you? Will you see them? Will you understand who they are? Will you respect their ways of seeing things and their goals, although they may be different from your own viewpoints and your own goals for them? American Indian and Alaska Native clients often do not care what you know until they know that you care. How can you demonstrate caring?

> Everything the power of the world does is done in a circle. The sky is round, and I have heard that the earth is round like a ball and so are all the stars. The wind, in its greatest power, whirls. Birds make their nests in circles, for theirs is the same religion as ours. The sun comes forth and goes down again in a circle. The moon does the same and both are round. Even the seasons form a great circle in their changing and always come back again to where they were."
>
> —Black Elk, Oglala Sioux (as interpreted by J. G. Neihardt)
>
> *Source: Black Elk & Neihardt, 1932, p. 121.*



Your journey around the circle begins in the East, where the day dawns. East is the direction of awakening, newness, and beginnings. The East is about learning and understanding American Indian and Alaska Native cultures as much as you are able. The East explores historical roots, historical trauma, current native experiences, cultural worldview, beliefs, and values. What is the importance of these to your clients today? What do you need to know to work with your clients?

In the South, you should look at the importance of your culture in your work and consider the roots of your own views, assumptions, values, and practices. In the South, you see similarities and differences and open yourself to learn. This quadrant is about becoming culturally aware and competent. Here, you focus on the roles of culture and cultural identity in the provider–client relationship.

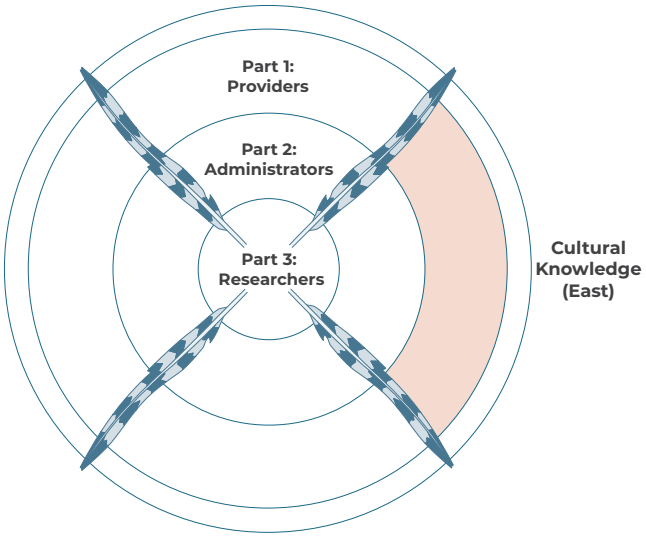
Continuing to the West, you will learn how your clients might view their own needs for healing and change and their ideas about help-seeking, treatment, healing, recovery, and prevention. What are your clients' beliefs about illness? This quadrant focuses on the holistic view of behavioral health.

The North is where you will learn to wisely implement the clinical skills that ensure the use of culturally responsive interventions, including

traditional and best practices. This quadrant highlights practice-based approaches and activities informed by science and by the healing traditions of native healers, medicine, and recovery groups. The North also signifies a time of transition—changing things to make them better as you continue your path.

Beginning in the East: The Direction of Cultural Knowledge

In the circle, East is the direction of preparation, beginnings, and grounding. This section will help you to better understand the American Indian and Alaska Native experience of life, both historically and currently. This section begins with a discussion of Native American history, followed by a discussion of how that history continues to affect contemporary American Indians and Alaska Natives. It then presents some information about American Indians and Alaska Natives today and some challenges that many Native Americans face.



American Indian and Alaska Native History: Effects of Colonization

A grasp of events in their people's past is essential for understanding American Indian and Alaska Native clients today. The American history you learned in school most likely began in the 17th century and was about European settlers and their descendants. This does not reflect the experiences of American Indians and Alaska Natives. This summary of American Indian and Alaska Native history does not do justice to the richness of their past, but it can give you a sense of the centuries-long evolution of their cultures and how the lives of Native Americans have been disrupted by contact with other peoples. Ever since the Europeans' arrival and colonization of North America, the history of American Indians and Alaska Natives has been tied intimately to the influence of European settlers and to U.S. government policies. The lives of American Indians and Alaska Natives today are, to some extent, the result of their mistreatment at the hands of European (including Russian) settlers. Early colonists would not have survived without the assistance of Native Americans, yet within a relatively brief span of years, those colonists were killing their native hosts to claim land, degrading their environment, exposing them to infectious diseases from which their natural immunity could not protect them, and even enslaving them.

Many native communities have origin stories. Passed down from one generation to the next, these symbolic and traditional narratives explain creation—the beginning of life, of place, and of the world—and are shaped by the individual community's culture, region, and language. Many origin stories and legends have been passed through oral tradition, but some have been recorded for preservation. Origin stories prescribe how people should be in the world and their responsibilities to the Earth and to each other. These stories have great relevance in providing care and in healing. (For a review of oral narrative themes and an annotated list of resources across regions, see Bastian and Mitchell, 2004.)

In early colonial times, European settlers and American Indians established some mutually profitable trading networks on the East Coast. However, the Spanish used American Indian forced labor in mines and on ranches in the Southwest, the British forcibly took land for agriculture, and the Russians captured Alaska Natives for work in the fur trade. American Indians and Alaska Natives increasingly resisted European attempts at dominance but found themselves repeatedly defeated in local wars. As a result, they lost population, land, and power.

Shortly after the U.S. government was created, the Northwest Ordinance laid out policies that allowed confiscation of native lands in exchange for the payment of goods and monetary annuities. A department was established to keep track of the treaties signed and the funds disbursed and was later upgraded to a bureau. The Indian Office became part of the War Department in 1824 and moved to the Department of the Interior in 1849. Unfortunately, the treaties were often broken, ignored, or forgotten.

In 1830, as American settlers pushed westward, Congress passed the Indian Removal Act to force American Indians to relocate west of the Mississippi River. It was believed that American Indians could be more readily assimilated into mainstream culture if they were concentrated in one area; they could be "civilized," and their native cultures would disappear. Whether voluntarily or by force after a military defeat, brutal marches of American Indians ensued, and the loss of life was tremendous. In the southeastern United States, an estimated 100,000 Cherokee, Choctaw, Creek, Chickasaw, and Seminole people were relocated in wintertime, during which thousands died of disease and starvation; this is known as the Trail of Tears.

Within 10 years, the resettlements to what are now Nebraska, Kansas, and Oklahoma were completed, but intertribal conflicts surfaced. The American Indians who now had to share their land resented the new arrivals. American settlers moved into new areas, the Indian Office became more corrupt, and pressures on hunting grounds and reservation lands increased. More tribes were sent to live on reservations of marginal land where they had little chance of prospering. The Plains tribes suffered the extermination of buffalo herds, depletion of water resources, economic depredation, and loss of human lives (Hirschfelder & de Montaño, 1993).

The Indian boarding school movement began about 1875 as a part of an effort to assimilate American Indian and Alaska Native children into mainstream culture. The government removed children from their families and communities, often by force, and placed them in schools often hundreds and even thousands of miles away from their homes. In some areas, generations of families attended boarding schools. By 1899, there were 26 off-reservation schools scattered across 15 states. The number of boarding schools grew, and by the 1930s, nearly half of all American Indian and Alaska Native children were enrolled in a boarding or industrial school. Some schools were still operating as recently as the 1970s. The emphasis within the Indian educational system later shifted to reservation schools and public schools, but boarding schools continued to have a major impact for many years thereafter because they were perceived to be an effective means of assimilating American Indians into mainstream culture. The boarding school experience also prevented the transmission of tribal culture, language, traditional parenting skills, and naturally occurring patterns of family socialization. Recently, the extent of child physical and sexual abuse that occurred at the boarding schools has come to light. A 1990 report, published by the National Resource Center on Child Sexual Abuse, found widespread abuse occurring over years, particularly at missionary schools.

President Grover Cleveland signed the General Allotment Act (also known as the Dawes Severalty Act) in 1887. This law broke up reservation land into portions allotted to Indian families and individuals. The government then sold the leftover reservation land at bargain prices. This Act, intended to encourage American Indians to farm the land and otherwise integrate them into U.S. society, had disastrous consequences. In addition to losing surplus tribal lands, many natives lost their allotted lands in future sales and had little left for survival (Hirschfelder & de Montaño, 1993).

The Bureau of Indian Affairs (BIA) intruded further into Native American life in the early 20th century. Community celebrations were prohibited, and

BIA workers assumed management of reservation health care, education, public safety, and road maintenance. *The Meriam Report* (known by the surname of its author, Lewis Meriam, but officially titled *The Problem of Indian Administration*), published in 1928, exposed problems that had worsened under this system and marked a policy change that resulted in passage of the Indian Reorganization Act in 1934.

Indian policy shifted again near the end of World War II. Congress began to withdraw federal support and to abdicate responsibility for Native American affairs. Over the following two decades, under a policy known as "termination," many federal services were withdrawn, and federal trust protection was removed from tribal lands and given to the states. At the same time, the Indian Relocation Act encouraged Native Americans to move to urban areas where they were more likely to find jobs. This further weakened tribal ties and sense of community (Hirschfelder & de Montaño, 1993). Many families never returned to their reservations.

Self-determination became the new watchword of policy toward American Indians and Alaska Natives in the late 1960s and 1970s. The Indian Self-Determination and Education Assistance Act of 1975 codified the policy, which repudiated termination policies and permitted tribes to enter into contracts to manage aspects of tribal governance, such as education. The Indian Child Welfare Act of 1978 put an end to the practice of adopting out American Indian and Alaska Native children into non-native homes. In keeping with self-determination, the American Indian Religious Freedom Act of 1978 ended the ban on traditional spiritual practices. Despite the prohibitions and Christianizing efforts by various churches, indigenous culture and spirituality have survived and are widely practiced. Even in areas where many American Indians and Alaska Natives practice Christianity, traditional cultural views still heavily influence the way in which Native Americans understand life, health, illness, and healing (Kalt et al., 2008).

An important class action suit, known as *Cobell v. Salazar,* was filed on behalf of a large group of American Indians against the Departments of Treasury and the Interior in 1996. It asserted that the government had failed to account for monies held in trust since tribal lands had been allotted to individuals beginning in 1887; that other assets held in trust had been mismanaged; and that royalties were owed to individuals for leases of their lands for grazing, oil, gas, and other resources. The issues in the suit were enormously complex, and it was not settled until 2010. The government agreed to set aside $3.4 billion, of which $1.5 billion would compensate approximately 500,000 individuals, and $1.9 billion would buy back land to benefit tribes (Campbell, 2013).

AMERICAN INDIANS AND ALASKA NATIVES IN MILITARY SERVICE

Approximately 12,000 American Indians and Alaska Natives volunteered for military service in World War I—an estimated 25 percent of the total male American Indian population at the time (Britten, 1997). During World War II, more than 44,000 Native American men and women served in the military. This is about 13 percent of the 350,000 individuals that made up the American Indian and Alaska Native population at the time (Armed Forces History Museum, 2013).

In World War I, the U.S. military began using American Indians and Alaska Natives as code talkers. Initiated by Choctaws in World War I, American Indians and Alaska Natives used their language in a code for transmitting messages on the battlefield. The code was never broken. During World War II, the armed forces began to recruit Kiowa, Cherokee, Navajo, Tlingit, Comanche, Seminole, and at least 25 other tribes and nations to transmit coded messages. Beginning in 2000, 29 code talkers were awarded special Congressional Gold Medals for their service (National Museum of the American Indian, 2007).

Five American Indians received the Congressional Medal of Honor for their service during World War II, and three received it for their service in the Korean War (Center for Military History, United States Army, 2011).

The experience of Alaska Natives with foreign cultures was, in some ways, similar to that of American Indians, but the basic state history is quite different, owing in part to its climate and geography. The Aleuts were the culture most affected by contact with Russian explorers and fur traders after their arrival in the early 1700s. Few Russians actually settled in Alaska, but they were able to coerce the Aleuts into doing their marine hunting for them, using Alaskan seaworthy vessels and weapons that were well suited to this pursuit. Other inhabitants of coastal areas, such as the Yup'ik, Chugach, and Tlingit, who relied on fishing and hunting, were also affected (Korsmo, 1994).

No land was set aside for Alaska Natives to use. They simply lived where they chose and inhabited much of the land, particularly where game, fish, and other foods were plentiful. Yet, as among American Indians, missionaries undertook the assimilation of the native population by forbidding the use of traditional languages and customs and sending the children to boarding schools where they would become more "American." Physical, emotional, and sexual abuse by adults and other students at these schools added to the losses of family relationships and cultural traditions (LaBelle, 2005).

With the purchase of Alaska in 1867 and the discovery of gold near Juneau in 1880 and in the Yukon in 1896, the area became a valuable asset to the United States. According to the Mining Act of 1872, however, Alaska Natives were not permitted to stake mining claims, and they were often paid less than Whites for the same work (Ongtooguk, n.d.). Schools for Alaska Natives were operating under federal supervision within 20 years. Alaska became a U.S. territory in 1912. Generally, Alaska Natives' land claims were respected in accordance with the 1884 Organic Act, but there were some problems. For example, the Alaska Native Allotment Act, passed in 1906, provided reservation land only for hospitals, schools, and reindeer (Korsmo, 1994).

Alaska Natives were reorganized by law in 1936. Few groups chose to create reservations. Many Alaska Natives were opposed to reorganization, as was the territorial governor, who feared that the Alaska Native groups would stagnate and that reservations would become subsistence enclaves. Commercial fishing and canning industries opposed reservations, as they wanted to ensure access to water (Korsmo, 1994).

Alaskan statehood, granted in 1959, became the catalyst for clarification of natives' land claims. If their claims were to be respected as required by the 1884 treaty, mining, oil, and other industries could not confiscate Alaska Native territory. These land issues mobilized Alaska Natives to form the Alaska Federation of Natives in 1966. Representatives of 17 native organizations met to present a united voice for a fair settlement.

Five years later, the Alaska Native Claims Settlement Act resolved land issues by law. Alaska Natives would receive the title to 40 million acres of land that they already occupied. To compensate them for the loss of their claims to other lands, they would also receive nearly $1 billion over 11 years; Alaska Natives would be organized into 12 corporations that would administer the land and funds (R. S. Jones, 1981).

Although it appears that governmental agencies have become more aware of past injustices toward American Indians and Alaska Natives, it is difficult—if not impossible—to make amends for centuries of disrespect and hostility. American Indians and Alaska Natives have demonstrated their resilience and have responded to the self-determination mandate by taking control of tribal government; by fostering economic development of reservations; and by making their voices heard on environmental, healthcare, and other issues that affect them.

Exhibit 1.1-1 provides information on major events in American Indian and Alaska Native history. Not all events are included in both the previous narrative and the timeline, so you may benefit from reading both.

EXHIBIT 1.1-1. Timeline of Significant Events in Native American History

TIME PERIOD	EVENT
c. 28,000–12,000 B.C.	Groups migrated from Asia into North America, perhaps across a land bridge connecting the two continents.
c. 11,000 B.C.	Archaeological evidence indicates that people inhabited a region near Clovis, NM, meaning that the original groups had migrated substantial distances.
c. 10,000 B.C.	Other groups continued their migration to populate the woodlands in what is now the Northeast.
c. 6,000 B.C.–1 A.D.	During the Archaic period, big game moved eastward, and native groups moved from what is now California to the Southwest. They planted maize.
1 A.D.–1000 A.D.	In the Formative period, native groups living in the Southwest diversified from those living in the Southeast (Dutton, 1983). Anasazi, Mogollon, Hohokam, and Hakataya civilizations flourished. Agricultural techniques evolved, and pottery was in use. In the Northeast, Adena, Hopewell, and Mississippian cultures prospered. They are noted for their fine art, agriculture, and metalwork.
1000–1600	The Great Plains were repopulated by native groups, drawn in part by the reappearance of big game.
1607–1630	British and Dutch settlers made contact with American Indians in Virginia, Massachusetts, and New York.
1720–1750	Russian explorers arrived in the Aleutian Islands and established fur trading.
1787	The Northwest Ordinance established fair policies toward natives living in the area claimed by the United States.
1820–1840	Russian settlers had initial contact with Alaska Natives, exposing them to fatal diseases such as smallpox and syphilis. Alaska Native populations decreased by 20–50 percent in the groups most affected.
1830	The Indian Removal Act passed, marking the beginning of an assimilationist policy for Native Americans. They were required to move west of the Mississippi River.
1832	Liquor was prohibited in Indian Country; 2 years later, penalties were set for violating the ban. It was finally repealed in 1953.
1834	What became the BIA was established to administer and manage lands held in trust for American Indian tribes and Alaska Natives by the U.S. government.
1867	The United States purchased Alaska from Russia. The Treaty of Cession recognized three groups of residents: Russian subjects who could return to Russia within 3 years, Russian subjects who chose to remain in Alaska and become Americans, and uncivilized tribes (those who had virtually no contact with Russians). Missionary boarding schools similar to those in the lower 48 states were soon established.

Continued on next page

EXHIBIT 1.1-1. Timeline of Significant Events in Native American History (continued)

TIME PERIOD	EVENT
1879	The Carlisle Indian School (in operation until 1918) and other boarding schools opened with the goal of separating Native American children totally from their cultures and turning them into members of the mainstream society. Children were forced to cut their hair and wear mainstream clothing; they were taught English and forbidden to speak their original languages. Their names were changed, Christianity replaced their traditional spiritual practices, and they were taught that their native cultures were inferior. The guiding philosophy was, "kill the Indian, save the man."
1887	The General Allotment Act (also known as the Dawes Severalty Act) became law. It allotted land to individuals and provided for the land's use in agriculture and its sale in the future. Allotted lands would be held by the U.S. government in trust for 25 years. Designed to continue assimilation policies, it resulted in further losses of Native American lands.
1924	The Indian Citizenship Act, also known as the Snyder Act, was signed into law on June 2, 1924. The Act created national citizenship for indigenous people in the United States, but the qualifications for state citizenship were determined by each individual state. The final state to grant full citizenship to American Indians was New Mexico in 1962. Overall, the Indian Citizenship Act was more inclusive than previous policies pertaining to citizenship, but it was not until the Nationality Act of 1940 that all people who were born on United States soil were automatically considered citizens.
1934	The Indian Reorganization Act was signed into law. Its purpose was to develop Native American economic resources and restore tribal self-government. The allotment system was ended.
1936	Alaska Native cultures were included in reorganization. The law recognized tribes, permitted establishment of tribal lands, and allowed self-government.
1945–1961	Congress adopted policies to terminate federal obligations to tribes, known as the "termination era." Three primary policies and strategies were used. First, the relocation program was designed to relocate American Indians and Alaska Natives away from reservations and Alaska Native villages into cities to force assimilation. Second, a resolution was passed to end the special federal relationship with many tribes and terminate their status as tribes. Tribes were given the choice of being paid for their lands or having their lands held in trust by a Native American corporation. Finally, Congress extended state jurisdiction into Indian Country, which shifted the responsibility to the states.
1955	The Indian Health Service (IHS) was created within the Department of Health and Human Services (HHS) to provide health care to Alaska Natives and American Indians who are members of federally recognized tribes.
1956	The Indian Relocation Act, touted as employment assistance, encouraged Native Americans to move to urban locations where jobs were more plentiful. By the 1990 Census, 51 percent of Native Americans lived in urban areas.

Continued on next page

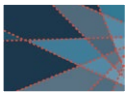


EXHIBIT 1.1-1. Timeline of Significant Events in Native American History (continued)

TIME PERIOD	EVENT
1958–1967	The Indian Adoption Project removed Native American children from their families and placed them in boarding schools or with non-native families. Public child welfare services removed many more children in the 50s and 60s. In states with the largest native populations, an estimated 25 to 35 percent of American Indian and Alaska Native children were removed; of these, 85 percent entered foster care or were adopted by non-native families. The Indian Child Welfare Act ended this practice in 1978.
1959	Alaska became a state.
1960s	In response to public outcry, the federal termination policy was ended and replaced by a policy that encouraged self-determination. Recognition was extended to some tribes that had previously been terminated, and additional tribes were recognized. The Indian Civil Rights Act of 1968 allowed the federal government to intervene in intratribal disputes, while extending, in part, constitutional rights to American Indians and Alaska Natives.
1971	Pressed by the Alaska Federation of Natives, the Alaska Native Claims Settlement Act became law, granting 40 million acres of land and nearly $1 billion in compensation for land lost to 12 native corporations.
1988	The Indian Gaming Regulatory Act established a commission to regulate gambling casinos on tribal lands.
1989	The oil tanker *Exxon Valdez* spilled an estimated 260,000–760,000 barrels of crude oil in Prince Edward Sound, AK. The environmental damage was severe. Populations of sea birds and mammals, as well as other marine species, were significantly reduced, radically altering the lives of Alaska Natives whose economy depended on them. Even 25 years after the spill, a great deal of oil remained on nearby shores. The Chugach Corporation declared bankruptcy as a result of the spill but has since recovered.
1995	Alyeska, which owns the Trans-Alaska Pipeline System, created the Alaska Native Program to meet legal obligations to employ, promote, train, and help educate Alaska Natives. The agreement was renewed in 2007.
2010	The class action lawsuit *Cobell v. Salazar* was settled for $3.4 billion in favor of the Native American plaintiffs. Funds are to compensate individuals for their interest in lands leased by the federal government while it was trustee for the lands and to buy back land so that tribes can consolidate their holdings.
2013	The Violence Against Women Reauthorization Act granted federally recognized tribes jurisdiction over protective order violations, domestic violence, and dating violence that occur on tribal lands. Previously, non-native perpetrators of these crimes were not often prosecuted, as federal, state, and tribal law enforcement all lacked the authority to act.

Sources: Campbell, 2013; Dutton, 1983; Hirschfelder & de Montaño, 1993; Martin, 2003; Pritzker, 1998.

The Importance of History for American Indian and Alaska Native Behavioral Health

The overview of historical events presented above shows that for more than 500 years, American Indians and Alaska Natives have endured multiple traumatic events as a result of colonization. As a behavioral health service provider, you need to be aware that your American Indian and Alaska Native clients continue to experience repercussions from these events. It may be difficult for you to read and think about these events, in part because you know that they have had such damaging effects on American Indians' and Alaska Natives' lives (discussed in the next section), but an understanding of how trauma affects clients is vital to your effectiveness as a provider.

Clinicians and researchers call the process through which past traumatic events affect one's present-day functioning historical trauma. Historical trauma has been defined as the "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma" (Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283).

Another author has described historical trauma as "collective complex trauma inflicted on a group of people who share a specific group identity or affiliation—ethnicity, nationality, and spiritual affiliation. It is the legacy of numerous traumatic events a community experiences over generations and encompasses the psychological and social responses to such events" (Evans-Campbell, 2008, p. 320). It is collective in that it affects an entire people, rather than an individual, and complex in that it does not have a single traumatic cause. Historical trauma has also been referred to as a "soul wound" that affected and continues to affect the physical, social, cultural, and psychological health of American Indians and Alaska Natives (B. Duran, Duran, & Brave Heart, 1998).

Dr. Maria Yellow Horse Brave Heart applied the concept of historical trauma to American Indians and Alaska Natives when she noted parallels between Holocaust survivors and their children and American Indians and Alaska Natives whose ancestors had suffered massive trauma. She observed that contemporary American Indians and Alaska Natives continued to experience grief about traumatic events in their history that they were unable to resolve, and this was further exacerbated by additional disruptions in native cultures (e.g., forced out-of-home placement of children into boarding schools, the banning of traditional ceremonies and practices), which in turn affected traditional responses to grieving, such as described in "Traditional Cultures and Historical Trauma" (Brave Heart et al., 2011).

You may find that your American Indian and Alaska Native clients experience grief for somewhat different reasons than other clients do. Common reasons for grief include the loss of their communities, loss of life, loss of freedom, loss of land, loss of self-determination, loss of traditional cultural and religious practices, loss of native languages, and the removal of children from their families. Historical trauma may involve events that happened hundreds of years ago or more recent traumatic events, such as forced placement in boarding schools or environmental disasters (e.g., the *Exxon Valdez* oil spill, gasoline pipeline breaks on the Crow reservation in Montana), which have done both material and cultural harm.

Brave Heart and others found that traditional models of responses to trauma were inadequate to explain the whole complex of behavioral and social problems that American Indians and Alaska Natives

TRADITIONAL CULTURES AND HISTORICAL TRAUMA

A stronger connection to traditional cultures may help reduce the effects of historical trauma on American Indians and Alaska Natives, as the loss of traditional cultural practices may have exacerbated the effects of historical trauma. Brave Heart (2003) gives an example of this drawn from Lakota history. The Lakota culture had specific rituals and practices for grieving that allowed for a year of publicly expressed mourning, followed by a ceremony to heal that grief. U.S. policies outlawing native ceremonies interrupted the process of grieving over events such as the Wounded Knee Massacre of 1890, in which the U.S. Army killed between 150 and 300 Lakota men, women, and children.

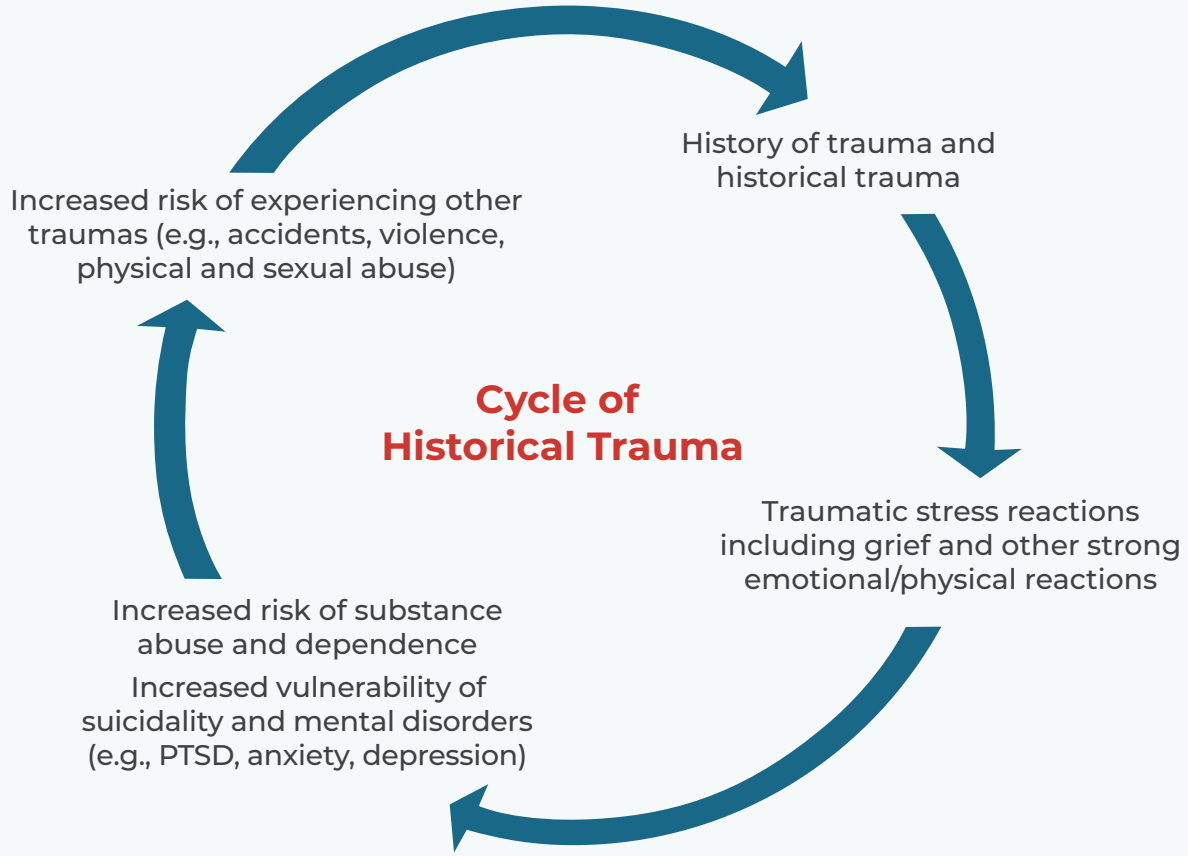
have experienced. When you view the larger picture, historical trauma appears to contribute to various problems, including socioeconomic effects, problematic behaviors, and, especially, various mental and substance use disorders. Other relevant factors that mark historical trauma as different from other trauma are that the distress resulting from the trauma is collective rather than individual, and the cause of trauma comes from people outside the community affected by it (Evans-Campbell, 2008). Historical trauma is also intergenerational in that the original trauma continues to have effects on subsequent generations that did not experience it directly.

You might find it helpful in your practice to use some of the measures that have been developed to evaluate how salient historical trauma is for your clients. Research using those measures does indicate that American Indians and Alaska Natives frequently think about historical losses (Whitbeck, Adams, Hoyt, & Chen, 2004).

The Effects of Historical Trauma on American Indians and Alaska Natives Today

Many providers who work with American Indians and Alaska Natives believe that historical trauma can cause anger, grief, and shame that contribute to substance use disorders, suicidality, and increased vulnerability to mental disorders such as post-traumatic stress disorder (PTSD). These, in turn, increase risk for additional trauma, perpetuating its effects (Exhibit 1.1-2).

EXHIBIT 1.1-2. Cycle of Historical Trauma



Traumatic events often have material, economic, psychological, and cultural repercussions. Among American Indians and Alaska Natives, historical loss is associated with greater risk for substance abuse, depressive symptoms, more feelings of anger, and a higher likelihood of engaging in binge eating (Clark & Winterowd, 2012; Ehlers, Gizer, Gilder, & Yehuda, 2013; Whitbeck et al., 2004; Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009). Historical trauma may also affect future generations in a number of ways at national, community, family, and individual levels (Sotero, 2006). Trauma can affect future generations physically (e.g., by raising the risk of certain diseases), socially (e.g., by increasing child abuse and domestic violence), psychologically (e.g., by causing depression or PTSD), and spiritually (e.g., by losing hope for the future). Some theorists suggest trauma is also stored on a biological level; that is, one generation passes it down to the next.

One important way historical trauma is transmitted across generations is through its effects on parenting. Brave Heart (1999) suggests that trauma experienced by parents can disrupt traditional parenting practices and increase substance abuse, which in turn negatively affects parenting. Trauma may affect trust and intimacy and the ability to form a healthy bond with one's children. Parents tell stories of historical events or of their own experiences that may cause secondary traumatization. Children also witness and, to some extent, internalize their parents' reactions in times of stress when their parents' responses to traumatic situations are triggered.

STORY OF THE SACRED HOOP OF 100 EAGLE FEATHERS

"In Black Elk's vision, the Hoop of the World referred to the communities of Native people. In his vision, he saw the Native people going through a long time of suffering during which the hoop was broken. And then he saw that the people would begin to heal. The Elders have told us that we have now entered the time of healing and the 'coming together time.' The Sacred Hoop is the symbol of that time of healing. The Sacred Hoop of the Wellbriety Movement was born from a vision in 1994...."

Mission of the Sacred Hoop: Healing Individuals, Families, Communities, and Nations

"The Hoop was built in a sweat lodge over a weekend in May of 1995. On the first day of summer that year, a multicultural Elders gathering was held in Janesville, WI, to provide prayers for the Hoop and align its purpose to the coming healing time. The Elders placed the four gifts of Healing, Hope, Unity, and the Power to Forgive the Unforgivable into the Hoop. The first Sacred Hoop Journey began in the spring of 1999.

"Since the Sacred Hoop was blessed, it has traveled over 53,000 miles to Native American communities across the United States.... When the Sacred Hoop comes to a community, the people gather for ceremonies and talk about living a sober and healthy life that is balanced emotionally, mentally, physically, and spiritually."

Source: Coyhis, 2007. Reprinted with permission.

Adverse childhood events, beyond actual trauma and including things such as parental illness or inadequate family resources, affect the psychological development of children and increase their risk for problems such as PTSD and substance abuse. TIP 57, *Trauma-Informed Care in Behavioral Health Services,* includes additional information on the effects of trauma on parenting and on behavioral health in general (SAMHSA, 2014b).

The Benefits of Focusing on Historical Trauma

The concept of historical trauma is intended to help you, the provider, find ways of discussing current trauma and emotional or behavioral problems in a context that is not "stigmatizing" (Brave Heart et al., 2011). By working with a concept of historical trauma, you can present trauma as a collective experience, and thus one that communities can work together to overcome (Gone, 2013). You may find that the most effective methods of treating the effects of historical trauma typically involve families and communities and supportive networks of people working to overcome similar problems or challenges (e.g., tribal canoe journeys in the Pacific Northwest). These networks often work to connect clients with their traditional cultural beliefs and practices and may include tribal elders and healers who offer spiritual guidance and healing in a manner that is congruent with American Indian and Alaska Native beliefs.

American Indians and Alaska Natives Today

If you have even a modest familiarity with American Indians and Alaska Natives, you know that they lead diverse lives. American Indians and Alaska Natives are professionals, business people, scientists, academics, athletes, artists, soldiers, teachers, community builders, and clergy. They are hunters, fishers, harvesters of wild and cultivated foods, and medicine men and women or traditional healers.

Your clients may live in a relatively small geographic area and share a tribal identity. As a whole, the American Indian and Alaska Native population is extremely diverse and encompasses people from 573 federally recognized tribes, each with its own culture, and many more tribes that are recognized by states only or that are seeking federal recognition (Indian Entities Recognized, 2018). American Indians and Alaska Natives speak more than 150 different languages, and diverse tribes have varying customs and beliefs. American Indians and Alaska Natives, even those from the same culture, may have widely differing levels of identification with those native cultures.

> "We are many. We are diverse. We represent our many cultures. We are a resource. We influence our people. We have roots and heritage. We live in two worlds. We feel unity when we gather. We have dual citizenships. We are the caretakers for many of our aging elders and children. We are the link to those who have left home. We are you."
>
> —Katherine Gottlieb, Aleut, President, South Central Foundation, Anchorage, AK
>
> *Source: National Urban Indian Family Coalition, 2009, p. 5.*

As a provider, you know the importance of treating each client as an individual. With that in mind, much of the information that follows describes how American Indians and Alaska Natives as an entire population differ from other groups and may not apply to specific American Indian and Alaska Native clients. Talking individually with your clients about their culture and its meaning to them is essential before you make decisions about how to treat those clients. The West section presents a discussion of assessment, including the assessment of cultural identification, and TIP 59 (SAMHSA, 2014a) contains a chapter on culturally responsive evaluation and treatment planning.

According to Census estimates released in 2018, 6.8 million people in the United States identified as Native American, either alone or in combination with another race. This number represented only 2.1 percent of all people in the United States.

Of those 6.8 million, 4.1 million identified solely as Native American, and 2.7 million identified as Native American in combination with another race (Census Bureau, Population Division, 2018).

The number of people who identify as Native American has been growing since the 1960s. This appears to be because a growing percentage of the population has chosen to identify as Native American. The choice often is based on people's Native American ancestry, not because of cultural affiliation. This is a subject of some debate within the American Indian and Alaska Native population, with some individuals welcoming these "new" Native Americans and others being concerned that these individuals are ignoring the importance of American Indian and Alaska Native cultures in defining themselves as Native American. For the latter group, belonging to an American Indian and Alaska Native tribal entity is the best way to identify whether someone is "culturally" Native American (Gone & Trimble, 2012).

The American Indian and Alaska Native population is younger than the United States population as a whole, with a median age of 31.3, compared with 38.0 for the whole population (Census Bureau, Population Division, 2018). One unfortunate reason for this is that American Indians and Alaska Natives tend to die earlier from a number of health problems (see the discussion under the "Physical Health" section). Like other Americans, most American Indians and Alaska Natives work in urban areas, but they are more likely than the population as a whole to live in rural areas. According to the HHS Office of Minority Health (2018), 60 percent of American Indians and Alaska Natives live in urban areas. About 22 percent live on reservations or off-reservation trust lands. American Indians and Alaska Natives whose primary residence is on reservations, trust lands, or bordering rural areas often migrate between cities and those rural areas and maintain ties in both areas.

American Indians and Alaska Natives account for a greater proportion of the population in certain states, particularly Western ones. According to the Census Bureau's Population Division (2018), the states with the highest proportion of native populations are Alaska (where native people make up 20.0 percent of the population), followed by Oklahoma (13.8 percent), New Mexico (12.2 percent), and South Dakota (10.4 percent).

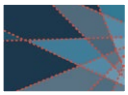
WHO ARE NATIVE AMERICAN TRIBAL MEMBERS?

Having Native American ancestry does not automatically qualify a person as a member of a Native American nation or tribe. Tribal members are those who are officially enrolled in a tribe or similar entity. Tribes have the right—because they are sovereign nations with their own governments—to decide who is and is not a member. The criterion used most often by tribes is "blood quantum," or documentation that one is descended from historical tribal members. Blood quantum refers to the amount of tribal blood a person possesses as determined by his or her ancestors. In some tribes, a person might be full-blooded Native American but may not meet the requirement for tribal membership, because some ancestors were members of other tribes.

The Status of American Indian and Alaska Native Tribes

American Indians and Alaska Natives are unique among racial/ethnic groups in the United States. In addition to being U.S. citizens only since 1924, they may be members of federally recognized sovereign nations or tribes within the United States. As of this publication, the U.S. government has recognized 573 tribal entities (Indian Entities Recognized, 2018). Other native communities are only recognized by certain states or are in the process of applying for recognition. Not all nations refer to themselves as "tribes." For example, American Indians in the Southwest may refer to their nation as a *pueblo*, other tribes may refer to their community as a "band," and Alaska Natives may identify according to the village to which they belong.

These sovereign nations are subject to federal law, but to only some state laws. Federal law recognizes that native sovereign nations have the authority to manage certain functions of their own government on tribal lands and that, in turn, the federal government has a duty to protect members of these nations and to provide them certain services (e.g., health care) according to obligations set out in treaties with individual tribes.



U.S. GOVERNMENT TREATIES

Treaties are made between the governments of nations. Therefore, making a treaty was a recognition by the U.S. government (and earlier, European and colonial governments) that native communities were sovereign nations and that the land belonged to the native communities that were granting rights to it in exchange for certain guarantees and payments. Those treaties and federal laws enacted afterward meant that the federal government had legal and financial responsibilities in relation to federally recognized tribes.

Much of the time, especially early on, these treaties made little sense to tribes. The agreements were explained in languages foreign to them and were presented in a written form that was incomprehensible to the tribal leaders, so they were forced to rely on interpreters to understand what was being proposed. The whole concept of owning land and rights to it was alien to American Indian and Alaska Native people. The fact that the United States did not fulfill its treaty obligations created a complex network of problems that took decades to untangle. Nevertheless, recognition of the sovereignty of native communities has provided the foundation of the tribes' claims on the United States ever since.

American Indians and Alaska Natives governed themselves and related to each other as sovereign nations long before the European colonization began. Tribal authorities today may police their own lands, create laws to govern them, manage their own courts, provide other essential services, provide housing, run schools, and, in some cases, manage health care in part through the use of IHS funds. Some tribes also run businesses for the benefit of tribal members. Research suggests that native people who have self-governance are more economically prosperous and may have better behavioral health outcomes, such as a lower suicide rate, as well (Chandler & Lalonde, 2008; Taylor & Kalt, 2005).

MYTHS AND FACTS ABOUT AMERICAN INDIANS AND ALASKA NATIVES

Myth: All American Indians and Alaska Natives have a distinctive physical appearance that you can use to identify them.

Fact: Given the diversity among tribes after centuries of intertribal and interracial marriage, there are no distinguishing features that identify American Indians and Alaska Natives.

Myth: Most American Indians and Alaska Natives live on reservations.

Fact: About 22 percent of American Indians and Alaska Natives live on reservations or on trust lands off-reservation, according to the HHS Office of Minority Health (2018). Another 60 percent live in urban areas.

Myth: Gambling casinos are making many American Indians and Alaska Natives wealthy.

Fact: Fewer than half of the federally recognized tribes operate gaming facilities. Most profits from gaming go to improve a broad range of tribal services, and only about one-quarter of tribes with gaming give direct payments to tribal members. The size of those payments varies considerably, but in most cases it is only a small supplement. Several smaller tribes account for a disproportionate share of revenues that are dispersed to individuals (Kalt et al., 2008).

Myth: All Alaska Natives are Eskimos.

Fact: The U.S. government recognizes more than 200 tribes in Alaska. The Alaska Native Heritage Center identifies 11 distinct cultures. The Unangax and Alutiiq, who occupy the Aleutian Islands, were affected most heavily by contact with Russian explorers and adopted elements of their religion, cuisine, and language. Their life around the oceans makes their lives and livelihoods very different from inland cultures, such as the Athabascans, who have traditionally migrated with the seasons, and the Inupiaq and St. Lawrence Island Yup'ik of the far North. In some areas, the term "Eskimo" is considered derogatory.

Continued on next page

MYTHS AND FACTS ABOUT AMERICAN INDIANS AND ALASKA NATIVES (CONTINUED)

Myth: American Indians and Alaska Natives have an innate, unquenchable appetite for alcohol and become extremely violent when they consume too much.

Fact: When Native Americans were first exposed to alcohol in the 18th and early 19th centuries, some abstained, and others drank in moderation. They did not display an immediate craving for alcohol. No evidence suggests that American Indians and Alaska Natives uniformly respond violently to being inebriated.

Myth: American Indians and Alaska Natives are more susceptible to the effects of alcohol than are people of other races.

Fact: This has no basis in science. Genes that increase the risk of substance use disorder and related factors, such as tolerance and craving for alcohol, are no more common among Native Americans than among White Americans. This myth deflects attention from the historical context of the introduction of alcohol into native communities by European traders and explorers and the effects of historical trauma.

Myth: The solutions to problems in native communities—alcohol abuse in particular—have to come from outside those communities.

Fact: The most successful substance abuse treatment programs have originated within native communities and use local models of recovery. This allows clients to link their health and well-being to that of the community. The myth serves to perpetuate the dominance of the mainstream culture and a patronizing attitude.

Myth: American Indians and Alaska Natives receive a lot of services at no cost, such as education and health care.

Fact: A safety net of local, state, and federal tax dollars helps maintain educational and healthcare institutions in native communities, just as it contributes to other economically impoverished areas. Regarding education, about 93 percent of more than 600,000 Native American students attend public schools, which are supported by local, state, and federal funds. About 42,000 students attend 183 Bureau of Indian Education schools, most of which are tribally controlled.

A combination of Medicaid, IHS funding, state and local funds, federal discretionary grants, and tribal funds pays for behavioral health services for American Indians and Alaska Natives. Individuals may be eligible for funding from some or none of these sources. About 2 million people from federally recognized tribes and 34 urban Indian communities (of the 5.2 million who identified as Native American in the 2010 Census) received health care from IHS over a 3-year period (IHS, 2011). Increasingly, tribes have contracted for behavioral health services, which they operate themselves.

Myth: American Indians and Alaska Natives are honored by American Indian mascots.

Fact: These portrayals are coarse stereotypes. Although some depictions may be less offensive than others, they are all caricatures that obscure the uniqueness of the individuals who make up the population. Most American Indians and Alaska Natives are offended by these mascots.

The Economic and Social Conditions of American Indians and Alaska Natives

As you know, the lives of American Indians and Alaska Natives vary widely, but Native Americans are more likely than members of other racial or ethnic groups to face economic hardships and social problems. Many of these problems likely contribute to behavioral health issues among American Indians and Alaska Natives.

Income and poverty

Poverty is a significant and consistent variable across all social conditions that American Indians and Alaska Natives face. According to the Census Bureau (2018), 25.4 percent of American Indians and Alaska Natives were living in poverty, compared with 13.4 percent of the total population. American Indians and Alaska Natives had a median household income of $41,882, compared

with $60,336 for the population as a whole. The percentage of American Indians and Alaska Natives living in poverty was even higher in some states—as high as 51 percent for native households in South Dakota. Research with a variety of populations, including American Indians and Alaska Natives, suggests that poverty can contribute to the development, persistence, and severity of some mental and substance use disorders.

Unemployment

Unemployment is high among American Indians and Alaska Natives; in 2017, 7.8 percent were unemployed, compared with 3.8 percent of White Americans (Department of Labor, Bureau of Labor Statistics, 2018). Four years earlier, the American Indian and Alaska Native unemployment rate had been above 10 percent for 5 consecutive years (Austin, 2013). The unemployment rate is even higher for Native Americans living on reservations and other tribal lands (Pettit et al., 2014). In 2010 there were numerous states (which included Alaska, Arizona, California, Maine, Minnesota, Montana, New Mexico, North Dakota, South Dakota, and Utah) where fewer than 50 percent of Native Americans ages 16 and older living on or near reservations were employed (Department of the Interior, Office of the Assistant Secretary–Indian Affairs, 2014). This included people out of the labor force. Unemployment is associated with an increased risk for substance abuse for American Indians and Alaska Natives, and it may contribute to other behavioral health problems.

Fewer than half of all American Indian and Alaska Native women who experience violence report the crime to police. Of those who report, an estimated 60 to 90 percent of cases are not prosecuted. Native women who experience violence and live on reservations or in villages face the greatest barriers in obtaining prosecution because of jurisdictional conflicts, lack of jurisdiction, and limited tribal criminal justice funding.

Sources: Amnesty International, 2006; Bachman et al., 2008.

Housing and homelessness

American Indians and Alaska Natives have a high rate of homelessness. In 2017, 3 percent of people entering homeless shelters were Native Americans, although they made up less than 2 percent of the population (Henry, Watt, Rosenthal, & Shivji, 2017). American Indians and Alaska Natives who have houses are also more likely than the general population to live in overcrowded conditions or to lack kitchen facilities or complete plumbing (Pettit et al., 2014). In part, this crowding may occur as a result of accepting relatives into the household who may not have housing. For more comprehensive information on homelessness, see TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013a).

Education

Compared with the general population, American Indians and Alaska Natives are less likely to graduate from high school or to have an equivalency, bachelor's, or advanced degree (Ogunwole, 2006). Education protects against substance abuse, depression, suicidality, and other behavioral health problems for American Indians and Alaska Natives, as well as for other populations.

Trauma

Compared with members of other major ethnic or racial groups (i.e., African Americans, Asian Americans, Latinos, White Americans), American Indians and Alaska Natives are more likely to suffer from many different types of trauma. Rates of trauma exposure are especially high for American Indian and Alaska Native women, relative to women in the population as a whole (Manson, Beals, Klein, Croy, & AI-SUPERPFP Team, 2005).

Higher rates of certain types of trauma exposure (e.g., car accidents, unintentional injuries from other accidents) are related to the fact that many American Indians and Alaska Natives live in rural areas, where they may engage in more outdoor activities and have poorer infrastructure (e.g., bad roads, greater driving distances). High rates of binge drinking and other substance abuse can

also increase risk for accidents. There are fewer hospital facilities on native lands, so accidents are more likely to be fatal; American Indian and Alaska Native people are about two and a half times as likely to die from unintentional injuries as are members of the general population (IHS, 2017). Socioeconomic conditions, health disparities, and racism that contributes to violence against American Indians and Alaska Natives affect other types of trauma.

Different types of trauma exposure are associated with increased risk for a number of different behavioral health issues (see Ehlers, Gizer, Gilder, & Yehuda, 2013). For more information on the links between trauma and mental and substance use disorders, see TIP 57 (SAMHSA, 2014b).

Violent crime

American Indians and Alaska Natives are more likely to experience violent crime than are members of any other major racial or ethnic groups—about twice as likely to experience it than African Americans, 2.5 times more likely than White Americans, and more than 4.5 times as likely as Asian Americans (Perry, 2004). What may be even more remarkable is that, compared with every other major racial or ethnic group, Native Americans are more likely to experience violence from members of other racial or ethnic groups and are more likely to experience violence from strangers (Harrell, 2012). Native women are more likely than members of any other major racial/ethnic group to be survivors of rape. Acts of sexual violence against American Indian and Alaska Native women are mostly committed by members of other races. A recent report showed that, among American Indian and Alaska Native victims of sexual violence, 96 percent of women had experienced sexual violence by non-natives, whereas only 21 percent reported sexual violence by other Native Americans (Rosay, 2016). At the same time, arrest rates for most other crimes among American Indians and Alaska Natives are comparable to those for the general population (Department of Justice, Federal Bureau of Investigation, 2018).

BEYOND TRAUMA: SOUTH DAKOTA URBAN INDIAN HEALTH

South Dakota Urban Indian Health (SDUIH) provides holistic health and behavioral health services by integrating traditional ways into its treatment programs. SDUIH created a culturally specific recovery group called Beyond Trauma in response to community need. Beyond Trauma recognizes that many substance use disorders in the American Indian community stem from historical, childhood, and ongoing trauma. The program holds that addressing trauma is crucial to support ongoing recovery and improve the quality of relationships with self, family, and the community—a key ingredient in recovery. The Beyond Trauma support group helps participants "create rewarding and enjoyable lives, beyond a survivor identity" (p. 10). The group opens with a prayer and smudging. Then, participants share their challenges and celebrate how they have overcome those challenges. Participants develop strong, trusting relationships with one another. The recovery group is also an opportunity to forge lasting relationships and share substance-free activities with others in the community. One key benefit of Beyond Trauma is the opportunity for participants to see resilience in their peers and then, through self-reflection, begin to recognize it in themselves.

Source: Urban Indian Health Institute, 2014.

Child abuse

Abuse and neglect in childhood are associated with increased risk for substance abuse, anxiety disorders, and mood disorders. Research conducted with American Indians and Alaska Natives confirms this link (e.g., Libby, Orton, Novins, Beals, & Manson, 2005).

Rates of childhood abuse among American Indians and Alaska Natives vary considerably among tribes, and different studies have found widely different rates. Native children continue to be overrepresented in the child welfare system, with higher rates of reported child maltreatment compared with other racial and ethnic groups. One study also found that American Indian and Alaska Native children were more likely to die from abuse than were White American or African American children (Dakil, Cox, Lin, & Flores, 2011).

Domestic violence

American Indian and Alaska Native men and women are more likely to report having experienced domestic violence than are men and women from other racial/ethnic groups (Breiding, Chen, & Black, 2014). As with other types of violent crime, non-Native Americans commit the majority of domestic violence toward Native Americans.

Having experienced domestic violence has been associated with binge drinking and other types of substance abuse for American Indians and Alaska Natives (Oetzel & Duran, 2004), and severe intimate partner violence has been associated with increased risk for mood disorders and anxiety disorders for American Indian and Alaska Native women (B. Duran et al., 2009). (See also TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* [Center for Substance Abuse Treatment, 2009b].)

Physical health

American Indians and Alaska Natives are more likely than other racial or ethnic groups to have certain physical problems, including tuberculosis, diabetes, and cardiovascular disease (National Center for Health Statistics, 2014). They are also more likely to report current health as only poor to fair. Mortality rates from many causes are higher for Native Americans than for the general population. Death rates are higher related to alcohol (520 percent higher), diabetes (177 percent higher), chronic liver disease and cirrhosis (369 percent higher), and tuberculosis (450 percent higher) than for the general population (IHS, 2014).

Many health problems in American Indians and Alaska Natives have a behavioral component. Seven of the 10 leading causes of death for Native Americans have a behavioral component and relate to lack of exercise, poor diet and nutrition, tobacco use, or alcohol use (Kochanek, Murphy, Xu, & Tejada-Vera, 2016).

A lack of access to quality health care also contributes to American Indians' and Alaska Natives' poor health. Although most Native Americans live in urban areas, IHS provides care at a limited number of urban sites, and these sites receive only a small percentage of IHS funds. Thus, even American Indians and Alaska Natives who are eligible for IHS services may not have access to a program. Moreover, IHS offers services only for members of federally recognized tribes, which excludes nearly two-thirds of American Indians and Alaska Natives. Many American Indians and Alaska Natives who do not receive IHS services lack medical insurance and may not seek medical care because they cannot afford it (Urban Indian Health Institute, 2008).

THE ROLE OF CULTURE IN BEHAVIORAL HEALTH SERVICES

As a treatment provider, you will want to help your clients be as healthy as possible and lead a balanced and meaningful life. To do so, you need to understand how a client defines health, balance, meaning, and similar constructs, as well as the specific culture or cultures that are relevant for each client. Many American Indian and Alaska Native cultures share certain values and beliefs; however, what is important for one person or community may differ from another individual or tribe. And, as with any racial, ethnic, or cultural group, differences exist within the same community among members.

For many American Indians and Alaska Natives, the process of healing a mental or substance use disorder will involve reconnecting with their traditional culture, although for others, it may involve distancing themselves from some cultural activities that were connected with substance abuse. Researchers have found that a stronger connection to one's traditional native culture or to certain parts of it (such as spirituality) can be a protective factor against some mental and substance use disorders, although other variables such as gender and place of residence affect this as well. Reconnecting clients with their traditional culture may, depending on the clients' preferences, also aid in the treatment of those disorders. (See the West section discussion of traditional healing and other cultural practices in behavioral health services.)

The Importance of American Indian and Alaska Native Culture to Your Clients

To determine the widely varying role of American Indian and Alaska Native culture in your clients' lives, you will need to discuss it with and assess each client. Some associate very strongly with

their traditional native culture, whereas others consider themselves to be members of mainstream American culture and have little or no connection to native culture. Still others have high acculturation to another nonmainstream culture while maintaining a connection with their tribal culture. Many American Indians and Alaska Natives are multicultural, and they are able to successfully navigate among cultures including mainstream culture.

The process whereby a person from one cultural group learns and adopts another culture is called acculturation. If an individual fully adopts another culture, it is called assimilation. An individual who practices biculturalism is considered to be equally fluent in both his or her culture of origin and mainstream culture. This is often referred to as "walking in two worlds" among American Indians and Alaska Natives. "Enculturation" is a term describing the process by which one learns about a culture. It often describes an individual's knowledge of and connection with his or her traditional culture (Stone, Whitbeck, Chen, Johnson, & Olson, 2006).

Exhibit 1.1-3 shows a sample cycle of assimilation and reconnection of native cultural identity, beginning with traditional native identity and proceeding to reconnection.

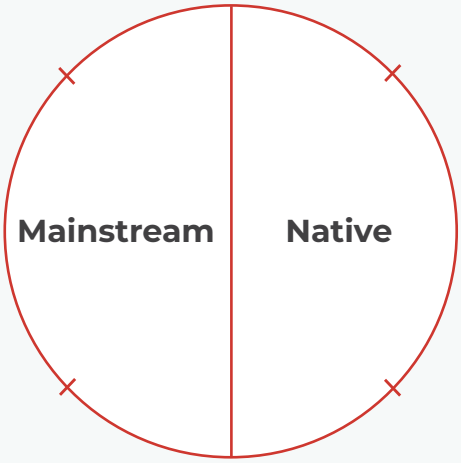
EXHIBIT 1.1-3. Cycle of Assimilation and Reconnection

Reconnection

- Makes conscious effort to return and learn native ways
- Begins to participate in native community activities and customs
- Invests in learning native language, arts, and sociopolitical issues
- Begins to reconnect with identity as native

Assimilated

- Speaks only English
- Has no connection with native communities, spirituality, or traditions
- Doesn't identify with native identity



Traditional

- Speaks only native language
- Lives on reservation, native village, or trust land
- Participates in native traditions (e.g., subsistence lifestyle, ceremonies, traditional medicine)
- Being native is core identity: Walks in the native world

Bicultural

- May speak native language and English
- May live in or near native community or migrate back and forth between native community and urban areas
- Participates in both traditional and non-native activities (e.g., employment, education, interests, relationships)
- Being native is key, yet not sole identity

Acculturation is not a static process. At different points in time, individuals may be at different places on this continuum. It does not represent a hierarchy of values; there is no right or wrong place to be on this continuum. What is important is that clients feel comfortable with their levels of acculturation and not feel acculturative stress because of pressure to be one way or the other.

The East (right) side of the circle in Exhibit 1.1-3 indicates that some native people live traditional lives in traditional American Indian and Alaska Native communities. They may have little contact with non-Native Americans; they may speak only their own languages. They may engage in a subsistence lifestyle, although they may make use of modern technology, such as using snowmobiles instead of dogsleds when hunting. Their worldviews are very similar to those held by their people over centuries. People who are totally immersed in their indigenous cultures would be unlikely to seek treatment from outsiders. When they seek help, they will more likely work with traditional healers.

On the West (left) side of the circle are people who seldom think of their native culture and do not see it as a defining characteristic of who they are. They may recognize that they have native ancestry and even identify their race as American Indian or Alaska Native because of it, but they are very comfortable with mainstream culture, have mainstream values and worldviews, and do not feel that their native ancestry should play a role in their behavioral health services.

Most American Indians and Alaska Natives fall somewhere between these two poles. They may live away from their tribal lands at least part of the time. If they live in a city, they may be active in an American Indian and Alaska Native community center and participate in traditional ceremonies, pow wows, and other native cultural gatherings on weekends or during vacations. They may socialize with other natives as well as non-Native Americans. Some know their tribal language and speak it at home, but most do not, although they may wish they had learned it. They consider themselves bicultural (South).

The North (upper portion) of the circle represents reconnection, thus completing the cycle. Many American Indians and Alaska Natives are making a conscious effort to reconnect with native ways. They are reconnecting and investing in developing a native identity. This may include reengagement of tribal-specific or pan-Indian cultural activities.

Consider this circle for a moment in regard to your own ethnic heritage. How important are the cultures of your ancestors? How do those cultures affect you?

Commonalities Among American Indian and Alaska Native Cultures

Despite the diversity among American Indian and Alaska Native cultures, similarities among them provide common ground. Some beliefs and values are shared by most American Indian and Alaska Native cultures and are distinct from those of mainstream American culture. These are beliefs that are likely to be held by American Indians and Alaska Natives who at least partially associate themselves with native cultures, although for those who are fully acculturated to mainstream American culture, even these broad beliefs may not be relevant.

The American Indian and Alaska Native worldview

The way American Indians and Alaska Natives look at life and the world around them—their worldviews—differ vastly from those of mainstream Americans. Europeans who came to this country believed that the earth and its creatures should serve their needs. American Indians and Alaska Natives believe that they are only one part of creation, dependent on nature, and meant to live in harmony with all things—not just people, but also animals, plants, and the elements. Native traditions teach that all these things have life and deserve respect. Native Americans also traditionally believe in the importance of balance and harmony at all levels of life: internally for the individual, socially among people, and naturally in relationships with animals and the rest of creation. This worldview continues to influence American Indians and Alaska Natives.

ALASKA NATIVE VALUES

Alaska Native cultures have certain values that are of paramount importance to their members. Below are some values that the five major Alaska Native cultures share, although there may be some minor variations among them.

Show respect to others: Each person has a special gift.

Share what you have: Giving makes you richer.

Know who you are: You are a reflection on your family.

Accept what life brings: You cannot control many things.

Have patience: Some things cannot be rushed.

Live carefully: What you do will come back to you.

Take care of others: You cannot live without them.

Honor your elders: They show you the way in life.

Pray for guidance: Many things are not known.

See connections: All things are related.

Source: Alaska Native Knowledge Network, 2006.

The importance of community for American Indians and Alaska Natives

Native cultures are more community oriented than mainstream American culture and less concerned with the importance of individual efforts and privileges. American Indians and Alaska Natives define themselves as members of a family, community, tribe, and nation. Native cultures are most strongly maintained by those living in an Alaska Native village or on tribal lands, but those who live some distance from those lands may still identify strongly as members of a tribe.

Community norms and values play an important role in all aspects of life for American Indians and Alaska Natives, including treatment for and recovery from mental and substance use disorders. Involving family and community members in treatment is important in providing effective services for most American Indians and Alaska Natives. When you provide services in a location that is predominately Native American, you will want to elicit input from community members on how services are rendered and what types of services are needed. However, keep in mind that shame concerning behavior or treatment-seeking related to substance use or mental illness can also affect your American Indian and Alaska Native clients, who may be wary of seeking services because of what others in the community may think.

American Indians and Alaska Natives typically value connectedness and personal relationships. Your interest in the community and in building relationships with community members can help them accept you as a provider and your program. Individuals may be more willing to seek your services and have a more positive experience in treatment. By not limiting your involvement in the community to the treatment milieu but also engaging in the cultural, social, and recreational activities of the community, you will better understand how life there functions.

Family structure

The family is extremely important to American Indians and Alaska Natives, and native families differ in some ways from the mainstream American norm. Some native societies are matrilineal in social organization and descent. This means, in part, that families may trace their ancestral lineages through the maternal side, pass property through female heirs, grant women key decision-making roles in governance, and readily assign custody to mothers or grandmothers. American Indians and Alaska Natives typically define family as extending beyond the nuclear unit, sometimes including people who are not blood relations. About half of American Indian and Alaska Native family households include members of the extended family, and about one-quarter include people who are not directly related to the primary residents. About 30 percent of American Indian and Alaska Native families are headed by single mothers. Grandparents also often raise children, sometimes with assistance from other members of the extended family.

Because extended families are often very close, you may find that they expect to be involved in the treatment process along with their loved ones. Grandparents, aunts, uncles, cousins, and "adopted" family members who are not blood

relatives may play important roles. It is important for you to ask your clients about their families and their willingness to be involved in treatment. You can ask new American Indian and Alaska Native clients questions such as, "Where did you grow up?" "Who raised you?" or "Who are the members of your family?"

American Indian and Alaska Native spiritual beliefs

American Indians and Alaska Natives observe many spiritual practices. Although these spiritual practices reflect diverse, specific beliefs about such things as the creation of the world or the appropriate ceremonies to perform at given times, many share certain basic spiritual principles. These involve living in harmony and balance with others and with the world, believing that there is order to the universe, and feeling a connection with others and with all life.

Spirituality is important for most American Indians and Alaska Natives. For example, 79.2 percent of American Indians and Alaska Natives ages 12 to 17 in 2014 stated that religious beliefs are an important part of their lives, and 72.3 percent believed that their beliefs shape decision making (Center for Behavioral Health Statistics and Quality, 2015). Having a stronger commitment to traditional spirituality is a protective factor against suicide and some mental and substance use disorders for American Indians and Alaska Natives (Eastman & Gray, 2011; Garroutte, Goldberg, Beals, Herrell, & Manson, 2003).

Many American Indians and Alaska Natives are Christians, although many belong to groups that incorporate some native beliefs and practices into Christianity, such as the Native American Church. Less than 0.3 percent of the U.S. population (about one-sixth of the Native American population) identify as practicing traditional Native American religions (Pew Forum on Religion & Public Life, 2008). Still, even among American Indians and Alaska Natives who identify solely as Christian, traditional native spiritual beliefs may affect their view of the world and their place in it. In some native communities, both Christian and native ceremonial rituals occur at the same time (e.g., taking first communion and wearing regalia, smudging at baptisms).

What You Need To Understand About the American Indian and Alaska Native Experience Today

American Indians and Alaska Natives are, genetically or by adoption, members of a community that has experienced centuries of assault on their culture and still survives. To the extent that your American Indian and Alaska Native clients have been connected to native family and community, they know this history, and it likely continues to affect them. They also probably have a strong positive connection with their people and the place from which they come. American Indians and Alaska Natives today are more likely than members of other groups to face a host of problems, including poverty, unemployment, trauma, criminal victimization, physical health problems and disparities, and mental and substance use disorders. However, they continue to be a resilient people who can draw on the strength of their cultures, communities, and families to help face these problems.

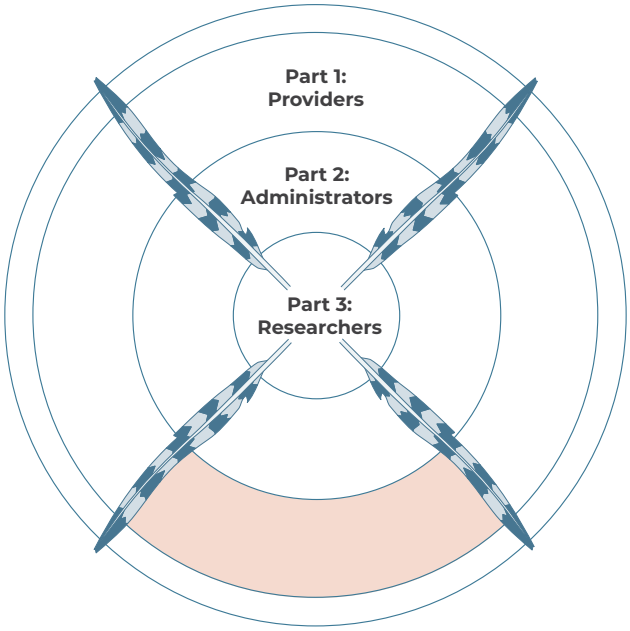
> **The Navajo concept of *hozhq* is used in everyday speech to express one's interconnectedness with other people and the land, balance, and harmony in one's life—elements that are part of one's health and happiness. For example, when someone is leaving another individual, the person may say, *hozhqqgo naninaa doo*: "May you walk about according to *hozhq*." In part, it is a reminder to go about deliberately.**
>
> *Source: Witherspoon, 1977.*

> Realize that we as human beings have been put on this earth for only a short time and that we must use this time to gain wisdom, knowledge, respect, and the understanding for all human beings since we are all relatives."
>
> —Cree proverb
>
> *Source: Saskatchewan Indian Cultural Center, 2014.*

Moving to the South: The Direction of Cultural Awareness and Competence

Because you are reading this TIP, you must already be concerned about cultural competence. If you want to know more about treating clients from American Indian and Alaska Native cultures, you need to make some changes in your practice to best meet their needs, and that means you recognize a need for cultural competence.

Cultural competence is important for all clients, but this section discusses how your cultural competence can affect your treatment of American Indian and Alaska Native clients specifically and how you can build cultural competence when working with those clients. Sections that follow investigate how your cultural competence in relation to native ideas of health and healing can positively affect treatment (the West) and how cultural competence can help you tailor and implement treatment and prevention services for mental illness and substance abuse to make them appropriate for your American Indian and Alaska Native clients (the North). TIP 59 (SAMHSA, 2014a) has a more detailed discussion of how to provide culturally responsive treatment for all clients and includes information on assessing your own cultural identity, models of cultural identity development, and core competencies for providers related to this topic.



Cultural Awareness and Competence (South)

You develop cultural competence in stages, starting with cultural awareness, which is itself a three-stage process. If you have cultural awareness, you will examine how your own beliefs, experiences, and biases affect your definitions of normal and abnormal behavior, behavioral health, and recovery from behavioral health problems. After developing awareness, you will need to expand your knowledge of American Indian and Alaska Native cultures, then work on applying that knowledge to your practice. You can also work to ensure that the organization that employs you takes cultural competence seriously and builds its own organizational cultural responsiveness, a topic discussed at greater length in Chapter 4 of TIP 59 (SAMHSA, 2014a).

Developing Cultural Awareness

Three steps are involved in developing cultural awareness. Becoming aware of cultural differences is the necessary first step. The second step is gaining awareness of your own cultural values and the role they play in your life. The third step is developing an understanding of cultural dynamics, such as cultural barriers, prejudice, and racism, which may occur when members of diverse cultures interact.

Step 1: Awareness of cultural differences

The first step in providing culturally responsive treatment, no matter what the population, is to

> We are social beings; as Alaska Natives we possess a strong history of successes through unity and togetherness. We feel a need to belong. A danger in not knowing who you are is the attraction to be somebody else."
>
> —Students of the Gaalee'ya Project
>
> *Source: University of Alaska Fairbanks, 2013, p. 5.*

become aware of the differences between the culture with which you identify and that of your clients. Once you do so, you will better understand how your clients' cultures may affect them and how your culture affects your interactions with people from other cultures.

Your American Indian and Alaska Native clients are probably already aware of the differences between mainstream American cultures and native cultures. They have likely had to negotiate these differences all their lives. As noted in the discussion of acculturation, most American Indians and Alaska Natives are somewhat acculturated to mainstream society while also being at least somewhat comfortable with their traditional cultures. However, even the most traditional American Indians and Alaska Natives will be exposed to mainstream culture sometimes, whereas most mainstream Americans will have little contact with Native American cultures. This means that you will likely have a lot more to learn about American Indian and Alaska Native cultures than Native American clients will have to learn about mainstream American culture.

If you are completely enmeshed in mainstream American culture, it is easy to assume that your values are the norm. You may not be aware of how other cultures define values and beliefs because you assume that everyone naturally shares your values and beliefs. In some cases, you may even consider signs of straying from that norm as symptomatic of mental illness, even though that behavior may be perfectly acceptable within your clients' cultures (e.g., a client who has had visions during a sweat lodge or another ceremony might be considered psychotic in mainstream culture).

When you lack cultural awareness, you may make assumptions based on the attitude that your American Indian and Alaska Native clients are pretty much the same as you are—or that they should be if they are to recover from their problems. Without cultural awareness, you more easily discount the importance of how culturally defined beliefs, values, and attitudes influence your impressions of clients and the treatment plans you formulate with them.

> **Some practitioners assume that all Native American clients have difficulty in making eye contact. This preconception can oversimplify your clients' behavior and often overshadow the need to explore other explanations if they are quiet, take time to respond, or are looking away. Be overly cautious of stereotypes. Your clients have many sound and historical reasons for being wary of treatment. Your responsibility is to be trustworthy and to take the time needed to build trust and to invest in relationships.**

Of course, your cultural identity may differ from that of mainstream society. Your family may be immigrants or come from a culture within the United States that has values that differ from the mainstream. In that case, you are probably further along in the process of becoming culturally aware and have already thought about your own cultural identity and its relationship to mainstream American culture. Still, even in those cases, you must be careful not to assume that the experiences of a Native American negotiating these cultural differences are the same as the experiences of those in your own cultural community. American Indians and Alaska Natives have a unique history and face unique challenges in their interactions with mainstream culture and its institutions. Even if you have worked with American Indian and Alaska Native clients before or have a cultural connection of your own to American Indian and Alaska Native

cultures, you may still not understand the specific culture of an individual American Indian and Alaska Native client. You will want to keep in mind the diversity of American Indian and Alaska Native cultures and remember that acceptable practices in one culture may not be acceptable in another.

One way to begin noticing cultural differences is becoming conscious of how your own culture shapes your beliefs, values, perceptions, and behavior. Observe your reactions to American Indian and Alaska Native clients' responses and presentation and take time to look at how their cultural, linguistic, and historical experiences may differ from your own; do not assume that every individual from the same cultural group will respond the same way. It is a delicate balance—being aware that culture plays a significant role while avoiding generalizations and allowing for individual differences.

Step 2: Self-assessment of your values

The next step in becoming culturally aware is to look at how your culture affects your beliefs and values. Your culture may be tied to your racial or ethnic identity, or you may identify with mainstream American culture, in which case that culture will help define your beliefs and values. Your culture will shape other things too: perhaps the music you listen to, the food you eat, the holidays you celebrate, the religious or spiritual beliefs you have, your choice of occupation, and the way you spend your leisure time. It will influence your attitudes toward authority, health and wellness, and behavioral health services. Your cultural identity is unlikely to be static, and even the act of becoming aware of your cultural beliefs can cause some change to those beliefs, or at least an openness to changing them.

One way to evaluate how culture affects your beliefs is to look at some beliefs and values common to most, if not all, American Indian and Alaska Native cultures and consider how your beliefs may be similar or different. Exhibit 1.1-4 lists eight cultural values and offers possible explanations as to why these values became important for native societies and how they affect behavior. As you think about these, also think about how your own beliefs and values may differ. It is not a matter of judging one value as right and the other as wrong, but rather, improving your understanding of American Indian and Alaska Native values and beliefs as well as your own.

Step 3: Understanding the effects of cultural differences

After examining just these few cultural differences, you can see the potential for misunderstanding and miscommunication in relationships with American Indian and Alaska Native clients. If you do not understand American Indian and Alaska Native cultures, you might easily mistake modesty and humility for a lack of engagement or a lack of interest in working to acquire wealth as being unmotivated or lazy.

Such misunderstandings feed prejudice, discrimination, and microaggressions at a societal level and in treatment. The third part of developing cultural awareness is understanding how cultural differences can result in prejudice, stereotyping, and racism. Within the treatment setting, this involves evaluating how cultural differences can create misunderstandings that in turn lead to inadequate treatment for American Indian and Alaska Native clients. This is not an easy topic to explore; it requires that you also look at ways in which you and your organization may have discriminated or been biased against people from a culture that is different from your own.

Your American Indian and Alaska Native clients' priorities, values, and styles of communication may differ from yours. Their reasons for seeking healing may be different from what you have experienced before. Their goals may be different from what you expect, and their behaviors in your treatment setting may differ from what you ask of them. You may be frustrated when clients seem slow to open up, arrive late or not at all for sessions, do not speak up in group discussions or group therapy, do not look you in the eye, and evade answering your questions.

But what about the American Indian and Alaska Native clients' frustrations? From their point of view, the provider may seem uninterested in understanding them. He or she may seem to think that a diagnosis—labeling a person—is the

EXHIBIT 1.1-4. Traditional American Indian and Alaska Native Values and Beliefs

NATIVE CULTURAL BELIEFS AND VALUES	QUESTIONS ABOUT YOUR BELIEFS AND VALUES
Cooperation, collectivism, and harmony. Historically, native societies needed a high level of cooperation to survive (e.g., obtaining sufficient food). American Indians and Alaska Natives place value on the importance of the group rather than on the individual. Sharing is vital. Likewise, there is considerable emphasis on living in harmony with nature and with others. To ensure group harmony, groups generally reach decisions by consensus rather than by majority rule.	Are you more cooperative or competitive? Do you value individual efforts more or less than group efforts? Do you see value in arguing? Do you see benefits to a more cooperative society? Do you see drawbacks? Do you see the influence of your family and your family's culture in these beliefs? Is nature something to be conquered or organized?
Modesty and humility. In some ways, this grows out of a focus on collective effort and harmony. In American Indian and Alaska Native cultures, efforts at self-aggrandizement are typically seen as inappropriate. Modesty means that native people may appear cautious with words and actions. Being humble means that one listens to others and doesn't talk for the sake of talking or to make oneself appear more important. Words are used sparingly, and because words are believed to have power, a lot of thought is given to the content and delivery of speech. Sometimes nothing is said. Avoiding eye contact is another aspect of humility, because direct eye contact may be considered a challenge.	Do you feel the need for personal recognition? How important is modesty to you? Does your culture reward humility? Do you think people who don't talk much are shy or disengaged, or do you see other reasons for such behavior? Do you appreciate people who are good conversationalists? Do you assume that people who talk about themselves are more open? Are you suspicious of people who don't? As you listen, do you feel that you need to fill up the silences? Do you think it is important to make eye contact to assert yourself or to create a connection with another individual? Do you assume that people who don't make eye contact have something to hide?
Respect for personal freedom and individual autonomy. Although at first this may seem contrary to the emphasis on cooperation and valuing the group above the individual, it is actually an important part of it. For a close-knit society to work, each member has to respect that others will act honorably and for the good of the whole. This also means that personal advice is not often given, because to do so might suggest that the person receiving the advice did not already know the correct course of action.	Do you think it helps other people to be instructed on how to act? In your culture, is advice freely given? Is being able to give and take criticism considered important? In your culture, is it important for people to make their own mistakes, or is it important for someone to give advice when they believe it is needed?

Continued on next page

EXHIBIT 1.1-4. Traditional American Indian and Alaska Native Values and Beliefs (continued)

NATIVE CULTURAL BELIEFS AND VALUES	QUESTIONS ABOUT YOUR BELIEFS AND VALUES
Respect for tradition and elders. Valuing tradition is necessary if a culture is to survive against the social forces that push it to assimilate. American Indian and Alaska Native cultures perceive respect for tradition as more important than innovation and change. Native cultures have a great deal of respect for elders as those who survived adversity and gained wisdom from it. Those elders help maintain traditions. American Indian and Alaska Native cultures originally communicated by spoken word, which contributes to their respect for this oral tradition. Such cultures prioritized spoken traditions and endeavored to keep them unchanged, whereas written tradition allows change while still preserving past versions. In many native communities, maintaining oral traditions is very important; some forbid writing down traditional stories.	How important are your own cultural traditions to you? Does your culture's history influence how you value those traditions? Do you think that the ability to change is more important than maintaining ties to the past? Are children in your culture taught the traditional language of the family? Do you know songs or stories in your primary language? Does your culture value youth more than age? Does your culture look on its elderly as sources of wisdom gained from experience? In your culture, are the older members emulated as role models?
Work should be done to meet needs, not to accumulate wealth. Native societies did not traditionally stockpile resources or wealth. Strong communal bonds fostered resource sharing. People were not left to fend for themselves. Some native languages do not even have words for ownership in the same sense that European languages do. In these cultures, people who take more than they need would be viewed with suspicion. People may gain respect not for having lots of possessions, but rather for their generosity in giving possessions away. Native societies value generosity and hospitality. Some native cultures traditionally give gifts or distribute surplus wealth. The Athabaskan and other Northwest native cultures hold potlatches to celebrate or honor specific events, whereby one group may host the celebration and distribute gifts to the guests (Langdon, 2002).	How important are material things to you? Does your culture praise people who are wealthy? Does it consider wealth a mark of greatness? Does your culture encourage people to work no matter what? Does it encourage accumulation as a bulwark against future problems? Is it important to pass on wealth to children? How important is it in your culture for people to be independent, and does that affect your attitude toward giving to others and accepting others' generosity? Can you trace your beliefs about money, such as the relative importance of generosity or thriftiness, to your family and your family culture?
Spiritual orientation in all aspects of life. American Indian and Alaska Native spiritual traditions do not separate the spiritual and material, but rather see the two as inexorably linked. Thus, the spiritual pervades daily life and is not compartmentalized. This also means that the natural world can itself be perceived as spiritual or mystical, and what is observed in daily life can teach a spiritual lesson.	How central to your life are your own spiritual and religious beliefs? Are they always present, or do you put aside times to focus on spiritual matters and at other times concern yourself with practical things? Does your culture or religion see the physical world as cut off from the divine or spiritual world? Does your culture define the spiritual as embodied in one host or in everything and every being?

Continued on next page

EXHIBIT 1.1-4. Traditional American Indian and Alaska Native Values and Beliefs (continued)

NATIVE CULTURAL BELIEFS AND VALUES	QUESTIONS ABOUT YOUR BELIEFS AND VALUES
Cooperation with nature. According to American Indian and Alaska Native spiritual beliefs (described in the East), all of nature is alive and worthy of respect. The Earth and all that is on it are considered sacred and worthy of protection. Native societies could traditionally gain sustenance from the natural world in a relatively resource-rich environment, which encouraged this respect. These cultures found that maintaining balance helped resources last.	What are your attitudes toward nature and your place in it? Does your culture believe human beings are at the summit of all things on Earth or merely a part of it, and how does that belief affect attitudes toward the rest of the world? Do you think that scarcity of resources and competition with others means that people should take what they can get from the Earth while it lasts?
The present is more important than the future. Emphasis is on living from day to day and is measured by natural occurrences (e.g., seasonal changes, sunrise/sunset, moon phases). This, combined with attitudes that prioritize listening and paying attention to the world around them, leads these societies to be focused on the present. Focusing too much on the future might keep people from paying attention to the present. Some native languages do not even have a future tense. American Indian and Alaska Native cultures also value patience, believing that things will be done in their own time. This means that it is not as important to get things done on time as it is to let things go their natural course.	How important is it in your culture to plan for the future? Do you think society needs careful planning to function best? Do you believe that schedules and deadlines are necessary to be productive? What are your attitudes about time and promptness? Which do you value more: getting things done on schedule or taking the time to get things done as they should be? Can you trace your attitude about promptness to your family's habits? Is your family from a culture where people value promptness? Does your culture value patience?

WHAT ARE MICROAGGRESSIONS?

Microaggressions are brief, everyday slights, insults, snubs, derogatory statements, or indignities that communicate hostility or negative, judgmental messages to a person in a marginalized group based on his or her race, ethnicity, religion, nationality, sexual orientation, gender expression, gender identity, disability, age, socioeconomic status, or other identity characteristics. Microaggressions may be intentional or unintentional, conscious or unconscious, or verbal or nonverbal acts or environmental cues. Racial microaggressions are a subtle form of racism based on stereotypes of a specific racial or ethnic group. Examples of microaggressions perpetrated against American Indian and Alaska Native people include Indian mascots in high school, college, and professional sports; a White supervisor at work jokingly calling an American Indian subordinate "Chief"; a teacher in a mainstream class singling out an Alaska Native student to stop being so quiet and speak up; or a non-native behavioral health service provider diagnosing an American Indian client with a social anxiety disorder because he has difficulty maintaining eye contact.

Microaggressions have harmful consequences, including damaging the mental health of recipients; exacerbating the psychological effects of historical trauma; contributing to health problems; creating a hostile work or school environment; promoting and perpetuating stereotypes in the broader society; and contributing to the creation of inequities in education, employment, and health care. When providers are unaware of their prejudices and biases toward American Indians and Alaska Natives, their acts of microaggression can damage the therapeutic relationship, increase the premature termination of treatment, and significantly affect treatment.

Source: Sue et al., 2007.

important thing, not the individual. The provider, or the program, is full of advice based on that label and tells the client what he or she should do, as if the client were a child and not capable of reaching his or her own conclusions. The provider seems rude, taking notes, completing paperwork first, or looking directly at the client in a manner that seems disrespectful and sometimes challenging or intrusively intimate. The provider asks a question but is too impatient to wait for the client to think carefully about what is a true and important response. In the group sessions, not only do others give the client advice, but they also expect the client to give advice to others, which is not how one shows respect to others. Much of what typically occurs in treatment may be offensive or at least strange to an American Indian or Alaska Native client.

Culturally responsive behavioral health agencies that serve American Indian and Alaska Native clients adapt to best fit the needs and preferences of those clients. This does not mean that you have to ignore problems, but rather, you need to find a way to address them that will not alienate your American Indian and Alaska Native clients. This is an ongoing process of learning for you, and beginning that process is the next step in developing cultural competence.

Next Steps in Developing Cultural Competence

After building cultural awareness, you will want to further expand your cultural competence by improving your knowledge of American Indian and Alaska Native cultures. Then, you will look for ways to apply that knowledge, using your knowledge of these cultures to frame treatment-related issues in an appropriate manner, adapt treatment strategies and interventions to be culturally appropriate, and develop new ways to provide services for your clients (e.g., through working with American Indian and Alaska Native traditional healers). You will need to regularly reassess your knowledge and your program so that changes can be made to improve the cultural relevance of your services. A helpful acronym for understanding how your knowledge of native cultures (or any cultures, for that matter) can assist in treatment is given in the box that follows.

RESPECT: A MNEMONIC FOR CULTURALLY RESPONSIVE ATTITUDES AND BEHAVIORS

- **R**espect: Become familiar with communication styles. Understand how respect is shown in American Indian and Alaska Native cultures and show respect through verbal and nonverbal communications. Learn to listen. Be comfortable with silence and never interrupt or point with your fingers in conversations.
- **E**xplanatory model: Devote time to understanding how clients perceive their presenting problems, how these problems are understood in American Indian and Alaska Native cultures, and how healing takes place. Be respectful of traditional approaches to healing.
- **S**ociocultural context: Recognize how tribal affiliation, culture, language, gender, gender roles, education, socioeconomic status, sexual and gender orientation, community, family, social organization (e.g., matrilineal), geographic location, and so forth affect treatment.
- **P**articipation: Appreciate that clients may have different expectations about treatment. Take time to understand your clients' perspective and attitudes toward treatment. Discuss the clients' expectation of roles.
- **E**mpathy: Express, verbally and nonverbally, the significance of your clients' concerns so that they feel you understand. If possible, share some of your own experiences.
- **C**oncerns and fears: Elicit clients' concerns and apprehensions about entering a treatment setting and about the behavioral health system.
- **T**herapeutic alliance/**T**rust: Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but that you must earn it. Native clients are likely to place more importance on who you are, rather than what you accomplished, in determining their level of trust in you.

Sources: Bigby & American College of Physicians, 2003; Campinha-Bacote et al., 2005.

Improving Your Knowledge of American Indian and Alaska Native Cultures

You can use a number of ways to improve your grasp of American Indian and Alaska Native cultures, and it is best if you try to make use of all of them. You can learn through reading, attending trainings and seminars, listening to other providers who work with this population, and, most importantly, talking with your clients and other American Indians and Alaska Natives.

Native people can tell you a lot about their cultures, either directly through their responses to questions about their cultures or indirectly through observation both in and out of the treatment setting. You can also talk to other American Indians and Alaska Natives in the community to clarify what you hear from your clients and evaluate it sensibly (e.g., do not assume that the client who engages in binge drinking is speaking for the community when he says that such drinking is acceptable). Working with traditional healers or elders (discussed further in the North section) or identifying a community member who is willing to serve as a cultural consultant are two ways to develop relationships with American Indians and Alaska Natives who are not clients. It also can be helpful for you or your program to become involved in community activities beyond the treatment setting.

To many American Indians and Alaska Natives, mental and substance use disorders do not only affect clients who enter the doors of your treatment center; they affect the entire native community or communities to which those clients belong. By engaging in activities in these communities, you and your program can improve your standing with them and begin to enlist their aid in promoting the recovery of your clients, as well as improving your understanding of your clients' cultures. This involvement may take the form of behavioral health-related community education and prevention services, which are a natural extension of treatment services. However, other types of engagement, such as in community recreational and cultural activities, can also be helpful.

Applying Your Knowledge to Behavioral Health Services

As you learn about your clients' cultures, you can practice applying that knowledge in different ways that will help you improve your interactions with American Indian and Alaska Native clients. You will learn what is appropriate and inappropriate as far as behavior is concerned, which sorts of interactions are likely to elicit positive responses, and which will elicit negative responses from your clients. Communication styles and the use of personal space are culturally defined, and by learning about them, you can make your communications with American Indian and Alaska Native clients more effective. For instance, both research and clinical experience suggest that they respond poorly to providers who try to instruct them on how to behave. They respond well to providers who share their own experiences, use stories, and give examples of how behavioral changes have helped in their own lives, provided the sharing is not excessive.

You will also learn how American Indian and Alaska Native cultures affect behavior in and out of the treatment setting and how cultural beliefs and values can be used to help create positive behavioral changes. Knowing about the socioeconomic and political forces at work in native communities and about Native American history will further help you understand the mental and substance use disorders that affect these communities.

Improving Your Cultural Competence

You will need to continually reevaluate your knowledge of American Indian and Alaska Native cultures and your skills in interacting with clients from those cultures. This may involve correcting false impressions and learning new ways to apply knowledge in practice. You may learn that information that applied to clients from one native culture is not effective with those from another culture (see "The Importance of Knowing the Specific American Indian and Alaska Native Cultures of Your Clients" box for an example).

Several instruments are available to help you assess your cultural competence. These are discussed in TIP 59 (SAMHSA, 2014a) and Part 2, Chapter 2,

of this TIP. Other resources are available online, including the Cultural Competence Health Practitioner Assessment from Georgetown University's National Center for Cultural Competence and the American Speech–Language–Hearing Association's Self-Assessment for Cultural Competence.

It is important to regularly reassess your own skills and knowledge, but you will also need the assistance of your program to evaluate the quality of care provided to American Indian and Alaska Native clients. Providing culturally responsive treatment should improve the quality of care and outcomes for these clients.

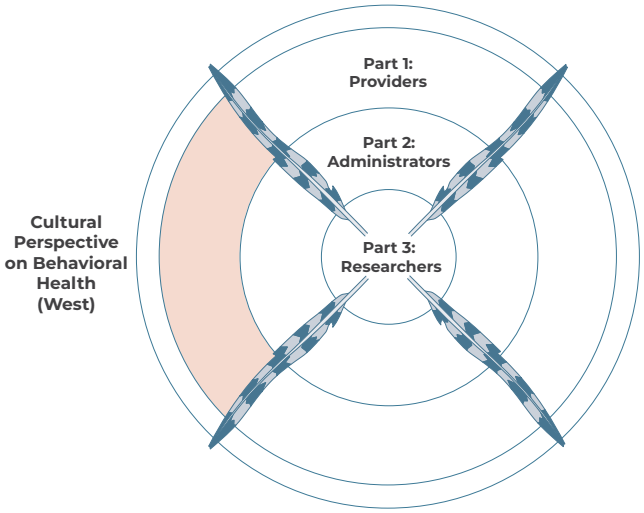
THE IMPORTANCE OF KNOWING THE SPECIFIC AMERICAN INDIAN AND ALASKA NATIVE CULTURES OF YOUR CLIENTS

This TIP emphasizes that not all native cultures are the same. For that reason, you need to learn about the specific culture or cultures of your American Indian and Alaska Native clients. As an example, consider the case of 12-Step groups. A common criticism by American Indians and Alaska Natives is that the groups place a great deal of importance on self-disclosure and confession, which are practices that run counter to many native beliefs concerning humility and appropriate public behavior. However, not all American Indian and Alaska Native cultures have problems with such behavior, and the case of the Coast Salish people is an important exception. This group of tribes traditionally lived on the coast of what is now Washington State and British Columbia in extended families of hundreds of people that did not have established leaders, but rather, reached group decisions democratically. The Salish had a tradition of public confessional dancing, and some later adopted the Shaker religion in which public confessions of "sin" were common. Given these traditions, the public confession aspect of 12-Step groups and the loose democratic organization of those groups may fit well with Salish culture, and Salish people in recovery from substance abuse have generally felt very comfortable with the practices of 12-Step groups.

Source: Jilek-Aall, 1981.

Continuing West: Cultural Perspective on Behavioral Health

As you may expect, traditional American Indian and Alaska Native views on health and healing are considerably different from the mainstream models of health, illness, and treatment with which you are probably very familiar. In the West section, you will find more information about American Indian and Alaska Native concepts of health and wellness, illness and disease, and medicine and healing. This section introduces traditional healing practices and the function of native healers, a topic much larger than can be fully addressed here. This section also addresses American Indian and Alaska Native preferences and beliefs about behavioral health and seeking out behavioral health services. Although the focus is on mental and substance use disorders, the division between physical and behavioral health is not one that is typically recognized in native cultures, so the section begins with a discussion of health in general before moving on to behavioral health.



Although the material that follows is useful, it is very general. You will benefit from further exploring the specific health and healing beliefs of the American Indian and Alaska Native cultures to which your clients belong. The Part 3 literature review (available online) summarizes some resources that may be of assistance. Talking to medicine men and women, healers, and spiritual guides from the cultures you work with would be especially helpful.

American Indians' and Alaska Natives' Concepts of Health and Illness

There is no single American Indian and Alaska Native view of health and healing. Even traditional native cultures differ considerably regarding specific beliefs about the causes of illness and how best to treat them. As discussed further below, most American Indians and Alaska Natives try to balance traditional and mainstream views of health and healing, and many will seek help from both mainstream providers and traditional healers.

Certain basic principles apply to health and illness as they are understood by most, if not all, American Indian and Alaska Native cultures:

- **Health is viewed holistically.** American Indian and Alaska Native cultures rarely make a distinction among physical, mental, emotional, and spiritual health. One aspect of health is believed to affect the others; addressing a problem at one level may help heal problems at other levels. A holistic view also means that prevention and treatment are not divided but seen as part of the same process.
- **Illness affects an individual's community as well as the individual.** The holistic view of health may also extend to the relationship between the individual and his or her community. A health problem that affects one person will have effects on a family, community, tribe, and other individuals as well. This also means that healing the community can positively affect individual health and that the process of healing may need to occur at the community level to be effective for the individual.
- **Being healthy means living in harmony and balance.** Illness occurs when an individual is out of harmony, and healing is a process of restoring balance. This balance is both internal (affecting one's internal mental, physical, and spiritual state) and external (affecting one's relationships with all living beings). Another potential source of imbalance is cultural; American Indians and Alaska Natives may feel a loss of balance or harmony in trying to find equilibrium between the values of two cultures. This is one reason why healing may involve reconnecting with a traditional culture.

Be thoughtful about how you discuss presenting problems. Remember that your clinical training is influenced by the culture and common practices of mainstream health care. These practices can conflict with or be insensitive to American Indian and Alaska Native beliefs. Native people may see labeling an illness (i.e., giving it a name) as a naming ceremony that increases its power. Likewise, they may view discussing prognosis or consequences of a behavior or illness as a prediction or prophecy, believing that thought and language have the power to shape reality and the future.

- **Illness may be purposeful or personified.** An illness may be purposeful, in the sense that it occurs because an individual or a relative has broken some cultural taboo or natural law, which creates a state of disharmony and hence a state of illness. These violations may have occurred recently, in the past, or in a previous generation. Because of this, in some American Indian and Alaska Native cultures, a person may be held at least in part responsible for developing an illness, and the individual who has the illness may see it as his or her responsibility to bear the symptoms. An illness may also be personified in the sense that it has a spirit, and that spirit may need to be addressed as part of the healing process.

Traditional medicine and healing

The traditional view of medicine and healing is significantly different from that of the mainstream healthcare system. Even the word "medicine" has a different meaning in American Indian and Alaska Native tradition. Medicine, in native cultures, is the essence of being or spirit that exists in everything on Earth (Garrett, 1999). Medicine may be good or bad, depending on how it affects the individual. For example, it is good if it restores balance and harmony and bad if it disrupts balance

Behaviors that mainstream providers might label as symptoms of mental illness may be seen among American Indians and Alaska Natives as the expression of special gifts (e.g., hallucinations, manic symptoms). Native peoples may also perceive physical conditions as sacred; for example, dementia may be viewed as a process or sign that the person's spirit has already crossed over into the next world. Although the body has remained behind as it prepares to leave, the person's spirit is already communicating in the spirit world, making it difficult for those left behind to understand the person's language and behavior. Therefore, caring for individuals who are transitioning may be perceived as sacred work.

and harmony. When counseling American Indian and Alaska Native clients with drinking problems, one provider suggests to clients that alcohol is medicine and that by taking it without proper knowledge, the drinker is practicing a form of witchcraft on himself or herself by consciously ingesting bad medicine (E. Duran, 2006).

Traditional healers may be referred to as "medicine men" or "medicine women," but to avoid confusion among different meanings of "medicine," this TIP refers to American Indian and Alaska Native "healing practices" rather than to "medicine." However, terms such as "services" and "practices" may not make sense to some American Indian and Alaska Native clients, so when framing inquiries on the use of traditional healers, it is probably better to use the term "help-seeking."

Traditional Native American healing is a body of wisdom for transforming illness into health through the integration of mind, body, emotion, and spirit. Traditional healing usually involves physical actions like participating in ceremonies or taking herbal remedies. Often, a whole family or community is involved in the healing process through group rituals. Traditional healing can benefit clients in a number of ways (see the "How Does Traditional Healing Work?" box).

In traditional healing, there is much less concern with diagnosis. Healers may have no specific label for a problem but will focus on what may have caused the problem (e.g., breaking a taboo, difficulties stemming from mainstream culture, social or relational conflicts) and what can be done to address it. In some American Indian and Alaska Native cultures, some illnesses or problems (e.g., alcohol dependence) may be recognized as outside or "White man's" problems that traditional healers cannot properly treat, instead requiring mainstream providers' attention.

HOW DOES TRADITIONAL HEALING WORK?

- American Indian and Alaska Native healing practices typically involve community and serve to restore a sense of connection to tribe and culture.
- Traditional practices often increase social support, thereby improving health outcomes.
- Healing rituals improve participants' coping abilities and quality of life. Traditional healers are the keepers of stories with the tribal community. These stories represent themes and often serve to guide individuals on how to handle various problems.
- Traditional healing helps individuals transcend their experiences by identifying the meaning and purpose of those experiences within the context of the community, including the environment.
- Some traditional healing rituals alter participants' consciousness, which in turn can produce a spiritual transformation that affects overall health.

Part 3, the online literature review, has more information on traditional healing's effectiveness.

Traditional Healers

Traditional healers are people who were often recognized even as children as being empathic and having a gift for working with people to lessen their pain. If these talents are recognized in a youth, he or she might be taken as an apprentice by the tribe's traditional healer. If not, he or she will learn from other healers. Training goes on over many years. Some American Indian and Alaska Native cultures (e.g., the Navajo) have carefully defined ceremonies and practices for healing that need to be taught. Other native cultures (e.g., the Inuit) have traditions in which the individual healer must learn through visions and interactions with spiritual entities, and the practice of healing may vary among individual healers.

> **In urban areas, it may be difficult to find a traditional healer. Often, individuals have to travel far or go to the reservation to find healers with the same cultural traditions. Depending on tribal affiliation, traditional healers from other tribes may be accepted or rejected. It may depend on the historical relationships between tribes, individuals' beliefs and practices, and the traditional healer's willingness to work with individuals who are not members of the same tribe.**

The healer does not have the same relationship to the client as a medical provider does, nor is healing something that just occurs in a specialized facility. A traditional healer will recognize that healing is not something that is done by one person to another, but involves participation by the individual, spiritual entities, family, and friends, as well as the healer. Traditional healing may be provided in the client's home, other homes or buildings in the community, or outside the community in a natural setting.

Traditional healers will often only work with members of their own tribe, but some may be willing to work with other Native Americans or even with people of other races. Most traditional healers are spiritual guides and practice traditional native spirituality. Some American Indians and Alaska Natives may not want to work with traditional healers because of religious differences. Christian traditions such as those associated with the Native American Church and the Pentecostal Church also provide healing rituals to American Indians and Alaska Natives. Traditional healing practices and beliefs may be expressed within a Christian context.

Generally, traditional healers do not charge fees for treatment but will accept gifts for services rendered and money for transportation, if needed. There is no official body that sanctions traditional healers, and there are fraudulent practitioners who claim to represent native traditions. As a provider, you should obtain recommendations of traditional healers from tribal members and leaders. If healers are accepted by their tribes' elders and community leaders, they can generally be expected to be authentic.

> **"Plastic shamans" is a term used for individuals who pose as traditional healers or spiritual leaders without any true affiliation to the traditions, healing practices, and culture that they claim to represent. Most often, but not always, they are non-native individuals who steal, misrepresent, and exploit indigenous practices, native knowledge, and sacred ceremonies for monetary or other self-gratifying gains.**

Equally important, you should not facilitate traditional healing practices with native or non-native individuals unless you are an authentic native healer. From time to time, non-native providers have become so enthralled with native culture that they begin to incorporate their interpretation of a

traditional healing practice with clients, implying that it is a native practice. Offering this practice to clients misrepresents and exploits native cultures and crosses many ethical boundaries, beginning with the failure to practice within your area of competence.

American Indian and Alaska Native Healing Practices

The specific practices, rituals, and ceremonies involved in traditional native healing vary considerably among tribes, and clients may feel uncomfortable with or feel that they will gain no benefit from practices associated with other tribes. Some American Indians and Alaska Natives may not feel comfortable with ceremonies that have overtly "supernatural" elements (Hartmann & Gone, 2012). Religious preferences may also affect whether a client finds traditional healing practices acceptable; for example, an American Indian with a strong Christian identity may seek healing from his or her church and feel strongly about not wanting to participate in ceremonies that come from traditional spiritual practices.

Many American Indians and Alaska Natives, especially those in urban settings, may be interested in traditional healing but not know much about it. These clients may want education about traditional healing practices before committing to them. Such education should be provided by individuals experienced in these healing traditions—either healers themselves or community elders with strong ties to their traditional cultures.

Some traditional healing practices are common to more than one tribe, including:

- Offering tobacco with one's prayers, often done in a group.
- Burning herbs or smudging for purification, which can be done alone or in a group.
- Participating in a talking circle, where an object is passed from one person to the next, and each participant is listened to, allowing everyone to express feelings and thoughts.
- Giving herbal medicines either to an individual or to members of a group as part of rituals or for their medicinal properties.
- Performing a sweat lodge or spirit lodge, in which participants sit in an enclosed structure around a pit of hot rocks—a communal experience of purification, prayer, and healing that has been found to improve emotional and physical well-being.
- Performing tribal dances—community events, some of which may be physically strenuous.
- Chanting and singing in groups, which require intense participation and can go on for days.
- Creating personal medicine bags that hold specific meaning for the owner.
- Engaging in other traditional ways, such as going to a winter fish camp, carving, tanning hides, and the like.

In the North section, you will read more about how to integrate American Indian and Alaska Native spiritual and healing practices into a behavioral health program.

American Indian and Alaska Native Perspectives on Behavioral Health Problems

American Indian and Alaska Native clients' views of behavioral health interventions will likely contain elements of both traditional and mainstream treatment services and possibly from Christian healing traditions. Native people often use both types of treatment services. Nonetheless, as a provider, you need to remember that traditional healing practices do not separate mental disorders from physical and spiritual ones. They do, however, recognize problems that mainstream health care identifies as mental and substance use disorders, even if they are only symptomatic of other underlying problems. Traditional healers may look at someone who would be diagnosed with depression and view the same symptoms as problems stemming from breaking a taboo or from unbalanced relations with family or community. Whatever the cause, the symptoms would still call for treatment to restore balance and harmony.

For many behavioral health issues (e.g., substance abuse, suicidality), the underlying cause may be the loss of connection to traditional native culture, historical trauma, and conflict between native and mainstream culture. For example, Native

American recovery movements have traditionally viewed alcohol as an instrument in the European subjugation of native peoples. This is one reason that many American Indians and Alaska Natives talk about their culture as a form of healing or prevention, particularly in relation to mental and substance use disorders. Participation in traditional cultural activities (e.g., potlatches, pow wows, crafts, singing, dancing) is a component of many behavioral health programs that provide services primarily to American Indian and Alaska Native clients. However, if clients in early recovery have used alcohol or drugs during community activities in the past, they may need to limit participation or acquire support before and during community activities as a relapse prevention step.

METHAMPHETAMINE IN INDIAN COUNTRY

Methamphetamine has disproportionately devastated native tribal communities. Mexican drug cartels have been deliberately targeting rural reservations for the sale of meth and as distribution hubs. Native Americans now experience the highest meth usage rates of any ethnic group in the United States.

"Some of the reasons drug cartels have targeted Native communities are the complex nature of criminal jurisdiction on Indian reservations, and because Tribal governmental police forces have been historically under funded and understaffed. However, given this new challenge, Tribal leaders have been at the forefront of new and creative solutions and approaches that many other communities may find helpful in their struggles" (National Congress of American Indians, 2006, p. 1).

For more information on substance use patterns and their effects on behavioral health, see Part 3, the online literature review, and the *American Indian/Alaska Native Behavioral Health Briefing Book* (IHS, 2011).

Mental and Substance Use Disorders Among American Indians and Alaska Natives

You are already aware that American Indians and Alaska Natives are at increased risk for certain behavioral health conditions (e.g., substance use disorders, anxiety disorders) and related problems (e.g., suicidality). The sections that follow will help you understand how such disorders affect American Indians and Alaska Natives and the reasons behind this increased risk. For a detailed review, please refer to the TIP's online literature review.

Alcohol and other substance use disorders

American Indians and Alaska Natives generally start using alcohol and other substances at a younger age than do youth from other major racial/ethnic groups. Early substances use is linked with greater risk for substance use disorders. Poverty and unemployment, common problems for Native Americans, are themselves risk factors for alcohol and other substance use disorders, as are the disruption of families, trauma exposure, historical trauma, and continuing discrimination.

The primary substance of abuse for American Indians and Alaska Natives, as it is for Americans in general, is alcohol. Although many Native Americans do not drink at all, binge drinking and alcohol use disorders occur at high rates relative to other populations. Binge drinking among American Indians and Alaska Natives largely reflects the drinking patterns to which they were first exposed when alcohol was introduced to their cultures through the drinking patterns of White American frontiersmen, fur traders, and others. Other factors

IS BINGE DRINKING DANGEROUS?

Binge drinking, or consuming large amounts of alcohol in a short period, causes serious health risks despite the recovery periods between binges. The body metabolizes alcohol at a fairly steady rate. When larger amounts of alcohol are consumed, the body is not able to keep up with the consumption. Higher blood alcohol concentrations occur, and the body and its organs are exposed to the higher concentrations for longer periods. This leads to cumulative and devastating effects on the body. Binge drinking is associated with higher death rates, injuries, heart attacks and other cardiac problems, liver damage, poor control of diabetes, and cancer. Additional factors, such as gender and age, influence the body's ability to metabolize alcohol.

also influence binge drinking, such as the difficulty of consistently getting alcohol on dry reservations or in remote native villages, the perceived or established social norms surrounding the use of or abstinence from alcohol at local community events, and unemployment and poverty (which may mean for some that alcohol can only be purchased intermittently).

The second most common substance of abuse for Native Americans is marijuana, and American Indians and Alaska Natives are more likely to develop cannabis use disorder than are members of many other racial groups. Both methamphetamine and prescription opioid abuse are growing problems for American Indians and Alaska Natives and are of major concern in a number of native communities. Geographic factors partly affect patterns of substance use (e.g., Native Americans are more likely to live in states where methamphetamine abuse is more common), as do the same risk factors that affect alcohol abuse.

Mental disorders

Among American Indians and Alaska Natives, the most significant mental health concerns today are traumatic stress, depression, anxiety, and bipolar disorders (see Part 3's literature review for more information). Research suggests that American Indians and Alaska Natives are more likely than the general population to have psychological distress that interferes with daily functioning and to have higher suicidality. As with other populations, mental disorders in American Indians and Alaska Natives frequently co-occur with substance misuse and substance use disorders.

Important differences exist among native cultures as to the types of symptoms they most often express or report to providers. For instance, American Indians and Alaska Natives are more likely to report somatic (physical) symptoms related to depression. Keep in mind that physical and psychological symptoms are not typically separated from each other.

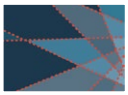
Depression is a common diagnosis associated with traumatic stress and is one psychological consequence of it. American Indians and Alaska Natives experience very high rates of trauma with the background of historical trauma. Individual traumas—including suicides in the community, domestic violence, physical and sexual assaults, and accidents—are the most common traumas contributing to the development of traumatic stress disorders. The effects of historical trauma and other traumas can negatively affect behavioral health and may increase the risk of developing substance use, mood, and anxiety disorders.

Preferences and Barriers Regarding Behavioral Health Services

Preferences

Many providers believe the myth that American Indians and Alaska Natives do not seek treatment for mental and substance use disorders. In stark contrast to this stereotype, native people actively seek help from traditional healing, mainstream treatment, and mutual-help groups, or a combination of these interventions. American Indians and Alaska Natives who live in native communities and are more traditional prefer services provided in the community to those provided off the reservation or outside the community and traditional healers over mainstream behavioral health service providers. However, even on reservations, clients will use both mainstream and traditional healing. Although some individuals may prefer American Indian and Alaska Native providers, cultural competence and interpersonal qualities play a significant role when it comes to provider preference.

> **Some individuals may prefer to travel a considerable distance to seek services off the reservation if they are concerned about maintaining their anonymity in their local community. For instance, it is highly probable that clients will know people working at the treatment program if they seek services within their community. Your clients may also be reluctant to attend the program because it is located somewhere where it is difficult to remain anonymous when entering the building or parking their cars.**



American Indians and Alaska Natives use behavioral health services at a rate second only to White Americans and may be even more likely to use substance abuse services specifically. They are more likely to believe that people with mental disorders can get better without professional help and less likely to believe that therapy can teach people new ways of coping with problems.

It may be easy to mislabel clients' reluctance to use mental health services as treatment resistance or the result of prejudice against people with mental illness. However, reluctance may result from well-grounded, historically based mistrust in outside institutions. This is a response to events such as the history of boarding school placement and unwarranted removal of native children to non-native foster and adoptive homes.

> **Screening and assessment of psychotic disorders are difficult in some Native American cultures that consider seeing visions a positive event not necessarily indicative of psychosis.**

Barriers to treatment services

American Indians and Alaska Natives face many barriers to accessible health care, including behavioral health services. These obstacles contribute significantly to the development of health disparities among native people. There are different levels of barriers regarding the use of behavioral health services (e.g., sociocultural, systemic, individual), and these obstacles need to be anticipated. Addressing systemic barriers, such as insufficient government funding, may be too great a challenge for an individual provider, but some obstacles are within your control. You may be able to address these obstacles directly or find creative ways around them; the first step is taking the time to understand the most common barriers. The following list highlights common barriers to treatment:

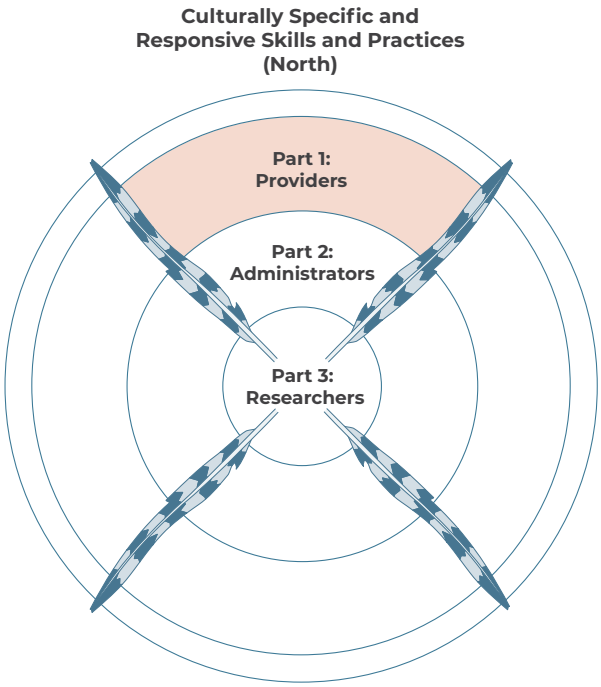
- Physical distance from service providers
- Concerns about maintaining anonymity in smaller communities
- Shame and prejudice associated with mental health services
- Lack of child care and transportation
- Perception that treatment contradicts cultural values of noninterference and self-reliance
- Limited number of American Indian and Alaska Native providers
- Lack of culturally competent providers who fully understand things such as emotional expressions, the role of historical trauma in presenting symptoms, and the effects of the cumulative stress of violence and discrimination
- Failure to consistently conduct individual assessments on cultural identification and traditional healing practice preferences
- Limited funding or treatment options of tribal or community services
- Failure to establish cultural brokers, including tribal leaders or native mentors, to help in arranging traditional healing practices from authentic providers
- Inability to provide services in native languages
- Mistrust of government-funded social services

The North section that follows presents more information on how to adapt your program to make it more effective for American Indian and Alaska Native clients, including how to integrate traditional healing and cultural activities and how to modify standard behavioral health interventions to integrate native culture.

Arriving in the North: The Direction of Culturally Specific and Responsive Skills and Practices

How can your knowledge about American Indian and Alaska Native cultures help you provide treatment that is more effective for your clients? In the North quadrant, you will find answers to that question. The North will give you information about how to modify your behavioral health services to best meet the needs of American Indian and Alaska Native clients.

Native American clients will likely feel more comfortable in treatment and have better outcomes if they find that you understand their culture and respect it and them. Prevention programs are more effective for American Indians and Alaska Natives if you spend time learning about their community and culture.



Not all American Indian and Alaska Native clients identify with or wish to connect with their traditional cultures, but culturally responsive services offer all clients a chance to explore the impact of culture (including historical and generational traumas), acculturation, discrimination, and bias and how these relate to their mental and substance use disorders. They also assist interested clients in recognizing cultural strengths that can support recovery. Adding American Indian and Alaska Native cultural practices to a program can improve outcomes for all clients.

Cultural competence is important throughout the continuum of outreach, prevention, treatment, and continuing care. Part 2 of this TIP discusses considerations for cultural responsiveness in outreach, operational issues, and treatment environments, as does TIP 59 (SAMHSA, 2014a).

Culturally Responsive Relationships: Provider Guidelines and Considerations

As your understanding of native cultures increases, you will see how your behavior in treatment settings can positively or negatively affect your relationships with American Indian and Alaska Native clients, whom mainstream behavioral health services often fail. Providers sometimes label American Indian and Alaska Native clients as unresponsive or resistant to treatment because they do not recognize their clients' preferences or needs and how best to positively address those needs and concerns that initially brought them to treatment. This failure may occur at a programmatic level, but it can also result from interactions in which clients perceive providers as paternalistic, impatient, disrespectful, or ill-informed about their cultures.

To avoid some potential problems in counseling American Indian and Alaska Native clients, remember the following general guidelines for providing care, fostering communication, and building relationships. These guidelines may improve services for many American Indian and Alaska Native clients, but consider each in light of what you know about your individual client.

Knowing yourself

Be who you are. American Indians and Alaska Natives prefer providers who are authentic—who can simply be themselves. Respect your own cultural heritage and be willing to talk about it from the outset. Do not try to be "Native American" or to act in preconceived ways that fit your views of how American Indians and Alaska Natives behave. Doing so disrespects clients' culture. However, you should adjust your treatment approach to be culturally responsive.

Use your own experience. American Indian and Alaska Native clients may not respond well if you simply tell them what they should do, but they will respond positively to you if you share your own experiences of how you have coped with

> **Health problems are associated with higher rates of depression. American Indians and Alaska Natives often report a triad of depression, diabetes, and alcohol abuse. Cardiovascular disease has joined this equation and is a leading cause of death in native people in recent years.**

problems or of how others in your practice have dealt with their presenting issues. Remember that many native people often see those giving them advice as meddlers. This perception can be simply stated, "If I respect you, I will not interfere in your life." Native clients are more likely to be initially suspicious of services or individual providers until a relationship has formed—so be wary of giving advice too quickly. If you offer suggestions, make sure you yourself can follow them. Remember, "Walk the walk; do not just talk the talk." For example, if you emphasize the value of community, then it is important to periodically attend local community cultural events.

Supporting communication

Listen and respect silence. The most important thing you can do is listen. Many American Indian and Alaska Native people are slow to speak. There are good reasons for this; they believe that words are important and must be chosen, and your clients may need to think carefully about what they are going to say before they say it. In some native cultures, being quiet is a way of showing respect. If English is a second language, clients may pause between sentences to allow themselves to translate their thoughts before speaking. Make sure to give people time to formulate an answer before you move on. Accept that there will be times of silence and that this silence is not "unproductive." Be patient and avoid jumping in to finish your clients' sentences.

Adjust your eye contact. In some American Indian and Alaska Native cultures, it is disrespectful to hold eye contact. You will have to judge what seems appropriate for the client you are treating. If your client does not want to make eye contact, then do not, and do not assume because he or she looks away that he or she is not interested or being dishonest. Your client may be trying not to be disrespectful to you, or he or she may be thinking about how to respond.

Observe nonverbal communication. As you listen and observe, you may feel that you miss important parts of the conversation. Some communication is unspoken, implied, or embedded in the conversation or story. Nonverbal communication and the space between verbal exchanges are important. The best way to learn communication styles is to observe clients and others in the community and to ask questions about nonverbal communication, including nonverbal cues.

> A man's life proceeds from his name, in the way that a river proceeds from its source."
>
> —N. Scott Momaday (1976, p. 49), Kiowa, quoting his great-grandfather, Pohd-lohk

Determine and value linguistic preferences and abilities. Language is important. Many anthropologists believe language is culture: once language is lost, the knowledge that accompanies that language is lost as well. This is particularly devastating for native communities, which have relied on the oral tradition, particularly for storytelling. Many American Indian and Alaska Native communities are working to save their languages before the few elders who are fluent are gone.

For most American Indians and Alaska Natives, English is their primary language, but about 15 percent speak a native language in their home, and about 13 percent speak another language other than English, usually Spanish (Siebens & Julian, 2011). A number of those individuals speak English as a second language. You should ask American Indian and Alaska Native clients whether they are comfortable receiving services in English, and if not, connect them to services in their own language or find a trained translator to assist in providing services. Some native languages have fairly few speakers, so a translator may not be available in your area, but providing services with a translator who is teleconferenced into treatment sessions is one option that you may consider

> **Native American Indian communication style can be comparable to the spokes on a wheel, and, out of respect for the listener, the main point may be left implicit.**
>
> *Source: LaFromboise, 1995.*

(TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* [SAMHSA, 2015], has more information on this option).

Use hopeful language and avoid labeling. Mainstream behavioral health models often emphasize diagnosing and treating the "disorder." However, focusing on naming the disorder is likely to be counterproductive with American Indian and Alaska Native clients. In native cultures, names and naming traditions are extremely important. Naming a person identifies those traits a person is expected to live up to. Thus, labeling a client as having a specific disorder can be a form of self-fulfilling prophecy. Naming a disorder may also be shaming to American Indian and Alaska Native clients.

The same concerns apply to discussing prognosis. Some clients may believe that stating something that could happen in the future will cause the event to occur. You may find this belief particularly challenging if you tend to focus on the consequences of substance abuse. Yet American Indian and Alaska Native community members may not readily seek treatment with you if prognosis is a common part of your approach. They may believe that the future is unknowable, save to the Creator. Before discussing consequences of behaviors or disorders, seek the counsel of someone knowledgeable about your clients' culture and ask clients about their beliefs and preferences.

Frame things in more hopeful terms and use a strengths-based perspective whenever possible. Calling an American Indian or Alaska Native "a person in recovery" rather than "a person with an alcohol use disorder" will likely improve the client's reaction and possibly the prognosis.

Remaining flexible and embracing new opportunities

Be flexible with your time. American Indians and Alaska Natives sometimes speak of "Indian time," which reflects an attitude that things will get done in their own time or in the "right" time and not according to predetermined schedules. If possible, try to accommodate this, and be prepared for clients who may want to contact you after your office hours. Have an open-door policy and hold office hours for drop-in visits. Do not take it personally when clients arrive late; work with them to find solutions that meet both your needs.

> "As a counselor working at the university's health services serving Native American students, I found that setting aside recurring time slots during the week for drop-ins increased participation in other services, including prevention activities. This open-door approach created a welcoming atmosphere."
>
> —Anonymous

Expect more family involvement. For many American Indians and Alaska Natives, family is central. Family can be an excellent motivator for help-seeking and a support to recovery. If your client is connected with family, he or she may want family members to participate. However, as with all families, some family members may be a source of conflict or unsupportive. If your client is estranged from family, this is an important issue.

It is likely that your American Indian and Alaska Native clients' families will want to be involved to a greater extent than families from other racial and ethnic backgrounds. The definition of "family" for American Indian and Alaska Native clients will likely include extended relations, such as second cousins, family friends, and other unrelated community or village members. It is important to avoid using your own definition of family in determining who should participate in family sessions. Likewise, family hierarchies, structure, traditions, roles, and rules may vary from tribe to tribe. Therefore, it will be crucial to learn about families and family systems in the context of tribal affiliation, acculturation level, and individual and community historical events.

Anticipate laughter. Most American Indians and Alaska Natives have an incredible sense of humor. This love for laughter and the use of humor span many generations. Humor is often a means of addressing and surviving many difficult and painful situations. It can also help address a specific

AMERICAN INDIAN AND ALASKA NATIVE HUMOR: ITS ROLE IN COMMUNICATION AND HEALING

"One of the best ways to understand a people is to know what makes them laugh. Laughter encompasses the limits of the soul. In humor, life is redefined and accepted. Irony and satire provide much keener insights into a group's collective psyche and values than do years of research.

"It has always been a great disappointment to Indian people that the humorous side of Indian life has not been mentioned by professed experts on Indian Affairs. Rather the image of the granite-faced grunting redskin has been perpetuated by American mythology.

"The Indian people are exactly opposite of the popular stereotype. I sometimes wonder how anything is accomplished by Indians because of the apparent overemphasis on humor within the Indian world. Indians have found a humorous side of nearly every problem, and the experiences of life have generally been so well defined through jokes and stories that they have become a thing in themselves.

"For centuries before the white invasion, teasing was a method of controlling social situations by Indian people. Rather than embarrass members of the tribe publicly, people used to tease individuals they considered out of step with the consensus of tribal opinion. In this way, egos were preserved and disputes within the tribe of a personal nature were held to a minimum.

"Gradually people learned to anticipate teasing and began to tease themselves as a means of showing humility and at the same time advocating a course of action they deeply believed in. Men would depreciate their feats to show they were not trying to run roughshod over tribal desires. This method of behavior served to highlight their true virtues and gain them a place of influence in tribal policymaking circles.

"Humor has come to occupy such a prominent place in national Indian Affairs that any kind of movement is impossible without it. Tribes are … brought together by sharing humor of the past."

Source: Deloria, 1988, pp. 146–147.

problematic behavior without showing disrespect to an individual or family. The role of humor and its intricacies within native cultures cannot be explained in one or two paragraphs. It is a central aspect of native life, yet this attribute often goes unnoticed by non-natives.

As a provider, you need to know that humor may significantly help your client to be more resilient. Humor can promote healing. Equally important, humor can have implied or hidden meanings. Do not readily assume that humor is a defense to distract from underlying issues. Think about the context of the humor. It may express straightforward humor, indirectly emphasize the importance of something, distract from painful experiences, or signal that trust is evolving in the relationship.

Give things time. You may misjudge the strength of relationships with American Indian and Alaska Native clients because you think sufficient time has passed for these relationships to solidify. Therapeutic relationships with American Indian or Alaska Native clients may take more time to develop than relationships with other clients. Native clients may be suspicious because of prior provider experiences that did not go well or because they see you or your program as representations of a government that has, more often than not, hurt rather than helped American Indians and Alaska Natives. The time it takes for American Indian and Alaska Native clients to develop a relationship with you may also indicate that they are taking the relationship seriously and evaluating it carefully. Thus, it is essential that you take sufficient time to show clients that the relationship is important to you as well and that you value each client as a person, rather than as a "task" that you are trying to complete.

Plan to provide practical assistance as well as therapy. From a holistic perspective of health and healing (i.e., perceiving everything as connected), it is natural for clients to expect broader discussions and to seek help that falls outside a typical behavioral health focus. This may include discussing concerns about or seeking suggestions from others in the community. Like many clients who seek behavioral health services, American Indians and Alaska Natives have multiple needs. Treatment planning should include a "case management" approach that helps address housing, transportation, education, vocational training, unemployment, legal assistance, physical health care, child care, relationship and community concerns, and domestic safety. A more expansive view of treatment will strengthen your therapeutic relationship and help you give native clients the support necessary for long-term recovery.

Be open to new ways of conducting treatment. As you work with American Indian and Alaska Native clients and with other providers who are experienced in providing services for Native Americans, you will likely hear of different techniques and activities that can enhance services for your American Indian and Alaska Native clients. You may need to consider using different interventions or altering interventions in some way. For example, if talk therapy is difficult for your clients, you might consider incorporating more experiential exercises in the session, such as walking meditation, using artwork to tell a story or display a current struggle, visualizations, or sculpting (see the "Sculpting: An Experiential Approach to Treatment" box).

Mainstream approaches may not be an effective avenue, and they may not be the first step in treatment. It is important for some native people to seek consultation with a traditional healer prior to coming to a counseling program. For others, a referral to a culturally oriented program may be more appropriate (e.g., Alaska Native spirit and cultural camps). Adjustments will need to be made on an individual basis to provide the most appropriate treatment, but it will be helpful if you can present clients with options.

SPIRIT AND CULTURAL CAMPS

"For those working with individuals who struggle with the effects of alcohol and other substance abuse in their lives, it has become increasingly evident that the pathway to healing is substantially stronger for those who have been raised with traditional Alaskan values [when they] reunite with those values" (First Alaskan Institute, n.d., p. 9). In the past decade, communities have developed several treatment program alternatives using a camp setting model to provide spiritual and cultural guidance (e.g., the Tanana Chiefs Conference Old Minto Family Recovery Camp, an Athabascan alternative to substance abuse treatment).

The camps offer a path to prevention for children and adults and a way to recovery for families. Many camps are seasonal and provide opportunities to connect, experience, and practice traditional ways (e.g., subsistence practices, language, dance, history). Some camps are specifically organized to address substance use disorders and recovery through an integrated cultural approach using community, group, and individual modalities.

SCULPTING: AN EXPERIENTIAL APPROACH TO TREATMENT

Sculpting is a tool for making an external picture of an internal process such as an experience, a perspective, feeling, or presenting concern. It includes the use of postures, positions, gestures, spacing, and objects to demonstrate a presenting issue or theme. For example, imagine a family photograph. Now picture the client as the photographer who asks other participants to stand in a certain position in relationship to one another. In sculpting, the client is the photographer, and you are the assistant who guides the process.

The photographer (client) repositions other people in the room to demonstrate current concerns. In a group setting, you might have the person create a picture using other group members to demonstrate the potential barriers to abstinence. The client would discuss and name each barrier, then each group member would represent one or two barriers, and the client would position them according to importance. Or you, the provider, might become the photographer so that you can demonstrate a concept or pattern for the client. For example, you might help the client name personal strengths that he or she has demonstrated throughout his or her life, followed by setting up a picture of these strengths, either using group members or a drawing (if it is an individual session). In doing so, the individual receives a powerful picture: it is knowledge that the client will not likely forget, because it goes beyond words. It is a powerful physical, emotional, and visual experience.

Recognize and support the significant role of prevention in American Indian and Alaska Native communities. As a provider, you need to understand that native communities believe that cultural knowledge and practice are the pathway to prevention and healing. Many American Indians and Alaska Natives view mental and substance use disorders through a historical lens whereby such disorders are illnesses of infliction characterized by historical losses, deculturation, and racism. Individual behavioral health conditions are seen as symptomatic of the aftereffects of this history in the community. Honoring children and young people is a common tenet of American Indian and Alaska Native cultures. Without culture and the young, there is no future. Therefore, considerable efforts are underway to maintain, introduce, and teach cultural traditions and other cultural knowledge as prevention activities. Likewise, communities are using community readiness assessment and prevention strategies to help address specific problems represented within the community. As a provider, it is important to promote, support, house, and help facilitate the development of these prevention activities in native communities.

Making introductions as a provider: First meeting

Remember American Indian and Alaska Native etiquette for introducing yourself. Be sure not only to give your name and job title, but also to explain briefly something about yourself, what you are doing, and why. It may help if you can use some examples from your own experience. It is often far more important to talk about who you are than what you have done. For example, talk about things such as your family (past or present), your birthplace, and where you grew up. You should also introduce your program and what it does, as not all clients will have prior experience with behavioral health services or understand how they work. American Indians and Alaska Natives generally want to know who you are before deciding if they should trust you. Take your cue from clients when it comes to offering a handshake and expect that it may be very light rather than hearty; this is a sign of politeness and respect in some tribes. Keep your eye contact brief at first until you observe the habits of your clients. This, too, could be a sign of respect. Listen carefully to how your clients introduce themselves. Get comfortable with your own silence rather than allowing your potential anxiety about silence in a conversation to push you to talk too much or ask too many questions.

Explain confidentiality. All clients may have concerns that information about themselves and what they say in treatment might be shared with others, but this is an especially strong concern in smaller, rural communities such as those that exist on many reservations. You should tell new clients what information will be shared and with whom. As mentioned earlier, clients may have strong concerns about being seen entering a treatment

facility or parking their car outside. One solution is arranging alternative transportation, if available. Another major concern about confidentiality is that clients may know someone who works at the facility. In a small community, it is common to have relatives or other people clients know working in the program they are attending. This can be a significant barrier. Clients may not believe in the promises and policies of confidentiality. After gaining consent, connecting clients with other community members who are in recovery may help decrease these concerns. Sometimes, these concerns will only be alleviated by referring clients to another facility.

> **American Indians and Alaska Natives have historical cause to wonder whether behavioral health service providers will recognize them for who they are, respect them, and assist them in walking their life paths. History has taught native peoples that it is dangerous to trust outsiders. Their lives—the lives of their parents and grandparents—have been taken or forever altered by outsiders.**

Choosing Directions: Intake, Assessment, and Treatment Planning

This section is not a primer on how to complete intakes or assessments or how to develop treatment plans; it is expected that you know how to conduct these tasks. Instead, the suggestions presented below highlight several key ingredients and considerations when planning services with your American Indian and Alaska Native clients.

Obtain clients' perspective first. Ask how your clients see the current situation, what led up to the current concerns and the decision to enter treatment, what caused the problems, and what thoughts they have about how to return to a more balanced state. Ask what clients have already heard about the kinds of concerns or problems they are having and what steps or paths they have already

> **Your clients may view intakes and assessments as unnecessary. Some American Indians and Alaska Natives are accustomed to traditional healers who know what their problems are without taking a history. Engage the client before paperwork.**

taken to heal or gain relief. How do they see the problem? Ask how it affects different aspects of their lives: spiritual, relational, emotional, physical, and mental. How does what other people say about the problem affect your clients? Ask them what they may need to do to heal and what successful healing would look like for them. Also listen for clients' motivation for recovery. Common motivations for addressing mental illness and substance use disorders include the need to be a responsible parent or involved family member, the importance of religious and spiritual practices, criminal justice involvement, and the need to support a healthy community.

Explore and assess cultural identity. It is vital to spend time understanding the way individuals frame their own cultural heritage throughout their lifetime—from the past to the present. As you spend time with your clients, listen for the importance and influence of native culture. Some clients may have little connection or identification with American Indian and Alaska Native culture; other clients may have strong ties to native culture and primarily relate to the world in traditional ways. Most clients will identify with a particular native culture or cultures, but some will have a more pan-Indian identity. Many who grew up in traditional and mainstream culture will have adopted a bicultural perspective, maintaining their identity as American Indian or Alaska Native and operating in both the traditional and the mainstream cultures. Cultural identity does not need to be assessed using an inflexible continuum that perceives the process of becoming acculturated to a new culture as lessening one's identification with one's original culture. American Indians and Alaska Natives have clearly demonstrated fortitude, resourcefulness, and an ability to negotiate both cultures at the same time. There are a few instruments available

QUESTIONS TO HELP YOU ASSESS CULTURAL IDENTITY

Learning how your clients identify with their culture will help guide the healing process and influence the selection of treatment approaches. Asking open-ended questions will help you learn more about your clients' treatment preferences and needs as well as their identification as American Indians and Alaska Natives. For illustrations on how to ask questions, use the Native American Motivational Interviewing Manual (Venner, Feldstein, & Tafoya, 2006). It suggests questions such as, "For many native people, cultural identity is important, and people have all different levels of comfort and belonging with one or more cultures. What is important for me to know about your cultural identity as we begin to work together?" (p. 53).

Below are some sample questions. As a precautionary note, remember not to move quickly from one question to the next. Take your time. In addition, remember that it is inappropriate and disrespectful to ask for detailed information about ceremonies.

- How do you self-identify?
- Who raised you?
- Where were you raised?
- Who is in your family? Who is helping to raise your children?
- How have you been exposed to the culture of your tribe? Stories? Ceremonies? Community events?
- What languages do you speak? Which do you prefer?
- How would you describe your spiritual beliefs? How do you practice your spirituality?
- What is your experience with traditional healing practices?
- How important is it to you to work with a healer or medicine person in addition to your treatment here?
- Do you have a traditional healer or advisor who is currently working with you?

to assess cultural identity for American Indians and Alaska Natives, such as the Native American Acculturation Scale (Garrett & Pichette, 2000).

Assess trauma, including historical trauma. American Indians and Alaska Natives experience high rates of trauma and traumatic stress responses, such as PTSD. They disproportionately experience many kinds of trauma, including types that may be particularly difficult for clients to discuss (e.g., childhood abuse, sexual abuse). Still, it is important that you evaluate the trauma experiences of your American Indian and Alaska Native clients, as such experiences can affect behavioral health in many ways. TIP 57 (SAMHSA, 2014b) discusses how trauma can affect behavioral health and how to assess trauma and its effects.

As you read in the East section, historical trauma is an important concept for understanding American Indians' and Alaska Natives' behavioral health, and many clinicians who work with this population identify the assessment of historical trauma response as a key element in behavioral health services for American Indians and Alaska Natives. The "Symptoms of Historical Trauma Response" box presents possible symptoms of response to historical trauma.

SYMPTOMS OF HISTORICAL TRAUMA RESPONSE

- Survivor's guilt
- Depression
- Psychic numbing
- Emotional fixation on trauma
- Low self-esteem
- Victim identity
- Anger
- Self-destructive behavior
- Substance misuse
- Hypervigilance
- Compensatory fantasies
- Preoccupation with death
- Death identity (e.g., fantasies of reunification with the deceased)
- Loyalty to ancestral suffering and the deceased
- Internalization of ancestral suffering
- Internalized oppression

Source: Brave Heart, 2005.

Identify treatment goals that are important to your clients. As with all your clients, you will need to help your American Indian and Alaska Native clients identify treatment goals that are appropriate and meaningful for them. If your program primarily serves American Indians and Alaska Natives, then your program and your colleagues will help guide you in developing effective treatment plans. Experience working with American Indian and Alaska Native clients will improve your ability to develop culturally responsive plans.

Your planning should reflect information you have gathered from talking to and spending time with your clients. As you learn more about your clients' lives, their degree of cultural affiliation, their religious or spiritual beliefs, and the stories of family members, you will need to adjust your plans to make the best use of clients' strengths, supports, values, and cultural identity.

Keep in mind that your client's values and beliefs may be different from yours. For example, you may hear less about goals of personal achievement and success and more about goals of being a contributing family and community member and upholding the pride and traditions of the native culture. Spend time discussing with your client what he or she might need to do to obtain balance in life and heal from present difficulties.

The following are some common themes that may be identified in treatment planning:

- Connect or reconnect with traditional ways of life and practices.
- Identify cultural strengths and how to use these strengths when distressed or in maintaining recovery from substance abuse.
- Gain greater understanding of the role of personal and historical trauma in presenting symptoms and substance misuse.
- Find opportunities to participate in community events that support recovery.
- Reflect on how alcohol or other substances have interfered with cultural identity or practices and affected relationships with others.
- Consider how introduction, sale, and use of alcohol and drugs contributed to oppression.
- Identify elders, family members, and other community members who will support recovery.
- Explore how spirituality might help with present difficulties.

Incorporate options for cultural activities in treatment planning. Connecting or reconnecting American Indian and Alaska Native clients to cultural practices can improve their behavioral health and quality of life. If clients so desire, treatment plans should accommodate cultural and spiritual activities that can support recovery from mental and substance use disorders. Seek help from members of clients' tribes to determine the appropriateness of an activity, because a community event may involve alcohol, thus increasing your clients' exposure to alcohol and other substances that may compromise recovery.

The specific activities involved will vary according to the client's preferences and the native culture to which he or she belongs. Some activities (e.g., spirit camps, ceremonies, traditional hunting or fishing) may need to be scheduled independently outside the treatment center, whereas others (e.g., sweat lodges, traditional crafting, smudging or purification, talking circles) may be conducted at the program site and integrated with counseling activities. By providing opportunities to meet community elders, traditional healers, and native peer support and recovery coaches, your client will have a clearer image of what healing pathways he or she needs to choose. Providing these activities can help your client connect to traditional practices that may more effectively communicate important lessons and address his or her presenting problems.

Provide alternative methods for receiving services, if needed. If you work in a program that already provides telecounseling, uses the Internet for videoconferencing, or holds recovery meetings by conference call, you know these are effective ways of providing behavioral health services. (See TIP 60 [SAMHSA, 2015] for more information on using these technologies.) Many Native Americans, particularly in Alaska, live in remote areas and may be unable to access services at an agency or program. In such cases, phone or computer technology may be the best way for clients to

After participating in specific ceremonies, the client may need to observe practices as outlined by the healer, such as avoiding specific types of food. You can talk with the traditional healer and the client to understand any restrictions or practices that the client will need to follow.

connect with behavioral health services. Another alternative method is the use of mobile treatment programs for integrated behavioral health services that provide more services than the more common mobile crisis units (see Jiwa, Kelly, & Pierre-Hansen, 2008). Although the approach is still in its infancy, integrated mobile units can provide a one-stop center to address health from a holistic perspective, including substance abuse, mental illness, and other health issues. Mobile units are a viable alternative for native communities that face barriers to accessibility.

Engage American Indian and Alaska Native healers in treatment. There are many paths to recovery, and traditional healing practices can work well alongside the treatment you offer. Traditional healing ceremonies can be powerful experiences that help heal a variety of behavioral health issues. Traditional healers can also be valuable allies, helping you adapt your treatment to be more effective. When your client is working with a traditional healer, ask if he or she would like to invite the healer to help plan the treatment. Traditional healers may be able to help connect your client to American Indian and Alaska Native recovery communities and can continue to support his or her recovery and promote positive change after your client has left the program. Ask him or her to coordinate with you in your work with American Indian and Alaska Native clients.

If your client is not working with a traditional healer, ask if he or she would like to do so. Your client may know of a healer or may need assistance in locating one who is appropriate, as there are different types of traditional healers and traditional healing practices, depending on the tribe and training of the traditional healer. Although you may want to be helpful in contacting a traditional healer, your client may have a specific belief about the type of healer best suited to his or her problems. Therefore, talk with your client first, and determine together how to arrange access to a traditional healer.

There are no organizations to certify native traditional healers, so you will need to talk with clinical supervisors, other providers, elders, tribal organizations, or people in the community to find appropriate ways to integrate authentic traditional healers. Some healers will only work with members of their own tribe, just as some clients will only want to engage in healing practices that are from their own tribe. Some clients will also avoid traditional healers because of religious differences, although their own church (e.g., the Indian Shaker Church, the Pentecostal Church) may have healing practices. Also, some traditional rituals are only meant for men, and healers may exclude women from participating. Some healers may not support all types of behavioral change. If your client population is drawn from several tribes, you will need to develop a network of traditional healers that represent these tribes. Some treatment providers and programs develop a formalized process and agreement with traditional healers ahead of time so that their services are readily available when needed.

Even if an American Indian or Alaska Native client is uninterested in traditional healing, he or she may still wish to have more involvement in traditional native cultural practices. Encourage such participation, as it may have a number of benefits. You can help your client find cultural activities in your area that are appropriate for him or her.

Considering Culturally Adapted Treatment Approaches

The adaptation of mainstream treatment approaches across cultures is still in its infancy, but it is clear that culturally adapting evidence-based interventions congruent with American Indian and Alaska Native worldviews and cultural practices is an effective approach. In choosing an approach with American Indian and Alaska Native clients, it is important to examine the acceptability of the belief system that underlies the modality. For

example, therapeutic modalities often focus on the past, present, and future, and, as highlighted earlier, living in the present—the here and now—is a key concept for many native cultures. However, this does not mean that the treatment focus should avoid historical trauma and other trauma (including discrimination), but rather that the discussion should be oriented to present-day paths toward healing and resolutions.

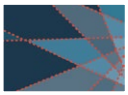
Other considerations in adapting an approach include assessing how the approach matches communication styles, traditional cultural values, cultural taboos and practices, and cultural identity (for review, see Gray & Rose, 2012). For example, rational emotive behavioral therapy is very directive compared with motivational interviewing (MI) and other cognitive–behavioral approaches. Directive, advice-laden, confrontational treatment approaches that deemphasize the therapeutic relationship are contraindicated for American Indian and Alaska Native clients (J. King, Trimble, Morse, & Thomas, 2014). Such approaches can create resistance in people across cultures but are especially culturally insensitive to native people. Of course, this also depends on individuals' cultural identity, level of acculturation, and treatment expectation.

American Indian and Alaska Native clients generally respond well to various treatment modalities, including individual-, group-, family-, and community-based approaches. (For a review of various programs and projects, see Urban Indian Health Institute, 2014.) When considering group therapy, it is important to think about the constellation of the group. Who is in the group? If there are non-natives in the group, how will this affect American Indian and Alaska Native participants? How do you need to conduct the group differently? If all participants are native, does the group contain individuals from diverse tribes? If so, what is the relational history among the specific tribes? Some individuals may initially have a difficult time participating with a member from a particular tribe; other individuals may worry about confidentiality if members from their own tribe or community are in the group.

When it comes to family treatment, it is essential to identify who is family. As with any family process, it will be important to understand and honor the family's history, system, hierarchy, and other dynamics. Culture, historical trauma, and outside influences greatly affect family dynamics. For example, what is the impact of a grandparent's or great-grandparent's boarding school experience on the family system? How does this history influence parenting skills, cultural identity, trust, and traumatic stress?

Community-based interventions are another powerful modality; they address current individual problems through a larger lens. If individual substance use disorders and mental illness are viewed as symptoms of the native community's history of trauma and discrimination, then it is natural to address problems from a broader perspective using culturally based community approaches rather than, or in combination with, individual and family modalities. These approaches are in line with cultural values, and traditional healing practices can easily be an essential ingredient. Community-based interventions are built on a belief in self-determination: that healing and the solutions to behavioral health come from within the community. These interventions will need guidance from native facilitators. They also require a presence and investment in the community, as well as initial permission, acceptance, and participation of tribal leadership and other influential tribal members. Community interventions need to include youth, elders, and other community members.

> **Native nations have developed many behavioral health programs and interventions to address and find solutions to community problems, such as substance misuse, diabetes, other health issues, suicide, parenting issues, and sexual violence. Talking circles, educational groups, youth gatherings, drum-assisted recovery, outdoor adventure, and cultural heritage days are a few examples of community-based interventions used over the past two decades.**



Although culturally adapted EBPs are few, American Indian and Alaska Native practice-based approaches are evolving. Practice-based approaches (knowing what works through experience, clinical judgment, cultural knowledge, and client feedback) are much more culturally responsive and accepted in native communities than EBPs are. Keep in mind that the importance of using EBPs is generated from mainstream ideology. Thus, there is danger in an "outsider" attempting to impose an approach without considering the culture and self-determination of American Indian and Alaska Native communities. Moreover, the research that supports EBPs generally fails to have adequate American Indian and Alaska Native representation.

> **Culturally adapted treatment practices are generally passed orally from one therapist to another at meetings or other gatherings of providers for native people (Gray & Rose, 2012).**

Exhibit 1.1-5 provides information on a selection of culturally adapted treatment practices. Some other prevention and treatment interventions have been evaluated with American Indian and Alaska Native clients, and the number of such interventions continues to grow. For further discussion, see Part 3, the online literature review. Culturally adapted approaches include MI, family systems (i.e., network therapy), community reinforcement, mindfulness approaches, and cognitive–behavioral therapy (CBT). Take into account that this is only a sample and that if an approach is not mentioned below, it does not mean that the approach is a poor choice for American Indian and Alaska Native clients or that it can be provided without modification. When selecting culturally adapted approaches, consider them in light of the specific culture; cultural identity; traditional healing practices; presenting problems; strengths; and needs of the client, family, and community (Trimble, Scharron-del-Rio, & Hill, 2012).

EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Motivational Interviewing (Miller & Rollnick, 2013) MI is client centered and focuses on active listening, stages of change, self-talk, empathy, and other core elements to elicit "change talk."	• Is found to be effective for treating American Indians and Alaska Natives • Is nonconfrontational and noninterfering • Uses active listening skills • Teaches the culturally appropriate idea that what you say to yourself is what will happen • Emphasizes the importance of relationships and empathy	• Have adequate training and use current American Indian and Alaska Native adaptations • Have clients create personal stories for each stage of change • Present stages of change model as a circle • Remember that self-disclosure is not a traditional communication style	• *Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities* (Venner et al. 2006) • *Trainer's Guide to* Motivational Interviewing: Enhancing Motivation for Change—A Learner's Manual for the American Indian/ Alaska Native Counselor (Tomlin, Walker, & Grover, 2014)

Continued on next page

EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches (continued)

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Family Therapy Therapies that incorporate family/community systems, are developmental, have a community orientation, or have a generational focus are more relevant for American Indian and Alaska Native clients.	• Uses the natural support system of the individual • Provides treatment in a small community context • May be designed to accommodate large extended families (i.e., network therapy) • Can easily take place in the client's home • Recognizes the importance of families in the context of the community • Focuses on strengthening families and family cohesiveness • Decreases risk for substance misuse and improves treatment outcome	• Recognize cultural differences in hierarchy, dynamics, and history • Determine how family is defined • Explore how every family member feels about being in a session with one another and with you • Invite other key individuals into the session (e.g., community elders) when appropriate • Consider home visits • Use genograms to explore family patterns, strengths, history, social support, and so on • Use family sculpting technique, which uses a more kinesthetic approach to learning • Have families develop their own stories of strength	• Network Family Therapy was originally developed to treat American Indians and Alaska Natives living in urban communities; it uses the individual's natural support system and community (Attneave, 1969; Galanter, 1999; LaFromboise & Fleming, 1990) • *American Indian Families: An Overview* (Sutton & Broken Nose, 2005)
Trauma-Informed Treatment Interventions focus on how trauma may affect an individual's life and his or her response to services.	• Recognizes the importance of trauma, including historical trauma, in providing care for individuals, families, and communities • Integrates knowledge about trauma into procedures, practices, and settings • Creates pathways to healing through developing awareness, safety, and support • Improves treatment outcomes	• Use for grief resolution and trauma mastery • Incorporate into parenting programs • Integrate traditional practices and healing approaches	• *Historical Trauma and Unresolved Grief Intervention* (Brave Heart, 1998) • *Pathway to Hope: An Indigenous Approach to Healing Child Sexual Abuse* (Payne, Olson, & Parrish, 2013): A trauma-informed training program focused on ending the silence surrounding sexual abuse in rural Alaska Native communities and promoting community-based approaches to healing

Continued on next page

EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches (continued)

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Community Reinforcement Approach (CRA) This model was developed using behavioral therapy principles for substance use disorders.	• Relies on positive reinforcement drawn from the client's community and family • Provides an alternative to substance use with cultural practices • Presents an opportunity for community to participate	• Design reinforcements specific to community needs and with governance input	• Navajo version of CRA makes use of relational ties and reinforces the use of Navajo cultural and spiritual practices (Miller, Meyers, & Hiller-Sturmhöfel, 1999)
Mindfulness-Based Interventions Mindfulness approaches for behavioral health combine CBT and Asian philosophies of spirituality. They are focused on attending to current experiences and thoughts as an observer.	• Is more accepting because the philosophy was developed outside mainstream behavioral health • Matches more consistently with the belief systems and importance of a focus on the present found in many American Indian and Alaska Native cultures	• Consider using walking meditations, which easily fit into traditional coping strategies • Suggest and talk about how to use mindfulness exercises while engaged in traditional and subsistence practices • Consider using Acceptance Commitment Therapy; it combines mindfulness and value-based decision making and behavior	• Mindfulness-Based Relapse Prevention (Witkiewitz, Greenfield, & Bowen, 2013) • Suicide Prevention for Native American Youth (Le & Gobert, 2013)
CBT CBT develops specific skills to promote behavioral change.	• Adapts cross-culturally with ease • Focuses on the present • Recognizes the importance of accepting personal responsibility for changing behavior • Includes attitude of partnership between provider and client • Can address a variety of issues (e.g., parenting)	• Honor the principle of noninterference • Avoid overuse of a very directive approach; instead, assume the honored role of consultant and provider of resources for the client • Adapt for video-conferencing when appropriate	• Cognitive–Behavioral Therapy With American Indians (McDonald & Gonzales, 2006) • Cognitive–Behavioral Therapy for Native American Youth With PTSD Symptoms (Goodkind, LaNoue, & Milford, 2010)

Continued on next page

EXHIBIT 1.1-5. Examples of Culturally Adapted Treatment Approaches (continued)

THEORETICAL APPROACH	POTENTIAL BENEFITS OF APPROACH	ADAPTATIONS FOR NATIVE AMERICAN CULTURES	SPECIFIC INTERVENTIONS AND RESOURCES
Matrix Model This is a structured treatment experience provided in various formats for intensive outpatient programs.	• Uses a variety of support strategies • Educates clients and their families • Builds skills • Includes relapse prevention • Integrates CBT, contingency management, MI, 12-Step facilitation, and family involvement	• Be careful not to focus so much on the manual and process that it overrides the time needed to build a trusting provider–client relationship • Foresee problems of becoming too structured and inflexible in schedule • Use culturally adapted tools	• Matrix Model: Culturally designed client handouts for American Indians and Alaska Natives (Matrix Institute on Addictions, 2014)
Behavioral Therapy This therapy focuses on changing behavior using learning principles and psychoeducation.	• Is less culturally biased than some other treatment models • Does not rely on culturally defined ideas of family and self for basic principles • Focuses on present behavior, rather than on the past, which is consistent with many American Indian and Alaska Native cultures	• Have clients identify their own goals for behavioral change • When using positive and negative reinforcement to support change, make sure reinforcements are culturally appropriate • Do not suggest goals or behavioral reinforcement based on another population; doing so would be an attempt to enforce conformity	• The Coping With Depression model (Lewinsohn, Antonuccio, Breckenridge, & Teri, 1984) was adapted for use with Native American older adults by Manson and Breenneman (1995)

Building Supports and Supporting Recovery

Most people across cultures fare better in recovery if they have an adequate support system. This is also true for American Indians and Alaska Natives: community support is often a key ingredient whether you are providing care for someone who lives on a reservation, in another rural area, or in an urban area. Below are some suggestions for how you can improve support systems for your American Indian and Alaska Native clients.

Connect clients to American Indian and Alaska Native recovery supports. Get to know the traditional healers, providers, and programs in your community and the home communities of your clients. By helping your clients connect with traditional healers, family, and community programs, you can help them build a support system that will promote recovery long after they leave your program. You will also need to search out recovery resources in your area that support American Indians and Alaska Natives and learn about their methods. You may need to identify specific supports that are available for tribal members in your area as well as those that might be useful to American Indians and Alaska Natives regardless of tribal affiliation. You can begin by talking with service providers from tribes or urban native programs and your state's behavioral health division. Besides typical recovery

supports (such as mutual-help groups), involvement in community activities, when and where appropriate, is an important avenue in recovery promotion for American Indians and Alaska Natives.

Identify appropriate support. Establishing a support system is only effective if it addresses the unique needs of the individual and family. For example, although social support is one of the most important factors in maintaining recovery, the perceived and real probability of encountering social conflict or social pressure is a greater risk factor for relapse of substance use or a reoccurrence of psychological symptoms among American Indians and Alaska Natives than among any other ethnic or racial group. Therefore, it is important not just to ensure support, but also to explore potential conflicts and minimize exposure at least in the early stages of recovery from substance abuse or mental distress. Some individuals have shared that they needed to make major changes in the first year of recovery by staying away from some people and community events to avoid social pressure to use.

> "Here the destruction stops.
> We will heal ourselves,
> We will heal our wounded relationships,
> We will heal our children,
> We will heal our Nations.
> On this day, our future history begins."
>
> *Source: White Bison, 2002, p. C.*

Use mutual-help approaches that are culturally appropriate. Mutual-help is often an important part of long-term recovery for people with mental and substance use disorders, including many native people. American Indians and Alaska Natives have a long history of using mutual-help specifically to address alcohol use disorders that continues to this day. Some American Indians and Alaska Natives may have difficulty with the public speaking (and, in particular, public confession) aspect of mutual-help groups, but for those who do participate, mutual-help groups appear to be beneficial.

The 12-Step model is helpful for many American Indians and Alaska Natives in recovery from substance use disorders who typically find its focus on nondenominational spirituality culturally relevant. American Indians and Alaska Natives have made adaptations to this model to make it more culturally appropriate. For example, the Salish Indians (mentioned in "The Importance of Knowing the Specific American Indian and Alaska Native Cultures of Your Clients" box), whose culture had historical precedents for group talk and confession, have made their own adaptations to the model. The Red Road to Wellbriety is an example of melding together the older teachings of native recovery, recovery circles, the code of Handsome Lake, ancestral teachings, and the 12-Step program. "The Red Road is a way of achieving sobriety and healing personal and cultural wounds. The Red Road is a way of breaking the cycle of destruction that so often accompanies historical trauma and oppression" (White Bison, 2002, p. E).

Fostering Community Connections

As an individual provider, you can informally build relationships in American Indian and Alaska Native communities that will help you be more effective and better received by the community, improve how clients and their families and friends perceive you, increase your understanding of your clients' culture, and become aware of the strengths and problems of the communities in which your clients live. If you want to deliver prevention messages, they will likely be better received coming from other community members than from you or your program alone.

Not all areas will have a significant native community, but even away from Indian Country, American Indians and Alaska Natives may have support networks based either on shared tribal identity or, in cases where no tribes are dominant, on a pan-Indian identity. In urban native communities, there are often informal community leaders who are known to and respected by many American Indians and Alaska Natives and to whom they may go for advice. What follows are some suggestions to guide you in developing community relationships within American Indian and Alaska Native communities.

> **Non-native people often talk to get to know a person. Native Americans may expect that you wait until you know someone before you speak to them in depth or in confidence.**

Take your time. Do not move too quickly to establish yourself. Take time listening and learning about how things work in the community. The last thing you want to do when you are new in a community is step on someone's toes or make a mistake that you have to live down later. As an example, a counselor arrives in a small community. Within the first 2 days, the counselor confronts the program director and his supervisor because some staff members are relatives. The director's niece and the supervisor's sister work within the same program. Rather than waiting to build community relationships and to understand the community environment, the counselor runs roughshod over the treatment community and erodes the potential for building relationships inside and outside the center.

Learn about the culture. American Indians and Alaska Natives have very distinct beliefs, languages, traditions, and nations. What is the history and tradition of the people as they tell it? What is their clan system, if they have one? Do they identify more strongly with the mother's or the father's lineage? What are the customs in extended family relationships? Learn as much about the culture as you can through interacting with others, reading native writings, and being an observer and respectful participant in community events. Know proper etiquette in attending community events or if you are invited to ceremonies. When is it appropriate to speak or to be silent? Do not attempt to participate in a dance, drumming, or any other ceremony without a guided invitation. Learn culturally correct terms (e.g., "regalia" instead of "costume"). If you can, find a community member, such as an elder, a provider, or a person in recovery, with whom you can build a close relationship and who can guide you.

Introduce yourself. Try to introduce yourself to all community members whom your work may affect (in a small community, that may be everyone). Tell them what brings you there and what you are there to do and find out how you can best work together without duplicating services. Show respect for how each person lives and for his or her privacy and mind your own business. Remember that you are a guest; they will decide in their own time how they see you based on how you handle yourself. Act graciously and remember that you are there to learn, not to instruct.

Learn from elders. Showing respect for elders is extremely important in American Indian and Alaska Native cultures. They are the bearers of native history, language, knowledge, and ways. Spending time with elders is a good way to learn about the community and earn trust. One way to show respect is by listening without interruption or imposing time limits. This may lead to broader acceptance in the community. Learn the protocol for consulting an elder; you may want to bring a gift.

See and be seen. Learn what kinds of events and gatherings are important to community life and attend them if it is appropriate for you to do so. Educational programs, school and sporting events, and music programs are common community events. If you attend, bring food to share at the event. In some communities, hunting, fishing, gathering berries and roots, tapping trees for maple syrup, and processing these foods are time-honored traditions that are often done as a community, and it may be possible to participate in such activities if you are invited or if you ask. A provider who only stops by to hold office hours risks being seen forever as an outsider who does not understand or even want to understand what life is like in the community.

Respect the intellectual property of native culture. You are not in the position to interpret or comment on cultural values, events, or ceremonies. Equally important, it is not ethical to publish; blog about; or post videos, comments, or pictures related to such cultural property on any social network platform. Confidentiality needs to extend beyond clients' personal information: native culture is the intellectual property of tribal members themselves. Whether or not a tribe asks you to sign a confidentiality agreement regarding their cultural and intellectual property, keeping cultural information private is the correct, moral, and legal thing to do.

Since colonization, American Indians and Alaska Natives have had their culture stolen, destroyed, misused, romanticized, and misrepresented without much thought to the history and existing realities of oppression. As a provider, you need to be sensitive not only to the history of the government's efforts to eradicate native culture, but also to individual actions that have eroded and can further erode native culture. Native culture belongs only to native people. The culture includes, knowledge pertaining to beliefs, language, ceremonies, ways of being, traditions, hunting and gathering sites, medicine, events, sacred items or sites, and artwork.

You may be in a position to provide presentations, reports, or information to other agencies or organizations regarding the use of services, research, demographic data, or case studies of American Indians and Alaska Natives. If so, it will be critical that you first review all releases of information with the appropriate governing body of the particular tribe or people to get approval.

Use your program or facility to provide community services. Many behavioral health programs that serve American Indians and Alaska Natives have found it helpful to integrate a range of services and to host or house cultural and community activities. Some behavioral health programs have integrated services including, but not limited to, HIV testing and prevention, medical services, childcare and family services, housing assistance, job training, life skills training, and parenting classes. Integration of services increases accessibility for clients. Also, the facility needs to invest in the community. A simple approach is to use the facility's space for hosting cultural events, educational programs, and community activities (e.g., a New Year's Eve sobriety pow wow). Doing so increases program visibility and, potentially, community trust. It is far easier to go to a facility that you know than to one that is disconnected from the community.

Be prepared to help communities develop community-wide initiatives. As described in the West section, American Indians and Alaska Natives typically have a holistic view of health that encompasses the individual, the family, and the community, and many native communities have had success with interventions that involve efforts at the community level, such as gathering of Native Americans and community readiness programs (Plested, Jumper-Thurman, & Edwards, 2015). Such interventions may combine legal, prevention, treatment, cultural, and other community-building elements to address health problems, such as substance abuse, HIV, diabetes, sexual violence, suicide, and their effects on the entire community.

> **Gathering of Native Americans is a 4-day community event that focuses on health and well-being to bring about community healing. This approach values traditions while increasing the community's strengths. This community event addresses topics such as historical and cultural trauma, suicide, and substance abuse, among others.**

Treatment programs should not be the main actor in the development of such initiatives. To be effective, community-based interventions need to develop from the will of the community. Usually a few concerned community members will start the ball rolling and may reach out to local providers for assistance. Programs can then provide information, technical assistance, and other support to community members who want to help.

Where Do You Go From Here?

As you have read this chapter, you probably started thinking about how it translates to your day-to-day interactions and responsibilities as a provider. Now that you have some fundamental information, the next chapter will provide more specific information and examples of providing culturally responsive care. You will meet a number of American Indian and Alaska Native clients who are experiencing or have experienced substance abuse or psychological distress. Part 1, Chapter 2, provides stories, examples of client–provider dialogs, and ideas about how to provide care. As you proceed, bear in mind that being a culturally competent provider involves a commitment to learning cultural knowledge, exploring cultural awareness and

competence, understanding cultural perspectives of behavioral health, and adopting culturally specific and responsive skills and practices. Not only that, but it also necessitates a willingness to invest in relationships with your clients and the community.

Part 1, Chapter 2

Introduction

In this chapter, you will meet four American Indian and Alaska Native clients and their providers. Some of the providers are non-native, and others are native, although they may be working in tribes different from their own. The consensus panel has made significant efforts to present realistic counseling scenes using culturally responsive approaches that include integrating traditional healing with mainstream approaches such as motivational interviewing (MI), family therapy, and psychoeducation, as well as other modalities.

This chapter centers around four stories. Each story includes some background for the provider, tells the history of the client, and highlights learning objectives as well as client–provider dialog that demonstrates specific knowledge and skills for providing behavioral health counseling to American Indians and Alaska Natives. The stories capture culturally relevant issues in a variety of specific situations and treatment settings. These stories highlight key elements and tools for providing culturally responsive care that supports healing. The consensus panel does not intend to imply that the approach used by the provider in each story is the best option, but rather, that it is an informed, practice-based approach that reflects culturally competent skills you can implement in real-world settings.

> **Be mindful that some of your clients may see recovery as a journey in whole-person wellness, including spiritual, physical, emotional, and cognitive health combined. They may be less focused on simply getting relief from presenting symptoms and more focused on finding their footing and walking in balance within themselves and for their family and community.**

About the Stories and Vignettes

A collaborative effort using a consensus process led to development of these four stories. The consensus panel used a composite of client experiences in counseling to come up with the backgrounds, geographic regions, and other identifying details of the clients in the vignettes, so that the histories and client–provider dialogs are not complete accounts of specific people. Any associations with actual people, presenting problems, or events are coincidental.

MASTER PROVIDER NOTES

These are comments about the strategies used, possible alternative techniques, and insights into the client–provider relationship. These notes represent the combined experience and wisdom of the consensus panel and other contributors to this TIP. As you proceed, keep in mind that some suggestions may not be culturally congruent or appropriate for your client. Moreover, it is important that you, as the provider, have the necessary training and clinical supervision to engage in these clinical activities.

The consensus panel took great care in creating histories that demonstrate common, yet diverse, themes in behavioral health services. Panel members chose a series of American Indian and Alaska Native stories that represent differences in geographic location, gender, cultural identity, age, alcohol and drug use, and behavioral health concerns. However, the consensus panel has had to be selective out of necessity; histories and vignettes cannot capture every aspect of culturally responsive treatment or represent the wide variations in presenting problems among American Indians and Alaska Natives.

How To Approach the Stories and Vignettes

Each story consists of an introduction outlining the provider's cultural background and work setting; the client's story, including presenting concerns and treatment needs; learning objectives for readers; the client–provider dialog; and a summary. To complement the client–provider dialog, clinical information relevant to the dialog is embedded at times into the transcripts using italic text in brackets and through master provider notes and other informational text boxes. In some cases, you will learn about consultations between the provider and his or her supervisor or native consultant.

The four stories and vignettes incorporate the key concepts discussed in Part 1, Chapter 1:

- The first vignette demonstrates the importance of engaging and building a trustworthy relationship between the provider and client (Vicki). Through honoring traditional ways, the session addresses Vicki's personal commitment to treatment.
- In the second vignette, the provider meets Joe, the client, in a pretreatment session prior to his transfer to court-mandated treatment. Joe lives on a reservation and has a history of methamphetamine dependence. The vignette demonstrates key ingredients of culturally responsive treatment using a pretreatment and a treatment session.
- The third vignette focuses on ways to facilitate support, to honor family, and to help Marlene, the client, reconnect to traditional ways to maintain recovery living in a remote Alaska Native village. The vignette contains an individual and a family session.
- The fourth vignette begins with addressing homelessness in Alaska. Philip, the client, has been living in a camp outside an Alaskan urban area, far removed from his village and family, without the means to return to his village. Beginning with an initial outreach strategy, the story highlights how Philip accesses treatment and other social services to begin his recovery. The story reveals the role of traditional ways in sustaining recovery.

Exhibit 1.2-1 highlights provider and client characteristics for each vignette.

EXHIBIT 1.2-1. Vignette Summary Table

Vignette	Client Demographics	Family History	Cultural and Spiritual History	Educational and Vocational History
1 **Vicki**	Female; age 50; single; enrolled in tribe in the Midwest; has lived on a reservation her entire life	Raised by grand-parents and parents; grandparents were very traditional; both parents are alcohol dependent; she is guardian of two nieces (5 and 7); sister is drug dependent	Raised in traditional spirituality; mother was Catholic	Sent to boarding school in Oklahoma from 8 to 12 years of age; completed general education development (GED); not working now
2 **Joe**	Male; age 28; single; enrolled and living on a reservation in the Southwest; migrates on and off reservation	Grew up with parents and grandparents on reservation; grandparents practice traditional ways; oldest of seven; parents drank and smoked marijuana	Bilingual; traditional upbringing	Sent to boarding school; dropped out of school; works off and on in construction and as an artist
3 **Marlene**	Female; age 30; married; lives in a village in western Alaska	Grew up in an Alaska Native village; family member died by suicide 15 years ago; mother and grandmother had depression; lives with husband and four children; husband misuses alcohol	Bilingual; traditional upbringing; considerable subsistence skills and involvement in subsistence activities	Finished 10th grade; works seasonally as fish processor; part-time employment as store clerk and janitor; prefers subsistence lifestyle
4 **Philip**	Male; age 40; divorced; grew up in a remote Alaska Native village; moved from village in Arctic Slope to a more urban area; currently camping outside city with other individuals who are homeless	Raised by paternal grandparents; mother was alcohol dependent; father left village before his birth; youngest of four children; history of physical and emotional abuse; no contact with son or ex-wife in 7 years	Bilingual; traditional upbringing but feels conflict between his cultural traditions and Catholic Church; good subsistence skills; involved in subsistence activities; traditional artist	Traditional wood carving skills; high school graduate; accepted into Navy but rejected after drug testing positive for marijuana; worked in small engine repair; not currently working

Continued on next page

EXHIBIT 1.2-1. Vignette Summary Table (continued)

Vignette	Alcohol and Drug History	Co Occurring Conditions and Other Clinical Concerns*	Legal History	Provider Characteristics
1 Vicki	Alcohol is primary drug of choice; two prior treatment episodes; has had periods of sobriety	History of diabetes and being overweight; history of emotional, physical, and sexual abuse at boarding school; lifelong history of depression; potential retraumatization at being mandated to residential treatment; historical trauma	Two convictions for driving under the influence (DUIs); child endangerment charge; driver's license suspended; involved in tribal wellness court	Karen grew up in a predominantly White suburban area, but has some native blood in her background with a mix of cultures represented in her family's traditions; provider at the residential treatment center for 3 years; licensed alcohol and drug counselor
2 Joe	Methamphetamine is primary drug of choice; began drinking at 13; alcohol binges began at 14; dealt drugs previously; drug-free for 2 months	Protracted withdrawal symptoms; some confused thinking and paranoia initially as well as nightmares	Spent a total of 4 years in prison; recently released after 2 months in jail; court-ordered to alcohol and drug evaluation and treatment	Mike grew up on the reservation; provider at the tribe's treatment center for 4 years; in recovery
3 Marlene	Alcohol (mainly homebrew) is primary drug of choice; referred to residential treatment; relapse history; drinks to self-medicate; first residential treatment	Unresolved grief issue; history of sexual abuse by stepfather; history of depression; family concerns	Office of Children's Services involvement	Nolee, Alaska Native, grew up in remote village; interned as village-based provider; counselor at residential treatment program
4 Philip	Alcohol is primary drug of choice; periodic use of marijuana; began experimental alcohol and drug use at age 9; drinks daily; no prior history of treatment	Homeless; history of suicide in his family; unresolved grief associated with losses of family members and friends; has no money to return home to his village; feels disconnected from his relatives; worried about prejudice as an Alaska Native, leading to hesitation in asking for help	Two old misdemeanor convictions; one DUI and public intoxication charge	Anthony, Alaska Native; received scholarship from his village corporation; attended school in Arizona; made commitment to give back to his native community on his return; provider at a native treatment center

*Effects of historical trauma are assumed across all vignettes.

TRADITIONAL HEALING

"Traditional Healers and Elders say that the Great Spirit works through everyone, so that everyone has the ability to heal, whether it's the mother who tends to the scrapes of her child, a friend who eases your pain by kind words or the Healer who heals your sickness. Everything that was put here is healing—the trees, the earth, the animals and the water. In the past, knowledge of the medicines was a natural part of everyone's learning. We knew what plant medicines were for and how to prepare offerings for them. When we needed special help beyond what was common knowledge, we looked to our Medicine men and women and Healers. This familiarity with the healing properties of the plants that grew around us was empowering. It was something that belonged to the community. This knowledge is no longer widespread and many of the illnesses that our communities are faced with today were not seen in the past. Many native people are seeking emotional, mental, and spiritual healing for past abuses and traumas; for the pain that they are carrying as a result of what generations of their families went through; and for a loss of identity because of separation from family and culture. Others are seeking help for physical illnesses such as diabetes and arthritis that affect native people in disproportionately large numbers.

"Native people know that everything in Creation—the plants, trees, the water, wind, rocks and the mountains—have spirit. As part of Creation, we also are sacred and have spirit. Healing is understood in terms of the spiritual basis of everything. Our approach to healing is through ceremony. When we put our tobacco down as an offering to these things we call Creation, our spirit is making that connection so that we will be able to get that life source from them. Our healing ways are referred to as Traditional Healing. This way of healing is holistic, based on an understanding of the interconnectedness of all life and the importance of balance and harmony in Creation. Just as in Creation all things are connected but have different functions, so our mind, body, spirit, and emotions are part of the sacred circle of life and are interconnected. When one of them is out of balance, it affects the others. If you have a physical problem, it is connected to your spirit. If your mental state is out of balance, it will cause emotional turmoil. Traditional Healing is the restoring of balance to the mind, body, spirit and emotions. There needs to be harmony and balance in us just as there is in all of Creation. When that harmony and balance is lacking, sickness ensues. It is said that a great deal of healing comes from ourselves because we want to be healed. In taking responsibility for our own healing, we may participate in ceremonies. This can include our daily ceremony of offering tobacco. It can also include other healing ceremonies that we participate in under the guidance of Healers and conductors, such as the sweat lodge, the shaking tent, the Sundance, the fast, and the vision quest. When you start on a healing journey, you are making a commitment to help yourself, your family and your community. Although ceremonies differ from First Nation to First Nation, basic beliefs are similar. We have all come to take care of the spirit. Use of sacred items such as the pipe, the drum and the eagle feather can help us make the connection with Creation. It is said that all of Creation can give us teachings, that our way is a loving way that teaches us about kindness, caring, sharing, honesty and respect. When we pray, the spirits that travel with us hear our prayers. They recognize us clearly when we let them know our spirit name. In this way, our spirit name is said to be fifty percent of our healing and balance and also, because with it, we know who we are, we know where we belong, we know where we are going, and we know where we came from."

Source: Anishnawbe Health Toronto, 2000, p. 1.

Vignette 1—Vicki: Establishing Relationships, Acknowledging the Past, and Choosing Treatment

Overview

This story illustrates how providers can engage clients to begin developing a therapeutic relationship and guide them to make a commitment to treatment and to well-being. The story begins when Vicki attends an intake interview at a residential treatment center to which she has been referred as a result of a court order. This treatment center is located in a small town in a rural area near two reservations and has a reputation of working well with American Indian and Alaska Native clients, who represent about 20 percent of the program's population. Vicki has attended another treatment center in the region twice before.

Vicki first meets Karen, who facilitates the intake interview and will be her primary provider if she attends the program at the new facility. Karen, who has some native blood in her mixed-race background, was raised in a predominantly White neighborhood of a suburban community. She was raised with a mix of cultures represented in her family's traditions, although she wasn't particularly aware of that. After college, she served with Volunteers in Service to America (VISTA) and developed a preference for rural living. Building on her undergraduate work in psychology and her personal interest in counseling people with substance use disorders, she became a licensed alcohol and drug treatment provider.

Karen has been working at this treatment center for 3 years, and she is learning that there is more to her job than treating drug and alcohol dependence. She has come to look at her work as helping people make decisions and changes that restore balance in their lives. She knows that finding out what the vision of a balanced life means to each of her clients is important. For her American Indian and Alaska Native clients, she has found that this vision is influenced by their life experiences, historical trauma, cultural identity, and beliefs. It is important to her to understand her clients individually and to provide a welcoming environment where they can make their own choices.

For additional guidance in using MI, refer to *Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities* (Venner, Feldstein, & Tafoya, 2006).

She also knows that trust in non-natives and in mainstream services does not come easily for many American Indians and Alaska Natives. She has come to understand that her relationships with clients are paramount and that relationships are built through time, investment in the individual and community, and active listening. She also recognizes that many presenting problems among American Indian and Alaska Native clients are a consequence of historical trauma, discrimination, and poverty. Karen has learned to appreciate the fortitude and resilience of native people and believes that MI and other strengths-based approaches in assessment and counseling are more suitable than others.

Vicki's Case History

Vicki is a 50-year-old American Indian woman who lives on a small reservation in the Midwest. She was referred by the tribal court for inpatient drug and alcohol treatment. Vicki currently lives with her two nieces, ages 5 and 7, as their guardian. Vicki's sister is drug dependent and lives in a nearby town. She has little to do with her children. Vicki is single and reports that she has had unhealthy relationships with men, previously choosing abusive men with alcohol use disorders.

Vicki has lived on the reservation all her life, except for 4 years in boarding school. Her parents were from different tribes, and she is enrolled in her father's tribe but lives on her mother's reservation. She feels some prejudice because she is not enrolled in the tribe on whose reservation she is living. Both her grandparents and parents raised her.

Vicki's grandparents and father were very traditional in their spirituality, but her mother was Catholic. Vicki was sent to boarding school in a neighboring state between the ages of 8 and 12. She has painful memories of boarding school and disclosed that she suffered emotional, physical, and sexual abuse. Her parents died before Vicki was 25 years old. Both Vicki's parents had alcohol use disorders.

Vicki believes that she has been depressed all her life and that she drinks to make her nightmares and memories go away. She has abstained from alcohol for significant periods. Seven months is the longest reported abstinence, and this occurred when she assumed the guardianship of her nieces. When she is healthy and abstinent, Vicki likes to practice the traditions she learned from her grandmother. She considers herself traditional and feels guilty that she does not practice consistently.

Vicki has a GED. She is not working now because of her drinking and legal problems; however, she has worked on several occasions at the casino and other places during her periods of abstinence. In terms of physical health, Vicki has diabetes. She is overweight but not obese.

Vicki was arrested and convicted for a DUI 5 years ago. Recently, she was arrested and charged with a second DUI, along with child endangerment. Her nieces were in the car when she was stopped by police, and they were subsequently placed in the tribal group home. Vicki's license is now suspended and she has spent several days in jail. She is involved with the tribal court. During the assessment, Vicki was quite distraught over her nieces' placement and began talking about her boarding school experiences. Vicki stated that she is quite upset with herself for allowing this to happen to her nieces.

Vicki's court assessment recommended inpatient treatment. The evaluator suggested in the report that Vicki may have traumatic stress based on her history of abuse at the boarding school and in relationships with men. Therefore, it is likely that Vicki will experience some retraumatization in being mandated to residential treatment. The evaluator suspects that this may have contributed to her poor outcome in prior treatments. The report stressed the importance of anticipating retraumatization and investing in building a safe environment for Vicki's success in the program.

Objectives for Vignette 1

The objectives are:

1. To illustrate how to begin building a trusting relationship with Vicki, using culturally responsive interviewing skills.
2. To demonstrate approaches that will help Vicki look at her situation, including the roles that historical trauma, traumatic stress, and alcohol play in her current difficulties.
3. To highlight how to help Vicki make her own individual decision about treatment, even though she was mandated to treatment by the court.
4. To illustrate the importance of identifying Vicki's motivations and strengths, including cultural strengths, that may help her in maintaining recovery.

Some strategies embedded in the dialog include active listening skills (such as reflections, summarizations, and open-ended questions), self-disclosure, scaling, and decisional analysis (weighing pros and cons). Beyond specific techniques, the most important provider characteristics are genuineness (where your words match your actions and beliefs) and empathy (the ability to perceive another's experience and communicate this perception back to the client verbally or nonverbally).

This vignette uses MI, as well as overlapping strategies from other theories or approaches, including cognitive–behavioral therapy (CBT), self-efficacy theory, a person-centered approach, and culturally responsive treatment.

Client–Provider Dialog

PROVIDER: Hello, Vicki. Thank you for coming in. My name is Karen. I will be your provider if you decide to come into treatment, and that's what I'd like to talk with you about. Please, have a seat. May I get you a glass of water or a cup of coffee or tea?

VICKI: Yes, thank you. Tea, please. *[As the provider gets tea, Vicki looks around the office. She sees an interesting mix of art, including a basket in the traditional style of her tribe. She also spots an abalone shell, a package of sage, and a box of matches.]*

MASTER PROVIDER NOTE

The office is arranged for provider and client to sit at a slight angle to each other, rather than directly face-to-face. The provider and Vicki move away from the desk to remove the physical barrier to conversation.

THE SMUDGING CEREMONY

The abalone shell (or in some traditions, a clay bowl or flat stone), sage, and matches are materials used for smudging. A non-native provider might make these materials available for use by clients, although it is best to let clients perform the smudge. It involves prayer, burning a small amount of an offering (typically sage, cedar, or sweetgrass), and using the smoke to purify the people and space. The holder of the shell or bowl approaches each person present, who may choose to draw the smoke toward his or her body, his or her heart, and over his or her head. The purpose is to clear away bad spirits and energies and dedicate what happens in the space to the Creator. Smudging is a ceremony that must be done with care, as participants are entering into a relationship with the unseen powers of these plants and with the spirits of the ceremony.

PROVIDER: *[Karen returns with their tea.]* Oh, I see you've noticed the shell. I've found that some people who meet with me feel better if they begin with a smudge to clear the energy in here and bless what happens in this room. Is that something you would like to do for us?

VICKI: Okay. That would be good. *[She performs the ritual, which takes about 5 minutes.]*

MASTER PROVIDER NOTE

Karen only mentions the smudge ritual when she sees that her client is interested in the shell. For some clients, this is a comforting offer. Others are not comfortable sharing it in this interview situation. Smudging can be a powerful ceremony.

PROVIDER: Thank you. We have time together to talk about if you want to come into treatment and how we might work together, if that's what you choose. I'd like to get to know you a little today, and I'm going to ask you to share about yourself, so I want to share a bit about myself, too. I grew up south of here, and my heritage is English, Cajun, African American, and (names a southeastern tribe). I've been counseling here for almost 3 years, and before that I worked with VISTA in a community west of here. I really liked the area. I am in a relationship, and he works for a local company. We both like our work, so we plan on staying and making our home here.

MASTER PROVIDER NOTE

Typically, providers are trained not to share personal information with clients. With indigenous cultures, it is very important to tell your client who you are. If you are native, mention your tribal affiliations; if you are not native, say a bit about where you come from.

VICKI: Are you enrolled?

PROVIDER: No. I don't qualify. I grew up away from that culture and reservation. I have lived closer to cities most of my life, but I wish I was more connected.

VICKI: I'm not enrolled here, either.

PROVIDER: That's got to be a bit difficult, I would think.

VICKI: I've been here a long time, though, and I live in my grandmother's house. She was a tribal member, and people liked her. They're pretty good to me, but I feel the difference. I'm still an outsider in some ways. Especially at election time, when I can't vote for tribal council. Mostly, it's okay. I have close friends.

PROVIDER: It sounds like you've made a home here. So, tell me, what are some things that led you here?

VICKI: I got a DUI, and the court said I have to go to treatment.

REFLECTIVE LISTENING SKILLS

Reflective listening skills take considerable time to develop. This skill set needs intentional practice even after years as a provider. Yet, all too often, providers perceive reflective listening as a very basic clinical skill and assume that they use it well.

Reflective listening, also known as active listening, involves more than simply paraphrasing what the person has stated. It moves beyond focusing solely on content or action-oriented responses (immediately giving advice or suggesting a plan of action).

Reflective listening begins with repeating or paraphrasing in your own words the words of your client. However, this is the basic form of reflective listening. There are different and more skillful levels of reflective listening, and each type of reflection has a specific intention—for example, signifying an understanding of the client's concerns, identifying discrepancies in a nonthreatening and accepting manner, or evoking further client discussions. Reflections may involve reflecting back the client's statements using empathic statements, attaching implied feelings, or making some interpretation while rephrasing the client's statement.

Reflective listening requires active silence, attending to the story of the person sitting with you, listening for what is not being said but implied, checking out your reflection to make sure it matches what your client is trying to say, and approaching every client with empathy—the ability to feel, imagine, and express what it may be like for your client.

PROVIDER: You're here mainly because the court sent you because of your DUI. The court believes you need treatment in order to stop drinking. Is that right?

VICKI: The court says I need to go to inpatient treatment; that's why I'm here.

MASTER PROVIDER NOTE

A common pitfall in counseling and during intake interviews is stacking questions. This is when you ask two or more questions in a row before your client responds. For example, "How are you feeling about being sent to treatment again? What was treatment like before?" Rather than sticking to one question, the provider stacks the questions often to solicit more discussion. Many providers do not realize that they are asking more than one question at a time. Unfortunately, most clients tend to focus on and respond to one question, or they become confused about what the provider is trying to ask. Stacking questions is commonplace, but it is more likely to happen if the provider is anxious or uncomfortable with silence or the pace of the session.

PROVIDER: How do you feel about being here today?

VICKI: I came in angry. The smudging helped, though. With the DUI, I only had a few sips, and the girls were okay. I think the cops were getting into my business.

PROVIDER: So, you're pretty upset about this. You think everything was under control, but then the cops got into your business. I imagine that it doesn't seem fair to you that you got sent here. And still, you showed up. Even though you don't like the idea, there's something you care about a lot that brought you here. Am I getting that right?

VICKI: I'm willing to go to treatment because I need to keep my nieces. I've been in treatment before—two times.

MASTER PROVIDER NOTE

Karen's reflection about "something you care about a lot that brought you here" invites Vicki to talk about what motivates her to come for the interview and to treatment. It also emphasizes that Vicki is making a choice, despite the fact that treatment is court mandated.

PROVIDER: Okay, so you've been in treatment before. And even though those treatments didn't solve your problems, the court wants you to try it again. How are you feeling about being sent to treatment again?

VICKI: The providers didn't really take the time to get to know me or my history, but they sure could tell me how to run my life.

PROVIDER: I hear you—that it will be very important if we work together that I listen closely to your story and get to know you. I really do want to, and I appreciate you telling me all of this. I'll really need your help in telling me about yourself.

VICKI: I don't know. Why should I tell you my private stuff? At the other place, I didn't tell them much. I saw how they used the information. One lady got her children taken away.

PROVIDER: That would be horrible for you. Keeping your nieces is the reason you're here. They are really important to you. *[Vicki nods and says, "Yes."]*

MASTER PROVIDER NOTE

By adding an empathic response while stressing the importance of her nieces, Karen reinforces Vicki's motivation in attending treatment and in addressing her alcohol use. It also reflects Vicki's concerns. Active listening skills are an important approach in building trust and imparting basic empathic responses.

PROVIDER: So, no wonder you're worried about sharing. Is it okay if I share a little with you about how it would work if I were your provider here? *[Vicki nods.]* First, I've already mentioned about confidentiality and the few situations that would require me to share your information. I don't anticipate that this will happen. Next, we have individual and group counseling here. You would talk about your private issues with me here in my office, or we might take a walk sometimes and talk—but just you and me. You are the one who will decide what you want to bring up in group—things you want to talk about and maybe ask some advice about. It's your choice. The rest of the activities are focused on learning about your addiction problem, ways to walk a recovery path, and how to have a social life without alcohol and drugs. I will not make you hang out your laundry for everyone to see. You're the one who decides what to say and who to talk with about those things. Does that help?

VICKI: Yes, but I don't know you. How can you understand my life, when you're not even native?

MASTER PROVIDER NOTE

One of the qualities most valued in providers is authenticity. Many American Indian and Alaska Native clients see authenticity as a primary characteristic in selecting providers. Whether you are a provider with or without native heritage, it is important to respect your own cultural heritage, life experiences, and upbringing and to be willing to talk about them from the outset. As expressed in Part 1, Chapter 1, it is not a good idea to try to act in a preconceived way that fits your views of how American Indians and Alaska Natives behave, making biased assumptions that all native people or a particular tribe has a prescribed way of being. In other words, don't try to be native when you are not or misrepresent yourself as traditional when this has not been a part of your history as a native person.

PROVIDER: True. Hmm. Well, I understand your concern about my not getting it because I'm not native. I can't deny that it gives us a challenge. I hope to learn as much as I can from you and listen to hear what it has been like for you. What I can say is that I'm learning from other native people here. But we—you and I—are not alone. We have native staff, peer specialists, and elders who are very much a part of this program, and we will all work together to help you determine your path through your current situation. I also personally believe that someone only knows me as much as he or she listens to me, and it takes time. So, that's what I try to do here as a provider.

VICKI: That makes me feel a little better. I never had an outsider listen to me. Got any kids?

PROVIDER: No, and my nieces and nephews live a long way from here. Are we good for now? *[Vicki nods.]* I think from what you've said that the main reason you're here now is that you really care a lot about your nieces, and you want to get them back with you.

VICKI: I love them. I've raised them since they were babies. It's hurting me that they're in placement. I don't want them to go through what I went through in boarding school. It's driving me crazy, just the thought that they're not with me.

MASTER PROVIDER NOTE

Over the course of treatment, Vicki will learn about trauma, traumatic stress reactions, historical trauma, and healing. Further assessment will occur in later sessions.

PROVIDER: Your nieces are very important to you. You don't want them to be away from family or experience the things that you went through. So, you're here today so that you can continue to take care of them. *[Vicki nods.]* Can I ask you when you say the word, "crazy," what does crazy feel like for you?

VICKI: Crazy means that I'm anxious. When I feel crazy, I keep thinking about something over and over again. I can't seem to concentrate on anything else but my nieces. What are they doing? I want their lives to be different from mine. I have to do something about them.

PROVIDER: So sometimes feeling "crazy" is a sign—a sign that you need to make a move or do something different?

VICKI: Yes, and that's what the court says, too. If I go to inpatient, then everything will be okay.

PROVIDER: So, you've decided you will do what it takes to get the girls back. And here you are. That's a big decision to make, and it shows real strength, respect, and care on your part. If you decide to come in to this program, hopefully we can work together to make this experience good for you. Would it be okay with you, considering the DUI, if I can learn more about your drinking history? I'd like to hear about how you got started with your drinking.

LISTEN FOR THE MEANING: COGNITIVE–BEHAVIORAL STRATEGIES

A key strategy in CBT is helping people explore the meaning of their experiences, difficulties, or verbal expressions. In other words, it is not what is said, but rather the meaning that is attached to the word, statement, or experience. CBT and other approaches call this "idiosyncratic meaning," or in simpler terminology, "individual meaning." As a provider, you are accustomed to, and often desensitized to, hearing common client expressions when they relate to a feeling or experience. Yet, the heart of treatment is taking the time to look and explore the individual meaning behind the word, statement, or experience. How often have you heard a client say that they feel crazy, blue, frustrated, or upset, just to name a few? It is easy to overlook these terms in a discussion and assume you know the meaning the client is trying to express. Instead, take the time to ask about these generic words. "When you say you feel crazy, what does crazy mean to you? What does crazy feel like for you?" By taking the time to ask these simple questions, the conversation moves from the surface of the experience closer to the core.

VICKI: *[Initial silence.]* I started when I was 11 and would sneak sips from my parents' beer. I started drinking and smoking weed *[marijuana]* when I was 13.

PROVIDER: *[Nods.]* And recently?

VICKI: Mostly it's been alcohol. I don't drink all the time, but sometimes I have had too many drinks.

MASTER PROVIDER NOTE

Karen affirms and strengthens Vicki's decision to come to treatment and lets Vicki know it will be geared toward her individual needs.

MASTER PROVIDER NOTE

Be mindful of how you ask questions. A core counseling skill is choosing questions that are mostly open-ended, or questions that require more than a one-word or one-phrase response, such as:

- "What brings you here?"
- "Describe the situation that led you to come to this appointment."
- "What is your theory about what is going on?"
- "When you look back on that given situation, can you describe how you reacted when it first happened?"
- "How would you know that you have healed from this emotional pain?"

Do not quickly fill the relational space with chatter. Allow silence. Some providers get anxious with silence in sessions. Thus, they are more likely to bombard clients with closed-ended questions to get responses or complete intake interviews.

I've stopped from time to time, once for 7 months when I first began caring for my nieces. I don't see myself as having a problem, although I probably drank too much when the cops pulled me over.

PROVIDER: Sometimes there are periods when you feel good and you don't drink at all, and then there are times when you drink too much.

VICKI: *[Vicki nods, then some silence.]* I can go 2 to 4 days a week until the booze runs out, and then I'll stop. Sometimes it depends on what's going on. I might not drink for a week or month at a time. When I'm feeling down, I'll get drunk. *[Silence.]* I try to control it around my nieces. I guess I didn't do that when I was drinking and driving with them in the car.

PROVIDER: On one hand, you see yourself having control because you don't drink all the time, but on the other hand, you notice it's getting out of control because it's directly affecting your nieces.

MASTER PROVIDER NOTE

A double-sided reflection, commonly used in MI, is used when the client has mixed feelings about a behavior or making a decision. It emphasizes the client's own pro and con statements. For example, you say, "So, on the one hand ... but on the other hand ...." Using double-sided reflections helps the client see both sides of the situation from his or her experience. It is also a more palatable way of highlighting the not-so-good things without creating resistance.

Have I said that correctly? *[Vicki nods.]* Sometimes you reach out to drinking when there are other things going on. People usually do things that make sense to them. How does your drinking make sense to you?

VICKI: When I start drinking, it's like walking into peaceful woods. I don't think about things as much. It helps until the alcohol runs out. Then, I don't feel so good. Sometimes my past comes back after I've been drinking for a few days. Then, I feel as if there is a storm in my head; I can't turn off my worries, past, or thoughts about my nieces. It messes with my diabetes.

PROVIDER: At first, drinking feels like a safe place you can retreat into. After a few days of the drinking, you're not feeling good and your diabetes is not controlled. The things that are bugging you come back into your mind. Maybe you're almost glad when you run out because you feel pretty bad by that time. What else? Sounds like there's more to the story.

MASTER PROVIDER NOTE

The provider summarizes Vicki's negative effects from drinking and introduces the idea that stopping a binge is a relief. Tagging a new perspective onto a reflection of the client's statement is an approach used in MI. Karen's last reflection offers Vicki an open-ended opportunity to say more about this.

USING METAPHOR IN COUNSELING

Metaphors are figures of speech that liken one seemingly unrelated thing to another (e.g., "I am drowning in my sorrow"). Metaphor often symbolizes a feeling, behavior, characteristic, or an experience. Here, Vicki uses metaphor to compare her agitation to a storm.

American Indians and Alaska Natives have a long oral tradition that includes metaphors and images embedded within stories. Although you, as the provider, may introduce or use metaphor in counseling (e.g., having people visualize something that represents their strengths), make sure to track the metaphors that your clients introduce in discussions. It is far more powerful to use the language and images of your client than to create ones that may not match their experiences. You could carry Vicki's metaphor further by asking, "How long does the storm last?" "When do you know that the storm is over?" "In what ways have you tried to weather the storm?" Later, you can work with the same image to discuss how she could protect herself in a storm.

Metaphors typically involve a combination of visual images and words. Used in counseling, they can be quite grounding for some clients; they use the metaphor as a cue to be, to act, or to remember something. Metaphors can become powerful reminders. Take, for example, a client who had difficulty refusing to drink alcohol when her cousin would show up at her home. At some point in counseling, she had talked about how much she loved her old car with the designer stainless steel brake pedal shaped like a foot. Later in treatment, the image of the foot pedal came back as a reminder for her to take it slow, avoid making decisions quickly, and set limits when needed to avoid drinking. Using the image of the brake pedal, she coined the expression, "braking old habits."

VICKI: I worry about the girls. They don't get off to school on time when I'm drinking. I take good care of the girls. They're not abused. They love their auntie.

PROVIDER: What other worries do you have about your drinking and your girls?

MASTER PROVIDER NOTE

Vicki's love for the girls is her strongest motivation for complying with the court order for treatment. MI calls this strong personal interest Vicki's intrinsic motivation. By asking Vicki to talk more about her worries regarding the effects of her drinking on the girls, Karen hopes to strengthen Vicki's interest in addressing her alcohol use.

VICKI: Well, they like it better when I'm not drinking. We have fun together. They get real quiet and want to stay at home when I'm drinking. They're good girls.

PROVIDER: Maybe they get a little worried about you when you're drinking, and then they want to stay close. Perhaps they want to keep you safe, or they miss their auntie when you drink?

VICKI: I never thought of that. They don't say anything about it. I'll have to think about that.

PROVIDER: Okay. What are some other not-so-good things that happen when you do drink?

VICKI: I kept a job for 8 months and then went out drinking for a few days. They fired me. I've had a few good jobs, but they all end like this.

MASTER PROVIDER NOTE

Common counseling mishaps include trying to solve a problem quickly before listening in depth or using real or potential negative consequences as a reason to change behavior. These can be ill-timed counseling habits when working with most individuals and populations, but they are particularly problematic and culturally insensitive to many American Indian and Alaska Native clients. Remember that some may see the discussion about consequences as foretelling and "quick advice" as the inability to listen or to be present. Instead, providers should focus on clients' current concerns and the history of the presenting circumstances in the beginning of the relationship.

PROVIDER: Sounds like if you took care of this drinking, you'd be able to work more steadily.

VICKI: I'm thinking maybe I should stop. It would be better for me and the girls.

PROVIDER: You have some good reasons of your own for stopping. How far have you gotten with the idea of stopping?

MASTER PROVIDER NOTE

Karen wants to evoke more of Vicki's personally motivating reasons for stopping drinking while letting her know she sees the effort Vicki is already putting into changing.

VICKI: I've been thinking and praying on it. I've been to church. I've cut down on my drinking in the last couple of months. I don't drink nearly as much as I used to or as often.

PROVIDER: More than thinking, even. It sounds like you've already done some things about it. You've even had some success—not drinking for several months—and you're now using alcohol less. You've already proven to yourself that you can make difficult choices and changes.

MASTER PROVIDER NOTE

Karen affirms Vicki's thinking and points out that she is already taking action for change. She is not just contemplating; she is acting. She is building Vicki's confidence that she can make more changes.

VICKI: I've been working on it. Sometimes I go to church like my Mom. She taught me Catholic ways. Yet, I am more traditional like my grandma and grandpa. They taught me, and I've been to drum ceremonies to celebrate the season. We would go to naming ceremonies. They prayed every morning. I do, too, when I'm not drinking or hungover. I always feel good when I do pray. I feel connected. But sometimes I feel conflicted because my mom was Catholic, and I prefer more traditional ways. And then sometimes, I read the Alcoholic Anonymous "Big Book" that I got in my first treatment. It's confusing sometimes.

PROVIDER: There are many ways to think about spirituality and the paths to healing. You already seem to get some strength and help from your spiritual practices. *[Vicki nods, and the provider waits before speaking again.]* We have people available to you to help with your spirituality and finding the path that fits for you. We have a traditional elder who works with us here as a spiritual advisor to help our clients who want some guidance or would like to use traditional healers. You should also know that we have a chaplain, some AA people in recovery, and other native and non-native peer specialists in the program.

VICKI: Okay. I've been thinking about seeing a traditional healer for some time, but I'm not sure yet. *[Provider nods.]*

PROVIDER: Maybe now's a good time to summarize what I've heard so far, to make sure I'm understanding. We talked about the court order and how it's a threat to your life with the girls unless you get treatment and quit drinking. You told me how your drinking started and got you here. You began drinking very young, starting with sneaking sips from your parents when you were 11, and then at 13 starting to use on your own. It seemed pretty normal to you because your parents drank a lot, too. You have drinking episodes now. You like the beginning of each episode more than the end; by the time you've finished the alcohol you have, you feel pretty bad. It interferes with your health. It contributes to the girls missing school, and they change a little when you are drinking. We don't know what they're thinking and feeling at those times when you're drinking. It's hard for you to keep a job. The court order got you here but being able to keep a job and, especially, to take care of the girls are your biggest reasons for wanting to quit. You're also looking for some spiritual ways that might help you feel stronger and more peaceful about life. Have I got that right? *[Vicki nods; then there is silence.]*

MASTER PROVIDER NOTE

Summaries like this one serve several purposes. They are a good barometer for an accurate understanding between the client and the provider. Second, the important elements of the client's problem come together for the client to hear. In turn, this helps the client clarify her experience by allowing her to hear her own thoughts and experiences from someone else—in essence, hearing herself more clearly.

VICKI: Right now, I worry about my nieces. I don't want them to have the same experiences that I had in boarding school, now that they're in placement. It's driving me crazy and making me very sad. This is not something I want to talk about, but it's important for me to get my nieces out of the group home. I don't want them to be harmed. I don't want them to go through what I went through. I don't want them to have the nightmares or feel depressed. I don't want to lose them, and I don't want them drinking, like I do, to deal with it. It's important for me to get over this court thing that's going on.

COURT ORDERS AND MANDATES FOR TREATMENT

You need to know the relationships among local tribal, county, state, and federal courts. These relationships and jurisdictional issues vary from tribe to tribe. Learn tribal codes; there is often an opportunity to make recommendations in tribal courts, sometimes called wellness courts.

PROVIDER: So, knowing what you feel right now and knowing what alcohol has done for you, you know how important it is to change your drinking right now. Say, on a scale of 1 to 10 where 1 means that change is least important and 10 is most important, what number are you at?

VICKI: I'd say a 9. It's important for me to get my nieces out of placement, and I need to change how things are going.

PROVIDER: So why a 9 and not an 8 or a 7?

VICKI: I have to show my nieces that there is another way to handle things. I have to show them that I can do it. I want to get done with the courts, get a job, and get them back. I want them to know about traditional ways. I want them to have something to hang on to besides me. And I don't want them to use alcohol like I do.

PROVIDER: So, on the same scale, how ready are you to make a decision about your drinking?

VICKI: That's an 8. It's time. I have been sensing this for some time that I need to stop drinking and go back to treatment. I just don't know if I can stop drinking for any length of time. I just get worried that I won't know what to do if I feel low, get an urge, or see my friends.

PROVIDER: *[Karen nods.]* You're ready, but you need to find ways to manage your mood and deal with situations around alcohol. *[Vicki nods.]* You have some big decisions to make right now. How confident, on a scale of 1 to 10, are you that you can make these changes right now?

VICKI: I can do treatment, but I'd say a 6 about quitting drinking. I have my doubts that it will stick just because of my history, and that's why it's a 6 and not higher. However, I have done it before, and I have gotten something out of each treatment. It's not lower than a 6. Everything is slowly getting worse every time I drink, and trouble seems to find me more often. I'm hoping this time it sticks.

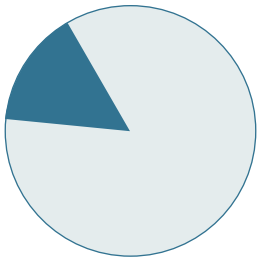
MASTER PROVIDER NOTE

Karen has learned that although Vicki rates her importance for quitting drinking at 9 on a scale of 1 to 10, her confidence is somewhat lower. Vicki fears that she will not be able to cope with her past or deal with the urge or pressure to drink. Working on Vicki's confidence in walking a new path will be very important in treatment. Helping her learn and practice ways to cope with other challenges will also be important.

USING SCALES IN COUNSELING

Several therapies use scales to assess, intervene, and evoke further discussions. For example, behavioral therapy and CBT for traumatic stress use the Subjective Units of Distress Scale (SUDS; Wolpe & Abrams, 1991; a scale from 0 to 10, in which 0 means feeling no stress and 10 means feeling exceptionally distressed or overwhelmed) to assess the client's level of stress from one session to the next. The SUDS serves as a quick gauge of the client's current stress level when retelling or reexperiencing a traumatic memory. Behavioral approaches use the client's SUDS level to identify the appropriate starting place for trauma-specific interventions.

CBT also uses percentages to help access the strength of a client's belief. This form of scaling can be artfully used to challenge a belief that may be interfering with the client's well-being. For example, how strong is the client's belief that he or she is not able to get sober (where 100 percent represents a definite belief that he or she will not stop drinking)? If a client states that he or she is 99 percent sure that he or she can't stop, the provider can ask why he or she didn't give it 100 percent or what would need to happen to bring the number down. Or the provider may ask if there was ever a time that this number was lower. Again, the importance of scaling extends far beyond the number that the client reports. When used prudently, it can be a powerful tool to challenge absolute or catastrophic thinking, often referred to as "all-or-nothing" thinking. To demonstrate these questions visually, the provider can use a circle and ask the person to draw a slice that demonstrates the strength of his or her belief. From this starting place, you can then have the person redraw and experiment with what it feels like to make the slice smaller or larger.



In this vignette between Karen and Vicki, Karen uses the importance, readiness, and confidence scales from MI (Miller & Rollnick, 2013). Each question asks for the client's perception about change using a scale from 1 to 10. For example, "How important is it for you to make this change? How ready are you to make this change now? How confident are you that you can do it?" As with any scaling, the initial numerical answer is not as important as the subsequent questions. For instance, "Why did you give it a 9 and not an 8? What makes it a 7 and not a 9? What would need to happen to have a higher or lower number?" These follow-up questions promote a more indepth conversation and elicit talk about change.

PROVIDER: So, coming into treatment and not drinking are pretty important for you. What do you think it would take for you to have even more confidence in these changes you want to make?

VICKI: I want to participate in traditional ways and get back to living some of the ways of my grandpa and grandma. I want to be that person for my nieces that my grandma was for me. *[Vicki starts crying.]* I feel my grandmother with me. *[Silence for a minute or more.]*

PROVIDER: *[Silence initially.]* It's very important to you to give to your nieces what you received from your grandma. Your grandma loved you a lot. What would your grandma want for you today?

VICKI: She'd want me to live my life and raise the girls in a good way. She is saying to me to stay close to her. When I think about it, I don't feel connected to her when I drink. I need to rely on her more, and I need her help and guidance.

PROVIDER: Maybe your grandmother is guiding you today. Perhaps she guided you here today.

MASTER PROVIDER NOTE

Talking about grandma provides some comfort after thinking about her painful past, need for treatment, decision to not drink, and relationship with her nieces. For American Indians and Alaska Natives, thinking of deceased relatives is often a way to connect with strength and spirituality. What have always brought native people through hard times are relationships with their Creator and their relatives.

MASTER PROVIDER NOTE

Because Vicki brought her grandmother into the conversation, and she had clearly been a positive influence and role model, Karen ended the session by invoking her influence and value system.

VICKI: She is important to me. I don't want anything to get in the way of feeling her in my life.

PROVIDER: Vicki, I appreciate you letting me talk to you about this. Have you thought about what your grandma might be saying right now about your decisions on treatment and drinking?

VICKI: She'd be happy. She would be proud that I am honoring my nieces and community by not drinking and going to treatment. And that's what I'm going to do.

Summary

Vicki came to the treatment center for her intake interview. She was court-ordered to treatment because of a DUI that also endangered the children she is raising. The provider introduced herself appropriately for Vicki's culture and assured Vicki that the conversation was confidential, which helped ease Vicki's initial distrust. She also took time to invite Vicki to smudge, a way of honoring Vicki's traditional customs and introducing a spiritual dimension to the interview experience. Vicki's agreement to perform the smudge reminded her of her values and influenced the tone of the meeting. Rather than conducting a highly structured interview, Karen, the provider, asked Vicki to tell her story about what happened and guided a conversational interview using an MI orientation with cross-sectional strategies from other approaches. As she talked about the areas of her life, Vicki began identifying the consequences of her drinking. Vicki's interest in ways that treatment could help her increased during the interview, and Vicki made a commitment to treatment that was motivated by her relationships and concerns rather than the court order that initiated this process.

WELLNESS COURTS

According to the National Drug Court Resource Center (2012) website, "a Tribal Healing to Wellness Court is not simply a tribal court that handles alcohol or other drug abuse cases. It is, rather, a component of the tribal justice system that incorporates and adapts the wellness concept to meet the specific substance abuse needs of each tribal community. It provides an opportunity for each American Indian and Alaska Native community to address the devastation of alcohol or other drug abuse by establishing more structure and a higher level of accountability for these cases through a system of comprehensive supervision, drug testing, treatment services, immediate sanctions and incentives, team-based case management, and community support. The team includes not only tribal judges, advocates, prosecutors, police officers, educators, and substance abuse and mental health professionals, but also tribal elders and traditional healers. The concept borrows from traditional problem-solving methods used since time immemorial and restores the person to his or her rightful place as a contributing member of the tribal community. The programs utilize the unique strengths and history of each tribe and realign existing resources available to the community in an atmosphere of communication, cooperation and collaboration."

For more information about wellness courts, see *Tribal Healing to Wellness Courts: The Key Components* (Flies-Away, Garrow, & Sekaquaptewa, 2014).

The above resource is also available online (www.wellnesscourts.org/files/Tribal%20Healing%20to%20Wellness%20Courts%20The%20Key%20Components.pdf).

Vignette 2—Joe: Addressing Methamphetamine Dependence, Reconnecting With Family, and Recovering on the Reservation

Overview

This vignette illustrates the importance of establishing a good provider–client relationship starting with the first pretreatment session. The dialog begins with the treatment provider, Mike, meeting Joe during his incarceration. The second session takes place after his transfer to a court-mandated treatment program. The pretreatment and treatment sessions focus on how to address treatment issues using experiential exercises in a culturally responsive way, such as highlighting strengths, addressing dreams, connecting with relatives, and identifying readiness for change.

Joe's Case History

Joe is a 28-year-old, single American Indian man living on a reservation in the Southwest. He is an enrolled member of the tribe. He grew up on the reservation with his parents and grandparents. His grandparents are traditional and practice their native spirituality. Joe is bilingual, speaking both his tribal language and English. He returned to live on the reservation 5 months ago after living in an urban area for 10 years. He had frequently visited and stayed for weeks at a time with extended family on the reservation during those years.

He is the oldest of seven siblings. When Joe was growing up, his parents drank alcohol and smoked marijuana. Joe started drinking alcohol when he was 11 years old and smoking marijuana when he was 12. He developed a pattern of drinking to intoxication by the time he was 13, and by age 14 he was binge drinking. Joe first got into trouble with the law as a teenager and was sent to detention, then to boarding school from ages 14 to 17. At boarding school, he was introduced to methamphetamine. He quickly became dependent, with methamphetamine being his drug of choice. He dropped out of school before graduating, left home, and moved to the city, where he continued to use methamphetamine.

During his evaluation, Joe said that he spent a lot of time "on the street," homeless. He reported that he never felt comfortable in the city, that he always felt like a stranger. He said he was ashamed to return home with nothing to show for himself. He finally did return to the reservation because he ran out of resources and was scared that something would happen to him on the streets. Recently, Joe has been exhibiting some signs of paranoia and confused thinking.

With his 11th-grade education, Joe was able to work from time to time in construction and as an artist. Over the years, his dependence on methamphetamine became stronger until he was unable to work because he would not show up. He would stay awake for 4 to 6 days at a time. When he was finally able to "crash," he would sleep for days, miss work, and lose his job. When Joe was not working, he would steal, deal drugs, and do whatever he needed to do to continue his habit, hence his involvement with the law.

Joe has spent a total of 4 years in jail for various alcohol- and drug-related charges. Joe was court-ordered to receive an alcohol and drug evaluation and subsequently mandated to attend treatment. He has spent 3 months in jail and is now entering treatment to serve the remainder of his time. Joe says that he wants to go to treatment and that he knows he can change his life.

Objectives for Vignette 2

This vignette includes two sessions. The first session takes place during Joe's incarceration, and the second occurs upon his transfer to the tribal treatment center. Treatment attendance is more likely to improve if you begin building the provider–client relationship before admission. Likewise, clients will more likely follow through with the next level of care if you physically introduce them to the new group or service.

Making connections is essential. In this vignette, Joe meets his provider before leaving jail. In other scenarios, you, as the provider, may need to facilitate a client's transition from one service to the next (e.g., assist a client moving to a

continuing care group after attending an intensive outpatient program). To improve the likelihood of follow-through and to increase the client's feeling of connection, you may consider attending the first meeting at the new program with your client or introducing your client to the new provider before transferring him or her to the new service, even if the service is not located within the same facility.

The objectives are:

1. To review common symptoms of methamphetamine use.
2. To introduce the use of a pretreatment session to establish a connection and supportive relationship with Joe prior to his admission into treatment.
3. To illustrate some ways to discuss cultural identity, traditional practices, and language needs and preferences in treatment.
4. To provide general cultural guidelines for using strengths-based practice.
5. To use a culturally adapted Stages of Change model as an experiential exercise that honors traditional ways, culture, and connection to promote healing.

Client–Provider Dialog

Pretreatment session: Session one

We meet Joe at two points in his recovery: early in his incarceration, and 3 months later, after his transfer to serve out his sentence in treatment. In the first session, the provider meets Joe in jail, where he has been incarcerated for a couple of weeks. The tribal treatment program provides an initial meeting to help with the transition to treatment, if Joe continues to choose treatment. Mike, a provider from the tribe's treatment center, meets Joe during his withdrawal from methamphetamine. Joe has nightmares and exhibits some mild involuntary twitching in his face during the first meeting, although he says that most symptoms have significantly lessened. During the first session, he appears restless, reports feeling very depressed, and shows some paranoid thoughts. Joe wants to go to treatment, and he reported to the court evaluator that he is likely to relapse without it.

PROVIDER: Hello, Mr. ——. I'm Mike, one of the providers at the treatment center. I grew up in this area, although I spent my twenties in Los Angeles. *[Mike tells Joe his lineage.]* I think during that time, I spent more time traveling back to the reservation than being away. After I got into recovery, I wanted to work on the rez and help others. It finally happened about 4 years ago. How are you feeling about being here?

MASTER PROVIDER NOTE

Ask your client how he or she would like to be addressed. This is a core counseling and relationship-building skill. As with any client, native or non-native, using more formal introductions before determining a preference shows respect. Honoring the importance of names is fundamental, particularly within American Indian and Alaska Native cultures. Sometimes, a client will want to be addressed by his or her Indian name. As discussed in the first chapter, the use of diagnostic labels during sessions can also be quite disquieting to your client—it is another way of naming.

JOE: You can call me Joe. I'm all right. Just nervous.

PROVIDER: You're in a tough situation. *[Mike gives time for silence.]* What can you tell me about your nervousness?

JOE: What?

PROVIDER: Joe, where do you feel this nervousness?

JOE: Yeah, it's hard to stay still and then be put in a six by eight. It's tough being here. I could jump out of my skin. At least, I don't have to worry right now about using. *[Joe becomes silent for a while.]* I'm not much of a talker.

MASTER PROVIDER NOTE

The provider notices that Joe is cooperative but having a hard time answering questions because of decreased ability to concentrate (likely a withdrawal symptom from methamphetamine). He changes his style so that he does more of the talking, soothing and reassuring Joe, and asks questions using a slower pace to give him time for thinking and to keep him engaged in the conversation. Mike, the provider, is uncertain still about language preferences and assumes that Joe is translating from his native language to English.

PROVIDER: I know some of the things you've been going through. I also know coming down off meth is tough. I admire you for working through it. *[Silence for a minute or more; Joe nods.]*

PROVIDER: Joe, I know from your evaluation that you were brought up traditional. I understand you're bilingual. I'm not good with our language myself. Would you feel more comfortable with a translator?

MASTER PROVIDER NOTE

On Joe's reservation, as on many others, traditional people may speak their native language in daily life. Because Joe grew up in a traditional family, the provider offers to provide a translator.

JOE: No. My English is good. I used to speak my language more when I lived at home, but in the city, I speak English. I've never felt at home in the city, and my traditional ways always call me back. For me, I don't belong there. I don't trust the city; it's treated me badly.

PROVIDER: *[Nods.]* So, you are coming home. I'm glad that you are. Welcome home, Joe. *[Joe begins to tear up, and Mike gives space and time in the session for him to be with his feelings.]* Joe, if you're ready to hear, let me take a minute to talk about why I'm here, what you can expect if you come to treatment, and then talk about some common, but passing, symptoms of methamphetamine withdrawal. *[Joe nods.]* The most important thing I want to say, though, is that I'm here to help make the transition from jail to treatment a little easier. I also want you to have a sense about me before coming to treatment, because we will be working together. *[Mike proceeds to talk about the logistics of admissions and the early phase of treatment.]*

THE LOSS OF LANGUAGE

According to Manatowa-Bailey (2007), "When a language dies, the loss to a tribal community—and to the world—is beyond measure. Entire systems of thought, belief, and practice become permanently removed from the storehouse of human knowledge.... The harm caused to indigenous communities by language loss is undeniable. When you remove a people from their language, you cut out the heart of their identity. When a language dies, everything that is attached to it—prayer, song, stories, dances, ceremonies, and every other aspect of a tribal system—becomes more difficult to sustain.... The challenge is great. Of the estimated 154 tribal languages that still exist, 56 percent have only a few elderly speakers. The Indigenous Language Institute reports that 89 percent of all North American languages are in danger of extinction. Of 2 million American Indians, only 18 percent still speak their tribal language, and the vast majority of these are elderly. Moreover, almost half of the 18 percent belong to a single tribe: the Diné (Navajo) Nation."

JOE: I need help. I'm having a rough time, and I don't like what is happening. I feel low. I can't stop thinking, and I have lots of dreams. Some of them don't feel right.

PROVIDER: Joe, before I talk about the common signs of meth withdrawal, what do you think is going on with your dreams?

JOE: I don't know if I want to talk about it.

PROVIDER: *[Nods.]* Okay, you don't need to tell me.

JOE: I keep seeing so many things that I can't focus on any one thing to tell you, but I keep seeing myself repeatedly walking into this room filled with people and empty baskets and a bird standing in the corner. I feel compassion coming from the bird, but I don't know what it means right now. Let's drop it. *[Mike nods. Joe's response indicates to the provider that he likely sees his dreams as spiritual messages.]*

MASTER PROVIDER NOTE

There is no universal belief about dreams across American Indian and Alaska Native cultures. In some native languages, the word for "sleep" translates as "the time when the spirit travels." In Joe's culture, dreams, sometimes referred to as visions, are powerful spiritual messages. The provider is aware of this and is interested in considering if this is the case with Joe's dreams or if they are related to methamphetamine withdrawal.

PROVIDER: *[Silence.]* Joe, I want you to know that I'm here with you and want to help. At some point, you may want to talk about this reoccurring dream or other dreams. Sometimes dreams become quite clear in their own time. But it doesn't have to be with me. In our program, we have providers, peer specialists, elders, and access to traditional healers.

JOE: *[Nods.]* I don't know, can't think about it right now.

PROVIDER: It's hard thinking about things right now. I know it's tough, and you're going through the worst of the withdrawal while in jail without much support. But what I do know is that you have many relatives who care about you.

JOE: I'd like to be with my grandfather. *[His grandfather is living; he has come to visit Joe.]*

PROVIDER: Where would you like to be with him?

JOE: *[Quickly responds.]* Well, not here. Besides, there is not enough furniture or food. *[He starts laughing.]* It feels good to laugh! Haven't done that for a while.

STRENGTHS-BASED PRACTICE: ALL CLIENTS HAVE STRENGTHS THAT HAVE BROUGHT THEM THIS FAR

The experience and effects of historical trauma, institutional racism, prejudice, and disparities can easily undermine people's perception of personal strengths. Coupled with the negative changes in self-perception and self-talk that can easily occur with addiction and psychological distress, individuals can begin to believe that their lives are worthless, their futures are hopeless, and their contributions to the community are insignificant.

Working from a strengths-based perspective is typically a good fit when developing and implementing American Indian and Alaska Native prevention and treatment programs and approaches. Among many native people, and particularly those who are more traditional, there is a belief that what you attend to becomes your reality, so emphasizing and safeguarding the clients' strengths—including individual, family, community, cultural, spiritual, and environmental strengths—is essential in healing and recovery. In culturally adapting strengths-based practice, American Indians and Alaska Natives may be reluctant to talk about their strengths; this can be seen as boasting. Strengths-based practice is much more than having a superficial conversation in which you ask clients to name their strengths. Strengths-based practice acknowledges how people fortify themselves and use strengths and resources they have been given or received. It draws on strengths passed from previous generations and from tribal or cultural heritage. What can people depend on? What are their resources? As a provider, it is important to promote this understanding of strengths-based practice.

Continued on next page

STRENGTHS-BASED PRACTICE: ALL CLIENTS HAVE STRENGTHS THAT HAVE BROUGHT THEM THIS FAR (CONTINUED)

Below are a few core values and beliefs of strengths-based approaches that you may want to convey to your clients and integrate into your practice (Hammond, 2010):

1. Everyone has strengths and resources from varied origins, including individual, community, family/intergenerational, elder, cultural and tribal, spiritual, traditional healing practices, and environmental.
2. What you say to yourself or attend to becomes your reality. If you always tell yourself that you can't get sober, then what are the chances that you will? The focus on strengths-based practice requires changing the script, internal dialog, or focus to match your vision of recovery.
3. It is helpful to focus on your strengths, skills, traditions, beliefs, and support when tackling problems. You can draw on wisdom from the past with your elders, family, community, and traditions.
4. Change is possible, but more likely if it occurs with support, care, and guidance from others. Change is more feasible when you make connections.
5. Ask yourself what has gone well so far (no matter how insignificant it may seem), then recreate it, and build on it. For example, in this vignette, Joe shows several strengths, including his traditional upbringing, artwork, connection with his grandfather, family and community support, prior success in withdrawing from methamphetamine, and willingness to enter treatment.
6. Start with what you know. Start with your story. You are the expert. Change only happens if you see it as an important part of your story.

Group Exercises: Gathering of Strengths and Storytelling. These exercises can be easily adapted for individual sessions. As a provider, remember to approach these exercises appropriately. They provide an opportunity for individuals to gather strengths and resources both inside and outside of themselves. Although some providers have used boasting sessions, this is typically inappropriate in American Indian and Alaska Native cultures and promotes a very limited perspective of strengths-based practice.

Gathering of Strengths. This activity begins with a discussion about strengths. What are they? Use the group to generate a sample list of strengths. The list could include strengths from many different sources, such as participation in seasonal activities, ceremonies, and rituals; skills with crafts or art; involvement and participation in traditional healing and other traditional practices; family, community, and individual attributes; intergenerational and ancestral strengths; stories remembered and told; sports participation; and beliefs in connectedness, as well as other spiritual beliefs. Once the group creates a list of strengths, break up the group for 15–30 minutes so that each member can select and gather two or three items that symbolize a strength that he or she has received in their life. The items may come from nature or items within the program. Make sure you set appropriate boundaries as to where they can go and what they can use in the program. (As with any population in treatment, if you do not set guidelines, it could on occasion cause problems, such as someone's going into someone else's room and using a personal item.) Creating a sense of safety is a primary role for a provider. Upon their return to the group, use a talking circle format. Have everyone take a turn and talk about the items that they chose and what the items personally represent. The group facilitator helps process the stories with the group at the end of the session.

Storytelling: Stories of Strengths. This activity follows the same format as above. It begins with a discussion about strengths; then, everyone individually takes 15–30 minutes to create a story that shows or represents strengths that will help them in their recovery. When they return to the group, use a talking circle format. Have people take turns and tell their story. They can be as creative as they would like, and the storytelling exercise may extend to the next session or to activities outside the group. For example, a client may want to draw the story between sessions or create a collage. The group may have access to materials so that they can create a group banner using beads, ribbons, and other materials. An alternative is to introduce the topic of strengths prior to the end of a group session to avoid the time limit for creating stories. Then ask group members to create a story of strength before the next session. The group facilitator helps process the stories with the group in the session. Another alternative is to use this exercise in multiple family treatment groups; the family comes together, creates a story, engages in a medium to represent the story, and presents it in a family talking circle format.

> **Across American Indian and Alaska Native cultures, people often insert joking and laughter into their conversations, knowing that laughter is good medicine and strengthens the connections between people.**

PROVIDER: Yeah, laughter is good medicine.

JOE: *[Nods and becomes quiet. After a minute of silence to think about whether he wants to say more about his grandfather or how to talk about his visits with his grandfather, he continues.]* My grandfather is an artist.

PROVIDER: *[Nods.]* And you?

JOE: I haven't done anything in a year or so. I can't seem to be quiet enough to draw. I feel trapped. Drawing makes me focused, but I can't seem to get into it right now. But it is something I have always hung on to. I carry memories of my grandfather spending hours drawing with me.

PROVIDER: It sounds like your artwork brings you strength and connects you to your grandfather. It sounds as if this is a good path.

JOE: Yeah, I know. I just don't feel still enough in my own skin to do it now.

PROVIDER: It will pass, your shakiness. But maybe you don't have to wait till you are back comfortably in your own skin. *[Mike will reassess this once Joe transitions to treatment. Some mindfulness strategies may help Joe become more comfortable with his current experience so that he can return to drawing.]* Joe, you may be through the worst part of the physical withdrawal from meth—but would it be okay with you if I spent time talking to you about some of the normal withdrawal symptoms of meth? I know you've gone through this a few times. *[Joe nods, and a portion of the session is devoted to normalizing the symptoms of withdrawal.]*

PROVIDER: *[The session ends with this last exchange and a promise to reconnect in the treatment program.]* Well, hang in there. You're going through withdrawal right now, and it will pass in time. You know already that some withdrawal symptoms have lessened, but it's not easy. You've told me you want to get treatment and make changes in your life, so I would like to check back with you again before you come to treatment. Is that okay with you?

JOE: Yeah.

PROVIDER: I look forward to seeing you again.

MASTER PROVIDER NOTE

Recognize that talking about consequences or the potential effects of drugs and alcohol can be perceived, by some American Indian and Alaska Native clients, as an omen. Mike is sensitive in asking for permission to talk about the effects of withdrawal.

Pretreatment session discussion

The session focused on compassion and connection—creating a connection prior to treatment. The provider guided the discussion toward strengths, including Joe's artwork and relationships with others. The provider was supportive and presented information about treatment; even though Joe had considerable knowledge and experience in withdrawing from methamphetamine, the provider offered information about withdrawal to normalize Joe's current symptoms.

Early treatment session: Session two

Three months have passed, and Joe has been admitted to the treatment program. After his intake interview and assessment, he reconnects with Mike and reports very little discomfort and few withdrawal symptoms. Upon entering treatment, he did not feel that people were out to get him as he had when he was in jail. He quickly began to participate in all program activities, and he recognized the importance of returning to his traditions. Joe wants change and has initiated it through his active participation within the program. Yet, he frequently states that he is anxious about having cravings and fears that he may relapse as he had before. He wants to honor his family by staying sober and clean. He does not want to return to that place of shame where he promised himself every

day that it would be different, only to go back and do the same thing again.

Grounded in traditional culture, Joe's treatment program is tribally run and located on the reservation. The program uses a holistic model expressed with traditional teachings about the sacred circle and uses the Red Road format—an American Indian and Alaska Native worldview of the 12-Step program. A smudging ceremony opens the morning meetings, and clients within the program have personal options to participate in sacred ceremonies, including sweat lodge, pipe ceremony, and healing ceremonies. The program's philosophy is to incorporate teaching of tribal culture wherever possible and to allow clients to decide for themselves about participating in the spiritual ceremonies. Participation in these ceremonies is chosen rather than required.

During the early phase of treatment, Joe initially learned more about the addiction and withdrawal processes he had been through and the chronic nature of his use that makes abstinence a goal of recovery. He began attending native 12-Step meetings and, with the help of treatment staff and his peers, began to experience how traditional practices and the 12-Step program could provide healing.

PROVIDER: It's been a while since I saw you last. You look better. How do you feel?

JOE: The jumpiness is better. But I still hit the ceiling if a door slams.

PROVIDER: To be where you are is a good thing right now.

JOE: People don't understand how hard it is to get off meth. I am feeling better, but I'm struggling. I keep thinking I have to do things differently, but it feels like it would be too much. Everyone keeps telling me I'm going to get through this.

PROVIDER: What do you think?

JOE: I've done it before, but I always start using again. I feel stuck; I know what I have to do, but I don't seem to do it for long. Then I walk away and feel pretty bad.

PROVIDER: Joe, would you be willing to look at how you're stuck? I have an exercise that might help you sort some of this out. You don't have to know what to do; I will guide you. The exercise is looking at where you are in the circle of change. Are you willing to give it try?

[Joe nods, and Mike proceeds to review the Stages of Change model, adapted culturally for this session (Exhibit 1.2-2). Then Mike uses string to form a large circle on the floor in the middle of the room. He then introduces each stage of change directionally along the circle before asking Joe to stand up. Mike asks Joe to think about where he would place himself along the circle and then stand on that spot.]

JOE: *[Joe places himself between preparation and action.]* I stand here because I've decided to come to treatment, so I'm taking action. But I'm also in preparation, thinking about how I'm going to stay away from meth and alcohol.

PROVIDER: What does it feel like to stand where you positioned yourself?

JOE: It still doesn't feel right. I think this is as far as I get when I've been in treatment before. I get stuck on this section of the path.

PROVIDER: Would you be willing to try other parts of the circle? Maybe if we stand at different places *[stages]* along the circle, you will begin to understand the how's and why's about getting trapped here. *[Joe nods in agreement.]* So, Joe, you're standing in between preparation and action. Let's move back to contemplation and stand in this space. What is this like for you?

JOE: It's a miserable place. I spend most of my time here, thinking that today is the day to stop using, only to go back again. I don't like it here. In this place, I know that things are not good, but I feel like I can't move, and I am holding a bag of bad feelings: that I'm disappointing my family and bringing shame to my tribe. There's no hope here.

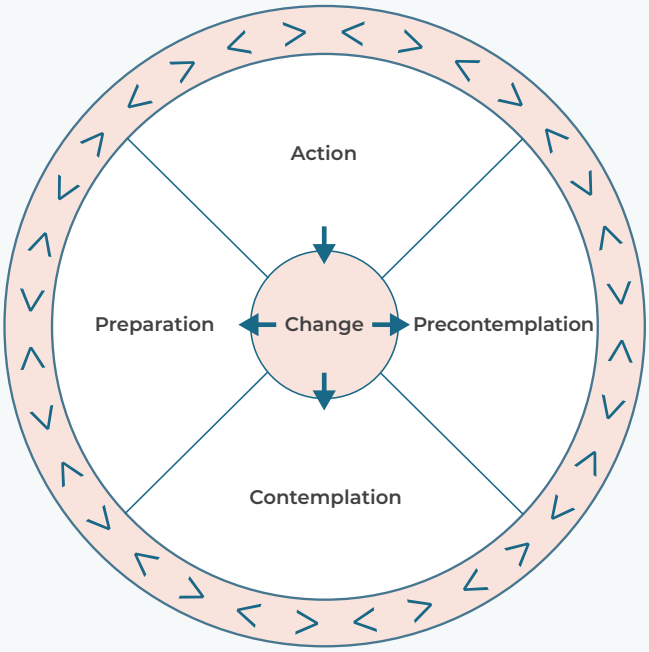
PROVIDER: Joe, let's bypass the preparation phase and stand firmly on action so you can compare what it might feel like to stand here versus in contemplation. What does it feel like to stand here?

EXHIBIT 1.2-2. The Stages of Change Model

The Stages of Change model was never meant to be a linear model of change behavior. Change does not typically occur at one time, but rather, it is a journey. In this model, individuals can move back and forth from different places along the cycle of change or stay in one place. For example, individuals can be painfully aware of needing to make a change, so they quickly move from thinking about it (contemplation) to action. At that moment, they might become so overwhelmed with their new decision that it compels them back to contemplation. Others may prepare or take small steps toward a decision for some time after knowing that they need to change. Still others may deny that change is needed. Decisions and change behavior are never static. In the Stages of Change graphic, you will notice arrows facing both directions on the outer concentric circle. These arrows represent an individual's ability to move in either direction. You will also notice three of the arrows pointing away from the inner concentric circle, Change. These arrows emphasize that individuals can move away from change and revert to previous behaviors, beliefs, or ambivalence about making a decision to change. They may even return to precontemplation, where they deny that change is needed.

Precontemplation. Individuals in this part of the cycle do not see a need to do anything different or to make changes. They are unaware that their current behavior is producing negative consequences. When others address their behavior, they are more likely to place the responsibility on circumstances outside of themselves and report that others are overreacting or overly concerned about the problem behavior. They do not see a need to make a different decision or to make any changes.

Contemplation. Individuals standing in this place think about changing a particular behavior or want to make some change, but they have mixed feelings about it. This can be a painful place—knowing that you need to make a change, promising yourself you are going to follow through with it, and then not doing it. Individuals are aware that their behavior is problematic, but they may feel stuck, ambivalent, or overwhelmed with the idea of doing something about it.



Preparation. In this place within the cycle, individuals are preparing to make a change. They are taking small steps toward changing behavior or making a decision. They are likely to gather some information about the particular change—for example, talking with someone about it, cutting down use, or changing some behaviors around it. They are standing at the doorstep.

Action. Individuals within this part of the cycle are committed and have decided to change. They are working on obstacles that may lead them back to old behaviors and engaging in activities that help support their change. Within this model, individuals who have sustained change for 6 months are considered to be in maintenance.

The Stages of Change model was culturally adapted to highlight the importance of cycles in native culture.

Source: Prochaska, DiClemente, & Norcross, 1992. Adapted with permission.

JOE: I have this mental picture that I'm home—that my family (at least some relatives) is proud of me. I feel like I can stand tall here—that I'm not carrying such weight or shame. I have this image of walking into our community center and people greeting me. I feel connected to my traditions. But then I get nervous when I'm here for any length of time. I feel like I might not do it right, and then I start getting cravings.

PROVIDER: Let me just check this out with you. When you stand in action, you feel as if you are standing with others. *[Joe nods.]* But then you start getting nervous, or maybe even experience some urges to use, and it feels like too much. Then what happens?

JOE: I start pulling back from relatives, and I start using again and go back to the streets.

PROVIDER: Your first signs of using are feeling nervous, as if it's too much, and dealing with it alone?

JOE: Yes.

PROVIDER: Let's just experiment a little bit more. What might you say or visualize to yourself when you're feeling nervous or when it feels like it's too much standing in action?

JOE: I picture in my mind that people are welcoming me at the community center—that I don't have to do it alone. My relatives are here, and my grandfather is standing, waiting for me to walk down the path.

PROVIDER: I want you to hold this image and words, but for a moment, I want you to walk back to contemplation. What is this like, again?

JOE: I really don't want to be here. It's like a waiting place. You know where you want to be, but you can't get there. And you are the only one waiting, waiting alone. *[Mike acknowledges Joe's pain.]*

PROVIDER: Joe, let's walk back up to action. What's it like to return here?

JOE: This is where I belong. I belong back here. I've just got to remember that no matter what I'm feeling that there are people I can go to—that I don't have to leave this place alone or do it by myself.

PROVIDER: Are you willing to hold onto the image of being welcomed back in the community as a reminder? *[Joe nods.]*

JOE: I got it. I want to stay here. I think this picture will keep me on a good path.

[Both continue to discuss some ways to gain support and to avoid isolation using traditional healing practices and connecting with a peer specialist at the center.]

Summary

The results of Joe's court assessment suggested he would benefit from residential treatment. He agreed to attend the alcohol and drug treatment program at the tribal center and expressed that he wanted treatment. Joe underwent the most acute part of withdrawal in jail. The pretreatment session within the correctional facility provided Joe

MASTER PROVIDER NOTE

Participation in traditional ways, including sacred ceremonies, should be more than an add-on to the treatment program. Native spirituality is central to American Indian and Alaska Native health and recovery for those who practice; living native traditions is much more inclusive and grounding than a treatment plan targeting a specific problem, such as substance abuse or a mental health issue. Actively involving traditional healers to assist in the healing process can be extremely powerful in promoting recovery. Using traditional peer specialists for individuals who want to walk the recovery path in traditional ways can be a very compassionate and supportive approach.

an initial connection right at the time when he was ready to make significant changes. Treatment gave him an opportunity to structure his recovery in a safe place to begin his journey. In the early phase of treatment, Joe began to see the connection between his drug use and his feelings of isolation and shame. He felt that he had disappointed his family and community. Using an experiential exercise based on the Stages of Change model, Joe was able to identify major barriers in recovery. He recognized that walking his path meant walking with others, asking for help, and engaging in traditional practices. The community has become a symbol for recovery and healing.

CULTURALLY RESPONSIVE COUNSELING WITH AMERICAN INDIANS AND ALASKA NATIVES

Take cultural cues from clients. Until you learn otherwise, it is best to assume that your clients may be culturally traditional. You can assess specifically for this as the session progresses.

Welcome your clients. The American Indian and Alaska Native way is to offer food, water, and a place to be comfortable. The consensus panel suggests that you treat your American Indian and Alaska Native clients like relatives.

Introduce yourself. It's important to share a bit about your family background and where you come from, as well as what your role is in this meeting.

Use an open-ended style. The provider sets the tone for the relationship. The consensus panel suggests conducting sessions and assessments in an open-ended, relational style to encourage an engaging connection between providers and clients. Encourage clients to tell their stories, listening for personal values that might motivate clients for recovery and strengths that might assist them. Ask questions to fill in missing information.

Build on people's values. Values are the motivators for change. Simply looking at a problem is not enough for clients to make a difficult change. It is how the problem interferes with people's well-being—the way it stops clients from living their values—that motivates change.

Honor the importance of family, community, and connectedness. American Indians and Alaska Natives often relate strongly with their family, community, and environment. When working with individuals, remember to involve other support individuals in the family and community to help support recovery.

Make room for silence. Remember that many American Indians and Alaska Natives speak carefully, thinking about their words before talking. This is especially true when your clients are bilingual and perhaps speak their native language at home.

Vignette 3—Marlene: Facilitating Support, Creating Family Connections, Honoring Traditional Ways, and Recovering in Remote Alaska Villages

Overview

This vignette begins with a counseling session to help Marlene prepare for a session with her family. The vignette covers considerable ground in highlighting the challenges of remote village life in Alaska, assessing the role of traditional ways and subsistence in recovery, and promoting the importance of intergenerational healing. The second session is a family session that allows all members to talk about the effects of and their relationship with alcohol, to connect family members who are more likely be supportive of recovery, and to provide opportunities for the family to tell their story so they can heal, gain strength, and be guided in recovery.

Marlene's treatment provider is Nolee, an Alaska Native who left her remote village to obtain her education and training. From her life experiences as an Alaska Native who grew up in a remote village and through her internship as a village-based provider, Nolee brings a wealth of cultural knowledge to the relationship. When she meets Marlene, she has several years' experience in counseling Alaska Natives and a vibrant referral network, as well as skills in using technology for long-distance services. Nolee works with Marlene throughout her stay to secure support from her family and community.

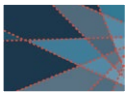
Although this vignette focuses on family connections, Nolee also reinforces participation in traditional practices to help maintain abstinence; provides psychoeducation about the binge pattern of alcohol use; introduces the concept and normalizes the symptoms of traumatic stress; and emphasizes the importance of support throughout her treatment stay during individual, group, and community meetings. Nolee identified a key objective in preparation for continuing care planning: to develop Marlene's interest and comfort in using technology at her village's health clinic as a recovery tool upon discharge. This included online participation in native recovery support groups, regular email communication with a peer specialist, and follow-up videoconferencing or phone calls. Nolee believes that comfort with a skill comes through practice, so she arranged to have Marlene participate in a few online support meetings and facilitated a couple of phone calls to her peer support specialist. This helped her become more accustomed to using the technology before she was discharged from inpatient treatment.

Marlene's Case History

Marlene is a 30-year-old Alaska Native who lives in her native village in western Alaska. She was referred to residential treatment by an outpatient program after she had repeated returns to use during treatment. This is her first inpatient treatment experience.

Marlene was raised in her tribe's traditional culture. English is her second language; she speaks her native language in her daily life. Marlene declined to have an interpreter during her initial interview and treatment. She communicates well in English, although she spends time gathering her thoughts before speaking.

Marlene is married and lives with her husband and their two children in the village. The Office of Children's Services became involved with Marlene's family after repeated reports of neglect. Currently, both children are staying with her mother. She needs to complete treatment successfully and maintain abstinence to ensure that she remains their primary caregiver. In outpatient treatment, Marlene was diagnosed with alcohol dependence and depression. She reports unresolved issues stemming from the suicide of a cousin 15 years ago. She blames his death on his drinking and expressed anger toward her mother for not attending his funeral.



ALASKA NATIVE VILLAGES: CURRENT CHALLENGES

Villages range in size from populations of fewer than 100 to nearly 1,000, which is considered a large village. Communities are close, and tribal councils are elected from among the villagers, so leadership reflects the village's social culture. In remote villages, there's a high reliance on government funding, and the cost of living is much higher. Many communities lack economic vigor, thus impeding sufficient employment; adequate utilities; and safety protection, including police, housing, and fire departments. Many jobs are part time to employ more people in the community. A significantly higher percentage of families who live in remote villages are economically poorer (Martin & Hill, 2009) than families who live closer to larger towns or cities; they also tend to be poorer than non-natives who live in Alaska.

Villages rely primarily on seasonal work and subsistence practices, including hunting and fishing. For native people, subsistence is a way of life, culture, self-determination, and identity, but there are many external challenges facing subsistence among native people, particularly the effects of commercial fishing and policies. According to the Alaska Department of Fish and Game, only 2 percent of consumption occurs through subsistence harvesting, whereas nearly 97 percent of resource consumption occurs through commercial entities (Alaska Department of Fish and Game, n.d.).

Many villages have limited services, including health care, courts, and police departments. Communities that do not have road access depend on small planes, snowmobiles (commonly referred to as snow machines in Alaska), or boat transportation when weather permits. Villages often rely on state police stationed hundreds of miles away; response times reflect availability, situation severity, weather, and transportation. Some villages have assigned village public safety officers, who have limited responsibilities and abilities to protect. Many Alaska Native communities experience some of the highest rates of family violence, alcohol abuse, sexual assault, and suicide in the United States. Women in native communities are 12 times more likely to be physically assaulted and three times more likely to be sexually assaulted than the national average. Suicide rates among Alaska Natives are almost four times greater as well (Indian Law & Order Commission, 2013).

Leadership, resources, and funding capacity of tribal health organizations determine the types and level of behavioral health services in each region. The Alaska Area Native Health Service provides financial and personnel support to the Alaska Native Tribal Health Consortium and other Alaska Native healthcare providers servicing remote villages and rural and urban areas (Indian Health Service, n.d.). Through self-governance, Alaska Native organizations and corporations oversee most funds designated for health care.

At the village level, the community often relies on community health aides at the clinic, who are first responders in managing emergencies, administering first aid, assessing injuries and illness, prescribing medication (under physicians' licenses), conducting preventive services, and facilitating telehealth, where available. Village-based providers may also be available to provide and broker further assessments and referrals for more severe behavioral health conditions. Other healthcare professionals may visit the village on regular schedules, but this depends considerably on geographic barriers, weather, and funding. Approximately 80 percent of primary care and nearly all specialty physicians reside near Anchorage (Alaska Federal Health Care Partnership, 2015). The challenges in accessing care in remote villages can lead to limited, delayed, or inconsistent care across modalities, including mental health, addictions, general medical, specialty health care, and prevention services.

Marlene shows respect toward her mother and is submissive toward her, honoring her traditional upbringing. Marlene reported earlier childhood memories of her mother and grandmother both being depressed, frequently telling stories of the "Great Death" (epidemics that decimated entire families, villages, and generations). Marlene's depression also stems from a history of sexual abuse from her stepfather. Her mother thinks that Marlene should forgive her stepfather, yet her mother reported the sexual abuse that led to his incarceration. Marlene denies any difficulties stemming from the sexual abuse and says that she does not want to talk about it in treatment. She has no suicide history or current thoughts of harming herself.

She has been drinking homebrew to self-medicate and exhibits increased tolerance. Marlene binge drinks, consuming alcohol during the short periods when it is available. She attributes her past relapse episodes to her husband; she explained that she drank many times with him at home. When he left the house to drink somewhere else in the village, she often would attempt to find him and then would stay and drink with him. Thus, her use often mirrored her spouse's use. She never thought it was much of a problem until recently, when he suddenly stopped drinking about a year ago. She maintains that her husband's use was more serious. In the last 6 months, her husband has regularly left the village for work. Last month, Marlene began binge drinking for a few days when her husband was not home. This led to a report that she had neglected her children. She does not recall the incident but is worried about the outcome if she does not finish treatment or stop drinking when she is discharged.

Homebrew is made with simple household ingredients. The practice of making homebrew is well known in native villages. Individuals make their own spirits for many reasons, including limited availability and accessibility, costs, prohibition, and a means of income. Homebrew can be particularly dangerous to drink depending on sanitation during processing, the ingredients selected to create fermentation, the additives to alter taste, and the chemical properties after production. Homebrew can be toxic, and its effects may be fast acting. Not all villages ban alcohol sales, but a significant number of villages have imposed local controls on alcohol, banning sales, importation, or possession.

ADULT BINGE DRINKING

In adults, binge drinking is defined as having five or more drinks (for men) or four or more drinks (for women) on the same occasion at least once in the past 30 days.

- Binge drinking among Alaska Native adults appears to have decreased by 22 percent since 1992–1994.
- One in five (20.4 percent) Alaska Native adults report binge drinking.
- The prevalence of binge drinking among Alaska Native adults is similar to that of Alaska White (19.8 percent) and U.S. White adults (18.9 percent).
- Alaska Native binge drinking rates vary by tribal health region, ranging from 11.7 to 29.5 percent.
- Binge drinking can damage the body significantly. It exposes the body and its organs to higher blood alcohol concentration and longer exposure as it is being processed in the body.
- Binge drinking is associated with unintentional and intentional injuries, alcohol poisoning, poor control of diabetes, high blood pressure, stroke, liver damage, and neurological damage, among other consequences.

Sources: Alaska Native Epidemiology Center, 2014; Centers for Disease Control and Prevention, 2014.

Marlene has a 10th-grade education. She is sporadically employed and has a work history that includes fish processer, store clerk, and janitor. She prefers a subsistence lifestyle to holding a job. Marlene's cultural strengths include hunting, tanning hides, trapping, fishing, beading, sewing, and berry picking. She does not use alcohol during her subsistence activities.

Objectives for Vignette 3

The objectives are:

1. To demonstrate how to prepare the client for a family session.
2. To reinforce how traditional ways, including subsistence activities, can be a pathway to prevention and recovery.
3. To provide several activities that involve children inside and outside the family session to reinforce the strength of culture, family, and community.

4. To illustrate how to conduct a family session early in recovery to build support from relatives.
5. To indicate how traumatic stress is embedded across generations among American Indian and Alaska Native cultures and that its effects can be felt through the incidence of depression, parenting difficulties, and self-medication.
6. To anticipate the geographic challenges of remote villages in securing recovery support services and the challenges of developing and implementing a plan prior to discharge so that the client can practice skills, including those that involve technology, thus increasing comfort and the likelihood of follow-through.

Client–Provider Dialog

Marlene is in her second week of treatment. She arrived at a residential treatment center some distance from her home village. Marlene is worried about her children and what will happen to her relationship with her husband now that he has stopped drinking. During the first 10 days, several other areas were identified and addressed, including psychoeducation about the binge pattern of alcohol use among women, the main components of trauma-informed care (including the education and normalization of traumatic stress symptoms), the importance of safety, the need for support, and the role that subsistence can play in maintaining abstinence. The first dialog includes a brief exchange between the client and the provider to prepare for their family session. The next dialog is a family session that includes Marlene's mother, spouse, great-uncle (elder), and two children (Ben, age 12, and Tanya, age 10). The great-uncle is an elder on the traditional tribal council. Marlene's provider, Nolee, is also an Alaska Native. She obtained her education and provider training in the Anchorage area and completed her internship as a village-based behavioral health service provider in a remote village north of Fairbanks, AK.

MASTER PROVIDER NOTE

In American Indian and Alaska Native communities, even in urban areas, it is common that a provider will have multiple connections or relationships with a client besides the professional relationship. The client and provider may be related or live in the same community or village. The client may be a store clerk, teacher, mechanic, or librarian with whom the provider has done business for years. They may participate in the same social or community groups, have family and friends in common, or have children who are friends. When this happens, it is important that the provider makes use of clinical supervision to discuss and clarify boundaries and assures the client of confidentiality.

Preparation session prior to family session: Session one

MARLENE: *[Enters the office.]* My family is traveling tomorrow for the family session and family weekend.

PROVIDER: You sound surprised.

MARLENE: *[Marlene appears tearful.]* I don't know what to say to them, especially my children, and my great-uncle. He is an elder and a member of our traditional tribal council.

PROVIDER: Let's take this session to think about this.

[Marlene nods, and Nolee spends some time to ease into the conversation after talking about her family's travel arrangements and checking in with Marlene about her week in treatment.]

MARLENE: *[Marlene sits in silence for some time.]* I want my children to know our ways. I'm worried that I've shown them something different. I think my mother and great-uncle would agree. They've always maintained our ways. When I do participate in community events, including subsistence activities, I begin to feel that I'm on the right path. At the same time, the first feeling that comes flooding into my mind is shame when I'm not drinking. I blame myself, and I feel it sometimes in the community.

MASTER PROVIDER NOTE

Community, and one's reputation in the community, are important American Indian and Alaska Native values. People generally want to be contributors and well thought of, bringing respect and honor to the family within the community. Providers should be particularly sensitive to honoring this value in discussions.

PROVIDER: What happens when you feel this shame? Where does that feeling of shame first begin in your body?

MARLENE: I don't know. *[Time passes.]* I don't know what to do. I just want to run from this feeling. And I do. I run with alcohol.

PROVIDER: Have you ever listened to what the shame has to say?

MARLENE: I first hear in my head that I'm not a good person or mom. I sometimes feel as if nothing will come of my life. The feeling is all about the bad things that have happened because of drinking.

PROVIDER: When you listen to it, its message is about the past and not the present moment. *[Marlene nods.]* What do you think would happen if you didn't run—if you stood in the feelings?

MARLENE: I don't think I could do that. Don't think I ever have done that for long.

PROVIDER: So many feelings meet you at the door when you first stop drinking. Do you think it will pass, if you don't go back and run with alcohol?

MARLENE: It does pass, but not right away when I go to camp. Hunting and tanning make me focus on what needs to be done. I don't drink when I hunt; animals can smell it. When I go out hunting, I don't think of anything else. I am happy. It's cleansing.

PROVIDER: So, when you first don't use, initially bad feelings come. Then if you stay with it, it passes. When you live your traditional ways, the bad feelings leave you.

MARLENE: *[Marlene nods.]* Being with others who are not drinking at the time helps and being with my mom and great-uncle at the camp makes a difference. I am home.

MASTER PROVIDER NOTE

Marlene has reported feelings of depression during her intake. As a standard of care, she would initially have a medical evaluation to rule out any specific conditions. Depending on severity, she may also need a referral for a psychological evaluation to determine the most appropriate course of treatment using traditional and mainstream approaches.

As a provider, it is important to recognize that depressive symptoms may be a consequence of her drinking, trauma (including historical trauma), or other environmental conditions. Although this does not preclude the need for additional treatment to address her depressive symptoms, you need to know that depressive symptoms can emerge from a number of causes. For example, traumatic stress can be displayed through depressive symptoms alone. In other words, the person will not have the classic symptoms of traumatic stress outlined in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (American Psychiatric Association, 2013), but instead have depression as the main symptom of traumatic stress. Also, individuals with a history of trauma may use drugs and alcohol to self-medicate the effects of their experiences. Unfortunately, self-medication often leads to a vicious trauma cycle, whereby the use of alcohol or drugs increases the likelihood of trauma, and then the new trauma reinforces ongoing self-medication with substances.

PROVIDER: What might you need to say to your mom and your great-uncle during the family session?

MARLENE: My mom had a rough time in her life, but she is better now. I know she wants me to be well. I want to show both of them respect.

PROVIDER: Is that what you want to say? *[Marlene nods.]* How would you like to show them respect?

MARLENE: Taking care of my kids. Seeking out people who don't shame me or who don't want me to drink for support. Traditional ways.

PROVIDER: When you say, "Taking care of your kids," what does that look like?

MARLENE: Teaching them old ways but giving them chances to learn new ways as well. Our village is changing quickly. I want them to know that they can learn the old and that knowing our ways will help them with change. I worry that I've taught them, like I've been taught, to use alcohol to cope.

[This dialog took some time in the session. Marlene paused frequently, collecting her words and thinking about how she wanted to say this.]

PROVIDER: Marlene, I'm drawing a circle on this paper. Let's fill this circle with traditional ways and beliefs, the values of community, the things that you would like to teach your children. *[They spend additional time in the session as Marlene fills in the circle.]* What would you like to name this circle?

MARLENE: This circle is for my children. It's how I want to be with them. Um, maybe the circle of gifts.

[Nolee then asks Marlene what she would like to do with the "circle of gifts." Marlene decides that she wants to share the circle with her children alone when they come for the session and program.]

SUBSISTENCE: LIVING TRADITIONAL WAYS

"Hunting and fishing links today's skiffs and nylon nets with the willow fish traps of the past.... 'Our belief system—the way our creator spoke to us was through his own creation—through the animals and the fish,' said the 49-year-old Yup'ik. 'We not only hunt and we eat. That's the way he spoke to us was through nature. So, when we participate in subsistence it's like reaffirming who we are'" (Thomson, 2000).

"Traditional hunting and fishing benefits go far beyond nutritional value and benefits, they are central to maintaining cultural norms and language. They reinforce the deeply embedded value of a shared sense of community and responsibility for the welfare of others. By working together, Alaska Natives meet and overcome the challenges found in the Alaskan outdoors. In this region, it is common among native members who are better equipped to hunt and fish, to distribute food to the less well-off in the community. Hunting and gathering are key components of traditional living. The act of hunting itself can be ceremonial. What is eaten, and what is left untouched are often life lessons retold from the elders to their young through the art of storytelling. Accordingly, traditional hunting, fishing, and gathering is more than what Alaska Natives do; it embodies who they are as a people as traditions are passed down from one generation to the next. This way of life provides for the cultural, spiritual, physical, emotional, social, and economic wellbeing of Alaska Natives" (Alliance for a Just Society & Council of Athabascan Tribal Governments, 2013, p. 5).

Two projects in Alaska have evaluated the feasibility of a community intervention to prevent suicide and alcohol abuse among rural Yup'ik Alaska Native youth in two remote communities. The interventions, originating in an indigenous model of protection, were built around traditional and subsistence activities which were presented as a *Qungasvikm*—a toolbox containing 36 activities or modules (Mohatt, Fok, Henry, People Awakening Team, & Allen, 2014).

MASTER PROVIDER NOTE

The "circle of gifts" can be easily incorporated into family programming to help parents share stories with children about traditional ways and values. You can also use this circle to discuss how traditional ways provide lessons on how to cope with life circumstances. This exercise can easily be adapted as a group activity in treatment, whereby clients complete, share, and process their circle within the group or community. It provides an opportunity to use storytelling to express how traditional ways can guide recovery.

PROVIDER: Marlene, I'm thinking about your husband attending the session. What would be helpful?

MARLENE: I've known him my whole life. We're on better ground since I got here. *[Marlene begins to laugh.]* You know, he's shown me how to drink and how not to. I'm proud of him. For years, I thought I was going to lose him the same way as my cousin. He would get so down about not working all the time.

PROVIDER: Is there anything you haven't said that you need to say to him?

MARLENE: He knows I'm proud of him for not drinking and for finding work. He is walking the walk. Now he works more regularly, even though it's still seasonal. People really respect him in the village. He turned things around.

PROVIDER: Before we end this session, is there anything that you haven't spoken here that may come up in the family session? *[Marlene shakes her head, no.]* Marlene, our next session will be the family session. It will be a time for listening, a time to share stories, and a time to heal. Is there anything else that you need to talk about in the family session? *[Marlene says, "No."]* How would you like to close this session?

Family session: Session two

Marlene's mother, great-uncle, and two children arrived for the session. Her husband was not able to attend because of work. Prior to the session, Nolee made arrangements so that Marlene's husband could call in during the session for at least part of the session. Nolee divided the family session into three segments. The first portion, called the listening circle, involved everyone, including her two children. The second portion of the session only included her great-uncle, mother, and spouse, and the final portion involved the entire family in creating a family recovery crest.

MASTER PROVIDER NOTE

When preparing your client for a family session, it is always wise to ask whether there is anything that he or she hasn't said that might come up in the family session. This is not unique to American Indian and Alaska Native clients. Sometimes, the client or the family will use the session to make a surprising announcement (e.g., affairs, separations, custody). Although you surely cannot stop this from happening with the client or another family member, asking this question will at least alert the client that this is the time to talk about it: *before* the family session. The family sessions—at least the initial one—that may include extended relatives and children are not an appropriate place or a safe place to rid oneself of a secret or a surprise. As a provider, you want the initial session to build connections; to increase awareness of the effects of substance use or psychological problems on the family; and to bridge any gap of support to ensure recovery of the individual, family, and community. If the client does have a secret, then you both can talk about how and when it may be addressed.

The first segment of the family session: The listening circle

[During the welcome, introductions, opening words, and format outline, Nolee asks the elder (great-uncle) if he wants to say anything or ask anything before the session starts. Then, Nolee asks the family a question to confirm that everyone knows why they are here.]

MASTER PROVIDER NOTE

In family sessions, providers should not assume that everyone in the family was told why they were attending the session or why the client is in treatment. After introductions and opening words, the provider should deal with this assumption by beginning with a question about everyone's understanding of why they were invited to attend the family session. This question helps guide the session, and it allows for a gentle approach. As a provider, you do not want to be the messenger. Instead, it is important that clients explain the reason in their own words if they have not done so prior to the session. If the client is struggling, you may ask if he or she would like you to say something about the purpose of the session. Overall, this approach shows respect, but it also provides information on how communication occurs within the family.

Keep in mind that some clients may avoid stating the real reason for the session. In this scenario, you will need to spend time in facilitating a further discussion, so the family session is based on the real purpose for treatment. This scenario is uncommon. Yet, if it occurs, you can switch the format briefly and state that the session will involve meeting the family individually, in dyads, and as a whole: that you will be asking different members at different times to be in the family session while others wait in another room. You should say that the family session will always end with everyone together. If this scenario occurs, it usually involves clients' reluctance to talk about the presenting difficulties with their children. In this case, you walk the children out of the room, guiding them to another room that includes adult supervision and an activity. You want to let the children know that you will be returning shortly to bring them back into the session. Then, you return to the family session and privately discuss clients' reluctance and how they would like to handle the discussion with their children. You invite the children back into the room and follow the plan that was discussed. You can also use the same strategy if clients did not tell an adult family member about the reason for the session.

[Everyone acknowledges in their own words that Marlene's drinking was a problem. They all address concern for Marlene. When the children speak, although quite reluctantly, the younger, Tanya (age 10) states that she misses her mom.]

TANYA: I miss you. *[Both mom and Tanya become tearful.]*

MARLENE: *[Some silence.]* I know, but I need to be here so that I can come back to you.

PROVIDER: Tanya, if there was one thing that you would like to change in your family, what would it be?

TANYA: I want my mom back. I don't want anyone taking her away.

MARLENE: *[Tearful.]* Tanya, who do you think is taking me away?

TANYA: *[She looks at her mom and surprisingly mentions the alcohol. Marlene didn't think that her children really knew about her drinking.]* Alcohol takes you away.

[Marlene doesn't say anything, but it is clear that this has affected her.]

PROVIDER: *[Nolee takes newsprint and lays it on the floor in the center of the family circle. She draws the word "alcohol."]* Tanya, what would you like to say to alcohol right now?

[Marlene encourages her.]

TANYA: *[She begins to show anger.]* I don't like you. You always take my mom. Why don't you leave her alone?

[Nolee prompts Tanya and asks her if there is anything else she would like to say to alcohol.]

TANYA: I just want to be with my mom.

PROVIDER: Who else would like to say something to alcohol? *[Nolee redirects everyone to speak as if alcohol were in the room and toward the paper on the floor.]*

MARLENE'S MOTHER: You used to take me too. You have taken too many people in our village and my family. I want it to stop. I'm so glad that I have my daughter and son-in-law back. I'm going to do anything I need to keep them away from you. You don't belong here, in our village, or our camps. I want to say goodbye to you. You are not from us. I love my daughter, and I see her suffer when she is with you. *[Marlene's mother reaches next to her daughter and holds her hand.]* I've been looking at my daughter as the problem, not you.

HONORING CHILDREN, MAKING RELATIVES

This is a cultural adaptation of the Parent–Child Interaction Therapy approach. This adaptation supports traditional native parenting practices and values, focuses on parents who have difficulty with parenting skills or with addressing their children's problematic behavior. It incorporates an essential native belief that children are the center of the circle (Bigfoot & Funderbunk, 2011).

PROVIDER: Does anyone else want to say something to alcohol?

MARLENE: *[Nods and pauses.]* You've taken so much from me. I've known you for some time. And the goodbye will be hard, but I don't want to lose my children to you. I need to walk away. I need to walk a different path, to learn more from our old ways, to show our ways to my children. It's a White man's disease, so I need to fix it here. Then I can get away from it. You have broken the circle.

PROVIDER: Who else would like to speak? *[This portion of the session continues. Family members take turns speaking about alcohol. Then the provider asks everyone what they heard as they sat in the room and listened to each other. Afterward, the session transitions into having just the adults in the session as the children go with another provider who works with children.]*

A traditional elder is someone who follows the teachings of ancestors. It is said that traditional elders walk and talk the good way of life. Traditional elders teach and share the wisdom they have gained of the culture, history, and language. The sharing of their wisdom is healing (Anishnawbe Health Toronto, 2011). Not every older person is recognized as an elder of the tribe. It is important to help your client identify an elder who will be supportive of his or her journey of recovery into wellness.

The second segment of the family session

[The session continued after the children left the room. This next portion includes Marlene, her spouse, her mother, and her great-uncle. In this session, Marlene's spouse ends his phone participation early because of his work schedule.]

PROVIDER: As you have all stated, the exercise helped you remove the alcohol from the person. That alcohol is the problem, not the person. Marlene, what do you think this means?

MARLENE: I never looked at it that way. I am not the disease. I don't need to carry the shame. It doesn't mean that I haven't done things while drinking, but I'm a different person when I don't drink. Alcohol pushed out what needs to be in the center of the circle—our traditional ways, my children, and family.

MARLENE'S MOM: I've been blaming other things besides alcohol.

GREAT-UNCLE: I am honored in being here and being invited to attend the session. Alcohol is a problem in our village; but it was not ours. It was brought to us. Alcohol pulls you away from yourself, family, and ways of knowing. *[Marlene nods and is tearful.]* When you are ready to come home, you know that our ways can replace alcohol—that instead of looking at alcohol in the center of the circle, our culture can be there.

MASTER PROVIDER NOTE

Noninterference is a common value across American Indian and Alaska Native cultures. It is an unspoken relational boundary between relatives and others; it allows things to happen the way they are meant to be. Noninterference helps maintain peace or decreases conflict within the family and community, reinforces the importance of interdependence and autonomy, and allows people to learn from their own actions. When practiced, it shows respect. It is one of several native beliefs and practices that help maintain peace within the community. For providers who have some knowledge of American Indian and Alaska Native cultures, noninterference can easily be misconstrued. Noninterference is not synonymous with unwillingness to act. Rather, it allows relatives, including children, to have choices. Therefore, interventions that present or explore alternative choices when clients face challenges are effective as long as suggestions are not directive.

[Time passes in silence for a few minutes as Marlene is visibly overwhelmed.]

PROVIDER: *[Nolee checks in with the great-uncle and Marlene to gain informal permission to continue in the session.]* Marlene, what will help you replace alcohol in the center of the circle?

MARLENE: Don't know. *[Silence.]* Going home to camp. They tell me here that I need to be around people who support me.

SPOUSE: *[On the phone.]* You know it's hard, but people in the village who I didn't think would be supportive have been. I've gone to the clinic to meet up with two other people in the village who have decided not to drink. I just thought everyone drank. Marlene, there are people around you who don't drink and who want you well. I want our lives not to center on alcohol, but around our family.

[Marlene acknowledges with a "yes" on the phone. Her husband has to leave the session at this point because of his work schedule.]

PROVIDER: Who is in your life right now that can stand with you and support you as you heal?

MARLENE: All of this feels too much. I am not used to it. Don't know if I can trust it. I don't trust myself. I do trust what everyone is saying today. It's hard to hear, but good to hear, too.

[The session continues with a discussion of how to obtain support and what type of support her mom, great-uncle, and spouse could provide. Nolee and Marlene's great-uncle explore subsistence practices Marlene could resume without alcohol. Nolee introduces several Internet options to access regular support from those in recovery once she returns to the village. Nolee conducts a brief family systems psychoeducation on wellness and illness: one person, experience, or part of the system can affect the whole system (or community) for better or worse.]

FAMILY THERAPY: USING A SYSTEMS APPROACH

In becoming culturally competent, a provider must select strategies that complement traditional healing ways. One theoretical orientation that can be easily adapted is the use of family system approaches. In Alaska Native and American Indian cultures, individuals function as a part of the group, whether it be family, clan, or community. Family therapy approaches that incorporate a systems perspective recognize that everything occurs in context with everything else. If change occurs in one area, then the surrounding area will change as well. If one person changes, it affects everyone in the family and village, whether the change is for the good or not.

The third segment of the family session: Family recovery crest

At the end of the session, Nolee gathers the entire family to create a recovery crest. She first gains informal permission from the elder and then asks if he will guide the family. She asks them to create a crest by drawing important animals, images, and symbols that represent stories and strengths of their family history. She suggests that they talk about the stories as they create the crest. This

activity continues after the family session ends at the facility. They will have an opportunity to share their creation at a community meeting during the family program. The family uses their clan crest, along with other symbols that represent family stories of personal survival, subsistence, cultural values and beliefs, community, and the like. Once the family has a clear idea about the activity, Nolee takes the opportunity to thank the family for coming, for the gift of sharing, and for the ability to support and listen to each other. She gives each member a small gift made by other treatment community members: a beaded ribbon. After checking in with everyone in the family, she asked the great-uncle if he would like to provide the closing.

MASTER PROVIDER NOTE

It is often easier for people who practice traditional ways to talk while engaged in an activity (e.g., Hopi quilt making). This has become a cultural style of relating to others. In subsistence cultures, people use visiting time as an opportunity to get something useful accomplished at the same time.

Summary

During treatment, Marlene recognized the importance of surrounding herself with people who provide support and do not drink. She practiced how to reach out to others using technology so that she was confident she will be able to do so when she returns to her remote village. Marlene is likely to face other challenges beyond the geographic barriers; she may need additional traditional and mainstream interventions to help heal from traumatic experiences, including witnessing her cousin's death, sexual abuse, and historical trauma. Binge drinking has been her primary coping strategy when she was not engaged in subsistence activities or at camp.

During treatment, she came to understand that her participation in subsistence activities had saved her from more devastating effects of alcohol abuse. Although Marlene spoke of many activities that would need to occur for her to maintain recovery, she defined recovery as reconnecting to her traditional ways for herself and her family. She used the exercise highlighted in the family preparation session to begin talking with her children about traditional ways, beliefs, and strengths. Before her discharge, she enrolled her children in a cultural camp conducted by elders in her community.

During treatment, Marlene acknowledged that she had self-medicated with alcohol to manage her low mood and past traumas. She gained a significant insight when she recognized that alcohol was in the middle of the circle, rather than her children or family.

During treatment, Marlene decided that she needed to change the legacy for her children. She hopes her children will see and learn from her, their father, her mother, and her great-uncle—that coping can happen without alcohol and that traditional ways can guide them through life's hardships. If her children start drinking or using drugs later on, she wants to show through her sobriety that recovery is possible: that there are healthy options.

YUUYARAQ: THE WAY OF THE HUMAN BEING

To gather an understanding of the experiences for many Alaska Native tribes and villages, *Yuuyaraq: The Way of the Human Being* provides a descriptive and historical narrative. This seminal work introduces the idea of generational trauma and the continual effects of the "Great Death"—epidemics that affected Alaska Natives from 1700 to the 1940s (Napoleon, 1996).

TLINGIT CULTURAL VALUES

Haa aani. Connection: honoring our land

Haa Shuká. Past, present, and future generations: honoring our ancestors and future generations

Haa latseen. Strength: achieve inner and physical strength

Wooch yax. Balance: maintaining spiritual and social balance and harmony

(For more information, see Sealaska Heritage Institute, 2009.)

SUGGESTIONS FOR WORKING WITH INDIVIDUALS WHO PRACTICE TRADITIONAL WAYS

- Accommodate the interactive style of traditional clients while not overwhelming American Indian and Alaska Native clients with too much verbal and written information. English may be a second language for traditional American Indian or Alaska Native clients, so an interpreter may be necessary. The speed and complexity of verbal communication may be difficult for clients to understand and absorb at the same time, and written assignments may not work. The pace of conversation for traditional people is often slower than for non-native clients and staff. Coming from cultures in which the written word is relatively new, the truth and accuracy of oral communication is important. Words are chosen carefully. American Indians and Alaska Natives who are traditional are excellent listeners and learn by listening, watching, and doing. This level of attention will be sustained as long as the learning is relevant and valued by clients.
- Learn and respect traditional values. For example, for those who practice traditional ways, community and family needs are often more important than individual needs. Entering treatment for the sake of others can be a powerful motivator. Self-sufficiency and noninterference are fundamental values. Individuals have the right to make their own choices and learn from them without interference or directives from others. Giving uninvited advice violates these values. For many American Indian and Alaska Native cultures, saying "no" is seen as disrespectful; therefore, teaching and rehearsing refusal skills that match people's communication styles is vital.
- Many traditional people live in communities that are remote and offer few mainstream recovery resources. As a provider, you must learn to incorporate traditional supports and activities for healing. You will want to learn how to integrate telehealth and innovative strategies in your clients' continuing care plans to provide alternatives in accessing recovery support, including online recovery meetings, peer support, follow-up calls, videoconferencing with providers (if accessible), home visits, and transportation. Keep in mind that many clients will return home to those who still use or drink.

TALKING CIRCLES

A talking circle, rooted in the traditional practices of native culture, is a gathering used to consider a particular problem or issue. The talking circle provides a nonhierarchical safe format whereby everyone has a voice and can speak without interruption. It is an effective approach that can be easily adapted as a peer-led or elder- or provider-facilitated circle within a treatment program. The talking circle expresses the American Indian and Alaska Native values of cooperation over competition, respect for everyone, and noninterference.

Format

People gather in a circle, usually seated, and the facilitator might open with some "good words" or a prayer. Before the circle keeper or elder introduces a topic or question, he or she speaks about the purpose of the circle, lists the ground rules, and introduces the meaning of the talking object (or the talking stick). Often, the object selected has significance, which may or may not be conveyed in the opening. The facilitator may also invite requests for other ground rules.

The facilitator then introduces questions or a topic and asks participants to reflect and respond. Moving clockwise, the object passes from one person to the next. Only the person who holds the object can speak. It is considered rude for anyone else to speak, even in a whisper to someone close by. It is expected that everyone listens to the speaker, as they would expect people to listen to them in return. These circles can take time, as every person must be given the opportunity to speak. The person holding the item can talk as long as he or she wants or say nothing at all. Traditionally, it may take one circle or a number of times around before it ends. Talking circles can last for hours. If individuals join the circle late, they are given an opportunity to speak. If someone begins to talk out of turn, the circle keeper reminds the group of the ground rules and refocuses attention back to the person with the talking object.

Continued on next page

TALKING CIRCLES (CONTINUED)

Using Talking Circles in a Treatment Setting

There are important differences between a talking circle and a therapy group. Both may have a place in your treatment approach. A significant difference between the two is that there is no discussion, feedback, or interpretation from anyone (including the facilitator) while or after a participant shares in the talking circle.

Sample topics for circles include:

- What is a valuable lesson you learned "the hard way" regarding your drug or alcohol use?
- How has alcohol use affected your community? Your family? You?
- What do you plan to do each day to honor your decision to stay sober?
- How do alcohol or drugs harm your spirit, mind, and body?
- What are things that you can do to keep you well? Or to heal?

Another difference between a talking circle and a therapy group is the issue of time. In most treatment programs and settings, activities run on time schedules. When using a talking circle format, here are some potential modifications:

- The circle keeper sets up the talking circle as a continual process, in which people sit in the same order and speakers resume in the same order upon returning to the circle. The circle may spread across several days, using the scheduled group time within the program.
- Alternatively, the leader might ask permission to limit the amount of time for each circle member to speak to allow completion in the available time.

For more information and application of talking circles in behavioral medicine, see Mehl-Madrona and Mainguy (2014).

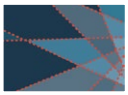
For an example of a community talking circle, including dialog, process, and ceremony, see Picou (2000). This descriptive article provides excerpts from circles focused on the personal and community effects and losses from the *Exxon Valdez* oil spill.

HOW TO FIND TRADITIONAL HEALERS

Providers working with American Indian and Alaska Native clients need relationships with traditional healers to collaborate in providing meaningful and powerful treatment and recovery services. Some tips to keep in mind:

- Finding traditional healers is sometimes difficult. American Indian or Alaska Native individuals doing healing work often keep a low profile, as secrecy was essential during the many generations when practicing traditional ceremonies was illegal, and this secrecy became a custom. Hence, be wary of anyone who approaches your treatment program unsolicited to market him- or herself as a healer; this behavior contradicts traditional ways. This individual is likely a "plastic shaman" or impostor.
- As a result of the government's efforts to suppress and eradicate native spiritual practices and the introduction of Christian religions by missionaries and boarding schools, many American Indians and Alaska Natives do not know or do not practice their tribe's spiritual traditions. Interested providers may have to ask many people in order to find helpful information.
- American Indians and Alaska Natives who practice traditional spiritual ways are often protective about their practices. As in recent years, interest in their practices has become trendy in some non-native circles, even resulting in non-native people presenting themselves as healers and conducting their interpretation of sacred practices and ceremonies. This is seen as a serious violation of sacred practice; it profoundly disrespects traditional healers, who have spent many years learning and preparing for their work.

Continued on next page



HOW TO FIND TRADITIONAL HEALERS (CONTINUED)

- You will find it easier to locate credible traditional healers as you develop relationships in native communities and as people develop trust in your motives and intentions. You could ask people who know you through professional or personal recovery activities. Tribal behavioral health, healthcare, and court services providers may be helpful sources of information. It is important to use respected members of the native community to vet appropriate healers. Certain issues may require a healer with specialized skills. Judicious choice of sources also prevents the use of inauthentic individuals posing as healers.
- Traditional elders can often refer you to spiritual advisors, some of whom are called teachers, medicine men and women, shamans, or healers. In some traditions, practitioners resist these names, simply calling themselves "someone who helps."
- Your inquiries must be made in person, not over the phone or email. When you visit an elder, it is proper to bring a gift such as a package of tobacco, sage, sweetgrass, or cedar. Ask the person who refers you to an elder about the local practice regarding gifts.
- When you visit with an elder, thank the person for meeting with you, and tell him or her how you got there, including information about yourself and what need you are looking to fill for your clients. Ask what ideas he or she has about what might be helpful. Be interested, but respectful, in the person's own path to this work.

Vignette 4—Philip: Making Connections Between Losses and Alcohol Use, Using One-Stop Outreach and Case Management Services for Homelessness and Treatment Service Needs, and Building Relationships Using Traditional Practices in Recovery

Overview

Philip's story is all too common in Alaska. Alienated from his home village because of his drinking and lack of resources, Philip has been camping outside a city with other individuals who are homeless. Here he finds acceptance, freedom from racism and prejudice, and a group to which he can belong; however, he does not want to continue camping. He reports periodic, but extended, binge drinking and presents with sadness over the repeated deaths in his village from suicides and accidents of young people, including one nephew, a cousin, and close friend. Philip wants to find housing and help, but he struggles in asking for assistance. He believes that homeless shelters, treatment programs, or other services with four walls will be too confining and that he will face more prejudice.

> We have a duty to each other, and we need to make a difference. Everyone has a specialty—we need to utilize this expertise and in turn, offer our services to our people."
>
> *Source: Ukpeagvik Iñupiat Corporation, 2015, p. 5.*

In this vignette, Anthony, an Alaska Native provider, meets with Philip at a native treatment center. Philip had agreed to come to the program for a few days for detoxification, but he emphasized that it was only for a few days to get out of the cold and to sober up. Anthony, the provider, is a 24-year-old recent graduate who attended school in Arizona and returned to Alaska to be with his family and to work within the Alaska Native community. He frequently says that he owes his education to his *aaka* (grandmother), who helped him think about what was most important—to serve others and the community. Anthony obtained a scholarship from his village corporation and made a commitment to himself to give back to the community upon his return. Anthony is focused on learning about available regional resources to assist those who have been separated from family, displaced from home or lodging, and unable to find employment.

Philip's Case History

Philip is a 34-year-old Alaska Native male who moved to the city approximately 6 months ago from a remote village. He has been living in a camp on the outskirts of town with other people who are homeless. He was self-referred to a native program after participating in a 1-day, one-stop event for individuals who are homeless to access services. Philip was provided transportation to the treatment services and agreed to enter detox.

He is the youngest of four children (two brothers and one sister). He describes his sibling relationships as close, particularly with his sister and her family. Before Philip was born, his father left the village and reportedly did not know that Philip was his child for several years. Philip also disclosed that he experienced physical and emotional abuse as a child and that his mother was alcohol dependent. His maternal grandparents assumed legal custody of him when he was around 11 years of age. Philip notes that he was raised Catholic. He stated that the church, as well as other Christian religions, historically did not accept his village's cultural traditions, and he feels conflicted in his traditional spiritual beliefs and about religion in general.

> Never look for a *psychological* explanation unless every effort to find a *cultural* one has been exhausted."
>
> —Margaret Mead
>
> *Source: Benedict & Mead, 1959.*

HOMELESSNESS IN ALASKA

Not unlike homeless populations in the lower 48, members of Alaska's homeless population often have a history of mental or substance use disorders, physical or sexual victimization, or military service (or some combination of these). Some Alaska Natives leave their village with the hope of finding lower living costs and employment and training opportunities in urban areas. Housing and living expenses in rural areas are rising faster than wages, forcing at-risk families to migrate to urban areas. If the individual or family spends all their money after migrating to the city or town, it is then difficult to afford transportation to return home or to communicate with their relatives, who may be able to cover the costs of return to the community. The individual or family then find themselves unable to access affordable housing. They are often forced to make very difficult decisions between housing and other basic needs. At the same time, affordable housing, emergency shelters, and transitional housing in urban areas are limited. For example, Fairbanks, AK, has one shelter, and it serves an area of 90,000 square miles (Department of Housing and Urban Development, 2016).

Models of Addressing Homelessness

Some of the most effective models of addressing homelessness are services focused on one-stop outreach and Housing First principles.

Housing First. Housing First goals are to end homelessness and promote client choice, recovery, and community integration. Housing First engages people whom traditional supportive housing providers have been unable to engage by offering immediate access to permanent independent apartments in buildings rented from private landlords. Clients have their own lease or sublease and only risk eviction from their apartments for nonpayment of rent, creating unacceptable disturbances to neighbors, or other violations of a standard lease. To prevent evictions, teams work closely with clients and landlords to address potential problems. Refusal to engage in treatment does not precipitate a loss of housing. Relapses to substance abuse or mental health crises are addressed by providing intensive treatment or facilitating admission to detoxification or the hospital to address the clinical crisis. Afterward, clients return to their apartments (Stein & Santos, 1998).

Stand Down for Homeless Veterans. This program brings services to one location, enabling individuals to access services at one stop on a given day. Stand Down for veterans who are homeless was modeled after the Stand Down concept used during the Vietnam War to provide a safe retreat for units returning from combat operations. At secure base camp areas, troops were able to take care of personal hygiene, get clean uniforms, enjoy warm meals, receive medical and dental care, mail and receive letters, and enjoy the camaraderie of friends in a safe environment. Stand Down afforded battle-weary soldiers the opportunity to renew their spirit, health, and overall sense of well-being. Stand Down for veterans who are homeless focuses on similar objectives, and achieving those objectives requires a wide range of support services and time. The program is successful because it brings these services to one location, making them more accessible to veterans who are homeless.

Project Homeless Connect. Similar to Stand Down, Project Homeless Connect is a 1-day, one-stop event to provide housing, services, and hospitality in a convenient one-stop model directly to people experiencing homelessness. It is a collaborative effort between service providers, government agencies, the private sector, and the community. It is a way to bring providers, agencies, and the community together so that the individual or family can obtain access to services in one setting.

IS IT A CULTURAL BELIEF OR IS IT A DIAGNOSIS?

Some American Indian and Alaska Native cultures believe they are experiencing—or will experience—bad things as a means of making right or paying for a wrongdoing, such as breaking a cultural taboo. This wrongdoing may be something that a person has done or something that occurred within his or her family from a previous generation. Admitting this can sound paranoid or delusional if the provider is not familiar with the individual's traditional spiritual or cultural beliefs.

Philip began experimenting with drugs and alcohol at age 9. He drank and used whatever his mother had around the house. He is unsure of the amounts he used but reports that it was "a lot." After Philip began living with his grandparents, he no longer drank or used alcohol or drugs until after graduation from high school, when he began to drink and smoke marijuana. He reports that he did not use regularly until he left his village, because his use depended on availability. Since moving to town, his use of alcohol has steadily increased. He usually drinks every day, getting drunk about three or four times a week, but his use continues to depend on whether he can share someone else's stash or buy alcohol. Philip reports that his marijuana use is irregular and that he smokes "only when someone has it." He says that he does not go searching for the drug, nor does he use other drugs at this time. He describes himself as a "quiet, nervous, and sad" drinker. In the past decade, he states that he has lost a few friends and relatives to suicide and snow machine accidents in his village. He describes his nervousness and low mood as something that never leaves him.

Philip is divorced and has not had contact with his ex-wife and son for about 7 years. His ex-wife moved to another Alaska village and then out of state about 5 years ago to live with her sister. Philip's relationships with women have all been short-term; he reports that all of the women he has dated have had trouble with drinking, with the exception of his ex-wife. The marriage lasted for almost a year and ended soon after the birth of their son. Philip feels bad that he is not raising his son.

> "These are the stories I heard at home and in my village when I was a child. There was an elder woman in our village who said something negative about never wanting to have children with disabilities. All of her children were already born and raised. But her granddaughter was born deaf. It came back to her. There was a skinny boy who always teased people who were overweight. He became obese as an adult. The thought process is that what you put out there is going to come back."
>
> —TIP Consensus Panel Member

In his village, when he is not drinking, he assists elders by cutting wood and hunting for them, and he has been involved in carving projects for the community. He is a traditional wood carver and as a young adolescent became interested in traditional Northwest artwork, called formline. He also does small engine repairs to snow machines and boats.

Philip has never been in treatment. He fears that it would feel like being in jail and is worried that everyone would be prejudiced toward him, as he has heard several people in town refer to "the drunk natives downtown." He wants his freedom, yet he recognizes that he needs help. He reports that he feels that no one will understand his cultural ways and how they affect his life. As an example, Philip explains that he believes he has "wronged" someone in the past and that is why his life is "like this." Although he cannot identify the person he has "wronged," he is sure that he has been disrespectful or is "paying for it now" for some wrongdoing in his family.

Philip graduated from high school but, because of his drinking, he struggled to keep employment in the village. He was accepted into the Navy but was released after a urinalysis came back positive for marijuana. He is a skilled self-taught carpenter and has had jobs as a laborer in the past. He is a carver, like his maternal grandfather, but reports that his drinking and recent move to the city prevent him from doing this work. He has two misdemeanor convictions: one for DUI and another for public intoxication. Philip relocated to the city after the loss of a close friend in his village and his inability to find work near his village. His poor work history and his criminal record make his job search difficult.

Since moving to the city, he has been unable to find a job. Although he had been living with friends, he has been camping with other individuals who are homeless in a park outside of town for

the past 2 months. Philip reports that he does not like living in the camp. Although he knows how to survive and camp and has done so most of his life, he is fearful of being beaten up, freezing to death, and being arrested. He worries that his drinking will lead to these consequences, as it has for other people living this way. He reports that he no longer wants to live close to a city. He just wants to stop drinking so he can return to his village, but he does not have the money to return home, and he is not sure that he would be welcomed. He has had no contact with family for months.

Objectives for Vignette 4

The objectives are:

1. To highlight that outreach and case management can be powerful tools in breaking down barriers to housing and treatment.
2. To reinforce the importance of Housing First principles.
3. To demonstrate how to help Philip connect his alcohol use and history of losses.
4. To show the use of experiential exercises to welcome clients back to their community.
5. To reinforce the use of traditional practices and the community as a path toward recovery.

Client–Provider Dialog

This vignette provides excerpts from three sessions: one session in the detoxification unit, an individual session in residential treatment, and a group session. The first session begins at a detoxification center that serves Alaska Natives. Philip agreed to come to the detoxification center after he attended a one-stop event for homelessness in the nearby city. He stated that he would not have known about it, except that several people came to their camp to talk about it. The program's philosophy is Housing First, so Philip will be provided housing options if he chooses to leave after detoxification.

Once Philip agreed to go to the Alaska Native program, arrangements were made to store his belongings and limited camping gear. This was a pivotal factor for Philip in deciding to go to the program. He is not sure if he wants to stay and honestly reports that his main motivation is to get out of the cold, maybe find housing, and sober up. Yet, he does admit that he is interested in returning to his village. At the same time, he has mixed feelings in returning home; he does not want to "show up in his current state," and he is almost certain that he would not find work. Philip is anxious in the first session during detoxification and not sure he can stay in the "four walls." The intake worker had already established language preferences; Philip prefers English. He already requested that he be called Philip, rather than using his last name to address him.

Detoxification counseling session

PROVIDER: Good morning, Philip. My name is Anthony. I am Alaska Native and have been working at this treatment facility for the last year. My family and I come from a remote village located in the Arctic Slope region; most of my family still lives there. I want to thank you for seeing me today. An outreach worker brought you in two nights ago, and I'd like to spend some time talking about your situation. Is that okay with you? *[Philip nods.]*

MASTER PROVIDER NOTE

In counseling strategies that focus on building relationships, including MI, it is good practice to ask permission when introducing a set of questions or before providing suggestions.

PROVIDER: What would be important for me to know about you or your situation right now?

PHILIP: I'm in pretty bad shape right now. I needed "three hots and a cot" and didn't want to go to a city program. They don't say good things about us. I've been camping, and we had to move several times because police would come to check on us or try to get us into a program. I was getting tired and wanted to get out of the cold. *[Some silence.]* Not sure this was a good move.

PROVIDER: You're not sure about your decision to come here, even though you want to get out of the cold and sober up. *[Philip nods yes.]*

PHILIP: I thought coming to a city would bring in some money. It didn't happen that way. After staying with some friends, I felt as if I was a burden and needed to get out. I've been drinking more now than I ever did.

PROVIDER: So, it's more than three hots and a cot; the alcohol was getting to you.

PHILIP: Not sure what happened. I've had bad times before, but if the booze is around—I drink it. I guess I always did.

PROVIDER: Was there ever a time when you didn't drink it, even if it was around?

PHILIP: When I lived with my grandparents and my sister's family. I respected them, and they are the few people I know who don't drink in my village. My grandparents always say, it is White man's poison. I'm beginning to believe it. Sometimes I feel possessed. It controls me. *[Philip begins to look very uneasy or anxious. He starts looking at the door.]*

PROVIDER: Can I ask you what just happened? Are you feeling okay? *[From the provider's perspective, Philip has started looking pale and uncomfortable.]*

PHILIP: I got to get out of here.

PROVIDER: Do you mean that you need to leave this room or leave the detoxification center? *[No response.]* Philip, do you want to stand outside? *[He replies, "Yes." They both go outside and stand together. Some time passes before there is an exchange.]* How's this?

PHILIP: Feels better. *[Pause.]* Sometimes I just have to get up and walk. *[Philip and the provider talk briefly about how this can be done while he is finishing up detoxification.]*

PROVIDER: *[Still outside.]* Philip, can I ask you another question? *[He nods.]* How has alcohol possessed you?

PHILIP: I've drunk when I didn't want to drink or I promised myself that I wouldn't drink. I've done things that I would never do if I didn't drink. Sometimes, I think I left my grandparents and family because of it. I couldn't be around them and drink. The drink pulls me to another world. *[Philip gestures that it's good to go back inside.]* It's getting cold.

PROVIDER: *[They begin walking back to the office.]* Philip, I can see that alcohol has caused you many losses, and from what you say, it's robbed you of your family and support.

PHILIP: *[Some time passes before Philip responds.]* It's taken my nephew, cousin, and another friend in my village. It also has me by the throat. That's the image I have.

PROVIDER: *[Anthony nods.]* It's cutting off your breath. *[Philip nods, and then more silence]*.

PHILIP: I want to find my way back.

PROVIDER: Back to?

PHILIP: To my life, my way of life, to my family. *[Pause.]* I'm missing seasonal camp now.

PROVIDER: How do you see doing this?

PHILIP: Got to face the evil spirits. And got to give back the White man's poison.

PROVIDER: Any thoughts on how to do this? *[Philip shakes his head no.]* Do you want to know how we might do that here? *[Philip nods. Anthony then uses the remainder of the session to talk about the Alaska Native services after detoxification and then potential housing opportunities after treatment, if Philip does not return to his village.]*

PHILIP: *[Humorously.]* I guess I am here for more than three hots and a cot. I heard the food wasn't that good anyway. *[Philip agrees to the next steps but worries that he will feel trapped. To conclude, they develop a plan for how Philip can alert others when he is feeling trapped. At the end of detoxification, he moves to inpatient and keeps Anthony as his provider.]*

Individual treatment counseling session

This session takes place during Philip's second week of treatment. He spent 5 days in detoxification prior to his transfer to the residential unit. The residential program is a 45-day average stay, followed by step-down services, including housing, continuing care services, and continued case management. The Alaska Native treatment program supports Housing First principles, whereby the case manager helps facilitate appropriate housing options if clients do not complete treatment. Every effort is made to support clients and to encourage treatment. Overall, the native program focuses on connection with others and with heritage; one main ingredient that supports the program principles is the staffing patterns. If clients in detoxification agree to residential treatment, the providers assigned during detoxification follow the same clients throughout residential treatment.

In this session, the dialog returns to the losses that Philip has encountered in his life. Some of his losses are related to his alcohol use, whereas other significant losses have happened when relatives have been under the influence. These losses have occurred against the backdrop of historical traumas experienced across generations among Alaska Natives. A few years ago, Philip's nephew died by suicide while drinking, and one of Philip's close friends also took his own life. Philip left his village shortly after his friend's death. The dialog begins halfway through the session and focuses on Philip's concerns after treatment.

> ***TO LIVE TO SEE THE GREAT DAY THAT DAWNS: PREVENTING SUICIDE BY AMERICAN INDIAN AND ALASKA NATIVE YOUTH AND YOUNG ADULTS***
>
> This manual lays the groundwork for community-based suicide prevention and mental health promotion plans for American Indian and Alaska Native youth and young adults; it also addresses risks, protective factors, and awareness and describes prevention models for action.
>
> *Source: HHS, 2010.*

[Anthony, the provider, and Philip greet each other. Anthony offers Philip some coffee at the start of the session. They have had three individual sessions, and Anthony also conducts one daily group session that Philip attends. The group sessions are centered on the principle that culture is prevention and the path to healing. The group sessions use relapse prevention strategies and incorporate cultural beliefs, traditions, elder participation, and creative works. The following dialog begins midsession.]

PROVIDER: Philip, I noticed that you appear to be focused more on the losses in your family and village this week. I hear more energy spent on this than talking about your alcohol use or other concerns. I know from our prior talks that you, as well as your village, have experienced significant losses. Would you be willing to tell me more about these losses?

PHILIP: *[Philip waits a bit to respond, looking away from Anthony, and then nods.]* Everyone knows everyone in our village. Alcohol has taken my nephew Rob, my friend Lee, and another cousin. Both my nephew and Lee were drinking when they killed themselves. Every time I walked down the road, I saw Lee. We did everything together, setting up camp, hunting, fishing, and smoking fish. *[Philip starts telling a funny story about Lee when they were fishing for humpies (pink salmon). Anthony just listens as Philip tells the story.]*

PROVIDER: You've known Lee all your life.

PHILIP: *[Philip nods.]* I left not so long after his death. *[In a prior session, Philip had already disclosed that the community had a ceremony to honor Lee.]*

PROVIDER: Do you think this was one of the reasons you left?

PHILIP: When he died, I didn't want to do the things I would normally do. I felt as if I did something wrong or maybe I didn't do what I was supposed to do. When I could get it, I would drink alone and didn't want to show my grandparents or my sister that I was drinking. I respect my grandparents and left thinking that I could get a job somewhere else and get away from things. Lee's death really affected everyone in the village.

PROVIDER: It sounds as if Lee's death pushed you further toward alcohol, and alcohol pushed you further away from your family and community.

PHILIP: I feel as if I'm carrying Lee. I have this image and this feeling. Years ago, while hunting, he broke his ankle. I had to help him get back to camp and then get help. I remember carrying him partway, and I have that same feeling at times. Sometimes I drink when I feel it.

PROVIDER: What does it mean to you? *[Philip looked confused about the question.]* When you have this feeling of carrying Lee, what is it saying to you?

PHILIP: Not sure. *[Silence.]* We have always looked out for each other. And I know he's looking out for me. I just can't find a place for his death.

PROVIDER: Knowing what you know, what might it be like to return to your village?

PHILIP: I think it might be hard for me not to drink, and I would be reminded again and again. Sometimes I think I need to find a place where I can let Lee be with all. *[Using his wit and humor, Philip replies.]* I guess I've been carrying him and keeping him all to myself.

PROVIDER: You may want to give some thought as to how you might do that—to find a place where you can let him be with all. *[Time passes in the session.]*

MASTER PROVIDER NOTE

As a provider, it is important to match the language and the words used by the client in the session; for example, the phrase, "find a place where you can let him be with all." Even if you are from the same clan, house, village, region, or tribe as your client, it is a mistake to assume that beliefs and the expression of those beliefs are the same. Considerable differences exist, often influenced by life experiences, family upbringing, elders, as well as outsiders (e.g., historical influence of missionaries on traditional beliefs and practices).

PROVIDER: I know you haven't had any recent contact with relatives from your village, and you wanted to get sober before making any contact.

PHILIP: I miss my relatives, and my grandparents are getting older. I feel as if I shamed them for leaving, but I've had no way of getting back to them or even contacting them before coming here. I feel pulled to go home, but I have nothing to share.

PROVIDER: When you say, nothing to share, what do you mean?

PHILIP: I haven't changed, well, until now. I didn't find work or housing. I didn't deal with Lee's death. I feel pulled.

PROVIDER: To go home? *[Philip nods.]*

PHILIP: I need to be sober for my family and community. I know that I need to do something to share Lee's life and my loss. I need to be someone in the community who shows a different path, away from alcohol and suicide.

PROVIDER: So, your time here is a way back home. *[Philip nods.]*

[The session ends on this last exchange. Anthony reminds Philip that there are others in the program, including peer support staff and elders, and that he might want to spend time sitting with these feelings and talking about Lee as well as the things he might do to replace alcohol and his cravings for alcohol. Philip had already begun to do this in the group and treatment community, but he now appears more interested in connecting with peer specialists and elders who are involved in the treatment program.]

Group treatment counseling session: Welcome home

This group session, facilitated by Philip's provider *(Anthony)*, takes place a few days after the individual session depicted above. Anthony is trained and accustomed to using experiential group exercises to help clients connect to their feelings and gain awareness. He also believes that these exercises are more akin to native teachings and learning styles that integrate mind, body, spirit, and the environment as one. Prior to using the experiential

LEARNING FROM THE ELDERS

As professionals, we are taught from a Eurocentric framework that involves many rules and regulations. When involving elders in the treatment process, remember not to be overly rigid in imposing structure on how they should participate. Although there may be specific regulations that you must follow as a treatment provider, remember that imposing unnecessary rules and structure can be a further display of devaluing native culture. Remember that traditional practices were banned and forbidden in Alaska Native communities and among American Indians. When providing some direction to clients on how to consult elders in treatment and in the community, you should suggest that clients seek guidance rather than merely ask for advice. As stated by one consensus panel member, "Asking for an opinion is different than asking for guidance."

Inuit Elders' Message on Suicide Prevention

When you feel overwhelmed, sad, or have a problem that seems to have no solution:

- **Talk to someone you trust:** Keeping problems inside will just make them seem worse.
- **Change your thoughts:** Remind yourself that although life is sometimes difficult, things will change, days are never the same; tell yourself that you can make changes; tell yourself that you can feel better.
- **Get outside into nature, be active:** This will help take your mind off problems and make you feel better.
- **Focus on helping others:** You will feel good about yourself and take your mind off your problems.
- **Don't isolate yourself:** Go out, be with others, be active.
- **Pray:** You can always talk to God.
- **Stay busy:** Learn new things; do things.
- **Learn how to handle arguments** and problems with other people.
- **Believe in yourself:** Don't put yourself down; learn ways to develop strength and competence.
- **Remember that you are not alone:** Others care about you; others have had similar problems and made it through.
- **Learn traditional skills:** You will feel proud to be an Inuk.

Source: Korhonen, 2006, pp. iv–v.

exercises, he assessed Philip's readiness and willingness to participate. In this segment, the dialog centers on an experiential exercise called "Welcome Home."

The Welcome Home exercise is rooted in Virginia Satir's communication theory and experiential practices (Satir & Baldwin, 1983). It has been carried through the work of many clinicians and facilitators trained in experiential, sculpting, and psychodramatic techniques. The origins of this exercise stem from the Vietnam era, when service members returning to the United States were not welcomed home and were often insulted or shamed by the community (Greene, 1989).

In more recent years, the Welcome Home exercise has been adapted through the work of Jane Middelton-Moz (1989, 2010) and others to help heal, honor, and welcome home American Indians and Alaska Natives who attended boarding schools. Many American Indians and Alaska Natives who returned from these institutions never had an opportunity to be welcomed home. Coupled with the history of trauma that occurred and the shame-based strategies often used and reinforced in the boarding schools, many returned home with no sense of belonging. This exercise provides an opportunity to change this on an emotional level.

The following dialog presents another way of setting up the Welcome Home exercise for an individual.

[Anthony already checked in with all group members. The session focused on discussing what it would mean to return home sober (e.g., home meaning community, family, village). Then, the Welcome Home exercise was introduced, and Philip was asked to help set up the exercise.]

WELCOME HOME: BOARDING SCHOOL EXERCISE

Jane Middleton-Moz's healing workshops facilitate a powerful exercise wherein she has participants form two concentric circles—an inner and an outer circle. Those who attended boarding school are standing in the inner circle, and those who did not form the outer circle. The inner and outer circle members face each other. Those standing in the outer circle offer handshakes or hugs and verbally welcome the inner circle members home or back from boarding school. When the first welcome is complete between each pair, the inner circle moves in the same direction (clockwise or counterclockwise) to the next person and repeats the process again and again until the circle rotates completely back to the starting place. This exercise can be exceptionally powerful and emotional, providing a great healing experience.

As a facilitator, several points are important to remember. It doesn't matter if there are not the same number of participants in each circle. If you have an uneven number between circles, you just give more time for people to receive or give "Welcome Home" greetings. Also, you want to make sure you leave plenty of time for everyone to talk about their experience, whether they're standing in the inner circle or the outer circle. Sometimes, individuals who are standing in the outer circle may begin to recognize similar feelings—not belonging to or feeling like a part of a community or group. In this scenario, you can have them switch circles.

You can use alternatives to this exercise when you are facilitating a Welcome Home for only one or two people in a group. One alternative is to have everyone join a large circle, and then you, as the provider, walk with the identified person around the large circle to receive "welcome home" gestures. In this exercise, you have the person move from one person to the next after being greeted and welcomed home.

PROVIDER: Philip, would you be willing to use your experiences and the memories of your village, family, and relatives to do this next exercise about returning home? You don't have to know what to do, I will guide you. *[Philip agrees. Then Anthony asks Philip to stand. He then asks if the remaining eight members could stand in front of the room. Participation is optional.]*

MASTER PROVIDER NOTE

In conducting experiential group exercises, it is important to facilitate them near the beginning of the session so that every group member has an opportunity to talk about the meaning of the exercise afterward.

PROVIDER: Philip, I want you to imagine going home to your village. Can you picture it? *[Philip nods.]* What do you picture?

PHILIP: I'm getting out of the plane and walking into town. I don't feel right in my own skin.

PROVIDER: What else do you notice?

PHILIP: I feel nervous. I am wondering who I'm going to see first.

PROVIDER: Okay. Now, Philip, I want you to imagine that you are walking down the road. *[Philip nods.]* Now, picture people in your village standing outside greeting you as you were walking into town. Can you picture them? *[Philip says, "Yes."]* Who do you initially notice?

PHILIP: My grandparents, my sister, her husband, my niece. *[He becomes tearful.]*

PROVIDER: *[Anthony prompts Philip.]* Anyone else?

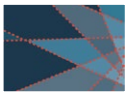
PHILIP: Warren *[cousin]*, Ben *[friend]*, and Enoch *[elder]*.

PROVIDER: What is it like to picture your relatives welcoming you to the village?

PHILIP: I don't know. *[Pause.]* It feels as if I don't deserve it.

PROVIDER: Philip, can you help me out just a little longer? I know that it's bringing up some feelings. *[Philip nods.]*

PROVIDER: *[Anthony nods in return.]* Philip, let's just assign everyone in the group to stand in as one



of your relatives. It doesn't matter who represents whom. *[Everyone quickly, along with Philip's input, chooses or is asked to play a role]*. Think for a moment about how each person would greet you. Remember it is the way that you would like to be greeted and welcomed home.

PHILIP: *[He begins with his grandfather.]* My grandfather would just greet me this way. *[Philip demonstrates.]* He wouldn't say anything. My grandmother would hug me, and say… *[After Philip assigns an expression or greeting for everyone, each member is asked to remember the greeting. Then Philip is asked to imagine once again that he is walking into town; he stands across the room and walks slowly toward the group as if walking into town. As he comes close to the group, group members share their greetings with Philip once he stands in front of them.]*

PROVIDER: Philip, I just want you to take it in as you are standing and listening to the welcome. I am standing here with you to also welcome you home.

PHILIP: *[He doesn't say much at this time, but he is very focused on the greetings. He listens as each member welcomes him home.]* I don't have words for what I'm feeling.

PROVIDER: Maybe it's about just taking it in. *[Anthony maintains the silence for a bit.]* Philip, can you take a mental picture of this scene that you created, and hold onto it? *[Philip nods. During the exercise, another group member (Karen) was visibly affected by the exercise. Anthony asked if she would like to experience the Welcome Home.]*

PROVIDER: Philip, would you be willing to further assist the group, reverse roles, and take Karen's place in being someone from the community that welcomes her home? *[He agrees.]* Philip, this is an opportunity for you to experience this from both sides. And, as you welcome Karen home, I want you to think how you might feel welcoming her home regardless of her past, her alcohol use, her unemployment, and her history of being homeless. *[Then Karen and Philip switch roles. The exercise is repeated, with members of the community welcoming her home. Anthony then asks what the experience was like for Karen. She talks about the*

MASTER PROVIDER NOTE

Remember, you should always be walking alongside your client in experiential exercises to safely facilitate, to remain engaged in his or her experience, and to respond quickly, if needed. Similarly, it is important to gently remind the group not to have private conservations during these exercises. Experiential exercises can be powerful, and side conversations can be disruptive or easily be interpreted as judgmental commentary when a participant feels vulnerable.

When you assign roles and scripted messages, it is important that the group atmosphere is nonshaming when a role player forgets his or her role or phrases. You can always tell the group that there is shame-free forgetting and that if you forget your role or line, someone in the group will be able to recall.

Also, it is typically ineffective to have clients ad lib in their roles, especially during an exercise that is initially focused on an individual. Often, their dialog would reflect their own life circumstances rather than that of the group member who is the center of the experiential exercise. All too often, this group member will feel less connected to the exercise as a result and report that this is not his or her experience.

It is better to assign one or two phrases for each role generated by the central client. Even with this limited verbal exchange, the exercise can be surprisingly powerful and healing. As a provider, your foremost role is to create and maintain safety; therefore, assigned phrases are a better choice in general in this rendition of Welcome Home. Of course, there will be moments where impromptu exchanges happen—and healing occurs. As a provider, you need to be mindful not to shut down those spirit-filled moments, when appropriate.

healing she experienced in the exercise; for many years, she hasn't felt as if she belongs. Some other group members begin to share similar stories, and still others talk about how meaningful it was for them to be in the role as a greeter. Afterward, the focus of the group exercise returns to Philip.]

MASTER PROVIDER NOTE

Role reversal can be a powerful counseling tool. Typically, it can help manage the intensity of the experience by removing the group's focus from the client. It allows the client to see a different perspective and can lead to more compassion and awareness of others and of himself or herself. By providing an opportunity for other group members to experience the exercise or to process the experience afterwards, it turns an individually focused exercise in a group to a group experience.

PROVIDER: Philip, I would like to take this opportunity to thank you for leading this group exercise. Is there anything else that you would like to share?

PHILIP: When I took the other role, I realized that I haven't been hearing the caring messages from my family. Before I left, I cut those voices off. I walked away carrying Lee and the losses that his death caused. The drink helped to drown the losses too. I think I need to find a way to return home. And I need to carry Lee home and find a place for him surrounded by his relatives.

[The session ends. About a week later, Philip had the idea of doing a carving to honor Lee once he returns to the village after treatment. It becomes clear that Philip has made a decision to return to his village. The treatment program helped support Philip in contacting his sister, who had wanted him to stay and live with her family before he left. Philip made contact with his sister prior to his decision to go to an Alaska Native transitional housing unit before returning home.]

USE OF SOCIAL MEDIA TO CONNECT ALASKA NATIVES WHO ARE HOMELESS WITH THEIR FAMILIES

The Facebook group Forget Me Not has taken off since its inception and currently has thousands of members. An Ahtna Athabascan positive rap singer and motivational speaker "came up with the idea after speaking with a homeless Native woman who approached him asking for spare change. The woman told him she was from —— 'She got real teary-eyed and said she wanted to go home. Before I left I told her I would do what I can.'

"But after he returned home, [he] couldn't remember her name or anything other than the town she was from. He knew there must be a better way to help Native homeless people connect with the families who have lost track of them. After about a week he came up with the idea of using Facebook. He started a group that he named after the Alaska state flower, the forget me not....

"Members can post pictures of homeless people they encounter on the street and list their names and village of origin along with any message they might want to send to their loved ones. Connections are made and the word spreads. Of course, some homeless people don't wish to participate, which is fine. 'I'm not trying to sell them anything....' Family members seeking homeless relatives can also post pictures and request the group's help. That's how Jerry —— found her brother Johnny.

"Using Facebook to connect the homeless ... with their families in far-off villages opens a channel more profound than most people realize. Native identity is often reestablished as friends and relatives reach out across cyberspace. The surface appearances of homelessness and alcoholism, which is all many see, lose their illusion of permanence when a channel of communication with the past is opened. Homeless Natives remember who they really are and begin the path back to wholeness."

Source: Hopper, 2015, paragraphs 5–9.

Continuing care planning

Throughout Philip's treatment, staff worked hard to anticipate and develop plans for his continuing care, particularly housing, if he decided not to return to his village. Near the completion of his residential treatment, Philip wanted more time before returning home. His case manager arranged his transfer to a transitional housing facility with the Tribal Housing Authority. The facility provides continuing care for substance abuse treatment, employment counseling, and an onsite computer training center. Philip's hope is to return to his carving and to gain sufficient skills to work within his region's corporation, even though employment is limited.

Philip was determined to spend 6 months in transitional housing and return to his village for summer camp. He agreed with the house rules, including vocational training or employment after 28 days of entering the program and maintaining sobriety. Case management was involved in his transitions to provide additional support and interventions if a return to use occurred or housing issues resurfaced. After 6 months, Philip returned to his village. He has a part-time job, spends time carving with his grandfather, lives with his sister's family, and uses some telehealth services and phone contact through the community health center for continuing care services. In honor of his friend Lee, who died from alcohol use and suicide, Philip began to volunteer at the school and provide traditional art lessons, including formline art and carving.

Summary

In treatment, Philip began to draw the connection between his experiences of loss, alcohol consumption, and the role that both played in separating him from his relatives, village, traditions, and history. Without initial outreach, Philip may not have had access to housing, treatment, or any further choices in whether he could return to his village. The one-stop model to assess his needs and to aid in accessing culturally appropriate services broke the downward spiral brought on by lack of employment and housing, his disconnection from his community, and his alcohol use. Outreach services addressed barriers that obstructed Philip's interest in treatment and laid the groundwork through case management to help him gain access to Alaska Native treatment services, transitional housing, job training, and reunification with his village. Philip returned to his village knowing that he could make a contribution. Through teaching his traditional skills and art, he would help younger people connect with their history, traditions, and community. He helped young people gain awareness of their own gifts and contributions. Through his own challenges, he learned that tradition was a powerful pathway to healing.

> May the story give you strength.
> May the belief relieve your pain."
>
> —Mohawk Onondaga healer
>
> *Source: Peate, 2003.*

This page intentionally left blank.

TIP 61

BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives

For Behavioral Health Service Providers, Program Administrators, and Clinical Supervisors

Part 2 of this **Treatment Improvement Protocol** addresses how to improve treatment outcomes for American Indian and Alaska Native clients by increasing provider competencies; providing holistic, trauma-informed services; and adopting culturally responsive program policies and procedures.

TIP Navigation

Executive Summary
For behavioral health service providers, program administrators, clinical supervisors, and researchers

Part 1: Practical Guide to the Provision of Behavioral Health Services for American Indians and Alaska Natives
For behavioral health service providers

Part 2: Implementation Guide for Behavioral Health Program Administrators Serving American Indians and Alaska Natives
For behavioral health service providers, program administrators, and clinical supervisors

Appendix and Index

Part 3: Literature Review
For behavioral health service providers, program administrators, clinical supervisors, and researchers

SAMHSA
Substance Abuse and Mental Health Services Administration

Contents

PART 2: IMPLEMENTATION GUIDE FOR BEHAVIORAL HEALTH PROGRAM ADMINISTRATORS SERVING AMERICAN INDIANS AND ALASKA NATIVES

Part 2, Chapter 1 125
Introduction 125
Becoming a Culturally Responsive Organization 125
Workforce Professional Development 139

Part 2, Chapter 2 155
Introduction 155
Developing a Culturally Competent and Responsive Workforce 155
Developing Native EBPs 178
Integrating Care: Traditional Practices in Behavioral Health Programs 181
Creating Sustainability 186

Exhibits
Exhibit 2.1-1. Evidence-Based Tribal Practices 133
Exhibit 2.1-2. Navigating Life Curriculum Sessions 134

APPENDIX—BIBLIOGRAPHY 201

INDEX 213

Part 2, Chapter 1

Introduction

An Overview of Part 2

In Part 1, this Treatment Improvement Protocol (TIP) focused on the knowledge, skills, and application of cultural competence in counseling. In Part 2, attention turns to implementing this knowledge on an administrative level. This chapter reflects the voices of consensus panel members and others who have contributed ideas to the development of this TIP. This section highlights the knowledge, challenges, and strategies important to program development, implementation, and sustainability. It is designed for administrative staff, including program directors, managers, and clinical supervisors providing services in villages, in rural and urban areas, and on reservations. It is written for those who have less cultural knowledge or experience in providing services and for others looking for ideas on how to meet the day-to-day challenges in program management, including workforce development. Whether you are a native or non-native provider, the information serves as a guide on how to remain culturally responsive to your clients and community.

Chapter 1 first addresses key ingredients in developing a culturally responsive organization. The next section highlights organizational challenges and paths to solutions. Then, the chapter addresses workforce and professional development with emphasis on activities that support investment in staff and future leadership. The chapter ends with a review of culturally responsive behavioral health competencies to serve as a guide for staff development and program aspirations. Chapter 2 contains samples of additional resources and materials that support day-to-day administrative and programmatic activities. Part 1 is equally important for administrators, program managers, and clinical supervisors to read, as it sets the course for Part 2.

> It's not how you integrate culture into services but how you integrate services into the culture."
>
> —Deborah Painte
>
> *Source: National Indian Child Welfare Association, 2015, p. 3.*

Becoming a Culturally Responsive Organization

Cultural competence refers to the ability to effectively provide services to clients with diverse values, beliefs, and behaviors. Within an organization, it involves the ability to tailor services and service delivery in a culturally relevant and meaningful way. For a guide to creating a culturally responsive organization, refer to TIP 59, *Improving Cultural Competence,* Chapter 4 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a).

As noted in Part 1, Chapter 1, of this TIP, serious health disparities exist among American Indians and Alaska Natives, leading to poorer health outcomes when compared with the general population nationally. Many factors contribute to native health disparities, including an inadequate healthcare delivery system, insufficient funding, absence of culturally appropriate education, language barriers, inaccessible and unavailable services, poor infrastructure, and the lack of culturally responsive services and trauma-informed care.

Approximately 6.8 million people in the United States identified as American Indian or Alaska Native in 2017 (Census Bureau, Population Division, 2018). Tribes and villages have a unique government-to-government relationship with the United States that has been shaped by colonialism, nation-to-nation treaties, federal laws, executive

WHY IT MATTERS: THE ORGANIZATIONAL BENEFITS OF CULTURALLY RESPONSIVE CARE

A 2013 report by the Health Research & Educational Trust outlines numerous benefits to organizations that take a culturally responsive approach to care.

Social Benefits

- Increases mutual respect and understanding between patient and organization
- Increases trust
- Promotes inclusion of all community members
- Increases community participation and involvement in health issues
- Assists patients and families in their care
- Promotes patient and family responsibilities for health

Health Benefits

- Improves patient data collection
- Increases preventive care by patients
- Reduces care disparities in the patient population
- Increases cost savings by reducing medical errors, number of treatments, and legal costs
- Reduces the number of missed medical visits

Business Benefits

- Incorporates different perspectives, ideas, and strategies into the decision-making process
- Decreases barriers that slow progress
- Moves toward meeting legal and regulatory guidelines
- Improves efficiency of care services

See the full report, *Becoming a Culturally Competent Health Care Organization* (Health Research & Educational Trust, 2013), for more information.

orders, and Supreme Court decisions. Although you might think of American Indians or Alaska Natives as a single racial or ethnic group, there are 573 federally recognized tribes. Each individual nation has its own history and culture with wide variations in language, membership, and resources. This is significant for you as an administrator, particularly if your program serves a community where clients come from different tribes—such as programs that provide services in urban communities. By developing your organization's capacity for culturally responsive care, you will more likely meet the needs of a diverse American Indian and Alaska Native population. Part 3, the online literature review of this TIP, contains more information about variations in behavioral health needs within native populations. "Why It Matters: The Organizational Benefits of Culturally Responsive Care" (see above) outlines the benefits of an organization's cultural responsiveness.

Qualities of a Culturally Responsive Organization

This section briefly describes some distinguishing characteristics of a culturally responsive organization serving American Indian and Alaska Native clients and communities, along with suggestions for specific actions to take to make them a reality. Please note that this list, although comprehensive, is not definitive. You may find that your organization needs to respond differently to meet the needs of your community.

Involve the community and take an active role

Communities can play an important role in improving the provision of behavioral health services and treatment. Creating culturally responsive services requires the participation of the native community, including leaders, council members,

community members, potential clients, and their families. Engaging and establishing a positive relationship with local leadership and the native community can work to alleviate initial feelings of mistrust and can serve as a resource to strengthen your program's effectiveness. For example, community leaders who support your program may be able to conduct more effective outreach than the program can by itself. Similarly, community involvement can lead to a sense of ownership and pride in the services.

By involving the community, providers can identify potential obstacles early on and develop ways to overcome these challenges with the help and advice of tribal community partners. Community members can also provide invaluable assistance in other areas, such as providing information about the most pressing behavioral health problems within the community, coordinating the services of traditional healers for your services, and recommending individuals who can provide staff education and training on local native culture(s) and history.

Likewise, make it a point to engage with the community outside of the program. This will help the community become more familiar with the organization's presence and may potentially increase awareness and use of program services.

Pursue a collaborative relationship with tribal leadership

The support of tribal leadership is critical to establishing a positive, trust-based relationship with the American Indian and Alaska Native community and to helping ensure the program's success and sustainability over the long term. Reach out to a tribal leader (e.g., a council member or health board director), but remember to listen when you meet. As a service provider, you are working for him or her. Show an interest in and learn from the information people share with you. It may help if you or a senior staff member serves as community liaison to keep tribal leaders and representatives up-to-date about the program and to respond to any questions, comments, or concerns.

ENGAGING WITH TRIBAL COMMUNITIES

Etiquette Do's

- Listen and observe; be comfortable with silence.
- Correctly pronounce names (use American Indian/Alaska Native names when appropriate).
- Be transparent about your role and expectations.
- Establish rapport.
- Invite questions and knowledge seeking.
- Accept offers.
- Shake hands respectfully.

Etiquette Don'ts

- Don't talk too loud or fast.
- Don't impose personal values or beliefs.
- Don't claim a vague tribal affiliation.
- Don't point your finger.
- Don't rush things.
- Don't touch sacred items.
- Don't take pictures without permission.
- Don't shake hands aggressively or assertively.

Source: Kauffman & Associates (personal email and document attachments, March 1, 2016).

Understand and respect tribal and community differences

American Indian and Alaska Native history, traditional practices, protocols, and ceremonies vary across tribes. For example, you will often find a blend of traditional spiritual practices and organized religion within a single tribal community. It is important to inquire and educate yourself about these differences rather than making assumptions. Ultimately, each American Indian and Alaska Native client experiences his or her culture in a unique way. It is up to the organization to work with the client to understand the client's experience and to tailor services accordingly by asking about his or her tribe and cultural identity.

Gain knowledge of tribal history and understand its impact and the impact of historical trauma in the community

Clients and the community may express an initial lack of trust when you first attempt to engage them. This behavior is often rooted in negative experiences with past providers and in the effects of historical trauma, recent traumas, and racism. The organization must openly acknowledge these experiences and their effects on the community. Most importantly, the program needs to incorporate trauma-informed care across all levels of service—ensuring that each staff member approaches interactions with clients from this perspective.

Engage in honest, open, and culturally appropriate communication

Trust is established in part through honest communication. When communicating with clients or the native community, be clear in meaning and realistic in regard to expectations about your services. Follow through with your message and promises to clients and the community, as your behavior will serve as evidence of your trustworthiness and commitment as a provider. In addition, remember that culturally responsive communication operates in two directions, and although your program disseminates information to clients, be open to receiving information and feedback as well. Actively listen to this input, as it can help you revise your program's services or approach to better meet community needs.

In addition to honest communication, it is important to use culturally appropriate communication when engaging with American Indian and Alaska Native clients and community members. Use clients' preferred language when either speaking in person or using written materials. This may require the use of an interpreter. In many communities, it is customary to let tribal elders speak first without interruption. Thus, when engaging with elder tribal

TRAUMA-INFORMED CARE: A CRITICAL APPROACH IN PROVIDING CULTURALLY RESPONSIVE SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES

"In our view, community healing along with individual and family healing are necessary to thoroughly address historical unresolved grief and its present manifestations. The process is not quick nor is it easy. However, without such a commitment to healing the past, we will not be able to address the resultant trauma and prevent the continuation of such atrocities in the present. Nor will we be able to provide the positive and healthy community activism needed to stop and prevent the social pathologies of suicide, homicide, domestic violence, child abuse, and alcoholism so prevalent in American Indian communities—as in society at large—today.

"The crux of our argument has far-reaching implications for other colonized, oppressed peoples throughout history and those being oppressed, as we write, that are obvious to us. Wherever peoples are being decimated and destroyed, subsequent generations will suffer. We need only heed the traditional American Indian wisdom that, in decisions made today, we must consider the impact upon the next seven generations. The concept of historical unresolved grief has powerful implications not only for healing from our past but for giving us the strength and commitment to save ourselves and future generations."

Source: Brave Heart & DeBruyn, 1998, p. 75.

What Is Trauma-Informed Care?

"A program, organization, or system that is trauma informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings, and seeks to actively resist re-traumatization."

Source: SAMHSA, Trauma and Justice Strategic Initiative, 2012, p. 4.

For a comprehensive guide to creating a trauma-informed behavioral health service, refer to TIP 57, Trauma-Informed Care in Behavioral Health Services *(SAMHSA, 2014b).*

members—either in conversation or as clients—you should expect to be silent and actively listen as the elder speaks. When sharing information or a specific message, try using stories or real-life examples rather than technical language where possible.

Respect and value native knowledge and cultural worldviews

A culturally responsive organization understands the inherent value of tribal knowledge and demonstrates respect for tribal values and worldviews. For example, a tribal welcome may involve an offer, such as shared food or a gift. It would be rude to refuse this welcoming gesture. You might also offer food—particularly traditional foods—during program activities or client intakes when appropriate. You may need to make a similar effort to integrate cultural and traditional practices into program services and interventions as appropriate for each client. For example, a treatment plan for a client who prefers the use of traditional healing methods may include the use of healing circles, sessions with a traditional healer, or (if the client is physically capable) sweat lodges or fasting. Policies and procedures need to reflect the value of traditional practices, and leadership needs to afford clients and staff opportunities either on facility grounds or at an alternative place in the community to access these healing traditions. In addition, the organization needs to honor native knowledge in determining evidence-based and best practices.

Commit and support the importance of cultural knowledge and culturally responsive services at all levels

As an administrator, you need to demonstrate that leadership is committed to supporting and integrating culturally responsive services at all levels, from office manager to board members. Set aside a portion of the organization's operational budget or pursue grant and other funding opportunities to support costs and activities targeting cultural responsiveness, including staff training, interpreter services, and community outreach efforts. Include language that reflects the organization's commitment to cultural responsiveness in the mission and vision statements as well as in policies and procedures manuals. Consider creating an advisory board or internal workgroup dedicated to evaluating and promoting the organization's efforts to effectively respond to the cultural needs of clients and the community (i.e., implementing an organizational self-assessment).

At a staff level, make staff education and training in cultural competence a part of the orientation process for new hires and a regularly scheduled professional development activity for current program personnel. Institute recruitment and hiring policies aimed at diversifying the organization's workforce and at promoting an American Indian and Alaska Native behavioral health workforce and leadership for the next generation.

Recognize tribal community strengths

One of the benefits of engaging with American Indian and Alaska Native communities as partners is that it offers an opportunity to identify and make use of tribal resources and strengths, such as family ties, larger community networks, physical resources, intergenerational knowledge and wisdom, and community resilience. It may also involve other tribal departments or partner agencies that can offer resources and support. This strengths-based approach builds on the strengths and resilience of the community to create solutions, rather than focusing solely on issues or areas in need of improvement.

STRENGTHS OF TRIBAL SYSTEMS OF CARE

- Grassroots foundation
- Local leadership
- Culture as core
- Influence of language
- Vision for the future
- Power of communication
- Organizational infrastructure
- Tribal college and state university partnerships
- Integration of new treatments
- Tribal wraparound services
- Investment in advocacy
- Tribal–borough–county–state relationship
- Tribal peer support

Source: National Indian Child Welfare Association, 2015.

> "Historically, the Indian Health Service (IHS) was an entirely federal system, but in recent decades it has evolved in a profound way. Tribal governments now directly manage more than half of IHS-appropriated funds and the great majority of physical facilities under self-governance contracts and compacts. In addition, 34 nonprofit Urban Indian Health centers provide care for AI/AN [American Indian/Alaska Native] people and other underserved communities in urban locations. The IHS, Tribal, and Urban health care facilities have come to be known collectively [as] the Indian Health System."
>
> *Source: Hays, Carroll, Ferguson, Fore, & Horton, 2014, p. 986.*

Administrative Challenges and Paths to Solutions

Program administrators may face a wide range of challenges when attempting to design and implement programs and services specifically tailored to meet the needs of American Indian and Alaska Native clients. Although some of these challenges include operational concerns about funding sources and reporting requirements, certification, and staffing, others are more often encountered when working with native communities in different settings. For example, programs that provide services to clients on a reservation must learn to work collaboratively with the community and tribal leadership. Programs serving clients in an off-reservation urban setting will need to work with the communities and tribal services, and also tailor services and staff training to effectively meet the needs of clients from different tribes who present a more diverse range of history, culture, and values. Although daunting, it is possible for programs to plan for and effectively address these challenges. What's more, these issues provide an opportunity for program administrators to effectively engage with tribal, rural, and urban Indian communities throughout the program implementation process. This collaborative relationship not only helps ensure that services provided are culturally responsive, but also helps position the program for long-term success by using community buy-in, commitment, and support.

Although the challenges listed below involve operational and workforce development issues, many difficulties stem from administrative staff giving insufficient attention to the importance of engaging in culturally competent practices. By overlooking these practices, administrators themselves avoid recognition of their own cultural awareness and bias, fail to invest in learning about local culture(s) and American Indian and Alaska Native history, neglect to understand and use the principles of culturally responsive services and processes, and disregard the involvement of local native governance and communities before planning and implementing a specific service or program for American Indians and Alaska Natives.

The consensus panel identified several administrative challenges. The items below draw attention to core challenges that most programs face in developing, implementing, evaluating, and sustaining services, yet they do not represent every obstacle. In the following section, several core challenges are presented along with ideas on how to address them. These suggestions are called the "path to solutions."

Determining how best to collect, organize, and manage data

Service providers may have limited infrastructure to gather, manage, and maintain data, including limited access to computers, software applications, and culturally relevant digitized intake, assessment, and planning tools.

Path to solutions

- Contact well-established American Indian and Alaska Native treatment services and organizations to gain knowledge about culturally

relevant digitized tools. It is not likely that you, as the administrator or program manager, will need to create these tools. Instead, you may need to adapt existing tools to reflect more tribe-specific information.
- Seek grants that assist in building infrastructure to implement services.
- Crowdsource for acquisition of computers and software applications.
- Seek technical assistance from other American Indian and Alaska Native service providers.

Analyzing data for reporting purposes and for securing funding

Service providers typically face considerable reporting requirements, especially when the service uses multiple funding sources. Although extensive data may be already available within the treatment service program, service providers may not know how to analyze the data for reporting purposes. Likewise, service providers may not have access to technical assistance or resources to summarize and interpret the data in a meaningful way to validate service needs, outcomes, or impact to obtain future grants or other funding resources. (Service providers who are already fiscally challenged in implementing programs are less likely to view data analysis to be as important as care.)

BUILDING THE EVALUATION CAPACITY: GATHERING, ANALYZING, AND USING DATA

Factors that facilitate evaluation capacity of local programs serving American Indian and Alaska Native populations include but are not limited to the accessibility of culturally competent technical assistance providers, investment in building strong program–provider relationships, support of innovative and cultural adaptations of evidence-based strategies, respect for circular views on change, use of culturally responsive evaluation methods, and focus on strengths-based programming. For more information on building evaluation capacity serving American Indian and Alaska Native populations, see SAMHSA, Center for Substance Abuse Prevention (CSAP), 2014.

Path to solutions

- Gain culturally competent technical assistance from the outset either from the grant source or other similar programs using the same funding source to learn how best to gather and analyze data.
- Whether you are a native or non-native service provider, remember that tribes have experienced a long history of abuse surrounding data misuse. Tribes have faced significant negative consequences when their identified data have been used for research, including loss of contracts and resources, disregard for tribal community member or tribe-specific confidentiality, loss of employment, and so forth. As a provider, you need to develop a plan in collaboration with native community leadership on how the information is used with integrity.
- Research needs to be approved through the tribe's institutional review board or tribal council. Data are property, and property ownership needs to be determined and agreed upon with tribal governance. Keep in mind that staff may also be reluctant to gather certain or consistent data because their value is not understood; data collection takes too much time away from building relationships; or there is concern about data misuse, confidentiality, or gathering information in a manner that is not culturally responsive. These concerns need to be addressed through conversations with staff, supervision, and staff trainings.

Obtaining program funding

First and foremost, service providers need to understand how to access the funds necessary to maintain or expand behavioral health services in American Indian and Alaska Native communities. Programs with limited resources often need to obtain funds from multiple sources. Although this is a viable option, it can also create competing and conflicting interests and reporting demands from the different funding sources. With limited resources, service providers not only have to make difficult decisions on service provisions; they also need to be quite creative in using these funds to maximize the benefits.

Path to solutions

- Diversify funding streams. Funding limitations can cause a program to fail before implementation even begins. Programs should be prepared to secure funding from a diverse range of sources. Potential funding sources include IHS, Medicaid, Medicare, state and local coffers, discretionary federal funds, the Bureau of Indian Affairs, and tribal budgets. This kind of variation in funding options is necessary to sustain a program over time.
- Partner or contract with established programs to maximize the use of available funds for services.

Increasing access to services

Providers working with American Indian and Alaska Native populations frequently face challenges implementing effective programs in remote communities where clients have difficulty accessing services because of a lack of service awareness, transportation, phone or Internet services, child care, or insurance or healthcare financing. For some, the distance to the service provider is prohibitive. Programs may also not have viable options to refer clients who have geographic hardships or would prefer to use a different service provider. Even if a referral is feasible, the challenges that often exist in interagency communication and collaboration may create additional obstacles for clients in gaining access to equitable and appropriate care.

Path to solutions

- Incorporate a client needs assessment and evaluation as part of the program's operation. By identifying service needs, providers can tailor services to meet the current cultural and treatment needs of the community. A needs assessment allows a program to identify and build on the community's strengths and resources and provides another avenue through which to engage tribal leaders and community members. Regular evaluation will help programs assess the impact of their efforts, identify strengths and weaknesses, and guide program development, capacity building, and sustainability efforts.
- Provide one-stop services so that clients and their families can access services at one location, including outreach activities to connect individuals with available services.
- Offer a "warm handoff" whereby clients are physically taken and introduced to the new service to bridge the referral gap. Under these circumstances, clients are more likely to follow through with the referral.
- Develop outreach, educational programs, and community events in multiple languages.
- Provide mobile or telehealth services. Bring the services to the client rather than the client to the services. In planning these services, think through the process carefully. Will the client or family members need child care during the mobile service? Is the community educated about how telehealth works at the health clinic?
- Form partnerships between states and tribes. Refer to *Partnering With Tribal Governments To Meet the Mental Health Needs of American Indian/Alaska Native Consumers* (National Association of State Mental Health Program Directors, 2015).

Integrating care

American Indian and Alaska Native perspectives on healing are holistic. The beliefs surrounding the path to illness as well as healing are integrated; the mind, body, spirit, or environment are seen as one; all is connected. When programs do not integrate behavioral health services, primary health care, and other social services, they fail to encompass a culturally responsive approach to treatment, and ultimately can have a significant negative impact on treatment seeking, quality of and responsiveness to care, and outcome.

Path to solutions

- Build alliances between services to coordinate care.
- Include a cultural component in services, if possible (e.g., craft workshops).
- Create accessible one-stop services.
- Include health and behavioral health service providers. For example, use a psychiatric nurse practitioner in house to assess for co-occurring conditions.

Developing native evidence-based practices

For years, considerable focus has been placed on employing mainstream evidence-based practices (EBPs) in native programs and in communities.

Although mainstream EBPs can be effective avenues of intervention, they are perceived as mainstream approaches while ignoring or failing to honor native practices, knowledge, and culture. For many years, funding has been tied to these mainstream EBPs, while representation of American Indian and Alaska Native participants in the research that supports these mainstream EBPs is nearly nonexistent. Changes are now occurring, including increases in native-specific, culturally adaptive research and in representation of American Indian and Alaska Native individuals among research participants. We now see an increase in respect, acknowledgment, and focus on native ways of knowing; the establishment of community-based and tribal participatory research; and the development of research mentor programs for American Indians and Alaska Natives, such as the National Institute on Drug Abuse's American Indian/Alaska Native Researchers and Scholars Work Group's Native-to-Native Mentoring program.

Path to solutions

- Gain technical assistance or support from SAMHSA's National American Indian and Alaska Native Addiction Technology Transfer Center (NAI & AN ATTC) to review EBPs that may be culturally adapted to your clients and their needs.
- Use a Native American framework in creating criteria for evidence-based tribal practices (Exhibit 2.1-1; refer to Exhibit 2.1-2 for a sample curriculum).

Creating sustainability

Although many service providers face funding issues from the outset, the more formidable task is maintaining interventions and programs for the long term after initial funding has ended. The consensus panel emphasized that service programs often face sustainability issues after initiation of newly funded programs. Although well-established programs and tribal organizations can dedicate more resources for fund development to secure long-term financial sustainability, most programs, regardless of current status, are concerned with sustainability for the future.

SAMHSA'S TRIBAL TRAINING AND TECHNICAL ASSISTANCE CENTER

This Center supports native community self-determination through infrastructure development, capacity building, and program planning and implementation.

EXHIBIT 2.1-1. Evidence-Based Tribal Practices

In the Native American framework, there are several specific criteria for evidence-based tribal practices. These criteria are:

1. **Longevity:** A tribal practice rooted in long-held traditions (e.g., canoe journey, sweat lodge, and subsistence practices).
2. **Teachings:** A tribal practice based on specific teachings (e.g., the medicine wheel, origin stories).
3. **Values:** A tribal practice that incorporates the values and worldview of American Indian and Alaska Native cultures (e.g., a holistic tribal treatment practice focused on harmony and acceptance).
4. **Principles:** A tribal practice that is rooted in traditional principles (e.g., Mehl-Medrona's principles of treatment of chronic illness; 1997).
5. **Elders:** A tribal practice that is reviewed and approved by elders. It constitutes evidence of appropriateness and effectiveness within the Native American framework.
6. **Community:** A tribal practice that is guided by community feedback.

Source: Oregon Addictions & Mental Health Division, n.d.

EXHIBIT 2.1-2. Navigating Life Curriculum Sessions

SESSION TITLE	SESSION GOALS/FOCUS*
1. Canoe Journey as a Metaphor for Healing	• Introduce and discuss the Four Seasons/Four Winds, a traditional Suquamish/S'Klallam concept used to frame daily life and teach life skills, a schedule set by nature that traditional livelihood revolved around. • Discuss the Northwest native traditional canoe journey and how it can serve as a metaphor for life. Each session ends with a reflection back to this concept. Other traditional beliefs are also discussed. • Information about alcohol is also included.
2. Who Am I? Beginning at the Center	• Learn about S'Klallam and Suquamish values, traditional ways to introduce oneself, self-awareness genealogy, family ties and integrity, and how to use the concept of the Four Seasons/Four Winds as a part of self-definition. Participants are encouraged to explore the idea of a physical self, mental self, emotional self, and spiritual self. • Information about marijuana is also included.
3. How Am I Perceived? Media Awareness and Literacy	• Focus on how American Indians/Alaska Natives and, specifically, how the Suquamish and S'Klallam people are portrayed in the media; learn how to recognize when stereotypes are being used, how American Indian and Alaska Native culture has been exploited and history has been misrepresented, and how to stand up against stereotypes. • Information about prescription drugs is also included.
4. Community Help and Support: Help on the Journey	• Learn about the importance of community, how they are a part of many communities, and the importance of giving back to their community; learn how to identify where they can go for help in their own community; learn what it means to be a mentor and how they can become mentors for those around them. • Information about club drugs and stimulants is also included.
5. Moods and Coping With Negative Emotions	• Learn about different emotions and positive and negative self-talk; learn about depression and suicide, how to cope with negative emotions and difficult situations, and how to find a safe person or place to express emotions. • Information about inhalants is also included.
6. Who Will I Become? Goal Setting	• Explore what kinds of goals are important and learn a step-by-step approach to setting goals; begin to understand the importance of goal setting and learn how to cope with obstacles that might hinder achieving set goals. • Information about hallucinogens is also included.

*Traditional stories, cultural activities, and speakers from the community are woven throughout the sessions.

Continued on next page

EXHIBIT 2.1-2. Navigating Life Curriculum Sessions (continued)

SESSION TITLE	SESSION GOALS/FOCUS*
7. Overcoming Obstacles: Solving Problems	• Learn how to recognize when there is a problem, learn ways to solve problems and make good decisions, and discuss where to go when there is a problem; learn how to define a problem, brainstorm solutions, pick the best solution, make and act on a plan, and review/revise the plan if needed. • Information about nicotine is also included.
8. Listening	• Teach listening skills: Effective listening is discussed and the importance of listening is illustrated through Suquamish and S'Klallam storytelling and other traditional activities. Traditional values stress respect and the belief that you must be an effective listener before you can become an effective communicator. • Information about methamphetamines is also included.
9. Effective Communication: Expressing Thoughts and Feelings	• Teach effective communications skills, including how to disagree respectfully, how to use refusal and assertiveness skills, and how to deal with peer reactions to assertiveness. Participants practice positive ways to resolve conflict and to express feelings. • Information about opiates is also included.
10. Safe Journey Without Alcohol/Drugs	• Learn about addictions, how expectancies influence perception, and about the consequences of drug and alcohol use/abuse. • Reflecting on the "canoe way of life" as an example of "life's journey."
11. Strengthening Our Community	• Focus on finding leaders within the tribal community to serve as role models; learning about the Boldt decision, tribal sovereignty, leadership, and how to make good choices within the community. • This session includes field trips into the community to volunteer with important community projects.
12. Honoring Ceremony	• This ceremony is a way to acknowledge youth for program completion and honor their unique attributes. Mentors are invited by the youth to attend and can talk about the youth and their accomplishments. Tribal elders, leaders, and families are also invited to witness the ceremony and share a meal. • Gifts are prepared and given formally, and digital stories are shared.

*Traditional stories, cultural activities, and speakers from the community are woven throughout the sessions.

Source: Donovan et al., 2015. Adapted with permission.

Path to solutions

The following suggestions are adapted from the *National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program: Exploratory Description of Financing and Sustainability in American Indian and Alaska Native System of Care Communities* (Walter R. McDonald & Associates & ICF Macro, 2009). The comprehensive report highlights the key elements of sustainability and steps to develop a flexible sustainability plan. Some examples of the report's recommendations are highlighted next:

- Begin planning for long-term financial sustainability on the first day funding begins, or even before actually receiving the grant, taking care to build planning on the foundation of local cultural strengths (p. 16).
- Create a sustainability planning team that includes key decision makers (e.g., tribal-elected officials, administrators, program planners, finance staff) (p. 16).
- Conduct a site visit to another tribal system that has successfully implemented a sustainability strategy for a peer-to-peer learning opportunity (p. 18).
- Develop a staff training curriculum based on local tribal values and service design to advance staff service skills and credentials (p. 17).
- Meet with the state credentialing board for licensed behavioral health service providers to discuss the tribal curriculum concept and ensure that the state licensing board will approve the tribal curriculum (p. 17).
- Develop a data-driven argument that shows the need for tribal system of care funding, emphasizing human and financial cost-savings by redeploying funds from high-cost state services that tend to be less effective to lower cost tribal services that tend to be more effective (p. 17).

Developing a culturally competent and responsive workforce

Program administrators struggle to meet the demands of staff development. Immediate demands, often caused by staff shortages and turnover, take precedence over long-term strategies to invest in the future workforce. However, program administrators need to be committed to developing a culturally competent workforce when providing services to American Indian and Alaska Native clients. This commitment involves attracting, supporting, and retaining native staff; creating or obtaining relevant tribal-specific curriculums that increase cultural competence; and implementing strategies to promote ongoing professional development to increase competence and promote leadership skills, such as the provision of clinical supervision and professional mentoring.

The Native American Center for Health Professions created a digital mentoring website called We Are Healers. The website showcases short, engaging videos of American Indians working in health professions and provides a behind-the-scenes look at their jobs. These stories help American Indian students explore health fields and connect to mentorship tools and resources. See more at www.wearehealers.org/home-video.

Path to solutions

- Connect with tribal colleges and create internships.
- Conduct outreach to elementary and secondary schools and organizations serving younger people in native communities to promote interest in the field at an early age.
- Develop facilitator-led educational groups to promote interest.
- Create mentoring programs for clinical and administrative roles.
- Become a resource for how to find educational assistance (e.g., federal traineeships, internships, scholarships).
- Encourage tribal colleges to incorporate certifications into their programs, including in-class and online courses.
- Create opportunities with state universities to develop American Indian curriculums along with internships and work-study programs in tribal communities.

Collaborating with native communities and tribal leadership on a regular basis

American Indian and Alaska Native cultural beliefs revolve around the value of connectedness and the importance of relationships. Relationship building needs to be the center supporting pole in developing services. Native communities have

WORKFORCE DEVELOPMENT IN PRACTICE: THE SPOKANE TRIBE HEALTH AND HUMAN SERVICES BEHAVIORAL HEALTH PROGRAM

To address staff shortages in a geographically remote area, the Behavioral Health Program implemented two workforce development strategies. The first focuses on providing professional development opportunities for qualified tribal member employees over a 2-year period. The second strategy involves a partnership with the National Health Service Corps (NHSC) Loan Repayment Program as an approved service site. This program attracts staff by reducing and eliminating student loans in exchange for the provision of medical, dental, and behavioral and mental health services to underserved populations.

Source: IHS, 2011.

considerable cause not to trust behavioral health services, which historically have imposed culturally blind diagnoses; employed institutionalism, such as boarding schools and mandated state hospitalizations; have failed to provide adequate funds or have misappropriated funds; have tied the availability of resources to adopting mainstream EBPs or certification processes that inadequately represent native populations and force assimilation; and failed to recognize and honor American Indian and Alaska Native sovereignty. Without investment and involvement in native communities and their leadership to gain guidance, services will be poorly matched to the population and underutilized by the community, and funding for these services will further strain agency and tribal resources.

Path to solutions

- Engage the community and tribal leadership early and regularly. Community and tribal governance involvement in behavioral health service planning and implementation is a key factor in achieving long-term success.
- Plan ahead to allow significant time for relationship building. Often, the time required to build trusting connections is underestimated.
- Make sure community members are involved in program service implementation, including staff assignments, board appointments, inclusion of traditional healers and elders, and use of native peer specialists.
- Develop local community focus and advisory groups to discuss key service needs.
- Engage the community by housing community events at the facility as well as attending local community events, when appropriate.
- Honor sovereignty. Most federally recognized tribes in the Unites States exist as sovereign nations. Providers who serve American Indian and Alaska Native clients must acknowledge and respect this sovereignty by working with the community and their tribal leadership when planning for and implementing behavioral health services. Understanding sovereignty is critical to successful service provision and program sustainability. Specific laws, codes, regulations, and procedures vary from tribe to tribe and may be quite different from state laws (e.g., employment regulations).
- Use community-based models for intervention and prevention, such as the Community Readiness Model (Plested, Jumper Thurman, & Edwards, 2014).

Fifty-four percent of the mental health programs and 84 percent of the alcohol and substance abuse programs [in native communities] are now operated by tribes. This evolution in behavioral healthcare delivery and management is changing the face of behavioral health services in Indian Country. In the last decade, tribes have increasingly used the Indian Self-Determination and Education Assistance Act to establish and provide their own behavioral health services (IHS, 2011, p. 1).

ENGAGING NATIVE COMMUNITIES: THE COMMUNITY READINESS MODEL

The Community Readiness Model was developed in 1994 at Colorado State University with the aim of building the capacity of tribal communities/nations so that they might recognize and build on the strengths from within to begin a healing process of healthy change.

The Community Readiness Model will help you assess the community's readiness for change, the needs of the community, and strategies to address needs related to the identified specific issue (e.g., HIV/AIDS, suicide, substance abuse).

The Community Readiness Model:

- Provides the community "truth" about an issue, which may or may not be the real "truth," thus setting strategies based on the community's readiness.
- Models community change that integrates a community's culture, resources, and level of readiness to more effectively address the identified issue.
- Allows communities to define issues and strategies in their own contexts.
- Builds cooperation among systems and individuals.
- Increases capacity for the identified issue and intervention.
- Encourages community investment in the issue and awareness.
- Is applicable to any community (geographic, issue-based, organizational, etc.).
- Can address a wide range of issues.
- Guides the complex process of system and community change.

Sample Content of Manual: Dimensions of Readiness

Dimensions of readiness are key factors that influence your community's preparedness to take action on (THE ISSUE). The six dimensions identified and measured in the Community Readiness Model are comprehensive in nature. They are an excellent tool for diagnosing your community's needs and for developing strategies that meet those needs.

A. **Community Efforts:** To what extent are there efforts, programs, and policies that address (THE ISSUE)?

B. **Community Knowledge of the Efforts:** To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?

C. **Leadership:** To what extent are appointed leaders and influential community members supportive of (THE ISSUE)?

D. **Community Climate:** What is the prevailing attitude of the community toward (THE ISSUE)? Is it one of helplessness or one of responsibility and empowerment?

E. **Community Knowledge About the Issue:** To what extent do community members know about or have access to information on (THE ISSUE), and how it impacts your community?

F. **Resources Related to the Issue:** To what extent are local resources (e.g., people, time, money, space) available to support efforts?

Your community's status with respect to each of the dimensions forms the basis of the overall level of community readiness.

Source: Plested et al., 2014.

Workforce Professional Development

As an administrator, your responsibilities include providing staff with the resources to effectively meet the needs of clients and the community. A core resource is the investment in building and improving the skills and capabilities of behavioral health staff through education, training, clinical supervision, and other activities. These professional development activities can play a powerful role in building clinical competence, in creating leadership opportunities, and in recruiting and retaining staff. In turn, your commitment to professional development may improve client treatment engagement from the initial intake to continuing care, treatment outcomes, and treatment acceptance in the community.

> **Staff training and education are important elements in building skills, including personal strategies in how to develop therapeutic relationships. However, skill training never replaces the importance of investing in the relationship. Although this is old knowledge, science related to substance abuse supports it: the provider's empathy and interpersonal ways have the greatest impact on outcome among individuals seeking treatment (Miller & Rose, 2009).**

As with most actions, the effects of professional development are circular. Staff members see training and education as a benefit, the training improves the functioning of your organization, clients have better treatment experiences and outcomes, the program becomes more accepted and respected in the community, the program attracts more individuals to the program (including others who develop an interest in providing services), and the process continues. The following sections address training and education, clinical supervision, and mentoring.

Training and Education

The immediate goal of education and training is to improve the capacity of staff members to effectively perform their duties in their current roles. In other words, you are helping staff members to become better providers to meet the needs of your clients. However, if the goal of education and training ended here, it would be a disservice to staff and American Indian and Alaska Native communities. Education and training goals should extend beyond current needs. With the current challenges in building an American Indian and Alaska Native workforce as well as a culturally competent non-native behavioral health workforce, education and training also need to focus on the development of leadership and administrative skills for the next generation.

> "When you see a new trail, or a footprint you do not know, follow it to the point of knowing."
>
> —Santee Sioux
>
> *Source: C. A. O. Eastman, 1907, p. 522.*

> **CSAP'S PREVENTION FELLOWSHIP PROGRAM**
>
> **Developing the Next Generation of Prevention Leaders: Prevention Internship Program for Tribes and Tribal Organizations**
>
> The Prevention Internship Program, a component of CSAP's Prevention Fellowship Program, invites qualified individuals with strong interest in substance abuse prevention and behavioral health for a 10-week paid internship program in participating tribal organizations throughout the United States. The Prevention Internship Program prepares interns to provide capacity-building technical assistance to support integration of mental and substance use disorder prevention services within tribal organization systems. Interns benefit from hands-on experience and trainings in mental and substance use disorder prevention, the Strategic Prevention Framework, workforce development, and evaluation. Interns learn new techniques, best practices, and knowledge from their professional and cultural experiences.

In addition to using basic provider and intervention materials to guide your education and training activities, supplementary information on the community itself can inform you of the potential training needs of your staff. This information can be obtained from a community needs assessment; client, family, and community feedback on clinical services; and reports on current events in the community (e.g., suicide rates in the community, the availability of new drugs of abuse, the incidence of diabetes, the occurrence of traumatic events). Although these areas are essential in guiding your plans, cultural training is paramount in laying a strong foundation when serving American Indian and Alaska Native clients and communities.

THE ADDICTION TECHNOLOGY TRANSFER CENTER NETWORK

The Addiction Technology Transfer Center (ATTC) Network offers a variety of training and educational opportunities for behavioral health service providers serving Indian Country. The ATTC Network strives to improve the health and well-being of American Indians and Alaska Natives through access to "high-quality, evidence-based, culturally appropriate, self-directed behavioral health services and recovery supports ... that both honor and contribute to the health and well-being of native communities, tribes, and individuals." The ATTC Network offers access to resources, including training curriculums, webinar presentations, online trainings, evidence-based best practices, and various informational print materials on topics such as:

- Culturally informed clinical supervision.
- The impact of colonization on native communities.
- The Native American lesbian, gay, bisexual, transgender, and questioning (LGBTQ)/Two-Spirit curriculum.
- Professional readiness: Attitudes and values.
- The Native American curriculum for state-accredited, nontribal mental health and substance abuse programs in South Dakota.

See https://attcnetwork.org/centers/national-american-indian-and-alaska-native-attc/home.

Program staff serving American Indians and Alaska Natives in rural areas may benefit from training in computer use and phone technologies that can deliver care over a distance rather than exclusively in person. (See TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services* [SAMHSA, 2015]).

Providing cultural training and developing cultural competence form a main pathway in reducing health inequalities. We know that understanding tribal history and culture results in better healthcare communications with American Indian and Alaska Native clients and improved client outcomes (see review by Clifford, McCalman, Bainbridge, & Tsey, 2015). The following segments focus on cultural training, with an emphasis on resources, content, and logistics.

> It is critical that [behavioral] healthcare professionals understand the stress and anxiety associated with AI/AN identity, the AI/AN acculturation and deculturation that trigger mental health disorders, and the need for traditional and cultural practices as a part of the treatment and prevention process."
>
> *Source: IHS, 2011, p. 10.*

Staff training on American Indian and Alaska Native history and culture

Staff training on American Indian and Alaska Native history and culture is essential in providing culturally competent care. Training provides an orientation to cultural worldviews, practices, and historical events and an opportunity for participants to examine their own cultural identity and beliefs and how these beliefs influence their perspectives on healing, communication, relationships, and clinical

practice. But staff training on culture also necessitates a relearning of history. For many non-native and American Indian and Alaska Native people, formal education has either misrepresented historical events, failed to address American Indian and Alaska Native history, or minimized the dire consequences of "forced assimilation" policies that led to historical trauma and subsequent conditions that survive today. Embracing this relearning from a native perspective provides an opportunity to see native nations and American Indian and Alaska Native people with "eyes wide open." Please see Part 1, Chapter 1, for an overview of historical events.

Staff training also needs to incorporate the culture and history of the specific tribes and communities who will use your services. Remember that each tribe and community has its own history. Staff training on American Indian and Alaska Native culture and history represents an opportunity to affect staff attitudes toward clients and increase cultural awareness of themselves and others. Appropriate training can strengthen the rationale for trauma-informed care; help staff become more cognizant of the impact of racism, microaggressions, prejudice, and historical trauma on clients, their families, and their communities; and encourage the exchange of knowledge between non-native and native staff and clients.

Some staff members may not see the need for cultural training either because they see themselves as experts, believe that they already have cultural knowledge, disregard outright the value of cultural competence, or are culturally blind, failing to see that differences exist (e.g., "I treat everyone the same"). This attitude gives administrative or clinical supervisors an opportunity to provide a rationale, to discuss, and to reinforce the importance of cultural competence as a provider in the organization. Nonetheless, it may be a sign that your organization needs to conduct an organizational assessment on cultural competence, followed by the development and implementation of a plan to raise awareness, improve practices, and endorse polices that improve cultural competence with staff members and with organizational leadership. For specific information on how to become a culturally responsive organization, refer to the step-by-step guidelines outlined in TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a).

> Often, each level of the organization (leadership, staff, and clients) views cultural competence in differing ways. The key is flexibility—the flexibility to change and make things better. We worked with an organization [that] had concerns about serving their American Indian and Alaska Native clientele in a culturally appropriate way. They decided to use Community Readiness [Model] as the assessment tool for cultural competence. They treated the Board, the program management, the staff, and clients as separate communities during the organizational assessment. By doing this, they had four separate and distinct communities and readiness scores. Results were interesting. The Board and management thought the organization was very culturally responsive, but the frontline staff and clients did not agree. This was a wakeup call for the Board and program management. They immediately took the readiness scores into an all-day staff retreat, and each 'community' put together a strategic plan to raise readiness levels related to cultural competence. It was wonderful to see the change in the organization. The assessment itself was the intervention."
>
> —Pamela Jumper Thurman, Ph.D., Western Cherokee, TIP Chair and Panel Member

WHAT IS CULTURAL COMPETENCE?

The U.S. Department of Health and Human Services (HHS) defines cultural competence as "the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services" (HHS, 2003, p. 12). Cultural competence is an ongoing developmental process achieved over time and, as a result, requires a long-term commitment if it is to succeed.

Arranging staff cultural training

You can choose from a wide range of formal and informal instructional methods, including the use of a curriculum during group supervision or as a peer-led supervision group, regularly scheduled training sessions or educational lunches with various presenters or trainers, staff support to attend and participate in training and cultural activities in the local tribal community, and cultural programs led by American Indian and Alaska Native elders or other community members, including immersion programs. Part 1 of this TIP provides material that can be easily adapted for training.

SAMHSA's *American Indian and Alaska Native Culture Card: A Guide to Build Cultural Awareness* is an example of material available for staff education and training. This informative material and similar resources are available for free from SAMHSA's website (https://store.samhsa.gov).

As an administrator, you may have specific questions or concerns related to staff education and training on American Indian and Alaska Native history and culture. Before scheduling any kind of education and training, it is important to keep a few things in mind:

- Your support of and commitment to education and training as an administrator is vital to the success of such efforts.
- You need to be willing to commit program resources, including allowing time for trainings, rearranging schedules, and devoting funds for a trainer. If funds are limited, do not assume that you cannot provide the training. You may want to contact the NAI & AN ATTC, local trainers, or tribal colleges. Some trainers may volunteer their services if they know that the program has limited funds.
- Community leaders and cultural advisors should be involved in or lead the design of the cultural training. This will not only help focus staff education and training on the history, culture, and values unique to your clients, but it will also help build community partnerships.
- Learning and training styles need to be culturally responsive; that is, favoring engagement over abiding strictly to schedules or using experiential group activities rather than lectures.
- You need to obtain feedback and evaluate the training to guide the selection of future training content, trainer selection, style of presentation, and location of training.

NATIVE AMERICAN REHABILITATION ASSOCIATION'S CULTURAL ADVISORS

The Native American Rehabilitation Association of the Northwest, Inc. (NARA) provides culturally appropriate education, physical and mental health services, and substance abuse treatment services to American Indians and Alaska Natives in the region. Culture and traditional practices are central components of the agency's mission and activities. To help ensure the appropriate and accurate representation of American Indian and Alaska Native culture, NARA has established and collaborates with staff Cultural Advisors. These Advisors lead NARA's Cultural and Community Services and work with all NARA programs to provide cultural competence training for staff and cultural activities and services for NARA's clients.

Identifying potential cultural trainers

Selecting someone to train staff members in American Indian and Alaska Native culture(s) and history involves careful consideration, as having someone who provides inaccurate information will do more harm than providing no training at all.

Whom you choose to serve as your program's cultural trainer will depend on answers to several questions:

- Are clients mainly from a single tribe or community, or is there representation from various tribes?
- How often will staff members need training?
- Will the trainer receive financial compensation for services?
- Is the trainer American Indian or Alaska Native?
- What specific cultural knowledge and experience does the trainer need to have that clearly matches client needs?
- Is the trainer endorsed by the local community and tribal governance?
- Does the trainer have a good reputation for engaging staff members?
- Have you asked for guidance from tribal and community leaders in trainer selection?
- Are you working collaboratively with tribal leadership and community leaders to design the cultural training with the trainer?
- Are you going to conduct a one-time training or ongoing training to promote knowledge adoption?

Selecting training materials for cultural training

General recommendations on selecting content center around several principles: relevance and accuracy of content, adaptability to practice, ease of understanding, tribal endorsement, and ability to engage participants. For cultural training, a number of online resources recommend content, training tools tailored to specific tribes and communities, and training guidelines. The last section in this chapter, "Provider Competencies," can also guide you in selecting content areas. Refer to Part 2, Chapter 2, for cultural training resources for nontribal behavioral health service providers.

Trainings need to be designed specific to the tribe(s) represented in your program, the services provided, and constraints of the geographic region, such as trainings for health clinics in remote villages. Along with tribe-specific training materials and other resources, Part 1, Chapters 1 and 2, can be used as a supporting resource for trainings. The case histories and vignettes in Part 1, Chapter 2, can be adapted and used as role plays to engage participants. The following is a sample list of content areas for cultural training:

- Tribal history
- Family structure, dynamics, and parenting practices
- Common terminology and languages
- Tribal governance
- Role of elders
- Tribal justice and wellness court system
- History of U.S. government policies and treaties with tribe(s)
- Tribal and state relations
- Worldviews
- Historical traumas, including those specific to the tribe, village, or region (e.g., Trail of Tears, chemical contamination of water, boarding schools, sexual assaults, kidnappings, loss of land and resources, sweeping epidemics)
- Tribe-specific artwork and food
- Beliefs and attitudes about illness and healing
- Tribal constitutions and codes
- Role of health clinics
- Tribal sovereignty
- Children services and the Indian Child Welfare Act
- Educational system
- Attitudes toward alcohol and drugs

WHAT MAKES SOMEONE A QUALIFIED CULTURAL TRAINER?

Dixon and Iron (2006) include a list of qualifications for cultural trainers used by an Alaskan hospital. In their work, a qualified cultural trainer is someone who:

- Has knowledge of the specific topic(s).
- Is respected by his or her community.
- Has good rapport with people, including people outside his or her community (e.g., healthcare providers).
- Is comfortable with public speaking.
- Can speak, read, and write in the local tribal language.
- Has experience providing training and lives a traditional subsistence way of life.

NATIVE AMERICAN CURRICULUM FOR STATE ACCREDITED, NON-TRIBAL MENTAL HEALTH & SUBSTANCE ABUSE PROGRAMS IN SOUTH DAKOTA

This training program offers professionals an opportunity to improve their awareness of Native American culture, resulting in an enhanced treatment experience for Native American clients. The primary intent of this substance abuse-related curriculum is to provide an educational experience primarily for non-native staff members of state-accredited, nontribal mental health and substance abuse programs in South Dakota. The curriculum is also relevant for those working to address other aspects of behavioral health. Although this curriculum focuses primarily on Dakota, Lakota, and Nakota groups located in South Dakota, it has the potential to be adapted to reflect the ways of other indigenous groups located in other states. This curriculum contains 19 modules. For certification hours and other pertinent information, contact the NAI & AN ATTC (see https://attcnetwork.org/centers/national-american-indian-and-alaska-native-attc/home).

Leaving Footprints: Cultural Training

Duane Mackey, Ed.D., a Santee Sioux tribal member, received his M.A. and Ed.D. from the University of South Dakota. He taught middle school and high school and coached football, golf, and basketball. He practiced as a guidance counselor and became the first Director of Indian Education for the Sioux City School System. His team twice won the Nebraska state boys basketball tournament, which later led to his very strong commitment to human rights for American Indians.

He dedicated his life to improving American Indian human rights and enhancing American Indian opportunities in education and research. He became a faculty member at the University of South Dakota, Addiction Studies Program, and was a Director of Native American Initiatives in the Prairielands ATTC, now known as the NAI & AN ATTC. In particular, Dr. Mackey developed American Indian curriculums specifically designed for nontribal substance abuse treatment providers and has significantly influenced the field's recognition that cultural training is paramount. He has left footprints that will continue to influence care offered by native and non-native providers.

In memory of Dr. Duane Mackey, *"Waktaya Naji,"* TIP Consensus Panel Member.

The Dr. Duane Mackey *"Waktaya Naji"* Award

This award acknowledges individuals who, in their addiction study careers, have made significant contributions in education, research, mentoring, and service among American Indian and Alaska Native peoples. The award signifies the promise of continued success of an individual and serves to inspire others to contribute to the addiction treatment field for American Indian and Alaska Native people. It also recognizes individuals who, through their concerted efforts, have untiringly promoted and espoused the ideals of equality and justice for all peoples.

- Cultural practices (e.g., potlatches)
- Traditional healing
- History of ceremonies
- Cultural etiquette and respect
- Cultural awareness and humility
- History of health services and experiences among American Indians and Alaska Natives, including the changing patterns of governance
- Influence of geographic regions
- Role of public safety officers
- Native EBPs

Providing education resources: Staff opportunities

Educational opportunity is another important ingredient of promoting professional development, improving the quality and outcome of services and supporting future leadership. Likewise, it can serve as a recruitment and retention strategy. Several specialized education and scholarship programs are available for students who wish to enter the behavioral health field, as well as for recent graduates just entering the health field. Several programs are available, such as the IHS Extern Program; IHS preparatory, pregraduate, and professional scholarship

EDUCATIONAL INTERNSHIPS AND FELLOWSHIPS

- The IHS Externship Program: www.ihs.gov/scholarship/ihsexternprogram
- SAMHSA: Minority Fellowship Program: www.samhsa.gov/minority-fellowship-program
- Centers for Disease Control and Prevention: Public Health Training Fellowships: www.cdc.gov/Fellowships

Loan Opportunities

- The NHSC Loan Repayment Program: https://nhsc.hrsa.gov/loanrepayment
- The IHS Loan Repayment Program: www.ihs.gov/loanrepayment
- (Alaska) SHARP-II: Providing Support-for-Service to Health Care Practitioners: http://dhss.alaska.gov/dph/HealthPlanning/Pages/sharp/default.aspx
- The Idaho State Loan Repayment Program: https://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/SLRP%20FAQs%207-18.pdf

programs; and the NHSC Loan Repayment Program, for individuals in the healthcare field who are willing to commit to filling needed positions within IHS. The IHS Loan Repayment Program offers assistance repaying health education student loans for qualified candidates (both native and non-native) in exchange for a multiyear service commitment at a program or facility that serves an American Indian or Alaska Native community (see the IHS website for more information: www.ihs.gov/loanrepayment). Several states offer similar programs. In addition, the American Psychological Association offers a Pre- and Postdoctoral Minority Fellowship Program funded through SAMHSA.

Clinical Supervision

Providing culturally competent clinical supervision is an important ingredient in professional development. Done well, it can help providers meet client needs in a culturally competent way; reinforce a community atmosphere among program staff; promote a nonjudgmental approach to learning; bridge the gap between education and day-to-day experience in the field; help you, the administrator, retain staff; reduce health inequalities; and improve intervention outcomes. TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (Center for Substance Abuse Treatment [CSAT], 2009a), provides considerable information on clinical supervision in behavioral health organizations, and it can serve as a primer for implementing clinical supervision. This section addresses the dynamics and challenges of clinical supervision that may arise when working cross-culturally with non-native and native supervisors, supervisees, and clients.

If you, as a clinical supervisor, are going to serve as a resource and mentor in Indian Country, you need skills in providing trauma-informed care, culturally adaptive and native EBPs, family therapy, and motivational interviewing (MI). You also need to have knowledge about traditional healing practices and build relationships and connections with spiritual advisors, traditional healers, elders, and others in the community.

If you are an administrator managing a small tribal program or other community service, you may doubt that you can provide clinical supervision with limited funding, staff resources, and time

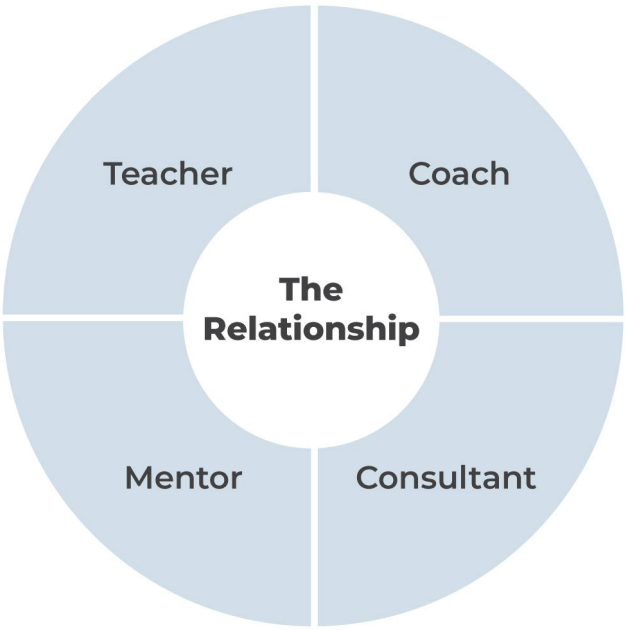
WHAT DO WE MEAN BY CLINICAL SUPERVISION?

Clinical supervision is "a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices."

Source: CSAT, 2009a, p. 3.

constraints. Foremost, clinical supervisors do not have to be full-time employees or work within the same program; they can be professionals who serve in a consulting role. Although licensing requirements and laws may restrict how you use supervisors; you may be able to find alternative ways of providing clinical supervision, such as telehealth supervision, facilitated group supervision, and peer-to-peer supervision groups.

Most importantly, clinical supervision needs to occur in a safe, supportive, and nonjudgmental environment. Not unlike previous recommendations on embracing the spirit and philosophy of MI in counseling, the spirit of MI can be culturally responsive in supervision. Although several models of supervision exist, one model, Bernard and Goodyear's (2004) four roles of clinical supervision, is compatible with MI and can be culturally adapted. Each role is an important element in building supervisor–supervisee relationships, and the roles change according to the needs of the supervisee as well as the supervisee's client. For example, one moment you may be educating about the importance of traditional practices, whereas in the next moment you may be encouraging your supervisee to try something different in a session. The authors caution against using one particular role; instead, they advise supervisors to step out of their comfort zone to share knowledge, to encourage, to guide, and to collaborate.



As reinforced throughout this TIP, relationships in American Indian and Alaska Native cultures are often not formed in prescribed environments or roles. Generally speaking, American Indians and Alaska Natives do not define relationships based on titles, degrees, or positions; instead, relationships are often formed by the knowledge that you are known and accepted in the community and that you have a genuine interest in the community.

SIX AREAS OF COMPETENCE AS A CULTURALLY COMPETENT SUPERVISOR

1. Supervisor-Focused Personal Development: Supervisor has done extensive self-exploration regarding personal values, biases, and personal limitations.
2. Supervisee-Focused Personal Development: Supervisor fosters supervisee self-exploration, awareness, and knowledge.
3. Conceptualization: Supervisor promotes an understanding of the impact of individual and contextual factors on clients' lives, such as the influence of stereotypes and personal identity.
4. Skill Development: Supervisor encourages flexibility between mainstream and both traditional and alternative interventions (for example, talking circles) as appropriate.
5. Process: The supervisor–supervisee relationship is characterized by open and respectful communication.
6. Outcome/Evaluation: Supervisors evaluate supervisees on their cultural competence, recommending additional or remedial education and training to address performance areas in need of improvement.

Sources: Ancis & Ladany, 2001; Inman, 2008.

Establishing a cross-cultural supervisor–supervisee relationship

Culture is a major factor that influences the relationship in clinical supervision. Differences in individual worldviews, values, traditions, history, and experiences inherently influence a person's biases, expectations, and behaviors. These differences get played out in clinical supervision. Remember there are at least three players: the supervisor, the supervisee, and the client—each with unique experiences,

history, culture, and expectations that influence the supervisor–supervisee relationship. From the outset, clinical supervision discussions should center on these areas. Initiating early discussions with supervisees regarding individual backgrounds and expectations can help establish a foundation on which to develop trust and empathy, and it demonstrates to staff your awareness of and willingness to discuss issues related to race and culture in a safe and supportive manner (Inman, 2008).

Here are some questions to help guide your own self-awareness as a supervisor and facilitate a collaborative exploration with your supervisee (Corey, Haynes, Moulton, & Muratori, 2010):

- How do you describe your (both supervisor and supervisee) ethnic and cultural identity?
- What are the various cultural groups to which you belong?
- In what ways do your worldviews (e.g., values, views, cultural practices) influence how you work with clients and staff?
- How might your cultural differences or similarities affect your clinical supervisory relationship?
- How would you rate your knowledge of and comfort with discussing cultural issues, on a scale from 1 (very uncomfortable) to 10 (very comfortable)? Discuss what would need to happen to make you more comfortable or less comfortable. For example, if your supervisee initially responds with a 9 as very comfortable, you could ask, "What would need to happen to make it less comfortable, let's say a 7. What would need to happen to make it a 10?" These questions make the discussion more informative and engaging rather than just talking about the rationale of the initial rating.
- What challenges have you faced working with clients or coworkers whose culture differed from your own?

CONDUCTING A CULTURAL AWARENESS SELF-EVALUATION

An effective supervisor can acknowledge that he or she may have preexisting assumptions or experiences regarding different cultures that could influence his or her interactions with staff members. It is crucial, then, that you be willing to evaluate your personal values, attitudes, experiences, and practices and how they could affect your interactions with supervisees and clients. Corey et al. (2010) offer some questions to consider as part of this self-evaluation:

- How did I learn my cultural values?
- What is my experience with other cultures and my perception of these cultures?
- How might my beliefs affect the ability to supervise effectively?
- How do I define the relationship between culture and therapy?

For additional resources and assessment tools, refer to TIP 59 (SAMHSA, 2014a).

Supervision dynamics: Non-native supervisor with American Indian or Alaska Native supervisee

A non-native supervisor of native supervisees should be able to demonstrate an understanding of the history, values, and culture of American Indians and Alaska Natives. However, it is not enough to know about the history and culture. You, as the clinical supervisor, need to demonstrate openness and humility to learn, including the willingness to learn about the history and culture specific to the tribe or tribes represented in the program and among staff. You are not the expert on American Indian or Alaska Native history or ways, regardless of your background. Instead, you should remain receptive and flexible in modifying supervision

> It is important to be flexible and humble as a clinical supervisor. I was thinking about gardening in our community, and how staff from the community would show up. We would come together to harvest the garden. During this time, there was a lot of 'talk' occurring, a coming together to listen, learn, and honor the wisdom of each other and our journey."
>
> —Betty Poitra, Turtle Mountain Band of Chippewa, Belcourt, ND, TIP Contributor

styles and techniques to match your supervisees' needs and to improve your listening and relational skills when working with American Indian and Alaska Native staff and clients.

Equally important, clinical supervisors need to monitor the supervisor–supervisee power dynamic, which is often affected by differences in race and culture. For example, White supervisors need to recognize that they may symbolically represent a history of oppression to an American Indian or Alaska Native supervisee. Although they should pay attention, listen, and help supervisees discuss their experiences in the role of supervisee, White supervisors should not refocus the session on their own feelings of "White guilt" or shame; nor should they attempt to share past experiences that may appear similar. In simple terms, it is not about you; rather, it is about your listening and learning. Similar to the role of provider in MI, your supervisees are the experts on their own experiences. You are there to help facilitate and guide the process.

Supervision dynamics: Non-native supervisor with non-native supervisee

In the non-native supervisor–supervisee relationship serving American Indian and Alaska Native clients, supervisors need to understand the history, culture, and beliefs of the community. They also need to become lifelong learners in cultural competence by seeking cultural consultation and further education and training, and by participating, when appropriate, in native community activities. When supervising non-native staff, a significant responsibility as a supervisor is reinforcing the value of and need for culturally responsive care while providing the resources to do so. Supervisors should attempt to increase their own and their supervisees' awareness of how mainstream values and privilege affect treatment. Also, supervisors need to promote a strengths-based and trauma-informed approach, rather than a perspective that views clients' presenting concerns through the lens of deficits or pathology (e.g., framing clients'

SUPERVISION AND CLIENT EXPERIENCES: THE INFLUENCE OF CULTURE

American Indian and Alaska Native staff members working with American Indian and Alaska Native clients may encounter challenges that differ from those experienced by their non-native colleagues. Native supervisees may find that American Indian and Alaska Native clients want to discuss and obtain more personal information from them. As a supervisor, your role is to facilitate a discussion about what is culturally and clinically appropriate and find a balance that honors self-disclosure as well as boundaries. Remember that different cultures have different needs and expectations about personal space, emotional boundaries, and interpersonal boundaries.

Relationships are particularly influenced by community size. For example, if you live in a village of 600 people, it is likely that your clients will be the store clerk, the pilot, and your child's teacher or coach. In this scenario, there is no feasible way you can avoid many multiple relationships. Multiple relationships occur when a provider is in a professional role and another role with the same person, which raises ethical concerns for providers. Boundaries among American Indians and Alaska Natives are more flexible, so it takes some effort to balance boundaries and relationships.

Another experience among native and non-native supervisees is the request from clients to meet needs outside the program's parameters. For example, the provider has a client who asks directly for his or her advice and assistance in helping his niece who is depressed. Although he may be court-ordered to attend treatment, the client is more focused on getting help for his niece, even bringing her for his session at the center. As a clinical supervisor, you may believe it is inappropriate to comply with the client's request. You may go further and assess that the client is focusing away from the reasons for his admission. Yet, it is not uncommon that American Indian and Alaska Native clients will seek assistance for others, especially after trust is formed in the relationship. Although your program may not be able to provide assessment and treatment services for his niece, you may be able to link the client to services and to anticipate that this will naturally happen if the program has developed good relations with the community. By anticipating that this is likely to happen, you can plan ahead on how best to manage informal requests for services and facilitate the access to care that falls out of the scope of services within your program.

behavioral reactions through a trauma-informed lens rather than interpreting the reaction as a diagnostic symptom of a personality disorder). For specific suggestions and questions on how to facilitate cultural awareness during supervision, refer to "How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision," TIP 59 (SAMHSA, 2014a, p. 93).

Supervision dynamics: American Indian or Alaska Native supervisor with non-native supervisee

American Indian and Alaska Native supervisors should be cognizant of their beliefs and assumptions about non-native staff and how those beliefs may affect their relationships with non-native supervisees. At the same time, supervisors should also be aware of and make it a point to address supervisee beliefs and biases that may affect supervisee relationships and interactions with American Indian or Alaska Native clients. Using the self-awareness and self-reflection questions highlighted in this chapter; the South direction in Part 1, Chapter 1, in this TIP; and TIP 59 (SAMHSA, 2014a); supervisors can guide discussions to further promote the development of cultural competence.

Supervision dynamics: American Indian or Alaska Native supervisor with native supervisee

Supervisors should be conscious of differences and issues that may arise in native supervisee–supervisor relationships, especially cultural identity and competence. Foremost, do not assume that native supervisees are culturally competent or knowledgeable about the specific tribes you serve. Cultural identity may vary widely between you and your supervisees. You may be more traditional; they may have limited lifetime exposure to American Indian and Alaska Native cultures. You may have lived on a reservation your entire life; they may have lived in urban areas disconnected from their heritage. You may use traditional healing and ceremonies; they may rely on mainstream health care only. As a supervisor, build a bridge that enables supervisees to become culturally competent while honoring their path in cultural identity.

POTENTIAL BENEFITS OF MENTORING PROGRAMS

- Take the behavioral health services field into the next generation.
- Provide professional networking opportunities.
- Develop mentee's leadership qualities.
- Encourage intellectual and professional development and stimulation.
- Support professionals currently providing behavioral health services.
- Provide a learning opportunity for both the mentee and mentor.
- Offer opportunities to share knowledge and experiences and build collaborations.
- Foster agency growth and workforce development.

Source: NAI & AN ATTC, 2015.

Mentoring

Mentoring is another professional development activity that helps build and improve the skills and capabilities of staff members. It is evolving into a key workforce development approach in preparing the next generation of American Indian and Alaska Native behavioral health leaders and professionals. It complements native ways of knowing.

Mentoring is typically a collaboration between two entities or individuals who have different levels of experience, such as a mentor–mentee relationship, whereby one person has more experience or a different experience to share; an organization that supports mentorship programs using its expertise to further develop the skills of an early career professional, including programs for youth; or an agency-to-agency mentorship program that shares knowledge and leadership skills to improve service capacity and sustainability.

Mentoring is key to building an American Indian and Alaska Native behavioral health workforce. Although staff members may have educational degrees, certifications, and licenses that have required practicum and internship experiences, mentorship programs do not have to require educational levels, licenses, or certifications or even have specific age requirements, depending on the

A NOTE TO ADMINISTRATORS

Ethics in Research With American Indian and Alaska Native Communities and Clients

Researchers and administrators have an ethical responsibility to seek approval for research from tribal governance when working with American Indian and Alaska Native clients, tribes, and communities, regardless of location (e.g., Alaska Native Corporations, Urban Indian Health Organizations, American Indian tribal governments). Tribes need to give informed consent using a formal memorandum of agreement. This document clarifies the exact nature of the research; information that will be shared; how it will be shared; who will be involved in the research; what level of community involvement is required; who owns the data; who has copyright control; and how confidentiality is protected for the individual, tribe, and community. As an administrator, remain vigilant in respecting American Indian and Alaska Native intellectual, cultural, and spiritual property, including the acquisition and use of data.

goals of the mentorship. Mentoring can be tailored formally or informally to match the needs and desired outcome for the individual or organization.

Provider Competencies

Competence means capability. Are your staff members knowledgeable about American Indian and Alaska Native culture? Is this knowledge tribe specific? Do they possess an understanding of American Indian as well as Alaska Native history and its effects on native families and communities today? What knowledge do they have about traditional healing and beliefs about illness and health? As an administrator or clinical supervisor, you want to determine the knowledge, understanding, skills, and attitudes needed for providers to be culturally competent to meet the needs of your clients.

The text that follows lists provider competencies focused on the training, knowledge, understanding, skills, and attitudes needed to work with American Indians and Alaska Natives. The Western Interstate Commission for Higher Education (1998) convened an expert panel that compiled this list of competencies to serve as guidelines for managed care organizations providing mental health services to American Indian and Alaska Native clients. These competencies can guide the selection of your professional development activities as outlined in the previous section. This list is not exhaustive, and the order of items does not reflect priority or the sequence in which to acquire certain skills and knowledge. An understanding of American Indian and Alaska Native history should support all the competencies discussed below. Although these competencies focus primarily on mental health, the majority of these factors also are important to effective substance abuse treatment and interventions with American Indian and Alaska Native clients.

Training competencies

The following list identifies specific training needs for providers working with American Indian and Alaska Native clients and communities. The training includes:

1. Specialized assessment and service delivery techniques that meet the cultural needs of American Indian and Alaska Native clients.
2. Recognition and integration of the unique features of traditional, transitional or acculturating, and multicultural and multiracial clients and families.
3. Appreciation of culturally based traditional healing systems and traditions of American Indian and Alaska Native communities served.
4. Techniques to engage and build alliances with communities, as well as culturally acceptable and therapeutic boundary-setting with American Indian and Alaska Native clients.
5. Interdisciplinary team interaction and functioning to promote effective care.
6. Use of clients' preferred language in the treatment process.
7. Treatment of American Indian and Alaska Native LGBTQ/Two-Spirit people, with attention to issues related to combined prejudice regarding mental illness, ethnicity, sexuality, and gender roles.

8. Documentation or communication of specialized assessment and service delivery methods such that staff who are not culturally competent will be able to benefit from it.

Knowledge competencies

Knowledge competencies should begin with self-awareness and self-knowledge about personal beliefs, values, norms, stereotypes, and biases and how these may influence personal and professional interactions, particularly with clients. The following list identifies the areas of knowledge necessary to be culturally responsive toward American Indian and Alaska Native clients, supervisors, and other staff members. Areas of culturally responsive knowledge include:

1. Differences in symptom expression, symptom language, and symptomatic patterns presented by American Indian and Alaska Native clients.
2. Differences in thresholds of individual and social distress in American Indian and Alaska Native clients and tolerance of symptoms exhibited by their natural support systems, including individuals, families, and individuals' or families' informal and formal social context.
3. Differences in the attribution of mental illness and issues around prejudice/shame specific to American Indian and Alaska Native cultures.
4. Differences in the acceptability and effectiveness of different treatment modalities in American Indian and Alaska Native populations.
5. Culture-bound syndromes associated with the American Indian and Alaska Native communities served by the program.
6. Use of formally trained interpreters by clinicians unable to communicate with clients using clients' preferred language.
7. Effects of class and ethnicity on behavior, attitudes, and values.
8. Help-seeking behaviors common among American Indians and Alaska Natives.
9. Self-treatment behaviors often found among American Indians and Alaska Natives, including substance misuse and self-medication.
10. Roles and manifestations of spirituality, tradition, and faith in American Indian and Alaska Native communities.
11. Roles of verbal and nonverbal language, speech patterns, and communication styles in American Indian and Alaska Native communities.
12. Effects of human service policies on American Indians and Alaska Natives and reduction of barriers through informed participation in systems change efforts.
13. Resources (e.g., agencies, individuals, informal helping networks, research) that can be used on behalf of American Indian and Alaska Native clients and communities.
14. Roles and types of power relationships within the community, agency, or institution and their impact on American Indians and Alaska Natives.
15. Recognition of the ways that mainstream professional values may conflict with or be responsive to the needs of American Indians and Alaska Natives.

Understanding competencies

The following list describes areas of understanding that are particularly salient when working with American Indian and Alaska Native clients and communities, such as understanding historical factors that affect health, the effects of historical traumas, and traditional medicine. These areas include:

1. Historical trauma that affects the mental health of Native Americans, such as racism, forced relocation, loss of sacred lands, and boarding school experiences.
2. Factors that define cultural differences among sovereign tribal nations and communities, including differences related to history, traditions, values, belief systems, acculturation and migration history, and language; this information is particularly important for providers who serve multiple tribes.
3. Particular psychosocial stressors and traumas relevant for American Indian and Alaska Native clients, including war, personal trauma, unique aspects of cultural survival and maintenance, and socioeconomic status.
4. Cultural variations across Indian Country.

5. Native clients in a family life cycle and intergenerational conceptual framework, in addition to individual identity development in relation to family and cultural developmental frameworks.
6. Differences in culturally acceptable behavior or psychopathological characteristics of American Indians and Alaska Natives.
7. Traditional healing practices and the role of belief systems (e.g., religion, spirituality) in the treatment of American Indians and Alaska Natives.
8. A community-based system of mental health services for American Indians and Alaska Natives, including appropriate, culturally relevant components and characteristics.
9. Public administrative issues in developing, implementing, and evaluating programs for American Indians and Alaska Natives.
10. Dynamics of language use and conceptual frameworks among monolingual and bilingual clients.
11. The effects of the acculturation process on American Indians and Alaska Natives.

Skill competencies

The following list provides an overview of culturally responsive clinical skills necessary for behavioral health service providers. These skills include the ability to:

1. Interview and assess minority clients and families based on psychological, social, biological, cultural, political, spiritual, environmental, and economic models.
2. Communicate and listen effectively across cultures.
3. Assess American Indian and Alaska Native clients with an understanding of cultural differences in psychopathology.
4. Formulate culturally responsive service plans (case management and treatment) that are appropriate for clients' and their families' concept of mental illness.
5. Create and implement multidisciplinary service plans (case management and treatment), including culture, family, and community.
6. Use culturally appropriate community resources (e.g., family, clans, societies, church, community members, other groups).
7. Provide psychotherapeutic and psychopharmacological interventions with an understanding of the cultural differences in treatment expectations and biological response to medications.
8. Recognize the limitations of standardized psychological tests and testing procedures when used with American Indian and Alaska Native clients.
9. Use a culturally sensitive approach to conducting research.
10. Provide education and advocacy interventions that promote clients' and families' voices and ownership in shaping the service delivery system.
11. When feasible, use the clients' language to elicit the range and nuances of emotions, feelings, dynamics, and so forth.
12. Know when and how to use interpreters and understand the limitations of using interpreters. Be aware of how interpreters (knowingly or unknowingly) may censor and modify information during the process of interpretation.
13. Learn the particulars of social conventions (from engaging protocols to termination rituals) within American Indian and Alaska Native cultures.
14. Be open to continually learning the cultures of American Indian and Alaska Native clients and families through varied and multiple techniques (e.g., conferences, visiting in community, reading books, hanging out, attending community forums). Cultural competence is a learning process, not a product.
15. Be aware of racial and ethnic differences and know when to respond to culturally based cues.
16. Assess the meaning of race and ethnicity for individual clients.
17. Differentiate symptoms of intrapsychic stress from stress arising from the social structure.
18. Work toward empowerment of clients and minority communities.

19. Use community resources on behalf of American Indian and Alaska Native clients and their communities.
20. Use agency resources on behalf of American Indian and Alaska Native clients and their communities.
21. Recognize and combat racism, racial stereotypes, and myths held by individuals and institutions.
22. Evaluate new techniques, exemplary practices, research, and knowledge for their validity and applicability in working with American Indians and Alaska Natives.

Attitudinal competencies

The following list identifies attitudes and values that providers need to cultivate to work effectively with American Indian and Alaska Native clients and communities. They include:

1. Personal qualities that reflect genuineness, accurate empathy, nonpossessive warmth, and a capacity to respond flexibly to a range of possible solutions.
2. Acceptance of ethnic differences between people and how these differences affect the treatment process.
3. Willingness to work with clients of various ethnic minority groups.
4. Respect for the immigrant, migration, colonization, and dissolution of culture experience.

Before You Leave

As an administrator, your greatest challenges include funding and sustainability of your services, recruitment and retention of staff, implementing of workforce development activities, and employing strategies to support future leadership among American Indian and Alaska Native youth. Through collaboration with other organizations, making use of available resources, and involving community leadership, the route across rough waters will be safely navigated with others. The next chapter provides many hands-on resources that support the administrative issues, needs, and tasks outlined in this chapter.

> It must not be forgotten that our old ones aspired and dreamed, created and struggled, and cared for one another. This generation and future generations must remember that their greatest legacy is the teaching that everyone has healing gifts to build our common decency and wholeness."
>
> —Martin Waukazoo, Lakota
>
> *Source: Nebelkopf & Phillips, 2004, p. 5.*

This page intentionally left blank.

Part 2, Chapter 2

Introduction

> "If you have one hundred people who live together, and if each one cares for the rest, there is one mind."
>
> —Shining Arrow, Crow

The final chapter of this TIP provides you with organizational tools to help you, as administrators and program managers, address a number of the challenges mentioned in Part 2, Chapter 1. As you discover your unique pathways to designing and implementing programs and services specifically tailored to meet the behavioral health needs of American Indian and Alaska Native clients, this chapter offers you tools for:

- Developing a culturally competent and responsive workforce.
- Developing native evidence-based practices (EBPs).
- Integrating care, including traditional practices in behavioral health programs.
- Creating sustainability.

Some of these tools were originally developed for a specific American Indian or Alaska Native tribe or community, so in some circumstances, the material was revised to make it suitable for a pan-native population. Further adaptations may be required if your program is serving a specific tribe or community to make the material more culturally relevant. The tools presented in this chapter are either in the public domain, have been adapted from the original, or have been reprinted with permission from the author for use in your program.

Developing a Culturally Competent and Responsive Workforce

The first step in developing a culturally competent and responsive workforce in American Indian and Alaska Native communities is hiring and then orienting new staff to the community, culture, and traditions of the people they will be serving. The Indian Health Service (IHS) has produced a number of publications (available at www.ihs.gov/retention/retentionstrategies) that may be helpful to your program in recruiting and retaining staff. The *New Hire Quick Reference Guide* (IHS, 2015a) describes specific tasks for working with newly hired staff in your organization, including the community liaison (see "The Role of the Community Liaison"). The tasks are organized chronologically beginning prior to the employee's start date and continuing through the first 6 months.

THE ROLE OF THE COMMUNITY LIAISON

A key staff member involved in the orientation of new behavioral health employees is the community liaison. The community liaison keeps the lines of communication open between the local community and the Indian health facility or behavioral health program. A tribal leader, an accepted community member, an elder, or a supervisor at your program may act as the liaison. He or she takes on specific roles, such as:

- An ambassador who understands your program's mission and fosters goodwill and respect in the community, while also promoting the vision and values of the local tribe.
- A leader who maintains strong, collaborative relationships between your program and the local community and shares information about local events and community issues with your program, tribal entities, and community stakeholders.
- A guide who will introduce new staff to the community and expose staff to many aspects of the tribal culture, including ceremonial events, observances, and traditions.

Source: IHS, 2014.

NEW HIRE QUICK REFERENCE GUIDE

1. Prior to the Start Date

Welcoming an employee to your Indian health facility and paving the way for long-term success is easy if you set up an action plan that appropriately addresses his or her ability to succeed within the organization from the start. Your plan to integrate him or her into your facility should begin immediately following his or her acceptance of the job offer and incorporate the essential steps below.

ACTION	TO BE COMPLETED BY
One of the most important documents a new hire needs is an official letter of hire from Human Resources (HR) detailing the position, responsibilities, salary, and specific hiring terms. This letter provides official documentation of employment, which is necessary for mortgage lenders, school enrollment, health insurance, benefits, and utility activation, as well as other key tasks needed to settle in. Include a "Welcome" letter and an information packet containing information about the facility, community (background, traditions, observances), local site amenities (housing, transportation, schools, businesses, services, etc.), and other pertinent information about your site 1 month prior to the new hire coming on board. Include a point of contact such as a liaison or mentor at the facility.	Chief Executive Officer (CEO)/ Clinical Director/Supervisor
Identify staff with similar responsibilities to function as the new employee's coach/mentor for work-related processes and procedures.	CEO/Clinical Director/Supervisor
Work closely with your HR representative and arrange to have all necessary paperwork ready for the new employee's arrival.	CEO/Clinical Director/ Supervisor/HR Representative
Likewise, notify your Information Technology (IT) department of the new hire and arrange to have all the necessary technology and telecommunications equipment set up prior to his or her arrival (computer, email, phone, beeper, etc.).	CEO/Clinical Director/ Supervisor/IT Department
Prepare the new employee's work area with any necessary office supplies prior to arrival date.	CEO/Clinical Director/Supervisor
Add the new employee to the department or unit's organizational contact and routing lists within a week of reporting date.	CEO/Clinical Director/Supervisor
Schedule the new employee's first-week activities and prepare his or her agenda, including names, titles, and departments/areas of key contacts with whom he or she will meet.	CEO/Clinical Director/Supervisor
Send an introductory email to staff announcing the new employee's arrival, function, and location.	CEO/Clinical Director/Supervisor
Make plans to have lunch with the new employee or arrange to have lunch brought in to the facility for a meet-and-greet with the staff on the first day.	CEO/Clinical Director/Supervisor
Identify an appropriate community/facility representative to serve as a cultural liaison for the new hire. Arrange to have the chosen liaison available to meet with the new hire during his or her first week to ensure he or she has an appropriate understanding of the community and tribal ways.	CEO/Clinical Director/ Supervisor/Cultural Liaison

Continued on next page

NEW HIRE QUICK REFERENCE GUIDE (CONTINUED)

2. The First Day

Although a new job can be exciting for someone new to your team, it can also bring first-day jitters and an overwhelming sense of stress while trying to remember names, learn new processes, and find his or her way around the facility. You can help to alleviate these concerns by putting the new hire at ease, assuring him or her that an organizational chart is available to use as a "who's who" resource and to map out each team within each department. Also, let the new hire know that you have an open-door policy should he or she have any questions or concerns. In doing so, you will immediately establish a sense of value and an understanding that your support is always available. Also, take the first day to confirm the new hire's schedule, daily responsibilities and, if applicable, any previously agreed-upon telecommuting arrangement, and then share that information with the HR department representative who's responsible for going over the new hire's employee orientation. It is important to let the employee know that he or she should allow a few hours that first day to go over all necessary documentation and employment benefits with HR.

ACTION	TO BE COMPLETED BY
Be available to personally greet the new employee as he or she arrives. Schedule meetings, conferences, and phone calls for later in the day.	CEO/Clinical Director/ Supervisor
Personally, lead the new employee through a tour of the facility. Orient him or her to specific locations, such as: • Lunchroom or break room • Bathrooms • Conference rooms • Office equipment and supplies • Parking	CEO/Clinical Director/ Supervisor
Introduce the new employee to the HR representative responsible for going over all paperwork, benefits, etc.	CEO/HR Representative
Introduce the new employee to all staff and the chosen mentor with whom he or she will work.	CEO/Clinical Director/ Supervisor
Orient the new hire to all technology: • Phone/intercom systems • Computer system • IT/security • Time-management software • Meeting schedules	CEO/Clinical Director/ Supervisor/IT Department
Introduce the new employee to the executive staff—CEO (if other than the supervisor), Chief Marketing Officer, Chief Financial Officer, etc.—to acquaint him or her with management and to serve as a welcome to the entire facility team.	CEO/Clinical Director/ Supervisor

Continued on next page

NEW HIRE QUICK REFERENCE GUIDE (CONTINUED)

3. The First Week

Orientation sessions are not just important to new employees. They are also essential to the Indian health program because they address the organization's policies and procedures and new-hire concerns and help staff members form accurate expectations about the job they have just taken on. Performing the tasks below will ensure that your new employees are fully on board right from the beginning.

ACTION	TO BE COMPLETED BY
Meet to review and discuss the new hire's IHS orientation, including explaining the following: • IHS Mission • Introduction to IHS (IHS 101) • Employee ethics • Communication • Customer service	Supervisor
Identify training and development activities needed within the first 6 months and sign up the new employee for appropriate classes.	Supervisor
Set performance expectations and discuss how and when the employee will be evaluated.	Supervisor
Review and discuss the employee's first week, answer his or her questions, and solicit his or her feedback.	Supervisor
Introduce the new hire to the community liaison chosen to help with his or her immersion to the community. Ensure the new hire understands the local traditions, heritage, cultural observances and ceremonies.	Supervisor/Community Liaison

4. Within the First 6 Months

Inspiring a new employee to want to remain at your Indian health facility is an ongoing task. Retention is a process that must be actively nurtured and developed during the tenure of each employee. This includes giving your employees the attention they require and deserve, offering encouragement and support, acknowledging a job well done and ensuring that he or she has a voice within your organization and that his or her input—as well as the input of all staff members—is key to the success of your facility. In short—give your employees a reason to stay!

ACTION	TO BE COMPLETED BY
Check in regularly with the new employee to see if there are any questions or concerns. Provide feedback often, including positive reinforcement.	CEO/Clinical Director/ Supervisor
Schedule a 6-month new-hire evaluation.	Supervisor
Provide monthly feedback to new employees regarding their job performance, including a formal performance evaluation in their third month.	Supervisor
Celebrate each new hire's 6-month anniversary with a planned lunch or other form of recognition.	CEO/Clinical Director/ Supervisor

Adapted from material in the public domain.

Once your staff is in place, it is essential to provide culturally appropriate education opportunities for immersion into tribal culture, training, and culturally appropriate clinical supervision for all staff, but particularly for non-native providers. Two instruments, the Native American Cultural Assessment Survey and the Sample Pretest for Non-Native Counselors, provided below, are adapted from the Native American Curriculum for State Accredited, Non-Tribal Mental Health & Substance Abuse Programs in South Dakota offered by the National American Indian and Alaska Native Addiction Technology Transfer Center.

A NOTE TO ADMINISTRATORS AND PROGRAM MANAGERS

The original training curriculum was developed to be applicable to a particular group of tribes, but in adapting these materials, the attempt was made to identify cultural practices that are common to a number of American Indian and Alaska Native cultures or are now considered pan-Native American. Not all of these practices may be relevant to a given native culture. These documents should be tailored, as appropriate, to specific cultures (e.g., highlighting specific traditional practices, introducing words from that culture's language). These surveys were intended to assess the cultural knowledge of substance abuse providers, but they are relevant in any behavioral health setting that offers services to American Indian and Alaska Native clients.

The Native American Cultural Assessment Survey is a useful tool to help you evaluate the cultural competence of your entire program, but it can also be used to give you a sense of how well your organization is doing in recruitment and hiring, providing culturally responsive training and supervision to your staff, and offering opportunities for staff immersion in the local tribal culture.

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY

Date: _____ **Facility Name:** _____

Directions:

Please provide information regarding the extent to which substance abuse programs in *[insert your state]* provide policies, programs, and services that reflect *[insert Native American tribes/groups found in your state]* cultures. Please check the appropriate boxes or fill in the appropriate numbers to best reflect your responses.

Please note the following:

- "Traditional" refers to Native Americans who understand and practice their cultural and spiritual beliefs/teachings
- NA refers to Native American
- S/A refers to Substance Abuse
- D/L/N refers to the South Dakota tribes, Dakota, Lakota, and Nakota

Respondent Data

Your Gender:

☐ Male
☐ Female
☐ Other

Your Predominant Ethnic Heritage:

☐ a. American Indian/Alaska Native
☐ b. Asian Pacific/Pacific Islander
☐ c. Black/African American
☐ d. Caucasian
☐ e. Hispanic or Latino-American
☐ f. Other: *(Please Specify)* _____

Certification Status:

☐ a. Not Certified
☐ b. Level I
☐ c. Level II
☐ d. Level III
☐ e. Prevention

Certified By: *(Check all that apply)*

☐ a. International Certification & Reciprocity Consortium (which has regional Native American certification exams)
☐ b. A regional association (e.g., the Regional Native American Chemical Dependency Association)
☐ c. State of *[insert state]*
☐ d. Other: *(Please identify)*

_____

Number of hours of training, specifically related to D/L/N cultures, that you have had in the last 12 months.

☐ a. None
☐ b. 1–5 hours
☐ c. 6–10 hours
☐ d. 11–15 hours
☐ e. 16–20 hours
☐ f. More than 20 hours

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

Program Data

Which of the following descriptors best identifies your program? *(Check all that apply)*

- ☐ a. Correctional facility
- ☐ b. IHS program
- ☐ c. Private program
- ☐ d. State program
- ☐ e. Tribal program
- ☐ f. Veterans Administration program
- ☐ g. Other: *(Please identify)*

_____

Type of services your program provides: *(Check all that apply)*

- ☐ a. Clinically managed low-intensity residential services (halfway house)
- ☐ b. Clinically managed residential detoxification services
- ☐ c. Day treatment services
- ☐ d. Early intervention services
- ☐ e. Gambling services
- ☐ f. Inhalant abuse/dependency treatment services
- ☐ g. Opioid substitution services
- ☐ h. Intensive outpatient services
- ☐ i. Medically monitored intensive inpatient treatment services (Adolescent)
- ☐ j. Medically monitored intensive inpatient treatment services (Adult)
- ☐ k. Outpatient services
- ☐ l. Prevention services
- ☐ m. Community mental health services
- ☐ n. Other: *(Please specify)*

_____

Program Accreditation Status: *(Check all that apply)*

- ☐ a. Accredited by the state of *[insert state]*
- ☐ b. Accredited by regional association (e.g., Northern Plains Chemical Dependency Association)
- ☐ c. Tribal accreditation
- ☐ d. Joint Commission on Accreditation of Healthcare Organizations Accreditation
- ☐ e. Accreditation status pending
- ☐ f. Nonaccredited program
- ☐ g. Other accreditation: *(Please specify)*

_____

Program Location: *(Check all that apply)*

- ☐ a. On a Reservation
- ☐ b. Off-Reservation—Rural Area
- ☐ c. Off-Reservation—Urban Area

Ethnic Populations Served:

- ☐ a. All ethnic populations
- ☐ b. Only persons of Native American/Alaskan heritage enrolled in a federally or state-recognized tribe/nation
- ☐ c. Other: *(Please identify)*

_____

Population(s) served: *(Check all that apply)*

- ☐ a. Adult females
- ☐ b. Adult males
- ☐ c. Co-ed adults
- ☐ d. Adolescent females
- ☐ e. Adolescent males
- ☐ f. Co-ed adolescents
- ☐ g. Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) adults
- ☐ h. LGBTQ adolescents
- ☐ i. Other: *(Please identify)*

_____

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

CLIENTS SERVED (Male/Female/Other)	MALE	FEMALE	OTHER
Total number of clients served during the past 12 months			
Total number of Native American clients served during the past 12 months			
Total number of Native American clients served during the past 12 months who reside on a *reservation setting*			
Total number of Native American clients served during the past 12 months who reside on *off-reservation settings*			
Total number of transient Native Americans served during the past 12 months			

Current Employee Certification Status:

CERTIFICATION	# ADMINISTRATORS	# COUNSELORS	# SUPPORT STAFF
Trainee			
Level I			
Level II			
Level III			
Prevention			

Highest Educational Levels of Staff Members:

EDUCATION LEVEL	# ADMINISTRATORS	# COUNSELORS	# SUPPORT STAFF
GED			
High School			
Associate's Degree			
Bachelor's Degree			
Master's Degree			
Ph.D.			

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

BOARD/STAFF/MEMBERS/CONSULTANTS	# NATIVE AMERICANS	# NON-NATIVE AMERICANS
Policy Board/Board of Directors		
Administrators/Directors		
Clinical Supervisors		
Certified Counselors		
Counselor Trainees		
Medical Staff		
Psychologists		
Traditional Cultural Staff Consultants		
Social Workers		
Cooks, Security, Others		
Aides/Technicians		
Clerical Staff		
Custodial/Groundskeepers		
Computer Support Staff		
Other: *(please specify)*		

Please provide further program information by circling the one most appropriate response number for each of the following statements. Use the following scale to express your level of agreement or disagreement with each statement:

1=Strongly Disagree 2=Disagree 3=Agree 4=Strongly Agree ?=Don't Know

1	Program staff receive training on how to assess NA clients' relationship with their tribal culture.	1	2	3	4	?
2	Program staff receive training on how to assess NA clients' relationship with their traditional tribal spiritual practices.	1	2	3	4	?
3	Program has purification/sweat lodge on its grounds.	1	2	3	4	?
4	Program has access to a purification/sweat lodge located off the grounds of the program.	1	2	3	4	?

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

1=Strongly Disagree 2=Disagree 3=Agree 4=Strongly Agree ?=Don't Know

5	Program conducts "client satisfaction surveys" to receive feedback from clients regarding NA programs and services.	1	2	3	4	?
6	When needed, the program provides NA language interpreters for clients and staff.	1	2	3	4	?
7	Program collects data of NA clients' experiences with their culture (language, songs, customs, etc.).	1	2	3	4	?
8	Program collects data of NA clients' experiences with their traditional, spiritual ceremonies (purification lodges, vision quests, sun dances, etc.).	1	2	3	4	?
9	Program has working relationships with one or more tribal health departments of reservations in the state.	1	2	3	4	?
10	Program has working relationships with one or more Urban Indian Health Departments in the state.	1	2	3	4	?
11	Program has working relationships with one or more IHS clinics or hospitals in the state.	1	2	3	4	?
12	Program has working relationships with one or more NA tribal mental health departments.	1	2	3	4	?
13	Program includes statements related to NA culture and spirituality in its mission statement.	1	2	3	4	?
14	Program board of directors or advisory board members monitor the program's progress of including NA cultural beliefs and spiritual practices into the treatment regimen.	1	2	3	4	?
15	Program routinely contacts tribal and other NA programs to recruit staff.	1	2	3	4	?
16	Program has a resource pool of NA women and men who can make presentations about culture and spirituality for staff and clients.	1	2	3	4	?
17	Program routinely uses the services of a medicine man/woman.	1	2	3	4	?
18	Program employs a Native American Cultural Advisor on a part-time basis.	1	2	3	4	?
19	Program employs a Native American Spiritual Advisor on a full-time basis.	1	2	3	4	?
20	All new staff members receive orientation about NA cultures and spiritual beliefs and practices.	1	2	3	4	?

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

Cultural/Spiritual Activities: Program Staff

Please use the following scale to identify the level of training that program staff members receive on the following aspects of D/L/N lifestyles:

1=No Training at All 2=Little Training 3=Moderate Training 4=Extensive Training ?=Don't Know

1	Urban/Reservation political structures	1	2	3	4	?
2	Urban/Reservation social structures	1	2	3	4	?
3	Urban/Reservation economics	1	2	3	4	?
4	NA tribal histories	1	2	3	4	?
5	Colonization	1	2	3	4	?
6	Oppression	1	2	3	4	?
7	Cultural genocide	1	2	3	4	?
8	Historical grief issues	1	2	3	4	?
9	Urban/Reservation mental health services	1	2	3	4	?
10	Urban/Reservation social service programs	1	2	3	4	?
11	Healing ceremonies and medicine people	1	2	3	4	?
12	IHS programs/services	1	2	3	4	?
13	Bureau of Indian Affairs social service programs	1	2	3	4	?
14	Urban/Reservation substance abuse programs	1	2	3	4	?
15	NA languages	1	2	3	4	?
16	Tribal pow wow and ceremonial songs	1	2	3	4	?
17	Tribal artwork	1	2	3	4	?
18	Tribal crafts	1	2	3	4	?
19	How to make pow wow dancing regalia	1	2	3	4	?
20	How pow wows are structured	1	2	3	4	?
21	How tobacco is used in ceremonies	1	2	3	4	?
22	How other herbs *[insert appropriate ones for NA cultures in your state]* are used in ceremonies	1	2	3	4	?

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

1=No Training at All 2=Little Training 3=Moderate Training 4=Extensive Training ?=Don't Know

23	On the purposes of purification ceremonies	1	2	3	4	?
24	On the purposes of fasting/vision quest ceremonies	1	2	3	4	?
25	On the purposes of dancing ceremonies	1	2	3	4	?
26	On the purposes of other cultural ceremonies appropriate to NA cultures in the state	1	2	3	4	?
27	The family structure of the culture(s)	1	2	3	4	?
28	How healing ceremonies are conducted	1	2	3	4	?
29	How greeting or welcoming ceremonies are conducted	1	2	3	4	?
30	How ceremonies honoring an individual are conducted	1	2	3	4	?
31	How naming ceremonies are conducted, if applicable	1	2	3	4	?
32	The traditional religious beliefs of the culture(s)	1	2	3	4	?
33	On the purposes of Native American Church meetings	1	2	3	4	?
34	On appropriate uses of the sacred medicine, peyote	1	2	3	4	?
35	Cultural continuum/acculturation process as it relates to NA cultures in the area	1	2	3	4	?
36	Red Road concepts	1	2	3	4	?
37	Customs and protocols for grieving, wakes, funerals, and memorials	1	2	3	4	?
38	Other: *(please describe)*	1	2	3	4	?

Staff training regarding cultural/spiritual activities mostly occurs:

- ☐ a. Onsite
- ☐ b. Offsite
- ☐ c. Does not apply

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

The number of times, in a fiscal year, that the following program staff members attend offsite training programs to learn about NA cultures and spirituality. *(Circle appropriate number)*

Policy Board Members	0	1	2	3	4	5	6	7	8	9	10/+
Advisory Board Members	0	1	2	3	4	5	6	7	8	9	10/+
Program Administrators	0	1	2	3	4	5	6	7	8	9	10/+
Counselors	0	1	2	3	4	5	6	7	8	9	10/+
Clerical Support Personnel	0	1	2	3	4	5	6	7	8	9	10/+
Support Personnel	0	1	2	3	4	5	6	7	8	9	10/+

Number of times, in a fiscal year, that the following staff members attend onsite training programs to learn about NA cultures and spirituality. *(Circle appropriate number)*

Policy Board Members	0	1	2	3	4	5	6	7	8	9	10/+
Advisory Board Members	0	1	2	3	4	5	6	7	8	9	10/+
Program Administrators	0	1	2	3	4	5	6	7	8	9	10/+
Counselors	0	1	2	3	4	5	6	7	8	9	10/+
Clerical Support Personnel	0	1	2	3	4	5	6	7	8	9	10/+
Support Personnel	0	1	2	3	4	5	6	7	8	9	10/+

Cultural/Spiritual Activities: Clients

Please use the following scale to express your beliefs regarding amount of information clients receive during their treatment experience about the following aspects of NA cultures and spirituality:

1=No Information at All 2=Little Information 3=Moderate Information 4=Extensive Information ?=Don't Know

1	Reservation political structures	1	2	3	4	?
2	Reservation social structures	1	2	3	4	?
3	Reservation economics	1	2	3	4	?
4	Tribal histories	1	2	3	4	?

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

1=No Information at All 2=Little Information 3=Moderate Information 4=Extensive Information ?=Don't Know

5	Colonization	1	2	3	4	?
6	Oppression	1	2	3	4	?
7	Cultural genocide	1	2	3	4	?
8	Historical grief issues	1	2	3	4	?
9	Reservation mental health services	1	2	3	4	?
10	Reservation social service programs	1	2	3	4	?
11	Healing ceremonies and medicine people	1	2	3	4	?
12	IHS programs/services	1	2	3	4	?
13	BIA social service programs	1	2	3	4	?
14	Reservation substance abuse programs	1	2	3	4	?
15	Classes in NA languages	1	2	3	4	?
16	Tribal pow wow and ceremonial songs	1	2	3	4	?
17	Tribal art work	1	2	3	4	?
18	Tribal crafts	1	2	3	4	?
19	How to make pow wow dancing regalia	1	2	3	4	?
20	How tobacco (or other appropriate herb) is used in ceremonies	1	2	3	4	?
21	How sage (or other appropriate herb) is used in ceremonies	1	2	3	4	?
22	How pow wows are structured	1	2	3	4	?
23	On the purposes of purification ceremonies	1	2	3	4	?
24	On the purposes of fasting/vision quest ceremonies	1	2	3	4	?
25	On the purposes of engaging in traditional outdoor activities (hunting, fishing, etc.)	1	2	3	4	?
26	On the purposes of dancing ceremonies	1	2	3	4	?
27	How welcoming ceremonies are conducted	1	2	3	4	?
28	How healing ceremonies are conducted	1	2	3	4	?

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

1=No Information at All 2=Little Information 3=Moderate Information 4=Extensive Information ?=Don't Know

29	How honoring ceremonies are conducted	1	2	3	4	?
30	How naming ceremonies are conducted	1	2	3	4	?
31	On the purposes of Native American Church meetings	1	2	3	4	?
32	On appropriate uses of the sacred medicine, peyote	1	2	3	4	?
33	Cultural continuum/acculturation process as it relates to NA cultures	1	2	3	4	?
34	Red Road concepts	1	2	3	4	?
35	Customs and protocols for grieving, wakes, funerals and memorials	1	2	3	4	?
36	Other: *(please describe)*	1	2	3	4	?

Program allows clients to bring/use the following while in treatment:

ITEM	YES	NO	DON'T KNOW
Appropriate objects for cultural/religious ceremonies			
Appropriate herbs for cultural/religious ceremonies			
Appropriate foods for cultural/religious ceremonies			
Tobacco for ceremonial/religious purposes			
Peyote for ceremonial/religious purposes			

When can clients begin to participate in NA cultural or spiritual ceremonies while they are in the treatment program?

- ☐ a. Never
- ☐ b. During the first week of treatment
- ☐ c. Beginning with the second week of treatment
- ☐ d. Beginning with the third week of treatment
- ☐ e. From the fourth week of treatment
- ☐ f. At any time
- ☐ g. During certain steps or phases: *(Please describe)* _____
- ☐ h. Other: *(Please describe)* _____

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

Cultural Resources

Please use the following scale to identify the following D/L/N cultural resources available for clients and staff at your facility:

1=Not at All 2=To a Small Extent 3=To a Moderate Extent 4=To a Great Extent ?=Don't Know

1	Books	1	2	3	4	?
2	Videotapes or DVDs	1	2	3	4	?
3	Cassette tapes or CDs	1	2	3	4	?
4	CD-ROMs	1	2	3	4	?
5	Computer software programs	1	2	3	4	?
6	Paintings/photographs/prints	1	2	3	4	?
7	Native American newspapers	1	2	3	4	?
8	Other media	1	2	3	4	?
9	The cultures of local NA peoples are reflected in the decor (pictures, prints, furniture design, etc.) of the facility	1	2	3	4	?
10	The cultures of other NA peoples are reflected in the decor (pictures, prints, furniture design, etc.) of the facility	1	2	3	4	?
11	Other: *(please describe)*	1	2	3	4	?

Treatment Continuum

Please use the following scale to express your beliefs regarding the extent to which NA cultures and spirituality are integrated into the following:

1=Not at All 2=To a Small Extent 3=To a Moderate Extent 4=To a Great Extent ?=Don't Know

1	Intake/assessment	1	2	3	4	?
2	Treatment/recovery planning	1	2	3	4	?
3	Client educational programs	1	2	3	4	?
4	Individual counseling	1	2	3	4	?
5	Group counseling	1	2	3	4	?
6	Family counseling	1	2	3	4	?
7	Discharge planning	1	2	3	4	?
8	Other: *(please describe)*	1	2	3	4	?

Continued on next page

NATIVE AMERICAN CULTURAL ASSESSMENT SURVEY (CONTINUED)

Please use the following scale to express your beliefs regarding the extent to which the following are part of the intake, screening, assessment, treatment, and discharge process for NA clients:

1=Not at All 2=To a Small Extent 3=To a Moderate Extent 4=To a Great Extent ?=Don't Know

1	Screening for diabetes	1	2	3	4	?
2	Screening for HIV, hepatitis C, and other sexually transmitted diseases	1	2	3	4	?
3	Boarding school issues	1	2	3	4	?
4	Racial discrimination issues	1	2	3	4	?
5	Exploration of historical grief issues	1	2	3	4	?
6	Tribal/cultural identity	1	2	3	4	?
7	Knowledge of tribal culture	1	2	3	4	?
8	Levels of participation in tribal culture	1	2	3	4	?
9	Knowledge of tribal history	1	2	3	4	?
10	Knowledge of tribal language	1	2	3	4	?
11	Experiences with purification ceremonies	1	2	3	4	?
12	Experiences with vision quests	1	2	3	4	?
13	Experiences with other cultural ceremonies	1	2	3	4	?
14	Experiences in ceremonies conducted by a NA spiritual leader or medicine person	1	2	3	4	?

Program Needs

Note: If additional space is needed for your responses, please use additional sheets with each of your responses numbered for the appropriate question.

What do you believe are your program's greatest needs to integrate NA cultural and spiritual ways into the treatment regimen?

What do you believe are the greatest cultural and spiritual needs of your NA clients?

Thank you for your participation.

Source: Mackey & Zavadil, 2003a. Adapted with permission.

You can use the Sample Pretest for Non-Native Counselors to assess the knowledge of non-native providers before and after cultural competence training to evaluate how effective the training was in educating providers on key items of American Indian and Alaska Native culture.

SAMPLE PRETEST FOR NON-NATIVE COUNSELORS

1. What is the theoretical basis for the high prevalence of type 2 diabetes among Native American populations?
   a. The shortage of medical personnel (doctors, nurses, etc.) in healthcare facilities on reservations
   b. Being overweight and having insufficient physical activity
   c. A lack of education about the prevention of diabetes
   d. A common virus that is unique to American Indians

2. What are the language dialects of the tribal groups of tribes in your state?
   a. *INSERT*
   b. *APPROPRIATE*
   c. *LANGUAGE*
   d. *GROUPS*

3. "Vision quest" ceremonies are primarily held to:
   a. Learn how to interpret dreams
   b. Learn how to become a medicine person
   c. Treat diabetes and health conditions related to alcohol abuse
   d. Offer prayers

4. In relationships with the federal government, what distinguishes the Native American tribal groups from other ethnic minorities?
   a. Tribal groups have different languages, songs, dances, dress, and customs
   b. Tribal groups live primarily in remote areas
   c. Tribal groups are sovereign nations with their own governments
   d. Tribal groups can be members of the National Congress of American Indians

5. What states are included in the (insert area that includes your state) area of IHS?
   a. *INSERT*
   b. *APPROPRIATE*
   c. *STATES*
   d. *HERE*

6. The primary purpose of sweat lodge ceremonies is to:
   a. Offer prayers
   b. Provide opportunities to learn about tribal lore
   c. Create a sauna-like experience
   d. Offer opportunities for social interaction outside of the treatment setting

7. To be recognized as a Native American by the U.S. federal government, what is the minimum amount of American Indian blood required?
   a. 1/2
   b. 1/3
   c. 1/4
   d. 1/8

Continued on next page

SAMPLE PRETEST FOR NON-NATIVE COUNSELORS (CONTINUED)

8. A pow wow is:
   a. A Native American extended family
   b. A social gathering of Native Americans
   c. A religious ceremony
   d. None of the above

9. Treaties, negotiated between the U.S. government and various tribal nations, usually contained which one of the following provisions?
   a. Tribes ceding lands for various resources (e.g., food, education, health benefits)
   b. The right of the federal government to employ Native Americans as scouts for the U.S. Army
   c. The right of individual Native Americans to vote in national elections
   d. The right for tribal nations to hunt buffalo

10. On the national level, the BIA is a part of the:
   a. Department of Agriculture
   b. Department of Tribal Relations
   c. Department of Justice
   d. Department of the Interior

11. The Indian Reorganization Act was passed in 1934 to:
   a. Establish reservations
   b. Reorganize the BIA
   c. Allow most tribes to manage their own affairs
   d. Establish reservation boundaries

12. Which of the following is NOT a part of Grant's Peace Policy?
   a. Indians were placed on reservations so that the "dictates of humanity and Christian civilization" could be met
   b. Schools and churches were to be established so that Indians would be taught a better way of life
   c. The government would hire "competent, upright and moral" agents to care for the Indians
   d. Profiteers could make money on the supplies needed by the Indians

13. Native American substance abuse programs receive their funding primarily from:
   a. The BIA
   b. The IHS
   c. The Department of Justice
   d. The Congress of American Indians

14. In which year were all American Indians granted U.S. citizenship?
   a. 1924
   b. 1990
   c. 1920
   d. 1936

15. Pan-Indianism as it relates to American Indians is:
   a. The belief that all American Indians are related
   b. A movement that promotes unity of American Indians of all tribes, pueblos, etc.
   c. A Native American musical tradition
   d. None of the above

Continued on next page

SAMPLE PRETEST FOR NON-NATIVE COUNSELORS (CONTINUED)

16. Which of the following is a hypothetical cause of substance abuse among the American Indian population?

a. American Indians have a genetic make-up that makes them more susceptible to substance addiction
b. When the future looks hopeless, risky behaviors such as substance abuse are less costly since there is less to lose
c. Heavy alcohol consumption was adopted as a norm from whites which was then transferred from generation to generation
d. Native American cultural patterns allow heavy alcohol consumption as an acceptable social behavior that produces positive bonding among tribal members
e. All of the above

17. The Native American Freedom of Religion Act of 1978 allowed for Native Americans to:

a. Travel overseas to attend religious events
b. Practice their own tribal spiritual beliefs and practices
c. Become members of various church denominations
d. Become missionaries

18. All restrictions limiting Native Americans' ability to purchase liquor from retail establishments (e.g., bars, saloons, etc.) the same as other U.S. citizens were lifted in which year?

a. 1924
b. 1934
c. 1953
d. 1975

19. Native Americans:

a. Get monthly checks from the U.S. government
b. Get free monies for higher education
c. Get free health care
d. None of the above

20. Historical trauma for Native Americans refers to:

a. Disappointment concerning historical events
b. The idea that traumatic events in the past continue to cause trauma among Native Americans today
c. An attempt to gain reparations for actions of the U.S. government
d. A painful childhood

21. The entities that provide managed health care for Native Americans are:

a. IHS, Tribal Health, BIA, and Public Health
b. IHS, County Government, BIA, and Public Health
c. IHS, BIA, Tribal Government, and Private Clinics
d. IHS, Tribal Health, Urban Indian Health Programs, Veterans Administration, and Medicine People

22. Generally, the preferred learning style of the more traditional Native American is:

a. Visual
b. Kinesthetic
c. Auditory
d. All of the above

Continued on next page

SAMPLE PRETEST FOR NON-NATIVE COUNSELORS (CONTINUED)

23. The Red Road approach to treatment and recovery primarily includes:

a. Adapting the 12 Steps to fit Native American cultural groups
b. The cultural and spiritual ways of Native American tribal groups
c. The services of guest speakers who are knowledgeable about Native American history
d. The cognitive model that includes the book *Wounded Warriors*

24. Which of the following use peyote in their ceremonies?

a. The traditional medicine man
b. The traditional medicine woman
c. The Native American Church
d. None of the above

Answer Key:

1) B	6) A	11) C	16) E	21) D
2) C	7) C	12) D	17) B	22) D
3) D	8) A	13) B	18) B	23) B
4) C	9) A	14) A	19) D	24) C
5) B	10) D	15) D	20) A	

Source: Mackey & Zavadil, 2003b. Adapted with permission.

American Indian and Alaska Native Workforce Development Resources

The following table highlights additional resources available to assist you in your efforts to develop a culturally competent and responsive workforce.

FIRST NATIONS BEHAVIORAL HEALTH ASSOCIATION (FNBHA) LISTING OF NATIVE WORKFORCE DEVELOPMENT PROGRAMS

PROGRAM TITLE/ AUTHOR	DESCRIPTION	OUTCOMES	WEBSITE
Alaskan Rural Human Service Program, University of Alaska Fairbanks and State of Alaska	Paraprofessional training and clinical supervision to serve remote villages with small populations and minimal access to licensed providers. Addresses substance abuse, suicide prevention, social services.	Provided culturally congruent interventions with professional support via telemedicine and scheduled visits.	www.uaf.edu/rhs
Consultation Model With Traditional Healers, IHS policy, PL 95-341. American Indian Religious Freedom Act	IHS and tribally operated health and behavioral health programs. Includes cultural orientation for new staff, providing space and time for ceremonies and linguistic and diagnostic consultations.	Provided licensed and certified care and treatment and local validation process for healers and practices.	www.ihs.gov
Project Making Medicine, Dolores Bigfoot, Ph.D., University of Oklahoma	One year of clinical training for providers for tribally based treatment of child traumatic stress disorders. Includes cultural adaptations of trauma-focused cognitive–behavioral therapy.	Improved local providers' clinical child treatment skills, increased cultural effectiveness of treatment and cultural competence of non-native providers.	———
HHS, Mental Health Technicians, Counselor Aide Positions, IHS	Paraprofessional training with clinical supervision and consultation by licensed staff, funded positions; able to serve as interpreters; may include telemedicine, addressing recruitment and retention issues for rural locations, and language and cultural barriers.	Increased cultural competence of care, career ladder opportunities for tribal providers.	www.ihs.gov

Source: FNBHA, 2009. Adapted with permission.

ADDITIONAL TRAINING AND WORKFORCE DEVELOPMENT RESOURCES

- Information on the effectiveness of the Native American Curriculum for State Accredited, Non-Tribal Mental Health & Substance Abuse Programs in South Dakota training for non-native providers is available in the form of a conference poster (Mackey, Zavadil, Skinstad, Peters, & Summers, 2008) and can be downloaded online (www.888betsoff.com/links/08_presentations/handouts/1B.pdf).
- *Through the Diamond Threshold: Promoting Cultural Competency in Understanding American Indian Substance Misuse* (Robbins, Asetoyer, Nelson, Stilen, & Tall Bear, 2011) includes a number of exercises that can be used with non-native providers and other staff members to better understand issues related to American Indian and Alaska Native behavioral health issues and services. Twelve training activities are included, along with training agendas for using the activities in a half-day, whole-day, or 2-day training.
- The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Tribal Training and Technical Assistance (TTA) Center supports native community self-determination through infrastructure development, capacity building, and program planning and implementation. The TTA website offers a series of training webinars on a variety of behavioral health topics (https://www.samhsa.gov/tribal-ttac/webinars).
- The Alaska Commission for Behavioral Health Certification (ACBHC) has established a process to nominate a traditional provider who offers services in your behavioral health program for lifetime certification. The ACBHC defines a traditional provider as an individual who is either an Alaska Native or who has been raised with traditional values, provided voluntary services, and been a positive force in reducing substance abuse in the community. This certificate is a way to acknowledge and validate the knowledge and wisdom of traditional healers. You can download the application form online (www.akcertification.org/wp-content/uploads/sites/13/2018/08/Traditional-Counselor-Recognition.pdf).

Developing Native EBPs

As you consider developing and implementing EBPs in your behavioral health service program, a good first step is to review current practices and programs that are specifically designed for American Indians and Alaska Natives. The table below presents summaries of these evidence- and practice-based programs and interventions that you might want to consider. It is based on criteria developed by an expert panel at a meeting sponsored by FNBHA in 2008 at Portland State University in Portland, OR.

FNBHA CATALOG OF EFFECTIVE BEHAVIORAL HEALTH PRACTICES FOR TRIBAL COMMUNITIES

Community Prevention and Education; Cultural and Subsistence Skill Development

PROGRAM TITLE/ AUTHOR	DESCRIPTION	OUTCOMES	WEBSITE
Community Readiness Model, National Center for Community Readiness, Colorado State University	Semi-structured surveys of key community stakeholders to assess readiness for prevention or intervention on identified problems including mental health, substance abuse, HIV; all ages	Community outreach, capacity building	www.triethniccenter.colostate.edu/community-readiness-2
Gathering of Native Americans (GONA), Tribal Tech, LLC and Kauffman & Associates, Inc.	Structured 4-day journey to promote community wellness and healing to address a variety of problems including substance abuse, historical trauma, suicide, behavioral health; all ages	Pending	www.samhsa.gov/sites/default/files/gona-goan-curriculum-facilitator-guide.pdf
Cultural Immersion Events: Camps, rides, walks, canoe journeys, fish camps, extended family gatherings, indigenous food and herb gathering, indigenous arts and crafts	Events planned by local tribal populations to address historical trauma, substance abuse, family dysfunction, gangs, teen pregnancies, obesity and diabetes; all ages	Community outreach and engagement; promote healing; increase self-image; strengthen family and community relationships; increase social, recreational, and subsistence skills	———
Circles of Care, University of Colorado and National Indian Child Welfare Association (NICWA)	3-year participatory community training and evaluation to address children and families with emotional problems	Community capacity building, engagement, use of data	www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/coc/Pages/ProgramOverview.aspx and www.nicwa.org

Continued on next page

FNBHA CATALOG OF EFFECTIVE BEHAVIORAL HEALTH PRACTICES FOR TRIBAL COMMUNITIES (CONTINUED)

Early Intervention/Skill Building

PROGRAM TITLE/ AUTHOR	DESCRIPTION	OUTCOMES	WEBSITE
To Live To See the Great Day That Dawns, Department of Health and Human Services (HHS)	Community-based suicide prevention, using a menu of evidence- and culture-based practices	Local workforce training and community mobilization to reduce suicide risk	https://store.samhsa.gov
Positive Indian Parenting, NICWA	Parenting curriculum, developed by American Indian/Alaska Native Organization. Widely adopted and open to local cultural adaptations. Addresses child welfare and early intervention	Increased parenting skills, incorporating tribal cultural features	https://www.nicwa.org/training-institutes
Native H.O.P.E., Clayton Small, Ph.D., and One Sky Center	Native Youth Training Manual, includes school and community screening tools, focusing on suicide prevention	Increasing strengths, identifying warning signs, incorporating culture and ceremony	www.oneskycenter.org/wp-content/uploads/2014/03/NativeHopeYouthTrainingManual_000.pdf

Individual and Family Treatment

PROGRAM TITLE/ AUTHOR	DESCRIPTION	OUTCOMES	WEBSITE
Honoring Children Series, Dolores Bigfoot, Ph.D., University of Oklahoma	Adaptation of Parent–Child Interaction Therapy; mental health promotion addressing child trauma	Improved parenting skills, early childhood intervention of child trauma	www.icctc.org/HCMC%20TFCBT%20Adaptation%200711.pdf
Wraparound in Indian Country, Deb Painte, Native American Training Institute, University of Texas and University of Denver	Family consultation in multidisciplinary care planning; tribal adaptation of practice-based wraparound services	Family and youth advocacy and empowerment	www.nativeinstitute.org
Talking Circles, Public Domain	Facilitated discussion; participants sit in a circle and pass object clockwise, signifying one's turn to speak; addresses substance abuse and mental health issues	Peer support, also used as a type of focus group to engage community interest in a topic	———

Continued on next page

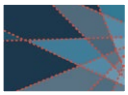
FNBHA CATALOG OF EFFECTIVE BEHAVIORAL HEALTH PRACTICES FOR TRIBAL COMMUNITIES (CONTINUED)

PROGRAM TITLE/ AUTHOR	DESCRIPTION	OUTCOMES	WEBSITE
Equine-Assisted Therapy, Numerous tribal and private-sector practitioners	Equine-assisted therapy for tribes incorporates cultural and historical issues and addresses substance abuse prevention and treatment, developmental disabilities, and incarcerated populations	Increased trust, relationship- and skill building	———

Recovery Services and Supports

PROGRAM TITLE/ AUTHOR	DESCRIPTION	OUTCOMES	WEBSITE
American Indian and Alaska Native 12-step meetings and fellowship, Public Domain	Structured meetings to address alcohol, drug abuse, and gambling addictions; adults and youth	Peer support for sobriety and rehabilitation	www.nai-aa.com
Sobriety Campouts, Public Domain	Intertribal event addressing individual, family, and community substance abuse	Peer support, family and community focus	———
Healing Forest, Wellbriety, Sons and Daughters of Tradition, White Bison, Inc.	Community events and structured prevention and treatment addressing historical trauma, adult and youth substance abuse, violence, self-destructive behaviors	Community healing, reduced substance abuse, mentoring/ skill building for youth	www.whitebison.org
Native American Church, Public Domain	Guided intertribal ceremony	Peer support, community cohesion, cultural enhancement	———
Sobriety pow wows	Intertribal cultural event	Builds social and recreational skills, community cohesion	———
Sweat lodge ceremonies	Spiritual purification ceremony	Builds connection to Creation/Creator	———

Source: FNBHA, 2009. Adapted with permission.



Integrating Care: Traditional Practices in Behavioral Health Programs

As mentioned previously, the American Indian and Alaska Native perspective on healing is holistic. In addition to integrating primary health care and other social services into your program, it is critically important to integrate traditional healing practices and healers into your behavioral health services for American Indian and Alaska Native clients. Likewise, you need to determine what tribal practices to include in American Indian and Alaska Native clients' treatment and recovery plans and evaluate what benefit might be expected from them. This section contains an administrative tool, a Tribal Practice Approval Form, which can help you with this task.

The Oregon Addictions & Mental Health Division (n.d.) has created a process for approving evidence-based tribal practices. The application form and instructions can help you identify, evaluate, and monitor American Indian and Alaska Native cultural and healing practices unique to your tribal community that you might want to include in your behavioral health service program.

OREGON ADDICTIONS & MENTAL HEALTH DIVISION EVIDENCE-BASED PROGRAMS TRIBAL PRACTICE APPROVAL FORM

1. Name of Tribal Practice _____
2. Brief Description _____

   _____

   _____

3. Other Examples of This Tribal Practice *(Replications)*

   _____

   _____

   _____

4. Evidence Basis for the Tribal Practice: Historical/Cultural Connections

   Longevity *("Grandmother test")* _____

   Teachings on which practice is based _____

   Values incorporated in practice _____

   Principles incorporated in practice _____

   Elder's approval of practice *("three elderly women test")* _____

   Community feedback/ evaluation of practice _____

5. Basic Problems (or Goals) Addressed by This Tribal Practice

   _____

   _____

   _____

Continued on next page

OREGON ADDICTIONS & MENTAL HEALTH DIVISION EVIDENCE-BASED PROGRAMS TRIBAL PRACTICE APPROVAL FORM (CONTINUED)

6. Target Populations

_____

_____

_____

7. Risk and Protective Factors Addressed

COMMUNITY:

Risk Factors	Protective Factors

FAMILY:

Risk Factors	Protective Factors

PEER:

Risk Factors	Protective Factors

SCHOOL:

Risk Factors	Protective Factors

INDIVIDUAL:

Risk Factors	Protective Factors

Continued on next page

OREGON ADDICTIONS & MENTAL HEALTH DIVISION EVIDENCE-BASED PROGRAMS TRIBAL PRACTICE APPROVAL FORM (CONTINUED)

8. Tribal Practice—Personnel

_____

_____

_____

9. Tribal Practice—Activities

_____

_____

_____

_____

_____

_____

_____

_____

_____

10. Tribal Practice—Materials

_____

_____

_____

11. Tribal Practice—Optional Elements

_____

_____

_____

12. Outcomes

Longevity *(vs. avoidable death)* _____

Health *(vs. diagnosis-specific morbidity)* _____

Ability *(vs. disability)* _____

Well-being *(vs. pain and suffering)* _____

Social/Community/Cultural Connectedness _____

Abstinence from/nonharmful use of AOD _____

Employment _____

Education _____

Continued on next page

OREGON ADDICTIONS & MENTAL HEALTH DIVISION EVIDENCE-BASED PROGRAMS TRIBAL PRACTICE APPROVAL FORM (CONTINUED)

Healthy family _____

Good behavior *(e.g., noncriminal)* _____

Stable housing _____

Psychological *(attitudes; beliefs; knowledge; skills; lifestyle)* _____

13. Contact Person for Agency Providing the Tribal Practice

Person _____

Phone _____

Email _____

Instructions:

1. **Name of Tribal Practice—**The name of the practice is important. It can be convenient to have the same name reflecting a tribal practice that is used in many tribes (e.g., sweat lodge ceremony). However, every implementation is somewhat different—one canoe journey is not exactly the same as another, even in the same tribe. Identify a name that reflects the tribal practice that you wish to use in your program.
2. **Brief Description of Tribal Practice—**A brief description covers the critical elements of the practice; it is a summary of the specifics in items 5–12: goal; target population; key elements; providers; and outcomes.
3. **Other Examples of the Tribal Practice—**A powerful proof of effectiveness is simply the fact that a tribal practice has been implemented in other locations ("replication"). Give some examples of replication of this practice as a way to establish its potential effectiveness.
4. **Evidence Basis for the Tribal Practice: Historical/Cultural Connections—**Evidence for the validity of a tribal practice is not limited to quantitative research. Other types of evidence increase your knowledge of the effectiveness and validity of practices in local and cultural contexts. In the Native American framework, several specific criteria for valid tribal practices include longevity ("Grandmother test"), teachings on which practice is based, values incorporated in practice, principles incorporated into practice, elder's approval of practice ("three elderly women test"), and community feedback/evaluation of practice.
5. **Program Goal—**Describe one, broadly stated purpose—the intended outcome—for the tribal practice. A goal may be stated as reducing a specific behavioral health problem or as improving health and thriving in some particular way. For example, reduction of a specific mental illness like posttraumatic stress disorder, depression, childhood maladjustment, attention deficit hyperactivity disorder, or co-occurring (substance use and mental) disorders.
6. **Target Population—**Use the Institute of Medicine's Universal, Selective, and Indicated categories to classify your practice. Universal means everyone in a target group whether at risk or not at risk for having a behavioral health problem (e.g., youth). Selective means that the target population for a program is known to be at risk for developing the behavioral health problem (e.g., youth who are children of a parent with a substance abuse problem). Indicated means that the target population consists of individuals who exhibit some signs of the behavioral health problem (e.g., underage drinking youth). In addition, describe the target population in terms of sociodemographics or other characteristics.

Continued on next page

OREGON ADDICTIONS & MENTAL HEALTH DIVISION EVIDENCE-BASED PROGRAMS TRIBAL PRACTICE APPROVAL FORM (CONTINUED)

7. **Risk and Protective Factors**—Describe the risk and protective factors associated with the community, family, peer group, school/workplace, and the individual that are addressed by the tribal practice.
8. **Tribal Practice Personnel**—Describe the personnel (e.g., elders, medicine people, teachers, registered nurses, physicians, certified counselors, volunteers) and their roles and qualifications needed to perform the practice.
9. **Tribal Practice Activities**—Describe the specific and concrete elements of the tribal practice. It is not necessary to include details that are particularly sacred such as the use of specific symbols in sacred sand painting; however, it can be helpful to describe other activities in detail.
10. **Tribal Practice Materials**—Describe the materials you will need to engage in the practice such as a canoe, billboards, brochures, horses, sweat lodge, auditorium, campgrounds, cultural artifacts, etc.
11. **Tribal Practice Optional Elements**—Describe optional materials or elements (e.g., prizes, certificates of completion) for this practice.
12. **Outcomes**—The possible areas in which a tribal practice might have outcomes is listed in the form. For any applicable outcome category, describe what changes the tribal practice will achieve (e.g., Social/Community/Cultural Connectedness might include increased knowledge of cultural songs and prayers, identification of participants with their culture, increased involvement in cultural events [e.g., pow wows]). Identify any available measures of the listed outcomes.
13. **Contact Information**—Provide contact information for the individual responsible for and knowledgeable about the tribal practice.
14. Once you have filled out this form, create a separate document, such as a workbook or manual, that describes the key elements of the practice, the personnel and practice materials required, and outcome measures of the effectiveness of the practice. This document can help you review the evidence, establish credibility with third parties, manage the practice, measure outcomes, and provide technical assistance to other behavioral health service programs that may want to implement similar tribal practices as part of their programs.

Source: Oregon Addictions & Mental Health Division, n.d. Adapted with permission.

A printable version of this form can be downloaded from www.oneskycenter.org/osc/health-care-issues/evidence-based-practices-and-best-practices.

Creating Sustainability

Sustaining programs and systems of behavioral health care is an especially important issue in many American Indian and Alaska Native communities, where time-limited funding may be available to initiate a new service but not to support long-range services. The self-assessment tool that follows, developed by SAMHSA's Center for Mental Health Services (CMHS) and the Child, Adolescent and Family Branch (2003), is intended to help communities and systems of care (SOCs) plan for sustaining their behavioral health initiatives. The self-assessment tool developed for American Indian and Alaska Native communities and SOCs should be used prior to developing a sustainability plan.

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL

The American Indian/Alaska Native Sustainability Self-Assessment Tool is intended to help you evaluate the progress that your community has made in developing and implementing strategic plans for sustaining an integrated behavioral health SOC and explore barriers that may need to be addressed to move forward. You can use the results of this self-assessment to complete a sustainability strategic plan, assess your community's progress in implementing sustainability plan strategies, or determine changes or modifications to your existing sustainability plan to increase the likelihood for success. This tool is designed to facilitate discussion among stakeholders, including representatives of behavioral health service programs, tribal representatives, and youth/family members. Although this particular tool is focused on assessing sustainability of youth and family services, it could be adapted to assess behavioral health services for adults, as well. The term "tribal" is used broadly throughout this document and refers to the 573 federally recognized American Indian tribes and Alaska Native villages. However, state-recognized tribes and off-reservation native communities may be included as part of the target population of non-native SOC communities.

Consider the following broad questions as you complete this assessment. When exploring SOC elements and sustainability objectives, ask yourself, "Where do we want to be?" and, "What do we want to sustain?" For key indicators of success, ask, "How will we know when we have gotten there?" (For examples of key indicators, see the checklist at the end of this tool.) For progress ratings, use the "rating of progress" scale below. To identify barriers to achievement, ask, "What is standing in the way of our progress?"

Rating of Progress:
1 – No plan to address
2 – Plan developed to address
3 – Early stage of implementing plan
4 – Good progress in implementing plan
5 – Plan fully implemented for sustaining or continuing post-grant

Community: _____ **Date:** _____

Vision and Philosophy

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
A clear vision for sustaining the SOC framework has been defined and disseminated.			
Vision links with and supports local tribal culture.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Through social marketing practices, the needs of tribal children, youth, families, community partners, and stakeholders are integrated into the vision, philosophy, and goals of the SOC.			
The right key stakeholders, representing the diversity of the tribal community served, have been involved in defining and disseminating the vision.			
Clear-cut objectives for the cooperative agreement/grant have been identified through a planning process and are developed and disseminated to tribal leadership and the tribal community.			
SOC values and principles are continually redefining the larger community-based service delivery system.			
A definition for sustainability of the SOC framework to implement change at the policy, system, and practice level has been written in language that supports cultural values and is easily understood by the tribal community and disseminated.			
Ongoing education and training on SOC vision, philosophy, goals, and operation is being provided to tribal leadership, the tribal community, and key stakeholders.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

Service Array

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Services that families and youth (inclusive of the full diversity of the community) prefer and find useful, including integration of traditional practices, are continually being created as needs change.			
Partner agencies and state, federal, tribal, or private resources support or fund the full array of services (including traditional practices).			
Access to appropriate and effective services and supports, including traditional practices, has been increased to meet needs.			
Ongoing mechanisms for providing individualized (with full recognition and support of cultural and linguistic preferences), integrated, and coordinated care are being implemented. Mechanisms include (a) appropriately trained or credentialed paraprofessional or professional staff, (b) supervision and professional development plans for staff, (c) appropriate level of community and cultural knowledge, and (d) incentive and rewards in place for consistency in promotion of SOC principles in family services.			
Mechanisms are in place to assure a service array that meets the relevant needs of the demographics of the community (based on age, race, ethnicity, language, spiritual identity, physical ability/disability, language, legal status, etc.).			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Ongoing mechanisms have been developed to decrease reliance on out-of-community and out-of-state placements and are being implemented. Includes a strong link with tribal courts, tribal child welfare, juvenile and other jurisdictional decision-makers; tracking decreases in the number of out-of-community placements; tracking increases in the number of in-community placement resources; and ensuring that in-community placement resources have adequate resources and a high level of family involvement.			
Ongoing training and technical assistance on culturally and linguistically competent service delivery, and on culturally and linguistically competent evidence-based and promising practices to SOC staff, family members, youth, community providers, and other stakeholders is being provided within the context of a well-thought out, long-term training plan.			

Management and Coordination

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Centralized location for management of SOC implementation has been identified and is fully operational.			
Leadership for sustainability of SOC implementation efforts is maintained with a focus on continuity through continual training, workforce development, skill-building, and leadership development.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Ongoing mechanisms for using data and evaluation to support planning, development, and maintenance of implementation efforts have been created, with particular emphasis on partnership with the tribal community and ongoing community feedback loops.			
The leadership framework, administrative and service policies, and organizational structures reflect the flexibility and innovation required of an effective SOC.			

Interagency Planning and Coordination

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Ongoing mechanisms for interagency planning and coordination at the state/tribal/territorial and local policy and system level are in place.			
Ongoing, shared administrative processes (e.g., memorandums of agreement) among two or more agencies that involve family members and youth are in place.			

Family and Youth Involvement

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Families and youth (reflective of the full demographics and diversity of the community) are actively involved in policymaking and system reform, and they fill administrative or consultative roles at the system level.			
Families and youth (reflective of the full demographics of the community) are active participants in evaluation efforts.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Families and youth (reflective of the full demographics and diversity of the community) are active participants in evaluation efforts, with good understanding of how the evaluation efforts protect confidentiality and can serve to improve community services.			
Families and youth (reflective of the full demographics and diversity of the community) are involved in the service planning and delivery process, through serving on planning teams or other ways of providing their perspective.			
Families and youth (reflective of the full demographics and diversity of the community) participate in training, both as trainers and as participants in training activities.			
Peer-to-peer support is in place within the local provider network and among the other tribal SOC communities across the country.			

Cultural Competence

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Cultural and linguistic competence is evident at the system, policy, and practice levels and demonstrated by system administrators who value the cultural strengths and cultural resources of the community; service policies that clearly state that the system values and seeks ways to increase partnership with cultural resources; and practices that routinely include the use of cultural resources as part of the treatment/care plan, as appropriate to the family.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Social marketing practices ensure that messages, images, and outreach strategies are culturally and linguistically appropriate.			
Systemwide leadership, including tribal officials, is committed to continuing the lead for change processes that result in culturally competent services that families respond to positively.			
Cultural and linguistic competence is adopted as a personal mission for each individual staff person and volunteer involved in the SOC network.			
Policies are established that ensure cultural and linguistic competence is the required standard of service.			
Structures are established to ensure the planning and implementation of culturally and linguistically competent services.			
Adequate resources—spiritual, cultural, financial, personnel, and volunteer—to support cultural and linguistic competence are established.			
The service array is constructed to provide appropriate and acceptable services tailored for, and responsive to, the unique range of families served by the SOC.			
Management information systems (MIS) are designed to track services (with consideration of the cultural appropriateness and usefulness of counting traditional practices), clinical and functional outcomes, and service satisfaction based on the unique demographics of persons served.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Quality management/quality improvement systems are designed to measure impact of services tailored to the unique demographics of the community.			
Cultural competence is infused into the core plans and operations of agencies, programs, and organizations involved in the SOC.			
Diverse cultural and linguistic communities are meaningfully involved in all components of the SOC: planning, administration, care coordination, service provision, and evaluation, etc.			
Cultural competence is a focus of systemwide collaboration.			
Mechanisms are in place to support attitudinal change of all members of the system (tribal governance, executive, tribal and nontribal provider, practitioner, families and youth, community at large).			
Mechanisms are in place to facilitate continual cultural knowledge development of all members of the SOC at institutional, supervisory, and individual levels.			
Mechanisms are in place to provide linguistic access throughout the entire system in compliance with Title VI of the Civil Rights Act and to others with limitations in communication (e.g., limited literacy or disability).			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

Political and Economic Support

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
An analysis has been conducted to determine the full range of financial and other available resources that have been, or could be, available to sustain the SOC.			
Partnerships at federal, state, tribal, and other local levels are developed and maintained to effect mutually beneficial outcomes.			
Tribal community members have been involved in interpreting the findings of their community's evaluation effort, and the findings are integrated in the design and implementation of the SOC framework.			
Key stakeholders representing the diversity of the community (including federal, state, tribal, and local public officials) are involved in the initiative and are committed to sustaining and expanding the SOC.			
Political and policy-level support for the SOC approach has been generated at the federal, state, tribal, and local level.			
Policies have been reformed or developed to support system change at the federal, state, tribal, and local levels to sustain the initiative.			
Coalition-building among advocates, including those representing specific cultural, racial, ethnic, linguistic, religious, and other communities, is being supported to impact change.			
Strong interagency relationships, both within and outside of the tribal community, are being cultivated or are in place.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
A strong family organization that reflects and effectively supports the diversity of families in the community is evolving or in place and is supported by the community at large.			
The SOC framework and its values and principles are infused within the broad tribal service delivery system.			

Strategic Financing Strategies

SOC ELEMENTS AND SUSTAINABILITY OBJECTIVES	KEY INDICATORS OF SUCCESS	PROGRESS RATING	BARRIERS TO ACHIEVEMENT
Determination of available financial resources (known and untapped), including matched resources, is being conducted.			
A plan for maximizing federal, state, tribal, and other local revenue is in place and is being implemented.			
Strategies for creating more flexibility in existing funding streams have been developed and implemented.			
Partnerships among the tribal–public–private sectors have been developed.			
Financing strategies are developed that ensure continued access to appropriate and acceptable services for all demographic groups within the community.			

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

Roster of Participants:

As members of the community, we actively participated in completing the Sustainability Self-Assessment Tool. List all participants, including each participant's Name, Agency Affiliation or Youth/Family Member, and Date.

Name	Agency Affiliation or Youth/Family Member	Date

Examples of Key Indicators for Some of the Attributes of the SOC Framework

Service array

- ☐ Services focus on both the individual and the tribe.
- ☐ Service staff is available during times convenient and acceptable to families.
- ☐ Services are provided at locations convenient to families and at locations of the families' choosing (e.g., homes, schools, tribal centers, or other community-based settings).
- ☐ The service array recognizes the value and strength of families' cultures and includes culture-based services.
- ☐ Transportation is provided.
- ☐ Childcare is provided.
- ☐ Families are aware of the referral process and can self-refer into the service delivery system.
- ☐ Flexible funds are in place to meet unique needs, including traditional practices.
- ☐ Service plans are individualized according to the child's and family's strengths and needs.
- ☐ Crisis and transition plans are provided as part of the treatment planning process.
- ☐ Staff, families, and youth have been trained on the process for linking strengths with needs to develop service plans and coordinate care.

Management and coordination

- ☐ Current program leaders are supported by the formal tribal leadership and tribal community and report reduced stress.
- ☐ New generations of leaders are identified and reflect the diversity of the community served.
- ☐ Training and support of all leaders involved in the effort is being conducted, resulting in decreased staff turnover and increased job satisfaction.
- ☐ Clinical reviews, fiscal oversight, management monitoring, and quality improvement processes are in place.
- ☐ A social marketing plan is completed, detailing how the appropriate use of data can positively impact state and local policy.

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

Interagency planning and coordination

- ☐ Interagency structure is in place and meetings are conducted among tribal and relevant nontribal organizations for system-level policy, planning, and coordination purposes.
- ☐ Training curriculums and materials are developed jointly by cooperating agencies and organizations.
- ☐ Joint training is conducted with staff of cooperating agencies and organizations.
- ☐ Staff are shared or coordinated between cooperating agencies and organizations.
- ☐ Staff are out-stationed or co-located at cooperating agencies and organizations.
- ☐ Procedures for pooling, blending, or braiding of funds across agencies are established.
- ☐ Process for cross-system communication is in place.
- ☐ Interagency service and treatment planning meetings are conducted regularly.
- ☐ Interagency case/care management and case/care review meetings are conducted regularly.
- ☐ Joint staff meetings are conducted.
- ☐ Joint hiring/recruitment of staff is conducted that reflects the diversity of the population served.
- ☐ Professional development and credentialing are a joint effort between tribal organizations and local colleges.
- ☐ Interagency cooperation is in place for shared administrative forms, unified case records, integrated MIS, and joint administrative/system implementation meetings.

Family and youth involvement

- ☐ Families and youth are hired as part of the administrative team or the service, marketing, evaluation, or cultural competency teams.
- ☐ Families and youth are provided with information, enabling them to actively advocate for policy, system, and practice change.
- ☐ Families and youth are involved in reforming existing policies.
- ☐ Families and youth are represented on governing and policy bodies and committees.
- ☐ Family members and youth attend meetings and receive stipends for childcare, transportation, and other assistance that enables their full participation.
- ☐ Family members and youth are involved in developing and providing training to service providers.
- ☐ Family members and youth are involved in recruiting, interviewing, and selection of agency staff.
- ☐ Families and youth are involved in data gathering.
- ☐ Families and youth are part of a process for reviewing outcome and evaluative data.
- ☐ Families and youth are part of the management team process to review the data for quality improvement purposes and to develop services and supports.
- ☐ Family members and youth are partners in service planning meetings.
- ☐ Family members and youth may include or exclude the participation of specific individuals in the service planning process.
- ☐ Family members and youth identify and prioritize problems, concerns, or challenges and develop goals.
- ☐ Youth and families have been trained to understand how data can be used effectively to advocate for programs and services.
- ☐ Youth and families have received training on various topics related to advocacy, funding sources, multisystems, governance board participation, policy development, and the evaluation process.

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

- ☐ Youth groups and family organizations have marketable skills needed by community organizations that sustain their involvement.
- ☐ Youth groups and family organizations have partnered with community organizations to gain financial and philosophical support.
- ☐ Youth are supported by other youth through youth groups and peer mentoring.
- ☐ Other family members and the family organization support families.

Cultural competence

- ☐ Tribal people help to plan and implement effective, appropriate, and acceptable services.
- ☐ Tribal organizations and other tribal community groups are involved in providing services, developing the service array, and advising providers.
- ☐ Recruitment and hiring of staff is conducted in a way that staff fit with the cultural background of the children/families served.
- ☐ Staff training in cultural competence is conducted for all staff and volunteers at all levels on an ongoing basis.
- ☐ Youth and family culture and background are assessed in service planning, including things that are important to them such as spirituality, religion, tribal culture/traditions/beliefs, family traditions, community definition of wellness, beliefs about health and illness, and sexual orientation.
- ☐ Services are adapted to respond to the cultural perspective of each child, youth, and family.
- ☐ A mission statement is in place that articulates principles, rationale, and values for providing culturally and linguistically competent services and supports.
- ☐ Processes to systematically review policies and procedures are in place to assess how they support the consistent delivery of culturally and linguistically competent services to tribal families.
- ☐ Policies and procedures are in place to periodically review the current and emergent demographic, sociocultural, economic, organizational, institutional, and political trends in the geographic area.
- ☐ Requirements are established that contracting procedures, funding proposals, and requests for services include performance criteria for culturally and linguistically competent practices.
- ☐ Dedicated structures (e.g., committees, task forces, work groups) are in place with the charge to facilitate the infusion of cultural and linguistic competence elements at all levels of the organization.
- ☐ Cultural learning for all staff is designed on an individualized basis to include self-assessment of knowledge of the tribal community, guidance and appropriate exposure to the spiritual and cultural values of the community, participation in cultural and community events, formal training (e.g., workshops, courses, seminars, etc.), and use of cultural brokers, spiritual guides, and other community consultants.
- ☐ Key documents are translated into languages that are predominant in the community, especially documents that must be signed or have legal or service access implications (including implications for confidentiality).
- ☐ Marketing materials positively reflect the cultural strengths of the community.
- ☐ Appropriately trained interpreters (e.g., in mental health and interpretation) are on staff or on call for face-to-face and telephone interpretive services.
- ☐ Leadership toward change is evident at policy, administration, practice, community, and family levels.

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

Political and economic support

- ☐ Process to assess the current and future economic health of the community, including job viability for families, is in place and considered as services are developed.
- ☐ Strong and positive relationships exist between SOC leadership and key tribal, state, and federal leaders.
- ☐ Tribal, state, and U.S. congressional elected officials respect and know the tribal SOC.
- ☐ Process to assess leadership decision-making and power styles of stakeholders and the impact on the tribal SOC is in place.
- ☐ Tribal, state, and national election dates are known, and the impact on the tribal SOC is considered.
- ☐ Tribal SOC models: self-determination; equal partnerships between nontribal and tribal partners; leadership welcomed from all levels of the community; and the tribal community demonstrates that it buys in to the SOC.
- ☐ Tribal institutional leadership is stable and supportive of SOC principles.
- ☐ Tribal institutions have structures, policies, and procedures that match the cultural norm (tribal institutions are in sync with tribal values).
- ☐ Quality improvement process is in place for administrative and program practices and used on a regularly scheduled basis.
- ☐ Clinical and fiscal utilization management is in place.
- ☐ Quality assurance is managed through a process incorporating families and youth.
- ☐ Social marketing plan is in place, utilizing data as a means to impact policy change.

Strategic financing strategies

Assessment:

- ☐ Determination of all available (known and untapped) funds and matched dollars assessed.
- ☐ Full understanding of the financial strengths and challenges of an SOC developed within a clinic setting, as opposed to a nonclinic setting.
- ☐ Ability to redeploy funds is assessed as is the potential impact of redeployment on the community's well-being.

Partnerships:

- ☐ Relationships developed with other child-serving system leaders to start discussion of the benefits of pooled resources to expand the fiscal base and leverage funds.
- ☐ Relationship with the state mental health authority in place.
- ☐ Relationship with the state Medicaid office in place.
- ☐ Relationship among tribal–public–private leadership at state and local levels is established and fosters fiscal investments in children and families.

Readiness:

- ☐ Leadership understands the licensing requirements and state-negotiated service categories needed to seek Medicaid or Title IV-E waivers.
- ☐ Programs are operated more efficiently by cutting costs and reinvesting funds.
- ☐ Plan for training, licensing, and credentialing of staff in place, per Medicaid reimbursement requirements.
- ☐ Process in place for peer-to-peer fund development advice from other tribal SOC communities.

Continued on next page

AMERICAN INDIAN/ALASKA NATIVE SUSTAINABILITY SELF-ASSESSMENT TOOL (CONTINUED)

Action:

- ☐ All administration and program staff take responsibility to ensure reasonable program expenditures.
- ☐ Reinvestment is accomplished by allocating funds that can be "saved" through redeployment, refinancing, or reductions in spending, or using in-kind resources.
- ☐ Diversification of funding is accomplished.
- ☐ Federal revenue is leveraged by taking advantage of programs that provide funding contingent on state, local, or private financing.
- ☐ Grants are written and submitted on a regular basis.
- ☐ Funds are pooled, blended, or braided to create unified funding streams.
- ☐ Categorical funding across agencies is coordinated and aligned to support community services.
- ☐ Devolution or de-categorization of funding streams is completed to remove narrow eligibility requirements and rules and to expand array of supports and services currently unavailable to families.
- ☐ Medicaid or Title IV-E waivers are being sought and implemented.
- ☐ Technical assistance is provided to public and private agencies to increase their understanding of what is needed to create and sustain SOC services and supports.

Source: SAMHSA, CMHS, & Child, Adolescent and Family Branch, 2003. Adapted with permission.

The tools presented in this chapter can help you, your staff, and your community build a sustainable program and system of services designed to meet the behavioral health needs of American Indian and Alaska Native clients. As an administrator or program manager, you are in a central position to know which of these tools will best serve your mission and how best to adapt them to your organization's and community's particular needs.

> Let us put our minds together and see what life we can make for our children."
>
> —Sitting Bull (1831–1890), Hunkpapa Lakota

Appendix—Bibliography

Abbott, P. J. (1998). Traditional and Western healing practices for alcoholism in American Indians and Alaska Natives. *Substance Use and Misuse, 33*(13), 2605–2646.

Adekoya, N., Truman, B., & Landen, M. (2015). Incidence of notifiable diseases among American Indians/Alaska Natives—United States, 2007–2011. *Morbidity and Mortality Weekly Report, 64*(1), 16–19.

Alaska Department of Fish and Game. (n.d.). *Subsistence in Alaska: FAQs.* Retrieved August 30, 2016, from www.adfg.alaska.gov/index.cfm?adfg=subsistence.faqs#QA17

Alaska Federal Health Care Partnership. (2015). *Alaska challenges.* Retrieved August 30, 2016, from www.afhcp.org/about/alaska-challenges (page no longer available).

Alaska Native Epidemiology Center. (2014). *Statewide data: Adult binge drinking.* Anchorage, AK: Author.

Alaska Native Knowledge Network. (2006). *Alaska Native values for curriculum: Alaska Native cultures.* Retrieved August 30, 2016, from www.ankn.uaf.edu/ancr/Values/index.html

Aldred, L. (2000). Plastic shamans and Astroturf sundances: New Age commercialization of Native American spirituality. *American Indian Quarterly, 24*(3), 329–352.

Alliance for a Just Society & Council of Athabascan Tribal Governments. (2013). *Survival denied: Stories from Alaska Native families living in a broken system.* Washington, DC: Alliance for a Just Society.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association. (2015). *Interested in practicing in an underserved area?* Retrieved August 30, 2016, from www.apa.org/about/gr/issues/nhsc/practice.aspx

Amnesty International USA. (2007). *Maze of injustice: The failure to protect indigenous women from sexual violence in the USA.* New York, NY: Author.

Ancis, J. R., & Ladany, N. (2001). A multicultural framework for counselor supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd ed., pp. 63–90). New York, NY: Brunner-Routledge.

Anishnawbe Health Toronto. (2000). *Traditional healings.* Toronto, Canada: Author.

Anishnawbe Health Toronto. (2011). *Anishnawbe Health Toronto.* Toronto, Canada: Author.

Armed Forces History Museum. (2013). *The role of Native Americans during World War II.* Retrieved September 26, 2018, from www.lhschools.org/Downloads/Native%20Americans%20in%20WWII.pdf

Arundale, W. (2006). *The healing constellation: A conceptual framework for treating trauma among Athabaskan women in Alaska* [Unpublished doctoral dissertation]. Union Institute and University, Cincinnati, OH.

Association of American Medical Colleges. (2005). *Cultural competence education.* Washington, DC: Author.

Attneave, C. L. (1969). Therapy in tribal settings and urban network intervention. *Family Process, 8*(2), 192–210.

Austin, A. (2013). *High unemployment means Native Americans are still waiting for an economic recovery* (Issue Brief 372). Washington, DC: Economic Policy Institute.

Bachman, R., Zaykowski, H., Kallmyer, R., Poteyeva, M., & Lanier, C. (2008). *Violence against American Indian and Alaska Native women and the criminal justice response: What is known* (Document No. 223691). Washington, DC: National Criminal Justice Reference Service.

Bastian, D. E., & Mitchell, J. K. (2004). *Handbook of Native American mythology. Handbooks of World Mythology.* Santa Barbara, CA: ABC-CLIO.

Battiste, M. (Ed.). *Reclaiming indigenous voice and vision.* (2000). Vancouver, Canada: University of British Columbia Press.

Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental health disparities in a national context. *American Journal of Psychiatry, 162*(9), 1723–1732.

Benedict, R., & Mead, M. (1959). *An anthropologist at work: Writings of Ruth Benedict.* Boston, MA: Houghton Mifflin.

Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision.* Boston, MA: Pearson Education.

Bigby, J., & American College of Physicians. (2003). *Cross-cultural medicine.* Philadelphia, PA: American College of Physicians.

Bigfoot, D. S., & Funderburk, B. W. (2011). Honoring children, making relatives: The cultural translation of parent-child interaction therapy for American Indian and Alaska Native families. *Journal of Psychoactive Drugs, 43*(4), 309–318.

Black Elk & Neihardt, J. G. (1932). *Black Elk speaks.* New York, NY: W. Morrow.

Brave Heart, M. Y. H. (1998). *Historical trauma and unresolved grief intervention: Implications for clinical research and practice with indigenous peoples of the Americas* [PowerPoint presentation]. Retrieved September 25, 2018, from www.ihs.gov/telebehavioral/includes/themes/newihstheme/display_objects/documents/slides/historicaltrauma/historicaltraumaintro_011113.pdf

Brave Heart, M. Y. H. (1999). Gender differences in the historical trauma response among the Lakota. *Journal of Health and Social Policy, 10*(4), 1–20.

Brave Heart, M. Y. H. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7–13.

Brave Heart, M. Y. H. (2005). From intergenerational trauma to intergenerational healing: A teaching about how it works and how we can heal. *Wellbriety, 6*(6), 1–8.

Brave Heart, M. Y. H., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs, 43*(4), 282–290.

Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*, 60–82.

Breiding, M. J., Chen, J., & Black, M. C. (2014). *Intimate partner violence in the United States—2010.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Britten, T. A. (1997). *American Indians in World War I.* Albuquerque: University of New Mexico Press.

Brown, J. E., & Cousins, E. (2001). *Teaching spirits: Understanding Native American religious traditions.* Oxford, England: Oxford University Press.

Campbell, B. (2013). Corbell settlement finalized after years of litigation: Victory at last? *American Indian Law Review, 37*(2), 629–647.

Campinha-Bacote, J., Claymore-Cuny, D., Cora-Bramble, D., Gilbert, J., Husbands, R. M., Like, R. C., … Tang, G. (2005). *Transforming the face of health professions through cultural and linguistic competence education: The role of the HRSA Centers of Excellence.* Washington, DC: Department of Health and Human Services, Health Resources and Services Administration.

Castro, F. G. (1998). Cultural competence training in clinical psychology: Assessment, clinical intervention, and research. In A. S. Bellack & M. Hersen (Editors in Chief and Vol. Eds.), *Comprehensive Clinical Psychology: Vol. 10, Sociocultural and individual differences* (pp. 127–140). Oxford, England: Pergamon.

Census Bureau. (2015). *Profile America Facts for Features: American Indian and Alaska Native Heritage Month: November 2015.* Washington, DC: Author.

Census Bureau. (2016). *Profile America Facts for Features: American Indian and Alaska Native Heritage Month: November 2016.* Washington, DC: Author.

Census Bureau. (2018). *2017 American Community Survey 1-year estimates.* Washington, DC: Author.

Census Bureau, Population Division. (2018). *Annual estimates of the resident population: April 1, 2010 to July 1, 2017.* Washington, DC: Author.

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health.* NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Military History, United States Army. (2011). *Native American Medal of Honor recipients.* Retrieved September 25, 2018, from https://history.army.mil/html/topics/natam/natam-moh.html

Center for Substance Abuse Treatment. (2009a). *Clinical supervision and professional development of the substance abuse counselor.* Treatment Improvement Protocol (TIP) Series 52. HHS Publication No. (SMA) 14-4435. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2009b). *Substance abuse treatment: Addressing the specific needs of women.* Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Centers for Disease Control and Prevention. (2008). Alcohol-attributable deaths and years of potential life lost among American Indians and Alaska Natives—United States, 2001–2005. *Morbidity and Mortality Weekly Report, 57*(34), 938–941.

Centers for Disease Control and Prevention. (2014). *Fact sheet: Binge drinking.* Atlanta, GA: Author.

Chadwick, J. Q., Copeland, K. C., Daniel, M. R., Erb-Alvarez, J. A., Felton, B. A., Khan, S. I., ... Payan, M. L. (2014). Partnering in research: A national research trial exemplifying effective collaboration with American Indian nations and the Indian Health Service. *American Journal of Epidemiology, 180*(12), 1202–1207.

Chandler, M. J., & Lalonde, C. E. (2008). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In L. Kirmayer & G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 221–248). Vancouver, Canada: University of British Columbia Press.

Chinman, M., Hamilton, A., Butler, B., Knight, E., Murray, S., & Young, A. (2008). *Mental health consumer providers: A guide for clinical staff.* Santa Monica, CA: RAND.

Chino, M., & Debruyn, L. (2006). Building true capacity: Indigenous models for indigenous communities. *American Journal of Public Health, 96*(4), 596–599.

Chipp, C., Dewane, S., Brems, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2011). "If only someone had told me …": Lessons from rural providers. *Journal of Rural Health, 27*(1), 122–130.

Clark, J. D., & Winterowd, C. (2012). Correlates and predictors of binge eating among Native American women. *Journal of Multicultural Counseling and Development, 40*(2), 117–127.

Clark, J. J., Leukefeld, C., & Godlaski, T. (1999). Case management and behavioral contracting: Components of rural substance abuse treatment. *Journal of Substance Abuse Treatment, 17*(4), 293–304.

Clifford, A., McCalman, J., Bainbridge, R., & Tsey, K. (2015). Interventions to improve cultural competency in health care for indigenous peoples of Australia, New Zealand, Canada and the USA: A systematic review. *International Journal for Quality in Health Care, 27*(2), 89–98.

Collins, R. L., & McNair, L. D. (2002). Minority women and alcohol use. *Alcohol Research and Health, 26*(4), 251–256.

Commission on Civil Rights (2004). *Broken promises: Evaluating the Native American health care system.* Washington, DC: Author.

Corey, G., Haynes, R., Moulton, P., & Muratori, M. (2010). Becoming a multiculturally competent supervisor. In *Clinical supervision in the helping professions: A practical guide* (2nd ed., pp. 121–138). Alexandria, VA: American Counseling Association.

Coyhis, D. (2007, March). *Story of the sacred hoop of 100 eagle feathers.* Red Lake, MN: Red Lake Nation Healing Day.

Cruickshank-Penkin, D., & Davidson, M. (1998). *Working with Native American clients in alcoholism and substance abuse: A native and non-native perspective, Trainer's manual.* Albany, NY: New York State Office of Alcoholism and Substance Abuse Services.

Dakil, S. R., Cox, M., Lin, H., & Flores, G. (2011). Racial and ethnic disparities in physical abuse reporting and child protective services interventions in the United States. *Journal of the National Medical Association, 103*(9–10), 926–931.

Deloria, V. (1988). *Custer died for your sins: An Indian manifesto.* Norman: University of Oklahoma Press.

Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General.* HHS Publication No. (SMA) 01-3613. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Department of Health and Human Services. (2003). *Developing cultural competence in disaster mental health programs: Guiding principles and recommendations.* HHS Publication No. (SMA) 03-3828. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Department of Health and Human Services. (2010). *To live to see the great day that dawns: Preventing suicide by American Indian and Alaska Native youth and young adults.* HHS Publication (SMA) 10-4480, CMHS-NSPL-0196. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2002). *Understanding our users: How to better deliver health information online to American Indians and Alaska Natives; Report on evaluation set-aside project tailoring web sites for special populations.* Washington, DC: Author.

Department of Health and Human Services, Office of Minority Health. (2018). *Profile: American Indian/Alaska Native.* Retrieved September 24, 2018, from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62

Department of Health and Human Services, Office of the Inspector General. (2011). *Access to mental health services at Indian Health Service and tribal facilities* (OEI-09-08-00580). Washington, DC: Author.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (2005). *Successful strategies for recruiting, training, and utilizing volunteers. A guide for faith- and community-based service providers.* HHS Publication No. (SMA) 05-4005. Rockville, MD: Center for Substance Abuse Treatment.

Department of Housing and Urban Development. (2016). *Emergency shelters and transitional housing.* Retrieved August 30, 2016, from http://portal.hud.gov/hudportal/HUD?src=/states/alaska/homeless/shelters (page no longer available).

Department of Justice, Federal Bureau of Investigation. (2018). *Crime in the United States, 2017: Table 43; Arrests by race and ethnicity, 2017.* Washington, DC: Author.

Department of Labor, Bureau of Labor Statistics. (2018). *Labor force characteristics by race and ethnicity, 2017* (BLS Report 1076). Washington, DC: Author.

Department of the Interior, Office of the Assistant Secretary–Indian Affairs. (2014). *2013 American Indian population and labor force report.* Washington, DC: Author.

Dixon, M., & Iron, P. E. (2006). *Strategies for cultural competency in Indian health care.* Washington, DC: American Public Health Association.

Donovan, D. M., Thomas, L. R., Sigo, R. L., Price, L., Lonczak, H., Lawrence, N., … Bagley, L. (2015). Healing of the canoe: Preliminary results of a culturally tailored intervention to prevent substance abuse and promote tribal identity for native youth in two Pacific Northwest tribes. *American Indian and Alaska Native Mental Health Research, 22*(1), 42–76.

Ducharme, L. J., Knudsen, H. K., & Roman, P. M. (2008). Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support. *Sociological Spectrum, 28*(1), 81–104.

Duran, B., Duran, E., & Brave Heart, M. Y. H. (1998). Native Americans and trauma of history. In R. Thornton (Ed.), *Studying Native America: Problems and prospects* (pp. 60–76). Madison: University of Wisconsin Press.

Duran, B., Oetzel, J., Parker, T., Malcoe, L. H., Lucero, J., & Jiang, Y. (2009). Intimate partner violence and alcohol, drug, and mental disorders among American Indian women in primary care. *American Indian and Alaska Native Mental Health Research, 16*(2), 11–27.

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other native peoples.* In A. E. Ivey & D. W. Sue (Series Eds.), *Multicultural Foundations of Psychology and Counseling.* New York, NY: Teachers College Press.

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology.* Albany, NY: State University of New York Press.

Dutton, B. P. (1983). *American Indians of the Southwest.* Albuquerque: University of New Mexico Press.

Earle, K. A., & Cross, A. (2001). *Child abuse and neglect among American Indian/Alaska Native children: An analysis of existing data.* Seattle, WA: Casey Family Programs.

Eastman, C. A. O. (1907). The school days of an Indian boy: As recalled by himself. *Pennsylvania School Journal, 55*(12), 519–526.

Eastman, S., & Gray, J. S. (2011, August). *Spirituality as a protective factor in American Indian mental health.* Paper presented at the meeting of the American Psychological Association, Washington, DC.

Eby, L. T., Burk, H., & Maher, C. P. (2010). How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover. *Journal of Substance Abuse Treatment, 39*(3), 264–271.

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., … Coyle, D. (2006). Clinical supervision and burnout: The influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing, 15*(8), 1007–1015.

Ehlers, C. L., Gizer, I. R., Gilder, D. A., Ellingson, J. M., & Yehuda, R. (2013). Measuring historical trauma in an American Indian community sample: Contributions of substance dependence, affective disorder, conduct disorder and PTSD. *Drug and Alcohol Dependence, 133*(1), 180–187.

Ehlers, C. L., Gizer, I. R., Gilder, D. A., & Yehuda, R. (2013). Lifetime history of traumatic events in an American Indian community sample: Heritability and relation to substance dependence, affective disorder, conduct disorder and PTSD. *Journal of Psychiatric Research, 47*(2), 155–161.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence, 23*(3), 316–338.

First Alaskan Institute. (n.d.). *Culture Camp directory and resource guide: Alaska Native Culture Camps.* Retrieved September 19, 2018, from https://firstalaskans.org/wp-content/uploads/2014/03/spirtcamp5.pdf

First Nations Behavioral Health Association. (2009). *FNBHA catalogue of effective behavioral health practices for tribal communities.* Bellingham, WA: Author.

Fisher, D. G., Pearce, F. W., Statz, D. J., & Wood, M. M. (2003). Employment retention of health care providers in frontier areas of Alaska. *International Journal of Circumpolar Health, 62*(4), 423–435.

Fisher, P. A., & Ball, T. J. (2003). Tribal participatory research: Mechanisms of a collaborative model. *American Journal of Community Psychology, 32*(3–4), 207–216.

Flies-Away, J. T., Garrow, C., & Sekaquaptewa, P. (2014). *Tribal healing to wellness courts: The key components* (2nd ed.). West Hollywood, CA: Tribal Law and Policy Institute.

Galanter, M. (1999). *Network therapy for alcohol and drug abuse* (Expanded ed.). New York, NY: Guilford Press.

Garner, B. R., Funk, R. R., & Hunter, B. D. (2013). The relationship between clinician turnover and adolescent treatment outcomes: An examination from the client perspective. *Journal of Substance Abuse Treatment, 44*(4), 444–448.

Garrett, M. (1999). Understanding the "medicine" of Native American traditional values: An integrative review. *Counseling and Values, 43*(2), 84–98.

Garrett, M. T., & Pichette, E. F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. *Journal of Counseling and Development, 78*(1), 3–13.

Garroutte, E. M., Goldberg, J., Beals, J., Herrell, R., & Manson, S. M. (2003). Spirituality and attempted suicide among American Indians. *Social Science and Medicine, 56*(7), 1571–1579.

Glisson, C., Schoenwald, S. K., Kelleher, K., Landsverk, J., Hoagwood, K. E., Mayberg, S., … The Research Network on Youth Mental Health. (2008). Therapist turnover and new program sustainability in mental health clinics as a function of organizational culture, climate, and service structure. *Administration and Policy in Mental Health, 35*(1–2), 124–133.

Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology: Research and Practice, 35*(1), 10–18.

Gone, J. P. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. *Transcultural Psychiatry, 50*(5), 683–706.

Gone, J. P., & Alcantara, C. (2005). Practice makes perfect? Identifying effective psychological treatments for mental health problems in Indian country. In E. H. Hawkins & R. D. Walker (Eds.), *Best practices in behavioral health services for American Indians and Alaska Natives* (pp. 113–142). Portland, OR: One Sky Center.

Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology, 8,* 131–160.

Goodkind, J. R., Lanoue, M. D., & Milford, J. (2010). Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth. *Journal of Clinical Child and Adolescent Psychology, 39*(6), 858–872.

Gray, J. S., & Rose, W. J. (2012). Cultural adaptation for therapy with American Indians and Alaska Natives. *Journal of Multicultural Counseling and Development, 40*(2), 82–92.

Greene, B. (1989). *Homecoming: When the soldiers returned from Vietnam.* New York, NY: Putnam.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy (Chicago), 43*(4), 531–548.

Gurley, D., Novins, D. K., Jones, M. C., Beals, J., Shore, J. H., & Manson, S. M. (2001). Comparative use of biomedical services and traditional healing options by American Indian veterans. *Psychiatric Services, 52,* 68–74.

Hammond, W. (2010). *Principles of strength-based practice.* Calgary, Canada: Resiliency Initiatives.

Harding, A., Harper, B., Stone, D., O'Neill, C., Berger, P., Harris, S., & Donatuto, J. (2012). Conducting research with tribal communities: Sovereignty, ethics, and data-sharing issues. *Environmental Health Perspectives, 120*(1), 6–10.

Harrell, E. (2012). *Violent victimization committed by strangers, 1993–2010* (NCJ 239424). Washington, DC: Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Hartmann, W. E., & Gone, J. P. (2012). Incorporating traditional healing into an urban American Indian health organization: A case study of community member perspectives. *Journal of Counseling Psychology, 59*(4), 542–554.

Hawkins, E. H., & Walker, R. D. (2005). *Best practices in behavioral health services for American Indians and Alaska Natives.* Portland, OR: One Sky National Resource Center.

Hays, H., Carroll, M., Ferguson, S., Fore, C., & Horton, M. (2014). The success of telehealth care in the Indian Health Service. *Virtual Mentor, 16*(12), 986–996.

Health Research & Educational Trust. (2013). *Becoming a culturally competent health care organization.* Chicago, IL: Author.

Henderson, J. A. (2009). Legitimacy and contextual issues in traditional Lakota Sioux healing. In M. Incayawar, R. Wintrob, & L. Bouchard (Eds.), *Psychiatrists and traditional healers* (pp. 13–24). Hoboken, NJ: Wiley.

Henry, M., Watt, R., Rosenthal, L., & Shivji, A. (2017). *The 2017 Annual Homeless Assessment Report (AHAR) to Congress.* Washington, DC: Department of Housing and Urban Development.

Hilty, D. M., Luo, J. S., Morache, C., Marcelo, D. A., & Nesbitt, T. S. (2002). Telepsychiatry: An overview for psychiatrists. *CNS Drugs, 16*(8), 527–548.

Hilty, D. M., Marks, S. L., Urness, D., Yellowlees, P. M., & Nesbitt, T. S. (2004). Clinical and educational telepsychiatry applications: A review. *Canadian Journal of Psychiatry, 49*(1), 12–23.

Hilty, D. M., Nesbitt, T. S., Kuenneth, C. A., Cruz, G. M., & Hales, R. E. (2007). Rural versus suburban primary care needs, utilization, and satisfaction with telepsychiatric consultation. *Journal of Rural Health, 23*(2), 163–165.

Hilty, D. M., Yellowlees, P. M., Cobb, H. C., Bourgeois, J. A., Neufeld, J. D., & Nesbitt, T. S. (2006). Models of telepsychiatric consultation–liaison service to rural primary care. *Psychosomatics, 47*(2), 152–157.

Hirschfelder, A. B., & de Montaño, M. K. (1993). *The Native American almanac: A portrait of Native America today* (1st ed.). New York, NY: Prentice Hall General Reference.

Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). *An action plan on behavioral health workforce development.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

Hopper, F. (2015, July 20). Facebook group connects homeless Alaska Natives and their families. *Indian Country Today*. Available from https://newsmaven.io/indiancountrytoday/archive/facebook-group-connects-homeless-alaska-natives-and-their-families-ncvOn4yQxUyJy9s_nsH0yA

Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs; Bureau of Indian Affairs Notice, 83 Fed. Reg. 34863 (July 23, 2018).

Indian Health Service. (n.d.). *Alaska Area* [Factsheet]. Retrieved September 21, 2018, from www.ihs.gov/alaska/includes/themes/newihstheme/display_objects/documents/hf/area.pdf

Indian Health Service. (2011). *American Indian/Alaska Native behavioral health briefing book.* Rockville, MD: Author.

Indian Health Service. (2014). *Community liaisons: Paving the way for incoming Indian health professionals* [Brochure]. Rockville, MD: Author.

Indian Health Service. (2015a). *New hire quick reference guide.* Rockville, MD: Author.

Indian Health Service. (2015b). *Trends in Indian health 2014 edition.* Rockville, MD: Author.

Indian Health Service. (2017). *Indian health focus: Injuries 2017 edition.* Rockville, MD: Author.

Indian Law & Order Commission. (2013). *A roadmap for making Native America safer: Report to the President & Congress of the United States.* Los Angeles, CA: Author.

Indian Youth Suicide: Hearing before the Senate Committee on Indian Affairs, 109th Cong. 22 (2006) (testimony of Jo Ann Kauffman, President, Kauffman and Associates, Inc.).

Inman, A. G. (2008, August). *Race and culture in supervision: Challenges and opportunities.* Paper presented at the meeting of the American Psychological Association, Boston, MA.

James, R., Tsosie, R., Sahota, P., Parker, M., Dillard, D., Sylvester, I., … Kiana Group. (2014). Exploring pathways to trust: A tribal perspective on data sharing. *Genetics in Medicine, 16*(11), 820–826.

Jilek-Aall, L. (1981). Acculturation, alcoholism and Indian-style Alcoholics Anonymous. *Journal of Studies on Alcohol Supplement, 9,* 143–158.

Jiwa, A., Kelly, L., & Pierre-Hansen, N. (2008). Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance abuse programs. *Canadian Family Physician, 54*(7), 1000.

Johnston, S. L. (2002). Native American traditional and alternative medicine. *Annals of the American Academy of Political and Social Science, 583*(1), 195–213.

Jones, P., & Williams, A. M. (2007). *Self care: A guide for addiction professionals.* Silver Spring, MD: Central East Addiction Technology Transfer Center.

Jones, R. S. (1981). *Alaska Native Claims Settlement Act of 1971 (Public Law 92-203): History and analysis together with subsequent amendments* (CRS Report No. 81-127 GOV). Retrieved September 25, 2018, from www.alaskool.org/projects/ancsa/reports/rsjones1981/ancsa_history71.htm

Jumper Thurman, P., Plested, B. A., Edwards, R. W., Foley, R., & Burnside, M. (2004). Community readiness: The journey to community healing. In E. Nebelkopf & M. Phillips (Eds.), *Healing and mental health for Native Americans: Speaking in red* (pp. 77–86). Walnut Creek, CA: AltaMira Press.

Kadis, J. (2014). Workforce planning: How to recruit and retain mental health workers. *Community Living Briefs, 2*(1), 1–9.

Kalt, J. P., Cornell, S., Henson, E. C., Taylor, J. B., Curtis, C., Grant, K. W., … Lee, A. J. (2008). *The state of the native nations: Conditions under U.S. policies of self-determination; The Harvard Project on American Indian Economic Development.* New York, NY: Oxford University Press.

Katz, C. L., & Schuetz-Mueller, J. (2015). *A guide to global mental health practice: Seeing the unseen.* New York: Routledge.

Katz, J. R., O'Neal, G., Strickland, C. J., & Doutrich, D. (2010). Retention of Native American nurses working in their communities. *Journal of Transcultural Nursing, 21*(4), 393–401.

Kaufman, C. E., Beals, J., Croy, C., Jiang, L., & Novins, D. K. (2013). Multilevel context of depression in two American Indian tribes. *Journal of Consulting and Clinical Psychology, 81*(6), 1040–1051.

Keltner, B., Kelley, F. J., & Smith, D. (2004). Leadership to reduce health disparities: A model for nursing leadership in American Indian communities. *Nursing Administration Quarterly, 28*(3), 181–190.

Kim, C. (2000). Recruitment and retention in the Navajo Area Indian Health Service. *Western Journal of Medicine, 173*(4), 240–243.

King, J., Trimble, J. E., Morse, G. S., & Thomas, L. R. (2014). North American Indian and Alaska Native spirituality and psychotherapy. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (2nd ed., pp. 451–471). Washington, DC: American Psychological Association.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *Lancet, 374*(9683), 76–85.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of Substance Abuse Treatment, 35*(4), 387–395.

Knudsen, H. K., Johnson, J. A., & Roman, P. M. (2003). Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment, 24*(2), 129–135.

Kochanek, K. D., Murphy, S. L., Xu, J., & Tejada-Vera, B. (2016). Deaths: Final data for 2014. *National Vital Statistics Reports, 65*(4), 1–122.

Korhonen, M. (2006). *Suicide prevention: Inuit traditional practices that encouraged resilience and coping.* Ottawa, Canada: National Aboriginal Health Organization.

Korsmo, F. L. (1994). The Alaska Natives. In F. L. Korsmo (Ed.), *Polar peoples: Self-determination and development* (pp. 81–104). London, England: Minority Rights Group.

LaBelle, J. (2005). *Boarding school: Historical trauma among Alaska's native people.* Anchorage, AK: National Resource Center for American Indian, Alaska Native, and Native Hawaiian Elders.

LaFromboise, T. (1995). *Counseling and therapy with Native American Indians* [Video]. Available from https://search.alexanderstreet.com/preview/work/bibliographic_entity%7Cvideo_work%7C1778779?ssotoken=anonymous

LaFromboise, T. D., & Fleming, C. (1990). Keeper of the fire: A profile of Carolyn Attneave. *Journal of Counseling and Development, 68*(5), 537–547.

Langdon, S. J. (2002). *The native people of Alaska: Traditional living in a northern land.* Homer, AK: Wizard Works.

Le, T. N., & Gobert, J. M. (2013). Translating and implementing a mindfulness-based youth suicide prevention intervention in a Native American community. *Journal of Child and Family Studies, 24,* 12–23.

Lewinsohn, P. M., Antonuccio, D. O., Breckenridge, J. S., & Teri, L. (1984). *The Coping With Depression Course: A psychoeducational intervention for unipolar depression.* Eugene, OR: Castalia.

Libby, A. M., Orton, H. D., Novins, D. K., Beals, J., & Manson, S. M. (2005). Childhood physical and sexual abuse and subsequent depressive and anxiety disorders for two American Indian tribes. *Psychological Medicine, 35*(3), 329–340.

Libby, A. M., Orton, H. D., Novins, D. K., Spicer, P., Buchwald, D., Beals, J., … AI-SUPERPFP Team. (2004). Childhood physical and sexual abuse and subsequent alcohol and drug use disorders in two American-Indian tribes. *Journal of Studies on Alcohol, 65*(1), 74–83.

Lobo, S., & Vaughan, M. M. (2003). Substance dependency among homeless American Indians. *Journal of Psychoactive Drugs, 35*(1), 63–70.

Lowe, J., Riggs, C., & Henson, J. (2011). Principles for establishing trust when developing a substance abuse intervention with a Native American community. *Creative Nursing, 17*(2), 68–73.

Lowe, J., & Struthers, R. (2001). A conceptual framework of nursing in Native American culture. *Journal of Nursing Scholarship, 33*(3), 279–283.

Lucero, E. (2011). From tradition to evidence: Decolonization of the evidence-based practice system. *Journal of Psychoactive Drugs, 43*(4), 319–324.

Mackey, D., & Zavadil, F. (2003a). *Native American Cultural Assessment Survey of Accredited Substance Abuse Programs in South Dakota.* Iowa City, IA: Prairielands Addiction Technology Transfer Center.

Mackey, D., & Zavadil, F. (2003b). *Native American curriculum for state accredited, non-tribal substance abuse programs in South Dakota: Pre-test.* Iowa City, IA: Prairielands Addiction Technology Transfer Center.

Mackey, D., Zavadil, F., Skinstad, A. H., Peters, C., & Summers, K. M. (2008). *Outcomes of a Native American cultural education program for non-native counselors.* Poster session presented at the meeting of the Midwest Consortium on Problem Gambling & Substance Abuse. Retrieved September 27, 2018, from www.888betsoff.org/links/08_presentations/handouts/1B.pdf

Manatowa-Bailey, J. (2007). On the brink. *Cultural Survival Quarterly, 31*(2). Retrieved September 19, 2018, from www.culturalsurvival.org/publications/cultural-survival-quarterly/brink

Manson, S. M., Beals, J., Klein, S. A., Croy, C. D., & AI-SUPERPFP Team. (2005). Social epidemiology of trauma among 2 American Indian reservation populations. *American Journal of Public Health, 95*(5), 851–859.

Manson, S. M., & Brenneman, D. L. (1995). Chronic disease among older American Indians: Preventing depressive symptoms and related problems of coping. In D. Padgett (Ed.), *Handbook on ethnicity, aging, and mental health* (pp. 284–303). Westport, CT: Greenwood Press.

Marbella, A. M., Harris, M. C., Diehr, S., Ignace, G., & Ignace, G. (1998). Use of Native American healers among Native American patients in an urban Native American health center. *Archives of Family Medicine, 7*(2), 182–185.

Martin, J. E. (2003). "The greatest evil": Interpretations of Indian prohibition laws, 1832–1953. *Great Plains Quarterly, 23*(1), 35–53.

Martin, S., & Hill, A. (2009, July). *The changing economic status of Alaska Natives, 1970–2007* (Web Note No. 5). Retrieved September 19, 2018, from https://pubs.iseralaska.org/media/991d5687-00f8-4151-ba1a-cae4be5d2346/WebNote5.pdf

Matrix Institute on Addictions. (2014). *Matrix Model: Culturally designed client handouts for American Indians/Native Alaskans.* Los Angeles, CA: Author.

Mays, V. M., Gallardo, M., Shorter-Gooden, K., Robinson-Zanartu, C., Smith, M., McClure, F., … Ahhaity, G. (2009). Expanding the circle: Decreasing American Indian mental health disparities through culturally competent teaching about American Indian mental health. *American Indian Culture and Research Journal, 33*(3), 61–83.

McCormick, R. M. (1998). Ethical considerations in First Nations counselling and research. *Canadian Journal of Counselling, 32*(4), 284–297.

McDonald, J. D., & Gonzales, J. (2006). Cognitive behavioral therapy with American Indians. In P. A. Hays & G. Iwamasa (Eds.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (1st ed., pp. 23–45). Washington, DC: American Psychological Association.

McFarland, B. H., Gabriel, R. M., Bigelow, D. A., & Walker, R. D. (2006). Organization and financing of alcohol and substance abuse programs for American Indians and Alaska Natives. *American Journal of Public Health, 96*(8), 1469–1477.

McKay, J. R., Lynch, K. G., Shepard, D. S., & Pettinati, H. M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence: 24-month outcomes. *Archives of General Psychiatry, 62*(2), 199–207.

Mehl-Madrona, L. (1997). *Coyote medicine: Lessons from Native American healing.* New York, NY: Scribner.

Mehl-Madrona, L. E. (1999). Native American medicine in the treatment of chronic illness: Developing an integrated program and evaluating its effectiveness. *Alternative Therapies in Health and Medicine, 5*(1), 36–44.

Mehl-Madrona, L., & Mainguy, B. (2014). Introducing healing circles and talking circles into primary care. *Permanente Journal, 18*(2), 4–9.

Meyer, D., Hamel-Lambert, J., Tice, C., Safran, S., Bolon, D., & Rose-Grippa, K. (2005). Recruiting and retaining mental health professionals to rural communities: An interdisciplinary course in Appalachia. *Journal of Rural Health, 21*(1), 86–91.

Middelton-Moz, J. (1989). *Children of trauma: Rediscovering your discarded self.* Deerfield Beach, FL: Health Communications.

Middelton-Moz, J., & Dwinell, L. (2010). *After the tears: Helping adult children of alcoholics heal their childhood trauma* (Rev. and expanded ed.). Deerfield Beach, FL: Health Communications.

Miller, W. R., Meyers, R. J., & Hiller-Sturmhöfel, S. (1999). The community-reinforcement approach. *Alcohol Research and Health, 23*(2), 116–121.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

Miller, W. R., & Rose, S. G. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64*(6), 527–537.

Moghaddam, J. F., & Momper, S. L. (2011). Integrating spiritual and Western treatment modalities in a Native American substance user center: Provider perspectives. *Substance Use and Misuse, 46*(11), 1431–1437.

Mohatt, D. F., Adams, S. J., Bradley, M. M., & Morris, C. D. (2005). *Mental health and rural America: 1994–2005.* Rockville, MD: Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy.

Mohatt, G. V., Fok, C. C. T., Henry, D., People Awakening Team, & Allen, J. (2014). Feasibility of a community intervention for the prevention of suicide and alcohol abuse with Yup'ik Alaska Native youth: The Elluam Tungiinun and Yupiucimta Asvairtuumallerkaa studies. *American Journal of Community Psychology, 54*(1–2), 153–169.

Momaday, N. S. (1976). *The names: A memoir.* New York, NY: Harper & Row.

Morgan, R., & Freeman, L. (2009). The healing of our people: Substance abuse and historical trauma. *Substance Use and Misuse, 44*(1), 84–98.

Moss, R. K., Taylor, T., & May, P. A. (2003). *Robert Wood Johnson Foundation Healthy Nations Initiative evaluation: The stories and lessons of fighting substance abuse in Native American communities.* Princeton, NJ: Robert Wood Johnson Foundation.

Napoleon, H. (1996). *Yuuyaraq: The way of the human being.* Fairbanks: Alaska Native Knowledge Network, University of Alaska Fairbanks.

Naquin, V., Trojan, J., O'Neil, G., & Manson, S. M. (2006). The Therapeutic Village of Care: An Alaska Native alcohol treatment model. *Therapeutic Communities, 27*(1), 106–121.

National American Indian and Alaska Native Addiction Technology Transfer Center. (2015). *American Indian & Alaska Native Leadership Academy 2015–2016: Mentor application.* Iowa City, IA: Author.

National Association of Community Health Centers. (2011). *Clinical recruitment and retention toolkit.* Bethesda, MD: Author.

National Association of Resource & Development Councils. (2007). *Workbook for understanding and improving partnerships with American Indian and Alaska Natives.* Washington, DC: Author.

National Association of State Mental Health Program Directors. (2015). *Assessment #4: Partnering with tribal governments to meet the mental health needs of American Indian/Alaska Native consumers.* Alexandria, VA: Author.

National Center for Health Statistics. (2014). *Health, United States, 2013: With special feature on prescription drugs.* HHS Publication No. 2014-1232. Hyattsville, MD: Author.

National Congress of American Indians. (2006). *Methamphetamines in Indian Country: An American problem uniquely affecting Indian Country.* Washington, DC: Author.

National Drug Court Resource Center. (2012). *What is a Tribal Healing to Wellness Court?* Retrieved August 30, 2016, from http://ndcrc.org/node/351 (page with post no longer available).

National Indian Child Welfare Association. (2015, September). Lessons learned: Observations and reflections on 20 years of tribal systems of care. *Honoring Innovations.* Retrieved October 2, 2018, from www.nicwa.org/wp-content/uploads/2016/11/2015_LessonsLearned_Newsletter.pdf

National Museum of the American Indian. (2007). *Native words, native warriors* [Companion website to exhibit]. Retrieved September 21, 2018, from https://americanindian.si.edu/static/education/codetalkers/html/index.html

National Rural Recruitment and Retention Network. (2013). *Recruiting for retention: The recruitment and retention manual of the National Rural Recruitment and Retention Network, Inc.* (Rev.). Fountain City, WI: Author.

National Urban Indian Family Coalition. (2009). *Urban Indian America: The status of American Indian and Alaska Native children and families today.* Seattle, WA: Author.

Native American Alliance Foundation. (2006). *Tribal healing to wellness court.* Albuquerque, NM: Author.

Native American Center for Excellence. (n.d.). *Steps for conducting research and evaluation in Native communities.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

Nebelkopf, E., & Phillips, M. (Eds.). (2004). *Healing and mental health for Native Americans: Speaking in red.* Walnut Creek, CA: AltaMira Press.

Niven, J. A. (2010). Client-centered, culture-friendly behavioral health care techniques for work with Alaska natives in the Bering Strait region. *Social Work in Mental Health, 8*(4), 398–420.

Northwest Frontier Addiction Technology Transfer Center. (2003). Co-occurring disorders Part 2: Native Americans. *Addiction Messenger, 6*(5), 1–3.

Oetzel, J., & Duran, B. (2004). Intimate partner violence in American Indian and/or Alaska Native communities: A social ecological framework of determinants and interventions. *American Indian and Alaska Native Mental Health Research, 11*, 49–69.

Ogunwole, S. U. (2006). *We the people: American Indians and Alaska Natives in the United States* (CENSR-28). *Census 2000 Special Reports.* Washington, DC: Census Bureau.

Ongtooguk, P. (n.d.). *Alaska's cultures: Alaska Natives fight for civil rights.* Retrieved November 6, 2018, from https://alaskadigitalacademy.org/akh/articles/article498a.html

Oregon Addictions & Mental Health Division. (n.d.). *Oregon Addictions & Mental Health Division Evidence-Based Programs Tribal Practice Approval Form.* Retrieved October 25, 2018, through www.oneskycenter.org/osc/health-care-issues/evidence-based-practices-and-best-practices

Payne, D., Olson, K., & Parrish, J. W. (2013). Pathway to hope: An indigenous approach to healing child sexual abuse. *International Journal of Circumpolar Health, 72*(1).

Peate, W. F. (2003). *Listening with your heart: Lessons from Native America.* Tucson, AZ: Rio Nuevo.

Perry, S. W. (2004). *American Indians and crime: A BJS statistical profile, 1992–2002* (NCJ 203097). Washington, DC: Department of Justice.

Pettit, K. L. S., Kingsley, G. T., Biess, J., Bertumen, K., Pindus, N., Narducci, C., & Budde, A. (2014). *Continuity and change: Demographic, socioeconomic, and housing conditions of American Indians and Alaska Natives.* Washington, DC: Department of Housing and Urban Development.

Pew Forum on Religion & Public Life. (2008). *U.S. Religious Landscape Survey: Religious affiliation; Diverse and dynamic.* Washington, DC: Author.

Picou, J. S. (2000). The "Talking Circle" as sociological practice: Cultural transformation of chronic disaster impacts. *Sociological Practice, 2*(2), 77–97.

Plested, B. A., Jumper-Thurman, P., & Edwards, R. W. (2014). *Community readiness manual on suicide prevention in Native communities (Community Readiness Model handbook)* (Rev. ed.). Retrieved November 6, 2018, from www.samhsa.gov/sites/default/files/tribal_tta_center_.3.b_commreadinessmanual_final_3.6.14.pdf

Poupart, J., Red Horse, J., Martinez, C., & Scharnberg, D. (2001). *To build a bridge: Working with American Indian communities.* St. Paul, MN: American Indian Policy Center.

Pritzker, B. (1998). *Native Americans: An encyclopedia of history, culture, and peoples.* Santa Barbara, CA: ABC-CLIO.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102–1114.

Reese, R. J., Conoley, C. W., & Brossart, D. F. (2002). Effectiveness of telephone counseling: A field-based investigation. *Journal of Counseling Psychology, 49*(2), 233–242.

Reynaga-Abiko, G. (2006). A guide for culturally sensitive clinical practice with Native Americans [Review of the book *Mental health care for urban Indians: Clinical insights from native practitioners* by T. M. Witko (Ed.)]. *PsycCRITIQUES, 51*(34).

Rhoades, E. R. (2009). The Indian Health Service and traditional Indian medicine. *Virtual Mentor, 11*(10), 793–798.

Robbins, R., Asetoyer, D., Nelson, D., Stilen, P., & Tall Bear, C. (2011). *Through the diamond threshold: Promoting cultural competency in understanding American Indian substance misuse.* Kansas City, MO: Mid-America Addiction Technology Transfer Center.

Roebuck, M. (2007). *The strength-based approach: Philosophy and principles for practice*. Cornwall, Canada: Youth Now Intervention Services.

Rosay, A. B. (2016, May). *Violence against American Indian and Alaska Native women and men: 2010 findings from the National Intimate Partner and Sexual Violence Survey* (NCJ 249736). Department of Justice, National Institute of Justice.

Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. *Journal of Substance Abuse Treatment, 40*(1), 67–76.

Saskatchewan Indian Cultural Center. (2014). *Plains Cree elders' quotes*. Retrieved September 24, 2018, from www.sicc.sk.ca/plains-cree-elders-quotes.html

Satir, V., & Baldwin, M. (1983). *Satir step by step: A guide to creating change in families*. Palo Alto, CA: Science and Behavior Books.

Schacht, R. M., & White, M. (2003). Improving employment outcomes for American Indians and Alaska Natives with alcohol dependency: Vocational rehabilitation strategies. *Journal of Ethnicity in Substance Abuse, 2*(4), 31–62.

Sealaska Heritage Institute. (2009). *Sealaska Heritage Institute cultural values*. Juneau, AK: Author.

Shore, J. H., Shore, J. H., & Manson, S. M. (2009). American Indian healers and psychiatrists. In M. Incayawar, R. Wintrob, & L. Bouchard (Eds.), *Psychiatrists and traditional healers: Unwitting partners in global mental health* (pp. 123–134). Hoboken, NJ: Wiley.

Siebens, J., & Julian, T. (2011). *Native North American languages spoken at home in the United States and Puerto Rico: 2006–2010*. Washington, DC: Census Bureau.

Skinstad, A. H. (2013). It takes a village—a community—to help our children stay healthy: Recovery oriented system of care (ROSC) in American Indian and Alaska Native communities. *Prevention and Recovery, 2*(5), 6–7.

Smith, L. T. (1999). Articulating an indigenous research agenda. In L. T. Smith (Ed.), *Decolonizing methodologies: Research and indigenous peoples* (pp. 123–141). London, England: Zed Books.

Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice, 1*(1), 93–108.

Spillane, N. S., & Smith, G. T. (2007). A theory of reservation-dwelling American Indian alcohol use risk. *Psychological Bulletin, 133*(3), 395–418.

Stein, L. I., & Santos, A. B. (1998). *Assertive community treatment of persons with severe mental illness*. New York, NY: Norton.

Stone, R. A., Whitbeck, L. B., Chen, X., Johnson, K., & Olson, D. M. (2006). Traditional practices, traditional spirituality, and alcohol cessation among American Indians. *Journal of Studies on Alcohol, 67*(2), 236–244.

Substance Abuse and Mental Health Services Administration. (2010). *Recovery oriented systems of care (ROSC) resource guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2013a). *Behavioral health services for people who are homeless*. Treatment Improvement Protocol (TIP) Series 55. HHS Publication No. (SMA) 13-4734. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2013b). *Results from the 2012 National Survey on Drug Use and Health: Summary of national findings*. NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014a). *Improving cultural competence*. Treatment Improvement Protocol (TIP) Series 59. HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014b). *Trauma-informed care in behavioral health services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2015). *Using technology-based therapeutic tools in behavioral health services*. Treatment Improvement Protocol (TIP) Series 60. HHS Publication No. (SMA) 15-4924. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, & Child, Adolescent and Family Branch. (2003). *American Indian/Alaska Native Sustainability Strategic Planning Template. American Indian/Alaska Native Sustainability Self-Assessment Tool*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention. (2014). *Building the evaluation capacity of local programs serving American Indian/Alaska Native populations: Lessons learned*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration, Trauma and Justice Strategic Initiative. (2012). *SAMHSA's working definition of trauma and guidance for trauma-informed approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration, Tribal Training and Technical Assistance Center. (2014). *Evidence-based programs and practices handout*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: Wiley.

Sutton, C. T., & Broken Nose, M. A. (1996). American Indian families: An overview. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 31–44). New York, NY: Guilford Press.

Sutton, C. T., & Broken Nose, M. A. (2005). American Indian families: An overview. In M. McGoldrick, J. Giordano, & N. Garcia-Preto (Eds.), *Ethnicity and family therapy* (3rd ed., pp. 43–54). New York, NY: Guilford Press.

Tamminen, A. W., Smaby, M. H., Powless, R. E., & Gum, M. F. (1980). Preparing Native American counselors for the chemically dependent Native American. *Counselor Education and Supervision, 19*, 311–317.

Taylor, J. B., & Kalt, J. P. (2005). *American Indians on reservations: A databook of socioeconomic change between the 1990 and 2000 Censuses.* Cambridge, MA: Harvard Project on American Indian Economic Development.

Thomson, L. (2000). Subsistence: Hunting and fishing rights—an essential part of life for many Native Alaskans—were put in peril with the Alaska Native Claims Settlement Act. *Juneau Empire*. Retrieved October 19, 2018, through http://eastnet1.asdk12.org/~Christopherson_Alaska_Studies3/S00318BCD.18/Booklet_13_Statehood_web.pdf

Tjaden, P., & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey* (NCJ 210346). Washington, DC: Department of Justice, National Institute of Justice.

Tomlin, K., Walker, R. D., & Grover, J. (2014). *Trainer's guide to* Motivational interviewing: Enhancing motivation for change; A learner's manual for the American Indian/Alaska Native counselor. Portland, OR: One Sky Center.

Towle, A., Godolphin, W., & Alexander, T. (2006). Doctor–patient communications in the Aboriginal community: Towards the development of educational programs. *Patient Education and Counseling, 62*(3), 340–346.

Tribal Law & Policy Institute. (2003). *Tribal healing to wellness courts: The key components.* (NCJ 188154). Washington, DC: Department of Justice, Office of Justice Programs.

Trimble, J. E., Scharron-del-Rio, M. R., & Hill, J. S. (2012). Ethical considerations in the application of cultural adaptation models with ethnocultural populations. In G. Bernal (Ed.), *Cultural adaptations: Tools for evidence-based practice with diverse populations* (pp. 45–67). Washington, DC: American Psychological Association.

Tullar, J. M., Amick, B. C., III, Brewer, S., Diamond, P. M., Kelder, S. H., & Mikhail, O. (2016). Improve employee engagement to retain your workforce. *Health Care Management Review, 41*(4), 316–324.

Ukpeagvik Iñupiat Corporation. (2015). Shareholder highlight - Kelsey Campbell Haake. *Nasirvik, 11*(3), 5.

University of Alaska Fairbanks. (2013). *Science in relation to traditional native ways.* Fairbanks, AK: Author.

Urban Indian Health Commission. (2007). *Invisible tribes: Urban Indians and their health in a changing world.* Seattle, WA: Author.

Urban Indian Health Institute. (2008). *Reported health and health-influencing behaviors among urban American Indians and Alaska Natives: An analysis of data collected by the Behavioral Risk Factor Surveillance System.* Seattle, WA: Author.

Urban Indian Health Institute. (2014). *Supporting wellness: Substance abuse services at urban Indian health organizations.* Seattle, WA: Author.

Urban Indian Health Institute, Seattle Indian Health Board. (2015). *Supporting sobriety among American Indians and Alaska Natives: A literature review.* Seattle, WA: Author.

Venner, K. L., Feldstein, S. W., & Tafoya, N. (2006). *Native American motivational interviewing: Weaving Native American and Western practices; A manual for counselors in Native American communities.* Retrieved September 25, 2018, from https://casaa.unm.edu/download/nami.pdf

Walls, M. L., Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2006). Mental health and substance abuse services preferences among American Indian people of the Northern Midwest. *Community Mental Health Journal, 42*, 521–535.

Walter R. McDonald & Associates & ICF Macro. (2009). *National evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program: Exploratory description of financing and sustainability in American Indian and Alaska Native system of care communities; Summary report & appendices.* Rockville, MD: Authors.

Walters, K. L., & Simoni, J. M. (2002). Reconceptualizing native women's health: An "indigenist" stress-coping model. *American Journal of Public Health, 92*(4), 520–524.

Western Interstate Commission for Higher Education. (1998). *Cultural competence guidelines in managed care mental health services for Native American populations.* Boulder, CO: Author.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33*(3–4), 119–130.

Whitbeck, L. B., Walls, M. L., Johnson, K. D., Morrisseau, A. D., & McDougall, C. M. (2009). Depressed affect and historical loss among North American indigenous adolescents. *American Indian and Alaska Native Mental Health Research, 16*(3), 16–41.

White Bison. (2002). *The Red Road to Wellbriety: In the Native American way.* Colorado Springs, CO: Author.

Witherspoon, G. (1977). *Language and art in the Navajo universe.* Ann Arbor: University of Michigan Press.

Witkiewitz, K., Greenfield, B. L., & Bowen, S. (2013). Mindfulness-based relapse prevention with racial and ethnic minority women. *Addictive Behaviors, 38*(12), 2821–2824.

Wolpe, J., & Abrams, J. (1991). Post-traumatic stress disorder overcome by eye-movement desensitization: A case report. *Journal of Behavior Therapy and Experimental Psychiatry, 22*(1), 39–43.

Yuan, N. P., Bartgis, J., & Demers, D. (2014). Promoting ethical research with American Indian and Alaska Native people living in urban areas. *American Journal of Public Health, 104*(11), 2085–2091.

Yutrzenka, B. A., Todd-Bazemore, E., & Caraway, S. J. (1999). FourWinds: The evolution of culturally inclusive clinical psychology training for Native Americans. *International Review of Psychiatry, 11*, 129–135.

Index

A

access to services. *See* increasing access to services
acculturation, 30–31, 35, 56–57, *140*
active listening (also referred to as reflective listening), *61*, 74–75, *77–78*
Addiction Technology Transfer Center (ATTC) Network, 133, *140*, 142, *144*. *See also* Substance Abuse and Mental Health Services Administration: National American Indian and Alaska Native Addiction Technology Transfer Center (NAI & NA ATTC)
administrative challenges, 130–137. *See also* solutions, paths to
adverse childhood events, 23. *See also* child abuse
Alaska Commission for Behavioral Health Certification (ACBHC), *177*
Alaska Federation of Natives, 16, *19*
Alaska Native Allotment Act, 16
Alaska Native Claims Settlement Act, 16, *19*
Alaska Native Program, *19*. *See also* Trans-Alaska Pipeline System
alcohol
    death rate from, 29
    myths, *26*
    use disorder and other substance use disorders, viii, 6, *26*, 47, 52, 65. *See also* vignette 1
American Indian/Alaska Native Behavioral Health Briefing Book, *47*
American Indian/Alaska Native Sustainability Self-Assessment Tool, 186, *186–200*
American Indian and Alaska Native Culture Card: A Guide to Build Cultural Awareness, *142*
American Indian Religious Freedom Act of 1978, 15
American Speech–Language–Hearing Association's Self-Assessment for Cultural Competence, 42
ancestry, 24, *24*, 31–32
anonymity/confidentiality, *48*, 49, 55–56, 60, 66, 78, *99*, 131, *150*, *191*
assessment/assessing
    American Indian/Alaska Native Sustainability Self-Assessment Tool, 186, *186–200*
    community prevention and education, *178*
    cultural identity, 9, 30, 34–36, 56–57, *57*, 87, 147, 149
    Native American Cultural Assessment Survey, 159–160, *160–171*
    using scales, *84*
    values, 36, *37–39*
assimilation, 16, *17–18*, 30, *30*, 137, 141
attitudinal competencies, 153
authenticity, 50, 59, *78*

B

Becoming a Culturally Competent Health Care Organization (2013 report), *126*
behavioral health services
    barriers, 49
    preferences, *48*, 48–49
Behavioral Health Services for People Who Are Homeless (TIP 55), 27
biculturalism, 30, *30*, 56
Black Elk, *11*, *22*
blood quantum, *24*
boarding school(s), 14, 16, *17–19*, 20, 49, 60, *71–72*, 74–75, 79, 83, 86, *108*, 117, *118*, 137, 143, 151, *171*. *See also* Carlisle Indian School
Brave Heart, Maria Yellow Horse, 20
Bureau of Indian Affairs (BIA), 14, 132

C

canoe journey, 23, *133–134*, *178*, *184*
care integration. *See* integrating care
Carlisle Indian School, *18*. *See also* boarding school(s)
case management, 54, 152
Center for Mental Health Services (CMHS), 186
Center for Substance Abuse Prevention's (CSAP's) Prevention Fellowship Program, *139*
Centers for Disease Control and Prevention's (CDC's) Public Health Training Fellowships, *145*
child abuse, 22, 28. *See also* adverse childhood events
circle model. *See* key elements for providing culturally responsive care for American Indians and Alaska Natives in behavioral health services
clinical supervision
    conducting a cultural awareness self-evaluation, *147*
    six areas of competence as a culturally competent supervisor, *146*
    supervision and client experiences: the influence of culture, *148*
    supervision dynamics, 147–149
Clinical Supervision and Professional Development of the Substance Abuse Counselor (TIP 52), 145
Cobell v. Salazar, 15, *19*

cognitive–behavioral therapy (CBT), 61, *63–64*, 75, *79*, *84*, *176*
colonization, 13–15, 20, 67, 140. *See also* historical trauma
commonalities among American Indian and Alaska Native cultures, 31–33
community
-based interventions/approaches, 60, *62*, 67, 101
collaborating with, 136
connections, 65–67
cultural and subsistence skill development, *178*
differences, 127
effective behavioral health practices for. *See* First Nations Behavioral Health Association (FNBHA) Catalog of Effective Behavioral Health Practices for Tribal Communities
engaging with, *127*, 128–129
event(s), 46, 48, 58, 65–66, *67*, 99, *180*. *See also* Gathering of Native Americans (GONA)
healing, *67*, *128*, 180. *See also* Gathering of Native Americans (GONA)
importance of, 32, *134*
involvement, 9, 126–127, *150*
leaders, 45, 65, 127, 131, 142–143, 153
liaison, 127, 155, *155*, *158*
members, 32, 41, 52, 56, 58, 60, 65–67, *126*, 127–128, 131–132, 137, *138*, *155*, *194*
prevention and education, *178*
readiness model, 137, *138*, *178*. *See also* dimensions of readiness
reinforcement approach (CRA), *63*
screening tools, *179*. *See also* Native H.O.P.E.
strengths, 129
competencies. *See* provider competencies
consensus panel, 5, 8, 10, 69, *69*, *95*, *112*, *117*, 125, 130, 133, *144*
continuing care planning, 96, 121
creation, 11, *13*, 31, 33, *73*, *101*, *180*
Cree proverb, *34*
culture/cultural(ly)
American Speech–Language–Hearing Association's Self-Assessment for Cultural Competence, 42
Becoming a Culturally Competent Health Care Organization (2013 report), *126*
conducting a cultural awareness self-evaluation, *147*
connecting/reconnecting with, *29*, 43
cultural activities, *29*, 31, 41, 47, 49, 58–59, *134–135*, 142, *142*
cultural advisors, 142, *142*, *164*
cultural awareness development. *See* developing cultural awareness
cultural camps, 54, *54*
Cultural Competence Health Practitioner Assessment, 42
cultural identity, 7, 9, 12, 30, 34–36, 56–58, *57*, 60, 61, 87, 127, 140, 147, 149, *171*
cultural immersion events, *178*
culturally adapted treatment. *See* examples of culturally adapted treatment approaches
culturally appropriate communication, 128, *156*
culturally responsive counseling with American Indians and Alaska Natives, *95*
culturally responsive relationships. *See* culturally responsive relationships: provider guidelines and considerations
culturally specific, *12*, *28*, 49, *50*
cultural trainer(s)/training, 140–143, *143–144*
developing a culturally competent and responsive workforce, 136. *See also* workforce and organizational development
establishing a cross-cultural supervisor–supervisee relationship, 146–147
Georgetown University's National Center for Cultural Competence, 42
importance of, 129, 141
Improving Cultural Competence (TIP 59), 8, 23, 34, 41, 50, 125, 141, *147*, 149. *See also* How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision
improving your cultural competence, 41–42
improving your knowledge of American Indian and Alaska Native cultures, 41
influence of, *148*
Leaving Footprints: Cultural Training, *144*
loss of, 7–8
mainstream, x, xii, 7, 8, 10, 14, *18*, *26*, 30–32, *35–36*, *39*, 42, 43, 44, 46, 56
organizational benefits of culturally responsive care, *126*
providing culturally responsive care. *See* key elements for providing culturally responsive care for American Indians and Alaska Natives in behavioral health services
role of, vi, 9, *29*
six areas of competence as a culturally competent supervisor, *146*
Tlingit cultural values, *106*
culturally responsive relationships: provider guidelines and considerations
knowing yourself, 50–51
making introductions as a provider: first meeting, 55–56
remaining flexible and embracing new opportunities, 52–55
supporting communication, 51–52
cycle of
assimilation and reconnection, 30, *30*
historical trauma, *21*

D

data use and analysis, 130–131, *131*. *See also* evaluation capacity
Dawes Severalty Act (also known as the General Allotment Act), 14, *18*
Department of the Interior, 14–15, 27, *173*
Department of the Treasury, 15
depression, 46, 48, *50*, *64*, 96–97, 99, *100*, *134*
developing cultural awareness
- step 1: awareness of cultural differences, 34–36
- step 2: self-assessment of your values, 36
- step 3: understanding the effects of cultural differences, 36, 40
- traditional American Indian and Alaska Native values and beliefs, *37–39*

developing native evidence-based practices (EBPs)
- culturally adapted treatment. *See* examples of culturally adapted treatment approaches
- effective behavioral health practices for tribal communities. *See* First Nations Behavioral Health Association (FNBHA) Catalog of Effective Behavioral Health Practices for Tribal Communities
- *Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities*, *61*, *74*
- Oregon Addictions and Mental Health Division Evidence-Based Programs Tribal Practice Approval Form, 181, *181–185*. *See also* integrating care

diagnosis, viii, x, 8–9, 36, *39*, 44, 46, 48, 52, *87*, *100*, *111*, 137, *138*, 149
Diagnostic and Statistical Manual of Mental Disorders (DSM–5), x–xi, *100*
dimensions of readiness, *138*. *See also* Community Readiness Model
Diné. *See* Navajo
discrimination, racism, and prejudice, 10, 34, 36, *39*, 47, 49, 60, *72*, 74, *89*, 110, 112, 141, 151, 153, *171*
domestic violence, 19, 29
double-sided reflection(s), *80*
Dr. Duane Mackey *"Waktaya Naji"* Award, *144*. *See also* Mackey, Duane
dream(s), 86, 88–89, *89*, *172*. *See also* visions

E

economic and social conditions of American Indians and Alaska Natives
- child abuse, 28. *See also* adverse childhood events
- domestic violence, 29
- education, 27
- housing and homelessness, 27. *See also* vignette 4
- income and poverty, 26–27
- physical health, 29
- trauma (rates of), 27–28
- unemployment, 27
- violent crime, 28

education. *See* training and education
1884 Organic Act, 16
elders
- learning from, 66, *117*
- message on suicide prevention, Inuit, *117*
- traditional, 22, 23, *23*, *32*, *38*, 41, 45, 46, 58, 59, 66, *73*, 82, *104*, *109*

enculturation, 30
etiquette, 55, 66, *127*
evaluation capacity, *131*. *See also* data use and analysis
evidence-based practices (EBPs)
- developing for tribal populations. *See* developing native evidence-based practices (EBPs)
- examples of. *See* examples of culturally adapted treatment approaches

examples of culturally adapted treatment approaches. *See also* evidence-based practices (EBPs)
- behavioral therapy, *64*
- cognitive–behavioral therapy (CBT), *63*
- community reinforcement approach (CRA), *63*
- family therapy, *62*
- Matrix Model, *64*
- mindfulness-based interventions, *63*
- motivational interviewing, *61*
- trauma-informed treatment, *62*

Exxon Valdez oil spill, *19*, *20*, *108*
eye contact, *35*, 36, *37*, *39*, 51, 55

F

Facebook, *120*. *See also* social media
family
- and youth involvement, *190*, *197*
- recovery crest, 102, 105
- session(s), 52, 96, 98–99, 101–102, *102–103*, 104–106. *See also* vignette 3
- structure, 32–33
- therapy/treatment, 60, *62*, 69, *90*, *105*, *145*, *179*. *See also* vignette 3

fellowship(s), *139*, 145, *145*, *180*. *See also* internship(s)
First Nations Behavioral Health Association (FNBHA) Catalog of Effective Behavioral Health Practices for Tribal Communities
- American Indian and Alaska Native 12-Step meetings and fellowship, *180*
- Circles of Care, *178*
- Community Readiness Model, *178*. *See also* dimensions of readiness
- cultural immersion events, *178*

equine-assisted therapy, *180*
Gathering of Native Americans (GONA), *178*
Healing Forest, Wellbriety, Sons and Daughters of Tradition, *180*
Honoring Children, *179*
Native American Church, *180*
Native H.O.P.E., *179*
Positive Indian Parenting, *179*
Sobriety Campouts, *180*
sobriety pow wows, *180*
sweat lodge ceremonies, *180*
talking circle, *179*
To Live To See the Great Day That Dawns, *179*
Wraparound in Indian Country, *179*
First Nations Behavioral Health Association (FNBHA) Listing of Native Workforce Development Programs. *See also* workforce and organizational development
Alaskan rural human service program, *176*
consultation model with traditional healers, *176*
HHS, mental health technicians, counselor aid positions, *176*
Project Making Medicine, *176*
funding, 129, 131–133, 136, 153, *173*, *200*. *See also* grants

G

Gaalee'ya Project, *35*
gathering
of Native Americans, 67, *67*, *178*
of strengths, *90*
General Allotment Act (also known as the Dawes Severalty Act), 14, *18*
Georgetown University's National Center for Cultural Competence, 42
Gottlieb, Katherine, *23*
grants, 26, 129, 131, 136, *200*. *See also* funding

H

harmony and balance, vi, 9, 11, *22*, *29*, 31, 33, *33*, *37*, 43, 46, *69*, *73*, 74, *106*, *133*
healing and medicine, traditional, 7–11, 23, *29*, 31, 40–49, *44–45*, 54, *56–57*, 58, *59*, 59–61, 64, *69*, *73*, *94*, 105, *108–109*, 129, *176–177*, 181
health, concepts of, 43
historical trauma. *See also* colonization
benefits of focusing on, 23
cycle of, *21*
defined, 20, *20*
effects on American Indians and Alaska Natives today, *21*, 21–23
effects on parenting, 22
importance of, vi, 8
symptoms of historical trauma response, *57*
traditional cultures and, *20*
holistic view of health and healing, vi, 8, 43, 67
homebrew, 98, *98*
honoring
children, 55, *104*, *179*
traditional ways. *See* vignette 1
hopeful language, 52
housing and homelessness, 27. *See also vignette 4*
How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision, 149. *See also Improving Cultural Competence* (TIP 59)
hozhq, *33*
humor, 52–53, *53*. *See also* laugh(ter)

I

Idaho State Loan Repayment Program, *145*
identity
cultural, 7, 9, 12, 30, 34–36, 56–58, *57*, 60, 61, 87, 127, 140, 147, 149, *171*
native, *30*, 31–32
illness, concepts of, 43–44, *43–44*, 55, 60
Improving Cultural Competence (TIP 59), xi, 8, 23, 34, 41, 50, 125, 141, *147*, 149. *See also* How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision
income and poverty, 26–27
increasing access to services, 132
Indian Child Welfare Act of 1978, 15, *19*, 143
Indian Citizenship Act (also known as the Snyder Act), *18*
Indian Civil Rights Act of 1968, *19*
Indian Gaming Regulatory Act, *19*
Indian Health Services (IHS) resources
Externship Program, *145*
Loan Repayment Program, *145*
New Hire Quick Reference Guide, 155, *156–158*
Indian Health System, *130*
Indian Relocation Act, 15, *18*
Indian Removal Act, 14, *17*
Indian Reorganization Act, 15–16, *18*, *173*
Indian Self-Determination and Education Assistance Act of 1975, 15, *137*
intake, 56, *56*, *77*, *80*, 85
integrating care, 132, 181, *181–185*. *See also* Oregon Addictions & Mental Health Division Evidence-Based Programs Tribal Practice Approval Form
intellectual property, 66
intergenerational trauma. *See* historical trauma
internship(s), 136, *139*, *145*. *See also* fellowship(s)
introductions, 55, *87*

J

K

key elements for providing culturally responsive care for American Indians and Alaska Natives in behavioral health services
- cultural awareness and competence (south), *12*, *34–35*, 34–36, *37–40*, 40–42, *42*
- cultural knowledge (east), *12–13*, 13–16, *15*, *17–30*, 20–34, *32–34*
- culturally specific and responsive skills and practices (north), *12*, 49–61, *50–57*, *59–67*, 64–68
- cultural perspectives on behavioral health (west), *12*, *42–45*, 42–49, *47–49*

knowledge competencies, 151

L

label(ing), 36, 40, *43–44*, 44, 50, 52, *87*
Lakota, *20*, *144*, *160*
laugh(ter) 52, *53*, 89, 91, *91*. *See also* humor
Leaving Footprints: Cultural Training, *144*
loan opportunities
- Idaho State Loan Repayment Program, *145*
- Indian Health Service (IHS) loan repayment program, 145, *145*
- National Health Service Corps (NHSC) Loan Repayment Program, *137*, 145, *145*. *See also* Spokane Tribe Health and Human Services Behavioral Health Program
- *SHARP-II: Providing Support-for-Service to Health Care Practitioners*, *145*

loss of language, viii, 20, *88*

M

Mackey, Duane, *144*. *See also* Dr. Duane Mackey "*Waktaya Naji*" Award
mainstream
- culture/society, xii, 7–8, 10, 14, *18*, *26*, *30*, 30–32, 35–36, 46, 56
- treatment/models of care, *6*, 10, 42–44, *43–44*, 46, 48, 52, 54, 59, 61, 63, 69, 74, *100*, *106–107*, 132–133, 137

mascots, *26*, *39*. *See also* microaggressions
master provider notes in vignettes, *69*, 70. *See also* vignettes 1, 2, 3, and 4
Matrix Model, *64*
Mead, Margaret, *110*
mental disorders, 7–9, 21, *21*, 46, 48–49
mentoring, 133, 136, *136*, *149*, 149–150
Meriam Report, 15
metaphor(s), *81*, *134*
methamphetamine, *47*, 48, 86–88, *88–90*, 91, *135*
microaggressions, *39*. *See also* mascots
military service, *15*
mindfulness, *63*, 91
Mining Act of 1872, 16
motivational interviewing, *57*, 60, *61*, *74*, *145*. *See also* *Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities*
mutual help, 65. *See also* 12–Step
myths and facts about American Indians and Alaska Natives, *25–26*

N

National Drug Court Resource Center, *85*
National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program: Exploratory Description of Financing and Sustainability in American Indian and Alaska Native System of Care Communities, 135
National Health Service Corps (NHSC) Loan Repayment Program, *137*, 145, *145*. *See also* Spokane Tribe Health and Human Services Behavioral Health Program
National Indian Child Welfare Association (NICWA), *178–179*. *See also* Positive Indian Parenting
National Resource Center on Child Sexual Abuse, 14
Native American Center for Health Professions, 136. *See also* We Are Healers
Native American Cultural Assessment Survey, 159–160, *160–171*
Native American Curriculum for State Accredited, Non-Tribal Mental Health & Substance Abuse Programs in South Dakota, *144*, 159, *177*
Native American Motivational Interviewing: Weaving Native American and Western Practices—A Manual for Counselors in Native American Communities, *61*, *74*
Native American Rehabilitation Association of the Northwest, Inc. (NARA), 142
Native H.O.P.E., *179*
nature, 8, 31, *37*, *39*, *90*, *101*, *117*
Navajo, *33*, 45, *63*, *88*
Navigating Life Curriculum Sessions, *134–135*
Neihardt, J. G., *11*
New Hire Quick Reference Guide, 155, *156–158*
nonverbal communication, *40*, 51
Northwest Ordinance, 14, *17*

O

Oglala Sioux, *11*
open-ended questions, *57*, *80*
Oregon Addictions & Mental Health Division Evidence-Based Programs Tribal Practice Approval Form, 181, *181–185*. *See also* integrating care
organizational development. *See* workforce and organizational development

P

Pan-Indian, 31, 56, 65, *173*
partnering with tribal governments to meet the mental health needs of American Indian/Alaska Native consumers, *132*
paths to solutions. *See* solutions, paths to
personification of illness, 43
physical health, *29*
planning
    continuing care, 96, 121
    treatment, 9, 54, 56–61, *94*, 129, 196
plastic shamans, *45*, *108*. *See also* shamans
Poitra, Betty, *147*
Positive Indian Parenting, *179*. *See also* National Indian Child Welfare Association (NICWA)
pow wow(s), 31, 47, 67, *165*, *168*, *173*, *180*, *185*
practice-based approaches, 10–11, 13, 61, *61–63*
prayer(s), *22*, *28*, 46, *73*, *76*, *107*, *172*, *185*
prejudice. *See* discrimination, racism, and prejudice
Pretest for Non-Native Counselors. *See* Sample Pretest for Non-Native Counselors
pretreatment, 70, 86–87, 91, 94. *See also* vignette 2
professional development. *See* workforce and organizational development
Project Homeless Connect, *111*
provider competencies
    attitudinal, 153
    knowledge, 151
    skill, 152–153
    understanding, 151–152

Q

questions
    about beliefs and values, *37–39*
    to assess cultural identity, 56–57, *57*
Qungasvikm, 101

R

racism. *See* discrimination, racism, and prejudice
reconnection, vi, 9, *29–30*, 30–31, 43, 58, 86–95
Red Road, 65, 92, *175*
reflective listening (also referred to as active listening), *61*, 74–75, *77–78*
RESPECT: a mnemonic for culturally responsive attitudes and behaviors, *40*

S

Sacred Hoop of 100 Eagle Feathers, *22*
sage, 75, *76*, *109*, *168*
Salish, *42*, 65
Sample Pretest for Non-Native Counselors, 159, 172, *172–175*
Santee Sioux, *139*, *144*
scale(s), 57, 83, *83–84*, 147, *163–166*, *170–172*, *186*
sculpting, 54, *55*, *62*, 117
settlers. *See* colonization
sexual violence/abuse, 7, 14, 16, *21*, 28, 57, *62*, *72*, 75, 97, *97*, *111*
shamans, *45*, *108–109*. *See also* plastic shamans
SHARP-II: Providing Support-for-Service to Health Care Practitioners, *145*
skill competencies, 152–153
S'Klallam, *134–135*. *See also* Suquamish
smudging ceremony, 46, *76*, 85, 92
Snyder Act (also known as the Indian Citizenship Act), *18*
social media, *120*. *See also* Facebook
social supports, 64–65
socioeconomic conditions. *See* economic and social conditions of American Indians and Alaska Natives
solutions, paths to, 130–137. *See also* administrative challenges
South Dakota Urban Indian Health (SDUIH), *28*. *See also* trauma: Beyond Trauma support group
spiritual beliefs, 33, *39*, *174*
Spokane Tribe Health and Human Services Behavioral Health Program, *137*. *See also* National Health Service Corps (NHSC) Loan Repayment Program
stacking questions, *77*
staff training. *See* training and education
stages of change, *61*, 87, 92, *93*, 95. *See also* motivational interviewing
Stand Down, *111*
storytelling, 51, *90*, *101–102*, *135*
strengths
    -based practice, *89–90*
    gathering of, *90*
    of tribal systems of care, *129*
Substance Abuse and Mental Health Services Administration (SAMHSA)
    American Indian and Alaska Native Culture Card: A Guide to Build Cultural Awareness, *142*
    Minority Fellowship Program, 145, *145*
    National American Indian and Alaska Native Addiction Technology Transfer Center (NAI & AN ATTC), 133
    Tribal Training and Technical Assistance Center, *133*
Substance Abuse Treatment: Addressing the Specific Needs of Women (TIP 51), *29*
suicide
    prevention, 33, *63*, *67*, *101*, *115*, *117*, *128*, *176*, *178–179*
    statistics, 6, 25, *97*
supervision. *See* clinical supervision

Suquamish, *134–135*. *See also S'Klallam*
sustainability, 132–133, 135–137, 186, *186–200*
sweat lodge, *22*, 35, 46, 58, *73*, 92, 129, *133*, *163*, *172*, *180*, *184*

T

talking circle, 46, 58, *60*, *90*, *107–108*, *146*, *179*
Tanana Chiefs Conference Old Minto Family Recovery Camp, *54*
Termination Era, *18*
therapeutic relationship(s), *39–40*, 54, 60, 74, *139*
Through the Diamond Threshold: Promoting Cultural Competency in Understanding American Indian Substance Misuse, *177*
Thurman, Pamela Jumper, *141*
timeline of significant events in Native American History, *17–19*
Tlingit cultural values, *106*
tobacco (ceremonial/religious use), 46, *73*, *109*, *165*, *168–169*
To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults, *115*, *179*
traditional
- American Indian and Alaska Native values and beliefs, *37–39*
- culture(s), 20, *20*, *29*, 30, 35, 43, 46, 50, 92
- healing and medicine, 7–11, 23, *29*, 31, 40–49, *44–45*, 54, *56–57*, 58, *59*, 59–61, 64, 69, *73*, *94*, 105, *108–109*, 129, *176–177*, 181
- practices in recovery. *See* vignette 4
- ways, *28*, 46, 54, 56, 58, 70, 82–84, 87–88, *94*, 96, 98, 100–101, *101–102*, 104, 106, *106–108*, *134*

Trail of Tears, 14, 143
training and education
- arranging staff cultural training, 142
- attitudinal competencies, 153
- identifying potential cultural trainers, 142–143
- knowledge competencies, 151
- Leaving Footprints: Cultural Training, *144*
- Native American Curriculum for State Accredited, Non-Tribal Mental Health & Substance Abuse Programs in South Dakota, *144*
- providing educational resources, 144–145
- selecting training materials for cultural training, 143–144
- skill competencies, 152–153
- staff opportunities, 144–145
- training competencies, 150–151
- understanding competencies, 151–152

Trans-Alaska Pipeline System, *19*. *See also* Alaska Native Program
trauma
- Beyond Trauma support group, 28. *See also* South Dakota Urban Indian Health (SDUIH)
- historical. *See* historical trauma
- -informed care/treatment, 23, *62*, 99, 125, 128, *128*, 141, *145*
- rates of, 27–28
- *Trauma-Informed Care in Behavioral Health Services* (TIP 57), 23, 28, 57, *128*

Treatment Improvement Protocols (TIPs)
- *Behavioral Health Services for People Who Are Homeless* (TIP 55), 27
- *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (TIP 52), 145
- *Improving Cultural Competence* (TIP 59), 8, 23, 34, 41, 50, 125, 141, *147*, 149. *See also* How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision
- *Substance Abuse Treatment: Addressing the Specific Needs of Women* (TIP 51), *29*
- *Trauma-Informed Care in Behavioral Health Services* (TIP 57), 23, 28, 57, *128*
- *Using Technology-Based Therapeutic Tools in Behavioral Health Services* (TIP 60), 52, 58, *140*

treatment planning, 9, 54, 56–61, 64–98, *94*, 129, 196
Tribal Healing to Wellness Courts: The Key Components, *85*
tribal systems of care, *129*
trust
- gaining, 11, *28*, *35*, *40*, 53, 55, *64*, 66–67, 70, 75, *78*, 85, *109*, *117*, *126*, 127–128, 137, 147–148
- lack of, 5–6, *7*, 22, 49, *56*, 74, 88, 105, 128, 137
- (legal), 15, *17–19*, 24, *25*, *30*

12–Step, *42*, *64*, 65, 92, *180*. *See also* mutual help

U

understanding competencies, 151–152
unemployment, 27
Using Technology-Based Therapeutic Tools in Behavioral Health Services (TIP 60), 52, 58, *140*

V

values, Alaska Native, *32*, *37–39*
vignette 1—Vicki: Establishing Relationships, Acknowledging the Past, and Choosing Treatment, 74–85
- court orders and mandates for treatment, *83*
- listen for the meaning: cognitive–behavioral strategies, *79*
- master provider notes, *76–85*
- objectives for vignette 1, 75
- reflective listening (also referred to as active listening), *77*
- smudging ceremony, *76*, 76–77, 85

using metaphor in counseling, *81*
using scales in counseling, *84*
Vicki's case history, 74–75
wellness courts, *83*, *85*
vignette 2—Joe: Addressing Methamphetamine Dependence, Reconnecting With Family, and Recovering on the Reservation, 86–95
culturally responsive counseling with American Indians and Alaska Natives, *95*
Joe's Case History, 86
loss of language, *88*
master provider notes, *87–89*, *91*, *94*
objectives for vignette 2, 86–87
vignette 3—Marlene: Facilitating Support, Creating Family Connections, Honoring Traditional Ways, and Recovering in Remote Alaska Villages, 96–109
Alaska Native villages: current challenges, *97*
family session(s), 96, 98–99, 101–106, 102–106
family therapy: using a systems approach, *105*
homebrew, 98, *98*
Honoring Children, Making Relatives, *104*
how to find traditional healers, *108–109*
Marlene's case history, 96–98
master provider notes, *99–100*, *102–103*, *105–106*
objectives for vignette 3, 98–99
subsistence: living traditional ways, *101*
suggestions for working with individuals who practice traditional ways, *107*
talking circle, *107–108*
Tlingit cultural values, *106*
Yuuyaraq: The Way of the Human Being, *106*
vignette 4—Philip: Making Connections Between Losses and Alcohol Use, Using One-Stop Outreach and Case Management Services for Homelessness and Treatment Service Needs, and Building Relationships Using Traditional Practices in Recovery, 110–121
continuing care planning, 121
detoxification counseling session, 113–114
group treatment counseling session: welcome home, 116–120
homelessness in Alaska, *111*
individual treatment counseling session, 115–116
Inuit elders' message on suicide prevention, *117*
is it a cultural belief or is it a diagnosis?, *111*
learning from the elders, *117*
master provider notes, *113*, *116*, *118–120*
objectives for vignette 4, 113
Philip's case history, 110, 112–113
To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults, *115*
use of social media to connect Alaska natives who are homeless with their families, *120*
Welcome Home: Boarding School Exercise, *118*
vignettes, 69–121
master provider notes, *69*, 70. *See also* vignettes 1, 2, 3, and 4
vignette summary table, *71–72*
Violence Against Women Reauthorization Act, *19*
violent crime, 28
visions, *22*, 35, 45, *49*, *73*, 74, *89*. *See also* dream(s)

W

"*Waktaya Naji*" Award. *See* Dr. Duane Mackey "*Waktaya Naji*" Award
Waukazoo, Martin, *153*
We Are Healers, *136*. *See also* Native American Center for Health Professions
Wellbriety, *22*, 65, *180*
wellness courts, *83*, *85*
withdrawal, *72*, 87–89, *88–89*, *91*, 91–92, 94
workforce and organizational development
American Indian/Alaska Native Sustainability Self-Assessment Tool, 186, *186–200*
Center for Substance Abuse Prevention's (CSAP's) Prevention Fellowship Program, *139*
education. *See* training and education
integrating care, 181, *181–185*. *See also* Oregon Addictions & Mental Health Division Evidence-Based Programs Tribal Practice Approval Form
listing of workforce development programs. *See* First Nations Behavioral Health Association (FNBHA) Listing of Native Workforce Development Programs
loans. *See* loan opportunities
mentoring, 133, 136, *136*, *149*, 149–150
Native American Cultural Assessment Survey, 159–160, *160–171*
New Hire Quick Reference Guide, 155, *156–158*
provider competencies, 150–153
Sample Pretest for Non-Native Counselors, 159, 172, *172–175*
supervision. *See* clinical supervision
sustainability, 132–133, 135–137, 186, *186–200*
training. *See* training and education
worldview, 8–9, 12, 31, 59, 92, 129, *133*, 140, *147*
Wounded Knee Massacre, *20*

X

Y

Yup'ik, *25*, *101*
Yuuyaraq: The Way of the Human Being, *106*

Z

SAMHSA Knowledge Application Program Resources

TIPs may be ordered or downloaded for free from SAMHSA's Publications Ordering webpage at https://store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

To receive monthly updates about TIPs and other SAMHSA Knowledge Application Program (KAP) resources on substance misuse and addiction treatment, subscribe to the KAP Email List by going to https://eepurl.com/dyBY3n.

HHS Publication No. (SMA) 18-5070
Printed 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

SAMHSA
Substance Abuse and Mental Health Services Administration