# Achieving Balance:
# Including Native Americans in California County Mental Health Services

*Results and Recommendations based on*
*The Native American Inclusion Technical Assistance Survey*

*Prepared by the Inter-Tribal Council of California, Inc. for*
*The California Department of Mental Health*
*5/6/09*

## OVERVIEW

With the passage of the Mental Health Services Act (MHSA) in 2004, Native American communities in California immediately recognized the opportunity to develop holistic and transformational services for tribal people and to close the gap on the vast mental health disparities they experience. However, enormous barriers exist in the efforts to realize this potential. To assist in overcoming these barriers, the California Department of Mental Health contracted with the Inter-Tribal Council of California, Inc., to facilitate relationships and policymaking that support the inclusion of Native people in county mental health governance, policies and programs. In 2009, a survey was launched in order to assess the capacity and technical assistance needs of county mental health divisions to include Native American individuals and communities in the implementation of the MHSA. The survey was launched with the assistance of the California Mental Health Directors Association, and was sent to all 60 city and county mental health divisions. Twenty-eight of these divisions responded; this is a narrative summary of their responses. An overview of the survey results may be found in Appendix I.

## A. ASSESSMENT OF DATA NEEDED TO BRIDGE COUNTY MENTAL HEALTH TO NATIVE AMERICAN ORGANIZATIONS

The survey began with an assessment of data used for policy and program development in county mental health divisions. Questions in this section asked counties what kinds of information they would find useful, as well as soliciting information about how county mental health divisions collect and utilize data in their implementation of the MHSA.

On the whole, counties identified an overall need for detailed information about tribes, tribal organizations, cultural specialists and tribal healers. Several counties noted that they are currently collaborating with Native American Health Centers in their area to develop information about tribal communities, and two counties noted that they have experienced some success hiring tribal people as professionals in key roles to increase their knowledge and relationships to tribes. Particular need was expressed for information about local tribes, as well as introductions to cultural specialists and traditional healers. One county noted that developing this information is essential for developing needed trust with local Native American (N/A) communities. San Bernardino County noted some success in partnering with local Fontana Native Indian Center and the Native American Council, which has resulted in introductions to other tribal councils and facilitated outreach and engagement with local tribal communities.

In their efforts to track the participation and involvement of Native Americans in local mental health processes, counties by and large relied on documentation of participation by Native Americans through sign-

in sheets at stakeholder events and quarterly reports on MHSA outreach and engagement activities and service, as well as on community and staff feedback and recommendations from cultural specialists. However, several counties noted that more proactive relationship development is necessary and underway. San Francisco and Placer Counties utilized funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance outreach activities to Native American communities. Placer County reported using SAMHSA funding to increase engagement, and also conducted a Community Readiness Assessment in which members of the Native American community developed a strategic plan for engagement and development. The Native Network planning group of Placer County met monthly and has adopted several community-directed goals, such as re-vitalizing the Auburn Big Time Powwow after a nine-year absence from Placer County. San Francisco County noted that bureaucratic barriers hinder the collection of data on American Indians and Alaska Natives, in part due to the fact that few utilize county mental health services, and also due to the fact that service data from the Indian Health Services database is not reported to city or state health departments.

Counties further reported that inclusion of Native Americans as an unserved population in MHSA services occurred largely through case management as well as through inclusion on local boards and committees. To a much lesser extent, Native Americans were hired in county mental health divisions. No counties reported that from their perspective Native Americans were completely left out of MHSA services. Several counties noted Prevention and Early Intervention activities focused on Native American populations, and Colusa County reported that it has created a policy to assign additional points to Native Americans for workforce, education and training scholarships. San Bernardino County noted that a key responsiveness policy has been implemented to be able to provide services from a Native American clinician if a client requests it.

Finally, Native American utilization of mental health services is reportedly tracked primarily by computer database records, followed by meeting and training attendance sheets. It was noted, however, that there are gaps in this data system and that Native families are often misidentified. One county reported that a recent chart audit revealed a very large disparity in the information management system data on Native American participants in mental health programs.

## B. ASSESSMENT OF OUTREACH AND ENGAGEMENT ACTIVITES USED TO LINK COUNTY MENTAL HEALTH TO NATIVE AMERICANS

This section of the survey solicited information on strategies used by counties to engage Native American communities in the MHSA. Most responding counties reported "Attend Meetings" as the primary outreach and engagement strategy, followed by engaging N/A community members on boards and committees. Significantly, thirteen counties reported "Resource Sharing" as an outreach and engagement strategy. In describing their outreach and engagement strategies, counties continued to value collaboration with local Native American Health Centers, to engage in dialogue and focus groups, and to broker direct meeting with directors of local N/A organizations. Colusa County reported that all of their MHSA plans include specific strategies to reach N/A populations, and San Francisco County noted that five Native American clients were recruited to participate in their recent annual state mental health audit.

Counties were also asked to describe strategies they have found successful for developing partnerships with tribal communities. The strategy that met with the most success was identifying and engaging tribal leaders, brokers and cultural specialists, followed by attending tribal community events, and once again, including tribal people on boards and committees. Counties also developed specialized contracts appropriate for Native American providers, and attended tribal community events. Ten counties reported making presentations to tribal organizations and Native American people. One county noted that changes in tribal leadership have been a barrier to partnership. Two counties reported that they have not yet made any

progress in developing partnerships, and one noted that they have encountered complexity in their outreach activities, in that local tribal leaders have expressed that they are offended by being invited to meetings and boards due to their tribal affiliation.

## C. ASSESSMENT OF TECHNICAL ASSISTANCE USED TO REDUCE DISPARITIES AND REMOVE BARRIERS BETWEEN COUNTY MENTAL HEALTH AND NATIVE AMERICANS

Part C of the survey was primarily designed to solicit the technical assistance needs of counties in working with N/A communities. Asked to report on areas where they would like assistance, counties reported high needs for understanding Native protocols, opening dialogue, cultural sensitivity and case management systems designed for cultural inclusion of Native Americans. A key need was expressed for developing culturally-relevant services as well as for understanding the health issues that manifest from cultural displacement and historical trauma. One county expressed the desire for a "positive, open and culturally appropriate/sensitive relationship with Native Americans . . . not only for the good of the Native American community, but for our collective good through the richness they add to our community and our heritage."

Counties were also asked if they would benefit from assistance in developing strategies to include Native American healing approaches into mental health treatment. They expressed the highest need to connect with cultural specialists, followed by spiritual healers, traditional tribal teachers, and medicine men and women. Placer County noted that their local Native Network has provided resources for Nisenan/Maidu language classes, history and traditional life skills. San Joaquin County has adopted policies that allow Full Service Partnership flexible funds to be used for funding traditional healers, but expressed interest in learning more about utilizing these practices in mental health treatment.

## D. ASSESSMENT OF OUTREACH AND ENGAGEMENT RESOURCES USED TO PROMOTE INCLUSION OF NATIVE AMERICANS WITH COUNTY MENTAL HEALTH

Part D of the survey assessed the barriers encountered in developing partnerships with N/A communities, as well as the human and informational resources counties have utilized for this purpose. It also asked counties to assess their own state of readiness to include Native Americans in county mental health programs.

Counties reported multiple barriers to developing relationships and including tribal people in mental health programs. The leading barrier identified was the challenge of building a relationship of trust and confidence with Native American communities. A related barrier was reported when counties found tribal people and organizations unresponsive to standard invitations issued through newspapers, letters, phone calls and emails. Not understanding Native protocols was also cited, as was the inability to identify appropriate leaders to approach. Counties noted challenges of outreaching to multiple communities of tribal people, difficulty knowing whether efforts have been effective, and wide dispersal of Native people in urban settings. Many acknowledged that "trust is a long-term project" that will require ongoing efforts. One county thoughtfully noted, "Unresponsiveness may be due to our lack of effective relationship and outreach with the Native American Community rather than lack of responsiveness or interest on the community's part."

Counties reported marginal success in securing assistance from Native Americans in developing mental health programs and service plans. Ten counties reported assistance from tribal leaders or community members, while fewer were able to report inclusion of tribal governments or programs, tribal organizations and cultural specialists. In a number of cases Native American Health Centers were able to render assistance, and in the case of one rural county, initial attempts failed but engagement was more successful when the community faced environmental problems after a storm.

Counties also expressed a desire for more information about tribal resources and education to be posted online. The greatest need was for links to tribal governments, programs and services that are county-specific. Also of interest were links to cultural specialists and consultants, tribal organizations and tribal healers. One county noted "the more information, the better," and several stated that information about key features of local Native American customs, spirituality, and healing are necessary rather than just a list of names. One county suggested posting information about upcoming Native American events online.

Counties reported having developed only limited resources, particularly online resources, for their Native American community members. Ten counties reported outreach efforts at community health fairs and similar events; seven had presented trainings or given presentations, and five counties had pamphlets or brochures targeting Native American communities. Just two counties reported that they have website links to tribal governments or programs. One county noted that county policy presents a barrier and limits their ability to post linkages to non-county programs. Placer County reported that its MHSA steering committee has produced a Native Resource Guide for the Western Slope, which includes contact information for local cultural organizations and tribal governments.

Finally, counties were asked to assess their own level of readiness for inclusion of Native Americans in county mental health governance, planning, programs and services. Seven counties assessed themselves as "Ready," twelve as "Somewhat Ready" and three as "Not Ready." Several counties commented on their desire to strengthen efforts underway and to develop opportunities under Prevention and Early Intervention and Workforce, Education and Training. Monterey County plans to deepen their relationships by developing a contract with a Native American provider. Overall, counties welcomed assistance in developing further inclusion of Native Americans in mental health programs and policy.

Attached are several appendices on critical topics to assist counties in their inclusion of Native American communities in mental health programs.

## TABLE OF APPENDICES

Appendix I: Summary of Results of the 2009 Native American Inclusion Technical Assistance Survey
Appendix II: Outline of Basic Competencies for Outreaching to Native American Communities
Appendix III: Literature Review and Resource Guide to Historical Trauma and Post-Colonial Stress in American Indian Populations
Appendix IV: Considerations for Working with Native Healers
Appendix V: Achieving Results in the Healthy Nations Initiative

## Appendix I
## Summary of Results of the 2009 Native American Inclusion Technical Assistance Survey

Conducted by Inter-Tribal Council of California, Inc.

### NATIVE AMERICAN INCLUSION TECHNICAL ASSISTANCE SURVEY 2009

*With 28 of 60 California City and County Mental Health Divisions Participating*

**A. ASSESSMENT OF DATA NEEDED TO BRIDGE COUNTY MENTAL HEALTH TO NATIVE AMERICAN ORGANIZATIONS**

1. Would Your County Benefit from Data and Information Identifying Local:

- TRIBES 19
- TRIBAL ORGANIZATIONS 18
- TRIBAL CULTURAL SPECIALISTS 18
- TRIBAL HEALERS 17

2. How Does Your County Keep Track of Strategic Efforts to Increase Stakeholder Involvement of Native American Communities?

- ANALYSIS OF REPORTS 10
- DEPARTMENT AND COMMITTEE FEEDBACK 13
- DOCUMENTATION ON LEVELS OF PARTICIPATION BY NATIVE AMERICANS 18
- STAFF MEETING FEEDBACK 12
- RECOMMENDATIONS FROM CULTURAL SPECIALISTS 10

3. How Does Your County Include Native Americans as Part of Your Un-served Population in MHSA Services?

- CASE MANAGEMENT AND REFERRALS 15
- BOARDS AND COMMITTEES 15
- EMPLOYMENT 6
- DO NOT INCLUDE IN MHSA SERVICES 0

4. How Do You Track Utilization of Mental Health Services by Native Americans?

- WALK-IN SIGN-IN SHEET 4
- CLIENT FILES 10
- MEETING/TRAINING ATTENDANCE SHEETS 10
- COMPUTER DATABASE RECORDS 20

**B. ASSESSMENT OF OUTREACH AND ENGAGEMENT ACTIVITIES USED TO LINK COUNTY MENTAL HEALTH TO NATIVE AMERICANS**

1. Identify Activities Your County Has Utilized to Engage the Native American Community:

- BOARDS AND COMMITTEES 12
- EMPLOYMENT 3
- ATTEND MEETINGS 18
- INCREASED CONTRACTS FOR SERVICES 8
- RESOURCE SHARING 13

2. What Strategies Have You Used That Were Effective in Partnering with Tribal Communities?

- ATTENDED TRIBAL COMMUNITY EVENTS 13
- MADE PRESENTATIONS TO TRIBES, TRIBAL ORGANIZATIONS OR PEOPLE 10
- IDENTIFIED, ENGAGED TRIBAL LEADERS, BROKERS & CULTURAL SPECIALISTS 16
- INCLUDED TRIBAL PEOPLE ON BOARDS AND COMMISSIONS 13

**C. ASSESSMENT OF TECHNICAL ASSISTANCE USED TO REDUCE DISPARITIES AND REMOVE BARRIERS BETWEEN COUNTY MENTAL HEALTH AND NATIVE AMERICANS**

1. Would Your County Benefit from Assistance in Developing Strategies to Increase Stakeholder Involvement for Tribal Communities in any of the Following Ways?

- UNDERSTANDING TRIBAL PROTOCOLS 18
- OPENING UP DIALOGUE AND COMMUNICATION WITH NATIVE AMERICANS 18
- CULTURAL SENSITIVITY 18
- CASE MANGEMENT SYSTEM DESIGNED FOR "CULTURAL INCLUSION" OF NATIVE AMERICANS 19

2. Would Your County Benefit from Assistance in Developing Any of the Following Strategies to Include Native American Healing Approaches to Mental Health Treatment?

- MEDICINE MEN/WOMEN 14
- TRADITIONAL TRIBAL TEACHERS 14
- SPIRITUAL HEALERS 16
- CULTURAL SPECIALISTS 18

**D. ASSESSMENT OF OUTREACH AND ENGAGEMENT RESOURCES USED TO PROMOTE INCLUSION OF NATIVE AMERICANS WITH COUNTY MENTAL HEALTH**

1. What Challenges Have You Faced in Forging Partnerships with Tribal Communities?

- UNRESPONSIVENESS TO STANDARD INVITATION (e.g. Newspapers, Letters, Phone Calls and Emails) 14
- INABILITY TO IDENTIFY APPROPRIATE TRIBAL LEADERS, TRIBAL BROKERS, TRIBAL CULTURAL SPECIALISTS AND TRIBAL PEOPLE 9
- NOT UNDERSTANDING NATIVE PROTOCOL 10
- BUILDING A RELATIONSHIP TO INCREASE TRUST AND CONFIDENCE 17

2. What Native Americans Have Assisted You in Developing Your Mental Health Programs/Service Plans?

- TRIBAL GOVERNMENT AND/OR PROGRAMS/SERVICES 7
- TRIBAL ORGANIZATIONS 6
- TRIBAL CULTURAL SPECIALISTS 6
- TRIBAL LEADERS/TRIBAL COMMUNITY 10

3. What Type of Information Would You Find Helpful to be Posted on the California Mental Health Directors Association Website Regarding the Native American Community?

- LINKS TO TRIBAL GOVERNMENTS AND TRIBAL PROGRAMS OR SERVICES THAT ARE COUNTY-SPECIFIC 19
- LINKS TO TRIBAL ORGANIZATIONS 17
- LINKS TO CULTURAL SPECIALISTS / CONSULTANTS 18
- LINKS TO TRIBAL HEALERS 15

4. What Information Does Your County Provide Pertaining to Mental Health Issues/Concerns in Native American Communities? What Information Is Currently Available on Your Website Pertaining to Native Americans and Mental Health?

- WEBSITE LINKS TO TRIBAL GOVERNMENT OR TRIBAL PROGRAMS/SERVICES 2
- PAMPHLETS AND BROCHURES 5
- TRAININGS/PRESENTATIONS 7
- OUTREACH EFFORTS (COMMUNITY HEALTH FAIRS, ETC.) 10
- NONE 7

5. What is Your County's Level of Readiness for Inclusion of Native Americans in County Mental Health Governance, Planning, Program and Services?

- READY 7
- SOMEWHAT READY 12
- NOT READY 3

## Appendix II
## Outline of Basic Competencies for Outreaching to Native American Communities

Survey results indicate that counties are at many differing stages of outreach and engagement with California tribal communities, and some have already successfully applied cultural knowledge to collaborative efforts. However, an outline of basic competencies for working with Tribal Communities is helpful to guide county mental health divisions in their endeavors.

Training has been conducted by Native American organizations in these key issues over the past several years, and is available on an ongoing basis from the Inter-Tribal Council of California, Inc., www.itcc.org. It is recommended that a thorough knowledge of these core issues be mastered prior to approaching tribal communities:

### I. History Relevant to the Mental Health of Native Americans

- California Tribal People: Key Public Policy -- Genocide
- Urban Tribal People: Key Policy -- Forced Relocation
- The Mission Experience
- The Boarding School Experience
- Traditional Practices and Ceremonies Outlawed by Federal Law in 1881

### II. Current Issues In Mental Health Engagement of Tribal Communities

- Discussions of Data In the Aftermath of Genocidal Policies
- American Indian Religious Freedoms Act of 1978
- Extent of Disparities for American Indian People
- Diversity of Tribes Represented in California (Urban and Rural)
- Knowledge of Tribal People Living Within Local County
- Issues of Sovereignty and Protocols for Approaching Tribal Communities
- Myths of Casino Wealth Ameliorating Need for Health and Human Services Interventions
- Impacts of Intergenerational or "Historical" Trauma on Today's Native People
- Integrated and Holistic Approaches to Tribal Communities

### III. Several Key Directions for Mental Health System Partnership with Tribal Communities

- Building Native Community Capacity Using the Healthy Nations Model (see Appendix V)
- Community Health Promotion Based on Traditional Practices (including talking circles, powwows, storytelling and sweat lodge ceremonies)
- Integrated (or Pluralistic) Treatment Models Combining Mental Health Clinical Models with Traditional Practices

# Appendix III
# Literature Review and Resource Guide to Historical Trauma and Post-Colonial Stress in American Indian Populations

By Dr. Maria Yellow Horse Brave Heart and Tina Deschenie


Recent studies on historic and multigenerational trauma among Native people have assisted individuals and communities in dealing with the continuing after effects. Following in the footsteps of Native American elders and activists, social workers, mental health professionals, and scholars are seeking to revitalize cultural traditions to combat problems of alcoholism, drug abuse, suicide, and mental illness -- all symptoms of historical trauma. Resources in this guide include relevant studies, websites, and a video. They provide information for students researching this topic, anyone interested in the healing process, and practitioners in the field.

**BOOKS**

Brave Heart, M.Y.H. (2004). **The historical trauma response among Natives and its relationship to substance abuse: A Lakota illustration.** In E. Nebelkopf & M. Phillips (Eds.), *Healing and mental health for Native Americans: Speaking in red* (pp. 7-18). Lanham, MD: AltaMira Press. This chapter explains historical trauma theory and the historical trauma response. Includes ways to incorporate the theory in treatment, research, and evaluation and concludes with implications for all massively traumatized populations.

Brave Heart, M.Y.H. (2001). **Clinical assessment with American Indians**. In R.Fong & S. Furuto (Eds.), *Cultural competent social work practice: Practice skills, interventions, and evaluation* (pp. 163-177). Reading, MA: Longman Publishers. This chapter includes information about incorporating historical trauma theory in assessment.

Brave Heart, M.Y.H. (2001) **Clinical interventions with American Indians.** In R. Fong & S. Furuto (Eds.), *Cultural competent social work practice: Practice skills, interventions, and evaluation* (pp. 285-298). Reading, MA: Longman Publishers. This chapter includes information about incorporating historical trauma theory in interventions.

Duran, E., Duran, B., Brave Heart, M.Y.H., & Yellow Horse, S.D. (1998). **Healing the American Indian soul wound.** In D. Yael (Ed.), International *handbook of multigenerational legacies of* trauma (pp. 341-354). NY: Plenum Press. In this chapter, the authors propose the concept of historical trauma and soul wound. Topics discussed include historical legacy, survivor syndrome/survivor's child complex, chronic and acute reactions to colonialism, and healing.

Gagné, Marie-Anik (1998). **The role of dependency and colonialism in generating trauma in First Nations citizens: The James Bay Cree.** In D. Yael (Ed.), *International handbook of multigenerational legacies of* trauma (pp. 355-372). NY: Plenum Press. This chapter focuses on the intergenerational effects of colonization trauma and examines the process of transmitting this trauma among the Cree of James Bay in Canada.

Robin, R.W., Chester, B., and Goldman, D. (1996). **Cumulative trauma and PTSD in American Indian communities.** In A. Marsella, M.J. Friedman, E.T. Gerrity, & R.M. Scurfield (Eds.), *Ethnocultural aspects of post-traumatic stress disorder: Issues, research, and clinical applications* (pp. 239-253). Washington, DC: American Psychological Association. This chapter summarizes what is known about the prevalence of psychopathology and multiple psychiatric disorders among American Indians. The current definition of Post-traumatic Stress Disorder (PTSD) fails to describe the impact of severe, multiple, and cumulative trauma among American Indians. They suggest other frameworks for conceptualizing the experience.

Tafoya, N. & Del Vecchio, A. (1996). **Back to the future: An examination of the Native American holocaust experience.** In M. McGoldrick & J. Giordano (Eds.), *Ethnicity and family therapy* (2 nd Ed., pp. 45-54). NY: Guilford Press. This chapter asserts that mental health professionals must be aware of the multigenerational disruption of positive development that results from 500 years of historical trauma for Native Americans as well as the persistent destructiveness of oppression and racism. Clinicians need to educate clients about historic trauma and support them through the process of grieving personal and tribal losses of language, tradition, and religion.

**DISSERTATIONS**

Abadian, S. (2000). **From wasteland to homeland: Trauma and the renewal of indigenous peoples and their communities.** *Dissertation Abstracts International Section A: Humanities & Social Sciences, 60*(7-A), 2591.
This study suggests that unresolved or poorly resolved individual and collective trauma help explain present-day conditions in many indigenous communities. Trauma is likely to be replicated. A set of interventions employed by increasing numbers of aboriginal communities in various guises, described as "culture as treatment," are effective to counter traumatically-induced social pathologies.

Ball, T. J. (1999). **Prevalence rates of full and partial PTSD and lifetime trauma in a sample of adult members of an American Indian tribe.** *Dissertation Abstracts International Section A: Humanities & Social Sciences, 60*(2-A), 0387. This study assessed the prevalence rates of lifetime trauma and PTSD among American Indian adults as well as the impact of the 1950s era federal policy of termination. The research incorporated an historical perspective, and Termination Trauma was assessed. The results validated the theory that the prevalence rates of lifetime trauma and PTSD were higher in the adult population of American Indians studied. In addition, the concept of Post-Colonial Stress Disorder was supported.

Brave Heart-Jordan, M.Y.H. (1995). **The return to the sacred path: Healing from historical trauma and historical unresolved grief among the Lakota.** *Dissertation Abstracts International Section A: Humanities & Social Sciences, 56*(9-A), 3742. This was the first study to develop and define historical trauma theory and address historical unresolved grief associated with the Wounded Knee Massacre and the forced removal of Lakota children to boarding schools. This study examined the effectiveness of a 4-day group intervention. The results of this quasi-experimental study confirmed positive responses. An extensive literature review includes relevant Jewish Holocaust citations as well as other trauma literature. Copies can be ordered from the Takini Network, TakiniNet@aol.com.

Cashin, J. (2001). **Trauma and multigenerational trauma caused by genocide and oppression: A comparison of Western and Native American healing methods.** *Dissertation Abstracts International Section B: The Sciences & Engineering, 61*(12-B), 6758. This dissertation examines multigenerational trauma that is caused by genocide and oppression. The literature reviewed covers multigenerational trauma, biological origins of traumatic states, trauma transmission, and healing/therapeutic methods including body-centered therapy, Hakomi, and EMDR (Eye Movement Desensitization and Reprocessing).

Whelshula, M. M. (2000). **Healing through decolonization: A study in the deconstruction of the Western scientific paradigm and the process of re-tribalizing among Native Americans.** *Dissertation Abstracts International Section B: The Sciences & Engineering, 60*(7-B), 3624. This study examined colonization and development of a decolonization healing practice. A description of the Colville Tribes' brutal colonization is included. The accounts of the colonization are examined through a psychological study of the victims' trauma. This study explores the importance of re-tribalizing through recovering the cosmology and traditional knowledge of indigenous cultures.

**ARTICLES**

Brave Heart, M.Y.H. (1998). **The return to the sacred path: Healing the historical trauma response among the Lakota.** *Smith College Studies in Social Work, 68*(3), 287-305. This was the first journal publication on the historical trauma intervention and theory.

Brave Heart, M.Y.H. (1999). **Oyate Ptayela: Rebuilding the Lakota nation through addressing historical trauma among Lakota parents.** *Journal of Human Behavior in the Social Environment, 2*(1-2), 109-126 and in H. Weaver (Ed.), *Voices of First Nations People: Considerations for human services*. New York: Haworth Press.
This qualitative study examined a Lakota parenting curriculum addressing historical trauma and its impact upon parenting. Results show that parents experienced the curriculum as effective, particularly the focus on both historical trauma and the reconnection with traditional Lakota values.

Brave Heart, M.Y.H. (1999) **Gender differences in the historical trauma response among the Lakota**. *Journal of Health and Social Policy, 10*(4), 1-21. This study addresses gender issues.

Manson, S. M., Beals, J., & Klein, S. A. (2005). **Social epidemiology of trauma among two American Indian reservation populations.** American *Journal of Public Health,95*(5), 851-859. This study examined the high prevalence of trauma in two large American Indian communities. The Indians' lifetime exposure rates to at least one trauma were 62.4%-67.2% among male participants and 66.2%-69.8% among female participants. Members of both tribes more often witnessed traumatic events, experienced traumas to loved ones, and were victims of physical attacks than their counterparts in the overall U.S. population.

Struthers, R., & Lowe, J. (2003). **Nursing in the Native American culture and historical trauma.** *Issues in Mental Health Nursing, 24*(3), 257-272. Historical trauma affects both health status and social milieu. To heal historical trauma, culturally appropriate strategies are needed. When encountering historical trauma, mental health care providers can use the Conceptual Framework of Nursing in the Native American Culture.

Walters, K. L. & Simoni, J. M. (2002). **Re-conceptualizing Native women's health: An "indigenist" stress-coping model.** American *Journal of Public Health, 92*(4), 520-524. This commentary presents an "indigenist" model of Native women's health, a stress-coping paradigm that situates Native women's health within the larger context of their colonization. Traumas and life stressors (such as the "soul wound" of historical and contemporary discrimination among Native women) influence health and mental health outcomes.

Whitbeck, L. B., Adams, G. W., & Hoyt, D. R. (2004). **Conceptualizing and measuring historical trauma among American Indian people.** American *Journal of Community Psychology*, *33*(3-4), 119-130. This article reports on the development of two measures relating to historical trauma: The Historical Loss Scale and The Historical Loss Associated Symptoms Scale. Frequencies indicate that the current generation of American Indian adults have frequent thoughts pertaining to historical losses and that they associate these losses with negative feelings. Two factors of the Historical Loss Associated Symptoms Scale indicate one anxiety/depression component and one anger/avoidance component. The results are discussed in terms of future research and theory pertaining to historical trauma among American Indian people.

**ORGANIZATIONS**

**Takini Network, Inc.** This is an American Indian non-profit organization founded in 1992 to help Native peoples heal from historical trauma through community education, training, and research. The mission includes improving the quality of life for American Indian children, youth, and families as well as future generations, through improving parenting and coping skills and healing boarding school trauma. The Takini Network seeks to restore Native communities and move beyond survival to empowering the People. *Takini* is a Lakota word for survivor and for one who has been brought back to life. Contact: takininet@aol.com or (303) 759-0975.

**White Bison, Inc.** offers sobriety, recovery, addictions prevention, and wellness/ "wellbriety" learning resources to the Native American community nationwide. White Bison's mission is to assist in bringing 100 Native American communities into healing by 2010. The site provides information on wellbriety services, an online magazine, products, and links to other organizations. www.whitebison.org/
Contact: info@whitebison.org, (719) 548-1000.

**Four Worlds Centre for Development Learning** was formed by aboriginal elders and community leaders on the Blood Indian Reservation in Alberta, Canada, in search of a solution to the social devastation brought on by alcohol,

poverty, and an increasing sense of powerlessness. The organization is part of an international network that assists communities in health, education and training, and community development. The site provides information on services, publications, and links to other organizations.
http://fourworlds.ca. Contact: anyone@fourworlds.ca, (403) 932-0882.

**VIDEOS**

***Celebration of Survival: The Takini Network*** (2002). Videographed by Gemma Lockhart, produced by Takini Network. This 25-minute video defines historical trauma and describes the historical trauma healing work of the Takini Network and the first international historical trauma healing conference in 2001. A limited number of copies are available through TakiniNnet@aol.com.

***Jidwá:doh Let's Become Again*** *(2005).* Directed by Dr. Dawn Martin-Hill (Mohawk), produced by the Indigenous Studies Programme at McMaster University, National Aboriginal Health Organization, and the Indigenous Health Research Development Program. This documentary highlights the International Indigenous Elders Summit, hosted at Six Nations, Ontario, Canada, in 2004. The elders speak about their understanding of historical trauma and about healing collectively using indigenous knowledge and traditional practices. Youths chronicle their perspectives. The film includes the Unity Ride, a 2200 kilometer ride and run. To order, call (519) 445-4714, email alidarnay@yahoo.ca, or go to www.ihrdp.ca.

***Healing the Hurts*****,** ISBN 1-896905-41-2, produced by Four Worlds Centre for Development Learning.
This 60-minute video documents the devastating effects of the boarding schools that shattered aboriginal culture, children, families, and communities throughout North America. Viewers join Native participants from Canada and the United States during a 4-day, culturally-based healing process for understanding and recovering from this type of traumatic experience. It can be ordered from http://fourworlds.ca/ or call (403) 932-0882.

*Dr. Maria Yellow Horse Brave Heart (Oglala and Hunkpapa Lakota) is the founder and director of the Takini Network, which is the only national organization focusing on historical trauma treatment and therapy. Tina Deschenie (Diné) is a language activist, poet, and frequent contributor to Tribal College Journal.*

*Editor's note: Because of the importance of this topic, we welcome any additional resources that readers would like to share. Send them or any comments about the issue to editor@tribalcollegejournal.org. Submitted references will be included in the Resource Guide section for Vol. 17, N.3 on the TCJ website.*

## Appendix IV
## Considerations For Working with Native Healers

***Adapted from Healing and Mental Health for Native Americans: Speaking in Red, Edited by Ethan Nebelkopf and Mary Phillips (Eds.). (2004). Lanham, MD: Alta Mira Press.***

Trust and Exploitation

There is concern about protecting traditional Native American healing practices from exploitation and misconceptions (Nelson J., Healing and Mental Health for Native Americans, p. 145):

> *The models of treatment that are the most effective are those in which traditional Native American thinking and practice are utilized in conjunction with Western practice. In order to accomplish this integration, the therapist must understand and validate traditional Native American cosmology. In essence, the therapist cannot simply learn to apply cross-cultural techniques in the hope that these will help the client. The therapist must believe and practice these beliefs in his/her personal life if the intervention is to benefit the client. There is nothing more offensive to a Native American client than a therapist who is pretending to understand and provide therapy within a traditional perspective if that therapist is mimicking a value system through the production of therapeutic techniques.*
>
> -Duran and Duran (1995)

According to research, another barrier is trust. Although in one study Navaho people had confidence in traditional Navajo medicine, they feel that they could not find a trustworthy practitioner, and that there were some people masquerading as Native healers (Kim and Kwok, 1998).

Costs Are Differently Considered

According to one research study, cost was cited by 36 percent of the persons in the Navajo tribe as the reason for not seeking Native healer care and was the most common barrier to Native healer care (Kim and Kwok, 1998). Costs are differently conceived of than in traditional mental health treatment: "The cost of visiting a Navajo healer includes such customary expenses as transportation, food for all those who participate in a ceremony, and costs of materials needed, such as buckskin or herbs." (Murillo, L. Healing and Mental Health for Native Americans, p. 112).

Culturally-Appropriate Interaction with Healers

"It is common practice for Native healers not to 'charge' a fee for their work. A Native healer in modern times must hold a regular job to support a family. In addition to their full time employment, Native healers are expected to serve the community on a twenty-four-hour basis. Native healers are required to travel long distances when they are requested to work with Native patients. The burden of time and travel expense is on the healer. Native people who are aware of this situation typically will help out with healers' travel expenses by finding a place for them to stay, feeding them, and pooling money to pay for gas and for a healer's time. This is done without the healer's requesting payment. This burden on the Native healer is a major reason so few people will commit to a healer's lifestyle of voluntary community service." (Murillo, L. Healing and Mental Health for Native Americans, p. 112).

Time Commitment for Traditional Healing

Time for Native healing practices can be extensive, some ceremonies require a week to perform, and consultations may take hours (Gurley et al, 2001).

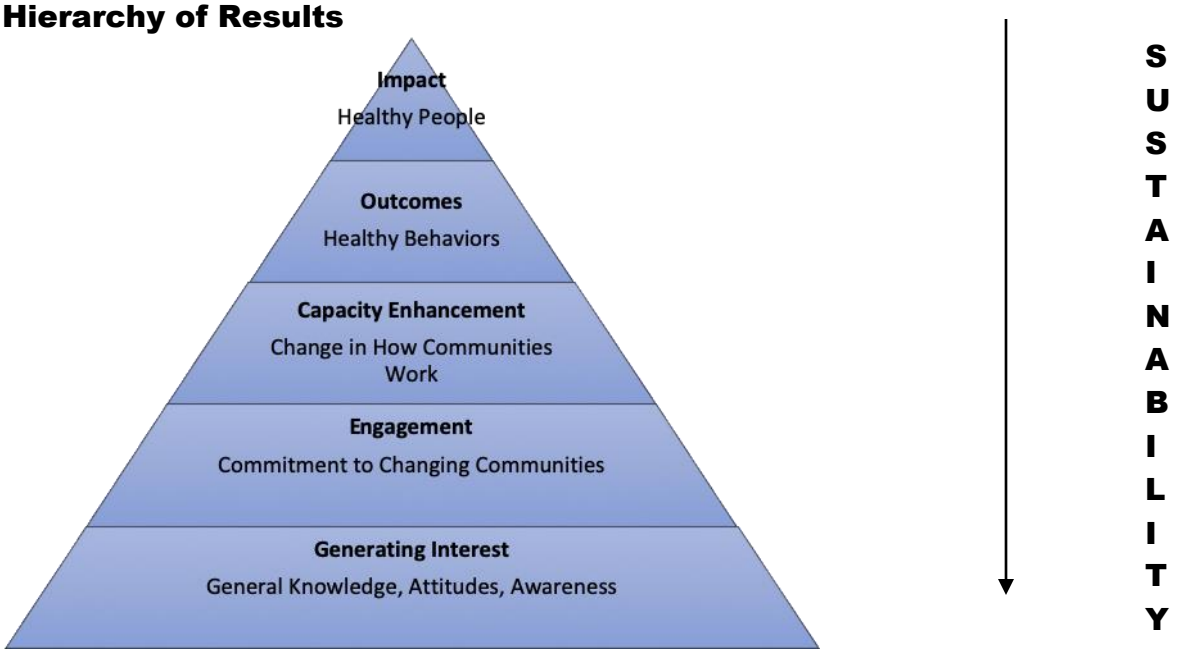
## Appendix V
## Achieving Results in the Healthy Nations Initiative

Adapted from Noe, T., Fleming, C. and Manson, S. (2004). **Reducing Substance Abuse in American Indian and Alaska Native Communities.** In E. Nebelkopf & M. Phillips (Eds.), *Healing and mental health for Native Americans: Speaking in red* (pp. 19-31). Lanham, MD: AltaMira Press.

The Hierarchy of Results is a developmental model of community engagement which was successfully implemented in the Healthy Nations Initiative, a substance abuse reduction project funded by the Robert Wood Johnson Foundation between 1992 and 2002. This model could be successfully utilized with many populations, but was particularly successful in deconstructing stages of intervention and demonstrating outcomes in Native American communities. Project researchers note that these key outcome indicators create a hierarchy of results that are strongly associated with community change (Cohen and Kibel 1993; Capra and Steindl-Rast 1991). For more information on the implementation and outcomes of the Healthy Nations Initiative, see www.uchsc.edu/ai/hni.

> *This hierarchy of results is a set of increasingly difficult accomplishments that must be realized on the way toward the ultimate result (community impact). In rare cases, a single program may be sufficiently potent to pass through several stages in the hierarchy and produce an impact. It is more likely that a succession of complementary programs, each building on the results of the prior ones, is necessary to reach the ultimate impact, that is, reducing substance abuse and its sequelae.*
>
> (Noe, T., Fleming, C. and Manson, S. 2004. P. 21)

### Hierarchy of Results




(Adapted from Noe, Fleming and Manson 2003)

"This conceptual model for the 'Healthy Nations' initiative illustrates the dynamic of creating community change for Health - like the tip of an iceberg, there is a great deal of change needed 'below the surface' before improvements in health become visible" (Dilley, J. et al, 2007).

## A Note About Sustainability in Native American Programs

Achieving sustainability is a critical goal in all community-based program development, but it is essential in working with Native American community programs. Healthy Nations researchers noted the comments of a program leader:

> *We have a responsibility to our program recipients. They've had so many losses in their lives, and if we come in for a year or two or three and give them hope, only to have the program go away, we've just caused another loss and further hopelessness in their lives.*
>
> (Noe, T., Fleming, C. and Manson, S. 2004. P. 26)

Efforts at program development that create a cycle of hopelessness and mistrust are counterproductive and will undermine long-term efforts to work with Native Communities. Utilizing the Hierarchy of Results to guide program planning resulted in almost all Healthy Nations grantees sustaining all or a portion of their substance abuse reduction activities. These were the means of achieving sustainability:

1. Existing tribal or organizational departments incorporated program activities, integrating them into existing programs.
2. Volunteer community groups took ownership, raising funds to support activities.
3. New grants and contracts were secured in some cases, and program activities were shifted to another funding source in others.
4. A tribal government or organization adopted programs wholesale and continued the activities.
5. Tribes or organizations collaborated with community members, such as a parent organization, to transition ownership to volunteer community groups.
6. Tribes or organization developed an endowment model, responding to submitted proposals for activities.
7. Groups adopted a fee-for-services model to cover program operating expenses.

## Successful Practices in the Healthy Nations Initiative

Researchers in the Healthy Nations Initiative observed a number of commonalities that led to effective program outcomes:

- Consistent and effective leadership.
- Incorporating a culture-focused approach; culture becomes "the program" rather than an add-on.
- Achieving community ownership and buy-in, involving community members at all levels of planning and implementation and adopting an approach of "doing with" the community rather than "doing for" the community.
- Developing creative and entrepreneurial approaches.
- Comprehensive efforts that impacted as many community systems as possible.
- Establishing effective collaboration.