

Center for Native Child and Family Resilience:

Literature Review



Center for
Native Child
and Family Resilience





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Introduction

Many prevention models in Indian Country build resilience by using Tribal cultural values, the transmission of family traditions, and the experiences of Tribal youth. Guided by these values, traditions, and experiences, Tribal communities have launched initiatives showing great promise in developing resilience-based models for child abuse prevention. The experiences of Tribal communities suggest that these approaches are often effective in enhancing family resilience and in reducing the risks of harm to children and adults—yet rarely have these strategies used collaborative, community-based evaluation to demonstrate their effectiveness.

As part of a Children’s Bureau project to raise awareness of Tribally engaged prevention and intervention efforts, the Center for Native Child and Family Resilience (the Center) supports and enhances the development and demonstration of resilience-related approaches to Tribal prevention of child maltreatment. The Center embraces the unique opportunity to honor and advance the valiant community efforts that improve Native family resilience and to help empower Tribal communities of care by using culturally engaged, community-based evaluation models to demonstrate the effectiveness of these efforts and to disseminate Native solutions to the field.

Sponsored by the Children’s Bureau, the Center is a partnership between JBS International, Inc., the Tribal Law and Policy Institute, and Mathematica Policy Research. The Center honors and advances knowledge of culturally relevant practice models, interventions, and services that contribute substantively to child

maltreatment prevention efforts and family resilience. In this literature review, the Center takes stock of the literature on practices that have been used in Tribal communities to confront and solve child maltreatment, with an emphasis on Tribally owned and internally developed practices, practices that have undergone a transformative process of cultural adaptation, and evidence-based practices that show promise for cultural adaptation.



Background

“We know that Native American wisdom exists within our stories, language, ceremonies, songs, and teachings. We know our Native ways are effective. We know that these ways are different from the Western worldview. We know we are experts in practicing and implementing our traditional ways to enhance the health of our people. We know our ways are unique and specific to Tribal groups. The authenticity of our Native American cultural wisdom is acknowledged and validated by our families, our clans, our communities. This knowledge has been validated for centuries by our ancestors. This knowledge exists within American Indian and Alaska Native communities, it is known by our people, and we will protect this sacred knowledge.”

—“American Indian and Alaska Native Cultural Wisdom Declaration,” *National Tribal Behavioral Health Agenda* (p. 5)



Within Tribal nations,¹ children are traditionally considered sacred beings. Accordingly, entire Tribal communities take great pains to ensure children were protected—physically, emotionally and spiritually—from birth. The profound community and cultural disruptions instigated by colonialism and genocide gravely undermined the Indigenous ways of knowing (including those embodied in child-rearing practices), a process that lives on in the legacies of forced assimilation. Taken together, these processes and the material conditions they have created substantially account for the contemporary suffering experienced by many Tribal communities across the United States and beyond, including rampant child maltreatment and neglect (Cross, Earle, & Simmons, 2000).

Though the limited surveillance and monitoring data on American Indian/Alaska Native (AI/AN) families make impossible determining exact rates for child maltreatment and neglect, the AI/AN population disproportionately experiences these problems. Data from the National Child Abuse and Neglect Data System indicate an estimated child maltreatment rate of 14.2 per 1,000 children for AI/AN children, the highest rate by race and ethnicity (Department of Health and Human Services, 2018). AI/AN children have an increased risk of exposure to many types of violence in their communities, including assault, violent threats, sexual assault, and homicide. They are 2.4 times more likely to die from gunshots than white children and teens (Children's Defense Fund, 2013, p. 2).

The tenacity of this child welfare crisis in Indian Country is further exacerbated by legal and social services infrastructures that regularly use culturally incongruent prevention efforts and interventions to address child maltreatment, which unintentionally re-traumatizes the Native children and families that these institutions seek to help. A recent study supported by the Department of Justice, Office on Violence Against Women described the features of



legal and social services infrastructures that Native communities experience as predominantly Western mechanisms for preventing and addressing child maltreatment, including abrupt removal of children from the household; lack of services assisting parents to regain custody of children; lack of domestic violence shelters, transitional housing, and permanent housing on reservations; and weak collaboration across individual agencies addressing family violence (e.g., domestic violence programs, child protection agencies, substance abuse treatment centers). Perhaps most troubling is that issues of culture, tradition, and values are often missing links in many Tribal social services agencies. Western ideas and practices often take priority in prevention and intervention efforts, with Native values and ideals occupying a peripheral position, at best (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2014).

¹ Talking collectively about populations is a politically charged task, and doing so about American Indian/Alaska Native (AI/AN) populations is especially fraught with concerns about reductionism and cultural erasure. We recognize the diversity of Tribal nations in the United States (and beyond), but in characterizing general phenomena, we use AI/AN, Native American, Indigenous, etc. interchangeably in this literature review when referring to this population collectively. In addition, it is worth noting that child maltreatment frequently varies from Tribal region to region and that the challenges faced in each locale may differ widely.

Given that issues of child maltreatment and neglect arise from, and are inextricably tied to, the long-term undermining of Tribal social structures, practices, and forms of knowledge by external forces, it follows that the most appropriate solutions to current maltreatment crises in Indian Country lie in the hands of Tribal communities themselves. Tribally created and adapted models, imbued with cultural integrity, have the power to not only provide therapeutic and holistic response to children and families in crisis, but also have the potential to stop the cycle of violence in entire families and communities and to bring about sustainable and long-term social change. Providing Tribal communities with resources to assist them with reclaiming traditional and cultural knowledge is the keynote of culturally responsive intervention and prevention efforts.

In the followings sections, we highlight some of the major risk and protective factors identified in our review and outline some structural constraints on this literature review. We then present the major findings of our review, including sample interventions, and discuss the review's relationship to this project's next task: the environmental scan.

Risk Factors, Protective Factors

There are well-established risk and protective factors that are applicable regardless of one's culture. Examples of such risk factors include parental substance abuse, history of child abuse and neglect, and neighborhood violence. Protective factors include, but are not limited to, strong parent-child relationship, access to health and social services and high level of parental education (see Appendix 1 for an expanded list of the risk and protective factors and their associated ecological level). Among AI/AN youth, one of the major societal risk factors of health inequities (including child maltreatment and abuse) is the history of oppression, domination, and marginalization experienced by Indigenous persons as a result of colonization.

Intergenerational trauma and **historical trauma** are concepts used to describe the trauma inflicted on groups sharing an ethnic or national background (see generally: Burnette & Hefflinger, 2016; Evans-Campbell & Campbell, 2014). Under the umbrella of inter-

generational and historical trauma are several well-established and commonly cited risk factors for child maltreatment among AI/AN populations, including perceived discrimination (Whitbeck et al., 2001), parental/familial financial strain (Whitbeck et al., 2009), parental mental health and substance abuse problems (Cheadle & Whitbeck, 2011), familial adverse childhood events, and chronic illness and unintentional injuries (Felitti et al., 1998). Adding to the complexity of this conundrum is the high degree of collinearity and inter-relatedness among these risk factors, limiting our ability to draw causal connections. For example, on the Pine Ridge Indian Reservation in South Dakota, 70 percent of adults are unemployed. Here also, issues of substance abuse, homelessness, rape, and child abuse are everyday challenges, and the homicide rate is more than five times the national average (U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2012). Until a few years ago, the reservation only had 8 officers to respond to the needs of its population of approximately 17,000 residents. This example illustrates the need for intervention and prevention efforts in Indian Country that consider multiple layers of ecology, including family, community, political, and legal spheres.

If intergenerational and historical trauma are the primary risk factors of child maltreatment in Indian Country, protective factors for this population must encapsulate the ways in which AI/AN people approach and respond to adversity in healthy ways. In particular, cultural continuity is often situated as an overarching framework for examining Native resilience, wellness, and well-being. Identification with, participation in, and understanding of one's culture, especially among AI/AN populations, is believed to provide a buffering effect against the vast majority of social ills facing Native communities today, particularly child maltreatment (Baldwin et al., 2011; Barney, 2001; Garrett et al., 2011; Stumblingbear-Riddle & Romans, 2012). Spirituality and connectedness are particularly important for AI/AN youth (Hill, 2009), as are the institutions of community and family, especially extended family (Gone & Trimble, 2012). There is growing evidence that Native youth who are culturally and spiritually engaged are more resilient than their peers (Rieckmann, Wadsworth, & Deyhle, 2004; Yoder, Whitbeck,



Hoyt, & LaFromboise, 2006). Research has also found that Indigenous caregivers find traditional ceremonies (e.g., sweat lodges or prayers) more effective than standard health treatment protocols (Walls, Johnson, Whitbeck, & Hoyt, 2006). The integration of traditional healing practices into prevention and treatment for Native children and youth is, therefore, essential. According to Bassett, Tsosie, and Nannauck (2012), “Indigenous means of treatment through culture may include any or all of the following: language, traditional foods, ceremonies, traditional values, spiritual beliefs, history, stories, songs, traditional plants and canoe journeys” (p. 25).

Constraints

A multitude of child welfare practices exist throughout Tribal communities, although a number of structural features prevent this review from possessing enough information about the nature and effectiveness of such programs or their methods of implementation. Though these practices may have been used successfully cross-generationally, even for centuries, they nonetheless may not have produced the kind of documentary paper trail that positions them for appearing in a literature review.

Roughly speaking, this literature review addresses the academic or scholarly documentation of programs, models, and interventions. The gap between academic cultures and institutions, on the one hand, and AI/AN populations, on the other, reflects the broader social gaps between both (a) the cultures of academics

and frontline service providers and (b) hegemonic Eurocentric cultures and Tribal cultures. This gap plays out in many contexts; for example, most federal health care funding supports only those interventions that are backed by mainstream medical research and evidence-based practices, considered the standard for acceptable mental health treatment. Such practices and priorities not only distort or undermine the knowledge base developed in Indian Country—they also inadvertently reinforce the cultural trauma inflicted on Native populations, which, in turn, leads to an erosion of natural protective factors, such as language, spiritual beliefs, ceremonies, and values.

This epistemic blind spot is mitigated by the fact that this literature review is a preliminary step; it is an investigation into documented programs, i.e., programs with a presence in the literature. It is preliminary in that it is not designed to give a complete map of the existing programmatic options; it will, instead, inform the work done in the environmental scan. Such a scan plays a heightened role in this project precisely because the literature itself may not adequately reflect the conditions on the ground. The literature review serves as preliminary material, an informative guide for those undertaking the environmental scan.

Methodology

Search Methods

To identify peer-reviewed literature, we relied primarily on academic databases, including Medline, PsycINFO, Health Policy Reference Center, and SocINDEX. We combined the following strategies using database-specific syntax:

- Search by keyword/Boolean string
- Search by SmartText
- Search for specific authors
- Search for specific journals
- Search by citation

In addition to searching academic databases, we cast a wide net by exploring online search engines (e.g., Google Scholar), as well



as websites from government agencies (e.g., Administration for Children and Families, Substance Abuse and Mental Health Services Administration [SAMHSA], and Indian Health Service[IHS]), grantees, nonprofits, stakeholders, and higher education.

We limited our search results to articles published after 2001, making some exceptions for especially promising pieces, and we used search terms addressing the topics of AI/AN prevention efforts, intergenerational trauma, trauma-informed care, resilience and protective factors, evidence-based practices, child maltreatment, interventions, and behavioral health.

Subsequently, we reviewed the abstracts of the articles returned by these searches, sorting and identifying the articles that either were directly relevant to the project or provided useful reference or background information. Relevant articles, those that detailed promising practices or interventions, were further categorized by type of intervention, risk and protective factors, intervention type, focus areas, and Tribal level of engagement. Articles that contained information about risk and protective factors related to child maltreatment, as well as those that were more theoretical in nature, were categorized as reference material.

The distinction that quickly asserted itself as the primary organizational focus was between prevention programs/interventions that:

- Were developed entirely within a Tribal culture and setting (**Tribally Created**);
- Originated outside of Tribal culture but had been adapted for use in a Tribal setting (**Tribally Adapted**); and
- Showed promise for adaptation within a Tribal setting, though no such adaptations existed yet (**Promising, Not Adapted**).

As a result, the articles in this review address more than just existing child welfare interventions in Indian Country; they include existing interventions from child welfare that show promise for adaptation for use with AI/AN populations, as well as interventions from child welfare, mental health, and related fields that have been adapted for use with AI/AN populations. The section encompassing the Promising, Not Adapted interventions also includes some gener-

al guidance or theoretical frameworks for adapting programs in the Tribal context. When possible, we included information about how these practices were adapted, because these steps could serve as crucial resources to help adapt interventions that have not previously been used with Native populations.

Article Review Process

We began by creating a database from the initial search results. The team used article abstracts to determine whether an article was (1) relevant, (2) possibly useful as reference material, (3) required further discussion for categorization, or (4) not useful. Following this first pass, we acquired the relevant articles, read them, and further categorized them by the types of intervention, ecological level, risk and protective factors, etc. (See Appendix 1, the Code Book, for classification scheme details.)

The process itself was iterative, in that the review of abstracts and articles led to refined search strategies, which, in turn, produced additional materials for review and categorization. For any subsequent articles, we followed the process outlined above. Once we categorized the relevance of the article, as well as the type of intervention it described (i.e., Tribally Created; Tribally Adapted; or Promising, Not Adapted), we again reviewed the relevant articles and wrote a summary for each intervention or program. Each summary contained pertinent information about the intervention(s) described within the article, including a high-level description of the intervention or program, risk factors addressed, any adaptations made, and, if applicable, the process used to make those adaptations. The summary also included any evidence regarding effectiveness of the intervention.





Presentation of Literature Review Findings

We present our findings organized into three broad categories, based on the adaptation level of the interventions the articles described:

- **Tribal Creation.** The intervention/prevention program, service, policy, strategy, program, practice model, or combination thereof described in the article was created entirely within Tribal culture and settings.
- **Tribal Adaptation.** The intervention/prevention program, service, policy, strategy, program, practice model, or combination thereof described in the article was created outside Tribal culture, and it has been adapted (without losing fidelity to its core components) for use in a Tribal setting.
- **Promising, Not Adapted.** The intervention/prevention program, service, policy, strategy, program, practice model, or combination thereof described in the article was created outside Tribal culture and has not been adapted for use in a Tribal community but shows promise for such an adaptation.²

As expected, the majority of the literature described interventions originating outside of Tribal culture and setting that were subsequently adapted to it. The number, variety, and varying quality and focus of articles that we found requires that we take a high-level approach to the Findings section. For each of these categories, we provide an overview of the major types (or clusters) of programs and describe in greater detail examples of each type (or cluster). This approach allows the reader to understand, at once, the overall status the literature's content and some sense of what the programs described in the literature are like as implementations.

For each of the categories (i.e., Tribally Created; Tribally Adapted; and Promising, Not Adapted), the goal was to provide the reader a better understanding of the key elements, intended effects, and



results of certain interventions and programs. To do this we used the following criteria when thinking about how to highlight specific programs:

- **Innovative.** The programs are distinctive and involve innovative processes that appear to present promising solutions to challenges affecting children and families. They contain a coherent strategy or vision that promises to improve a significant aspect of familial and community relations.
- **Responsive.** The programs devoted efforts to identify specific needs within the community and to respond to those specific needs. The community served found the program useful.
- **Culturally Compatible.** The programs, as situated within a broader health system, are in accord with the current beliefs, understandings, values, and future goals of the community.

² These formulations are based on *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*, (Framework Workgroup, 2014, p. 5).



- **Community Component of Services.** The programs are strengthening the relationship of the AI person to his or her community. The programs are well received and have support from the surrounding community and Tribal government.
- **Government or Nonprofit Operation.** The programs operate within the Tribal nations' governments or operate as nonprofit organizations.
- **Respect for and Enhancement of Tribal Ways of Knowing.** The programs demonstrate respect for the value of Indigenous ways of knowing and promote Tribal administration of wellness.
- **Intergovernmental Cooperation.** The programs achieve benefits of coordinated, consensual, and mutually respectful relations between Tribal and non-Tribal justice agencies.

The order in which programs/interventions appear in each section is no indication of a ranking or any other comparative ordering. The program/intervention was merely chosen because of its reflection of the selection criteria. This literature review is meant to present a snapshot of documented programs/interventions rather than present a hierarchical or exhaustive list. Programs/interventions highlighted in the literature review were selected based on the authors' research and knowledge, with input from the Children's Bureau.

A final note, before turning to the findings: A review of the literature necessarily examines the nature and scope of *publications*. There are two consequences of this focus. First, there is not a 1:1 relationship between articles and interventions; some publications described multiple interventions, and some interventions are the subject of multiple publications. More importantly, this literature review provides a snapshot of the material appearing in (by and large) peer-reviewed, academic journals; it is a snapshot of a particular source of information. This material, though, only serves as a preliminary inquiry informing the *environmental scan*, which will focus on getting a view of programs and interventions not described by the academic literature.

Tribal Creation

Overview

Our first set of findings addresses articles that describe intervention/prevention programs, services, policies, strategies, programs, or practice models *created entirely within Tribal culture and settings*. These are a natural starting point for our discussion because they highlight what Tribes have already accomplished using models and methods completely at home in Tribal culture; demonstrate the creativity and variety of models and methods already implemented; and frame the material in the later portions of the Findings section, which covers interventions, programs, etc., originally created outside the Tribal context and have been adapted (or look promising for adaptation) in a Tribal context.

Summary of Findings

Tribally created programs typically addressed family and community resilience building, clustered in three areas:

- **Community Healing as Wellness Enhancement.** Understanding that AI/AN community and culture are sources for and sites of wellness enhancement.
- **Tribal Family Life Skills and Resilience.** Enhancing resilience through enhancing family life skills.
- **Youth Interventions and Bicultural Skills Enhancement.** Improving youth aptitude with AI/AN cultures *and* mainstream, Western culture bolsters youth resilience.

While these categories are distinct, they are interrelated, and programs may address several at once. Consider, for example, the **Historical Trauma and Unresolved Grief Intervention (HTUGI)**, a "short-term, culturally congruent intervention for grief resolution and trauma mastery that has been used among a coping segment of an underserved American Indian adult population with elevated health disparities" (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012, p. S180). HTUGI uses Lakota history, concepts, and ceremonies to help heal historical trauma and to



improve health outcomes. In this way, HTUGI uses community healing to enhance wellness *while* enhancing participants' bi-cultural skills.

A trio of high level conclusions sum up the literature regarding Tribally created programs:

Culture Matters. Many of the models addressed a specific Tribal community rather than provide more generic inter-Tribal solutions. Tribal community members also played a key role in the design and implementation of these interventions, often advising or facilitating the programs.

Mixed Modalities Enhance Learning. Many of the Tribal Creations used mixed modalities, combining experiential learning with curriculum-based learning. The interventions were innovative in their use of ceremony, ceremonial leaders, and storytelling tradition.

Collaboration Can Benefit and Center Tribes. Many Tribal Creations resulted from collaboration with Elders, service providers, academic institutions, and grant providers. These collaborations did not dilute the centrality of Tribal goals or needs.

Community Healing as Wellness Enhancement

AI/AN communities are not just any communities; they are communities that have survived and thrived for centuries in the face of historical and intergenerational trauma. As Whitbeck, Adams, Hoyte, and Chen (2004) note,

[T]he ethnic cleansing [of AI peoples] did not end with military defeat and occupation of territory. Rather, it persisted for generations. This means that American Indian people are faced with daily reminders of loss: reservation living, encroachment of Europeans on even their reservation lands, loss of language, loss and confusion regarding traditional religious practices, loss of traditional family systems, and loss of traditional healing practices. (p. 121)

The resulting loss of cultural identity and connection “can be measured and studied in association with other risky behaviors, such as alcohol and drug abuse, obesity, and psycho-social problems, as well as poor health conditions” (Hodge & Nandy, 2011, p. 6).

Among the factors that have protected Native Americans in the face of the numerous historical and contemporary traumas and challenges are the diversity among Native American groups, Indigenous Ways of Knowing (IWok), cultural identity rooted in the Tribal nation and community, the importance of familial ties, the integral role for Elders as wisdom keepers, traditional Native spiritual ways, communication styles that emphasize moderation and harmony, and using humor as a tool for coping with adversity (Garrett et al., 2014, pp. 472–476).

Put simply: culture matters, because it provides the context and tools for people to understand their world and thrive within it. Programs that bolster and affirm cultural connectivity serve to foster resilience.

A few programs we found were oriented toward using culture as an agent or the subject of healing. The Robert Wood Johnson Foundation's **Healthy Nations Initiative** ([HNI], formally named “Healthy Nations: Reducing Substance Abuse Among Native Americans”), provided grants to support “the development of community-wide efforts to combat substance abuse, integrating public awareness campaigns, prevention programs, and facilitation of services for treatment, aftercare and support” (Noe, Fleming, & Manson, 2003, p. 16). Commonalities among the most effective programs included the incorporation of a culture-focused approach, where culture “became ‘the program’ for the most effective grantees instead of culture as an ‘add on’,” and the development of comprehensive efforts that sought to address “as many community systems as possible, (e.g., schools, families, peers, neighborhoods, and [T]ribal organizations)” (Noe et al., 2003, p. 23).

Similar findings about the importance of incorporating cultural identity and addressing society-wide trauma appear in “A Community-Based Treatment for Native American Historical Trauma: Prospects for Evidence-Based Practice” (Gone, 2013), which describes a



study commissioned by Canada's Aboriginal Healing Foundation (AHF) as a part of five coordinated research projects documenting "therapeutic approaches and activities for a select number of AHF-funded programs intended to redress the legacy of residential schools in Canadian Aboriginal communities" (Gone, 2013, p. 753). The results indicated that the approach was helpful at the individual level, with individuals coming to recognize and cathartically express these traumas found "by counselors to inaugurate lifelong habits of introspection and self-improvement," as well as at the sociocultural level, in that the "healing journey entailed a reclamation of [I]ndigenous heritage, identity, and spirituality that program staff thought would neutralize the pathogenic effects of colonization" (Gone, 2013, p. 751).

Tribal Family Life Skills and Resilience

A significant theme in the literature of Tribal Creations addresses the ways that AI family resilience factors offer protection against the harms of family violence, substance use, and mental health issues. Historical trauma can change families as they work to survive and adapt to their circumstances and environment. While this adjustment may be smooth for some, for others the stress and

burden cause them to feel alone, overwhelmed, and less able to maintain vital family functions. Traumas, as experienced by any or all members of a family, often shake family foundations. Traumas can cause traumatic stress responses in family members, in turn causing consequences that ripple through family relationships and impede optimal family functioning. Efforts of Tribal healing and repair focus upon cultural and interactive family skill building in an effort to bring healing.

Programs in this area addressed two kinds of challenges. The first type of challenge, addressed by the majority of programs, operated at the level of interpersonal relationships and violence. Typically, these programs sought to foster resilience in individuals (e.g., women who survived intimate partner violence or gifted AI adolescents). Burnette & Hefflinger's (2016) article, "Honoring Resilience Narratives: Protective Factors Among Indigenous Women Experiencing Intimate Partner Violence", presented the results of ethnographic interviews with AI/AN women who had experienced intimate partner violence. A thematic analysis of the interviews indicated that the protective factors included: "(a) an educational orientation; (b) affirming talents and abilities; (c) constructive coping, which included helping others and expressing emotions; (d) faith; (e) optimism and resilience perspectives; and (f) self-reliance and inner strength" (Burnette & Hefflinger, 2016, p. 63). Another article, "Pathway to Hope: An Indigenous Approach to Healing Child Sexual Abuse" (Payne, Olson, & Parrish, 2013), documents the history, content, and evidence behind the **Pathway to Hope** program, a healing-centered intervention based upon input from a group of Tribal community experts: respected AN elders, Native victim service providers, and young Native adults from Tribal cultures. The group recognized the role of child sexual abuse in historical and intergenerational trauma, which was compounded by the culture of silence cited in AN communities. No known prior program attempting to promote healing from child sexual abuse in Alaska had originated strictly from the core concepts, values, and beliefs of Alaska's Indigenous people.



A few programs specifically addressed socio-cultural structures that can directly undermine the wellbeing of individuals and families. For example, the **Family Wellness Warriors Initiative** (Gottlieb, 2007; Gottlieb & Outten, 2011) was a project that took a moment of institutional change in AN health care—the restructuring of the former IHS health care system—to implement community-created, culturally accommodating solutions to reduce family-wellness risk. This model has expanded to include a training program that helps build partnerships between AN health care organizations, government agencies, social services providers, and faith communities.

Youth Interventions and Bicultural Skills Enhancement

The third major component of the literature on Tribal Creations was programs that provided youth with bicultural skills enhancement in order to ensure their wellness and well-being, with a special emphasis on wellness related to substance use and abuse. This bicultural skills “approach teaches American Indian individuals to draw on both Native American and popular American cultures—instead of identifying with only one culture—to better adapt to, interact with, and thrive within both cultures.”³ The focus on bicultural competency and skills enhancement is natural, given that programs “focused on youth empowerment seem to be more successful when youth are trained in bicultural competency. Adolescents who could demonstrate their ability to function successfully in both Native and mainstream cultures may be less likely to develop problems with alcohol or drugs” (Hawkins, Cummins, & Marlatt, 2004, p. 317). Programs in this category also tended to rely on mixed modalities to enhance learning, integrating ceremony, ceremonial leaders, storytelling, and other traditional activities. For an example of a youth-oriented, bicultural, skills-enhancing program that used mixed modality learning, see the “Canoe Family”-related programs in the Community Component of Services section, below.

Indeed, the sample Tribal Creations, below, are all from this category: Honoring Ancient Wisdom and Knowledge² (HAWK²), Zuni Life Skills Development Program, “Canoe Journey, Life’s Journey” curriculum, and Nagi Kicopi. There are two additional bicultural skills programs to discuss:

The first, **Elluam Tungiinun**, appears in the literature alongside Nagi Kicopi in “Cultural Interventions for American Indian and Alaskan Native Youth: the *Elluam Tungiinun* and *Nagi Kicopi* Programs” (Allen et al., 2011). *Elluam Tungiinun*, which means “toward wellness,” prevents youth suicide and alcohol abuse in children aged 12–18 by providing various ways for the participants to experience wellness. It is modeled on the People Awakening Project that helped AN people develop a path toward sobriety.



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³ See “Bicultural Competence Skills Approach” at <https://youth.gov/content/bicultural-competence-skills-approach>.

The program consists of various cultural experiences or program activities, including Elders and parents sharing their experiences; making connections to each of these activities or experiences; and highlighting the connection between choosing wellness, understanding, and reasons for living. An evaluation of the community protective factors (including safety, alcohol prohibitions, role models, opportunities for youth, and support) provided initial evidence indicating that the program is effective.

The other intervention is **The Natural Connection (TNC)**, a program at the Institute for American Indian Arts in Santa Fe, New Mexico described in “Substance Abuse and Spirituality: A Program for Native American Students” (Navarro, Wilson, Berger, & Taylor, 1997). TNC “addressed cultural traditions, [T]ribal history, and spirituality as avenues toward improving self-esteem” (Navarro et al., 1997, p. 4) and thereby improving substance use prevention outcomes. TNC’s work, had several components: introductory and advanced courses, co-led by psychologists, that included readings considered classics in Native American literature and relied heavily on group discussion; presentations and ceremonies led by traditional healers and spiritual leaders from many Tribes; and student projects. The authors suggest that the “project demonstrated strong promise to the effective link of cultural ceremony, spirituality and traditional values in prevention of substance abuse and addiction” (Navarro et al., 1997, p. 3), but they also noted that the “search for spiritual commonality was complicated by the students’ diverse backgrounds” and that several “female students wanted more emphasis on the importance of women in Native American history, traditions, spirituality, and the arts” (Navarro et al., 1997, p. 7).

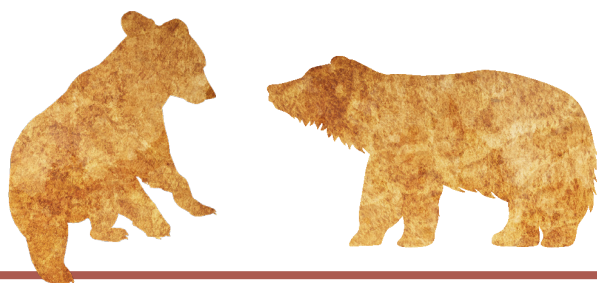
Sample Tribal Creations

Of the broader criteria for inclusion in the literature review, a few are particularly relevant to Tribal Creations. In this section, we’ll look at one program in a bit more depth for each of the following criteria:

- **Innovative.** The programs are distinctive and involve innovative processes that appear to present promising solutions to challenges affecting children and families. The programs contain a coherent strategy or vision that promises to improve a significant aspect of familial and community relations.
- **Responsive.** The programs devoted efforts to identify specific needs within the community and to respond to those specific needs. The community served found the program useful.
- **Community Component of Services.** The programs are strengthening the relationship of the AI person to his or her community. The programs are well received and have support from the surrounding community and Tribal government.
- **Respect for and Enhancement of Indigenous Ways of Knowing:** The programs demonstrate respect for the value of Indigenous ways of knowing nations and promote Tribal administration of justice in Tribal territory.

Innovative

A novel intervention that enhanced bicultural competence to reduce substance abuse among AI/AN youth was the **Honoring Ancient Wisdom and Knowledge² (HAWK²)** program (Raghupathy & Forth, 2012), which combines multimedia and culturally tailored interventions. Much like the Canoe Journey (see Community Component of Services, below), the HAWK² program embeds efforts to produce bicultural competency in the lessons. An adaptation of the statewide Indian Drug Prevention Program, HAWK² is innovative in its use of computer-based skills enhancement to transfer substance abuse knowledge and skills training. The multimedia features include games, animations, and video clips, which help convey its “underlying emphasis on *bicultural competence*, i.e., the development of skills for negotiating both





mainstream and Native cultures” (Raghupathy & Forth, 2012, p. 462). A review by end-users (45 Native youth aged 11–13) indicated that, while there were some elements that needed fine tuning (e.g., the pacing of narration),

[T]he alpha prototype received very high ratings by the youth on overall usability features such as like-ability (mean rating: 4.8/5), ease of use (mean: 4.5/5), comprehension (4.6/5), and future use (5.0/5). Likewise, practitioners who reviewed the program found it to be “timely,” “compelling,” and “definitely something that could be used in our schools” (Raghupathy & Forth, 2012, p. 466).

Responsive

The **Zuni Life Skills Development Program** (LaFromboise & Lewis, 2008) is designed for high-school students as a suicide prevention program. It was developed collaboratively by Stanford University and Zuni community leaders in response to a number of suicides by youth in their community. The community played a key role in the development of the intervention and evaluation. It is a life skills training course that builds help-seeking behavior. It utilized small group work, role modeling, and community gatekeeping. Additionally, this type of intervention relies on collaboration between the community and the intervention designers because the community can specify the target problem(s) and design the appropriate response. As the name implies, this intervention was specifically tailored to be used by and compatible with the Zuni culture.

The intervention consisted of 7 major units was offered 3 days a week for a year and had booster sessions in the third year. The units were (LaFromboise & Lewis, 2008, p.347):

- Build self-esteem
- Identify emotions and stress
- Increase communication and problem solving
- Recognize and eliminate self-destructive behavior
- Learn about rates of suicide across Tribes, risk factors for suicide, warning signs of suicide, and facts and myths of suicide

- Receive suicide crisis intervention training
- Engage in individual and collective goal setting

The development of the Zuni Life Skills Development Program led the way for the development of the American Indian Life Skills Development Curriculum, which was a curriculum that contains cultural values and respect that are important to all Native Americans, such as kindness and respect. This version encourages users to adapt the content to fit their own specific Tribe and cultures, while maintaining the same skills portion. The American Indian Life Skills Development Curriculum was implemented in a high school in Oklahoma, resulting in a dramatically decreased suicide rate.

Community Component of Services

One form that fashioning a developmental and bicultural skills approach from the tools of the Tribal culture has taken involves the “Canoe Family” practice (Hawkins, Cummins, & Marlatt, 2004) of Northwest Coastal Tribes, which provides structured, prosocial activities that can function as effective alternatives to substance use:

Throughout the year, youth who belong to the Canoe Family participate in a wide range of activities designed to prepare them for annual canoe journeys to visit other Tribes both in British Columbia and the Pacific Northwest. Such activities include participation in “talking circles” with elders and respected community members, the construction of large ocean-going canoes that can carry groups of paddlers from one community to another and learning how to navigate the waters of Puget Sound. When visiting canoes arrive at a particular destination, the event is celebrated with cultural protocols that include feasting on local specialties, singing, dancing, and participation in potlatches (gift-giving ceremonies). The only requirement for involvement in the Canoe Family is that youth make a commitment to being clean and sober throughout all activities. Participation in the Canoe Family is clearly a desirable and prestigious alternative to being involved in activities associated with drinking and taking drugs. (Hawkins et al., 2004, p. 317)



A number of programs have used this practice as the basis of their interventions. One curriculum, **Canoe Journey, Life's Journey**, wedded the Canoe Family with the imagery of the medicine wheel to organize the journey and the skills it bolsters, with preliminary "analyses suggest[ing] positive outcome trends at the 3-month follow-up" (Hawkins et al., 2004, p. 318). A subsequent project, the Healing of the Canoe (HOC), adapted this curriculum to other Tribal contexts. HOC was an academic-Tribal partnership between the University of Washington Alcohol and Drug Abuse Institute and the Suquamish and Port Gamble S'Klallam Tribes. Assessments of HOC found that integrating "evidence-based components of positive youth development and Tribal-specific culture, traditions, and values, the curricula have the potential of reducing substance use; increasing hope, optimism, and self-efficacy; and facilitating cultural identity" (Donovan et al., p. 67).

Respect for and Enhancement of Tribal Ways of Knowing

The **Nagi Kicopi** program (Allen et al., 2011; Freeman et al., 2016) serves Lakota youth on the Pine Ridge Reservation who are challenged with serious emotional and behavioral problems. The program offers traditional services and healing methods for youth, including ceremonies and customs. The families of the youth were also invited to participate. The Lakota protocol is for the traditional healer to talk to the designated Elder and caregiver for the youth to determine the appropriate healing ceremony, which is chosen specifically for each youth and based on seven sacred Lakota ceremonies. In addition to the healing ceremonies, each youth had an intervention plan that also included teachings about identity development and cultural practices.

The program begins with a spiritual assessment done during a ceremony in order to discover the root of the problem. The family is then assigned a care worker and given any follow up ceremonies by the medicine man. Initial assessments include family history, psychosocial assessments, assessments required by SAMHSA, as well as other locally created assessments that reviewed immersion

in Oglala tradition and culture. One of the key assessments used is the Oglala Global Assessment of Functioning (GAF), created specifically for this project and modeled after the GAF associated with the Diagnostic and Statistical Manual of Mental Health Disorders-IV. The final Oglala GAF has four domains (spiritual, physical, emotional, and cognitive). The assessments used had been deemed culturally appropriate by Lakota Elders. Scores on this assessment serve as the basis for service planning to address each of the four domains. Nagi Kicopi revealed that traditional healing and cultural practices, as well as the promotion of cultural identity, had statistically significant positive effects on the perceived familial and individual functioning of Lakota youth and their families. The results demonstrated that healing ceremonies had statistically significant positive effects on multiple areas of family functioning, decision-making, and conflict resolution. The size of the effect indicates that the results have strong practical significance and lends support the claim that if Native peoples' mental health problems are rooted in historical events, then the solution may well be rooted in Tribal culture and Tribal history. Although SAMHSA funding has not continued, the program continued because the community thought it was a valuable resource and found funds to maintain it.

Tribal Adaptation

Overview

The literature on Tribal Adaptations includes programs that were originally developed for use outside of Tribal culture and have been adapted to be used within a Tribal setting, without changing the core components of the program. We expected this literature to be more expansive, as evidence-based interventions already have an existing literature base, as well as documentation and evaluation procedures. This expectation proved correct in the review of the literature, which highlighted a variety of ways that Tribes adapt existing models and put them into practice in Tribal communities. As indicated in the introduction to this section, the Tribal Adaptation category represents the bulk of published work reviewed.



As with Tribal Creations, programs adapted for use with Tribes serve to bring Indigenous ways of knowing and value systems to the center of interventions. All Tribal Adaptations programs and models reviewed included elements that increase cultural and community engagement and internal healing from myriad threats to family functioning: enhanced communication, improved prosocial behaviors, or expanded knowledge base. In enhancing Tribal family resilience, many of the Tribally adapted models embraced the community, child, adult, or family as a whole—mentally, emotionally, spiritually, and culturally. All these interventions demonstrated a critical investment in the future of Tribal family life.

Summary of Findings

Tribal Adaptation efforts described here serve as examples of what may be achieved when Tribes and Tribal organizations adapt practice models and bring the intervention congruent with Tribal culture.

Both elements—the program’s basis in effective models and its community and cultural engagement—were essential to success. The review of models adapted for use with Tribes revealed three major categories:

- **Culturally Engaged Resilience Skills Enhancement.** Traditional cultural ways treated as strengths that buffer against and help to overcome negative influences.
- **Contextual Services Development.** Responsive services that require evaluating and understanding the context in which they arise.
- **Treatment of Risk Issues.** Direct treatment that addresses family risks, including social isolation, family disorganization, parenting stress, and violence (including intimate partner violence).

Culturally Engaged Resilience Skills Enhancement

HeavyRunner & Marshall (2003) indicate that cultural resilience embraces the notion of traditional cultural ways as strengths that buffer and help to overcome negative influences. Such resilience is particularly protective in times of familial stress. Spirituality is a consistent source of strength of Tribal cultures to leverage to promote wellness and to instill confidence in the face of challenges. Better understanding of this link between spirituality and wellness is critical to addressing child maltreatment and to building family resilience.

A first step at incorporating Tribal spirituality into well-being and resilience is through the use of spiritual assessments, such as conducting a spiritual ecogram or genogram. There are subtle differences between genograms and ecograms, with the biggest difference being that *genograms* portray spirituality across three generations, while *ecomaps* illustrate the current spiritual relationship, and *ecograms* combine the two in one place (Hodge & Limb, 2011). Several scholarly works examine distinct aspects of conducting spiritual assessments with Native American clients. The article “Helping child welfare workers improve cultural competence by utilizing spiritual genograms with Native American families and children”



(Limb & Hodge, 2010) reviewed the potential use of a spiritual genogram assessment tool with Native American child welfare clients while “Utilizing spiritual ecograms with Native American families and children to also promote cultural competence in family therapy” (Limb & Hodge, 2011) reviewed the use of a spiritual ecogram by family therapists working with Native American families. Both studies received feedback, noting the importance of attention to detail in developing the ecogram to ensure the use of culturally appropriate language and the centering of the client’s Tribal worldviews.

Similarly, “Social Work With Native People: Orienting Child Welfare Workers to the Beliefs, Values, and Practices of Native American Families and Children,” (Limb, Hodge, & Panos, 2008), discusses the importance of developing interventions focused on the view of the person and family from a holistic perspective. The alternative, focusing on the proximate or immediate *reason* for the intervention (e.g., an instance of maltreatment, a person’s substance abuse problem), tends to support the belief that the problem or issue resides in the person rather than in the person’s environment and social structures. To be effective, interventions must grasp the whole person, family, or situation as fully situated in context. The worldview model focuses on achieving and maintaining a balance between the spiritual, mental, and physical aspects of the person. The underlying value of this approach is that it allows for selecting interventions that target the relationships between multiple risk and protective factors. In practice, this means that, rather than being understood as a problem to solve, clients are referred to as being out of harmony or balance—that they are part of a broader system that needs healing. The resulting interventions are more effective because they are focused on bringing the person back into balance, rather than on addressing a single symptom in isolation (Limb et al., 2008).

One worldview model, the **Relational Model of Wellness (RMW)**, represents the four-quadrants of a person that must come into balance for healing: context, mind, body, and spirit. Using RMW when working with Native American clients in a

child welfare context requires child welfare workers to consider all four areas of the human experience and how they interact in order to understand how to promote wellness and healing in their clients (Limb et al., 2008).

Developing a cultural, spiritual connection also requires participating in spiritual and cultural practices. **Drum-Assisted Recovery Therapy for Native Americans (DARTNA)** is an approach to substance use disorders (SUDs) that builds upon many elements of the **Wellbriety Movement** (detailed below) while incorporating “drumming as its primary focus of treatment” (Dickerson et al., 2014, p. 37). The DARTNA protocol consists of 3-hour treatment sessions, provided 2 times per week over a 12-week period by an AI/AN licensed substance abuse treatment provider and a cultural leader. The protocol and educational focus is separated into four parts corresponding to each of the four quadrants of the Medicine Wheel (Dickerson et al., 2014, p. 37). Results from assessment measures supported the intervention as “a culturally appropriate and acceptable substance abuse treatment for AI/ANs” (Dickerson et al., 2014, p. 51).

One of the more recognizable models of cultural engagement is the Wellbriety Movement, which brings a holistic and cultural dimension to the established Alcoholics Anonymous (AA) 12-Step program. The blending of Indigenous ways of knowing with the AA model creates the possibility of understanding wellness and sobriety in social, rather than individualistic, terms. The Wellbriety movement spurred many projects, with some led by White Bison (Moore & Coyhis, 2010). White Bison created a program for training peer recovery support people or “Firestarter,” to help facilitate Wellbriety in native communities. By 2010, White Bison trained over 350 Firestarters and was tracking outcomes with the assistance from university evaluators. Outcomes tended to show program efficacy on a variety of fronts, including abstinent lifestyle, social growth, and satisfaction with the training. Building on the work of White Bison, Coyhis wrote *The Red Road to Wellbriety: In the Native American Way*, spurring many related projects across the continent. For a summary of the history of the Wellbriety move-



ment, see “Rebuilding Native American Communities” (Coyhis & Simonelli, 2005). For a more detailed study of the Wellbriety movement’s historical development, conceptual framework, ties to other Native practices, and comparisons with non-Native values, see their subsequent piece, “The Native American Healing Experience” (Coyhis & Simonelli, 2008).

Contextual Services Development

Contextual services models seek to keep Native families together and to strengthen communities in a way that is responsive to their family and community circumstances. As in trauma-informed care, these are responsive services that require evaluating and understanding the context in which they arise. To achieve this goal, the models include both direct practice and systemic interventions. The Tribal Practice Model (Lucero, Leake, Scannapieco, & Hanson, 2017) uses **Business Process Mapping (BPM)** to outline the practices and strategies currently used within the Tribe; in turn, these results are used in developing a practice model. BPM involved a detailed discussion of the life of a case in Tribal court, from referral to closure, which allowed for the identification of gaps and points of intervention. Six months after the BPM process was completed, the authors administered a questionnaire to BPM participants examining how well the BPM tool fit within a Tribal cultural context. Overall, these methods found that participants felt the approach led to a better understanding of the agency and the practice model; however, upon follow-up, participants did not report using the maps developed as a reference.

Similarly, the **Circles of Care** framework uses the **Systems of Care (SOC)** framework to address the unique needs of AI/AN children and adolescents with serious emotional disorders by centering the child and emphasizing cultural competence. Both of those priorities align with many AI/AN cultures. SOC has helped frame the needs of the child within a cultural context and has resulted in the creation of services that combine traditional AI/AN approaches with conventional biomedical approaches. Unlike some of the other models, SOC is a framework for providing services, rather than a specific service or intervention; it does not specify what intervention or service to use.



Research has indicated increased child and family satisfaction and reduced out-of-home placement, but there is no clear tie to improved outcomes (Novins & Bess, 2011).

In an adaptation of **Intensive Case Management**, the Denver Indian Family Resource Center (DIFRC) provides “strategies... that non-Native caseworkers and supervisors can utilize to create an environment in their own agencies that supports culturally based practice with Native families while incorporating a trauma-informed understanding of service needs of these families” (Lucero & Bussey, 2015, p. 97). This is particularly crucial in an urban setting, where Native families could be miles or states away from their Tribal community. To improve outcomes, the DIFRC program ensures that frontline providers understand the relationship between trauma and substance abuse, as well as how these may play a role in child welfare issues faced by urban Natives; provides a thorough assessment for trauma and referral to trauma-informed



services; and provides intensive, clinically based case management. One project working with a Tribal Temporary Assistance for Needy Families program boasted a 96 percent success rate for keeping Native children in the home or in a home with extended family members (Lucero & Bussey, 2015, p. 102).

Like the DIFRC tailoring strategies for non-Native caseworkers in urban areas, the health communication process model discussed in "Fetal Alcohol Syndrome [FAS] Among Native American Adolescents: A Model Prevention Program" resulted in a "culturally appropriate, age-specific multimedia FAS prevention package" (Ma, Toubbeh, Cline, & Chisholm, 2002, p. 291). Materials produced for the package included a curriculum guide with 19 lessons, a video entitled "Faces Yet to Come," and a project website. Phase 3 evaluated the effectiveness of the prevention program by surveying 90 randomly selected students at 2 middle schools. Results indicated that students "showed significant knowledge increase" and had favorable reactions to the program (Ma et al., p. 292). Both programs show the effect and importance of contextualizing services to the target community.

Treatment of Risk Issues

As we have seen, there is a wide range of interventions based on models or protocols developed outside of a Tribal context, each appropriating diagnostic, interventional, and treatment protocols addressing direct treatment applications to address family risks (such as social isolation; family disorganization; parenting stress; and violence, including intimate partner violence) and modifying them for greater congruence with Tribal culture. Tribal services and communities have also drawn on external strategies for treatment and remediation, with the following interventions being especially common among articles in the literature review:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Parent Child Interaction Therapy (PCIT)
- Motivational Interviewing (MI)
- Community Reinforcement Approach (CRA)

- Medication-Assisted Treatment (MAT)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an intervention for addressing maladaptive, trauma-related beliefs and correcting a child's negative emotional and behavioral response to trauma. In general, TF-CBT is consistent with AI/AN teachings and beliefs. An important cultural adaptation of TF-CBT was made in a cultural reconfiguration of the intervention, known as **Honoring Children, Mending the Circle (HC-MC)** (BigFoot & Schmidt, 2009; BigFoot & Funderburk, 2011; BigFoot & Schmidt, 2012; Gray & Rose, 2012). HC-MC is a cultural adaptation of TF-CBT that was recreated through a partnership with Tribal stakeholders and community providers. Specifically, the partnership integrated the following core constructs: (1) All things are interconnected; (2) All things have a spiritual nature; and (3) Existence is dynamic. While TF-CBT is an evidence-based treatment, none of the articles found presented the results of the HC-MC being used within the AI/AN community.

Likewise, the **Parent Child Interaction Therapy (PCIT)** is known for evidence-based treatment coaching sessions, where parents are observed and coached through interactions with their child (BigFoot & Funderburk, 2011; BigFoot & Schmidt, 2009). PCIT is compatible with AI/AN traditions and culture, and a Tribally Adapted PCIT, *Honoring Children, Making Relatives*, incorporates traditional AI/AN philosophies (such as Circle Theory and Old Wisdom) into the core components of PCIT. The method of adaptation included reviewing the original PCIT; developers of PCIT working with AI/AN to review the literature and make adaptations; receiving feedback from cultural members, practitioners, and community; and, finally, making translations of PCIT. As a result, *Honoring Children, Making Relatives* includes AI/AN parenting teachings, practices, traditions, and rituals, while remaining true to the core components of PCIT (BigFoot & Schmidt, 2009).

Motivational Interviewing (MI) has a relatively robust record of replication and demonstration in AI/AN communities. MI increases



a client's desire to change by discussing with the client both the pros and cons of changing his or her behavior. *Native American Motivational Interviewing: Weaving Native American and Western Practices* (Venner, Feldstein, & Tafoya, 2006) documents an adaptation that could be used with Native American communities. The goal of the manual was to be helpful yet, at the same time, sensitive to and reflective of Native American communities and the struggles they face dealing with alcoholism and substance abuse. The authors wanted to create a manual that was easy to use and practice with Native American clients. The final product was informed by two focus groups, one composed of community members and one composed of behavioral health providers.

In "Pilot Outcome Results of Culturally Adapted Evidence-Based Substance Use Disorder Treatment With a Southwest Tribe" (Venner et al., 2016), the authors adapted the **MI and Community Reinforcement Approach (MICRA)** to use with AI/AN populations to address substance use in a rural community setting. The combination of the two treatments was done at request of a Tribal partner. The Tribal partner also worked collaboratively with the university partners to adapt the intervention. The intervention's MI element included culturally consistent greetings and introductions, a reliance on spirituality and family as appropriate, and the use of counselors fluent in Native language. CRA adaptations includ-

ed using more visual cues and making language more accessible. Though the sample was small, results indicate that MICRA may be effective in reducing substance use and in improving psychological functioning. For more information on how MI has been adapted for other groups such as youth or teen mothers, please see the annotated bibliography.

Medication-Assisted Treatment (MAT) uses medication and behavioral therapy to assist in the treatment of SUDs. Strong cravings to use the substance is one of the main reasons people continue to struggle to stay off drugs. In MAT, the use of medication, in conjunction with behavioral techniques, can help a user manage cravings, leading to an increased likelihood of sobriety. The IHS created the Prescription Drug Abuse Workgroup to combat the increase in overdose deaths because of prescription opioids in the community. It was charged with creating a series of policies and programs to help prevent overdose deaths. It developed the [Opioid Dependence Management website](#), which includes guidelines, screening tools, assessments, and promising practices for use in treating and combatting opioid use disorders. Importantly, pharmacists in the IHS have expanded their role to include patient consultation, education, and care coordination in pain management and MAT clinics. They have obtained the ability to prescribe naloxone and organized naloxone initiatives in conjunction with first responders. Many pharmacists have completed a variety of trainings (e.g., using MI) and developed culturally sensitive materials to engage the community and to establish a connection with patients (Duvivier, et al., 2017; Rieckmann, Moore, Croy, Aarons, & Novins, 2017).

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a primary prevention/early intervention program designed to identify people with alcohol abuse problems through an initial screening. After the initial screening, clients are provided with education and feedback specific to the participant. The authors indicated some success using the intervention when implemented and adapted to a specific AI/AN community to reduce drinking and the chance of children born with Fetal Alcohol Spectrum Disorders (Montag et al., 2015).





Much effort has gone into the reduction of familial risks and in increasing resiliency in Native families through the reduction of substance use and increase of sober living skills among the family members. Other adapted interventions that appeared multiple times in our search included **Dialectical Behavioral Therapy, Incredible Years**, and **Alcoholics Anonymous** (beyond the Wellbriety initiatives). Please see the annotated bibliography for more literature on these interventions.

Sample Tribal Adaptations

Of the broader criteria for inclusion in the literature review, a few are particularly relevant to Tribal Adaptations. In this section, we'll look at one program for each of the following criteria:

- **Culturally Compatible.** The programs, as situated within a broader health system, are in accord with the current beliefs, understandings, values, and future goals of the community.
- **Intergovernmental Cooperation.** The programs achieve benefits of coordinated, consensual, and mutually respectful relations between Tribal and non-Tribal justice agencies.
- **Community Component of Services.** The programs are strengthening the relationship of the AI person to his or her community. The programs are well received and have support from the surrounding community and Tribal government.

Culturally Compatible

Other Tribally Adapted programs engaged in cultural enhancements include **Home Visiting-Healthy Families America** (Barlow et al., 2006; Barlow et al., 2015; Mullany et al., 2012; Walkup et al., 2009; Barlow et al., 2013). The studies focused on a home visiting intervention called **Family Spirit**, which uses paraprofessionals to deliver services to young (teenage and young adult) AI mothers living on the reservation. The content for Family Spirit includes prenatal and infant care lessons that reflected local Native practices, though they did not contain community-specific traditions or spiritual beliefs. The paraprofessionals delivering the intervention were AI women, who were bilingual in their Native language, and they were trained to respect the cultural orientation of each

participant. Studies supported the effectiveness of Family Spirit for increasing knowledge and involvement of young mothers, reducing maternal risks, and improving child developmental outcomes (Barlow et al., 2013; Barlow et al., 2006; Barlow et al., 2015).

Intergovernmental Cooperation

In-home services provide an effective model for engaging many demographics, including teens, young adults, and entire family units. "It Takes a Village: Using a Community-Defined Practice Approach to Develop a Tribal In-Home Services Model for Alaska Native Families" (Johnson, Walters, & Armstrong, 2015) documents the **Alaska Disproportionality Reduction Project**, a 4-year implementation project funded by the Children's Bureau and awarded to a consortium of AN Tribal entities. Based on the disproportionate number of AN children in out-of-home placement, the project goals included the development of in-home service models focused on the preservation of families through in-home services and supports. The in-home models were developed using a community-driven approach, with the balance and expectation of the incorporation of safety elements. The results of the evaluation led to the achievement of a shared vision between the Tribal consortium and the state child welfare system for AN children and families. Participants noted their feeling of empowerment that came from identifying and articulating their vision for keeping children safe in their communities and their ability to incorporate their cultural traditions into a SOC for their community as a protective factor for their families. It should be noted that the data are limited to qualitative responses.

Community Component of Services

A spiritual and cultural developmental approach to prevention was further engaged in "Walking On: Celebrating the Journeys of Native American Adolescents with Substance Use Problems on the Winding Road to Healing" (Novins et al., 2012). **Walking On** is an intervention developed by the Cherokee Nation and the University of Colorado's Centers for American Indian and Alaska Native Health in response to findings of community-based participatory research. The program uses an "explicit blend of traditional Cherokee healing and spirituality with science-based practices such



as cognitive behavioral therapy and contingency management... to address the specific needs and worldviews of Native American adolescents with substance use problems and their families" (Novins et al., 2012, p. 154). Walking On's intervention building phases include "Finding the Winding Road", "Staying on the Path" and "Widening the Road". Walking On also includes skill-building teachings, Native American ceremonies to celebrate and support the process, and contingency-management protocols. The authors indicate that although the work is ongoing, and the evidence base is in development, the program shows "the potential of Tribal-community-university partnerships, combined with a community-based participatory research process, for addressing the most challenging substance abuse problems facing Native American communities" (Novins et al., 2012, p. 158).

Promising, Not Adapted Practices

Overview

Much like Tribal Adaptations, the Promising, Not Adapted category involves intervention/prevention programs, services, strategies, policies, practices, or practice models that were created outside Tribal culture. Unlike Tribal Adaptations, these programs have not yet been adapted for use in a Tribal community. What makes these programs noteworthy is that they have components that may make Tribal Adaptation achievable. For example, a few of the interventions in this category were used with AI/AN populations or with a culturally diverse population (including AI/AN), but the intervention or model was not altered or adapted to reflect the cultural views or practices of the population within which it was being used.

Thus, some of the interventions in this category have been used or implemented in Indian Country but are not, as such, Tribal Adaptations. For an intervention to qualify as Tribally Adapted, it should have strong cultural components and take into consideration its specific population. This means that AI/AN culture, worldview, and experiences must be taken into account and used to modify the existing intervention to meet the needs of the particular com-



munity. Specifically, adaptations should include an understanding of the culture for which the program will be adapted, including early history, religion, political events, cultural identity, and living conditions. Any modifications and adaptations must be the result of a collaborative process between the target population, community, intervention developer, and child welfare service system (Framework Workgroup, 2014). Programs that merely reproduce an evidence-based practice in Indian Country are noteworthy and may serve as the basis of Tribally adapted practices, but they are not Tribal Adaptations themselves.

Summary of Findings

There were a much smaller number of articles classified under the category of Promising, Not Adapted. As a result, the articles appearing in this section fall into two categories:

- **Culturally Diverse Populations.** Interventions used with participants that identified as AI/AN or with an otherwise culturally diverse population.
- **Moving From Promising to Adapted.** Suggestions for adapting intervention(s) or recommendations about which interventions might lend themselves to adaptation for implementation within a Tribal community.

Interventions that already had a strong basis in serving AI/AN populations were good candidates for undergoing additional adaptations to make them congruent with Tribal culture by, for example, incorporating Tribal values or Indigenous ways



of knowing. In addition, some articles highlighted the need for further research to examine how the intervention could be adapted for use with people from different backgrounds and whether certain intervention elements are effective with people of different backgrounds (Goodman, 2013).

Our criteria for inclusion in this category was not open ended, however. As with any literature review, the results are limited to the terms and definitions used for searching the field. This literature review focuses on models that appeared in conjunction with the terms “Native American” or “American Indian.” There are likely many programs in the child welfare field that have been shown to be effective when adapted for use with other cultures. Given their ability to be effectively adapted for other cultures, these interventions could hold promise if they were to be adapted for use in a Tribe or Tribal community. While this category of interventions may hold promise, it also would have expanded the scope of the review to the point of changing its purpose from “finding literature on resilience and child welfare practices in Indian Country” to “finding literature that might be useful for resilience and child welfare practices in Indian Country.” (A literature review with the latter goal would, effectively, be simply a literature review of child welfare practices.) Thus, the material in this subsection is not about what generally might work in Indian Country, but rather the portion of the existing literature *about* Indian Country that describes programs that were not adapted to Tribal culture but were used (or explicitly proposed as models for use) with AI/AN populations nonetheless.

Culturally Diverse Populations

Programs in this section were used with a culturally diverse population, including AI/AN populations, though there did not appear to be any efforts by either the Tribe or the intervention developer to specifically adapt the intervention to a Tribal context. The purpose or risk factors targeted by each of the interventions addressed varied. The highlighted programs target trauma and resilience, a behavioral skills intervention, and alcohol use among teenagers.

SafeCare (Chaffin, Bard, BigFoot, & Maher, 2012) is a manualized intervention for teaching behavioral skills. It is a highly structured, home-visiting model that addresses parent-child interaction, basic caregiving, home safety, and child health. Those delivering the SafeCare model received training from the SafeCare training institute. As part of a large randomized control trial comparing SafeCare to services as usual, this study specifically examined the outcomes of an AI population ($n=354$), with a focus on recidivism and the acceptability of the manualized intervention to the AI population. For the cases that are included under normal SafeCare inclusion criteria (i.e., parents of preschoolers), AI recidivism reduction rates were similar to the participants who were not AI. The study supported the use of SafeCare with an AI population, although it was not adapted for a particular Tribe or Tribal community. The AI parents who participated in the program reported a better working alliance with providers. Given the promising results from the initial study, it would be assumed cultural adaptations to the program may lead to increased success.

Transgenerational Trauma and Resilience Genogram (TTRG)

(Goodman, 2013) is a counseling tool that facilitates clients in visualizing complex aspects of trauma by integrating various frameworks for understanding and addressing trauma. It allows counselors to explore the context surrounding a client’s trauma and lives more generally and helps promote greater insight, which could promote greater resilience and healing. The use of the TTRG is guided by the following principles (Goodman, 2013):

- Include a comprehensive or ecosystem understanding of trauma.
- Focus on strengths.
- Be culturally responsive.
- Attend to social considerations through a critical or liberatory perspective.

This article provides a case illustration of the tool with someone who is of Native American descent. While the article demonstrated success with the intervention, the study was based on a



very small sample. Further research could examine how the TRRG could be adapted for use with people from different backgrounds, communities, or families and whether certain aspects of TRRG are effective for certain groups of people. (For examples of Tribally Adapted use of genograms, see Goodman, 2013, p. 15.)

Another evidence-based approach appeared in, “Multilevel Prevention Trial of Alcohol Use Among American Indian and White High School Students in the Cherokee Nation” (Komro et al., 2017), which describes a trial program implementing and comparing several alcohol-prevention interventions for youth living in the Cherokee Nation. The population for the trial was racially diverse and included a 14-county jurisdictional service area of the Cherokee Nation.

The trial included a control group, one group implementing **Communities Mobilizing for Change on Alcohol (CMCA)**, one group implementing **CONNECT**, and a group that implemented a combination of the two. The CMCA initiative is a community-organized intervention targeting alcohol consumption only. CONNECT focuses on universal screening and brief intervention. Although these programs are not specifically designed for use with Native Americans, they have been identified as evidence-based tools.

School-based social workers served as CONNECT coaches, meeting with students privately, using MI, and conducting a health consultation once a semester with each student. The sessions included educational information and encouraged healthy responses to the use of alcohol. Social workers mailed postcards with behavioral tips to the students’ homes three times each year, and they placed posters and other campaign information in the schools and in popular locations throughout the community.

Researchers used surveys to collect data over a 3-year period. Of the participants, nearly half identified as AI and half as white. However, the trial was not designed to distinguish responses of youth with different races. Since almost 50 percent of participants identified as AI, a secondary analysis was conducted; no differential treatment effects were noted based on the race of the youth.



Students with exposure to CMCA, CONNECT, or a combination of both showed a reduction in the probability of 30-day alcohol use and of heavy episodic drinking, as compared to the students in the control group. The results of the trial supported the effectiveness of both a community-organizing approach and universally implemented, school-based interventions in both racially and culturally diverse communities and schools. The trial further demonstrated that CMCA and CONNECT are effective approaches that can be beneficially implemented in diverse communities. These interventions focused on community leadership and engagement. In addition, the trial included an organization of local citizens, community resources, and the investment of the community to see a different result for their youth.



Moving From Promising to Adapted

Ultimately, any existing intervention that is significantly adapted (i.e., changes were made to the core components) for any reason, including for improved cultural congruence, should undergo an evaluation to ensure the altered intervention is effective in addressing the outcomes targeted by the original intervention and to measure what effect, if any, the cultural adaptations had. As a result, we included in this section articles that specifically outline efforts to engage Tribes in creating and adapting interventions and how to evaluate the resulting intervention. Baldwin, Brown, Wayment, Nez, and Brelsford (1998) put forward a 4-step model for this process:

1. Build collaborative relationships, e.g., by gaining entry into the community, hiring Indigenous staff, and forming an advisory board.
2. Develop interventions by adapting theories to local contexts, and obtain local input.
3. Include training and monitoring as a part of the implementation.
4. Assess the project by conducting process and outcome evaluation, and assess capacity enhancement.

The evaluation literature is based on strong theoretical perspectives for conducting evaluation in Tribal communities, using collaborative relationships and partnerships to change community dynamics and make improvements. For example, “Methods of evaluating child welfare in Indian country: An illustration” (Fox et al., 2011) outlines the specific challenges that present when academics and other professionals try to conduct an evaluation in Indian Country. These challenges can impact both the quality and quantity of data collected and might cause professionals to overlook evaluations lessons that could have been obtained through community participation and collaboration. Specifically, any evaluator conducting an evaluation in Indian Country should engage the community, include opportunities to build on community strengths, facilitate collaborative and equitable partner-

ships, and develop a process and plan for capacity building and co-learning.

Sample Promising, but Not Adapted Programs

Of the broader criteria for inclusion in the literature review, a few are particularly relevant to promising, not adapted interventions. In this section, we’ll look at one program for the following criteria:

- **Intergovernmental Cooperation.** The programs achieve benefits of coordinated, consensual, and mutually respectful relations between Tribal and non-Tribal justice agencies.

Intergovernmental Cooperation

One of the many benefits of the Indian Child Welfare Act (ICWA) is its specifications for handling termination of parental rights (TPR) in cases of Native American children. This, combined with the explicit preferences for placement that are required when a child is removed from the home, makes TPR much more difficult with Native American families—an important and salutary effect given that the historical context includes numerous interventions forcing children from their homes, communities, and Tribes. The Adoption and Safe Families Act of 1997 (ASFA) followed ICWA approximately 20 years later, with a significant emphasis on permanency, including TPR and adoption. However, ASFA timelines and procedures can create conflicts with ICWA, and ASFA does not specify how to address these conflicts.





While Tribes may or may not see TPR as acceptable parts of plans for establishing permanency for a child, the concept of permanency is highly valued in Indian Country. Tribes have historically used customary adoption as a means for providing permanency for a child within his or her community, Tribe, extended family, or clan.

The article “Customary Adoption as a Resource for American Indian and Alaska Native Children” (Cross & Fox, 2005) describes promising changes to the Western view of adoption, allowing for children to maintain connections with their birth family and Tribe for a multitude of reasons. **Customary adoption** creates family systems and care structures without the need for legal intervention and ensures that care for the child is not in question. However, two factors—the passage of ASFA and Tribes having the ability to be direct title IVE agencies—have created incentives for Tribes to adopt customary adoption as a means for establishing permanency within the Tribal child welfare system. Granting this status to customary adoption allows the Tribal courts to formally recognize these family systems and provides families with formal permanency plans and legal protections for the caregivers, family members, or parents. While customary adoption provides a mechanism for achieving permanency, it does not require TPR, as traditionally required in adoptions. Customary adoption is unique in that it recognizes the child’s permanent parent-child relationship with the long-term caregiver without simultaneously requiring the severing of the parental rights of the legal birth parent or the child’s ties to clans, Tribes, or extended families.

The practice of customary adoption has been adopted by many Tribes and adapted for their particular community. The challenge exists when public child welfare systems may not necessarily accept a customary adoption as an approved plan.



Concluding Remarks

Overall, this review revealed literature that focuses heavily on Tribal Adaptations, includes a somewhat smaller array of Tribal Creations, and turned up a few Promising, Not Adapted practices. There was a wide variation in the type of published articles available in each category, though we were able to extract a few themes that will guide this project as we move forward.

Any type of program or intervention in Indian Country should include core elements and foundational practices of working with Native families and Tribal communities. Despite trainings and implementation of legislation aimed at ensuring the use of culturally relevant services in the protection of Native American children and families, there continues to be a lack of understanding among child welfare workers about how to work effectively with Native American clients and about the cultural elements of effective practice in Tribal communities. As a result, it is important for all models and providers to include information about the conceptual framework for working in Indian Country, including the core concepts of worldview, spirituality, harmony and wellness, oppression, social dominance and wellness, cultural competence, assessment, and treatment. For example, while trauma-informed practice is increasingly widespread in child welfare practice, understanding the unique role of intergenerational and historical trauma—including



the latter's ongoing manifestations—in AI/AN communities is crucial for ensuring the success of adapting trauma-informed practices to these communities.

In addition, it is essential for researchers and practitioners to understand that external conceptions of child welfare practice may be at loggerheads with, or simply exclude, concepts of child welfare in Indian Country—a fact that itself is reflected in this literature review. The protective factors in our code book came from the literature's standard accounts of protective factors. However, the protective factors enhanced by Tribal Creations and Tribal Adaptations were not well represented by that list. While the standard protective factors embody a level of abstraction proper for the goals of universality and neutrality aspired to by Western-style social sciences,

they were also so generic that they were inadequate for capturing myriad protective factors, including:

- Historical trauma resilience
- Cultural identity
- Native language
- Traditional healing practices
- Kinship/Elders/community connection
- Spiritual practice/knowledge/ceremony
- Spiritual values

The absence of these factors is not just a theoretical oversight. For example, the area of spirituality historically has been neglected by child welfare workers. While many understand the importance of spirituality when working with a specific person, they may feel that because they may not share or understand the client's spiritual beliefs, spirituality should not be included in conversations regarding services or interventions. Avoiding the discussion of spirituality may lead to treatments that do not address the whole person. Discussing spirituality affirms the idea that spirituality is an important part of the person and opens the door to a range of interventions and practices that incorporate Native American values (Limb, Hodge, & Panos, 2008).

Generally, the public child welfare system abides by Western ways of practice, which institutionalizes the role of frontline child welfare workers as focused on the targeted treatment plans and interventions that address the problem(s) that brought the family to the attention of the child welfare system. The interventions are centered on making changes to the family, client, or circumstance directly. While these types of linear models are measurable, they fail to address the issues from a holistic perspective, and, as a result, they fail to adequately grasp the needs and services for the whole person, family, or situation in their full context. Focusing interventions in this manner tends to support the belief that the problem resides in the person.





While the linear model of work does not tend to have a positive impact on Native American families, the worldview model has shown promise. The worldview model relies on achieving and maintaining a balance between the spiritual, mental, and physical aspects of the person. The underlying value of this approach is that it allows for selecting interventions that target the relationships between multiple factors. In practice, this means that, rather than being understood as a problem to solve, clients are referred to as being out of harmony or balance—that they are part of a broader system that needs healing. The resulting interventions are more effective because they are focused on bringing the person back into balance, rather than on addressing a single symptom in isolation. There are multiple versions of worldview models. One such worldview model, the Relational Model of Wellness (RMW), represents the four quadrants of a person that must come into balance for healing: context, mind, body, and spirit. When working with a Native American client, social workers must consider all four quadrants when assessing the needs of and services for the client. Using RMW when working with Native American clients in a child

welfare context requires child welfare workers to consider all four areas of the human experience and how they interact in order to understand how to promote wellness and healing in their clients (Limb et al., 2008).

Next Step—Environmental Scan

The articles uncovered as part of the literature review described intervention creation efforts, implementation and adaptation efforts, and evaluation as they are understood in the academic literature. As we developed this review, we came to see at least two crucial limitations to this approach, which we aim to rectify with our work in the environmental scan.

The first limitation is the one discussed above: that the standard vocabulary for describing risk and protective factors was insufficiently concrete to adequately capture the cultural protective factors unique to Indian Country. Our environmental scan efforts will incorporate and center these concepts from the very start.

The second limitation is that we rarely encountered an article or series of articles that provided a complete picture and traced the story of the intervention from creation and/or adaptation, through implementation and evaluation, and, finally, on to sustainability. Regardless of the category (Tribally Created or Adapted) we were often left feeling that the story was incomplete and wondering what happened to the intervention. Specifically, some of the following questions came to mind:

- What was the process used to adapt the intervention? What were the lessons learned, and how could that process be replicated?
- Has the intervention ever been evaluated? If so, what were the results? If not, why?
- What would it take to evaluate the intervention?
- Was the intervention continued? Why or why not?
- If an intervention was sustained, what efforts made that possible (e.g., community support, monetary support, etc.)?





We can use these questions to guide our efforts in the upcoming environmental scan in three ways:

1. Use the connections from the Environmental Scan and Compendium Workgroup to follow up with the Tribes that participated in some of the Tribally Created or Adapted interventions identified through the literature review.
2. Include the questions above as a part of the fact-finding portion of the environmental scan when engaging the Tribes that have been identified as having an intervention.
3. Pose the questions to members of each of the workgroups when inquiring about whether they are aware of any interventions that were adapted for the use in other cultures.

Through the environmental scan, we will identify the important community-level research and demonstrations of innovative, cultural, and practice-based strategies (including community-based research initiatives) that are improving Tribal families and children within Indian Country. Using the collective knowledge from our environmental scan and Compendium Workgroup, as well the literature review, the team will develop a semi-structured survey that incorporates the questions above to assess and document community demonstrations, cultural models of care, and practice-based initiatives that impact Tribal family resilience and the reduction of risk of child maltreatment.

The scan will focus on Tribal community service agencies consisting of Tribal, governmental, and nonprofit entities that work with, and on behalf of, Tribal community members across a range of child welfare, family resiliency, health, and social issues. Agencies and individuals that comprise this community of practice often work in Tribal communities using Tribal traditions, collaboration, and local innovation in service delivery. Increasingly, the



interventions and activities in which Tribal communities and families are engaged encourage the inclusion of components related to evaluation and education. These very factors will be queried to achieve a broader scope of the program impacts or success of the community-based practice.





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APPENDIX 1 Codebook

Terms Defined

Relevant—This indicates the abstract describes a program, service, strategy, policy, practice, or practice model (prevention or intervention) used in or designed to be used in Native or Indigenous communities.

For reference—This work provides background and serves as an important theoretical base or generalized theory of change. It can include theoretical frameworks or support for general strategies of prevention and intervention.

Tribal Level of Engagement

All quotes in this section come from McLeroy, K. R., Norton, B. L., Kegler, M. C., Burdine, J. N., & Sumaya, C. V. (2003). Community-based interventions. *American journal of public health*, 93(4), 529-33.)

Tribal Community as setting—“As setting, the community is primarily defined geographically and is the location in which interventions are implemented. Such interventions may be citywide, using mass media or other approaches, or may take place within Tribal community institutions, such as neighborhoods, schools, churches, work sites, voluntary agencies, or other organizations. These community-based interventions may also engage community input through advisory committees or community coalitions that assist in tailoring interventions to specific target groups or in adapting programs to community characteristics” (p. 530).

Tribal Community as target—The “goal of interventions and programs that treat the Tribal community as the target is creating healthy community environments through broad systemic changes in public policy and community-wide institutions and services. In this model, family health status characteristics of the community are the targets of interventions, and community changes. Several significant public health initiatives have adopted this model. For example, community indicators projects use data as a catalytic tool to go beyond using family behaviors. Strategies are tied to selected risks, and success is defined as improvement in the risks over time” (p. 530).

Tribal Community as resource—“This model is commonly applied in community-based health promotion because of the widely endorsed belief that a high degree of community ownership and cultural participation is essential for sustained success in population-level health outcomes. These programs are aimed at marshaling a community’s internal resources or assets, often across community sectors, to strategically focus their attention on a selected set of priority health-related strategies. Whether a categorical health issue is predetermined or whether the community selects its own priorities, these kinds of interventions involve external resources and some degree of people external to the community that aim to achieve health outcomes by working through a wide array of community institutions and resources” (p. 530).

Tribal Community as agent—The “emphasis in this model is on respecting and reinforcing the cultural or organic adaptive, supportive, and developmental capacities of families” (p. 530). Community resources are provided through cultural institutions, including Elders, helpers, families, informal cultural manners, neighborhoods, schools, the workplace, agencies, and political structures. These naturally occurring units of solution meet the needs of many, if not most, community members without the benefit of direct professional intervention. The goal of community-based programs in this model is to carefully work with these culturally occurring solutions. “This necessitates a careful engagement of cultural ways and processes, in advance, of any intervention. It also requires an insider’s understanding of the culture and community to identify and work with these naturally occurring solutions to address family problems. This approach may include strengthening community through including informal cultural networks, ties between individuals and the organizations that serve them. The model also necessitates addressing issues of common concern for the community, many or most of which are not directly health issues” (p. 530).

Adaptation Level

Tribal Creation—The intervention/prevention program, service, policy, etc., was created entirely **within** Tribal culture and setting.

Tribal Adaptation—The intervention/prevention program, service, policy, etc., was created **outside** Tribal culture, and it has been adapted (without losing the core components) to be used in a Tribal setting.

Promising, Not Adapted—The intervention/prevention program, service, policy, etc., was created **outside** Tribal culture; it has not been adapted for use in a Tribal community but looks like it could be.

Ecological Level/Risk Factors

ECOLOGICAL LEVEL	ASSOCIATED RISK FACTORS	
Individual, Child-Level Factors	<ul style="list-style-type: none"> » Low birth weight » Pregnancy or birth complications » Child temperament or behavior » Child disability 	
Family/Parental Factors	<ul style="list-style-type: none"> » Parental substance abuse » Involvement in criminal behavior » Family conflict or violence » Mental health problems » Child perceived as problem by parents » History of child abuse and neglect » Large family size 	<ul style="list-style-type: none"> » Exposure to stress, parental temperament, teenage/young parent/s » Single or unmarried parents » Low level of parental education » Use of corporal punishment » Unplanned pregnancy » Physical health problems » Low self-esteem » Social isolation
Social/Environmental Factors	<ul style="list-style-type: none"> » Socioeconomic disadvantage » Parental unemployment » Housing stress 	<ul style="list-style-type: none"> » Lack of access to social support, lack of pre-natal care » Neighborhood disadvantage » Neighborhood violence

Ecological Level/Protective Factors

ECOLOGICAL LEVEL	ASSOCIATED PROTECTIVE FACTORS	
Individual, Child-Level Factors	<ul style="list-style-type: none"> » Social and emotional competence » Attachment to parent/s 	
Family/Parental Factors	<ul style="list-style-type: none"> » Strong parent/child relationship » Parental self-esteem » Family cohesion » Two-parent household » High level of parental education 	<ul style="list-style-type: none"> » Self-efficacy » Family functioning » Knowledge of parenting and child development » Parental resilience » Concrete support for parents
Social/Environmental Factors	<ul style="list-style-type: none"> » Positive social connection and support » Employment » Neighborhood social capital » Adequate housing » Socioeconomically advantaged neighborhood » Access to health and social services 	



Intervention Type

All quotes in this section come from Child Welfare Information Gateway. (2013). Framework for prevention of child maltreatment. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. (Retrieved from: <https://www.childwelfare.gov/topics/preventing/overview/framework>)



Primary—Assumes that there are no identified or alleged risk of family violence or child endangerment: this might include such interventions as public health campaigns, perinatal health screens, student education programs and family education programs. In

this series of interventions family resiliency is increased by a variety of impact areas which serve to increase the practice of healthy cultural family relationships.

“Primary prevention activities can be directed at the general population and attempt to stop the occurrence of maltreatment. All members of the community have access to and may benefit from services directed at the general population. Primary prevention activities with a universal focus seek to raise the awareness of the public, service providers, and decision-makers about the scope and problems associated with child maltreatment. Universal approaches to primary prevention might include:

- Public service announcements that encourage positive parenting;
- Parent education programs and support groups that focus on child development and age-appropriate expectations and the roles and responsibilities of parenting;
- Family support and family strengthening programs that enhance the ability of families to access existing services, resources and support interactions among family members; and
- Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect.”

Secondary—Approaches that focus on the responses of identified risk of family violence, such as police crisis response to child endangerment, child protection services pre-hospital care, abuse of substances by the parents, substantial prenatal risk. In this series of interventions family resiliency is increased by a variety of impact areas which serve to contraindicate or mediate risks to children as well as increase the practice of healthy cultural family relationships.

“Secondary prevention activities with a high-risk focus are offered to populations that may have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities. Programs may direct services to communities or neighborhoods that have a high incidence of any or all



of these risk factors. Approaches to prevention programs that focus on high-risk populations might include:

- Parent education programs located, for example, in high schools that focus on teen parents, or within substance abuse treatment programs for mothers and families with young children;
- Parent support groups that help parents deal with their everyday stresses and meet the challenges and responsibilities of parenting;
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes;
- Respite care for families that have children with special needs; and
- Family resource centers that offer information and referral services to families living in low-income neighborhoods.”

Tertiary—Approaches that focus on long-term care in the wake of family violence, such as rehabilitation and reunification, treatment programs, counselling, that attempt to lessen trauma or reduce long-term disability associated with violence. In this series of interventions family resiliency is increased by a variety of impact areas which serve to specifically mediate risks to children treatment or empowerment of healing family practices as well as increase the practice of healthy cultural family relationships.

“Tertiary prevention activities focus on families where maltreatment has already occurred (indicated) and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence. These prevention programs may include services such as:

Intensive family preservation services with trained mental health counselors that are available to families 24 hours per day for a short period of time (e.g., 6-8 weeks);

- Parent mentor programs with stable, non-abusive families acting as “role models” and providing support to families in crisis;

- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes; and
- Mental health services for children and families affected by maltreatment to improve family communication and functioning.”

“Distinctions between primary, secondary, and tertiary prevention, while perhaps useful for some purposes, do not necessarily reflect the way prevention-related services are actually organized and provided on the ground. Rather than sorting prevention initiatives into mutually exclusive categories, prevention is increasingly recognized as a continuum.”

Focus Areas

Family–Strategies focus on the family as the target of skills enhancement, resilience building, and change.

Child–Strategies focus on the children as the target of skills enhancement, resilience building, and change.

Community–Strategies focus on the community as the target of skills enhancement, resilience building, and change (likely primary or secondary efforts).

Tribe–Strategies primarily focus on Tribal nation or cultural norms as the target of skills enhancement, resilience building, and change.





APPENDIX 2 Literature Review Interventions

INTERVENTION NAME AND DESCRIPTION	RISK FACTORS	PROTECTIVE FACTORS	FOCUS AREAS	ADAP-TATION LEVEL	TRIBAL LEVEL OF ENGAGE-MENT
Talking Circles, structured so that all participants were provided weekly educational sessions and given the opportunity to discuss depression, substance abuse, and healthy living	<ul style="list-style-type: none"> » Physical health problems » Social isolation » Mental health problems » Parental substance abuse 	<ul style="list-style-type: none"> » Knowledge of parenting and child development » Neighborhood social capital » Social and emotional competence 	Community	Tribal Creation	Resource
Transgenerational Trauma and Resilience Genogram (TTRG)	<ul style="list-style-type: none"> » Trauma 	<ul style="list-style-type: none"> » Positive social connection and support » Self-efficacy » Family functioning » Parental resilience 	Child, Family	Promising, Not Adapted	Setting
Intensive Case Management (ICM); Family Preservation Model	<ul style="list-style-type: none"> » History of child abuse and neglect » Family conflict or violence 	<ul style="list-style-type: none"> » Concrete support for parents » Positive social connection and support 	Family	Tribal Adaptation	Setting
Alaska Disproportionality Reduction Project	<ul style="list-style-type: none"> » Lack of access to social support » Family conflict or violence » History of child abuse and neglect 	<ul style="list-style-type: none"> » Social and emotional competence » Access to health and social services 	Child, Family	Tribal Adaptation	Target, Setting
Business Process Mapping (BPM) as a tool to develop culturally based Tribal child welfare practice models	<ul style="list-style-type: none"> » Lack of access to social support » History of child abuse and neglect 	<ul style="list-style-type: none"> » Positive social connection and support » Build trust and confidence in community » Access community support when faced challenges » Access to health and social services 	Community	Tribal Adaptation	Target
Pathway to Hope	<ul style="list-style-type: none"> » History of child abuse and neglect 	<ul style="list-style-type: none"> » Positive social connection and support 	Community	Tribal Creation	Agent, Setting
Customary Adoption	<ul style="list-style-type: none"> » History of child abuse and neglect » Family conflict or violence » Parental substance abuse » Involvement in criminal behavior 	<ul style="list-style-type: none"> » Family cohesion » Concrete support for parents » Positive social connection and support » Access to health and social services 	Child, Family	Tribal Adaptation	Target



INTERVENTION NAME AND DESCRIPTION	RISK FACTORS	PROTECTIVE FACTORS	FOCUS AREAS	ADAP-TATION LEVEL	TRIBAL LEVEL OF ENGAGE-MENT
Web-based survey that is culturally appropriate and attractive to the target population	» Child temperament or behavior	» Social and emotional competence » Attachment to parent(s) » Self-regulation skills » Relational skills » Problem-solving skills » Involvement in positive activities	Community, Family	Promising, Not Adapted	Setting, Target
Honoring Children, Mending the Circle (HC-MC)	» Child temperament or behavior » Mental health problems » History of child abuse and neglect » Exposure to stress	» Social and emotional competence » Attachment to parent/s » Self-efficacy » Family functioning » Knowledge of parenting and child development » Parental resilience » Concrete support for parents	Child, Family	Tribal Adaptation	Target
Spiritual Genogram	» Trauma/mental health problems » Multiple family and community stressors	» Self-efficacy » Family functioning » Knowledge of parenting and child development » Parental resilience » Concrete support for parents	Family	Tribal Adaptation	Setting
Wellbriety	» Parental substance abuse » Involvement in criminal behavior » Family conflict or violence » Mental health problems » Child perceived as problem by parents » History of child abuse and neglect » Use of corporal punishment	» Positive social connection and support » Access community support when face challenges	Community, Family	Tribal Adaptation	Target
Healthy Nations Initiative	» Parental substance abuse » Involvement in criminal behavior » Family conflict or violence » Mental health problems	» Positive social connection and support » Access to health and social services	Community, Family	Tribal Creation	Setting, Target



INTERVENTION NAME AND DESCRIPTION	RISK FACTORS	PROTECTIVE FACTORS	FOCUS AREAS	ADAP-TATION LEVEL	TRIBAL LEVEL OF ENGAGE-MENT
Elluam Tunjiinun	<ul style="list-style-type: none"> » Parental substance abuse » Involvement in criminal behavior » Family conflict or violence » Mental health problems » Child perceived as problem by parents » History of abuse and neglect » Use of corporal punishment 	<ul style="list-style-type: none"> » Positive social connection and support 	Child	Tribal Creation	Target
Community Readiness Model (CRM); Canoe Journey, Life's Journey	<ul style="list-style-type: none"> » Child substance abuse » Multiple interventions 	<ul style="list-style-type: none"> » Positive social connection and support » Neighborhood social capital » Adequate housing » Access to health and social services 	Community	Tribal Creation	Agent
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	<ul style="list-style-type: none"> » Parental substance abuse » Involvement in criminal behavior » Family conflict or violence » Mental health problems » Child perceived as problem by parents » History of child abuse and neglect » Use of corporal punishment 	<ul style="list-style-type: none"> » Positive social connection and support 	Family	Tribal Adaptation	Target
Honoring Children-Making Relatives	<ul style="list-style-type: none"> » Child temperament or behavior 	<ul style="list-style-type: none"> » Positive social connection and support » Neighborhood social capital » Positive school environment 	Child, Family, Community	Tribal Adaptation	Target
Historical Trauma and Unresolved Grief Intervention, RezRIDERS	<ul style="list-style-type: none"> » Mental health problems » Socioeconomic disadvantage » Exposure to stress » Neighborhood disadvantage » Historical trauma 	<ul style="list-style-type: none"> » Positive social connection and support » Access to health and social services » Social and emotional competence 	Child	Tribal Creation	Setting, Resource, Agent
Spiritual Ecogram	<ul style="list-style-type: none"> » Mental health problems 	<ul style="list-style-type: none"> » Social and emotional competence » Family functioning » Family cohesion 	Child, Family	Tribal Adaptation	Setting, Resource



INTERVENTION NAME AND DESCRIPTION	RISK FACTORS	PROTECTIVE FACTORS	FOCUS AREAS	ADAP-TATION LEVEL	TRIBAL LEVEL OF ENGAGE-MENT
Walking On	<ul style="list-style-type: none"> » Mental health problems » Parental substance abuse 	<ul style="list-style-type: none"> » Family cohesion » Access to health and social services » Social and emotional competence 	Child, Family	Tribal Adaptation	Setting, Agent, Resource
Motivational Interviewing (MI); Community Reinforcement Approach (CRA); MICRA	<ul style="list-style-type: none"> » Parental substance abuse » Mental health problems » Exposure to stress 	<ul style="list-style-type: none"> » Access to health and social services » Self-efficacy » Social and emotional competence 	Family	Tribal Adaptation	Setting
Motivational Interviewing (MI)	<ul style="list-style-type: none"> » Parental substance abuse 	<ul style="list-style-type: none"> » Self-efficacy » Positive social connection and support » Access to health and social services 	Child, Family	Tribal Adaptation	Target
Medication-Assisted Treatment (MAT)	<ul style="list-style-type: none"> » Parental substance abuse 	<ul style="list-style-type: none"> » Access to health and social services » Positive social connection and support 	Family	Tribal Adaptation	Target
Nagi Kicopi	<ul style="list-style-type: none"> » Child temperament or behavior » Child disability » Mental health problems 	<ul style="list-style-type: none"> » Positive social connection and support » Self-efficacy 	Child, Family	Tribal Creation	Target
SafeCare	<ul style="list-style-type: none"> » History of child abuse and neglect/use of corporal punishment » Socio-economic disadvantage » Housing stress » Parental unemployment » Exposure to stress » Parental temperament » Young parents 	<ul style="list-style-type: none"> » Knowledge of parenting and child development » Strong parent/child relationship » Family functioning » Self-efficacy 	Family	Promising, Not Adapted	
Communities Mobilizing for Change on Alcohol (CMCA); CONNECT	<ul style="list-style-type: none"> » Parental substance abuse » Neighborhood disadvantage » Socio-economic disadvantage » Mental health problems 	<ul style="list-style-type: none"> » Access to health and social services » Positive social connection and support » Involvement in positive activities » Healthy lifestyles/activities » Physical health/fitness 	Child, Community, Family	Promising, not adapted	Resource



INTERVENTION NAME AND DESCRIPTION	RISK FACTORS	PROTECTIVE FACTORS	FOCUS AREAS	ADAP-TATION LEVEL	TRIBAL LEVEL OF ENGAGE-MENT
Family Spirit (2006) ¹	<ul style="list-style-type: none"> » Parental substance abuse » Exposure to stress » Parental temperament » Teenage/young parents » Housing stress » Mental health problems » Low level of parental education » History of child abuse and neglect/use of corporal punishment » Single or unmarried parents » Lack of pre-natal care 	<ul style="list-style-type: none"> » Knowledge of parenting and child development » Parental self-esteem » Self-efficacy » Parental resilience » Attachment to parents » Family cohesion » Strong parent/child relationship » Concrete support for parents » Access to health and social services 	Child, Family	Tribal Adaptation	Setting
Honoring Resilience Narratives: Protective Factors Among Indigenous Women Experiencing Intimate Partner Violence (IPV)	<ul style="list-style-type: none"> » History of child abuse and neglect » Use of corporal punishment 	<ul style="list-style-type: none"> » Level of parental education » Positive school environment » Increasing coping skills 	Family	Tribal Creation	Target
Native American Prevention Project Against AIDS and Substance Abuse	<ul style="list-style-type: none"> » Parental substance abuse » Socioeconomic disadvantage » Low self-esteem » Social isolation 	<ul style="list-style-type: none"> » Positive social connection and support 	Community	Promising, Not Adapted	Setting
Drum-Assisted Recovery Therapy for Native Americans (DARTNA)	<ul style="list-style-type: none"> » Parental substance abuse » Low self-esteem » Social isolation 	<ul style="list-style-type: none"> » Positive social connection and support » Access to health and social services 	Child, Family	Tribal Adaptation	Agent
Family Wellness Warriors Initiative	<ul style="list-style-type: none"> » Mental health problems » Lack of access to pre-natal care » Low self-esteem » Social isolation » Family conflict or violence » Parental substance abuse 	<ul style="list-style-type: none"> » Positive social connection and support » Access to health and social services 	Child, Family, Community	Tribal Creation	Agent
Adolescent Coping with Depression (CWD-A)	<ul style="list-style-type: none"> » Mental health problems » Family conflict or violence 	<ul style="list-style-type: none"> » Relational skills » Self-efficacy » Problem-solving skills » Positive social connection and support 	Child	Tribal Adaptation	Target

¹ The Family Spirit intervention is listed multiple times based on publication date.

INTERVENTION NAME AND DESCRIPTION	RISK FACTORS	PROTECTIVE FACTORS	FOCUS AREAS	ADAP-TATION LEVEL	TRIBAL LEVEL OF ENGAGE-MENT
Model for Fetal Alcohol Syndrome Prevention in Native Americans (NIH)	<ul style="list-style-type: none"> » Low birth weight » Pregnancy or birth complications » Parental substance abuse » Lack of access to social support 	<ul style="list-style-type: none"> » Parental self-esteem » Knowledge of parenting and child development » Parental resilience » Concrete support for parents 	Family, community	Tribal Creation	Target
The Natural Connection (TNC)	<ul style="list-style-type: none"> » Low self-esteem » Parental substance abuse » Lack of access to social support 	<ul style="list-style-type: none"> » Positive social connection and support » Self-efficacy 	Community	Tribal Creation	Agent
HAWK2	<ul style="list-style-type: none"> » Parental substance abuse » Family conflict or violence 	<ul style="list-style-type: none"> » Social and emotional competence » Relational skills » Problem-solving skills » Positive social connection and support » Self-efficacy 	Child, Community	Tribal Creation	Resource
Healing Forest Model	<ul style="list-style-type: none"> » Low self-esteem » Social isolation » Lack of access to social support 	<ul style="list-style-type: none"> » Positive social connection and support » Self-efficacy » Social and emotional competence 	Family, Child	Tribal Adaptation	Resource
Zuni Life Skills Development Program	<ul style="list-style-type: none"> » Low self-esteem » Lack of access to social support » Depression » Substance abuse 	<ul style="list-style-type: none"> » Parental self-esteem » Positive social connection and support » Self-efficacy 	Family, Child, Community	Tribal Creation	Agent





APPENDIX 3 Annotated Bibliography

Tribal Creation

Garrett, M. T., Parrish, M., Williams, C., Grayshield, L., Portman, T. A. A., Rivera, E. T., & Maynard, E. (2014). Invited commentary: Fostering resilience among Native American youth through therapeutic intervention. *Journal of Youth and Adolescence*, 43(3), 470–490. <http://dx.doi.org/10.1007/s10964-013-0020-8>

The authors plumb contemporary research and practice to provide “a comprehensive overview and understanding of the needs of Native American youth for researchers, educators, and practitioners” (p. 470). Among the factors that have protected Native Americans in the face of the numerous historical and contemporary traumas and challenges are the diversity among Native American groups, Indigenous Ways of Knowing, cultural identity rooted in the Tribal nation and community, the importance of familial ties, the integral role for Elders as wisdom keepers, traditional Native spiritual ways, communication styles that emphasize moderation and harmony, and using humor as a tool for coping with adversity (pp. 472–76).

While there are general epistemic barriers that mental health professionals and researchers must overcome when addressing the needs of ethnic minorities, these problems are particularly acute in the case of professionals working with and within Tribal contexts. Rather than focus on individual, high-risk or maladaptive behaviors of Native clients, frontline providers must understand the long-term, cumulative effects of historical and intergenerational trauma on Native youth. In addition, Native youth may have different help-seeking behaviors than peers in more mainstream communities, which, in turn, may exacerbate misdiagnosis when treated “by clinicians unfamiliar with their cultural contexts and cultural-specific displays of distress” (p. 481).

The article suggests a number of practical recommendations for addressing Native client wellness (pp. 484-85): foster cultural connections, encourage physical health, examine and teach about the historical context, promote positive cultural identity, reduce isolation and enhance social connections, reduce generational splits, enhance coping mechanisms, use the noninterference principle, and work from a social-justice and client/community-advocacy perspective.

We can see how these recommendations play out in the remainder of this section, which describes Tribal creations that address historical and intergenerational trauma; intimate partner violence (IPV), sex trafficking, and sex abuse; substance use and abuse; mental health and suicide; general protective factors; culture; outreach; and family.

Historical and Intergenerational Trauma

Charbonneau-Dahlen, B. K., Lowe, J., & Morris, S. L. (2016). Giving voice to historical trauma through storytelling: The impact of boarding school experience on American Indians. *Journal of Aggression, Maltreatment & Trauma*, 25(6), 598–617. <http://dx.doi.org/10.1080/10926771.2016.1157843>

Charbonneau-Dahlen et al. examine historical trauma among American Indian (AI) mission boarding school survivors. The study, which relied on snowball sampling, used the Dream Catcher-Medicine Wheel (DCMW) model to enhance the storytelling of the participants in the descriptive, exploratory qualitative study. The DCMW model, combined with recorded storytelling sessions, provided a rich audiovisual framework for preserving and articulating the participants’ sense of loss and communal grief. The study identified three major themes: “First, unable to voice mission boarding school experiences for most of their adult lives, each affirmed the rediscovery of Native



spirituality as empowering. Second, all expressed appreciation for traditional methods woven into storytelling sessions, particularly the DCMW. Finally, all indicated they experienced release and healing through telling their stories” (p. 598).

DeJong, J. A., & Holder, S. R. (2006). Indian boarding schools and the Therapeutic Residential Model project. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 13(2), 1–16.* Retrieved from <https://pdfs.semanticscholar.org/0fb2/e22fac1a74ee8a2a0c14d384ca7b20d2098a.pdf>

DeJong and Holder discuss the Therapeutic Residential Model Project, funded by the Office of Indian Education Programs (OIEP) of the Bureau of Indian Affairs. The OIEP implemented the model in 2001, basing it off of six essential elements (p. 6):

1. Comprehensive mental health and substance abuse services
2. Comprehensive student screening and assessment
3. Professional development for staff
4. Safe and secure environment
5. Cultural relevance
6. Home, school, community, and Tribal interaction

The other pieces in the volume provide case studies of the five implementation sites, as well as cross-site evaluation.

Gone, J. P. (2009). A community-based treatment for Native American historical trauma: Prospects for evidence-based practice. *Journal of Consulting and Clinical Psychology, 77(4), 751–762.* Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.470.124&rep=rep1&type=pdf>

In this piece, Gone describes a study commissioned by Canada’s Aboriginal Healing Foundation (AHF) as a part of five coordinated research projects documenting “therapeutic approaches and activities for a select number of AHF-funded programs intended to redress the legacy of residential schools in Canadian Aboriginal communities” (p. 753). The study involved interviews 19 First Nation staff and clients in a Native American healing lodge that incorporated Western therapeutic and Aboriginal cultural practices. Thematic content analysis of the interviews indicated that four “components of healing discourse emerged. First, clients were understood by their counselors to carry pain, leading to adult dysfunction, including substance abuse. Second, counselors believed that such pain must be confessed to purge its deleterious influence. Third, the cathartic expression of such pain was said by counselors to inaugurate lifelong habits of introspection and self-improvement. Finally, this healing journey entailed a reclamation of indigenous heritage, identity, and spirituality that program staff thought would neutralize the pathogenic effects of colonization” (p. 751).

Intimate Partner Violence, Sex Trafficking, and Sex Abuse

Burnette, C., & Hefflinger, T. (2016). Honoring resilience narratives: Protective factors among indigenous women experiencing intimate partner violence. *Journal of Baccalaureate Social Work, 21(1), 63–78.* <https://doi.org/10.18084/1084-7219.21.1.63>

Burnett and Hefflinger examined the protective factors among AI/AN women experiencing IPV. A thematic analysis to ethnographic interviews of 29 AI/AN women who had experienced IPV indicated that the protective factors included: “(a) an educational orientation; (b) affirming talents and abilities; (c) constructive coping, which included helping others and expressing emotions; (d) faith; (e) optimism and resilience perspectives; and (f) self-reliance and inner strength” (p. 63).



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*(3), 49–68. Retrieved from [http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2011/11\(3\)_Oetzel_Intimate_Partner_Violence_49-68.pdf](http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2011/11(3)_Oetzel_Intimate_Partner_Violence_49-68.pdf)

Oetzel and Duran approach IPV issues in AI/AN communities using a social-ecological framework. Determinants of IPV were divided according to level: individual (sex, age, socioeconomic status, substance use, and cultural identity), interpersonal/family (gender roles and family bonds), organizational (lack of routine IPV screening in health-care settings and of infrastructure for addressing IPV), and community (effects of European colonization). Each level has interventions associated with it, with most of the recommendations matching those in the Wahab and Olson piece.

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), 21067. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.780.544&rep=rep1&type=pdf>

Tribes have made numerous efforts to stem and heal child sexual abuse. One such program, Pathway to Hope (PTH), “addresses child sexual abuse from a historical trauma lens, noting, for instance, that the higher rates of sexual abuse among certain Tribes, regions and communities is linked in part to years of oppression, marginalization and attempted genocide, but may also be perpetuated by internalized oppression and lateral violence among Tribal members” (p. 2). Payne, Olson, and Parrish describe the PTH program, providing information about the history of the program, its contents, its expansion over time, and evidence of its efficacy. Starting from the assumption that the culture of silence cited by AN people obstructed healing and compounded the trauma of child sexual abuse, the program provides a video, guidebook, and 3-day community facilitator training that “are based on the belief that community change and healing can only take place through practices of respecting and honoring the knowledge of Native people and following these guiding principles:

- (a) Indigenous People/Tribal Communities must take responsibility for the safety and healing of children.
- (b) Indigenous People/Tribes must have ownership of social problems, as well as the development of solutions to those problems.
- (c) Reclaiming and reviving cultural values, beliefs, [and] practices to heal children and those victimized as children must begin with understanding historical trauma and in multigenerational dialogue.
- (d) On-going mentoring and support for ‘Indigenous couriers of community change’ is “essential for Tribal communities to achieve long-term change in attitudes and responses toward children who were victims of sexual abuse” (p. 4).

The PTH program was created by AN people and intended to be guided from the wisdom of the community members, as well as strongly based in the spiritual beliefs and practices of the people. While the program was originally launched with the intention of using Native facilitators as faculty, the authors share the challenge that no Native facilitators have taken on that role, leading to limitations in the number of trainings that are available. This has also affected the ability to continue to build on the program and to embrace and build on new ideas, approaches, and processes. Without the ability to move forward, combined with the lack of sustainable funding, the program is no longer available. In addition, the program did not have a program evaluation component, further limiting the possibility of future work without evidence of success.



Pierce, A. (2012). American Indian adolescent girls: Vulnerability to sex trafficking, intervention strategies. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center*, 19(1), 37-56. Retrieved from <https://pdfs.semanticscholar.org/8915/ad60d51452f390321aec62a7942326035b36.pdf>

Pierce describes the few examples of published research addressing Tribally created and engaged interventions addressing sex trafficking. The author Pierce discusses the efforts of the Minnesota Indian Women's Resource Center, which offers two programs that address commercial sexual exploitation: an expanded version of its Oshkiniigikwe Program (serving girls and women ages 11-21) and the Phoenix Project (providing outreach programming at two Minneapolis alternative high schools specifically serving AI/AN youth). The programs included risk assessment, education, case management, advocacy, and support groups to at-risk AI/AN girls and young women. Comparison of intake and ongoing periodic assessments indicate that the programs "can help reduce risk of addiction and commercial sexual exploitation [by promoting] improved safety and stability in housing situations, healthier sources of social support, and improved relationships with parents/adult caregivers. Input from the girls served through the program suggests that they most value having caring adults that do not judge them but, instead, provide education and support based on cultural norms for trusting girls to make their own decisions at the time they feel ready to do so" (p. 51).

Wahab, S., & Olson, L. (2004). Intimate partner violence and sexual assault in Native American communities. *Trauma, Violence, & Abuse*, 5(4), 353-366. Retrieved from <https://pdfs.semanticscholar.org/53cb/d9b32634f008e1fb7b27cc01d3b087e1684d.pdf>

Wahab and Olson suggest that the risk factors for IPV in American Indian/Alaska Native (AI/AN) communities include institutional and internalized oppression (e.g., racism, classism, and sexism), oppressive practices, alcohol and drug use, lack of employment opportunities, and the destruction of Native family and community structures. In response, they provide three categories of interventions: community-based, including grassroots efforts, such as "shelters for battered women and children, crisis hotlines, and support groups; health-care based, including programs at Indian Health Service (IHS) hospitals that screen for IPV; and federal and national organizations, including the Office of Violence Against Women (Department of Justice). The article includes tables with sample interventions by category.

Substance Use and Abuse

Donovan, D. M., Thomas, L. R., Sigo, R. L. W., Price, L., Lonczak, H., Lawrence, N., ... & Purser, A. (2015). Healing of the canoe: Preliminary results of a culturally grounded intervention to prevent substance abuse and promote Tribal identity for Native youth in two Pacific northwest tribe. *American Indian and Alaska Native Mental Health Research*, 22(1), 42-76. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4374439/>

The "Canoe Journey, Life's Journey" curriculum was used in a subsequent project, the Healing of the Canoe (HOC). HOC was an academic-Tribal partnership between the University of Washington Alcohol and Drug Abuse Institute and the Suquamish and Port Gamble S'Klallam Tribes. The assessment of HOC in the article found that integrating "evidence-based components of positive youth development and [T]ribal-specific culture, traditions, and values, the curricula have the potential of reducing substance use; increasing hope, optimism, and self-efficacy; and facilitating cultural identity" (p. 67). For a description of the "Canoe Journey, Life's Journey" curriculum, see Hawkins et al. (2004) above.

Hawkins, E. H., Cummins, L. H., & Marlatt, G. A. (2004). Preventing substance abuse in American Indian and Alaska Native youth: Promising strategies for healthier communities. *Psychological Bulletin*, 130(2), 304-323. Retrieved from <http://falmouthinstitute.com/files/SS047/Strategies%20to%20Support%20Youth/Hawkins-Cummins-Marlatt-ATOD%20Prevention%20in%20Native%20Youth.pdf>

Hawkins, Cummins, and Marlatt provide an “overview of the published literature on substance use prevention among AI adolescents, focusing on the most widely used drugs: tobacco, inhalants, alcohol, and marijuana” (p. 304). Following a review of the substance use patterns, epidemiological information, and risk factors for substance use, the piece describes an array of published literature and studies about prevention efforts found effective in Tribal communities. The promising approaches to prevention included strategies such as “(a) conceptualizing prevention and behavior change as part of a continuum, (b) using a stepped-care approach, (c) utilizing a bicultural-focused, life-skills curriculum, and (d) establishing community involvement and collaboration throughout the development and implementation of prevention efforts” (p. 315).

The article discusses a few implementations that combine many of these elements. The Tri-Ethnic Center for Prevention Research at Colorado State University’s community readiness model (CRM) “emphasizes that unless a community is ready to initiate a prevention program, it is likely to not happen at all or to fail” (pp. 316-17). As a result, the CRM builds on stage theory of organizational change model, describing methods for assessing community readiness for program implementation and presenting “suggestions for ways to increase community readiness at each stage” (p. 317).

Also highlighted in this piece is the program, Journeys of the Circle, which began with a series of focus groups with urban Native youth. The focus groups brought to light the “Canoe Family” practice of Northwest Coastal Tribes, which provides structured, pro-social activities that can function as effective alternatives to substance use. A subsequently developed curriculum, “Canoe Journey, Life’s Journey,” was found to have distinct impact on empowering resilience of the youth through a culturally determined place of leadership.

Navarro, J., Wilson, S., Berger, L. R., & Taylor, T. (1997). Substance abuse and spirituality: A program for Native American students. *American Journal of Health Behavior, 21(1), 3–11.*

Navarro, Wilson, Berger, and Taylor describe a broader approach to using cultural interventions, as a means of prevention used by The Natural Connection (TNC), a program at the Institute for American Indian Arts in Santa Fe, New Mexico. TNC “addressed cultural traditions, [T]ribal history, and spirituality as avenues toward improving self-esteem” (pg. 4) and thereby improving substance use prevention outcomes. TNC’s work had several components: introductory and advanced courses, coled by psychologists, that included readings considered classics in Native American literature and relied heavily on group discussion; presentations and ceremonies led by traditional healers and spiritual leaders from many Tribes; and student projects. The authors suggest that the “project demonstrated strong promise to the effective link of cultural ceremony, spirituality and traditional values in prevention of substance abuse and addiction” (p. 3), but they also noted that the “search for spiritual commonality was complicated by the students’ diverse backgrounds” (e.g., student raised in urban settings as opposed to on reservations) and that several “female students wanted more emphasis on the importance of women in Native American history, traditions, spirituality, and the arts” (p. 7).

Noe, T., Fleming, C., & Manson, S. (2003). Healthy nations: reducing substance abuse in American Indian and Alaska Native communities. *Journal of Psychoactive Drugs, 35(1), 15–25.* <https://doi.org/10.1080/02791072.2003.10399989>

The Robert Wood Johnson Foundation’s initiative, “Healthy Nations: Reducing Substance Abuse Among Native Americans” (HNI), aimed at a number of outcomes, including generating interest in the program’s messages and activities, engaging a wide-range of stakeholders, enhancing institutional capacity, and improving outcomes and impact. The study found that the HNI programs: “(1) increased interest in substance abuse prevention and treatment by increasing the number of individuals who attend program-sponsored events and activities; (2) actively engaged key people in the implementation process by recruiting and using them as program advocates and volunteers; (3) enhanced community capacity by increasing the number of activities and trained personnel and resources allocated to their programs; (4)



influenced policy changes regarding how the community and its organizations and institutions address substance abuse issues; and (5) created the necessary infrastructure to institutionalize and sustain programs" (p. 23). The most effective programs shared several characteristics related to their success, including that they:

- "Maintained consistent and effective leadership. Programs that experienced significant within key program personnel often realized substantial setbacks in implementation success."
- "Incorporated a culture-focused approach. Culture became 'the program' for the most effective grantees instead of culture as an 'add on.'"
- "Achieved community ownership and 'buy in.' Effective programs stressed that community members should be involved at all levels of the planning and implementation and incorporated the perspective of 'doing with' the community instead of 'doing for' the community."
- "Developed creative and entrepreneurial approaches. 'Thinking outside of the box' was often a characteristic of the most successful programs."
- "Developed comprehensive efforts. Programs that sought to impact as many community systems as possible (e.g., schools, families, peers, neighborhoods, and [T]ribal organizations), were repeatedly the most effective."
- "Established effective collaboration. Programs that established effective collaborative linkages across service organizations and successfully combined resources and talents were more effective" (p.23).

Petoskey, E. L., Van Stelle, K. R., & De Jong, J. A. (1998). Prevention through empowerment in a Native American community. *Drugs & Society, 12*(1-2), 147–162. http://dx.doi.org/10.1300/J023v12n01_10

Petoskey, Van Stelle, and De Jong describe a program of the First American Prevention Center, a Tribally chartered organization of the Red Cliff Band of Lake Superior Chippewa. As a part of its 5-year grant, the Center developed a school-based curriculum (*The Red Cliff Wellness School Curriculum*), a teacher training program, leadership training activities, and a community curriculum with modules covering the "Spiritual and Cultural Perspective on Substance Abuse," "A Family Perspective on Substance Abuse," "Accessing Resources Through Effective Cooperation Between Tribal and Non-Tribal Agencies," and "Comprehensive Community-Based Planning." The preliminary findings of assessment efforts indicated that "change toward increased empowerment can be successful using strengths in Native American communities. This change, however, takes time and cannot be forced without disempowering individuals and communities" (p. 160).

Raghupathy, S., & Go Forth, A. L. (2012). The HAWK² program: A computer-based drug prevention intervention for Native American youth. *The American Journal of drug and Alcohol Abuse, 38*(5), 461–467. <https://doi.org/10.3109/00952990.2012.694531>

Raghupathy and Go Forth's article describes an adaptation of the statewide Indian Drug Prevention Program (SIDPP), which is a "culturally tailored intervention aimed at preventing substance abuse among Native youth in grades 4–6" that has as an "underlying emphasis on bicultural competence, i.e., the development of skills for negotiating both mainstream and Native cultures" (p. 462). The Honoring Ancient Wisdom and Knowledge² (HAWK²) intervention uses "engaging multimedia features such as games, animations, and video clips to impart substance abuse prevention knowledge and skills training" from SIDPP (p. 462). A review by end-users (i.e., 45 Native youth, aged 11–13) indicated that, while there were some elements that needed fine tuning (e.g., the pacing of narration), "the alpha prototype received very high ratings by the youth on overall usability features such as like-ability (mean rating: 4.8/5), ease of use (mean: 4.5/5), comprehension (4.6/5), and future use (5.0/5). Likewise, practitioners who reviewed the program found it to be 'timely,' 'compelling,' and definitely something that could be used in our schools"(p. 466).

Walsh, M. L., & Baldwin, J. A. (2015). *American Indian substance abuse prevention efforts: A review of programs, 2003–2013. American Indian and Alaska Native Mental Health Research, 22(2), 41–68*. Retrieved from <https://pdfs.semanticscholar.org/8433/bb22c6b8f762b515d3567dc76605a6e155bd.pdf>

Walsh and Baldwin examined 18 articles covering 31 substance abuse prevention (SAP) programs implemented in AI/AN communities. Their interest was in exploring the relationship between a pair of empirical facts: first, that SAP programs “frequently have not been able to meet the unique cultural needs of AI/ANs” (p. 41) and, second, that “theory-driven programs are more effective than programs that are not theoretically based” (p. 42). In particular, they “hypothesized that, if SAP programs were theoretically connected [to] and driven by AI/AN communities, [they would be] more likely [to] be integrated into those communities; to be measured and evaluated accurately; to be sustained; and to be deemed successful for those participating” (p. 42). Because the articles reviewed did not consistently articulate the role of theory in the SAP programs, the findings of the study are limited and tentative. However, the authors indicate that, despite the possibility of integrating “scientific theories of behavior change (Western-based) with Indigenous holistic health belief systems,” many of the SAP “in AI/AN communities are based on an individual, risk-factors approach, [as] opposed to a strengths-based approach” incorporating the more social or collective values of many AI/AN communities (p. 49).

Mental Health and Suicide

LaFromboise, T. D., & Lewis, H. A. (2008). *The Zuni Life Skills Development Program: A school/community-based suicide prevention intervention. Suicide and Life-Threatening Behavior, 38(3), 343–353*. Retrieved from <http://204.14.132.173/pi/oema/resources/ethnicity-health/native-american/zuni-life-skills.pdf>

The Zuni Life Skills Development Program is designed for high school students as a suicide prevention program. It was developed collaboratively by Stanford University and Zuni community leaders in response to a number of suicides by youth in their community. The community played a key role in the development of the intervention and evaluation. It is a life-skills training course that builds help-seeking behavior. It utilized small group work, role modeling, and community gatekeeping. Additionally, this type of intervention relies on collaboration between the community and the intervention designers because the community can specify the target problem(s) and design the appropriate response. As the name implies, this intervention was specifically tailored to be used by and compatible with the Zuni culture.

The intervention consisted of 7 major units, was offered 3 days a week for a year, and had booster sessions in the third year. The units were (p. 347):

- Build self-esteem
- Identify emotions and stress
- Increase communication and problem solving
- Recognize and eliminate self-destructive behavior
- Learn about rates of suicide across Tribes, risk factors for suicide, warning signs of suicide and facts and myths of suicide
- Receive suicide crisis intervention training
- Engage in individual and collective goal setting

Included in each of these were skills-training elements, provision of information about certain behaviors, modeling, behavioral rehearsal, and feedback. Results from a multi-method evaluation (which included self-report, behavioral observation and peer-rating) indicated the



intervention reduced suicidal thoughts and feelings of hopelessness and increased problem-solving and suicide-intervention skills. The development of the program led the way for the development of the “American Indian Life Skills Development Curriculum,” containing cultural values and respect that are important to all Native Americans, such as kindness and respect. This version encourages users to adapt the content to fit their own specific Tribe and cultures, while keeping the skills portion the same. The curriculum was implemented in a high school in Oklahoma, resulting a dramatically decreased suicide rate.

General Protective Factors

Allen, J., Mohatt, G. V., Rasmus, S. M., Hazel, K. L., Thomas, L., & Lindley, S. (2006). The tools to understand: Community as co-researcher on culture-specific protective factors for Alaska Natives. *Journal of Prevention & Intervention in the Community, 32*(1–2), 41–59. https://doi.org/10.1300/J005v32n01_04

The authors describe a pair of studies examining sobriety and alcohol use in AN populations: “The first [was a] qualitative [study], whose research objective was discovery oriented, and whose specific aim was identification of protective factors in Alaska Native sobriety. Results were used to develop a heuristic model of protective factors, and a measure based on these factors. The research objective of Study 2 was piloting of this measure and initial validation of the instrument’s internal structure” (p. 44). The protective factors identified by the research fell into three groups: community characteristics (i.e., communities with “positive adult role models, rites of passage in which one had the opportunity to contribute to the community, limit setting on alcoholic behavior, and provision of safe places for children”); family characteristics, especially elements of a close relationship with parents (i.e., “a parental teaching role, provision of an environment that was safe, and abusive alcoholic behavior was not tolerated, . . . modeling of sobriety, [expressions of] affection[,] praise, and of specialness of the child, [and] the transmission of cultural expectations and values”); and individual characteristics of youth that included “wanting to become a role model; giving to others by contributing to the community in both material and less tangible, more interpersonal ways; belief in oneself as someone of value and potential; and awareness of consequences of one’s behavior, and of interconnection” (pp. 47–48). The work cites the efforts of several projects, including the People Awakening Project, that serve as models of participatory action research and community-based evaluation, which were critical to the ability to measure and achieve meaningful data in Native populations.

Berns, R. M., Tomayko, E. J., Cronin, K. A., Prince, R. J., Parker, T., & Adams, A. K. (2017). Development of a culturally informed child safety curriculum for American Indian families. *The Journal of Primary Prevention, 38*(1–2), 195–205. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5495468>

Safety Journey was developed in response to feedback from Tribal communities when the initial Healthy Children, Strong Families 1 (HCSF1) intervention was piloted, and they were informed that the research design included randomization to a control arm that did not receive any type of intervention. It is delivered via mailed materials and was developed with input from a team of researchers, Tribal research staff, and safety experts from the IHS and focused on the major causes of injury-related death. On a monthly basis, the program’s topics educate participants on these various dangers in the hope they can make better decisions for their family. Satisfaction surveys were administered to participants who remained in the study the entire 12 months. The majority of the participants indicated they were either satisfied or very satisfied with the intervention and felt the materials were either helpful or very helpful.

Hodge, F. S., & Nandy, K. (2011). Predictors of wellness and American Indians. *Journal of Health Care for the Poor and Underserved, 22(3), 791–803.* Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3287368>

Hodge and Nandy describe the results of a randomized household survey of 457 AI adults in 13 rural health care sites in California. The survey examined respondents' sense of wellness, which many Tribes define as "the physical, mental/emotional, spiritual, and environmental traits that together form balance and harmony in life" (p. 6). Of particular interest to child and family resilience efforts, participating in AI cultural practices and other forms of "cultural connectivity (speaking [T]ribal language, participating in AI practices, and feeling connected to community) [were] associated with perceptions of wellness" (p. 6).

Tomayko, E. J., Prince, R. J., Cronin, K. A., Parker, T., Kim, K., Grant, V. M., ... & Adams, A. K. (2017). Healthy Children, Strong Families 2: A randomized controlled trial of a healthy lifestyle intervention for American Indian families designed using community-based approaches. *Clinical Trials, 14(2), 152–161.* Retrieved from <https://europepmc.org/articles/pmc5499663>

Healthy Children, Strong Families 2 (HCSF2) is a healthy lifestyle intervention that aims to combat obesity in children ages 2–5. It encourages increased consumption of fruits and vegetables, decreased consumption of sugar, increased physical activity, and decreased sedentary activities. It also targets stress and sleep. It builds off the HCSF1 trial that was delivered via home visiting and mailed intervention. The HCSF2 intervention was part of a randomized controlled trial (RCT) with five AI communities across the county. The families were assigned to this intervention, known as Wellness Journey, or to an active control, known as Safety Journey. (See Berns et al., 2017, both above and below, for more information on the development of Safety Journey). After a year, the groups switched interventions. Wellness Journey was delivered via materials that were mailed monthly and included social networking support, such as text messaging and a dedicated Facebook page. While results were not available in the article reviewed, lessons learned included the usefulness of Facebook for participant retention and for contacting hard to reach participants. They also found that the use of local, site-specific coordinators was very important for recruitment, data collection, and participant retention.

Culture

Allen, J., Mohatt, G. V., Rasmus, S. M., Dogs, R. T., Ford, T., Dogs, E. I. C. T., & Camp, R. M. (2011). Cultural interventions for American Indian and Alaska Native youth: The Elluam Tunjiinun and Nagi Kicopi Programs. In M. C. Sarche, P. Spicer, P. Farrell, H. E. Fitzgerald (Eds.), *American Indian and Alaska Native children and mental health: Development, context, prevention, and treatment* (pp. 337–364). Santa Barbara, CA: Praeger/ABC-CLIO.

The first cultural intervention described in this book chapter, Elluam Tunjiinun, is aimed at preventing youth suicide and alcohol abuse in children aged 12–18. It means "towards wellness" and consists of various ways for the participants to experience wellness. It is modeled on the People Awakening Project that helped AN people develop a path toward sobriety. The work to build the intervention was done by a large team of people, guided by a community planning group that included Elders, representatives from various children's groups, churches, and other Tribal and community leaders.

The program is made up of various cultural experiences or program activities that typically last one or two sessions. Elders and parents then share their experiences; make the connection to each of these activities or experiences; and highlight the connection to choosing wellness, understanding, and reasons for living. An evaluation of the community protective factors (safety, alcohol prohibitions, role models, opportunities for youth and support), using a quasi-experimental design, was conducted, and initial evidence regarding the effectiveness of the program is positive. This included assessing the protective factors at the community level at four different points in time (twice prior to



administration of the intervention, once during the intervention, and once at the conclusion of the intervention). Additionally, it was woven into the community narrative, another form of program effectiveness.

The second cultural intervention described in this book chapter, Nagi Kicopi, is a program for Lakota youth with severe emotional disturbance (SED). It came about as part of a Substance Abuse and Mental Health Services Administration (SAMHSA) Circles of Care grant to develop a system of care to address children that experience SED and is based on Oglala cultural practices and values. Key people involved included traditional medicine men; care coordinators; and a licensed psychologist that integrated other diagnostic systems, such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

The program begins with a spiritual assessment done during a ceremony in order to discover the root of the problem. The family is then assigned a care worker and given any follow-up ceremonies by the medicine man. Initial assessments include family history, psychosocial assessments, assessments required by SAMHSA, and other locally created assessments that reviewed immersion in Oglala tradition and culture. One of the key assessments is the Oglala Global Assessment of Functioning (GAF), which was created specifically for this project and modeled after the GAF associated with the DSM-IV. The final Oglala GAF has four domains (spiritual, physical, emotional, and cognitive). Scores on this assessment serve as the basis for service planning to address each of the four domains. Follow-up is done at 3 months to decide if any of the domains require additional services. While funding through SAMHSA has not continued, the program was because the community thought it was a valuable resource and found funds to maintain it.

Berns, R. M., Tomayko, E. J., Cronin, K. A., Prince, R. J., Parker, T., & Adams, A. K. (2017). Development of a culturally informed child safety curriculum for American Indian families. *The Journal of Primary Prevention, 38*(1–2), 195–205. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5495468>

AI children are more likely to be affected by unintentional injuries, with mortality rates being 2.3 times higher than other children. Risk factors leading to the disproportionate numbers for AI/AN children include limitations in access to emergency medical care, lack of proper child restraint in motor vehicles, substandard housing, poverty, and substance abuse. Based on the need to address the disproportionate number of injuries, a group of Tribal researchers, academic staff, Tribal community members, and national child-safety experts developed a safety curriculum and deployed it as a part of a larger program, the HCSF2. The larger program was a family-based intervention targeting the prevention of obesity in young children between the ages of 2–5.

The curriculum was broken out in two portions: the Wellness Journey (focused on obesity prevention) and the Safety Journey (focused on improving the safety of children). Each journey lasted for 1 year, and, at the end of the year, participants would switch to the other journey. Families were provided with lessons and information mailed to them on a monthly basis. The mailing would include specific information to guide the family in various topics, with a focus on lessons for caregivers on how to make safe choices for their family and, ultimately, avoid unintentional injuries. The safety mailings were dispersed based on accidents and injuries that may be connected to seasonal activities. The newsletters included information for the caregivers and activities to engage the children.

Following implementation of the program, the participants were surveyed regarding their satisfaction with the information received. The majority of responses indicated the information was “helpful” or “very helpful” in their responses for improving child safety. More broadly, the data collected revealed more awareness of safety issues, action, and family time. In addition, multiple community interventions were developed, including campaigns aimed at increasing the use of child safety seatbelts and reducing incidents of driving under the influence of substances.



Brave Heart, M. Y. H., Elkins, J., Tafoya, G., Bird, D., & Salvador, M. (2012). Wicasa Was' aka: Restoring the traditional strength of American Indian boys and men. *American Journal of Public Health, 102*(S2), S177–S183. Retrieved from <http://www.aihec.org/our-stories/docs/BehavioralHealth/2014/Wicasa%20Wasaka-Restoring%20the%20Traditional%20Strength%20of%20American%20Indian%20Boys%20and%20Men.pdf>

This article provided a history of historical trauma and its impact on traditional roles and examined health disparities in Lakota men. It then provided two interventions aimed at addressing historical trauma and health disparity. One of the interventions was the Historical Trauma and Unresolved Grief Intervention. It is a short-term intervention designed to help AI adults with health disparities cope with grief and trauma. While it can be and has been used with multiple Tribes, it has primarily been used with Lakota men. Participants in the intervention attended a traditional mourning resolution ceremony, facilitated by survivors of historical trauma, in the Black Hills, a sacred healing place for Lakota. After the traditional ceremony, such as Wiping of the Tears, participants revealed how powerful the intervention was to experience.

Post-intervention participants reported they felt that the intervention was helpful in reducing grief and trauma responses. Aspects of the intervention that participants felt were particularly helpful were the group processing, the spiritual components, and the ability to work through boarding school trauma. Additionally, men reported more joy, more affect tolerance, and decreased psychic numbing.

Also mentioned in the article was RezRIDERS, an intervention for AI youth aimed at health promotion, i.e., decreasing substance abuse and depression and increasing positive relationships and youth development. It is an experiential intervention that focuses on the use of extreme sports and challenging environments as a way to shift from engaging in high-risk behaviors. Elements of the intervention also include cultural mentorship, optimism exercises, trust building, and community projects. RezRIDERS is unique in the ability to culturally tailor it to different Tribes by using a CBPR approach. In this way, it can also build the capacity of local researchers.

Freeman, B. J., Coll, K. M., Two Dogs, R., Iron Cloud Two Dogs, E., Iron Cloud, E., & Robertson, P. (2016). The value of Lakota traditional healing for youth resiliency and family functioning. *Journal of Aggression, Maltreatment & Trauma, 25*(5), 455–469. <http://dx.doi.org/10.1080/10926771.2015.1079282>

The Nagi Kicopi program serves Lakota youth on the Pine Ridge Reservation, who are challenged with serious emotional and behavioral problems. The program offers traditional services and healing methods for youth, including ceremonies and customs. The families of the youth were also invited to participate. The Lakota protocol is for the traditional healer to talk to the designated Elder and caregiver for the youth to determine which healing ceremonies may be appropriate for each youth. The interventions were chosen specifically for each youth and were based on seven sacred Lakota ceremonies. In addition to the healing ceremonies, each youth had an intervention plan, which also included teachings of identity development and cultural practices.

To study the impact of traditional healing on family functioning and youth resiliency, the Oglala Lakota Sioux conducted research of the interventions and healing ceremonies used to treat the youth in the Nagi Kicopi program. To assess the impact, the caregivers of the youth were administered assessments before and after the interventions. The assessments used had been deemed culturally appropriate by Lakota Elders. The results demonstrated statistically significant results for the impact of the healing ceremonies on multiple areas of family functioning, decision-making, and conflict resolution. Follow-up interviews confirmed the participants' belief that the traditional healing had a positive impact on their families.



Husted, J., Johnson, T., & Redwing, L. (1995). Multi-dimensional adolescent treatment with American Indians. *American Indian and Alaska Native Mental Health Research*, 6(3), 23–30. Retrieved from <https://pdfs.semanticscholar.org/523b/c3517868602e1369d75c0d71dfbb27165d5f.pdf>

O'Inazin is an inpatient treatment center for Tribal adolescents facing difficulties in life, including: alcoholism, incest, physical abuse, and neglect. The adolescents in the program have significant behavioral problems, including truancy, antisocial behavior, and substance abuse. The treatment center is located in on the reservation in eastern South Dakota and focuses on the use of traditional values and treatments. The program teaches and encourages positive behavior in a culturally relevant environment. It enforces consistency in behavior and clear consequences, using a system of increased freedom options as positive reinforcement for improved behavior. The program also offers counseling by AI adults; specific groups for the residents to attend, which address issues of IPV; and Alcoholics Anonymous. The facility further offers family therapy for the adolescent and his or her family.

In addition to therapeutic interventions, the treatment center provides experiences and education specific to traditional Dakotah thoughts and values. Adolescents are provided lessons in Dakotah history, language, and tradition by Tribal Elders and offered frequent opportunities for sweats.

The study was conducted to assess the effectiveness of the program for the adolescents, all of which were enrolled from the Sisseton-Wahpeton Sioux Tribe. The study measured school performance and antisocial behavior of the adolescents following release. The results found that the AI adolescents who completed the program tended to have improved school performance in the years following their release, as well as a reduction in involvement in the criminal justice system.

Mohatt, N. V., Fok, C. C. T., Burket, R., Henry, D., & Allen, J. (2011). Assessment of awareness of connectedness as a culturally-based protective factor for Alaska Native youth. *Cultural Diversity and Ethnic Minority Psychology*, 17(4), 444–455. Retrieved from <https://pdfs.semanticscholar.org/b244/fde990e6bb57b1d35b7f7ae200c52f9108a8.pdf>

This paper examined the utility of the Awareness of Connectedness Scale (ACS) as a practical measure of connectedness among AN youth. The authors argue that a holistic sense of connectedness of an individual with his or her family, community, and physical environments is an important component of Indigenous world views. Specifically, connectedness is viewed as a protective factor against substance abuse and suicide, as well as an in aid in recovery from substance use disorders (SUDs). The ACS development took place within a larger, community-based, participatory research (CBPR) project that seeks to identify AN pathways to sobriety and to strengthen culturally based protective factors. The 18 items are targeted at assessing awareness of self as a member of a broader human and natural community, including an awareness of connections between one's own well-being and the wellbeing of other entities in the various ecological spheres that one occupies. The ACS assesses the degree to which a person endorses the concept of interrelatedness between self, family, community, and natural environment.

The authors concluded that the construct of connectedness is related to hypothesized suicide and substance abuse protective factors, such as reasons for living and communal mastery among AN youth. The authors hypothesize that ACS provides a measurement tool that may be useful for examining possible relationships between Native American cultural identification and positive behavioral health outcomes.

Winderowd, C., Montgomery, D., Stumblingbear, G., Harless, D., & Hicks, K. (2008). Development of the American Indian Enculturation Scale to assist counseling practice. *American Indian and Alaska Native Mental Health Research*, 15(2), 1–14. Retrieved from [http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2015/15\(2\)_Winderowd_Development_AIES_1-14.pdf](http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2015/15(2)_Winderowd_Development_AIES_1-14.pdf)



This paper examined the utility of the American Indian Enculturation Scale (AIES) as a practical measure of enculturation for AI people. Enculturation is the process by which an individual learns about and identifies with his or her own cultural roots. The AIES was developed to be used in counseling practice to assess enculturation of AI people, with an emphasis on participation in one's Tribal activities, including spiritual practices. The authors argue that such practices are related to protective factors of resiliency. The instrument consists of 16 items thought to reflect the common experiences of traditional AI people across a variety of Tribes.

The authors concluded that the AIES is a culturally relevant and practical measure of enculturation or traditionality and is reliable and valid with AI clients, as well as with AI people in the community (i.e. non-clinical samples). It appears to be a relevant measure for AI people from a variety of Tribes across the nation. There may be some traditional ways not included in this measure that would be relevant for a particular Tribe or Nation, such as Alaska Natives. Therefore, the authors encourage practitioners and researchers to use this measure and to adapt the items, as needed, to be congruent with the traditional ways of the people from particular Tribes and Nations.

Outreach

Dick, R. W., Manson, S. M., Hansen, A. L., Huggins, A., & Trullinger, L. (2007). The Native TeleHealth Outreach and Technical Assistance Program: A community-based approach to the development of multimedia-focused health care information. *American Indian and Alaska Native Mental Health Research, 14(2), 49–66.* Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.457.9943&rep=rep1&type=pdf>

A challenge facing intervention projects aimed at assisting AI populations is the geographical dispersion of those populations; one tool for overcoming that challenge is telehealth technologies, which leverage telecommunications technology to provide virtual resources that could not otherwise (or cost effectively) be made available. One such project is the Native TeleHealth Outreach and Technical Assistance Program (NTOTAP), a project of the Center for Native American TeleHealth and TeleEducation of the American Indian and Alaska Native Programs at the University of Colorado at Denver and Health Sciences Center.

NTOTAP addresses the transfer of technical knowledge to community health advocates and professionals, with a focus on three goals: "(a) increase community members access to health care resources, (b) provide the technical training to develop health care resources, and (c) promote capacity building and sustainability at the local level" (p. 51).

The program's initial cohort featured nine participants from a range of professions and educational backgrounds, each of whom received financial compensation (and other fiscal support), operational and technical mentors, technical training, and technological resources necessary for participation. Of the nine participants, eight completed the program by developing a website, interactive CD-ROM, or video.

Gottlieb, K. (2007). The family wellness warriors initiative. *Alaska Medicine, 49(2), 49–54.*

Gottlieb, K., & Outten, B. (2011). Family wellness warriors. *Family & Community Health, 34(3), 235–241.* <http://dx.doi.org/10.1097/FCH.0b013e318219623b>

The two articles found on the Family Wellness Warriors initiative (FWWI) seemingly present the program a bit differently. Gottlieb (2007) described an AN health care organization, called the Southcentral Foundation (SCF). It describes a customer-owned system that was created to meet the needs of its consumers. It was designed to improve services for Native people, focus on culture, and encourage families to take charge of their lives. It offers health and wellness services, including behavioral health, primary care, dental, and residential treatment options. SCF took over the health care system from the IHS. The system, when run by IHS, had multiple complaints and was not meeting



the needs of its clients. SCF began to change the system by asking what the clients wanted; conducting surveys, listening conferences, and advisory boards; and collecting data and word of mouth from the AN people. After gathering this information, SCF researched best practices and created an infrastructure to support the changes requested by the clients. As a result of this new system, SCF reports decreases in the use of urgent care, emergency room services, and hospitalizations. Customer satisfaction has increased, as have screening rates and illness prevention.

Gottlieb and Outten (2011) discuss the FWWI as a program designed to heal individuals who have experienced trauma, so trauma is not passed on to younger generations. It encourages younger generations to speak out if they or someone they know is being harmed. It relies on traditional values of AN people and was developed when eight AN women met with the Chief Executive Officer from SCF. The first training event was derived from the Open Hearts Ministry Survivors of Abuse Leadership Training Seminar. They enhanced it through cultural adaptations. Critical components of the initiative are spirituality/faith and sharing/story-telling.

FWWI is a program of SCF but remains focused on ANs. Currently, it offers multiple types of training, including leadership training, trainings tailored to select populations, and multi-day introductory trainings. The trainees learn how to respond to and build trust with people who disclose experiences of trauma or abuse. As of 2011, 3000 people had been trained by FWWI. Leaders in the AN community feel that FWWI is effective at trying to address the problem. Additionally, evaluation efforts in the form of pre/post-tests of participants have shown significant changes. This means that through participation in the training, participants have been able to make personal changes.

Family

Drywater-Whitekiller, V. (2014). Family group conferencing: An indigenous practice approach to compliance with the Indian Child Welfare Act. *Journal of Public Child Welfare*, 8(3), 260–278. <https://doi.org/10.1080/15548732.2014.907102>

A substantial portion of historical and intergenerational trauma for AI communities involves programs that devastated familial relations and structures: “children being placed out of their homes and away from their families and [T]ribal influences” via boarding schools and foster care and adoption (p.263). The Indian Child Welfare Act (ICWA), passed in 1978, sought to remedy the latter by providing preferential placement to the Tribes in foster care, adoption, and termination of parental rights (p. 264). Drywater-Whitekiller argues that family group conferencing (FGC) can help improve ICWA compliance and has the potential to facilitate active efforts from public child welfare systems via facilitating remediation services and perpetuating kinship networks. She suggests that FGC “is particularly promising for smaller and more culturally knowledgeable tribal child welfare systems” (p. 273).

FGC is a means of solving problems within a cultural context, using cultural and familial connectivity as a protective factor in the case planning process with families where children may be at risk. In addition, using FGC in Tribal child welfare allows agencies to be able to recognize the culture, tradition, heritage, and history of a family or Tribe.

While this article revealed multiple elements for consideration when implementing the FGC program in Tribes, there were no overall findings available post implementation or listed in the article that would lead the reader to determine what level of success Tribes may or may not have had with implementation.

Robbins, R., Tonemah, S., & Robbins, S. (2002). Project Eagle: Techniques for multi-family psycho-educational group therapy with gifted American Indian adolescents and their parents. *American Indian and Alaska Native Mental Health Research, 10*(3), 56–74.

Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.454.2660&rep=rep1&type=pdf>

Project Eagle is psychoeducational group therapy for gifted AI adolescents and their parents. It was originally funded by OIEP and designed as a leadership program. Its goal is to improve relationships between parent and child, promote cultural identity, increase altruism and self-disclosure, and improve leadership skills. While it has been conducted in many formats, the format presented in this article consisted of three phases. In phase one, participants met over the weekend, 4 hours on a Friday and 8 hours on a Saturday. These sessions involved psychoeducation sessions that involved conflict management, decision-making, problem-solving, and group cohesion. In the second phase, held a few months later, the families planned and held a school or community event. The third phase, held another few months later, was another 7-hour psychoeducational session. The entire experience concluded with sharing of projects and an awards ceremony. The article provides an in-depth description of what is included in the long psychoeducational session, a case example, and examples of the community project.

At the conclusion of the last session, participants were asked to evaluate the program by answering questions on a five-point scale. They were also asked to answer open-ended questions. Results from the evaluations indicate that participants felt safe and were able to explore their relationships with their parent. They also felt that the project helped them to build self-confidence and to explore their AI identity. Project Eagle has been offered in multiple settings and, as a result, was often adapted to meet the unique needs of each group.

Tribal Adaptation

Barlow, A., Mullany, B., Neault, N., Compton, S., Carter, A., Hastings, R., ... & Walkup, J. T. (2013). Effect of a paraprofessional home-visiting intervention on American Indian teen mothers' and infants' behavioral risks: a randomized controlled trial. *American Journal of Psychiatry, 170*(1), 83–93. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4542092>

Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., ... & Carter, A. (2015). Paraprofessional-delivered home-visiting intervention for American Indian teen mothers and children: 3-year outcomes from a randomized controlled trial. *American Journal of Psychiatry, 172*(2), 154–162. Retrieved from <https://www.jhsph.edu/research/affiliated-programs/family-spirit/proven-results/publications/Barlow%20Mullany.pdf>

Barlow, A., Varipatis-Baker, E., Speakman, K., Ginsburg, G., Friberg, I., Goklish, N., ... & Reid, R. (2006). Home-visiting intervention to improve child care among American Indian adolescent mothers: A randomized trial. *Archives of Pediatrics & Adolescent Medicine, 160*(11), 1101–1107. Retrieved from <https://pdfs.semanticscholar.org/6120/2c6347ac0e039ce5ee2e60f44e1717f806b8.pdf>

Mullany, B., Barlow, A., Neault, N., Billy, T., Jones, T., Tortice, I., ... & Walkup, J. (2012). The Family Spirit Trial for American Indian teen mothers and their children: CBPR rationale, design, methods and baseline characteristics. *Prevention Science, 13*(5), 504–518. Retrieved from https://www.jhsph.edu/research/affiliated-programs/family-spirit/_docs/proven-results/publications/5_-Mullany_Barlow_et_al._2012.pdf

Walkup, J. T., Barlow, A., Mullany, B. C., Pan, W., Goklish, N., Hasting, R., ... & Ginsburg, G. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(6), 591–601. Retrieved from https://www.jhsph.edu/research/affiliated-programs/family-spirit/_docs/proven-results/publications/2_-Walkup_Barlow_et_al._2009.pdf

Home Visiting interventions are generally a primary prevention intervention targeted toward a high-risk population. They can be delivered by nurses or by paraprofessionals, cover various content, and be delivered to a wide variety of high-risk populations. They tend to report positive outcomes for maternal and child health and behavior outcomes, though given the wide variety of possible intervention topics and diversity among providers, it is hard to specify the key components of the home visiting intervention. The procedures for the home visiting program used in these studies was based on the “critical elements” of home visiting authored by “Healthy Families America” (Walkup et al., 2009). The critical elements include “who are well trained and supervised; have manageable caseloads; and who are compassionate, nonjudgmental, and interpersonally effective” (Walkup et al., 2009).

The studies focused on a home visiting intervention called Family Spirit. It is delivered by paraprofessionals to young (teenage and young adult) AI mothers living on the reservation. The content for Family Spirit was based on content put forth by the American Academy of Pediatrics’ Caring for Your Baby and Child: Birth to Age 5. It includes prenatal and infant care lessons and was reflective of local Native practices but did not contain community-specific traditions or spiritual beliefs. The paraprofessionals delivering the intervention were AI women, who were bilingual in their Native language and trained to respect the cultural orientation of each participant.

The studies were RCTs, with one employing a 3-year, follow-up period that compared the Family Spirit intervention to an active control. The studies supported the effectiveness of Family Spirit for increasing knowledge and involvement of young mothers, reducing maternal risks, and improving child developmental outcomes.

Batliner, T., Fehringer, K. A., Tiwari, T., Henderson, W. G., Wilson, A., Brega, A. G., & Albino, J. (2014). Motivational interviewing with American Indian mothers to prevent early childhood caries: Study design and methodology of a randomized control trial. *Trials*, 15(1), 125. Retrieved from <https://trialsjournal.biomedcentral.com/articles/10.1186/1745-6215-15-125>

Dickerson, D. L., Brown, R. A., Johnson, C. L., Schweigman, K., & D’Amico, E. J. (2016). Integrating motivational interviewing and traditional practices to address alcohol and drug use among urban American Indian/Alaska Native youth. *Journal of Substance Abuse Treatment*, 65, 26–35. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4732924>

Dickerson, D., Moore, L. A., Rieckmann, T., Croy, C. D., Venner, K., Moghaddam, J., ... & Novins, D. K. (2018). Correlates of motivational interviewing use among substance use treatment programs serving American Indians/Alaska Natives. *The Journal of Behavioral Health Services & Research*, 45(1), 31–45. <https://doi.org/10.1007/s11414-016-9549-0>

Gilder, D. A., Geisler, J. R., Luna, J. A., Calac, D., Monti, P. M., Spillane, N. S., ... & Ehlers, C. L. (2017). A pilot randomized trial of motivational interviewing compared to psycho-education for reducing and preventing underage drinking in American Indian adolescents. *Journal of Substance Abuse Treatment*, 82, 74–81. <https://doi.org/10.1016/j.jsat.2017.09.004>

Hanson, J. D., Miller, A. L., Winberg, A., & Elliott, A. J. (2013). Prevention of alcohol-exposed pregnancies among nonpregnant American Indian women. *American Journal of Health Promotion*, 27(3_suppl), S66–S73. Retrieved from https://www.researchgate.net/profile/Jessica_Hanson6/publication/51876440_Development_of_a_Media_Campaign_on_Fetal_Alcohol_Spectrum_Disorders_for_Northern_Plains_American_Indian_Communities/links/56df3d9208aee77a15fcf7e0.pdf

Tiwari, T., Albino, J., & Batliner, T. S. (2015). Challenges faced in engaging American Indian mothers in an early childhood caries preventive trial. *International Journal of Dentistry*, 2015. Retrieved from <https://www.hindawi.com/journals/ijd/2015/179189>



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 from <https://jpo.wrlc.org/bitstream/handle/11204/3768/Native%20American%20MI%20Manual.pdf?sequence=1>

Venner, K. L., Greenfield, B. L., Hagler, K. J., Simmons, J., Lupee, D., Homer, E., ... & Smith, J. E. (2016). Pilot outcome results of culturally adapted evidence-based substance use disorder treatment with a southwest Tribe. *Addictive Behaviors Reports*, 3, 21–27. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4778727>

MI is a client-centered way of being with people. It is said to increase a client's desire to change through discussing with the client both the pros and cons of changing his or her behavior. The hope is that, through this conversation, behavior can change in a positive direction. The spirit of MI allows the therapist to see the positive in each client, work with the client as an equal, and focus on drawing out the desire and motivation to change behavior from the client, as opposed to telling or making the client make changes (Venner et al., 2006).

Native American Motivational Interviewing: Weaving Native American and Western Practices (Venner et al., 2006) has been adapted for use with Native American communities. The goal of the manual is to be helpful yet, at the same time, sensitive to and reflective of the Native American communities and the struggles they face dealing with alcoholism and substance abuse. The authors wanted to create a manual that was easy to use and practice with Native American clients. The manual was created through a partnership between academia and the people providing substance abuse treatment in the Native American community. While the exact process used to create the manual was not outlined, the manual was reviewed by two focus groups, one composed of community members and one of behavioral health providers. The community members provided valuable information and feedback about Tribal communication styles and norms. The behavioral health providers, who were familiar with providing substance abuse services in their communities, met to learn how MI is provided in general and then provided input on offering it in Native communities.

MI With Adults. Venner et al. (2016) adapted MI and the community reinforcement approach (CRA) to be used with AI/AN to address substance use in a community (rural) setting. This was a small pilot study in preparation for a larger RCT that used an intervention that combined the two interventions, MI and CRA (MICRA). (Please see p. 7 for description of CRA.) The combination of the two treatments was done at the request of the reservation partners, who also worked collaboratively with the university partners to adapt the intervention. For MI, this included culturally consistent greetings and introductions; a reliance on spirituality and family, as appropriate; and use of counselors fluent in the Native language. Adaptations in this area were based on work by Venner, Feldstein, and Tafoya (2007). CRA adaptations included more visual cues and making language more accessible. While this was a very small sample (n=8), results indicate that MICRA may be effective in reducing substance use and in improving psychological functioning.

MI With Youth. One study (Dickerson et al., 2016), described the process used to integrate MI with traditional AI/AN culture to create MI and Culture for Urban Native American Youth (MICUNY) to design a program that addresses alcohol and drug use in urban AI/AN youth. The goal of the program is to reduce alcohol and drug use and to increase well-being, spirituality, and cultural identification for the youth involved in the MICUNAY workshops. For example, the program uses traditional MI strategies, such as identifying the pros and cons of substance use, but also integrates AI/AN practices, such as the Northern Plains Medicine Wheel. Focus groups were conducted in large, urban areas and were used to identify challenges for urban AI/AN youth and the content of the program.

Another study (Gilder et al., 2017), as part of a larger study, used an RCT to compare MI with psycho-education to reduce underage drinking in AI/AN youth. While the intervention was not specifically adapted, the person conducting the MI sessions was an AI/AN young adult, who had been trained in MI and had attended a workshop conducted by one of the authors of the above manual. This workshop

specifically targeted the integration of AI and Western practices in MI for AI adolescents. While this was a small study, it indicated there was not a significant difference between the two arms of the study. However, and perhaps more importantly, it was noted that both interventions had a successful impact on preventing and reducing underage drinking.

Dickerson et al. (2018) examined factors that influence the use of MI in AI/AN substance abuse treatment programs. This research was part of a larger study (see Novins et al., 2016, for an associated article). Given the consistency with AI/AN culture, MI shows promise for use in treating SUDs in AI/AN populations. In an effort to learn more about MI use in AI/AN substance abuse programs, this study examined implementation factors associated with MI use, program characteristics, perceptions of MI, and how clinicians learned about MI. This paper presents an extensive array of findings, but the following present a few highlights:

- Of the 192 programs surveyed, the majority of programs were familiar with MI (88 percent). Of those 88 percent, 75 percent were either currently using MI or those who had used it in the past but not currently.
- The majority of respondents found MI to be either very effective (40.5 percent) or somewhat effective (58.7 percent).
- 100 percent of implementers were either satisfied or somewhat satisfied. Tribally owned programs were also more likely to implement MI, compared to other forms of ownership.

Batliner et al. (2014) describes an RCT that uses MI to encourage AI mothers improve oral health behavior with their children. 600 new mothers were randomized to receive an enhanced, community, oral health service or MI plus the enhanced, community, oral health service. Participants will be followed (study is underway) until the child's third birthday. The study will examine the number of cavities, pattern, and dental cost among the children at ages 1, 2, and 3 years. It will also examine the knowledge and oral-health-related behaviors of mothers and their children at ages 1, 2, and 3.

The MI used in this study followed a culturally specific script that was developed with a Native MI consultant. MI providers were local people who attended a two-day training that emphasized the integration of Western and AI practices developed by a Native MI expert. During the training, participants focused on the communication skills needed to work with people using the MI spirit. Additionally, the trial had a community advisory board that was responsible for serving in an advisory capacity for the development team related to the project as a whole but also in relation to the development of project specific materials. Materials were specifically developed that reflect tribal colors and symbols.

Tiwari et al. (2016) presents the challenges faced in engaging this population in treatment efforts. Challenges include low priority placed on oral health, transportation, and other environmental barriers. Additional barriers related to distrust, racial differences, and communication were present. Study staff made every effort to mitigate these barriers using home visits, applying new communication methods, and interacting with participants in multiple arenas. In general, these efforts were well received. Conclusions of the study indicate that these prevention efforts need to target AI mothers with the goal of improving knowledge of oral health.

Hanson et al. (2013) examined the effectiveness of a telephone- and mail-based intervention on the reduction of alcohol-exposed pregnancies in a population of AI women of child-bearing age. It focused on risky drinking and contraception use. The article states the intervention is based on MI constructs and that the measurements were modified from the Project CHOICES program. AI women from three self-selected Tribes were recruited through an advertised toll-free number. The ads included Native languages and images and Tribal members. To encourage the dissemination of culturally appropriate materials, AI women from the three Tribes were asked their opinions.



When participants called in, they were asked questions adapted from the Project CHOICES program. These questions were repeated at 3 months, 6 months, 9 months, and 1 year. If participants agreed, they were then sent intervention materials in the mail and received follow-up phone calls every 3 months. The follow-up calls used MI techniques to determine readiness to change drinking behavior and repeated the assessments conducted at baseline. After the call, participants were again mailed intervention materials.

Results indicate that this intervention was successful in reducing self-reported drinking behaviors. This included a decrease in the maximum number of drinks in any one sitting, in the average number of drinks per week, and in the average number of drinks in one sitting. This was paired with a significant increase in the use of contraceptives between baseline and 3 months, which was followed by nonsignificant increases for the remaining time period. There are multiple limitations to this study, which include the self-selection of participants, the lack of a comparison group, the large number of women of women who did not complete the study, and the self-report nature of data collection.

Beckstead, D. J., Lambert, M. J., DuBose, A. P., & Linehan, M. (2015). Dialectical behavior therapy with American Indian/Alaska Native adolescents diagnosed with substance use disorders: Combining an evidence based treatment with cultural, traditional, and spiritual beliefs. *Addictive Behaviors, 51*, 84–87. <https://doi.org/10.1016/j.addbeh.2015.07.018>

Dialectical Behavioral Therapy (DBT) is an evidence-based therapy often used to treat borderline personality disorder and substance use. It uses mindfulness as a core component and targets the behaviors of substance abuse hierarchically. For example, it first addresses life-threatening behaviors and then behaviors that could interfere with treatment. Next, it addresses substance abuse behaviors that interfere with quality of life and, lastly, focuses on behavior skills. This study included the core DBT skills, as well as DBT skills specific to the treatment of addictions.

In this study, a version of DBT that included cultural, spiritual, and traditional practices was used to treat adolescents in a substance use residential treatment center. Additionally, a medicine man/spiritual counselor from a local Tribe provided weekly, sweat lodge ceremonies, smudging ceremonies, and talking circles. This medicine man had attended DBT trainings and was able to integrate the traditional practices into the mindfulness skill being taught by DBT. Progress was measured by the administration of a self-report questionnaire pre/post treatment. Results showed that the majority of the adolescents reported being either being recovered or improved at the end of treatment. None of the adolescents reported deteriorating during the study period.

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. Retrieved from <http://www.icctc.org/Honoring%20Children%20Making%20Relatives%2006-21-2011Final%20Submission.pdf>

BigFoot, D. S., & Schmidt, S. R. (2009). Science-to-practice: Adapting an evidence based child trauma treatment for American Indian and Alaska Native populations. *International Journal of Child Health and Human Development, 2*(1), 33–44.

Parent Child Interaction Therapy (PCIT) was originally developed for families of children ages 2–6 with disruptive behavioral disorders. It combines social learning techniques, family systems, play-based therapy, and child behavior therapy. It provides parent training and attempts to arm parents with the skills needed to set limits and to reverse negative behavior patterns (BigFoot & Funderburk, 2011). There are two phases of the intervention, which cover approximately 15 weeks. The goals of the first phase include reinforcing positive child behavior and improving the parent-child relationship. The second phase focuses on giving effective instructions and on following through and giving consistent consequences. PCIT is known for live coaching sessions, where parents are observed in a room and coached, via a wireless microphone, through interactions with their child (BigFoot & Funderburk, 2011).



PCIT is very compatible with traditional ways and, as a result, Honoring Children, Making Relatives encompasses traditional AI/AN philosophies (such as Circle Theory and Old Wisdom) within the core components of PCIT. The method of adaptation included reviewing the original PCIT; developers of PCIT working with AI/AN to review the literature and make adaptations; receiving feedback from cultural members, practitioners, and community; and, finally, making translations of PCIT. As a result, it includes AI/AN parenting teachings, practices, traditions, and rituals, while still remaining true to the core components of PCIT (BigFoot & Schmidt, 2009). BigFoot and Funderburk (2011) give specific practical examples of how language cadence, engagement, play, and verbal responses can be modified for use in an AI/AN context. This article also supplies case examples.

BigFoot, D. S., & Schmidt, S. R. (2009). Science-to-practice: Adapting an evidence based child trauma treatment for American Indian and Alaska Native populations. *International Journal of Child Health and Human Development*, 2(1), 33–44.

BigFoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology*, 66(8), 847–856. Retrieved from <http://www.itcmi.org/wp-content/uploads/2013/04/TBCAC-cultural-adaptation-article2010.pdf>

BigFoot, D. S., & Schmidt, S. R. (2012). American Indian and Alaska Native children: Honoring children—Mending the circle. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 280–300). New York, NY: Guilford Press.

Davidson, T., & De Arellano, Michael. (2014). Cultural considerations for assessment and treatment in child maltreatment cases. In R. M. Reece, R. F. Hanson, & J. Sargent (Eds.), *Treatment of child abuse: Common ground for mental health, medical, and legal practitioners*, (2nd ed., pp. 118–131) . Baltimore, MD: Johns Hopkins University Press.

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 & Adolescent Psychology*, 39(6), 858–872. Retrieved from <https://europepmc.org/articles/pmc3045814>

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. Retrieved from https://ruralhealth.und.edu/pdf/jmcd_0412_vol40.pdf

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an intervention used to address maladaptive, trauma-related beliefs and to correct a child's negative emotional and behavioral response to trauma. This includes correcting erroneous thoughts about the world, the child, and the traumatic event. It uses gradual exposure and involves the child's parents as a way to support the child, reduce distress for the parents, and teach behavioral strategies (BigFoot & Schmidt, 2010).

In general, TF-CBT is consistent with AI/AN teachings and beliefs. Honoring Children, Mending the Circle (HC-MC) is a cultural adaptation of TF-CBT that was adapted and created through a partnership with Tribal stakeholders, local programs, and providers. They worked together to integrate their Tribal culture, beliefs, and practices into the existing intervention. Specifically, they integrated the core constructs that all things are interconnected and have a spiritual nature (Bigfoot & Schmidt, 2010). An extensive description of the adaptations and the HC-MC intervention can be found in BigFoot and Schmidt (2010, 2012) and Gray and Rose (2012). BigFoot and Schmidt (2009) gives a summary of the process used to make adaptations. Additionally, there are tools and engagement strategies designed and framed to assist therapists in implementing HC-MC. This adaptation to TF-CBT is reflected in the language used for the intervention and also by allowing the core principles and treatment concepts to be meaningful to the AI/AN community. It maintains the core components of TF-CBT,



while keeping family culture and traditions at the forefront. BigFoot and Schmidt (2010) provides a case illustration of how HC-MC could be used. None of the articles presented the results of the HC-MC being used within the AI/AN community.

Campbell, A. N., Turrigiano, E., Moore, M., Miele, G. M., Rieckmann, T., Hu, M. C., ... & Nunes, E. V. (2015). Acceptability of a web-based community reinforcement approach for substance use disorders with treatment-seeking American Indians/Alaska Natives. *Community Mental Health Journal, 51*(4), 393–403. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4295007>

CRA is often used to treat alcohol and other SUDs. It includes skills that promote and help the client choose and be satisfied with drug-free sources of reinforcement. Core CRA topics include relapse prevention skills, improving psychosocial functioning, and HIV prevention. In this pilot study, CRA was offered on computer (the Therapeutic Education System) at their treatment center. There were a total of 32 module or topics that the participants could choose from, and they took 15–20 minutes each. Participants were instructed to complete 4 modules per week over a total of 8 weeks.

This was a pilot study designed to examine the acceptability of the intervention to a group of AI/AN individuals in outpatient treatment for alcohol and other SUDs. In-depth interviews were conducted with the participants, and two themes emerged: (1) Participants found the information was relevant to their recovery and (2) The content could be improved to make the course more acceptable and to increase engagement among AI/AN participants. This could be accomplished through better representation of AI/AN culture in the content. Specifically, it would be helpful to insert humor, Native storytelling and words, Native actors, and depictions of the natural world. Additionally, the content could be improved by including Native spirituality and removing any content or suggestions that run counter to AI/AN culture.

Dionne, R., Davis, B., Sheeber, L., & Madrigal, L. (2009). Initial evaluation of a cultural approach to implementation of evidence-based parenting interventions in American Indian communities. *Journal of Community Psychology, 37*(7), 911–921. <https://doi.org/10.1002/jcop.20336>

Incredible Years (IY) is a primary-prevention and family-strengthening program focused on strengthening interactions between parents and their children by promoting the parents' ability to encourage language, emotional, and social development and by decreasing harsh discipline. The long-term goal of IY is to advance the social and emotional behavior of children and to prevent and treat the early onset of conduct problems.

Adaptations include the introduction of a motivational phase, which was a three-session, motivational interview procedure the Indian Family Wellness Assessment designed to encourage AI parents to participate in the intervention. The interview sets the historical context for the current difficulties a family may be facing and conveys a message of hope and strength that extends throughout the generations.

The motivational phase is followed by the BASIC IY intervention. It was implemented with families during home visits and was delivered without modification in order to retain its core components. However, the skills taught in the intervention were overlaid and connected to traditional AI traditions, beliefs, and values, and culturally based stories were offered for each skill. For example, the value of respect for others that is held in AI families was provided as context for the relationship-building play skills that are a focus of the IY program.

Preliminary results show support for the intervention through improvements in parenting and child behaviors. Importantly, participants report satisfaction with the intervention, with a majority of participants liking the program and able to see the benefits for themselves, their child, and their family. The majority of participants report seeing improvement in their child's behaviors and in their relationship.



Duvivier, H., Gustafson, S., Greutman, M., Jangchup, T., Harden, A. K., Reinhard, A., & Warshany, K. (2017). Indian Health Service pharmacists engaged in opioid safety initiatives and expanding access to naloxone. *Journal of the American Pharmacists Association, 57*(2), S135–S140.

Rieckmann, T., Moore, L., Croy, C., Aarons, G. A., & Novins, D. K. (2017). National overview of medication-assisted treatment for American Indians and Alaska Natives with substance use disorders. *Psychiatric Services, 68*(11), 1136–1143.

Medication Assisted Treatment (MAT) uses medication and behavioral therapy to assist in the treatment of SUDs. Strong cravings to use the substance is one of the main reasons people continue to struggle to stay off drugs. In MAT, the use of medication, in conjunction with behavioral techniques, can help a user manage cravings, leading to an increased likelihood of sobriety.

The IHS created the Prescription Drug Abuse Workgroup to combat the increase in overdose deaths due to prescription opioids in the community. It was charged with creating a series of policies and programs to help prevent overdose deaths. The workgroup developed the *Opioid Dependence Management* website, which includes guidelines, screening tools, assessments, and promising practices for use in treating and combatting opioid use disorders. Importantly, pharmacists in the IHS have expanded their role to include patient consultation, education, and care coordination in pain management and MAT clinics. They have obtained the ability to prescribe naloxone and organized naloxone initiatives in conjunction with first responders. Many pharmacists have completed a variety of trainings, such as motivational interviewing (MI), and developed culturally sensitive materials to engage the community and to establish a connection with patients.

Figley, C. R., & Burnette, C. E. (2017). Building bridges: Connecting systemic trauma and family resilience in the study and treatment of diverse traumatized families. *Traumatology, 23*(1), 95–101. Retrieved from https://www.researchgate.net/profile/CR_Figley/publication/309764486_FigleyBurnette2016Traumatology/links/58222dca08aeb45b58824806.pdf

While not specifically focused on AI/AN families, this article reviewed the background of systemic trauma and family resilience. It outlined methodological considerations when studying resilience, recommendations for trauma treatment of diverse families, core components of systemic trauma treatments, and future directions in research for treating families who have experienced trauma. Recommendations regarding systemic trauma treatment of families include using the family systems approach, which relies on four assumptions: (1) the uniqueness of families, (2) interactional nature of families, (3) mutually supportive families, and (4) life transition and traumatic stress.

The article also outlines core components of systemic trauma treatments within a therapist's work with individuals or families and puts forward promising practices in the area. The core components include elements such as screening and triage, addressing grief and loss, and relapse prevention. (For the full list, please see p. 99 of the article.) It then points the reader towards the *National Traumatic Child Stress Network* website to search for promising practices. The website's interventions include many of the core components outlined, are designed to treat individuals and families, and may contain culturally specific components. This includes Strengthening Family Coping; Cognitive-Behavioral Intervention for Trauma; and Honoring Children, Respectful Ways.

However, despite the existence of the above interventions, there is much additional work to do to address trauma in ethnic minorities. For example, many interventions focus on the parent and child but fail to address the entire family. There are few interventions that integrate specific elements of the community and culture. Expanding the selection of interventions that are culturally specific could enhance the treatment and increase participation. Additionally, there are very few interventions that have been empirically validated. As a result, there is a large need to evaluate the effectiveness of some of these interventions to see what works and to determine the active ingredients that allow them to work.

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 & Adolescent Psychology, 39(6), 858–872.* Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3045814>

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is designed to be used with children and adolescents aged 11–15 from diverse populations that have experienced trauma and have symptoms of post-traumatic stress disorder (PTSD). It also targets anxiety and depressive symptoms, which are often experienced in conjunction with or because of experienced trauma. CBITS assists the recipients in making maladaptive thoughts and behaviors more functional through six different techniques: education, relaxation training, cognitive therapy, real-life exposure, stress or trauma exposure, and social problem solving.

The authors describe a pilot study (n=24) of an adaptation to CBITS completed with AI adolescents (grade 6-8). Adaptations were accomplished through two meetings among research team members, community members from each of the Tribes, and prevention and clinical staff. The meetings allowed the group to discuss and make adaptations to the group, parent, and individual sessions. One of the schools also served as a practice implementation site. Adaptations included removing Eurocentric examples and inserting examples based on the participants' cultural beliefs (e.g., how to explore death in a culturally appropriate manner, how long it is acceptable to talk about someone after he or she has died). At the 3-month follow-up, participants reported a significant decrease in the level of anxiety, avoidant coping strategies, and PTSD symptoms, as well as a slight decrease in depressive symptoms. However, at the 6-month mark, PTSD symptoms and avoidant coping strategies were closer to baseline.

The authors expressed some concerns about implementing CBITS in AI communities. While there was good attendance for those who opted into the study (which may be due to its being located within school, during school hours), there were a large number of parents who did not give consent for their children to be screened; of those who were screened in, 30 percent of parents declined to consent for them to participate. This might be due to the stigmatizing nature of the screening and intervention process.

Gorman, J.R., Clapp, J.D., Calac, D., Kolander, C., & Nyquist, C. (2013). Creating a culturally appropriate web-based behavioral intervention for American Indian/Alaska Native women in Southern California: The Healthy Women Healthy Native Nation Study. *American Indian and Alaska Native Mental Health Research, 20(1), 1–15.* Retrieved from <https://pdfs.semanticscholar.org/d56f/ef9ca2ca8dd82201491d18b65d8d7c4f24f6.pdf>

Livingston, M. D., Komro, K. A., Wagenaar, A. C., Kominsky, T. K., Pettigrew, D. W., & Garrett, B. A. (2018). Effects of alcohol interventions on other drug use in the Cherokee Nation. *American Journal of Public Health, 108(2), 259–261.* doi: 10.2105/AJPH.2017.304188

Komro, K. A., Wagenaar, A. C., Boyd, M., Boyd, B. J., Kominsky, T., Pettigrew, D., ... & Molina, M. M. M. (2015). Prevention trial in the Cherokee Nation: Design of a randomized community trial. *Prevention Science, 16(2), 291–300.* Retrieved from <https://link.springer.com/article/10.1007/s11121-014-0478-y>

Montag, A. C., Brodine, S. K., Alcaraz, J. E., Clapp, J. D., Allison, M. A., Calac, D. J., ... & Chambers, C. D. (2015). Preventing alcohol-exposed pregnancy among an American Indian/Alaska Native population: Effect of a screening, brief intervention, and referral to treatment intervention. *Alcoholism: Clinical and Experimental Research, 39(1), 126–135.* <https://doi.org/10.1111/acer.12607>

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a primary prevention/early intervention program designed to identify people with substance use problems through an initial screening. After the screening, those identified are provided with education and



feedback specific to the participant. If warranted, the participant is then referred to specialized treatment. SBIRT has been used in multiple settings, such as emergency rooms, to motivate participants to reduce substance use intake.

In this context, SBIRT was used to reduce drinking and, as a result, the chance of fetal alcohol spectrum disorders in women of child bearing age within the AI/AN community in Southern California. The authors indicate they used a version of SBIRT that was adapted to the specific community. Adaptations to the intervention were made through a focus group process, using a semi-structured interview guide with open-ended questions, a detailed description of which can be found at Gorman et al., (2013). Overall, the focus groups identified five key ways to make the intervention more culturally relevant. They were (Gorman et al., 2013):

1. Make the program more personal and relatable. Include pictures and a personal story.
2. Emphasize confidentiality.
3. Incorporate family and community orientation.
4. Tailor content to our community.
5. Include more information about how alcohol can negatively impact children's health.

Overall findings from the study indicated the assessment, even without the intervention, may decrease risky drinking for AI/AN women that drink.

In another context, SBIRT was supplemented with family and community components (and called CONNECT) and was used to reduce drinking by youth. The study was designed as a primary prevention method and was implemented in a school setting, targeting all high school students (Komro et al, 2015). It integrated components from youth-focused strategies and various suicide prevention elements. In addition to focusing on identifying high-risk youth and referring them to treatment, it also focused on multicultural and social competencies, including positive role models and social interactions.

Communities Mobilizing for Change on Alcohol (CMCA) (Komro et al., 2015) is a community-driven, environmental-change intervention that focuses on reducing the availability of alcohol in the community. It also focuses on increasing control over access to and consumption of alcohol by adolescents. Its goal is to affect how youth see access to alcohol, the enforcement of alcohol, and the risks related to alcohol use. CMCA aims to reduce the number of places that sell alcohol to minors, access to alcohol through parents and siblings, community tolerance to alcohol, and youth problems related to the consumption of alcohol.

CONNECT (Livingston et al., 2018) and CMCA were found to be effective at reducing alcohol use in the adolescents enrolled in the trial, as evidenced by a reduction in 30-day alcohol use, heavy use, and alcohol-related consequences. Additionally, this article attributes a reduction in non-alcohol use, including marijuana and prescription drug use, to CONNECT. CMCA also reduced use of chewing tobacco, marijuana, and prescription drug use.

Kelley, M. J. (1997). "Native Americans, neurofeedback, and substance abuse theory." Three year outcome of alpha/theta neurofeedback training in the treatment of problem drinking among Dine (Navajo) people. *Journal of Neurotherapy*, 2(3), 24–60. Retrieved from <http://neurofeedbackclinic.ca/journals/addictions/add01.pdf>

Alpha/Theta Neurofeedback Training is a secondary intervention/therapy where people are taught to increase the amplitude and coherence of alpha/theta brainwaves in their occipital lobes using a special EEG machine. In this study, the therapy was being tested to see if it decreased alcohol consumption and other behavioral indicators of substance abuse. Both the biofeedback and neurofeedback techniques



were adapted into the Navajo cultural perspective. The adaptations were written up, reviewed, and received a “blessing” by a Navajo “singer” medicine man. Adaptations included Navajo terminology, metaphors, imagery, and music. When needed, they incorporated a Navajo therapist to provide encouragement, blessings, and guidance.

While there were a number of limitations to the study, it appeared that this method did bring about long-term changes. Drinking became less significant, and life skills improved. Additionally, participants reported finding the training enjoyable and self-empowering. The clients felt the Navajo additions to the therapy were successful and may have made the training more powerful.

Kratochwill, T. R., McDonald, L., Levin, J. R., Bear-Tibbetts, H. Y., & Demaray, M. K. (2004). Families and schools together: An experimental analysis of a parent-mediated multi-family group program for American Indian children. *Journal of School Psychology, 42(5), 359–383.* Retrieved from <http://www.familiesandschools.org/app/uploads/2014/10/FAST-RCT-UW-Madison-WCER-School-of-Education-Article.pdf>

Families and Schools Together (FAST) is a two-phase, primary prevention program to build protective layers around at-risk children. It includes intensive parental involvement, which aims to promote a child’s resiliency and to reduce long-term, negative outcomes. FAST engages parents to be the primary prevention agent and, as a result, incorporates a home visit as an engagement tactic. FAST is built upon two philosophies: (1) all parents love their children, and (2) parenting can be interrupted by circumstances that parents cannot control. As a result, FAST emphasizes a positive approach that supports parents and empowers them to become the primary intervention for their children.

In this study, about 60 percent of the FAST program was adapted, with 40 percent of the core components remaining. (The specific adaptations can be found on pp. 366-369 in the article.) The College of Menominee Nation was involved in the adaptation process. There were three Tribes to be involved in the study, and the adaptations made by the college ensured both consistent expression of Tribal values and a respectful sharing of history and heritage. These adaptations were reviewed by members of the American Indian Language and Culture Education Board of Wisconsin. Overall, the adaptations made were an attempt to make the intervention more accessible; to use role modeling, action oriented, and present-focused intervention approaches; and to integrate traditional healing methods with culturally appropriate interventions. Additionally, FAST was facilitated by a culturally representative team.

The goals of this study were to adapt the FAST program, so it would fit with the three American Indian Nations, increase the academic performance of the participants, and reduce problem behaviors associated with dropping out. The authors reported achievement of only modest success, with a statistical difference between FAST and non-FAST students on a measure of academic competence; however, the evidence gathered from the curriculum-based measures, such as the reading and math, did not support this. While there was limited participation (lower than expected), surveys distributed to parents indicated satisfaction with the program.

Listug-Lunde, L., Vogeltanz-Holm, N., & Collins, J. (2013). A cognitive-behavioral treatment for depression in rural American Indian middle school students. *American Indian and Alaska Native Mental Health Research, 20(1), 16–34.* Retrieved from [http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2020/20\(1\)_Listug-Lunde_A_cognitive-behavioral_treatment_16-34.pdf](http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2020/20(1)_Listug-Lunde_A_cognitive-behavioral_treatment_16-34.pdf)

Adolescent Coping with Depression is a group-based course that is based on traditional cognitive behavioral therapy (CBT), which emphasizes decreasing negative thoughts and feelings and risk behaviors and increasing positive activities, such as coping and self-regulation skills.



The study involved collaboration from many types of school and community stakeholders. Additionally, before the study began, an outside expert on AI/AN mental health was asked to consult and provide input on the study, including course design, materials, and the evaluation. Modifications made included adapting the terminology and language, so it was appropriate and understandable by middle school students. Cultural adaptations included changing examples and scenarios to reflect culturally appropriate activities and incorporating discussions about the cultural impact of skills such as eye contact, assertiveness self-disclosure, and constructive criticism. Additionally, the class was offered as part of the regular school schedule, and the name was changed to Skills Development Class to remove the stigma associated with attending a class with depression in the title.

The rural, AI, middle school students that participated in the intervention group experienced a significant decrease in depressive symptoms at the end of the intervention. This decrease was maintained at a 3-month follow-up. Both decreases in depression were mirrored by the treatment as usual (TAU) group. Participants from the intervention group experienced a clinical, but nonsignificant, decrease in anxiety symptoms. Only those who participated in the intervention (as compared to TAU) maintained this decrease at the 3-month follow-up. Students reported the class was helpful in improving their mood and thought friends and family were generally supportive. Additionally, the school counselor reported that this group-session format had engaged some middle schoolers and caregivers who, in the past, had refused individual services.

Novins, D. K., & Bess, G. (2011). *Systems of mental health care for American Indian and Alaska Native children and adolescents*. In M. C. Sarche, P. Spicer, P. Farrell, H. E. Fitzgerald (Eds.), *American Indian and Alaska Native children and mental health: Development, context, prevention, and treatment* (pp. 189–204). Santa Barbara, CA: Praeger/ABC-CLIO.

Systems of care (SOC) attempts to address the unique needs of children and adolescents with serious emotional disorders (SED). It is a set of core values and guiding principles that outlines an approach to meeting the needs of and caring for those with SED and their families. It provides guidance on how SOC should be organized and the types of services that should be provided to children and their families.

The core values of SOC place an emphasis on cultural competence and on placing the child at the center of services, which aligns with many AI/AN cultures. SOC has been useful in helping these communities shape new ways to approach mental health services for their children and families. It has helped frame the needs of the child within a cultural context and has resulted in the creation of services that combine traditional AI/AN approaches with conventional, biomedical approaches.

For example, Circles of Care is a federally funded initiative aimed at helping develop culturally appropriate service models for AI/AN youth. It supported grantees to develop community-specific SOC of care models, and, as a result, the processes and the procedures can be used to help other Tribes improve their own SOC.

SOC is seen as a framework within which to provide services. It is not a specific service or intervention, nor does it specify what intervention or service to use. Research has indicated increased child and family satisfaction and reduced out-of-home placement; however, there is no clear tie to improved outcomes.

Schinke, S. P., Tepavac, L., & Cole, K. C. (2000). *Preventing substance use among Native American youth: Three-year results*. *Addictive Behaviors, 25*(3), 387–397. [https://doi.org/10.1016/S0306-4603\(99\)00071-4](https://doi.org/10.1016/S0306-4603(99)00071-4)

The adapted primary prevention intervention that was used in this study was described as cognitive behavioral skills associated with substance abuse prevention. It further describes it as being derived from a “conventional theoretical model of life skills training” and tailored to the specific setting in which it took place, which was Native American youth (3rd, 4th, and 5th graders) in Western reservations. The

goal was to equip Native children with the skills needed to resist substance abuse, both within their Native culture and in the wider world outside their reservation.

Each intervention session incorporated Native culture through the inclusion of Native American values, legends, and stories within the skills being taught. Due to the diversity within Native American Tribes of the Plains and the multitude of Tribes represented, adaptations sought to include content and traditions that were popular among many of the Tribes. Participants practiced the new skills first in role-play situations and then to situations from their daily lives that were volunteered by participants. While practicing, they received feedback, coaching, and instruction from group leaders.

Results from the study indicated that youth who received the intervention had lower rates of smokeless tobacco, alcohol, and marijuana use. Rates of cigarette smoking did not differ, based upon receipt of the intervention.

Substance Abuse and Sobriety

Coyhis, D., & Simonelli, R. (2005). *Rebuilding Native American communities*. *Child Welfare*, 84(2), 323–336.

Coyhis, D., & Simonelli, R. (2008). *The Native American healing experience*. *Substance Use & Misuse*, 43(12-13), 1927–1949.
<https://doi.org/10.1080/10826080802292584>

Moore, D., & Coyhis, D. (2010). *The multicultural Wellbriety peer recovery support program: Two decades of community-based recovery*. *Alcoholism Treatment Quarterly*, 28(3), 273–292. <https://doi.org/10.1080/07347324.2010.488530>

The Medicine Wheel and the 12-Step approach to addictions recovery combines the Four Laws of Change for Native American community development, the Healing Forest Model, and the Medicine Wheel with the Alcoholics Anonymous (AA) 12-Step program. Blending Native ideas and practices with AA's Big Book to create *The Red Road to Wellbriety: In the Native American Way*, Coyhis built on earlier work by White Bison (see below), ultimately leading to a variety of related projects across the continent.

The approach's core notion is "wellbriety," a translation of a word in the language of the Passamaquoddy nation (Maine), meaning "going beyond 'clean and sober'" by entering a journey of healing and balance—mentally, physically, emotionally, and spiritually. For many Native Americans, it also means recovering culturally" (Coyhis & Simonelli, 2008, p. 1928). Where AA typically construes alcoholism (and substance abuse) in individualistic terms, the wellbriety approach addresses the specific social, political, and economic causes of substance use and abuse in Native populations.

White Bison created a program for training peer recovery support people, Firestarters, to help facilitate wellbriety in Native communities. By 2010, White Bison trained 388 Firestarters, tracking the outcomes of 326 with the assistance of evaluators from Johns Hopkins and Argosy Universities. Outcomes tended to show program efficacy on a variety of fronts, including abstinent lifestyle, social growth, and satisfaction with training (Moore & Coyhis, 2010).

Coyhis and Simonelli (2005) provide a summary of the history of the wellbriety movement and a more detailed study of its historical development, conceptual framework, ties to other Native practices, and comparisons with non-Native values, in their subsequent piece (Coyhis & Simonelli, 2008).

Dickerson, D. L., Venner, K. L., Duran, B., Annon, J. J., Hale, B., & Funmaker, G. (2014). Drum-Assisted Recovery Therapy for Native Americans (DARTNA): Results from a pretest and focus groups. *American Indian and Alaska Native Mental Health Research, 21(1), 35–57.* Retrieved from [http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2021/21\(1\).pdf#page=37](http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2021/21(1).pdf#page=37)

Drum-Assisted Recovery Therapy for Native Americans (DARTNA) is an approach to SUDs that builds upon many elements of the well-briety movement, while incorporating “drumming as its primary focus of treatment” (p. 37). The DARTNA “protocol consists of 3-hour treatment sessions, provided 2 times per week over a 12-week period... by an AI licensed substance abuse treatment provider and a cultural leader. Each week sequentially focuses on a step of A.A./N.A., starting with Step 1 in Week 1 and ending with Step 12 in Week 12. The protocol and educational focus is separated into four parts corresponding to each of the four quadrants of the Medicine Wheel” (p. 37).

Two measures were used to assess DARTNA effectiveness: the DARTNA pretest and focus groups. Results from these measures supported the intervention as “a culturally appropriate and acceptable substance abuse treatment for AI/ANs” (p. 51).

Lucero, N. M., & Bussey, M. (2012). A collaborative and trauma-informed practice model for urban Indian child welfare. *Child Welfare, 91(3), 89–112.* Retrieved from https://www.researchgate.net/profile/Nancy_Lucero/publication/235748410_A_Collaborative_and_Trauma-Informed_Practice_Model_for_Urban_Indian_Child_Welfare/links/00463515cc9a5bbd34000000.pdf

The Denver Indian Family Resource Center (DIFRC) Family Preservation Model seeks to keep Native families together; provide services and support; and strengthen communities, families, and family members in order to prevent Native children from being removed from their home. To achieve this goal, the model includes both direct practice and systemic interventions. The direct practice interventions are delivered by the case management services, which focus on supporting and strengthening the family. Importantly, these services recognize the need for the child to remain connected to his or her culture and family. The systemic services support ICWA compliance, improve cultural responsiveness of services and providers, and increase collaboration within the community.

This model was evaluated through two different projects on two different populations. One project focused on either preventing removal of a child or promoting the timely return home of a Native child; the second project focused on families receiving Temporary Assistance for Needy Family that may have a higher risk for involvement with the child welfare system. Results indicated positive changes for both populations in the area of family safety. In the first population, 81 percent of the families kept the children in the home, placed with family members, or returned. In the second population, 96 percent of the children stayed with their parents or were placed with extended family members. Many clients had positive things to say about the services they received while involved with the project. Overall, these evaluations revealed that this practice model shows promise for use with urban Native American families facing out-of-home placement.

Lucero, N. M., Leake, R., Scannapieco, M., & Hanson, S. (2017). Evaluating the cultural fit of an approach for practice model development for Tribal child welfare. *Journal of Public Child Welfare, 11(1), 91–107.* <https://doi.org/10.1080/15548732.2016.1242446>

This article examined when Tribes used Business Process Mapping (BPM) to outline the practices and strategies currently used within their Tribe and to utilize the results to ultimately develop a practice model. BPM involved a detailed discussion of the life of a case from referral to closure. Mapping the entire process serves as a way to identify the components that are present and then to modify or develop areas of the practice model that need adjustment. Tribes then implemented the practice model they developed using BPM.

Six months after the BPM process was completed, the authors administered a questionnaire to BPM participants examining how well the process fit the Tribal cultural context in which it was implemented, how it was facilitated and delivered, and how well the resulting maps were helpful to Tribal child welfare practice. The questionnaires were administered 6–8 months after the process. Individual interviews were conducted after select participants completed the questionnaires, while focus groups regarding the process were completed 1 and 2 years following completion of the process. Additionally, a case file review, consisting of 4–9 cases from each Tribe, was conducted at the 2-year mark as a way to assess use of the practice model then. Overall, these methods found that participants felt BPM led to a better understanding of the agency and the practice model; yet, upon follow-up, participants did not report using the maps as a reference. They also reported that BPM led to greater understanding of agency roles and responsibilities. This was a new process for many participants, and, as a result, they faced some challenges and frustrations in communication style. Participants reported that while the process may have resulted in an accurate depiction of the practice model, it did not take into account how workers weave culturally specific practices into their practices.

Ma, G. X., Toubbeh, J., Cline, J., & Chisholm, A. (2002). A model for fetal alcohol syndrome prevention in Native American population. In G. X. Ma & G. Henderson (Eds.), *Ethnicity and substance abuse: Prevention and intervention* (pp. 284–295). Springfield, IL: Charles C. Thomas Publisher LTD

The authors describe the development and implementation of a fetal alcohol syndrome (FAS) prevention program built on the health communication process model. Phase 1 of the project was a professional needs assessment, which was administered as a survey of 49 prevention professionals randomly selected from a list of such professionals in six states with large AI/AN populations: Alaska, Arizona, California, Montana, New Mexico, and Oklahoma. In Phase 2, the authors used the results of the needs assessment to develop a “culturally appropriate, age-specific multimedia FAS prevention package” (p. 291). Materials produced for the package included a curriculum guide with 19 lessons, a video entitled “Faces Yet to Come,” and a project website. Phase 3 evaluated the effectiveness of the prevention program by surveying 90 randomly selected students at 2 middle schools. Results indicated that students “showed significant knowledge increase” and had favorable reactions to the program (p. 292).

Novins, D. K., Boyd, M. L., Brotherton, D. T., Fickenscher, A., Moore, L., & Spicer, P. (2012). Walking on: Celebrating the journeys of Native American adolescents with substance use problems on the winding road to healing. *Journal of Psychoactive Drugs*, 44(2), 153–159. <https://doi.org/10.1080/02791072.2012.684628>

Novin et al. describe an attempt to address the substance abuse prevention needs of Native American adolescents in a culturally appropriate fashion. The intervention, developed with by the Cherokee Nation and the University of Colorado’s Centers for American Indian and Alaska Native Health in response to findings of community-based participatory research, is called Walking On. The program uses an “explicit blend of traditional Cherokee healing and spirituality with science-based practices such as cognitive behavioral therapy and contingency management... to address the specific needs and worldviews of Native American adolescents with substance use problems and their families” (p. 154). Walking On’s intervention has 4 phases: three 3-month-long phases, followed by a fourth, open-ended phase that allows for ongoing treatment. The first three phases are “Finding the Winding Road (focusing on treatment engagement, rewarding abstinence from substances, and building basic relapse prevention skill”), Staying on the Path (focusing on developing more independence in applying these skills”), and Widening the Road (focusing on more advanced skills, such as time management and mentoring others)” (p. 156). Walking On also includes 15 skill-building teachings, 11 Native American ceremonies to celebrate and support the process, and contingency-management protocols. The authors indicate that although the work is ongoing, and the evidence base is in development, the program shows “the potential of [T]ribal-community-university partnerships, combined with a CBPR process, for addressing the most challenging substance abuse problems facing Native American communities” (p. 158).



Various Assessments

Gowen, L. K., Bandurraga, A., Jivanjee, P., Cross, T., & Friesen, B. J. (2012). Development, testing, and use of a valid and reliable assessment tool for urban American Indian/Alaska Native youth programming using culturally appropriate methodologies. *Journal of Ethnic and Cultural Diversity in Social Work, 21*(2), 77–94. <https://doi.org/10.1080/15313204.2012.673426>

This article describes the creation of an assessment tool designed to measure program outcomes for AI/AN youth and families. The tool was developed using CBPR. Participants included Tribal Elders and youth, agency stakeholders and staff, and other stakeholders. All were viewed as equal partners. The article describes the process used to create the assessment, what was included in the assessment, and the sources of the various assessment measures. The assessment was initially used with youth receiving case management services. The article reports that the assessment tool achieved adequate reliability and convergent and discriminant validity in initial use with the group.

Guttmanova, K., Wheeler, M. J., Hill, K. G., Evans-Campbell, T. A., Hartigan, L. A., Jones, T. M., ... & Catalano, R. F. (2017). Assessment of risk and protection in Native American youth: Steps toward conducting culturally relevant, sustainable prevention in Indian Country. *Journal of Community Psychology, 45*(3), 346–362. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5718384>

This article describes adapting (to an AI/AN context) part of the Communities That Care (CTC) tool, “a science-based prevention operating system that incorporates two cornerstones of prevention science: (a) measuring exposure to risk and protective factors that influence harmful behaviors among youth in the community and (b) matching widespread risks in the community with tested, effective preventive interventions that target these factors to reduce problem behaviors” (p. 347). The study examined “the basic psychometric properties of the CTC Youth Survey (CTC-YS),” assessing the reliability of “scores derived from the 32 measures of family, school, community, and peer or individual RPFs [risk and protective factors] assessed by CTC-YS for the national sample as a whole and separately for the Native American youth” (p. 352).

The study found that, in general, “the CTC-YS measures of RPFs in the community, family, school, and peer or individual domains yield scores that are reliable and valid within the Native American sample of youth” and that “prevention and intervention programs that focus on these factors [prioritized by the study] have the potential to improve the health of the nation’s youth, including Native American youth” (p. 354).

Winters, K. C., DeWolfe, J., Graham, D., & St. Cyr, W. (2006). Screening American Indian youth for referral to drug abuse prevention and intervention services. *Journal of Child & Adolescent Substance Abuse, 16*(1), 39–52. doi: 10.1300/J029v16n01-04

The IHS Personal Experience Screening Questionnaire (IHS-PESQ) is a tool that screens for drug abuse. It assesses for severity of the abuse, as well as psychosocial risk factors. The original PESQ only distinguishes between no/very little drug abuse issue and problem drug abuse. The authors sought to add a third category (mild or moderate problem) and to evaluate psychometric properties when used in an AI population. In adapting the screening tool to be used with Native youth, two revisions were made: (1) peyote and mescaline were removed from the list of possible hallucinogens due to their possible use in religious ceremonies, and (2) scoring rules were revised, so there could be three scoring groups.

While this study relied on self-report data, the psychometric results support the use of the modified screening tool with AI youth. It also finds initial support for the addition of the third category (mild/moderate) of drug abuse.



Spiritual Genograms and Ecograms

Hodge, D. R., & Limb, G. E. (2011). Spiritual assessment and Native Americans: Establishing the social validity of a complementary set of assessment tools. *Social Work, 56*(3), 213–223. Retrieved from https://www.researchgate.net/profile/David_R_Hodge/publication/51577464_Spiritual_Assessment_and_Native_Americans_Establishing_the_Social_Validity_of_a_Complementary_Set_of_Assessment_Tools/links/00b495359a2b277dd4000000/Spiritual-Assessment-and-Native-Americans-Establishing-the-Social-Validity-of-a-Complementary-Set-of-Assessment-Tools.pdf

This article gathers feedback from a group of experts in Native culture on various spiritual assessment tools (e.g., history, lifemap, genogram, eco-map, and ecogram). Overall analysis was sorted into a set of overall strengths and weaknesses for the group of assessments. Strengths included relief, the significance of being able to explore this important cultural aspect, and the flexibility of the assessments. Limitations included the complexity of the assessments, need to use culturally appropriate language, privacy surrounding spirituality, ability of practitioners to do the assessments, and possible conflicts with Native American worldviews. As a result of these limitations, the authors put forth areas for improvement, including modifying language, training for practitioners, and validation with by Tribes.

Limb, G. E., & Hodge, D. R. (2010). Helping child welfare workers improve cultural competence by utilizing spiritual genograms with Native American families and children. *Children and Youth Services Review, 32*(2), 239–245. Retrieved from https://www.researchgate.net/profile/David_R_Hodge/publication/268145299_Promoting_Cultural_Competence_Utilizing_Spiritual_Genograms_with_Native_American_Families_and_Children/links/57a3611e08ae28c09543f20d.pdf

This article reviewed the potential use of a spiritual genogram assessment tool with Native American child welfare clients. A team of experts reviewed, rated, and provided feedback on the tool. The authors then adapted the tool to make it more applicable to Native American culture. The experts were asked about the strengths and limitations of using the tool with Native American clients. Overall, the group of experts was a bit cautious about the use of genograms but indicated that if done properly, they could be useful. They liked the visual illustration of spirituality and extended family. Other feedback indicated that the language used in the tool could pose a problem. For example, many of the questions were too detailed, and some of the words were not considered culturally appropriate. As a result of the feedback from this study, the article puts forth a new set of questions that caseworkers could use to conduct a spiritual assessment with Native American families.

Limb, G. E., & Hodge, D. R. (2011). Utilizing spiritual ecograms with Native American families and children to promote cultural competence in family therapy. *Journal of Marital and Family Therapy, 37*(1), 81–94. <https://doi.org/10.1111/j.1752-0606.2009.00163.x>

This article reviewed the potential use of a spiritual ecogram assessment tool, by family therapists, with Native American children and families. A team of experts reviewed, rated, and provided feedback on the tool through an instrument designed specifically for this study. Results from the survey were varied and represented divergent viewpoints. Respondents felt the ecograms did allow for a holistic view of the family, were more visual, and allowed active participation by the family. However, some respondents felt that ecograms can appear complicated, and it may be overwhelming for the family. They felt the language in the sample question set was too detailed and that some of the words used in the questions were not considered culturally appropriate. Additionally, the practice of putting the person at the center and including the deceased in the ecogram may run counter to cultural norms. As a result of the feedback from this study, the article puts forth a new set of questions that caseworkers could use to conduct a spiritual assessment with Native American families.



Other Tribally Adapted Programs

Antonio, M. C., & Chung-Do, J. J. (2015). Systematic review of interventions focusing on Indigenous adolescent mental health and substance use. *American Indian and Alaska Native Mental Health Research, 22*(3), 36–56. Retrieved from [http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2022/22\(3\)_Antonio_Adolescent_interventions_36-56.pdf](http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2022/22(3)_Antonio_Adolescent_interventions_36-56.pdf)

Kenyon, D. B., & Hanson, J. D. (2012). Incorporating traditional culture into positive youth development programs with American Indian/Alaska Native youth. *Child Development Perspectives, 6*(3), 272–279. <https://doi.org/10.1111/j.1750-8606.2011.00227.x>

Generally, the positive youth development (PYD) framework takes a strengths-based approach to improving the health and well-being of youth. It “uses positive socialization to build on youth’s existing strengths... and prevent high-risk behaviors such as substance abuse, violence, and school dropout” (Kenyon & Hanson, 2012, pp. 273–274). Adapting PYD to Tribal contexts allows the programs to incorporate a range of additional, culturally specific strengths into the traditional PYD approach (e.g., learning customs and healing practices).

Kenyon and Hanson (2012) lay out the policies and practices that have given rise to and support the use of the PYD framework with AI/AN youth, the AI/AN values that make it an effective adaptation, and the challenges such adaptations face. The article concludes with descriptions of two PYD programs adapted for AI/AN youth: Project Venture, which has used outdoor education; PYD; traditional AI/AN activities to successfully decrease substance abuse; and the Zuni Life Skills Development Curriculum, which led to reduced suicidal ideation and hopelessness and increased problem-solving and suicide-intervention skills.

Antonio and Chung-Do (2015) reviewed 474 articles on PYD-based programs for use with AI/AN populations, finding 8 to be eligible and 6 focused on AI/AN populations. The articles tracked the outcomes for Tribally adapted PYD programs (in Alaska, New Mexico, Oklahoma, Northern Ontario (Canada), the Northern Plains [U.S.], and the North Island of New Zealand) that addressed suicide, depression, anxiety, alcohol use disorder, mental health, tobacco cessation, and resilience. Interventions generally had “positive or expected outcomes relating to mental health and substance use” (p. 50).

Chambers, R., Tingey, L., Beach, A., Barlow, A., & Rompalo, A. (2016). Testing the efficacy of a brief sexual risk reduction intervention among high-risk American Indian adults: Study protocol for a randomized controlled trial. *BMC Public Health, 16*(1), 366. Retrieved from <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-016-3040-y>

Project RESPECT is an evidence-based intervention designed to increase HIV testing and to reduce risk (i.e., to increase condom use). A study of participants enrolled in a Project RESPECT trial indicated they had lower rates of sexually transmitted infections and higher condom use. The intervention helps motivate participants to reduce risk through the use of teachable moments. Project RESPECT was adapted and turned into Educate, Motivate, Protect, Wellness and Respect (EMPVWR) through the input of community stakeholders and Tribal leaders. They participated in three advisory board meetings, during which they renamed the intervention and made four key adaptations: (1) change of location (clinic to home or community-based setting), (2) trained paraprofessionals replaced clinic workers, (3) self-administered sample collection replaced clinic collection, and (4) change in target population from clinic population to AI adults with history of substance abuse or mental health problems. The goal of EMPVWR was to increase condom use and to decrease sexual risk-taking and substance use. The article describes the intervention and the adaption process and gives an overview of the study, but, as the trial was currently underway when article was published, results were not available.



Chino, M., & DeBruyn, L. (2006). Building true capacity: Indigenous models for Indigenous communities. *American Journal of Public Health, 96*(4), 596–599. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470558>

One challenge facing Tribal communities seeking to implement evidence-based programs, particularly capacity-building strategies, is that “the conceptualization and implementation of capacity-building strategies are themselves . . . based on imported Western frameworks rather than on [I]ndigenous epistemologies” (p. 596). Part of this challenge is structural, insofar as discussions about capacity building tend to be academic and to take place far from the frontline organizations in Tribal areas. To help overcome this gap, the Community Involvement to Renew Commitment, Leadership, and Effectiveness (CIRCLE) Framework provides a “4-step, cyclical, iterative process and philosophy for program design and community development for indigenous people [that] incorporates Western concepts of community capacity building and parallels the values of community-based participatory research” (p. 597). The model’s four steps, built out of the culture and folkways of indigenous people, are: building relationships, building skills, working together, and promoting commitment. The article includes a table of programs that have incorporated the CIRCLE framework, the organization that implemented the programs, the years of implementation, and the funding sources for the programs.

Goodkind, J., LaNoue, M., Lee, C., Freeland, L., & Freund, R. (2012). Feasibility, acceptability, and initial findings from a community-based cultural mental health intervention for American Indian youth and their families. *Journal of Community Psychology, 40*(4), 381–405. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235231>

This article describes the second of a two-part CBPR study, Teen Health Resiliency Intervention for Violence Exposure (THRIVE), that was part of a Tribe-university collaboration to create and pilot an intervention, Our Life (OL). OL, open to youth aged 7–17 years, had four main components: (a) recognizing and healing historical trauma through discussion, experiential methods, and traditional cultural practices; (b) reconnection to traditional culture and language through learning from traditional practitioners and elders; (c) parenting/social skill-building; and (d) further healing and building relationships between parents and youth through equine-assisted activities (p. 385).

OL’s model “predicted that increased enculturation, self-esteem, and positive coping and parenting strategies could help to buffer the effects of stressors faced by AI youth (e.g., poverty, discrimination) that lead to depression, PTSD, and substance abuse” (p. 387). The program’s evaluative work indicated that these predictions were accurate and that, “for youth who completed at least nine intervention sessions, their traditional cultural identity, self-esteem, positive coping strategies, quality of life, and social adjustment increased. Analyses revealed that increases in child self-esteem, positive coping strategies, and social functioning were maintained at least 1 year postintervention, while cultural identity, adolescent self-esteem, and quality of life increased and then began to attenuate at the follow-up time points” (p. 398).

Johnson, M. H., Walters, M. G., & Armstrong, M. I. (2015). It takes a village: Using a community-defined practice approach to develop a Tribal in-home services model for Alaska Native Families. *Journal of Public Child Welfare, 9*(5), 487–505. <https://doi.org/10.1080/15548732.2015.1098581>

The Alaska Disproportionality Reduction Project was a 4-year implementation project funded by the Children’s Bureau and awarded to a consortium of AN Tribal entities. The project was facilitated by the Western and Pacific Child Welfare Implementation Center (WPIC). Based on the disproportionate number of AN children in out-of-home placement, the project goals included the development of in-home service models focused on the preservation of families through in-home services and supports. The in-home models were developed using a community-driven approach, with the balance and expectation of the incorporation of safety elements, as required by the state child welfare agency. WPIC provided facilitation and technical assistance to the project, focusing on the use of implementation science and organizational change research on large-scale system change.



Evaluation methods included ethnographic research focused on the process of the development of the in-home service models. The qualitative data included information from meetings, trainings, interviews, and observations. The focus on the data included a review of how the communities conceptualized child safety and incorporated it into the development of the models. The results of the evaluation revealed the project led to the achievement of a shared vision between the Tribal consortium and the state child welfare system for AN children and families. The feedback from participants included a feeling of empowerment in an ability to identify and articulate their vision for keeping children safe in their communities and to incorporate their cultural traditions into a system of care for their community as a protective factor for their families. The data collected were limited to qualitative responses and do not include findings on whether or not the actual models created affected the level of disproportionality or child safety.

Kulis, S. S., Ayers, S. L., Harthun, M. L., & Jager, J. (2016). Parenting in 2 Worlds: Effects of a culturally adapted intervention for urban American Indians on parenting skills and family functioning. *Prevention Science, 17*(6), 721–731. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939122>

The parenting curriculum, *Parenting in 2 Worlds* (P2W), is a 10-week course based on the Latino parenting curriculum, *Preparando la Nueva Generación*. P2W was culturally adapted for use in working with urban AIs, using CBPR. Many of the adaptations included a focus on cultural values and common intertribal cultural elements, distinctive AI views on rearing children, and family challenges directly related to life in an urban setting. The P2W program is designed to respond to the needs of AIs living in urban settings and to the challenges faced living in that setting. It works to strengthen parenting through a focus on family functioning, relationships, overall family functioning, and parent-child communication.

The program goals include empowering parents, building and strengthening family functioning, and increasing problem-solving and communication. The curriculum also focuses on the unique characteristics and challenging experiences of AI youth and families as they live in urban areas and away from Tribal lands.

Evaluation for the P2W program was completed using pre- and post-test data focused on testing the efficacy of the P2W program as a way to improve family functioning and to strengthen parenting skills. Participants reported significant improvement in their abilities and use of positive parenting practices, supervision, and family cohesion. Test results further revealed a reduction in discipline problems and parent-child conflicts.

Le, T. N., & Gobert, J. M. (2015). Translating and implementing a mindfulness-based youth suicide prevention intervention in a Native American community. *Journal of Child and Family Studies, 24*(1), 12–23.

The basis of this intervention was the Mind Body Awareness Project (MBA), which was, in turn, based on the Mindfulness-Based Stress Reduction program. It was originally developed for difficult-to-engage, at-risk youth populations. It was used with incarcerated youth, who were predominantly African American or Latino, but was never used with Native American populations. The intervention was adapted through a multiphase process. First was a presentation to a group of Native American Elders, followed by meetings with cultural committees and Tribal councils to discuss mindfulness and its relation and applicability to Tribal culture. Moving forward from phase one required approval from all three of groups, as well as buy-in from a Tribal champion.

Phase two required buy-in and permission from the school site, as well as a close examination of the curriculum to see how it might be culturally modified and fit within a larger, community-wide suicide prevention effort. This resulted in revisions to the content of the original program and the addition of two modules, for a total of nine. The intervention included modules on mindful breathing, mindful listening,

mindfulness of nature, mindfulness of body, mindfulness of thoughts, mindfulness of emotions, cultivating compassion and empathy, judgment and forgiveness, and aligning with vision. The delivery of the intervention remained true to the original. Classes were held at a Native American school and were facilitated in a circle to encourage participation. All facilitators were members of Confederated Salish and Kootenai Tribes. Facilitators attended 2½ days of trainings.

Phase three included attending to the evaluation by identifying appropriate measures, developing the research design in collaboration with the community, and obtaining human subject approval. A total of eight youth agreed to participate in the pilot. The evaluation included a baseline survey, administered during the first week of class, as well as one administered at the conclusion of the class. Participants' satisfaction with the intervention and recommendations for improvement were gathered through open-ended interviews at the conclusion of the class. Results from both measures indicated that youth were quite receptive to the intervention and enjoyed starting the day with the class. They reported greater ability to focus attention and awareness of thoughts, the intervention was helpful in building relationships, and the ability to share in a safe space to be valuable. The next phase in the development of the intervention is to refine the curriculum based on the feedback received from the pilot.

Lucero, N. M., & Bussey, M. (2015). Practice-informed approaches to addressing substance abuse and trauma exposure in urban Native families involved with child welfare. *Child Welfare, 94(4), 97–117.*

This article describes an adaptation of intensive case management by the Denver Indian Family Resource Center (DIFRC), to provide “strategies from the DIFRC approach that non-Native caseworkers and supervisors can utilize to create an environment in their own agencies that supports culturally based practice with Native families while incorporating a trauma-informed understanding of service needs of these families” (p. 97). To improve outcomes, the DIFRC program ensures that frontline providers understand the relationship between trauma and substance abuse, as well as how these may play a role in child welfare issues faced by urban Natives; provide a thorough assessment for trauma and referral to trauma-informed services; and provide intensive, clinically based case management.

Tingey, L., Larzelere-Hinton, F., Goklish, N., Ingalls, A., Craft, T., Sprengeler, F., ... Barlow, A. (2016). Entrepreneurship education: A strength-based approach to substance use and suicide prevention for American Indian adolescents. *American Indian and Alaska Native Mental Health Research, 23(3), 248–270.* Retrieved from [http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2023/Tingey_23\(3\)_Entrepreneurship_education_248.pdf](http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/journal/Documents/Volume%2023/Tingey_23(3)_Entrepreneurship_education_248.pdf)

Tingey et al. describe the development and evaluation of a Tribe-university partnership, the Arrowhead Business Group-Apache Youth Entrepreneurship Program (ABG), that uses entrepreneurship education to strengthen protective factors for substance use and suicide, including connectedness, hope, mastery, and self-control. Using a positive youth framework, which “posits that youth who develop mastery and are supported by caring adults and peers to cultivate new skills are more likely to exercise control over their lives by making healthy choices and withstanding external pressures,” the authors drew on Native (“Making Waves”) and non-Native (Network for Teaching Entrepreneurship) entrepreneurship curricula (p.251).

The curriculum provides about 60 hours of training, with the first 10 lessons taught during a 5-day, residential, summer camp, and the remaining 6 lessons delivered through the academic year. Unlike many other entrepreneurship education programs, the “ABG curriculum was designed to promote a cooperative methodology to entrepreneurship and to teach youth how the entire community benefits from business creation” (p. 260).



Varcoe, C., Browne, A. J., Ford-Gilboe, M., Dion Stout, M., McKenzie, H., Price, R., ... & Khan, K. (2017). Reclaiming Our Spirits: Development and pilot testing of a health promotion intervention for Indigenous women who have experienced intimate partner violence. *Research in Nursing & Health*, 40(3), 237–254. Retrieved from https://www.researchgate.net/profile/Annette_Browne2/publication/316344227_Reclaiming_Our_Spirits_Development_and_Pilot_Testing_of_a_Health_Promotion_Intervention_for_Indigenous_Women_Who_Have_Experienced_Intimate_Partner_Violence_RECLAIMING_OUR_SPIRITS/links/5a1f908b458515a4c3d4a95e/Reclaiming-Our-Spirits-Development-and-Pilot-Testing-of-a-Health-Promotion-Intervention-for-Indigenous-Women-Who-Have-Experienced-Intimate-Partner-Violence-RECLAIMING-OUR-SPIRITS.pdf

Reclaiming Our Spirits (ROS) is a health promotion intervention for Indigenous women living in Canadian urban settings. ROS built on an earlier evidence- and theory-based intervention, the Intervention for Health Enhancement After Leaving (iHEAL), which “was designed to be delivered by a registered nurse (RN) working within the scope of professional practice, in collaboration with an advocate (e.g., a domestic violence worker) over 6 months through approximately 12–14 face-to-face meetings in women’s homes or safe locations” (p. 238). iHeal featured six components (p. 239):

1. Safeguarding physical and emotional safety and developing risk management skills
2. Managing basic material and economic resources, energy, and skills
3. Managing symptoms and their distress
4. Renewing self by Identifying individual needs, desires, feelings, and abilities
5. Regenerating family by assessing family interaction patterns
6. Cautiously connecting by assessing current and potential relationships with people and organizations

ROS added 10 Aboriginal Women’s Intervention principles (p. 240): Being Aboriginal is a strength; Identity is a priority; History is in the present; Diversity is valued; Woman-led; Culture and tradition; Women in historical and cultural context; Healthy interventionist; Sustainability; and Cultural safety. The pilot study assessment indicated that “the intervention may facilitate a decrease in women’s depressive and trauma symptoms and increase women’s sense of agency, control, and [quality of life]. However, the trend toward worsening pain suggests that the intervention did not help women manage their pain and perhaps increased their awareness of pain” (p. 249).

Promising but Not Adapted Practices

Baldwin, J. A. (1998). Conducting drug abuse prevention research in partnership with Native American communities: Meeting challenges through collaborative approaches. *Drugs & Society*, 14(1-2), 77–92. https://doi.org/10.1300/J023v14n01_07

There are a number of challenges that have served as barriers between researchers wanting to work with Native American communities and the communities they want to study: too little Tribal or community participation beyond the data collection process, findings published in ways that contribute to controversy rather than solutions, Native American community suspicions about researchers, perceived intrusiveness of research projects, insufficient Tribal policies guiding research projects, results not contributing to problem solving, and researchers using



non-Native theoretical frameworks for interpreting findings (pp. 80–81). Using the *Native American Prevention Project Against AIDS and Substance Abuse* as a model for research methods that overcome these barriers, Baldwin et al. propose a 4-step model:

- Build collaborative relationships, e.g., by gaining entry into the community, hiring indigenous staff, and forming an advisory board.
- Develop the interventions that adapt theories to local contexts, and obtain local input.
- Include training and monitoring as a part of the implementation.
- Take time to assess the project by conducting process and outcome evaluation. and assess capacity enhancement.

Chaffin, M., Bard, D., BigFoot, D. S., & Maher, E. J. (2012). Is a structured, manualized, evidence-based treatment protocol culturally competent and equivalently effective among American Indian parents in child welfare? *Child Maltreatment*, 17(3), 242–252. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4443699/>

SafeCare is a manualized intervention designed to teach behavioral skills. It is a highly structured, home-visiting model that addresses parent-child interaction, basic caregiving, home safety, and child health. Those delivering the SafeCare model received training from the SafeCare training institute.

This article examines the outcomes of SafeCare, compared to services as usual in a large RCT in Oklahoma, focusing specifically on the use of SafeCare with the AI population (n=354) that was included in the larger RCT. It examines recidivism and acceptability of the manualized intervention to the AI population.

For the cases that were included under normal SafeCare inclusion criteria (i.e., parents of preschoolers), AI recidivism reduction rates were similar to those in the control, and SafeCare also reduced parental depression symptoms in the AI population. This study supported the use of SafeCare with an AI population because the nonadapted version of SafeCare was rated by AI parents as producing a better working alliance with providers and more culturally competent, higher quality, and more beneficial than services as usual.

Cross, T. L., & Fox, K. (2005). Permanency for children and youth: Customary adoption as a resource for American Indian and Alaska Native children. In G. Mallon & P. McCartt Hess (Eds.), *Child welfare for the twenty-first century* (pp. 423–431). New York, NY: Columbia University Press.

One of the many benefits of ICWA is its specifications for handling termination of parental rights (TPR) in cases of Native American children. This, combined with the explicit preferences for placement that are required when a child is removed from the home, makes TPR much more difficult with Native American families—an important and salutary effect, given that the historical context includes numerous interventions forcing children from their homes, communities, and Tribes.

The Adoption and Safe Families Act of 1997 (ASFA) followed ICWA approximately 20 years later, with a significant emphasis on permanency, including TPR and adoption. However, ASFA timelines and procedures can create conflicts with ICWA, and ASFA does not specify how to address these conflicts.

While Tribes may or may not see TPR as an acceptable part of plans for establishing permanency for a child, the concept of permanency is highly valued in Indian Country. Tribes have historically used customary adoption as a means for providing permanency for a child within their community, Tribe, extended family, or clan. Customary adoptions create family systems and care structures, without the need for legal intervention, and ensure that care for the child is not in question. However, two factors—the passage of ASFA and Tribes having the ability to be direct title IVE agencies—have created incentives for Tribes to adopt customary adoption as a means of establishing permanency



within the Tribal child welfare system. Granting this status to customary adoption allows the Tribal courts to formally recognize these family systems and provides families with formal permanency plans and legal protections for the caregivers, family members, or parents. While customary adoption provides a mechanism for achieving permanency, it does not require TPR, as traditionally required in adoptions. Customary adoption is unique in its recognizing the permanent parent-child relationship with the long-term caregiver, without requiring the severing of the parental rights from the legal birth parent, clan, Tribe, or extended family.

While formal evaluations of customary adoptions were not completed as a part of this article, the intended outcomes from the work on customary adoptions is ultimately for Tribes to insure permanency for their children, while solving complex issues and requirements that involve multiple jurisdictions. In addition, through the use of customary adoptions, Tribes are able to preserve the connection between the child and the Tribe, providing a sense of belonging, while ensuring the rights and identity for the child remain intact.

Fox, K., Cross, T. L., John, L., Carter, P., Pavkov, T., Wang, C. T., & Diz, J. (2011). Methods of evaluating child welfare in Indian Country: An illustration. *Child Welfare, 90*(2), 11–27.

Evaluating programs and conducting research in Indian Country has historically reflected a Western conception of empirical or scientific inquiry, i.e., the researcher is the sole epistemic agent, with the people being observed not counting as bona fide sources of knowledge themselves (i.e., they are to be observed but not heard from). In addition, academics and other professionals entering a Tribal community for evaluation can be met with a level of distrust. These challenges can limit both the quality and quantity of the data collected and, in some cases, even introduce numerous inaccuracies. By using empirical or scientific methods of research, evaluations have overlooked lessons from Indigenous people that could be obtained through community participation and commitment.

Researchers can address these challenges by adapting the evaluation methods to emphasize the voices of the community members and by partnering with the Tribes to use Indigenous methods for information gathering in the evaluation process. Evaluations geared towards Indian Country can be successful if the plan includes the use of participatory research methods—methods that focus on community engagement, self-determination, and partnership—and that create a reciprocal transfer of knowledge among all partners involved. When an evaluation is conducted by non-Tribal members, the success or failure of the evaluation is dependent upon multiple factors, including equity, cultural norms, ethical considerations, and the control and ownership of the data.

To effectively use the conceptual framework of participatory evaluation, the evaluator must engage the community, include opportunities to build on the strengths, facilitate collaborative and equitable partnerships, and develop a process and plan for capacity building and co-learning. The cultural context lends itself to certain methodological considerations: evaluators should focus on the wisdom of the Elders as part of the evaluation practice; use qualitative research methods to better fit the preference for oral communication in Tribes; and dedicate resources to relationship building, reciprocity, and respectful communication.

Goodman, R. D. (2013). The transgenerational trauma and resilience genogram. *Counselling Psychology Quarterly, 26*(3–4), 386–405. <https://doi.org/10.1080/09515070.2013.820172>

The transgenerational trauma and resilience genogram (TTRG) is a tool used in counseling that allows one to visualize complex aspects of trauma by having users integrate various frameworks for understanding and addressing trauma. It allows counselors to explore the

context surrounding clients' trauma and lives more generally and helps promote greater insight, which could increase resilience and healing. The use of the TTRG is guided by the following four principles:

1. Include a comprehensive or ecosystem understanding of trauma.
2. Focus on strengths.
3. Be culturally responsive.
4. Attend to social considerations through a critical or liberatory perspective.

This article provides a case illustration of the tool with someone who is of Native American descent. Further research could examine adaptation of the TTRG for use with people from different backgrounds, communities, or families and whether certain aspects of TTRG are effective for certain groups of people.

Harris, E., McFarland, J., Siebold, W., Aguilar, R., & Sarmiento, A. (2007). Universal prevention program outcomes: Safe schools healthy students in a rural, multicultural setting. *Journal of School Violence, 6(2), 75–91.* https://doi.org/10.1300/J202v06n02_05

Through an effort to strengthen school-based resources, the Safe Schools Health Students Initiative (SSHSI) focused on decreasing violence, substance abuse, and mental health problems among children, youth, and adolescents. Focusing on student well-being and facilitating a network of community resources, participating schools implemented programs to address each of the risk areas, with the expected outcome of addressing and decreasing the use of alcohol and illicit drugs, violent and threatening behavior, and suicidal thoughts in rural education settings. SSHSI built on protective factors, including safe school environment; prevention of alcohol, tobacco and other drugs, and violence; early intervention for children and youth; improved student mental health; and strong connections between schools and the community.

Outcomes documented through school-wide surveys during the second year of implementation include reduced fighting at school for students in all grade levels, decreased absenteeism, decrease in youth destruction of others' property, and a decline in fighting more generally.

Specific models were used and implemented across the consortium of SSHSI schools:

- Second Step, a violence prevention program from preschool to middle school
- Life Skills Training, a program targeting middle school students and using cognitive-behavioral strategies to prevent the use of alcohol, tobacco, and other drugs
- Student Assistance Program, which placed trained mental health providers in the school setting to provide psychoeducational groups
- Guiding Good Choices, which prevented substance use among 9- to 14-year-olds by teaching parents communication and family management skills

In addition to implementing the models, the schools provided onsite mental health professionals, site coordinators to manage implementation, case managers to help families with service referrals, and prevention specialists to teach the models' curricula. Schools also had staff focused on truancy, and they improved security by installing security equipment and, in some schools, deploying additional school resource officers.



One of the challenges of the initiative was the need to serve multicultural populations using ethnic-specific models. The initiative was intended to provide models that were culturally relevant and effective for diverse ethnic groups. Attempts were made to locate prevention programs for Native Americans in the area of violence and substance abuse, with little success. The article referenced a suicide prevention program developed for Native American middle and high school students and an experiential substance abuse prevention program for Native American students.

Hays, P. A. (2006). Cognitive-behavioral therapy with Alaska Native people. In P. A. Hayes & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (pp. 47–71). Washington, DC: American Psychological Association.

This book chapter draws on the experiences of the author providing services to ANs in a community health center and in an AN counseling center. It gives an overview of the AN culture, including early history, religion, political events, cultural identity, and living condition. It then presents both the benefits and drawbacks to using CBT with AN populations, followed by high-level guidance on the ways that therapists can use CBT with AN clients. The article supplements the discussion with examples that demonstrate a particular CBT method or concept with a client. The author concludes with an extensive case example.

Katzman, J. G., Fore, C., Bhatt, S., Greenberg, N., Griffin Salvador, J., Comerci, G. C., ... & Karol, S. (2016). Evaluation of American Indian Health Service training in pain management and opioid substance use disorder. *American Journal of Public Health, 106*(8), 1427–1429. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4940640>

This article presents the results of an online training created through a collaboration between the IHS and an academic medical center. The goal was to create an online continuing medical education course for physicians centered on safe prescribing and pain management. To determine the effects of the intervention, study authors monitored change in knowledge, confidence, and attitudes. Participants completed surveys prior to completing the course and then again at the course conclusion. Change in knowledge between the pre-and post-test indicated a significant increase in knowledge, attitudes, and self-efficacy. Given the increased risk for use of opioids in AI/AN populations, this educational opportunity presents an opportunity to use technology to educate clinicians about opioids.

Komro, K. A., Livingston, M. D., Wagenaar, A. C., Kominsky, T. K., Pettigrew, D. W., Garrett, B. A., & Cherokee Nation Prevention Trial Team. (2017). Multilevel prevention trial of alcohol use among American Indian and White high school students in the Cherokee Nation. *American Journal of Public Health, 107*(3), 453–459. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5296689>

The trial was conducted among youth living in the Cherokee Nation to evaluate the effectiveness of a multilevel intervention designed to prevent underage alcohol use. The population was racially diverse and included a 14-county jurisdictional service area of the Cherokee Nation.

The trial included a control group, one group implementing Communities Mobilizing for Change on Alcohol (CMCA), one group implementing CONNECT, and a group that implemented a combination. The CMCA initiative is a community-organized intervention targeting alcohol consumption only. CONNECT focuses on universal screening and brief intervention. It should be noted that these programs are not specifically designed for use with Native Americans, but they have been identified as evidence-based tools.

School-based social workers served as CONNECT coaches, meeting with students privately, using MI, and conducting a health consultation once a semester with each student. The sessions included educational information and encouraged healthy responses to the use of



alcohol. Postcards were mailed to the homes of the students with behavioral tips three times a year. Posters and other campaign information were placed in the schools and throughout the community in popular locations.

Data were collected over a 3-year period using surveys. Of the participants, nearly half identified as AI and half as white. However, the trial was not designed to distinguish responses of youth of different races. Because almost 50 percent of participants identified as AI, a secondary analysis was conducted; no differential treatment effects were noted based on the race of the youth.

Students with exposure to CMCA, CONNECT, or a combination of both showed a reduction in the probability of 30-day alcohol use and of heavy episodic drinking, as compared to the students in the control group. The results of the trial supported the effectiveness of both a community-organizing approach and universally implemented, school-based interventions in both racially and culturally diverse communities and schools. The trial further demonstrated that CMCA and CONNECT are effective approaches that can be beneficially implemented in diverse communities. These interventions focused on community leadership and engagement. In addition, the trial included an organization of local citizens, community resources, and the investment of the community to see a different result for their youth.

McDonald, J. D., & Gonzalez, J. (2006). Cognitive-behavioral therapy with American Indians. In P. A. Hayes & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (pp. 23–45). Washington, DC: American Psychological Association.

This book chapter presents a brief overview of the cultural issues related to AI populations, psychology, and CBT. This includes an overview of acculturation and cultural identification of AIs and of AI mental health and care. It also includes a section that highlights areas that are important to understanding healing and wellness from an AI perspective, such as worldview, spirituality, harmony and wellness, oppression, social dominance and wellness, cultural competence, assessment, and treatment. This chapter concludes with a presentation of an extensive case example.

Novins, D. K., Croy, C. D., Moore, L. A., & Rieckmann, T. (2016). Use of evidence-based treatments in substance abuse treatment programs serving American Indian and Alaska Native communities. *Drug & Alcohol Dependence, 161*, 214–221. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4817996>

As part of a larger study, this paper reported on a national survey examining the use of evidence-based treatments (EBTs) in AI/AN substance abuse treatment programs. The respondents were from 5 categories: the 20 largest Tribes, urban AI/AN health clinics, AN health corporations, Tribes other than the 20 largest, and other local or regional programs. The survey, administered by phone or online (with all but two respondents opting for the latter), examined the extent to which the treatment programs serving AI/AN populations use EBTs.

While results of the survey indicate that almost all programs use at least 1 psychosocial EBT, the results cluster around 4 interventions: CBT, MI, relapse prevention therapy (RPT), and 12-Step facilitation. Respondents rated only two of those interventions, MI and RPT, as culturally appropriate. This indicates a need in the field for better guidance on how to adapt treatments and treatment manuals in a culturally appropriate way.

Foundational Material

Limb, G. E., Hodge, D. R., & Panos, P. (2008). Social work with Native people: Orienting child welfare workers to the beliefs, values, and practices of Native American families and children. *Journal of Public Child Welfare, 2*(3), 383–397. <https://doi.org/10.1080/15548730802463595>

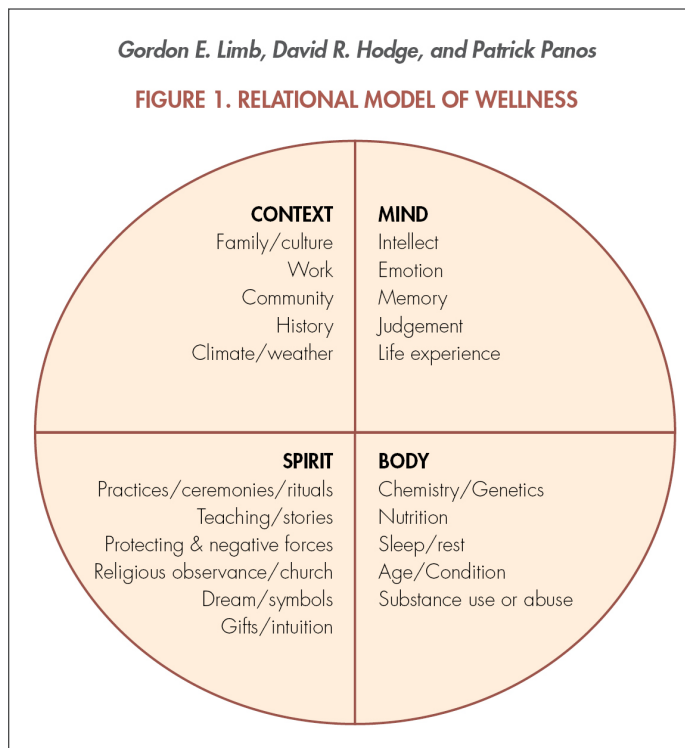
Despite trainings and implementation of legislation aimed at ensuring the use of culturally relevant services in the protection of Native American children and families, there continues to be a lack of understanding among child welfare workers about working effectively with Native American clients and the cultural elements of an effective practice.

In general, the institutional role of a frontline child welfare worker is focusing on the targeted treatment plans and interventions that address the problem(s) that brought the family to the attention of the child welfare system. The interventions focus on making changes to the family, client, or circumstance directly. While these types of linear models are measurable, they fail to address the issues intelligible solely from holistic perspective, and so they fail to adequately grasp the whole person, family, or situation in their full context. Focusing efforts this way tends to support the belief that the problem resides in the person.

While the linear model of work does not tend to have a positive impact on Native American families, the worldview model has shown promise. The worldview model focuses on achieving and maintaining a balance between the spiritual, mental, and physical aspects of the person. The underlying value of this approach is that it allows for selecting interventions that target the relationships between multiple factors. In practice, this means that, rather than being understood as a problem to solve, clients are referred to as being out of harmony or balance—that they are part of a broader system that needs healing. The resulting interventions are more effective, because they are focused on bringing the person back into balance, rather than on addressing a single symptom in isolation.

One such worldview model, the Relational Model of Wellness (RMW), represents the four quadrants of a person that must come into balance for healing: context, mind, body, and spirit. When working with a Native American client, social workers must consider all four quadrants when assessing the needs of and services for the client. Using RMW when working with Native American clients in a child welfare context requires child welfare workers to consider all four areas of the human experience and how they interact in order to understand how to promote wellness and healing in their clients.

Historically, the area of spirituality has been neglected by child welfare workers. While many understand the importance of spirituality when working with a specific person, they may feel that because they may not understand the client’s spiritual beliefs, spirituality should not be included in conversations regarding services or interventions. This avoidance posture may have the effect of dismissing of one of the quadrants, and any services or interventions made from it would not address the whole person. A child welfare worker inquiring about





the client's spiritual beliefs sends a message that spirituality is an important part of the person and opens the door to a range of interventions and practices that incorporate Native American values.

Another critical area, especially for non-Native child welfare staff working with Native American clients, is the importance of child welfare workers being conscious of their own value systems and of how those values impact their ability to respect the client's values and autonomy. Working with Native Americans requires child welfare workers to build trust and competence through engagement, relationship building, and effective communication. For example, the worker may need to allow more time for casual conversation and indirect communication. Most importantly, the child welfare worker needs to take the lead from the client regarding the approaches to verbal and nonverbal communication, acknowledging the client is the expert on his or her life.





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