SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

AMERICAN INDIAN/ALASKA NATIVE COMMUNITIES' TRAUMA INFORMED CARE WORK GROUP

Meeting Report

January 30, 2009

SUBMITTED TO:

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INTRODUCTION

This report summarizes the American Indian/Alaska Native Communities' Trauma-Informed Care Work Group's (Work Group) discussions held during the winter of 2008/2009. The report is designed to outline the history of this effort and review the input of the Work Group members regarding American Indian/Alaska Native Trauma-Informed Care principles.

PLANNING COMMITTEE

The planning committee was convened in the fall of 2008 and included the representatives listed below.

- **Diane Payne**, Tribal Justice and Policy Institute
- **Estelle Bowman**, Substance Abuse and Mental Health Services Administration
- **Jerry Gardner**, Tribal Justice and Law Institute
- **Jill Shepard Erickson**, Executive Director, First Nations Behavioral Health Association
- **Kana Enomoto**, Substance Abuse and Mental Health Services Administration
- **Kendri Cesar**, Substance Abuse and Mental Health Services Administration
- **Lorraine Edmo**, Department of Justice
- **Melissa Rael**, Substance Abuse and Mental Health Services Administration

The planning committee nominated a roster of possible participants and then selected a set of experts and key informants to serve on the Work Group.

OUTREACH AND REGISTRATION

Once the final invitee list was determined, an invitation letter with logistics information was implemented. The Work Group inaugural meeting occurred on December 8, 2008 in Palm Springs, CA. The meeting included a total of 23 participants, support staff, and observers.

PARTICIPANTS

Non-Federal Participants

- Rene Andersen, Western Massachusetts Women's Center
- Tillie Black Bear, White Buffalo Calf Woman Society, Inc.
- Rita Pitka Blumenstein, traditional healer and elder leader
- Bob Chaney, Southcentral Foundation
- Julia Davis-Wheeler, Nez Perce Tribe
- Teresa Descilo, Trauma Resolution Center
- Jill Shepard Erickson, First Nations Behavioral Health Association
- Cecelia Fire Thunder, Native Wellness Institute
- Jerry Gardner, Tribal Law and Policy Institute
- Grace Her Many Horses, community member
- Amanda Manbeck, White Bison, Inc.
- Elizabeth Neptune, Passamaquoddy Tribal Council
- Diane Payne, Tribal Law and Policy Institute

Federal Participants

- Captain M. Carolyn Aoyama, Indian Health Service
- Kana Enomoto, Substance Abuse and Mental Health Services Administration

Support Staff and Observers

- Barbara Aragon, Kauffman & Associates, Inc. (Facilitator)
- Kendri Cesar, Substance Abuse and Mental Health Services Administration (Support)
- Captain Andy Hunt, Substance Abuse and Mental Health Services Administration (Observer)
- Yvette Joseph, Kauffman & Associates, Inc. (Recorder)
- Jo Ann Kauffman, Kauffman & Associates, Inc. (Support)
- Ron Lessard, Corporation for National and Community Service (Observer)
- Lisa Neel, Kauffman & Associates, Inc. (Support)
- Eugenia Tyner-Dawson, Department of Justice (Observer)

OPENING

Cecelia Fire Thunder offered the opening prayer for the meeting.

WELCOME AND REVIEW OF THE AGENDA

Kendri Cesar, Substance Abuse and Mental Health Services Administration (SAMHSA) intern, introduced Acting Deputy Administrator Kana Enomoto, reviewing her accomplishments and role at SAMHSA. Acting Deputy Administrator Enomoto then welcomed the participants on behalf of SAMHSA and described the origins of her interest in American Indian/Alaska Native (AI/AN) communities' Trauma-Informed Care. She explained that proxy indicators such as crime statistics, related health issues, and substance abuse rates imply that many AI/AN people have experienced trauma. There is currently a lack of resources to address their needs. Individuals are clearly struggling and SAMHSA hopes to develop ways to help AI/AN people requiring assistance by providing support and resources for those working in these communities. The Work Group and the products it will develop are the first steps to meeting this goal.

MATERIALS PACKET

Lisa Neel reviewed the meeting materials packet. She noted that the documents were provided for reference and for specific interest, not as a reading assignment. The full meeting packet is enclosed as Attachment I.

PARTICIPANT EXPECTATIONS AND INTRODUCTIONS

The facilitator, Barbara Aragon, provided the introduction to the session by presenting a traditional Salish story about three brothers who travel to meet the Creator in search of medicine for their people to end an epidemic uncontrollable by previously known cures. The brothers face trials and lessons and eventually bring medicine back to their people. Overarching themes in the story included perseverance in doing community healing work, identifying and using local resources in healing work, maintaining a spiritual approach while conducting healing work, and restorative justice.

The participants introduced themselves and began to identify the themes and major issues of relevance to the day's topic. The meeting included representation from:

- SAMHSA leadership;
- SAMHSA Tribal Technical Advisory Committee;
- Tribal law enforcement;
- Trauma-Informed Care treatment providers;
- women's centers;
- domestic violence shelters;
- Tribal health systems;
- cultural healing experts;
- Tribal advocates;
- boarding school graduates;
- local youth suicide task forces;
- clinical providers;
- child protective services;
- the First Nations Behavioral Health Association;
- children's justice specialists;
- traditional healers; and
- Tribal elected officials.

The Work Group participants were united by their interest in the work and their desire to help AI/AN people who have experienced trauma. Participants also identified specific tools that are needed to address local needs including materials and training for law enforcement officers and a tool kit to help those working to heal children from trauma.

THEME IDENTIFICATION, GROUP WORK, AND REPORT-OUTS

The participants broke into three groups with the goal of creating a list of Trauma-Informed Care principles relevant to AI/AN communities. Each group discussed their specific concerns and then reported out to the entire team.

Every participant identified one unifying concept: the answers are within each of us. Frequently, concepts or remedies tested in or arising from other cultures have been applied in AI/AN communities. Despite the best of intentions, many of these programs and methods have been less effective than their AI/AN counterparts, sometimes even causing harm. Effective community engagement in planning and delivery is crucial to advancing Trauma-Informed Care work in AI/AN communities.

Context-Setting Theme Group: *Defining Trauma in American Indian/Alaska Native Communities*

Defining Trauma or Understanding Trauma in AI/AN Communities

While trauma is widely experienced by diverse populations in the world, there are some formal ways to measure its affect on individuals and populations, including the Adverse Childhood Experience (ACE) tool. There are additional ways to describe the trauma burden of a population, including indirect indicators such as crime, suicide, and violence. Most trauma experience accumulates over a

lifespan and is seldom the result of a single event. This accumulation/impact is why violence is a long-term public health issue. Many of the health impacts arising from trauma have their origins in exposure to interrelated but distinct sources including Historical/Intergenerational trauma; Early Childhood Trauma; and other traumatic events affecting the wellness of the individual such as sexual assault, domestic violence, or other immediate environmental traumas.

The Work Group discussed how the pervasive depression associated with 'historical trauma' (loss of land, loss of culture) can overshadow and hide unfolding trauma within the family or community, such as domestic violence, suicide, and early childhood trauma. There are compelling reasons to increase attention to and examine the scope and sources of childhood trauma (e.g., rape, sexual abuse, physical abuse) and avoid undue emphasis on the study of psycho-social effects of intergenerational or historical trauma. Although it is acknowledged that historical trauma influences everyone, it is important not to overlook or diminish the significant and current affects of early childhood trauma and contemporary violence within AI/AN families and communities. In order to stem the tide of violence in AI/AN communities, it is important to train service providers to routinely inquire about, assess, and identify clients who are experiencing or have experienced significant trauma.

Historical/Intergenerational Trauma

The concept of historical trauma or intergenerational trauma addresses the personal influences of history and unresolved trauma within a specific population or community. Such trauma is not exclusive to AI/AN people, but the role that authority figures and medical professionals played in this trauma is unique among American populations. Types of historical trauma include, but are not limited to wars, forced relocations, persecution of language or religion, and forced removal of children to boarding schools. Historical trauma left unaddressed by a population can lead to intergenerational manifestations of grief and dysfunction, such as:

- child abuse or neglect;
- racism;
- bloodism (discrimination based upon blood quantum[1]);
- bullying/lateral violence;
- crime or antisocial behavior leading to incarceration;
- mental health impacts;
- addiction/substance abuse;
- physical illnesses;
- sexual abuse;
- chronic depression and/or suicide;
- disconnection from the educational system/negative associations regarding education; and
- family violence.

[1] Blood quantum refers to a person's percent of tribal ancestry.

For some individuals, it is cultural dissonance itself, or "walking in two worlds," that creates traumatic challenges. All of these factors are both effects and perpetrators of this type of trauma.

Unresolved Early Childhood Trauma

In interpersonal violence and the resulting trauma, there are drivers (assailants), allowers (spectators), and targets (victims). Many AI/AN children are in environments where healthy adults are not present. As a result, they are vulnerable to predatory or violent adults and older children. Childhood trauma often co-occurs with or is the result of a family and community context of violence. Because of this, early childhood trauma is too often undisclosed, overlooked, or unrecognized. This pattern is supported by the violent behavior itself, which can be overt, covert or insidious. The harm is compounded when the community lacks professionally trained therapists who can help young people to effectively heal. Such a situation supports passive or active ignorance of harmful situations by authorities and community members. Left unresolved, early childhood trauma can create a complex dynamic for re-traumatizing events and relationships throughout life.

Two indirect ways to measure childhood trauma include reported events of domestic violence and sexual assault on women. Even though such crimes are routinely underreported, especially in AI/AN communities, Native families are clearly over-represented in their incidence.

Domestic Violence

According to the Bureau of Justice Statistics, the average annual rate of nonfatal intimate partner violence towards AI/AN women was 11.1 per 1,000 among persons age 12 or older in the years 2001 to 2005. This was more than two times higher than the next-highest racial category. This statistic only represents reported incidents and may not demonstrate the full scope of the safety disparity experienced by AI/AN women. While provocative, this measure is further weakened by its inability to express the chronic nature and resulting lifespan impacts of intimate partner violence.

Sexual Violence Against Women

The following is an excerpt from a recent Amnesty International report and literature review of AI/AN women's sexual violence survivor experiences.

> Sexual violence against Indigenous women in the USA is widespread -- and especially brutal. According to US government statistics, Native American and Alaska Native women are more than 2.5 times more likely to be raped or sexually assaulted than other women in the USA. Some Indigenous women interviewed by Amnesty International said they didn't know anyone in their community who had not experienced sexual violence. Though rape is always an act of violence, there is evidence that Indigenous women are more likely than other women to suffer additional violence at the hands of their attackers. According to the US Department of Justice, in at least 86 per cent of the reported cases of rape or sexual assault against American Indian and Alaska Native women, survivors report that the perpetrators are non-Native men.

Where women are so unsafe, children are often unsafe and are highly likely to be harmed as well as to witness the abuse and violence experienced by adult women. This simply underscores the need to address the creation of a safe environment for children when planning AI/AN care models. The current focus of prevention and intervention activities is on the needs of presenting adults. If local

planners and providers prioritize children, it may be possible to reduce future morbidity by rejecting the learned behavior of violence.

Impact of Trauma on Men

While domestic and sexual violence both harm men as well as women, the impact of trauma on men is more readily understood in the context of more general physical harm due to its very high prevalence. Violence among AI/AN men is heavily reflected in the incidence of violent death, including suicide.

- Among all youth and children, the AI/AN suicide rate is 14.8 per 100,000 people. This is almost 300% higher than that of whites of the same age.
- Males, aged 15-24, account for 64% of all AI/AN suicides.
- The suicide rate for AI/AN men aged 35-44 years remains high at approximately 40 deaths per 100,000 people. In other communities suicide is rare in men of that age.
- For AI/AN men aged 25-34 years, the rate of death due to homicide is 35.4, which is more than 400% higher than the rate for white men of the same age.
- In 2005, the AI/AN male violent death rate was estimated by the Centers for Disease Control to be 47.9 per 100,000. This is about the same rate as for blacks in the same time period and much higher than the national average of 20.5 per 100,000 Americans.

While these grim statistics note the scale of the literal loss of life, they only hint at the broader impacts that the loss of community and family supports have had on AI/AN men. The Aboriginal Healing Foundation describes the significant effects this loss has on AI/AN men.

> The story of Indigenous family violence is inextricably linked to the violence of colonialism and its legacy . . . As adults began experiencing the frustrations of oppression within their own communities, similar patterns began to establish themselves within the family structure. Parents, especially fathers who had become disenfranchised of their roles, began acting in oppressive and abusive ways within their own families. The family often became the only place that men felt any degree of control or influence. Never before had the tribal family and community experienced such division, internal conflict, and lack of balance.

This cycle of disconnection from family roles is exaggerated in Native people who are incarcerated, a population totaling more than 27,000 individuals in 2007.

Veterans

AI/AN people have a long history of participation in the U.S. armed services, which is disproportionately higher when compared to other populations. According to the Indian Health Service and Veterans Health Administration, AI/AN veterans "report the highest rate of unmet health care needs among veterans and exhibit high rates of disease risk factors" despite dual eligibility for services from these programs. The unmet health care needs include Post Traumatic Stress Disorder, a condition that can arise from traumatic experiences during military service.

Solutions Theme Group: *We All Have the Ability to Heal*

Recognizing and addressing trauma is central to the healing process. This discovery and naming process should be balanced with the underlying assumption that healing will be faster and more complete where communities are building on existing resilience and resources. Such resources can be spiritual, cultural, physical, or knowledge-based. Because individuals heal in the community,

recovery stories occur in relationship to relatives and other community members. The themes below outline some specific aspects of the healing processes identified by the Work Group.

Traditional and Other Existing Healing Models: *Recognizing What We Have*

The Work Group noted that in Western medicine it is necessary to scientifically prove that a particular treatment works. In contrast, traditional healing models often require the belief that a treatment works to be effective. This means that evidence-based intervention, while useful with many populations, may not always be the best path to healing from trauma for AI/AN populations. A cultural-based intervention may be more effective in the AI/AN context. In assessing possible interventions to provide trauma informed care, it is important to give credence to the experiential and practice-based evidence that cultural practices and traditional methods provide. Such an approach includes holism and a focus on existing strengths.

While specific healing ceremonies or pathways are necessarily private to their tradition of origin and can be limited in their adaptability, some general traditional concepts are essential to addressing community healing. These concepts include:

- community self-monitoring (cleaning up your own backyard, changing community acceptance of local crime and violence);
- care for others;
- accountability (individual and community);
- commitment to family;
- balance ("what is given to use has to be in balance");
- talk with the Earth/consider the gifts of nature;
- storytelling;
- humor;
- song and dance;
- recognition of spiritual needs as essential to healing; and
- strength and guidance in traditional/local values.

A renaissance of healing ceremonies may promote:

- spirituality;
- faith;
- resiliency; and
- experience leading to knowledge and increased resilience.

In Lakota the need for healing ceremonies is simply stated: "Bli he iciya" meaning to "*heal the spirit* at the point where everything is bad."

Leadership Development/Building Relationships

In AI/AN communities, there is an underlying need for training and access to mental health workers. It is essential to promote leadership among natural helpers by validating their work, supporting peer network programs, identifying emerging natural helpers (especially youth), and formally recognizing that many local workers may not have academic credentials matching their experience.

Current examples of community-based natural helper programs include the formally recognized services provided by paraprofessionals in Alaska villages and in service units in Maine. Tribal colleges are excellent existing partners for leadership development of this type.

Strengthening Research through Ownership of Data

While many traditional or local solutions are validated by generations of experience, AI/AN communities have benefited from appropriate adaptations or applications of care and prevention methods developed in other settings. To maximize this potential benefit, tribes should own their data, have approval authority over the publications, and have control over how data are collected and analyzed. Protocols for such work have been developed in several tribal settings through the foundation of local Institutional Review Boards. Shared commitment and respect with researchers provides tribes the opportunity to better share healing as a sacred journey and identify the reproducible elements of local answers.

Some specific lines of potential inquiry include:

- natural disasters, epidemics, and resulting impacts on communities;
- creating healing conditions (e.g., supports, safety, confidentiality, mentoring);
- heal the healers by addressing the traumatic history of caretakers, compassion fatigue or vicarious trauma, and effective self care; and
- providers' use of traditional healers.

Planning of Resources for Prevention

A final theme underpinning all the other solutions themes is the overall, clear need for coordination among funding streams to reduce the isolated progress of related programs (the silo effect) and inform collaboration of resources. Specifically, tribal workers could benefit from:

- the creation of long-term (i.e., 10-year) grants;
- the dedication of 80% of available resources to children and families;
    - resource allocation should include recognition of the needs of single-parent families as well as addressing the needs of men and boys;
- the dedication of 20% of available resources to youth;
- addressing vicarious trauma by providing information, support, and resources to those who work with trauma victims in AI/AN communities; and
- seeking equity between local and national treatment resources between alcoholism and trauma.

Further Discussion

After the report-out, Rene Andersen led the group through a brief review of the principles of Trauma-Informed Care based on her experience working in the area of women and trauma. She presented the following characteristics of Trauma-Informed Care:

- choice and control;
- safety and collaboration;
- trustworthiness;
- empowerment;
- finding voice;
- creating conditions for healing; and
- peer involvement in all aspects of care including development, implementation, and evaluation.

This list she provided was not comprehensive and was not meant to be a complete review of the current state of the science and experience in Trauma-Informed Care.

The Work Group subsequently defined eight principles of trauma-informed care in AI/AN communities.

CLOSING AND COMMITMENTS

The participants and observers gathered for a final ceremonial smudging provided by Yvette Joseph with a healing song provided by Tillie Black Bear. Each person reviewed his or her long-term commitments to the ongoing tasks of this work. Closing comments were offered by Cecelia Fire Thunder and Rita Pitka Blumenstein.

PRINCIPLES FOR TRAUMA-INFORMED CARE IN AMERICAN INDIAN/ALASKA NATIVE COMMUNITIES

1) **Trauma is Universal**: All people have been impacted by trauma in their lives. American Indian/Alaska Native communities need systems and providers that recognize that most people suffer the negative consequences of trauma and that the resulting symptoms are not, in and of themselves, pathological. Because trauma is so endemic that it is frequently considered normal, a non-diagnostic approach to working with those who have been harmed and those who have caused harm is not only compassionate, it may be necessary for effective healing.

2) **Native People are Resilient**: All individuals have the potential to heal from their trauma, but need a safe, healing environment in which to accomplish this. An open, supportive care-provider relationship where the trauma is acknowledged, validated, and recognized as a factor in current wellness concerns may improve outcomes. All efforts to address wellness should be based on the inherent strengths of the individual and community. All planning for healing should acknowledge local resilience.

3) **Trust, Safety, and Confidential Support**: Effective healing relationships are built on trust and foster empowerment and increased self-efficacy. Safe, sacred, and nurturing environments are necessary for healing. An integrated mind/body approach, intentionally designed to reduce arousal, is a primary goal in the creation of an effective healing space. The local justice system is a key partner in building a sense of safety and confidentiality in the healing community.

4) **Healing Models and Native Ceremony**: American Indian/Alaska Native healing models and cultural interventions that use ceremony, ritual, traditional counseling, support, and teaching methods can be just as effective as clinical healing models. These techniques can be even more effective than clinical methods because they can establish or re-establish meaning for those healing from trauma.

5) **Options Must Remain**: People who have experienced trauma need choices and control in an effective recovery process. The diversity of Tribes and Tribal practices must be recognized and honored in planning options for each individual.

6) **Roots of Trauma May Lead from Individual to Family, then to Community Healing**: Addressing the traumatic events an individual has experienced may uncover systemic cycles of trauma within the family or community. Trauma care must address healing of the individual, the family, and the community, not the individual alone. Healing from trauma in American Indian/Alaska Native communities may include: changing current community/Tribal expectations regarding violence; naming and addressing the impact of mass trauma events such as natural disasters, government policies, historical events; and acknowledging that violence is present while fostering community responsibility and including all relatives in the healing process.

7) **Community Provider and Justice Systems Must Be Engaged**: Changing community norms must include a collaborative approach among the Tribe's government, local justice system, educational institutions, and human service agencies.

8) **Non-Diagnostic, Non-Judgmental Care**: Judgment is an effective barrier to healing. Due to the type of current and historical trauma/loss experienced by American Indian/ Alaska Native communities, judgmental processes may be especially offensive and incompatible with healing from trauma. Treatments of trauma based upon formal diagnoses, which require judgment in the processes of categorization and measurement, require careful scrutiny for possible risk of harm. Any effective trauma-informed approach must continually strive for nonjudgmental processes and must carefully evaluate the helpfulness of formal diagnostic efforts.

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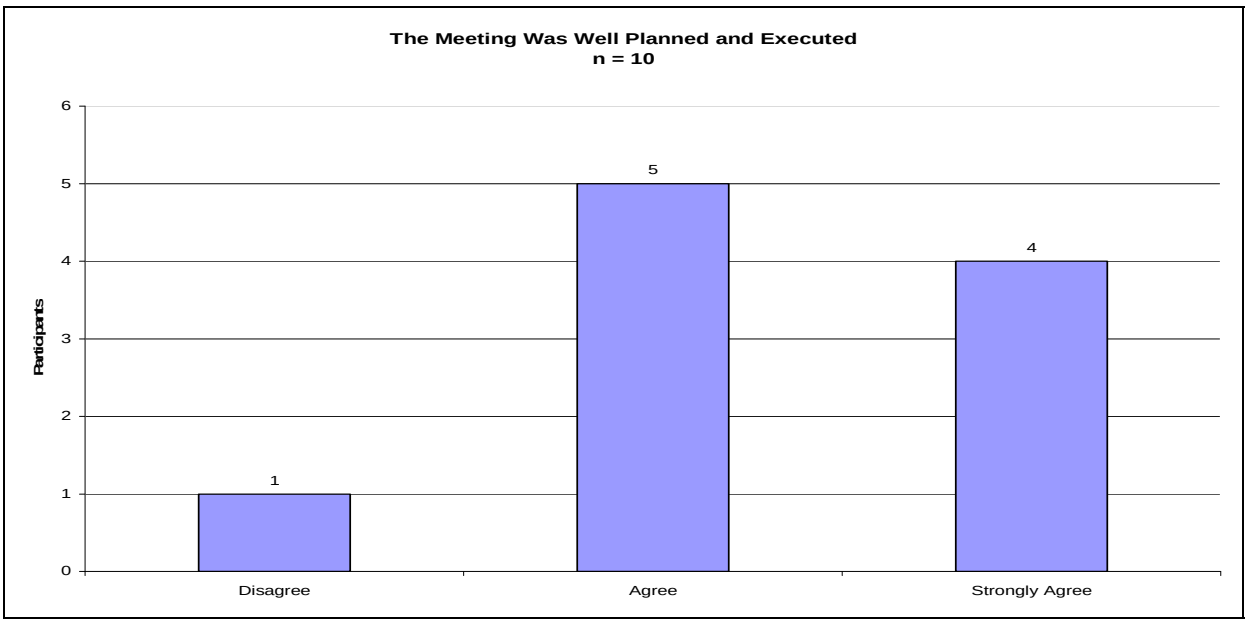
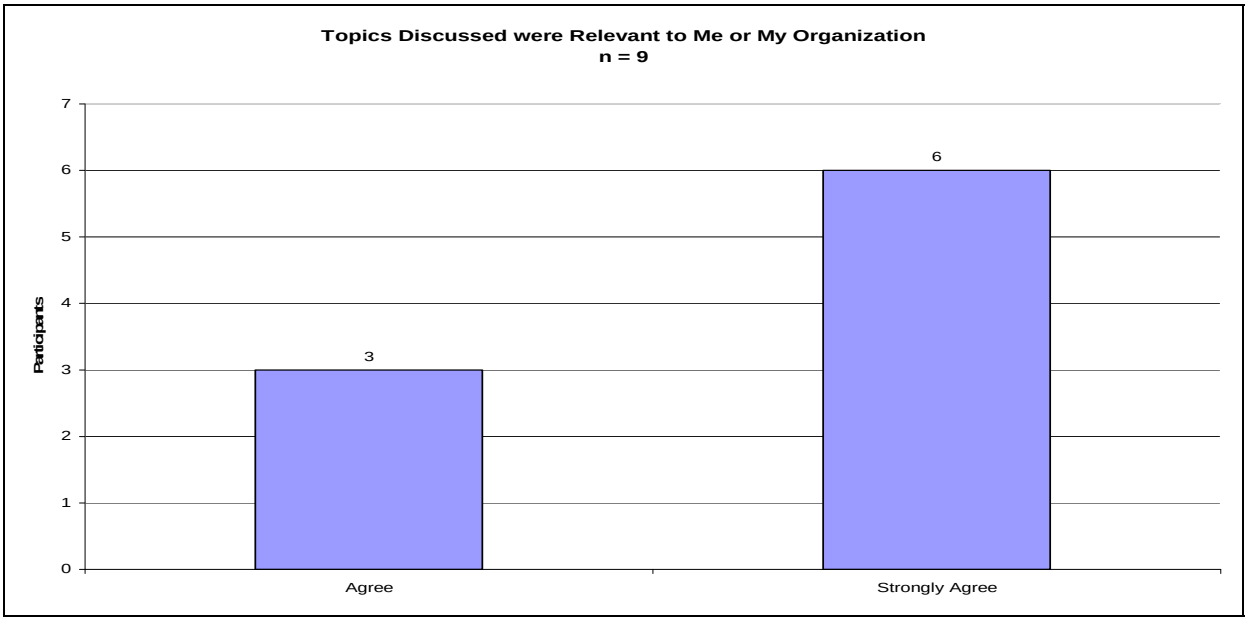
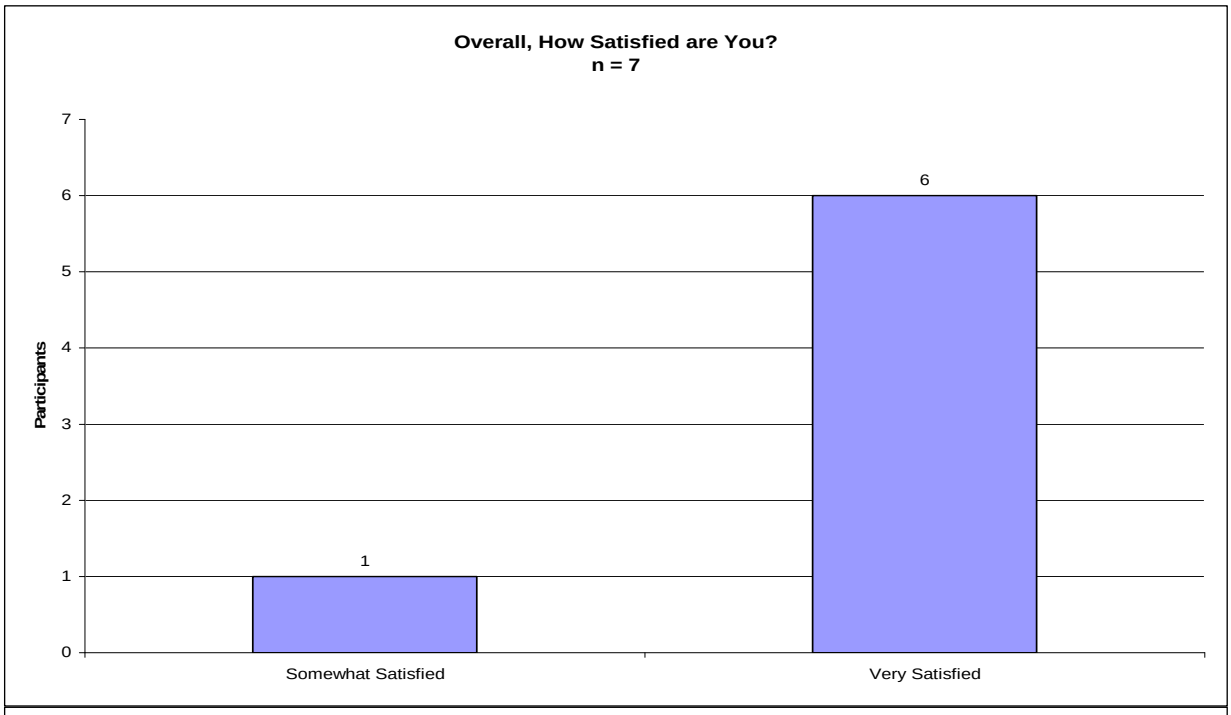
MEETING EVALUATIONS

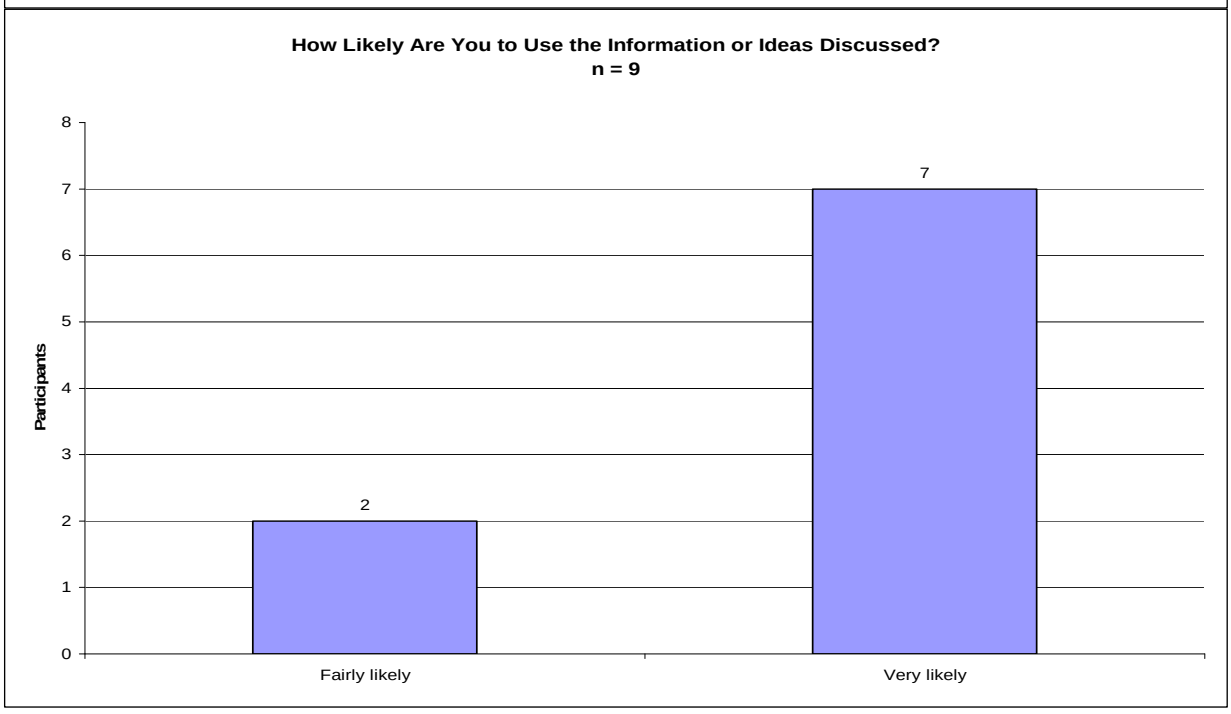
Qualitatively, participants noted their interest in the work and appreciation for the format of the meeting. Most of the negative comments expressed a desire for more time with the topic and the group. Most directly, one participant wrote simply, "You started something. Finish it."

Overall, the quantitative evaluations were very positive. Several participants expressed excitement at their participation and significant interest in the results. On average, the meeting rated a 3.60 on a sale of 1-4, where "4" represented "excellent." The graphs below represent a sample of the responses to the evaluations.









Full evaluation responses are included in Attachment II: Full Evaluation Responses.

ATTACHMENTS

Attachment I: Meeting Packet

Attachment II: Full Evaluation Responses