

# **Services to Native Populations in Rural and Frontier Regions**

*Developed for the*

**Center for Substance Abuse Treatment  
Division of State and Community Assistance**

**June 2002**

*Prepared under the*

**Center for Substance Abuse Treatment  
State Systems Technical Assistance Project**

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
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## TABLE OF CONTENTS

|  | <b>Page</b> |
|--|-------------|
| <b>I. INTRODUCTION</b> .....                             | 1           |
| A. Purpose of the Technical Assistance .....             | 1           |
| B. The Consultant's Background .....                     | 1           |
| <b>II. CONSULTANT ACTIVITY</b> .....                     | 3           |
| A. Methodology .....                                     | 3           |
| B. Consultations with CSAT and IHS Staff .....           | 3           |
| <b>III. SUMMARY OF MEETING DISCUSSIONS</b> .....         | 4           |
| A. Presentations and Discussions at the Meeting .....    | 4           |
| B. Meeting Purpose and Session Highlights .....          | 4           |
| <b>IV. OUTCOMES AND RECCOMENDATIONS—NEXT STEPS</b> ..... | 20          |
| A. Meeting Outcomes .....                                | 20          |
| B. Recommendations .....                                 | 20          |
| C. Next Steps .....                                      | 22          |
| <b>V. APPENDICES</b>                                     |             |
| A. Meeting Agenda  |             |
| B. Participant List                                      |             |
| C. Evaluation Summary                                    |             |

## I. INTRODUCTION

### A. Purpose of the Technical Assistance

In November 2000, the Center for Substance Abuse Treatment (CSAT) and the Indian Health Service (IHS) sponsored a meeting entitled “Provision of Treatment in Rural and Frontier Regions: Special Focus on Delivery to Native American Populations.” In response to feedback from participants in the 2000 meeting, CSAT and IHS agreed to do the following:

- Issue a report summarizing the proceedings of the November 2000 meeting
- Conduct a followup meeting to address strategies to enhance effective alcohol and other drug (AOD) treatment and prevention services for American Indian and Alaska Native populations

CSAT is one of three centers of the Substance Abuse and Mental Health Services Administration (SAMHSA). In September 2001, CSAT assigned these tasks to its State Systems Technical Assistance Project (SSTAP) contractor, Johnson, Bassin & Shaw, Inc. (JBS). JBS is a health and housing consulting firm based in Silver Spring, Maryland. JBS contracted the services of Linda Foley to prepare the report from the November 2000 meeting and to help plan and document the followup meeting. SSTAP delivered these services under the direction of Gayle Saunders, CSAT’s Government Project Officer for the SSTAP contract.

During planning meetings on November 2, 2001, and again January 17–18, 2002, Ms. Foley and the CSAT and IHS representatives developed strategies for addressing participant recommendations from the November 2000 Summit. As a result of these discussions, CSAT and IHS planned and held the followup meeting June 25–26, 2002, in Chandler, Arizona. Eighty-four participants representing State AOD agencies, AOD providers, IHS national and regional offices, CSAT, and the Center for Substance Abuse Prevention (CSAP) attended the conference.

Information in this report, like data in the original Summit report, provides consumer-driven ideas for continuing the dialogue necessary to create caring communities and deliver culturally responsive AOD service delivery systems for the indigenous people of rural and frontier States.

### B. The Consultant’s Background

Ms. Foley is a long-time trainer and skilled facilitator with more than 20 years of relevant technical assistance (TA) experience. She has served on national and State task forces that promote regional training efforts and interagency collaboration to deliver comprehensive healthcare promotion and education services to various populations. She assists clients from both the public and private sectors with all aspects of inservice training delivery.

Both Federal and State agency personnel praise her leadership in administering federally supported, multimillion-dollar contracts of national significance. Ms. Foley was a cofacilitator at

the CSAT- and IHS-sponsored Summit, "Provision of Treatment in Rural and Frontier Regions: Special Focus on Delivery of Services to Native Populations." She has also designed and delivered two national conferences and two sets of four regional State team-building workshops for CSAT, all of which earned high praise from the States.

Ms. Foley has B.S. and M.A. degrees in special education and has completed all course work and passed the examinations toward earning an Ed.D. from The George Washington University.

## II. CONSULTANT ACTIVITY

### A. Methodology

The consultant served as a resource for JBS staff and worked with CSAT, Division of State and Community Assistance (DSCA), and IHS personnel to plan and execute the followup meeting, “Looking Back, Moving Forward, Transitions: Substance Abuse Prevention and Treatment Services for Native Americans.” The meeting agenda, designed in response to data collected on current needs, incorporated many of the resources recommended by the invited States and the IHS regional directors to address the noted topics of concern. Meeting sessions focused on the following primary topics:

- **Fostering working relationships**—collaboration among AOD Single State Authorities (SSAs), tribes, IHS, and CSAT;
- **Combining traditional healing methods with science-based practices**—looking at ways to measure outcomes;
- **Funding Sources**—how to access available funds, combine multiple sources, work with Medicaid dollars, etc.; and
- **Personnel Development**—issues related to recruiting, training (including curriculum relevance), and certifying Native American counselors.

The consultant assisted with developing the invitation letters for the Summit followup meeting. She polled each of the invited States to set a meeting date that was convenient to all and prepared summary charts to reflect meeting date preferences and to delineate the names of the two CSAT-supported delegates who would be attending from each State, as well as the IHS area directors who responded positively to their letters of invitation. She conferred with CSAT and IHS staff to help develop the agenda items for the followup meeting. The consultant also participated in teleconferences and provided guidance to IHS for gathering input from IHS area directors. The consultant attended the followup meeting, providing input about the meeting and related activities, as requested, and developed the summary report.

### B. Consultations With CSAT and IHS Staff

Both agencies are committed to establishing strong working relationships with the Native Tribes and to continuing the work that was begun at the original Summit. CSAT went to great lengths to ensure that all feedback from the States was reviewed before the meeting agenda was developed. CSAT also supported the attendance of the SSA director or a designee and a tribal leader or Native service provider. IHS staff were equally vigilant in obtaining the IHS area directors’ input and strongly encouraged them to attend this important collaborative event.



### **III. SUMMARY OF MEETING DISCUSSIONS**

#### **A. Presentations and Discussions at the Meeting**

The presentations addressed the topics of concern noted in the feedback received from invited States and IHS area representatives. Meeting participants freely exchanged ideas during the open discussion sessions. An atmosphere of mutual respect was evident, and participants appeared to have no apprehension in stating their views. Clearly, a sense of congeniality that developed among the participants at the original Summit continued at the followup meeting as new people were assimilated into the collaborative process. However—while all present were keenly vested in the process and genuinely interested in achieving outcomes of increased understanding and better communication—the lack of key decisionmakers from many of the States (tribal leaders or State agencies) and the fact that so few IHS area directors were present led to a sense of preaching to the choir. Despite the absence of many policymakers or administrators, participants pledged to share the important information with their colleagues back home. Many reported that the sessions on identifying and securing funds and sessions on training/certification issues would be very useful in helping to bring about better services. Participants recommended that the dialogue be continued and expressed the sentiment that “Meetings of this type are sorely needed, but it is imperative that more people in policy and decisionmaking positions attend.”

#### **B. Meeting Purpose and Session Highlights**

##### **1. Meeting Purpose, Agenda, and Audience**

The purpose of “Looking Back, Moving Forward, Transitions: Substance Abuse Prevention and Treatment Services for Native Americans” was to sustain the momentum begun at the original Summit. Participants at that Summit noted their attendance had led to “. . . the opening of doors, creating an atmosphere of trust where information could be freely exchanged.” As a result, they said, communication channels among participating SSA directors, regional IHS representatives, and tribal members were widening, and the effect was going beyond the audience at the Summit.

Invitation letters were sent from the offices of Sheila Harmison, D.S.W., LCSW, Acting Director, DSCA, CSAT, and Richard Olson, M.D., M.P.H., Acting Director, Office of Clinical and Prevention Services, IHS, to SSA directors and the IHS area directors, respectively. The letters expressed that both CSAT and IHS wished to continue the support offered for strengthening the dialogue between State agency personnel and native tribal leadership. The letters also asked invitees for input to develop a responsive meeting agenda and reiterated the goals of the original Summit, which were to:

- Examine existing services offered to American Indian/Alaska Native (AI/AN) clients with the participating States;

- Promote expansion of services through identification of additional, available resources; and
- Promote dialogue between IHS area directors and staff from the cohort of States represented at the Summit.

As noted earlier, the meeting agenda was consumer-driven. It was developed using the feedback received from the invited States—incorporating many of the recommended resources—and the IHS area directors, to address noted issues of concern. The primary topics identified were respect for culture/traditional healing; collaborative relationships; funding sources; and personnel recruitment and certification requirements. (The meeting agenda is in Appendix A.)

The audience was composed of the SSA director or a designee, a tribal representative, and/or a service coordinator for Native populations from the rural and frontier States—Alaska, Arizona, California, Colorado, Idaho, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Wisconsin, Wyoming, and Washington—as well as representatives from the Red Lake Nation of Minnesota and IHS area directors or designees. A participant list is in Appendix B.

## 2. Plenary Sessions—Shared Mission and Common Themes

From the outset and throughout the meeting, participants reinforced the realization that family and community support were vital to those seeking recovery from addiction and trauma, both personal and domestic, as well as ethnic and historic. Presenters stressed the importance of having a shared understanding of cultural values and the appreciation of personal differences while developing treatment strategies. Participants were led each day by Native members (Regina Mullins and Vern Phillips) who sought spiritual guidance and asked, “Let us create compassionate communities.”

- **Greetings from Host State.** Staff from Arizona described the services that are offered to Native Americans, stating that the State needs to be ready to work with tribal entities as they implement their own departments of public health. Citing examples of rapid response to the tragic, recent fires, the State director said it was clear to the people of Arizona that recovery from past wounds/substance abuse begins with the community. She reported how well the members of the health and human services delivery teams, along with many volunteers, were working together. “Recovery from disaster—healing from the wounds of substance abuse, child abuse, domestic violence, etc.—will come about through community partnerships—expanded, committed environments of caring.” Referring to understanding the ways of others—Native Americans, the

IHS Regional Area Director said, “We need to be serious about what we do, be able to relate to people, see their hurt, and sometimes see their victory. I won’t ask you to cross the line, but walk the line, look over the line, so together we may remove barriers. We need to get out and meet people where they are.”

- **Welcome from Federal Partners.** Terrence Schomburg, Ph.D., Acting Branch Chief of the Performance Partnerships Grants Support Branch, DSCA, CSAT, welcomed participants; introduced members of the Federal CSAT, CSAP, and IHS staff, and invited each participant to introduce him or herself. He and Frank Canizales of IHS, Office of Public Health, Behavioral Health Program, who also serves as the CSAT Indian Desk, reiterated their agencies’ desire to support partnerships among States and tribal leaders and to continue the momentum of the original Summit. Our shared mission, as always, is to seek ways to address the suffering that addiction imposes on our families and communities. Mr. Canizales implored, “If the issues are not being addressed, tell us how to do so, we want to help.” Reference was made to recent remarks of Charles Curie, Administrator of SAMHSA, who also said that the Federal Government is supportive of State-level partnerships, that support emanates all the way from the President who wants to help people in recovery. Traditional methods of healing can be successfully integrated in service delivery systems. In response to the discussion of acceptance and understanding of cultural values, Dr. Schomburg said, “The only thing worse than being wrong, is being irrelevant. Please continue to take advantage of all the opportunities afforded to you, to communicate with us so we may hear and understand your needs.”
- **Historical Trauma—Its Origins, How it Affects the Lives of Native Americans.** Wilbur Woodis, who is detailed to CSAP part time from IHS, outlined the treatment of indigenous peoples in the United States to illustrate what many view as the causes for the guilt, shame, low self-concept, hopelessness, and depression that lead to alcoholism and substance abuse for an overwhelming number of Native Americans. Through a series of visuals—directional maps to show cause and effect—he established a contextual framework to allow participants to gain a better understanding of the trauma suffered by Native Americans, which was compared to the refugee experience. Unlike most refugees who find new homelands where they are allowed to continue practicing many of the traditions of their mother countries, Native Americans were continually attacked for practicing their cultural traditions. Those who survived the massive annihilations and loss of homeland, faced assimilation attempts, prohibition against using Native languages, disintegration of families through boarding schools and non-Indian adoptions, and other atrocious behaviors that led to utter despair. These practices

repeatedly conveyed a sense of cultural inferiority, a “less-than” feeling, that was carried from generation to generation. Suppression of feelings and denial of cultural roots became a survival technique, a form of ethnic, psychic numbing to reduce the pain. For a whole group of people, encompassing multiple generations, symptoms of severe intergenerational posttraumatic stress disorder (PTSD), were occurring.

Cultural devaluation and the soul wounds it creates may only be healed through extensive education based on cultural awareness, respect for the individual and one’s community, mutual trust, and upholding of family and community values. Peace and harmony may be restored, and physical health will be returned when the wholeness of humans is brought about through the reintegration of traditions in daily life. Self-acceptance, especially among the youth, is nurtured when an individual sees himself/herself valued by the world in which he lives.

Understanding the refugee experience and transgenerational PTSD not only has implications for successful treatment, but it gives great insight for prevention measures and provides clues for early intervention for those at high risk for alcohol and substance abuse. The foundation of IHS’s goal is to uphold the Federal Government’s obligation to promote healthy American Indian/Alaska Native people, communities, and cultures and to honor and protect the inherent, sovereign rights of tribes.

- **Spirituality and Traditional Ceremonies.** Restoration of balance through a life lived in harmony with nature is the focus of the White Bison, Inc. President Don L. Coyhis explained that the organization is dedicated to developing tools for change and restoring wellness to individual Native Americans and their communities, with the goal of reaching 100 communities by 2010. Often, the focus of Western culture emphasizes science to the detriment of the spiritual world; “intuition,” often associated with females, is completely ignored. The Native culture understands that the world is composed of two parts: the seen—consisting of objects subject to manipulation and scientific proof of outcomes; and the unseen—consisting of the natural and spiritual (not religious) realm. Traditional culture embraces a “big picture” view that incorporates these two parts of the world.

Early organization of tribes recognized the expertise of individual clans, each possessing knowledge of a particular realm of nature—ice, water, mountain, and desert people. The collection of the individual clan expertise allowed a tribe to be whole. The tribe had a built-in system of interdependence that valued the specific contributions of all its members. The dislocation of tribes and attempts at assimilation into the broader Western culture, with no regard for the rich

legacy of community values inherent in tribal life, have contributed significantly to feelings of despair and isolation among Native Americans today.

Realizing that “you have got to come home or you’ll always feel lost,” White Bison is helping indigenous peoples across the country to achieve harmony in their lives and to restore their sense of balance by conducting various traditional ceremonies, including songs, powwows, carrying of wellness hoops, and studying the traditional medicine wheel. Hundreds have joined the “journeys of healing” that have been conducted to date. People from 16 cities connected to walk the last journey; as many as 700 attend meetings. Most significantly, five generations of women carried the hoop at a recent meeting. Information about these journeys may be found at [www.healingourspirit.com](http://www.healingourspirit.com). (Participants were invited to join the Healing Our Spirit Worldwide Walk, September 2–4, 2002.) Quoting Mahatma Gandhi, “You must be the change you wish to see in the world,” said Don Coyhis, acknowledging the turtle clan on his mother’s side and the coyote clan on his father’s side. “I see great hope in our communities.”

- **Building Partnerships for Effective Treatment.** Establishing trust and mutual respect is critical to creating partnerships between the Federal Government and tribal leaders, as well as the States and tribes. Rod Robinson, consultant to the Wyoming State Substance Abuse Division, implored those who are sincere in their desire to bring about change and establish effective partnering for mutual gain to do their homework. He told them to learn all about those you wish to assist or those from whom you would like assistance. He asked: What do they/you value? How do they/you learn? What are their/your visions for a better life? He advised them to look for someone who shares your vision, and, together, find the courage to confront the issues and identify your mission. He asked: What should you look for and what is needed to sustain a partnership?

- S Perspective—Is it a real issue?
- S Passion—Is it worth your effort?
- S Professional Value—Will you give it your best?
- S Principle—Is it the right thing to do?
- S Priority—Are you willing to give it your time?
- S Persistence—Can you go the distance?
- S Performance—Can you carry the load?

There are barriers—distrust, lack of identity, feelings of low self-worth, humiliation, feelings of coercion, irresponsibility—to be moved to create meaningful partnerships. But these may be overcome, replaced with open-mindedness, a sense of belonging, self-esteem and value by others, equality

among others, and self-empowerment. The rewards are many for those who forge ahead and have the courage to engage in open communication to address the issues and resolve the conflicts.

Partnerships offer those we serve:

- S Hope for a better life;
- S Faith that together we will find the right path;
- S Courage to continue in our efforts;
- S Trust in ourselves and others;
- S Willingness to take responsibility for our actions in order to find solutions; and
- S Honesty.

### 3. Topical Sessions—Critical Highlights

Content for the concurrent topical sessions was developed in response to the more specific programmatic issues that participants noted on the feedback sheets that they completed before the meeting. Nationally recognized individuals or community leaders recommended by their peers for their expertise on noted issues were invited to participate on panels or lead small-group discussion sessions. Critical highlights from these discussions and panel presentations follow:

- **Traditional Healing.** Traditional healing uses history as a tool to help reeducate people. Regardless of how one person is taught, Thomas Eagle Staff points out the individual should seek to understand the ways of others. A cultural renaissance must occur among Native Tribes, a going back to understand cultural roots and restore ethnic pride. Fasting, sweat lodges, and sun dances are called into play to help individuals achieve balance and purification. Use of native language is playing a meaningful role. Relationships are important. Family units should be honored, not dismantled. At a beginning stage, harmony may be achieved through honoring family, language, culture, and spirituality. At the next level, practicing respect, courage, generosity, and wisdom leads to serenity. Traditional healing seeks to achieve harmony and spirituality. Proper balance increases the more native culture is introduced; this has implications for substance abuse treatment as well. A sense of belonging; that is, being part of a greater whole, provides the support necessary to make progress to overcome the feelings of desperation and isolation. There are strong implications here for the prevalent Western culture and behavioral health; the basic tenet of traditional healing is to approach the individual in the milieu where he/she is most comfortable.

- **Certification of Counselors.** Certification should acknowledge the cultural needs and traditional healing methods of Native populations. Marcida Eagle Bear and Florence Janis described their programs and what they have learned. The testing procedures for achieving certification do not address differences in learning styles. Often, the written examinations and the prerequisite educational requirements present insurmountable obstacles for would-be Native American counselors. Every State seems to be employing different strategies for certifying Native population counselors. Alaska is trying to combine its Native and non-Native certification programs. South Dakota reported having an Indian board supported by IHS and the State certification board that has developed a test that is more culturally sensitive. In the Northern Plains area, some difficulties, however, still exist. The Northern Plains area of South Dakota has its own certification board which is a member of the International Certification and Reciprocity Consortium (ICRC). It does not get IHS funding. The director of the Oglala Sioux Tribe Substance Abuse Healing Program reported that a culturally sensitive test has been developed, and the pass rates for American Indians have greatly increased. Minnesota has an Indian Desk in the State AOD agency and is able to monitor funds for training; it offers weeklong courses toward continuing education units for counselors. Nashville reported that its ICRC certification board is composed of tribal and IHS members; it provides training twice a year, providing about 35–40 hours of credit. In Nevada, a bachelor's degree is required, but a grandfather clause has been instituted to protect those Native counselors who were practicing before the degree became mandatory. New Mexico has two ICRC boards, one for Native counselors, the other for non-Native counselors. New Mexico has created a cultural sensitivity group to examine the tests and make suggestions for making them more culturally relevant. Much emphasis is also placed on helping counselors understand the clients they serve and the culture from which they come and with which they identify.

Certification procedures, as well as the mentoring and remedial help that sponsoring agencies can provide their staff, profoundly affect recruitment and retention of qualified, compassionate counselors. Many of the accommodations made to enhance Native Americans' performance on the certification tests, or the assistance offered to improve their language and writing skills, significantly help the non-Native population as well. Native Tribes could use specific assistance to help establish strategic plans for training and long-term retention of qualified staff; ways are needed to attract people and to keep them in classes. Individual recovery alone is not sufficient to become a counselor. The only way to decrease turnover and help maintain a workforce that reflects the client body it serves is to identify needs (related to counseling techniques as well as

knowledge of drugs). Then, responsive curricula that honor the unique learning styles of Native American students need to be developed and classes should be made available either locally or through distance learning mechanisms.

- **Best Practices.** Staff from various programs in several States were invited to present during the concurrent sessions. The programs they represented had reported success with the American Indian or Alaska Native populations, or the programs were implementing and monitoring newly developed programmatic or fiscal strategies that were responsive to topic areas identified through the needs assessment. Following are a few of the key concepts or take-home messages that these staff members imparted.

S **Guadalupe Community Oriented Recovery Effort.** Jesus Flores pointed out that a great deal of heterogeneity exists among the many Native Tribes. He said it is very important that public relations and outreach materials appeal to the specific group being targeted. Services must fit within the context of the community. Look to build programs that are locally driven and client-centered, that use a holistic approach—all services offered work in harmony. Employ staff who are respectful and culturally competent. Language is a critical tool in rekindling cultural roots.

S **Minnesota Indian Women’s Resource Center.** American Indian women play pivotal roles in their families. Rose Robinson said it is important to assist them to improve the quality of life for themselves and their families. Services to women need to focus on the whole family and incorporate a systems approach that builds on family support and addresses relationship issues. This is especially true regarding relapse and identification of individual triggers. The question of what is relevant to the community needs to be asked when programs are designed. Including members of the local community as service delivery staff offers an opportunity to provide good role models with whom the women in treatment can easily identify. In other words, “It takes a village.” Healing journeys for women need to focus on helping them overcome feelings of shame and guilt, which requires development of trust.

- **CA/Services to Address Indian Treatment Needs.** A five-member panel of representatives from California (Tony Cervantes, Toni Garcia, Marjorie McKisson, Sue Navarro, and Michelle Toth) presented California’s current system for financing services to Native Americans; the administrative structure

for organization and delivery of services; two innovative practices; and the TA and training offered to enhance and support service delivery.

- S     **Funding and Administrative Structure.** Critical to success in reaching rural tribes is identifying funding sources and assisting with coordination of services and helping communities work together to achieve a continuum of care. A flexible program to provide services to meet the unique needs of Native Americans has been established through an interagency agreement with California's Department of Alcohol and Drug Programs (ADP) and Department of Social Services. Through the program, a combination of Federal and State funds, Substance Abuse Prevention and Treatment (SAPT) Block Grant, Federal/State Medicaid, tribal Temporary Assistance to Needy Children, and other State monies are distributed to more than 30 Indian health clinics directly. Services and priorities are determined by the tribes, and money may be used for Western as well as traditional approaches to treatment. Funds are also available to support transportation services. Data are being collected on outcomes achieved through traditional methods. TA and help with licensing and certification are offered to all clinics to prepare them for receipt of funds and to ensure that clinicians have the required skills to implement services. Noteworthy is all the help being sought for aftercare and the development of community/environmental support, which is so pivotal to relapse prevention. Clinicians receive credit toward certification through the University of California, Davis for the coursework they complete.
- S     **Sacramento Urban Indian Health Program.** This program integrates health and education principles, focusing on building healthy communities through developing trust, responsibility, communication, and social skills. Confidence is built through work with horses (representing nature and skills associated with historical roots). Pain and trauma are worked through as women care for their horses. The women are empowered as they develop prowess as riders and trainers, which allows them to generalize and apply the skills to other broader areas of learning and daily life skills.
- S     **Chapa-Dey Indian Health Program.** Historical trauma or intergenerational PTSD is a root cause of much of the substance abuse, violence, depression, and other behavioral health problems among modern Native American populations. Alternative healing methods need to be honored and developed to help Native Americans restore

personal and ethnological pride. A holistic approach to recovery is needed. This program focuses on helping clients with self-determination through the concept of “community as resource” and “community as helper.” Individuals are helped to locate resources in their communities to develop their physical, spiritual, emotional, and intellectual selves.

S **American Indian Training Institute.** Clinicians need ongoing training and support and nurturing of colleagues to prevent professional burnout. Culturally relevant and substantive training, in addition to training provided by ADP via an interagency agreement, is available free to Native clinicians. Tremendous support comes from networking opportunities afforded through the Annual Indian School, and continuing education hours are available through the California Association of Alcohol and Drug Abuse Counselors and Board of Behavioral Sciences.

- **Collaborative Needs of Youth Residential Treatment Centers, Urban Programs, and Tribal Programs.** Key concepts were culled from presentations of staff representing the Tucson IHS Behavioral Health Regional Area in Arizona (Patricia Nye); the American Indian Health and Services in California (Seh Welch); and the Youth Regional Treatment Center in South Dakota (Thomas Eagle Staff).

It is important to prepare the families as well as the youth before enrolling clients in residential treatment programs. Also, addressing issues related to community reentry is especially critical in helping youth return to urban settings following residential treatment. While not very different for teens than for anyone else, reentry into the community can be very traumatic, and long-term support is needed for aftercare and continuing care to prevent relapse.

Funding is a considerable hurdle, as well as attracting and retaining staff to work with the hardcore populations in rural settings. Ways to coordinate services among youth centers and related agencies should be developed and encouraged; for example, the use of a universal intake packet to reduce overlapping efforts and save administrative costs. Personnel searches should emphasize recruitment of persons who are flexible, open-minded, and amenable to experimentation, as “hostile youth” are often very threatening to those with more traditional outlooks.

Youth programs need to help clients develop healthy lifestyles, paying particular attention to educational needs. Partnerships with vital members of the entire health service team as well as local communities need to be developed to create

the “communities of caring,” which are imperative to stimulate the feelings of belonging that youth so desperately need.

#### **4. Funding Information—Garnering Resources**

In keeping with the commitments made at the Summit—“to develop avenues to deliver technical assistance to the Tribes to make sure that opportunities for funding are publicized and assistance for access is offered”—the partnering agencies, CSAT and IHS, provided participants with two opportunities to learn about funding sources for AOD services to AI/AN populations. During the first session, participants were directed to sites and materials that present SAMHSA funding opportunities, and they were provided guidance through the application process. In the second session, information about the availability of funds and TA offered through IHS, as well as use of Medicaid funds for tribal entities, was provided. Following is a brief list of the tips and advice shared during the two sessions.

- **Securing Federal Grants for AOD Services to Native Americans.** Tribal leaders and staff of programs serving Native Americans should monitor closely, the publications and Web sites that post funding information. SAMHSA regularly posts funding information on its Web site ([www.samhsa.gov](http://www.samhsa.gov)). More information about upcoming funding opportunities is available at the Web site for the National Clearinghouse for Alcohol and Drug Information ([www.health.org](http://www.health.org)). The Web site for Join Together ([www.jointogether.org](http://www.jointogether.org)), a national resource for communities fighting substance abuse, is also a good source for funding news.

Another resource, “SNAPSHOT,” produced by SAMHSA, is considered the most comprehensive hard-copy guide. The booklet not only delineates upcoming grant opportunities and their anticipated announcement dates, but it also provides guidance for preparing applications. Of particular interest is the AI/AN and Rural Community Planning Program that is described. Handouts listing pointers for writing applications, projected Fiscal Year 2003 discretionary grant funding, and the current SAMHSA priorities were distributed. Participants were urged to obtain as much information as possible. They were strongly encouraged to “call someone,” and make contact with a resource in the government immediately when a grant application is being considered. One resource, among many, is Hector Sanchez of CSAT, who may be reached at 301-443-7508.

To ensure that a grant or cooperative agreement application is responsive and worthy of scoring, applicants must strictly adhere to the guidelines stipulated in the Guidance for Applicants issued by the government. Participants were urged

to understand SAMHSA needs and priorities so that the services being proposed match SAMHSA's program priorities. A member of the Pinal Hispanic Council from Eloy, AZ (Ralph Varela) told participants to recruit consultants if they need help identifying research areas or delineating appropriate evaluation strategies for their proposed projects. The council was awarded a Federal grant recently for an application it submitted. Participants were also told that a great deal of "passion" is needed to create a winning proposal, as well as an all-out commitment of time to meet routinely tight application deadlines.

Understanding local demographics is important once an area for study or service delivery strategy is determined and the target population identified. A very exhaustive list of the study approach's strengths and weaknesses with methods for overcoming the barriers need to be listed. Procedures for addressing staff attrition also need to be included. Appropriate process and outcome evaluation measures are important proposal components, and applicants should seek the expertise of a good psychometrist in developing this area. In addition to sound management plans, successful proposals should reflect ideas that are built on consumer input by demonstrating responsiveness to local needs. Efforts should be made to subcontract with other members of the community where possible, and as many individual (not form) letters of support from family members, consumers, etc., as possible should be garnered to boast a high level of community support.

Native populations may also look to the CSAP for support. CSAP promotes health and elimination of alcohol and drug abuse by employing aggressive prevention strategies. The CSAP mission is to "decrease substance use and abuse by bringing effective prevention to every community." Eduardo Hernandez-Alarcon, from CSAP's Division of State and Community Systems Development, described the State Incentive Cooperative Agreements for Community Based Action (State Incentive Grants [SIGs]). SIGs are intended to be used to coordinate funding to develop comprehensive strategies aimed at filling gaps by funding subrecipients, reducing drug use among youth, and implementing science-based approaches. SIGs are also intended for use in assisting States in measuring progress. Through SIGs, each totaling about \$3 million a year, community needs are assessed and strategies implemented to develop State, tribal, and community capacity. Data are now becoming available from the first cohort of States that received initial funds in 1997. It was pointed out that 85 percent of SIG monies go directly to the subrecipients, many of whom are Native Tribes. (Forty-two tribes are among the 441 local organization subrecipients.)

Many States have tribal representatives on their Statewide Coordinating Councils. Among them are Maine; New Mexico, based on its documented need; and Hawaii, which has a set-aside portion of SIG monies specifically for its Native populations. Participants were encouraged to work with States and learn how to become involved with their statewide councils. Other resources from CSAP are the five regional and one Southwest Border Centers for the Application of Prevention Technologies (CAPTs), which provide TA. Information about the SIGs and CAPTs may be found on Prevline, which can be accessed via the SAMHSA home page.

- **Utilizing Additional Resources and Accessing Technical Assistance.** IHS funds to pay for specialty health care services, including substance abuse treatment and prevention services, are extremely limited. Tribal providers and IHS facilities should seek funds through Medicaid and the States Children's Health Insurance Plan (SCHIP), created under Title XXI of the Social Security Act to expand coverage for Native Americans. Stephen Moss told participants that both programs are open-ended, Federal entitlement programs, with no prescribed limits, unlike the IHS allocation-driven budget. States are reimbursed at 100 percent for the cost of services provided to Native Americans by IHS facilities or tribes directly; so there is an incentive to offer services through IHS providers. About half of Native American youths (from families who earn too much for Medicaid, but too little for private insurance) may be eligible for SCHIP. However, they are not getting the services they need because their families are not aware of their eligibility, or because they experience such problems as trouble in completing enrollment forms. Administrative monies available through SCHIP may be used for outreach to low-income Native American families, health education, and promotion of community public health. States that have employed innovative information-dissemination strategies and outreach activities have reported great success in reaching and enrolling large numbers of eligible Native American youth.

Furthermore, the Medicaid and SCHIP planning processes provide a great opportunity for Native American stakeholders to have their concerns heard and give their input for meaningful services. The 2001 regulations for SCHIP require that, when proposals or amendments to plans are being developed, consultations with tribes be conducted. Clearly, it is in the interest of Native American provider organizations to meet Medicaid requirements and become eligible for Medicaid reimbursement as well as further their mission of providing services to youth in need by actively enrolling eligible Native Americans in the SCHIP program.

Two IHS Alcohol and Substance Abuse Program (A/SAP) staff members work 2 days a week, one within CSAT (Frank Canizales) and one within CSAP (Wilbur Woodis), to increase national consultation and collaboration for AI/AN behavioral health relating to access to services through State block and competitive grant opportunities. Also, information and technical support are available to the tribes from 12 Administrative Area Offices overseen by IHS. For legislative updates and IHS funding news, go to [www.IHS.gov](http://www.IHS.gov).

## 5. Tribal Collaborations—Participant Feedback and State Perspectives

Feedback on current service delivery was formally solicited twice during the meeting— once during a full discussion with all participants and later during a moderated panel of four SSA staff (three State Directors—Ben Brown, Christina Dye, and Donald Eubanks—and one designee, John Taylor). Following are the barriers to successful intervention that were noted, and the assistance useful in overcoming them. Also included are comments on the current status of and plans for addressing services delivery gaps.

- **General Discussion.**

S We, the Indian peoples, need to learn how to access and utilize all monies available to us, from every source; the next 3 years are critical.

S An historical perspective helps us all. It is important to heal the healer. Presentations on historical trauma and traditional healing are beneficial. Ways for effective outcome monitoring are needed.

S Government agency reports (like IHS history/area profiles) are very helpful.

S Disparity between funds to tribes and resources available to Native urban populations need to be addressed, so that one group is not served at the expense of the other.

S Tribal sovereignty need not be considered an obstacle to joint planning. Tribal members' input should be sought when services for Native populations are planned, and tribal leaders should be included on State advisory councils and planning committees for Block Grant applications. (This is in keeping with the government-to-government relations with Native American tribal governments addressed in the memorandum issued by President Clinton in April 1994.)

- S Data on Native American service delivery should be included in the data section of the SAPT Block Grant applications; Federal agency staff reported that ways to address this issue are presently being explored.
- S Sustaining programs is of great concern. Strategic planning needs to be done with State, Federal, and tribal staff to look at long-range goals and integration of funding sources and appropriate allocations. Native peoples need to use political structures, and tribal leaders need to let Congressmen know their needs.
- S Native Americans need guidance to develop systems for aftercare, which integrate medical, nursing, education, and rehabilitation and employment services, as these are sorely lacking in their communities. Asked if SAMHSA could assist in developing standards in this area, Federal staff replied that the government may only direct to resources and may not establish policy. Support is needed to develop policies for administering inpatient care as well as aftercare, and for regional youth treatment centers, too, along with procedures for staff development.
- S Greater emphasis should be placed on cultural issues and historical awareness. Staff were reminded about the differences between tribes and the need to not overgeneralize. Incorporating tribal consultations in developing CSAT-produced Treatment Improvement Protocols (TIPs) and Technical Assistance Publications (TAPs) would help address this issue. (Reference was made to the provisions for increasing tribal consultations in the pending Indian Health Improvement Act.) Participants were directed to the Special Report, “Increasing Cultural Sensitivity of the Addiction Severity Index” (Government Printing Office: 2001 621 986/96145), developed by CSAT and the Cultural Competence Series, Special Collaborative Monograph 9, “Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence” (DHHS Publication No. SMA 99-3440), developed by CSAP.
- S Tremendous barriers exist in the area of professional staff development for Native counselors. Many are not licensed/certified to provide counseling if they leave their reservations (unable to help with Native populations in urban settings). It was pointed out that Addiction and Technology Transfer Centers, funded by CSAT and CAPT, may be good resources for assistance in this area. Strong leadership is required

to help open dialogue with colleges and universities, so that remedial assistance may be offered and alternative learning strategies that recognize the learning styles of Native peoples are adopted. Geographic impediments to learning need to be addressed through video learning approaches; weeklong, retreat-type, intensive seasonal offerings; and other innovative distance learning methods.

- S More assistance is needed to support and organize networking among treatment center staff, so that best practices may be shared and more community collaboration may occur.
- S Participants encouraged staff from the State, regional, and Federal offices to attend their cultural activities and healing ceremonies, to visit their treatment centers, and communicate often, to increase levels of trust and understanding.

- **State Perspectives.** Great variation exists among States in administrative structures that govern services to Native populations; however, common concerns and areas of concentration emerge. They include:

- S Increasing tribal leader participation on advisory councils and boards and expanding circles of trust;
- S Helping tribes and urban programs participate in the grant process;
- S Allowing for creativity and innovation in tribal programs and allowing tribes to set up their own standards;
- S Building local service delivery and infrastructures;
- S Extending training to Native counselors and obtaining reciprocity for counselors on and off reservations;
- S Ensuring continuity and sustainability of tribal programs;
- S Addressing the disproportionately large numbers of Native Americans in correctional facilities;
- S Overcoming distance barriers to hospital and residential treatment;
- S Covering Native practices and expanding Medicaid encounter codes;

- S Blending funds from multiple sources to allow county and community control; and
- S Responding to issues related to managed care.

## IV. Outcomes and Recommendations—Next Steps

### A. Meeting Outcomes

Eager participants attended the 2-day meeting, easily engaging in dialogue during networking sessions and readily asking presenters questions during the consumer-driven topical sessions to learn how to apply new knowledge in their home communities. The afternoon of the second day was divided into two activities: a site visit to a local program (the Pascua Yaqui Tribe in Guadalupe Pueblo) and participation in a discussion around the continuation of joint future meetings.

### B. Recommendations

Throughout the meeting, participants voiced the need for additional, specific TA information in response to material being presented. The list below reflects recommendations for next steps, based on the needs.

1. **Mechanisms to continue the flow of information to the tribes need to be strengthened.** Presentations on alcohol and drug funding need to be conducted more frequently for tribal leaders.
2. **AOD service delivery summits should occur annually.** The momentum of this meeting and the November 2000 Summit should not be lost. A good dialogue has begun, and a level of trust is emerging.
  - A committee including tribal representatives should be established to plan the agenda.
  - More policymakers, such as IHS Directors, State Directors, and tribal leaders, need to be encouraged to come.
  - Strategic planning that reflects consumer input should be included in objectives for the meeting.
  - The meeting should be held in a State that prohibits travel to increase attendance and awareness of policymakers in that State.
  - IHS as well as CSAT need to include upper-level management as their representatives; SAMHSA should also send a representative.
  - Participant packets containing easily understood training materials should be distributed.

3. **Grantsmanship workshops need to be delivered.** Tribes and programs serving Native populations want hands-on training so that they may access funds and provide more services.
4. **On-site TA should be delivered.** State agency staff and tribal leaders need to learn more about one another and all about the specific programs in their own States.
5. **Mechanisms to improve Medicaid and SCHIP utilization need to be developed and taught to IHS and tribal providers.** Tribes would benefit from the kind of specialized training that was offered to SSAs in regional training activities.
6. **Assistance should include more traditional treatment modalities in the reimbursable services list.** Mechanisms need to be developed to measure effectiveness of traditional healing methods so that more of them are on recognized services lists.
7. **TIPs and TAPs need to include more culturally relevant material.** Assistance from Native providers and consumers should be sought when future editions are being developed.
8. **The concept of historical trauma should be shared to increase sensitivity and awareness.** State agency staff and others who provide services to Native populations would benefit from the cultural awareness training in this area.
9. **Certification procedures for Native counselors need addressing.**
  - The Federal Government, while not a professional certification body, needs to support a forum for dialogue between tribal providers, counselors, and certification bodies.
  - The National Association of Alcohol and Drug Abuse Counselors and ICRC need to be invited to hear the concerns of AI/AN populations.
  - Psychometrists for certifying bodies need to work with Native American populations to help develop culturally sensitive ways to evaluate counselor competency.
10. **Methodologies for strengthening community-based systems are needed.** Native providers need help to create a continuum of care by working with other providers.
11. **Government assistance is needed to coordinate multiple funding sources, and a unified budget is needed.** Coordination at the Federal level will make the application

process easier and reduce the necessity and complexity of trying to coordinate funds from so many sources with varying regulations.

### **C. Next Steps**

Pursuant to the recommendations made, Frank Canizales committed staff at IHS to explore the possibility for Federal support of the next meeting, with IHS taking the lead coordinating role. Don Davis, the IHS Phoenix Area Director, has agreed to share recommendations and learnings from the meeting with the other IHS Area Directors. Following circulation of the summary report and pending the approval for a federally supported meeting, planning for the meeting will commence.