*Journal of Psychoactive Drugs*, 43 (4), 302–308, 2011
Copyright © Taylor & Francis Group, LLC
ISSN: 0279-1072 print / 2159-9777 online
DOI: 10.1080/02791072.2011.628922

Routledge
Taylor & Francis Group

# Holistic System of Care: A Ten-Year Perspective

Ethan Nebelkopf, Ph.D.[a] & Serena Wright, M.P.H.[b]

**Abstract** — The Holistic System of Care for Native Americans in an Urban Environment is a community-focused intervention that provides behavioral health care, promotes health, and prevents disease. This approach is based on a community strategic planning process that honored Native American culture and relationships. Substance abuse, mental illness, homelessness, poverty, crime, physical illness, and violence are symptoms of historical trauma, family dysfunction, and spiritual imbalance. The holistic model links treatment, prevention, and recovery. The link between prevention and treatment is early intervention. Peer support is the link between treatment and recovery. Recovering individuals serve as role models linking recovery to prevention. Culture and spirituality build a strong and resilient foundation for recovery. This article documents the effectiveness of the holistic model over a ten-year period that it has been implemented at the Family & Child Guidance Clinic of the Native American Health Center in the San Francisco Bay Area. The holistic model has produced statistically significant reductions in substance abuse among adult Native American women, men, reentry, and homeless populations; reductions in substance abuse among Native American adolescents; reductions in HIV/AIDS high-risk behavior among Native American men, women, and adolescents; and decreases in acting out behavior among Native American severely emotionally disturbed children.

**Keywords** — behavioral, Indian, intervention, Native, prevention, recovery

The Family & Child Guidance Clinic of the Native American Health Center in the San Francisco Bay Area in collaboration with the Friendship House Association of American Indians has developed a Holistic System of Care for Native Americans in an Urban Environment (HSOC), a community-focused intervention that provides behavioral health care, promotes health, and prevents disease. The Holistic System of Care (HSOC) integrates mental health, substance abuse, and HIV/AIDS services. This integrated approach was based on a community strategic planning process (1998–2001) that honored Native American culture and relationships (Wright et al. 2011; Nebelkopf & Penagos 2005; Nebelkopf & King 2004, 2003).

In the Holistic System of Care, mental illness, substance abuse, homelessness, poverty, crime, physical illness, and violence are recognized as symptoms of historical trauma, family dysfunction, and spiritual imbalance. When individuals, families, and societies are out of balance, problems are identified depending upon the social institutions—school, criminal justice, health care, mental health, welfare, and housing systems—that have come into contact with the "identified client."

The holistic approach deals with the whole person. The emphasis is on self-help, empowerment, and building a healthy community. The holistic model links treatment,

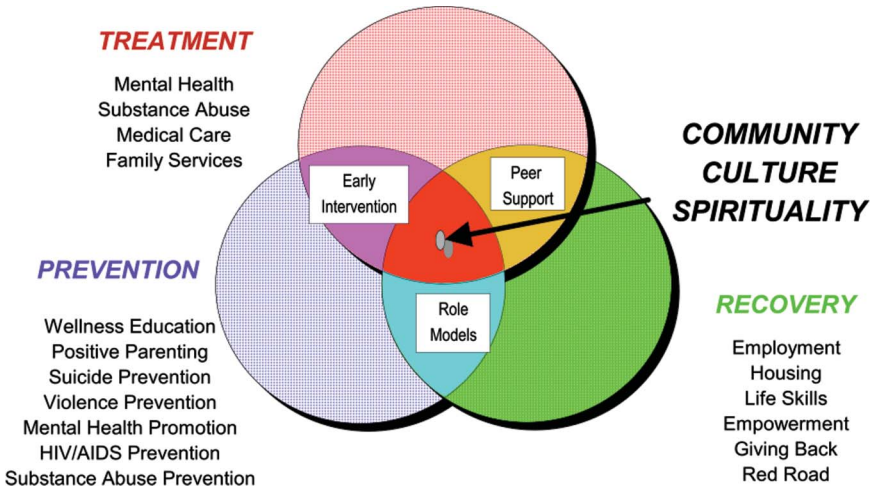
This work was supported by the Substance Abuse and Mental Health Services Administration Center for Mental Health Services project Urban Trails Oakland (SM 56051) and Urban Trails San Francisco (SM 059036); Center for Substance Abuse Treatment Native Women Circle (TI 019690), Native Women (TI 15707 and Native Men (TI 17203); and Center for Substance Abuse Prevention Native Voices (SP 13330). The contents of this article are solely the responsibility of the authors.

[a]Director, Behavioral Health, Family & Child Guidance Clinic, Native American Health Center, Oakland, CA.

[b]Director, Research and Evaluation, Family & Child Guidance Clinic, Native American Health Center, Oakland, CA.

Please address correspondence to Serena Wright, Director of Research & Evaluation, Native American Health Center, Family & Child Guidance Clinic, 3124 International Blvd, Oakland, CA 94601; phone: (510)434-5464, email: serenaw@nativehealth.org.

**FIGURE 1**
**Holistic Model Linking Treatment, Prevention, and Recovery (color figure available online)**




prevention, and recovery. Treatment includes mental health, substance abuse, medical care, family services, and traditional American Indian medicine. Prevention includes wellness education, HIV/AIDS prevention, substance abuse prevention, mental health promotion, and positive parenting training. Recovery includes employment, housing, and giving back to the community. The link between prevention and treatment is early intervention. Peer support is the link between treatment and recovery. Recovering individuals serve as role models linking recovery to prevention. Culture and spirituality build a strong and resilient foundation for recovery (Wright et al. 2011). HSOC is an institution-focused intervention as opposed to a problem-focused intervention (see Figure 1) (Gone & Alacantara 2005).

The holistic model integrates western science with American Indian culture. Evidence-based practices include Positive Indian Parenting (Cross, Friesen & Maher 2007; Cross & Hansel 1986) and Gathering of Native Americans (GONA) (Kauffman & Associates 1999). Cultural activities include talking circles, seasonal ceremonies, sweat lodge, Red Road, smudging and prayer. The challenge faced is to articulate and document the effectiveness of cultural activities in terms that western scientists can understand. HSOC frames traditional American Indian healing within a modern clinical context (Wright et al. 2011).

## BACKGROUND

The Native American Health Center (NAHC) is the largest agency serving American Indians in the San Francisco Bay Area. It has offices in San Francisco and Oakland and is governed by an all-Indian board of directors. NAHC is a nonprofit (501(c)3) organization that is recognized by the Indian Health Service (IHS) Urban Indian Health Program under Title V of the Indian Health Care Improvement Act. It is a licensed community clinic and certified as a Federally Qualified Health Center (FQHC). NAHC services include medical, prenatal, dental, HIV/AIDS, substance abuse, mental health, Women, Infants and Children (WIC, a federally-funded health and nutrition program), and youth programs. NAHC has provided medical, dental, and human services since 1972. Its mission is to assist American Indians to improve and maintain their physical, mental, emotional, social, and spiritual well being with respect for cultural traditions, and to advocate for the needs of all Indian people, especially the most vulnerable members of our community.

Sine 1985, the Family & Child Guidance Clinic (FCGC) of NAHC has provided culturally appropriate prevention and outpatient mental health and substance abuse services for American Indians and Alaska Natives (AI/ANs) in San Francisco, Oakland and Richmond, California. It also provides cultural programs and community events for youth and adults. FCGC facilities in San Francisco and Oakland are certified by the California Department of Alcohol and Drug Programs for outpatient substance abuse treatment. FCGC is a sister program to the Friendship House Association of American Indians, a residential substance abuse treatment program with licensed facilities in San Francisco and Oakland.

FCGC offers a wide variety of services including individual, group and family counseling, care coordination, psychological assessment, screening, alcohol and drug prevention programs for adults and youth, HIV/AIDS

prevention, and cultural activities, such as talking circles, traditional healing, and community events. The FCGC also has established relationships among organizations that serve Native families and youth as well as public agencies and advocacy organizations. FCGC is home to the Youth Services Program, which provides a drop-in center, after-school services, tribal athletics, substance abuse prevention and traditional cultural arts for 400 Native youth each year.

In 1997 FCGC had a staff of four and an annual budget of $150,000 with contracts from Indian Health Service and Alameda County. By 2011 FCGC had grown into a comprehensive behavioral health care system with 45 staff and a $6 million annual budget with 20 contracts, many from the centers within the federal Substance Abuse and Mental Health Services Administration (SAMHSA), such as Center for Substance Abuse Treatment (CSAT), Center for Substance Abuse Prevention (CSAP), and Center for Mental Health Services (CMHS); state agencies including the California Department of Alcohol and Drug Programs, Department of Mental Health, and Department of Social Services; local public health agencies in Alameda, San Francisco, and Contra Costa counties; the Indian Health Service (IHS); and private foundations. The phenomenal growth started in 1998 when FCGC was awarded a three-year planning grant of $300,000 per year through the Circle of Care initiative of the Center for Mental Health Services (CMHS) to develop a system of care for Native American children and their families in the San Francisco Bay Area.

As a result of this community planning process FCGC developed an innovative Holistic System of Care for Native Americans in an Urban Environment (Nebelkopf & King 2003). With the holistic model as a central foundation of our system of care, the Native American community crafted programs that met the specifications for federal requests for proposals (RFPs). From 1998 through 2011, the initial Circle of Care planning grant was leveraged into $45 million for implementation of 32 SAMHSA grants and cooperative agreements in substance abuse, mental health, and HIV/AIDS prevention.

The Holistic System of Care for Native Americans in an Urban Environment has generated selective interventions to reduce substance abuse among adult Native American women, men, reentry, and homeless populations; reduce substance abuse among Native American adolescents; reduce HIV/AIDS high-risk behavior among Native American men, women, and adolescents; increase social connectedness and quality of life for Native American adults with HIV/AIDS and mental illness; and decrease acting out behavior among Native American severely emotionally disturbed children. The goal of this article is to describe results from several analyses that indicate the success of HSOC in these areas, specifically substance abuse prevention and treatment and behavioral health outcomes in children.

## METHODOLOGY

Our evaluation methodology includes qualitative and quantitative processes, comparison of pre and post-test measurements, Final Evaluation Reports for SAMHSA projects, and articles in peer-reviewed journals and other publications on best practices. HSOC is not a singular intervention with a curriculum, but a complex approach with many variables that impact individuals in different ways. HSOC is a holistic approach that combats fragmentation built into institutional services and challenges scientific study because the intervention is not a concise variable that is easily tested in randomized comparison groups. In the Native American worldview everything is in relationship (Cross et al. 2000), so it is very difficult to isolate and single out specific influences. HSOC applies to adults and children; substance abuse and mental health; prevention and treatment. The results section below presents analysis of several SAMHSA projects, including treatment for adult substance abusers (Native Women and Native Men), children's mental health treatment (Urban Trails) and adolescent substance abuse prevention (Native Voices).

## RESULTS

### Native Men and Native Women

This series of studies includes research on 490 adult substance abusers, women and men, who received treatment from 2003–2008 and completed both a baseline and six-month follow-up questionnaire, regardless of whether or not they completed the prescribed course of treatment (Wright et al. 2011; Saylors & Daliparthy 2005; Saylors 2003; CSAT 1999). The results in this section pertain to several CSAT projects that included the Native Women's Circle and Native Men's Circle with a target population of adult substance abusers.

The NAHC Family & Child Guidance Clinic in collaboration with the Friendship House Association of American Indians (FH) provided outpatient and residential substance abuse services. Data was collected through funding support from two grants from CSAT to expand treatment capacity and prevent HIV/AIDS. They were collected using the Government Performance Results Act (GPRA) tool. This analysis was undertaken with the specific intent to assess changes over time in the following areas: substance use in the past 30 days; stress, emotion, or activities resulting from substance use in the past 30 days; arrests or crimes committed in the past 30 days; psychological variables unrelated to substance abuse; employment status; enrollment in school or training programs.

Of the 490 participants, 71% were women and 29% were men; 24% reported using alcohol or drugs in the prior 30 days at baseline, with a decline to 5% six months later ($p < .001$). Experiences of stress, emotion, or activities

resulting from substance use in the prior 30 days also showed a decreasing rate of change from 47% to 23% ($p < .001$). The number reporting either part or full-time employment increased from 11% to 20% ($p < .001$). The largest rate of change was seen in enrollment in school or a training program, moving from 7% to 17% ($p < .001$). The number reporting being arrested or committing a crime in the prior 30 days went from 31% to 5% ($p < 0.001$). Significant reductions were seen in the rates of non-substance abuse-related reports of: serious depression ($p < .001$), serious anxiety or tension ($p < .001$), hallucinations ($p < .001$), trouble understanding or concentrating ($p < .001$), trouble controlling violent behavior ($p < .01$), and suicide attempts ($p < .01$) (Wright et al. 2011).

These data demonstrate that HSOC is a viable model for use among urban Native Americans. Data demonstrate positive gains in terms of substance use indicators, consequences of substance use, criminal activity, employment, school and training program enrollment, and mental health. Differences were seen between treatment modalities. Residential clients demonstrated the most dramatic improvements, which can be partially attributed to very low baseline rates of employment, training program attendance, and school enrollment. Many are outwardly engaged in the world to improve their personal circumstances by six months post-baseline. While residing at the Friendship House, clients receive more intensive services/dosage, are much more protected, and are highly supported on a day-to-day basis. As a result, they have fewer opportunities to engage in drug or alcohol use (Wright et al. 2011).

This research demonstrates preliminary evidence of the effectiveness of HSOC in reducing substance use and improving related outcomes among adult Native Americans. This is a flexible model that has also been adapted to prevention and treatment of substance misuse as well as mental health, for both youth and adults. HSOC is a recognized model for use among urban Native Americans. The organizations utilizing these methods are demonstrated and acknowledged leaders in the field of substance abuse recovery and prevention among urban Native populations. Key to this success is the strong and important role of culture and cultural connection/reconnection along with mainstream methods. Brave Heart (2005) identifies the Women's Circle as a best practice for co-occurring disorders. This project includes cultural elements including an emphasis on a holistic approach to physical and spiritual wellness and linking individual health to community health and that of the natural world.

## Native Voices

This project was funded by a Center for Substance Abuse Prevention (CSAP) project called Native Voices with a goal of preventing substance abuse among adolescents. The HSOC demonstrated effectiveness in adolescent substance abuse prevention utilizing a four-day Gathering of Native Americans (GONA) hosted by Native American Health Center and Friendship House in 2009. The GONA is based on a theoretical perspective that reflects the culture and values of Native Americans and is supported by a documented body of empirical knowledge that indicates effectiveness (Aguilera & Plasencia 2005; Nebelkopf & King 2003; SAMHSA/IHS 2001).

The GONA provides a structured format for Native Americans to address substance abuse issues in a historical, social, and cultural context. The GONA curriculum was developed by a consensus of Native American professional educators and clinicians convened by the Center for Substance Abuse Prevention (CSAP) to assist grantees in support of community efforts to reduce and prevent alcohol and other drug abuse in American Indian communities and is one of the few American Indian cultural interventions that has been manualized (Kauffman & Associates 1999; MACRO/CSAP 1994). It is a culturally-sensitive curriculum developed to empower Native American communities in forming and implementing prevention strategies based on values inherent among Native cultures. Native values such as traditional and historical teachings, storytelling, ceremony and spirituality provide a foundation for developing community cohesion. GONA has been implemented in many Native American communities across the U.S. as a cultural approach to treatment, prevention, and community building.

This evaluation used a mixed methods approach to measure and interpret outcomes related to substance abuse and sexual risk for 186 youth. Signed-rank tests were used to ascertain changes in knowledge, and self-efficacy as a result of the intervention. There was a significant change in knowledge and self efficacy from pretest to six month posttest. McNemar's test was used to determine whether perception of substance use risk changed. Test results indicated that change in perceived cigarette risk was significant ($p = .02$). They also indicated that change in perceived alcohol risk was significant ($p = .003$). When asked about marijuana risk (smoking once or twice a week) test results indicated change in perceived marijuana risk was significant ($p < .0001$) (Nelson 2011).

## Urban Trails

Urban Trails was a children's mental health project (2003–2009) funded by the federal Center for Mental Health Services aimed to improve the mental health of youth and their families, focusing on severely emotionally disturbed (SED) children between the ages 0 to 21. The city of Oakland collaborated with NAHC to implement a culturally appropriate system of care for Native American children and their families utilizing the HSOC model.

The evaluation plan consisted of a longitudinal study of outcomes of the system of care. Performance measurement instruments included the Child Behavioral Checklist,

Behavioral and Emotional Rating Scale, Youth Services Survey, Caregiver Strain Questionnaire, and Family Life Questionnaire to collect data at baseline and every six months thereafter for three years. The number of children enrolled in the longitudinal study was 109: 65 males and 44 females. The age breakdown was: 15% were between the ages of 0–5; 27% were between the ages of 6–11; 25% were between the ages of 12 and 17 and 33% were age 18–23 (Johnson 2009).

A comparison of all tribal youth served through the CMHS System of Care program with the Oakland youth included these findings: 79% of Oakland youth reported using at least one substance prior to intake. A larger than expected number of Oakland youth used prescription painkillers (30.8%). Other substances used by large percentages of Oakland youth included alcohol (75%), cigarettes (65%), marijuana/hashish (60%), cocaine (39%), hallucinogens (35%) and Ecstasy (35%). Urban Trails' youth outcomes improved according to the National Evaluation measures in a number of areas compared to all youth at other funded sites. More Oakland youth experienced stability in living arrangements, a reduction in delinquent behavior, and improvement in caregiver's assessment of family life from intake to 36 months (Johnson 2009).

The local evaluation featured a comparison from baseline at intake to 24 months in treatment for 40 youth and their families. In the analysis from baseline to 24 months, there was significant improvement in symptoms and functioning of the overall population served under the Urban Trails Program. These findings were based on the scores of Child Behavioral Checklist 6–18 (CBCL 6–18; Achenbach & Rescorla 2001), which is administered to caregivers and measures behavioral and emotional problems in children. There was a significant improvement in internalizing, externalizing, and total problems scales. The improvements in internalizing problems as indicated by CBCL are anxious and depressive feelings and somatic complaints. Results also showed significant improvement with a reduction in rule breaking and aggressive behavior and improvements in overall problems as indicated by the total problems scale ($p < .05$) (King et al. 2009).

Results indicated significant reduction in global impairment for all youth as reported by their caregivers on the Columbia Impairment Scale (CIS; Bird et al. 1993). Thus there was improvement in relationships with caregivers, siblings, friends, and other adults, behavioral problems at home, work, and school, and managing positive and negative emotions, such as happiness, sadness, and anxiety ($p < .05$). The analysis showed that there was a significant decrease in Caregiver Strain from baseline to 24 months as measured by the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman 1998). There was a decrease in strain such as feelings of anger and resentment about the child, disruption of family and community life, and caregiver feelings of worry, quilt, and fatigue ($p < .001$) (King et al. 2009).

The results were also significant for Interpersonal Strength subscale ($p < .001$) and Total Strength Index ($p < .05$) on the Behavioral and Emotional Rating Scale (BERS-2 Caregiver; Epstein 2004) for all youth enrolled in Urban Trails. The BERS-2C measures various aspects of interpersonal, intrapersonal, family, affective, school, and career strengths as reported by youth/child's caregiver. These results illustrate increases in overall behavioral and emotional strengths, and specific increases in interpersonal strength such as a youth's ability to control his/her emotions or behaviors in social situations. This indicates improvement in interpersonal strength from baseline to 24 months (King et al. 2009).

These data indicate the importance of Urban Trails in having made a positive contribution. The decreases in aggressive behavior and depressive and anxious feelings in children and in experiences of strain in caregivers, along with improvement in functioning and strengths for all youth including Native American youth, offers evidence towards effectiveness of services provided with HSOC. Urban Trails, utilizing the HSOC, not only helps children/youth decrease their problematic symptoms, it also provides appropriate support and services for families and communities (King et al. 2009). Similar results were reported for a group of urban Indians in a similar children's mental health program in Los Angeles (Dickerson & Johnson 2010). Urban Trails was funded by CMHS for another six-year cycle in 2009 to replicate these results in San Francisco.

## DISCUSSION

Data presented here summarize key documentation of the success of the HSOC in terms of adult substance use treatment, adolescent substance abuse prevention, and children's mental health. In addition to the many successes the Native American Health Center had with implementation and sustainability of Urban Trails, staff have focused efforts on advocating for inclusion of the Holistic System of Care for Native Americans in an Urban Environment as an evidence-based practice.

HSOC is a recognized model for use among urban Native Americans. The organizations utilizing these methods are demonstrated and acknowledged leaders in the provision of prevention and treatment services and mental health services for Native Americans. Key to the success of these programs is the strong and important role of culture and cultural connection/reconnection along with more mainstream methods.

The Holistic System of Care (HSOC) was featured in *SAMHSA News* (Capers 2003). It has been identified as a best practice in health promotion and disease prevention

for urban Indians at high risk for HIV/AIDS by the Indian Health Service in 2007. In 2008, the California Department of Mental Health lists HSOC as a best practice in dealing with trauma-exposed individuals. The Acting Surgeon General of the United States visited the FCGC Youth Program in 2008 and gave the Tribal Athletics Program a Healthy Youth for a Healthy Future Champion Award for our efforts to curb and prevent childhood obesity within our community and our dedication to improving the overall health of our nation's youth.

FCGC has been honored by SAMHSA/CSAP for its participation in the Substance Abuse/HIV Prevention in Minority Communities Initiative (2002–2005) and by SAMHSA/CMHS for its participation in the Mental Health HIV Services Collaborative (2002–2006). FCGC staff actively advocate for Native Americans in the state of California and in San Francisco, Alameda, and Contra Costa counties. These counties have adopted holistic Native American strategies for allocating Mental Health Services Act (MHSA) funds and have provided funding for Native American wellness centers for prevention and early intervention. FCGC is active in a state coalition to reduce mental health disparities among ethnic minorities. In 2009 Indian Health Service presented FCGC with the National Behavioral Health Achievement Award for Innovation. In 2010, the city and county of San Francisco utilized the holistic model as the foundation for one of its mental health prevention and early intervention efforts, called the Holistic Wellness initiative.

The holistic model was chosen in 2009 by the National Consortium of Urban Indian Health Programs for inclusion in the Compendium of Best Practices for Indigenous American Indian/Alaska Native and Pacific Island Populations (Echo-Hawk 2011). This compendium has been compiled by the First Nations Behavioral Health Association in conjunction with the Pacific Substance Abuse and Mental Health Collaborating Council.

## CONCLUSION

These results provide evidence of the effectiveness of the Holistic System of Care for Native Americans in an Urban Environment for treatment with adult substance abusers and emotionally disturbed children, as well as for the prevention of substance abuse with adolescents. Further studies are being conducted to ascertain the effectiveness of HSOC in the prevention of substance abuse with adults utilizing this flexible and evolving model.

NAHC is moving toward inclusion of social media in its system of care, including Facebook, Twitter, and digital storytelling. In July 2011 the Native American Health Center Facebook page had 3,306 friends, or 3,306 people who actively read its content. Digital storytelling is the practice of using computer-based tools to tell stories. Storytelling is a natural component of Native culture. The process of creating digital stories and sharing them with friends, family, and community shows promise as a powerful prevention and healing tool with both adults and adolescents (Lambert 2011; http://www.youtube.com/watch?v=p6RGqQ8Rl9w&feature=related). NAHC has developed a Research & Media Center to guide our future efforts in this area.

## REFERENCES


Achenbach, T. & Rescorla, L. 2001. *Manual for ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Aguilera, S. & Plasencia, A.V. 2005. Culturally appropriate HIV/AIDS and substance abuse prevention programs for urban Native youth. *Journal of Psychoactive Drugs* 37 (3): 299–304.

Capers, M. 2003. SAMHSA-funded projects highlight American Indians & Alaska Natives. *SAMHSA News* 11 (2): 16–17.

Bird, H.R.; Shaffer, D.; Fisher, P.; Gould, M.S.; Staghezza, B.; Chen, J.Y. & Hoven, C. 1993. The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents. *International Journal of Methods in Psychiatric Research* 3: 167–76.

Brannan, A.; Heflinger, C. & Bickman, L. 1998. The Caregiver Strain Questionnaire: Measuring the impact on the family of living with a child with serious emotional disturbance. *Journal of Emotional and Behavioral Disorders* 5: 212–22.

Brave Heart, M.Y.H. 2005. Best practices for co-occurring disorders in American Indian and Alaska Native communities. In: E. Hawkins & R.D. Walker (Eds.) *Best Practices in Behavioral Health for American Indians and Alaska Natives*. Portland, OR: One Sky National Resource Center for American Indian and Alaska Native Substance Abuse Prevention and Treatment Services.

Cross, T.L. & Hansel. 1986. *Positive Indian Parenting: Honoring our Children by Honoring our Traditions—A Model Indian Parent Training Manual*. Portland, OR: National Indian Child Welfare Association.

Center for Substance Abuse Treatment (CSAT). 1999. *Cultural Issues in Substance Abuse Treatment*. Rockville, MD: Center for Substance Abuse Treatment, Department of Health and Human Services.

Cross, T.L.; Friesen, B.J. & Maher, N. 2007. Successful strategies for improving the lives of American Indian and Alaska Native youth and families. *Focal Point* 21 (2): 10–13.

Cross, T.L.; Earle, K.; Solie, H.E. & Manness, K. 2000. *Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities. Systems of Care: Promising Practices in Children's Mental Health, 2000 Series*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Dickerson, D. & Johnson, C. 2010. Mental health and substance abuse characteristics among a clinical sample of urban American Indian/Alaska Native youths in a large California metropolitan area: A descriptive study. *Community Mental Health Journal* Spring: 1–5.

Echo-Hawk, H. 2011. *Compendium of Best Practices for Indigenous American Indian/Alaska Native and Pacific Island Populations, A Description of Selected Best Practices and Cultural Analysis of*

*Local Evidence Building*. Portland, OR: First Nations Behavioral Health Association.

Epstein, M. 2004. *Behavioral and Emotional Rating Scale: A Strength-Based Approach to Assessment. Examiner's Manual. Second Ed*. Austin, TX: Pro-Ed.

Gone, J. & Alacantara, C. 2005. Practice makes perfect? Identifying effective psychological treatments for mental health problems in Indian Country. In: H.E. & W.R.D. (Eds.) *Best Practices in Behavioral Health for American Indians and Alaska Natives*. Portland, Oregon: One Sky National Resource Center for American Indian and Alaska Native Substance Abuse Prevention and Treatment Services.

Johnson, S. 2009. *Close-Out Training & Technical Assistance Site Visit Report, National Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program*. Calverton, MD: ORC Macro.

Kauffman & Associates. 1999. *Gathering of Native Americans: Substance Abuse Prevention Curriculum*. Rockville, Maryland: Prepared for the Indian Health Service Alcohol and Substance Abuse Program Branc and SAMHSA Center for Substance Abuse Prevention.

King, J.; Nebelkopf, E.; Patel, C. & Nebelkopf, S. 2009. *Urban Trails Final Report*. SM 56051. Oakland, CA: City of Oakland and Native American Health Center.

Lambert, J. 2010. *Digital Storytelling: Capturing Lives, Creating Community*. Berkeley, CA: Center for Digital Storytelling Digital Diner Press.

Macro International and Center for Substance Abuse Prevention (MACRO/CSAP). 1994. *Gathering of Native Americans Trainer Guide*. Calverton, MD: Macro International and Center for Substance Abuse Prevention.

Nebelkopf, E. & Penagos, M. 2005. Holistic Native network: Integrated HIV/AIDS, substance abuse, and mental health services for Native Americans in San Francisco. *Journal of Psychoactive Drugs* 37 (3): 257–64.

Nebelkopf, E. & King, J. 2004. A holistic system of care for Native Americans in the San Francisco Bay Area. In: E. Nebelkopf & M. Phillips (Eds.) *Healing and Mental Health for Native Americans: Speaking in Red*. Walnut Creek, CA: Altamira Press.

Nebelkopf, E. & King, J. 2003. A holistic system of care for Native Americans in an urban environment. *Journal of Psychoactive Drugs* 35 (1): 43–52.

Nelson, K. 2011. *Evaluation of Native Voices: A Prevention Program for Native Americans in an Urban Environment*. Berkeley, CA: University of California School of Public Health.

Substance Abuse and Mental Health Services Administration/Indian Health Service (SAMHSA/IHS). 2001. *Consultation with American Indians and Alaska Natives, A Report on the Continuing Dialogue Between the Department of Health and Human Services and Amerian Indian and Alaska Native Leaders*. Rockville, Maryland: SAMHSA/IHS.

Saylors, K. 2003. The Women's Circle comes full circle. *Journal of Psychoactive Drugs* 35 (1): 59–62.

Saylors, K. & Daliparthy, N. 2005. Native women, violence, substance abuse and HIV risk. *Journal of Psychoactive Drugs* 37 (3): 273–80.

Wright, S.; Nebelkopf, E.; King, J.; Maas, M.; Patel, C. & Samuel, S. 2011. Holistic system of care: Evidence of effectiveness. *Substance Use and Misuse* 46 (11): 1420–30.

Copyright of Journal of Psychoactive Drugs is the property of Haight Ashbury Publications and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.

Copyright of Journal of Psychoactive Drugs is the property of Haight Ashbury Publications and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.