Journal of Psychoactive Drugs, 43 (4), 297–301, 2011

ISSN: 0279-1072 print / 2159-9777 online
DOI: 10.1080/02791072.2011.628921

Routledge
Taylor & Francis Group

Reclaiming our Roots: Accomplishments and Challenges

Janet King, M.S.W.[a]

Abstract — Best practices for Native Americans are rooted in culture. However, reclaiming best practices is a challenge given the genocidal policies that outlawed Native culture. Despite this challenge Native people have proven resilient in restoring culture. The Native American Health Center in Oakland, California, has made cultural interventions an option for an urban, intertribal and sometimes multiracial Native American population to create and maintain their health on a spiritual, emotional, mental and physical level. Nevertheless, sustaining these cultural options to maintain health continues to be a challenge. While the passage of the Mental Health Services Act (MHSA) in 2004 in California to transform treatment of mental and behavioral health "as we know it" would seem to create a gateway for cultural options, mainstream mental health has a hard time perceiving cultural interventions as a viable means to treat mental illness and maintain wellness. Frequently, the author has attended meetings of decisionmaking bodies that oversee how MHSA money is spent and someone will blurt out after someone has described an innovative cultural intervention "What does that have to do with mental illness?" The following article discusses how the clash of the two cultures, Native and mainstream, continues to be a challenge for sustained funding to implement culturally competent programs.

Keywords — competence, culture, intervention, MHSA, prevention, trauma

Best practices for Native Americans are rooted in culture. Reclaiming these best practices are a challenge given the history in the U.S. of cultural genocide, which outlawed the practice of Native American culture. Consequences for practicing culture included being jailed or killed. Targets for this severe punishment were often times healers who conducted ceremonies to restore health and promote well-being. Despite this history, Native Americans have proven resilient at restoring culture and have even used culture as a base to develop interventions to promote wellness.

A greater challenge in restoring Native American best practices as mental health interventions is the culture of the mainstream mental health system itself. While a mainstream intervention template is therapist and client, Native templates for mental health interventions often involves community, natural helpers, traditional healers, events, ceremonies, and groups as well as therapist-client interaction. It is often a challenge to secure public mental health funds to sustain Native programs because Native best practices do not resemble mainstream best practices. Successes to secure funds are the result of advocacy, cultural competence training with public officials, and coalition-building with other populations who also benefit from best practices rooted in cultures different from the mainstream.

MENTAL HEALTH SERVICES ACT

In 2004, Californians voted to establish the Mental Health Services Act (MHSA, or Proposition 63; CA DMH 2011) as law to transform mental health services through a tax on the wealthiest Californians. While the slogan for this new law was "to change mental health as we know

This work was supported by the Substance Abuse and Mental Health Services Administration Center for Mental Health Services project *Urban Native Center for Life Empowerment* (SM 59473). The contents of this article are solely the responsibility of the author.

[a]Project Director, Urban Center for Life Empowerment, Family & Child Guidance Clinic, Native American Health Center, Oakand, CA.

Please address correspondence to Janet King, M.S.W., Project Director, Native American Health Center, Family & Child Guidance Clinic, 3124 International Blvd, Oakland, CA 94601, phone: 510-434-5421, email: JanetK@nativehealth.org.

it" there is a strong inertia to "do business as usual." This phenomenon to reproduce more of the same with money earmarked for transformation is called *entrenchment.*

One of the transformational goals of the MHSA is to move away from a fail-first system of care. Outcomes of a fail-first system of care mentioned in the MHSA are emergency psychiatric hospital admissions, incarceration, and the removal of children from their homes. The MHSA describes this approach as imposing "high costs on state and local government" and points out "failure to provide timely treatment can destroy individuals and families."

Another transformational goal promoted by the MHSA are establishing programs that "combine prevention services with a full range of integrated services to treat the whole person." The goal of the MHSA is to serve the underserved, not served or inappropriately served populations with "services that are culturally and linguistically competent." To do so, conventional mental health services would be provided alongside and interwoven into substance abuse prevention and early intervention services. This multifaceted and dynamic strategy continues to improve more than just physical health, but also broader wellness on the individual and community levels.

Services funded by the MHSA are to be "client-centered, family focused and community- based" (section 2e). County plans on how to spend MHSA funds designated to each county are supposed to be the result of a robust stakeholder process which includes input from clients, family members and members of the public as opposed to only county behavioral health employees. The MHSA promotes a "Recovery Vision" to promote "hope, personal empowerment, respect, social-connectedness, self-responsibility and self-determination."

NATIVE AMERICAN CULTURE

Embedded in Native American culture are the same values and goals that are called transformational in the MHSA. However, for Native Americans these values and goals are not considered transformational or innovative but are considered as ancient practices developed over time with the help of all our relations and original instructions from the Creator.

Native American ceremonies that have been performed for thousands of years throughout a person's life span from childhood to adulthood promote these same transformational outcomes envisioned in the MHSA: hope, personal empowerment, respect, social connections, self-responsibility and self-determination.

An individual's development was not left to chance, but was guided by ceremony and customs that gave each child and person a sense of belonging, recognition, information and mentorship into life's next stage (Cross 1986). In the rare cases (prior to colonization) that a person spoke of suicide, customs were in place to talk to this person to understand what made them feel that way (Moves Camp 2009). Each tribe had ceremonies to treat and bring closure to grief and trauma. Even though these cultural practices were not called a "system of care" they indeed functioned as a highly refined system of care. In fact, these indigenous systems of care echo the transformational goals that the current mental health system is aspiring to become.

Another transformational goal expressed in the California MHSA is a robust stakeholder process so that services developed are indeed designed by those who will use the services and not by those getting paid to administrate those services. Getting feedback from the community to set policy and design services is rooted in Native American culture. Iroquoian tribes had long council meetings to ensure that everyone, including children, got a chance to speak and cast votes. The Iroquoian council meetings would take several days, if necessary, to allow for everyone to express themselves. This is a much more robust stakeholder process to obtain input than the three minute time limits often imposed at state and county meetings.

This Iroquoian value of getting guidance from stakeholders is common among many Native American tribes. This value is reflected in the often-quoted words of Lakota leader Sitting Bull "Let us put our heads together to see what kind of world we will make for our children." Matters of great importance were always done with the thinking of many individuals to make sure the best ideas are put forward. In contemporary Native American culture this ancient value of getting feedback from stakeholders is reflected in the many needs assessments that are done to shape and reshape services (Nebelkopf & King 2004).

NEEDS ASSESSMENT

A common finding in many of our needs assessments is that Native Americans prefer to get services at a Native agency with Native staff or staff trained in Native American culture and history. This preference is aligned with the MHSA goal of creating a diverse workforce that reflects the diversity of cultures and populations in California.

In 2007, Alameda County conducted a series of focus groups with many population groups in Alameda County as a needs assessment to inform Alameda County Behavioral Health Care Services (ACBHCS) on how to spend MHSA prevention and early intervention (PEI) funds. One of the focus groups was held on December 11, 2007 at the Native American Health Center (NAHC) in Oakland to ensure that Native Americans had a say in the countywide needs assessment. A participant at this focus group reported that she "holds back" information and feelings if she talks to a provider "who does not understand where Native Americans are coming from."

Another common finding across multiple needs assessments with Native Americans is a preference for cultural interventions as a component of treatment. Another participant in the December, 11, 2007 focus group testified that the pride of her family increased when her two sons got their Indian names in a naming ceremony that was attended by a well-known Native celebrity. The role that the Native agency played in making this happen was providing the space and help to pay for the naming ceremony expenses.

PREVENTION AND EARLY INTERVENTION IN ALAMEDA COUNTY

Despite the entrenchment to do business as usual in the bureaucracy, NAHC has been successful in offering cultural interventions as therapeutic options for community members. This success is due partly to the cultural competence movement in which researchers are bearing out that community-defined practices have better outcomes than evidence-based practices for cultural communities (Isaacs et al. 2005). A big portion of this success has been the ardent advocacy of cultural brokers committed to delivering services identified in needs assessments by their constituents that promote wellness.

Three years after the passage of the MHSA in 2004 the 58 counties in California had the task of developing Prevention and Early Intervention (PEI) Strategies. This was new territory for many counties as mental health funds were often earmarked for treatment not prevention. As mandated by the new law, programs developed and funded by MHSA must include feedback from consumers and family members of underserved, not served and inappropriately served populations.

After Alameda County Behavioral Health Care Services (ACBHCS) conducted a needs assessment to inform the development of PEI strategies to be funded with MHSA funds, a struggle ensued between ACBHCS and cultural brokers from various cultural groups about the process to determine these strategies. ACBHCS's original design was to have one planning panel, which would take into consideration what was learned from the county-wide needs assessment and come up with PEI strategies that would address needs and solutions of the residents in Alameda county. The thinking was that cultural competence would naturally embed in the general strategies that the planning panel would come up with for the whole county.

Cultural brokers at community-based organizations were all too familiar with this assumption and knew that it never panned out that way. Specific interventions were needed for specific populations to be truly culturally responsive (Cross et al. 1989). Cultural brokers were successful in advocating for a separate planning panel to focus on the needs and solutions of underserved cultural communities to reduce disparities.

This advocacy paid off. For the first time public mental health money was being spent to fund cultural interventions for Native Americans and other cultural groups in Alameda County. In fact, there was language in the RFP saying that the bidder must demonstrate the ability to provide cultural interventions. As a result, many of the services identified in the December 11, 2007 needs assessment have been delivered with others in the making. More visits with a traditional healer have been made available in lieu of only being able to see a clinical therapist at NAHC in Oakland. At the focus group one participant stated that "one visit with the medicine man equaled several visits with a clinical therapist."

NAHC has increased access to traditional healers by having a medicine person as guest speaker for weekly groups. A medicine person has been a guest speaker at the weekly Family Wellness Class (Tuesdays), Positive Indian Parenting Class (Wednesdays) and Recovery Group (Thursdays). The medicine person has also been a guest speaker in the Young Men's Group that meets weekly in the youth department at NAHC. Since NAHC has been a recipient of MHSA money for prevention and early intervention, two youth summits have been held which was a collaborative endeavor with other Native American agencies also serving youth, to again increase access to culture and traditional healers as requested in many needs assessments.

Wiping of the Tears, a Lakota ceremony to treat and bring closure to grief and loss was held at a well-frequented Native agency for the community at large. This ceremony was conducted as a result of a community talking circle that took place months earlier in which the medicine person made an assessment to treat the grief and loss expressed in that talking circle by conducting a Wiping of the Tears ceremony on his next visit. Wiping of the Tears ceremony has also been conducted privately for families.

In addition to seeing families and individuals in counseling sessions at NAHC, traditional healers have gone to the hospital to visit community members, to group homes and to the homes of community members to counsel or conduct ceremonies.

Naming Ceremony was identified in the December 11, 2007 focus group as an intervention that brought family pride and grounding to Native families. Since NAHC has been a recipient of the PEI funds three naming ceremonies have been conducted with a total of 12 people, adults and children, who have received names. One mother who had a naming ceremony for her two-year-old daughter speaks often about the significance of being able to pass this tradition down her daughter.

Before NAHC was awarded the Alameda County MHSA prevention and early intervention funding, this mother struggled trying to make arrangements for her daughter to receive a name. Going back to her homeland was too expensive and there was no one in the area from

her tribe that could conduct the ceremony. With this grant, NAHC was able to make arrangements for a traditional healer to come to California from South Dakota to conduct the ceremony. This mother was happy as the naming ceremony is important for identity formation.

Richard Moves Camp, Lakota, is one of the traditional healers brought to NAHC on a regular basis to see clients, conduct ceremonies, and train staff. He was one of the leaders instrumental in the passage of the American Indian Religious Freedom Act in 1978, which allowed for ceremonies that were previously outlawed to be practiced again. Having a medicine person come more often and on a regular basis to NAHC has increased opportunities for staff development and cultural competence training. Training was arranged with administrative support staff across all departments. Interns doing a practicum at NAHC benefited from this training as well as our professional staff such as physicians, psychiatrists and other providers.

This access to culture and ceremony for an urban Native population is a blessing. It is not always feasible for families to return to traditional homelands to have ceremonies and for some who are several generations removed from their traditional homelands, access may be improbable because of that disconnection. Some tribes no longer have a land base and others have lost ceremonies due to genocide.

COMMUNITY HISTORY CLASS

In the fall of 2010, NAHC hosted a six-week Native American community history class in Oakland, California so that community members could understand their own behavioral health issues by learning the history that is not told in United States history books and is distorted by the media.

The class was re-offered in the spring of 2011 for eight weeks as recommended by the participants in the first series with a focus on identity formation. The false portrayal of United States history in school curriculums was identified in the focus group as a cause of mental distress for school-age Native American children. These falsities about Native Americans were also identified in a prevention and early intervention focus group held on February~2, 2008 in Contra Costa County. Native family members report that this is very troubling, causing many Native children to loose interest in school, drop out, and have combative relationships with their teachers. One focus group participant said you "pay with your grade" if you challenge the schoolteacher about the truths in history that is currently being taught in the classroom. A community history class, inclusive of Native perspectives, was suggested as a solution in both the Alameda County and Contra Costa County focus groups, providing input to the prevention and early intervention planning process in their respective counties.

For some Native American children, going to school causes distress. In *A Broken Flute: The Native Experience in Books for Children,* there are many accounts of youth and adults describing this experience. One child had such a disturbing experience in the third grade that she dropped out of school and sought counseling (Seale & Slapin 2005).

Children are not the only ones that have had disturbing experiences as a result of invalidating school curricula. In our Community History Class participants expressed what a gift is was to learn the true history and have a safe place to respond emotionally to that history—without the reprisal they received in college classes. The history class empowered participants to survive going to schools with invalidating curricula, and have provided them with language and resources to challenge these curricula. It has also been a place where "you know you are not alone" as expressed by one participant in a written evaluation of the class.

Healing was an unexpected outcome of the community history class as evidenced in the written evaluative statement from a participant: "I have learned to accept myself, my ethnicity, the color of my skin and my background in a different and more loving way than ever before."

Healthy identity and self-concept are associated with good mental health. Identity and self-concept was attacked in the genocidal policies aimed at Native American children forced to attend boarding schools far away from families and communities with cultures that foster a positive identity and self-concept.

DISCUSSION

Community events are therapeutic for Native Americans because it brings community together in one place. Being together helps to heal from the genocidal policies that forced family and community members to be separated from each other and confined in restrictive environments such as boarding schools, reservations, asylums or foster homes. Gatherings allow for the corrective emotional experiences with friends and relatives that were disallowed by being separated from one another.

Another reason why events and gatherings are therapeutic is that for the duration of the event Native values are the norm. This provides some respite from a world in which you are often the only Native person in your job, classroom or school and where mainstream linear values are the norm—the opposite of Native American relational values. Environments with values opposite from your own can be exhausting because they are loaded with opportunities for micro aggressions—subtle and sometimes overt doses of racism—putting the Native person on the spot to educate, defend, or shut down. Being immersed in systems with values opposite from your own can be invalidating and detrimental to identity formation. Gatherings such as pow-wows create opportunities to be mentored

by peers, professionals or natural helpers in the community. These community events are especially therapeutic when community members are involved in planning the event.

While the therapeutic effects of events and gatherings are very clear to Native providers, it has been a task to educate policy makers to think of events and gatherings as therapeutic interventions and part of a behavioral health program. A common response that cultural brokers have gotten is "How are a pow-wow and mental health related?" This can be detrimental if the policy maker who does not see the connection is someone who is voting on whether or not your proposal gets funding. In 2008, this was the case in Alameda County, in which the Native American prevention and early intervention strategy at first did not receive a high enough score to be included in the county's PEI plan to be funded with MHSA money. Gratefully, after some deliberation, the decision to include the Native American strategy was reconsidered and it has been through this grant that NAHC has been able to provide cultural interventions on a consistent basis.

Part of the difficulty is seeing events and gatherings as therapeutic interventions may be the different ways in which mainstream mental health policy makers and other cultural communities conceptualize mental health (Satcher 2001). This may be as a result of an emphasis on individualism as a norm in the mainstream culture as opposed to an emphasis on relationships as a norm in many ethnic communities. Also the stress of having to operate outside your value system may not be understood by members of the majority culture as it is not something they experience with the same intensity that Native Americans experience it. The feelings of being alone and isolated from members of your own cultural background are hard to relate to if you do not experience it yourself (Wise 2005). Having no awareness of the genocide in United States because it is not taught in the history books may be hard for mental health policy makers to understand the need to heal from it.

CONCLUSION

The importance of having cultural options, talking circles, events and gatherings as part of a person's treatment array is summed up very well by a community member who comes to NAHC for clinical services as well as to the groups and events sponsored by NAHC. This person said, "If you use the metaphor of water, therapy is only one river. History and culture is an ocean."

This community member is an avid reader of bulletin boards at NAHC and often finds out on his own about the special events, eight-week series of classes offered three times a year, and the one time conferences sponsored by NAHC. This person keeps us on our toes to make sure we get the word out about events and groups that are beneficial to the community since he has relied on these events to bring stability to his life.

In conclusion, Native American systems of care, ancient and modern, have been providing preventive, holistic care that empowers individuals, families and communities for a long time. These Native values and practices can inform the transformation efforts of the mainstream system of care. Public behavioral health funds can help Native Agencies restore the systems of care that went into exile as a result of genocidal policies that made it illegal to be Native. This restoration could be considered a long-awaited form of repatriation for the premeditated extermination of Native Americans in the United States.

REFERENCES

California Department of Mental Health (CA DMH). 2011. *Mental Health Services Act* (*Proposition 63)*. Available at http://www.dmh.ca.gov/Prop_63/MHSA/default.asp

Churchill, W. 1997. *A Little Matter of Genocide Holocaust and Denial in the Americas 1492 to the Present*. San Francisco, CA: City Lights Books.

Cross, T. 1986. *Positive Indian Parenting Honoring our Children by Honoring our Traditions*. Portland, OR: Parry Center for Children.

Cross, T.; Bazron, B.; Dennis, K. & Isaacs, M. 1989. *Towards a Culturally Competent System of Care, Vol. 1*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Isaacs, M.; Huang, L.N.; Hernandez, M. & Echo Hawk, H. 2005. *The Road to Evidence: The Intersection of Evidence-Based Practices and Cultural Competence in Children Mental Health*. Washington, DC: The National Alliance of Multi-Ethnic Behavioral Health Associations.

Moves Camp, R. 2009. *Cultural Competence Training*. Oakland, CA: Native American Health Center.

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.

Satcher, D. 2001. *Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health*. Rockville, MD: Office of the Surgeon General.

Seale, D. & Slapin, B. 2005. *A Broken Flute: The Native Experience in Books for Children*. Walnut Creek CA: AltaMira Press.

Wise, T. 2005. *White Like Me: Reflections on Race from a Privileged Son*. New York: Soft Skull Press.