WALKING IN BEAUTY ON THE RED ROAD

A HOLISTIC CULTURAL TREATMENT MODEL FOR AMERICAN INDIAN & ALASKA NATIVE ADOLESCENTS AND FAMILIES

PROGRAM DESCRIPTION AND CLINICAL MANUAL

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PREFACE

This document is a program description and clinical manual for the *Walking In Beauty On the Red Road*: *A Holistic Cultural Treatment Model (WBRR)* for American Indian and Alaska Native (AI/AN) adolescents and their families. This manual is designed as a foundation for substance abuse treatment programs to develop and replicate residential treatment for American Indian and Alaska Native adolescents. This model was formulated for rural programs that may wish to adapt this model to fit local need.

This document was primarily developed by four individuals: 1) Candice Sabin, Ph.D.; 2) Hoskie Benally, Jr. BS; 3) Susan K. Bennett, LMSW; 4) Eleanor Jones, MA. The following staff at Our Youth Our Future, Inc. (OYOF) participated in developing modules and cultural aspects of the program: Margaret Bluehorse Anderson, Raymond Keeswood, Renita Anderson, Tom Goodluck, Orlando Pioche, and other staff.

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“It Is Finished In Beauty”

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INTRODUCTION

OYOF opened in 1989 and evolved a 12-step program to an integrated model that provided Western and indigenous cultural services to our AI/AN youth and their families through the promotion of a holistic and drug free lifestyle. In 1997, in an effort to develop evidence-based AI/AN specific treatment, OYOF developed and implemented a two-year pilot project that evolved a cultural specific model to improve adolescent success in treatment. Subsequently, from 1999-2003, the model was evaluated through CSAT's initiative on Adolescent Treatment Models, formerly known as the funding initiative on Exemplary Adolescent Treatment Programs.

This manual describes the *Walking In Beauty On The Red Road* Model that was implemented and evaluated at the OYOF residential treatment center in Shiprock, New Mexico, Dine' Nation. The primary goal is to reduce the substance abuse epidemic affecting AI/AN youth and to help positively transform negative aspects of subsequent behavioral health and social issues. This model is dedicated to identify and address the spiritual and cultural needs of our youth and their families.

This treatment manual provides insight into how to interweave indigenous cultural beliefs and teachings with Westernized approaches while providing therapeutic treatment services. Current research has shown that cross-cultural treatment enhances therapeutic treatment when such services compliment the overall treatment process. Integrated indigenous cultural and Western approaches within a continuum of care context have been developed and implemented by American Indian professionals with positive and effective outcomes for AI/AN adolescents and their families affected by AOD and related underlying mental health disorders.

This manual encapsulates our hope for AI/AN people to write and implement their own cultural evidence-based treatment models. It is important for AI/AN people have a voice in the style and manner that treatment is assessed and implemented. This is especially true given the national trend for evidence-based treatment models that many times do not fit AI/AN cultures because these models lack of a flexibility and inability to serve as a living model for these communities.

Since the implementation of this model significant time has passed. This manual begins with a discussion of OYOF's history and evolution, an overview of AOD, and the behavioral health status of AI/AN adolescents. Next, we describe the general theoretical assumptions relating to AI/AN regarding how cultural specific beliefs are integrated. We briefly discuss culturally appropriate communication and interaction with Indian people. Finally, we provide descriptions of the treatment program components, clinical documentation, quality assurance process, program evaluation results, and program costs. Please note OYOF will be referenced as the program throughout the document.

I. ORGANIZATION HISTORY AND PROGRAM EVOLUTION

Our Youth, Our Future, Inc. (OYOF) is a private 501 (c)(3) non-profit organization incorporated both in the State of New Mexico and the Navajo Nation. OYOF has provided residential substance abuse and behavioral health treatment to over 1400 American Indian and Alaska Native adolescents and families. Established in 1989 in Shiprock, New Mexico, OYOF was funded through the 1986 Omnibus Bill that mandated substance abuse treatment for AI/AN people. OYOF was accredited through the Joint Accreditation of Hospital Organizations as a behavioral health facility, and was certified/licensed by the New Mexico Department of Children, Youth, and Family. The academic component or school was accredited through the North Central Association. OYOF employed over 48 American Indians at the treatment program. OYOF also received funding through Indian Health Services (IHS) and the New Mexico Medicaid program. The residential program closed in December, 2003, due to lack of continued funding.

In 1989, OYOF admitted their first adolescent into a typical 12-step model with an Adventure Based Counseling component. A medical model for treatment services was used and staff conducted no assessments to determine eligibility. The milieu was confrontation-shame based with minimal emphasis on culture. Treatment consisted of group and individual sessions with the counselors spending an average of three hours daily with their clients. The average successful completion rate was 53%, and many of the non-completers often exhibited behavioral dysregulation (e.g. the inability to resist an impulse and exercise self-restraint). At that time only 33% of the families attended treatment with their adolescents. The success of the program was not determined by any systematic follow-up data.

In 1997, OYOF made a two-year pilot organizational shift to address the behavioral health and social issues that adolescent and families were facing. This pilot project identified protective and risk factors and determined the factors that supported identification, engagement, and retention into treatment. Three levels of care were implemented to catalyze the successful completion of treatment and to cause a subsequent decrease in substance usage and other behavioral health and social issues. As a result of this project, we identified and implemented changes to the existing model. Some of the main tenets that were implemented included:

- The idea that treatment is a form of learning and one needs to understand different learning styles to individualize treatment and to improve outcomes.
- The need to identify and develop culturally and developmentally appropriate assessments.
- The belief that stages of change models help increase the likelihood of behavioral change.
- The need to identify behavioral management techniques and cognitive treatment modalities to support improved outcomes.
- The need to identify and address the co-occurring issues that negatively impact treatment success.
- The need to identify and implement cultural/traditional activities and ceremonies to engage families in treatment.
- The need to integrate western/medical model with the cultural traditional model of wellness into the group, individual, family, and treatment milieu.

- The need to implement a neurological milieu that utilized *"carefrontation"* not confrontation.
- The need to identify specific training needs of staff to implement best practices.
- The need to implement a full outcome based procedure to determine long-term success.
- The need to develop and involve a community network consisting of courts, probation officers, school officials, Tribal programs, and Indian Health Services.

As a result of this initial two-year study, OYOF decided that its mission and vision statement needed to be updated to correlate with the program's new model. The mission and visions statements were revised to read as follows:

Vision Statement

Our Youth, Our Future, Inc. is committed to assisting, empowering, and advocating on behalf of our adolescents and their families in their pursuit of a holistic drug-free lifestyle.

We must employ constructive means of alleviating barriers to treatment created by political divisions, inappropriate treatment approaches, cultural discrimination, and other obstacles.

We will foster collaboration to establish the vitally needed continuum of care that enhances the opportunity for recovery and sobriety.

Mission Statement

We are personally, professionally, and spiritually dedicated to establish and provide the highest standard of therapeutic care and a broad continuum of services in the treatment of alcohol addiction and other substance abuse along with co-occurring mental health disorders of adolescents.

We are dedicated to promoting the spiritual, emotional, mental, and physical well being of these adolescents and their families in their pursuit of a productive lifestyle.

II. OVERVIEW OF AOD AND BEHAVIORAL HEALTH STATUS OF AI/AN ADOLESCENTS

A. Prevalence of Alcohol and Other Drug Abuse (AOD)

The problem of AOD abuse is significant to the AI/AN community. Alcohol disorders, although not as rampant as stereotypes might suggest, are disproportionately prevalent in the AI/AN population, and are associated with a variety of social problems. Although tribes differ in general alcohol use rates, with overall rates less than the overall U.S. population, the general prevalence of *problem drinking* in AI/AN populations is substantially higher than overall U.S. rates, often by a factor of two or three times (see May, 1994, for detailed review). Brian McCaffrey (2000), the drug control adviser for the Clinton administration, reports that 19.6 percent of American Indian teenagers used illicit drugs, the highest rate of any group in the country. The national average for adolescents ages 12 through 17 is nine percent. While Indians as a whole drink alcohol at a lower rate then the general population, the alcohol-related deaths among Indian adolescents ages 15 to 24 are 17 times higher than the national average. For example, in the National Household Survey of Drug Use, the Substance Abuse and Mental Health Services Administration (SAMHSA, 1998), reported that the rate of *any* alcohol use in AI/AN populations was similar to overall population rates; however, the rate of alcohol dependence was 60 percent higher. Because general population surveys often focus on sustained heavy drinking or dependence, they may underestimate AI/AN rates of alcohol-related problems due to drinking style differences in AI/AN populations, where binge drinking is more common (May, 1994; Weisner, Weibel-Orlando, and Long, 1984).

The toll taken by alcohol-related problems on the AI/AN community in which 70 percent of the population lives off the reservation, is particularly staggering. For example, the death rate due to cirrhosis is 2.7 times that of the overall population rate, and the rates of alcohol-related hospital admissions, suicides, and automobile accidents are significantly elevated (Hisnancik, 1994; Lincoln, 1999). Overall alcohol-related mortality for AI/AN populations has been found to be almost four times that of Caucasians, although the rates vary from tribe to tribe (Christian, Dufour, and Bertolucci, 1989). In addition, several of the leading causes of death for AI/AN people between the ages of 15 and 44 years involve behaviors that are often AOD abuse related, such as suicide, homicide, or motor vehicle accidents. Although the AI/AN death rate due to alcoholism has declined 17 percent since 1980, this trend has shifted in recent years. Since 1990, the proportional rate has risen to seven times that of all races in the United States (Lincoln, 1999).

Most Indian adolescents by the age of 15 have tried alcohol and other drugs and the average age of first experimentation appears to be dropping (Taylor, 2000; Moncher, Holden, and Trimble, 1990). Beauvais (1996) reports that 74 percent of reservation Indian adolescents between seventh and twelfth grade have tried alcohol and 51 percent have become intoxicated. Other studies have reported rates of Indian adolescent alcohol use (lifetime prevalence) from 56 percent to 89 percent (May, 1982). Moncher et al. (1990) reported that 50 percent of non-reservation AI/AN adolescents and 80 percent of reservation AI/AN adolescents used alcohol on a moderate level compared to 23 percent of urban, non-Indian adolescents. AI/AN adolescents report higher rates of marijuana use ranging from 41 to 62 percent versus the U.S. general adolescent population of 28 to 50 percent. Inhalant abuse for the AI/AN adolescent is 17 to 22

percent versus 9 to 11 percent of adolescents in the general population. However, a wide variation occurs among tribes.

The potential adverse consequences of AOD abuse with Indian adolescents include a higher involvement with the juvenile justice system, increased mental health problems, and lower educational achievement. In addition, parental AOD abuse may lead to increased levels of child maltreatment and family problems that can potentially compound the risk for juvenile system involvement, mental health or educational problems, and youth involvement in AOD abuse.

B. Juvenile Justice System Involvement

LaFromboise (1988) reported that Indian people in urban areas are taken into custody for violations committed under the influence of drugs or alcohol four times as often as blacks and ten times as often as whites. Indian adolescents are over-represented in the juvenile justice system and have the second highest rate of juvenile correctional incarceration of any racial group (Duclos, Beals, Novins, Martin, Jewett, and Manson, 1998). Poupart (1995) examined juvenile court records from 1985 to 1989 in a rural Wisconsin county with a substantial (7.14 percent) American Indian population. Four decision points were analyzed: intake, detention, filing of a petition, and final disposition. At intake, 62.7 percent of American Indian youths were referred to the prosecutor compared with 38.7 percent of white youths. At each additional step in the process, native youth were more likely to experience a more severe outcome. Although AOD abuse is not the sole factor resulting in disproportionate juvenile justice system involvement among AI/AN youths, it is a prevalent factor in crimes occurring in Indian country. AOD use has been found to be a factor reported in 55 percent of violent crimes committed by American Indians, compared 44 percent for whites and 35 percent for blacks (Bureau of Justice Statistics, 1993).

C. Mental Health Status

Co-occurring emotional and behavioral disorders are prevalent among Indian adolescents (Duclos et al., 1998), and Indian adolescents who receive substance abuse treatment have a higher prevalence of co-occurring psychiatric disorders than their non-Indian counterparts Co-occurring disorders may be associated with a complex and interrelated group of risk factors: trauma or abuse, chronic environmental stress, poverty, social isolations, family problems, or parental psychopathology. Windle (1990) reports that familial influences (e.g., harsh disciplinary practices, marital discord, and parental psychopathology) have been consistently related to antisocial behavior and substance use in childhood and adolescence in general.

D. Abuse, Trauma, and Victimization

The 1978 Indian Child Welfare Act reports that the risk that AI/AN children have of experiencing child maltreatment is twice as high as for children in the general population. In a survey administered to 297 Indian adolescents attending a high school (grades nine through twelve) in a large southwestern Indian community, 51 percent of the students reported that they had experienced a traumatic event, with 37 percent experiencing more than one such event, and 16 percent reporting four or more events (National Center for American Indian and Alaska

Native Mental Health Research, 1999).

Child neglect has been reported to be especially prevalent among AI/AN families, although prior to passage of the Indian Child Welfare Act of 1978 (that recognized sovereign status to the tribes), concerns were raised that Native cultural practices were often mislabeled as neglectful behavior. More recent studies suggest that AI/AN child neglect cases are far more likely to be alcohol involved than among other populations (DeBruyn, Lujan, and May, 1992). In a survey of 2,037 AI/AN cases served by federally funded programs, substance abuse was reported to be present in 76 percent of neglecting fathers and in 78 percent of neglecting mothers, and was more likely to be associated with neglect than with either physical or sexual abuse (National Indian Justice Center, 1992).

When combined with a history of parental AOD problems, histories of abuse or maltreatment are associated with an increased risk of adolescent AOD problems. In a recent study of 4,023 adolescents (139 Indian adolescents) twelve to seventeen years of age, victimization and witnessed violence were found to double the risk of past-year alcohol and other substance abuse/dependence (Kilpatrick, Acierno, Saunders, Resnick, Best, and Schnurr, 2000). In addition, this study found that witnessing violence tripled the risk of abuse/dependence for all substances after the effects of demographics, familial substance use, and victimization were statistically controlled. The direct or indirect impact of witnessed violence on children and adolescents has been well documented (Bean, 1992; Ireland and Widom, 1994; Fitzpatrick and Boldizar, 1993; Groves, 1997; Kilpatrick et al., 2000; Ollendick, 1996; Swaim, Oetting, Edwards, and Beauvais, 1989), and prevalence rates of domestic violence among AI/AN populations have been reported ranging from 52 to 91 percent (Fairchild, Fairchild, and Stoner, 1998); Robin, Chester, and Rasmussen, 1998). Substance use may be used as a strategy to cope with the stress produced by experiencing or being exposed to interpersonal aggression. Kilpatrick, Acierno, Resnick, Saunders, and Best (1997) suggest that the use or abuse of substances following assault may be an effective, but maladaptive, strategy to reduce negative feelings. However, after controlling for the effects of demographics, familial substance use, and abuse or other forms of violent victimization, it was found that witnessing violence was among the most powerful risk factors for substance use disorders and negative affective states.

E. Prevalence of Suicide

Suicide is a complex behavior usually caused by a combination of factors. The majority of people who complete suicide have a diagnosable mental or substance abuse disorder or both, with the majority having a depressive illness (Surgeon General, 1999). From 1979 to 1992, suicide rates for AI/AN were about 1.5 times the rate for the general population (Surgeon General, 1999), with a disproportionate number occurring among young male American Indians (ages fifteen to twenty-four). This group accounted for 64 percent of all suicides by AI/AN. During the twelve months preceding the 1999 Youth Risk Behavior Surveillance Survey, one of five AI/AN adolescents (20.7 percent) seriously considered suicide with 17.6 percent making a suicide plan, 13.6 percent attempting suicide, and 4.4 percent requiring medical attention as a result of a suicide attempt.

F. Academic Status

A significant number of AI/AN students continue to attend Bureau of Indian Affairs (BIA) funded schools (U.S. Department of the Interior, 1988). Approximately 13,400 Indian adolescents currently attend boarding school, constituting about 14 percent of the AI/AN high school population. This percentage of students in BIA boarding schools is expected to increase as Federal and Tribal educators continue their struggle to strike a reasonable balance between local access to schools and educational quality, resulting in a re-centralization of some instructional resources (Development Associates, 1983). Indian boarding schools have been criticized for providing substandard education and fostering an unsafe environment for Indian adolescents. On the same note the public school system is also struggling to provide an appropriate environment for the Indian student to be successful.

All adolescents need knowledge and skills to compete in today's employment market. It is not enough to merely get by in school; one must excel in order to ensure a productive adulthood. Many AI/AN students who are indifferent toward school skip classes and drop out at high rates. Chavers (1991) estimates the dropout rate for Indian adolescents at 50 percent. In some Indian communities the dropout rate is 100 percent after the ninth grade. Traditional Western educational approaches may be incongruent with AI/AN learning styles or culture, potentially contributing to school disengagement.

Researchers all agree that AI/AN students with a strong sense of cultural and personal identity were more likely to have academic success and found no support for argument that traditionalism had a negative effect on academic success of the Native student (Willeto, 1999; Cummins, 2000; Cleary and Peacock, 1998). Instead, they found that "The key to producing successful Indian students in the BIA and public school system is to ground them in their AI/AN belief and value systems."

G. Impact of Historical Issues

The AI/AN people in the past were forced, and now seduced, into believing residential/boarding schools were the best way to educate and promote productivity in their children's lives. This has led to one of the main historical issues that our American Indian and Alaska Native adolescents face today. Many of today's AI/AN adolescents, parents and elders did not learn how to parent, and subsequently passed on the cultural loss, shame, and severe psychic pain of the cultural genocide they experienced. This cultural loss may have led to violence, domestic violence, severe child maltreatment (e.g. emotional, physical, and/or sexual abuse) and the use of alcohol and other substances to manage their lives. This genocide and the lack of assimilation has resulted in severing of their ancestral heritage and many of the AI/AN adolescents are culturally adrift, lacking a firm AI/AN identity, and continuing the proliferation of poverty, and other social problems.

Approximately 61 percent of adolescents admitted to OYOF treatment had attended residential/boarding schools. In light of the severity of AOD abuse and family problems in the lives of these adolescents, one could postulate that the core of these issues might stem from intergenerational transmission as a result of residential/boarding school experiences.
In current residential/boarding schools little or no parenting exists and many times the children/adolescents learn from their peers. A large deviant peer relationship to AOD abuse occurs and little parental/adult guidance is offered. Developmentally, the age that a child is

placed in a residential setting (sometimes as early as age four) can be devastating to the child and have a negative developmental impact.

Unfortunately, minimal scientific study looking at the impact of these experiences on lifetime AI/AN adolescent development has occurred. More attention needs to be focused on the historical relationship of residential/boarding school attendance and today's AI/AN substance use and severe family problems.

H. Treatment and Outcome Studies

American Indian and Alaska Native adolescents are an understudied population and limited literature exists on the treatment population, or on their response to common treatment approaches. Some evaluation studies have been conducted on AI/AN *adult* populations and have found disappointingly low rates of success in existing alcohol rehabilitation programs (Kline and Roberts, 1973; Lang, 1974; Snake, Hawkins, and LaBoueff, 1977; Towle, 1975; Weibel-Orlando, 1984). May (1986) reviewed Indian alcoholism programs and reported that they were inadequate to meet the needs of the Indian communities, both in terms of accessibility and cultural competency. Conventional western alcohol services have been described as a poor fit with native cultures, and the treatment approaches themselves may create unique barriers to service delivery. For example, confrontation techniques, confession-like disclosure of personal problems, or a complete emphasis on non-native religious precepts may be perceived as unhelpful or culturally incongruent for many AI/AN people. Also, programs in which staff is largely or exclusively nonnative, or [programs] located well outside AI/AN communities may also present cultural barriers. Alcohol treatment programs, incorporating native cultural approaches such as traditional healing methods and concepts have begun to appear in AI/AN communities. A number of these approaches have been described in the adult substance abuse treatment literature (see Abbot, 1998 for a review of many of these programs). Most represent a blend of American Indian and Western approaches, consistent with the fact that many Indian people use two health care systems - the mainstream medical system and traditional healers or medicine people (Coulehan, 1980; Stewart, May and Muneta, 1980).

Among Western treatment approaches, cognitive/behavioral and motivational interviewing techniques may be a potentially better fit with many native cultures. Mariano, Donovan, Walker, Mariano, Walker (1989) examined cognitive behavioral techniques and other social skills training approaches among AI/AN problem drinkers, noting that these techniques may be more easily adapted to AI/AN populations. This is due to the focus on specific patterns of behavior rather than a focus on changing philosophical, religious, or social belief systems. Motivational interviewing approaches also may be good choices because they explicitly avoid heavy confrontation, confessionals, or imposed problem definitions.

Currently no published randomized clinical trials exist that compare alcohol treatment programs incorporating traditional AI/AN cultural components with purely majority culture-based approaches. However, limited data suggest that incorporating Native American cultural elements may improve service access and retention, and possibly outcomes. First, affiliation with AI/AN culture in general may be associated with improved outcomes. Westermeyer and Neider (1984) examined ten-year follow-up data for adult AI/AN alcoholics exiting treatment. Clients having predominantly AI/AN friends and higher affiliation with AI/AN culture were found to have better outcomes. Walker, Benjamin, Kiviahan, and Walker, (1989) reported on a small sample quasi-experimental comparison of an Indian-specific program with a more general

treatment program. No differences were found in outcomes for service completers, but service utilization and retention was better in the Indian-specific program. Gutierres and Todd (1997) reported that AI/AN men and women stayed in treatment longer than their cohorts if they had participated in a culturally sensitive residential program. Fisher, Lankford, and Galea (1996) compared retention rates before and after changing to an approach emphasizing native lifestyles and beliefs in an Alaskan program. Their retention rates for AI/AN clients, which had lagged behind the rate for other racial groups, improved after clients changed to a more native culture-based approach, and subsequently their retention rates were similar to other racial groups.

Our experience at OYOF has echoed these findings. Prior to instituting a cultural model for youth in the residential AOD treatment program, retention rates through treatment completion were less than 54 percent. Within one year after incorporating AI/AN cultural practices and personnel, retention rates increased to 83 percent and increased to 88 percent by 2002. Therefore, in the development of the theoretical assumptions model, focus was placed on treatment modalities that would support and sustain AI/AN adolescents in successfully completing treatment. This would be accomplished through the interweaving of AI/AN traditional ceremonies, teachings, and activities with conventional western therapies. This model incorporates the traditional components that correlate with the Tribal lifestyle and beliefs.

III. GENERAL THEORETICAL AND OTHER ASSUMPTIONS

The theoretical assumption of this model is that the acculturation of many American Indian and Alaska Native (AI/AN) adolescents into their ancestral heritage has been incomplete or disrupted. Minority stress, exposure to child maltreatment, violence, intergenerational trauma, and/or lack of adequate parenting may have contributed to their substance abuse problem and to a range of possible co-occurring behavioral health, social issues, and academic achievement.

The model is designed to produce successful bicultural skills that facilitate one to adapt his/her behavior appropriately according to the cultural situation. The use of this model will also develop a firm AI/AN cultural identity. This AI/AN culture-focused and spiritual model offers cultural teachings, activities, sweat lodges, and other traditional ceremonies to foster client cultural pride, identity and values that support a harmonious lifestyle. This model assumes that sobriety, the ability to develop bicultural competence, the adolescent's competency regarding ethnic socialization, and the acquisition of a positive cultural identity are highly interdependent. High ethnic socialization skills and a strong cultural identity may serve as protective factors to decrease minority and environmental stress. In addition, cultural ceremonies develop and reinforce competencies that promote positive cultural identity, self-esteem, and a firm peer support system. Finally, the model supports both abstinence and harm reduction principles when abstinence is placed at risk. The overall model allows adolescents to evolve a framework to recognize and acquire skills of cross-cultural interdependence. While Navajo cultural beliefs and traditions provide the foundation of the OYOF model, the goal of this manual is inter-tribal and thus integrates other tribal beliefs and traditions.

A. Language of Spiritual Dialogue

AI/AN communities have strived for the right to maintain their languages and cultures. They have won that right legally but continue to lack the effective right. An effective right means to possess the means to access the knowledge, strategies, and resources necessary to resist destruction of one’s languages and cultures (Cantoni, 1996). Basically, those disenfranchised do not always have the tools to implement their legal rights. It is important that an effective solution be found to reverse languages and culture loss. Languages and cultures contain generations of wisdom, reaching far back into antiquity. Languages contain a significant part of the world's knowledge and wisdom. When a language is lost, much of the knowledge that the language represented is gone. Language is the way we express our being, thinking, seeing, and acting. Anthropologist Russell Bernard wrote:

> Linguistic diversity...is at least the correlate of (though not the cause of) diversity of adaptational ideas about transferring property (or even the idea of property itself), curing illness, acquiring food, raising children, distributing power, or settling disputes. By this reasoning, any reduction of language diversity diminishes the adaptational strength of our species because it lowers the pool of knowledge from which we can draw. We know that the reduction of biodiversity today threatens all of us. I think we are conducting an experiment to see what will happen to humanity if we eliminate cultural species in the world. This is a reckless experiment. If we don't like the way it turns out, there's no going back. (1992, p.82)

This vicious cycle of language and cultural shift is difficult to break and has led to the destruction of community infrastructures and the proliferation of many social problems that continue to protract the language shift. Language shift fosters dysfunctional behavior and results in a continuous breakdown of the society. For AI/AN people language loss coupled with the traumatic effect of the boarding schools have led to the breakdown of extended families. The extended family system is the central way of life for AI/AN people. Such extensive damage has been inflicted on AI/AN cultures that some people appear fatalistic about language loss and feel unable to solve the social problems associated with cultural unraveling.

Language also carries an unspoken network of cultural values. These values may not be on an overt level, however, they do shape each individual's self-awareness, identity, and interpersonal relationships (Scollon & Scollon, 1981). These values are important psychological correlates that help generate and maintain an individual's level of comfort, self-assurance, and consequently, success in life (Reyhner, 1996)

For many of AI/AN youth, culture and native language have been separated and they are trying to walk in two worlds with only one language that is from the dominant culture. This creates a very complex and stressful life. If, in addition to their native language, they learn to understand the hidden network of cultural values, this will add to their knowledge and skill development. This will serve as support in coping with cross-cultural values.

The OYOF program believes that without the knowledge of their native language and the concept of extended family, the AI/AN adolescent is cut-off from their elders, traditional community knowledge, and family values that are part of their rightful heritage. We look forward to a time that AI/AN people will not only be bilingual but also will be bi-literate, bi-cognitive, and bi-affective.

In this model, we stress that the native language be used whenever possible with interpreters and native language speaking clinicians. Non-speaking clinicians should be taught critical words and concepts to engage the adolescent and family. It is assumed that everyone interprets their language by making pictures in their head. This is not always the case with someone who knows more than one language. A good example of this was expressed by a Blackfoot speaker, Amethyst First Rider, at the 2003 Language of Spirituality Dialogues. She stated that even the simplest things in English, such as "The man is riding a horse," creates pictures in her mind, but when she says the equivalent in Blackfoot, no pictures are created only the feeling of riding (using horse-riding body motion). This is consistent with a kinesthetic (body-feeling) and illustrates the importance of understanding how individuals experience their world. This is especially true when treatment is involved and requires a major shift in thinking, feeling, and behaving. Program staff along with adolescents and their families need to be educated on their individual and cultural styles of experiencing their world. One crucial teaching concerns the difference between how Euro-languages and AI/AN languages are experienced and processed. Euro-languages are also produced orally, perceived auditorily and understood visually. AI/AN languages are produced orally, perceived auditorily and visually, but understood kinesthetically. The question, proposed by many, is whether knowledge can be collectively remembered longer kinesthetically than visually. This is an important aspect for the AI/AN adolescent when learning knowledge about their culture from elders.

A primary teaching that is modeled for and given to the adolescents is: "Your words are powerful and they either make you or break you...choose your words carefully and prayerfully...because words can profoundly affect one's health either through saying hurtful or loving things to our selves and others." The staff begins to teach the adolescent how to speak

appropriately to one another with respect. Adolescents have a tendency to say hurtful things when angry or teasing, and the teachings model how and why this is not acceptable. These teachings allow adolescents to shift and begin their healing. They are not allowed to talk their slang and gang ways and must use respectful language at all times. The adolescents are taught to introduce themselves according to their tribal ways (clanship or totem animal etc.) and how to greet others appropriately. Families observe that their child is more respectful when greeting them.

During cultural activities and ceremonies, the adolescents may not understand the words as many are conducted in the Navajo and/or Sioux languages. Though they are encouraged to hear and feel the words of the ceremony. It is believed that the words in the Navajo chants create a healing at a vibratory level and one does not have to understand the meaning of the words to receive healing. All adolescents are given this teaching and are prepared to enter ceremonies to receive a healing whether or not they understand the Native tongue. Staff, adolescents, and their families are afforded the opportunity to understand such Native language dynamics through training and education. This opens a whole new world for everyone to reframe their current life experiences.

B. Alternation Theory and Ethnic Socialization

1. Alternation Theory

Cultural competence has no single definition on which all scholars can agree (Segall, 1986). However, this model defines cultural competence as a combination of cultural knowledge, social skills, and personal attitudes. This includes a person possessing:

1. a knowledge of cultural beliefs and values,
2. positive attitudes towards majority and minority groups,
3. bicultural social efficacy,
4. bicultural communication ability,
5. a diverse role repertoire, and
6. a sense of being grounded in the culture (LaFromboise, Coleman, and Gerton, 1993).

Five patterns of cultural adaptation have been proposed for understanding bicultural functioning: 1) assimilation, 2) acculturation, 3) alternation, 4) multiculturalism, and 5) fusion (LaFromboise et al., 1993). The alternation pattern appears to be the most fluid and supportive pattern for attaining cultural competence. In this pattern, it is possible for an individual to know and understand two different cultures, and have the ability to alter behavior to fit the particular social or cultural context. Ogbu and Matute-Bianchi (1986) have noted, "it is possible and acceptable to participate in two different cultures or to use two different languages, perhaps for different purposes, by alternating one's behavior according to the situation" (p.89).

Many AI/AN people function in this bicultural pattern. McFee (1968), studying individuals on the Blackfeet reservation, found that many Indians were knowledgeable about both Blackfeet and Anglo-American cultures and were able to interact easily with members of each group, providing they were not perceived by the minority group as being overly identified with the majority group. Boyce and Boyce (1983) studied the

relationship between reported illness among Navajo students and cultural background. This study was conducted on first-year students at a reservation boarding school (the primary mechanism for acculturating Indian people until the 1970s). It found a significant positive association between the number of clinical visits, referrals for health or psychosocial problems, and the degree of cultural incongruity (dissonance between family and community cultural identities). This suggests that imposed acculturation, as opposed to bicultural alternation, might have a deleterious impact on health related behaviors, possibly including alcohol and other drug abuse.

The literature suggests that cultural minorities can become biculturally competent without experiencing psychological problems, totally assimilating, or retreating from contact with the majority culture, and that bicultural alternation may be a particularly adaptive pattern for AI/AN youth. This is supported through educational performance, where bicultural Indian college students have been found to be better adjusted, specifically in the academic and cultural domains, than their non-bicultural counterparts. A higher degree of participation in cultural activities, enrollment in American-Indian-oriented college courses, and a perception of their Indian heritage as an advantage resulted in higher grade point averages, more effective study habits, and a better utilization of resources to support academic success (Schiller, 1987). Individuals who have the ability to effectively alternate their use of culturally appropriate behavior also have been reported to demonstrate a higher cognitive functioning and mental health status than individuals who are monocultural, assimilated, or acculturated (Garcia, 1983; Rashid, 1984; Rogler, Cortes, and Malgady, 1991). One study of Navajo children from five elementary schools in Arizona (Beuke, 1978) revealed that students in the high-Indian/high-Anglo cultural identification category had significantly higher self-esteem scores than those in the low-Indian/low-Anglo category.

2. Ethnic Socialization

A number of authors stress the importance of focusing on the bicultural social skills of individuals in a cultural minority group who are experiencing difficulties within the majority culture. They have specifically suggested that bicultural skills are appropriate for helping AI/AN youth combat substance abuse and other mental health issues (LaFromboise, 1983; Schinke, Botvin, Trimble, Orlandi, Gilchrist, and Locklear, 1988). The ability to develop bicultural competence is based on one's level of ethnic socialization. Ethnic socialization is the cultural transmission of values and beliefs that is a part of effective individual and family functioning (Stevenson, 1996). Ethnic socialization consists of protective factors that promote the youth's ethnic heritage (e.g. history, cultural values, and teachings), and provide positive ethnic role models, exposure to cultural activities, and strategies for effectively negotiating oppressive circumstances within a multicultural society (Stevenson, 1996). Many AI/AN adolescents have limited ethnic socialization and remain without a sense of grounding within their own American Indian culture. American Indians in general have experienced generations of pressure to abandon AI/AN culture and assimilate into the majority culture.

C. Theory of Wellness and Unwellness

It is common knowledge in providing therapeutic services that the clinician will benefit by utilizing the strengths of a given client as a means to meet their individual needs as part of the rehabilitative effort. This provides an essential requirement for a clinician to develop and establish the adolescent alliance for a meaningful therapeutic relationship. The establishment of this pivotal adolescent-therapist relationship will require a therapist to examine their own personal and professional bias when treating AI/AN adolescents and their families.

AI/AN adolescents will have their own belief system and cultural philosophy on which they base their perspective and understanding of their existence and purpose in life. Although, they may use Western medical and therapeutic services, in most instances they will also have some reliance on their cultural beliefs and ceremonies in an effort to restore personal wellness. AI/AN adolescents may use Western medicine and cultural ceremonies simultaneously for healing and for gaining some understanding of their current adverse circumstances of unwellness. Therefore, it is an advantage for the medical or therapeutic professional to gain some understanding of the cultural beliefs of a given patient or adolescent to gain insight into the strengths for their integration into the medical or therapeutic process.

To acquire a level of competency in the integration of Western approaches with cultural beliefs and practices, a professional must become respectful and educated in regards to specific cultural aspects of the American Indian Nation with which they are interfacing services. Each Indian tribe has their own history, customs, ceremonies, language, and philosophy. Each Indian tribe has their own unique perspective of wellness and unwellness as well as, how they culturally address the prescription for a healthy lifestyle and adverse health issues. Also, each Indian tribe has cultural teachings to foster the ultimate goal of gaining an understanding of truth, knowledge, and acquiring wisdom.

American Indians share some commonalities in philosophy and beliefs towards the ultimate goal of achieving and maintaining balanced harmony. Balanced harmony refers to total wellness in the spiritual, emotional, mental, and physical dimensions of a given person that is commonly described as holistic wellness. Commonly shared beliefs include: 1) honoring Mother Earth and Father Sky, 2) viewing their earthly existence as a day-to-day ceremony in traveling the Circle of Life from infancy to old age, 3) spiritual respect for the four sustaining elements of Life of Grandfather Fire, Medicine Water, the Atmosphere of Life, and Mother Earth, as well as for all Creation. At an Inter-tribal level, spiritual beliefs and teachings are shared through Medicine Wheels of healing, Sweat Lodges, Sun Dances, Pow-Wows, and the Native American Church (NAC). A person may retain their own tribal beliefs but also, adopt the beliefs of another tribe by participating in certain rituals or ceremonies.

There are 567 federally recognized Indian Nations in United States. In spite of the enormous diversity among the tribes, they share a number of universal health, illness, and prevention beliefs.

1. American Indians/Alaska Natives have a belief in a Supreme Creator. In this belief system there are lesser beings.
2. Man is a three-fold being made up of a body, mind, and spirit.
3. Plants and animals, like humans, is part of the spirit world. The spirit world exists side-by-side and intermingles with the physical world.
4. The spirit existed before it came into a physical body and will exist after the body dies.

5. Wellness is having balanced harmony among the body, mind and spirit.
6. Illness affects the mind and spirit as well as the body.
7. Unwellness is disharmony in body, mind, or spirit.
8. Unwellness impacts the individual and their extended family
9. Natural unwellness is caused by the violation of a sacred or tribal taboo.
10. Unnatural unwellness is partially caused by witchcraft.
11. Each of us is responsible for our own wellness.
12. Death is not an enemy but a natural phenomenon of this earth walk.

The Navajo People identify themselves as Earth Surface People, the Five Fingered Ones, and Holy Beings. They believe their purpose on this earthly journey is to seek, establish, and advocate harmony, so as to *Walk In Beauty* on the *Corn Pollen Path*. They view total wellness as *Walking In Beauty*, meaning they are in balanced harmony in achieving holistic wellness within their spiritual, emotional, mental, and physical beings.

Navajos believe there are spiritual beings in each of the *Four Sacred Cardinal Directions*, known as *Holy People*. Each direction holds specific songs, prayers, gifts, seasons, and teachings, which provide meaning and guidance to achieve balanced harmony. As an example, the east direction holds the *Spirit of Spirituality*, the south direction holds the *Spirit of Emotional Stability*, the west direction provides *Mental Wellness*, and the north direction holds *Physical Health*. As for the *Seasons of the Year*, spring is in the east, summer in the south, autumn in the west, and winter in the north.

The *Circle of Life* for a Navajo begins in the east direction at the time of birth, in reaching the south direction as a young adult at the age of 25 or 26, reaching the west direction at the middle age of 51, and moving on to the north direction at the age of 76. Traveling from the north direction back to the east into the Old age of 102 completes the *Circle of Life*. When traveling this *Circle of Life*, we will encounter adversities of various circumstances that will result in experiencing *Hardship, Suffering, Loneliness, and Jealousy*. These adversities will negatively impact our spirituality, emotions, mental, and the physical aspects of whom we are causing disharmony and unwellness.

When we are experiencing a *Life of Disharmony*, we will manifest such adversities through unhealthy behaviors and attitudes within our professional careers, in our daily personal lives and our interaction with others including family members, friends, or people in general. The affects of stress, worry, lack of rest, unhealthy eating habits, and other dysfunctional beliefs that will negatively impact our physical health.

Similar to other AI/AN people, Navajos have their own beliefs of what causes unwellness. This may be related to the violation of natural laws, lack of self-discipline, contact with certain natural processes (e.g. exposure to lightening), or due to witchcraft. For the most part, to initiate the healing process Navajos will rely on Medicine People (hat'alii or singers) to perform a specific ceremony as prescribed to remedy the given sickness or adverse life occurrence being experienced. The Medicine Person, through songs, prayers, medicine herbs, and other ceremonial tools, will provide a holistic healing to restore balanced harmony in the affected spiritual, emotional, mental, and physical needs of a patient. Western medical doctors tend to only treat the physical health, while the Western therapist will affect only the emotional and mental health. Most Western health professionals will not directly address a patient's spiritual needs that is an essential aspect of restoring holistic health. It should be noted that Navajos do utilize the Western medical services but, when a medical doctor or therapist is unable

to provide a valid diagnosis or is having difficulty in remedying a physical or mental problem, then most Navajos will turn to their own traditional ceremonial practices. In many cases, a Navajo experiencing an illness will use both their ceremonial practices and Western medical practices simultaneously. It is very important for Western professionals to have an awareness and respect for the traditional healing practices of the Navajos and other American Indians and Alaskan Natives, whom they serve.

The following is a brief discussion of ceremonial utilization pertaining to the Navajo Belief System. In this discussion we will provide some insight to the Navajo concept of un-wellness and how a Navajo person will seek such traditional medicine services in resolving an illness or other life adversities.

There exists a multitude of individual ceremonies, but for the most part each specific ceremony can be performed to affect a remedy for the following common reasons to address disharmony or for continued well-being:

1. For continued well-being and prosperity.
2. For observance of life rituals such as birth, puberty, and weddings.
3. For continued protection or for re-establishment of spiritual protection.
4. For addressing disharmony that has resulted in physical and/or mental illnesses.
5. For purposes of Blessing, in rejuvenating all aspects of self and life activities.
6. To remedy the violation of cultural taboos causing disharmony.

Steps for Pursuance of Appropriate Ceremony for Re-Establishment of Harmony and Balance:

Step 1: The affected person: will seek diagnostic services from a diagnostician who utilizes one of the following techniques:

1. Hand Trembling
2. Star Gazing
3. Listener
4. Crystal Gazing
5. Charcoal Gazing

(Note: These are the most common diagnostic techniques and are not an exclusive list.)

Step 2: The diagnostician will prescribe one or more ceremonies and at that time the affected person will seek a practitioner who will conduct the specific ceremony prescribed. The prescribed ceremony may be a minor ceremony that takes a few hours or up to nine days for a major ceremony.

Step 3: The majority of the time, the Medicine Person, at the completion of the ceremony, will prescribe a reverence period to be observed by the ceremonial patient. This reverence time may be from 1 to 4 days. During this reverence period, the affected person is to drink prescribed herbs, meditate, avoid strenuous activities,

not use sharp objects, remain away from the fire, not cross rivers or water steams, avoid going out into the public and to sleep alone.

Navajo Beliefs Related To Unwellness or Disharmony

Basically, there are four general areas that unwellness or disharmony stem from. Unwellness or disharmony may be experienced through physical illness, emotional instability / a change of inner feelings, unusual daily occurrences, and nightmares. These four basic areas are explored by traditional diagnostic methods to determine the cause of the unwellness. Unwellness or disharmony may result from one or a combination of the four areas discussed as follows:

Conception to Birth: During the development of the fetus within the womb of the expecting mother, both the father and mother are expected to observe cultural taboos and have reverence for the developing child. If such taboos are violated purposely or by accident, it will result in pregnancy complications, or the child will experience some kind of unwellness after birth. Under certain circumstances, the mother may herself experience unwellness resulting from such related violations during pregnancy or after the birth delivery. The following are examples of such cultural expectations:

1. Refrain from attending any funerals.
2. Refrain from fishing or hunting.
3. Refrain from participating in certain major Healing ceremonies.
4. Refrain from visiting ancient ruins or sites.
5. To engage in related Cleansing Ceremony, should a miscarriage occur.

Self-Reverence and Responsibility: The unhealthy behavior and attitude of a given person will result in disharmony for which consequences may result. Every person has the gift of making choices and decisions even when wrong decisions or choices are made that will result in difficulties and hardships. Such hardships or difficulties are brought upon by the self due to an unwillingness to make personal changes towards healthy attitudes and behaviors. In many cases, although the results of our disharmony may stem from the boundary violations from another person or due to life circumstances, it is still our self responsibility to recognize that we can only heal ourselves with the support of others, by initiating the process towards the establishment of our own harmony. Such examples of disharmony or unwellness are as follows:

1. Choices or decisions that result in unmanageable stress or undesirable consequences.
2. Behaviors and attitudes, which result in unhealthy family environments, marital difficulties, domestic violence, and unhealthy relationships.
3. Behaviors and attitudes that reap legal consequences resulting in imposed restrictions, e.g. incarceration, conditions of parole, house arrest, and et cetera.
4. Behaviors and attitudes of others, that result in our disharmony of undue stress, low self esteem, or self guilt and anger.

Relationship with Nature: Physical or emotional unwellness may result from accidental contact with the occurrence of the processes of nature. Also, having knowingly or unknowingly violated the laws of nature through acts of not having reverence for living animals, reptiles, or birds may result in such sicknesses both physically and emotionally. This may include a lack of self-reverence and sacredness for their own Earthly existence through behaviors of self-harm or life threatening acts. Such examples of the violation of nature are as follows:

1. Knowingly or unknowingly coming in contact with where lightning has struck or with the current energies of such occurrences.
2. Coming in contact with the Ancient Way of Life, such as handling artifacts, bones, pottery, or entering into such ancient dwellings.
3. Killing of animals, reptiles, or birds in a reckless manner or without a constructive purpose.
4. Experiencing the energies of death through military duty, as a medical professional, and/or on a personal encounter.

Manipulation of Energy or Witchcraft: the thought or experience of the effects of Witchcraft is a way of life from the dark side. It is believed that such power can be learned and used to manipulate energy through prayers and songs that will result in physical or emotional sickness and/or the experience of unexplainable events of adversities. The use and affects of Witchcraft is a very strong cultural belief of the Navajo People that has parallels with the practice of Satanism and other demonic practices. It is easy to blame witchcraft for experiencing disharmony, but each person needs to recognize their own deficiencies that make allowances to have such energies cause negative impact. A person may allow their vulnerability to such energies due to their own unhealthy attitudes and behaviors, unhealthy lifestyles and practices, lack of spiritual beliefs or not engaging in periodic Protective and Blessing Way ceremonies. Therefore, it is the responsibility of each person to seek Balanced Harmony, in that, by seeking such Holistic Wellness, it provides a shield of Spiritual protection in diminishing their vulnerability from evil energies. Such examples of unwellness can be experienced as follows:

1. Having bad dreams or nightmares, which are warnings for the need to seek Spiritual help.
2. When a Coyote crosses your path or when an Owl visits and hoots outside your residence; for these are Spiritual Beings with a message of warning.
3. A sudden unexplainable feeling of insecurity, physical illness or a series of an adverse chain of events.
4. Experiencing mishaps or near miss accidents, which are unexplainable.

Above are only a few examples of unwellness or disharmony that can stem from each of the four discussed areas. Each experience of unwellness or disharmony will have a specific ceremonial remedy. When experiencing such adversities, a diagnostician may cite more than one of the areas and recommend several ceremonies to be pursued for re-establishment of health or Balanced Harmony. Ceremonies are a means for resolving

causes of Disharmony but, as Self Healers, we are ultimately responsible to seek continuous self development and growth that can only be achieved by Walking With Our Prayers and living the Teachings.

In the program, in addition to providing Western therapeutic services, the clients and their families were allowed to pursue ceremonies related to their given treatment issues. Such ceremonies when pursued were to resolve the disharmony from a cultural perspective caused by incest, sexual abuse, physical abuse, suicidal tendencies, expression, violation of cultural taboos, grief, involvement with Satanism, and the adverse spiritual affects of the use of drugs and alcohol. In addition, clients from another tribal group, chose to resolve their treatment issues through the use of inter-tribal Sweat Lodge ceremonies, Pipe ceremonies, Native American Church, and through their own Tribal practices. It needs to be noted that such cultural services were integrated into the overall treatment plan of a given client, based on their own identified spiritual preferences.

D. Theory of Cultural Treatment

The *Walking in Beauty on the Red Road (WBRR*) model has taken the traditional American Indian healing practices and blended it with the evidence-based theories to provide the best possible environment for healing. This blending has resulted in a theory that requires a clinician and Native American Healing Practitioner (NAHP) to be able to truly sit contiguously in two cultural worlds while assessing, engaging and maintaining an adolescent in treatment. A therapist must be able to blend his/her skills and knowledge of these two systems of care to provide best practices of care for AI/AN. This is not simply taking two very different systems and aligning them side by side, although this is essential, but creating the space for a pure blending so the adolescent and clinician are not consciously aware of the process. Therefore, this approach is not for all clinicians or NAHPs, but for the professional who is capable of meeting the adolescent where they will obtain their highest level of healing. Today most Western clinicians and/or NAHPs provide their care separately, either in their offices, hogans and/or teepee. This theory believes a professional may provide treatment outside their normal treatment environment such as in a hogan or teepee. Many AI/AN people are not comfortable sitting in clinics or offices and can be treated best in the environment that they perceive as safe where healing can occur. Over 70% of the AI/AN people utilize their traditional healing ways while also being treated by a Western doctor or clinician. This model interweaves this process and the dual healing work of NAHP and clinicians provides the best practices for AI/AN people.

1. Process of change

Change is a mysterious process. What is the catalyst for change? Unraveling a person's path in life may lead to an understanding of where the change from health to dysfunction began. Many times, a specific precipitant will be identified that *appears* to have been the initial catalyst. Though, it is not as easy to determine the catalyst in the reverse process that will initiate a person's return to health from dysfunction. In a family, two siblings may experience differing effects from the same traumatic event. One child may begin a path to dysfunction and the other, the path to extreme resilience. Each child's path in the healing process will be affected by their temperament, support systems, intelligence level, and most importantly, their ability to have relationships with others. In

order for any change to occur, a person's belief systems must be engaged.

AI/AN adolescents and their families in treatment may have lost contact with and/or are not consciously connected to the foundation of their ancestral beliefs. Many AI/AN people, during their period of growth and development, have gone through a process of having their childhood beliefs and cultural foundations questioned. For example, an Indian child may have been raised in a traditional AI/AN home as their family participated on a regular basis in traditional ceremonies, e.g. pow wows and sweat lodges. During childhood, this child was surrounded and inundated by their culture and learned from many traditional models within their community. Then a life-changing event occurs, for example a divorce or death in the family, and the child is inhibited from participation in and/or removed from their cultural environment. The child experiences the loss of their cultural support systems and a state of confusion in regards to their foundational beliefs. By the time the adolescent begins to engage in negative behaviors and/or substance abuse, there has been a severing of their cultural support systems, a primary protective factor.

When the adolescent returns to a place of safety and healing, memories from their traditional childhood experiences and knowledge of their cultural ways begins their walk on the *red road of healing*. Sometimes, an adolescent may experience an opposite reaction and distance themselves from their traditional ceremonies and activities beginning a further erosion of their belief system. There are a myriad of reasons that AI/AN adolescents and families disengage from their healing practices. Many adolescents are attempting to individuate from their family system and are involved with deviant peers that see the *old ways* as no longer useful. This may arise out of a desire to lift themselves out of the poverty and accumulated grief that is experienced in the lives of many AI/AN people. OYOF found that over 74% of the adolescents in the residential treatment program had experienced significant trauma as children and due to their anger with their families for lack of protection and support, many turned away from their traditional ways.

Another common conflict for AI/AN families begins with a conversion to Christianity when they may be told it is against the tenets of Christianity to continue to practice their traditional cultural ways. This model assumes that a belief in the Christian faith and the practice of traditional ceremonies and activities can compliment one another thus eliminating the need for AI/AN people to make a choice. The key postulate regarding this theory and model is that to truly facilitate change, the AI/AN adolescents and their families must begin to access their traditional ways, either through the teachings and/or actively participating in ceremonies. This will allow them to blend *the two worlds of healing* necessary to receive a *best practices* treatment.

2. Integration of Healing Practices

One of the main tenets of the model is a parallel process that engages with the conventional Western best practices and the AI/AN healing ceremonies and activities. The Western approach is very left brain, analytical and linear whereas, the cultural approach is right brain and circular. The NAHP, though, is very analytical in looking at the systems and symptoms. It is necessary to integrate both the left and right brain, being linear at times but always moving in a circular manner when providing the treatment. The NAHP will always look at what is visible and what is not visible. The Western clinician,

many times, will only look at the visible and overt behaviors. One can be successful at decreasing and eliminating these overt behaviors but without a full circle or cycle of internal change integrating the four aspects of the person (spiritual, emotional, mental, and physical), it will not be lasting. In this program's philosophy, both the Western model and the cultural model always complimented and supported each other throughout the treatment. No one system was more important than the other; they always worked in concert. When an adolescent and/or family was assessed and treated, the two systems worked to determine the level of engagement and intervention to facilitate change.

3. Creating a Place of Safety

Creating a sacred space where the adolescent and family feel safe and express their thoughts and feelings that lead them towards their healing is vital. Many AI/AN people have a basic distrust of western organizations such as hospitals, clinics and offices. Historically, this has been a place of pain and sorrow. To this day, many elders will not enter Indian Health Service Centers due to the belief they will not return to their families. This is an issue that is ingrained in the family from years of trauma experienced by the AI/AN people. This issue is not always evident in the treatment process but must always be assessed to determine their beliefs around the Anglo culture. This is especially true if there are Anglo clinicians. It is not good enough just to acknowledge the difference, one must understand the impact of generations of trauma at the hands of people in authority. This understanding begins with the initial engagement and continues throughout treatment and follow-up. This impact is not to be used as an excuse and the message that they are accountable for their behavior is reinforced. Clinicians and NAHPs must provide ongoing teachings of respect and making healthy choices. The treatment center was called the Hogan where respect was an expectation and one did not behave in a disrespectful manner without assuming accountability for disrespectful behavior. The instilling of respect was a reciprocal relationship between adolescent, family, program staff and the community.

4. Cultural Evaluation and Diagnosis

The western and cultural approach was used to identify and introduce the treatment issue, with the cultural approach integrating this for the individual and family. An example of this integration is seen in treating depression. The clinician would introduce the idea that the adolescent was depressed to the family and their elders. Due to a language barrier, the elder of the family could not interpret the concept and the NAHP was required to explain in their language a parallel concept. Language is very vital to educating the family, especially their elders. Unlike many Anglo families, the elders of a family would participate in treatment with the adolescent and the need for interpreters was vital. This is especially true when it came to processing their thoughts and feelings. The whole process became vital after discharge as well. Another example was in clinical team meetings when the members were unable to determine the issues at hand or what intervention would work. The cultural members would reframe within the cultural context and would identify a different approach for the issue (e.g. inability to get a client to engage in treatment, or change behavior etc.)

A specific ceremony was identified and conducted to support the adolescent, their family, and the clinical team to view issues from another perspective. A good example of

the power of AI/AN healing practices is in the use of a Smoking Ceremony. In the first two weeks of admission to residential treatment, there is a period of significant acting out behaviors. This is especially true if a majority of the adolescents in a treatment cycle, had experienced child maltreatment. A "Smoking Ceremony" would be conducted in the Hogan or teepee by a NAHP. This ceremony is designed to cleanse the individual from negative thoughts and emotions that are interfering with their healthy behavior or harmony. After this ceremony is conducted, the clinical team would see a significant reduction in targeted behaviors and an increase in motivation for treatment. However, it must be noted, that behavioral contracts and skills were also being introduced simultaneously, therefore the combination of these two interventions is believed to cause the pathway for change. A treatment program must access and address the four parts of a being, spiritual, emotional, mental, and physical. Our belief is the physical is the last form of being to manifest change, suggesting that the disharmony has been lodged in the spiritual being for many years.

The conventional western approach is to conduct cultural relevant assessments and then analyze the results and complete a report. This report is explained to the adolescent and family. The traditional AI/AN healing practice is to have a NAHP conduct a ceremony or in the case of Navajo medicine people do a diagnostic ceremony to determine the causal issue. They too collect the data, analyze it and complete a report. The main difference is the report is given in the moment and is conducted in an environment along with the Creator's and the Holy People's guidance. This sends a message to the client that the NAHP is not working alone on their own beliefs but accessing the spiritual realm for guidance in expressing the issues and the needed treatment.

The power of this theory is the integration of the NAHP process with that of the western clinician, especially when they have the same conclusions. It is equally validating when the NAHP and clinician have addressed a similar issue but explained and processed them differently. This allows the client to see the issue from two different vantage points. This confirms for the client that a problem exists that must be addressed. Since the NAHP and the western clinician have formulated similar diagnoses and approaches to resolve a problem, then that similarity may be safely included in the treatment plan.

5. Treatment Implementation

When the diagnostics, evaluations and treatment plan have been completed, certain difficult tasks remain. This is to say that the actual implementation of a truly integrated treatment remains. This process requires that the Western clinician and NAHP work together daily. The two must have respect for the other’s approach in order to understand and participate within both processes. They must develop a clinical culture that will tolerate and transcend disagreements and the ability to compromise on the treatment approaches. Since the two come from different centers in their healing practices, one cannot take precedent over the other. The client’s well-being must be considered at all times. A clinical team must be strong and flexible in their beliefs and should be cross-trained in the western treatment approaches plus understand and/or participate in AI/AN healing practices. It has been the experience of the writers that if an individual does not at least have a basic tolerance and understanding of another’s healing

world view, then he/she will not be able to be an active and effective healing agent within the context of this treatment model.

E. Integration of Cultural and Western Treatment

This model suggests that the adolescent treatment must integrate developmental factors that include differences in value and belief systems, differences in gender specific issues, variations in client readiness to change, and variations in levels of family support. It is important to determine a client's cognitive and social-emotional development and the level and severity of AOD usage to appropriately individualize treatment. In addition, we emphasize family and social issues that appear to have impeded the client's ability to maintain sobriety. The AOD program places no pressure on adolescents to accept that they have a disease, but does believe that AOD is a brain disorder that develops over time with significant usage. The program strives for abstinence; however, due to the high rate of co-occurring disorders, a tolerance for lapses and relapse is necessary and realistic. Finally, the AOD program interweaves the cultural/spiritual aspects throughout to enhance the client's understanding, from their culture, of the impact of AOD on their spiritual life.

Basically, this theory blends traditional wellness versus unwellness concepts and simply states that one's health can be disrupted through the violation of natural laws, lack of self-discipline, contact with certain natural processes, or through witchcraft. To initiate the healing process, for the most part, the program is open to reliance on Medicine People to provide a specific ceremony prescribed for the given sickness or adverse life occurrence. Likewise, AOD and subsequent behavioral and psychological problems result and require not only the spiritual/traditional aspects to be addressed, but these approaches must also understand pathways to this disruption. One must know how to change one's thinking, feelings, and beliefs about an experience in order to regain balance or harmony. It is important that the two worlds interconnect to provide the best environment for the adolescent and their family so they may begin their walk in recovery. Following is an overview of the pathway that many adolescents find themselves on due to violence and substance usage and the Western approaches that will support them in the engaging, seeking, establishing, and advocating for harmony and recovery.

1. Pathway to Adolescent AOD

Adolescents entering AOD treatment are more likely to have experienced child maltreatment along with other significant family issues and to have developed psychiatric disorders during early childhood, (e.g. a learning disability, attention deficit hyperactivity disorder (ADHD), or oppositional defiant disorder. The presence of these risks factors in an adolescent's early childhood usually has lead to disruption in their school success, increased association with other deviant peers, legal involvement, and early use of substances. By the time they experience their first treatment episode, they are usually poorly motivated towards treatment, have psychiatric problems, have decreased academic success, manifest family, and behavior problems, and display a limited range of coping and social skills. They are also likely to lag in important adolescent developmental tasks, including individuation, moral development, impaired conceptualization of future educational or vocational goals, and diminished family goals (Plomin and Rutter, 1998; Tims, Dennis, Hamilton, Buchan, Diamond, and Funk, 2002).

In addition to the above risk factors, AI/AN adolescents, also have to contend with the added issue of an incomplete or disrupted ancestral heritage. Minority stress, exposure to child maltreatment, violence, intergenerational trauma, and/or lack of parenting may have contributed to both their substance abuse problem and a range of possible co-occurring mental health problems. Minority stress and cultural loss are pivotal treatment aspects for AI/AN adolescents. The conventional medical treatment model has been described as a poor fit with Indian cultures, and such treatment approaches themselves may create unique barriers to service delivery. For example, confrontational techniques, confession-like disclosure of personal problems, or complete emphasis on nonnative religious precepts may be perceived as unhelpful or culturally non-congruent for many AI/AN adolescents. It is important to blend AI/AN and Western approaches, consistent with the fact that many Indian people use two health care systems - the mainstream medical system and traditional healers, or medicine people (Coulehan, 1980, Stewart et al., 1980). The Walking In Beauty on the Red Road (WBRR) model has integrated the stages of change theory, motivation enhancement techniques, cognitive behavioral theory along with a stress reduction model with the Navajo cultural teachings and ceremonies resulting in a model that engages a multi-modal approach that is necessary to address the many intricate issues in providing treatment for AI/AN adolescents and their families. The following section briefly describes the main tenets that the WBRR model incorporates.

2. Stages of Change

WBRR begins with the initial interaction and engagement of an adolescent often consisting of the triage team and/or a case manager and a NAHP. The initial stages of change or readiness for treatment are identified at this point. According to Prochaska, Norcross and DiClemente (1994), the *stages of change* are on a continuum expressed as: 1) Pre-contemplation, 2) Contemplation, 3) Preparation, 4) Action, 5) Maintenance and, 6) Relapse. In the same vein, Marlatt and Parks (1982) proposed a three stage model of change for addictive behaviors consisting of: 1) preparation for the *journey of habit change* involving motivation and commitment, 2) *implementation* of the change itself involving cessation or reduction in the addictive behavior on one's own or with the assistance of treatment, and finally, and most importantly, 3) the *stage of maintenance* which begins as soon as abstinence or controlled use are achieved and involves encountering and coping with the numerous challenges to return to the old addictive habit. It is important that the program thoroughly understands Prochaska et al. stages of change. Our experience tells us that the Marlatt and Parks (1982) three-stage model is a better fit with the AI/AN culture. They combined the pre-contemplation and contemplation stages into the preparation for the journey of habit change; the preparation and action stages reflect the state of change implementation; and finally, the maintenance and relapse stages into the stage of maintenance where abstinence or control has been achieved and involves active participation in facing the challenges of returning to an addictive lifestyle. The majority of the residential treatment process is spent in the areas of preparing for the journey of habit change and its implementation. After discharge, there is the preparation for maintenance and relapse throughout the treatment stage to provide skills to support treatment effect.

The WBRR has taken the three stage model of change and expanded it by adding the cultural/spiritual component in motivating and engaging the adolescent and their family to enter treatment with a minimal belief that they can change and bring their life back into control. This expanded version incorporates the identification of the cultural and spiritual level of change. This is based on the four directions and circle of life. The adolescent and family identify the impact of the AOD usage in this cultural level of care **(see Appendix A for diagram)**. This cultural level of care is superimposed on the western level of care according to the ASAM criteria and at this point, the adolescent and family begin their journey of change.

3. Motivation Enhancement Therapy and Technique

Miller and Rollnick (1991) Motivation Enhancement Therapy is very compatible with AI/AN culture with its emphasis on respect for the human spirit. The spirit of motivational interviewing embraces seven main tenets: 1) that the motivation to change comes from within the adolescent, 2) that the adolescent resolves the ambivalence to change, 3) that direct persuasion is not effective, 4) that the counseling style is a quiet one, 5) that the counselor helps examine ambivalence, 6) that readiness to change fluctuates, and 7) that the relationship is a partnership. The five main techniques that the counselor and other staff employ are: 1) to express empathy, 2) to develop discrepancy, 3) to avoid argumentation, 4) to roll with resistance, and 5) to support self-efficacy. The implementation of these tenets and techniques leads to an increase in quality of care resulting from the development of trust, respect, empathy, empowerment, and the successful improvement of treatment. These therapies and techniques are utilized throughout the residential treatment program.

4. Cognitive Behavior Therapy, Imagery, Relaxation, and Prayer

Cognitive Behavior Therapy (CBT), according to Beck and Ellis (1976)**,** is based on the belief that our thoughts, not external things, like people, situations, and events, cause our feelings and behaviors. CBT emphasizes the ability of individuals to make changes in their lives without necessarily having to understand why the change occurs. Although, cultural beliefs do embrace the idea that external events (e.g. witchcraft, taboo violations, personal boundary violations, etc.) can control feelings, thoughts, and behaviors. This model works with these differences in discussing the integration of self-responsibility, accountability, and healing-from-within that the culture supports. The WBRR model blends cognitive restructuring therapy to teach adolescents to change their distorted and erroneous cognitions that maintain their problem behaviors and teaches them to substitute more adaptive cognitions with cognitive behavioral coping skills therapy that teaches adolescents adaptive responses, both cognitive and overt behaviors, to deal effectively with difficult situations they may encounter. CBT requires that the adolescent be motivated to complete homework (e.g. academic assignments) and conduct self-report inventories and apply those skills within the milieu.

The use of imagery and prayer are important aspects of this approach. Imagery is a normal process and can be controlled. Such information can be stored as kinesthetic, aromatic, or tactile memories and pictures and often carries more meaning than words or sentences in a smaller space or within a shorter time frame as in the phrase, "a picture is worth a thousand words." Images are memories of events and can focus one on the past

or on the future. Images can cause affect shifts the same way that other cognitions do. Images can be positive and negative just as cognitions. These images can be spontaneous and can violate or align with one's cultural beliefs and desires. These images may be no more reflective of the adolescent's beliefs, desires and actual future behaviors. In addition, conscious decisions can replace the behaviors seen or interpreted from or in these images. However, a client can invest a great deal of emotional energy worrying about and insuring the acts are not performed. Very importantly, images may carry cultural symbols that have potent meanings about one's acceptance and competence in their community. [The use of symbols and images to convey wellness of an individual or community is an ancient art form familiar to all tribes. Such images are woven into baskets, blankets, or clothing, are painted onto pottery or hides, or are beaded into moccasins or other apparel seen in pow wows. Native people have long recognized the critical importance of this form of literacy because it expresses so many forms of social and spiritual well-being. The symbols and images are sacred and personal and are seen to insure and express one's competence in living life in a good and balanced manner.]

The use of relaxation techniques also helps an adolescent to learn the signs of tension in the body and to learn to release this tension. There are three kinds of relaxation techniques that are utilized: 1) progressive muscle relaxation, 2) guided imagery, and 3) autogenics or the teaching of one to create a feeling of warmth and heaviness throughout the body.

Finally, prayer is an extraordinary form of cognitive-behavioral treatment. When practiced, it can free one from feelings of anxiety and worry. When one prays out of love with all of one's mind and heart along with a belief that this will lift the social-psychological ills of one's current situation, prayer can improve their overall functioning. Conversely, culturally we walk with our prayers, meaning it is your duty to fulfill the responsibility of what you pray about. For example: One prays to be more honest and less dishonest. One will pray for guidance and ways to complete this goal. This constitutes having reverence for one's prayers.

5. Crisis Stress Debriefing Process

Over 74% of the adolescents who entered the treatment program had experienced trauma from a variety of events (child maltreatment, community violence, peer violence etc.) with 64% having serious emotional and mental disruptions that impacted their ability to develop appropriately and succeed in their community. Many times these adolescents had never reported these violent events. Treatment was their first exposure to an environment that provided a safe haven. These adolescents would begin to disclose these violent events as they became sober and developed skills to manage their feelings. While the program did not believe it was appropriate to completely open the adolescent to the depth of their feelings, a crisis debriefing model was modified from a critical stress debriefing model that is used during large community debriefings (Mitchell and Everly [updated version], 2001) In addition, this model was used by the staff to reduce their stress reaction from working with the adolescents and families. They would debrief each other in times of crisis and for challenging situations gained while working with difficult and painful situations. It was a significant support for the program and for maintaining the health and harmony of the staff that would carry over to our adolescents and families.

All staff including support staff were trained in the Critical Stress Incident Model (CISM) through the State of New Mexico Health Department. They received maintenance sessions twice a year to ensure that the model was being utilized appropriately. Client debriefings were conducted in an individual and/or family session with a non-evaluative discussion of their involvement, thoughts, reactions, and feelings resulting from the incident. It serves to mitigate the impact of stress that results from exposure to a stressful event and ventilate feelings. Educational and information components were also provided. CISM is not psychotherapy nor is it presented as therapy, however, it is a part of treatment. It will produce therapeutic effects in that it will assist the client and family to understand their stress affect, and it will also accelerate normal recovery process. The steps are as follows:

1. Introductory Steps: Stating this will help them deal with some of their thoughts, feelings, and reactions to the stressful event. Rules are explained around confidentiality.
2. Fact Step: This serves to recreate the event and present the facts that surround the incident. This initially may prove to be difficult for a person to acknowledge and staff must validate their feelings before going on to the next step.
3. Thought and Feeling Step: The client and/or family will discuss the event and describe their first or initial thoughts after the incident happened. This step will elicit information on any physical, emotional, cognitive or behavioral signs or symptoms they may be experiencing. No deep probing takes place. This step allows the person to determine the level of sharing.
4. Closure Step: One begins this closing of the session by adding reassurances, answering any questions, and acknowledging and eliciting any emotions the client may display that appear to be “on the surface” but are having difficulty expressing. For closure, the counselor will ask the client and/or family if they want to actively work on this in treatment and develop a preventative plan on how to manage thoughts, feelings, and behaviors that may arise. It is a time that the client and/or family may need additional referrals to support them through the process.
5. Documentation Step: Finally, the counselor must write a progress note and complete an incident form outlining the procedure and results. The counselors communicate this information to the clinical treatment team within 24 hours after the debriefing.

6. Theory of Emotional Intelligence

In the 1990s, Peter Salovey and John Mayer first proposed a theory of emotional intelligence. The definition of emotional intelligence includes five domains: 1) knowing one's emotions, 2) managing one's emotions, 3) motivating oneself, 4) recognizing emotions in others, and 5) handling relationships. In Daniel Goleman's book, *Emotional Intelligence* (1995), a report of the ABCs of emotional intelligence include "self-awareness, seeing the links between thoughts, feelings and reactions; knowing if thoughts or feelings are ruling a decision; seeing the consequences of alternative choices; and applying these insights to choices."

The HeartMath Solution was developed by Doc Childre, (Childre, Martin and Beech, 1999), over a 25 year period and has pioneered new biomedical research suggesting that *the heart is a source of intelligence* that can be harnessed to better manage stress and improve one's day-to-day life. The Institute of HeartMath (IHM) believes the heart and brain are dynamically linked by two-way communication systems. One of these is the autonomic nervous system. Most people know that the brain sends signals to the heart and other glands and organs, but it is less commonly known that the heart sends just as many messages to the brain. The heart's electrochemical messages profoundly affect the higher brain centers that govern functions such as language, creativity, problem solving and the ability to make appropriate choices. IHM's research has shown that when one's emotions are unbalanced, heart rhythms become jagged and uneven. This information is communicated to the brain and cortical processing is inhibited making it more difficult to think clearly and make good decisions. In contrast, IHM's studies have revealed that people can learn to stop stressful reactions by engaging the power of the coherent heart rhythms literally changing the messages the heart is sending to the brain. The Heart Math solution is a comprehensive system that provides information, tools, and techniques to access your heart intelligence. In order for the mind, emotions, and body to perform at their best, the heart and brain must be in harmony with one another.

The Heart Math model is a natural fit for AI/AN people in that for centuries Indian people have been using their prayers and ceremonies to slow the heart down and connect with the earth and their ancestors, and most of all the Creator. This connection is where the healing takes place and supports the person to return to harmony. Many of the ceremonies have a natural progression where all participants harmonize their breathing, heart energy through singing and prayers. This is very much the same process as the Heart Math method. The difference is in the language and the scientific study that has been completed.

Our program modified the Heart Math model to a "Heart Power" model for easy integration into a treatment program. This model and the skills that are developed through practice, supports adolescents and their families to manage stress, learn to communicate openly with a heart connection, and work together to identify creative solutions to different stressors in their lives. All adolescents, families and employees of the residential program were trained in the Heart Math Solution and the Heart Power model. These skills were utilized throughout treatment as a management of strong emotions, to minimize conflict with self and others, and to foster good decision making in times of stress.

7. Theory of Family Systems

The majority of family-based models propose that substance abuse and psychological problems are developed and maintained in the social context of the family. There are interactional patterns of behavior that explain the existence of emotional distress. Conversely, the Navajo belief is that families can be significantly impacted through external factors, such as land disputes, witchcraft, and external family disagreements as well as domestic violence. In evaluating an Indian family, these issues must be explored to see what the core belief of the family is in regards to the current family functioning.

Virginia Satir (1983) believed that individuals behave and communicate in groups by described family roles that serve to stabilize expected characteristic behavior patterns in a family. In 1989, Satir stated that the human contact is made through connection of skin, eyes, and voice tone. We learn pre-verbally through such connections. We recorded how our parents touched us, how they looked at us, and what their voices sounded like. This is congruent with AI/AN culture who believe that everything in our world impacts us, that our words are powerful, and that voice, laughter, and behavior can create or destroy. A beautiful example of this concept is in the story that a Medicine man tells about his child: "When my child was still in the womb of it's mother and she would become sick or upset, I would sing the old Navajo chants to her and she would calm down and rest. When our child was born and would cry or become fitful, I would sing these same Navajo chants and our child would immediately calm down and become peaceful." We believe the child was able to hear these chants and identified with them upon entering our *Glittering World*. [see glossary of terms}.

Satir proposed and described essential elements that blend with the necessary work with AI/AN families in treatment. Many AI/AN families have undergone disrupted relationships due to violence, abandonment, divorce, and the lack of healthy parenting. Traditionally AI/AN family networks were a function of their environment and a healthy interaction of respect, understanding, and guidance was present. The cultural conflicts brought forth by boarding schools and re-location programs separated many families. This resulted in trauma. The need to rebuild this healthy communication is vital to the success of an adolescent and their families in treatment.

Below are the main elements that the WBRR model incorporated regarding cultural teachings with families. These elements served as a foundation to support clinicians to build trust, make contact, build positive self-worth, and rebuild the importance of the human connection and an " I-thou relationship". It is not enough to have clinical tools. One must possess the vision and humanity to direct those tools. The following are the main elements used (for a complete examination of the model review Steve Andreas (1991), *Virginia Satir, The Patterns of Her Magic):*

1. Solution-oriented focus on the present and future
2. Positive intentions; no matter how horrible the behavior
3. No blame; hurtful or destructive behavior is a result of limited opportunities to learn how to respond more positively
4. Equality; use role-plays to teach family members an alternative to dominance and submission; communicating as equals
5. Provide positive alternative choices; teach people satisfying ways to interact, to support them in not returning to painful and destructive ways
6. Reframe behaviors and perceptions; reframing a problem behavior in a different context, so that it can be seen as having value there (e.g. a child acting out may be the way they can express their negative emotions)
7. Action; people change only if they fully experience the events or perceptions that words can only point to
8. Family sculpture; transforming words into action. It helps depict the family's system of interaction so that family members can see themselves more clearly
9. Association/dissociation; in associated memory the person re-experiences the

event fully, as it is happening again now. Dissociated memory is recalling a memory as an impartial observer as if watching a movie with decreased emotions

10. Expressiveness; actively eliciting responses from family members and connecting the positive ones immediately to the family to improve bonding.
11. Humor; is valuable by lightening a person's feeling state and in this state people are more flexible and creative.
12. Shifting referential index; seeing events from someone else's perspective providing powerful information for resolving difficulties (e.g. *Walking a mile in someone else's moccasins*).

Virginia Satir (1983) stated *I proceed from the theory that my therapeutic job is to expand, redirect, and reshape individual's ways of coping with each other and themselves, so they can solve their own problems in more healthy and relevant ways. Problems are not the problem; coping is the problem. Coping is the outcome of self-worth, rules of the family systems, and links to the outside world.* (P.156).

These are some of the main goals of the WBRR model that support family healing by helping them reframe their problems, learn healthy communication, develop strong abilities to cope with their adversities, and engage in forgiveness. These skills were integrated with the cultural teachings of the Clanship System, Navajo Philosophy, Values and Teachings, and Teachings of Boundaries that serve to strengthen individual and family relationships.

8. Clanship System

The following is the basic story that is told to the adolescents in order for them to identify their clan. Many times after this story telling, the adolescent will ask their family to explain their clanship with them. The clanship system is a major rapport-building tool for the program staff. Upon admission, the adolescent and family are asked what their clanship is and the staff will either be related through this clanship or someone on the staff is related. The staff begins to call this adolescent their son, daughter, grandfather, uncle etc. depending on the relationship. The adolescent is then addressed in this manner throughout treatment. This is a powerful aspect of the treatment and helps to make them feel safer and have identity. The following are examples of a teaching on the clanship and how it relates to our gifts of thinking, planning, living, and resilience. A workbook is given to the adolescent to learn about their clanship and they are asked to learn how to write the name and pronounce their clanship whenever they introduce themselves publicly **(This teaching on the clanship is found in Appendix B)**.

9. Navajo Philosophy, Values, and Teachings

We are Five Fingered, Earth Surface People, and Spiritual Beings, whose purpose is to seek, establish, and advocate harmony, so that we can Walk in Beauty on the Corn Pollen Road in the Circle of Life.

Navajo Values versus Societal

- Cooperation versus Competition
- Sharing versus Savings
- Respect for age versus Emphasis on youth
- Spirituality is life versus Religion is a segment of life
- Harmony with nature versus Dominance over nature
- Extended family versus Nuclear family
- Adopt/adapt versus Control/direct
- Lack of time consciousness versus emphasis on time
- Time is circular versus Time is linear

Blessing Way Teachings

- Be generous and kind
- Acknowledge and respect kinship and clanship
- Seek traditional knowledge
- Respecting values
- Respecting the sacred nature of yourself
- Having reverence and care of speech
- Be a careful listener
- Be appreciative and thankful
- Having a balance perspective in mind
- Expression of appropriate and proper sense of humor
- Maintaining strong reverence of yourself
- Maintaining enthusiasm and motivation for one's work and education
- Protect and care for one's work and education

Protection Way Teachings

- Never be lazy
- Never be impatient
- Do not be hesitant
- Never be easily hurt
- Never be overly emotional
- Do not be overly reluctant
- Never be overly argumentative
- Respect the sacred
- Do not over burden yourself
- Have self-discipline and be prepared for challenge
- Assert the potential
- Do not be shy
- Do not become angry
- Do not carry around expectations of negative events

Self-Awareness for Balanced Harmony

- Spiritual Being: Self-awareness of moral values, attitude, and behaviors
- Emotional being: Self-awareness of inner feelings and why
- Mental Being: Self-awareness of outlook on life and why
- Physical Being: Self-awareness of maintaining good health for a long life

10. Teaching Family Boundaries

A significant piece of providing cultural treatment to our Indian youth is making an effort to establish family harmony. We approached this through weekly family sessions. In our cultural beliefs, we embody a Spiritual, Emotional, Mental or Intellectual, and Physical Being and dimension. Most American Indians based this belief on the concept of balanced harmony, in that each of these four aspects of a person must be in balance or in a state of total wellness. When one or more of these dimensions are unbalanced, then that person is experiencing some degree of unwellness.

When the family experiences the state of unwellness or being unbalanced, this may be due to unhealthy family interactions, either intentionally or unintentionally. Family members may violate the boundaries of other family members with intent of self-gain, and such violation may be due to ignorance regarding how an action or behavior might adversely impact other family members. Each family member must gain understanding and acknowledge how their behavior or attitude has impacted others, and must be able to express how the actions of others have violated their own boundaries.

For most American Indians, the four-dimensional Beings of each person are connected to the four cardinal directions. Some First Nations of Canadian believe their Mental or Intellectual aspect is connected to the East direction, their Physical to the South, their Emotional to the West, and their spiritual being to the North. For presentation purposes, we will use the Navajo interpretation which places the Spiritual in the East, the Emotional in the South, the Mental or intellectual in the West, and the physical in the North.

In accordance to Navajo cultural beliefs, directional orientation begins in the East direction from which earthly birth occurs and represents *new beginning*. Ceremonial prayers and songs contain this circular sequence by moving in the clockwise direction to effect the four dimensions of a given person to restore Balanced Harmony, and in this case, to initiate Family Healing.

This circular orientation is referred to by most American Indians as the Medicine Wheel of Healing. This process can be initiated and used as follows:

- Having the family understand the definition of boundaries
- Having family understand the four dimensional Beings of whom they are
- Beginning in the East direction in presenting examples of voluntary violation related to each given dimensional Being

Examples of Boundary Violations:

* **East Direction-Spiritual Being-Beliefs and Values**
    1. Forcing your spiritual beliefs and values on others
    2. Not letting others participate in their own Spiritual choice activities
    3. Making fun of family members for their Spiritual activities
    4. Criticizing other spiritual or religious beliefs

*** South-Emotional Being-Respecting feelings of others**
    1. Not considering the feeling of others
    2. Not letting others express their feelings
    3. Taking out your anger on others
    4. Intentionally hurting the feelings of others

* **West Mental or Intellectual-Judging and Manipulation of others.**
    1. Creating fear through threatening behavior
    2. Manipulation of others for self-gain
    3. Making remarks about others, which are not true
    4. Making fun of others weaknesses or inabilities

* **North-Physical Being-Respecting image and Sacredness**
    1. Making fun of nationality, gender, and appearance
    2. Inappropriate touching
    3. Being physically aggressive with others
    4. Making unwelcome gestures to others

All of the above theories focus on one aspect of treatment: the ability to address one's dysfunctional beliefs around their usage of AOD along with the myriad of social, behavioral, and family issues that are impacted by this usage. These theories and models of treatment are all evidence-based while naturally integrating within the AI/AN culture and traditions.

IV. DESCRIPTION OF THE TREATMENT DESIGN AND DELIVERY OF WBRR MODEL

A. Treatment Design

1. Program Scope

The program provides AOD and behavioral health treatment in a residential setting for adolescents ages 12 to 19. The scope of services includes: 1) Diagnostic Center; 2) Moderate level residential treatment (average of 60 days); 3) Client advocacy during treatment and after discharge; and 4) follow-up tracking conducted for one year after discharge.

AOD and behavioral health treatment is a complex process requiring a team of specialized professionals. The program provides services using the *Walking in Beauty on the Red Road (WBRR)* model that addresses the seven life domains: 1) the medical, 2) education/employment, 3) alcohol/drug use, 4) family/social, 5) legal, 6) psychological and 7) cultural/spiritual status of the individual and family. Treatment motivation and barriers to recovery are assessed to individualize each adolescent's treatment episode. The WBRR model places a significant emphasis on active family and/or guardian involvement. The program provides additional services developing sobriety skills, pro-social / resiliency skills, and family skills along with cultural specific treatment, and academic improvement.

The program employs a multi-disciplinary approach to treatment in which services are coordinated within the program and the adolescent's community. The program provides continuous outreach by working closely with referral sources. In addition, WBRR seeks to collaborate in an extensive network of behavioral health organizations and social service agencies seeking to lower barriers for adolescents and families seeking alcohol, drug, and behavioral health services. In rural areas many times there is limited to no continuum of care. It is important for rural areas to coordinate available services and to work creatively to increase these services. This may require cross training. There is no room for turf protection.

The program incorporates Cognitive-Behavioral therapy, Motivational Enhancement therapy, Twelve-Step Facilitation therapy along with specialized cultural/traditional therapy. The program recognizes that no single therapy approach meets every individual's need and strives to individualize treatment approaches according to the ethnicity and developmental stage of the adolescent. This promotes the greatest opportunity for success for any adolescent in our treatment program.

2. Program Goals

1. Provide outpatient treatment for adolescents 12 to 19 years of age
2. Provide a central referral center for adolescents identified to have ATOD and/or co-occurring mental health issues and determine the needed level of care
3. Provide a direct treatment interface with the existing local, State, Tribal, and Federal resources throughout the Four Corners catchment area

4. Provide ATOD and co-occurring mental health treatment services reducing personal, family, social, physical, emotional, and cultural/spiritual distress to adolescents
5. Provide culturally sensitive clinical services inclusive to traditional spiritual values and attitudes to AI/AN adolescents, when appropriate
6. Provide a realistic, honest, caring and sincere treatment environment
7. Provide bilingual / bicultural professional and qualified paraprofessional personnel to meet different ethnic communication needs
8. Provide documented, verifiable and evaluated service delivery records pertaining to all client activities, planning, management, support services and training
9. Provide coordinated professional referral sources and develop a network to support an appropriate recovery environment
10. Provide accountability and accuracy in financial, property, inventory reporting and control

3. Program Services:

The program provides the following services to all adolescents over the course of a nine week treatment period after the initial triage and admission assessments:

1. Individual therapy in AOD and any identified behavioral health problem. A unit of individual therapy is a fifty (50) minute session.
2. Group therapy in AOD and identified behavioral health problem. A unit of group therapy is a fifty (50) minute session.
3. Multi-family therapy groups on AOD and any identified behavioral health issue. A unit of multi-family group therapy is a fifty (50) minute session.
4. Individual family sessions (if family is deemed ready to participate in such treatment). A unit of an individual family session is fifty (50) minutes.
5. Psychotherapy groups. A unit of psychotherapy group is fifty (50) minutes.
6. Didactic/education sessions on AOD, family functioning, gang behavior, child maltreatment, domestic violence, and cultural/traditional ceremonies/activities
7. Skill building groups (Cogintive-behavioral, relapse/refusal skills, communication, problem-solving/resiliency, Heart Power, and stress reduction skills)
8. Academic assistance and activities (continuation of credits and/or GED preparation.
9. Basic health education in relationships to physical development and disease prevention.
10. Alternative therapy (e.g. art activities, music therapy, drumming & singing, writing therapy, biblio-therapy, and dance therapy). The adolescent chooses one or more alternative therapy to attend during his/her treatment episode
11. Recreational activity to promote and foster physical health and develop appropriate leisure activities.
12. Adventure Based Counseling experience to foster confidence, self-image and self-esteem growth.
13. Cultural learning activities specific to AI/AN beliefs and practices. Clients participate with parental permission.

14. Spiritual/religious activities developing growth and understanding. Clients of all faiths may participate in their own unique spiritual practices. They will develop a plan with parental permission with their assigned counselor to receive the proper teaching.
15. Random urinalysis. To ensure successful progress in the program all clients will submit to random urinalysis to support ongoing sobriety. If a client receives a negative UA, then this is brought to the treatment team's attention and subsequent consequences will be implemented.
16. Psychiatric evaluation and recommendations, as needed.
17. Case management services.
18. Behavioral life skills management services.

4. Client Expectations and Grievance Process:

The clients who meet the program criteria are admitted and expected to make a commitment to the treatment provided. Failure to comply with the basic rules can result in a behavioral contract and/or review before the clinical team. This team consists of the clinical supervisor, assigned counselor, social worker, client advocate, parents, and referring therapists or agencies. This process is for clients to address those issues or concerns that they believe to be a violation of personal rights, invasion of personal privacy, or any type of suspected or alleged abuse. Every client or their family member has the right to express concerns openly and without recrimination for actions, attitudes or events that are perceived as being a personal violation or injury (rights and procedures are clearly outlined in the client handbook). This grievance is to be put in writing and is reviewed with the client and parent/legal guardian upon submission. The client or family member initiating a grievance has the right to request an internal review of the client's treatment plan by the Chief Operating Officer and/or the Clinical Director. An external review is also permitted at the expense of the client or family.

B. Delivery of WBRR Model

1. Identification Stage:

a. Triage

The triage team conducts the majority of the screening at the referral agency/agent sites, detention, social services, Indian Health Services and well as on site. The goal is to reduce barriers to accessing assessment and subsequent treatment. An initial one-page form is completed to determine if the client meets the basic admission criteria that all adolescents ages 12 to 19 are:

1. free of substances for 72 hours.
2. free of or are under complete control of any infectious disease.
3. free of a major <u>untreated</u> psychiatric personality disorder, (e.g. schizophrenia, psychotic disorder etc.). Clients on prescribed medication for a mental health issue are accepted, if client remains under psychiatric care.
4. and do not have gross to mild mental or physical retardation that would prohibit program participation.

The referring agency/agent and parent/guardian completes the intake form requesting screening/assessment to determine the level of care and treatment recommendations. The assessment team responds in writing and/or fax to the referral source acknowledging the inquiry within twenty-four (24) hours of receipt and sets an appointment for a screening/assessment for admission within seven (7) days. The referral source identifies any additional funding source(s) to support admission. The parent/guardian is required to complete all consent and release of confidentiality forms before the assessments are conducted.

The adolescent is screened to determine if they are currently under the influence of any substance. This screening may include a urinalysis. If no urinalysis is conducted, then the assessment counselor must determine the following: last usage, type of substance, and quantity of usage.

If the adolescent refuses, the interview is terminated until the adolescent is free of substances. The referral agency/agent is immediately notified. If the adolescent is court-ordered and/or on probation/parole, the assessment counselor must clearly inform the adolescent that the appropriate authorities will be notified. This can be conducted with the adolescent present and/or upon their departure. ***No assessment is conducted while the adolescent is under the influence of substances.*** If the adolescent is intoxicated upon arrival, the assessment counselor must conduct a ***detox risk screen*** to determine if the adolescent should be taken to the hospital. If the adolescent has had seizures in the past when detoxifying, they are referred and/or escorted immediately to the nearest emergency room and/or attending physician.

The assessment counselor completes the parent-guardian questionnaire and the following assessments to determine the appropriate level of care:

1. Addiction Severity Index (ASI) - Adolescent and Native American version for all AI/AN adolescents. Orion Healthcare Technology: http://NA.myAccucare.com
2. Mental Status Exam (MSE)
3. Short Blessed Test (to determine significant cognitive impairment)
4. Children's Functional Rating Scale (CFARS) - New Mexico State version.

If the ASI, CFARS, and clinical interview determine that the adolescent Level of care (according to the **ASAM** criteria) is a level III or stable IV, the clinical documents are presented to the admission team for review and admission. All of the other levels are referred to the appropriate treatment provider:

1. Level .5 (education is needed) = 0-9 hours weekly
2. Level I (Non-Intensive Outpatient treatment) = 9-16 hours weekly
3. Level II (Intensive Outpatient treatment) = 16-20 hours weekly
4. Level III (Medically monitored intensive inpatient) = 24 hour/7 day
5. Level IV (Medically managed intensive inpatient) = 24 hour/7day

The referral agency/agent receive a written report on the results of the testing within 5 business days.

b. Suicidal / Homicidal Ideation and/or Plan

During the triage phase if the adolescent presents any suicidal and/or homicidal ideation or plan, the clinical supervisor is contacted. The clinical supervisor conducts a clinical interview or provides supervision via phone to determine the severity of the risks and safety of the adolescent if assessment is being conducted in the field. If the adolescent is deemed suicidal/homicidal and/or presents serious risky behaviors, then the parent will be notified and acute hospitalization is pursued immediately. If the adolescent refuses, then the police are notified to transport the adolescent to the nearest hospital for psychiatric screening. In addition, the agency/agent is notified of the admission and/or episode immediately.

c. Evaluation and Admission Team:

The evaluation and admission team is a fair, unbiased team composed of the Clinical Supervisor (Licensed Clinical Psychologist, Licensed Clinical Social Worker, and/or Licensed Clinical Practitioner), Licensed Alcohol & Drug Abuse Counselor, Social Worker, Nurse, psychiatrist (when available), and Native American Health Practitioner (NAHP). This team reviews all clinical documentation and assessment results. Each request or application received for entry of a client into the program is:

1. screened against the admission criteria.
2. reviewed for all information and data provided.
3. reviewed against the waiting list status.
4. discussed for appropriateness and service needs expected.
5. recorded for all committee comments, suggestions and recommendations, and is attached to the application or placed in the client file.
6. communicated to the referral source and parents by the assessment counselor, the decision of the committee.
7. A comprehensive evaluation process is completed within seven days after this admission evaluation.

d. Waiting List

From time to time, there are referrals made that are accepted for entry into the program based upon available space. In the event there is no available space, the referring agency is given a specific time and date when the client can enter the program. The client is placed on a waiting list that reflects the first possible date of entry based on their current ranking on the list. The assistant to the clinical team is kept in contact with the client and the referring agency by mail to ensure the client's welfare and health are being addressed. The communications reflect the Program's desire for the client to enter the program on the date agreed and the client's efforts to retain sobriety and stability while waiting for admission. If needed, the program recommends other services or programs to support the client's efforts for sobriety.

2. Engagement/Initiation Stage

It is important to establish a structure that enables the client to personally engage in their treatment. An environment that will enhance the client to rapidly develop a personal connection and interaction is vital. Therefore, it is important to provide for a rapid admission or provide pre-treatment groups. If the client is in an acute crisis, it must be addressed and staff must relay a message that they have the client's best interests in mind. This begins to instill hope for change. It is important to explain how the program can help them address their needs and concerns. However, the key is the client's readiness to change and motivation for treatment. The level of denial of AOD impact on an adolescent's life is not unusual and must be addressed within an empathic and constructive manner.

The use of Motivational Enhancement Therapy during this initial engagement/initiation stage provides the best opportunity for the counselor to guide the adolescent to understand the depth of their AOD usage and its subsequent negative impact on their daily functioning. Some motivational strategies to prepare the client to develop a therapeutic relationship and buy into the concept of treatment are:

- clarify client goals and strategies for change.
- offer different choices for change.
- provide expertise when elicited from the client.
- negotiate a change plan.
- consider and lower barriers to change.
- help client develop a social support (positive changes in the family and social support networks of clients support early recovery).

At this stage the client will receive education and cultural lectures along with videos addressing the basic AOD impact on the physical, mental, emotional, and spiritual being. Group and individual sessions address this. The education and teachings will facilitate the client to begin identifying his/her AOD usage and its impact. Throughout this stage, the client begins to discuss personal experiences as the sessions become more personal and a level of trust has been established.

a. Admission Process

Upon admission, additional assessments are completed on each client, including assessments of physical, psychological and social status. The assessments are multi-disciplinary, as needed, and address strengths and weaknesses of each client in the context of his/her environment, including cognitive, emotional, cultural, development, psychosocial, and physical functioning along with the level of readiness to change.

The assessments are used in treatment planning and the development of appropriate treatment/interventions for each client. Initial screening of each individual's physical and psychological status and social functioning takes place through the intake assessments and the nursing assessment.

The program provides a battery of assessments, both general and culturally specific. Upon admission to the residential program, the assessment counselor conducts the following assessments on all admissions within 48 hours to determine individualized

treatment needs. The comprehensive battery of assessments will collect the following specific data:

1. client substance use
2. family substance use
3. physical examination (required within 48 hours of admission)
4. educational history
5. legal history and present status
6. parental consent
7. psychological and social history, if available
8. cultural awareness and identity
9. other relevant information maintained by other sources.

A **Nursing assessment** is completed within 24 hours from admission. It assesses the client's need for nursing care and includes an initial mental status examination and review of psychological status, a review of immunization status and determines the need for further assessment of nutritional status. Along with the history and physical examination, the nursing assessment aids in determining need for further medical or adjunct physical evaluations, such as optometry, audiology and dental.

A **History and physical examination** is completed within 48 hours of admission. The results of the medical history and physical examination and laboratory tests become part of the client's medical record. The history and physical examination includes diagnostic testing and laboratory assessments relevant to the determination of treatment needs, growth and development history, height and weight. If within 30 days of admission to the program, a comprehensive medical history and physical examination has been performed, a durable legible copy of this report may be used in the clinical record as the physical health assessment, provided that any subsequent changes are recorded at the time of admission. The following assessments are conducted and integrated into a comprehensive biopsychosocial within 14 days of admission.

1. Addiction Severity Index (ASI) update if the triage evaluation was more than 30 days before admission. This assessment determines the level of severity and treatment priority in the seven life domains (medical, academic, legal, substance usage, family/social, psychological, and cultural). The Native American ASI consists of the standard ASI plus additional items with cultural content (Accurate Assessments).
2. Mental Status Exam
3. Millon Adolescent Clinical Inventory (MACI) (Millon, 1993) is conducted at admission to identify and support mental health diagnosis, identify substance abuse proneness, and co-occurring emotional or behavioral issues.
4. Trauma Symptom Checklist For Children (TSCC) (Briere, 1995) is a self-report measure of trauma-related symptoms, including post-traumatic stress disorder, disassociation, anxiety, anger, and other common symptoms that may be trauma sequelae.

5. Childhood History developed by OYOF is used to identify any developmental disruptions.
6. Environmental Survey is a questionnaire that determines the level of violence in an adolescent's family and community. (Modified from Adolescent Treatment Model project)
7. Inhalant survey determines current and/or past use of inhalants of adolescent and friends.
8. Northwest Educational Achievement Test (NWEA) series is a norm-referenced test in the areas of reading, literature, and math that is used to determine the level of academic attainment and identify specialized educational needs.
9. Adolescent & Parent Cultural Assessment (Sabin & Benally, 1999). This instrument is an essential element of the program and is administered by a NAHP affiliated with the program. The instrument measures the client's cultural self-image, beliefs, activities, and broken taboos along with cultural identification within their tribe and within the Anglo-American culture. It specifically inquires into any culturally unique explanations (e.g. violation of cultural prohibitions) the adolescent and his/her family may believe are related to the adolescent's problems. The assessment provides a clear picture of strengths and protective factors of the adolescent and family.

Upon completion of all the assessments, the case manager along with the cultural counselor completes a comprehensive biopsychosocial-cultural report that includes a review of pre-admission information as well as assessment of current status. It is completed within 14 days of admission and includes:

- history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use;
- history of physical problems associated with dependence;
- client's perception of their own strengths and weaknesses;
- client's own perception of substance dependence;
- use of alcohol or other drugs by family members;
- types of previous treatment and responses to that treatment.
- family history of alcohol and drug abuse;
- educational level, vocational status and job performance history;
- social support networks - family and peers;
- client's sexual history, including sexual abuse (either as abused or as the abuser) and orientation;
- any history of physical or emotional abuse or neglect;
- interviews of family members and other significant others as available;
- legal issues if applicable;
- learning needs, abilities and readiness to learn;
- social and cultural influences, spiritual, cultural and religious perceptions, values and beliefs;

The Psychiatric/Psychological Assessment is completed within 7 days of admission by a psychologist or psychiatrist if deemed appropriate and includes:

- any learning impairment that might influence diagnosis and treatment;
- current and past psychiatric/psychological abnormalities;
- determination of degree of danger to self or others;
- report of past or current physical, sexual or emotional abuse or neglect;
- gross assessment of cognitive and neuro-psychological functioning or impairment;
- the spiritual orientation of the client;
- emotional barriers, desire and motivation to learn, physical and/or cognitive limitations, and language barriers;
- family status and assessment of the family's ability to provide support;
- family's and/or guardian's expectations for and involvement in the assessment, treatment and continuation of care or treatment for the client.

The recreational/leisure assessment of the client includes:

- the various life experiences of the client;
- the client's capacity for recreational/leisure opportunities;
- any deficiencies the client may be experiencing.

The Educational Assessment includes a review of pre-admission information from the client and home school as well as an assessment of current status. It is completed within 7 days of admission and includes: an assessment of basic skills in reading, math, spelling, writing/language and speaking/listening; and educational and vocational plans and goals.

Adjunct Medical Evaluations are completed, if appropriate, based on the medical and nursing assessment data. Adjunct medical evaluation may include: Nutrition Assessment by a certified nutritionist; Dental Assessment; and Optometry and audiology examination.

Clients in need of additional assessment not immediately available at the program are referred through personal physician, community health center and/or Indian Health Center.

If a client is re-admitted within 30 days of discharge, no new evaluations or assessments are required unless there have been significant changes. Previous evaluations and assessments are: reviewed, resigned, dated and referenced in the progress notes and forwarded into the current medical record.

If there has been a significant change in a particular area, such as a significant depression and was not evident upon the admission, the assessment is re-administered in that area. The original physical examination is reviewed and resigned by the program medical provide and/or affiliate.

b. Orientation

A designated intake staff person greets and conducts a preliminary orientation for the client and persons accompanying the client. The client handbook will be read and thoroughly explained in a group process and all questions will be answered. The following is covered with client and family.

- Client is given a tour of the facility, noting areas of restriction.
- Client is informed of the time and date of individual and group sessions.
- Client is given a Client's Rights Form that is to be read, signed and returned.
- The client is given the program's client handbook with goals and their purposes explained in full.
- The costs of treatment are explained and the responsibility to the client and family is fully explained.
- The level system is fully explained including the corrective actions to be taken if rules or expectations are not adhered to.

c. Three Levels of Care

The program strives to provide individualized treatment that will lend itself to the increased success of each client. These levels of care were developed from the need to have more homogenous groups to support rapid group cohesiveness. The other main issue is having peers who are exhibiting deviant behavior and mixing them with other adolescents who are not having these difficulties. It is especially important to separate those adolescents who are heavily AOD dependent from those who have just begun to engage in the use of AOD and early legal issues. Therefore, the program developed three basic profiles of adolescents who attended treatment. The Air, Water, and Earth groups are determined within three main categories of treatment issues and behaviors.

Within the first week of the admission and evaluation process, the client's clinical information will be reviewed and a level of care will be assigned (e.g. Air, Water, & Earth). The level of care is determined by a client’s specific needs and learning approaches. Each level has a team of three consisting of a substance abuse counselor, cultural counselor, and psychological aide. Each level will have approximately 8-10 clients with the three staff providing a minimum of six hours daily of individual, group, education, recreation, and/or family therapy.

The staff is with the clients from 8 a.m. to 3 p.m. daily, including lunch. The clients are under observation twenty-four hours a day and are never allowed to move throughout the program unescorted. The team approach will support the clients in receiving more individual attention. All of the team members will attend all facets of the treatment day.

When the client is assigned to attend the education lab, the team will attend and work with the client in this setting. If the client is having difficulty in the classroom, he/she can be removed and immediate intervention will be provided to support the client in returning to the education lab without disrupting the classroom.

There will only be a few situations in which all three groups are together. The community meetings are one of these situations where everyone discusses issues that are appearing in the milieu; meals will be together along with some recreation activities. The

last two hours of the of day (Monday to Friday) are set aside for the counselors to complete paperwork and the clients will be in study hall completing school work, treatment assignments, and/or relaxing. The clients will not have access to the counselors for these last two hours unless an emergency arises that the psychological aides cannot manage. The following is a description of the of the level of care for the Air, Water, and Earth groups:

Air Group focuses on the clients who experience learning disabilities, behavioral problems, attention deficit disorders, are severe inhalant users, and live the effects of fetal alcohol syndrome. These clients have short attention spans and will need to have tasks that help them to learn how to focus their mind and complete tasks successfully. The clients in this level typically will require intensive supervision with a structured approach. An Adventure Based Counseling is used to integrate the AOD education and skill development.

Many of the Air group may be at a remedial reading and writing level. They will require innovative approaches in providing education, individual and group therapy. For example, clients are required to write their life story along with a description of themselves under the influence o f AOD and one of themselves *walking on the red road of recovery*. If the client is unable to write, they are allowed to draw their story and orally share it. Of course, these remedial learning issues are addressed in the academic program. Shifting the modality of completing the tasks helps the client to learn alternatives to a task that may appear to be unsolvable. In addition, this allows the client to be a part of the team and not stand out as different.

The Air group learns better when physically engaged. The majority of these clients have a diagnosis(s) of Attention Deficit Hyperactivity Disorder (ADHD), Impulsive disorders, Oppositional disorders, and other behavioral dysregulation disorders that require special attention to teach them how to manage these behaviors.

Water Group focuses on a treatment approach that teaches the clients skills to manage their emotional dysregulation. Majority of these clients have experienced severe child maltreatment and may have depression, post-traumatic stress disorder (PTSD), and other related mood disorders.

These clients must be taught skills to manage their disturbing moods. Many of these clients engage in suicidal ideation and planning along with self-mutilation. One must be observant of these behaviors and should continuously evaluate these clients throughout the treatment process. Many of them manage their moods through these dangerous self-harm behaviors therefore, they can experience serious mood swings as the treatment progresses. These adolescents must be able to have a safe environment where they can express these feelings without a negative impact.

Earth Group focuses on a more traditional AOD treatment approach. These clients will be academically on target and have minimal behavioral health issues. Their substance usage will not be as severe and they will exhibit minimal behavioral problems. They will receive significant AOD education and relapse prevention along with other skill building processes. Majority of these adolescents have sufficient skills to manage their life issues but are easily swayed by deviant peers. Therefore, they are not placed in the same groups and activities with other deviant peers.

All levels of care receive the same content regarding treatment approaches, however, intervention modalities are appropriate to each level and target behaviors. All

levels integrate cultural/spiritual teachings, academic and adventure based counseling. The psychotherapy groups, lectures and assignments must be at an appropriate developmental level and gender specific where appropriate.

AI/AN cultural themes and principles are common to all three levels of care. Adolescents in all levels participate in the overall cultural/spiritual treatment and have multiple cultural/spiritual teachings, activities, and ceremonies (e.g. sweat lodges, talking circles, drumming and singing, early morning runs, meditation, medicine wheel training, Native American current events and story telling). For example, the sweat lodge teaches the individual the art of prayer utilizing four doors or rounds with drumming, singing, and prayers honoring the four directions. Each round or direction teaches different viewpoints for the purpose of purifying and healing oneself. The sweat lodge provides a culturally appropriate environment to express for one to express and share emotions that may not be otherwise expressed in a clinical setting.

The talking circle is a group process that provides a safe environment for individuals to share openly and honestly, and the process respects opposing viewpoints. The talking circle utilizes an eagle feather, and/or the talking stick as the conduit through which the individual speaks and is listened to until finished. The most important clinical aspect of the talking circle is that it gives the adolescent an opportunity, maybe for the first time, to be heard and understood without interruption or judgment.

The medicine wheel is a universal concept utilized in many cultures including European cultures. The medicine wheel concept correlates with the Navajo concept of the four directions and relates them to the different components of treatment. One teaching, for example, is that the gifts of thinking, planning, living, and resiliency are given from the Holy People within the Four Sacred directions. These gifts provide as a means for affecting how we use our mental being for a productive and fulfilling life during our journey on Mother Earth. The medicine wheel process demonstrates to the adolescent that substance usage has a negative impact on one's ability to successfully use the *sacred gifts* and subsequently make healthy decisions.

All care levels require group-based stress management skills training based upon the HeartMath Program (Childre, Martin, and Beech, 1999; Craig, 1999). In addition, adventure-based counseling (ABC), psychotherapy, smoking cessation groups, behavior modification groups, substance abuse groups, child maltreatment education and groups, domestic violence exposure groups, and violence prevention training are offered. All adolescents receive individual, group, and family therapy along with academic skills development services. Some clients who have experienced severe child maltreatment such as sexual abuse and continue to have difficulty with significant emotional dysregulation may require more individual sessions and the use of Eye Movement Desensitization and Reprocessing (EMDR) (see Shapiro, 1995 for complete review) to decrease the intrusive thoughts and feelings.

d. Level System

The program's level system is based on the Navajo philosophy of life that is based on the Navajo Four Worlds Emergence System. The client will move through these worlds as they progress / regress in treatment. They must achieve the "White World" level to be considered for discharge, and this coincides with their treatment plan and how well they are meeting their goals. All clients at admission are placed at a safety level for 10 days while they adjust to their new environment. The program staff completes an *intervention form* on each client during all three shifts. This form factors in physical, emotional/mental, behavioral and cultural/spiritual concerns. The staff checkmarks a behavioral item as it is observed along with the type of intervention utilized with additional comments recorded regarding the situation and/or incident. These intervention forms are entered into a database and are graphed weekly after which the counselor reviews the items with the client and his/her family. This provides them visual feedback on the behaviors that may interfere with treatment success. If a behavior continues or increases, then the client and family are brought in for a treatment team review where the intervention graphs are presented to help the client to develop a behavioral contract and to re-commitment to treatment.

The following is a brief description of the level system provided to client at admission along with expectations appropriate for each level. The description is general but can at least provide the reader with a conceptual understanding and framework for how one might implement a level of care system in a Native cultural context.

Application of Navajo Philosophy

At the time of birth, the existence between Mother Earth and Father Sky and between the four cardinal directions begins in that these cardinal directions embody teachings and principles to acquire gaining Truth, Knowledge, and Wisdom. These teachings basically come in sets of fours and are interconnected within Four Cardinal Directions. The Cardinal Directions are sets of teachings that cooperate with ceremonies of the Navajo People through songs and prayers. These ceremonies vary from Healing ceremonies to Blessing Way ceremonies for continued well-being and prosperity. The teachings are therapeutically adapted for use at the facility in the Sweat Lodge ceremony and in Traditional teachings.

How the colors represent each level

The Navajo believe that their creation began with emergence from four under worlds into the Glittering World in which we exist today. The Emergence being in the Black World moving or progressing to the Blue World, into the Yellow World, and up into the White World. This creation of the Emergence through the Four Worlds moves into the Glittering World of reality and opportunity. The progression corresponds to the Level System and allows staff to track culturally relevant progress towards recovery. To enhance and complete the level system, Navajo Four Dimensional Beings of a Person teachings are incorporated as well.

The Four Dimensional Beings of a Person must be in balance with one another for Harmony to result, or as the Navajos recount*: To Walk in Beauty*.

Black World-North-Physical Being

After a client completes the orientation phase of admission (safety status - ten days), they begin their residential treatment journey into the *Black World*. This is represented by the Black Jet Stone where ethics, reverence for nature, and resiliency develop where physical needs assessment and identification takes place. This phase may include a medical stabilization and exercise program, complete social detoxification, and an appropriate diet. When a client has completed the education of the physical impact on their body, has gained knowledge of the adverse physiological impact of drug usage, has settled into a daily routine, is not indecisive, ambivalent, or in denial about their need for treatment, then the client will be considered for emergence into the *Blue World* or the second level. Here, the client is in the *artist* way and must complete a picture of themselves when using substances and when clean and sober, must write or tape a narrative, and must complete the appropriate Step from the 12-Step Program regarding what they learned about themselves and the impact of substances on their body.

Most of all they must be able to demonstrate motivation and decrease evidence of denial. The client must be able to paint a picture of how and why they were admitted to residential treatment and how they are going to complete this journey. This must be presented to their individual counselor and then to their group (e.g. Air, Water, or Earth). They will receive feedback from their counselors and group members on their knowledge and behavior. If they are successful at this level, a client may petition their individual counselor and treatment team by completing the Emergence form that moves them to another level. The client must meet with the treatment team and demonstrate that they have met their initial goals and can move out of this phase. The team must give feedback regarding their decision within 24 hours after such a request.

A merit signifying the completion of this level consists of receiving a "Black Stone Person" and a 3 minute phone pass that may be used only under supervision.

Blue World-South-Emotional Being

The Blue World, represented by the Turquoise Blue Stone, is where one develops one's emotional being, medicine water knowledge, spirit of livelihood, faith, and planning. In the Blue World, they will address emotional needs, relating to their substance usage. These needs may stem from trauma, depression, anger, anxiety, loneliness, grief and other hurtful feelings. The client must understand how their substance usage has impacted their ability to meet their school and work responsibilities, how their negative emotions have impacted their ability to use their mind and make good decisions. The client must complete different workbook exercises on problem-solving, conflict resolution skills, heart power skills, 12-Step and must exhibit these skills within the milieu. They are not allowed any incident reports of aggressive behaviors to move to another level. They must be able to demonstrate that they are at the *hunter* way or to actively seek and establish harmony within themselves and their community. This will become evident in individual, group, and family sessions.

When it is determined that a client has made significant individual strides in understanding their emotional issues and demonstrates emotional stability in their behaviors and attitudes, consideration for emergence into the Yellow World is initiated. To move to the next level, the client must fill out an Emergence form in writing and/or

orally discuss what they have learned and the skills they have developed. The client must be able to convince group members and the clinical team of this development through any medium they choose (e.g. art, writing, taping, and openly discussing). The client must have met their initial goals and maintained progress of the *North* and have met all of the current goals on the treatment plan. Here, they will also begin to discuss and develop their plans for discharge.

The merit for completing this level consists of a blue stone, no "snack clean-up duty", and a five (5) minute phone pass.

Yellow World-West-Mental Being

The Yellow World, represented by the Yellow Abalone Shell, is where the mental being, breath of life, spirit of social well being, love and living develop. A client who enters the Yellow World will begin to focus on his/her mental being or dimension. This level determines a client's outlook on life regarding social skills, self-esteem, self-identity, and inter-relationships. This level may also include assessments and progress on family and significant other relationships and a successful integration of their coping skills with staff, peers, family, and others. They begin to discuss faulty thinking and decision-making and continue to gain knowledge about their thinking and how it impacts behavior. Here they exist in the *medicine person* way and continue their journey seeking, establishing, and advocating for harmony. By now they typically are free of cravings, their negative thoughts have decreased, and they are successfully managing their negative emotions and behaviors. For this reason they cannot receive any incident reports and must be an active member of their group and milieu. They are accountable for their actions and serve as a role model. The 75% of their treatment plan must be completed by now along with 50% of their discharge plan. They may petition using the Emergence form to move into the *White World* that is the last level before re-entering the *Glitter World* (e.g. returning to their home and community).

Merits are a yellow stone, caffeine free soda with counselor in an individual session, basketball/weightlifting at the Boys and Girls Club with other Yellow World clients, a seven (7) minute phone pass, and permission to stay up 30 minutes past bedtime on Friday and Saturday night.

White World-East-Spiritual Being

The White World level is represented by the White Abalone Shell and where spiritual being, Grandfather fire, spirit of spirituality, hope and thinking develop. White World reflects the beginning of ensuring the spiritual needs of the client. Spirituality is demonstrated through one's willingness to change in behavior, attitude and the re-establishment of sound moral reasoning. Here one exhibits a renewed enthusiasm for life, feeling good about whom they are, and the sensing of the need for meeting challenges after leaving the program. At this level, the client should understand that their sobriety and recovery depends on self-responsibility and following through with their aftercare plan. The client is in the *Warrior Way* or how to learn to protect his/her self from relapse by providing a foundation for on-going health. At this stage, clients exhibit insight on the importance of establishing a Higher Power, since they cannot maintain wellness by

themselves. They typically are role models in the milieu, exhibiting responsibility and displaying the ability to manage negative thoughts, emotions, and behaviors.

The client will present a written sobriety script, relapse plan, and academic / vocational plan individually, in the group, and petition a discharge review by the treatment team. To petition for the Glittering World (e.g. discharge) the client must have completed 80% of all treatment goals and present their relapse plan. Their parents must present their relapse plan for the client, and the probation officer, aftercare therapist or any other agency/agent who will support the client after discharge must present their plan for continued health before the treatment team. The team will make a decision and will provide the stipulations that the client must meet to move into the Glittering World.

Merits are a white stone, movie or bowling outing with other White World clients, and permission to stay up 30 minutes past bedtime, Friday and Saturday nights.

Glittering World (discharge)

The fifth level is the existing world we all live in. This represents realities, self-challenge, and doors of opportunities through seeking, establishing, and advocating for harmony. This level is achieved through successful completion at time of graduation. To prepare for emergence into this Glittering World, the client is given the teachings of the Four Gifts, and they must discuss how they will deal with these life realities. These teachings serve as a reminder that the world we live in has not changed and that we will have to adjust to and compensate for the Gifts by utilizing one's knowledge gained through the treatment process.

The ***Four Gifts*** are:

1. The Gift of Prejudice and Resentment
2. The Gift of Suffering and Sacrifice
3. The Gift of Loneliness
4. The Gift of Hardship.

The client will discuss, write, and/or draw how they will address these four adversities to determine their preparedness to return home and face the challenge of continuous sobriety and harmony. An honoring ceremony will be conducted before the community with invited guests describing the client's accomplishments in the program. They will be gifted a certificate of completion, sweet grass, a program shirt, and a 12-step coin (**see appendix C for complete description of level system**).

3. Retention Stage

In this phase of the treatment, the therapeutic relationship has been developed and active program participation is observed. As the treatment progresses, behavioral compliance will be evident as well as the improvement of any psychological issues. The client will be willing to openly discuss all areas of their AOD history and how they relate to their present struggles or experiences. At this time, alcohol and drug testing is a vital component to supporting abstinence and is conducted on a random basis weekly on each client and serves as a motivator. Motivation to change fluctuates, and the program must

provide ongoing encouragement. It is important for all staff to be respectful and non-confrontational when guiding the client. They must provide objective feedback about problems and the process of change. Focus on the client and their immediate environment and their needs will support success. Staff must maintain a positive alliance by asking clients for feedback about their individual, group, and family sessions. This is done in individual session and through surveys that the client and family complete regarding their perception of the program staff. This provides first hand feedback to the program staff on how they are influencing the client and in any modifications that might be needed in the therapeutic approach. This is particularly true when a client is observed regressing in treatment.

Staff must always be attentive and must remember details about the client since this relays a message of being truly interested and concerned. Staff must be consistent, dependable, and available while at the same time setting limits in a respectful manner. Staff, most of all, must be trustworthy. The staff must respond to angry outbursts by engaging clients with a calm and collected approach that allows the client to de-escalate and bring him/herself back into control. Some motivational strategies to implement with a client at the retention phase are:

- to reinforce the importance and benefits of remaining in recovery
- to support realistic change through small achievable goals
- to acknowledge difficulties for client in early stages of change
- to help client identify high-risk situations and coping strategies
- to find new reinforcers for positive change.

4. Maintenance and Discharge Stage

a. Maintenance Stage

At this stage, the client will demonstrate stable, psychosocial functioning. They will actively practice their skills in the milieu and with their family members. There can be a fluctuation of motivation and feeling of stability. This is especially true when one prepares for discharge. The program must reinforce the importance and benefits of continued recovery and remind the client of the changes they have successfully completed. Maintaining sobriety requires a different set of skills than becoming abstinent. It is important to help the client identify and experience drug free sources of pleasure. They must be able to experience joy and calmness within their day. The client at this stage will begin to have more freedom and engage in leisure activities that can be generalized to the home environment. A program must watch out for boredom and/or depression, since after some abstinence, a client can become depressed over what they have been through including negative events or memories of their past behavior.

b. Discharge Phase

In this phase, a plan is developed to address treatment needs the client will require in their community. Appropriate discharge planning is to support the development of a strong recovery environment that will enhance successful sobriety. Discharge planning begins with the initial referral and continues throughout the course of treatment. All clients will be discharged with a Continuing Care Plan developed by the client, parent(s),

program staff and other providers. The plan will be established at a minimum of one week prior to the scheduled discharge/return date to the client's resident community and will include an initial aftercare appointment and will delineate relapse prevention activities during the initial month post discharge. To be a successful discharge, clients must present their sobriety script, wellness plan, and academic plan at their discharge review meeting. This discharge review meeting is mandatory for the client, parent/guardian, counselor, client advocate, clinical supervisor, social worker, academic adviser, referral agent, probation/parole officer, and other service providers. This ensures successful client re-integration into the community.

The initial referral information includes discharge-planning questions, such as where the applicant will live after discharge. The discharge treatment team determines the appropriateness of discharge in the following domains:

1. Change in clinical status
2. Change in functional status
3. Health, welfare, & safety
4. Permanency and stability of home
5. Other quality life indicators (environmental).

Two days before discharge, the client will complete an ASI, cultural post-test, and satisfaction survey regarding the services received. An appointment with the program's client advocate and their aftercare provider will be arranged. The client will be given a card with the client advocate's name and an 800 number that they can call twenty-four/seven (24/7). This phone number gives the client a sense that the treatment program is providing ongoing support even after discharge. The phone number is also given to the family so they can keep in touch and call in time of crisis.

5. Follow-up Stage

The client advocate will contact the client and their family every 90 days (3,6,9, and 12 months) to determine how well they are functioning. A Global Appraisal of Individual Needs (GAIN) (Dennis, 1999) follow-up assessment is conducted at 6 and 12 months after discharge. If the family is in crisis or the client has relapsed, the client advocate will provide the family with referrals and/or assess the client for re-admission to the residential treatment program. The client advocate tracks the client through various means: postcards, flyers, birthday cards, phone calls, and 90 day visits in the field. The client and family consent to locate and fill out a locator form at the onset of treatment. This consent is effective for one year after discharge.

C. Personnel Orientation, Training, Development, Responsibilities and Supervision

1. Orientation of Personnel

All employees receive an OYOF orientation regarding goals, services, policies and procedures, responsibilities of position, development of rapport, appropriate boundaries with clients, and clinical documentation using the Accucare System. All employees must utilize the automated clinical documentation system. In addition, employees receive fire and safety training, review WBRR critical incident reporting system and receive WBRR model training before being allowed to work independently in the milieu. The period of training depends on the position particularly if it requires physical supervision and lasts until the employee is deemed qualified to provide treatment to specific clients.

2. Personnel Training, Development, Responsibilities, and Supervision

All direct service and supervisory staff must complete 24 hours of documented pre-service training in the following areas:

- Crisis management/intervention
- Behavior management
- Emergency procedures (including withdrawal screening)
- CPR & First Aid certification
- Establishing a client / therapist / case manager relationship
- Confidentiality and organizational & professional ethics
- Eligibility standards & outline service programs
- Organization structure, service mandates, policies & limitations
- Case advocacy skills
- Community resources
- Clinical documentation

Within 90 days of employment, the staff will receive an additional 20 hours of documented training in the areas:

- Etiology and symptoms of substance abuse and dependence
- Etiology and symptoms of emotional and neurobiological disorders
- Family systems
- Child and adolescent development
- Basic communication and problem solving skills
- Ethnic and cultural relevant issues
- Action and potential side effects of medications
- WBRR model (treatment of dual diagnosed clients)

All staff receives ongoing in-service training in areas that are deemed relevant to the treatment population being served by the program. A minimum of three annual in-service trainings are provided to treatment staff to support continuation of development and licensure.

Supervision is provided to the treatment staff by the clinical director, clinical supervisor, and/or the chief operating officer. A minimum of two hours of documented supervision is provided monthly. For group supervision, the clinical staff provides an audio and/or video of an individual or group session that is reviewed by the clinical team. The supervision log is the responsibility of the supervisor and is placed in personnel records each month. The log consists of:

- name & signature of staff and supervisor
- date of supervision
- theme of supervision
- type of supervision (individual/group)
- length of supervision

In event the clinical supervisor/therapist is the same person, staff are required to seek one-hour of monthly supervision from the Chief Operating Officer and/or a licensed professional. If no such professional is available inside the organization, then an outside consultant is used.

The contract therapist, if not working on a full-time or part-time basis, must seek one hour of supervision monthly to ensure quality of services and integrity of the treatment model are being maintained.

3. Qualifications

The program provides personnel who are trained, supervised, and deemed qualified to perform their clinical and administrative duties. This ensures that the highest standards of care and best practices support a successful client treatment outcome. Staff engaged in clinical treatment duties are licensed and/or licensed eligible within 90 days of employment in the State of New Mexico. They are trained in the *Walking in Beauty on the Red Road* (WBRR) model and follow the modules of the manual within training guidelines. No clinical employee is to provide treatment outside the scope of his/her licensure. Staff follows all ethical guidelines set by his/her governing licensing board, the Children Youth and Family Services Department (CYFD), and the Joint Commission of Accredited Hospital Organization (JCAHO). All direct or indirect service staff and student trainees working at the program undergo a criminal record check and clearance. All staff and student trainees comply with the State of New Mexico Child Abuse Reporting law and follow the program procedure for reporting. (**See appendix D for key staff qualifications).**

4. Program Environment

A majority of the adolescents admitted to the program exhibit significant behavioral disruption and emotional vulnerability, therefore, the milieu is very structured with a low stimulation. A behavioral log documents needed interventions that support the program's positive reinforcement model with no punishment. The staff does not engage in

confrontation but instead uses a care-frontation approach. Care-frontation allows the adolescent to have choices and to learn respect through staff modeling. If an adolescent becomes aggressive, and/or will not participate, the team discusses these choices with the adolescent.

In the first week, the adolescent is provided with the 7th direction teaching that is to be used for negative behavior management or when they need to be alone. That cultural teaching is as follows:

> The 7th direction is the direction inward to the heart where clarity, wisdom and genetic memories of ancient tribal counsel are held. The 7th direction room does not entail punishment. During early recovery, one often encounters Inktomi Tipi/Coyote (mental spider webs from the trickster), which are bouts of confusion and stress that interfere with decision-making. It is helpful to have a designated time and space to journey inward to the 7th direction (where the ancient ones reside) for spiritual reflection before making important decisions or prior to examining the need to change one's behavior. The client gains empowerment along with the skill of reflection and decision-making from such a spiritual perspective and vantage point. Upon entering the 7th direction room, the client will smudge with sage and sit calmly for up to 30 minutes listening to Native flute or drumming music. The client can hold the sage or sweet grass as a spiritual anchor and focus their awareness inward listening to their hearts and their own answers. Upon leaving the 7th direction room, the client writes or discusses the issue with a psychology technician or counselor depending on the level of severity of the issue. All clients entering the 7th direction room have a behavioral log completed documenting the intervention and the outcome. The case manager and/or shift supervisor is immediately informed of any significant treatment issues. This report is sent to the clinical team by the next day.

D. Client Profile

There are three major types of admission to the residential program. The majority of adolescents (70%) enter treatment involuntarily, that is they are given two choices: treatment or detention. The second typical referral is the adolescent who was cited for using AOD on school premises and must complete treatment to return to school. Finally, there is the self-referred adolescent who enters treatment on their own volition, perhaps motivated by family responses to their usage. It is rare that an adolescent will volitionally ask to enter residential treatment.

1. Demographics

Since 1989 the program has served over 1400 adolescents and their families. The following 2000 to 2002 demographics are based on 150 adolescents who entered the treatment program and who participated in the Four Corners Health Study. There were 66% male and 34% females with an average age of 16, ranging from 12 to 19 years old. The adolescents were American Indian with 67% raised on an Indian reservation and 33% raised in a border town or an urban area. The majority (63%) was raised by their mother, 12% by the father, 9% by Grandparents, 10% by extended family and 6% by both parents. The

average length of stay was 57 days with an average of 88% successful completion. The following are some basic admissions demographic data:

2. Alcohol and Other Drug Profile

Alcohol 98% and Marijuana 87% are the two main drugs with crack/crank and crystal methamphetamines (40%) as the third drug of choice along with 18% having a poly-substance dependence. The substance pattern of usage is with classmates (41%), family members (35%), drug dealing (33%), and gang members (25%). Many reported using alcohol and drugs while taking care of children (10%), while driving a car (33%), using in school (44%), and 85% reported being unable to stop using in the past year. Approximately 14% had been through "detox" 1 to 6 times with 18% experiencing an alcohol and drug overdose. While 42% reported they were unable to stop due to their environment, over 35% felted pressured to enter treatment, and 92% believed the treatment would help them improve their current life situation.

3. Bio-Psycho-Social-Cultural Status

A majority (91%) of the adolescents enter the program in "excellent" to "good" health and 12% needed treatment for an STD. Over 75% of the adolescents are either on probation and/or parole with over 74% continued to have AOD use after problems with the legal system. On an average of four times, these adolescents were placed in detention before a referral to AOD and mental health treatment was provided. The average age of their first detention was twelve.

Eighty-four percent perceived their home environment as stressful. About 67% had mothers who were using AOD, 39% had using fathers and 52% had siblings that would use. Majority of the adolescents were in single-family homes (72%), but over 62% had experienced domestic violence within their lifetime. Twenty-five percent had been gang members and approximately 31% had run away from home one or more times.

Approximately 10% spoke their Native language even though 67% had been raised on the reservation. Over 62% had been in boarding school as early as age four with an average of two years in the boarding school system. Sixty percent attended an organized church and forty-one percent attended Native American Church on a regular basis. Fifty-two percent reported using a Traditional Medicine Practitioner, 50% regularly attended ceremonies, and 52% utilizing sweat lodges some time in their life. Over 88% reported belief in a higher power who could assist them in life.

The majority of the adolescents (74%) had experienced trauma (child maltreatment) in their lifetime with 32% having traumatic events before the age of 12. About 68% were traumatized between the ages of 12 and 18. Over 56% had attempted suicide in their lifetime while *not* under the influence of AOD and over 70% reported thoughts and behaviors consistent with Post Traumatic Stress Disorder (PTSD).

Approximately 88% of adolescents had been expelled from school during their lifetime and 51% were actively enrolled in school at the time of their admission to the treatment program. The average academic attainment was 9th grade for both male and female and 28% were identified as having special education needs before admission. However, the treatment academic assessment revealed that 39% had difficulty reading and 25% difficulty writing. Over 82% were identified to be 2-3 grade levels below the standard

in reading, 3-4 grade levels below in language skills, and 1-2 grade levels below in math. This was a consistent academic trend seen throughout the program's history. It must be noted after completing 60 days in a special remedial and culturally relevant academic environment, 72% of the adolescents improve an average of 2 grade levels in reading and math, and 1 grade level in language skills.

E. Referral Sources

1. Profile of Referral Sources

OYOF was a regional AI/AN adolescent program. Therefore, adolescents from across the country were accepted. However, 80% of the adolescents came from a four state area (New Mexico, Arizona, Colorado, and Utah). Over seven tribes actively sent adolescents to the treatment program. Approximately 70% of referrals came directly or indirectly from the juvenile justice system. The remaining 30% came from Indian Health Services, Tribal treatment programs, school programs, and social service programs.

2. Program Participation of Referral Sources

The program's policy was to have the referral agency and/or agent involved with the treatment process. This entailed attending treatment reviews and family day, whenever possible. It was mandatory that the referring agency had a representative to participate in the discharge planning to ensure that the adolescent and family received ongoing aftercare services. This process included any treatment providers who were going to provide the aftercare treatment.

V. CULTURALLY APPROPRIATE CLINICIAN AND COMMUNICATION INTERACTION

When working with AI/AN people, it is not enough to be culturally sensitive. We must have a thorough knowledge and a respect for Native cultural ways of healing. Clinicians can either enhance or diminish a client's potential by their belief system. An AI/AN culturally sensitive clinician must understand basic concepts such as believing that cultural diversity can be a positive force in one's treatment, addressing one's stereotyping of the AI/AN culture, knowledge of ethnic membership, and the feelings associated with Native identity. Others include discounting cultural denial, not understanding that trust is a basic issue and trust is fragile no matter how long of a relationship with the client. We know that client-clinician matching is not as powerful as world-view matching.

Other vital educational and training areas for the non-native clinician working with AI/AN cultures are: 1) application of cultural beliefs in their understanding of etiology of disease, 2) language and the classification of illness, 3) the combined use of traditional modern medicine, 4) Native American Church and its impact on cultural health beliefs and practices, 5) understanding the catastrophic effects of cultural loss and collective grief issues, and most importantly 6) keys to developing a good professional relationship with the treatment population. The key to developing a good professional rapport within the AI/AN culture is that a clinician must understand basic courtesies that one is to integrate into the clinical setting and subsequent interactions. Basic social and individual communication consist of:

1. Welcoming the client. Always extend a sincere greeting and smile. The smile may not be returned but it is appreciated. Offer a gentle - not a firm - handshake to the adolescent and families; a firm handshake may be interpreted as too aggressive. In the Navajo tradition, the hand is extended to gently touch the other person's hand. Always thank client families for coming in and you are appreciative of their choosing your program.
2. Understanding that conversational courtesies such as "thank you", "excuse me", et cetera are not common in the Navajo culture. Although infrequently expressed by the Navajo person, they are grateful and will express this type of courtesy or gratitude over time.
3. Use eye contact cautiously. The AI/AN person expects some eye contact, however, prolonged eye contact is a sign of disrespect and should be avoided. This takes time and practice especially by the non-native clinician.
4. Perception on time. Most AI/AN people are present-oriented and clocks and time are not as important. They view time on a continuum with no beginning and no end. This issue of time should be taken into consideration when prescribing medication, scheduling appointments, and taking a history of illness.
5. Speak Clearly. Avoid using clinical terms that may not be understood. Attempt to describe what you are trying to communicate. Do not talk down to them but do talk with a soft tone and sincere voice. This will put the adolescent and their families at ease.
6. Respect silence. Be concise and give the adolescent and families time to interpret what you are saying and look for behavioral signs indicating non-understanding. Many times AI/AN people will say they understand out of politeness and respect. They are not prone

to ask questions, especially if someone is older, since to do so is a sign of disrespect. Therefore, the clinician must determine if they are communicating successfully.

7. Many AI/AN people believe stating something futuristic may cause the event to occur. This has obvious implications on how you present behavioral health issues. An example would be in explaining the results of an AOD assessment and stating that if something does not happen, there may be future problems. The client may believe you brought this ailment to them. It is important to explain such reports in appropriate language and many times, if an NAHP is available, they can culturally express it.

VI. CULTURAL-TRADITIONAL PROGRAM

The cultural traditional program is the foundation for all other treatment processes and modalities. The program has it's own program standards along with a credentialing process for NAHPs. There are general cultural and traditional teachings that are provided to the adolescent and families upon admission. The main teachings and ceremonies described below are used on a daily basis to open individual, group, and family sessions. This is not an exhaustive list but serves to provide the reader with a basic understanding on how to integrate the practices into the treatment setting.

A. Spiritual Grounding: Four Sacred Herbs

Native people believe that there are four sacred plants that the Creator left behind for them to use for healing. Tobacco, sweet grass, sage, and cedar are utilized for different ceremonies and everyday living. Sweet grass, sage, and cedar are the most common herbs used for smudging. Smudging is used as a cleansing and blessing ceremony. Many use smudging before they enter the sweat lodge and some use it before participating in ceremonies along with cleansing and blessing oneself at work or home. Smudging is one of the first ceremonies the children are taught when they enter our treatment program. They are given the teaching on how it can cleanse and bless them throughout treatment and how they can be sacred tools for them to use as a spiritual grounding when returning to the G*littering World.*

1. Smudging

Smudging is a powerful purification process that is simple and can be used almost anywhere. It helps to ground a person and to re-focus one's mind and spirit. There are various methods to smudging and varying cultural traditions define different approaches. The main aspects of smudging involve the use of sacred herbs; sometimes tied in a bundle. These herbs (sage, sweet grass, and cedar) are burned in a shell, pot, or other vessels that can handle intense heat. A sacred feather may be used to clockwise fan the smoke in the four directions. Smudging is used for medicine tools and instruments before and after ceremonies. An individual uses smudging to cleanse themselves of negative energy, thoughts, emotions, and bad dreams.

After cleansing oneself, the same herbs may be used to refresh oneself with positive energy by fanning the feather upward along the body. During smudging, the removal of jewelry and eyeglasses is an optional choice, depending on the cultural tradition. Smudging may be used in a hand washing motion and/or starting from the bottom of the feet and moving to the top of the head. Another process is to smudge the female or male side of one's body first and then the rest of the body and finish with a fanning of the smoke over one's head to send the energy away. The most important aspect of smudging is to have *the sacred intent within you.* This makes the interaction between the herbs and feather a special ceremony. Although, there is no one right way of smudging, the *sacredness* of this ceremony lies in *listening to your intuition* and the call of your *spirit.*

Smudging is utilized at the beginning of each group, individual, and family session. It is also used during significant emotional processing and helps the adolescent regain control. This is a powerful tool when adolescents are having difficulty sleeping and/or awaken from bad dreams. The use of the sacred herbs helps take them to a place of safety and control. The herbs are believed to dissipate the negative feelings and thoughts. They also serve to drive away bad spirits. One of the teachings that the adolescents receive is described below:

2. Cultural Teaching: Gift of Resilience From The Holy Ones

It is told by our Elders that at one time, Mother Earth and Father Sky had a disagreement related to the issue of control. Mother Earth stated that everything, which came from Her, was under Her control and Father Sky stated everything from the Air on up to the Sky was under His control. This dispute resulted in no interaction between the two Natural entities which was vital for Earthly survival.

This non-interaction lasted for about three or four years and the Air became very thin and there was no rain. Many of the plants, animals, and birds began to disappear due to this disagreement between their Mother and Father.

It came to the point when there only existed three Plants and one Bird. These Plants and one Bird gathered together to talk about what was happening. They too, were struggling to survive and were experiencing loneliness for their Plant, Animal, and Bird relatives. They decided to go to Mother Earth and express their concern.

They went to Mother Earth and expressed that because of the disagreement between Her and Father Sky, many of their living Relatives had disappeared, and they themselves were suffering. They further expressed that their suffering was due to the lack of interaction between their Mother and Father, which was vital for their healthy existence. Mother Earth offered her apology for the selfishness of Herself and Father Sky. She requested that the one surviving Bird fly up to Father Sky and ask for her forgiveness and for the return of their needed interaction. This Bird flew up to the Heavens and as it flew upward it disappeared from sight.

After the passing of four days, the three surviving Plants heard Thunder and saw Lightning way off in the Southern direction. With the sound of the second Thunder, the Dark Clouds came closer and with the third Thunder, it shook the ground. With the fourth Thunder, the Dark Clouds came right overhead, and as the Lightning flashed out came the one surviving Bird. The Bird flew down to Mother Earth and when it landed it brought needed Rain and the Air became full. This change in the environment was very noticeable and the Plants, Animals, and Birds, which had vanished, began to reappear.

The Plants, Animals, and Birds celebrated this re-establishment of the natural interaction between Mother Earth and Father Sky. For when it rains, it is the Mating between their Mother and Father and provides needed nourishment for their existence. After it rains, it provides a cool refreshing feeling and the appreciation for the Beauty of Life, which is reflected in the appearance of the multi-colored Rainbow.

This was all brought forth by the survival and resilience of the three Plants and one Bird. Because of their demonstrated Resilience for survival, the Holy Ones recognized this positive energy and made the three Plants and remaining Bird as an essential and important

part of all American Indian ceremonies. The three Plants were the Tobacco, Cedar, and Sage, and the surviving Bird was the Eagle.

When participating in Indian ceremonies, there is a frequent Spiritual usage of Tobacco, Cedar, and Sage, with the use of Eagle Feathers. These Sacred Plants and Eagle Feathers possess the positive intangible energies of Resilience, Courage, and Strength. One will internalize these positive energies when Praying or Meditating with Tobacco, when burning Cedar herbs, Blessing themselves with Sage, and fanning themselves with Eagle feathers. These Sacred entities are used in a Spiritual manner for continued good Health or Prosperity, or when facing difficult Challenges.

B. Sweat Lodge - *Inipi-Stone People Lodge Ceremony*

The sweat lodge is introduced to the adolescents the second week of treatment after they are off safety status. They receive the teaching on the building of a lodge, the purpose of the stone people, the structure of the ceremony, and the appropriate manner the sacred pipe is handled. The adolescents are taught how to build the fire and are responsible for preparing for the lodge every week under the supervision of a NAHP. The first week of sweat lodges are to help detox the physical, mental, emotional, and spiritual body. The adolescents are given teachings inside the sweat lodge that correlate with the teachings and focus of treatment that week. The sweat lodge lends itself in supporting the adolescent to sit quietly for long periods of time and to face hardship while maintaining reverence. The sweat lodge aids many of the adolescents in training their minds to focus their attention. It is also a wonderful environment where adolescents can discuss many issues that are sensitive and emotional. The sweat lodge serves many purposes but most of all it is a sacred place for healing. The following is a description of a sweat lodge and the facilitation process.

The sweat lodge is more than a building. It is an active dynamic energy force, as it transforms into a *holy sacred* place that connects the person with the *Creator*. All of the materials are gathered in a sacred manner and are interwoven to create the sacred place.

The **Poles** are usually made of willows and when gathered, tobacco is placed to show gratitude for their sacrifice. The willows are placed in a symbolic manner. Following Lakota tradition, four poles are tied together; bending to make the four sides standing for the four directions. The lodge is circular and the door of the lodge is placed facing the East direction, representing illumination and the spirit door. The lodge is built low so that one enters on their knees, reminding them to be humble and to understand we are no greater or lesser than other life-forms.

In the past, the lodge **Covering** was made of buffalo hides or the skins of other animals. Today, the majority of lodges are covered with canvas or heavy blankets. No matter the covering used, once it is completed, it becomes a living symbolism of the skin and body of the mother when one is still in her womb.

The **Stone People** are the lava rocks that are gathered in the same sacred manner, with tobacco placed to show gratitude for their sacrifice. When the stone people are heated and brought into the womb of the lodge, many times they are referred to as the *elders* or *grandfathers*. Many traditions speak of the stone people as the holders of wisdom from the ancient ones, and these teachings and healings are released through the steam. As our perspiration is returned to the Mother Earth in the form of water, the Earth is again nourished.

The **Pipe** is used by many tribes, but not by all cultural traditions. Some ceremonies will begin or end with a Pipe ceremony, depending on the purpose of the lodge. For some sweat lodges, prayer ties made of tobacco bundles are hung inside the lodge. Each tobacco tie we place in the lodge represents a prayer to our relatives and the *Creator* to ask for their help and healing during the ceremony. The pipe and tobacco are used to send the prayers up to the *Creator*. The most well known story in the Lakota tradition of the *White Buffalo Calf Woman* speaks of the sacredness of the pipe (see Black Elk's, *The Sacred Pipe*, for the complete version of the story). During some lodges, a pipe is not used and tobacco is wrapped in cornhusks or other leaves, that serve the same purpose as the pipe.

Topic: The ceremony consists of four different doors (rounds) where drumming, singing, and prayers honor the Four Directions. Each door represents different teachings for purifying and healing as determined by a NAHP. There is a minimum of 28 stone people. The eagle feather, drum, cedar, sage, tobacco and other sacred instruments may be utilized accordingly.

Goal: Allows the client to recognize their own strengths and become empowered to seek continued teachings about themselves as human beings in relationship to all living elements. Each door addresses different aspects of Creation and supports the participants to reconnect with *All Our Relations* through prayer and self discovery.

Task: Each person challenges themselves to complete all four rounds mentally, physically, emotionally, and spiritually.

Process: The process is an internal one, but the client must express him/her self to demonstrate gaining knowledge through prayers. The sweat lodge teaches some participants the art of prayer for the first time in their lives. In the Navajo tradition, males and females have their own sweat lodge for healing ceremonies led by same gender.

The sweat lodge is often described as the womb of the Mother Earth and many participants experience leaving the lodge having been *reborn*. Today, the sweat lodge is very important in treatment since it exemplifies holistic healing by allowing a return to a harmonious balance spiritually, emotionally, mentally, and physically. This ceremony reminds us of the need to continually purify the mind/body/spirit to humble oneself and recommit to Walking in Beauty.

C. The Smoking Ceremony

There are many types of Smoking Ceremonies. The program utilized a general Smoking Ceremony in the beginning phase of treatment to ground, refocus, and reintroduce the adolescents to the Spirits and the Holy People in the four directions. It is believed that many of the adolescents have not introduced themselves in a long while or may never have had this ceremony. The ceremony is explained to the adolescents and how it will assist them in being successful in treatment.

Another Smoking Ceremony is the Deer Way that is specifically for alcohol and other drug usage. This ceremony also addresses anxiety and worry. It serves to cleanse, refocus, and recapture the mind to improve one's life. This can be done with the program's NAHP or the family can have the family Medicine person conduct the ceremony.

There are other Smoking Ceremonies that are specifically for suicide, incest, or depression. This ceremony helps to clear the mind and appease the spirits who have been

offended and/or violated. This ceremony serves to instill hope along with sacredness and reverence. In the case of suicide it may be necessary to have the adolescent participate in a Blackening Ceremony and Protection Way Prayer. If the child has experienced incest, a Moth Way Ceremony and Smoking Ceremony may be conducted. The different Smoking Ceremonies are utilized throughout treatment as the cultural team deems necessary for the whole group and also for individual issues as they arise.

D. Protection Way Ceremony

This ceremony is conducted with an arrowhead and is used to blow the negative spirit, emotions, and thoughts back to where this spirit belongs. The arrowhead serves as a protection from the spirit being blown away, so it will not interfere with one's life and livelihood.

The Navajos have a complex series of healing ceremonies and/or chants. They are designed to restore harmony to the patient. Therefore, these are just some of the main ceremonies that the program uses daily with adolescents and families. This is not an exhaustive list of ceremonies.

E. Drumming and Singing

The physical drum is made from a wooden shell covered in rawhide. Today, deer, buffalo, and cowhide are used to cover the drum although a buffalo hide head is not unheard of. The average drum size is about twenty-six inches in diameter and can seat about eight drummers around it. There are individual drums, Pow Wow drums, and Native American Church drums, all having a distinct purpose and sound. A large Pow Wow drum was made and dedicated to the adolescents.

During the third week of treatment, the adolescents receive education on the reverence and sacredness of the drum and how it connects us to the earth and the path towards healing. It is not introduced before this since the adolescent has been in a high detox state and should not touch the drum while still under the influence of AOD. After receiving the teachings and the adolescent demonstrates appropriate reverence, they are allowed to access the drum to calm themselves, to practice their songs, and to support overall healing. They are always under the supervision of appropriate staff.

The NAHP explains the difference between the Southern and Northern style of singing at Pow Wows - how they differ in pitch and drumming styles. The Southern style has a more low pitch and softness, whereas the Northern style is high pitch and faster paced. There are intertribal songs such as Sun Dance and Four Direction songs. Clients are also exposed to the traditional songs of the Navajo with the Blessing Way and Protection Way songs.

VII. ALCOHOL AND OTHER DRUG (AOD) PROGRAM

The AOD program is designed to increase the knowledge of the adolescent and family regarding the impact of AOD usage on one's physical, mental, emotional, and spiritual being. This includes discussing the impact of intergenerational use of parents and extended family members. The adolescent and family will be able to determine the progression of the AOD addiction process and identify the current stage of progression regarding the family system. At the end of the 8-week AOD program, the adolescent and family members will develop a recovery plan for all members of the family. The long-term goal is for the adolescent and family system to actively engage in the recovery process after discharge. This includes accessing appropriate community and family networks to support the recovery process.

A. Alcohol and Other Drug (AOD) Education

Alcohol and other drug education begins by identifying the health consequences of AOD use. Motivational techniques help the adolescent assess, understand, and accept that their AOD usage has become a problem and is negatively impacting their life. A majority of the adolescents who attend OYOF engage in the use of marijuana, alcohol, inhalants, and cocaine. All adolescents receive education on the effects of cigarette smoking, marijuana, alcohol, inhalants, methamphetamines, cocaine, and other specific and identified drug usage.

The substance abuse module encompasses eight (8) sessions that will educate the adolescent on the process of AOD addiction. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process,* and *closure.* All sessions are opened and closed by *smudging and prayer.*

Session I - *Disease Concept* will allow the adolescent to learn the meaning of substance abuse and addiction along with gaining an understanding of the progression of alcohol and other drugs and how it affects their well-being: physically, mentally, emotionally and spiritually.

Session II - *Jellnick Chart* will allow the adolescent to identify the stages of progression with chemical dependency in their own life by becoming aware of their personal experiences and hidden secrets within that process.

Session III - *Alcohol* will allow the adolescent to become aware of how alcohol affects the body/mind/spirit along with their life patterning behaviors; incorporates a review process of the addiction cycles.

Session IV - *Cannabis* will allow the adolescent to become aware of how marijuana affects the body/mind/spirit and their life patterning behaviors; incorporates an understanding of the addiction process of marijuana.

Session V - *Tobacco and Nicotine* will allow the adolescent to learn the negative long-term effects of tobacco and nicotine (cigarettes, cigars, snuff and chewing tobacco) on the body/mind/spirit and why the nicotine in tobacco is a habit-forming drug. The adolescents,

as well as the staff members, are not allowed to smoke while in the treatment program. Therefore, the program provides a smoking cessation class and process to manage their cravings while in treatment. This is provided through the health program by the nurse practitioner.

Session VI - *Inhalants* will allow the adolescent to understand the basic facts about inhalant abuse and the inherent danger of inhalants on the body/mind/spirit.

Session VII - *Drugs and Behavior* allows the adolescent to understand the direct correlation between alcohol and inappropriate behavioral effects; incorporates a discussion of negative effects on the brain and spinal cord.

Session VIII - *Other Illicit Drugs* allows the adolescent to understand the inherent dangers and negative physical effects of different illicit drugs on their body/mind/spirit; re-emphasizes how substance abuse leads to negative consequences in their life.

1. Cultural Teaching and Ceremony: Vision of The Colored Waters

The Navajo People believe that the Holy People placed Sacred Stones in the Four Sacred Directions. They placed White Shell in the East, Turquoise Stone in the South, Yellow Abalone Shell in the West, and Jet Black Stone in the North. The colors of these Stones and Shells become the Sacred Colors to the Navajo People.

The Teaching is based on these Sacred Colors, which provides insight of how a Navajo person can relate to their awareness of Substance Abuse –A Blessing Way Story based on these colors is as follows.

A young Navajo boy and his little sister lived with their parents and extended family relatives near a large cornfield. Everyday this young boy and his sister went out in the afternoon to play in the cornfield. Towards the evening just before the Sun went down, they would come out of the cornfield and go home.

One day after playing in the cornfield, they began to make their way back towards their home. When they came out of the field of tall corn, they were surprised because they could not see their house.

They decided to climb up a little hill to see where they were and if they could see their home. When they reached the top of the small hill, they turned around and still could not see the way back to their home. The young boy and his sister again decided to climb to the top of the next hill. Again, when they climbed to the top of this next hill they still could not see where they lived. By this time the Sun sunk lower and the little sister began to cry. Her brother told her not to cry and assured her they would get home before dark.

The young boy, himself, was beginning to become scared, but did not want his little sister to know. He quickly looked around to see if he could determine where they were. When he looked around, he saw a patch of Mountain Tobacco plants. He remembered that his Grandfather had told him that if he needed help or guidance, that he needed to use Mountain Tobacco to pray. He knelt down and picked up some the Tobacco and crushed it with his fingers. He then placed the crushed Tobacco in a corn leaf, one he had inadvertently picked when walking through the cornfield earlier that evening.

He and his little sister sat down on the ground facing the East direction and he lit the Mountain Smoke. With much reverence, he smoked the tobacco and blew some of the smoke on to Mother Earth, towards Father Sky, and to each of the Four Sacred directions. He then blew some of the tobacco smoke on his hands and blessed himself and then blew some on his little sister's hand and she blessed herself.

He then began to pray for guidance to find their way back to their family and relatives. As he was praying, a bird flew out from the East direction and dropped white colored water in front of them. Then the bird said to them, that this kind of White Water will be coming and to tell your People not to drink this White Water. Then the bird flew off back into the East Direction.

As the young boy again, began to pray another bird flew out from the South direction. This bird dropped Blue Water in front of them and said this is good Medicine Water, and your People should drink only this kind of Water.

A third bird flew out from the West direction and dropped Yellow Water and stated to tell your People that this kind of Water is coming and they are to stay away from using this Colored Water. A fourth bird came from the North direction and again, dropped Dark Purple Water. This bird warned the young boy to tell his relatives not to drink this kind of water and to be aware because this kind of water will be coming to his People. The young Boy sat there smoking the tobacco and thinking about what he had just experienced with the four Birds from each direction. He put out the burning tobacco and placed it on the ground in front of them. Then he and his little sister turned around and at the bottom of the hill they could see the cornfield and their home on the other side. They both let out a deep sigh of relief and began to make their way back home.

When they reached their home, the young boy immediately went to where his Grandfather lived. As he entered the home of his Grandparents, he found his Grandfather sitting on the earth floor as if he had been waiting for the young boy. The young boy sat down by his Grandfather and respectfully waited for his Elder to speak first. The Elder reached out and put his hand on his grandson's shoulder and asked the young boy where he had been. Although, the young boy was excited, as calmly as possible he told of his and his little sister's experience of the birds and the Colored Waters from the four directions.

After the young boy was finished telling of their experience, the Elder explained that this experience was a Vision for the People. The Elder stated that the birds were the Holy People who lived in the four directions and that their message was a warning of destructive Waters, which would be coming. He further explained that the Blue Water from the South was a gift from nature for emotional stability and that the White, Yellow, and Dark Purple Waters would be man made and cause much disharmony for the People.

Today, we know that these Colored Waters have caused much destruction among our People. The White Water is known as Whiskey, the Yellow Water is Beer, and the Dark Purple Water is Wine. These Colored Waters have no boundaries and have resulted in substance abuse adversely impacting the Spiritual, Emotional, Social and Physical wellness of the People.

Ceremony: The sweat lodge and smoking ceremony (other individual ceremonies are used according to the severity of the AOD usage)

B. Relapse Prevention and Refusal Skills

All adolescents identify patterns of use, cues that lead to usage (e.g. emotional, peers, family), relapse patterns, and refusal skills. The group sessions focus specifically on the socializing ability of each adolescent in the group. In addition, each adolescent receives relapse prevention training and develops a written relapse plan that is presented at discharge to the community, consisting of family, aftercare counselors, probations officers, and program staff.

The relapse prevention and refusal skills module encompasses six (6) sessions that educate the adolescent on the warning signs and triggers that may lead to relapse. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process,* and *closure.*

Session I - *Relapse Process and Warning Signs* allows the adolescent to learn the warning signs (e.g. emotional, peers, and family) that lead to relapse and will assist them to identify through awareness the relapse triggers that may be barriers to their successful sobriety.

Session II - *Post Acute Withdrawal Syndrome (PAWS)* allows the adolescent to understand PAWS and will assist them to identify through awareness symptoms they may be experiencing that are a normal part of the recovery process.

Session III - *Stages of Recovery* allows the adolescent to learn to identify the stages of the chemical dependency and recovery process and to visually see their own progression through these stages by completing a V Chart.

Session IV - *Peer Pressure and Choices* allows the adolescent to learn the risk factors that lead to relapse and the protective factors that promote healthy ways to stay clean and sober; incorporates an understanding of the importance of stabilization related to their environmental and family systems.

Session V- *Coping Mechanisms* allows the adolescent to identify productive leisure time and family activities to promote a positive recovery; incorporates a discussion on daily problem solving, relapse patterns and refusal skills.

Session VI - *Relapse Prevention and Sobriety Script* allows the adolescent to develop a written relapse prevention plan (discharge plan) and a sobriety script (a self-talk method) identifying specific steps to maintain sobriety and social and support systems in the community to use to strengthen continued recovery.

1. Cultural Teaching: Gifts of Adversity

The four gifts of adversity are based on the teaching that we are given these gifts from the Creator to help us develop and learn how to deal with the realities of life. This teaching is usually conducted in the sweat lodge and each concept is presented at the appropriate door. The adolescents discuss ways to deal with these adversities when they are out in the world. The Four Gifts are:

- The Gift of Prejudice and Resentment
- The Gift of Suffering and Sacrifice
- The Gift of Loneliness
- The Gift of Hardship.

Ceremony: Sweat lodge and other specific ceremonies depending on individual needs.

C. Psychotherapy

All adolescents receive individual therapy according to their ability to manage individual treatment. The individual sessions serve to aid the adolescent to develop a deeper understanding of their AOD usage and other issues (child abuse, gender identity, and mental health) that serve as barriers to successful sobriety. In addition, the sessions support the adolescent in identifying strengths, and practicing interpersonal skills.

The purpose of group psychotherapy is to offer the adolescent the opportunity to become aware of their personal problems and barriers to accessing *the Red Road of Healing*, to learn to accept both the bad and good points in themselves, and how to cope with solving their problems in a more positive manner. Group therapy teaches the adolescent how to deal with people more effectively in ways that lend to a better adjustment to the world in which they live. In group, the emphasis is on the "here and now" problems and feedback. Cultural teachings are interwoven throughout the process. There were gender specific groups to deal with issues around child maltreatment, specific hygiene issues, peer violence (e.g. rape), and other milieu issues that required specific attention. All psychotherapy groups use the “Talking Circle”. The following is a brief description and process that is presented to the adolescents.

1. Cultural Teaching and Ceremony: Talking Circle

“ Respect means listening until everyone has been heard and understood, only then is there a possibility of “Balance and Harmony” the ultimate goal of Indian spirituality.”

-- Dave Chief, Grandfather of Red Dog

Talking Circle:

The circle is one of the oldest symbols in our world and can be seen throughout different cultures. The AI/AN people view the circle as the most important mystical symbol that connects one with the Creator and nature. The sacred circle has been used from decision making to conflict resolution and can be a valuable asset in a treatment setting.

The talking circle includes an eagle feather or a talking stick (wisdom tools) that embodies the wisdom and heart of the circle. They afford the opportunity for a group and individuals to speak their truth with creativity and without fear of condemnation.

The main rules of the "talking circle" are to speak with honesty, to be heart-felt, and have focused attention. This also allows members to listen without having to be busy creating a return response to the other group member. This experience serves as a teacher to those who have difficulty disciplining themselves in their communication with others. The "talking circle" benefits a group process and teaches by modeling and sometimes by total silence.

Process: The talking circle leader is invisible and allows the circle to manage itself once the group has become comfortable. However, the leader must hold the heart of the circle to maintain the integrity and wisdom of the sacred circle. The eagle feather or talking stick may go from person to person as they introduce themselves. Other times, one person will have the wisdom tool and speak. Then there will be times that he wisdom tool is placed in the center waiting for the spirit to move the group into their spirit work. The most important aspect of the group is to talk with clarity while sending heart energy to others when they are speaking. The sacred circle will end with a prayer, song, and a motivational statement from a member.

D. Twelve Step Program*:*

This is a brief, structured process that explains the basic 12-step concepts (e.g. surrender, higher power, moral inventory). The client fills out a 12-step workbook that guides them through the process. Many times, the client will stay at the first three steps for the majority of their treatment. Everyone progresses at their own pace. Alcoholic Anonymous meetings along with speaker meetings are conducted on site. The clients are not taken off the premises for meetings because historically the program found that these meetings served as environmental cues for relapse due to the smoking that occurs, causing an identification with old behaviors, encountering active users at meetings, and the fact that peers on the outside would supply drugs to the adolescent. Clients are encouraged to identify a sponsor before discharge to support sobriety after discharge. (See Nowinski, Baker and Carroll (1995), Twelve Step Facilitation Therapy Manual, Volume 1).

VIII. CULTURAL IDENTITY DEVELOPMENT AND SKILL BUILDING PROGRAM

The cultural identity development and skill-building program is based upon more traditional Western treatment approaches and focuses on both substance abuse and identified co-occurring disorders, with the particular combination of approaches determined by the treatment track combined with individual need. However, the cultural aspect is to help the adolescent develop a strong Indian identity that will serve as a protective factor. The program consists of cultural identity teachings and various skill-building groups: Cognitive-Behavioral, Behavior Modification, Anger Management, Coping & Problem Solving, and Heart Power, Independent Living.

A. Cultural Identity Development

This program is designed to introduce the Navajo creation story, legends, and history, self-sacredness and identity, philosophy of life, and spiritual practices for wellness and harmony.

Session I - Creation, Legends, and History of the Navajo; this session presents a video on *The Navajo, Legend of the Glittering World* (25 minutes). It discusses the five worlds legend, the legend of the four sacred mountains, along with handouts on the sacred mountains, earth, air, fire, and water, sacred plants and the log home (three types of Hogans). This provides a beginning foundation on how Navajo and Indian people believe their world began and the history that followed the creation.

Session II - Self Sacredness and Identity; this session discusses the teachings on individual self and kinship as it relates to extended family and community. The handouts provided are: The Success and Direction, Navajo Cosmology, How I Would Introduce Myself, Relationships, Cradle board, Origins of the Four Clans, Diagram of Clan Relationships, and Navajo Clan Chart. The adolescent will be able to identify, write, and introduce themselves through their clanship by the end of this session.

Session III - Navajo Philosophy of Life; teachings and meanings within the Four Cardinal Directions are presented. The handouts provided are: The Dineh Philosophy and Spiritual Knowledge for a Secular Society. The adolescent begins to develop a foundation on their own spirituality and how it relates to themselves, family, extended family, and community and their long-term recovery.

Session IV - Spiritual Practices for Wellness and Harmony; the video *American Indian Concepts of Health and Unwellness* (30 minutes) is presented and steps for seeking ceremonies are outlined, and the Four Roots of Disharmony are discussed. The handouts provided are: Utilization of Ceremonial Practices, The Chantways, Walking in Beauty (six standards of life), Native wisdom, and Dine' Psychology about Prayers and Songs.

After each session the adolescent will write, draw, or orally discuss the areas that they can identify and may use in their recovery process. The above teachings are interwoven throughout the Western skill building sessions. The NAHP and counselors will demonstrate correlates to each skill as they are presented.

1. Cultural Teaching: The Circle of Life

The following is the main cultural teaching that is presented for the adolescent to begin their self-inventory into their thoughts, feelings, words, behaviors, and interactions.

The Circle of Life

What have you spoken, where have you been and where do you want to go (self-inventory)? The Circle of Life begins with birth, young adulthood, middle age, and on into old age. As we journey, we encounter these milestones. These milestones are initiated with birth from the East direction; young adulthood is achieved by age 25 and 26, which is perceived as being in the South direction; middle age is at 51 years, which places one in the West direction, and the beginning of old age is realized at the age of 76, which is being in the North direction. From the North direction, one will begin to move back to the origin of the East direction, in that, old age will eventually place one back into the infancy stage of life in having to be cared for like a newborn. Ultimately, one will again experience birth, which will be birth into the spirit world. A full lifetime is perceived by the Navajo People by reaching the age of 102, which will have been enjoyment of being part of four generations.

As people in general, we all share the four dimensions, which compose our total being of the spiritual, emotional, mental, and physical aspects. When these four dimensions are in balanced harmony with each other, we then enjoy holistic wellness. Additionally, each given person is provided with personal unique gifts of voice, thumbprints, footprints, and a shadow. Our individual level of wellness will dictate how we will utilize these four gifts in our everyday life and throughout our personal journey.

Your Voice

When we are born into this earthly existence, we began with our first breath of air and expressed our first cry. Our first cry is not only heard by those in our presence, but is spiritually acknowledged by the Holy Ones, who exist in the Four Sacred Directions. The acknowledgement by the Holy Ones is the unique voice quality of a given person, which he or she will carry throughout their earthly journey.

This first cry will develop into the unique voice expression through words, laughter, singing, prayer and of course, through continued expression of crying during sadness and joy. Utilization of your voice in a responsible and healthy manner will result in fostering good energy and a positive self-image, as well as having a supportive impact on those around you. On the other hand, misuse of this gift will result in fostering negative energy within, as well as negatively impacting others by violating personal boundaries, which may include abusiveness.

Your inner state of being in harmony or disharmony is reflected through the use of the unique gift of voice. The question for self-inventory then becomes, how have you used your voice for personal functioning and how have you impacted others with this gift?

Your Thumbprints

The Navajo People have always acknowledged the sacred gift of having wind swirls on your right and left thumbs, which are known in current society as thumbprints. These wind swirls on your thumbs are associated with personal and professional goal setting as a means of understanding and achieving your purpose in life. Your existence in this earthly life is not by accident, but was a choice you made with the Creator to fulfill a spiritual and positive purpose.

After a rainfall, we enjoy the moisture and coolness, which nurtures our emotional being and at which time the spiritual energies of the Rainbow reveals itself. A Navajo person will, with their thumbs up, point towards the Rainbow in a spiritual and reverent manner and reflect on their personal achievements and goals. By doing this, they will spiritually place their own unique wind swirls or thumbprints on the Rainbow of many colors and recommit to their goals and purpose in life. They believe that the moisture of the rain and the beauty of the Rainbow will rekindle their emotional motivation in seeking and moving towards their own unique purpose in life.

It is known that those who continue to seek spiritual, personal, and professional goals through perseverance and commitment will come upon unexpected doors of opportunity. As they come to such door steps, they will grasp the door handle of opportunity, thus, placing their own unique thumbprint as a mark of progress towards a new experience for the ultimate understanding and attainment of truth, knowledge, and wisdom.

The question of self-inventory becomes: are you emotionally satisfied with your spiritual, personal, and professional life? If you are not enjoying such fulfillment, then what happened to such goals, what would you like to accomplish, and how do you motivate yourself to start this journey?

Your Footprints

When a person reaches middle age, they find themselves to have journeyed to the west direction. It seems that they suddenly find themselves standing at a place half way on the Circle of Life. They may experience an identity crisis, much like the time they had become an adolescent and finding themselves not fitting as a child, but yet not being an adult. Likewise, middle age seems to end the young adult phase of life and there is a feeling of beginning to move towards the latter stages of the journey. At this stage in life, a feeling of self-fulfillment at a spiritual and emotional level should be significant.

Like the wind swirls on our thumbs, we also, have sacred wind swirls on the ball of each foot, which identifies our unique personal journey. From the first time we learned to walk, to our present time in our life, we have made footprints on Mother Earth, which can be spiritually identified as belonging to a given person by their unique wind swirls. We can reflect back and visualize our footprints from childhood to the present, and note where our footprints have been. We know that we will not be proud of certain traces of our footprints, but it is hoped, for the most part we will have a positive feeling about where we have been. Where we have been is the reflection of our current feelings at a spiritual and emotional level of our personal fulfillment in our current life.

We should not have to wait until middle age or even in our latter stages of life to employ this journey of visualization of our footprints as a means of taking self-inventory about our present spiritual and emotional state. We know that we cannot change the past,

but we can use the adversities of the past to become our Medicine Bundle of healing for the future. The question becomes, what is your current spiritual and emotional state, whether positive or negative and why are we feeling unsatisfied with ourselves or why are we enjoying self-fulfillment?

Your Shadow

Your shadow is a true reflection of who you are. When you are happy, your shadow reflects happiness, and when you are sad, your shadow reflects sadness. When the time comes for your birth into the spirit world, ironically your shadow also disappears.

Your shadow is directly connected to your physical being. Your physical wellness is a reflection of your spiritual, emotional, and mental state. Too much worry and stress will result in lack of sleep, impact on eating habits, lack of motivation for physical exercise, et cetera.

Emotional adversities of worry and stress when not constructively resolved will result in looking at an unhappy and unhealthy shadow. Unresolved stresses over a long period of time build on one another, and may result in depression, substance abuse, frequent physical ailments, et cetera. Such adversities will manifest themselves by reflecting an underweight, overweight, or bent over shadow of unhealthiness.

By the time we reach the north direction of old age, we hope our shadow will reflect a healthy physical being. The question then becomes, what are we doing to ensure overall wellness of balanced harmony to foster an enjoyable and fulfilling lifestyle, which is based on not taking on unnecessary stresses and to constructively resolve such stresses when they occur? Will you still be strong enough to walk, hear, see, and be a role model with a healthy shadow at the age of 102, with four generations of other shadows around you?

B. The Cognitive-Behavioral Skill Building Group (CBSB)

The Cognitive-Behavioral Skill Building Group is to develop a stronger sense of self and self-awareness and increase one's sense of personal power. The core focus of this group is to support the adolescent in the development of emotional regulation skills. Emotional regulation is one of the main focuses of the Water Track.

The CBSB group is utilized with adolescents who display **emotional vulnerability**:

- a very high sensitivity to emotional stimuli
- a very intense response to emotional stimuli
- a slow return to emotional baseline once emotional arousal has occurred

The focus is to support them in developing skills to **modulate emotions** such as:

- to inhibit inappropriate behavior related to strong negative or positive emotions
- to organize oneself for coordinated action in the service of an external goal (e.g. act in a way that is not mood-dependent when necessary)
- to self-soothe any physiological arousal that the strong emotion has induced
- to refocus attention in the presence of strong emotion

As a building block for self- management, the group process focuses on changing the adolescent's **Negative Self-Talk** to a **Health Self-Talk.**

Challenging **Negative Self-Talk** examples include:

- Black & White Thinking
- Minimizing
- Mind-reading
- Errors in Blaming
- Should(s)

One example of a technique used to support **Health Self-Talk** is **The Columbo Technique (3C's):**

CATCH the thought
CHALLENGE the thought (Columbo)
CHANGE the thought
NEW SELF TALK - specific, accurate, positive, and productive
SUPPORTIVE ALLY - using internal supervisor who you can feel supported by, trust, and a reminder to you of freedom of choices.

This skill is presented throughout treatment and the clients are encouraged to practice the technique until it becomes an automatic process.

C. The Behavior Modification Skills Group (BMSG)

The Behavior Modification Skills Group is based on behavioral intervention that helps the adolescent identify thoughts, feelings, and triggers associated with their impulsive behaviors. The emphasis is on teaching youth how to monitor their behaviors and manage them successfully. This is a particularly important component for the Air Track.

The behavior modification skill module encompasses four (4) sessions. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process,* and *closure.*

Session I -*Identifying Thoughts, Feelings and Body Sensations* defines for the adolescent what impulsive behaviors are and assists them to identify what body sensations, thoughts and feelings are triggers associated with their impulsive behaviors; incorporates a written behavior chart on each adolescent that determines their point level system towards advancement.

Session II - *Identifying Triggers to Impulsive Behaviors* allows the adolescent to identify situations, people, and events that drive their impulsive behaviors and determines the consequences of their actions; focuses on developing an awareness of certain patterns and how to gain self-control of their behaviors.

Session III - *Monitoring Behaviors Through Charting* introduces a behavioral chart that the adolescent will use to track their behaviors for a period of one week; provides immediate feedback and awareness on an hourly basis increasing their motivation to self-control their behaviors.

Session IV - *Review of Behavior Chart and Skill-Building* allows the adolescent to identify reminders to assist them in maintaining self-control of their behaviors when confronted with a potential trigger situation; incorporates a review of their behavioral chart to look at improvement and reward efforts.

D. The Anger Management Skills Group (AMSG)

The Anger Management Skills Group teaches adolescents to understand and identify their anger triggers and patterns, as well as interpersonal conflict avoidance and nonviolent conflict resolution techniques. These skills focus on adolescents managing themselves in school, home, and community situations.

The anger management module encompasses six (6) sessions. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process,* and *closure.*

Session I - *How Anger Feels in the Body* provides for the adolescent a review of brief relaxation techniques learned in the Resiliency Group and examines physical sensations and feelings in the body that accompany anger.

Session II - *Identifying Triggers to Anger* allows the adolescent to identify people, behaviors, and feelings that trigger their anger; focuses on direct and indirect triggers and assists them in coping with their feelings of anger in a more effective manner.

Session III - *Difference Between Anger and Aggression* teaches the adolescent about their rights (e.g. to be listened to, not to be abused, to tell their side of a story before judgment is passed, and to their own property) and different ways others try to take away their rights; focuses on the differences between being passive, assertive or aggressive.

Session IV - *Alternative Responses to Aggression* teaches the adolescent some alternative responses to aggression; focuses on internal and external power and different ways people take our power away.

Session V - *Learning to Reduce Conflict and Maintain Personal Power* teaches the adolescent skills that will assist them in maintaining their power when provoked to anger; focuses on Conflict Avoidance Techniques to learn to reduce conflict while maintaining an appropriate level of control and preserving their rights and the rights of others.

Session VI - *Identifying Reminders and Thinking Ahead* assists the adolescent to identify reminders that will be helpful when confronted with potential aggressive situations; focuses on maintaining self-control and how to think ahead to the negative consequences of losing control of their anger.

E. The Coping and Problem Solving Skills Group (CPSSG)

The Coping and Problem Solving Skills Group teaches stress and coping strategies along with establishing boundaries. Education of family roles discusses the dysfunctional family's tendency to exhibit blurred boundaries and role confusion. The adolescent identifies healthy physical, emotional, and spiritual boundaries. This awareness of boundaries helps the adolescent develop a sense of responsibility, self-esteem, resiliency, and subsequent empowerment.

The **Coping Skills** module encompasses six (6) sessions. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process*, and *closure*.

Session I - *Development of Relaxation Skills (Part I)* teaches the adolescent about recognizing stress and becoming aware of its effects on the body; focuses on skills to promote relaxation and increase emotion-focused coping skills; includes keeping a stress diary for one week noting stressors encountered and coping strategies utilized.

Session II - *Development of Relaxation Skills (Part II)* teaches the adolescent about how to use visual imagery to reduce anxiety and further develop emotion-focused coping skills; discusses their stress diary and reviews the relaxation breathing exercises from previous session.

Session III - *Stress and Coping Strategies* continues to focus on stress and the development of emotion-focused coping skills by reinforcing learned relaxation techniques; includes a group discussion and practice with stress / relaxation cards.

Session IV - *Establishing Boundaries* allows the adolescent to identify appropriate role(s) in the family (dysfunctional families); focuses on boundary issues, including blurred boundaries and role confusion and appropriate and inappropriate touching.

Session V - *Identifying Thinking Errors* allows the adolescent to identify and become aware of common “thinking errors” that interfere with their ability to make good decisions and be effective problem-solvers; focuses on age-appropriate terminology to facilitate learning and retention.

Session VI - *Developing a Sense of Responsibility* teaches the adolescent about responsibility as an important resiliency skill to build self-esteem and self-confidence; focuses on responsibilities that are age-appropriate.

The **Problem-Solving skills** module encompasses six (6) sessions. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process*, and *closure*.

Session I - *Decision Making* defines for the adolescent what decision-making skills are and teaches them how to make the right decisions; focuses on listing and weighing options, measuring advantages against disadvantages and making positive choices; includes a discussion on leadership skills.

Session II - *Goal Setting* teaches the adolescent about defining and setting realistic short and long-term goals; includes a discussion on defining realistic goals, goal setting, starting points, goal modification and setting a deadline.

Session III - *Grief and Loss* allows the adolescent to define grief, understand the three major stages in the grieving process (shock and denial to anger or depression to acceptance), different types of grief and loss, and how to maintain a healthy grief and mourning process. (Be aware that some cultures do not talk about death).

Session IV - *Motivation* teaches the adolescent motivation skills to achieve their goals, education, relationships, and/or maintain their recovery and sobriety; focuses on awareness of negative motivation (e.g. using substances, being bored, negative friends, family problems, and issues with the legal system) and positive motivation (e.g. self-talk, discipline, spirituality, and healthy family relationships).

Session V - *Relationship Building* defines for the adolescent good relationship skills and how to build good relationships with positive talking and listening; includes identifying current skills and teaches how to improve these relationships.

Session VI - *Time Management* teaches the adolescent how to better manage their time; focuses on current time management and identifies wasted time, prioritizing, making changes, and balancing time between school, family, and personal needs.

1. Cultural Teaching: American Indian Image In The World Today

The following is the main cultural teaching that is introduced to the adolescents with this module. The teaching is in regards to the different professions of AI/AN people compared to today.

American Indian Image In the World Today

As an American Indian we can maintain our Cultural Identity, but still function in the World as it is today. We have a tragic history, which has resulted in intergenerational trauma from which we still are adversely impacted, but we have maintain our Pride in our Heritage, Culture, and Image. We can use our unique Identity and Image as strength for overcoming adversities and as a means to continue our self-development towards balanced harmony.

As Indian People we have established the positive Image of being Warriors, Hunters, Medicine People, and Artists. These Positive Images contain notable attributes for which an Indian person can strive for in their effort for self-awareness, self-development, and for eventual recovery. Like most Medicine Wheels for Teaching, this concept places given Images and related attributes in the Four Sacred directions. These Images, Attributes, and Directions are as follows.

East Direction: Image of Being a Warrior

Being a Warrior means to be able to be and Advocate for good Moral Values, to be a Role Model for others, and to fight against negativity which causes Disharmony of self and others.

1. Developing and maintaining good moral values through spirituality
2. Maintaining the spirit of hope for self and others
3. Being a positive thinker
4. Viewing hardships as a challenge for self-development
5. Honoring your gift of voice to express good words, prayers, and good songs.

South Direction: Image of Being a Hunter

Being a Hunter means that you go out and seek knowledge and skills, which will provide food, shelter, clothing, and transportation, for a stable and productive livelihood. To share your achievements with others in helping them overcome thirst, hunger, poverty, and for the opportunity to reach old age.

1. Knowing that positive goals will lead to unexpected doors of opportunity for a productive lifestyle
2. Maintain the spirit of faith in your Higher Power and in self for developing competence
3. Having good Planning Skills will provide a positive sense of direction
4. Knowing that Suffering can be a Motivator in identifying your purpose in life
5. Knowing that your thumbprints tell your past and will tell your future

West Direction: Image of Being a Medicine Person.

Being a Medicine Person means to understand that Healing comes from within and in that manner we become our own Medicine Woman or Man. When we have reached some level of healing, we can use such experiences to help Heal others, which will help us with our own continued Healing.

1. Having a positive Self Image, which will result in healthy social well-being.
2. Having Self Love, which will reflect compassion for others.
3. To use the adversities of the past as your Medicine Bundle for Healing.
4. To use incidences of Loneliness as a gauge of current mental status.
5. To reflect on your Foot Prints to evaluate your past Journey and commitment to a better Future.

North Direction: Image of Being an Artist.

Being an Artist is being aware of what you create within your Mind, in that, your thought processes will determine your future. As Indian People we are known for being very artistic with sculpturing, paintings, carvings, beading, etc., which comes from the Mind of the Artist that reflects their State of Harmony.

1. Connecting with the Beauty of nature for Healing.
2. Being Resilient in letting failures and disappointment become your Teachers.
3. Not letting Prejudice and Jealousy easily discourage you from your future Dreams.
4. Creating within your Mind, Ethical thoughts of self-respect and respect for others.
5. Maintaining good Physical health, which will reflect a Healthy Shadow when reaching Old Age.

Using these very real Cultural Images with the related positive attributes will stimulate thoughts and goals for reaching Balanced Harmony. These are only a few positive attributes based on the Navajo Philosophy of Life, but can be revised or additions can be made based on Cultural background.

Ceremony: These Teachings can be used in Sweat Lodge Ceremonies or for Spiritual Group activities.

F. The Heart Power Skills Group (HPSG)

The Heart Power Skills Group main goal is to teach adolescents how to develop empathy for self and others. Many adolescents feel unloved, confused, afraid, and stressed. The physical heart responds to love, and this can be measured in the electrocardiogram and in heart rate variability rhythms. When a youth or adult feels frustrated, angry, worried, fearful, or stressed, his or her heart rhythms become unbalanced and disordered. By learning to generate loving and appreciative feelings, heart rhythms come back into balance and regain their natural harmony. Harmonizing heart and brain through love can establish a complete intelligence and complete self, whereby each youth can look at life and realize there are no dead ends, but always possibilities. The heart power skill teaches the adolescent to develop *deep heart listening* that results in *intuitive listening* (Childre, 1996).

The Heart Power skills module encompasses four (4) sessions that will teach the adolescent an organized process for three key practical tools for uniting the heart and mind within themselves . The Heart Power skills are taught to the adolescent(s), families, and staff. The *Heart Lock-In* tool is practiced at the beginning of every morning, with every group session, in individual therapy, during meals, and at bedtime. This promotes relaxation and gives them an alternative to managing their feelings instead of becoming angry and stopping communication.

Session I - *Deep Heart Listening and Intuitive Listening* teaches the adolescent how to develop Deep Heart Listening that results in Intuitive Listening; focuses on three essential

elements to be aware of while listening: Word level (what is actually said), Feeling level (the feeling or frequencies behind the words) and Essence level (the real meaning).

Session II - *Heart Lock-In* teaches the adolescent to slow down and listen when they have a problem to solve or need more emotional balance; focuses in the heart and nurtures the entire mental, emotional, physical, and spiritual system.

Session III - *Freeze-Frame* teaches an adolescent how to release stress, manifest creative new ideas and/or how to solve a problem; focuses on a visual moving image that allows a head to heart shift that is helpful to the adolescent because it appeals to both kinesthetic and visual learning modalities.

Session IV - *Cut-Thru* assists the adolescent to release anxious, worried, depressed, or disturbed feelings; helps to release their pent-up feelings to better understand oneself or others who have hurt or upset them.

G. Independent Living

The adolescent is educated in the need to have support on all levels in the community. They are assisted in identifying different means of support that will enhance their success after discharge. At discharge, the adolescent identifies a cultural/spiritual community they plan to access (e.g. medicine man, sweat lodges).

The adolescent is taught the different life skills throughout their treatment. These classes were usually taught in the evening and weekends.

1. Identifying a career
2. Writing a resume
3. Preparing for job interviews
4. Successful grocery shopping
5. Native Food preparation (reading recipes and food preparation)
6. Balancing a checkbook

IX. FAMILY VIOLENCE PREVENTION AND INTERVENTION PROGRAM

A. Child Maltreatment and Trauma Philosophy

Our Cultural and Western theory of dealing with trauma is based on the importance of not focusing exclusively on the past and beginning to teach our young people to deal with the present through dealing with the thoughts, feelings, and beliefs around the traumatic event. The young person must be able to differentiate the traumatic experience in the past from the current reality. They begin to focus on living in the present without feeling or behaving according to demands belonging to the past. Teaching the young person to decrease their hyper-arousal by meditation, relaxation and exercise along with cultural and spiritual counseling and ceremonies improves overall treatment success. This also decreases intrusive reliving and stops the traumatic empty feeling cycle. As the young person develops new memories and confronts the old ones and changes the meaning, the neuro-connections to the old memories are significantly weakened. This theory is interwoven with the cultural teaching of the Seven Gifts of Life.

1. Cultural Teaching: Seven Gifts of Life

The sense of touch, taste, smell, sight, hearing, emotions, and dreams are addressed through intervention with the young person who experienced trauma. When they begin to utilize smudging, the sweat lodge, drumming, singing, the smoking ceremony, and counseling, the young person may begin to re-experience the traumatic event. Many times, these smells, sounds and words link them to the environment where they experienced the trauma. Our seven senses are intended for our healing of these memories. They can bring events to our awareness for continued cleansing, learning, and healing. We teach them that they are spiritually connected with the prayers that were put down at the time they were in the womb and they are connected to all of their prayers forever. These negative senses come to the surface affording them the opportunity to change their seven senses to support Walking in Beauty.

2. Cultural Teaching: Blessing Way Six Standards of Life

Both adolescents and families are given the *Blessing Way Six Standards of Life*. Then the counselors explain how this applies to their lives today in order to restore the Beauty that the Creator intended for them and allows them to connect and replace this teaching with the one of trauma.

Blessing Way Six Standards of Life

The Era of "the journey back to earth" was after the recreation of the four clans. The four original clans journey back from the west, towards the four sacred mountains. The Holy People started their journey, from within the four sacred mountains, to meet the four original clans, who were on the way back to their sacred land. Along the way, they met their children, the five-fingered ones and performed a blessing way ceremony.

A blessing way ceremony was performed for the returning original clans. During this ceremony, we were given our sacred language. The universal language of the Holy People, and the language they used to communicate with each other. We, (the five-fingered

ones), were given many good blessings by the Holy People throughout the ceremony that night. The stories are in the songs, prayers, and teachings.

In the midst of dawn, the Holy People concluded their ceremony for the first original clans. They were taken outside as a final gesture, before the Holy Ones departed to their sacred places. They stood in front of the dwelling as they got their final instructions from the Holy People.

The bird people were the last to leave; they gave their final blessings to the five-fingered ones. "We have instilled life's teachings, now go forth and apply the songs, prayers and instructions". This is where the six (6) standards of life derived. The six standards of life are:

There is beauty-
Before me,
Behind me,
Beneath me,
Above me,
Around me,
and With beauty I speak

Each of the six standards of life help the adolescent to identify how they can view their experiences from this way of thinking and put their lives back into harmony. (**For the complete teaching please see addendum E**).

B. Child Maltreatment Education

The **abuse** module encompasses six (6) sessions that will educate the adolescent on child maltreatment. In each session, the six standards of life are identified to help the adolescent to culturally reframe their experience. In addition, these sessions are in a gender specific group but also, are within the family treatment program. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process*, and *closure*.

Session I - *What is Physical Abuse* allows the adolescent to understand what types of behaviors are abusive and teaches them about physical abuse; the issue of safety is included in the discussion.

Session II - *Understanding Emotional and Psychological Abuse* teaches the adolescent about emotional abuse (e.g. verbal assault, double-message communication, constant family arguments) and psychological abuse (an attempt to control through threat or intimidation); includes a discussion on the effects of emotional and psychological abuse.

Session III - *Understanding Sexual Abuse I: Telling Your Story* teaches the adolescent to identify sexual abuse; creates a safe space to tell their story (breaking the secret is powerful in healing from sexual abuse); allows them to process their feelings and model empathy for the other group victims.

Session IV - *Understanding Abuse-Related Behaviors* assists the adolescent to identify the warning signs of possible sexual abuse and how to better understand behaviors exhibited by sexually abused children and adolescents; incorporates deep breathing or relaxation techniques before group closure.

Session V - *Dynamics of Sexual Abuse* teaches the adolescent how perpetrators attempt to keep children silent and why secrecy is so important to the perpetrator and so damaging to the victim; focuses the responsibility for the abuse on the perpetrator and identifies warning signs of future abuse and the intergenerational cycle of abuse.

Session VI - *Abuse-Related Coping Mechanisms* allows the adolescent to explore coping mechanisms employed to avoid being sexually abused; identifies the coping strategies that may negatively impact other situational areas of their life (e.g. ability to make friends, achieve intimacy, get along with authority figures).

C. Domestic Violence Education

The **domestic violence** module encompasses six (6) sessions that educates the adolescent about domestic violence in the family system. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process,* and *closure*.

Session I - *Defining Domestic Violence* assists the adolescent to understand the definition of domestic violence within the family and identify patterns of abuse; teaches them how domestic violence affects them individually and their family.

Session II - *Battering is Common and Serious* defines the myths and facts about domestic violence and why people stay in these relationships; includes the cycle of battering.

Session III - *Why Battering Takes Place* teaches the adolescent about stereotypical expectations of men and women's roles and behaviors and how that contributes to the incidence of abuse and battering of women and why “men don't tell” when they are the victims of battering; includes information on emergency safety plans and how to take positive steps toward long-range plans.

Session IV - *Youth and Domestic Violence* teaches the adolescent about the occurrence of domestic violence in youth relationships; includes a discussion on the common traits of a batterer.

Session V - *What Do You Do If You Are A Victim* assists the adolescent to understand behavior patterns in an abusive relationship; teaches them to identify if they are in an abusive relationship and how to handle their emotions.

Session VI - *Prevention Skills* teaches the adolescent how to help someone in a domestic violence relationship; includes developing a support system for the victim and ideas about how to prevent domestic violence in their community.

D. Gang Violence Education

The **gang violence** module encompasses six (6) sessions and will educate the adolescent on gang affiliation. Each of the sessions includes five components within each group process: *purpose, check-in, discussion, process,* and *closure.*

Session I - *Defining Gangs* assists the adolescent to understand the definition of a gang and why adolescents become members; includes a discussion of the pros and cons of joining a gang.

Session II - *Early Warning Signs of Gang and Drug Activity* assists the adolescent to become aware of the warning signs to gang involvement and different levels of gang involvement (e.g. make believe, at-risk, wanna-be, gang member, and hard-core gang member).

Session III - *Being Aware of Gangs* assists the adolescent to understand the risks in becoming a gang member and about initiation for both males and females into a gang.

Session IV - *Advice for Children* assists adolescents on the do's and don'ts of gang affiliation and why young people join gangs; gives advice to children on gang awareness.

Session V - *Types of Gang* assists the adolescent to identify different types of gangs including hand signs and colors; increases awareness of gang activity in their community.

Session VI - *Gang Prevention in Your Home* assists the adolescent to understand how gang prevention works and identify some ideas and suggestions for gang prevention in their home and community.

E. Family Therapy Program

A significant piece of providing cultural treatment to Indian youth is making an effort to establish Family Harmony. The family therapy program is based on the same bi-cultural philosophy and the family experiences the same cultural teachings, activities, and ceremonies as the adolescent experiences. All families receive training in heart power skills, communication, and parenting techniques. These skills are introduced immediately due to the vulnerability of our families. The family is provided education on substance abuse and relapse, mental health issues, child maltreatment, domestic violence, and other community violence. In addition, they receive support to renew or develop trust within the family through the use of adventure-based counseling and cultural counseling.

The family program has been very successful. In 1997, the family participation was 33 percent. However, following the implementation of the bi-cultural model, the weekly participation rate increased to 91 percent in 2000. Two main factors play a role in this success. The first factor is the shift in the message from a shame-based issue to one of a family experiencing long-term stress and lack of support. Secondly, the increase of cultural/spiritual activities serves to strengthen the family's ethnic foundation. Many of the families leave with new skills and a renewed motivation toward change. The main objective is to support the families in gaining a sense of pride and increase their identity as an AI/AN family

The family program is approached through weekly family sessions. This program is scheduled every Friday from 9:00 a.m. to 3:00 p.m., beginning with the second Friday of a treatment cycle. The families [includes the client sitting together with their family] receive the education together in the morning and in the afternoon break into three individualized tracks (Air, Water, and Earth) to process the materials. The parents are required to attend two Fridays a month with encouragement to attend every Friday. Each topic presented in the family weekly session is simultaneous with the scheduled weekly teachings received by the clients. The morning session includes cultural / traditional teachings and the Western educational component. These components consist of videos, music, and role-playing. After lunch, the families divide into their three groups (Air, Water, & Earth) for the process component.

During the sessions, each family is rated on the level of effort it takes the team to engage them in treatment. Families receive individual family counseling when the treatment team determines the appropriateness of this intervention. Families that have experienced child maltreatment receive individualized treatment according to the family's ability to be empathic and appropriate with the adolescent. The treatment is individualized according to the defensive screen (or lack of it) in each family. A family rating is completed on “family and client” for each session, according to how difficult it is to engage them in treatment: 1) not at all difficult, 2) very minor difficulties, 3) some difficulty, and 4) a great deal of difficulty. On a weekly basis, the clinical team reviews the ratings to determine if interventions and positive reinforcements are to be implemented for the next session. If an intervention is needed, the families will be given specific guidance on how to interact with their adolescent and other family members. Many times, a sensitive topic such as child maltreatment is disclosed for the first time to the family, and it is important that they receive immediate debriefing and subsequent individual family sessions to help them manage and deal effectively with the new information.

Session I - *The Addiction Process* assists the families to identify the stages of the substance addiction process; allows the families to become aware of the effects of substances in the family system.

Session II - *Disease Concept* assists the family to learn the effects of substance abuse on the emotional, physical, psychological and spiritual well-being of the family; allows the family to identify the illness, predictability, progression and outcome of the disease process.

Session III - *Communication Skills* assists the families to understand positive communication through active listening, sharing, reflecting and processing and how not to employ negative communications (e.g. judge, belittle, procrastinate, blame); incorporates

body language as a form of communication and fair conflict resolution. Incorporates the teaching of the Heart Power skill techniques.

Session IV - *Dysfunctional Families* assists families to identify roles in a dysfunctional family system and to become aware of each member of the family's role; incorporates family rules, boundaries and the dynamics of both functional and dysfunctional families. The families receive education on intergenerational traumatic parenting resulting from the long-term stress and historical issues specific to AI/AN people.

Session V - *Parenting Skills* assists parents to understand the importance of positive role modeling and leadership values within their family systems and community; incorporates better parenting skills and family values through listening, communicating and participating with their children; allows an honoring of each family's uniqueness through their generational family teachings.

Session VI - *Relapse Prevention* identifies barriers to effective interventions for the adolescent, family, and community in health care systems; includes standards of care, legal and ethical issues and resources. Families will develop positive strategies to support their adolescent's relapse plan and together will develop an aftercare plan, intervention plan and resources specific to their location.

Session VII - *Child Maltreatment* assists the family to understand the different types and signs of abuse (e.g. physical, emotional, sexual, and neglect); includes domestic violence, gang violence and bullying. [Families and adolescents are monitored closely for discomfort or reactions to the subject matter during and prior to leaving the session].

Session VIII - *Family Wellness* teaches family members about positive interactions among family members; involves sharing common values and enjoyment of each other's company while engaged in various activities; focuses on the quality of life rather than the absence of disease or conflict.

1. Cultural Teaching: The Four Gifts: Thinking, Planning, Living, and Resilience

The families receive many cultural teachings. One of the first to be presented, after the second family day, is the “Gifts of Thinking, Planning, Living, and Resilience”. The four gifts come from the teachings of the Navajo Clanship system. Clanship is a means of self-identity and is for the establishment of relationship between one another. It provides a path for meaningful interaction and respect for self and others. This provides a relevant teaching on the adverse impact of AOD on individuals and the family.

The Four Gifts: Thinking, Planning, Living, and Resilience

Like many other Navajo teachings, the Gifts of Thinking, Planning, Living, and Resilience are offered by the Holy People within the Four Sacred Directions. These Gifts

are provided as a means for affecting how we use our Mental Being for a productive and fulfilling Life during our Journey on Mother Earth.

The East Direction contains the gift of Thinking, the South contains Planning, the West offers Living, and the North Direction provides Resilience. These Gifts are interconnected through a circular process, which begins in the East Direction and makes a clockwise motion to the South, to the West, and to the North, and back to the East. Hopefully, we will use this process in making healthy decisions, which result in positive outcomes.

This process begins with using our thought process to come up with an idea to resolve certain circumstances or to meet a personal need. When we have identified this idea or thought, we then begin to contemplate or plan on how we will employ steps towards implementation. Implementation of an idea is the activation of a plan into action by beginning to make it part of our daily life. In making some action as part of our daily life, it will eventually result in a positive or negative experience or outcome. Whether the resulting experience is positive or negative, it becomes part of our resilience factor. The resulting outcome becomes part of our life experience and should stimulate new ways of thinking in moving ahead.

When we have a positive outcome, we enjoy the feeling that we have made good decisions and should continue to build upon this positive experience. If the results were negative, we will know we need to make changes in our approach and seek other constructive means to foster positive outcomes.

A positive experience will result in enhancing self-esteem, self-image, and self-confidence, which will increase the resilience towards adversities. A negative outcome can result in a feeling of failure, self-pity, and helplessness, which can foster low resilience when encountering adversities. Negative outcomes should not be viewed as failures, but viewed as gaining knowledge of what will not work and to pursue other options. The tendency when experiencing adversities is to isolate from others and to attempt to survive on self-willpower, but when a person is sincere in resolving personal adversities they will seek advice and encouragement from others.

Thus, the process begins in the East direction of identifying a thought or idea towards affecting resolution, then moving into the South in making plans towards implementation, then moving into the West by implementing the conceived idea towards resolution and realizing resulting outcome in the North direction. Then we return back to the East direction, making a full circle by employing our thinking process in building upon or re-thinking the experience in creating the next approach. These Four Gifts can be adversely impacted when substance abuse becomes a hindrance in affecting the Spiritual, Emotional, Social, and Physical wellness of a person. Such an affected person can be educated in how substance abuse has adversely impacted their abilities for Thinking, Planning, Living, and Resilience. Not only how each specific Gift has been impacted, but also, how the inter-connecting process has been disrupted.

Thinking: Our Navajo Elders teach that the Mind is a fragile and sacred gift. What a person thinks about on a frequent basis will dictate their attitude and behavior. Most likely, the thoughts of a person with a drug abuse problem will be about how and where to access drugs. This thinking may result with no consideration on how it impacts others or

what priorities should be attended to. It creates an attitude and behavior of self-centeredness, dishonesty, manipulation of others, et cetera. This adverse thought process can be interrupted with intervention and treatment, e.g. by receiving education on self-awareness and on how the use of alcohol has impacted the mind. In addition, when appropriate with American Indian cultural teachings and ceremonial practices, it can be employed in relation to the restoration of a productive mind. As for a Navajo person, *A Smoking Ceremony* could be utilized in conjunction with Western therapeutic approaches.

Planning: With a drug abuse problem, the ability for planning is negatively impacted. Such an affected person basically has no sense of direction and tends to live from day to day with the primary objective being accessibility to drugs. Such a person may identify future objectives or goals, but quickly defocuses from such aspirations due to the adverse impact of substance abuse, which creates barriers towards healthy planning. Their planning efforts will be more focused around where and how to get money or how to employ other means to satisfy their addiction to their drug(s) of choice.

Living: Living is the daily activities of a person in the pursuit of a productive and fulfilling future. Such a person employs past life experiences, whether positive or negative, towards a healthy lifestyle and in coping with current circumstances. A substance abuser will have a chaotic lifestyle, which is medicated by drug usage. The drug usage is a manifestation of disharmony of the Spiritual, Emotional, Social, and Physical aspects of a person. This means that spiritually, a person is reflecting a lack of moral values caused by drug usage, which is exhibited in their poor attitudes and misbehaviors. Their emotional state may be poor self-esteem, poor self-image, and a feeling of guilt and shame. Socially, they may be in a state of isolation or experiencing unhealthy interaction with their spouse, family, co-workers, and friends. Due to their inability to cope with the stressors of life, it may increase their drug usage, which may result in a lack of exercise, a lack of sleep, et cetera, and will adversely impact their physical health.

Resilience: Resilience is the ability to bounce back or pick yourself up and dust yourself off after experiencing a significant adversity or bad experience. It involves the ability to maintain a spirit of self-challenge despite set backs in Life. It is knowing that a significant part of life is experiencing hardships or disappointments, but using these times to learn about yourself and to take inventory of how this adversity occurred due to self-decisions and self-involvement. For the most part, a drug user has experienced repeated episodes of adversities and will have the attitude of blaming others for such hardships and disappointments. Their ability to take some responsibility for such adverse occurrences will be distorted by the emotional state of self-pity. Continued drug usage will only result in more adversities and further diminishment of their resilience factor. Until this cycle of drug usage can be interrupted, the drug user will continue to spiral downward emotionally and perhaps to major depression and becoming suicidal.

Ceremony: Families are invited to attend sweat lodges with their adolescent, whenever possible. Many families have individual family ceremonies conducted throughout the treatment process.

X. ADVENTURE BASE COUNSELING

The Adventure Base Counseling (ABC) is an innovative, highly structured group therapy model that provides participants a forum to learn more about themselves and others in order to help develop more appropriate and realistic patterns of behavior. The program is an integrated milieu experience where multiple learning opportunities are presented to motivate the adolescent's commitment toward responsible behavior and to maximize the learning potential of the experience.

ABC utilizes a wide variety of initiatives and activities that have been developed in areas of Acquaintance, De-Inhibitizers, Trust, Communication, Decision-making, Problem-Solving, Personal Responsibility and Social Responsibility. The selection and use of these initiatives and activities is somewhat individualized based upon specific goals and objectives for each group, developmental levels, personal strengths and weaknesses, as well as the strengths and weaknesses of the group.

A. Program Goals

1. To increase self-confidence and self-esteem in a challenging and supportive atmosphere where growth is encouraged and where the positive is emphasized.
2. To realistically define personal goals and strategies for implementation.
3. To develop and implement new behaviors and approaches to coping with peer and adult relationships.
4. To foster appreciation and respect for individual differences existing in a group.
5. To learn increased responsibility and social maturity by practicing interdependent behaviors within a cooperative success-oriented framework.

B. Self-Esteem and Behavior

The primary objective of ABC is to prepare identified clients to be successful in their behavior. However, to be successful, each client must accept the direct connection between their behaviors (or absence of behaviors) and real consequences. Once they accept this responsibility, effective action becomes possible, and with effective actions comes a rise in self-esteem and concomitant decrease in inappropriate behaviors.

ABC was utilized with adolescents in all three tracks (air, water, group) and with families, but it was primarily used with the Air Group. This treatment track uses a primarily behavioral or reinforcement-based model. Many adolescents in this track have a major substance abuse and often a co-occurring behavior disorder diagnosis [attention deficit hyperactivity disorder (ADHD), histories of severe inhalant use, and are often highly impulsive]. The less verbal and more physical approach of ABC aligns well with their learning styles (more holistic and less conventional linear forms of thinking and reasoning).

XI. ACADEMIC PROGRAM

A. Philosophy and Curriculum

Students must learn to celebrate their own small victories. *Progress* needs to be compared to their previous achievements, not to the achievements of other students. For a Native American child, the culture of their home environment and the mainstream school environment may differ by varying degrees. Bridging the sometimes conflicting views of the two worlds is explored within these philosophical teaching concepts to give each child the opportunity for a foundation in learning appropriate and necessary for both the mainstream and their cultural environment. A major obstacle for many Native American adolescents in a residential treatment program is they are "turned-off" from a structured educational system. This program focuses on Native American teachers and a culturally appropriate curriculum in a non-competitive environment with active family involvement. For high-risk adolescents, re-kindling a desire to feel successful in school is a strong protective factor for remaining in the educational system and continuing their recovery.

Most mainstream schools and teachers tend to not understand the different learning styles of Native American children, so the children are forced to adapt to a method of learning that may be foreign and awkward for them, e.g. many Native American students do not bring attention to themselves and rarely ask for assistance. In order to individualize methods of learning, the Native American students are assessed in two categories to determine their overall primary learning styles: 1) the first category determines if the adolescent is a visual learner, auditory learner, tactile learner or a combination of the three and, 2) the second category utilizes Howard Gardner's (1983) multiple intelligences theory of seven primary forms of intelligences: linguistic, musical, logical-mathematical, spatial, body-kinesthetic, intra-personal (e.g. insight, meta-cognition) and interpersonal (e.g. social skills). Gardner (1983) suggests that *teaching: learning* be individualized and focuses on the particular intelligences of each person because each culture tends to emphasize particular intelligences.

In existence since 1998, the academic program continued to grow in scope and add selective features of a typical school environment. The educational component is instilled within the paradigm of the treatment model. The school was accredited with the North Central Association (NCA) and works closely with the University of New Mexico Continuing Education Department at the local NCA level.

B. Achievement Level Test

Educational history is a pivotal part of the assessments upon admission to the program in order to determine the individualized Education Care Plan. The Northwest Educational Achievement Test (NWEA) series is a norm-referenced test in the areas of reading, language and math that is used to determine the level of academic attainment and specialized educational needs. The educational assessment package includes a review of pre-admission information from the adolescent and home school as well as an assessment of current status with the Northwest Evaluation Association Levels Test. This test is completed within seven (7) days of admission and includes an assessment of basic skills in reading, math, spelling, writing / language, speaking / listening and educational / vocational plans and goals.

C. Individualized Education Care Plan

The individualized Education Care Plan is based on the Northwest Evaluation Association Levels Test scores reported on a RIT scale. This scale has been thoroughly developed using item response theory and the Rasch model to create a measurement scale that allows the sensitive measure of a student's growth in achievement along a curriculum of instruction. The RIT score is designed to enable direct comparisons to a curriculum or to a criterion performance level; however, it can also be used in a norm-referenced manner to create scores like percentile ranks. These norm-referenced interpretations can be useful when school districts need to describe how the achievement of students, either individually or as a group, compares to some other reference group (Kingsbury, 1999). Many of the surrounding school districts are using the Northwest Evaluation Association level tests and our school is able to compare these scores.

An individualized Education Care Plan is designed to meet each adolescent's educational goals and objectives while in treatment. The adolescent is encouraged to have creative input into this educational component within their overall treatment plan. Their Education Care Plan and Education Summary, including grades, are shared with both the adolescent and clinical staff during clinical review meetings. Clinical staff is essential in providing the teacher with valuable clinical information and recommendations for each adolescent during these clinical team meetings. Throughout the adolescent's residential treatment, the clinical staff and the teacher confer on the adolescent's progress and grades.

One of the disadvantages of mainstream schools is they have large enrollments that preclude teachers from designing individual education plans for each student in their class, as well as, being able to effectively monitor each student's progress. For example in OYOF, if an adolescent is struggling with reading, the teacher may administer the Exemplary Center for Reading Instructions (ECRI) inventory. The ECRI inventory will test the adolescent on oral reading accuracy, oral and silent reading rates and comprehension. Based on the results of this test, the teacher may make a recommendation for further assessment(s) or may alter their individualized Education Care Plan.

D. Classroom Environment

Each of three classes consisted entirely of students from one of the three program tracks: *Air*, *Water*, and *Earth*. The *Air* group focuses on the adolescents who experience learning disabilities, behavioral problems, attention deficit hyperactivity disorder (ADHD) / attention deficit disorder (ADD), severe inhalant users and/or fetal alcohol syndrome (FAS) / fetal alcohol effects (FAE). The students in this group have a short attention span and difficulty concentrating on their schoolwork. Many of the students in this group are visual spatial learners who have problems in auditory linguistic learning environments. Many assignments were hands-on with tasks that allowed them to interact and learn to focus their mind. Lessons and teachings utilized concepts from their culture or home environment that made it easier for them to learn and complete tasks successfully. The class program required intense supervision and was well defined and structured with allowance for some flexibility. Since most of these students had issues with anger management and controlling aggressive behaviors, cooperative learning was one goal instituted. The students were given cooperative group projects to complete and held accountable by requiring that they ask for assistance from their peers before receiving assistance from the teacher. The *Air* group classes were scheduled in the morning to address their tendency to become restless and easily distracted in the afternoon.

The *Water* group focuses on the adolescents who experience emotional dysregulation with significant depression, post-traumatic stress disorder (PTSD) and other related mood disorders. This class of students is able to role-play and complete hands-on tasks.

The *Earth* group focuses on the adolescents that have substance abuse issues with minimal behavioral problems. This class is able to work on self-paced assignments and is the most likely group to work efficiently in a cooperative manner.

E. Teaching Style

Students are grouped by ability rather than by grade or age level. A variety of strategies are utilized via cooperative learning, utilization of graphic organizers, role-playing, and student directed curriculums. The teacher believes that the student needs to receive continual feedback about their lesson. Thus, teaching becomes a two way street where the teacher also receives continual feedback from the student in a non-threatening environment. Students are encouraged to tutor other students and to seek answers from among themselves before asking the teacher's assistance.

Students complete a survey that describes their previous educational experiences. Data compiled from the survey indicates that students are "turned-off" about mainstream schools primarily for the following reasons:

1. Teacher lessons were too fast paced.
2. Ample time is needed to process the information.
3. Many of the concepts were too foreign and they wanted more examples.
4. The teacher utilized one teaching style and they were bored.

The information received from these surveys was documented and used for planning units and lessons. The Bloom's Taxonomy (classification of levels of intellectual behavior important in learning) is utilized to produce the most effective and challenging lessons for students. A variety of instructional methods are provided to the students. Most of the methods used are simple, practical and fun with immediate feedback being given to the students. In order to emphasize each student's strengths and abilities, they are encouraged through praise and the reinforcement of positive behaviors, thereby, fostering the repeat of those behaviors.

When the adolescent is assigned to attend the education lab, a clinical staff will attend and work with them in this setting. If the adolescent is having difficulty staying focused, they can be removed and provided an intervention that will support them to return to the education lab without disrupting the classroom. During the entire cycle of residential treatment, the adolescent's process in healing is interwoven throughout all facets of the program. Therefore, the teacher and clinical staff understand that an imbalance in the physical, emotional, mental or spiritual being of the student directly affects educational learning. Addressing this issue and being flexible within daily instruction allows the student to build skills to strengthen their treatment recovery and improve the outcome for their education.

F. Networking with Colleges and Pursing Careers

Networking with other colleges is an excellent and effective way to assist students' academic needs. Many of the students were reluctant to ask for assistance and were not always aware of the various options after high school graduation. If the adolescent is almost finished

with high school and/or is 17 years or older, they are encouraged to make definite plans towards a higher education and/or a career. A strong emphasis is placed in assisting students in their career interest. The student is encouraged to focus on both their strengths and weaknesses in deciding on possible career options.

A Career Interest Computer Assisted Inventory is available at the Dine' College Learning Center, located within walking distance of the residential treatment center. Students could further research their options in the Dine' College Library. Some of these options included: 1) enroll in a G.E.D. program (especially if they were two to three grades behind academically and/or had earned few academic credits towards graduation), 2) enroll in Job Corp and select a job trade, 3) explore the various two-year degrees at San Juan College and, 4) investigate other colleges, universities and technical schools that offer their study of interest.

G. School Credits and Re-integration into Home School

A collaborative effort between the OYOF academic program, the local school districts and pertinent area school personnel allowed for smooth transitions back into the mainstream education system. School credits were earned during the sixty (60) day cycle of residential treatment and were transferable to the adolescent's Home School where they enrolled after successfully completing treatment. Each student earned up to 5 credits in academic schoolwork that covered a variety of concepts correlated with the following subjects: 1) Math, 2) English/Communications, 3) American History/Navajo Culture, 4) Life Science, 5) Health/Physical Education and, 6) Cultural Arts. The foundation of the academic program was based on a structured curriculum and a set of state standards that met the student's needs and the regulations of NCA, the licensing agency.

Students' grades and credits were cumulative from all the multi-components in the residential treatment program. This model utilized creativity and flexibility in determining grades and credits in the six class areas from all the activities, teachings, and schoolwork completed by each adolescent. Periodic monitoring of a student's progress was completed throughout the cycle and after completion of treatment. The area schools were cooperative with school assignments (if applicable), recommendations, and other follow-up visits so the adolescents received the greatest benefit from their residential treatment experience.

XII. HEALTH CARE CLINIC

A. Philosophy

The health clinic was located within the treatment center. This allowed the adolescent to have quick access to a medical professional. The clinic provided all of the nursing and medical screenings, daily health issues (colds, bruises, cuts, etc.) and pertinent health lectures throughout treatment. In addition, the health clinic conducted weekly urine AOD screens on a random basis.

B. Nutrition

The health clinic conducted a full nutritional screening along with specific items to identify anorexia and bulimia behaviors. Upon identification, a full nutritional assessment was conducted and a treatment plan was developed in conjunction with a medical doctor.

C. Health Lectures

The main lectures conducted were:

1. Personal hygiene
2. How To Keep Your Body Fit
3. STD and Aids Education Testing
4. Parenting Skills

D. Smoking Cessation

Research has shown that smoking prevalence is highest among AI/AN people. Therefore, the program did not allow any smoking on the premises. This includes adolescents, families, staff, or visitors. It was a smoke free environment. We believed that allowing the adolescent to continue to smoke reinforced the addictive process and worked against the program's principles. Due to this policy shift, the health clinic provided smoking cessation classes and a means for the adolescent to manage their smoking cravings.

Smoking Cessation Sessions: Tobacco addiction is a powerful habit. As part of the Health Education modules, two sessions are taught to the adolescents on becoming nicotine-free by kicking the habit of smoking cigarettes, chewing smokeless tobacco and/or dipping tobacco-based products.

Session I – *Nicotine is very addictive*: *Preparing to Quit* helps the adolescents understand the reasons they began smoking, to learn what nicotine does to their body, and allows them to identify their smoking habits and the triggers that could lead to a relapse. Most importantly, this session discusses how to recognize and cope with their withdrawal symptoms, which they may be experiencing.

Session II – *Coping Techniques for the Cravings* teaches the adolescents coping skills to avoid slips and relapse and offers them alternatives to quell the cravings, e.g. exercise, relaxation techniques, and eating healthy foods. Finally, they are educated about dangers of smoking for pregnant women and the effects of secondhand smoke, especially for babies and young children.

XIII. RECREATION AND LEISURE ACTIVITIES

The adolescent received daily recreation and leisure activities. They were allowed to play appropriate games such as volleyball, softball, and swimming at the local YMCA (twice a week). They were allowed to view appropriate movies (no violence or sexual themes) on the weekends and television viewing was allowed after homework and chores were completed. The television was closely monitored for appropriate content. There were cultural games that were taught such as the Shoo and String game; these are seasonal games and could not always be played. The adolescents attended community Pow wows and other cultural activities.

A. Morning and Community Runs

Running is a Native activity that is introduced after the first ten days of treatment. A lecture is conducted on the proper preparation for running long distances. They are given the teaching about running and the connection with their culture. Many of the adolescents are able to run ten miles within the nine-week period. The adolescents would learn about healthy competition through participation in community runs.

XIV. ADVOCACY AND TRACKING MONITORING PROGRAM

A. Crisis Advocacy Program (CAP)

Continued maintenance of sobriety can only be accomplished through active recovery program participation. To achieve continued sobriety for all clients leaving the program, if agreed upon, each client was assigned a CAP advocate to be available if client is in need of crisis counseling. This was to support ongoing sobriety and provide maintenance therapy when necessary.

The CAP provides a crisis toll-free number that is available twenty-four (24) hours daily. An advocate can be personally accessed 9 a.m. - 7 p.m., Monday through Friday and on-call staff will be available during non-business hours. The advocate will follow-up the next business day. This is not a suicide/homicide crisis hot line. During non-business hours, the on-call staff will direct the client to an appropriate site for an evaluation to be done. This program supports ongoing sobriety and will assist in networking clients into additional services and provide brief solution focused therapy in the field.

The CAP advocate is responsible to follow-up on clients who contact the program either through the toll-free phone number and/or walk-in after discharge.

Any referrals will be made to facilities designated by each client's Indian Health Service area and/or Medicaid / Managed Care provider.

XV. CLINICAL DOCUMENTATION AND QUALITY ASSURANCE

The following is the content for a basic clinical process that is necessary to meet the criteria for the accreditations and certifications. This is an important process that supports the ability to provide successful treatment and continue to improve services. The program utilized the Accucare Management Information System to manage the daily activities, billing, clinical records and quality assurance.

A. Treatment Plans

Treatment plans coordinate client treatment planning and identify special services and needs during the length of stay in the residential treatment program.

All client records are to be reviewed every other week by the Treatment Team; recommendations and suggestions are included in each client record. The treatment team reviews all active client records for the following:

- Assignment of the client to a counselor who shall ensure the initial treatment plan is completed in the first 14 business days after assignment.
- Applicability of Treatment Plan to meet immediate treatment objectives and the program philosophy, expertise and resources. Identified services are measurable in behavioral, emotional, physical, resources utilization, participation and schedule methodology to determine the effectiveness of treatment approaches and needs. Every two (2) weeks, the process shall reflect the reassessment of the client and their commitment to their treatment.
- Progress or regress of treatment.
- To check progress and observational notes for accuracy, date, signature and treatment plan reference including clinical notes documenting progress toward treatment goals.
- To review areas of concern, lack of participation, corrective actions and supportive activity as needed.
- The client and family shall have input into the design and implementation of the treatment plan; verification of time, date and outcomes shall be in the client file for review and monitoring. The client will receive a copy of their signed master treatment plan; upon request, the family may receive a copy.
- The family status and level of activity will be noted and actions taken are documented in the client's file.

The treatment plan includes measurable treatment objectives and the following:

- The treatment regiment: the specific therapies, activities, and adjunct services utilized to meet the treatment objectives.
- A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or activity.
- The staff member who will be providing the services.
- The projected schedule for completion of all re-evaluations/assessments of the client's progress and/or regress and revisions of treatment plans.

- The adolescent and their family/guardians will have an active role in treatment planning and delivery. A client's family is required to participate in treatment and non-compliance will be documented in the client's clinical record.
- An adolescent in the custody of CYFD will incorporate the client's Permanency Plan in the treatment plan, discharge plan and discharge summary.
- Documentation, signatures, notes and dates to verify the above.
- Required medical or physical corrective actions for identified deficiencies or needs.

A treatment record shall be maintained for each client that includes a timely and accurate summary of client assessment, treatment, reassessment and activity data. All service providers are responsible for maintaining appropriate clinical documentation for services provided to a client. The assigned counselor will review clinical documentation weekly to ensure that the clinical documentation is in the client's chart from all service providers. File Documentation shall include:

- Admission dates, intake data, clinical interview, release of confidentiality forms, and a consent to treatment form.
- All necessary personal, family, educational, medical, social and substance abuse histories are completed including signatures and dates.
- Initial and master treatment plan is present, signed and dated.
- Treatment Plan reviews are completed every two weeks and signed; progress on treatment goals and new treatment issues are identified and appropriate.
- Activities and services provided include level of participation, progress or regress and signed and dated. Any services or activities, being billed, that are not specifically included in the client's treatment plan must include a detailed explanation as to their relevance or impact towards the client's treatment regimen and be recorded in the clinical record.
- Progress notes include: a description of service provided, a clinical impression of the client's response or lack of response, and a plan (including future session dates, referrals to other service providers, and progress towards discharge plans). The progress note must be clear and reflect the exact activity, the date of the activity, duration, the setting of the activity, and who was in attendance for the activity (counselor, client, parents, or other groups members, et cetera). In addition, the progress note will clearly outline the achieved goals per treatment plan and goals not yet met. The progress note is signed by the facilitating counselor with a signature from the clinical supervisor, if required.
- Records shall be kept on file in secure, locked file cabinets and made available as requested for state or federal assessment purposes.

B. Treatment Reviews

Throughout treatment, discharge planning and readiness for discharge , with regard to the above domains, are addressed every two (2) weeks at the treatment team meetings and treatment review. The following events and items are to be completed:

- Based on the reassessment of client needs, the discharge date is established by the treatment team within 14 days of discharge.
- The continuing care/aftercare plan is developed by the client, parents, program staff and referral source during the discharge planning phase (two weeks before discharge) using input from the clinical staff and based upon treatment progress and assessment of current client needs.
- The status at discharge and recommended discharge goals and strategies are completed on the discharge summary, documented in the client's record, and presented at the discharge review meeting.
- A discharge order is written, indicating the reason for the discharge. A reason for termination is written, with reference to the status at discharge.
- The client and family are informed that the program will contact them every 3 months, 6 months, 9 months and 12 months for a two-year follow-up. The Client Advocate and/or field interviewer makes these contacts.
- The client is informed about how he/she may re-establish contact with the program in times of crisis (toll-free phone number).
- The client is discharged with a continuing care plan and any initial community appointments.
- Clients who successfully completed their treatment goals may participate in a closure ceremony.
- Clients and parents will complete an exit interview at the time of discharge.
- The typed **Discharge Summary** is completed and placed in the clinical record. A copy is mailed to the identified community referral agency/agent within 5 business days of discharge. It is completed by the assigned counselor, licensed alcohol drug abuse counselor, mental health counselor or clinical supervisor and includes:
  - An individual status report, which indicates the initial problems identified, problems identified during the course of treatment, and progress towards goals and objectives achieved.
  - An assessment of the client's alcohol and substance abuse status at the time of discharge.
  - An assessment of the client's educational, developmental, emotional, and spiritual needs.
  - The reasons for discharge.
  - The identification of the referral agency/agent and/or other service provider to whom the client may be discharged.
  - The aftercare plan developed by the client, parent, OYOF staff and other involved individuals, including acceptance or resistance for ongoing care.
  - Any additional referrals to additional services needed outside the scope of OYOF that are identified by the discharge treatment team.

C. Discharge Process

The program has multiple discharge statuses with which an adolescent may leave treatment:

- Completed - discharge to community
- External referral and transferred to another substance abuse treatment program
- Against medical advice (no-show after 3 visits, individual/family choice, juvenile justice agency request, transfer to other agency deemed not appropriate).
- Transfer to medical treatment
- Transfer to psychiatric care
- Transfer to criminal justice agency (OYOF agrees to transfer)
- Other (staff request/disciplinary)
- Other transfers (relocates to another area)
- Death
- Unknown (that does not fit in any of the above categories)

Special Procedures For Irregular Discharges Of Client (s):

- Discharges against clinical advice occur when a client or parent/guardian requests discharge and the treatment team advise against it because the residential treatment goals have not been met and the client is at a high risk of relapse or engaging in risky behaviors. Because this is a voluntary treatment program (except court-ordered clients), a client, 18 years old, or with the legal consent of the parent/guardian, has a right to be discharged, if requested.
- When a client requests discharge, the client is asked to write out his request for discharge and include the date and time of the request. This is placed in the client's clinical record.
- The parent/legal guardian must meet with the clinical treatment team to discuss the reasons for the discharge and efforts are made to develop an abbreviated aftercare plan at that time. The assigned counselor will provide appropriate referral names at the time of irregular discharge.
- The efforts and interaction related to this issue are documented in the client file. The client and legal parent/guardian are to sign the Against Clinical Advice discharge form.
- A discharge order is written indicating the reason for the discharge and that the discharge is Against Clinical Advice.

Other Discharges are those in which the client is discharged even though treatment has not been completed. Reasons for Other Discharges are:

- Noncompliance - major rule violations (violence, drug/alcohol use on campus after behavioral contract has been implemented and violated, and sexual activity).

Procedures for Other Discharge:

- The treatment team determines the need for discharge.
- The assigned counselor informs the community referring agency/agent and family of the discharge decision and assists with determining alternative treatment options.
- The parent/guardian or JPO/community referral source is asked to pick up the client as soon as possible.
- Efforts are made to allow for a reasonable period of time to arrange for transportation and/or alternative placement.
- A continuing care plan is established related to the client's ongoing needs and the client, parent/guardian are to sign the Against Clinical Advice discharge form.
- A discharge summary is written indicating the reason for the discharge and sent to referring agency/agent within 5 business days.

XVI. PROGRAM EVALUATION RESULTS

Due to the sensitive nature of data reporting and the protection of AI/AN sovereignty only a brief overview will be provided.

The WBRR is the integration of Western and cultural/traditional treatment modalities and strategies. The WBRR treatment model was created of this endeavor. The model was based on pre- and post-tests on all treatment modalities to determine that Western and cultural/traditional treatment modalities/strategies were successful with AI/AN adolescents and families. The program collected exit surveys with all adolescents and families with 98% reporting that the cultural/traditional treatment modalities/strategies were perceived as the most helpful in dealing with their AOD and other family issues. The family program was perceived as the next important with 96% reporting that it increased their awareness of their problems and their readiness to receive appropriate skills to deal with them. With the WBRR model, the program began to identify the major issues facing AI/AN adolescents and families in treatment and the issues impeding their success after discharge.

The program employs a promising evidence-based treatment model that incorporates a manualized, ecological approach for AI/AN youth with a major emphasis on the AI/AN cultural and traditional healing practices. The model was tested within CSAT's initiative on Adolescent Treatment Models (ATM), formerly known as the funding initiative on Exemplary Adolescent Treatment Program.

The specific goals of this project were: 1) to implement a cultural specific treatment approach that supports retention in the program and adequately maintains gains across follow-up, 2) to continue to evaluate the three-part clinical typology for consistency with the empirically derived client groups, and 3) to specifically determine whether the level-specific factors will predict major outcomes such as relapse, juvenile system recidivism, and psychometric outcomes.

The project was successful in conducting one-year follow-ups with 94% of the adolescents completing the 6 month assessments and a completion rate of 98% after one-year. The follow-up from the intake to 12-month follow-up, based on the Global Appraisal Individual Needs (GAIN), reflect on average a significant lowering of substance usage, fewer days of use, and a decrease in severity of the AOD issues. There were significant improvements in overall self-reported general mental distress and overall functioning; however, these changes were evident in some areas but not in others. Significant improvements were noted across a range of behavioral indices. All GAIN indices reflecting substance abuse behavior showed consistent improvements.

In addition, significant improvements were reported, including an increase in school attendance, reduced involvement in general or drug-related crimes, reduced conduct problems, improved attention, reduced impulsivity or hyperactivity, and improved vocational functioning. However, many indices reflecting emotional or internalizing problems did not show significant change, including indices for anxiety, depression, and suicidal or homicidal thoughts. Many of these adolescents continued to report significant emotional problems, including problems, related to trauma, depression, and feelings of poor self-efficacy. The findings also suggested that many of these adolescents continued to reside in high-risk environments. For example, the majority of the adolescents in the acute index group, in the environmental risk index, suggest that they did not have a supportive recovery environment. Qualitative data from these youth suggest that they have difficulty accessing adequate follow-up services for either their AOD use or emotional problems and that they are subject to a range of deleterious environmental influences.

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XIX. GLOSSARY OF TERMS

Alternation Theory. This is a cultural adaptation pattern that states it is possible for an individual to know and understand two different cultures, and have the ability to alter behavior to fit the particular social or cultural context.

Bicultural. Refers to the blending of two cultures through socialization. This concept involves a "double-consciousness, or simultaneous awareness of oneself as being a member and alien of two or more cultures" (LaFromboise et al. 1993, 395). This implies a competence in two cultures. This is the skill to function in two different cultures by switching between two sets of values and attitudes.

Boarding School. Is an important part of the experience for American Indians. Off-reservation boarding schools for American Indian children began on November 1, 1878, when Captain Richard H. Pratt opened the Carlisle Indian School. The goal of the school was to assimilate American Indian children into European culture. This became a part of official U.S. Government Indian policy. Attendance was mandatory and most of the schools were run by church organizations. By the 1930s, most off-reservation boarding schools were closed. However, even today, many American Indian children who live on the reservation still attend boarding schools. Some are still run by church organizations and the remaining ones are operated by the Bureau of Indian Affairs. It is no longer mandatory for American Indian children to attend Boarding School.

Clanship. Is not restricted to relatives of biological lines, but includes all members of one's own clan. There are approximately 130 or more Navajo clans. The names are predominantly those of localities. Each Navajo belongs to the clan of his/her mother, but is equally spoken of as "born for" the clan of his/her father. The father's clans men are all considered to be relatives. A girl might identify herself in Navajo by saying, "I am Bitter-Water, born for Salt Clan". Clanship is important in establishing the larger circle of one's relatives. A Navajo will go out of their way to show preference for a clan relative, even if the individual is not previously known. In the past, clanship was an important agency of social control while today, it still has important significance for the modern Navajo.

Conventional Western. This treatment approach is based on the scientific oriented biomedical community and tends to discount the importance of psychological and behavioral variables as important etiological and exacerbational factors in pathogenesis. This treatment usually includes medical doctors, nurses, and medication management as the major components with psychological counseling, social work, and other fields in an adjunct role.

Culture. Is a highly elusive term with many definitions depending on the context. For this manual, it is described as the language, food, traditions, customs, and rituals of a specific place and people. This also includes their values, worldviews, and perception of the world. Culture is not static rather it is an ever-evolving concept that cannot be confined to a single dimension.

Ethnic Socialization Theory. Is the cultural transmission of values and beliefs as a part of effective individual and family functioning. It consists of protective factors that promote the youth's ethnic heritage (e.g. history, cultural values, and teachings), provides positive ethnic role models, exposure to

cultural activities, and strategies for effectively negotiating oppressive circumstances within a multicultural society.

Evidence-Based Treatment. Since the middle 1980's, the nation has been moving into an era with an increased emphasis on outcome-based accountability. Evidence-based treatment programs have undergone rigorous program evaluation and have demonstrated their value in curing or arresting disease or relieving patients' distress overtime.

Glittering World. The Navajo creation story discusses three underworlds where important events happen to shape the fourth world or "glittering world". The Dine' (people) emerged from three previous underworlds into this fourth or glittering world through a magic reed. The first people from the other three worlds were not like the people of today. The Locust was the first to enter the fourth world. He saw water everywhere and other beings living there. Locust had to pass a test to enter the world and he did. This allowed the people to enter into the glittering world. Then the people built a sweat house and sang the Blessing song. From this the people met in the first house (Hogan) made exactly as Talking God had prescribed. In this Hogan, the people began to arrange their world naming the four sacred mountains surrounding the land and designating the four sacred stones that would become the boundaries of their homeland (this is just a summary and not the whole creation story). The glittering world is where the Dine' have met many challenges and adversities.

Hogan. Is an earth-covered house of the Navajo Indian that is used historically as the primary dwelling for the people. In contemporary times, the Navajo people utilize the Hogan as a place to have family celebrations, conduct ceremonies, and for other holiday celebrations.

Holy People. Supernatural beings, with superior powers, that exist beyond the natural world. The Navajo Indians believe the Holy People watch over their life and direct them through adversity, as well as joyful times.

Medicine Person. A medicine person is chosen by either holy people or by more experienced medicine people. Sometimes one may have to face death and then return to this world again to become a holy person. Medicine people can communicate with all creation, plants, animals, rocks, and everything. They are able to know which plants to use and what songs to sing so the plants can work to heal the patient. Many times, holy people or experienced medicine people will teach these songs to other medicine people. The medicine people are not doing the healing but simply the Creator is working through them to heal.

Native American Church. An organized religious group whose beliefs blend fundamentalist Christian elements with pan-Native American moral principles. The movement began among the Kiowa about 1890 (although there are different thoughts across the country around this movement and its beginnings). In 1918, groups from a number of tribes incorporated their movements as the "Native American Church" (NAC). By 1996, the church had 250,000 members in the United States, Mexico, and Canada.

Native American Healing Practitioner (NAHP). This individual is under the apprentice of a trained and respected Native healing practitioner in the community and/or has been practicing the Native

healing arts for a number of years within the community. These practitioners are recognized by the New Mexico Counseling Boards as cultural counselors/providers within a treatment setting with appropriate clinical supervision.

Pow Wow. Is the American Indian people's way of meeting together to join in dancing, singing, visiting, renewing old friendships and making new ones. This is a time to renew thoughts of the old ways and to preserve their heritage. The Pow Wow has different singing, drumming, and dancing styles. The Pow Wow begins with the Grand Entry. At this time the flags are brought into the arena. The flags generally include the U.S. flag, tribal flags, Pow Wow flag, and the eagle staffs of the various tribes present. These flags are brought in usually by veterans to remind the people they are part of the United States and to remember their ancestors who fought against this country. Following the veterans, other important guests include tribal chiefs, Princesses, elders, and Pow Wow organizers. Next in line are the male dancers and then the female dancers. Once everyone enters the arena, the song ends and a song is sung to honor the flag and the veterans. After a prayer, the dancing resumes, usually with a few Round Dances. After the Round Dances, intertribal dancing songs are sung and everyone dances to the beat of the drum.

Totem Animal. Totems are a part of the spiritual path but also represent far more in their value for understanding cultural heritage, as well as personality types. Each animal has symbolic significance and is a key to lessons or lesions learned that might need to be imparted by a spirit guide. In this sense, an animal totem embodies not only spiritual beings, messengers and guides in a similar sense to angels, but also embodies some firm principles in facing internal psychological conflicts that can have a bearing on many aspects of life, including the spiritual one.

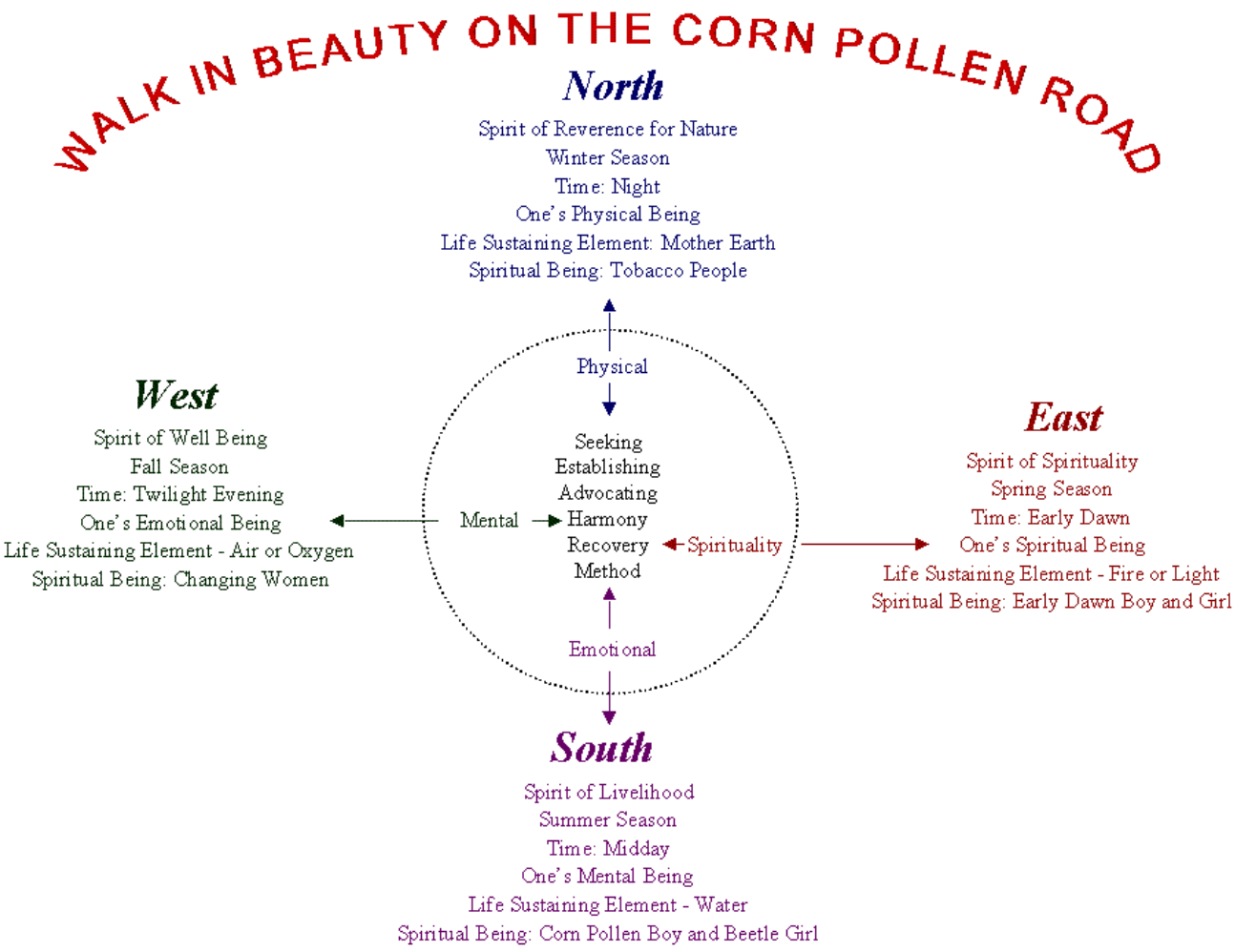
Traditional Healing. The healing traditions of American Indians have been practiced in North American as far back as 12,000 years and some suggest 40,000 years ago. The healing is based on a spiritual view of life. A healthy person is someone who has a sense of purpose and follows the guidance of the Creator. This guidance is written upon the heart of every person. To be healthy, one must be committed to a path of beauty, harmony, and balance. Gratitude, respect, and generosity are essential for a healthy life. There are various spiritual principles that maintain and restore health. These beliefs are shared by all tribes, however, the diagnosis and treatment may vary greatly from tribe to tribe.

Sun Dance. This is a ritual involving sacrifice and supplication to insure harmony between all living beings. The sun dance reflects relationships with nature that are characteristic of the Plains culture, and includes symbolic representations of various animal species, particularly the eagle and the buffalo, that once played vital roles in the lives of the people and are still endowed with sacredness and special powers.

Sweat Lodge. The sweat lodge is an important part of American Indian culture and has been used for socialization, celebration, cleansing of body and mind and preparation for war, marriage, or passage into adulthood. The sweat lodge is designed to promote health for the mind, body, and spirit. During the process, the participants share their worries, difficulties, and their appreciation for the good things of life. Strict confidentiality is adhered to and all participants are treated without judgment. There is usually a sweat leader who calls in the spirits from the four cardinal directions to provide guidance and healing.

XX. APPENDIX

Appendix A: Cultural Diagram of Level of Care



Appendix B: History of Clanship

The following is a brief history relating how the First Four (4) Clans originated.

In the beginning of time, after the emergence, the people quarreled at a place called "People Amongst", Dinetah. During that time, the decision was made by the chief-leaders to send "Changing Woman", also known as "White Shell Woman", to the West to live.

Changing Woman was reassured that the Moon and the Sun would be there to set each day to rest, and that she would not be alone. She was to take care of the Sun and the Moon. She hesitated, but in spite of this, she was sent on her journey to the west after performing several "Blessing Way" ceremonies on herself.

At this time The People feuded among themselves. As a punishment to her people to teach them not to quarrel, Changing Woman took with her all different kinds of essential natural valuables: Herbs / Plants, Dark Clouds, Dark Sky, Female and Male Rain, Wild Game, and the Sacred Mountains.

Back on the mainland the People, Dine, were having difficult times with the weather and nature as a whole. It had not rained for quite sometime and a bad drought had set in. Because it was so dry, forest, brush and prairie fires began. The People thought aloud: "Why doesn't it rain? What have we done to deserve such a punishment?". It took The People awhile to discover that "Changing Woman" had done this because of the quarrels they were having among themselves.

Immediately, a council was held. It was decided that an investigation should be made of the situation. The messenger, Hummingbird was asked to investigate. He was sent down to the west, to "Changing Woman's" floating house of turquoise. There the messenger found all the natural valuables and essential elements that The People had been missing. All these he brought back to The People in Navajoland (the mainland). Because of the quarrel that The People were having and after the return of all the natural elements to Navajoland, "Changing Woman" felt awfully lonely. This led her to originate the First Four Clans. It is said that she originated the
Clans appeared. The following were the clans:

The Bitter Water Clan. He was assigned Bullsnake as "his horse, his guide and protector. The four men were also each given a cane. The purpose of the cane was to dig a hole in the ground for water during their journey. Then the journey back to the mainland began.
On their journey back to the mainland, the People became thirsty for water, so one man was allowed to dig for water with his cane. The first person dug a hole in the ground for water. To The People's astonishment, the water was bitter. So this person was named The Bitter Water Clan. The waster was so bitter that they drank only a little.

Near the Water Clan. He was assigned a lion as "his horse", his guide and protector.
As the journey continued, The People became thirsty again. An elder person was asked to dig for water this time. He dug a hole in the ground for water with his cane. This person didn't have to dig very far or very long to get water. The water came above the ground surface immediately. This person was classified as "Near the Water" or "Water is Near".

The Towering House Clan. He was assigned Big Wolf as "his horse", his guide and protector. The journey continued. The third person was given a chance to get water. He began digging for water, but

all his efforts were unsuccessful. He became tired and left his cane leaning against the canyon wall and stood beside it. When the People saw his cane and him standing there next to it, it looked as if he was standing against a house, with the canyon wall in the background. So they called him "Towering House" clan, because he was unable to find water, he was given a different clan name.

Big Water Clan. He was assigned Big Bear, The Grizzly, as "his horse", his guide and protector. The journey proceeded once again and The People became thirsty. This time the fourth person Four Clans by rubbing her skin under her arms producing four men. Thus the First Four was given permission to dig for water. This person dug in the ground and found plenty of water, enough to cause a flood. So this person was classified as "Big Water".

The journey back to the mainland was near its completion. This journey is referred to as the "Blessing Way" or the "Beauty Way" journey back to Navajoland. Changing Woman or "White Shell Woman" was responsible for the Beauty and Blessing Way ceremonies; therefore, the songs that are sung are referred to as the Woman's Songs. The same songs are sung for a pubescent girl when preparing for her puberty ceremony, when she becomes of age.
In those days the Holy People were very close to the Navajos, and many times they actually visited and taught them. Through these teachings the power and the beauty of the Holy People became known to the Navajos, and as a result, they increased and prospered.
Under the guidance and protection of the Holy People, many more Navajo clans came into existence, and the small handful of people who had come into the Fourth World, even with the creation of the four clans by Changing Woman, grew and grew. Today, we know of the following additional clans.

Salt People. This resulted from the captivity of other tribal children. In this case, one girl who was captured lived at a place called "Salt Extends Out". This group of people grew to be called the Salt Clan.

Coyote Pass (Jemez). This clan is not particularly referred to as Coyote Pass but as Nahodeeshgiizh, from where the clan Ashiihi emerged. This marks the Coyote Pass and Ashiihi as very closely related.

Black Sheep Clan. These were the herdsmen of numerous black sheep in the same area as Nahodeeshgiizh.

The Mud Clan. This clan is closely related to Bit`ahnii. They became very close and good friends in the old days.

Water Edge or Edge of Water Clan. At the time this clan originated, berries were gathered close to and around a body of water, such as a spring or stream. These people ended up being the Water Edge Clan.

Salt Water Clan. This group came to be called the Salt Water Clan because it dwelled at a moist place where a lot of alkaline forms, which has a very salty taste.

Meadow People. Their clan name was given to them by the two who came to the water hole. The Haltsooi people evidently erected forked stick hogans for homes at a green meadow place, where they were given this clan name.

The Many Hogans People. The Totsohnii clans were the ones responsible for giving the Many Hogan Clan name to these people because they had many homes in one spot.

Water Flows Together. This particular group of people resided at a place called "Where The Water Flows Together". It was there a member of the Naakaii Dine`e clan saw a young girl in the water. So this person attempted to save the young girl, but each time the high tide of the water kept this person from rescuing the child. Finally, a rescue was made. This young girl was given this clan name.

The Mexican People, meaning Nomads. These groups of people were nomadic hunters who moved from one place to another to hunt for game. Naakai means nomad - moving about a lot. Some say they were captured once, despite their transient nature.

Red House People. These People lived in red houses, evidently made from red rocks and red clay; also referred to as a marker like a totem pole or wood sculpture.

Many Goats. This group of people consisted of herdsmen of many goats. They relied largely on the maintenance of large herds of livestock, especially goats, for their food. That is why they are called The Many Goats Clan.

Black or Dark Streak or Wood People (also referred to as the Bear People). This clan known as the "Bear People" emerged from the sacred mountains called Blanca Peak, White Shell Mountain or Dawn.

Red Bottom People (Painted Cheek is another translation for this clan). These people used to run a race with another clan group. The group that witnessed this clan group observed that these people had pink feet or red on the soles of their feet. This clan emerged from one of the sacred mountains called Gobernador Knob Mountain. (It is said that this particular clan has the right to inter-marry with any clan).

Tangle People. This clan group was also told that they belonged to the Spider People, because their teeth were like spider webs. They are closely related with the One That Walks Around Clan.

Yucca Fruit People, Strung Out-In-A-Line Clan. This clan group lived in an area where a lot of yucca fruit grew. The people gathered the yucca fruit and prepared and preserved the fruit for long winter months. The people living near them gave them the clan name.

One That Walks Around. A person belonging to this clan group said in a teasing way, "Why are you all tangled up?"- which later became Tangle People. Vice versa, a person belonging to the Tangle People gave him this clan name because he kept walking around him.

Near The Mountain Clan, or the Mountain Cove. This name is self-explanatory. The story regarding this clan begins as follows: This particular woman had just moved near some mountains. Therefore, she received the name, "The Woman Near The Mountain", which also became her clan.

Ute People Clan. This means that the Ute children were captured by the Navajos during their raids on the Utes. This is how we have Ute People Clan among us today.

Zuni Clan People. This name was given to this clan after they ran away from the Zuni's and returned to the reservation.

Zuni / Red Streak Running Into The Water People. This clan resulted from a young Navajo girl being captured by the Zuni's and returning to Navajoland, when she was given this clan name. This is the reason why the Navajos have such a clan among them.

Start of the Red Streak People (also, Bend of Red Rock). This particular group of people made their home at a bend in an area of red rock, so they received the clan name.

Sleep Rock Clan. This clan is related to the One That Walks Around Clan. It originated from the Taos Tribe.

The Reed People. This name came from the Hopi's. They were raised by the Under His Cover with Totsohnii Clan, which is the Rock Gap Clan, Many Hogans Clan, and a little of the Towering House Clan.

The stories here are not complete clan histories. However, they do show where the roads back into history lead. They tell how the Dine' lived when they first began to spread across the land, and how from the very beginning they were joined and strengthened by others they met. Whoever wishes to know more will seek out the history of their own clans.

Appendix C: Level System

Levels And Privileges

Safety Status

1. I will complete all required assessments.
2. I will be involved in the physical activities (walking, running, ropes course, etc.).
3. I follow the recommended diet plan at FCRATC.
4. I will take required medications (30-day Vitamin program and prescribed medication).
5. I do my personal hygiene and chores appropriately.
6. I will participate in all groups and individual sessions.
7. I will begin working on my Step One workbook, Life Story, and Journaling.
8. I will talk about my cravings and begin relapse education.
9. My Initial Treatment Plan has been explained and reviewed with me.
10. I have been placed on a *contract* for my own safety.
11. I have written an essay on “My Five Personal Strengths”.
12. I have begun my “Road Map” that will be finished at discharge.

Black World

1. I have completed ten days of Safety Status.
2. I have continued to meet my needs as established in Safety Status.
3. I have identified what triggers my anger and have begun processing this with my Case Manager.
4. I have attended Sweat Lodge(s) and other spiritual groups.
5. I am learning the pre-recovery stages of relapse in my group (Recognition of Addiction).
6. I presented my Life Story, Step One and other assignments in my group and in individual sessions.
7. I have identified five more personal strengths.
8. I have begun working on my treatment assignments from my Case Manager.
9. I am involved in the physical activities program on a daily basis.
10. My Master Treatment Plan has been explained and reviewed with me.
11. I have been addressing my emotions and getting along with staff.
12. I have written an essay, drawn a picture or talked bout what I have learned about cultural values.
13. I understand the cultural value of the Black World.
14. I complete my assignments in school

15. I am maintaining appropriate grades in the classroom.
16. I am displaying motivation in the classroom.

Because I was able to demonstrate progress in the **Safety Status** and **Black World**, I have earned the following privilege:

- Three minutes of incoming and outgoing phone calls to the immediate family members only.

Blue World

1. I have continued to meet my needs in the Safety Status and the expectations of the Black World.
2. I have addressed my emotions, feelings and taking healthy risks in groups.
3. I have learned about cravings, withdrawals and crisis management in relapse education.
4. I have written a plan on how to cope with my anger or other emotions.
5. I have processed my treatment assignments in my group, individual sessions, or with case managers.
6. I have started my Step One Poster, prevention charts, etc.
7. I have identified how my chemical use has impacted my body and mind and my life.
8. My family and I have participated in family day sessions.
9. I understand my write-ups are "learning about my behaviors".
10. I have identified five things I need from my family and others to be successful in treatment.
11. I understand the cultural value of the Black and Blue World(s).

Because I was able to demonstrate progress in the Safety Level physical needs, and the Black and Blue World's expectations, I have earned the following privileges:

- Five minutes of outgoing phone calls plus two five-minute incoming calls from immediate family members only.
- One hour lunch pass on family day (with a family member).

Yellow World

1. I have continued to meet my physical needs in the safety Status and the expectations of the Black and Blue World.
2. I have completed all assignments from my Case Manager and processed these.
3. I am coping with my anger in a healthy manner.
4. I have written an essay on each area of my issues and what I have learned.
5. I have been giving myself positive affirmations and listed 10 personal strengths.

6. I have attended _____ Sweat Lodges.
7. I am being kind and respectful to others.
8. I understand the cultural values of the Black, Blue, and Yellow World(s).

Because I was able to demonstrate progress in the physical needs of the Safety Status and expectations in the Black, Blue and Yellow World(s), I have earned the following privileges:

- One seven minute outgoing phone call and two seven minute incoming phone calls.
- Two hour off-site pass.

White World

1. I have continued to meet my physical needs as established in the Safety Status.
2. I have continued to meet the expectations of the Black, Blue, and Yellow World(s).
3. I have identified the things that will cause my relapse.
4. I have identified the things that will support my sobriety and health.
5. I have developed a discharge plan.
6. I have identified my strengths as a caring person in this community.
7. I have written five things I will do to give back to my family, friends and community after discharge.
8. I understand the cultural values of the Black, Blue, Yellow and White World(s).

Because I have met the physical needs of the Safety Status and the expectations of the Black, Blue and Yellow and White World(s), I have earned the following privileges:

- Seven minutes of an outgoing call and two seven minute incoming phone calls.
- Three hour off-site pass.

Glittering World

1. I have written on each direction and how I will handle these gifts when I leave treatment
2. I have completed my Road Map of my treatment and prepared to present it at my discharge review to my family and the staff.
3. I have understood the teachings and cultural values of the Black, Blue, Yellow and White and Glittering World(s).

I have developed my physical needs as established in the Safety Status and have developed the expectations of the Black, Blue, Yellow and White and Glittering World(s) and I have earned these privileges:

- Two seven minute outgoing phone calls and two seven minute incoming phone calls.
- Four hour off-site pass.

--Client levels will be determined every two weeks during Client Treatment Review. The requirements for advancing to each level need to be met. Be prepared to have assignments and proof of meeting the expectations and needs ready at every two-week interval.

--No one can move up a level until they have met the requirements.

--Anyone who is demoted to Safety Status will be required to wear Sweat Pants (length of status is determined by the Case Manager or the Clinical Staff).

Procedures/Expectations:

1. You shall participate in all scheduled physical, educational, therapeutic, and life skills activities.
2. You shall not intentionally physically or emotionally harm another client.
3. You shall strive to help other clients break the cycle of chemical dependency.
4. You shall actively explore your life open and honestly.
5. You shall actively seek to understand the role of chemical dependency in your life.
6. You shall accept full responsibility for your well being and recovery.
7. You shall accept full responsibility for your actions.
8. You shall adhere to all rules of the program and facility.
9. You shall complete all tasks assigned to the best of your ability.
10. You will support all rules as set forth at all times.
11. You shall express your feelings and attitudes clearly.
12. You will express respect, honesty and concern for self and others.
13. You will not leave the designated client areas without notifying appropriate staff.
14. You will be clothed in a presentable manner at all times per the program dress code.
15. You will not use language that is commonly known to be “cuss words”.
16. You will conduct yourself in a respectful manner to staff, clients, and others.

Appendix D: Key Staff Qualifications

Program Staff Configuration and Qualifications

Staff Configuration

The following is the staff configuration for a residential treatment center that is open 24 hours daily and has three shifts (AM, PM, and graveyard).

CEO/NAHP	1 FTE	8:00 am to 5 pm
Chief Finance Officer	1 FTE	8:00 am to 5:00 pm
Clinical Director/Psychologist	1 FTE	8:00 a.m. to 5 p.m. with 24 hour on call status
Clinical Supervisor M.A.	1 FTE	8:00 am. to 5 pm with rotating on call status
Licensed and/or certified alcohol and drug abuse counselor/NAHP	6 FTE	8:00 am to 5 pm with rotating on call status
Social Worker, M.A.	2 FTE	8:00 am to 5 pm with rotating on call status
Nurse Practitioner (licensed)	1 FTE	10:00 am to 7:00 pm with rotating on call
Registered Nurse/Assessments	1 FTE	8:00 am to 5:00 pm with rotating on call
Assessment/Medicaid Counselor	1 FTE	8:00 am to 5:00 pm
Physician	.25 FTE	
Psychiatrist	.25 FTE	
Therapeutic Residential Supervisor	1 FTE	10:00 am to 7 pm with rotating on call
Psychology Aides	20 FTE	24 hours daily to meet a staff to client ratio of 1 to 6 on daytime and evening shifts and 1 to 8 ration on the graveyard shift.
Psychology Aides (per diem)	6	On call aides
Special Educational Teacher	1 FTE	8:00 am to 5 pm
Education Aide	1 FTE	8:00 am to 5 pm
Client Advocate	1 FTE	10 am to 7 pm
Field trackers	3 FTE	Hours varied depending on need
Administrative Assistant	1 FTE	8:00 am to 5:00 pm
Clerk-Typist	1 FTE	8:00 am to 5:00 pm
Information Technician	1 FTE	8:00 am to 5:00 pm
Total FTE:	45.5 FTE	and 6 per diem

Program Staffing

The following are the basic guidelines to ensure adequate staffing to support client goals; and protect, foster and promote the health, welfare and safety of clients, staff and visitors. The staff will supervise clients at all times.

Client to staff ratios shall be maintained as follows:

- Group Sessions 12:1 with licensed counselor.
- Didactic Group Sessions 12:1 with licensed counselor.

- Adventure Based Counseling 12:1 with certified counselors
- Cultural and Spiritual activities/education 12:1 with Traditional Spiritual Counselor
- Activities and recreation therapy 5:1 with clinical staff and 8:1 including support staff
- Individual Therapy case load will be 5 clients per counselor.
- Group Therapy sessions shall be limited to fifteen (15) per group.
- All clinical staff will have demonstrated competency and have a New Mexico state licensure such as LADAC, LPC, LISW, and Ph.D.
- Native American Healing Practitioners must be apprenticed by a recognized medicine person and will conduct all cultural relevant activities. All cultural activities will be approved by the clinical team.
- All support staff will have an orientation and be assessed as competent to independently supervise clients or perform independent activities.

The following are the minimum qualifications for key clinical program staff:

a. Clinical director and/or clinical supervisor

- Master level in the behavioral health field and possess a State of New Mexico licensure
- At least 5 years experience in AOD and mental health disorders with adolescents and families.
- Must have 3 years experience working with American Indian adolescents and family
- Must have 2 years experience in administration and employee supervision
- Must have knowledge of the clinical documentation process
- Must have knowledge and skills of computer operation
- Previous experience in Third Party billing and state Medicaid standards, JCAHO/CARF accreditation and Children, Youth, and Family certification

b. Alcohol and Drug Counselor:

- The alcohol and drug counselor must possess a license and/or certification by the state of New Mexico
- Must have 1 year experience working with AOD
- Must have 1 year experience working with adolescents and families
- Must have 1 year experience working with American Indian people
- Must have knowledge and skills of computer operation

c. Social Worker

- Must possess a master degree in social work and be licensed eligible
- Must have 1 year experience with AOD and mental health disorders
- Must have 1 year experience working with adolescents and family
- Must have 1 year experience working with American Indian people
- Must have knowledge and skills of computer operation

d. Nurse Practitioner

- Must possess a master degree in nursing and be a licensed/registered Practitioner in the State of New Mexico
- Must have 1 year experience with AOD and mental health disorders
- Must have 1 year experience working with adolescents and family
- Must have 1 year experience working with American Indian people
- Must have knowledge and skills of computer operation

e. Registered Nurse

- Must have a bachelor's degree in nursing and be registered in the State of New Mexico
- Must have 1 year experience with AOD and mental health disorders
- Must have 1 year experience working with adolescents and family
- Must have 1 year experience working with American Indian people
- Must have knowledge and skills of computer operation

f. Special Education Teacher

- Must have a master degree in education with a special education certification in the State of New Mexico
- Must have 5 years experience teaching adolescents in special education
- Must have 1 year experience working with American Indian people
- Must have experience and knowledge to provide academic and vocational testing
- Must have knowledge and skills of computer operation

g. Psychology Technician

- Must be 21 years of age
- Must have an A.A. or B.A.., B.S. degree and/or three years of experience working with adolescents in a residential setting.
- Must have 1 year experience working with American Indian people
- Must have knowledge and skills of computer operation

Appendix E: Walking In Beauty Teaching

WALKING IN BEAUTY

Where did these 6 standards come from? What does it mean? Who gave us the 6 standards of life?

The notion of saying…

"There is beauty
before me,
behind me,
beneath me,
above me,
around me,
and with beauty I speak".

During the Era of "The journey back to earth" after "the re-creation of the four clans", the four original clans journeyed back from the west, towards the four sacred mountains. Haashch'eelt'i and the other Holy Deities started their journey, from within the four sacred mountains, to meet the four original clans, who were on the way back to their sacred land. They meet their children, the five fingered ones, west of Dooko'oslid.

A blessing way ceremony was performed by, Haashch'eelt'i for the returning original Clans. This is considered the third blessing way ceremony. This ceremony took place at "Evergreen Dwelling" west of Dooko'oslid. During this ceremony, we were given our sacred language; the universal language of the Holy Deities and the language that they used to communicate with each other. We, (the five fingered ones), were given many good blessings, by the Holy Deities throughout the ceremony that night. The stories are in the songs, prayers, and teachings.

In the midst of dawn, as Haashch'eeelt'i and the Holy Deities concluded their ceremony for the first original clans. They were taken outside as a final gesture, before the Holy Ones departed to their sacred places. They stood in front of the dwelling as they got their final instructions from Haashch'eelt'i and the other Holy Deities.

(This Blessing Way ceremony is the protocol for today's Blessing Way practices. It is a re-enactment or resemblance of this ceremony).

The bird people were the last to leave, they gave their final blessings to the five-fingered ones. "We have instilled life's teachings, now go forth and apply the songs, prayers and instructions. These are considered the six (6) standards of life.

“There will be beauty before me”

One of the birds relayed that his flights include a place in the east. There is a place in the folds of dawn, where everything is pure, virtuous and inspirational. A place where there are glittering rainbows, where crystal lights shimmer and where the jewels of moisture sparkle in abundance. Beyond the ease mountain, there exists another mountain. The Crystal/Mirage Mountain, which is the most magnificent place.

The blessing from the east will always be before you, a new horizon or a new beginning. There will always be beauty before you for as long as you shall live. There will always be brilliance, aspiration with many prospering dreams and visions. A place where restoration and rebirth exists. Where success and accomplishments are in abundance. There will always be hope and faith in this direction.

With each dawn will come a brand new day, that will bring an awakening to all mankind and other life forms. The “Holy Ones” will always be present before each one of us.

“There will be beauty behind me”

Another bird revealed that he also, travels to the west. Towards the sunset, where there is serenity. Where darkness refurbishes energy while our physical beings rest.

The land of the floating white shell, the home of White Shell Woman/Changing Woman, your place of origin. There will always be beauty from where you came. You are the five-fingered ones, the most exquisite creation. Always remember your lineage, and your identity must continually remain intact.

Your history is essentially foremost. “You need to be knowledgeable of your roots to apprehend your destination”.

You are the product of four clans, Maternal and paternal clans. You have a role in each and need to represent each accordingly. Each clan has their stories and teachings. Each is equivalently imperative. Living up to the principles of each clan is an obligation to parentage.

Spirituality is your foundation. “The Holy Ones” revealed that they will empower and coexisting live in the songs, prayers, ceremonies, stories and teachings. They will always be behind each one of us.

“There will be beauty beneath me”

The most treasured our Mother Earth, which is beneath us; the most beautiful place in the universe. The “Holy Ones” lived within the four sacred mountains before they left this land to us. We are their descendants.

The four sacred mountains epitomize our perpetual strength. The word Dzil means strength. Each mountain is sacred and adorned with precious gems; Sisnaajini, with white shell, T'soodzil, with turquoise shell, Dooko'oslid, with abalone shell, and Dibe Nit'sa, with black jet.

I am a child of Mother Earth.
Each day I walk upon her.
She is a mother to all forms of life
She has set her standards
For us to live by.
In peace, and never harm one another
For we are all her children
That she will always have a place for us
And all she wants from us is respect for one another
And live together in harmony.

That glorious morning, west of Dooko'oslid, the ultimate never-ending corn pollen path commenced. Our Mother Earth will always exist beneath us.

"There will be beauty above me"

The eagle stated that he travels beyond the clouds, towards the sky. He is aware of what is beyond the earth's atmosphere: the places of the Holy Deities, among the stars, constellations, galaxies and universe. From the sacred places in the universe, the Holy Deities will grant their blessings.

The winds, from the four directions, that brings the four seasons. As the climate changes, so does our Mother Earth. As we continue to put corn pollen upon our head, we will continue to grow and feed our physical and spiritual being. We will continue to grow upward, towards the sky. The elements from above continue to nourish our growth.

We must maintain the elements, which is contingent upon one another. We need the four sacred elements to survive. That we should not contaminate the sacred elements: the earth, water, air, and light/fire, that give life to all those that continue to exist.

From the Holy Ones and the elements above, there will be beauty from above us.

"There will be beauty around me"

From within the surroundings, there will be beauty from all life forms: the plants, animals and all that live with you on earth. To walk upon the pollen of the plants, which is represented in our ceremonies, as a binding agreement that we will be dependent upon one another. "We will walk the corn pollen path". The plants and herbs replenish our bodily needs and heal our ailments.

We have exchanged and acknowledged our binding with other life forms, by granting usage of certain articles from them to use in our ceremonies. The blessings of those we live with on earth are evident in our songs, prayers and teachings. There were specific covenants that we agreed to abide by to live amongst one another.

As children of the "Holy Ones", we shall abide by the Natural laws of the elements and the standards of life. To continue with our tradition, that we will flourish through many generations. To maintain K'e, as long as our fire is lit.

We will live together in peace and harmony. We will maintain our natural environment, never to contaminate our surroundings, so there would be beauty from within our surroundings.

"And, with beauty I will speak"

The Holy Ones conveyed to the original clans that they will exist in the songs, prayers and ceremonies, through the sacred language, to always call upon them and communicate with them forever. Your history, identity, and the teachings from us are within your language.

The Dine' language is our strength and our bonding with the Holy Ones. Maintaining our language is absolutely necessary, because it is dependent upon our survival.

And from within our soul, there will be beauty. With beauty we will speak, the sacred language of the Holy Ones, who will listen to the divine language that they left with us on that wonderful morning. As long as we speak our sacred language, the Holy Ones will exist at the tip of our tongues.

The Holy Deities left us the most precious of all that they possess. They left with us what they cherish, the most treasured of their blessings. They left their homeland within the four sacred mountains, for us. That we could live in beauty in the most phenomenal place in the universe.

And so, from that day on, the most beautiful journey, our life's journey, unveils and begins as Sa'ah Naaghai Bik'ehozhoon.