Healers Need Healing Too: Results from the Good Road of Life Training

By: Allyson Kelley and Clayton Small

Abstract:

Mental health professionals that work with American Indian and Alaska Native (AI/AN) populations are often viewed as ineffective because their professional training is based on a Western model of service delivery that is an extension of Western colonization. Research on effective training approaches for AI/AN mental health providers or mental health professionals that work with AI/AN populations is limited. The purpose of this study is to document the experiences and impact of the Good Road of Life (GRL) training on mental health professionals that work with AI/AN populations. A cross sectional mixed-methods design was used to answer the primary research question, "What is the impact of GRL training on mental health professionals who work in American Indian communities?" We used GRL ratings, self-reported impacts, knowledge gains, and pre-post Sources of Strength scores. Self-reported mean knowledge scores increased for all topics. Daily evaluations indicate that most participants felt more positive, knew more about the impacts of sobriety, and knew how to help a suicidal person. Sources of Strength mean scores increased in the following areas: confidence, belonging, historical trauma, using strengths to overcome difficulties, spiritual practices, resolved unhealthy relationships, and use of cultural resilience. Results indicate that GRL is an effective short-term training for professionals working in the mental health field throughout Indian Country.

Keywords: mental health professionals | American Indian | Alaska Native | Good Road of Life training | mental health training

Article:

Introduction

More than 68% of American Indian and Alaska Native (AI/AN) people live on or near Indian reservations, villages, or tribal lands, and 54% of AI/ANs live in rural or small-town areas (Dewees & Marks, 2017). These areas are often characterized by limited behavioral health resources and greater behavioral health needs. In the general U.S. population, AI/ANs are considered a minority; they experience lower incomes and poverty and have significant mental health needs due to historical, intergenerational, and present-day traumas (Brave Heart, Chase,

Elkins, & Altschul, 2011). Racial and ethnic minorities, along with low-income groups in rural areas, are the most impacted by a growing shortage of mental health professionals1 (Riding-Malon & Werth, 2014). A report by the New Freedom Commission on Mental Health found that more than 85% of the federally designated mental health professional shortage areas are rural (Riding-Malon & Werth, 2014), and AI/ANs in these areas are disproportionately impacted by the shortage of mental health professionals. AI/ANs have faced substantial behavioral health needs and continue to experience a growing mental health crisis that is compounded by the lack of mental health professionals and limited services (Health Resources & Services Administration, 2019). Previous research calls attention to the barriers that prevent racial and ethnic communities from accessing and receiving mental health services (U.S. Department of Health and Human Services [USDHHS], 2006). These barriers include stigma around mental illness; feelings of shame and discrimination; lack of insurance or underinsured status; ineffective communication by providers; and cultural attitudes, beliefs, values, and expectations (USDHHS, 2006). For some AI/ANs, another barrier is the feeling that mainstream mental health services are largely ineffective because they are not based on indigenous ways of knowing and fail to address these dimensions of well-being and health, such as spiritual, physical, mental, and emotional (Hodge, Limb, & Cross, 2009).

Research shows that high rates of suicide, substance abuse, social problems, and other mental health problems are related to cultural oppression and marginalization that AI/AN groups have experienced (Kirmayer, Simpson, & Cargo, 2003). Historical traumas have impacted past and future generations. AI/AN populations experienced social and cultural disruption, through the institutions of boarding schools, forced relocation programs, genocide, and punishment for speaking Native languages and practicing ceremonies. There is an emerging body of literature that supports practicing culture as treatment (Gone, 2013; Gone & Calf Looking, 2011). Cultural practices as a form of treatment may include regalia making, using indigenous language, practicing generosity and healthy relationships, participating in ceremonies and spiritual practices, and numerous other components of culture. The rationale for using culture as treatment is that culture reconnects AI/AN people to their identity, spiritual practices, traditional knowledge base, values, ceremonies, kinship systems, and healing practices (Gone, 2013; Kirmayer et.al, 2003). With the colonizing history of AI/ANs in the United States, and the distrust of Western therapeutic approaches, providers working with AI/AN populations must be knowledgeable about historical trauma and the significance of cultural practices as a form of treatment (Whitbeck, Adams, Hoyt, & Chen, 2004). For these reasons, training efforts are needed that increase provider responsiveness to culture and trauma.

Research on training AI/AN mental health providers or individuals who treat AI/AN clients is somewhat limited. Most research either documents the prevalence of mental disorders, calls for more culturally responsive service provision in a general way, or documents gaps in existing services. For example, Hodge and colleagues (2009) report that AI/ANs view mental health services as ineffective. Walls and colleagues (2006) conducted a study with tribal members from four reservations, and they found that mental health and substance abuse services provided by professional service providers were not effective. This same study found that when mental health providers lived off reservation, they were ranked as the least effective of all 21 professional services evaluated (Walls, Johnson, Whitbeck, & Hoyt, 2006). In another study, LaFromboise (1988) found that non-Native psychologists often try to impose their values on AI/ANs and called for more providers to become familiar with the mental health provision process in Indian Country. Gone and Trimble (2012) call attention to the staffing and funding issues of federal programs like the Indian Health Service. With limited resources and services, mental health problems among AI/ANs have exceeded the resources available on reservations and tribal lands

(Gone & Trimble, 2012). In sum, the current research on AI/AN mental health services indicates that one reason why existing services are ineffective is that they are based on a Western model of service delivery that is an extension of Western colonization. The Western model is plagued with challenges such as infrastructure, financing, and research. Institutional racism and discrimination contribute to ineffectiveness, where cultural practices, traditions, and spirituality are not valued as they should be (Findling et al., 2019). Interventions that increase mental health professionals understanding of the role of historical trauma through provider training is necessary to build effective mental health services.

This study focused on the Good Road of Life (GRL) training. It presents an example of a culturally relevant training model that supports mental health and related workforce professionals in understanding and responding to efforts to heal from historical and intergenerational trauma.

Good Road to Life

The GRL training was developed for Native people who are faced with extraordinary challenges and who may have lost the sacred connection to their cultural identity due to colonization and racism (Small, 1996). Developed by Dr. Clayton Small in 2007, the GRL training has been implemented in more than 20 states, reaching more than 15,000 participants. GRL draws upon similar concepts from the Gathering of Native Americans (GONA) by promoting hope, encouragement, and skills that support indigenous community action and advocacy. Similar to the GONA framework, GRL promotes building relationships, building skills and the concept of mastery, working together and interdependence, and promoting commitment and generosity (Chino & DeBruyn, 2006). GRL is used by federal agencies such as the Substance Abuse and Mental Health Services Administration, the Indian Health Service, and the Administration for Native Americans. Uses of the GRL curriculum vary, with adaptations for youth, family members, Native men, and organizations. Local unpublished evaluations have documented the effectiveness of GRL across populations, states, and age-groups; however, this is the first publication of GRL evaluation results that utilizes descriptive statistics to explore differences in pre and post knowledge scores among tribal professionals.

GRL is a culture- and resilience-based curriculum designed to use the sources of strength that Native people have, including spirituality, culture, and humor, to assist in the development of personal wellness, leadership, healthy relationships, and family preservation. The GRL curriculum is supported by a 225-page training manual that each participant receives and uses throughout the training. Training is offered over a 3-day period and approximately 18 hours. Chapter topics include the following: norms, curriculum overview, clan formation, colonization and racism, multigenerational trauma and breaking unhealthy cycles, sobriety, hostility and anger management, domestic violence, healing, forgiveness, grief, suicide prevention, sexual orientation, conflict resolution and healthy communication skills, and developing a personal wholeness plan for returning home. Interactive activities support GRL outcomes and include presentations, icebreakers, skits, group discussions, talking circles, and hands-on activities.

GRL Expected Outcomes

The GRL curriculum was designed to achieve seven outcomes.
- Improve skills to overcome barriers and deal with stress for workers
- Increase worker knowledge about cultural resilience using culturally appropriate activities

- Increase worker knowledge about communication and conflict resolution skills that strengthen relationships
- Increase worker knowledge about suicide risk factors by offering prevention education and awareness
- Provide peer counseling skills for workers that support each other's wellness and facilitate friendships
- Increase leadership skills of workers
- Empower workers to make healthy decisions

With the growing need to strengthen the mental health workforce effectiveness, this study documents the experiences of mental health professionals who attended a GRL training December 14-16, 2018 in Albuquerque, New Mexico. GRL was intended to be a healing exercise for mental health professionals attending the training and a knowledge building activity that would increase understanding about culture and historical trauma in AI/AN communities. The GRL training was based on the assumption that providers need healing too, and the GRL training would give providers an opportunity to heal while developing new skills that they could use with the population they work with. GRL was delivered as planned, without changes in topics or activities to accommodate any non-AI/AN professionals who attended the training. In some cases, non-AI/AN professionals listened and learned about culture and historical trauma, some for the first time.

The first objective of our study was to document the satisfaction among GRL participants—this was particularly important because it was the first time we had offered the training for AI/AN mental health professionals and mental health professionals that serve AI/AN communities. This objective supported our research question, "What is the impact of GRL training on mental health professionals who work in AI communities?"

Methods

Recruitment

Native Prevention Research Intervention Development Education (PRIDE) is a an American Indian non-profit organization committed to implementing cultural and spiritual based programs that inspire wellness, healing, leadership, and changes for individuals, families, communities, and organizations (www.nativeprideus.org). Native PRIDE is the organization that designed, implemented, and evaluated the GRL training. A five-member tribal community advisory board oversees all aspects of Native PRIDE outreach and training efforts using principles of community based participatory research (CBPR) including shared decision-making and ownership in the design and evaluation process (Kelley, Piccione, Fisher, Matt, Andreini, & Bingham, 2019). Native PRIDE offers GRL trainings in schools, communities, and organizations throughout Indian Country. For this study, Native PRIDE recruited participants using fliers, email communications, website, advisory board members, outreach to tribal mental health professional organizations, Indian Health Service, and in-person communications. Eligibility was not limited to AI/ANs or a specific geographic area; any mental health professional working in tribal communities was welcome to attend. Consistent with tribal values of inclusion and generosity, Native PRIDE trainings are open to rural, urban, frontier, and non-Native groups.

Evaluation Design

We used a cross sectional, mixed-methods study design to answer our primary research question. The following data sources were used: Sources of Strength Inventory pre and post scores, participant demographic information, and GRL daily evaluations. All data were collected in person using paper and pen survey methods. Native PRIDE collected daily evaluations at the end of each training day. Upon completion of the evaluation, participants were given a raffle ticket and had the chance to win gift cards, traditional foods, and artwork. Verbal consent was obtained from all individual participants, and all GRL participants were invited to participate in the daily evaluations, although it was not required.

GRL Daily Evaluations

Native PRIDE developed daily evaluations to measure knowledge increases in topics presented, the quality of presentations and presenters, and how meaningful session activities were to participants. These evaluation tools and the Sources of Strength survey were developed by Dr. Clayton Small as part of his dissertation in 2007. The Sources of Strength survey has been adapted for other age groups and trainings by Native PRIDE (Kelley & Small, 2016). The first section of the daily evaluation included three questions that addressed the quality of presentations and presenters. The first question asked, "Was the program easy to follow and understand?". Response options were No, Not Sure, or Yes. The next two questions asked about facilitators and activities, "The facilitators were organized, knowledgeable, and supportive" and "The session activities were meaningful and relevant to me." Response options for these questions were based on a 5-point Likert-type scale where 1 = Strongly Disagree and 5 = Strongly Agree. The next section included a set of questions that used a retrospective design to document knowledge changes as a result of the GRL training. We asked participants to circle their level of knowledge of a topic before and after the training using a 10-point scale where 1 = No Understanding and 10 = Complete Understanding. Topics varied based on the content presented each day and included: colonization, spirituality, historical trauma, grief and loss, forgiveness, healthy relationships, sobriety, suicide prevention, and conflict resolution. The next question asked, "How did the GRL training impact you?" and participants were instructed to select from a list of responses that applied to them. Response options were linked to content and previous work. Day 1 response options were "I feel more positive," "I feel more hopeful," "I understand the impact of colonization," "I feel more connected to my spirit," "I understand the impact of historical trauma and racism," and "I was not impacted." Day 2 response options were "I feel more hopeful," "I feel more positive," "I know more about healthy relationships," "I understand more about grief and loss," "I know how to forgive and why it is important," and "I was not impacted." Day 3 response options were, "I feel more hopeful," "I know why sobriety is important," "I feel more positive," "I know how to help someone who is suicidal," "I can use conflict resolution skills," and "I was not impacted."

Sources of Strength Pre- and Post-Survey

Our team administered the 14-item Sources of Strength (SOS) survey to document changes in strengths on the first day of the GRL training and on the last day of the GRL training. The survey was designed to assess constructs related to healthy relationships, communication, confidence, belongingness, historical trauma, generational trauma, addictions, spiritual practices, sexual orientation, cultural, and resilience. The SOS has been used with Native populations with a high degree of reliability and validity (Kelley & Small, 2016). SOS response options were based on a Likert-type scale where 1 = Strongly Disagree and 5 = Strongly Agree.

Analysis

We entered daily evaluations and the SOS responses into SPSS version 24.0. Our team calculated mean scores and standard deviations for each item. We calculated descriptive statistics for all items. Next, we used a paired t-test to compare pre and post mean knowledge scores. We used an independent samples t-test to compare pre and post mean SOS scores. All evaluations were included in the analysis, including those with missing data. Results were reviewed and validated by the Native PRIDE team and individuals that attended GRL.

Findings

There were 77 GRL participants total, and the daily evaluation response rate overall was 85.2% and varied by day (Day 1 = 88.3%, Day 2 = 83.1%, Day 3 = 84.4%). Table 1 summarizes the demographics of the GRL participants. Most were female (63.7%). The average age was 41.3 years (SD = 12.85). Tribal affiliation varied, and all but two of the participants were AI/AN. Most participants were clinicians working in mental health (51.5%), and their roles varied from clinical social worker or therapist to clinical director. Others (17.6%) worked in prevention programs related to substance abuse and mental health in tribal communities. Some worked in public health roles supporting mental health in positions such as coordinators, trainers, and community health (14.7%). The majority of GRL participants worked in rural communities in Washington, New Mexico, North Dakota, Utah, Oklahoma, Oregon, Arizona, New York, and South Dakota.

To answer the primary research question, "What is the impact of GRL training on tribal mental health professionals who work in AI communities?" we used GRL ratings, self-reported impacts, knowledge gains, and pre-post SOS scores.

Table 2 outlines the results of the first three questions related to the program, organization, and session activities.

Table 3 documents the mean knowledge scores before and after the GRL training from daily GRL evaluations. There was a statistically significant increase in knowledge reported before (M = 66.16, SD = 11.33) and after (M = 77.57, SD = 11.84) the training based on all topics presented, t(-12.54), p < .000, CI .95-13.23, - -.9.58. Further, Cohen's effect size value (d = .98) suggested a high practical significance (Cohen, 1988).

Table 4 highlights participant responses on how the training impacted them using fixed multiple-choice response options based on the topics presented and the intended outcomes. Results indicate that the GRL training increased the positivity of participants and increased knowledge of forgiveness, healthy relationships, spirituality, sobriety, and responding to someone who is suicidal.

Table 5 summarizes the SOS mean scores pre and post (before and after the GRL training). There was a statistically significant increase in SOS scores on all topics presented, before training (M = 60.81, SD = 4.63) and after training (M = 62.80, SD = 5.40) t(1.98), p < .05, CI .95, -3.9- .0024. Further, Cohen's effect size value (d = .39) suggested a small to medium practical significance (Cohen, 1988). The attendees reported increases in several areas of strength: feeling confident to deal with life stressors, sense of belonging to community and people, understanding the impact of historical trauma and racism, use strengths to overcome addictions and unhealthy behaviors, strong spiritual practices for healing and wellness, resolving unhealthy relationships, and use of culture to overcome challenges.

Table 1
Demographics of GRL Participants

Demographics	Percent	*n*
Gender (*n* = 69)		
Male	36.2	25
Female	63.7	44
Race/Ethnicity (*n* = 69)		
AI/AN	95.7	66
Non-AI/AN	2.9	2
Missing	1.4	1
Profession (*n* = 69)		
Prevention	17.6	12
Public Health	14.7	10
Clinician	51.5	35
Cultural Specialist	5.9	4
Law Enforcement	4.4	3
Educator	4.4	3
Missing	2.9	2

Table 2
GRL Ratings and Response Rates for Facilitators, Content, and Session Activities

Question	Percent Responding Yes	*n*
Was the program easy to understand?		
Day 1 (*n* = 69)	91.3	63
Day 2 (*n* = 69)	98.5	66
Day 3 (*n* = 65)	93.8	61
Were the facilitators organized, knowledgeable, and supportive?		
Day 1 (*n* = 69)	98.5	68
Day 2 (*n* = 100)	100	67
Day 3 (*n* = 65)	93.8	61
Were the session activities meaningful and relevant?		
Day 1 (*n* = 69)	82.6	57
Day 2 (*n* = 67)	94.0	63
Day 3 (*n* = 65)	89.2	58

Table 3
Self-Reported Mean Knowledge Before and After GRL Scale (1-10)

Topic	Before Knowledge	After Knowledge
Impact of Colonization (n = 69)	7.28 (SD=1.84)	8.48**(SD=1.33)
Spirituality (n = 69)	8.23 (SD=2.22)	9.26**(SD=1.58)
Historical Trauma (n = 69)	7.73 (SD=2.06)	8.80**(SD=1.28)
Grief and Loss (n = 62)	7.36 (SD=1.88)	8.89** (SD=1.33)
Forgiveness (n = 62)	7.53 (SD=2.06)	9.08**(SD=.93)
Healthy Relationships (n = 62)	7.50 (SD=1.8)	9.06**(SD=1.0)
Sobriety (n = 62)	8.22 (SD=1.64)	9.30**(SD=.91)
Suicide Prevention (n = 62)	7.88 (SD=1.75)	9.17**(SD=.87)
Conflict Resolution (n = 62)	7.87 (SD=1.96)	9.34**(SD=.84)
Overall Mean Knowledge Score	66.16 (SD=11.33)	77.57**(SD=11.84)

Table 4
Impacts of GRL on Participants

Highest Impacts	Percent	*n*
Day 1		
More positive	79.7	55
More hopeful	62.3	43
More connected to spirit	59.4	41
Day 2		
More positive	85.4	57
Know how to forgive/importance	80.6	54
Know healthy relationships	77.4	52
Day 3		
More positive	93.5	61
Know importance sobriety	87.1	57
Know how to help suicidal individual	87.1	57

Table 5
SOS Mean Scores Pre and Post

Constructs	Before SOS Mean	After SOS Mean
Satisfaction	3.44 (SD=.71)	3.44 (SD=1.0)

Relationships	4.00 (SD=.46)	4.00 (SD=.41)
Seek Support	3.96 (SD=.79)	4.02 (SD=.78)
Resolve Conflict	4.05 (SD=.45)	4.02 (SD=.55)
Confident	4.09 (SD=.61)	4.30* (SD=.55)
Belonging	4.09 (SD=.72)	4.38** (SD=.52)
Historical Trauma	4.09 (SD=.55)	4.30* (SD=.55)
Generational Trauma	4.14 (SD=.58)	4.23 (SD=.66)
Use Strengths to Overcome	4.18 (SD=.57)	4.47** (SD=.50)
Spiritual Practices	4.08 (SD=.73)	4.36* (SD=.63)
Resolved Unhealthy Relationships	3.88 (SD=.65)	4.14** (SD=.58)
Understand Depression and Suicide	4.20 (SD=.53)	4.26 (SD=.44)
Understand Sexual Orientation	4.04 (SD=.53)	4.24 (SD=.48)
Use Culture Resilience	4.19 (SD=.58)	4.40* (SD=.58)
Use Culture Overcome Challenges	4.21 (SD=.59)	4.35 (SD=.57)
Overall Mean SOS Score	60.81 (SD=4.63)	62.80* (SD=5.40)

**p<.01, *p<.05

Limitations

Evaluations show a high-level of satisfaction, positive impacts, and increases in sources of strength and self-reported knowledge scores—but these must be interpreted with caution. First, results may not be generalizable to other populations. Participants were recruited using convenience sampling methods and results only reflect the responses of participants able to attend the training. The small sample of participants and the lack of a control or comparison group limit the evaluation findings. Second, the retrospective evaluation design is based on self-reported knowledge gains and how participants feel their knowledge increased as a result of the training. Third, participants were from diverse mental health profession backgrounds and how we defined mental health professionals is unique to this training and population. For example, prevention specialists, public health specialists, law enforcement, and educators were classified as working in the mental health field, but just over half of the participants were clinicians. This is a unique classification for working in tribal communities, where mental health, spiritual health, physical health, and emotional health is viewed holistically, and therefore professionals working beyond the mental health field are asked to fulfill various healing and helping roles in their communities. Finally, the use of an independent t-test of the SOS scores from participants was required because not all participants completed the follow-up SOS survey.

Discussion

Results from this evaluation document significant positive impacts on tribal mental health professionals who work in rural and tribal communities throughout the United States. Results

also demonstrate a high-level of satisfaction with the GRL training, session activities, and facilitators.

GRL increased the strengths of AI/AN mental health professionals. The greatest increases in strengths that were statistically significant include: feeling confident to deal with life stressors, sense of belonging to community and people, understanding the impact of historical trauma and racism, use strengths to overcome addictions and unhealthy behaviors, strong spiritual practices for healing and wellness, resolving unhealthy relationships, and use of culture to overcome challenges. Trainings like GRL help professionals feel more positive about the future and increase their coping skills and availability to help others in need. Participant evaluations indicate that the training's biggest impact was helping them to feel more positive, and this is likely the result of the relationships that are developed, the skill building and exercises that participants engage in, and the atmosphere of the training that promotes acceptance, healing, and friendships.

From this training, and our collective experiences, we offer four lessons learned, designed to contribute new knowledge about supporting mental health professionals throughout Indian Country.

First, mental health and clinical professionals can benefit from a cultural and community based approach to therapy. This means getting out of the office and into the community when trainings like GRL are available. In doing this, they are visible to the community and are part of the community. Unless there are relationships established outside of the clinical office, there is limited trust established, and professionals will continue to be viewed as outsiders with limited effectiveness. A GRL mental health professional from Rosebud Sioux said, "You are not just doing this for yourself. You are doing this for everyone, your family, friends. You take your teachings and share these wonderful things. You tell them everyone can do this."

Second, we cannot give what we do not have. In the healing profession, this means that healers are healed, or at least have coping skills available so that when traumatic or stressful events arise, they will be able to deal with the situation in a healthy way. A GRL prevention specialist from the Pawnee Nation wrote this about the workshop, "The aspects of dealing with loss and dealing with shame, those have been the biggest for me personally. In my mind, you think about loss of family. But I have been going through a loss of hope and a loss of faith. I have learned how to heal."

We believe that understanding the unique trauma histories of AI/AN populations is a first step in being an effective mental health professional working with AI/AN populations. Understanding trauma histories requires that professionals have recovered from their own traumas and that they understand the healing process from an indigenous perspective.

Third, forgiveness is a powerful healing tool available to all. Part of the GRL training focuses on forgiveness, and we have found that professionals have more difficulty forgiving themselves than others. Self-care, self-forgiveness, and self-love are powerful when mental health professionals engage in these practices. A peer recovery specialist with the lived experience of recovery from the Seneca Nation reinforced the need for this training, regardless of professional status in the community: "It should be the same training for everyone, regardless of position." This quote is powerful because it reinforces the concept that healing and forgiveness is not just for individuals in need or crisis, but for everyone. It does not matter what position they hold or the qualifications and training that they have.

Fourth, we must find ways to continue the training and skill building beyond GRL. A GRL mental health professional from New Mexico reinforced this recommendation:

This training is a great building block for everyone that is trying to better themselves in their own areas and lifestyles. We all need building blocks. Like the four directions, there are building blocks in all directions and it is a continuous life circle, you can use anyone of those to build self-up. Programs like this help you study those directions and keep your learning circle going, building higher, higher, and higher.

When you open the door for healing from trauma, it is a process that requires a lot of follow-up. There is a need for transitional environments so that when professionals go back to the workplace carrying the feelings from the training, they have a resource and support system available.

Conclusion

Psychological distress, mental health problems, and substance abuse stem from the lingering effects of colonization (Gone, 2013). The GRL training is an example of a culturally based mental health professional training that increases knowledge of the underlying causes of mental health problems that AI/AN communities experience.

This GRL evaluation has taught us that healers need healing too. Findings from this study indicate that GRL may be an effective training for professionals working in the mental health field throughout Indian Country. By expanding training to mental health professionals, from different backgrounds and disciplines, it is possible to grow the capacity of AI/AN communities to address the mental health professional shortage while increasing the effectiveness of professionals through understanding of historical trauma and culture. Additional research is needed to explore the effectiveness of GRL on mental health professionals and the translation of skills and knowledge into practice settings. Continued efforts are needed that address the disproportionate impacts of colonization and trauma that AI/ANs experience; the GRL training offers culture-based teachings, resilience, healing, and hope for mental health professionals working with AI/AN populations.

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Author information

Dr. Allyson Kelley is a senior community health scientist and the founder of Allyson Kelley & Associates PLLC in Sisters, Oregon. She leads a multidisciplinary team of associates, and together they work to build evaluation capacity, understanding, and infrastructure that results in opportunities for community healing and transformation. Her work is driven by what communities identify as most important.

Dr. Clayton Small is an enrolled member of the Northern Cheyenne Tribe. His organization, Native P.R.I.D.E., provides prevention, wellness, healing, and leadership training throughout Indian Country. Dr. Small has developed prevention programs for the Bureau of Indian Affairs, Indian Health Services, SAMHSA, and the Department of Justice. His programs offer leadership and hope for American Indian, Alaska Native, and First Nations people.