



**A HOW-TO HANDBOOK ON CREATING COMPREHENSIVE,
INTEGRATED TRAUMA-INFORMED INITIATIVES IN
NATIVE AMERICAN COMMUNITIES**

CREATED BY

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ON BEHALF OF:

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INTRODUCTION

The Warrior Spirit -- by Kenneth White, Jr.

Our Ancestors were well. Our people were spiritually, mentally, and physically healthy. They had access to everything they needed. They had access to healthy food, to medicines, ceremonies and rituals that helped them maintain wellness. They had access to their language, their ancestors, and the oral traditions that taught them all the sacred ways. They had access to an earth that was abundant with wildlife, and they understood that if they respected the earth and the things upon it, it would respect them back. They had access to the celestial that provided their direction and told them about the seasons. They had access to their families, to the relationships that made them feel safe, that helped them feel loved. And always, everywhere, they had access to their Creator, who was central to all these things. They were always in relationship to everything, holistically connected to their universe.

But then something terrible happened, something interfered with our well-being – conquest, destruction of our way of life, genocide, removal of our children and destruction of our excellent childrearing techniques. All of these led to historical and childhood trauma that are responsible for so many of the problems that afflict our present-day communities.. In a speech about the causes and magnitude of historical and childhood trauma, at a conference entitled “Calling Upon the Warrior Spirit to Heal Historical Trauma”, a former tribal chairman asked the audience the following:

“Can you imagine for a moment our communities ...?”

- Without alcohol and drug addiction;
- Where suicide, sexual abuse, domestic violence is non-existent;
- Where we can quadruple our university graduate rate;
- Where we can gain full employment;
- Where we know how to improve the physical, emotional, spiritual and mental health of our people, thereby fostering a spiritual and cultural awakening where respect, compassion, sharing and service to each other are priorities, creating a society similar to that of our ancestors?”

The chairman went on to describe how that vision can be achieved by putting to work the discoveries neuroscientists have made about the causes and effects of childhood and historical trauma, coupled with use of the traditional healing practices tribes have relied on for thousands of years. The overriding focus of such an initiative is *healing*, achieved by relying on the warrior spirit that sustained Native Americans for thousands of years. Native elders advise that the term “historical trauma” is a condition, whereas “Calling Upon the Warrior Spirit to Heal Historical Trauma” is a Native American remedy to address this condition in many social, medical, and spiritual areas of need experienced by Indian populations.



Elders further advise that the Warrior Spirit is a living vibrant being that has been present in Indian Country for generations and is the force, healing power, essence and foundation that the Creator gave Native Americans to heal. Along with modern research, counseling, and treatment to Native Americans impacted by historical trauma, the Warrior Spirit must be recognized to provide holistic healing for our people.

THE GOAL OF THIS HANDBOOK

The Roundtable on Native American Trauma-Informed Initiatives (“Roundtable”) is pleased to offer this guide to Tribes and other Native American organizations on how to put in place a program to achieve that vision set out by Mr. White by implementing **a comprehensive, integrated, trauma-informed healing initiative** in their communities, one in which every member of the community is knowledgeable about what brain scientists, social scientists and their own culture have learned about the causes and effects of historical and childhood trauma as well as knowledgeable about the power of the warrior spirit. It is one in which every institution in the community – the schools, the courts and law enforcement, the child welfare program, the health and mental health programs, the tribal government and its enterprises, and every other program and institution in the community have implemented trauma-informed programs to help the members of the community who have been harmed by trauma and the overall community to heal.

While the Handbook continually refers to and recommends the creation of trauma-informed “programs”, creation of a trauma-informed community is more than putting in place a set of programs. It constitutes a paradigm change in how the community views itself and how community members treat each other, re-creating the environment of respect, courage, and mutual support that existed in traditional Native American societies. This can only occur by educating the entire community about trauma and its effects and involving the entire community in the development of the comprehensive integrated trauma-informed healing initiative.

In implementing such an initiative, it is critical to not view the community as being defined by its trauma. There are huge strengths in every Native American community that build on the qualities that enabled Native Americans to survive and thrive for thousands of years. Rather, the trauma should be viewed as a brake restraining the warrior spirit from going full speed – a brake that is the result of the harm caused by 500 years of conquest. Think of it as similar to driving with the emergency brake on. The goal of a comprehensive integrated trauma-informed initiative is to remove that brake so the strengths in the community can produce their maximum benefits and restore the vibrant communities powered by the warrior spirit.

The Roundtable is a non-profit 501(c)(3) certified, Native American controlled, volunteer organization created to provide information to Native American communities about the scientific discoveries regarding childhood and historical trauma, the implications of those



discoveries for many of the problems that have plagued Indian country for far too long – high rates of suicide, substance abuse, obesity, domestic violence, diabetes and other problems -- and how tribes and other Native American entities can put the science to work to address these problems. In addition to this Handbook, the Roundtable, on strictly volunteer labor, hosts a monthly virtual learning collaborative call for any interested party to discuss ways tribes can address trauma, presents to tribal councils and communities, hosts and speaks at conferences, and provides on-site technical assistance (for a fee) to tribes, school districts, and other community institutions seeking to implement a comprehensive integrated trauma-informed program on its reservation.

The reason the Roundtable is encouraging tribes to implement comprehensive integrated trauma-informed initiatives is that studies have repeatedly confirmed that if a child regularly experiences four or more Adverse Childhood Experiences (ACEs), such as being physically, sexually or mentally abused or living in a home with substance abuse or spousal abuse), that childhood adversity increases that person's risk, as he or she grows up, compared to someone who did not suffer childhood adversity, of suffering from:

- Alcoholism by 7.4 times
- Drug abuse by 10.4 times
- Suicide attempts by 12.2 times
- Diabetes by 1.6 times
- Cancer by 1.9 times
- Heart disease by 2.2 times
- Chronic lung disease by 3.9 times
- Living 20 fewer years than someone who did not suffer childhood adversity

The studies producing this data were done on white middle class urban individuals, but the above picture looks a lot like the health and social problems confronting many if not most Native American communities. Studies on historical trauma have produced similar results. As a result, childhood and historical trauma appear to provide the best explanation for the intractable problems that have plagued Native American communities for generations, and therefore offer a scientifically-based path for reducing these problems.

The goal of this Handbook is to help tribes achieve the vision set out at the beginning of this Introduction, a vision of reservations without the severe social problems that exist today, by providing information on historical and childhood trauma, describing the scientific discoveries that have support the conclusion that the problems are driven by trauma, and detailed suggestions for the concrete steps tribes can take to put to work the trauma-informed tools that have been shown to help overcome the destructive effects of historical and childhood trauma. The goal is to prevent the next generation from suffering the effects of trauma and to help the present generation to heal from their trauma.



Under a comprehensive, integrated trauma-informed approach, each institution on the reservation – the schools, the courts, law enforcement, housing, workforce development, Tribal Employment Rights Office (TERO), etc. – implements its own trauma-informed strategy. There is no one-size-fits-all approach that is appropriate for all of the different institutions in the community and no one-size fits all approach that works in every community. Fortunately, as discussed in this Handbook, for most if not all of these institutions there is a broad range of good trauma-informed programs for the institution to choose from. It is up to the community and each institution to select the one that seems to fit best with the institution’s needs and the community’s values.

At the same time they are developing their own trauma-informed strategies, the various institutions, under the leadership of the Tribal officials and Council, comes together through a trauma-informed coordinating committee to develop a tribal-wide strategy that insures the different institutions are all pulling in the same direction so their efforts are reinforcing each other. The coordinating committee also needs to set tribal-wide goals and priorities since it is not possible to successfully attack all of the causes of trauma at one time. The Menominee Tribe is the first in the country to implement a comprehensive trauma-informed program. While it is still a work in progress, it has already reduced the high school drop-out rate from 40% to 5%. The Tribe establishes annual goals for its program. For example, the Tribe’s trauma-informed coordinating body recently set as a goal for this year that of keeping families together. All of the institutions on the Reservation will make this their priority and will examine their programs to see what changes or improvements they can make in their programs to further this goal. (There is extensive material on the Menominee program in the attachments to the various chapters of this Handbook and in the Attachment and the Tribe is very generous in sharing its experiences with other tribal communities that contact them.)

Finally, Tribes have had their traditional practices and ceremonies to promote healing for thousands of years. As part of their comprehensive strategy, tribes need to incorporate their traditional wisdom into all of their trauma-informed programs and strategies, not to the exclusion of what western science has learned but in a partnership with them.

While there are a few tribes that have already started down this path, so you will not be breaking new ground, it is a challenging endeavor that requires courageous leadership, the coming together of the entire community, and a rethinking of many of the approaches and programs presently being used in Native American communities – approaches that have failed to solve these problems despite the huge amount of time and money that has been devoted to them. But the warrior spirit that sustained Native American people for thousands of years can still be called upon to help Native American communities implement such a program – one that is so critical to their future.

Finally, while the Handbook continually refers to reservations and tribes, the approaches offered in it can be adapted for use in urban Native American communities since the trauma does not stop at the reservation boundary and in more and more urban areas, the residents are creating



their own Native American communities. The approaches in the Handbook can be adapted for use in these urban communities as well as on reservations.

The reaction to presentations on trauma, sometimes, is that this approach is blaming the victims and/or providing an excuse for destructive behavior because you can say, “it wasn’t me doing it, it was the trauma”. Neither is true. The trauma-informed approach set out in this Handbook is not victim-focused. Rather, the theme is “Restoring the Warrior Spirit”. Yes, horrible things happened to Native Americans and continue to happen, but Native Americans thrived for thousands of years because of the Warrior Spirit. As a result of trauma science, we know now how childhood and historical trauma have created injuries to the brain that in turn cause the terrible conditions on many reservations. Rather than treating oneself as a victim, the Warrior Spirit says we must take responsibility for putting that science to work to help Native American people heal. It is the most important battle for this generation to fight.

THE ORGANIZATION OF THIS HANDBOOK

There is a huge amount of information available on the Web regarding almost every aspect of trauma. Two of the best sites are ACEsConnection and ACEsToo High, which have material on virtually every aspect of trauma and trauma-informed programs and have it in a well-organized, easy-to-access form. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Center for Trauma-Informed Care also have excellent material on their websites. As a result, there is no need to try to repeat all of that information in this Handbook. However, one area in which there is no easily accessible source is on trauma in Native American communities – the causes and effects of trauma, proven approaches in Indian country, and sources of expertise.

This Handbook seeks to fill that gap by focusing on what has been learned about trauma and trauma-informed programs that is directly relevant to Indian country. It begins with background information on Adverse Childhood Experiences (ACEs), neuroscience discoveries about trauma, scientific discoveries about historical trauma, and resilience, followed by chapters on why a comprehensive trauma-informed community is needed and how to go about establishing one. Since, as indicated above, in addition to a comprehensive strategy, each institution in the community must implement its own trauma informed programs, the subsequent chapters provide information on how to do that for each of those institutions – schools, workforce training programs, parenting, health and particularly pediatric programs, behavioral health programs, courts and law enforcement, drug abuse and particularly opioid programs, and obesity programs. Each chapter consists of a summary of effective programs for that sector. The chapter also contains citations to Attachments to the Handbook -- articles or other material providing in-depth information on the issue covered in that Chapter. All of the Attachments are provided at the end of the Handbook, divided by chapter. Since this Handbook was developed purely on volunteer time, the Roundtable lacked the resources to write expansive chapters that incorporated the information contained in the Attachments and instead provided the Attachments. There is a



wealth of information in that material and the reader is strongly encouraged to access that information. Consider the chapters as the doors to the information you need to develop a trauma-informed community. The Attachments are the rooms that have the in-depth knowledge to create such communities.

Because the material on trauma is so voluminous, the material provided in the Attachments cannot begin to be comprehensive. However, as indicated above, the Web is full of information on every aspect of trauma-informed programs and information on experts who can assist in implementing them.

A particularly valuable resource for tribes seeking to develop comprehensive trauma-informed programs has been developed by the Menominee Tribe. The Menominee Tribal Clinic developed a yearlong trauma informed training that was completed by their staff. The curriculum includes 27 self-study modules; each module was designed to take staff about 15 minutes to complete. Topics the curriculum addresses include: What is TIC, Applying TIC, Historical Trauma, ACEs, Brain Development, Epigenetics, Resilience, De-escalation, Self-Care, and Health and Trauma. Every 2 weeks modules with links to the videos or articles were sent to staff. Included in the modules were important points from each video or article and two questions for the staff. Staff replied electronically with their replies to the questions. Pre and post-test were given and scores have been compiled. Scores and staff understanding of the topics improved significantly. The curriculum has been shared and validated by Johns Hopkins University.

A list of the 27 modules module is found at Attachment A to this Introduction. The Menominee Clinic has generously offered to make the 27 modules and videos available to other Native American communities that are considering adopting a trauma-informed program. Requests to access the curriculum can be addressed to:

Diane Hietpas, MA, Care Coordinator
Menominee Tribal Clinic
PO Box 970, Keshena, WI 54135
715-799-5429 dianec@mtclinic.net

Finally, some of the chapters list, at the end, the names and contact information of expert consultants who are available to assist a tribe or reservation institution develop and implement its trauma informed strategy. Not all consultants working in this area are known to the authors of the Handbook so that list is not comprehensive, but just a start.

This Handbook was put together by the Roundtable on Native American Trauma-Informed Initiatives, a purely volunteer organization, on volunteer time and with limited resources. As a result, there likely are gaps in the information provided or statements that some in the field will disagree with. Because the Handbook is being disseminated on-line, it is easy to add to it or



correct it. Therefore, if a reader identifies gaps or information they believe needs to be revised or corrected; please provide that information to the Roundtable. It is hoped that with reader contributions, this Handbook will be continually expanded and improved over time.



CHAPTER ONE – INTRODUCTION TO TRAUMA – THE BASIC CONCEPTS

“It’s Not What You Did Wrong, It is What Happened to You”

An Overview

Exposure to trauma is the “gift that goes on giving”. During any kind of a stressful event, a vital part of our nervous system – the sympathetic nervous system – floods our brain and bodies with powerful chemicals that prepare us for fight-flight-freeze – the human stress response. These chemicals include adrenaline, cortisol (our natural steroid), and beta-endorphin. Adrenaline gets energy to our muscles and heart so we can respond to the emergency, cortisol diminishes our immune response in case we get injured while trying to survive, and beta-endorphins keep us from being paralyzed by pain because they are the naturally occurring opiates that our own bodies make.

However, human physiology is not well-designed for continuous, repetitive, or overwhelmingly stressful conditions, such as continually being physically, sexually or psychologically abused or living in a household full of inter-partner violence, drugs or substance abuse, especially when those conditions occur in childhood when our brains are still very vulnerable. The same repetitive and continuously stressful conditions occur when one is placed in a concentration camp or being forced onto a reservation or a boarding school where you live under a constant threat of harm or death day after day for years at a time.

Toxic stress is the term being employed to describe the strong and prolonged activation of the body’s stress management systems during these events. This becomes particularly problematic when it occurs during critical developmental periods, because of the multiple ways that this activation affects the progressive unfolding of what is called “basic brain architecture” Human brain development continues throughout our lives, an important phenomenon known as “neuroplasticity”, but there are critical periods in childhood and adolescence, when the brain needs just the right environment to grow and develop properly.

Exposure to continuing toxic stress in childhood – and overwhelming situations in adulthood such as combat, rape or crime victimization, or destruction of one’s community – creates hypersensitivity in the sympathetic nervous system so that it takes very little provocation to elicit the stress response and it takes a longer time for the opposite system, the parasympathetic system, to calm things down. As a result, persons who suffered toxic stress during their childhood may permanently live in a state of stress and fear of danger, even when there is nothing threatening in the real world to cause stress. This increased sensitivity is known as “chronic hyperarousal” and is at the heart of our understanding of post-traumatic stress disorder or PTSD. This all happens automatically and is not within the individual’s control. But chronic hyperarousal is a noxious state to be in and has a powerful negative influence on the ability to think, relate, and function. Consequently, human beings will do whatever they can to try to cope



and alter this internal state in some way. Unfortunately, alcohol, overeating, beating up one's spouse, and substances like opiates do provide temporary relief. Suicide provides permanent relief.

As explained by pediatrician Dr. Nadine Burke Harris, when you are walking in the woods and see a bear, your brain directs your body to flood the blood stream with cortisol and other stress hormones to enable you to fight or flee. Once the bear has moved on, your brain tells your glands to shut off the hormone flow. For people who suffered early childhood trauma, that bear was in the room with them every day (or night) while growing up. The important discovery neuroscience has taught us is that when people suffer extensive exposure to the bear, particularly during early childhood, that bear becomes implanted in their minds and stays there even when the bear is physically no longer in the room. Because the bear is permanently in their mind, it produces a continued flow of stress hormones, which leads them to believe they are in constant danger, which in turn controls their behavior in virtually every aspect of their lives, (as anyone would who believed he or she was in constant danger).

People who suffer toxic stress are thinking about the bear, not what the teacher or the supervisor is saying, so, as the ACE study found, they have a high rate of dropping out of school. They are set off by even the slightest criticism so they tend to have poor work performance. They look for ways to ease the stress, so, as the ACE study found, (see next section) they drink and thus have a higher rate of alcoholism; they are obese because they overeat; they engage in violent acts. Using drugs as an example, studies show that 54% of those using painkillers to get high and 78% of those using intravenous drugs had multiple ACEs. The studies also found a direct dose response in that the more ACEs you have had, the greater the likelihood that you will suffer from these outcomes. For example, a study found that each ACE increased the likelihood of early initiation into illicit drug use by 2 to 4 fold (See diagram at Attachment A).

In extreme cases, when the stress becomes unbearable, they commit suicide (A researcher at Johns Hopkins was able to predict with 96% accuracy which people in a large group had contemplated suicide just by the amount of cortisol in their blood. See Attachment B).

Another way to look at it is to think of two houses, one with a weakened foundation and one with a solid foundation. When the earth is quiet, both will stand without any problems and the weakened foundation will go unnoticed. However, when tremors occur, the solid one can withstand them with little or no damage. But for the weakened foundation, even a minor tremor can result in cracked walls or the collapse of the house. Patching the cracked walls will provide temporary relief but at the next tremor, the walls will crack again. What needs to be done is to shore up the walls so they can withstand the tremors. In cases where too much damage to the building has occurred, it will be necessary to dig deep and strengthen the foundation.

Similarly, a person whose foundation was weakened during childhood by multiple ACEs is more vulnerable to the "tremors and earthquakes" in their lives. As mentioned above, because their



stress levels are already so high, it takes very little provocation to elicit the stress response and it takes a longer time for the opposite system, the parasympathetic system, to calm things down. As a result, events other people can withstand – such as a teacher or boss yelling at them, a job loss, a divorce, or the oversupply of pills in a community – sets them off and drives them to find temporary relief, such as turning to alcohol or drugs. We know it is impossible to stop the “tremors” that occasionally occur in people’s lives and in their communities. To prevent those events from leading to this negative behavior, we need to shore up the walls of those who suffered severe childhood trauma by providing them with ways to reduce the power that their continually-flowing stress hormones have over their lives so that their ACEs do not drive them to such harmful and/or illegal behavior. Programs that shore up the walls are called resilience programs. These are programs that provide persons who suffered trauma with coping mechanisms to keep the small traumas from causing their walls to collapse. For those whose walls already collapsed – in that, for example, they are already addicted, we need to help them rebuild their foundations through the use of therapies that will get their bodies to stop or reduce the constant flow of cortisol so they are no longer as vulnerable to addiction. Finally, we need to work to make sure all houses built in the future have strong foundations by promoting positive parenting so that the next generation of children does not grow up in homes in which they suffer ACEs.

Not all persons with toxic stress turn to negative behaviors and not all persons engaging in negative behaviors had Adverse Childhood Experiences. The studies seem to indicate that some people have natural resilience while others were helped by having a strong supportive relationship with someone in their lives – a coach, a grandparent, a teacher – since strong supportive relationships are the most powerful antidote to trauma (but also the most difficult to implement through a program). However the studies showing the very strong correlation between Adverse Childhood Experiences and substance abuse, poor school or work performance, obesity, suicide and other outcomes identified by the ACE study makes toxic stress among the most scientifically validated causes of these problems.

As a result, to prevent or treat them, we need to 1) build houses with strong foundations by producing healthy home lives for the next generation, 2) teach resilience techniques to those who have weak foundations because they grew up with childhood trauma or suffer from historical trauma and thus suffer from toxic stress, and 3) provide in-depth treatment for those whose walls have already collapsed and are suffering from addiction or depression as a result. This Handbook seeks to provide a framework tribes can put in place to do all three of these things and thereby reduce the suicides, substance abuse, obesity, poor work performance, and other trauma-related problems that have caused so much pain in Indian country for much too long.

Implementing a comprehensive trauma-informed initiative is not simply putting in place a bunch of programs. It is a paradigm change that requires a new attitude and the adoption of a new culture, a more empathetic one that begins with recognizing the critical question: “It is not what is wrong with you. It is what happened to you.” Once the answer to that question is known,



whether it is in regard to an individual or a community, it then becomes possible to begin putting solutions in place. Fortunately, the culture a trauma-informed initiative calls for is very similar to the culture that was present in most traditional Native American communities. While some of that culture has been driven underground by what happened to Native Americans over the past 500 years, the core of it remains and can serve as the foundation on which tribal communities can build their comprehensive integrated trauma-informed Indian initiatives.

The Adverse Childhood Experience (ACE) Study

The ACE study has been called the most important scientific study nobody has heard of. It demonstrated a powerful relationship between the physical, psychological and emotional experiences people suffered as children and their behavior as adults and provides insights about the underlying cause of some of the most serious problems facing Indian communities – suicide, substance abuse, dropping out of school and poor work performance, obesity and diabetes, heart disease and cancer.

The study was conducted by the Kaiser Permanente Health Maintenance Organization in San Diego. A physician there, Dr. Vincent Felitti, was trying to find why women in a weight loss clinic would lose weight and then put it all back on. An initial small survey showed that many of these women had suffered sexual abuse as children. Seeking to explore the connection between early child adversity and adult health problems, Dr. Felitti partnered with the U.S. Center for Disease Control (CDC) to design and conduct a survey of all 17,000 members of Kaiser’s San Diego. The survey asked ten questions about their childhood experiences, which they labeled Adverse Childhood Experiences or ACEs. The questions fell into three categories, Did you, as a child, suffer from:

1. Abuse – physical, sexual or emotional;
2. Household dysfunction – parent treated violently by the other parent, substance abuse or mental illness in the home, parental separation, or parental incarceration
3. Neglect – physical neglect or emotional neglect:

A copy of the survey is at Attachment C to this Chapter. It is recommended that anyone working in the trauma area take the survey to understand their own history.

The survey results found a powerful correlation between ACEs and a host of physical, emotional and functional problems. It also found a very strong dose response. The more ACEs you had the more likely you were to have more of these problems. The problems identified are:

- Suicide
- Substance abuse, both alcohol and drugs
- Intimate partner violence



- Obesity
- Unintended pregnancies
- Diabetes
- Heart disease
- Pulmonary disease
- Dropping out of high school
- Poor work performance leading to poverty
- Incarceration
- A life span that is 20 years shorter than someone without any ACEs

These effects apply when controlled for all of the other factors one might think could contribute to these outcomes, such as income, race, ethnicity, etc. Several articles and charts providing more information on the ACE study may be found at Attachment D to this Chapter. At Attachment E is an excellent article on ACEs by Dr. Felitti, the co-author of the original ACE study. At Attachment F, you will find a paper by the U.S. Center for Disease Control and Prevention summarizing the findings of the ACE study. To show the costs of ACEs in a state with a large Native population, Attachment G contains a study on the “Economic Costs of Adverse Childhood Experiences in Alaska”. There is also a huge amount of information about the ACE study and subsequent studies on the Web at ACEsConnection, SAMHSA’s website and others.

ACES are not the only form of trauma that must be dealt with. People suffer severe trauma throughout the life span, whether rape, nearly being blown up in battle, or some other traumatic event. Programs to address trauma must help all of these trauma-suffers, not just those who suffered from ACEs. For purposes of convenience, this Handbook often just refers to “ACEs”, but whenever it appears, that term should be read as applying to all forms of trauma throughout the life span.

Slowly, but surely, the findings of the ACE study, which have been replicated numerous times, are working their way into public policy. But while policy makers are moving slowly, local communities have quickly and fully embraced it. More and more communities around the country are creating trauma-informed coalitions that bring together all of the key institutions in the community to implement trauma-informed programs and to educate the community about trauma science. The overarching goal of this Handbook is to encourage and assist Native American communities use the insights provided by the ACE study to develop such comprehensive integrated trauma-informed coalitions .(See Chapters 3 and 4). There are no other scientific theories that so fully explain the kinds of problems that effect Native American communities – suicide, alcoholism, diabetes, obesity, etc. And no other scientific studies that offer solutions to those problems. The solutions are not easy; they will take time, money and



most importantly, leadership. But for the first time there appears to be a scientifically validated approach for solving the problems that plague Native American communities.

Historical Trauma

Historical Trauma is defined as “the cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma. Closely related is “cultural trauma” defined as: “when members of a collective feel they have been subjected to a traumatic event that leaves indelible marks upon their group consciousness, marking their memories forever and changing their future identity in fundamental and irrevocable ways” (See Attachment H).

Many Native Americans have known for a long time that the effort over the past 500 years to exterminate Native Americans and to destroy their way of life and culture have left a lasting imprint on their people. As discussed in the previous sections of this chapter, the key question trauma-informed programs ask is not “what did you do” but “what happened to you”. While the majority culture tries to downplay what happened, the facts speak for themselves. By 1890, the percentage of Native Americans remaining in what is now the United States compared to the estimated number pre-conquest was smaller than the percentage of Jews remaining in Germany after the Holocaust. That is just the physical extermination. There was also the destruction of an entire way of life, being placed on reservations, the boarding school experience, and the individual traumas many tribes faced, such as having their lands flooded by federal dams.

The concept of historical or intergenerational trauma –trauma passed from generation to generation – originated with social science research on Holocaust survivors in the 1960s and 1970s. Relying on that research, such insightful Native American thinkers as Maria Yellow Horse Brave Heart, and Edwardo and Bonnie Duran, wrote perceptive papers applying the concept of historical trauma to Native Americans, what Ms. Braveheart called the “soul wound” Native Americans suffered as a result of the destruction of their way of life (See Attachment I). However, the majority of society tended to brush this work and other efforts to apply the concept of historical trauma to Native Americans as nothing but excuse-making for the problems that existed in Indian country (This tendency to brush it off is understandable given that acknowledging historical trauma creates responsibility on those who caused it to help remedy it).

But over the past few years, brain scientists, working with Holocaust survivors as well as lab animals, have discovered that living under intense and prolonged stress, such as that faced by those in concentration camps, causes physiological changes to the brain that help to explain the life problems many Holocaust survivors suffered from even when they were back living a normal way of life. This has been labeled community trauma, as against childhood trauma since it results from actions taken against an entire community.

In addition, as described in the news article at Attachment J, further research by brain scientists showed that these changes to the brain are inherited by the children of Holocaust survivors so



they suffer from the stresses created by the concentration camp even though they never set foot in one and grew up in comfortable families thousands of miles from the nearest camp. These studies provide the scientific evidence that historical or intergenerational trauma is a real physiological event and that it is passed from generation to generation until healing occurs.

The research has found that the changes to the brain caused by community trauma are very similar to those caused by childhood trauma in that both trigger a non-stop flow of stress hormones into the blood. Studies show that historical trauma, like childhood trauma, permeates all domains of existence – spiritual, physical, emotional and mental. As a result, it impacts personal identify, interpersonal relationship collective memory, and cultural and spiritual worldviews. *Examining the Theory of Historical Trauma Among Native Americans* at page 17, Attachment K. This article, by Kathleen Brown-Rice, provides an in-depth examination of historical trauma, with citations to numerous studies. A Google search of “historical trauma” will also produce a large number of citations.

In conclusion, brain research has confirmed that historical trauma is real and that it must be treated if those affected by it are to heal. There are few, if any, studies demonstrating that the approaches for helping people heal from ACEs will help them heal from historical trauma. However, since both forms of trauma cause the same changes in the brain, hopefully those approaches will work for both forms. In addition, the infusing of traditional culture and the use of traditional healing practices may be particularly effective in addressing historical trauma since they help to restore at least part of the Native American world that was destroyed by conquest (though there are no studies to confirm this due to the difficulties of conducting standard evaluations on traditional practices). For additional information on the use of traditional practices to address trauma, both historical and ACE-caused trauma, see Chapter 2 of this Handbook *Traditional Practices- Culture is Medicine*”.

The bottom line is that many Native Americans suffer from two forms of trauma – historical trauma caused by the destruction of an entire way of life, and childhood trauma which is the result of the breakdown of the traditional family-raising approaches Native Americans had developed and used successfully for hundreds of generations – a breakdown that, in turn, was caused by the destruction of an entire way of life. The scientific discoveries about the two forms of trauma, coupled with the traditional wisdom retained in Native American communities, offer a pathway out of the problems that these traumas have caused.

Science

One of the early criticisms of the ACE study was that while it showed a very powerful correlation between ACEs and such problems as suicide, substance abuse, obesity, diabetes, etc., it did not prove that ACEs “caused” these outcomes and there was no link known at that time to explain how the ACEs caused the outcome. However, a few years after the ACE study was completed, neuroscientists filled in this gap, finding the physiological mechanism by which



ACEs lead to these outcomes. As described in Section A, toxic stress causes the body to continually pour stress hormones into one's blood stream even when there is no actual threat facing that person. When the body is full of stress hormones, it does not make a difference whether there is or is not a real threat present. The body is telling the brain that the world is a dangerous place, leading those traumatized to devote their energy for the rest of their lives to protecting themselves from the perceived but non-existent threats and seeking relief from the stress. However, there was no explanation how adversity 30 or 40 years ago, during childhood, could cause stress hormones to flood the system during adulthood.

As neuroscientists have dug deeper and deeper into the process by which this occurs, they have come to identify physiological processes by which stress in childhood or in the destruction of a community lead to lifelong stress that is then passed on physiologically to the next generation. We all learned in high school biology that our genes are not altered by what happens in our environment and that the genes that are passed on to the next generation are not altered by what happened to the parents during their lives.

However, neuroscientists have learned that genes are not free-standing independent entities but part of a larger system, parts of which are impacted by what happens in our lives. They are more like light bulbs that sit there until someone flips a switch that turns them on. Genomes are the complete set of our DNA machinery, including but not limited to our genes, but include the switches that “express” (i.e., turn on) our genes.

In the latest step forward in understanding this process, neuroscientists at the University of Wisconsin-Madison compared the genomes of children who had suffered severe stress during early childhood with those who did not suffer stress. They found scores of differences between the genomes of the two groups. As reported in the article at Attachment L, the neuroscientists found differences between the two groups in the way that over 1400 genes expressed themselves, including those genes that regulate mood and attachment (Studies have shown that persons who suffered multiple ACEs have difficulty developing relationships or attachments). Most importantly, it resulted in the genes pouring stress hormones into the blood stream on a non-stop basis. Since this study was conducted years after the children suffered their early childhood stress, it seems evident that the changes to the genome, most likely their switches, caused by stress during early childhood, when the brain is at its most malleable, becomes a permanent change that stays with the person for the rest of their lives and is passed down to their children physiologically. While what happened to a person during childhood did not change his or her genes, it caused physiological changes to key parts of his or her genome that are connected to certain genes. As the recent study referenced above indicates, those genes, by causing their stress hormones to continually flow, appear to be responsible for, or lead to, the behaviors traumatized people engage in in an effort to deal with that stress, behaviors that unfortunately lead to the health or social problems identified by the ACE study – suicide, substance abuse,



obesity, etc. Thus we now have the neuroscientific explanation to support the findings of the ACE study.

Work done on Holocaust survivors and their children show the same kinds of damage to the brain results from severe and prolonged community trauma. While Native Americans and African Americans faced and continue to face similar community trauma, no such studies on Native Americans or African Americans appear in the literature. However, there is little reason to believe the outcome would be different.

Resilience

There are four broad categories of approaches for addressing childhood trauma: 1) preventing it in future generations; 2) identifying and treating it when children are young and their brains are still malleable; 3) providing trauma-informed treatment for those whose trauma has already taken over their lives, such as those suffering from substance abuse disorder; and 4) the subject of this chapter – teaching resilience to those who suffered ACEs but for whom their trauma has not (yet) taken over their lives.

As indicated, because the stress hormones in the system of a person who suffered trauma are already at a high level, a small additional incident that increases stress, such as a teacher or supervisor criticizing them, can lead to destructive behavior, such as exploding at the teacher or supervisor or turning to drugs or alcohol for relief. In teaching resilience, those who suffered from trauma are provided with coping mechanisms that they can use to prevent trauma from causing them to turn to the stress relievers that get them in trouble, when something in life increases their stress levels. The resilience techniques discussed below and throughout the Handbook have been shown to reduce the negative behaviors caused by trauma by reducing stress levels. They have been applied to youth, veterans suffering from PTSD, and many other populations that are at risk for engaging in trauma-precipitated behavior.

There are no scientific studies showing that any of these approaches for addressing childhood trauma can work for historical trauma, but given that the physiological effects of historical and childhood trauma on the brain is the same, it is hoped that the resilience techniques discussed below can also help to reduce the effects of historical trauma.

Also, for reasons scientists are just now beginning to investigate, some people appear to have developed resilience outside of any formal program. The initial evidence is that such people developed protective factors against trauma as a result of strong supportive relationships they had as children. See the Resilience/Stress Questionnaire at Attachment J. Unfortunately, it is difficult to develop a community-wide program that can achieve that or to implement it on a large scale. However, sports teams with a supportive coach, a teacher with the time to work with a few individual students, adults at Boys or Girls Clubs or Scouts, and religious societies, whether traditional or western, have regularly been identified as persons who helped youth



overcome the effects of the ACEs they suffered . Communities should do whatever they can to promote such organizations and the relationships they create.

In addition, there are a number of proven techniques for developing resilience that can be scaled so that they can be delivered to large groups, such as a classroom or veterans organizations, reaching a broad audience at a relatively low cost. In comparison, treatment therapies which generally require a one-on-one relationship between the patient and the therapist, can only help one person at a time, take a long time to become effective, and are costly since they require the time of a high cost professional.

Examples of Resilience Techniques

- **Yoga, Mindfulness, and Meditation** – Yoga, mindfulness and mediation have been found to be effective coping mechanism that have helped youth, veterans, and other groups to reduce their turning to destructive behavior such as substance abuse, risky sexual behavior, and suicide (See Attachment L). They have the benefit of being scalable in that a single part-time yoga, meditation or mindfulness instructor can teach an entire school these techniques, going from class to class. In the Menominee Public Schools, the first thing students do when they enter school in the morning is spend 15 minutes meditating. It has helped to reduce the high school drop-out rate and improved the overall environment in the schools. Many tribes incorporated meditation within their traditional practices and some are starting to connect those traditional meditation approaches to their efforts to address trauma. Therefore, before looking at the standard western meditation techniques, tribes should approach their elders and traditional practitioners to explore whether there are traditional meditation approaches and if so, how they can be used as part of trauma-informed initiatives in the schools and elsewhere in the community.
- **Drumming** – Another resilience technique demonstrates how wise Native American ancestors were. It has been demonstrated that “drumming accelerates physical healing, boosts the immune system and produces feelings of well-being, a release of emotional trauma, and reintegration of self” (See Attachment M). As the article indicates, in non-Indian communities, drum circles have been organized led by a facilitator who guides the group through a set of steps prior to the actual drumming. Native American communities should explore their own traditional practices connected with drumming and apply them to trauma-informed programs.
- **Equine-Assisted Psychotherapy** – It is well known that horses are used to help those with physical disabilities (called equine-assed therapy), but they have also been used for over 70 years to assist persons with behavioral health problems. Equine-Assisted Psychotherapy (EAP) does not always involve riding a horse, but often involves a group



standing on the ground and going through a series of exercises in an arena, such as leading a horse through a maze composed of objects laid out on the ground, with the person working to keep the horse from touching any of the objects. Programs on reservations have adapted the standard EAP procedures to incorporate traditional practices regarding the horse. For example, in the program for teenagers at the EAP program on the Gila River Reservation, the teenagers paint their horses for battle, symbolizing their battle against trauma. The program at Gila River has also been successful in assisting veterans to overcome their PTSD.

Secondary Trauma

Scientists have discovered that someone who is regularly exposed to persons with trauma – law enforcement officers, nurses, behavioral health counselors, teachers, first responders, prison guards, etc. – are vulnerable to becoming traumatized themselves. What has often been called “burn-out” is increasingly being recognized as secondary trauma. People with secondary trauma have higher rates than the public as a whole of the same problems that persons with trauma have – suicide, substance abuse, obesity, etc. For example, retired police officers have a suicide rate that is 63% higher than the population as a whole.

More and more communities are including programs to address secondary trauma as part of their comprehensive trauma-informed initiatives. For example, in Kansas City, the police department is offering yoga to their officers, which has been well received. The officers taking it say it provides them with a means to reduce their own stress levels when they come off of patrol, rather than, as happened too often in the past, their stress levels remain high and they take it out on their wives or children.

Secondary trauma is readily apparent on reservations, demonstrated by the high turn-over rates among teachers, medical personnel, and others. As tribes implement comprehensive trauma-informed programs, they should incorporate programs to address secondary trauma among those most vulnerable to it, the groups who are the very ones they are asking to be at the front line in their efforts to reduce the causes and effects of trauma in their community.

Summary of Chapter 1

Concluding this background part of the Handbook, trauma has now been demonstrated to be a physical injury to the body just like breaking your leg. As a result, it cannot be cured by telling someone who has been traumatized to “get over it” or by punishing them, any more than putting someone in jail will cure a broken leg. When the body screams for relief from the stress, it is very difficult to ignore its order to raid the refrigerator, visit the local drug dealer, or dig out that bottle of booze hidden under the mattress. Perhaps someday there will be a pill or an operation or another medical practice that will be able to undo the damage to the genome, but none exists today.



This Handbook describes the best approaches known to date for: 1) helping to prevent trauma, 2) teaching people resilience, or coping, mechanisms to help them resist the body's order to deal with their stress through illegal, unhealthy or destructive means, and 3) using trauma-informed therapy to help those who have been broken by trauma to rebuild their lives. In addition to the approaches in these three categories that have been successfully used in non-Indian societies there are the traditional Native American healing practices such as sweat lodges, talking circles in the Native American Church, and other ceremonies that have been shown to help promote resilience or heal trauma.

The overall message of this Handbook is that the best way to undo the continuing effects of the childhood and historical trauma that seems so pervasive on reservations is by implementing a comprehensive, integrated trauma-informed program in which every institution on the reservation is implementing a trauma-informed strategy of its choosing and the institutions are coordinating their efforts with each other and with their tribal leadership to insure that all three of the approaches referenced in the above paragraph are being fully addressed. The remaining chapters of this Handbook provide information on ways this has been done reservation-wide and in the different institutions, both in Indian and non-Indian communities, beginning with how to create a comprehensive integrated trauma-informed community. Making it happen is not easy; it will require patience, persistence, compassion and passion.

Finally, this is a new and emerging area. It is likely that new and better approaches than those set out in this Handbook will emerge in the coming years, so trauma-informed programs should try to keep abreast of those changes. Tribes should also experiment with approaches they think have merit based on their unique understanding of their communities, particularly traditional approaches or those that combine traditional and Western health approaches. Some of the approaches may not work, requiring a restart. However, the greatest crime is not starting at all and allowing the conditions that now exist on reservations to be the only world that future generations know.



CHAPTER TWO – USE OF TRADITIONAL HEALING PRACTICES

“Culture is Medicine”

Native Americans have successfully used their traditional practices for addressing trauma for thousands of years. Many of those practices had gone underground when such practices were banned by the Federal Government or lost as the result of boarding schools and relocation, so they may not be widely known in the community today. Even when available, they have been too often brushed aside by those promoting “Western” approaches to healing. However, there is growing recognition that it is not a choice between Western and traditional health practices. Both need to be tapped as part of a comprehensive integrated trauma-informed tribal initiative and each need to respect the other.

There is a growing literature of examples of traditional practices that have been recognized broadly as having healing qualities. As the article at Attachment E to Chapter 1 describes, drumming has been shown to be an effective approach for promoting healing. “Demonstrated results indicate that drumming accelerates physical healing, boosts the immune system and produces feelings of well-being, a release of emotional trauma, and reintegration of self.” Meditation has been demonstrated in numerous studies to help trauma victims achieve resilience, and many tribes’ traditional practices include some form of meditation that can be adapted for use in schools and other forums instead of relying on western forms of meditation.

Beyond these kinds of practices that have been recognized by Western medicine, most tribes have healing practices and ceremonies that have worked for thousands of years, but will never be able to meet the standards of “evidence-based” to satisfy those who demand programs meet those standards. However, tribes should rely on their own knowledge and experience over those hundreds or thousands of years to decide how to incorporate these traditional practices into their trauma-informed initiative. See Attachment B, Bassett, et. al. ““Our Culture is Medicine’ Perspectives of Native Healers on Post-trauma Recovery Among American Indian and Alaska Native Patients””.

Native American Health Care Solutions has developed a model design for a traditional healing facility that can be standalone or attached to a western health facility. It includes a healing circle, a sweat lodge and a teepee site. See Attachment C. (For more information contact Ken White Jr. at kgwhitejr@suddenlink.net).

But beyond specific practices and ceremonies, as the Menominee have emphasized, culture must be integrated into all aspects of a trauma-informed program. As stated by Proctor Waukon, the guide for the Roundtable on incorporating traditional practices:

“...We often model how we manage ourselves after the only model we have in recent history, that which has been provided to us by the dominant society. I believe that we can reconcile the way we do things so that our indigenous roots, values and practices



once again guide us, and bring us together to be a model for restoration and revitalization” (See Attachment B for Prosper’s full presentation).

As the Menominee Tribe has demonstrated, relying on tradition also means capturing the wisdom that the Tribe has accumulated over the thousands of years of its existence and making it applicable to the trauma informed initiative. For example, the Menominee Tribe took its ancient teachings on childbirth and child care and integrated them into their program to reduce teenage pregnancy, resulting in a substantial decrease in teen pregnancies. Each Tribe needs to mine its own traditions and own wisdom and decide how to make it part of its trauma-informed initiative.

The role of culture goes beyond just specific components of the healing process. The term “historical trauma” indicates that the wound is the result of the destruction of the tribe’s culture. A key part of healing means restoring as much of that culture as possible. For example, the Menominee Tribe has focused on restoring the Menominee language through classes in the schools and for adults. It is not part of a specific health component, but part of the larger effort to restore culture and thereby heal the wound.

As set out in the title to this Chapter, “Culture is Medicine”, perhaps the most powerful medicine of all. A tribe’s comprehensive integrated trauma-informed community initiative needs to draw on its own resources – its elders and its traditional healers – to determine how best to put this powerful medicine to work.



CHAPTER THREE – THE CORE ELEMENTS OF A COMPREHENSIVE INTEGRATED TRAUMA-INFORMED PROGRAM AND THE NEED FOR INTEGRATION

It is possible to identify seven core elements of a comprehensive integrated trauma informed initiative (One can probably find more categories but this is a good start). As each institution on the Reservation adopts trauma-informed programs that reflect its user population, it will find that such programs fit into one or more of these core elements. But rather than counting on all of the pieces falling into place by themselves, the coordinating committee needs to insure that all of the seven components are being provided by one or more of the institutions, under the oversight of the coordinating committee. Some of these elements are discussed again in the individual Chapters that follow but it is useful to see the overall picture because it helps in understanding why an integrated approach is so important. The seven elements are:

Primary Prevention

The long-term solution to ACEs is to improve parenting so that children do not grow up in homes in which they suffer ACEs. This is the equivalent of giving someone a vaccine to prevent a disease rather than having to treat the disease once it occurs. Primary prevention involves such programs as:

- Good parenting programs for prospective or young parents. Home visiting programs are particularly effective.
- Good parenting education programs in the schools, starting in middle school.
- Programs in which older women mentor families, such as the Family Spirit program developed by the Johns Hopkins Center for Native American Health, in which older women, the “grandmas”, who are often one of the most solid forces in the community, are trained and paid to work with young couples to help them become good parents.
- Reducing or eliminating single mother teenage pregnancies by implementing programs like the Menominee approach of tapping the Tribe’s culture on the sacred nature of parenting to reduce teenage pregnancies.
- Since much of the trauma that children suffer is the result of their parents’ trauma, in some cases all of the good parenting programs will not make a difference since they will not stop a traumatized parent from engaging in traumatizing behavior until the parent is helped to heal. As a result, this element must be combined with elements # 3- Resilience, and # 4-Treatment, which describe programs to help the parents deal with their own trauma. The Family Spirit program has now added such an element to its program.

Early Intervention – A Two Generation Approach

As indicated, trauma changes the brain. Neuroscientists have learned that when children are young, their brains are still malleable. As a result, if the trauma is caught early, it is possible, with help from behavioral health professionals, to undo the damage done to the child by the



trauma so they do not suffer from the effects of trauma when they grow up. Pediatricians are in a unique position to identify young children who appear to have been traumatized and to provide behavioral health assistance both to the child and the parents – the two generation approach. The pediatricians are not expected to provide intensive counseling but instead to team with a behavioral health counselor, with each doing what they do best. This element is discussed in greater detail in Chapter 6.

1. Resilience

As discussed above, resilience programs provide persons who suffered trauma with coping tools so the trauma does not control their lives. Teaching resilience such as meditation and yoga is a particularly important role for reservation schools, from pre-school on up through tribal colleges. In addition, the tribal initiative should explore other groups to whom resilience can be taught, such as veterans groups, prisoners, and perhaps most importantly, as mentioned above, to parents and parents-to-be so they have the coping mechanisms to keep their own trauma from infecting their children.

2. Treatment

Persons whose trauma has taken over their lives, for whom resilience training is not sufficient, such as alcoholics or persons suffering from substance abuse disorder, need trauma-informed treatment. The treatments that have been used up until now to address the effects of trauma, such as alcohol or drug abuse, have not had a high level of success, most likely because they were not based on trauma science and therefore were not addressing the underlying cause of the substance abuse or alcoholism, which the science has shown us is childhood and other forms of trauma. Providing treatment falls under the responsibility of the Tribe's behavioral health program, substance abuse program and/or alcoholism treatment program. It will be the responsibility of the coordinating committee to educate these programs about trauma science and to assist them in revising their treatment approaches to incorporate trauma-informed treatments. Treatment may involve one-on-one counseling or group therapy. Trauma-informed treatments include such methods as cognitive behavioral therapy and Eye Movement Desensitization and Reprocessing (EMDR). There needs to be a seamless line of communication between resilience providers and treatment providers so that, for example, students who are not responding to resilience training and are continuing to fail in school are referred to behavioral health counselors for treatment. Similarly, pediatricians need to refer parents and children from a traumatized household to behavioral health counselors

3. Workforce Training and Development

All of these elements require a trauma-informed workforce. Teachers need to become trauma-informed so they recognize when a student is being driven by their trauma and be able to determine when the student needs to be handled with the trauma-informed techniques the teacher has been taught and when they need to be referred to a behavioral counselor (See Chapter 6 on



Education). Pediatricians need to be taught how to identify traumatized families, how to use the ACE survey without retraumatizing the parent, and how to work as a team with behavioral health counselors. Parenting counselors need to be trained about trauma so they know when to refer family members to treatment. All of the professionals working to address trauma in the community need to be provided with programs and other assistance to enable them to avoid secondary trauma. Therefore training of those who will be responsible for implementing the trauma-informed strategy about trauma are key components of a comprehensive integrated trauma-informed tribal initiative .

4. Cultural and Traditional Values and Practices

While discussed in earlier chapters, it is not possible to overemphasize the importance of infusing and incorporating culture and cultural practices into all of the other elements.

5. Community Education

Finally, the entire community needs to be educated about trauma so they understand why programs are being delivered the way they are and why, for example, their children are meditating in school. Otherwise they will seek to terminate the programs. Community education is not a one-time effort. It must be an ongoing process, providing the community with increasing depth of knowledge about trauma, trauma science, and the programs being implemented to address trauma.



CHAPTER FOUR – CREATING A COMPREHENSIVE INTEGRATED TRAUMA-INFORMED TRIBAL COMMUNITY

What we have learned about trauma provides us with tools to address so many of the problems that plague reservation communities, leading to the \$64,000 question of how does a community put those tools to work? First, it requires each institution in the community to implement trauma-informed practices. The Chapters that follow set out ways the different institutions – education, workforce development, health, law enforcement and others – can do that. There is no one “correct” approach so each institution must select the approach that fits best with its and the community’s values and practices.

However, given the depth of trauma on most reservations as a result of the double whammy of historical and childhood trauma, no single institution can move the needle on trauma by itself. In fact, experience has shown that when one institution, such as a school, tries to initiate a trauma-informed effort on its own, the trauma in the rest of the community will pull it down. **For that reason, the single most important recommendation in this Handbook is that tribes need to implement a comprehensive integrated trauma-informed initiative in which each institution on the Reservation is implementing trauma-informed programs but in addition, they are doing so in a coordinated manner so that each institution’s efforts are reinforced by the efforts of the other institutions.**

As stated in the document from the Menominee Tribe at Attachment A to this Chapter:

“The simple premise of the Community Collaboration Workgroup is that causes of poverty, low academic achievement and poor health are interconnected – and therefore the resources and responses we bring forth to combat them must also be interconnected.”

Another way to view it is that the previous Chapter talked about ways to assist individuals in becoming resilient. Comprehensive integrated trauma-informed initiatives are ways to assist communities to become resilient. A resilient community has been defined as: “the sustained ability of a community to utilize available resources to respond to, withstand and recover from adverse situations, including ACEs [and by inference, from historical trauma]. Resilience initiatives align and leverage assets across multiple sectors of local communities to maximize residents’ ability to cope with adversity.”

The most frequent question the Roundtable receives from members of tribal communities who have learned about trauma and want to create a comprehensive integrated trauma-informed initiative is: How do we do it? What are the steps we need to take? Where is the assembly and operating manual? This Chapter seeks to provide that how-to information. The Handbook draws primarily from the experience of the Menominee Tribe, along with a few others, that together permit the Handbook to offer a few broad recommendations, However, each tribal



community will have to fill in the blanks using its own ways of getting things done and its own culture.

Creating a comprehensive integrated trauma-informed tribal community (CITITC) requires implementing trauma-informed programs in the various institutions on the reservation – the schools, the health care system, etc. However, implementing a CITITC involves more than implementing a set of programs. It requires creating a new culture or community mindset, moving from one that perpetuates cycles of trauma to one that reduces the array of trauma-related problems simultaneously and promotes health. Laura Porter, whose work is discussed at the end of this Chapter, calls these “self-healing communities”. It involves empowering the community to recognize it can create change, to recognize it does not have to live forever with high rates of suicide, substance abuse, diabetes, spousal abuse, etc., to engender hope that they can make this change, and by providing the community members and institutions with the power and the tools to make the change. Implementing a trauma informed program is often called creating a new paradigm, as against just creating a new program. This is what the Menominee Tribe has been able to accomplish and what this Chapter hopefully can assist other tribes accomplish.

The Chapter begins with a discussion of the recommended steps, followed by a picture of the process the Menominee Tribe followed. The single most important lesson based on the Menominee and the Roundtable’s experience is that building a comprehensive integrated tribal community takes a great deal of time and patience. There are so many pressing issues on a reservation that getting tribal leaders, program directors, or the community at large to pay attention to a new idea is a challenge. Ironically, they are so busy putting out fires caused by historical and childhood trauma they do not have the time to begin developing a program that will prevent those fires. Getting these entities to accept a new concept that requires thinking differently from the way they always have about problems on the reservation, takes time. Getting programs that historically have worked within their own silos to work together takes time. As a result, it will require dedication, leadership, patience and a high tolerance for frustration in many cases. However, hopefully the vision of a tribal community without alcohol abuse, substance abuse, youth suicide, obesity – and on and on – will provide the energy to persist until that vision is achieved.

SUMMARY OF THE STEPS FOR CREATING A COMPREHENSIVE INTEGRATED TRAUMA-INFORMED COMMUNITY

Getting Started, The Need for Leadership

Change of this magnitude takes leadership. It will require strong leadership from someone being driven by the warrior spirit. Someone(s) has to step up and take the lead. Possible options include:



- **Initiation Through Tribal Council Leadership** – The fastest way to start developing a comprehensive integrated trauma-informed tribal community (CITITC) is by educating the tribal council and other elected leadership about trauma science and the Menominee model and then have them direct the tribal staff to develop and implement a plan for creating a CITITC. At one tribe, after learning about trauma science at a conference, a councilman persuaded the Council to invite a speaker to present on the issue. After the speaker’s presentation to the full Tribal Council on trauma science and the Menominee accomplishments, the Tribal Council voted unanimously to direct all of the relevant tribal offices to come together to develop a comprehensive trauma-informed program and appointed one of the staff directors as the leader. It helped that the staff was already trauma-informed and eager to launch such an initiative. If it is possible to reach the Council in this manner, it will save all of the work needed to implement the alternative approaches set out below. However, it is recognized that Tribal Councils have so much on their plates that sometimes it can be difficult to get the time needed to educate them about a dramatically new approach.
- **Leadership from One or More of the Directors of a Major Program or Institution on the Reservation** – If the tribal leadership route is not available, it will require someone with stature in the community to assume the leadership role and launch the effort. On several reservations, the school superintendent has taken on leadership. No longer willing to tolerate the dysfunction in the school, they recognized that one can impose all kinds of performance standards on the school and teachers, but schools will never become true places of learning so long as the students remain traumatized. It is very difficult for traumatized students to learn. Because schools often are central institutions in a community, they provide an excellent launching pad for a CITITC. School boards are another potential source of leadership. Leadership could also come from other reservation institutions that recognize how a trauma-informed initiative could benefit their program, such as the Tribal Employment Rights Office (TERO), the Behavioral Health Program, or the health facility’s Pediatric Program that has received trauma-informed training from the Johns Hopkins School of Public Health – presently providing such training to 17 Native American health care facilities. (See discussion of that program in Chapter 6, Section A.) It could also come from a group of elders who are determined to improve their community. There really is no place from which leadership cannot come; all it takes is someone who has learned about the benefits of a CITICI and has the Warrior Spirit to take on this challenge because they are tired of seeing all the death, harm and dysfunctionality in their community.

On the Menominee Reservation the leadership came from two brothers, one who headed the health clinic and the other who was superintendent of schools. What they did next is set out below.



Organizing a Small Group of Directors of Reservation Programs or Institutions Committed to Promoting a CITITC

The first step the leader(s) need to take is to recruit a small group of other leaders, such as program directors or directors of other reservation institutions to serve on an ad hoc trauma-informed taskforce to promote the development of the CITICI. Ideally, this initial group should include representatives from the behavioral health program, the schools, the health facility, the workforce development program or the TERO, elders, and community representatives. The two brothers at Menominee initially brought together representatives of four tribal programs to serve as the implementing committee. Through patience and hard work, the committee now is composed of representatives of 41 tribal programs and institutions.

The ad hoc taskforce should hold regular meetings to work on the tasks that follow below. If funding is available it should bring in an outside consultant to help. It should work to grow the group by recruiting additional participants.

Reaching Out to the Community

One of the first steps the Menominee group took was to form a Community Engagement Workgroup that reached out to educate, involve and seek advice from the community, particularly the elders, who usually are among the first to understand the need for, and the importance of, a trauma-informed initiative. In reaching out to the community, the group should consider focusing on the benefits of trauma-informed solutions to one or a few problems that have the attention of the community, such as opioid use or youth suicide. While trauma is the underlying cause of so many of the problems on the reservation, it is easier to develop support by focusing on a few issues that have high visibility.

Through this outreach effort, the taskforce should add additional representatives from the community. Once a critical mass of community representatives has been incorporated into the taskforce, hold a community-wide meeting to explain about historical and childhood trauma and programs that address them. Give the community an opportunity to express its views. The meeting can also provide community members with an opportunity to talk publically about their trauma. For example, at the Umatilla Tribe, the community meeting specifically offered community members an opportunity to talk publically about their boarding school experiences. It would be helpful to have expert consultants speak at such meetings (The elected officials should be contacted and invited to be part of the meeting).

Develop a Statement of Purpose and Seek Tribal Council Recognition of the Taskforce

Based on the input from the community, the taskforce should develop a document to present to the tribal elected officials. The document should set out the purpose of the taskforce – to



develop a CITITC. It should also ask the council or chairman to designate the taskforce as an official body of the tribe, with a mandate to educate the community about trauma informed matters and to develop a comprehensive strategy for creating a trauma informed community. The taskforce should ask the elected officials to approve the document and to authorize funding for the taskforce so it can bring in the expertise needed for the remaining tasks set out below.

Educating the Employees of the Involved Institutions and Program

It is essential that the employees at all levels of the institutions involved in creating the trauma-informed initiative be educated about trauma, trauma-informed programs etc. One of the best ways to do this is to use the Menominee 27 modules (See Attachment B to the Introduction), showing perhaps one or two a week.

Educating the Community

The Menominee like to say that every person on their reservation is trauma-informed and that this is the key to their success. Therefore the first step after the taskforce is officially recognized must be to launch a major effort to educate the community about trauma science, what it can do, what it cannot do, and how the taskforce is thinking about implementing its trauma informed program, and then seek, in a sincere way, input from the community. If they think your outreach is simply tokenism because you have already decided how to proceed, you will lose your community.

Create a Coordinating Committee

Create a Coordinating Committee composed of representatives from each of these institutions, representatives from the community, traditional practitioners and members of the tribal leadership that, with the help of outside consultants, develops a strategic plan that describes how the reservation community will attack its trauma-caused problems using trauma-informed approaches (See Attachment B). The Coordinating Committee then needs to meet regularly to share ideas among the different institutions in order to promote the community-wide approach in which each institution knows what the others are doing and coordinate their efforts. Each year the Menominee Coordinating Committee, with input from the community and the tribal leadership, sets a specific priority and then develops a work plan to achieve that priority. The plan involves the participation of all of the institutions. For example, in 2018 its priority is keeping families together since family separation is highly traumatizing. When developing the plan, bring in experts in trauma in those areas to assist, but also bring in the elders to insure that whatever approach is developed incorporates traditional values and practices.



Developing an Overall Strategic Plan

Using the funding the Council provided or obtained from other sources to bring in expert consultants, the taskforce should develop a comprehensive plan for creating a CITITC. The Menominee Action Plan for 2017-2020 is at Attachment C to this Chapter. As it indicates, the plan builds on the traditional clan system, assigning each clan responsibility for implementing a component of the plan. In the beginning, have the plan focus on a single or a couple targets for the trauma-informed initiative, such as high school drop-outs, youth suicide or teenage pregnancy, in which the CITITC can have an immediate impact. Develop a plan that all of the participating reservation institutions will participate in. Be realistic in setting your goals. As the Menominee advise, paradigm changes may take years to occur. Over-realistic goals will cause the initiative to lose support. It is better to educate your community about how change will take time. Then, as progress is made on the initial goals, establish new goals and develop a new plan for accomplishing them.

Work with Each Reservation Institution

Work with each institution to assist the development of its own strategic plan on how it will implement a trauma-informed strategy. There is no single approach that will fit every one of the institutions. The schools need their strategy, the health facility needs its strategy, and the workforce development and TERO needs theirs. The next chapters describe some of the different trauma-informed programs in these different institutions that one can choose from. There are also subject-specific experts in each of these areas that can be helpful in developing the program for a particular institution. For example, the Menominee School District brought in Jim Sporleder, the former principal of the alternative school in Walla Walla, Washington – the subject of the movie *Paper Tiger* – which describes how Mr. Sporleder increased the graduation rate at the school from 25% to 75%.

Accept the fact that some institutions in the community will move more quickly than others to implement a trauma-informed program. It may be that one institution, such as the schools, is so committed to its trauma-informed initiative, that it can serve as the home for the coordinating committee, with a focus on building that one institution's trauma-informed profile as a way to motivate the other institutions to move forward.. The model above is just one possible route; there is not one right way. In sum, be opportunistic and go with where the energy and commitment is and build from there.

Data

Keep good data to be able to show the impact of the CITITC effort. It will help with fund raising and credibility-raising to have data showing that the CITITC has reduced the drop-out rate or the number of teenage pregnancies. Hard data of success is perhaps the most powerful tool you have



to be able to succeed. In addition, use the data to adjust your plans if problems are identified by the data.

Integrate the Efforts

Use the Coordinating Committee to promote cooperative relationships between programs that historically may not have worked together. There needs to be a strong relationship between the school and the behavioral health program (where the schools does not have its own adequately staffed behavioral health program) so that when a teacher identifies a student with severe trauma, the student can be seamlessly referred to counseling. An even better solution is having behavioral health professionals in the school as Menominee did through agreement between the schools and the Health Clinic. (Another innovative cooperative arrangement implemented by the Menominee Schools and its Health Clinic was that in order to reduce school time lost when students had to go to dental appointments – and to reduce missed appointments because students could not get out of school – the clinic moved part of its dental clinic to the school, thereby solving both problems. While not technically a trauma-informed action, it demonstrates the benefits of breaking down the silos – one of the elements of the overall CITITCI approach.

Incorporate Tribal Culture

Most importantly, at every stage of the process, incorporate tribal culture, values and traditions into every program, every meeting, every plan. The Menominee Tribe has done this and considers it a key to its success. The Tribe’s motto for its trauma informed initiative is “Connecting with the Past, Healing the Future”, and according to the Tribe: “Traditional cultural practices play a role in virtually every aspect of the Menominee trauma-informed practices.” As an example, as part of their program to reduce teenage pregnancies, they teach girls about how pregnancy is a sacred state of being under traditional culture as one part of its Menominee Grandfather’s values of respect, bravery, honesty, humility and truth program. They also provide the girls with culturally relevant reproductive health and support services. The result has been a reduction in pregnancies among girls 15-17 from 20 a year to just 5 a year. See Attachment D for more information on the integration of their cultural practices into their trauma-informed initiative. There is more information on incorporating culture and traditional practices into trauma-informed programs in Chapter 3.

More Community Education

Continue to consistently educate the community about trauma and the programs being implemented to address it.



Persevere

Keep on going. It has taken 500 years to create the present problems. They will not be solved overnight. The Menominee say it has taken ten years to have a flourishing program, but it is now paying off in so many areas, including a reduction in the high school drop-out rate from 40% to 5%, a reduction in teen pregnancies, and a 64% decrease in alcohol use by teenagers.

Attachment A contains a range of documents describing the Menominee approach. The Tribe invites visitors from other Native American communities considering creating a trauma-informed initiative to visit their reservation and tour the programs and facilities. Contact person is Wendell Waukau (wwaukau@misd.k12.wi.us) or Jerry L. Waukau (JerryW@MTCLINIC.NET). Depending on their schedules, they may be available to present to your tribal leaders or at conference held to educate your community about trauma-informed initiatives.

In addition to the comprehensive approach taken by the Menominee Tribe, a growing number of cities and states are implementing comprehensive trauma-informed initiatives. For example, both Wisconsin and Tennessee are working to become the first trauma-informed states in the country, revising all of their programs to be trauma-informed. The work in these non-Indian communities has useful lessons to teach tribal communities. As a result, articles on those programs and several local comprehensive trauma informed initiatives are also attached to this Chapter (See Attachment B).

Attachment C contains material on Laura Porter's Self-Healing Communities. From 1992 through 2012, the Self-Healing Communities approach was implemented in 42 non-Indian communities in the State of Washington. It shows that while it takes time, trauma-informed approaches can dramatically reduce many of the social problems of the kind that exist on reservations. In these Washington communities the accomplishments include:

- Birth to teen mothers were reduced by two-thirds;
- Youth suicide and suicide attempts were reduced by 95%;
- High school drop-out rates were reduced by half.

Each tribal community needs to review these various approaches and create its own approach that meshes with its traditional and present culture and situation. Every Tribe is different so that each Tribe's approach needs to be individually crafted. Hopefully the information on the Menominee approach and those of these non-Indian communities will provide tribes with information they can use to craft their own approach. The coordinating committee should also reach out to non-Indian trauma-informed initiatives in their state since those initiatives are usually very willing to assist tribal initiatives (A portion of the assistance the Menominee Tribe's trauma-informed initiative received was from a Wisconsin State program).



There are also a number of expert individual consultants and organizations available to assist a coordinating committee develop and implement its comprehensive, integrated trauma-informed program. It is highly recommended that the coordinating committee bring in such an expert to help implement its program. The experts known to the Roundtable (we do not claim to know them all) are listed below. Conduct an internet search to find their websites and to learn more about them:

- Dr. Tami DeCoteau – President, Roundtable on Native American Trauma-Informed Initiatives – tamidecoteay@yahoo.com
- Jodi Pfarr – who helped Menominee develop its program – jpfar.com
- Diane Wagonhals – Lakeside – dwagonhals@lakeside.com
- David Cross – The Karyn Purvis Institute at Texas Christian University – d.cross@tcu.edu



CHAPTER FIVE – EDUCATION

Schools are one of the most important institutions in any comprehensive integrated trauma-informed tribal initiative and are in a position to serve as the initiator of such an initiative or play a lead role for a number of reasons:

- Schools are respected institutions that have the stature to lead or co-lead such an initiative and have done so in several communities, including Menominee.
- Schools are central institutions in a community and thus have the ability to bring the community together.
- Schools can reach a group of students at one time in the class setting for such things as resilience training, instead of having to deal with individuals one-on-one.
- Schools have students for 6 or 7 hours a day so they are in a position to identify individuals who need one-on-one counseling.
- Schools need to succeed if the community is to heal. Students who dropped out of high school were 63 times more likely to end up in prison than are college graduates. Having a parent in prison is one of the ACEs.
- Schools need to adopt trauma-informed approaches if they are to succeed in proving student performance. Students who are traumatized have great difficulty learning because their minds are focusing on their fears, not on their teacher. In addition, they have difficulty accepting instruction and are likely to blow up at a teacher. For example, the data show that students with three or more ACEs are 2.5 times as likely to fail a grade (See Attachment A). A school district can establish all of the performance standards it wants for its teachers, but even the best teacher cannot teach a student whose mind is not present in the classroom.

The beginning of the national trauma-informed movement began in a school, the Walla Walla Alternative School. After the principal, Jim Sporleder, introduced trauma-informed practices, the graduation rate increased from 25% to 75% (An evaluation of the Walla Walla school is at Attachment B to this Chapter. It is also the subject of the film, Paper Tiger which can be accessed on YouTube). Since the Walla Walla schools showed how it can be done, thousands of schools around the country have begun implementing trauma-informed programs of the kinds described below.

What are the Components of a Trauma-Informed School?

There are a broad range of school-based trauma-informed programs (some of which are listed below). A school should explore these various programs and select the one it finds most consistent with its values and way of doing business. The basic elements of a trauma-informed school include:



- Training every employee in the school about trauma. This includes teachers, as well as administrative staff, janitors, bus drivers, etc.
- Providing resilience training to every student in the form of yoga, meditation, mindfulness or other proven resilience techniques. As mentioned, the students in the Menominee schools spend their first 15 minutes of the day meditating. The New Orleans school system has required every school in the system to teach yoga to its students.
- Training teachers how to identify signs of trauma in the classroom, such as a student repeatedly acting out or blowing up, and how to work with students who exhibit the signs of having been traumatized.
- Setting up quiet rooms teachers can send students who are blowing up because of trauma in order to give them an opportunity for their stress levels to come down so they can be talked to.
- Referring students with trauma who do not respond to resiliency programs to behavioral health counselors who are located in the school building. Having to send them off-campus weakens the program. Teachers cannot be expected to be behavioral health counselors.
- Hiring a sufficient number of behavioral health counselors, or enter into a relationship with the Tribe's Behavioral Health Program, to put counselors right in the school as the Menominee School District did.
- Start in preschool and offer these programs all the way up through the tribal college system. New York City recently hired Trauma-Smart, a non-profit consulting organization to train every employee of the City's Head Start program.

At the end of this chapter is a 23 page guide to creating a trauma-informed school prepared by the Missouri trauma-informed coalition called Alive and Well. While not specifically developed for Native American schools, it provides a culturally sensitive, step-by-step process for creating such a school, along with indicators of progress. Because it is such an excellent introduction to trauma-informed schools, it is included in the body of the Handbook rather than in the attachments in order to insure it is accessible to every reader of the Handbook.

- Finally, there are a host of other excellent resources to assist schools implement a trauma-informed school. For example Jim Sporleder, the principal at the Walla Walla Alternative School who launched the trauma-informed school movement, and Health Forbes have written an excellent book entitled *The Trauma-Informed School: Step by Step Implementation Guide for Administrators and School Personnel*, available on Amazon and other sources. Ms. Forbes hosts regular training conferences that can be found by going to the Beyond Consequences Institute – info@beyondconsequences.com



There are also a number of expert consultants and organizations available to assist a school implement a trauma-informed program. It is highly recommended that the school bring in such an expert to help implement its program. The experts known to the Roundtable, (we do not claim to know them all) are listed below. Conduct an internet search to find their websites and to learn more about them (Some of them were also listed as consultants who could assist a coordinating committee develop its comprehensive integrated trauma-informed strategic plan):

- Dr. Tami DeCoteau – President, Roundtable on Native American Trauma-Informed Initiatives – tamidecoteay@yahoo.com
- Jodi Pfarr – who helped Menominee develop its program – jpfar.com
- Wendell Waukau – Superintendent of the Menominee Public Schools and co-creator of the Menominee Tribe’s trauma-informed model -- Wendell Waukau <wwaukau@misd.k12.wi.us>
- Jim Sporleder – Consulting – jimsporlederconsulting.org
- Heather Forbes – Beyond Consequences Institute – info@beyondconsequences.com
- Jeri-Jacobers Kenner – TRAUMA SMART – jjacobes-kenner@saint-lukes.org
- Diane Wagonhals – Lakeside – dwagenhals@lakeside.com
- David Cross – The Karyn Purvis Institute at Texas Christian University – d.cross@tcu.edu

The Law Suit

The issue of providing trauma-informed programs in schools serving Native Americans is likely going to become a much more prominent and important issue in the near future as a result of a trauma-informed law suit brought against the Bureau of Indian Education (BIE). In a law suit brought on behalf of Native American students at a BIE elementary school on the Havasupai Reservation – at the bottom of the Grand Canyon, in the first court decision of its kind, a United States District Court in Arizona found that the physiological and behavioral changes caused by historical trauma and ACEs qualify as disabilities under the Section 504 of the Rehabilitation Act. The court decision goes on to find that the Bureau of Indian Affairs school, whose students have suffered multiple ACEs and historical trauma in their lives, not just in the school, violated the Act by:

“[F]ailing to establish systems that address [the students’] exposure to adversity and complex trauma so as to facilitate meaningful access to the benefits of public education... finding that these students are disabled under Section 504 by virtue of their complex trauma and adversity, including but not limited to: experiences of physical and sexual violence, involvement in the child welfare and juvenile justice systems, alcohol and substance abuse in the family and community, extreme poverty, denial of access to education, and historical trauma.”

Under the Rehabilitation Act, a disability is one that substantially limits one or more major life activities. The Plaintiffs argued and the court accepted that trauma limits ones abilities of



“learning, thinking, concentrati[ng] and communicati[ng]” and cited neuroscience evidence about how the brain’s physical response to trauma limits a person’s ability to fully benefit from an education.

Under the Rehabilitation Act, an entity using federal funds discriminates if it denies persons with disabilities the benefits of its program as the result of “thoughtlessness indifference or benign neglect” and must take corrective action to help the disabled persons to benefit from the program as much as possible. The Plaintiffs allege and the court accepted for purposes of the motion to dismiss that the Bureau of Indian Education failed to establish a system for identifying and assessing needs of students with trauma or providing them with programs to help them overcome the effects of their trauma. The BIE was found to have few or no special education, mental health or other professionals capable of providing trauma-informed help.

The case is still in its preliminary stage. Even though the court’s agreement with the Plaintiff’s legal arguments concerning trauma and disability overcome the most difficult barriers, the Plaintiffs still need to prove the allegations at trial (unless the Government agrees to settle). However, given what we know about trauma and the history of life in Native American communities, proving so should not be difficult. The court would then have to figure out appropriate remedies, which are limited to future actions by the BIE, not compensatory ones. It could include requiring the BIE to provide appropriate counseling and other support services to assist the students overcome their trauma so they can fully benefit from their education. In the view of the Roundtable, this would mean implementing the kinds of trauma-informed programs discussed in this Chapter. A copy of the decision is at Attachment C.

Since the Havasupai School is not that much different from any other BIE-run or funded school, what happens in the Havasupai case will have immediate implications for all of these other schools on reservations. It will mean that the BIE will need to provide or fund trauma-informed program in all of their schools. Hopefully, the BIE will see this law suit as an opportunity to seek funding from Congress to provide these needed services, which should improve the sorry performance record of BIE schools. Since state public schools also receive federal funding, they are also subject to Section 504 and, therefore, will need to offer trauma-informed programs if the plaintiffs succeed in this law suit.

For purposes of this Handbook, the law suit has two implications. First, it should increase the urgency among school districts on reservations to help initiate a comprehensive integrated trauma-informed program, rather than waiting for a court to order them to implement trauma-informed programs. Second, it can provide a powerful argument on why the funders of the school whether the state, the BIE, or the tribe, should provide the additional funding needed to implement such a program. It is not just that implementing a trauma-informed program will bring the school into compliance with the Disabilities Act. It will also provide the school with a neuroscience-based approach to improve the performance of their Native American students, something they have largely been unable to do using their present approaches, which address the



symptoms of the problem rather than the underlying cause which is childhood and historical trauma.



CHAPTER SIX – PHYSICAL AND BEHAVIOR HEALTH

The physical and behavioral health sectors on a reservation need to become one of the core partners in a comprehensive integrated trauma-informed initiative – for a number of reasons:

- Medical providers have a close trusting relationship with their patients and are thus in a position to have conversations with them about the highly personal issues involving trauma in their childhood or in their present homes.
- Medical providers have stature in their communities and therefore have the ability to educate the community and to bring representatives from other institutions into a trauma-informed initiative.
- Their skill sets are critical pieces of the solution.
- As the Chart at Attachment A indicates, trauma has a major impact on children’s health and mental health, increasing the risk of such problems as psychotic symptoms, teen pregnancy asthma and heart disease.
- Finally, a trauma-informed approach provides a way to reduce the workload on both the physical and behavioral health sectors. The problems that are caused by trauma very closely parallel the health problems that inundate reservation clinics and emergency rooms and overwork their staff – suicide attempts, alcohol and substance abuse (and the resulting accidents or fights that fill the emergency rooms), diabetes, obesity, cancer, heart disease and lung disease and other chronic diseases that fill the outpatient clinic waiting rooms. If the trauma-informed initiative can reduce these problems, it can significantly reduce the patient load on the clinic, emergency room and inpatient facility. The study at Attachment B, “The Impact of Adverse Childhood Experiences on Health Service Use Across the Life Course”, found that: “ACEs are strongly predictive of higher general practice use, of emergency care use, and increased hospitalization” (p. 172). Compared to persons with no ACEs, a person with four or more ACEs used the general practice services (clinic) three times more, used the emergency room twice as much, and had double the number of overnight hospital stays.

While this Chapter argues that the physical and behavioral health sectors need to work together more closely, the Chapter is separated into physical health and behavior health sections since the role of the behavioral health program needs to include, but also go beyond teaming with the physical health program.

Trauma-Informed Pediatric-Led Integrated Care for Children and Families

One of the things that make the physical health care sector such a key player in addressing trauma is that the pediatricians and primary care physicians and staff see virtually every child during their early years. In an insightful and moving book entitled “The Deepest Well”, Dr. Nadine Burke Harris, a pediatrician running a clinic in a low-income African-American community in San Francisco, describes how she began noticing that she was unable to find



medical explanations for the health problems many of the young children who were brought to her clinic. From talking to the parents, she also began to notice a pattern regarding the kinds of events that the children were experiencing at home. One of the most enlightening experiences was when, in trying to diagnose the cause of asthma in a child, she asked the mother whether she was able to connect the child's asthma outbreaks with any event in their home. The mother replied that they seem to occur when her father punches a hole in a wall of the house in a fit of anger.

That event, plus, learning about the ACE study, caused her to realize how many of the problems children brought were really the result of ACEs – and such that treating them required more than medical solutions. Recognizing she had neither the expertise nor the time to spend addressing the ACEs, she created a behavioral health unit in her clinic, had the parents fill out the ACE questionnaire, and referred children who appeared to be subjected to multiple ACEs to the behavioral health unit. That unit worked with the child and the family, using therapies that have been shown to be effective in reversing the effects of ACEs on young children. So often this resulted in improvements in the child's physical health as well as their overall wellbeing.

As a result of the work by Dr. Burke-Harris, the American Academy of Pediatrics, and the Johns Hopkins School of Public Health, among others, pediatricians and pediatric departments are now being encouraged to implement trauma-informed integrated pediatric care programs consisting of teams composed of pediatricians or primary care physicians and their assistants, behavioral health practitioners, social workers and others. Recognizing the value of such programs, the Indian Health Service contracted with the Johns Hopkins School of Public Health to train providers at 17 IHS or tribally-run health facilities to implement integrated pediatric care programs (See Attachment C). For information on the Johns Hopkins/IHS program contact Lawrence Wissow at Johns Hopkins (lwissow@jhmi.edu).

What does child trauma-informed integrated care look like?

According to the National Child Traumatic Stress Network, “Child trauma-informed integrated healthcare is the prevention, recognition, and response to trauma-related difficulties through collaboration of physical and mental health professionals with the child and family. This can be done by co-location of medical treatment, mental health care, and social services in health care settings, streamlined communications between providers, and full partnerships regarding treatment decisions among providers, the child, and family.” Attachment D

The components of an integrated care program include:

- **Screening** – The first step is screening for ACEs by asking parents (and children if old enough) to fill out an ACEs questionnaire when in the waiting room before their pediatric appointment. There are several questionnaires that have been developed that build on the basic ACEs ten questions used in the original study. One has been developed by the Center for Youth Wellness, the non-profit organization Dr. Burke-Harris created to



promote her work, and is available on their website. Under some protocols, the parent is not asked to disclose to the physician which ACEs are present in their home, just the total number. (See Attachment E “Why and How We Screen for ACEs” by Dr. Burke Harris’ organization, The Center for Youth Wellness; and Attachment E “Dozens of Kaiser Permanente Pediatricians in Northern California screen three-year olds for ACEs”)

There are some who object to universal screening on the grounds that filling out the questionnaire can re-traumatize people if the support services are not present. This is a valid concern, so ACE screening should only be done when the resources, such as behavioral health counseling, are in place to support the families being screened. Ideally, screening should be done as part of the integrated program described in this section.

- **Treatment** – If, upon screening, the ACE score is four or higher or the child is exhibiting symptoms of trauma, the parent and child are referred to a multi-disciplinary team embedded in the pediatric clinic (so there is no need for referrals) that include:
 - Behavioral health specialists who use various two-generation approaches to reduce the ACEs in the home and therapies to help the child heal from the ACEs he or she already suffered.
 - Care coordinators who will educate the family about the impact of ACEs and other forms of trauma and will make referrals to other providers who are external to the team, such as psychiatry, biofeedback programs, etc.
 - Where appropriate, referrals are made to social workers or home-visiting workers who utilize trauma-informed programs of the kinds discussed in Chapter 8 on Parenting.

- **Relationship-building** – The pediatrician or primary care provider stays involved throughout the entire process, building on the trusting patient-physician relationship to encourage the family to remain in the program as well as to treat whatever physical problems have resulted from the ACEs. Initially it was feared that parents would be reluctant to talk about these very personal issues around ACEs that reflect on the home environment. However, experience has shown that they are in fact not just willing but eager to talk about their own ACEs as well as those in their present family when the person listening is a trusted health care provider. Attachment F contains an article by the American Academy of Pediatrics, which strongly endorses ACE screening, that provides more information on the role of pediatricians in identifying and treating trauma, entitled: “Early Childhood Adversity, Toxic Stress and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health”

Behavioral Health Programs

As various Chapters in this Handbook note, the tribal or community behavioral health program must play a central role in a tribe’s comprehensive integrated trauma-informed program. It



needs to provide its traditional trauma-informed one-on-one or group counseling within the four walls of its program to those needing treatment (but do so using trauma-informed therapies). But it also needs to reach out beyond those four walls to work in a cooperative and integrated manner with other reservation institutions. As discussed above, it will need to integrate with the physical health program, particularly the pediatric and primary care staff as part of the Trauma-Informed Integrated Child Care program. As Chapter 5 on Education describes, it will need to work closely with the schools to provide help to those students who need more help than teachers can provide, ideally placing behavioral health counselors in the schools. As discussed in Chapter 7 on Workforce Development, the Arapaho casino embedded seven behavioral health counselors in its facility to reduce staff turnover. As the Chapter on using pre-doctoral psychology interns discusses, the behavioral health program must take the lead in applying for certification as a facility that can receive pre and post-doctoral interns and then must supervise them. Along with meeting more and different work responsibilities, these additional roles put the behavioral health team in a position to be leaders in reducing the trauma on the reservation and thus eventually, on their own workload.

In both their group or one-on-one counseling work and their outreach to other institutions in the community, the behavioral health staff needs to learn about and use trauma-informed services. Only those can get at the underlying cause of the trauma-based problems of many, but not all, of the externalities their patients are suffering from.

Trauma-specific services are defined as: “Evidence-based and promising prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.”

In turn, “trauma-informed care” is defined as: “Strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.” (Hopper, Bassuk and Olivet, 2010, p. 82”

It also involves:

“Vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of survivors and other consumer participation in the development, delivery, and evaluation of services.” (Bench Sheet on Behavioral Health, Campaign for Trauma-Informed Policy and Practices, Attachment G)

Attachment G also provides information on a range of trauma-informed interventions and promising practices. Cognitive behavioral therapy has been demonstrated to work for trauma victims but requires a lengthy treatment period. EMDR appears to also be effective while requiring less time to make an impact. The attachment briefly describes a number of other



approaches. Each behavioral health program will need to select the approaches most appropriate for its community and that is most compatible with the training of its staff. Regardless of which approaches it decides to use, it should also integrate traditional healing approaches into its overall approach, working with traditional healers and elders to determine how best to do that. As an example, an architectural firm has designed a physical layout for a traditional treatment facility that can be built in conjunction with a standard clinic, behavioral health facility, or hospital that includes a sweat lodge and a talking circle (See Attachment H).



CHAPTER SEVEN – WORKFORCE DEVELOPMENT

Before tribes had casinos, the reason given for the high unemployment rates on reservations was the absence of job opportunities. What has been surprising is that even on reservations with large successful gaming operations that have more jobs than they have tribal members, along with strong Indian preference in hiring programs through their Tribal Employment Rights Office (TERO), many of them still have unemployment rates far above the national average. Job placement and TERO officials have described how depressing it is for them to send someone out to a job, have them fired or quit a few weeks later, send them out again and have the same thing happen, and then see this repeated over and over again. Sending out them out for skill training often does not make a difference because either they do not succeed in developing skills at the training or they have the skills but they still are unable to retain employment.

The explanation seems to be that those persons who remain unemployed, particularly when jobs are plentiful, are suffering from childhood and historical trauma. Trauma studies have shown that persons with extreme trauma have particularly difficult problems in the workplace, including high rates of absenteeism, substance abuse on the job, inability to get along with co-workers and violent arguments with supervisors. A study by scientists at the U.S. Center for Disease Control and Prevention concluded: “Among both men and women, the unemployment rate in 2009 was significantly higher among those who reported having any ACEs than among those who reported no ACEs....ACEs appear to be associated with increased risk for unemployment among men and women” (The full study is at Attachment A).

Referring an individual whose brain has been injured by trauma to a job is like sending a quarterback back into the game after he tore his ACL. All of the pressure, all of the practice, and all of the motivational talk in the world will not change the fact that the quarterback will not perform as desired until his knee has healed. Similarly, for a tribe to achieve its goal of full employment, tribe members who have been injured by trauma must be helped to heal, which can be done either before sending them out into the workplace or training site or while they are in the workplace or training site. This is not a question of coddling the individuals or forgiving their misconduct. It is recognizing that there are physiological injuries present that must be addressed in order for them to succeed in the workplace.

For these reasons, one essential component of a comprehensive integrated trauma-informed tribal initiative must be a component to help those who are unemployed and/or failing on the job because of trauma. As described below, there are successful models for addressing trauma during the job training phase and during the actual employment phase.

The approach requires giving troubled employees or trainees the option and opportunity to receive behavioral health programs tailored for use in the workplace, with the incentive that if the employees complete these programs, they will obtain, retain, or reclaim their jobs. At the remarkable program implemented at the Arapaho Casino on the Wind River Reservation



described below, their successful trauma-informed employee recovery system had a 63% success rate. That means 63% of those employees referred for counseling because they were failing at their jobs ultimately retained their jobs and went on to become successful employees. This means the casino avoided the costs involved in having to hire and train new employees for each one of those positions, a substantial saving to the casino. It also provided a huge benefit to the Tribe since those employees are now supporting their families and providing role models for their children, and no longer receiving DWIs, hanging out on the street corner, or lounging in the arroyo with a bottle or a needle.

The Tribe can get employers, including its own businesses to implement such a program through several different means. Under the voluntary approach, it can ask the tribal business on the reservation to adopt trauma-informed approaches by educating and encouraging their casino and other tribal businesses to do so as a way of proving the concept before taking it to non-tribal employers and asking them to implement similar programs. An alternative is for the tribe to require employers to adopt such programs by revising their TERO ordinance to give the TERO the authority to compel employers to implement the trauma-informed programs described below, which would apply to all employers on the reservation. Or the tribal council can direct the tribally-owned businesses to implement such programs while leaving it optional for non-tribal businesses. In addition to one of the above, the Tribe should incorporate trauma informed components into their job training programs

Each of these approaches is discussed below:

The Voluntary Approach – the Wind River Hotel and Casino Model

Like many other tribal casinos, the Wind River (Wyo.) Hotel and Casino, owned by the Arapaho Tribe, was suffering high turn-over among tribal member employees. An innovative program implemented by the then H.R. director and now independent consultant Andi Clifford, an Arapaho Tribal member (aclifford72@gmail.com) has turned that around.

The basic component of this program is that employees who are in trouble and in danger of being terminated are offered the opportunity to receive counseling through a set of programs the Casino and Tribe have made available. The employee is referred to the casino wellness center which has seven behavioral health counselors employed by the casino who provide one-on-one counseling. They help to run three 12-step programs a day in the casino – with the 12 step approach revised to reflect tribal culture – and make referrals to the Tribe’s White Buffalo Recovery Center if the employees need additional help. The program turned to the elders for advice on the use of traditional healing approaches, so it now includes such components as sweat lodges and horse culture programs. An employee can use a program outside of the casino if he or she chooses so long as they provide proof that they are in the program. While undergoing recovery, they are able to use any vacation or sick leave. Otherwise they go without pay.



The incentive, which has proven to be a powerful one, is that the employees who are on the cusp of being fired are entitled to return to their job when they have completed their wellness program, but will be terminated if they do not complete the program. Some employees initially resisted saying “how dare you say I have a drinking problem”. The counselors show them their work record, e.g., missing work every Monday or being late every day, but they also have the leverage of telling them they must participate in the wellness program or they will lose their jobs. A key component is training staff and assisting them to deal with their own trauma as well as learning how to use the program. As mentioned above, 63% of those referred to the wellness program through the process described are back on the job as successful employees. A copy of the Wind River Casino’s Wellness Policies and Procedures implementing the program described above are at Attachment B.

The TERO Enforcement Approach

The elements of the TERO Enforcement Program are very similar to those of the Wind River Voluntary program – staff training, offering troubled employees an opportunity to maintain employment if they undergo counseling, etc. The difference is that rather than being implemented by the employer on a voluntary basis, it is mandated by the Tribe via a tribal ordinance that, like the TERO Indian preference requirements, applies to all covered employers on the reservation subject to the Tribe’s jurisdiction. As a result, it would apply to all employers, not just tribally-owned businesses, though the model ordinance at Attachment C limits coverage to employers engaged in projects costing over \$25 million, such as large construction projects, in order not to unduly burden small employers. The Ordinance does not anticipate that the employers have behavioral health counselors on their staff but instead provides that the employer refer troubled employees in danger of being fired to the tribe’s behavioral health program, which means the tribe has to be willing to staff up that program to handle this additional load. It also requires the employers to provide training on trauma to their supervisors so they know how to identify trauma and refer traumatized workers for help.

One way for the Tribe to phase in the Ordinance is to, initially, have it apply only to its own enterprises if it has them, in order to get experience with the program. This shows private employers that the program can be implemented without unduly burdening their ability to do their work and make a profit. Just as employers balked at having to comply with Indian preference programs when the TERO program began 40 years ago, they will balk at these new requirements. The requirements will therefore need to be introduced carefully with a great deal of training for those employers. Showing the program can work by starting with the tribe’s own enterprises is an effective way of reducing the pushback.

A model TERO ordinance implementing such a program by tribal law is provided at Attachment C. The major difference between the requirements in the Ordinance and the ones in the Wind River program is that the Ordinance sets up a fund, funded by the Tribe, to provide some



compensation to workers who are in counseling or recovery and not working so they can continue to feed their families while off the job and in the recovery process. The Ordinance provides that the Ordinance is to be implemented by the TERO, which has the experience enforcing requirements on employers. However, it is to do so in close cooperation with the tribe's behavioral health program.

The Ordinance approach has not yet been adopted by any tribe so there is no experience with it. Therefore tribes should proceed slowly in implementing it and be prepared to make changes if real-life experience in applying it proves to be difficult. For more information on the Ordinance, contact Daniel Press at dsp@vnf.com (the author of this Handbook and one of the founders of the TERO program).

By Tribal Council Mandate on Tribal Enterprises

Tribal councils have the ultimate authority over tribal enterprises and therefore the authority to require them to adopt this trauma-informed workforce development approach. Many Tribal Councils have been reluctant to impose requirements on their casinos and other enterprises because they do not want to reduce their profits. However, focusing so heavily on profit has done little or nothing to help that percentage of the tribal membership that is suffering from trauma and therefore a financial burden on the tribe. Investing in programs like these are investments in the future of the tribe since not only the employees benefit, but the benefits pass down to their children and grandchildren. While students can be reached in school, there are limited ways to bring trauma-informed programs to adults. Imposing these requirements on the tribe's enterprises offers one of the best opportunities, if not the best opportunity, to reach those adult tribal members who continue to exhibit the effects of trauma. Further, as the Wind River Casino found, implementing these programs may not actually reduce profits since they save money by reducing the high cost of employee turnover.

Trauma-Informed Job Training Programs

Another way to bring trauma-informed programs to the unemployed workforce is by incorporating trauma-informed components directly into the Tribe's job-training program. For example, as part of a program providing construction worker training, the first week of the training was devoted exclusively to an equine-assisted psychotherapy (EAP) program in which the trainees spent their days in the arena engaged in trauma-informed activities with the horses. The workers who participated in this program had a higher retention rate both in the training program and on the job, than those in similar programs that did not include the EAP component. Trauma-informed programs qualify as allowable costs under federal job training programs.



CHAPTER EIGHT – PARENTING PROGRAMS

As repeated throughout this Handbook, the most important long-term solution to trauma, particularly ACEs, is primary prevention in the form of programs to reduce or eliminate child adversity in the household. However, this is easier said than done. While parental education programs can be highly effective for parents who did not suffer trauma themselves, it is not always sufficient for parents who suffered trauma during their childhood and now exhibit the behavior that trauma produces – substance abuse, spousal abuse, obesity, and the like. Such parents are typically not interested in participating in any kind of parent education program or will drop out despite their best intentions because of their trauma. Also, they may be loyal to the abusive parenting approaches they were raised with and that caused their trauma.

There are a number of good parenting programs that provide in-home services and that take a two-generation approach that treat both the child and the parent. Congress has generally been generous in funding these programs, though some of the funding goes to states rather than directly to tribes. They include:

- The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Act which supports evidence-based home visiting programs in states (This program was recently reauthorized).
- The Nurse-Family Partnership Program has been shown in experimental trials to reduce state verified rates of abuse and neglect by 48%, reduce emergency room visits by 56%, and produce a 79% reduction in the number of days that children were hospitalized with injuries and ingestions during the first two years of life.
- The Triple P Program was demonstrated in a U.S. experimental trial to reduce the rates of child maltreatment in the counties in which it was implemented by 20% while also decreasing out of home placements and childhood injuries.

Given the high rates of trauma present on many reservations, in addition to utilizing these programs, the parenting programs need to particularly focus on addressing the parents' trauma. Chapter 6 on Health discussed therapeutic programs that can reduce ACEs in a household, such as the pediatric care program using such techniques as Parent-Child Interaction Therapy. Those programs involve therapy and therefore fall under the auspices of behavioral health and physical health domains. This Chapter provides information on parental education and outreach programs that tribes can adopt to promote good parenting outside of the clinic through the use of resiliency programs and other techniques that do not have to take place in the behavioral health facility. But as indicated throughout this Handbook, such programs need to be a part of an integrated initiative. For example, if a family engaged in one of the non-clinical programs discussed in this Chapter is identified as having serious trauma issues and therefore in need of therapy, the referral and assistance will occur seamlessly.



Another key to the success of such programs is the availability of highly-trained, sensitive and trauma-responsive facilitators, which can be a particular problem on remote reservations. One way to address that is to rely on home-grown talent. One of the programs discussed below, the Family Spirit Program, has tapped into one of the great strengths on reservations – the “grandmas” – by training mature tribal women to serve as counselors to young mother and mothers-to-be. The pre-doctoral and post-doctoral interns that can be obtained using the process described in Chapter 9 can also help to provide that workforce.

Below are three very different programs that are designed to assist parents. In each case, it is recommended that the tribe incorporate more intensive trauma-informed components, such as resilience training, than exist in the models discussed below, along with traditional wisdom and healing knowledge. These three programs do not begin to exhaust the number and diversity of programs available, but each seeks to intervene at a different point in the parenting process.

The Family Spirit Program

The Family Spirit Program was designed and is being implemented on over 130 reservations around the country by the Johns Hopkins University Center for American Indian Health. The program is designed to promote parents’ parenting skills, while assisting them to develop coping and problem-solving skills to overcome individual and environmental stresses. While not specifically taking a trauma-informed approach, it incorporates many elements that would be found in a program taking that approach and includes a strong cultural element.

The program trains and pays mature tribal women to be mentors to parents-to-be under which they deliver 63 lessons to the family in their homes within the following domains: prenatal care, infant care, child development, toddler care, life skills, and healthy living. The mentors also refer families to other resources to address specific needs. The program starts at least 28 weeks after gestation and continues to the child’s third birthday, with the home visits occurring weekly during pre-natal through the first three months, biweekly from 4-6 months, monthly from 7 to 22 months, and bimonthly from 23 to 36 months. Visits usually last 45 to 90 minutes and the goal is to develop a close, supportive relationship between the mentor and the family. The program is tailored to each tribal community and incorporates traditional practices into its approach. The program is presently exploring ways to bill Medicaid for the services the mentors provide. For more information, see Attachment A or google the Johns Hopkins Center for American Indian Health.

Universal Parenting Places

The ACE Awareness Foundation in Memphis, Tennessee has created several Universal Parenting Places (UPP), which are facilities that serve as judgment-free zones where parents and their children can receive professional counseling, emotional support, and referrals for family-related issues and concerns – no matter how small. It offers an array of groups and activities designed to



decrease toxic stress, thus reducing challenges to the children's emotional and behavioral health at the earliest point possible in their development. In addition to providing counseling based on trauma-informed principles, a UPP helps build parent-child bonds by offering an outlet where children and parents can relax and have fun. Services include support groups and therapeutic groups, improvisational theatre, music and drum circles, exercise classes and referral to community resources. For more information, see Attachment B and google the ACEs Awareness Foundation in Memphis.

Baby or Family Courts

Another very important way to promote good parenting is to implement programs whose goal is to keep families together. It is now well established that children who are sent off to foster care facilities end up with a high number of ACEs. As a result, there is a new push to take all steps possible, consistent with the safety of the child, to keep families together. One mechanism for doing that is what is variously called "baby" or "family" or "drug" courts, which have gained increasing popularity in light of the growing number of parents who are in danger of losing their children to foster care because of opioid or other kinds of drug addiction.

In such courts, rather than ordering that the child be removed from the home because a parent has been convicted of substance abuse, or, if the child has already been removed, in order for the convicted parent to get the child back, the court offers the parent(s) the option of participating in an intervention program that includes a wide range of coordinated services, parenting courses, drug treatment and domestic violence counseling, provided by a range of professionals, under the guidance of a case worker and under the supervision of the judge. As is the case with the court described in the newspaper article at Attachment C, all of these services should be trauma-informed in recognition of the fact that so much addiction (and most other problems that lead to bad parenting) is the result of Adverse Childhood Experiences. In an ideal world, these services and treatment would be provided to any parent having parenting problems and should not have to wait until the matter required court. That said, the likelihood of success goes up once the matter is in court because the judge plays a key role, not only through support and encouragement of the family, but also as a leverage of being the final decision-maker on whether to allow the child to remain, or return, home. This has proven to be a powerful incentive for the parent to stay with the treatment.

As the baby court article indicates, while these additional services cost the local governments money, they actually save the governments involved a substantial amount of money since foster care is so expensive. A study in Oregon found that baby or family court programs reduce average criminal justice and child welfare costs by \$13,000 per participant. The Menominee Tribe and the Rincon Band in California have established such courts. Menominee did so as part of its drafting of a revised Children's Code that supports the family court. For assistance in



developing a “family court”, contact the National Juvenile and Family Court Judges Association, which has a specific program to assist tribal courts.



CHAPTER NINE – USING PRE- AND POST-DOCTORAL INTERNS TO HELP STAFF THE TRIBAL COMPREHENSIVE TRAUMA INFORMED PROGRAM

Each pre-doctoral psychology student is required to spend a year interning under the supervision of a licensed psychologist in order to receive his or her doctorate degree (PhD or Speed). After receiving their doctorate degree, they must spend an additional year as a post-doctoral psychology intern or resident. The pre- and post-doctoral interns, working under the supervision of a licensed psychologist, can provide much-needed staffing for psychological and mental health programs on reservations at a very low cost and can, by billing Medicaid for the services they provide, actually bring in far more money than they cost the program.

Low cost pre- and post-doc interns can serve as one of the pillars of any reservation-based trauma-informed initiative. First, they can provide the same psychological services to traumatized individuals that a licensed psychologist can, using a range of approaches – from equine-assisted therapy to cognitive behavior therapy to cultural practices. In addition, they can work with the various community institutions (schools, law enforcement programs, the social services program, the health program, etc.) to help implement trauma-informed programs that are crucial to reservation-based trauma initiatives: teaching resilience to those already suffering from trauma and helping to prevent trauma in future generations.

It also gives the supervising psychologist the opportunity to train the interns to be capable of handling the unique issues they face on a reservation (before they learn “bad habits” at other locations). In the case of Standing Rock (see below), an important, but unexpected, benefit was that almost all of the psychologists who worked as interns returned to the area and/or continued to work on Native American issues. The intern program is a way to build the trained and committed workforce that will be needed to make a dent in trauma in Native communities.

A successful pre-and post-doc training program was operated by Dr. Tami DeCoteau, a licensed psychologist, on the Standing Rock Sioux Reservation a number of years ago – one post-doc worked in a K-12 school and one worked with incarcerated youth and adults. All of them focused on addressing the youth suicide epidemic on the reservation. The program was successful in reducing the youth suicide rate from about 30 per year to two per year.

Unfortunately, the program was destroyed by politics. The Indian Health Care Improvement Act authorizes IHS to operate and fund psychology intern programs but it has not asked Congress for the funding to do so. As discussed below, a tribe needs to advance some funds to start the program but once started, it is self-supporting. IHS should find a way to assist those tribes needing help with the start-up dollars.

Pre and postdoctoral psychology students are desperately looking for sites at which to do their internships. The number of internship placement sites is far fewer than the number of intern candidates, which means that annually approximately 1,000 pre-doctoral students are unable to find an internship placement. Creating more internship sites in Native American communities



will help to address this deficiency, as well as provide a guaranteed supply of critically-needed mental health providers to those communities. This imbalance between interns and approved sites will also ensure that even the most remote internship training sites will receive intern placements.

The cost of a pre-doc intern is \$30,000 a year and each intern can provide about 15 – 20 hours of direct patient care weekly. The cost of a post-doc resident is \$60,000 and they function similar to a full-time psychology staff person, with the majority of their time spent in patient care activities – some, but less, supervision than an intern requires. For a site to receive accreditation there needs to be at least two interns at the site. A model program would be one with two interns and one resident. There is also a need to pay the supervising psychologist, travel expenses, equipment, and other costs that come to about \$150,000 a year. Pre- and post-docs are qualified to provide the same range of services that their supervising psychologist can. A provision within the Indian Health Care Reform allows for billing of interns and postdoctoral residents at the federal reimbursement rate (approximately \$360/hr.) so long as they are billing through IHS or a tribal health facility. Thus, in a year, two interns and one post-doc can produce around \$1 million in income for the program sponsoring them while costing the program only \$150,000 for all three.

The program will need to advance a portion of that \$150,000, perhaps \$75,000-\$100,000, since it takes 5-6 months before the Medicaid reimbursement dollars start coming in. Once the reimbursements start flowing, the program will become self-supporting for the foreseeable future, in that there will be enough money from the Medicaid payments each year going forward to cover the next year's interns and supervisors.

A budget from an actual project is provided below. It assumes that: both pre- and post-doc students will be responsible for service delivery, but under the clinical supervision of a licensed psychologist. Service delivery is not limited to one-on-one counseling, but can include group activities like a sweat lodge or equine-assisted psychotherapy, so long as those participating are Medicaid-eligible. Medicaid will pay for traditional healing practices, but there is a need to learn how to work the Medicaid billing process.

Pre-doctoral students require 2 hours of face-to-face supervision at \$125/hour from a licensed psychologist, plus additional curriculum and training. Pre-doctoral students will provide about 20 hours of direct care per week. Post-doctoral students require 1 hour of clinical supervision per week and provide 30 hours per week of patient care. It is assumed the students will bill 40 weeks a year, leaving time for training, vacation and non-billable activities.



<u>Item</u>	<u>Rate</u>	<u>Cost</u>
Student Stipends – Standing Rock		
Interns	\$30,000/intern x 2 interns	\$60,000
Supervision by licensed psychologist	\$125/hr. x 2 hrs. x interns x 50 weeks	\$25,000
Postdoctoral residents	\$60,000/intern x 1 intern	\$60,000
Supervision by licensed psychologist	\$125/hr. x 50 weeks	\$6,250
TOTAL COSTS		\$151,250
REVENUE	1 interns x \$360/hr. x 20 hrs./wk. x 40 wks. = \$288,000 per intern x 2	\$576,000
	1 postdoc x 360/hr. x 30hrs/wk. x 40 weeks	\$432,000
TOTAL REVENUE		\$1,080,000
Minus Expenses		\$151,250
NET REVENUE		\$ 928,750

The biggest hurdle is that the program needs to be certified by the American Psychology Association before it is eligible to receive interns. This process takes several years for a new program to obtain certification, and has some administrative hoops to jump through. The most critical piece is that the tribe must have a licensed psychologist able and willing to oversee the program and provide the face to face supervision. For more information, go to the website of the American Psychological Association and search for the link to their pre-doctoral intern program or contact Dr. Tami DeCoteau (tamidecoteau@yahoo.com).



CHAPTER TEN – ADDICTION – OBESITY AND OPIOIDS

At first glance, it may seem strange to include obesity and opioids in the same chapter. However, the two have two critical things in common. First, both of these problems are causing pain, morbidity, and death on reservations. Second, both are symptoms of trauma and are addictions that people adopt when trying to cope. Neither can be successfully addressed without addressing the underlying trauma. See the seminal article by one of the authors of the ACE study, Dr. Vincent Felitti, “The Origins of Addiction, Evidence from the Adverse Childhood Experience Study” at Attachment A. Dr. Daniel Sumrok, a physician running a substance abuse clinic in Tennessee, describes overeating, using drugs and alcohol as unhealthy and/or illegal “ritualized compulsive comfort-seeking behaviors” engaged to address adversity experienced in childhood. The failure to focus on the real, underlying cause explains why programs to address both obesity and opioids have had such little success, despite the millions of dollars spent. As Dr. Sumrok states, “the solution is to address a person’s Adverse Childhood Experience individually and in group therapy, treat people with respect, provide appropriate medical assistance and help them find a ritualized compulsive comfort-seeking behavior that won’t kill them and/or put them in jail” (See news article on Dr. Daniel Sumrock at Attachment B).

This Chapter explores the connection between trauma and each of these problems and describes the trauma-informed solutions available that should be part of a comprehensive, integrated trauma-informed initiative.

Obesity

The original 1998 ACE study was conducted to find out why patients in a weight loss clinic at Kaiser Permanente in San Diego were losing a great deal of weight and then putting it all back on shortly afterwards. The 1998 ACE study has gone on to have ramifications far beyond weight loss. However, it has not lost its important lessons for addressing obesity, a serious and often deadly problem in Indian country. In a 2010 paper, Dr. Vincent Felitti, the co-author of the ACE study, revisited the issue of obesity and what the ACE study taught about that problem. “Based on that study and confirmed since” Dr. Felitti writes:

“Putting it plainly in regard to obesity, we have seen that obesity is not the core problem. Obesity is the marker for the problem and sometime is a solution. This is a profoundly important realization because none of us expects to cure a problem by treating its symptom” (p. 28). “The frequent reference to “the disease of obesity” is grossly in error, diagnostically destitute and apparently made by those with little understanding of the antecedent lives of their patients” (p. 28). “Obesity like tachycardia or jaundice is a physical sign, not a disease” (p. 28). (See Attachment C, Felitti, V.J. “Obesity: Problem, Solution or Both”

That trauma is a major cause of obesity is now firmly established. What Dr. Felitti’s article adds is that once a person is traumatized, obesity is a partial solution to trauma because it is



protective. Obesity can be a solution for people who were sexually abused “because men do not pay attention to obese women”. It is physically protective – thus the term “throwing your weight around” – and it is socially protective – people expect less from you when you are obese.

In regard to obesity among children, a particularly serious problems on reservations, Dr. Felitti says that while his research has had limited experience with children, he has noticed that among adults, they frequently say that the onset of their initial weight gain coincided with parental loss in childhood, usually by divorce. This highlights the importance of an integrated trauma-informed initiative since it may be that one of the most effective ways to reduce childhood obesity is to keep families together.

For all of these reasons, overeating is not the underlying cause of the problem. It is an attempted solution and “people are not eager to give up their solutions, particularly at the behest of those who have no idea of what is going on.” Dr. Felitti recommends a two part approach for addressing severe obesity:

1. Medically-monitored absolute fasting with supplements such as Optifast 70 to provide the body with the vitamins, minerals and other things that are needed to survive. The absence of food does not cause harm with these present because the body lives off of the fat that is being lost.
2. Group therapy. Removing food as a coping mechanism exposes the underlying issues that are the cause of the trauma. Helping patients address these issues is the harder part of the program. According to Dr. Felitti, group therapy is essential because “of the implicit support of the group and because participants quickly learn from each other’s self-observations.” The burden also falls on the counselors to ask meaningful questions that “help the patients discover what they already know at some level, and then use that discovery for their own benefits” Dr. Felitti points out that “the weekly two-hour group meetings of the Program are a complex endeavor that is difficult for some patients to engage in and is difficult to train staff to pursue vigorously” (p.26).

The long-term solution of course is to eliminate childhood trauma and overcome historical trauma, along with implementation of the resilience techniques that help people learn how to cope with trauma in healthy and legal ways. However, for those already suffering from trauma and eating as a coping mechanism, Dr. Felitti’s trauma-informed approach discussed above, and in the attached paper, provides one way to attack the problem of obesity. Since this can only be done in small groups, it will be a slow process. Hopefully, in addition, the resilience training will help young people (and perhaps adults) who have suffered from trauma and are already using eating as a coping mechanism to address their existing obesity.

Nothing in this approach is intended to minimize the importance of the valuable nutrition programs being implemented on more and more reservations. Healthy eating is a critical part of



any long-term solution to trauma. In addition, healthy eating is essential to producing healthy bodies and brains, regardless of an individual's experience, or lack thereof, with obesity. The trauma-informed programs to address obesity and the nutrition programs should work closely together.

Opioids and Other Substance Abuse Disorders

Dr. Felitti points out; “[t]he general principles underlying the unconscious compulsive use of food as a psychoactive agent are common to any of the addictions.” While a range of efforts to address the opioid epidemic are being launched, they largely ignore the powerful evidence showing the connection between opioid addiction and ACEs. The ACE study itself found that drug use “increases proportionately in a strong, graded, dose response manner that closely parallels the intensity of Adverse Childhood Experiences during childhood” (See “Trauma-Informed Approaches Need to be Part of a Comprehensive Strategy for Addressing the Opioid Epidemic” by the Campaign for Trauma-Informed Policy and Practice at Attachment D.)

A growing number of studies have shown a specific correlation between ACEs and opioid addiction. Individuals who reported five or more ACEs were three times more likely to misuse prescription pain medication and five times more likely to engage in injection drug use. Among the different forms of ACEs, sexual abuse and parental separation for women and physical and emotional abuse for men were the ACEs most high correlated with opioid abuse (While the data is not available for other drugs like meth, there is no reason to believe that any different results will be produced if such data were collected).

How does one use the knowledge about opioids and ACEs to address the epidemic? The data on ACEs and opioids is not a reason or excuse to cease the important work already under way to reduce the availability of drugs in Native American communities. However, until the ACEs are dealt with, people suffering from trauma will too often find illegal or unhealthy ways to address that trauma – including street opioids and meth. Therefore, a comprehensive integrated trauma-informed tribal program should include the following components (some of which are the same recommendations offered in the obesity section of this Chapter). In addition to treating those already addicted, the goal of these efforts is to keep the next person, the next group of adolescents, the next generation still unborn from suffering from substance abuse disorder.

- **Primary Prevention** – While it will not have an immediate effect, the long-term solution is to ensure children yet to be born do not grow up in homes in which they suffer ACEs. Unless the program goes this far upstream, tribes will continue to deal with individuals vulnerable to addiction for generations to come. There is the well-known story of a group of fishermen fishing by a stream when a baby floated by. The fishermen pulled the baby out. Then another baby came by that they pulled out, and soon the creek was full of babies. As the fishermen worked furiously to pull them out, one of them began walking away. His friends called, “where are you going? We are saving lives here.” He



answered, “I am going upstream to find out who is putting the babies in the creek so I can make them stop”. Primary prevention is the key upstream action needed so that tribes are not endlessly focusing their time and money on pulling their vulnerable members out of the substance abuse stream. Programs for primary prevention are discussed in detail in Chapter 10 on Parenting.

- **Resilience Training**

- Schools – Studies show that teaching student’s resiliency techniques such as yoga, meditation, and mindfulness, result in a lower likelihood of using drugs. For example, a recent study at the University of Cincinnati found that teaching mindfulness yoga to youth “...helped them develop long-term coping skills and concluded such programs are needed in earlier ages in schools to help vulnerable youth to channel their skills more effectively....These findings highlight the importance of implementing positive coping strategies for at-risk youth particularly for reducing illicit drug use and risky sexual behavior.” According to the author of the study, Professor Jacinda Dariotis, “Given the relative low cost of such programs and easy adaptations to different populations and settings... the return on investment may be substantial especially if they can reduce arrests, repeat offenses and other negative outcomes for risk-taking youth.”
 - Adults – While there has been an increase in teenage addiction, persons 16 through 55 are the most vulnerable to becoming victims of the epidemic. Unfortunately, they are also the most difficult to reach to educate about ACEs and opioids and teach resiliency techniques. As part of its trauma-informed initiative, the Tribe should explore opportunities to offer resilience programs to adults, whenever they gather on a regular basis, whether in clubs, athletic teams, churches, or similar entities. A particular entity to target is veterans’ organizations since veterans are particularly vulnerable to substance abuse disorder. As discussed in Chapter 8 on Workforce Development, the workplace and job training programs are also effective locations to provide resilience training.
 - Mothers-to-be – As part of any pre-natal program, resiliency techniques should be included to avoid the sad and increasing prevalence of babies born with addiction.
- **Treatment** – To increase the likelihood that treatment for those already addicted results in long-term abstinence, the treatment programs need to address the patient’s childhood trauma, otherwise they will continue to seek illegal or unhealthy coping mechanisms. Dr. Sumrok, like Dr. Felitti, recommends the use of group therapy along with the use of medications like buprenorphine. He also cautions that there is not necessarily a point at which a patient should be taken off the medication and stop group therapy. Dr. Sumrok



notes that we recognize diabetes as a life-long problem – one that does not go away – and we do not set deadlines to end treatment. Similarly, for many people, trauma does not go away. Drug treatment programs should be prepared to continue working with patients for the rest of their lives.

In conclusion, there is powerful evidence that most forms of addiction are the result of efforts to cope with trauma. As such, trauma must be addressed to help those addicted to heal. This makes it even more important that a tribal trauma-informed initiative be comprehensive and integrated and break down the existing silos among different programs – obesity, substance abuse, suicide prevention, etc. – as they all have a common origin. It does not mean that the various programs need to be eliminated and combined into a single program. Each requires its own treatment modalities. But they also have solutions in common, such as resilience training, that are more effective if done in an integrated and cooperative way among programs.



CHAPTER ELEVEN – LAW ENFORCEMENT AND COURTS

Incarceration is both a cause and effect of trauma, thereby creating a vicious cycle. Having a parent incarcerated is one of the ten original ACEs, thus one of the trauma-causing events. Incarceration is also one of the results of ACEs. Persons with ACEs are much more likely to end up incarcerated. 61% of all incarcerated adults have 4 or more ACEs. This cycle needs to be broken. The cycle can be broken by including the court system and law enforcement in the tribe's comprehensive integrated trauma-informed initiative. Fortunately, there are excellent sources of free or low-cost available to assist tribes make their law enforcement program and courts trauma-informed.

Law Enforcement

Law enforcement officers need to learn about trauma and be trained to recognize it in persons they are dealing with, particularly juveniles. If an officer threatens or uses force when arresting a suspect who is already suffering from trauma, the suspect will likely become even more violent, since the force or threat of force reinforces, and therefore sets off, that person's trauma response. Law enforcement officers in a growing number of communities are learning how to identify someone with trauma and how to engage with that person in ways that do not escalate the confrontation and not re-traumatize the person.

The Indian Country Child Trauma Center, formerly at the University of Oklahoma and now run by the Tribal Law and Policy Institute in California, with funding from the Office of Juvenile Justice and Delinquency Prevention, provides training and technical assistance to tribes on how to incorporate trauma-informed principles into a broader community policing approach whose core principles are 1) community partnership, 2) problem-solving policing, and 3) organizational transformation. For more information about this program, contact Anna Rangel Clough at the OJJDP Tribal Youth Center at the TLPI.

In addition, more and more police departments are recognizing that the best crime-fighting approach is to prevent crime, rather than punish crime after the fact, particularly regarding the use of drugs. This requires police departments to become pro-active and go beyond their traditional roles. For example, in Martinsburg, West Virginia and Johnson City, Tennessee the Police Departments took the initiative to promote trauma-informed programs in their communities. In Martinsburg, the police department reached out to the public school system to create a program in which police officers go into the elementary schools to talk to the students about drugs and trauma. As the Chief of Police stated: "The police and the schools have a unique and special connection with dysfunctional families and at-risk children. For many families the police and the school are their only positive connection with hope." (See "The Martinsburg Model" at Attachment A).

In Johnson City, the police department worked to make its own programs trauma-informed, by providing yoga and other programs to help its officers avoid secondary trauma. It then reached



out to the school system, the local health care institutions, the local courts, and other institutions to create a comprehensive trauma-informed program for the community.

Courts

It is finally being recognized that incarceration rarely rehabilitates. Over 60% of those incarcerated are back in prison within 3 years of being released. In response, an increasing number of courts are using trauma-informed principles to create what are called Wellness Courts (Sometimes called “baby courts”. See discussion on baby courts in Chapter 8 on Parenting). The goal of these courts is to offer those who come in front of them an opportunity to heal from their trauma while simultaneously paying their debt to society. As a result, the courts work closely with law enforcement, probation officers, behavioral health counselors, social workers, workforce developers, educators, and others to address the trauma that is the underlying reason that the person is now in custody. There are a growing number of relatively short-term therapies that have proven effective in assisting this population to heal, particularly adolescents. The Chief Justice of the Juvenile Court system in Memphis, Tennessee tells the story of two teenagers who came before him on charges of attempted murder. He offered them both the opportunity to receive trauma-informed assistance during their imprisonment (They both would be released when no longer juveniles). The one that accepted the offer became a straight A student at a Tennessee college after completing the program. The one that refused has been returned to prison, serving a 20-year term.

Tribes can receive excellent assistance in creating a trauma-free court system from the National Juvenile and Family Court Judges Association, which has provided such training to tribal courts under its tribal court assistance program.



ATTACHMENTS TO THE HANDBOOK ON CREATING A COMPREHENSIVE INTEGRATED TRAUMA-INFORMED NATIVE AMERICAN COMMUNITY

Attachments to the Introduction

- A. Information on the Menominee Clinic's 27 Module Training Program

Chapter 1 – Introduction To The Basic Concepts

SECTION A – OVERVIEW

- A – Diagram showing the effects of trauma
- B – Articles on the ability to identify who considered suicide attempts based on the amount of stress hormones in the blood

SECTION B -- THE ADVERSE CHILDHOOD EXPERIENCE (ACE) STUDY

- C – The ACE Test
- D – Felitti, VJ., Anda, R –The Lifelong Effects of Adverse Childhood Experiences
- E – Center for Disease Control, - Major Findings of the ACE Study
- F – “Economic Costs of Adverse Childhood Experiences in Alaska,” Alaska Mental Health Board

SECTION C – HISTORICAL TRAUMA

G –DEFINITIONS

- H – Brave Heart, MYH – *Wakiksusyapi*: Carrying the Historical Trauma of the Lakota
- I – Study of Holocaust survivors finds trauma passed on to children's genes
- J – Examining the Theory of Historical Trauma Among Native Americans

SECTION D – SCIENCE

- K – Wisconsin study showing childhood trauma changes the genome

SECTION E –RESILIENCE

- L – Resilience/Stress Questionnaire
- M – Articles on the use of yoga, meditation and mindfulness to promote resilience
- N – Use of drumming to promote resilience

CHAPTER 2 –USE OF TRADITIONAL HEALING PRACTICES

- A – Waukon, Prosper “Indigenous Leadership”
- B – Bassett, et. al. “‘Our Culture is Medicine’ Perspectives of Native Healers on Post-trauma Recovery Among American Indian and Alaska Native Patients
- C – White, K.G., Diagram of a Traditional Healing Circle with Health Center



CHAPTER 4 – CREATING A COMPREHENSIVE INTEGRATED TRAUMA-INFORMED TRIBAL COMMUNITY

- A – Multiple articles on the Menominee Tribe’s Trauma-informed program
- B – Multiple articles on trauma-informed programs in various non-Indian communities, including Missouri, Tennessee, Wisconsin, Oregon, and “Spotlights on trauma-informed coalitions in six communities around the country
- C – Porter, Laura, “Self Healing Communities”.

CHAPTER 5 – EDUCATION

- A – The Impact of Trauma on School Performance and Behavior
- B – Report on the Success of the Trauma-Informed program at Lincoln High School in Walla Walla Washington
- C – Court Decision in the Law suit by Havasupai Students against the Bureau of Indian Education Arguing that Trauma is a Disability Under the American Disability Act

CHAPTER 6 -- PHYSICAL AND MENTAL HEALTH

- A – Charts showing the impact of trauma on physical and mental health
- B – Bellis, M. et. al. “The Impact of Adverse Childhood Experiences on Health Service Use Across the Life Course”
- C – IHS Announces Pilot Program for Child Trauma-Informed Integrated Care
- D – “Why and How We Screen for ACEs” by Dr. The Center for Youth Wellness;
- E – Udesky, L. “Dozens of Kaiser Permanente Pediatricians in Northern California Screen three-year olds for ACEs”
- F – Garner, A. “Early Childhood Adversity, Toxic Stress and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health”
- G-- “Bench Sheet on Behavioral Health”, Campaign for Trauma-Informed Policy and Practices

CHAPTER 7 -- WORKFORCE DEVELOPMENT

- A – Lio, Y. et al. “Relationship between adverse childhood experiences and unemployment among adults from five US states
- B – Clifford, A. “Wind River Casino’s Wellness Policies and Procedures”
- C – Press, D. A Model Tribal “Overcoming Historical Trauma in the Workplace” Ordinance

Chapter 8 -- Parenting Programs



A – The Johns Hopkins Center for Native American Health, “Family Spirit Home Visiting Program”

B – ACE Awareness Foundation of Memphis, “Universal Parenting Places”

C – New York Times article on family courts

CHAPTER 10 – ADDICTION – OBESITY AND OPIOIDS

A – Dr. Vincent Felitti, “The Origins of Addiction, Evidence from the Adverse Childhood Experience Study”

B – Stevens, J. “Substance Abuse doc says’ Stop chasing the drug! Focus on the ACEs”

C – Felitti et. al – Obesity: Problem or Solution

D – “Trauma -Informed Approaches need to be Part of a Comprehensive Strategy for Addressing the Opioid Epidemic

CHAPTER 11 – LAW ENFORCEMENT AND THE COURTS

A – The Martinsburg Model