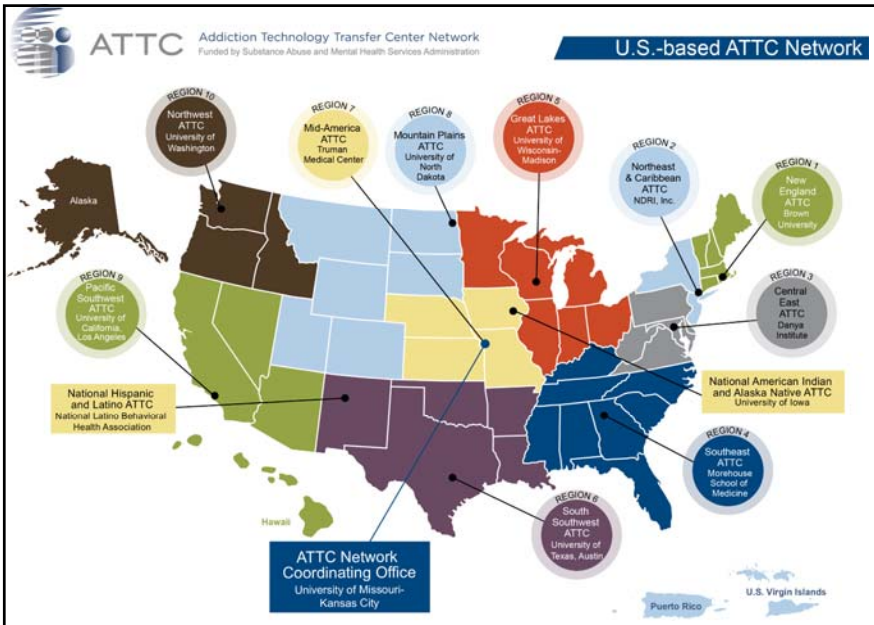
National American Indian & Alaska Native ATTC
Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Essential Substance Abuse Skills Webinar Series

# Group Counseling

Matt Ignacio (Tohono O'odham), PhC, MSSW

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Essential Substance Abuse Skills webinar series

This webinar is provided by the National American Indian & Alaska Native ATTC, a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

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# Webinar follow-up

## CEUs are available upon request for $15 per session.

- This session has been approved for 1.0 CEU's by:
  - NAADAC: The National American Indian & Alaska Native ATTC is a NAADAC (The Association for Addiction Professionals) certified educational provider, and this webinar has been pre-approved for 1.0 CEU.
- To obtain CEUs for this session, submit a CEU Request Form and payment to the Prairielands ATTC. A request form is available for download in the "Files" pod in the webinar screen. If you choose to download a file, a new tab will be opened in your browser, and you will have to click on the webinar window to return to view the webinar.
- Participants are responsible for submitting state specific requests under the guidelines of their individual state.

## Presentation handouts:

- A handout of this slideshow presentation is also available by download.

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# Webinar follow-up

**Evaluation: SAMHSA's GPRA**

This webinar is provided by the National American Indian & Alaska Native MHTTC, a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Participation in our evaluation lets SAMHSA know:

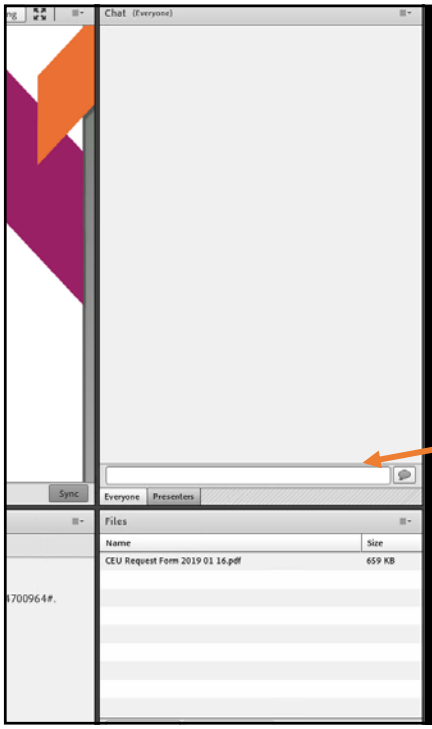
- How many people attended our webinar
- How satisfied you are with our webinar
- How useful our webinars are to you

You will find a link to the GPRA survey in the chat box. If you are not able to complete the GPRA directly following the webinar, we will send an email to you with the survey link. Please take a few minutes to give us your feedback on this webinar. You can skip any questions that you do not want to answer, and your participation in this survey is voluntary. Through the use of a coding system, your responses will be kept confidential and it will not be possible to link your responses to you.

**We appreciate your response and look forward to hearing from you.**




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# Adobe Connect Overview

## Participant overview:

- To alternate between full screen mode, please click on the full screen button on the top right of the presentation pod. (It looks like 4 arrows pointing out)
- To ask questions or share comments, please type them into the chat pod and hit "Enter."

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# Today's Speaker

**Matt Ignacio (Tohono O'odham), PhC, MSSW**
Matt is a doctoral candidate at the School of Social Work, University of Washington. Matt also works for the National American Indian and Alaska Native ATTC as a Research Support Manager. Matt has also worked for the National Native American AIDS Prevention Center (NNAAPC) as Project Manager overseeing HIV education and capacity-building assistance programs and as a national trainer working with tribal communities, tribal health departments, state health departments and community-based organizations. Additionally, Matt also served as lead author for a 2013 Centers for Disease Control and Prevention funded resource titled: Action, Compassion and Healing: Working with Injection Drug Users in Native Communities. The publication aimed to address the harm reduction needs of Native American/Alaska Native and Native Hawaiian injection drug users in rural/reservation and urban communities. Prior to NNAAPC, Matt worked in the Michael Palm Center for AIDS Care and Support at Gay Men's Health Crisis (GMHC). GMHC is the world's first and largest AIDS service organization located in New York City. His responsibilities included providing harm reduction-based alcohol and drug counseling and facilitating psycho-educational groups, as well as develop, implement and evaluate GMHC's first sterile syringe access program. Matt received his Bachelor of Arts in Sociology from the University of California, Santa Barbara in 2000, and in 2008, received his Master of Science in Social Work from Columbia University's School of Social Work.

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# Group Counseling

Essential Substance Abuse Skills

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## Group Counseling Overview:

- Part One: The "How To"
  - Types
  - Membership
  - Implementation
  - Facilitation
- Part Two: Group Work with Native patients
  - Communication Styles
  - Cultural Considerations
  - Engagement
  - Native Retention Strategies

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# Part ONE: The "How To"

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## Types of Groups

- **Psycho-educational:** Purpose is to provide information of specific issues, teach healthy coping skills, and to expand patient awareness of behaviors and consequences and to assist in motivating patient towards change. Frequently used to address substance use and other problematic behaviors. Facilitator takes the role as teacher.
- **Skills Development:** Purpose is to cultivate skills people will need to achieve and maintain abstinence. Operates from a cognitive/behavioral orientation.

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## Types of Groups

- **Cognitive/Behavioral Groups:** Leader focuses on providing a structured environment within which group members can examine the behaviors, thoughts and beliefs that lead to their maladaptive behaviors.
- **Support Groups:** Origins are in the self-help tradition, offer social support (unconditional acceptance, inward reflection) Especially useful for apprehensive patients, offer a safe environment. Help to de-stigmatize the problem or activity.

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## Group Membership

- Fixed and Revolving Membership
- Often referred to as “open” or “closed” groups
  - Open format- New members enter and exit group when ready
  - Closed format- Group begins and ends with same membership

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# Group Membership:

| Open Group: | |
|---|---|
| Pros | Cons |
| Dynamics with new members | Dynamics with new members |
| patients do not have to wait for services | Patient may have to wait due to size of group |

| Closed Group: | |
|---|---|
| Pros | Cons |
| Improved group cohesion | Participant time commitment |
| Learning builds on previous meetings | Patient has to wait to enter |

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# Group Membership:

**Before placing a patient in a particular group, the provider considers:**

- The patient's readiness
- Patient characteristics, needs, preferences
- patients may need to move to different groups as they progress through treatment, encounter setbacks, and become more or less committed to addressing problematic behavior

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# Group Membership:

## Voluntary – Involuntary

Involuntary:

- Coercion into group involvement may result in initial resistance, however may experience better outcomes overall.
- Legal obligations, family pressure, or any external motivating factor can lead to patients resisting the desire to discontinue before reaching goals.
- Self-motivation to change can inspire other group members and positively impact the group culture and norms.

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# Group Membership:

## Voluntary – Involuntary

Voluntary:

- Voluntary group members often assist in providing motivation for pre-contemplators or contemplators
- Can serve as effective mentors to other group members
- Self-motivation to change can inspire other group members and positively impact the group culture and norms.

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# Group Membership:

**Often:**

- Patients often indicate primary mode of help is through mutual support.
- In other words, it is not the facilitator that is most important, but the mutual support (people like them).
- We can relate – you want to see your classmates. Coffee groups, book clubs, weight loss – the content helps, as well as seeing peers.

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# Group Membership:

**Those members who self-reported improvement were significantly more likely to have:**

- Felt accepted by the other members:
  - Made specific references to particular individuals when queried about their experience.
- Perceived similarity of some kind among group members:
  - Some people feel more committed to particular individuals.

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# Group Membership:

## Self Help vs. Mutual Help

- **Self Help:** Implies the individual in treatment is the main contributor to the change process.
- **Mutual help:** Means the individual also assume partial responsibility for the recovery of their peers.

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# Implementation of Groups

**As facilitators, we are responsible for:**

- Establishing parameters for the group, providing general behavioral expectations while clarifying the purpose of the group.
- Instead of using the term: “Group Guidelines or Rules or Agreements,” try using, “Group Values.”
- Rules or Values, goals, confidentiality, and actions if one breaks those should be discussed at the beginning.
- Incorporate patient suggestions into group values.
- Ethics still apply if members express intent to harm themselves or others and mandatory reporting laws.

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# Implementation of Groups

- Try not to make group values too complicated or too restrictive.
- Focus on member safety, honesty, integrity and respect for self and others. Also focus on punctuality (begin on time, end on time).
- Values clarification: ask – what do I mean by establish some parameters for the group? Why do we want this for our group?
- Be open to amending/adding/adjusting.
- Review at each meeting if necessary.

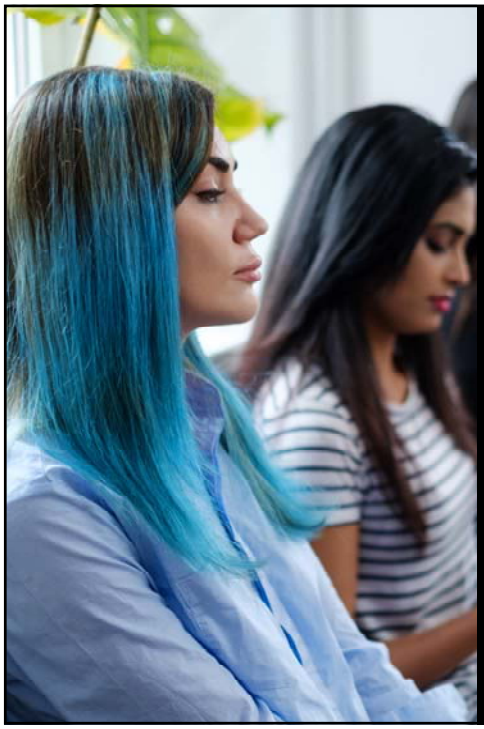
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# Implementation of Groups

**Examples of Group Values:**

- Respecting confidentiality
- Non-judgmental acceptance of others
- Willingness to self-disclose
- Participation by all group members
- Valuing the importance of the group
- Recognizing the available support in the group
- Respecting others
- Willingness to accept feedback
- Allowing others to speak without interruptions.

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# Implementation of Groups

- By providing an initial overview both individually and in the group:
  - Clients will then come to the group with appropriate expectations.
- Clinicians and clients can expect a greater degree of success.

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# Stages of Group Development Leadership Roles

| Group Stage | What the Group is Doing | Leadership Tasks | Likely Group Member Behavior |
|---|---|---|---|
| Forming | Getting to know each other and understanding the group task. | Introductory exercises, get to know group members and give group enough freedom to allow initiative, yet enough guidance to feel safe. | Dependent upon leader, uncertain what to do, searching for a 'strong' leader. |
| Storming | Getting edgy about achieving task, wondering if the group has the skills necessary | Give a sense of security, review and evaluate group performance so far. | Rebellion, testing leader's skills and authority, sense of apathy or hopelessness. |
| Norming | Allocating and settling into group roles, developing a procedure for achieving the group task. | Trust between group members is growing, and stronger relationships are developing between group members. Clarify boundaries and group values assist group members to move into roles and take more responsibility. | A sense of enthusiasm, members are beginning to take more responsibility for leadership of the group. |

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# Stages of Group Development Leadership Roles

| Group Stage | What the Group is Doing | Leadership Tasks | Likely Group Member Behavior |
|---|---|---|---|
| Performing | The group is involved in activity to achieve the task. | Encouragement, keeping the balance between group maintenance and task needs. | A sense of getting the job done, problems are easily overcome within the group. Little need for the leader's intervention. |
| Adjourning | Saying goodbye and evaluating the task. "Did we achieve what we set out to achieve?" | Helping the group members to say goodbye and face their next challenge. Making plans for the future. | Reminiscing, planning reunions. Group members often deny the end and make plans to keep in touch. There may be some regression to former problems or patterns of behaviour. |

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# Implementation of Groups

- In **creating** the group, remember that (in most cases) you are the single common element among all the group members.

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## Implementation of Groups

- In **shaping** the group, your experience and behavior, as well as the expectations of group members, will guide the formation of norms.

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## Implementation of Groups

- In **maintaining** the group, you function as a mediator, handling issues that might arise which threaten group cohesion.
- Your job is to help the group function properly, by showing confidence in your abilities, remaining calm & objective, and by providing a safe environment.

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# Typical Open-Continue Care group agenda (example)

Men's Continuing Care Group
5/23/19

1. Immediate Concerns (15 min)
2. Relation Exercise (guided meditation) (10 min)
3. Review Group Rules/ Expectations (10 min)
4. Welcome new patients/ note any scheduled graduations, absences, or planned/random UAs (10 min)
5. Check-ins (30min)
   - Name
   - Sobriety date
   - Events that brought you to Tx
   - Something your working on this week related to your recovery.

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# Typical Open-Continue Care group agenda (example/ cont.)

6. Topic: How do I better handle high-risk using environments in my recovery today? (60min)
   - Discussion of strategies and experiences
   - Worksheet or applied skills group exercise
   - Share worksheets or work group results, roleplay, or practice
7. Closing/ Graduations (if applicable) (20min)
8. Group note (5 min)
9. End

- Time: 90 minutes

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# Facilitation:

**Common tasks of group facilitator:**

- Maintain a safe environment
- Serve as group historian (summarize)
- Help patients remain in the “here and now” by redirecting or bringing them back to the purpose of the group
- Help patients discover answers for themselves, not to “solve problems”
- It’s okay to have fun. Have a sense of humor, but use professional judgment
- Redirecting “war stories” of the past or what was lost, or the overwhelming task of looking at the future years from now.
- If you can get group members to “I” statements, you are doing well.

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# Facilitation:

Facilitator – Co-Facilitator

Facilitator:

- Is prepared
- Responsible for all consent forms, sign-in sheets, other data
- Greet and welcome each participant
- Guide discussion
- Manage participation
- Thank participants
- Help clean up
- Complete debrief process

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# Facilitation:

Factilitator – Co-Facilitator

Co-Facilitator:

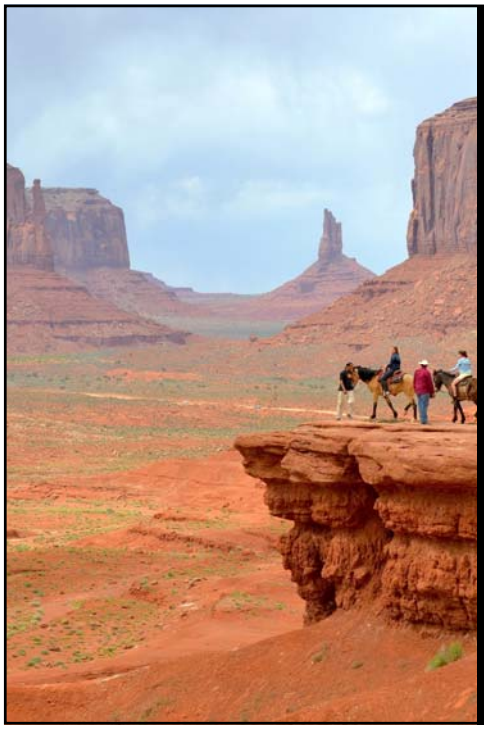
- Facilitators avoid sitting side-by-side
- One can be in charge of non-verbal cues of members
- Can handle sign-in, room temperature, visitors at door, etc…
- Monitor time
- Help clean up
- Complete debrief process

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# Part TWO: Group Work with Native people

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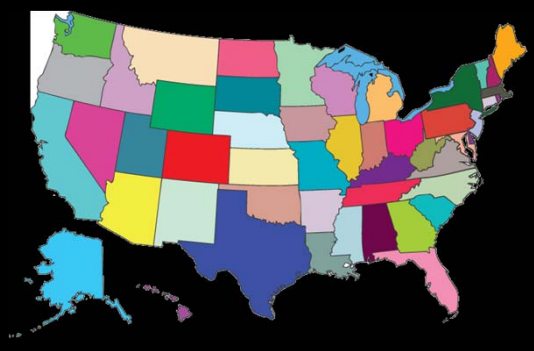
## Native People:

- Native American/American Indian
- Alaska Native
- Native Hawaiian
- First Nations
- Other Indigenous

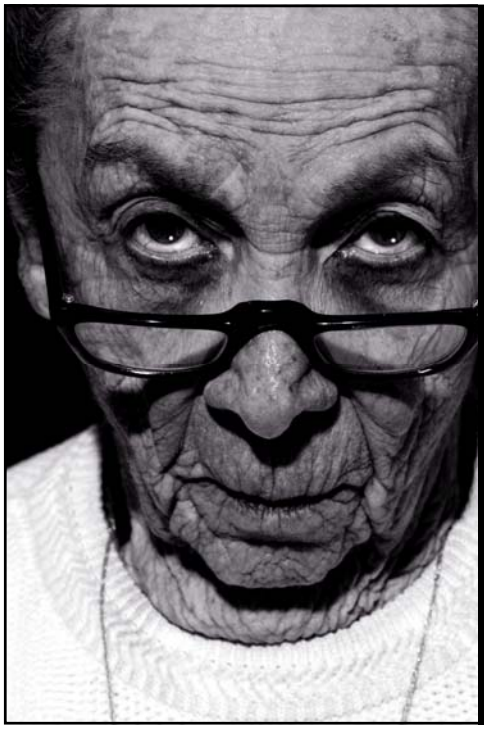
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## Native people:

- American Indian/Native American
  - 573 federally recognized tribes in the lower 48 states
- Alaskan Native/Native Hawaiian
  - 231 tribal communities in Alaska and within the Hawaiian Islands



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## Native Communication Styles:

…Can be very different in Indian Country

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## Native Communication Styles:

- Communication styles for Native clients cannot be generalized. However, it is an important concept to discuss when working to improve providers' ability to work with Native people.
- Native people are sometimes taught that listening rather than speaking immediately is important.

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## Native Communication Styles:

- Personal information about oneself and one's family is not easily shared.
- Silence or minimal sharing should not be interpreted as disinterest or an indication that nothing is wrong.

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## Native Communication Styles:

- Where English is the patient's second language, the speech may be thoughtful and slower.
- Some Native people, especially elders, may believe that talking about a topic wills it to come true.

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# Cultural Considerations:

- The clinical experience: (bio, psycho, social and spiritual) builds upon and fosters positive therapeutic relationships.
  - Builds trust (critical);
  - Increases the likelihood of treatment plan adherence;
  - Reduces patient attrition (keeps them coming back).

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# Cultural Considerations:

- And…
  - Re-affirms patients as experts in their own health/mental/behavioral/spiritual experiences;
  - In doing so, we help patients make positive changes in their lives (increases motivation).

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## Cultural Considerations:

- How does this fit within Native worldviews?
- Most often, working effectively with Native people requires a shift in the delivery of our services.
- How do we work from a culturally relevant perspective?

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## Cultural Considerations:

**Importance of spirituality:**

- Often part of cultural teachings:
  - Both learned and engrained in the community , ex. death, births, puberty ceremonies
- Spirituality is part of a holistic approach to wellness. Example:
  - Appreciation and respect for nature, environment and surroundings
  - Appreciation and respect for our health, bodies, mind and our connection to the past.

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# Cultural Considerations:

**In my experience, "taboo" subjects can include:**

- HIV – as opposed to Diabetes
- Sexual behaviors, particularly LGBTQ community
- Drug use
- General Issues of modesty & privacy
  - Cross-gender communication
  - Modesty is not about shyness, but about respect
- Others

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# Cultural Considerations:

**Native-Specific Cultural Risk Factors:**

- Lack of confidentiality (trust)
- Lack of social services (rural/reservation)
- Limited access to comprehensive health care
- Circular migration (rural/urban)
- Unresolved trauma(s): historical or otherwise
  - (ex. Urban relocation programs, boarding schools, history of abuse – sexual or otherwise)
- Racism – Homophobia - Xenophobia

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## Cultural Considerations:

- You have the opportunity to provide culturally respectful, meaningful mental health services.
- There is a pervasive and on-going need for Native-centric or culturally-sensitive mental health services (research and anecdotally mentioned).
- You have the ability to know and understand trends and needs – a key role!

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## Engagement:

**Confidentiality:**

- For some Native patients, is an absolute barrier to care, linkage to care, retention in care and aftercare.
- Native people may have a personal (family) experience with breaches of confidentiality.
- It is critical we maintain the highest level of confidentiality if we are serious about improving the quality of life for all people.

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## Engagement:

**Using 'culture' to help engagement process:**

- Introductions
- Reaffirming them as experts in their own experience
- Spirituality: opening and closing prayer (someone in the group from local community – elder in the group – you may have to lead it yourself)

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## Engagement:

- 10-second rule – esp. for elders
- Referral list: local Native organizations
- Show up for other Native events in community
- A two-way street
- Snacks/water
- Incentives

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## Engagement:

**Incentives (transportation, food, gift cards):**

- Literature speaks to the patient/provider relationship regarding incentives: Is the patient seeking services only for incentives or is the patient personally motivated?
- As long as the patient is returning for services - you have a golden opportunity to engage and build TRUST!

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## Native Retention Strategies:

**Building Relationships with Community Leaders:**

- Consistency is vital when building these relationships
- Be prepared to inform them of your program, intent, and progress.
- Give ample time to process information and to ask questions.

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# Native Retention Strategies:

**Getting Local Organization Support:**

- Outreach face-to-face
- No phone calls, emails or faxes
- If it is a new organization, start at the top.
- It may take multiple attempts

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# Native Retention Strategies:

- Integrating cultural activities such as dancing, beadwork, shawl making circles, and cooking traditional foods.
- Can be great ways to build a therapeutic relationship, trust, connection and knowledge
- Taking the professional out of the professional and creating more of the personal.

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## Native Retention Strategies:

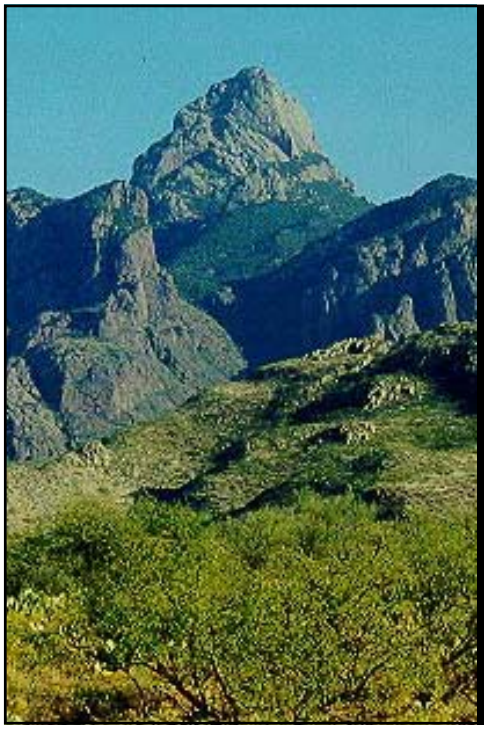
- Lastly, reminding patients of Native-specific cultural strengths builds motivation, courage and healing.
- Native patients do not hear this information very often
- However, I believe Native people know these strengths because they are demonstrated in stories, among our elders and through ceremonies.
- Sometimes if just needs to be pointed, reminded of and built upon.

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## Native Retention Strategies:

- Survivors
- Ancestors
- Resilient
- Adaptable
- Community -minded
- Spirituality
- Connection to the past
- Family, Elders and Youth
- Holistic Thinking
- Cultural Pride
- Language
- Food
- Land
- Ceremony

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# Thank You!

**Questions/Comments?**

matt717@uw.edu

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