



# NEWSLETTER

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## DIRECTOR'S CORNER

Welcome to the third issue of our newsletter. You may recall that the second issue was dedicated to evidence-based, experience-based, culturally-informed interventions in American Indian and Alaska Native behavioral health communities. I am very pleased by the discussion and the thoughts shared with our staff and colleagues about the topics raised, and sincerely hope that this issue prompts a similar reaction.

The field has seen many efforts at developing culturally-informed strategies (Walker & Bigelow, 2014) in assessment and treatment of behavioral disorders in Indian country. I hope the tribal programs continue to work on making evidence-based practices their own, as well as incorporating all the indigenous knowledge acquired through centuries into their practices. Drs. Walker and Bigelow (2014) share with us many ways of developing a model for conceptualizing culturally-informed practices in behavioral health while, at the same time, they clearly show respect for the vast amount of indigenous knowledge and experience that are now included in evidence-based practices.

*This issue is focused on Recovery-Oriented Systems of Care (ROSC), and the diverse ways this model can be adapted culturally. This issue includes an interview with Director Eva Petoskey, of the Anishnaabek Healing Circle Access to Recovery initiative, whose group has succeeded in completing this process. It takes a village to support an individual, a family, and to develop healthy communities, reducing substance abuse problems, and looking at*



recovery from a healthy, holistic, and wellness perspective. The Gathering of Nations (GONA) is a program developed many years ago specifically for American Indian and Alaska Native communities. Jami Bartgis, PhD, writes about the GONA program and its accomplishments since 1996 when it was started.

Through our travels in Indian Country, we have continued to be impressed with the accomplishments of adolescents and young adults who have reached sustained recovery from drug and alcohol abuse, and are convinced of the importance of celebrating their recovery stories. As a part of Recovery Month in September, we have begun a presence on Twitter, and will begin a digital story-telling program for adolescents and young adults on their road to a healthier life. Please follow us on Twitter: @NativeATTC, and find information for our digital story program on our web page.

**Program Developments.** The Center has completed an extensive cultural adaptation of the old ATTC Leadership Institute to American Indian and Alaska Native leadership needs. Our new Leadership Academy kicked off with the Immersion Training in the Meskwaki Casino and Hotel in August 2014, facilitated by Brent Lierman, PhD, member of the Cherokee Nation, and attended by American Indian and Alaska Native mentors and mentees. Our Enhancement Session will be held in Florida in January, and the Graduation Ceremony in Spring 2015 in Portland, Oregon.

**Training of Trainers (TOT).** We have initiated several TOT programs, with the goal

of being able to offer the programs locally with support from the home office. We are very pleased that many of our behavioral health professionals in Indian Country are interested in working with us and being trainers.

**Consensus building and using principles of community-based participatory programming (CBPR).** Our Center believes in including experienced American Indian and Alaska Native professionals and Elders in developing or revising our programs. For each of our projects, we work with a committee of advisors both before and after implementation. All our documents are living documents; we appreciate all the support and input we get from our colleagues in tribal communities across the country.

**Red Road Gathering.** Every September during Recovery Month, we celebrate the accomplishments of an American Indian behavioral health professional in substance abuse research, education and human rights. This Recovery Month is no exception. By means of the Dr. Mackey award, we are trying to make a change in the tendency of underacknowledging these achievements. Stay tuned to the announcement of the recipient of the Mackey Award later this month.

Finally, I hope you enjoy reading this newsletter, and that you share your thoughts with us. The next issue will cover Adolescents in Recovery, and successful adolescent programs.

Regards,  
Anne Helene Skinstad

*Walker, R.D., & Bigelow, D.A. (in press). Evidence-Informed, Culture-Based Interventions and Best Practices in American Indian and Alaska Native Communities. In P.E. Nathan & J.M. Gorman (Eds.), A Guide to Treatments That Work. New York: Oxford University Press.*



# RECOVERY-ORIENTED SYSTEMS OF CARE (ROSC) AND HOW THEY SUPPORT RECOVERY FROM A SUBSTANCE USE DISORDER

By Ken Winters, PhD, and Kate Winters, MA

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## Defining Recovery

What is the definition of the concept of recovery? Answering this basic question has been a topic of numerous publications in recent years, and has been the subject of two “think-tank” summits - SAMHSA’s CSAT National Summit on Recovery in 1995 (Sheedy & Whitter, 2009) and Betty Ford Foundation’s Summit on Recovery in 2007 (Betty Ford Institute Consensus Panel, 2007). We offer this illustrative definition from the CSAT Summit:

*Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.*

## WHAT IS ROSC?

Successful recovery from a substance-based addiction requires the support provided by a service system that is responsive to the needs of the individual and the family impacted by addiction. This form of service system is known as Recovery-Oriented Systems of Care (ROSC). ROSC supports an individual’s intentional journey toward recovery and wellness across the lifespan by creating and sustaining networks of formal and informal services and relationships that incorporate and support the language, culture, and spirit of recovery. An effective ROSC connects a person to services that are consistent with the individual’s culture, values and strengths, and provides choices among an array of treatment and recovery support options. To meet the personalized and dynamic needs of the recovering person, these options should evolve over time.

Effective treatment within a ROSC requires a clear formulation and identification of strategies that distinguish transient and mild-moderate forms of a drug problem from a drug problem that is severe, chronic, and complex. Also, treatment consistent with ROSC is personalized (clients have input into their own care, client goals address short-term needs as well as long term recovery management, and family members and significant others are actively involved in the treatment process).

## Community Involvement

At the center of ROSC is the individual who seeks help in becoming sober and healthy, physically, emotionally, socially and spiritually. A true recovery system recognizes the crucial importance of a supportive community, complete with professional groups working together to better the lives of identified clients. This includes educating community members as to the impact that a chronic disorder, such as addiction, has on entire communities and individuals. As such, this component is assigned high priority in ROSC. Communities facilitate the recovery of individuals by reaching out

to them, which includes supporting involvement in self-help groups, spiritual communities, and sober and drug-free communities.

There are many examples of successful efforts by tribal communities to incorporate the ROSC approach within a culturally-informed context. These efforts provide a formula for other communities to follow: the ROSC model provides the base approach but elements are adapted to meet the cultural and social needs of the community. In a subsequent section, we highlight examples of ROSC in tribal communities.

# CORE PRINCIPLES OF ROSC

The core components of effective recovery and how the ROSC model can support recovery are discussed in several publications (e.g., Babor et al., 2008; Gagne et al., 2007; McLellan et al., 2000; Minkoff and Cline, 2004; O'Connell et al., 2005; Sheedy, & Whitter, 2009). The ingredients of evidence-informed ROSC consist of core features that optimize an individual's success for recovery. These elements provide the programmatic characteristics that promote recovery principles. Based on our review of this literature, we describe nine primary principles of ROSC.

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**1. Multiple recovery pathways.** There are numerous pathways to recovery; no two people will have identical paths or use the same benchmarks to measure their journeys. In this light, recovery is a developmental and continuous process, during which the person continuously grows and improves their functioning, and benefits from lessons learned throughout the process.

But for all, recovery involves both a personal recognition that changes in one's lifestyle are needed, and a commitment that the person be an active agent of change in one's life and not a passive recipient of services. As a personal and individualized process of growth, recovery unfolds along multiple pathways. These highly personal pathways to recovery generally involve a redefinition of identity in the face of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions, and involve informal community resources, which provide support for sobriety. For some, recovery involves episodes of psychosocial and/or pharmacological treatment and may include involvement with mutual aid groups.

There is also the recognition that recovery may involve relapse and

other setbacks, which are a natural but not inevitable part of the recovery pathway. The literature consistently demonstrates that for many people, substance use problems and disorders are chronic conditions involving cycles of relapse and treatment readmissions over multiple years (McLellan et al., 2000).

**2. Integrated health focus.** ROSCs are networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat addiction. Services are community based and structured to address the long-term and complex needs of people living with addiction and co-existing mental health issues. There are linkages and connections between these formal and informal systems and, depending on the community resources available, these sectors should be integrated with both intensive specialized treatment to address acute care needs and extended continuing care to meet the long-term recovery management needs of the individual.

**3. Pro-recovery values.** The values of the ROSC model are based on the recognition that each person is the agent of his or her own recovery and all services are person-centered; that is, they are organized to support his or her recovery. Person-centered services offer choice, honor each person's potential for growth, focus on a person's assets and strengths, and attend to the overall health and well-being of the client. Thus, the person in recovery is the "agent of recovery" and has the responsibility and option to exercise choices and make decisions based on his or her recovery goals. Often, collaboration with friends, family, and significant others is part of this active process. This approach is in contrast to the passivity of being a patient or a voiceless recipient of services. Because the notion that an individual takes personal responsibility for his or her own recovery may be unfamiliar territory for some clients, it is incumbent on the treatment staff to shape these behaviors in the client. Clients must accept that a problem exists and be willing to take steps to address it.





A core essence of successful recovery is the personal belief that a person is not fated to repeat prior mistakes, and that things can and will change for the good. Greater hope and increased goal-oriented thinking have been shown to be positively correlated to length of time abstinent, quality of life, and self-efficacy (Irving et al., 1998). One way that a person's hope for a positive recovery can be instilled is by listening to peers share experiences about how they dealt successfully with drug-related problems. Including the voices and experiences of recovering individuals and their families promotes accurate and positive portrayals of drug addiction and works to fight stigma and discrimination associated with misconceptions about this disorder.

**4. Strengths perspective.** The strengths perspective emphasizes building on the client's assets, desires, abilities, and resources to assist in the recovery process. This perspective assumes that each individual has the capacity to draw from a variety of resources, skills, and motivations to focus on their strengths and create change in their lives. This focus includes helping the individual develop meaningful social and recreational activities, and supports the view that health and well-being can be promoted by taking thoughtful risks.

**5. Emphasis on chronic care strategies.** Consistent with the ROSC model, service strategies are organized to provide a shift from acute care methods to the broader adoption of chronic care strategies. The aim is for services to include primary treatment, post-treatment monitoring, early re-intervention, family programming, legal and financial services, and peer and community supports. Thus, specialized services for addiction are embedded within the more traditional medical, psychological, and social services of addiction treatment.

**6. Recovery is supported by informal sources.** People in recovery from addiction regularly note the important role of the support from informal sources, such as peers, family members and other significant others, churches and religious organizations, and programs at the workplace. These sources form vital support networks and services for people in recovery in several ways:

Providing specific medical, psychological or other services needed by the person; creating mutual aid (or "self-help") groups have been shown to play a significant role in the process of recovery; promoting the role of family members in recovery; and providing involvement in advocacy activities (e.g., shaping government and regulatory policies that support major components of ROSC).

**7. Cultural relevance.** A person's recovery needs to occur with the acknowledgement and integration of one's culture. Cross cultural studies have demonstrated the importance of delivering culturally competent care; when treatment and related services are delivered with cultural relevance, remission rates for minority populations are improved (e.g., Peterson et al., 2002). It may be that recovery rates of AI & AN clients are relatively low because services too often do not have cultural competence within the program structure and the training and experience of its counselors. Because traditional models and applications of drug counseling are based in Western cultures, it is vital that treatment systems have knowledge and skills that are suitable to the client's culture. A counselor can successfully work with a client who does not share the counselor's racial or ethnic heritage, but it is incumbent on the counselor to become culturally competent.

The U.S. Department of Health and Human Services, Office of Minority Health, provides standards for Culturally and Linguistically Appropriate Services (CLAS). The standards are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations. We provide a summary of these 15 standards. *See figure 1.1 on page 5.*

The advancement of culturally competent services for AI & AN individuals suffering from a drug addiction is a central focus of this ATTC. See our prior newsletter on evidence-based practices and programs for AI & AN populations and visit our website: [attcnetwork.org/americanindian](http://attcnetwork.org/americanindian).

**8. Research based.** The system is research-based and has ongoing education, training and monitoring. At a systems level, ongoing monitoring data are used to inform effectiveness of the treatment program and to identify areas that need adjustment. At the client level, the treatment and continuing care plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. Given the importance of comprehensive services for the promotion of recovery, the client's treatment plan should be regularly reviewed and adjusted as necessary in order to optimize the individual's access to comprehensive services.

ROSC is both evidence- and experience-based. A large body of experience supporting ROSC is the evidence from the nearly 80-year-long history of Alcoholics Anonymous (AA), which was founded in Akron, Ohio by Bill W. and Dr. Bob. A prominent example of the research base for ROSC are studies showing the effectiveness of the Community Reinforcement Approach (CRA), a strategy that has its roots in the pioneering work of Azrin and colleagues (Azrin et al., 1982) and further researched by Higgins and colleagues (e.g., Higgins et al., 2002). For a useful summary of research supporting ROSC, see the "guiding principles" report (Sheedy & Whitter, 2009); Chapter 7 focuses on elements of ROSC and Chapter 8 on ROSC implementation.



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Figure 1.1: Summary of standards for Culturally and Linguistically Appropriate Services (CLAS), from the US Department of Health and Human Services, Office of Minority Health

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that is responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
9. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

**9. Adequate and flexible financing.** An effective and sustainable ROSC system needs to be adequately financed so that clients can access the full continuum of services, ranging from acute to continuing care support. Funding should be sufficiently flexible to permit personalization of services to allow a customized array of services that can evolve over time in support of an individual's recovery. Here, Access To Recovery (ATR) grants provided from SAMHSA have been a critical component of successful adoptions of the ROSC model in Indian country since 2004.

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# RECOVERING TOGETHER: YOUTH AND FAMILIES DRIVE LOCAL SYSTEM OF CARE IN PARTNERSHIP WITH URBAN INDIAN HEALTH PROGRAM IN FRESNO

By: Jami Bartgis, PhD

In 2011, the Fresno American Indian Health Project (FAIHP) was awarded a three-year planning grant called Circles of Care. The Fresno Family Wellness Project, funded by the Substance Abuse and Mental Health Services Administration, supported the FAIHP and the local community in a three-year journey to develop a system of care model that would address the needs of local Native youth and families. Today, three years later, the Fresno Native community and surrounding tribes are bringing back a very old approach to prevention, intervention, and recovery support. Some will call what they are doing innovative, but the local community knows that this is old medicine applied to the world of today.

With a curriculum called the Gathering of Native Americans (GONA) and a community-based and participatory evaluation model, the FAIHP is partnering with a community evaluator and systems consultant to engage a local Community Advisory Board and Youth Council to guide the project. Through these efforts, the Fresno Family Wellness Project is moving the community to growth and healing through education, evaluation, and capacity development. The project has generated local community data by means of a needs assessment (published in 2013). It is also building community capacity for evaluation, is tracking youth and community-driven outcomes, and is growing a workforce of local Native mental

health providers using strength-based approaches to promote positive health and wellbeing in heart, mind, body and spirit. While many fully developed System of Care communities strive to be youth and family driven, culturally-competent, holistic and strength-based, the Fresno Native community and surrounding tribal partners are doing it naturally through a long history of health and healing knowledge that is again being passed down from generation to generation.

**This year marked the 3rd Annual Fresno Area GONA.** It was attended by 70 youth and over 30 staff and caring adults, including many of those serving on the Youth Council and Community Advisory Board. During this four-day camping event, youth are surrounded by the elements of quality air, water, earth, and fire in the Sierra Nevada Mountains and tribal elders and teachers ground youth in the local stories, customs, practices, and beliefs. Much of the local community planning is grounded in new knowledge generated by the community needs assessment, and annual GONA evaluations. This data helps the community understand the challenges Native youth and families face in the Fresno area and how to address those challenges within the GONA and through local services in the community. Based on last year's evaluation, the team worked to bring in the elements of fire and water. This year, a sweat lodge was built with help from local community members and two youth participants; four nights of sweats occurred throughout the four-day event. Youth and adults enjoyed an afternoon swim in natural water holes, water falls, lakes and streams; giving thanks and leaving offerings after they had finished. The community is using local knowledge, old and new, to support community healing from historical and intergenerational traumas and to develop individual and community commitments to restore balance back in the communities.

The GONA curriculum uses four worldview concepts that are consistent among indigenous communities. Local elders, spiritual leaders, community helpers, and trained GONA facilitators focus on instilling in youth *a sense of belonging, mastery, interdependence, and generosity*. The community had been planning and training for a year for this event. Months before, local community members took youth to gather medicine in special places to be available on the spirit table for the participants. The community members took the time to teach youth how to do this in the right way, respecting the plants and lands they come from. Trainings occurring throughout the year in preparation included mental health first aid, trauma-informed approaches, indigenous-based wraparound training, care coordination, and gatekeeper training for suicide prevention and referral. Trainings also included GONA facilitation from master GONA trainers so community members could begin growing and sustaining their own GONA.

On Day 3, as youth emerge from the water in the late morning a local elder calls them over for a circle. Youth come with giggles and anticipation but the elder calls their attention to the trees and they listen to the wind blowing through the leaves and become silent. The elder begins to teach them about all their relations and about giving thanks and offerings to the water that they just enjoyed. He is teaching about interdependence and begins to make the link to generosity.

*"If you take,  
and take, and take,  
everything in life will be  
taken from you. If you give,  
and give, and give, everything  
in life will be given to you."*

*- Pascal Casey, San Carlos  
Apache, Elder*





Afterward, a few youth commented on the power they felt in that circle and the meaning in all the elder's words. Later that day, a youth who had been trained in GONA facilitation supported a mini-teaching on the medicine wheel as a tool for balance of physical, mental, emotional, and spiritual health, reinforcing the concepts presented by the elder. At last year's GONA, the Youth Council had adapted and piloted a Medicine Wheel-based self-assessment tool, called the Personal Balance Tool, to see how useful it could be as a holistic and strength-based assessment for Native youth. This year, the Youth Council made new improvements, including using color-coded forms and crayons and improving upon the questions. They then piloted the tool a second time in hopes of publishing the first youth-authored peer-reviewed journal article presenting a youth-developed assessment tool as a gift for other Native youth programs. The youth have already shared the tool with other communities, and San Diego County just approved the tool for use in the San Diego American Indian Health Center Prevention and Early Intervention Program serving San Diego

Native youth. The participating Fresno Youth Council understand that their work and efforts have the potential to make them a leader in the health field for youth-driven, culturally-competent, holistic, and strength-based assessment. However, this is secondary to their efforts to use local knowledge and skills to heal themselves, families, and communities. While the Fresno Family Wellness Project Circles of Care is coming to an end, a new road is ahead as youth and families and their local health project prepare to implement the System of Care and, in the spirit of generosity, continue to give gifts and blessings along the way.

*For more information, contact:* Jennifer Ruiz, Executive Director, Fresno American Indian Health Project at [jruiz@faihp.org](mailto:jruiz@faihp.org).

*Acknowledgements:* FAIHP would like to give special thanks to the GONA planning committee, community advisory board, youth advisory board, and the tribes of the San Joaquin Valley who supported the GONA and system of care planning effort with their time, their prayers, and their resources.



## SHARE YOUR STORY

We are looking for stories of American Indian & Alaska Native adolescents in recovery to be a part of **NATIONAL RECOVERY MONTH**, September 2014!

Find out more, or send us your story! Contact Kate Thrams:

Email: [kate-thrams@uiowa.edu](mailto:kate-thrams@uiowa.edu)

Website: [attcnetwork.org/americanindian](http://attcnetwork.org/americanindian)

Twitter: [@NativeATTC](https://twitter.com/NativeATTC)



Photo: iStock

# *In the Time of the Seventh Fire*

## A CONVERSATION WITH EVA PETOSKEY

DIRECTOR, ANISHINAABEK  
HEALING CIRCLE ACCESS TO  
RECOVERY INITIATIVE

[www.atrhealingcircle.com](http://www.atrhealingcircle.com)

By Ken Winters, PhD, and Kate Winters, MA

**Ken Winters:** Hello Eva, and thank you for agreeing to be interviewed for the National American Indian and Alaska Native Addiction Technology Transfer Center newsletter. I thought we'd start out by asking you to provide some information about yourself, and how your earlier life experiences may have influenced your work developing the Anishinaabek Healing Circle (ATR) Program in Michigan.

**Eva Petoskey:** I am Anishinaabe; my Anishinaabe name is Ozhaawashko Giizhigookwe, or Blue Sky Woman, and I am Migizi Dodem or Eagle Clan. I am also an enrolled member of the Grand Traverse Band of Ottawa and Chippewa Indians (GTB) and I am married to John Petoskey who is also a GTB tribal citizen. We are the parents of two children, a daughter and son. They're grown and off in college, our daughter is in law school and our son is an undergraduate. We raised our children in our traditional tribal homeland in Peshawbestown, Michigan where we have lived for the past 26 years.

I was born in 1952, so I grew up in a generation where there was still a great deal of oppression of indigenous rights and culture. However, viewing this through the eyes of resilience and strength, I can say that the circumstances I was born into provided me, and a generation of other Native people, with the many opportunities to work for change. Over the course of my lifetime, I have seen great accomplishments. As a result of prayer and advocacy, I've seen the liberation of indigenous voices. There's still a lot of work to be done, but comparing today to the world I was born into, we have more freedom to live in our homeland and express our indigenous beliefs. I think we are living in a sacred time, as we say in the Anishinaabe prophecies; we are living in the Seventh Fire. The Seventh Fire is a time of great spiritual awakening within our people, leading to the Eighth Fire. The Eighth Fire is a time in which the indigenous people will have a message for the whole world about living in a balanced way with the rest of our relatives, including the Earth, the plants, and the animals. I think we are entering the Eighth Fire. I have been blessed to live in this time of

the Seventh Fire, and I have been happy to be part of the spiritual and cultural awakening in our communities; the rising up of our people from what was for many of us a multigenerational legacy of trauma and addiction.

Speaking about my own family, we have a couple of generations of severe alcoholism in some members of the family. But like many other families, we also had remarkable role models for spiritual resilience. My mother, who was born in 1915, and my maternal grandmother, who was born in 1876, were both very strong indigenous women. There are always resilient individuals; people with gentle, quiet and powerful strength who hold things together over time in the face of the enormous challenges. Within my own family, for instance, both my mother and my grandmother attended boarding school. I did not, but my mother went to the Mount Pleasant Indian School in Mount Pleasant, MI, and my grandmother attended Carlisle Indian School in Carlisle, PA. The experience of boarding school, for many people, placed them or their relatives in harm's way, unfortunately these experiences often led to a vulnerability that arises from a center pain and fear, leaving a deep lasting impression.

There are many other forms of trauma and disruption that took place within our families over generations, and I think all Native people carry those wounds. It's important for us, as we approach our work in recovery and healing, to open and heal those wounds and to look back reflectively and learn about our common past. Understanding intergenerational trauma is a foundational aspect of healing in indigenous communities all over the world. It is equally important to recognize and honor the spiritual legacy, and the legacy of resistance, that have carried us over time. It is important to acknowledge the ancestors and community members that have walked a path of resistance and spirituality before us. They are more powerful than the trauma. Sometimes when we see tragedy in our communities we feel so much sadness, and it's hard to always see the great legacy



of spiritual strength that has kept us alive – if it weren't for that powerful legacy we wouldn't be here. Sometimes I just marvel at the fact that there's an indigenous person walking in North America, or anyplace on the planet, given all of the efforts, whether intentional or unintentional, to displace us and diminish our lives for the benefit of others.

I share a common experience with other Native people, the joy and pain of a generation. I experienced the intergenerational trauma of separation, oppression, racism. I had the benefit, though, of living in a household where my mother was very resilient and in recovery herself. I was fortunate that she put her sacred work as a mother first and protected me and my siblings. I have a lot of experience in my life listening to stories, and the breadth of trauma that many of our people have experienced is difficult to heal. That's part of our shared experience. I'm in recovery myself from drug addiction as a young person. I had a very close brush with death as a young woman. Even after that, it took me a few years before I got on a good road.

I have been in recovery and free from all alcohol and other drugs for over 36 years now. I have dedicated my life to supporting healing and recovery. Over time, I have come to understand my own personal history on an emotional, intellectual, and social level and I see how I am connected to others. I have also connected with my spirit on a deep level. When I find myself in despair, I have an inner place of resilience given to me by the Creator; this inner place allows me to see a large view, to see a vision of healing and to have a beautiful clear view of what has happened in my lifetime. In this resilient place I am able to see all of our people standing up and speaking their truth. This inner sacred place, accessible to me without traveling on the outside, is an awesome gift for which I am eternally grateful.

It is from this place of spiritual resilience that I work. Much of my work in this world is bureaucratic; report writing, grant writing and other administrative tasks. Sometimes that role is oppressive but I am fortunate to have that resilient place and I continue to find inspiration from other people. Eventually, I hope to turn my work over to a younger person so I can spend more time dreaming.

**Kate Winters:** *I can tell you that, in preparing for this and looking for you on the internet, you really have quite a list of accomplishments, for which you can be very pleased.*

**Eva Petoskey:** Thank you for saying that. I think we come into the world with a particular purpose. Along with being a mother, this is my sacred work; my work is part of my spiritual journey.

**Ken Winters:** *You mentioned healing and recovery in your personal story, which was very poignant. How much do you think Westernized views of recovery have been useful to you as you built your program to bring recovery to indigenous people?*

**Eva Petoskey:** When I think about recovery in Native communities,

there are a lot of levels to consider. Much of the healing work in our communities has happened outside of programs through natural support systems and ceremony. There has been a lot cultural and economic revitalization in our Anishnaabe homeland, the Great Lakes area and throughout Indian country. I talked about this earlier; the waking up and lighting of the Seventh Fire. If we move to more of a program level, I've worked in the substance abuse field for about as long as I've been sober, for the past 36 years, so I've seen change over a long period. I started out in substance abuse prevention working with kids, and I've done a variety of things. I'm not a clinician; I'm a consensus builder. In that role I do a lot of listening and then work with people to develop resources and create initiatives that emerge from the community and are responsive to the needs and culture of the community.

I'm currently the Director of the Anishnaabek Healing Circle Access to Recovery (ATR) initiative. This initiative has emerged out of the work of a coalition of tribal people and programs that have worked together here in Michigan over the past 30 years. The ATR initiative receives funding from SAMHSA but the key priorities for our ATR project have emerged from the local tribal communities. The ATR funding has been flexible enough to truly support community healing. We're currently working on the development of healing teams; these teams are based on a partnership between Western approaches to treatment, traditional healing, and the engagement of the tribal recovery community. In our programs people use a variety of approaches. For example, we've used the Matrix Model within some of the tribal treatment programs and people have used cognitive behavioral therapy and motivational interviewing with

some modification. So there are a lot of counselors, therapists, and social workers that have worked effectively with the tribal behavioral health systems. Over the past 25 years, most of the tribes in Michigan have developed behavioral health departments. At first, they were separated into substance abuse and mental health branches, and sometimes there's still a little of that separation, but now there's more integration going on. There has been an ongoing process of testing various Western approaches to treatment; the effectiveness of these approaches depends on the individual client's needs. Western approaches have utility and they are a really important part of the treatment or Healing Teams. We have also identified techniques that are specifically focused on treating people who have experienced trauma.

In addition to these Western approaches, traditional healers are another important part of the Healing Teams. I'm happy to say that in most of the tribal communities in Michigan, traditional healers are integrated into the local behavioral health service array. Certainly in our work with the Access to Recovery Initiative and the Anishnaabek Healing Circle, we have been able to support the expansion of traditional healing and other cultural services. Good examples of the

*"I have  
been blessed to live in  
this time of the Seventh Fire,  
and I have been happy to be part  
of the spiritual and cultural awakening  
in our communities; the rising up of our  
people from what was for many of us a  
multigenerational legacy of trauma  
and addiction."  
- Eva Petoskey*

integration of traditional healers into Healing Teams are present in several Michigan communities, but one great example that comes to mind is a tribal community where some of the herbal remedies and medicines that the traditional healer prescribes are now regularly dispensed by the tribal pharmacy. Also, with our Anishinaabek Healing Circle, we have been able to not only strengthen the collaboration with traditional healers, but we have also been able to expand other services like talking circles, sweat lodges, and regalia making. We've also sponsored drumming and song classes as part of the Anishinaabe Healing Circle service array.

Another part of the Healing Team that we're currently developing is peer recovery mentoring; this is a really important part of the Healing Team configuration. It's not only important to have clinical services and traditional healing services available, but it is extremely important to engage the recovery community in the Healing Teams. A combination of approaches is needed. We've trained about 70 people in peer recovery mentoring; most are peers, but not all. We've also trained supervisors since we are working on incorporating peers into the Healing Teams at the local level. Our long range vision is to have Western clinical approach, traditional healing, and peer recovery mentoring available to all tribal people seeking recovery. It is critically important to engage the recovery community into this integrated Healing Team model. All of the efforts to motivate people from different orientations to work together can be a challenge, but we're making progress.

**Ken Winters:** *Kate and I work with youth in a lot of projects, and we've always wondered how challenging it is getting younger people to buy into traditional healing practices. Do they resonate to that readily?*

**Eva Petoskey:** It depends on their upbringing. In our communities there are some people who resonate deeply with their culture and some who do not. That's why we need to have a variety of services available, because it really is about choice. When you're in recovery, especially early recovery, you don't even know what you want. You're not even ready to resonate with anything that's deeply spiritual. For a while, most people are still in detox. This is especially true given the current rise of prescription drug and opiate abuse, the process of detoxing takes much longer than we realize. It's certainly beyond a 72-hour detox. It's probably more like several months, or even the first year of recovery, before you can get beyond those powerful impulses and triggers that people have developed throughout their addiction.

So, do the young people resonate with the traditional healing? Definitely, yes they do in some cases and no they don't in other cases. There is the stage of development between 16 and 25 where youth are really at risk. In

some people this stage starts earlier and in some it ends later. I think this extended adolescence is a result of the way we raise our children today. A lot of children don't experience rites of passage that could help them find focus and purpose, so they remain adolescents for a long time, searching for what they're going to do. It's a complicated developmental path in American society today, and this is true for our Native and non-Native children. There are differences but it's tough to be an adolescent today regardless of your cultural background. There is a lot of negative peer pressure in our tribal communities.

I want to talk about resilience here, not only because I think that it's important to talk about, but also a lot of people are still suffering in that dark place where they don't know who they are and can't find that center. In our language, we have a word that I love, Mino-Bimaadiziwin. There are many levels of meaning to that word. One of the levels I learned recently is that the first part of the word, the "min" part, is related to the words in our language that have to do with seeds. A lot of people say that the word translates as, "to live a good life" or, "to walk in balance," but at another level, if you break down the word and the concepts behind it, it means "the seed of your life, the seed that has given you life." The second part of the word – and I'm not a fluent speaker, so this is what I've been told – is "to move the spirit forward." So the whole word expresses how we go forward in a spiritual way from the center, from the seed that created you.

Going back to your question about young people, it takes a long time. For so many of us, do we ever find that place that represents the seed from which we came? Do we feel it, understand it? There are so many things that keep us from that. On the indigenous journey, there are so many things that have kept us from our own seed and center.

**Ken Winters:** *We're very intrigued by the Healing Teams you talked about. How much local community support is needed for a Healing Team to work well, and do you find some features in communities that help promote a Healing Team? Are there features that create problems or barriers to the work of a Healing Team?*

**Eva Petoskey:** On the side of what promotes it, to really have Healing Teams requires the leadership of many people working together for a vision for healing. You must have genuine collaboration and a supportive learning community. You need people who are willing to listen to each other, because in order to bring a Healing Team together, people with diverse backgrounds, training and skills must work together in a mutually respectful manner. For example, if a clinician comes to the table with specialized training, whether a social worker, therapist, psychologist, or even a psychiatrist; that individual must be open to unfamiliar ideas. If that openness is missing, it's pretty hard to join together with other team members in a circle of mutual respect. People must be willing to listen deeply to diverse points of view to be an asset to the Healing Team. The same applies to traditional healers and peer mentors— all people have assets and attitudes. There are different paths that bring people to the healing circle but there must be mutual respect; it has to be an even playing field. The clinician can't think that somehow they're better than the peer mentor, and likewise the peer mentor can't think they're superior because of their lived experience. There has to be mutual respect for the idea to work. A lack of mutual respect is what would work against development of Healing Teams; interjecting so much of ego that you

*"I think we come into the world with a particular purpose. Along with being a mother, this is my sacred work; my work is part of my spiritual journey."*

*- Eva Petoskey*



Photo: iStock

can't have respect for the other person and the assets they bring to the process.

**Kate Winters:** *In talking about the Healing Teams, things that are essential and things you want to overcome, did you experience some pushback when you were first developing the concept? When you were presenting the concept, did people have trouble with the even playing field or the mutual respect you just mentioned?*

**Eva Petoskey:** Yes. We still have trouble with that. Not so much in the tribal network, because the network is a really strong learning community, so we have conversations over and over again until people co-create the ideas. However, at first there was resistance from the clinicians, especially toward the recovery community. Not so much toward the traditional healers, because people working in a tribal community understand the need for the traditional healer in the tribal cultural context. What I think people have a harder time with, and we're still working on, is bringing the recovery community to the table as an equal player. That was a new idea, and it really helped us to do the peer mentor training. There were many questions about what peer mentoring is; how we could make it work, and it was hard for some people to see the benefit from their own point of view. We have couple of pilot programs that have been really successful with some awesome people in the forefront who have come back to our tribal network to share how they have used peer mentoring and discuss successes and challenges. It's all about a slow process of change. There always seems to be pushback by someone to any new idea.

**Kate Winters:** *Because things are developing and moving along, and there's wider recognition of the importance of recovery and peer recovery mentoring, has there been a growing interest among young people to study and join the recovery profession?*

**Eva Petoskey:** That's a good question, because we're very concerned about workforce development. There aren't many people, particularly

young people, coming into the field for a number of reasons. Certainly, if you're coming in as a peer mentor, it won't pay you very well; you might be a volunteer or paid as a paraprofessional. Even clinicians might be able to earn more in a non-Native environment. I don't think we're unique here in Michigan, but a lot of our tribal young people aren't going off to college, and so they're not becoming clinicians. We have some, but not many. When I came to the field, many tribal people were struggling to become certified counselors. Very few people had a degree. Things have changed now, and we have many more clinical resources in our tribal systems. However, a lot of clinicians working on our Michigan tribal communities are non-Native, because we don't have the workforce of Native people with master's degrees in social work. So it's harder for people to come into the field for a number of reasons: it's demanding work, it doesn't pay well, and there isn't much glory, at least on a superficial level. On a deeper level, it's up there with motherhood: it is sacred work.

**Kate Winters:** *So, thinking ahead, what are some needs that are still unmet that you need to target?*

**Eva Petoskey:** I don't think the Healing Team concept is fully operational. It's something that emerged and then we started finding words for it. But I think it's still emerging, and we're still seeing how to maintain it in our organizations and communities.

I think another big issue in Indian country is the need to create healthy tribal organizations to promote wellbeing in our communities. I have a lot of friends who feel like they don't want to work for their tribe anymore because the organizational climate is not healthy. They are moving their healing circle outside the tribal arena. So there is an ongoing need to have healthy tribal organizations that can support healing instead of having to do the healing work outside the tribal organization. I've done a lot of my work with rural reservation communities, but this organizational wellness issue is present in rural and urban Indian organizations. It's a big issue, and I think it's an unarticulated issue that needs to be addressed.

Workforce development will be an on-going challenge in the near future – we don't know where our future workforce is going to come from, and how we're going to recruit more people into the field. I also think more work needs to be done on the engagement of the recovery community, because this can have a number of positive outcomes if it's done in a good way. It can offer opportunities for people, whether volunteer or paid mentoring roles, to give-back to their community. Not everyone joins AA or NA, which has service as a key value, but I think the peer mentoring also has the same value of giving back to the community. There's a lot more we could do to mobilize the strengths in the community, because that's the long-term strategy for healing. Mobilizing people at the grassroots level offers great potential for sustainability beyond the life of a program. It's important to help people develop tools for themselves so they're not dependent on a program. Still, programs can help too, and I don't diminish the power of a good, community-based program to do awesome things.

*Date of interview, July 8, 2014*





## TRAININGS, EVENTS and OPPORTUNITIES: SEPTEMBER

9/3/2014 12 noon - 1 pm Central	Behavioral Health webinar series: <i>Overview of the Tribal Temporary Assistance for Needy Families Program</i>	Online, see webinar registration information below*
9/3-5/2014	18th Annual United Tribes Tribal Leaders Summit, <i>Center staff will exhibit at this event</i>	Bismarck, ND
9/15-17/2014	<i>South Dakota Native American Curriculum Training</i>	Sioux Falls, SD; contact Jacki Bock, see below**
9/16-17/2014	Presentation: <i>Ethics and 42CFR Training</i> , Great Plains Behavioral Health Directors Meeting	Council Bluffs, IA
9/17/2014 12 noon - 1:30 pm Central	Essential Substance Abuse Skills webinar series: <i>Counseling Families, Partners, &amp; Significant Others</i>	Online, see registration information below*
9/18-19/2014	Red Road Gathering, <i>Center staff will exhibit at this event</i> , Dr. Duane Mackey "Waktaya Naji" award will be presented at this event.	Vermillion, SD

## OCTOBER

10/1/2014 12 noon - 1 pm Central	Behavioral Health webinar series: <i>Nutrition and Behavioral Health</i>	Online, see registration information below*
10/8-9/2014	National Hispanic and Latino ATTC conference, <i>Center staff will present at this event</i>	Austin, TX
10/14-16/2014	<i>South Dakota Native American Curriculum Training</i>	Rapid City, SD; contact Jacki Bock, see below**
10/15/2014 12 noon - 1:30 pm Central	Essential Substance Abuse Skills webinar series: <i>Professional and Ethical Responsibilities</i>	Online, see registration information below*
10/22-23/2014	<i>Alcohol and Drug Exam Review Training</i>	Albuquerque, NM
10/24/2014	<i>Ethics Training</i>	Albuquerque, NM

\*Webinars require advance registration. Go to our website: [attnetwork.org/americanindian](http://attnetwork.org/americanindian) and click on *Trainings & Events* to see a full list of upcoming webinars and registration information. Questions? Contact Kate Thrans at [kate-thrans@uiowa.edu](mailto:kate-thrans@uiowa.edu) or 319-335-5362.

\*\* To register for this training, contact Jacki Bock: [jacki-bock@uiowa.edu](mailto:jacki-bock@uiowa.edu); 319-335-5564

## Finding Peace

Sean Bear, Sr., BA, CADC, Sac and Fox Tribe of Mississippi in Iowa; Senior Behavioral Health Consultant

*Long ago, all my relations had known that whatever we do to the earth, we also do to ourselves (much like Karma). They lived with the teachings of a circular world (the great web), that where something begins, it will also end. That is how they knew that only as a whole can true peace be found. Just as a tree with branches, they too must work in harmony with its roots, or it will cease to be.*



### The True Peace

- Black Elk, Oglala Sioux & Spiritual Leader (1863 - 1950)

*"The first peace, which is the most important, is that which comes within the souls of people when they realize their relationship, their oneness, with the universe and all its powers, and when they realize that at the center of the universe dwells Wakan-Tanka (the Great Spirit), and that this center is really everywhere, it is within each of us. This is the real peace, and the others are but reflections of this. The second peace is that which is made between two individuals, and the third is that which is made between two nations. But above all you should understand that there can never be peace between nations until there is known that true peace, which, as I have often said, is within the souls of men."*

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