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

IOWA

SAMHSA
Substance Abuse and Mental Health Services Administration

ESAS: Group Counseling

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ATTC
Addiction Technology Transfer Center Network
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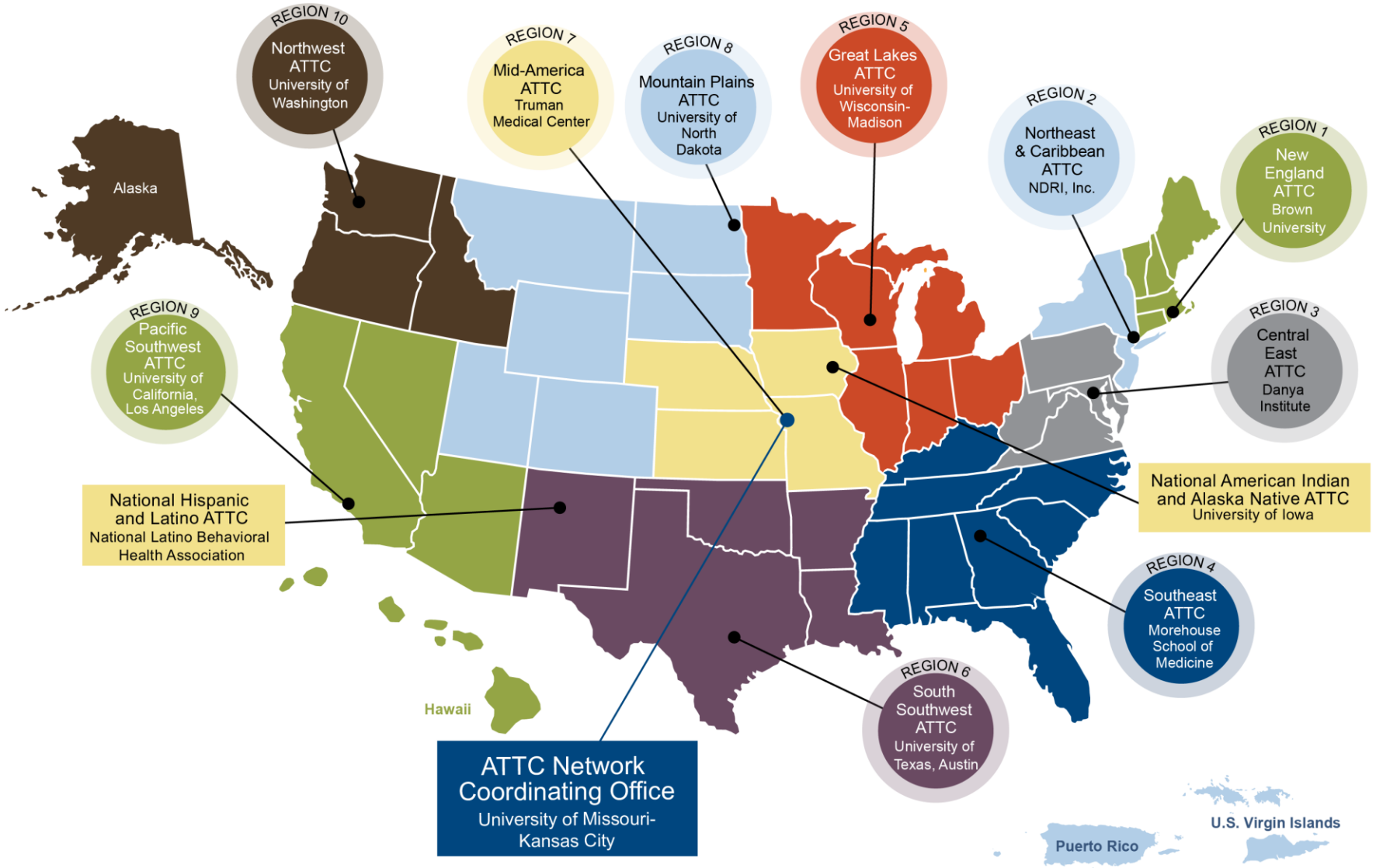
American Indian & Alaska Native Addiction Technology Transfer Center

U.S.-based ATTC Network



SAMHSA

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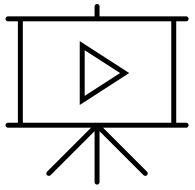
The National American Indian and Alaska Native Addiction Technology Transfer Center is supported by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

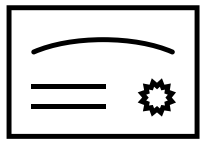
The content of this event is the creation of the presenter(s), and the opinions expressed do not necessarily reflect the views or policies of SAMHSA, HHS, or the American Indian & Alaska Native ATTC.

Follow-up

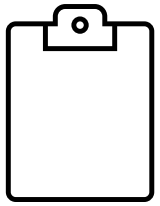
Following today's event, you will receive a follow up email, which will include:



Links to the presentation slides and recording, if applicable



Information about how to request and receive CEUs



Link to our evaluation survey (GPRA)

Land Acknowledgement

We would like to take this time to acknowledge the land and pay respect to the Indigenous Nations whose homelands were forcibly taken over and inhabited.
Past and present, we want to honor the land itself and the people who have stewarded it throughout the generations.

This calls us to commit to forever learn how to be better stewards of these lands through action, advocacy, support, and education.
We acknowledge the painful history of genocide and forced occupation of Native American territories, and we respect the many diverse indigenous people connected to this land on which we gather from time immemorial.

While injustices are still being committed against Indigenous people on Turtle Island, today we say thank you to those that stand with Indigenous peoples and acknowledge that land reparations must be made to allow healing for our Indigenous peoples and to mother earth, herself.

Dekibaota, Elleh Driscoll, Meskwaki and Winnebago Nations
Ttakimaweakwe, Keely Driscoll, Meskwaki and Winnebago Nations
Ki-o-kuk, Sean A. Bear, 1st. Meskwaki

Today's Speaker

STEVEN G. STEINE, MA, CADC

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Steve earned his B.A. in Communications (1994) and his M.A. in Substance Abuse Counseling Program (1997) from the University of Iowa. He has been a certified Alcohol and Drug clinician with the State of Iowa since 1997. He was born and raised in Iowa and has worked in the Behavioral Health Services and non-profit sector for 23 years, providing both direct patient care, as a clinician, and provided supervision as a clinical manager. Since January of 2019, he has been working for the National AI/AN ATTC at the University of Iowa. He has been in recovery for over 34 years and has committed his life and profession to helping others in the recovery process.

Group Counseling

Essential Substance Abuse Skills

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

Part ONE: The “How To”

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.

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.

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

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

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

Group Membership(cont.)

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.

Group Membership (cont.2)

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.

Group Membership (cont.3)

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.

Group Membership (Cont. 4):

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.

Group Membership (Cont. 5)

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.

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.

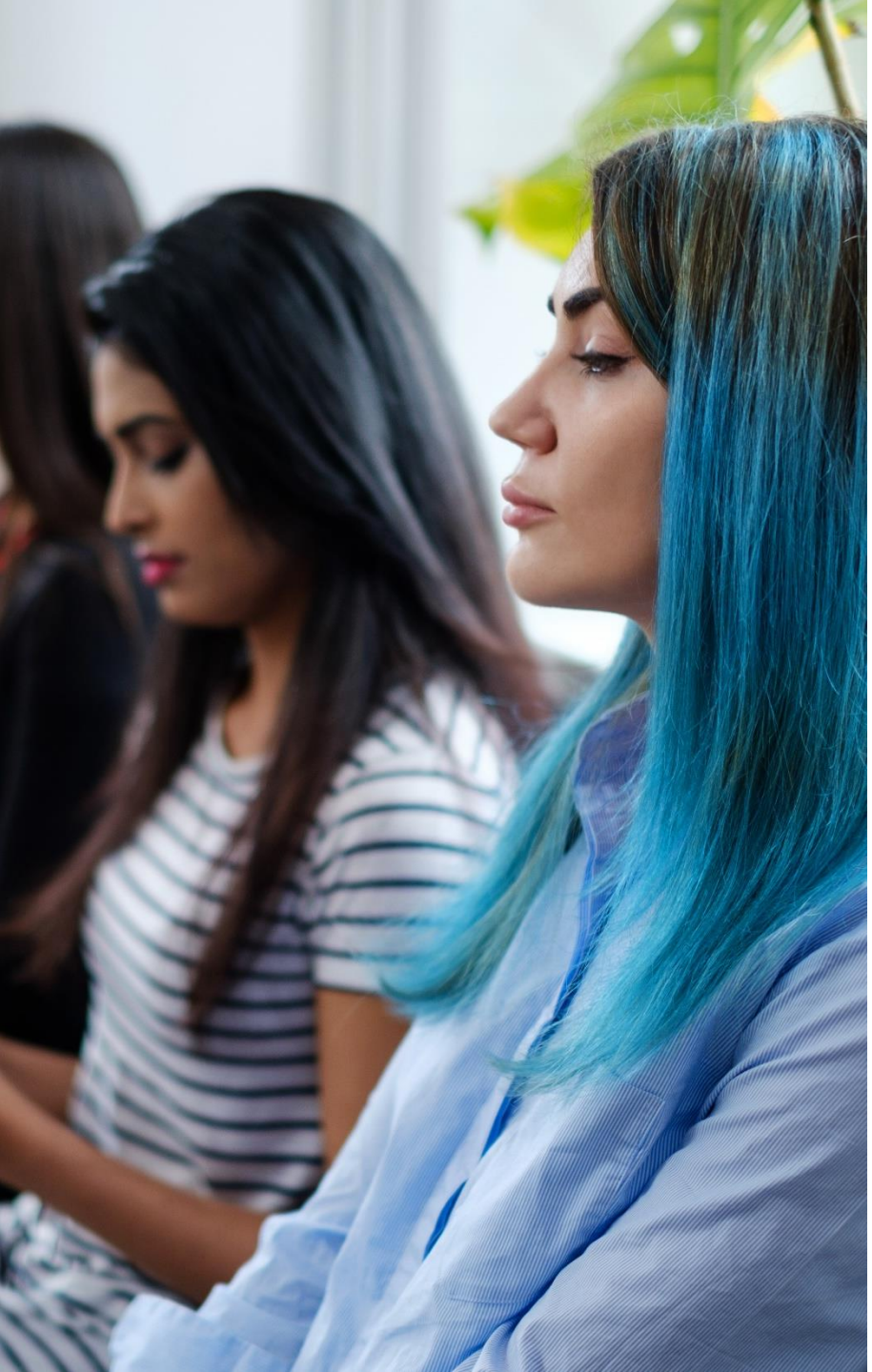
Implementation of Groups (cont.)

- 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.

Implementation of Groups (cont. 1)

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.



Implementation of Groups (cont. 2)

- 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.

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.

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.

Implementation of Groups (cont. 3)

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

Implementation of Groups (cont. 4)

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

Implementation of Groups (cont. 5)

- 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.

Typical Open-Continue Care group agenda (example)

Men's Continuing Care Group
5/23/19

1. Immediate Concerns (15 min)
2. Relaxation 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.

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

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.

Facilitation (cont.)

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

Facilitation (cont.)

Facilitator – 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

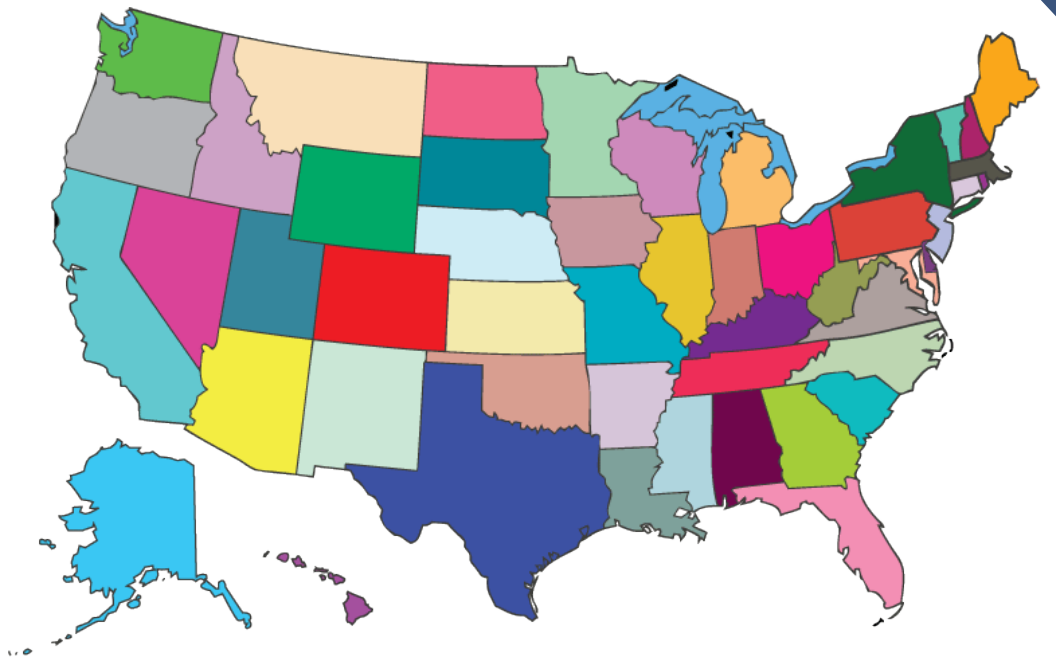
Part TWO: Group Work with Native people

Native People:

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

Native people (cont.)

- 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



Native Communication Styles…

…Can be very different in Native Communities

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.

Native Communication Styles (cont.)

- 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 something is wrong.

Native Communication Styles (cont.2)

- 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.

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).

Cultural Considerations (cont.)

- 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).

Cultural Considerations (Cont.2):

- 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?

Cultural Considerations (Cont.3)

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.

Cultural Considerations (Cont. 4)

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

Cultural Considerations (Cont. 5)

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

Cultural Considerations (Cont. 6)

- 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!

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.

Engagement (cont.)

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)

Engagement (cont. 1):

- 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

Engagement (cont.2):

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!

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.

Native Retention Strategies (cont.):

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

Native Retention Strategies (cont.2):

- 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.

Native Retention Strategies (Cont. 3):

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

Native Retention Strategies (cont.4):

- 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?

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