Practices for the Sacred Circle:

Considerations for Mental Health Providers' on implementation of treatment options for use with American Indian/Alaskan Native youth

A need was identified to provide specific treatment options for use with American Indian/Alaskan Native youth as part of this toolkit revision. Two areas are addressed. These areas are treating trauma in American Indian and Alaskan Native communities and the use of the Good Lives Model of Offender Rehabilitation, (see Ward and Stewart, 2003). It is important to note that other methods have been endorsed for this purpose in treating adults and adolescent sex offenders, especially Relapse Prevention and the Risks-Needs-Responsivity models.

Several additional areas utilized for treatment of trauma reactions have also been implemented for this purpose. They include various forms of de-conditioning and family therapy models. The reader is encouraged to review these tecāiques since they are directly applicable to treatment of American Indian/Alaskan Native youth. However, further review of these tecāiques is beyond the scope of this toolkit.

Dolores Subia BigFoot, PhD, and colleagues have published culturally enhanced treatment for Adverse Childhood Experiences, (ACEs), that specifically addresses trauma informed treatment in this population. These efforts are in response to the disproportional impact caused by the emotional responses to traumatic events or incidents in Native populations. Partners in these efforts have included the Indian Country Child Trauma Center.

Two evidenced-based practices, Trauma Focused Cognitive Behavior Therapy (TF-CBT) and Problematic Sexual Behavioral Cognitive Behavioral Therapy (PSB-CBT) were adapted through making cultural changes in content as part of these efforts. Additional frameworks titled, Honoring Children, Mending the Circle (HC-MC), and Honoring Children, Respectful Ways (HC-RW), have been further addressed. Research in these areas is limited and greater research efforts are required which directly involve Native researchers.

Research involving Trauma Focused-Cognitive Behavioral Therapy is readily available on the TF-CBT website and through other sources. Various publications are further available for this purpose. These tecāiques are rigorously tested, and address issues related to several mental health concerns and diagnostic areas. Parents have been found to benefit from these treatment efforts when they are involved with their children during treatment sessions.

Children and parents are prepared for joint sessions to occur. These sessions can involve family therapy activities. One strength of this focus is to allow elders to share previous family and tribal history and experiences that may have been lost to the youth because of boarding school experiences and other traumatic events. Healing practices and native beliefs are readily shared in the family therapy environment. This model of sharing traumatic events and related emotions becomes good practice to generalize disclosure of future needs.

The Good Lives Model (GML) of Offender Rehabilitation was developed by Tony Ward and his colleagues. A website is available for gaining additional information (www.goodlivesmodel.com/index/shtml). This website lists over 200 publications representing research on these tecāiques. The model is referred to as "a strength-based approach" utilized to build strengths and capabilities in people.

Applying the GLM to youth is at an early stage but there is emerging research in this area. It is a general rehabilitation theory with application to a wide range of offenses. This model is used internationally and in various programs including those treating individuals with substance use disorders. Indigenous offenders have been treated using these methods as well as those with intellectual disability, young offenders, and both male and female offenders.

The effectiveness of the Good Lives Model has been questioned due to lack of empirical (research) evidence. A recent systematic review conducted of outcome studies concluded that the model did not show an ability to reduce repeat offending. It is important to note that this review included only six studies. Proponents have indicated that the model does not have a specific treatment component but rather represents a theory of rehabilitation.

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An original model was based on nine primary goods which were hypothesized to reflect desired outcomes people wish to obtain in life. These "human goods" were increased to 11 in further research and publications. These goods are:

- Life (including healthy living and functioning)
- Knowledge (how well-informed one feels about things that are important to them)
- Excellence in play (hobbies and recreational pursuits)
- Excellence in work (including mastery experiences)
- Excellence in agency (autonomy, power and self-directedness)
- Inner peace (freedom form emotional turmoil and stress)
- Relatedness (including intimate, romantic, and family relationships)
- Community (connection to wider social groups)
- Spirituality (in the broader sense of finding meaning and purpose in life
- Pleasure (feeling good in the here and now)
- Creativity (expressing oneself through alternative forms).

One important issue to address is the need to adapt the Good Lives Model to working with children who are displaying Problematic Sexual Behavior. This first involves understanding the difference involving assisting a young person to develop a rehabilitation focus. This involves acquiring various skills, increasing the capacity for positive change, and understanding or developing a sense of personal well-being. The youth require appropriate resources to develop these and related skills.

Youth are expected to engage in these processes that have obtained varied developmental levels. This requires interviewing and potential assessments to specify developmental levels of each child being seen in various cognitive, social, language, academic and other areas. Various adaptations are likely to be needed to complete and validate this process. This assessment model requires further study and development before it is ready for employment beyond an experimental level.

The literature provides insights into this need and process which may be helpful. One cautionary step is to establish an initial rapport with the young person and family members to engage in the process of therapy as a team with the therapist providing direction and suggestions. This approach can utilize the Trauma Focus Cognitive Behavioral Therapy information outlined above. It is often helpful to adapt language, concepts, and tools necessary for adequate intervention services to be designed and implemented.

One option available in the literature developed from the Good Lives Model is referred to as G-MAP. This tecāique has structured the 11 primary goods into eight key needs and employs language more likely understood by youth. Adaptions have been developed for use with youth 12 to 18 years of age. This process can be repeated with young people at multiple points in time. The goal in treatment is for youth to find ways they can achieve primary goods they want without causing harm to others or risk to themselves. Another part of this goal structure is to avoid blaming or somehow engaging in shaming them or other conditioning and other types of stigmas. The final goal of this type of therapy is for the young person to develop an individualized intervention plan for use in appropriately obtaining the human goods they desire.

This information details methods to extend the program model for use with younger American Indian/Alaskan Native children in the future. Plans for additional research are needed to guide this process and ensure that the outcome(s) are evidence-based and able to be replicated in further research. The researchers engaged in this process should be mindful that the use of approach goals and supporting appropriate internal and external resources are likely to include the use of relapse prevention and risk, need, and responsivity methods.

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