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Professional Ethics While Working With American Indian and Alaskan Native Populations

Section 1: Introduction

References: 5, 6, 7, 12, 16, 17, 20, 26, 27, 33, 34, 37, 41, 43, 44, 45, 46, 51, 52

Definitions

The U.S. Census Bureau defines an American Indian or Alaska Native (AI/AN) person as having "origins in any of the original peoples of North and South America (including Central America), who maintain tribal affiliation or community attachment" (as cited in U.S. Department of Health and Human Services, Office of Minority Health [OMH], 2025, para. 2).

The definition from the Bureau of Indian Affairs (2017a) builds on the one from the U.S. Census Bureau by stating, in general, "an American Indian or Alaska Native person is someone who has blood degree (or quantum) from and is recognized as such by a federally recognized tribe or village (as an enrolled tribal member) and/or the United States" (para. 1).

Blood quantum is "the degree of American Indian or Alaska Native blood from a federally recognized tribe or village that a person possesses" (Bureau of Indian Affairs, 2017a, para. 1). Blood quantum requirements vary from tribe to tribe, and whether they are an appropriate way to identify members is often debated among Native Americans (Yehieli & Grey, 2005).

The Bureau of Indian Affairs (2017b) states that terms American Indian or Alaska Native "denote the cultural and historical distinctions between persons belonging to the Indigenous tribes of the continental United States (American Indians) and the Indigenous tribes and villages of Alaska (Alaska Natives, i.e., Eskimos, Aleuts, and Indians)" (para. 1).

The United Nations (n.d.) has published a common definition of Indigenous peoples as “the descendants of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived. The new arrivals later became dominant through conquest, occupation, settlement, or other means” (p. 1). Indigenous people are those who practice unique traditions, have their own language, and maintain social, cultural, economic, and political characteristics and beliefs distinct from those of the majority in the society in which they live. They strive to keep and reproduce ancestral environments and systems. They self-identify as indigenous individuals and are accepted by their communities. They have a strong link to territories and natural resources (United Nations, n.d., p. 1).

No single federal criterion, tribal standard, definition, or blood quantum level establishes a person as AI/AN. It is important to consider a person’s knowledge of their tribe’s culture, history, language, religion, family relationships, and their level of identification as an AI/AN individual (Bureau of Indian Affairs, 2017a, para. 1).

Terminology

According to Treuer (2023), Native American communities in the U.S. do not agree on the terms that are most appropriate when talking about North America’s first people (Treuer, 2023). The term “Native American” was used starting in the 1970s as an alternative to “American Indian.” Still, over time, it has expanded to include all Native peoples and may now be too broad to describe distinct populations (Bureau of Indian Affairs, 2017b). Native American is increasingly used less by some groups who prefer American Indian or Alaska Native (AI/AN) (National Museum of the American Indian, n.d.).

On the other hand, it has been noted by some groups that referring to Indigenous/Native people as “American Indians” can be misleading, as “America”

is a term that was not used until after colonization. The term “Indian” can also be misleading, as it is considered a “mislabeling based on Columbus’s confusion about where he was when he first arrived in the Americas” (Treuer, 2023, p. 40). Columbus initially thought he was in India, and despite this being false, the term has persisted, which is why some people object to its use when describing Native people (Treuer, 2023, p. 40).

The National Museum of the American Indian (n.d.) notes that the terms Native, Native American, Indian, and American Indian are acceptable and are often used interchangeably in the U.S (para. 2). Alaska Native is also an appropriate term (Bureau of Indian Affairs, 2017b). Treuer (2023) advises that the words Native, Native American, and Indigenous are “politically correct,” though they leave things open to more than one interpretation. He notes that the terms Native and Indigenous have value to Native people, as they have a “deep affinity” for other Indigenous people across the world, as they share common struggles and experiences. However, they are not always equivalent (Treuer, 2023, pp. 39-40).

Furthermore, some Indigenous/Native people may prefer to use the original names of their nations or specific tribal names, which have existed for thousands of years. They may also consider their identity to be separate from the “American” identity (National Alliance on Mental Illness [NAMI], n.d.).

Truer (2023) writes that each tribe has its own “terms of self-reference,” making it difficult to find appropriate terms, especially when they are not the ones employed by U.S. or tribal governments. His guidance is to be thoughtful and open about word choices, to understand others’ sensitivities, and to engage individual community members and their families in respectful conversations to learn which terminology resonates most with them (Treuer, 2023).

Though individuals and organizations may use a range of terms, this course primarily uses American Indian or Alaska Native (AI/AN) and other terms, such as Native, Native American, or Indigenous, depending on the source.

Of note, the U.S. Census Bureau collects and reports data using the terms AI/AN.

The American Indian and Alaska Native Population in the U.S.

Recent data from the U.S. Census Bureau (2025) show the following statistics for the AI/AN population, which is one of the six major race categories defined by the U.S. Office of Management and Budget.

- In 2024, 7.7 million people made up the AI/AN population alone or in combination with other racial groups.
- This population is expected to grow to 9 million by 2060, representing 2.5% of the total U.S. population.
- 574 Indian tribes were federally recognized in 2025. About 220 of these tribes are in Alaska.
- 325 American Indian reservations were recognized in 2025.
- 221 Alaska Native village statistical areas existed in 2025
- Over 123,000 single-race AI/AN people were Veterans of the U.S. Armed Forces in 2024.

In addition, the 2020 U.S. Census Bureau report found that from 2010 to 2020:

- The number of Americans who identify as AI/AN, either fully or partially, grew from just over 5 million in 2010 to close to 10 million in 2020.

- The Alaska Native alone population grew by nearly 11% to just over 133,000.
- The Alaska Native population, alone or in combination with other races, increased by nearly 46% to nearly 242,000 people.
- The American Indian alone population grew by approximately 12% to close to 2,160,000 people.
- The American Indian population, alone or in combination with other races, nearly doubled to close to 6,364,000 people (Sanchez-Rivera et al., 2023).

Furthermore, the 2020 U.S. Census Bureau report found:

- Over half of the American Indian alone population lived in 5 states: Oklahoma, Arizona, California, New Mexico, and Texas.
- Over 77 % of the Alaska Native alone population resided in Alaska, followed by smaller percentages in Washington, California, Oregon, and Texas (Sanchez-Rivera et al., 2023).
- About 87% of AI/AN people, alone or in combination with other races, live in urban areas, including major cities such as Anchorage, Alaska; Oklahoma City, OK; Phoenix, Arizona; Los Angeles, CA; and New York, NY. About 13% of the AI/AN population lives on reservations or tribal lands (Bunten & Begay, 2025; U.S. Census Bureau, 2020, as cited in Indian Health Service, n.d.a).

American Indian and Alaska Native History

When working with AI/AN clients, their history, dating back to colonization, must be taken into account. This section provides a summary of some of the historical events that have affected AI/AN people.

When Europeans arrived in the 17th century to what is now known as America, many Native communities were already highly developed, with systems of agriculture, government, and commerce with other tribes, as well as their own resources, land, territory, culture, and language (Bunten & Begay, 2025; Nagayama Hall, 2023). Each tribe and community that already resided there was considered a nation in its own right (Bunten & Begay, 2025).

For many years, Europeans significantly mistreated Native people and displaced them from their homes as their need for land and resources grew. Wars and diseases carried by European people also caused a remarkable number of deaths in the Native population (Nagayama Hall, 2023).

As time went on, Europeans signed treaties with Native people to acquire land and other resources. In exchange, they were not allowed to exert their power over the Native nation's affairs. When America established its independence, it also sought the same protections against foreign governments and reaffirmed its ability to enter into treaties with Indian nations. The U.S. did not always uphold its treaty commitments with Indian Nations; the federal government often broke, ignored, or forgot them.

From the late 1700s until the early 1900s, legal proceedings diminished Native Americans' rights, removed them from their homelands, often to reservations policed by federal officers, and altered their customs and practices (Howard University School of Law, 2026). Children were also taken from their families and were forced to live in boarding schools that were often far away from home. If parents refused to send their children to boarding school, they were denied food and other resources. While at boarding school, Native children were forced to go to church, diminishing their own spiritual practices. They were also abused, and some children died. Many of the schools were underfunded, and children were not adequately prepared for higher education. There was mainly vocational

training to help them work in industrial or manual labor jobs. To this day, AI/ANs receive less education and have fewer opportunities than other groups in the U.S., which are two factors that have led to poverty and unemployment.

Also during this time period, the U.S. government put federal policies in place that outlawed Native religion and spiritual practices, attempting to “civilize” Natives and convert them to Christianity. The Dawes Act of 1887 also discontinued reservations and helped Native people become property owners so they could farm, which was considered more civilized than hunting.

In the early 1900s, Native people began to gain some civil rights, and in 1924, they became official U.S. Citizens (Nagayama Hall, 2023). It was not until the 1930’s that Native Americans regained the land promised to them and the power to self-govern by the Indian Reorganization Act. This power did not last long because the federal government began rolling back its services and withdrawing protections in the 1950s.

However, starting in 1968 until the present, also known as the Self-Determination Era, civil rights activists have used political, legal, and civil tactics to force the U.S. to reconcile their mistreatment of Native Americans. The Indian Civil Rights Act was passed in 1968, which allowed Natives to self-govern. Then, in the 1970s, various Acts were passed that increased the authority of tribes and limited the removal of children from their families for adoption or foster care, which was common practice until this time. There have also been environmental activism and laws to protect Native people (Howard University School of Law, 2026).

This overview of AI/AN history shows that this population has endured many traumatic events and significant oppression that continues to have an ongoing impact on many of their lives. When clinical social workers and other mental health providers are working with American Indian and Alaska Native clients, they

need to understand the unique historical and present-day concepts that apply to this population, including tribal partnerships and governing laws.

Tribal Partnerships and Governing Laws

A tribe (also known as a tribal nation) is “a sovereign nation with control over its own laws and resources that has a special legal and political relationship with the United States government” (Northwest Center for Public Health Practice, n.d., para. 1). The terms “tribe” and “nation” are often used interchangeably in the U.S. though they mean different things for Native people.

Most tribal nations are federally recognized, which means that the federal and state governments acknowledge and treat each of them that holds this designation as a sovereign nation (Northwest Center for Public Health Practice, n.d.). As noted above, there were 574 federally recognized tribes in 2025 (U.S. Census Bureau, 2025). Some tribal nations have only state recognition, meaning that the state in which they are located recognizes them as a sovereign nation. It has been estimated that there are at least 36 state-recognized tribes in 11 states (Evans-Campbell & Walters, 2024).

Tribal nations have been granted sovereignty primarily through treaties, federal court decisions, and other federal actions. However, since 1978, they have been able to petition for recognition, though this is a costly and challenging process (Northwest Center for Public Health Practice, n.d). Many people hold dual citizenship in their tribal nation and the U.S. (Nagayama Hall, 2023).

According to Hurst & Garcia Vazquez (2025), “federally recognized tribes have the protection, services, and benefits of the federal government and possess a government-to-government relationship with the U.S. Government. They also have responsibilities, powers, limitations, and obligations as organized Nations and are entitled to immunities and privileges as recognized tribes” (para. 5).

Through the Bureau of Indian Affairs, federally recognized tribes receive services that are comparable to state and local government programs, including resource protection, education, social services, law enforcement, courts, real estate, and agriculture and range management. Other federal agencies also offer health care services through a network of reservation-based clinics and hospitals (U.S. Department of the Interior, n.d.). Many non-federally recognized tribes have strong cultural identities and ties to their communities, though they generally do not receive the same services (Nagayama Hall, 2023).

Course Overview

Though AI/AN individuals comprise about 3% of the U.S. population, there are many unique considerations to working with this growing population. According to the Substance Abuse and Mental Health Services Association (SAMHSA) (2018), AI/AN people today are:

> *"Members of a community that has experienced centuries of assault on their culture and still survives. To the extent that AI/AN clients have been connected to native family and community, they know this history, and it likely continues to affect them. They also probably have a strong positive connection with their people and the place they come from. AI/ANs today are more likely than members of other groups to face a host of problems, including poverty, unemployment, trauma, criminal victimization, physical health problems and disparities, and mental and substance use disorders. However, they continue to be a resilient people who can draw on the strength of their cultures, communities, and families to help face these problems"* (p. 33).

Social workers and other mental health professionals working with AI/AN individuals need to learn about their history and current experiences, and develop

specific competencies to provide culturally responsive care to this population. This course will review:

- The ethical definition of cultural competency for AI/AN populations.
- Approaches to moving beyond stereotypes in multicultural counseling.
- The history of alcohol, substance use, and mental health factors in AI/AN communities.
- Best practices for clinical social work practice with this population.
- Current treatment interventions that are sensitive to the needs of this community.
- Mental health disparities and ways to address them.

Section 1 Key Terms

Tribe (also known as a tribal nation) - is “a sovereign nation with control over its own laws and resources that has a special legal and political relationship with the United States government” (Northwest Center for Public Health Practice, n.d., para. 1).

Sovereign nation - has a centralized government and the power to govern a specific geographical area.

Reservation - a place many AI/AN people call home and strongly associate with, even if they do not live there. Cultural and community events are often held at reservations. They are also places where tribes invest resources to strengthen their communities (Treuer, 2023, p. 52).

Federally recognized tribe - receives protection, services, and benefits from the federal government and maintains a government-to-government relationship with

the U.S. Government. They also have responsibilities, powers, limitations, and obligations as organized Nations and are entitled to immunities and privileges as recognized tribes (Hurst & Garcia Vazquez, 2025, para. 5).

Section 2: Cultural Competency and Moving Beyond Stereotypes

References: 4, 8, 9, 10, 15, 24, 28, 29, 30, 31, 36, 41, 49, 50

Cultural competence is crucial for all clinical social workers and other mental health providers, as well as the clients they serve. Many distinct cultures exist within the AI/AN communities, as not all people within them hold the same beliefs or engage in the same practices. Therefore, cultural competence is essential in working with the AI/AN population. To understand cultural competence, one must first understand culture and develop cultural awareness.

Culture

According to the National Center for Cultural Competence (n.d.a), culture is defined as:

> *"The learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they "know" about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death"* (para. 1).

Whitfield, McGrath, and Coleman (1992, as cited in Herring, 1999) propose 11 elements to understand culture and cultural patterns. Each element can be used in any culture and includes how people tend to:

- “Define their sense of self
- Communicate and use language
- Dress and value appearances
- Embrace certain values and mores
- Embrace specific beliefs and attitudes
- Use time and space
- Relate to family and significant others
- Eat and use food in their customs
- Play and make use of their leisure time
- Work and apply themselves
- Learn and use knowledge” (p. 11)

Cultural Awareness

One way to think of cultural awareness is the mindful recognition of similarities and differences among groups. It includes understanding what culture is and what it is not, how people become part of a culture, and the role of culture in their lives. It also entails awareness of power, privilege, and oppression (National Center for Cultural Competence, n.d.a).

The purpose of cultural awareness is to understand the differences between the culture that the self identifies with and the culture of the clients they serve. Once

this understanding is achieved, a mental health provider can better grasp how their culture and a client's culture shape them, and how culture affects interactions with people from other cultures.

Without cultural awareness, a clinical social worker or other mental health provider's own culture could be imposed on their clients, resulting in assumptions and unethical practice behaviors. The importance of cultural values, beliefs, and attitudes and how they influence the assessment process, treatment planning, and impressions of clients may also be discounted (Barsky, 2018; National Center for Cultural Competence, n.d.a.; Substance Abuse and Mental Health Services Administration [SAMHSA], 2018).

To apply cultural awareness in practice, clinical social workers and other mental health providers must first develop this awareness, then assess their own cultural influences on their values, worldviews, beliefs, traditions, norms, and perceptions, which constitutes self-reflection, and then they must also understand these effects among the people they serve.

Regarding AI/AN clients, they are likely aware of the differences between their native and mainstream cultures. They have navigated these differences throughout their life, which means that most clinical social workers and other mental health providers will likely have more to learn about their culture than AI/AN clients need to learn about the mainstream one. Even if a clinical social worker or other mental health provider is from a different culture than the mainstream American one, it is still important not to assume the experiences of AI/AN clients. And even if a provider has worked with AI/AN clients before or is personally connected to the AI/AN culture, they may still not fully understand the specifics of their clients' experiences due to the diversity within this community.

Some strategies for developing cultural awareness include:

- Noticing how the self's culture shapes beliefs, values, perceptions, and behaviors.
- Observing clients and understanding how their experience differs from one's own (SAMHSA, 2018).
- Acknowledging where understanding is lacking and being willing to learn.
- Being open to others' characteristics and empathizing with their life experiences.
- Recognizing that the client is the most knowledgeable person about themself and what is best for them.
- Learning from other people who have different beliefs, values, and worldviews (OMH, n.d.b).

The next step is to complete a values self-assessment. A values assessment helps an individual understand their culture and how it shapes beliefs, values, and other aspects of life, including which holidays they celebrate, the occupation they choose, their attitudes towards health and wellness, and more. A values assessment can be done more than once throughout a person's life, as culture is unlikely to remain the same as people develop, grow, and have different life experiences. No-cost values assessments can be found through the Values Institute and SAMHSA's Guide for Providers Serving AI/ANs (p. 37-39). SAMHSA's guide also outlines Native cultural beliefs and values for learning and comparison to one's own values.

The final step in cultural awareness is to understand the effects of cultural differences. If there are misunderstandings of cultural differences with clients, especially those from the AI/AN community, prejudice, stereotyping, and discrimination can develop. It may also lead to a client receiving suboptimal treatment. For example, if an AI/AN client does not make direct eye contact and

takes time to respond in conversation, it may not indicate ambivalence or disengagement; it may simply reflect normal behavior in their culture. Therefore, differences in culture as well as possible and actual misunderstandings need to be evaluated and addressed, though this is not an easy topic to explore. It is beneficial to explore differences from both the client's and the provider's perspectives to achieve a deep understanding. Self-reflection and supervision can be helpful when exploring these topics (SAMHSA, 2018).

Cultural Competence

Cultural competence in clinical social work and other mental health practices extends beyond awareness to build knowledge and emphasize effective practices and actions. While there are several different definitions of cultural competence, the U.S. Department of Health and Human Services (as cited in the National Center for Cultural Competence, n.d.b), defines it as:

> *"A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities"* (para. 23).

In social work practice, cultural competence is an ethical responsibility to clients, as outlined in the National Association of Social Workers (NASW) Code of Ethics (2021), which states:

Ethical Standard 1.05 - Cultural Competence

"(a) Social workers should demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should demonstrate knowledge that guides practice with clients of various cultures and be able to demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups. Social workers must take action against oppression, racism, discrimination, and inequities, and acknowledge personal privilege.

(c) Social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction), recognizing clients as experts of their own culture, committing to lifelong learning, and holding institutions accountable for advancing cultural humility.

(d) Social workers should obtain education about and demonstrate understanding of the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(e) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients' use of and access to electronic technology and seek to prevent such potential barriers. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services" (para. 17-21).

The NASW has also published 'Standards and Indicators for Cultural Competence' (2015), which defines cultural competence in the following way:

> *"Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, spiritual traditions, immigration status, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each"* (p. 13).

In these standards, cultural competence is operationally defined as "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings" (National Association of Social Workers [NASW], 2015, p. 13-14).

The NASW also notes that cultural competence requires "a high level of professionalism and knowledge (NASW, 2015, p. 14). It is also a lifelong process for social workers who will continue to encounter diverse clients and new situations in their practice.

The NASW's standards for cultural competence are intended to help social workers respond effectively to cultural diversity in practice and policy. The standards are as follows:

1. "**Ethics and Values** - Social workers shall function in accordance with the values, ethics, and standards of the NASW (2008) Code of Ethics. Cultural competence requires self-awareness, cultural humility, and the commitment to understanding and embracing culture as central to effective practice.

2. **Self-Awareness** - Social workers shall demonstrate an appreciation of their own cultural identities and those of others. Social workers must also be aware of their own privilege and power and must acknowledge the impact of this privilege and power in their work with and on behalf of clients. Social workers will also demonstrate cultural humility and sensitivity to the dynamics of power and privilege in all areas of social work.

3. **Cross-Cultural Knowledge** - Social workers shall possess and continue to develop specialized knowledge and understanding that is inclusive of, but not limited to, the history, traditions, values, family systems, and artistic expressions such as race and ethnicity; immigration and refugee status; tribal groups; religion and spirituality; sexual orientation; gender identity or expression; social class; and mental or physical abilities of various cultural groups.

4. **Cross-Cultural Skills** - Social workers will use a broad range of skills (micro, mezzo, and macro) and techniques that demonstrate an understanding of and respect for the importance of culture in practice, policy, and research.

5. **Service Delivery** - Social workers shall be knowledgeable about and skillful in the use of services, resources, and institutions, and be available to serve multicultural communities. They shall be able to make culturally appropriate referrals within both formal and informal networks and shall be cognizant of, and work to address, service gaps affecting specific cultural groups.

6. **Empowerment and Advocacy** - Social workers shall be aware of the impact of social systems, policies, practices, and programs on multicultural client populations, advocating for, with, and on behalf of multicultural clients and client populations whenever appropriate. Social workers should also participate in the development and implementation of policies and

practices that empower and advocate for marginalized and oppressed populations.

7. **Diverse Workforce** - Social workers shall support and advocate for recruitment, admissions, and hiring, and retention efforts in social work programs and organizations to ensure diversity within the profession.

8. **Professional Education** - Social workers shall advocate for, develop, and participate in professional education and training programs that advance cultural competence within the profession. Social workers should embrace cultural competence as a focus of lifelong learning.

9. **Language and Communication** - Social workers shall provide and advocate for effective communication with clients of all cultural groups, including people of limited English proficiency or low literacy skills, people who are blind or have low vision, people who are deaf or hard of hearing, and people with disabilities (Goode & Jones, 2009).

10. **Leadership to Advance Cultural Competence** - Social workers shall be change agents who demonstrate the leadership skills to work effectively with multicultural groups in agencies, organizational settings, and communities. Social workers should also demonstrate responsibility for advancing cultural competence within and beyond their organizations, helping to challenge structural and institutional oppression and build and sustain diverse and inclusive institutions and communities" (NASW, 2016, p. 4-5).

Following NASW's Code of Ethics and Standards for Cultural Competency supports work with clients from diverse cultures, including AI/AN communities. Best practices and culturally competent treatment interventions for working with AI/AN clients are explored later in this course. However, SAMHSA (2018) offers the

following model to understand how cultural knowledge can support culturally competent treatment.

RESPECT: A Mnemonic for Culturally Responsive Attitudes and Behaviors (specific to AI/AN clients)

Respect	Familiarize oneself with communication styles and understand how respect is shown in different cultures. Also, show respect through verbal and nonverbal communications. Listen intently. Be comfortable with silence, do not interrupt, or point with fingers during conversations.
Explanatory model	Dedicate time to understanding how clients view their presenting problems and how the problems are understood in their culture, as well as how healing happens. Be respectful of traditional (or native) approaches to healing.
Sociocultural context	Learn about and acknowledge how sociocultural factors affect assessment and treatment, including tribal affiliation, culture, language, gender roles, education, family, community, geographic location, and more.
Participation	Appreciate that clients have their own expectations about treatment that may differ from your own. Assess and understand a client's viewpoint on treatment and discuss their expectations, especially among roles.
Empathy	When a client shares their concerns, express verbal and nonverbal empathy to help them feel heard and understood. If a relationship has been established, it may be appropriate to share a personal experience.
Concerns and fears	Ask open-ended questions and discuss any concerns or apprehensions the client has about treatment.

Therapeutic alliance/Trust	Commit to behaviors that support and enhance the therapeutic relationship, including earning trust.

(SAMHSA, 2018, p. 40)

Weaver (1999, as cited in Cowling, 2018) also provides best practices for working toward cultural competence with AI/AN clients. There are three overall categories: knowledge, skills, and values.

- **Knowledge:** being aware of history, including treaties, sovereign status of different nations, policies, and how laws have prohibited AI/ANs independence in America. Knowledge also includes understanding historical trauma, family systems, communication norms, belief systems, and identity systems. There can also be a familiarity with the concepts of oppression, colonialism, and racism that all AI/AN people have experienced on various levels.
- **Skills:** active listening, comfort with silence, being in tune with symptoms of post-traumatic stress disorder (PTSD), suicide risk, and alcohol dependency. Skills also include navigating policies, organizations, reservation structures, urban communities, and agencies such as the Indian Health Service.
- **Values:** being grounded in community and a value system that relates to the Indigenous people, including respect, open-mindedness, and a willingness to take a step back from one's own thoughts and beliefs.

Moving Beyond Stereotypes in Multicultural Counseling

Multicultural counseling is "an approach to therapy that acknowledges and values diversity in individuals and takes into account the unique experiences, backgrounds, and cultural perspectives of clients. It aims to create a therapeutic

environment that is inclusive, respectful, and supportive of individuals from diverse cultural backgrounds" (Center for Mindful Psychotherapy, n.d., para. 3). Within this therapeutic environment, providers can help clients navigate their unique cultural experiences and challenges while honoring that culture and one's identity within it can impact their mental health and well-being (Resilient Mind Counseling, 2023).

Sessions often include exploring a client's cultural background and other aspects of their life that have influenced their experiences, beliefs, and values. Clinical social workers and other mental health providers can use this approach in various treatment modalities for mental health, trauma, relationship issues, personal growth, life transitions, work issues, women's issues, and grief and loss. Multicultural counselors communicate in a culturally sensitive way and are skilled in culturally responsive interventions (Center for Mindful Psychotherapy, n.d.)

One challenge that mental health providers may encounter in multicultural counseling is stereotyping and bias. A stereotype is a "set idea that people have about what someone or something is like, especially an idea that is wrong" (Cambridge Dictionary, n.d., para. 1). Stereotypes can oversimplify a person by thinking that they are the same as all the other people in the group they identify with. They can also reduce a person's identity to a few traits versus the many that people typically possess (Meister, n.d.).

Cultural competency can combat stereotypes in clinical practice. Part of cultural competency is understanding the effects of cultural differences. If there are misunderstandings about cultural differences with clients, especially those from the AI/AN community, stereotypes can develop, impacting the therapeutic relationship, leading to a lack of rapport, causing miscommunication and mistrust, and resulting in suboptimal care (Resilient Mind Counseling, 2023).

The following are steps that a clinical social worker or other mental health professional can take to reduce stereotypic thinking:

- Replace the stereotype: become aware of the stereotype being held and develop alternatives to it.
- Counter-stereotypic imaging: remember someone from the stereotyped group who does not fit the stereotype.
- Individuating: See each person individually and pay attention to the unique aspects of them beyond the stereotypes of the group(s) they identify with.
- Perspective-taking: Consider the perspective of someone else who is different from oneself.
- Contact: Be open to getting to know people from different social groups and spending time with them, which will help build confidence over time.
- Emotional regulation: Reflect on any negative feelings towards people from different groups. Positive emotions during a clinical encounter make it more difficult to stereotype.
- Mindfulness: Stay focused on the present so a stereotypic thought can be recognized before it may be acted upon (OMH, n.d.a).

These actions likely take time and consistency, but can be effective when used intentionally. Education and training are also beneficial for building these skills.

Section 2 Key Terms

Culture - “the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they “know”

about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death" (National Center for Cultural Competence, n.d.a, para. 1).

Cultural awareness - the mindful recognition of similarities and differences among groups. It includes understanding what culture is and what it is not, how people become part of a culture, and the role of culture in their lives. It also entails awareness of power, privilege, and oppression (National Center for Cultural Competence, n.d.a).

Cultural competency - "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (U.S. Department of Health and Human Services, as cited in the National Center for Cultural Competence, n.d.b, para. 23).

Section 2 Reflection Questions

How are you developing and fostering cultural awareness and competency in your work?

After reading the material in this course, are there any steps you need to take to continue developing your cultural competency?

Section 3: Substance Use and Mental Health Factors in American Indian and Alaska Native Communities

References: 1, 2, 3, 12, 13, 19, 22, 27, 32, 35, 38, 39, 41, 42, 46, 47, 48

Before discussing substance use and mental health factors impacting AI/AN communities, it is important to review trauma, including historical trauma, as it has a strong connection to substance use and mental health in these communities.

Trauma

Many AI/AN people have experienced at least one traumatic event in their lifetimes, and many, if not all, have been impacted by historical trauma that happened across generations (also called intergenerational trauma). Historical trauma is a risk factor for substance use and mental health disorders (SAMHSA, 2018).

Intergenerational trauma "occurs when a traumatic event takes place to either an individual, family, or collective community and gets passed down to subsequent generations. Traumatic events are often perpetrated by outside sources rather than within the family itself" (Abbriano, 2022, para. 3). Examples include oppression, discrimination, and violence, which have all been experienced by AI/AN communities.

According to Abbriano (2022), "historical trauma is an example of intergenerational trauma and refers to the legacy of traumatic events that are experienced by a collective group of people. Often, these communities have faced oppression, and the social and psychological effects can be observed among succeeding generations" (para. 5). In AI/AN communities, historical trauma may be referred to as a "soul wound" that affects many aspects of health, including

physical, psychological, social, and cultural (SAMHSA, 2018). Three characteristics encompass historical trauma, including:

- Wide-ranging, long-lasting effects on the health and well-being of survivors and their descendants.
- Collective suffering within a community as a result of highly traumatic events.
- Malicious, purposeful intent of the people, often outsiders, who caused these traumatic events (Evans-Campbell & Walters, 2024; Wesley-Esquimaux & Smolewski, 2004, as cited in Abbriano, 2022, para. 5).

The effects of historical trauma have been well studied and documented, and can present as:

- Substance abuse
- Suicidal thoughts
- Depression
- Anxiety
- Suicidality
- Post-traumatic stress disorder
- Low self-esteem
- Shame
- Anger
- Violence

- Trouble regulating emotions (Brave Heart, 2000 & Evans-Campbell, 2008, as cited in Abbriano, 2022, para. 5; SAMHSA, 2018).

It is important to recognize that each tribe has its own history of contact with the Europeans, but that they all have similar experiences of loss and trauma because of colonization and the significant oppression that has followed. Most AI/AN individuals believe that the historical trauma they have experienced, including the loss of culture, is at the heart of substance use and mental health disorders within their communities.

AI/AN individuals may also experience grief as a result of historical trauma, which may be a different type of grief than what some other clients experience. Their grief can be related to the loss of their communities, lives, freedom, land, self-determination, native cultural and religious practices, native languages, and the loss of children who were removed from their families (SAMHSA, 2018).

In addition to historical trauma, there is trauma that happens throughout the lifespan, called lifetime trauma, which is also connected to substance use disorders across AI/AN communities. Lifetime trauma is reviewed later in this section.

Substance Use

Evans-Campbell and Walters (2024) state, “substance use among AI/ANs is a complex and highly varied phenomenon” (p. 266). There are variations by age, tribal nation, and region, with some communities having very high rates of substance use disorders while others have lower rates. Most AI/AN adults do not have issues with substance misuse, and many abstain from using at all. However, at the same time, research has found that AI/ANs have some of the highest rates of illicit drug, alcohol, and tobacco use in their lifetime, which has led to many serious chronic health problems and resulted in premature deaths (Evans-

Campbell & Walters, 2024). There have been suggestions that genetic factors play a part in the high rates of substance use. However, there has not been a direct link between genetic factors and substance use in AI/AN communities (SAMHSA, 2018).

Alcohol Use

Current substance use in AI/AN communities has been directly linked to the introduction of alcohol by the colonists. Before colonization, some Native American nations produced fermented beverages, though this was uncommon, as substances were restricted to specific areas and used primarily in ceremonies. However, historical evidence has shown that colonists introduced alcohol to tribal communities in the 16th century with the intention of undermining them. Colonists used alcohol a lot in trade negotiations, which could have elevated its status. They also brought it into communities that did not have any social or political shared norms and parameters for using substances, so when European settlers and traders modeled heavy drinking as normal behavior, it became this way in AI/AN communities as well.

During the mid 1700s, the negative impact of alcohol on tribal communities was widely known in the U.S. By the mid 1800s, federal prohibitions against alcohol use on reservations were put into place. Tribal communities also initiated prevention efforts to restrict alcohol sales to AI/AN communities and increase cultural connectedness. When the 18th Amendment was repealed in the 1930's, the tribal ban on alcohol remained in place for a few more decades, until 1953, when Congress reformed the law that ended AI/AN alcohol prohibition in general (Evans-Campbell & Walters, 2024).

Despite this history with alcohol, its use remains the primary substance being abused and a significant issue in AI/AN communities today. The Office of Minority Health (2026b) has reported the following statistics on alcohol use in AI/AN adults:

- In 2024, those ages 21 and over were 3% more likely than all U.S. adults over 21 to have binged alcohol in the last month.
- In 2024, they were 3 times more likely to have received substance use treatment in the past year when compared to the U.S. population overall.
- In 2022, they were 5 times as likely to have an alcohol-induced death as the U.S. population overall.

The 2024 National Survey on Drug Use and Health, conducted by SAMHSA, found the following about alcohol use in AI/AN people aged 12 or older:

- Almost 69% reported consuming alcohol at some point in their lifetime.
    - Among youth aged 12 to 17, the rate was about 22%.
    - Among those aged 18 and older, the rate was approximately 77%.
- About 46% reported drinking alcohol in the last year.
    - Among youth aged 12 to 17, the rate was about 14%.
    - Among those aged 18 and older, the rate was just over 50%.
- Approximately 30% had used alcohol in the last month.
    - Among youth aged 12 to 17, the rate was about 6%.
    - Among those aged 18 and older, the rate was 34%.
- Close to 20% reported binge drinking in the past month, which was defined as consuming 5 or more drinks for men and 4 or more drinks for women on occasion.

- About 6% reported heavy alcohol use in the past month, which was defined as binge drinking on five or more days in the past month (National Institute on Alcohol Abuse and Alcoholism, 2025).

While the prevalence of alcohol use in the past month and year is lower for the AI/AN population when compared to the general U.S. population, binge drinking remains similar across races. Heavy alcohol use and alcohol-related mortality are higher in the AI/AN population (Indian Health Service, 2023). At the same time, AI/AN people are more likely than some groups to abstain from alcohol and are about three times more likely to have become abstinent than former drinkers in the general population. They are also more likely than all other major racial and ethnic groups to seek substance abuse treatment (National Institute on Alcohol Abuse and Alcoholism, 2025).

Opioid Use

In addition to alcohol, opioid use is a growing epidemic in tribal communities, especially in Indian Country (where Native people have lived and continue to live). Opioids are often considered a gateway drug that leads to poly-substance use with other illicit drugs. The following are statistics concerning opioid and illicit drug use in AI/AN adults:

- They have the highest opioid-related overdose death rate when compared to other racial and ethnic groups.
- They die at higher rates from opioid related (nearly 3 times higher) and heroin-related (4 times higher) overdoses than any other group in the U.S., which accounts for a 500% increase in AI/AI overdose mortalities since 2000.
- Well over half of opioid involved deaths involved other illicit drugs, including cocaine, benzodiazepines, and methamphetamine.

- From 2006 to 2012, nearly 80% of AI/AN drug overdose deaths were in the Pacific Northwest region and were related to prescription opioid misuse.
- Heroin use after opioid addiction is becoming more common, with death rates of heroin overdoses rising 236% from 2010 to 2014.
- Native men are twice as likely as Native women to die from opioid and heroin overdose, and these deaths are most common in people who are 25 to 54 years old or living in urban settings (Evans-Campbell & Walters, 2024).

Tobacco Use, Nicotine Vaping, and Illicit Drug Use

The 2021-2023 National Surveys on Drug Use and Health, conducted by SAMHSA, found the following about tobacco use, nicotine vaping, and illicit drug use.

- Nearly 40% used tobacco products or vaped nicotine in the last month.
- Nearly 40% used an illicit drug in the past year, with the most common drug being marijuana (at almost 33%). About 6% misused opioids or central nervous system stimulants in the last year as well.

Notably, AI/AN adults had the highest rates of using tobacco products or vaping nicotine and illicit drug use (SAMHSA, 2024). The second most commonly abused substance for AI/AN people is marijuana (SAMHSA, 2018)

The Office of Minority Health (2026b) has reported the following statistics on drug use in AI/AN adults:

- In 2024, they were 9% more likely than U.S. adults overall to have ever used an illicit drug.
- In 2022, AI/AN people were twice as likely to die from a drug overdose as the overall U.S. population.

Substance Use Disorders

A substance use disorder is a complex condition. The American Psychological Association (2023) defines it as “a cluster of physiological, behavioral, and cognitive symptoms associated with the continued use of substances despite substance-related problems, distress, and/or impairment” (para. 1). Substances include several classes of drugs, from caffeine, tobacco, and alcohol to stimulants and hallucinogens.

Symptoms of substance use disorders fall into four main categories:

- Impaired control
    - Taking the substance in larger amounts or over a longer time than intended.
    - Unsuccessful attempts or a continuous wanting to cut down or stop the use of a substance.
    - Spending much time obtaining, using, and recovering from the effects of a substance.
    - Having ongoing cravings, a strong desire, or urges to use the substance at any time.
- Social problems
    - Not being able to manage roles and responsibilities at work, school, or home due to substance use.
    - Continuing to use the substance regardless of recurrent social or interpersonal issues.
    - Reducing or stopping participation in social, recreational, or occupational activities due to substance use.

- Risky use
    - Continuing to use a substance even when it causes dangerous situations.
    - Continuing to use a substance despite knowing about a physical or psychological problem that is possibly being made worse by the substance.
- Pharmacological effects
    - Increasing the amount of the substance used to achieve the desired effect (tolerance).
    - Developing withdrawal symptoms when the use of the substance stops. These symptoms are relieved by using more of the substance (American Psychiatric Association, 2024; Hartney, 2024).

The 2021-2023 National Surveys on Drug Use and Health, conducted by SAMHSA, found the following about substance use disorders in AI/AN adults:

- Approximately 27% had a substance use disorder in the past year, with drug use disorders being more common than alcohol use disorders.
- In 2024, they were 37% more likely than U.S. adults overall to have a substance use disorder and a mental illness.
- In 2024, they were 3 times more likely to have received substance use treatment in the past year when compared to the U.S. population overall.
- Nearly 70% of those asked about recovery from a substance use problem responded that they were currently in recovery, though only about 19% responded that they thought they had an issue with drugs or alcohol.

AI/AN adults had the highest rates of substance use disorders when compared to some other racial and ethnic groups (SAMHSA, 2024).

Impact of Substance Use on Physical Health

Alcohol consumption and illicit drug use can also increase the risk of chronic illnesses and communicable diseases. Risk is particularly increased for obesity, diabetes, unintentional injury, and premature mortality. When inequities in socioeconomic and environmental factors are added to a chronic disease, it has been called a “synergistic epidemic” or “syndemic,” which accelerates poor population health, especially during pandemics and environmental disasters (Evans-Campbell & Walters, 2024, p. 270)

When looking at the overall impact of the COVID-19 pandemic and substance use disorders in AI/AN adults, it has been noted that their average life expectancy has dropped by close to 7 years, from 72 to 65 years old, which has not been seen in the general U.S. population for close to 80 years. The following are considered drivers of this earlier mortality:

- COVID-related deaths
- High levels of distress due to COVID-related deaths
- Opioid overdoses
- Issues with accessing substance use prevention services and treatment
- Lack of recovery support service
- Death by suicide
- Chronic liver disease (Evans-Campbell & Walters, 2024)

Risk Factors

Many factors contribute to the high rates of substance use among AI/AN people. The likely reasons for high rates of substance use in AI/AN communities are that they are "exposed to a greater degree to the same risk factors that are predictors of problems for everyone, such as poverty, unemployment, and trauma (including historical trauma), as well as loss of cultural traditions" (SAMHSA, 2018, p. 7). In addition to cultural suppression, there have been genocidal attacks on Indigenous communities, land loss, forced relocation, removal of children from their homes, and a lack of access to culturally responsive services and education (Evans-Campbell & Walters, 2024).

Socioeconomic Factors

Socioeconomic challenges greatly impact AI/AN communities and contribute to substance abuse risk. In a report from the U.S. Census Bureau titled "Poverty in the United States: 2024":

- The AI/AN alone population had the highest poverty rate at approximately 20% when compared to other races and ethnicities.
- The lowest poverty rate was close to 8% for the White alone, non-Hispanic population (nearly 12% difference when compared to AI/AN alone).
- The AI/AN population's poverty rate, alone or in combination, was close to 18%.
- For both groups (AI/AN alone or in combination), those 18 and under have the highest poverty rate, with it reaching nearly 26% in the AI/AN alone population (Shrider & Bijou, 2025).

Some drivers of poverty in AI/AN communities include:

- Changes in the U.S. economy, including significant job losses in construction and manufacturing, a lack of minimum wage increases, and greater employment instability.
- Policies at the local and tribal level do not always align with federal policies (Redbird, 2020).
- Tribal governments also lack a tax base, so they rely on business revenue to fund services. The COVID-19 pandemic disproportionately affected tribal revenues, as one survey found that 75% of respondents reduced economic development services due to decreased revenue.
- Native American communities may also have less access to banking, which can be more expensive, as there are typically more fees for receiving money or cashing checks without a bank account. They also have fewer opportunities to build wealth, such as owning a home or building credit, which can help create other economic opportunities.
- Greater rates of unemployment and less education, especially quality or higher education, which can lead to fewer job opportunities or lower-paying jobs (Joint Economic Committee, n.d.)

In 2024, the estimated median 12-month household income for the AI/AN population was $62,240, which is nearly $20,000 less than that of other U.S. households. In addition, the unemployment rate was nearly 8% compared to 5% for the total U.S. population (OMH, 2026b).

Research in a variety of populations, including AI/ANs, suggests that poverty is a contributor to some mental health and substance use disorders developing and persisting, as well as their severity. Unemployment also puts AI/AN people at higher risk for substance abuse, and it may contribute to other behavioral health problems (SAMHSA, 2018).

Regarding educational attainment, about 78% of AI/AN adults aged 25 and older had a high school diploma or higher, compared with 90% for the total U.S. population. Additionally, only 16% of AI/AN adults had a bachelor's degree or higher, compared to 36% of the total U.S. population (OMH, 2026b).

Notably, more tribal nations have been investing in education since the 1980s. Although educational attainment is lower, more AI/AN adolescents and young adults have attended high school and college than ever before. One in 5 reservations also offer elementary and high school education, which benefits community members who have moved back to rural parts of the country (Redbird, 2020).

Microaggressions

Microaggressions are "the common and persistent experiences of discrimination and racism encountered by people from diverse groups. Such experiences may be covert or overt and include daily discriminatory stressors" (Evans-Campbell & Walters, 2024, p. 272). Research has shown that microaggressions are correlated with symptoms of distress and that daily discrimination can be more distressing than occasional or time-limited discrimination. For example, in AI/AN individuals, discrimination is related to distress and substance use disorders, and experiencing discrimination in childhood is linked to increased PTSD symptoms and polydrug use (Evans-Campbell & Walters, 2024).

Acculturation Challenges

Another risk factor for AI/ANs is social pressure to fit in with their native culture and mainstream practices. This challenge may arise when they transition from a reservation to an urban environment and try to navigate a culture different from their ancestors'. Cultural norms and behaviors in these two environments are often very different, making integration difficult. Using substances can provide an

escape from the pressures associated with acculturation and the conflict AI/ANs may feel between the two environments (Soto et al., 2022).

Lifetime Trauma

In addition to historical trauma, AI/AN people are more likely to suffer from many different types of lifetime trauma. Trauma exposure is associated with an increased risk of certain behavioral health issues, such as substance abuse. The following are examples of lifetime trauma exposure.

- Many AI/AN people live in rural areas, where infrastructure, such as roads, may be less developed, and outdoor activities are more common. Car accidents and unintentional injuries from other accidents can be related to both. High rates of binge drinking and other substance use also increase risk for accidents. Since there are fewer resources for medical care in rural areas, accidents are more likely to be fatal.
- AI/ANs are more likely to experience violent crimes than any other racial and ethnic group. Violent acts against AI/ANs are typically done by members of other racial and ethnic groups and strangers (SAMHSA, 2018).
- Interpersonal violence is one of the most significant trauma experiences within Indigenous populations. Research has found that AI/AN people are more likely to be victims of intimate partner violence when compared to other racial and ethnic groups. One study found that 55% of AI/AN women and just over 43% of AI/AN men were victims of intimate partner violence at some point in their lives, compared to 34.5% of White women and 30% of White men. Interpersonal violence can be sexual and/or physical and includes stalking and psychological aggression as well.
- Child maltreatment is another significant trauma experience in this population. AI/AN children have the second-highest rate of referrals that

require a response from a child welfare agency and the highest substantiated victimization rate of any group (Evans-Campbell & Walters, 2024). One study also found that AI/AN children are more likely to die from abuse than White American or African American children (SAMHSA, 2018).

Familial Substance Use

When AI/AN parents and other family members use substances, the likelihood that youth will also use them is increased. Possible explanations for this association are adults modeling substance use and having a tolerant attitude towards it, as well as adults not monitoring their children or being the ones to offer them drugs or alcohol. AI/AN youth often spend a great deal of time with their family members and community, so it can be difficult for them to refuse substances from an adult. Youth likely want to be accepted by their family and participate in community ceremonies where substances may be used, which can influence their use. Furthermore, spending a lot of time with family creates increased access to substances in the home (Soto et al., 2022).

Protective Factors

Within AI/AN communities, protective factors that may reduce the impact of trauma on substance use disorders and other health conditions include culture and connection, identity attitudes, and spirituality.

Culture and Connection

While there is a lot of cultural diversity among Indigenous/Native communities in the U.S., it is common for there to be some similarities, including an appreciation for land and nature, being connected to the past and others in the community,

fostering family bonds, following Elders' wisdom, and honoring meaningful traditions (NAMI, n.d.).

Many AI/AN people are deeply connected to their Native communities and culture, even if they do not live on tribal land. Some communities offer culturally responsive prevention and intervention services related to substance use. These services may include community events such as healing ceremonies focused on well-being and sobriety, rituals, role modeling, and storytelling. Healing is often focused on an individual and their family system, highlighting the importance of sobriety. The focus on community can be powerful in recovery (Evans-Campbell & Walters, 2024).

Additionally, when a person has strong social support from family and friends, including ongoing parental involvement and positive peer relationships, they are less likely to use substances (Soto et al., 2022). Therefore, a connection to people may be just as important as a connection to one's culture.

Identity Attitudes

A positive identity can contribute to wellness in Native communities. When people can separate themselves from negative attitudes related to colonization, they can experience fewer effects of trauma, including substance use. When people feel positive about who they are and their connection to their culture, they are often more resilient against discrimination and racism and less likely to misuse substances (Evans-Campbell & Walters, 2024).

Spirituality

Spiritual beliefs and practices vary widely across Native communities, but there are some commonalities. For example, a common spiritual belief is the importance of "living in harmony and balance with others and with the world,

believing that there is order to the universe, and feeling a connection with others and with all life" (SAMHSA, 2018, p. 33). Additionally, according to Evans-Campbell and Walters (2024), "many traditional and spiritual customs require sobriety, which not only supports individual healing but helps ensure AI/AN community survival and the ability to thrive" (p. 275). Furthermore, some spiritual practices focus on reconnecting with family, community, and cultural traditions, as well as the mind-body-spirit connection, all of which promote recovery and healing (Evans-Campbell & Walters, 2024).

Mental Health

The Office of Minority Health (2026a) defines mental health as being about "how we think, feel, and connect with others. It affects how we handle stress, make decisions, and go about our daily lives" (para. 1). When our mental health is good, life may feel easier, manageable, and enjoyable. However, when mental health is not good, physical health and self-esteem may decline, responsibilities can become more challenging, and it can feel harder to relate to others.

Some people have mental health symptoms that make it difficult to function in their day-to-day lives, which may be an indication of a mental health condition, such as depression, anxiety, or post-traumatic stress disorder. Other people may not be diagnosed, but still have challenges with their mental health, which includes feeling stressed or overwhelmed (OMH, 2026a).

Evans-Campbell and Walters (2024) state that it is appropriate for AI/ANs to have some of the highest rates of mental health disorders in the U.S. because of the oppression that their communities have endured throughout history, as well as the high rates of lifetime trauma exposure and ongoing marginalization. Depression, anxiety, and PTSD are commonly experienced by people who have

experienced trauma. These conditions have been linked to alcohol use and substance use disorders in AI/ANs.

According to the National Alliance on Mental Illness (NAMI) (n.d.), “mental health and emotional well-being among Indigenous/Native people are often closely tied to cultural traditions of prayer and ceremony. More recently, these supportive cultural traditions have been endangered by forced assimilation” (para. 11). One way that forced assimilation has occurred is when children were separated from their families and communities to receive their education in boarding schools that did not encourage their culture or language. Some children were violently disciplined and died, while others who were in this environment were left to deal with the trauma they experienced. Another occurrence of forced assimilation was through federal policies that limited the rights of AI/AN people.

In addition to substance use disorders described above, the result of the various traumas that AI/AN people have experienced is mental illness and suicide (NAMI, n.d.). The 2024 National Survey on Drug Use and Health, conducted by SAMHSA, found the following about mental health in AI/AN adults:

- In 2024, they were 11% more likely to report having a mental illness in the last year when compared to U.S. adults overall.
- They had higher rates of psychological distress, feelings of worry, nervousness, or anxiety, and a major depressive episode in the past year than some other groups.
- In 2024, they were 17% less likely than U.S. adults overall to have received mental health treatment in the past year.
- In 2022, AI/AN people were 91% more likely to die by suicide than the U.S. population overall (OMH, 2026a).

AI/AN adults have higher rates of suicide, suicidal ideation, and other mental health problems when compared to other groups. At the same time, close to 20% do not have health insurance, a rate more than twice that of the general population (OMH, 2025).

Data from a different survey, titled the National Epidemiologic Survey on Alcohol and Related Conditions-III, found the following about AI/AN adults:

- They had higher lifetime rates of PTSD when compared to non-Hispanic white people (approximately 23% to nearly 12%), as well as higher rates of alcohol use disorder in the past year (nearly 20% to just over 14%), and comorbid lifetime PTSD with an alcohol use disorder in the past year (6.5% to nearly 2.5%).
- AI/AN men were three times more likely to have PTSD and an alcohol use disorder, and AI/AN women were two times more likely to have both when compared to non-Hispanic White men and women (Evans-Campbell & Walters, 2024).

Co-occurring substance use and mental health disorders are often complex for various reasons, one of them being that they can exacerbate one another. Research has shown that a lack of coping strategies, self-efficacy, and problem-solving skills, as well as cognitive behavioral processes (an individual thinking that they will not be greatly affected by substances), are reasons that people struggle with both substance use and mental health disorders. For example, people with mental health disorders, such as depression, anxiety, or PTSD, may self-medicate to cope with their mental health symptoms and be relieved from any emotional pain that they may be experiencing. Substance use also allows them to escape from their problems and feelings of inadequacy (Soto et al., 2022).

Section 3 Key Terms

Intergenerational trauma - “occurs when a traumatic event takes place to either an individual, family, or collective community and gets passed down to subsequent generations. Traumatic events are often perpetrated by outside sources rather than within the family itself” (Abbriano, 2022, para. 3).

Historical trauma - an example of intergenerational trauma and refers to the legacy of traumatic events that are experienced by a collective group of people. Often, these communities have faced oppression, and the social and psychological effects can be observed among succeeding generations” (Abbriano, 2022, para. 5)

Lifetime trauma - the cumulative impact of trauma that occurs during a person’s life, from childhood to adulthood.

Substance use disorders are complex conditions. The American Psychological Association (2023) defines them as “a cluster of physiological, behavioral, and cognitive symptoms associated with the continued use of substances despite substance-related problems, distress, and/or impairment” (para. 1).

Microaggressions - “the common and persistent experiences of discrimination and racism encountered by people from diverse groups. Such experiences may be covert or overt and include daily discriminatory stressors” (Evans-Campbell & Walters, 2024, p. 272).

Section 3 Reflection Questions

What are your thoughts on the statistics presented in this section? Was there anything that surprised you?

What risk and protective factors do you see most commonly in your practice?

Section 4: Best Practices for Clinical Social Work Practice with the American Indian and Alaska Native Population

References: 12, 15, 21, 25, 40, 41, 52

The first best practice for clinical social workers and other mental health providers working with AI/AN people is to acknowledge the diversity among them. Generalizing about cultural information when working with Native Americans is discouraged, as each person's culture and experience of it are likely to differ. For example, when considering mental health and substance use specifically, there are different views on these issues, attitudes about seeking help, and the appropriate treatment. There are also different perspectives on using diagnostic terminology because naming certain things may have spiritual significance to a person.

Treating each client as an individual is already a core value of clinical social workers and other mental health providers. However, it is even more essential when working with AI/AN people, given the great diversity and experience within their communities.

In addition to acknowledging diversity, clinical social workers and other mental health providers are encouraged to become familiar with the history, culture, and practices of the specific tribe(s) their clients identify with. They are also encouraged to learn about tribal sovereignty, tribal governance systems, resources, and AI/AN-specific services, as this will support all aspects of mental health care, including treatment planning and referrals. Alongside their own research, they can talk individually with their clients about their culture and its meaning to them. AI/AN clients will likely feel more comfortable and achieve better outcomes if their providers understand and respect them and their culture. Furthermore, clinical social workers and other mental health providers are

encouraged to obtain the skills to provide individualized, culturally competent care. For example, in an initial assessment or interview, asking about a client's involvement in traditional healing practices can be helpful in treatment planning (Evans-Campbell & Walters, 2024; SAMHSA, 2018; Yehieli & Grey, 2005).

Clinical Practice Considerations

This section will cover some clinical practice considerations when working with AI/AN clients.

First, it is important to understand that mistrust exists within AI/AN communities based on the oppression, discrimination, and racism they have faced for centuries. Next, AI/AI people may not seek services or treatment due to certain cultural considerations, but even if they do, they may be ambivalent about change or avoid engaging with it. These can be considered healthy responses to perceiving that their health, wellness, and safety could be threatened.

Communication

Knowing how to communicate appropriately is a key best practice for clinical social workers and other mental health providers. Part of this knowledge is understanding the language preferences and communication norms of the communities they are working with.

In terms of language, many Native Americans today speak English as their primary language, but they may incorporate indigenous phrases and words into everyday speech. For some people, English is their second language. A best practice for language preferences and abilities is to ask AI/AN clients if they are comfortable receiving services in English. If they are not comfortable with it, it is important to connect them to services in their language or to have a trained translator available, either in person or via teleconference.

When a clinical social worker or other mental health provider meets an AI/AN client for the first time, they should listen to how the client introduces themselves. Some clients may prefer a handshake while others do not, so the cue for this greeting can come from the client. Then they can introduce themselves to the client by stating their name and job title, explaining what their work entails, and sharing something personal. In some AI/AN cultures, it is more important for a person to talk about who they are, so this can be done briefly during introductions by mentioning a birthplace or something about one's family. Then, describing services and how they work also supports transparency and understanding on behalf of the client, especially if they have never received support for a mental health or substance use issue. Observing eye contact can help a provider understand their client's cultural preference in this area. Direct eye contact may be avoided when communicating with another person, and greater body distance is often observed, both of which are signs of honor and respect. Adjusting eye contact may also be appropriate based on a specific client's culture.

Explaining confidentiality should also take place during an initial meeting. It is normal for clients to have concerns about whether their information and what they share during treatment will be discussed with anyone, especially in smaller communities. A clinical social worker or other mental health provider should inform their client about what they will share, if any, and with whom. A client may also have concerns about being seen at a particular office or center, especially if they know others who go there for treatment or work there. The provider can explore transportation and/or parking options with them and also help them navigate an office. Ultimately, if the client is not comfortable and does not consent, they may be better served at another facility.

During the initial meeting and other sessions, clinical social workers and other mental health providers will likely find it helpful to listen intently, observe

nonverbal communication, ask open-ended questions, anticipate long pauses for reflection, and allow time for responses, as best practices in communicating with AI/AN clients. Being silent and patient is key.

In general, Native Americans are reserved, subtle, and thoughtful when expressing their thoughts and feelings directly. They believe words are important and should be chosen wisely, so they often think carefully before speaking, and in some cases, they may use humor. Their speech may use metaphors, stories, and examples to communicate their message. They may be quiet or stoic. In some cultures, being quiet is respectful. If English is their second language, they may pause to give themselves time to translate their thoughts into speech (SAMHSA, 2018; Yehieli & Grey, 2005).

It will take time to establish rapport and build trust with AI/AN clients, especially with non-Native workers (Evans-Campbell & Walters, 2024). Taking the time to get to know the client as a person, rather than only in this role, is beneficial in building a trusting relationship, as it shows an interest in them and confirms they are valued.

Once a relationship is established, AI/AN clients may respond well when providers share their own experiences or discuss how others in their practice are addressing the same issues. They will likely respond better to this approach than to accepting suggestions about what they should do. However, again, providers should not share this information too early in the relationship, as it may lead to skepticism or mistrust. It can also be beneficial to be mindful of the terms used to name or describe a disorder for which a client is seeking help. In some AI/AN cultures, naming a disorder or labeling the person with it can be viewed negatively and may make them feel ashamed. For example, using person-centered language like “a person in recovery” instead of “a person with a substance use disorder” is likely to be received more positively. Framing the issue in a hopeful way and focusing on

strengths when possible will likely improve the client's reaction to the work they are doing with a provider and their outcome.

Provider Preference

One myth that exists is that AI/ANs do not seek treatment for mental health and substance use disorders. However, many native people seek help from traditional healers, mainstream providers, mutual help groups, or a combination of all of them. This statement is true for people living on reservations and for those who do not. AI/AN people who live in native communities and are traditional in their beliefs often prefer to receive services in their own community instead of outside of it. Others may prefer to travel a distance to seek services to remain anonymous. Some may prefer AI/AN providers, but cultural competency and interpersonal skills also play a role in provider preference. For example, AI/ANs may prefer to work with someone who is their authentic self. Providers who know their own cultural heritage and are willing to talk about it show respect for their own culture as well as their clients'. However, their clinical approach should still be culturally responsive to their client's needs (SAMHSA, 2018).

Informed Consent

Because of mistrust among Native American people, they may be hesitant to sign informed consent forms that clinical social workers and other mental health providers likely need for services. They may also want their family to be involved in their care to assist them in reviewing forms or making decisions.

Scheduling

Some Native Americans may place less emphasis on time than people in American culture, so it can be helpful to adopt a flexible, open schedule, if possible. Having office hours for drop-in visits, varying scheduling times, and an open-door policy

may be helpful strategies for addressing issues with traditional, predetermined schedules that clients may not adhere to (SAMHSA, 2018; Yehieli & Grey, 2005).

Family and Community Considerations

Most Native Americans value family and community more than mainstream American culture, which is often focused on individual efforts and privileges. For example, extended family members are often strongly involved in each other's lives. Aunts and uncles in a child's extended family may be close and serve as second parents. Grandparents may also raise children with the support of extended family members. Depending on the tribe, a mother may have more than one father to her children and may not live with a spouse. Families may also include elders in raising their children. Additionally, people who are not blood relatives may be considered family.

AI/ANs may also feel a strong responsibility to honor elders and to bring honor to one's family, tribe, ancestors, and community. As a professional, it is important to respect this and not shame a person for it.

On the other hand, tension may exist in families when traditional Native American society and values are broken down. Some elders and other family members may feel less valued if younger generations choose a different path and societal roles that are not valued in their culture (SAMHSA, 2018; Yehieli & Grey, 2005).

No matter the client, it is important to understand their tribal culture regarding family and community, as well as their individual family system. Some questions that clinical social workers and other mental health providers can ask to understand a person's family and community are:

- Where did you grow up?
- Who was responsible for raising you?

- Who are the members of your family? (SAMHSA, 2018, p. 32)

Screening and Assessment

A clinical social worker or other mental health provider should follow the screening, intake, and assessment process outlined in their practice, agency, or program. The following are considerations when planning services with AI/AN clients. Keep in mind that some clients may view intakes and assessments as unnecessary, as they may have seen a traditional healer who does not take a history or ask the types of questions that are typically asked during a traditional mental health and/or substance use screening, intake, or assessment.

Screening

Mental Health and Substance Use

If using standard tools to screen for mental health, the following ones have been found culturally appropriate for Indigenous adults:

- The Center for Epidemiologic Studies Depression Scale (CES-D)
- The Patient Health Questionnaire-9 (PHQ-9)
- The Kessler Psychological Distress Scale (and its adaptations) (Meldrum et al., 2023).

Regarding suicide, the Indian Health Services (2017) recommends the Ask-Suicide Screening Questions (ASQ) tool. Though it takes minimal time to administer, it has been shown to increase screening rates and combat under-detection. The tool is not intended to replace other clinical tools that further assess risk, such as the PHQ-9.

Regarding substance use screening, the Indian Health Service (n.d.b) recommends:

- The Alcohol Use Disorders Identification Test (AUDIT)
- The Alcohol Use Disorders Identification Test - C (AUDIT-C)
- The CAGE (a four-item assessment test)
- The Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS)

They also recommend the Screening, Brief Intervention and Referral to Treatment (SBIRT) model, which is an evidence-based approach to identify, reduce, and prevent problematic alcohol and illicit drug use, abuse, and dependence (Indian Health Service, n.d.b, para. 6).

Assessment

When assessing AI/AN clients, it is important first to obtain their perspective on their current situation. It may be appropriate to ask them what events led to their concerns and the decision to seek help, what caused the problems, how the problems are impacting their spiritual, relational, emotional, physical, and mental health, and what they think about how they can achieve a more balanced state. It may also be beneficial to ask them what their family and/or community is saying about the problem and how it is affecting them, what they already know about these types of problems, and if they have already done anything to move towards healing. Additionally, ask them what they think they need to do to heal and what successful healing would look like. It is important to listen to their motivations for healing as well. Furthermore, assessing trauma, including historical trauma, is an essential part of the assessment process when working with AI/AN clients (SAMHSA, 2018).

Historical Trauma

One best practice for clinical social workers and other mental health providers is to assess, acknowledge, and address historical trauma. According to SAMHSA (2018), “most American Indians and Alaska Natives believe that historical trauma, including the loss of culture, lies at the heart of substance use and mental disorders within their communities” (p.8). When interacting with AI/AN clients, it is essential to be mindful that each tribe has its own history with Europeans and colonization. Some providers may think it is less important to focus on addressing the history and role of trauma in their clients’ lives. However, when working with AI/AN individuals, incorporating the role of historical trauma in psychosocial assessments, treatment plans, and implementing healing strategies is critical. The following are symptoms of historical trauma to be mindful of and to assess for:

- Mental and/or emotional numbing
- Depression
- Misusing substances
- Being fixated on trauma
- Hypervigilance
- Anger
- Self-destructive behavior
- Survivor’s guilt
- Low self-esteem
- Identifying as a victim
- Internalizing oppression

- Preoccupation and internalization of ancestral suffering
- Loyalty to and identifying with deceased family members

Working with the concept of historical trauma can help providers discuss trauma as a collective experience that communities can support each other through. Framing trauma, both past and current, in this way can help it seem less stigmatizing (SAMHSA, 2018).

Cultural Identity and Aculturation

Not all AI/AN clients will want to connect with their native cultures. However, culturally responsive services offer them the opportunity to explore the impact of culture, discrimination, bias, and acculturation, both past and present, as they relate to mental health and/or substance use disorders (SAMHSA, 2018, p. 50). It is essential to spend time learning about a client's cultural heritage and the importance and influence of the native culture in their lives (SAMHSA, 2018).

One important aspect of the assessment process is gaining an understanding of the client's degree of culturalization and the level of acculturation they identify with most (Herring, 2019; SAMHSA, 2014). Acculturation can be defined as "the socialization process through which people from one culture adopt certain elements from a dominant culture in society" (SAMHSA, 2014, p. 295). Choney et al.'s model of acculturation includes 5 levels:

1. A traditional orientation: A person is completely oriented toward their native culture.
2. A transitional orientation: A person is more oriented toward their native (or traditional) culture but has some familiarity with mainstream culture.
3. A bicultural orientation: A person is equally comfortable and has knowledge of both their native (or traditional) and mainstream culture.

4. An assimilated orientation: A person is mostly oriented toward mainstream culture but has some familiarity with their native (or traditional) culture.
5. A marginal orientation: A person is not comfortable with either culture (SAMHSA, 2014, p. 25).

This concept is important to clinical practice because it provides a deeper understanding of a person's relationship with their native culture and other cultures they may be exposed to. There is evidence that the degree of acculturation is associated with how Native people, especially youth, perceive and respond to helping services (Herring, 1999).

One tool that can help mental health providers assess acculturation in adults is the Native American Acculturation Scale, which measures acculturation on a continuum from traditional Native American to assimilated mainstream American. There are 20 questions about language, identity, friendships, behaviors, background, and attitudes. Another tool that mental health providers can use with adults is the Rosebud Personal Opinion Survey, which evaluates "language use, values, social behaviors, social networks, religious affiliation and practice, home community, education, ancestry, and cultural identification" (SAMHSA, 2014, p. 254).

The following are examples of questions that can help understand a client's culture. As noted in the communication section above, it is best to ask open-ended questions and to allow for time for a response before moving to the next question:

- How do you self-identify?
- What experiences have you had that exposed you to the culture of your tribe?
- What language do you speak? Which one do you prefer?

- How do you describe your spiritual beliefs? How do you practice them?
- Do you have experience with traditional healing practices? If so, are you currently working with a traditional healer?
- How important is it to you to work with a traditional healer alongside our work together?

Minimizing Bias

One way to minimize bias during the assessment process is to use Dana's Assessment Model when working with Native adult clients. The five steps to this application include:

1. Completing an acculturation assessment.
2. Having a culture-specific delivery style.
3. Using the client's native or preferred language.
4. Selecting assessment measures appropriate for cultural orientation and client preferences.
5. Using a culture-specific strategy when informing the client about the findings from the assessment process (Herring, 1999, p. 45).

Other Clinical Practice Considerations

Offering Services

A clinical social worker or other mental health provider can offer services in person in a clinic or office setting. However, AI/AN clients may live in remote areas and experience barriers to accessing care. In these instances and others, telehealth may be an effective way of providing services.

Creating and Implementing Services

If clinical social workers or other mental health providers are interested in creating a new program or establishing themselves within an AI/AN community to provide direct clinical services, it is important to learn about the community's culture and build relationships within it. Both will take time and investment in people and their culture. Providers may be required to meet with multiple people throughout an often lengthy process, as tribal consensus is important in all aspects, but especially in welcoming people into their community. Clients, potential clients, and their families, as well as leaders and councils, should have an opportunity to provide input on the types of services that are needed and how they will be delivered. Building relationships and showing an interest in the community helps encourage their involvement in the process (SAMHSA, 2018).

American Indian and Alaska Native Perspectives on Health

A single perspective on physical and mental health and healing does not exist within AI/AN communities, but there are some commonalities among most AI/AN cultures. First, many AI/AN people try to balance their native views with mainstream ones and often seek help from mainstream providers and traditional healers. Second, physical, mental, emotional, and spiritual health are all viewed together (holistically), and one aspect is believed to affect another. Treating a problem within one of these areas may help others. Third, any aspect of health affects not only the individual but their family, community, and tribe, which can mean that healing and/or the process of it within a community can positively impact physical health. Fourth, illnesses are often believed to occur when a person is out of harmony, so healing includes restoring internal and external balance. Lastly, AI/AN people may believe that an illness is purposeful, meaning it occurred because an individual or their family went against their culture or natural law, thereby creating an imbalance (or the illness). This perspective means that an

AI/AN person may be held partly responsible for an illness developing, and that, in turn, the person with the illness may feel it is their responsibility to bear the burden of symptoms. An illness may also be personified, with a spirit that may need to be addressed as part of healing (SAMHSA, 2018).

Mental Health

More specifically, one best practice for clinical social workers and other mental health providers is to recognize the presentation and perspectives of AI/AN individuals on mental health. Native Americans may express mental health conditions as "vague physical symptoms such as aches, pains, and lethargy" (Yehieli & Grey, 2005, p. 114). Therefore, it is important to keep in mind that most AI/AN people do not view physical and psychological symptoms as separate from one another. Symptoms of a mental illness, such as hallucinations and manic or depressive symptoms, may be seen as an expression of a special gift. However, these types of issues and behaviors are typically more concerning in mainstream mental health care.

Instead of viewing a mental health condition or substance use disorder as a disease or diagnosis, some AI/AI people view these issues as a symptom that reflects an imbalance in how a person is relating to the world (SAMHSA, 2018). As stated by Yehieli & Grey (2005), "some Native Americans believe that mental illnesses are caused by patient disharmony with their environment, the spiritual world, or personal relationships. In other Native American cultures, mental imbalances may be considered the result of violations of cultural prohibitions, negative energy, or evil spirits" (p. 114). Many Native Americans believe that mental health conditions, such as depression or anxiety, "may be best treated through traditional medicinal, spiritual, and ritual purification practices" (Yehieli & Grey, 2005, p. 115).

Another best practice is to be mindful of the way a presenting problem is discussed with an AI/AN client. Training for most clinical social workers and other mental health providers is influenced by mainstream culture and common practices in mental health care. AI/AN clients may feel that these practices are insensitive to their beliefs. For example, they may not want to name an illness or condition, as they may believe that this gives it more power in their life. They may also not want to discuss the consequences of their behavior, if it is related to substance abuse, for example, as they may think this type of language has the power to shape their reality and future negatively (SAMHSA, 2018).

Lastly, it is important to be mindful that any exploration of mental health and/or substance use disorders is contextualized within the framework of institutionalized racism and historical traumatic events experienced by all AI/AN people. Though communities have shown strength and resilience throughout history, both continue to impact communities in many different ways (Evans-Campbell & Walters, 2024, p. 277).

Section 4 Key Terms

Culturalization - a complex concept that describes the process of changing behaviors and values of one culture as a result of contact with another culture (Herring, 1999, p. 14).

Acculturation - “the socialization process through which people from one culture adopt certain elements from a dominant culture in society” (SAMHSA, 2014).

Section 4 Reflection Questions

If you are not currently working with AI/AN clients, are there certain best practices that you want to begin focusing on?

If you are currently working with AI/AN clients, what are some best practices that you have found effective?

Section 5: Culturally Appropriate Treatment Interventions

References: 12, 23, 41

Many evidence-based treatment practices have primarily emerged from mainstream culture and do not involve participation from native cultures. While these approaches have value, practice-based strategies, along with native healing practices, will likely play a more significant role in treatment interventions for AI/AN clients.

When choosing an evidence-based practice with AI/AN clients, "it is important to examine the acceptability of the belief system that underlies the modality" (SAMHSA, 2018, p. 59). For example, living in the present is an important aspect of daily life for AI/ANs. So, a psychodynamic approach that primarily focuses on a person's past, such as their childhood and past relationships, to resolve current challenges may not be the most appropriate modality for AI/AN clients, especially if it is used alone.

It is also important to consider the communication style of a treatment modality, as many AI/AN clients have a specific style based on their cultural norms (SAMHSA, 2018). For example, cognitive-behavioral therapy and rational-emotive therapy are structured and direct. In contrast, client-centered and holistic therapies are less direct and may offer more opportunities to hold space for clients (Levine, 2025). Less directive therapies may be more effective for some AI/AN clients, given their communication norms.

There are other considerations when treatment includes group work, family involvement, and community-based interventions. When thinking about group therapy, it is critical to consider who is in the group (only natives or some natives and non-natives), how the group is conducted or structured, and how this will affect a client. In family therapy with AI/ANs, a clinical social worker or other mental health provider needs to understand the family system, hierarchy, dynamics, and cultural and historical influences. Community-based interventions can be effective when an AI/AN's problems are viewed as symptoms of the community's culture and/or their history of trauma.

Some AI/AN clients may view the introduction of an evidence-based practice or treatment modality as a message that there is only one way to do things, which can devalue the respect for many paths, practices, and beliefs that lead to healing (SAMHSA, 2018). Instead, embracing evidence-based practices and culturally appropriate modalities, while also being open to the idea that "healing is intuitive, interconnected with others, and comes from within, from ancestry, from stories, and from the environment" can help show alignment with AI/AN communities and the way they may approach treatment (Evans-Campbell & Walters, 2024; SAMHSA, 2018, p. 10).

According to SAMHSA (2018), "culturally responsive treatment requires establishing a standard of respect, focusing on strengths, and addressing underlying personal and historical trauma issues as appropriate. Traditional interventions (both client-centered and community-centered) and care that are integrated with mainstream treatment methods are recognized as best practices for native communities" (p. 6).

Holistic Perspective on Treatment

According to SAMHSA (2018), treatment interventions need to be inclusive of all aspects of an AI/AN person's life (holistic), including the spiritual, emotional, physical, social, behavioral, and cognitive factors that are seen and those that are under the surface. AI/AN people believe they cannot separate these aspects of their lives and that all of them provide a path to recovery, while embracing both native and mainstream healing practices (p. 8).

Involving family and community members in treatment and recovery from mental health and substance use disorders may be a cultural norm of value for many AI/AN people. Since many AI/AN people value their culture and community, maintaining or restoring a connection to these aspects of their lives can help prevent and treat mental health conditions and substance use disorders. When a person is connected or reconnected to their communities and native health practices, they may "reclaim the strengths inherent in traditional teachings, practices, and beliefs, and begin to walk in balance and harmony" (SAMHSA, 2018, p. 9). Therefore, treatment models that focus on the individual but are community-centered and culture-focused tend to be more effective than those that focus only on the individual (Evans-Campbell & Walters, 2024).

Additionally, a treatment planning approach that includes case management to address practical needs and provides therapy can be effective with AI/AN communities. Since they often view their lives, including their health and healing, as connected, it is common for AI/AI clients to seek help with concerns outside of traditional therapy that focuses on mental health and/or substance use. They may have issues with housing, transportation, unemployment, child care, relationships, and safety. Viewing treatment from psychological, behavioral, and practical perspectives can strengthen relationships and help clients succeed in the long term. Furthermore, staying open and flexible to a variety of treatment

interventions can be helpful when working with AI/AN clients. For example, they may not be receptive to traditional talk therapy, so experiential techniques such as art, meditation, or physical activities like walking may be more effective therapeutically.

Addressing historical trauma is especially important in the treatment process. Some of the most effective treatment methods involve families, communities, and other sources of support working together to overcome challenges. Connecting clients with these networks can also connect them with their native cultural beliefs and practices, leaders, and healers who can offer guidance and healing aligned with AI/AN cultural values (SAMHSA, 2018).

Traditional Healing

In mainstream culture, the words “medicine” and “healing” are typically positive concepts. People take medicine to feel better, and healing means they are recovering from an illness or condition (SAMHSA, 2018). However, in AI/AN culture, medicine “is the essence of being or spirit that exists in everything on Earth” (Garrett, 1999, as cited in SAMHSA, 2018, p. 43). Medicine can be positive or negative depending on how it impacts a person and their family. For example, it can be considered a good thing if it restores harmony, but it is most likely considered a bad thing if it disrupts it.

As noted above, many AI/AN people will seek help from both traditional healers and mainstream providers. Some may want to consult a traditional healer before entering a mainstream intervention program. Traditional healers may be called “medicine men or women,” but this can be confusing, as “medicine” has multiple meanings in their culture. Using words like “healing” or “help seeking” may resonate more with AI/AN clients.

Traditional healing transforms illness into health by addressing the mind, body, and spirit. Ceremonies, rituals, and storytelling may be performed by traditional healers, with the whole family or community present, to promote healing and restore connection to a tribe and its culture. These practices vary among tribes but are intended to increase social support, improve coping strategies and quality of life, and identify the meaning and purpose of illness within the community. Some rituals alter a person's consciousness to produce spiritual transformation. Religious beliefs may shape a person's views on traditional healing and acceptable practices. Some traditional healing practices that are common among more than one tribe include:

- Burning herbs for purification.
- Taking herbal remedies.
- Being a part of a talking circle where each person can express their thoughts and feelings.
- Participating in a sweat lodge or spirit lodge.
- Tribal dancing.
- Changing and singing.

Traditional healers receive several years of training to ensure they understand and can perform defined ceremonies, practices, and traditions. They have a different approach and relationship with clients than mainstream medical providers. They view healing as something done with the affected individual, spiritual entities, family, friends, and the healer. Healing is typically done in the client's home, another location within the community, or a natural setting outside the community, unlike mainstream medical care, which is provided in a variety of facilities. Traditional healers do not charge for their services, but they may accept gifts. As a best practice for clinical social workers and other mental health

providers working with clients who may interact with traditional healers, recommendations from elders and community leaders are encouraged, as there is no organization regulating the care they provide. Clinical social workers and other mental health providers should also not interpret healing practices or try to incorporate them into their own practice, as this misrepresents and exploits native cultures while also crossing ethical boundaries.

Traditional healers may look at symptoms of mental health conditions, such as depression or anxiety, as problems that are arising as a result of someone breaking a natural law or being unbalanced in their relationships with the family and community. A traditional healer would treat symptoms to restore balance and harmony regardless of the symptoms.

A client may want to involve a traditional healer in the treatment offered by a clinical social worker or other mental health provider.

- If a client is not already working with a healer, it is appropriate to ask them if they would like to work with one. If they answer yes, talk with them about how to arrange for this type of support while keeping in mind that others, such as clinical supervisors or tribal leaders, may need to help connect the client with an authentic healer.
- If a client is already working with a traditional healer, it is appropriate to ask if they would be open to their involvement in treatment planning and care. Some traditional healers can be allies to mental health providers and help support the work being done in treatment.
- If a client is not interested in working with a traditional healer, a provider can still assess and plan for their interest in involving native practices in their care (SAMHSA, 2018).

Treatment Planning

When engaging in treatment planning, it is important to recognize, support, and expand on what Native communities are already doing in these areas, especially in terms of preventing and treating mental health conditions and substance use disorders. However, clinical social workers and other mental health professionals must do this in a culturally sensitive manner that recognizes history and contemporary experiences (Evans-Campbell & Walters, 2024).

As with any client, it is important to help identify treatment goals that are appropriate and meaningful to them. Treatment planning should include information obtained during the assessment process, as well as from time spent learning about clients and their communities. Treatment plans and goal-setting may look different for AI/AN clients compared to clients from other cultures. For example, they may be less about personal achievement and more about how they can contribute to their family or community, or uphold their cultural beliefs, values, and traditions.

Goals should focus on achieving balance and harmony with their current problems. Setting goals may include opportunities to connect or reconnect with cultural practices and/or spiritual activities that support their healing, such as ceremonies, hunting or fishing, sweat lodges, talking circles, or purification. It may be beneficial to seek guidance from the individual client's family and their community, with their consent, to help determine the appropriateness of a practice or activity. For example, though attending a community event is an opportunity to receive social support, if alcohol is involved, it may be in the best interest of the client not to attend if they are in recovery from using substances.

Culturally Adapted Treatment Modalities

One essential aspect of treatment planning is understanding each individual client to select the most appropriate treatment modality. While AI/ANs typically respond well to various approaches, the following practices are considered culturally appropriate for this population. However, the clinical social worker or other mental health professional offering these modalities must be culturally competent and skilled in the therapy and its adaptations for AI/AN cultures.

- **Motivational interviewing** - a form of nonconfrontational, client-centered therapy that focuses on active listening, stages of change, and the elements that support change, such as self-talk and empathy. It teaches a person that what they say to themselves will come true and emphasizes the importance of relationships.

- **Trauma-informed treatment** - a type of therapy that focuses on how trauma impacts a person's life. It recognizes the importance of trauma and creates pathways to healing.

- **Cognitive behavioral therapy** - though this type of therapy is considered directive, there is a way to adapt it so that the mental health provider is a resource or guide to the client. It can be helpful for AI/AN clients because it focuses on the present moment and allows them to take ownership of change.

- **Mindfulness-based interventions** - an approach that focuses on the present moment and attending to thoughts and feelings in a non-judgmental, non-attached way. It has been found to align with some AI/AN belief systems and offers an opportunity outside of traditional talk therapy.

- **Family therapy** - this type of therapy can be more relevant for AI/AN clients, with their focus on family and community systems. It involves their natural

support system and focuses on strengthening the family, which can decrease risk for substance use disorders.

- **Community reinforcement approach** - a model that relies on positive reinforcement from a client's family and community.

Building Social Support

Many clients, regardless of culture, do better when they have social support, especially AI/ANs, since family and community are essential parts of their culture. It is crucial to work with clients to identify appropriate sources of support, including people who are helpful and those who increase distress. It can also be helpful to support them in setting boundaries with people who may be more harmful than helpful to their healing. Additionally, depending on the client, it may be beneficial to connect them with other providers or programs, mutual-help groups, traditional healers, or tribal members in their area who can be supportive throughout treatment (SAMHSA, 2018).

Section 5 Key Terms

Culturally responsive treatment with AI/AN clients is an area of practice that requires establishing a standard of respect, focusing on strengths, and addressing underlying personal and historical trauma issues as appropriate. Traditional (or native) interventions and care that are integrated with mainstream treatment methods are recognized as best practices for native communities (SAMHSA, 2018, p. 6).

Holistic treatment and care - focus on the spiritual, emotional, physical, social, behavioral, and cognitive aspects of a person's life. AI/ANs believe that all of these

aspects are interconnected, so one cannot be addressed without impacting another (SAMHSA, 2018).

Traditional healers - individuals who perform ceremonies, rituals, and storytelling to transform illness into health by addressing the mind, body, and spirit. They may work with individuals, families, and communities. It is beneficial if they are authenticated by tribal leaders (SAMHSA, 2018).

Section 5 Reflection Questions

If you are not currently working with AI/AN clients, what aspects of culturally appropriate treatment will come naturally to you? What areas will be challenging?

If you are currently working with AI/AN clients, what has your experience been with providing culturally appropriate treatment? Are there areas of your practice or program that you would like to improve?

Section 6: Mental Health Disparities

References: 11, 13, 27, 41, 52

According to SAMHSA (2018), "AI/ANs have persistently experienced serious health disparities in access to care, funding, and resources for health services. They face disparities in the quality and quantity of services, treatment outcomes, and health education and prevention services" (p. 6). NAMI (n.d.) also notes that although there is a need for mental health care among Indigenous/Native individuals, the number of people who access treatment is small in comparison. This issue is not only because of access to mental health and substance use services, but it is also because of the limited availability and acceptability of mental health and substance use services for AI/AN people. The first step to addressing barriers is understanding them. While some may be beyond the

control of clinical social workers and other mental health providers, others are within their control (SAMHSA, 2018). This section discusses in detail the barriers to accessing adequate mental health and substance use care.

Geographic Barriers and Isolation

While a large percentage of Indigenous/Native people live in urban areas, many also live in rural and isolated areas, but not in tribal ones (also called reservations). In these instances, they may not have the mental health services in their area to meet their needs. The Indian Health Service has clinics and hospitals available within the organization. However, these places are on reservations owned by federally recognized tribes, and the majority of AI/AN people do not live in these areas, creating another barrier to accessing care (NAMI, n.d.).

Some AI/AN people may have concerns about remaining anonymous in smaller communities when seeking help, so access to care remains an issue if they do not want to seek care where they reside, but live a distance from other places that provide care. AI/AN people may also feel shame related to receiving mental health care, causing them to feel more isolated in their problems (SAMHSA, 2018).

Poverty and Unemployment

As outlined earlier in this course, high rates of poverty and unemployment exist for AI/AN people, which create barriers to care. Transportation and other resources, such as child care, are more limited due to poverty, hindering an individual's ability to access the services they need (NAMI, n.d.; SAMHSA, 2018).

Mistrust

Because of the tumultuous history with the U.S. government, many people within the Indigenous/Native community do not trust services that the federal government may be able to provide (NAMI, n.d.). They may also distrust organizations or feel that providers will not be effective in caring for their needs in a culturally competent manner (SAMHSA, 2018).

Language Barriers

There are over 150 different native languages. Though many Native Americans today speak English as their primary language, they may incorporate indigenous phrases and words into everyday speech (Yehieli & Grey, 2005). The 2017-2021 American Community Survey (ACS) conducted by the U.S. Census Bureau found that Native North American language use decreased by 6%, from about 364,000 speakers in 2023 to about 342,000 speakers in 2021. In the total U.S. population, those aged 5 and over was more than 310 million in 2021, and about 67 million people spoke a language other than English at home (Griffiths & Mejía, 2025, para. 4). Some language traditions among Native communities are especially strong, such as those in the American Southwest (including Arizona and New Mexico) and Alaska (Griffiths & Mejía, 2025; NAMI, n.d.). The ACS also found that over 70 Native North American languages are spoken after English, most prominently in 9 states, including Alaska, Arizona, Mississippi, Montana, New Mexico, Oklahoma, South Dakota, Utah, and Wyoming. Nearly half of those who spoke a Native North American language spoke Navajo, with this being in the top 15 languages in 4 states, including Arizona, New Mexico, Utah, and Wyoming (Griffiths & Mejía, 2025)

Language differences are a consideration in assessment and treatment. For example, a Native person may not relate to the terms “depression” or “anxiety.” If

English is not their primary language, they may also have difficulty conveying their thoughts and feelings in English. There may also be frustration between the client and their provider when neither understands what the other is trying to say or the true meaning.

Lack of Cultural Competence

Since Indigenous/Native populations have a different understanding of mental health than some other groups in the U.S., they may not see the value in receiving this type of care. If they decide to seek care, there are only a limited number of AI/AN providers. Another issue can arise when Indigenous/Native people are open to receiving treatment, but the individual or program providing it is not culturally, spiritually, and traditionally appropriate in their delivery of services or care. For example, their assessments may not include questions about acculturation or preferences for traditional healing practices. Some individuals or programs may also fail to establish relationships with tribal leaders who can help arrange traditional healing practices from authentic providers for their clients (NAMI, n.d.; SAMHSA, 2018).

Inadequate Funding

The history of underfunding the Indian Health Service has led to significant challenges in providing services to Indigenous/Native communities. Inadequate funding undermines the overall quality, availability, and accessibility of mental health care (NAMI, n.d.).

In 2022, the federal government made a large investment through the American Rescue Plan to support Tribal governments and Native communities, aiming to provide relief to families struggling financially and to support economic recovery. However, these funds were in response to the COVID-19 pandemic, not

specifically focused on mental health services, and additional funding for needs in these communities is not guaranteed (Department of the Treasury, 2022).

Addressing Barriers

Providing telehealth services is one way to increase access to care for people with geographic barriers and those who are isolated. Socioeconomic barriers can be addressed by identifying programs and resources that support AI/AN people. Family and community members may also be available to help with some tasks, such as child or elder care. To address mistrust, one solution is to learn about AI/AN cultures and work toward achieving cultural competence, which also addresses the lack of it. Part of cultural competence is understanding language preferences and having a translator available. Other solutions may be offered by engaging AI/AN communities in discussions about the barriers they face.

Conclusion

As shown throughout this course, AI/AN people have endured many challenges throughout history, which continue to impact them today through high rates of mental health conditions and substance abuse, as well as socioeconomic factors such as poverty and unemployment. They may also face acculturation conflicts, family issues, discrimination, and racism. One of the most significant issues at the core of it all is historical and lifetime trauma, which are both prevalent throughout AI/AN communities. However, despite the challenges, there is resilience and strength in culture, connection, identity, and spirituality among AI/AN people. Clinical social workers and other mental health professionals need to look at the whole picture, including the past, present, and future, when working with AI/AN clients. In addition, being skilled in best practices and culturally appropriate

interventions is key to building trust and improving outcomes in these communities.

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