A Journey: American Indian Behavioral Health Programs Building Culturally Competent Clinical Skills and Adapting Evidence-Based Treatments

by

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ABSTRACT

There are federal mandates attached to funding for behavioral health programs that require the use of evidence-based treatments (EBTs) to treat mental health disorders in order to improve clinical outcomes. However, these EBTs have not been constructed with American Indian/Alaskan Native (AI/AN) populations. There are over 340 EBTs, and only two outcome controlled studies have demonstrated effectiveness with AI/AN populations to treat mental health disorders. AI/AN communities often have to select an EBT that is not reflective of their culture, language, and traditions. Although EBTs are frequently used in AI/AN communities, little is known about the adaptation process of these interventions with the AI/AN population. For this study, a qualitative design was used to explore how American Indian behavioral health (AIBH) organizations in the Southwest adapted EBTs for cultural relevancy and cultural appropriateness. One urban and two tribal AIBH programs were recruited for the study. Over a six-week period, 24 respondents (practitioners and cultural experts) participated in a semi-structured interview. Transcripts were analyzed using the constant comparative analysis approach. As a result, four themes emerged: 1) attitudes towards EBTs, 2) how to build culturally competent clinical skills, 3) steps to adapt EBTs, and 4) internal and external organizational factors required to adopt EBTs. The four themes identify how to build a culturally responsive behavioral health program in Indian country and are the purview of this dissertation.

DEDICATION

To my mom and grandmother who taught me about our traditional ways and how to maintain that in today's society. I wish you were still here to see me on this journey but I know you are here in spirit.

To my wonderful loving husband, Travis, who cheered me on when I thought I could not cross the dissertation finish line. Thank you for your unconditional love, kindness, and great sense of humor.

To my dad, godparents, and relatives – thank you for your prayers, songs of hope, and stories of resiliency. With your support I was able to reach my goals.

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CHAPTER 1

INTRODUCTION

American Indian/Alaska Native (AI/AN) communities experience behavioral health needs that are often addressed through evidence-based treatments (EBTs) that do not reflect their culture, language, and traditions. These EBTs often emphasize evidence-based findings that were not discovered with AI/AN populations, so there is a potential mismatch of EBTs for AI/AN populations. Although these treatments are frequently used, little is known about the adaptation process of EBTs in American Indian behavioral health (AIBH) organizations. Thus, it is vital to explore how AIBH agencies enhance EBTs for AI/AN clients. Examining practitioners and cultural experts' experiences adapting EBTs informs clinical practices in Indian country and is the purview of this dissertation.

Statement of the Problem

There are 5.2 million AI/AN people in the United States that make up 1.7% of the population (U.S. Census Bureau, 2010). In addition, there are 573 federally recognized tribes, with the majority located in the western region of the United States (Bureau of Indian Affairs National Archives, 2017). The leading causes of death for AI/ANs are heart disease, cancer, unintentional injuries, and diabetes (Indian Health Services [IHS], 2018; U.S. Health and Human Services, Office of Minority Health [OMH], 2018b). In general, the AI/AN population is young, low income, and has low educational attainment compared with the general U.S. population (Sarche & Spicer, 2008; OMH, 2018b). In 2014, the second leading cause of death for AI/ANs between the ages of 10 and 34 years

old was suicide (OMH, 2018a). AI/AN adults are two times more likely to feel a sense of hopelessness and worthlessness most of the time compared with non-Hispanic Whites (OMH, 2018a). These mental health disparities contribute to feelings of depression, anxiety, isolation, loneliness, and an overwhelming sense of grief and loss (Sarche & Spicer, 2008). Despite these disparities, AI/AN have their culture, language, and traditions that instill a sense of pride that needs to be preserved and provide a sense of resiliency (Dickerson et al., 2016; Novins & Boyd et al., 2012; Rasmus et al., 2016).

Federal Reports that Mandated the Use of EBTs

Two federal reports in the early 2000s prompted the mandate for use of EBTs by behavioral health services across the country. The President's New Freedom Commission on Mental Health report (2003) developed goals to improve the quality and accountability of mental health services to address organizational and system fragmentation in the service delivery system. The report (2003) identified gaps in the mental health delivery system and made recommendations to federal, state, and local governments as well as public and private health care providers to transform the mental health system. The report argued that the mental health delivery system needs to use evidence-based psychotherapies as standard practice, and new research evidence should be used to develop new interventions to prevent and treat mental illnesses. Since then, higher education programs in different health-related disciplines, including social work, have modified curricula to ensure students can implement evidence-based practice (Oh et al., 2019). For instance, incorporating research evidence into clinical practice is seen as a major competency.

In addition, the Institute of Medicine (IOM; 2001) report, "Crossing the Quality Chasm: A New Health System for the 21st Century," outlined six aims to improve the quality of health care. Those aims were that care should be safe, effective, patient-centered (responsive to patient preferences), timely (reduce waits and delays of care), efficient, and equitable (IOM, 2001). The goal was to ensure that health care systems meet these aims so patient clinical outcomes show improvement. These two reports influenced mental health delivery systems at federal, state, and local levels that directly affected the IHS and tribal behavioral health systems. These two federal reports from the IOM and President's New Freedom Commission on Mental Health, influenced federal agencies (e.g., American Psychiatric Association, Centers for Disease Control and Prevention [CDC], Centers for Medicare & Medicaid Services [CMS], National Institute of Mental Health [NIMH], and Substance Abuse & Mental Health Services Administration [SAMHSA]) to mandate that mental health treatments must show effective clinical outcomes, meaning they must be evidence-based interventions. The following section explains how this mandate affected behavioral health services at the IHS.

The Indian Self -Determination and Education Assistance Act (1975)

AI/AN tribes have a unique relationship with the U.S. federal government. This unique relationship stems from the federal trust obligations the U.S. government agreed to when AI/ANs surrendered vast tracts of rich land to live on government reservations (National Congress of American Indians [NCAI], 2019). In exchange for the land, the U.S. government committed to provide health care, education, and public safety services

to AI/AN communities (NCAI, 2019). The Indian Self-Determination and Education Assistance Act of 1975 (PL 93-638) gave the U.S. government authority to enter into contracts with tribal governments for federal programs/services (Getches et al., 2017; Pevar, 2012). The Act was the start of self-determination, where the transition from federal government domination of programs and services was contracted to AI/AN tribal governments, and now they could plan and conduct administration of federal programs. Those federal programs include health and human services, law enforcement, education, early childhood services, environmental protection, housing, and resource management (Getches et al., 2017). The Indian Self-Determination and Education Assistance Act of 1975 (PL 93-638) is referred to as "638" compacts and contracts (Getches et al., 2017).

The Act gave AI/AN tribes the autonomy and self-determination to provide health care that is culturally congruent to meet their community needs (Pevar, 2012). The Act is discussed because of its impact on health care services to AI/ANs. EBTs profoundly influenced how AIBH organizations currently operate. The Act allowed tribes to bill third-party revenues (private or public insurance companies) for health care services, and tribes were eligible for various federal grants (Warne & Frizzell, 2014). Furthermore, the Act changed the fiscal operation of AIBH organizations because they could bill for mental health services (National Indian Health Board [NIHB], 2016). Currently, the public and private insurance companies require providers to select an EBT that requires masters-level clinicians to implement EBTs to remain in compliance with insurance regulations on providing effective mental health services (NIHB, 2016). This has impacted the workforce at tribal and IHS facilities.

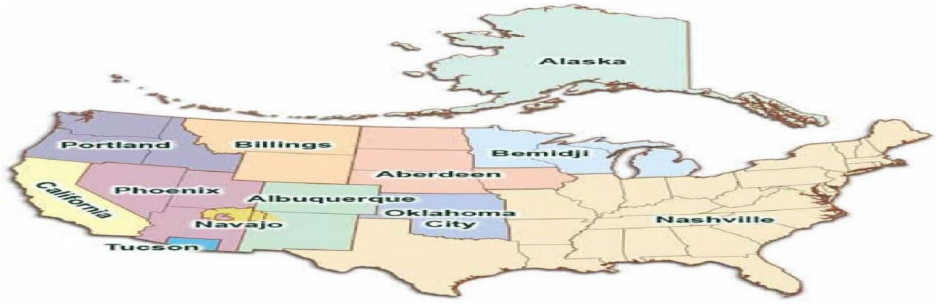
Indian Health Service Infrastructure

The IHS is responsible for providing primary health care and behavioral health services to members of federally recognized AI/AN tribes (IHS, 2018). Presently, there are 12 regional IHS area offices (see Figure 1), which serve as administrative units that oversee services at the local and regional levels (IHS, 2011). Primary care and behavioral health services are provided in small, rural communities across 660 sites that span more than 36 states. The IHS operates 31 hospitals, 52 health centers, two school health centers, and 31 health stations (NIHB, 2016). In contrast, there are 34 Urban Indian Health programs supported through IHS funding that are eligible for federally qualified health center status (NIHB, 2016). Approximately 70% of AI/ANs live in urban areas (IHS, 2018; 2020).

The two federal reports from the IOM and President's New Freedom Commission on Mental Health impacted IHS by changing their mental health services to coincide with the medical home model that integrates primary care and behavioral health services (IHS, 2011). So those receiving health care at IHS need to identify a primary care provider to access any health care service, including specialty care (IHS, 2011).

Figure 1

A Map of the IHS Regional Offices (IHS, 2011)



IHS has three funding systems of care—tribal, urban, and IHS. The Urban Indian Health Centers receive funding from the Indian Healthcare Improvement Act, which receives a small fraction of IHS funding (Warne, 2011). The IHS system receives direct funding from IHS (direct service delivery systems). The tribal systems of care (self-governance systems) receive funding from IHS to contract their services (Warne, 2011).

Within IHS direct service systems, IHS manages the hospitals and clinics (Warne, 2011). For self-governance (tribal) health systems, the tribes manage their hospitals and clinics through compacts permitted under the Indian Self-Determination and Education Assistance Act (1975), referred to as 638 contracts (Warne, 2011). These 638 contracts allow AI/AN tribes and tribal organizations to manage certain federal programs that provide services to their members, such as health care.

AI/AN tribes operate half (50%) of the health care systems in their communities: 15 hospitals, 256 health centers, nine school-based health centers, and 282 health stations (including 166 AN village clinics; NIHB, 2016). There are 12 regional adolescent treatment centers (seven are IHS operated and five are tribally operated; IHS, 2011). Seventy percent of AI/ANs reside in urban areas and often do not have access to health care if their tribe has contracted (638) their health care services. It means enrolled tribal members have to go back to their home community to receive health care. If someone is an enrolled member of the Hopi tribe, residing in Albuquerque, New Mexico, and their tribe contracted (638) their health care services, they have to go back to their home community (Hopi reservation) to receive health care. If that individual is sick and lives in Albuquerque, they have to drive 3 hours to go "home," which is not feasible. That is why

most urban AI/ANs apply for Medicaid, Medicare, or private health insurance to receive care at an Urban American Indian health care clinic that is not in their home community. Those who live on or near their home community can access health care more readily at their tribal system of care (NIHB, 2016). IHS system of care is fragmented between urban and tribal health care services.

IHS Fiscal Budget

To add to the fragmented health care delivery, IHS depends on yearly discretionary funds from Congress to operate their facilities (IHS, 2011). The IHS has been historically underfunded (IHS 2011; Warne, 2007), which affects services such as routine cancer screenings, mental health, and other prevention services (NIHB, 2016). In 2016, the per capita IHS medical expenditure per person was $2,834, compared with per capita medical expenditures for Medicaid recipients ($7,492), Medicare recipients ($12,744), and for the Veterans Administration (VA) recipients ($9404; U.S. Commission on Civil Rights, 2018). This demonstrates how severely underfunded IHS is compared to Medicaid, Medicare, and the VA.

The IHS behavioral health budget is impacted from the sparse funding. There are two line items in the IHS behavioral health budget: mental health and substance abuse (See figure 2). Approximately 90% of the substance abuse and 54% of the mental health budget line items are contracted (638) to the tribes to deliver behavioral health services to meet their local needs (IHS, 2020). Less than half of the mental health budget remains with IHS (direct services; see Figure 2) because the tribes have a limited workforce to provide specialized care, with a 38% job vacancy rate (NIHB, 2016). Therefore, if

individuals need mental health counseling or more intensive treatment, they have to go to an IHS directly funded facility, not a tribally (638) operated one. In 2014, the IHS behavioral health workforce had over 500 providers to serve 5.2 million AI/ANs (NIHB, 2016). In 2014, the total number of mental health outpatient encounters annually at IHS facilities was 491,000 compared with substance abuse outpatient encounters, which totaled 88,000 (NIHB, 2016). There are more mental health needs (491,000) and a severe lack of behavioral health workforce to address the need.

IHS Reimbursements

IHS supplements their budget from Medicaid (69%), Medicare (21%), and other private health insurance (10%; IHS, 2020) reimbursements. This illustrates that IHS mental health departments have to blend funding in order to provide outpatient mental health services. It also requires IHS and 638 programs to use EBTs because Medicaid and Medicare mandate it for behavioral health services.

Figure 2

IHS Mental Health and Substance Abuse Budget

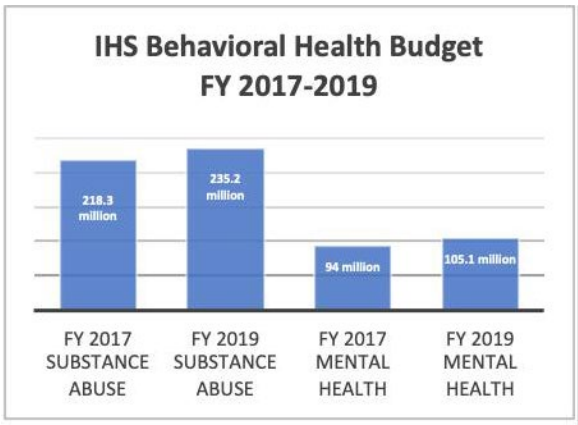
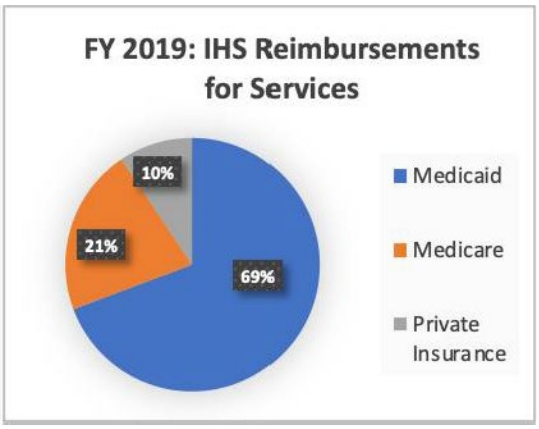


Figure 3

FY 2019: IHS Reimbursements



IHS External Resources

To augment the IHS budget, AIBH programs partner with external resources to enhance their behavioral health systems. The National Indian Health Board (NIHB) and the Office of Tribal Affairs and Policy were asked by tribal leadership to develop the National Tribal Behavioral Health Agenda, which coordinates behavioral health priorities across federal agencies. Those agencies are the Bureau of Indian Affairs (BIA), CDC, CMS, Health Resources and Services Administration, IHS, National Institutes of Health (NIH), U.S. Department of Justice, and U.S. Department of Veterans Affairs (NIHB, 2016). The agenda is not a strategic plan, but rather a blueprint for identifying priorities across federal agencies to address AI/AN behavioral health goals. The blueprint provides tribal leadership with a document to refer to when advocating for funding and resources (NIHB, 2016). The agenda prioritizes that culturally tailored evidence-based practices effectively meet AIBH program expectations (NIHB, 2016).

Another external resource for tribal and urban behavioral health programs is the tribal advisory committee created by SAMHSA (2007) to help tribes address behavioral health priorities. In 2008, IHS created the National Tribal Advisory Committee on Behavioral Health comprised of elected tribal leaders from each IHS regional office (see Figure 1) that provides recommendations on behavioral health priorities and funding allocations (IHS, 2018). A third group, the IHS National Behavioral Health Work Group, was formed in 2010 and is a technical advisory group comprised of mental health professionals across the country who provide expert advice on services, programs, interventions, strategic planning, and goal development (IHS, 2018). All three groups

work closely with tribal leaders and have similar goals to reduce behavioral health disparities in Indian country and to promote culturally relevant health promotion and healing interventions (NIHB, 2016). One common factor among all these external partners is they work with SAMHSA, who is a vital partner for behavioral health care services in Indian country.

EBTs Available for AI/ANs

According to Kazdin (2015), there are over 340 evidence-based psychotherapies to address mental health and substance use disorders in the general population, yet in a systematic review, only two culturally adapted psychotherapy interventions (cognitive behavioral therapy and motivational care planning) to treat mental health disorders were found to be effective with AI/AN populations (Pommerville et al., 2016). Furthermore, in the empirical literature, I found five additional culturally adapted EBTs for AI/ANs to treat mental health disorders. The five adapted psychotherapies were parent-child interaction therapy (Bigfoot & Funderlark, 2011), cognitive processing therapy (Pearson et al., 2018), dialectical behavioral therapy (Beckstead et al., 2015), and motivational interviewing by two researchers (Dickerson et al., 2016; Venner et al., 2016). Out of the seven culturally adapted psychotherapy interventions, five are for adolescents (Beckstead et al., 2015; Bigfoot & Funderlark, 2011; Dickerson et al., 2016; Listug-Lund et al., 2013; Nagel et al., 2009) and two are for adults (Pearson et al., 2018; Venner et al., 2016). Out of 340 evidence-based psychotherapies, there are only seven EBTs that demonstrated effective outcomes to treat mental health for AI/ANs.

According to Echo-Hawk, “Indigenous communities are faced with having to select an EBT that is rooted in non-native social and cultural contexts with no known effectiveness for Indigenous communities” (2011, p. 269). AIBH programs are faced with learning how to facilitate “638” contracts to manage their health care systems, bill for health care services, and then select an evidence-based intervention that most likely did not demonstrate effective clinical outcomes with AI/AN populations.

AIBH programs that receive federal (CDC, IHS, Medicaid, SAMHSA) and state funding are mandated (IOM, President’s New Freedom Commission on Mental Health) to implement an EBT with minimal research on treatment effectiveness. This mandate poses an ethical dilemma about how to provide culturally appropriate care (Echo-Hawk, 2011; Gone & Alcantara, 2007; Moore et al., 2015; Nebelkopf et al., 2011; Walker & Bigelow, 2011). Mandating tribal programs to implement EBTs contradicts principles of self-determination (choose your own intervention) and tribal sovereignty (self-governance). Self-determination implies that tribes have the right to determine what interventions they utilize in their programs to fit their population’s needs (Warne & Frizzell, 2014). The evidence-based mandate asks tribes to take a considerable risk and select an EBT that has not been tested with AI/ANs.

Therefore, it is critical to request for federal agencies (e.g., CDC, IHS, Medicaid, SAMHSA) to assist tribes to deliver effective EBTs that fit their social and cultural context (Echo-Hawk, 2011; Gone & Alcantara, 2007; Moore et al., 2015; Walker et al., 2015). One recommendation is for AIBH programs to ask federal agencies (e.g., IHS, NIMH, Medicaid, SAMHSA) what available EBTs are there to treat the most significant

mental health disparities. A second recommendation is to ask what culturally adapted EBTs exist that have demonstrated effective clinical outcomes to treat mental health disorders (depression, anxiety, and post-traumatic stress disorder) for AI/ANs. A third recommendation is to request technical assistance to evaluate the effectiveness of culturally adapted EBTs to assess clinical outcomes for AI clients (Leske et al., 2016). Understanding how AIBH programs adapt EBTs for cultural relevancy is vital to improving clinical outcomes that address mental health disparities in Indian Country.

Purpose of the Study

The purpose of the study was to explore how practitioners and cultural experts at AIBH organizations culturally adapt EBTs. The three aims were: (1) What process do practitioners and cultural experts use to conduct cultural adaptations? (2) What internal and external organizational factors (facilitators and barriers) explain the adoption of EBTs? (3) Are EBTs a good fit for AIBH organizations?

To answer the research questions, a qualitative research design was required because there is scarce empirical literature on the use of EBTs in AIBH organizations (Gone & Trimble, 2012; Nebelkopf et al., 2011). In addition, there is a heightened distrust of research in AI/AN communities, so a culturally sensitive approach was required (Brayboy, 2005; LaVeaux & Christopher, 2009). Little is known about the process of adaptation of EBTs in AIBH organizations, so capturing the practitioners' and cultural experts' experiences creates new meaning and insight to build theory (Brayboy, 2005; Guba & Lincoln, 1994; Padgett, 2017). A qualitative approach allows participants to provide their own meaning of the phenomena being studied, using their rich

description, which is empowering. For these reasons, this is an exploratory study, and a qualitative design was an appropriate method to use (Tracy, 2013).

Significance of the Study

The study fills a research gap that focuses on mental health practitioners' and cultural experts' experiences at AIBH organizations regarding their process for adapting EBTs, which largely have not been developed for AI/AN clients. The NIHB received input from tribal leadership to address five behavioral health goals. One goal is to seek federal support for addressing behavioral health systems improvement by supporting tribal programs through (a) support of tribal efforts to incorporate cultural interventions into program activities that effectively meet program requirements, (b) support of tribally driven assessments, strength-based, and tribal best practices, and (c) engagement in capacity building to support tribes to include culture as an effective treatment in prevention and intervention services (NIHB, 2016). The National Institute of Mental Health Strategic Plan for Research (2020) has an objective (4.3.A) to adapt, validate, and scale up programs currently in use that improve mental health services for underserved populations (NIMH, 2020). Thus, the research findings from this study can inform the NIHB, NIMH, and AIBH programs about the guiding principles used to adapt EBTs for AI/AN populations. Identifying the adaptation process AIBH programs use would provide an evidence-based framework that is based upon AI/AN cultural values, knowledge, and traditions for effective treatment.

CHAPTER 2

LITERATURE REVIEW

This literature review is divided into seven sections. First, I describe the historical development of evidence-based practices (EBP) and compare the evidence-based practice process with the definition of EBT. Next, an explanation of two types of evidence-based research is provided. The exploration, preparation, implementation, sustainment (EPIS) model is included to provide an overview of organizational factors to consider when adopting EBTs. The gaps in effective psychotherapy interventions for AI/ANs will be described, and a national study of AIBH workforce characteristics will be explained. Cultural adaptation frameworks will be outlined to demonstrate how AIBH organizations can use these approaches in their programs. Tribal critical race theory is included to explain how the study will examine the conclusions of the study. Lastly, a brief description of tribal participatory research (TPR) principles and community-based participatory research (CBPR) principles are explained as the research method utilized in the study.

Evidence-Based Practice

The evidence-based practice (EBP) movement developed from the field of medicine and psychology (Okpych & Yu, 2014; Thyer, 2015). The medical field called it evidence-based medicine, and psychology called it empirically supported treatments (Drisko, 2014; Drisko & Grady, 2015; Okpych & Yu, 2014; Thyer, 2015). The definition of EBP from social work considers it a practice, of integrating research evidence into clinical practice to ensure that the client's needs, values, and preferences, as well as the

clinician's expertise, are all blended to provide effective services (Drisko & Grady, 2015; Gibbs & Gambril1, 2002).

EBP Process

Gambrill introduced the EBP process into the field of social work in 1999 (Thyer, 2015; Walker, 2007). The EBP process is the use of current empirical evidence in making decisions about the care of clients (Thyer, 2015). The EBP process utilizes research evidence to find an appropriate intervention that takes into account the client's preferences, values, clinical state, and environment (Gibbs & Gambrill, 2002; Sackett et al., 2000). In this process, the client is an active participant in the decision-making process (Council on Social Work Education, 2018; Gibbs & Gambrill, 2002). The EBP process includes five steps: (1) formulate a practice-based research question related to the client's needs and circumstances; (2) search the literature for the best evidence available; (3) critically analyze the evidence for quality and applicability to the client's situation; (4) integrate the findings (evidence) into clinical practice with consideration of the client's preferences, values, and needs; and (5) evaluate the effectiveness of the intervention to seek ways to improve it the next time (Gibbs & Gambrill, 2002; Thyer, 2015). To be clear, the EBP process is a decision-making process as opposed to evidence-based practice, which is a practice to integrate research evidence into clinical settings. Both processes use research evidence to improve clinical outcomes.

EBT Definition

EBT is an intervention that demonstrates effective outcomes in at least two experimental studies and consequently appears in a clinical treatment manual (Drisko & Grady, 2015; Thyer, 2015). To meet the EBT definition, researchers other than the developer of the intervention must conduct those studies (Drisko & Grady, 2015). It is a specific treatment that has scientific evidence to produce effective clinical outcomes (Drisko, 2014; Drisko & Grady, 2015).

Two Types of Evidence-Based Research

There are two types of research as it pertains to evidence-based interventions: efficacy research and effectiveness research. Efficacy research examines treatment interventions under controlled conditions, whereas effectiveness research examines interventions under real-world conditions (Singal et al., 2014). Efficacy research examines interventions under controlled conditions and is concerned with internal validity (i.e., the effects observed due to the independent variable; Singal et al., 2014), and most of the research samples are relatively homogeneous. In efficacy research, some participants are excluded if they are at low risk for producing the primary outcome, as are those who are considered non-compliant or who have comorbid medical conditions (Singal et al., 2014). Efficacy studies are primarily conducted with White middle and/or upper-class populations, thus excluding a large portion of racial and ethnic minorities (Miranda et al., 2005; Ünlü Ince et al., 2015). According to Miranda et al. (2005), there were no mental health treatment efficacy studies with AI/ANs.

Effectiveness research includes heterogeneous samples comprising participants who have comorbid medical conditions. This type of research is concerned with external validity (i.e., the treatment results generalizable to other settings; Singal et al., 2014). Effectiveness studies generally compare treatment outcomes to treatment as usual (Singal et al., 2014) and are interested in how interventions work with diverse populations (Miranda et al., 2005). The distinction is important given that the majority of effectiveness studies for AI/ANs are for substance abuse disorders, not mental health disorders (Leske et al., 2016), even though AI/ANs have a high rate of suicide and depression (OMH, 2018a).

The Exploration, Preparation, Implementation, Sustainment (EPIS) Model Explains Adoption of EBTs

The EPIS model (Aarons et al., 2011) proposes that agencies who adopt EBTs go through four stages of adoption: exploration, preparation/adoption, implementation, and sustainment. This model will help assess if AIBH programs experience a similar form of adoption. The exploration phase is when the organization considers innovations (EBT) to an organizational challenge that can improve service delivery (Aarons et al., 2011; Despard, 2016). The preparation/adoption phase is a decision to pilot a new intervention to improve services (Aarons et al., 2011; Despard, 2016). Implementation is the process of integrating an EBT into the program and examining whether it fits the work productivity demands of the agency (Aarons et al., 2011; Despard, 2016). Sustainment is maintaining an EBT as routine practice while hiring qualified staff to implement it and

monitor the program with the available funds and staff resources (Aarons et al., 2011; Despard, 2016).

The four phases (EPIS) have inner and outer contextual levels (Aarons et al., 2011; Moullin et al., 2019). Figure 4 presents the four factors within the outer context, which are sociopolitical environment, funding, client advocacy, and inter-organizational networks. The outer context refers to the environment outside the organization. The sociopolitical systems (outer context) are federal, state, and local policies along with funding streams that impact the organization's structural operations and training capacities (grants, state, and local funding; Aarons et al., 2011). The client/consumer advocacy organizations are about how they impact the organization's operations (Aarons et al., 2011). The inter-organizational relationships are the government, funders, managed care, professional societies, and advocacy groups that influence the organizational structures (Moullin et al., 2019).

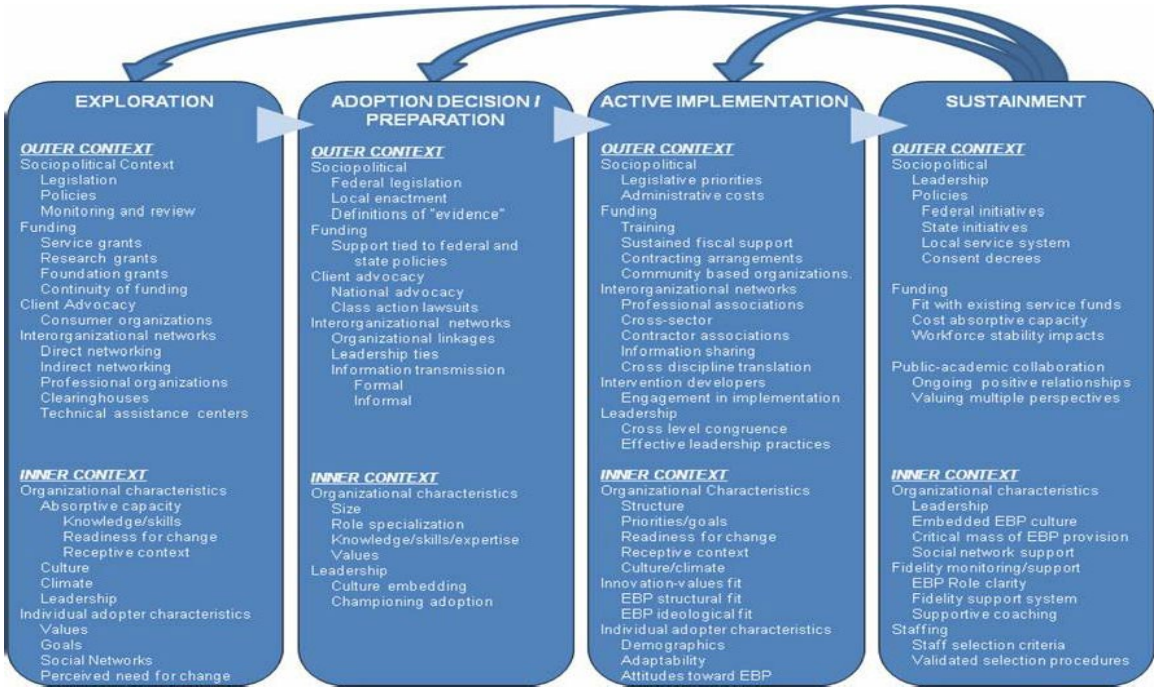
The inner context contains organizational characteristics. Those inner organizational factors refer to the organization's leadership, organizational climate and culture, organizational structures, internal resources, internal policies, staffing, and practices (Moullin et al., 2019). These inner and outer contexts are interactive and dynamic and reflect the complex relationship between systems. The outer context contains the client population, and the inner context is the organization and the provider systems (see Figure 4).

When implementing an EBT, it is important to consider the four outer contextual factors (sociopolitical environment, funding, client advocacy, and inter-organizational

networks) and the inner factor (organizational) to ensure resources are available to implement an EBT. This framework assists leadership and practitioners in determining what EBT to select (exploration); if adaptations are needed, how to adapt it (preparation); to apply the intervention to the target population (implementation); and to evaluate the intervention (sustainment) to improve fit (Moullin et al., 2019). The EPIS model is a framework that AIBH programs can utilize to identify their inner and outer contextual resources to implement an EBT or adapt it successfully. The model identifies barriers to and facilitators of (i.e., guidance) adopting EBTs.

Figure 4

EPIS Model by Aarons et al. (2011)



Having a network and resources to implement an EBT effectively requires relationships among the organization, the larger community, and academic partners. If the EBT fits the organizational culture, the staff will be more likely to adopt it (Despard,

2016). Secondly, if the organization's mission aligns with key public priorities, there are increased opportunities to access funding locally, statewide, and federally (Despard, 2016). If the organization accepts Medicaid, it can be reimbursed for services and have access to local, state, and national networks. This is a facilitator because it brings in funding to BH programs. Because tribes bill half their BH services to Medicaid, they have access to a network. Having access to formal and informal networks to advocate for funding is required to maintain an EBT (Despard, 2016).

Barriers to Adoption of EBTs

Practitioners' perception that research does not translate into practice when working with ethnic minority groups creates a barrier to adopting EBTs (Adams et al., 2009; Bellamy et al., 2006; Rubin & Parrish, 2007; Trowbridge & Lawson, 2017). Some practitioners view EBTs as cookie-cutter approaches that ignore the value of clinical expertise and wisdom, as well as clients' preferences (Bellamy et al., 2006; Rubin & Parrish, 2007). There are not enough empirical studies that include marginalized groups to inform practice (Rubin & Parrish, 2007). Bellamy et al. (2006) assert there is a disconnect between what practitioners need for their clients and researchers' goals. Also, there is mistrust from community agencies and practitioners regarding research on vulnerable underrepresented populations (Rubin & Parrish, 2007).

Not having access to a network of colleagues who have practice-based knowledge to implement or adapt EBTs to share lessons learned is a barrier (Aarons et al., 2012; Bellamy et al., 2006; Trowbridge & Lawson, 2017). A lack of organizational support for practitioners to dedicate time to do research and the internal capacity to access the review

studies are additional barriers (Bellamy et al., 2006; Rubin & Parrish, 2007). AIBH organizations have a limited workforce to implement EBTs, so this could be a potential barrier for them.

Facilitators of Adoption of EBTs

For practitioners to adopt an EBT, they need training and policies that support it, plus time to review research studies (Rubin & Parrish, 2007). It is vital to have internal (those familiar with EBTs) and external partners (academic partners) to provide feedback to supervisors and practitioners (Bellamy et al., 2006). To adopt EBTs, all departments need to buy into the value that an EBT provides to practitioners, clients, and the organization (Bellamy et al., 2006). To assist in adoption of EBTs, BH organizations should provide engaging environments to build relationships and foster learning to bridge the gap between research and practice (Trowbridge & Lawson, 2017).

All these barriers and facilitators need to be considered when adopting an EBT. Do AIBH programs have the internal resources (leadership, clinical expertise, organizational culture and climate, and readiness for change) needed to implement an EBT? Do AIBH programs have external resources (funding, policies, academic partnerships, inter-organizational networks, and consumer support) to implement EBTs?

A Review of Psychotherapy Interventions for Indigenous Populations

The systematic review of psychotherapy interventions for Indigenous populations and a national study on the use of EBTs in AIBH organizations identified gaps in the literature. A systematic review of psychotherapy interventions for Indigenous populations (Canada, Australia, New Zealand, and the United States) revealed 44 peer-reviewed

publications (33 peer-reviewed articles and 11 dissertations) and two controlled outcomes studies that demonstrated effectiveness with Indigenous people (Pommerville et al., 2016).[1] The interventions used in the two outcomes studies were motivational care planning with an Aboriginal population (Nagel et al., 2009) and Adolescents Coping with Depression (group cognitive behavioral therapy) with middle school students at a midwestern school on an American Indian reservation (Listug-Lund et al., 2013). Seven articles looked at treatment for depression and/or anxiety, two for posttraumatic stress disorder (PTSD), and no studies looked at treatment for bipolar disorder, schizophrenia, personality, or eating disorders (Pommerville et al., 2016).

In the empirical literature, I found five culturally adapted psychotherapy outcomes studies to treat mental health disorders. Bigfoot and Funderburk (2011) culturally adapted a parent-child interaction therapy for parents whose children were exposed to trauma (Honoring Children Making Relatives). The second intervention was dialectical behavioral therapy in which the mindfulness portion was adapted for AI/AN adolescents who were diagnosed with a substance abuse disorder (Beckstead et al., 2015). The third intervention was motivational interviewing that integrated traditional practices into treatment (used Medicine wheel concepts and integrated cultural activities with MI discussions) for AI/AN adolescents with substance abuse disorders (Dickerson et al., 2016). A fourth intervention (Pearson et al., 2018) adapted cognitive processing therapy to address trauma, substance use, and HIV risk among young adult AI/AN women. The adaptation included the incorporation of cultural knowledge and practices (Pearson et al.,

[1] Substance abuse prevention studies were excluded if they did not include mental health treatment.

2018). The last intervention (Venner et al., 2016) utilized culturally adapted MI and community reinforcement approaches to address depression and substance use disorders with AI/AN adults.

The substance abuse prevention literature has several outcomes studies, in contrast to mental health, which has seven culturally adapted outcomes studies that demonstrate a lack of culturally relevant EBTs for AI/ANs. AIBH organizations and tribal leadership need to examine whether culturally adapted EBTs are effective interventions for their populations to improve the quality of care (Larios et al., 2011; Lengha et al., 2014; Novins & Moore et al., 2012; Novins & Croy et al., 2016; Pommerville et al. 2016). In addition, developers of EBTs need to partner with AI/AN communities to identify components of EBTs that can be culturally adapted while adhering to the core components of the intervention.

Even though studies show that culturally adapted EBTs provide effective clinical outcomes with ethnic minority populations, there is conflicting evidence that unadapted interventions are equally effective (Ünlü Ince et al., 2014). A recent meta-analysis of 56 random control trials focused on ethnic minorities found unadapted psychotherapy interventions to treat depression had a moderate effect (d = .50) in reducing symptoms of depression when compared with White populations (Ünlü Ince et al., 2014). Of the 56 interventions, a majority of the interventions used cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT; Ünlü Ince et al., 2014). There was no significant moderating effect of race or ethnicity observed (Leske et al., 2016; Ünlü Ince et al., 2014), which demonstrates that unadapted psychotherapy to treat depression is just as

effective for ethnic minorities as for White American populations (Ünlü Ince et al., 2014). The findings coincide with Miranda's (2005) study that CBT and IPT to treat depression improves outcomes for African Americans and Latinos as much as or more than for White Americans. In conclusion, these findings illustrate that CBT and IPT are effective with ethnic minorities, but the question remains whether these therapies would be effective with AI/AN populations. Would CBT and IPT require cultural adaptations? More research on mental health interventions for AI/ANs is necessary to improve the quality of care to reduce mental health disparities.

A National Study: Use of EBTs in Substance Abuse Programs Serving AI/ANs

The first and only national study of AI/AN substance abuse treatment programs was designed to study the awareness and attitudes towards the use of EBTs (Novins & Aarons et al., 2011; Novins & Moore et al., 2012; Novins & Croy et al., 2016; Moore et al., 2015; Rieckmann et al., 2016). Approximately 445 programs were asked to participate in the study; 192 programs from 50 urban/suburban and 142 rural communities completed the survey (Novins & Aarons et al., 2011; Novins & Moore et al., 2012; Novins & Croy et al., 2016). Of the 445 programs that were asked to participate, 11% refused, and 15% did not respond to the invitation (Novins & Moore et al., 2012; Novins & Croy et al., 2016). One-hundred and thirty-eight communities that were contacted did not have substance abuse treatment programs (Novins & Moore et al., 2012; Novins & Croy et al., 2016).

It is important to highlight the three-stage sampling frame used in this study to demonstrate the complexity of AIBH organizations that are IHS, tribal "638," or urban

Indian health organizations (Novins & Moore et al., 2012). Also of note is how they used CBPR principles in the study. First, the researchers convened an advisory board to discuss the use of EBTs and define the project design (Novins & Moore et al., 2012), which is a CBPR principle to create a process that enables equitable engagement in research and partnership development (Wallerstein et al., 2018). Second, the researchers conducted key informant interviews and focus groups with 18 substance abuse treatment programs that serve AI/ANs and asked about their use of EBTs in their program (Lengha et al., 2014, Moore et al., 2015; Novins & Moore et al., 2012). According to CBPR, conducting key informant interviews generates priorities the community is concerned about or wants to address to inform research and action that benefits all partners (Wallerstein et al., 2018). Third, the researchers developed and conducted a national survey of AI/AN substance abuse treatment programs to identify awareness and use of EBTs and factors that impact the implementation and dissemination of these treatments. The advisory committee assisted in the development of the survey instrument to promote co-learning and capacity building for all partners (Wallerstein et al., 2018).

The researchers used a stratified sampling method that divided the programs into five strata based on the size of the populations they served. The strata were also divided among four geographic regions: (1) the Pacific Coast; (2) Intermountain West and Southern/Central Plains; (3) Northern Plains, Midwest, and Northeast; and (4) Southeast and Mid-Atlantic (Novins & Moore et al., 2012). The Southwest region was not included in the sample. The current study is situated in the Southwest so it will add to the empirical literature information about the way AIBH programs have adapted EBTs.

AIBH Staff Characteristics From the National Study

Approximately 90% of the respondents were clinical program directors. Sixty percent were women, and 50% identified as AI/AN. More than half of the staff had a master's degree (60%) and were licensed in the counseling profession (66%), and 24% had worked in their current position for more than ten years (Pommerville et al., 2018; Rieckmann et al., 2016). The main disciplines represented were addiction specialists (95%), mental health clinicians (73%), and social workers (66%; Rieckmann et al., 2016; Sheehan et al., 2007). More than half of the staff were mid-level practitioners with more than ten years of experience providing mental health services. Understanding their attitudes towards the use of EBTs is important information to capture and compare with the results of this study.

AIBH Program Characteristics From the National Study

A majority of the AI/AN substance abuse treatment programs offered individual therapy (99%), group therapy (83%), and psycho-educational services (71%; Novins & Croy et al., 2016; Pommerville & Gone, 2018; Rieckmann et al., 2016). The four EBTs most commonly used by AI/AN substance abuse treatment programs were cognitive behavioral therapy (82%), relapse prevention therapy (69%), MI (67%), and 12-step facilitation (54%; Novins & Croy et al., 2016; Pommerville & Gone, 2018). More than half the staff endorsed MI and relapse prevention therapy as culturally appropriate therapies; however, only 31%–54% reported using parts of the manual, leaving room to adapt the intervention (Novins & Croy et al., 2016). Thirty percent of the staff said they were concerned about the cultural relevance of the EBT interventions provided to their

clients (Moore et al., 2015; Novins & Moore et al., 2012, 2016; Rieckmann et al., 2016). Given that more than a third used parts of the manualized intervention (EBT), what adaptations are practitioners integrating into the intervention? Are practitioners including cultural factors (beliefs, values, and norms) in the intervention?

The rural AI/AN substance abuse programs had staff with more years of clinical experience compared with urban programs (Rieckmann et al., 2016). Among traditional healing services, rural programs are more likely to employ elders and offer pastoral counseling compared with urban programs, which offered more cultural activities (talking circles, smudging, drumming, beading, dancing, and tanning; Rieckmann et al., 2016).

Those who were more open to evidence-based practices were frontline clinical staff, program directors, and programs that have key stakeholders to improve services (Rieckmann et al., 2016). Rural programs were more likely to collect outcomes data, whereas the urban programs utilized outside evaluators, employed strategic planning, and participated in research/evaluation studies (Rieckmann et al., 2016). This reveals that urban AIBH programs had more access to external resources (academic partners, evaluators, key stakeholders) compared with rural programs, which had internal staff to collect outcomes data. Given that both rural and urban programs report being open to using EBTs, do they receive the supervision and training to implement it?

What Is Cultural Adaptation?

Cultural adaptation is a systematic modification of an EBT that considers language, culture, and context in a way that is compatible with the target population's

worldview (Burlew, 2013; Castro et al., 2010). Cultural adaptations are the middle ground between two diverse approaches: (1) a universal approach that views the intervention as applicable to all subcultural groups and does not need adaptation (Falicov, 2009); and (2) culturally specific or culturally grounded approaches that consist of the target population's unique values, beliefs, traditions, and practices of the cultural group, elements that are included in the intervention (Barrera & Castro, 2013; Falicov, 2009). Culturally adapted interventions maintain the core elements of the EBT while changing the social (relationships with family and community), cultural (values, norms, beliefs, worldviews), and contextual factors (environment, setting) of the intervention to be more culturally relevant for the target population (Burlew et al., 2013). The cultural adaptation view recognizes ethnic groups have their own healing practices and those components need to be infused in EBT to make it culturally relevant to engage the target population (Falicov, 2009). Several studies with AI/AN populations have found that cultural adaptations can improve engagement and retain the target group's involvement in treatment (Belone, 2017; Burlew et al., 2013; Castro et al., 2010; Dickerson et al., 2016; Falicov, 2009; Marsiglia & Booth, 2015; Novins & Boyd et al., 2012; Rasmus et al., 2016).

Cultural adaptations are categorized into surface and deep structural adaptations (Burlew et al., 2013; Marsiglia & Booth, 2015; Resnicow et al., 2000). A surface adaptation changes visible features of EBTs to fit the social and behavioral aspects of the target population, such as language, music, audiovisual, or print materials that enhance the intervention engagement process (Burlew et al., 2013; Cabassa & Baumann, 2013;

Castro et al., 2010). This type of adaptation does not modify the core intervention components designed to create behavioral change (Burlew et al., 2013; Castro et al., 2010). A deep structural adaptation involves revising the core components of EBTs to fit the target group's historical and cultural values (Burlew et al., 2013; Castro et al., 2010). An example of a deep structural adaptation reflects how American Indians (target population) view mental illness and the healing activities they use to treat mental illness. Capturing this information is crucial to adapt an EBT to enhance cultural relevancy and engagement of the target population (Burlew et al., 2013; Cabassa & Baumann, 2013; Castro, 2010).

What Constitutes an Adaptation?

Barrera and Castro (2006) identified four factors to justify when an EBT needs to be adapted: (1) lack of clinical engagement, (2) unique risk and/or resiliency factors of the target population, (3) unique symptoms of a clinical problem, and (4) lack of intervention effectiveness for the target population (i.e., small effect size; Barrera & Castro, 2006; Castro et al., 2010). These four factors are similar to Whitbeck's (2006) study of culturally specific prevention in AI communities.

Griner and Smith (2006) did a meta-analysis of interventions that were culturally adapted. They reviewed 76 published and unpublished studies and found that half the studies used two to four types of adaptations. The most common modification included using the client's native language (other than English) while implementing the intervention, and clients were matched with therapists of the same ethnic identity (Castro et al., 2010; Griner & Smith, 2006). The average effect size was d = .045, indicating a

moderate effect for culturally adapted interventions (Castro et al., 2010). By comparison, culturally adapted interventions provided to homogeneous groups were four times more effective than interventions provided to heterogeneous groups (Castro et al., 2010; Griner & Smith, 2006).

Cultural adaptations require the involvement of consumer, community, and key stakeholders' involvement (Lau, 2006). Adapting EBTs involves increased time and resources (staff and funding). Before adaptations occur, a stakeholder group is convened to review the EBT to identify what to change to enhance engagement, retention, and learning. Focus groups and stakeholder interviews are methods to identify cultural adaptations that need to be included in EBTs (Barrera & Castro, 2006; Lau, 2006; Kumpfer, 2017).

Fidelity and Fit

The reason to culturally adapt an EBT is to improve the fit with the target population's worldview and increase engagement and retention (Barrera et al., 2011). Implementation science stresses that when adapting an EBT, it is vital to keep the core intervention elements to ensure fidelity (Castro et al., 2010). Cultural adaptations take time, funding, and expertise, and BH programs must assess these resources to determine whether they are available (Castro et al., 2010). Ultimately, it is up to the organization to decide which adaptations fit their program's mission and goals and their clients' priorities (Barrera & Castro, 2006; Castro et al., 2010).

Cultural Adaptation Stage Models

There are numerous cultural adaptation models (Burlew et al., 2013), but I chose the three models depicted in Table 1 because they appear to be a good fit for AIBH programs organizational structure. The strengthening families model (Kumpfer et al. 2008) has been implemented with AIs, African Americans, Hispanics, Asian Americans, and Pacific Islanders in 17 different countries (Castro & Barrera, 2010). The culturally specific prevention model (Whitbeck, 2006) has been used with AIs for prevention programming and includes five steps. The strengthening families model and the culturally specific prevention models were selected because they have been used with AI populations and have demonstrated effective outcomes. The heuristic model (Barrera & Castro, 2006) has not been used with AIs but might be useful for AIBH programs that are under-resourced due to staff shortages and time limitations because it has only four cultural adaptation steps. See Table 1 for a summary of the three cultural adaptation models.

The three models have two aspects in common: (1) They all start with a needs assessment to identify risk and protective factors unique to the target population, and 2) they agree adaptations need to be evaluated to demonstrate improved clinical outcomes. Kumpfer (2008) differs from Barrera and Castro (2006) because Kumpfer advocates the original EBT needs to be implemented before adaptations are made. Kumpfer (2008) also requires fidelity checks with consultants and weekly feedback sessions on the progress and limitations of the adapted intervention. This requires additional staff and expertise that AIBH programs may not have (IHS, 2011). In contrast, Barrera and Castro (2006;

2013) advocate constructing preliminary adaptations to the original EBT and then testing the adapted intervention. They state there is no need to implement the original EBT only the adapted version, which is more efficient for AIBH programs when time and staff resources are constrained (Barrera & Castro, 2006; 2013).

Table 1

Three Cultural Adaptation Models

The Strengthening Families Model Kumpfer et al. (2008)	The Heuristic Model Barrera & Castro (2006)	Culturally Specific Prevention Model Whitbeck (2006)
1) Gather needs assessment data on risk and protective factors of the target population.	1) Gather information from the stakeholder group (identify risk/protective factors and concerns of target group).	1) Meet with the AI community (including elders, tribal leadership, providers, and community advisory boards) and researchers to identify key risk/protective factors.
2) Select the best EBT to culturally adapt (look for intervention with large effect size).	2) Cultivate a preliminary adaptation design (develop recruitment strategies, make preliminary modifications to the original intervention on the basis of data from Step 1).	2) Do a baseline survey that identifies the extent of the problems and protective factors.
3) The first step is to implement the original EBT and identify any modifications that need to be made.	3) Test the preliminary adaptation design (draft the adapted version and pilot test it).	3) Work with the community and cultural experts to translate the key risk/protective factors that fit the cultural context.

The Strengthening Families Model Kumpfer et al. (2008)	The Heuristic Model Barrera & Castro (2006)	Culturally Specific Prevention Model Whitbeck (2006)
4) Select staff to implement the EBT (training and supervision must be provided).	4) Adaptation refinement (evaluate adaptation within a research design framework to determine the effectiveness of engagement, theory, and intervention).	4) Develop measures of the key risk/protective factors that are unique to the cultural context.
5) Implement the EBT with fidelity (including fidelity checks and consulting with program developers).		5) Conduct trials of the culturally specific intervention and do assessments.
6) Document cultural adaptations created with the pilot group and schedule weekly feedback sessions on the progress and process.		
7) Revise program materials based on cultural adaptations to enhance engagement.		
8) Evaluate changes from the beginning to the end of cultural adaptation to improve outcomes.		

The culturally specific approach by Whitbeck (2006) includes elders and community members to create a needs assessment to identify key risk and protective factors. Elders are included because in AI cultures they are the carriers and transmitters of cultural knowledge and ways of knowing; therefore, they have important cultural wisdom to share (Whitbeck, 2006). The model uses existing culturally specific research to develop assessments and interventions targeting key risk and protective factors (Whitbeck, 2006). The model emphasizes the importance of cultural translation (the

process of adapting key variables to reflect the social context) of key risk and protective factors that are understandable to the target population, thus making the adaptations more culturally relevant and meaningful (Whitbeck, 2006). The next step is to identify measures of the key risk and protective factors. The last step is to develop and implement culturally specific interventions and evaluate the effectiveness (Whitbeck, 2006). AIBH organizations can use this model to create culturally specific interventions grounded in Indigenous knowledge.

Tribal Critical Race Theory

This research was informed by theory to guide the design of the methodology used and the analysis of findings. Critical Race Theory is about transforming race, racism, and power (Delgado & Stefancic, 2017). It recognizes the notions of community and group empowerment to develop ideas and narratives around each group and its particular situation (Delgado & Stefancic, 2017).

The theoretical framework most appropriate for this study was Tribal Critical Race Theory (CRT) developed by Brayboy (2005). It is informed by CRT, political/legal theory, political science, anthropology, education, and American Indian studies. Tribal CRT was used to guide this research to explain the mistrust of research with AI/AN communities and the impact of colonization and its effects on adopting EBTs. The theory provides a context that adapting EBTs must be congruent to AI/AN values, customs, and Indigenous knowledge. Tribal CRT has nine tenets that are listed below (Brayboy, 2005).

1. Colonization is widespread in society.

2. U.S. policies toward Indigenous peoples are constructed from imperialism, White supremacy, and a desire for material gain.
3. Indigenous peoples occupy a unique space that accounts for a legal, political, and racialized identity.
4. Indigenous peoples have a desire to obtain and reinforce tribal sovereignty, tribal autonomy, self-determination, and self-identification.
5. The concepts of culture, knowledge, and power take on new meaning when observed through an Indigenous lens.
6. Governmental and educational policies toward Indigenous peoples are intimately linked around the problematic goal of assimilation.
7. Tribal philosophies, beliefs, customs, traditions, and visions for the future are central to understanding the lived realities of Indigenous peoples, but they also demonstrate the differences and adaptability among individuals and groups.
8. Stories are not separate from theory; they makeup theory and are, therefore, legitimate sources of data and ways of being and knowing.
9. Theory and practice are connected in deep and explicit ways in which scholars must work towards social change.

Tenet 1 of Tribal CRT applies to the fact that treatment guidelines for mental health disorders were built with primarily White, African American, Latino, and Asian populations; the exclusion of AIs is a form of colonization (Miranda et al., 2005; Ünlü Ince et al., 2014). Respectfully seeking AI/AN participation in developing treatment guidelines and interventions for mental health disorders is critical in providing culturally

competent care (LaVeaux & Christopher, 2009). Tenet 2 states that U.S. policies are constructed from imperialism, White supremacy, and material gain (Brayboy, 2005); this tenet is applicable to the four periods of AI policies and history (the General Allotment and Assimilation, Indian Reorganization, Termination and Relocation, and Self-Determination) that reinforced relocation, assimilation, and almost eradicated AI populations (Getches et al., 2016; Pevar, 2012). Federal entities (IHS, NIH, Medicaid, SAMHSA) directing AI tribes to select an EBT that has not demonstrated long-term effectiveness is a form of imperialism and does not honor self-determination (Echo-Hawk, 2011; Gone, 2012). Tenet 3 of Tribal CRT acknowledges the unique relationship AI tribes have with the U.S. government, which differs from Latinos, African Americans, and Asian Americans. AIs have to prove their tribal membership to demonstrate they are an enrolled member of a tribe, whereas other ethnic groups do not have this requirement (LaVeaux & Christopher, 2009). In addition, the U.S. government has a unique federal trust responsibility with tribal governments to provide health care, education, law enforcement, and protection of natural resources (Getches et al., 2016; Pevar, 2012). This federal trust responsibility must be upheld, and therefore, tribal consultation with federal agencies must occur to seek guidance about what interventions work to reduce mental health disparities in Indian country (Nebelkopf et al., 2011). Tenet 4 reflects the Indian Self-Determination and Education Assistance Act (1975), which gave tribal governments the autonomy, sovereignty, and self-determination to manage federal programs in their communities (substance abuse, community health representatives, law enforcement, education, health care, housing, and environmental protection, and natural resources

management; Getches et al., 2016; Warne & Frizzell, 2014). The Act supports tribes to select and adapt EBTs that fit their communities to enhance engagement and retention in BH services (Gone, 2012; Walker & Bigelow, 2011). Honoring tribal sovereignty (self-governance) is an essential element in developing research partnerships (LaVeaux & Christopher, 2009; Wallerstein et al., 2018; Walters et al., 2010). Tenet 5 applies to tribes exerting their political power to advocate that EBTs include Indigenous ways of knowing and cultural values that are more aligned with their communities to enhance the well-being of their people (LaVeaux & Christopher, 2009; Walters et al., 2010; Whitbeck, 2006)

Tenet 6 acknowledges that the majority of the clinical efficacy trials did not include ethnic minority populations; to generalize that EBTs are effective for all ethnic minorities is not culturally responsive and constitutes unethical practice (Miranda et al., 2005; Ünlü Ince et al., 2014). This type of exclusion can be seen as a form of assimilation (Miranda et al., 2005; LaVeaux & Christopher, 2009; Nebelkopf et al., 2011; Walker & Bigelow, 2011; Walker et al., 2015). Tenet 7 is important because the majority of EBTs are not created from an Indigenous lens that honors tribal beliefs, customs, and traditions so EBTs need to be adapted (Gone, 2009, 2011). To expect AIs to engage in mental health services that do not fit their cultural worldview is unethical and can cause more harm than good. Including Indigenous ways of knowing in treatment interventions respects Indigenous epistemologies and creates a knowledge exchange between the provider and client (Walters et al., 2010). Tenet 8 is vital to engagement and retention of services (stories are not separate from theory) in order to create clinical guidelines that

emphasize cultural sensitivity and cultural responsiveness to actively hear clients' stories, history, and accounts of why they are seeking services (Castro et al., 2010). Client stories are data; it informs the practitioner of the type of services needed and seeks the client's input that enhances the treatment process (Gibbs & Gambrill, 2002). Tenet 9, actively seeking input from AI tribes about the effectiveness of EBTs is vital to understanding mental health disparities from an Indigenous lens (Walker et al., 2015). The tribes decide what works best for their people (LaVeaux & Christopher, 2009; Walters et al., 2010). Honoring the tribes' self-determination to select a mental health treatment that respects Indigenous wisdom, cultural ways of knowing, and values is crucial to enhancing community members' sense of well-being and healing in life (Whitbeck, 2006).

TPR and CBPR Principles

In this study, all tenets of TPR principles (LaVeaux & Christopher, 2009) will be utilized. The TPR principles were informed by CBPR principles, so both approaches are intertwined. The exception is that TPR has principles applicable to tribal communities that have specific guidelines to do research in their community, as opposed to CBPR, which has general guiding principles to do research with diverse communities. Both TPR and CBPR are used in the study because TPR principles are more culturally responsive to tribal communities' unique needs as it pertains to research, and CBPR principles identify community-engaged approaches. The methodology section explains how I used TPR and CBPR principles in the study (Chapter 3). Table 2 outlines TPR and CBPR principles. The principles are on a continuum, reflecting a fluid process, and does not reflect a step order process.

Table 2

Community-Based Participatory Research (CBPR) Principles and Tribal Participatory Research (TPR) Principles

CBPR Principles (Israel et al., 1998)	TPR Principles (LaVeaux & Christopher, 2009)
1. Recognize the community as a unit of identity.	1. Acknowledge historical experiences with research and work to overcome the negative experiences of research.
2. Build on the strengths and resources within the community (protective factors).	2. Recognize tribal sovereignty.
3. In all phases of the research process, facilitate collaborative partnerships.	3. Recognize the difference between tribal and community membership.
4. Integrate knowledge and actions for the mutual benefit of all partners in the research.	4. Understand tribal diversity.
5. Promote co-learning and empowerment that addresses social inequalities.	5. Plan for extended timelines.
6. The process is cyclical and iterative.	6. Identify key gatekeepers.
7. Address health from a positive ecological perspective.	7. Prepare for leadership turnover.
8. Disseminate findings and knowledge gained to all partners.	8. Interpret data within a cultural context.
	9. Utilize Indigenous ways of knowing.

AI/AN communities have a heightened sense of mistrust with research as a result of their past experiences with the U.S. federal government (broken treaties) and unethical research implemented in their communities. The recent incident was at Arizona State University (ASU), which approved a research study with the Havasupai tribe. A genetic researcher at ASU, who had initial institutional review board (IRB) approval with the

Havasupai tribe, wanted to understand why more than half of that population had type 2 diabetes (Garrison, 2013). As part of the research protocol, DNA samples were collected from Havasupai participants (Garrison, 2013). In 2003, Carletta Tilousi (Havasupai tribal member) discovered the DNA samples donated for the research project were being used for non–diabetes-related research that was not approved in the study (Garrison, 2013). Tilousi learned the DNA samples were used for studies on schizophrenia, migration theories, and population inbreeding, without consent from the tribe. The Havasupai tribe filed a lawsuit against the Arizona Board of Regents in 2003 over the misuse of the DNA samples and lack of informed consent and collection of samples (Garrison, 2013). A settlement was reached in 2010 (Garrison, 2013). The Havasupai case demonstrates the historical injustices with research in AI/AN communities and the exploitation it brings upon vulnerable, marginalized populations. That is why using TPR and CBPR principles is essential to doing research with AI/AN communities.

CBPR Principles

CBPR approaches aim to support equitable participation from all research partners, community, and key stakeholders to develop a clear understanding of the problem the research project wants to address (Israel et al., 1998). There is a commitment to conduct research that shares power with and engages community partners in the research process (Israel et al., 1998). The CBPR principles guide the research partnership to decide on core values and principles that reflect the collective vision of the research project and collaborative decision-making process (Israel et al., 1998). For these reasons, CBPR is selected because it provides an alternative to traditional research approaches.

CBPR approaches engage communities in the research process and build upon the community's strengths, knowledge, and action to implement social change (Israel et al., 1998).

Recognizing the community as a unit of identity, building upon their strengths, and facilitating a collaborative research partnership is essential to building trust and transparency in AI communities (CBPR Principles 1-3). I utilized these approaches when I sought input about the research design and recruitment strategies to obtain participation in the study. I sought the necessary tribal approvals to do the research with the AIBH programs to build a collaborative research partnership (CBPR Principle 3) and shared the study's findings with the respondents and tribal administrations who participated in the study (CBPR Principle 8).

As explained in Chapter 3 (methodology), I asked permission to conduct the research study with the three AIBH programs, each had their own research protocols. Each program asked how this study would benefit their community before they approved the study, so CBPR Principle 4 was followed. I worked in the Southwest for 20 years as a clinical social worker; I built relationships with some AIBH programs and I learned about sharing information, equitable decision-making, and providing training, and supporting programs. The knowledge I have gained through these experiences was used to promote co-learning, integrate the research partners' knowledge, and participatory actions into the research process (CBPR Principles 4 and 5). My research timeline was flexible because AIBH programs have other priorities and it was important to honor their timeline and have a dialogue about research engagement (CBPR Principle 6). The purpose of the

research study was to focus on the assets AIBH programs have to adapt EBTs and how they maintain the adoption of EBTs at their programs. The research focus was from a positive point of view: how AIBH adapt EBTs to ensure culturally congruent care (CBPR Principle 7).

TPR Principles

TPR principles acknowledge the mistrust of research, the effects of colonization, and what historical trauma means to AI populations (Principle 1; LaVeaux & Christopher, 2009). Understanding these perspectives in AI communities is a priority before starting any research project. Many tribes have established research protocols or codes of conduct for research conducted in their communities (LaVeaux & Christopher, 2009). Tribal governments are taking control of the decision-making process of research on their land (tribal sovereignty; TPR Principle 2). Honoring tribal IRB protocols and research policies (tribal sovereignty) is a significant precedent to follow to build trust and transparency (TPR Principle 2). Viewing the community as a unit of identity as in CBPR approaches is important, but in tribal communities there are unique differences between those who are enrolled tribal members and those who are community members (TPR Principle 3). As community advisory boards are established, it is important that the members of the community are appropriate representatives of their community, so it is fundamental to ask tribal leadership and key community stakeholders who should participate as an advisory board member (TPR Principle 3).

Understanding the tribal diversity (values, customs, traditions, and practices) of the community is a step the researcher has to take to grasp the depth of acculturation and

enculturation attitudes the tribal community has (TPR Principle 4). Plans for extended timelines (TPR Principle 5), recognizing key gatekeepers (TPR Principle 6), and preparing for leadership turnover (TPR Principle 7) are intertwined. Understanding the tribal government structure is key to forming a collaborative relationship with the tribal community, so identifying the key gatekeepers is vital to maintaining a relationship. The key gatekeepers (elders, respected community members, or tribal administration officials) provide support and help develop trusted relationships with key members of the tribe to ensure participation in the project. They also provide guidance on culturally appropriate protocols during the research project. Some tribes have annual elections for tribal leadership, so turnover could affect the tribe's priority for research, which impacts the research study's timeline. Having an approved tribal resolution helps the project move forward independent of the political leadership (LaVeaux & Christopher, 2009).

Interpreting data within the cultural context (TPR Principle 8) and using Indigenous ways of knowing (TPR Principle 9) are interwoven. Having community members included in the data analysis and interpretation phase is important because they provide the context (values, attitudes, practices, and beliefs) of the local community. This ensures the data is interpreted correctly through the tribal community's lens. This also applies to the tribe's approval of what can be released or shared with the public from the research study (LaVeaux & Christopher, 2009). Utilizing Indigenous ways of knowing aids in the interpretation of the data (LaVeaux & Christopher, 2009). Each tribe has unique cultural methods of implementing projects and creating interventions, so researchers need to be cognizant of this and ask the tribal members what they should

share and keep confidential (LaVeaux & Christopher, 2009). This increases trust with the community, and the data are more accurately represented (LaVeaux & Christopher, 2009).

Summary

The six sections of the literature review (EBP compared with the EBP process and a definition of EBT, two types of evidence-based research, the EPIS model, gaps in effective mental health treatment for AI/ANs, cultural adaptation frameworks, and tribal CRT) were to create a historical context of the evolution of EBTs in AIBH organizations and to illustrate the lack of culturally incongruent EBTs for AI/AN populations. In this chapter, the reasons I selected TPR and CBPR principles for the research method were explained.

In the methodology section (Chapter 3), I will explain how TPR and CBPR principles were utilized in the study. I include why a qualitative research design was selected. In addition, I will describe the data collection and data analysis process that I used, and I will summarize the trustworthiness established in the study.

CHAPTER 3

METHODOLOGY

To answer the research question, "How do AIBH organizations adapt EBTs for cultural relevance?" I designed a qualitative study. The study explores how practitioners (behavioral health directors and mental health clinicians) and cultural experts adapt EBTs. Furthermore, it investigates which internal and external organizational factors (facilitators and barriers) lend themselves to adopting EBTs and whether EBTs are a good fit for AIBH organizations. To date, there is minimal literature on the process AIBH organizations use to adapt EBTs for cultural relevancy (Gone & Trimble, 2012; Miranda et al., 2005; Pommerville et al., 2016). Because this study comprises three AIBH organizations' that serve marginalized, vulnerable populations, tribal participatory research (TPR) methods were used. This chapter includes my background to facilitate a collaborative relationship with the three AIBH organizations. I also explain the use of TPR principles, the data collection process, and data analysis. Last, I summarize how rigor and trustworthiness strategies were used in the study.

Justification for a Qualitative Study

In the extant literature there are cultural adaptation models (Burlew et al., 2013) but limited information on how behavioral health programs adapt EBTs for AI clients (Gone & Trimble, 2012; Miranda et al., 2005; Pommerville et al., 2016). Therefore, a qualitative approach was required. The study explored how practitioners adapt EBTs within AIBH settings. Since AIBH programs primarily serve AI clients and are considered a vulnerable, marginalized population that had negative experiences with

research in the past, a qualitative approach is essential to build trust and rapport (Padgett, 2017). I sought to gain a deeper understanding of how practitioners adapt EBTs, how they sustain the adaptations, and how they keep their clients engaged in services. To capture this process, a qualitative approach was more appropriate than a quantitative approach, which would reduce participants' stories to numbers and thus would be an inappropriate design to use (Padgett, 2017).

Background of Indigenous Researcher

My name is Charlene Poola, and I am Navajo and Hopi-Tewa. My clans are Big Water and Spider. My mother was Navajo, and my father is Hopi-Tewa. Home for me is First Mesa, Polacca, Arizona. In American Indian culture it is important to identify who you are and where you come from, and I used this approach when recruiting the three AIBH organizations to participate in this study.

I have worked in the Southwest for over 20 years as a preventionist and licensed clinical social worker and built numerous partnerships with several AIBH programs. Working in Indian Country is a small world, and often Indigenous researchers are asked, "Where are you from?"— meaning who are you, who are your parents, and where is your home community. It is important to share this information to make a connection to other Indigenous researchers and community members because it forms an authentic relationship. My parents worked in tribal and urban AI communities addressing health inequities, and some providers knew my parents and saw my brothers and I grow up. Knowing who I am and where I come from built trust with AI communities. I have

worked with the three AIBH organizations in this study in the past on a few behavioral health projects.

Sampling Procedure

A purposive sampling frame was used to recruit one urban and two tribal AIBH programs in the Southwest that implemented EBTs at their programs. A purposive sampling frame was selected because participants had to meet a certain criterion: They had to work in either a tribal or urban AIBH program. Also, they had to be a behavioral health (BH) director, mental health clinician, or a cultural expert who implemented EBTs at their program. To reflect ideas from diverse backgrounds, tribal and urban BH programs were selected because tribal programs generally provide services to a homogeneous population, whereas urban programs generally provide services to a heterogeneous population. To honor tribal sovereignty, I asked the BH directors and tribal administration for a list of potential participants to ensure I followed community protocols to facilitate a collaborative partnership.

Settings for Communities A and B

Community A and Community B are tribal communities in the Southwest. Both have a tribal governance structure with tribal leadership, tribal administrations, and tribal councils. Communities A and B have various programs that include Head Start, family and social services, senior services, prevention services, behavioral health departments, tribal courts, and departments of education, housing, and tribal enrollment. There are other programs available in the community; this is not an exhaustive list. Communities A and B receive tribal 638 (Public Law 93-638: Indian Self Determination Act and

Education Assistance Act) funding, as described in Chapter 1, to operate some of their programs. They also receive Bureau of Indian Education, Bureau of Indian Affairs, Indian Health Services (IHS), federal, state, and county funding. This is not a complete list of funding, but it demonstrates how diverse their funding streams are to sustain their programs. Both communities speak their Native language and continue to practice their traditions. To protect the communities' identities, limited information is provided about the community environment.

Setting for Community C

Community C is an urban AIBH organization that serves over 100 tribes in the Southwest. Community C's BH organization provides primary care, dental, homeless outreach, behavioral health services, and traditional wellness/recovery services. Community C is an urban center and has an executive director and a board of directors. There is no tribal governance structure in Community C. The urban BH program has a few satellite offices that offer primary care services to more populated areas where more AIs reside. They receive federal, IHS, state, city, and county funding.

Recruitment Strategy

I spoke with the three AIBH organizations about my research study in May (2019) to seek their input about my research design and how to recruit participants. I provided the three BH directors with a one-page description (see Appendix A) that outlined the purpose and aims of the study, participant requirements to enroll in the study, and the data collection method (semi-structured interview). I included a biographical sketch, so they knew who I was. Even though I personally know the BH directors, it was

important to have a one-page description of the study so they could share it with their respective leadership, program managers, and staff.

The Use of Tribal Participatory Research Principles in the Study

The research approach primarily used was tribal participatory research (TPR) principles (LaVeaux & Christopher, 2009), as outlined in Chapter 2. Community-based participatory research (CBPR; Israel, 1998) principles were utilized too because TPR originated from these core principles.

TPR was the primary research approach because the study was with two tribal BH programs. TPR recognizes the past negative experiences AI communities had with research (Principle 1) and identifies strategies to overcome these experiences while honoring tribal sovereignty (Principle 2). TPR has nine principles; the following text illustrates how I used these approaches with Communities A, B, and C.

TPR Principle 1 (acknowledge historical experiences with research and work to overcome those negative experiences of research; LaVeaux & Christopher, 2009): I had worked with the three AIBH organizations on previous projects. I built trust and a collaborative relationship with the BH directors; they were key to connecting the researcher to tribal administrations. They provided the culturally appropriate ways to address tribal administration and what cultural protocols to follow.

Part of the CBPR principles (1, 2, 3) is to identify the community as a unit of identity, build on their strengths and protective factors, and include them at all phases of the research process. The BH directors provided input on the research design, and I asked how best to recruit participants for the study. Since we had a working relationship, we

had these conversations by telephone or email. The one phase they were not included in was the creation of the interview protocol. But I did pilot the questions with a community stakeholder who had 10 years of experience with these BH programs and is a valued community member. The community stakeholder provided insight on what questions to keep and change/omit.

TPR Principle 2 (recognize tribal sovereignty): I respectfully followed the tribal and urban research protocols to collaborate on a research study. I obtained institutional review board (IRB) approval at two levels, the academic institution, and the tribal/urban levels. First, I had discussions with the three BH directors about my study before I started the IRB protocol to acquire their feedback about the study design and recruitment of participants. When I spoke with a community member about my project, they recommended I included cultural experts because the study is about cultural adaptations of EBTs, and the cultural experts have the cultural knowledge.

Community A—Research Protocol Process

I contacted the BH director to inquire about the tribe's research protocol (June 2019), and they referred me to the tribal administrator (TA). The TA requested we have a phone conversation about the study, because their administration would be on travel for two months (July 2019-August, 2019) and they did not want to delay the project. We talked in late July, and the TA requested I submit a formal letter requesting tribal administration to review my research study so they would put it on their agenda. The letter included the purpose of the study, participant qualifications, and my contact information. I submitted the letter and waited several weeks. I followed up with the BH

director of Community A, they intervened, and the TA responded shortly after requesting a follow-up call.

I spoke with the TA by telephone (August 27, 2019), and they asked how the study would serve their community. I shared that the study's purpose was to identify how AIBH programs adapt EBTs to ensure cultural relevancy and how to know whether we are producing effective outcomes. They were knowledgeable about BH disparities and shared how the community addressed it historically and culturally. After our discussion, the TA had a new appreciation of the study and said it would "identify a healing approach" and not a deficit approach. They saw how other AIBH programs could benefit from the study when the cultural adaptations process of EBTs was identified. They were intrigued by the research question and could see the benefits of the study.

I asked if I needed to present to tribal council, and the TA said no, they would share the information with tribal leadership. They requested I keep them and the BH director apprised of the research study via email. I asked if they could provide a list of potential participants for the study, and they referred me to follow up with the BH director.

The TA requested I share the results of the study with them and tribal leadership before publishing anything. I agreed. Community A provided a letter of approval to implement the study in October 2019.

Community B—Research Protocol Process

The BH director of Community B, requested I email the TA to review their research protocol. I emailed the TA in July 2019. The TA requested we meet in person to

discuss the research study (August 16, 2019). I provided the TA with a one-page document that outlined the purpose of the study, participant recruitment strategy, my biographical sketch, and contact information. At the presentation, I went over the research study (purpose, participant recruitment, and data collection). I emphasized that I would obtain tribal approval before sharing any findings of the study. The TA asked how the study could benefit the community. After our discussion, the TA realized the findings of the study could be used to enhance another BH project being implemented in their community.

At the end of the discussion, the TA supported the study. I asked whether I need to present to tribal council. The TA said they would share the information with tribal leadership and reiterated the research study is not considered a sensitive topic. I asked the TA if they could recommend any cultural experts to interview, and they provided two people to contact. The TA said they would follow up in two weeks.

After that initial meeting, I emailed the TA of Community B and did not receive a response until October 2019. In the interim, I called the BH director asking for advice on how best to approach tribal administration about my study. The BH director suggested I email tribal leadership directly. I was hesitant because I wanted to be sensitive to the tribal government's priorities and not upset anyone. At the same time, the holiday season was near, and I was running out of time to schedule interviews.

I emailed the tribal leader in mid-October 2019, and they were aware of the study because the TA shared the information. The tribal leaders understood the importance of deadlines and provided a letter of approval in late-October 2019 to implement the study.

They requested that if I plan to publish the results of the study to seek tribal leadership approval first. I agreed.

Community C—Research Protocol Process

For Community C, I emailed the executive director (ED) in July 2019, requesting a meeting to discuss the study. We met in person on August 1, 2019, and I provided an overview of the project using a one-page outline. We immediately discussed the study. The ED's primary concern was how long the interviews would take and whether participants would receive an incentive. The ED emphasized that staff who volunteered to participate must do the interview on their lunch hour or when they are off work. I abided by this rule.

The ED had questions about how the study would serve the larger community. I shared that there was minimal information in the literature about the cultural adaptation processes AIBH use and to capture that information would benefit AIBH program development. I emphasized that the results would be shared with the ED before publishing. I asked whether I needed to present to the board of directors. The ED required Arizona State University (ASU) IRB approval first, then a letter of approval to implement the study would be provided. Since Community C is an urban BH program, it is not governed by a tribe, so the ED had the authority to approve the research study.

TPR Principle 3 (recognize the difference between tribal and community membership) and Principle 6 (identify key gatekeepers) overlap: AIs are the only racial group in the U.S. that must prove membership through enrollment, defining who is a tribal member compared with who is a community member (Christopher et al., 2011).

When identifying key gatekeepers in tribal communities, it is important to recognize who are enrolled tribal members and who are community members. The two tribal BH directors were key gatekeepers to provide cultural and research protocols, identify key stakeholders, identify cultural experts, and make the appropriate introductions to tribal administration and leadership. They also knew who were community members and who were enrolled members of the tribe. The key gatekeeper for Community C (urban) was the BH director, who provided guidance on their internal research protocols and provided a list of potential participants to interview. All the BH directors in this study, vouched that I was a trusted ally in the AI community.

TPR Principle 4 (understand tribal diversity and its implications): Communities A and B are tribal communities where the population is relatively homogeneous. Community C is an urban community where the population is heterogeneous and has over 100 tribes. As the researcher, I understood the community characteristics since I had worked with all three programs in the past. I was aware of the tribal community's cultural values, beliefs, and practices and felt comfortable asking the practitioners (BH directors and mental health clinicians) and cultural experts to voluntarily participate in the study. Within Communities A and B, I knew 3 participants.

As for Community C, I was familiar with that community's characteristics too. I felt comfortable asking practitioners (BH directors and mental health clinicians) and cultural experts to volunteer for the study. I knew 4 participants who volunteered for the study. Indian Country is small, and I have 20 years of experience working in the Southwest, so it is expected I would know some of the participants.

TPR Principle 5 (plan for extended timelines): It was a 5-month period (June 2019-October 2019) before all three communities approved the research study. I honored the tribal and urban communities' research protocols (tribal sovereignty) and their extended timelines for their approval letters to implement the study. This took patience and diligence to continuously check in with the BH directors to ensure I was being culturally appropriate while receiving approval for the study. Often tribal communities have competing priorities because they have numerous programs to oversee that are attached to federal, state, and local funding priorities. Plus, they have to address community members' needs and safety concerns and ensure they have access to resources that take priority over research. The urban community has a waitlist of community members trying to access BH services, and that takes priority, as do staff training and supervision needs. I was cognizant that these items took priority over my research and built in an extended timeline.

According to CBPR Principle 4, integrating knowledge and action to benefit all research partners is crucial to creating a collaborative research relationship. Based on my past experiences doing research with tribal and urban organizations, I understood that their priorities are their clients and program needs; research is often second. I tried to integrate these past experiences with research and built it into my timeline.

TPR Principle 7 (prepare for leadership turnover): Since Community C is an urban BH organization, not managed by a tribal governance structure, I was not concerned about leadership turnover. The ED is committed to staying in a leadership role to enhance access to BH services for AI clients.

Tribal communities A and B have annual elections, and I understood that after October it would be increasingly difficult to obtain tribal approval for any research study. That is why I worked diligently for the entire month of October to obtain tribal approval. This demonstrates the importance of understanding tribal governance structures and operations. Also, it is important to know when there are traditional activities in the communities because most communities are closed for business until the activities are completed. This process is cyclical and iterative (CBPR Principle 6) and it takes time to understand the business and cultural operations of tribal communities.

TPR Principle 8 (interpret data within the cultural context): The research study examined how AIBH programs adapt EBTs for cultural relevancy, so it was vital to include cultural experts in the study. The cultural experts provided the cultural lens and context to adapt EBTs, so their participation was crucial.

I started data analysis in March 2020 when COVID-19 impacted the country. I was unable to interpret and analyze the data with participants because tribal communities were shut down from March to September. Some programs opened on a limited basis at the beginning of October, but no "outsiders" were allowed in Communities A and B for any reason. For Community C, their program shut down temporarily, and then practitioners started to see clients virtually; no in-person contact was allowed.

I contacted all participants to share the aggregate results of the study in September 2020 and three participants responded. I shared the study's findings with them via Zoom. They endorsed the findings. I presented the findings to Community A's tribal administration; they approved the study findings and agreed I could share the results at

conferences. They requested that when it came time to publish the results, they receive a copy first to view for accuracy. I agreed.

With Community B, I emailed the TA and because the community was shut down for business due to COVID-19, I did not get a response until late September. The tribe had difficulty with internet access so I could not present the study's findings via Zoom. Because they were closed to outsiders due to COVID-19, I could not present the findings in person to tribal administration; the tribal leader requested I submit a USB drive with my presentation of the study's findings in early October. I provided a letter, sharing my gratitude that they approved my study, outlined the four major findings, and asked two questions. The questions were (1) Can I present the aggregate findings at conferences? and (2) What is your protocol for publishing the study? I stated in the letter that I would share the manuscript before publishing to obtain their feedback. The tribal administrator called and approved my study's findings and approved that I could share the results at conferences. They requested that when it came time to publish the results, they receive a copy first, to view for accuracy. I agreed.

For Community C, I shared the study's findings and the ED approved it. The ED agreed I could share the results at conferences and requested a copy of the manuscript before I published it. I agreed.

In tribal communities, it is important to make every effort to share the study's findings with tribal administration and leadership. It honors tribal sovereignty and reduces negative experiences with research. It promotes co-learning and increases all research partners' ability to gain knowledge of how to do research in a respectful and

reciprocal manner (CBPR Principle 8). Based on Community A, B, and C's positive feedback and endorsement of the study's findings, I established CBPR Principle 8.

TPR Principle 9 (utilize Indigenous ways of knowing): It was important to recruit AI participants in this study because they bring their Indigenous ways of knowing to create culturally appropriate interventions and programs. Each tribe has unique values, practices, and philosophies, so it was important to capture their cultural knowledge in this study. Utilizing TPR methods and having an established trusting relationship with the three AIBH programs resulted in a community-engaged study. The end result was that it created a long-term research relationship for future work.

As for CBPR Principle 5 (promote co-learning and empowerment that addresses social inequities), I am unsure whether the study addressed social inequities. I was unable to present the findings to Community B via Zoom or in-person to obtain their feedback. I will continue trying to attain their approval to share the study's findings at conferences and publish the results. The research process promoted co-learning, and the pandemic (COVID-19) impacted tribal operations and programs; now, we have to rely on a virtual world to do business. When a community is rural, internet access is limited, which impacts projects; thus, patience and due diligence becomes a virtue.

Participant Demographics

After IRB approvals were obtained (ASU/tribal/urban), the BH directors provided a list of participants for the study. A total of 28 participants were referred to participate. Four declined to participate (two could not adequately answer the research question, one was on sick leave, and the last one never returned my calls or email requests).

The final sample size was 24 participants (four behavioral health directors, 15 mental health clinicians, and five cultural experts). Eight (33%) men and 16 (67%) women participated in the study. The average age was 35-44 years old (42%). Participants' ethnicities were White (n = 9), Latino (n = 2), and American Indian (n = 13). Nineteen participants (79%) had clinical licenses to provide mental health services (LPCC, LMSW, LCSW, LMFT, or PsyD), two had at least some college, and three graduated from high school. Due to a small sample size and the need to protect participants' identities, I must provide general demographics and am not providing tribal affiliation.

The average number of years participants provided mental health services was 12 years (SD = 9.7 years). The average number of years participants provided mental health services to AI clients was nine years (SD = 9.1 years). The average number of years participants worked in Indian country was 12 years (SD = 13.3 years). An interesting finding was that 42% of the participants worked in Indian country, meaning the majority of the participants worked at urban BH programs, not tribal programs. This correlates with data indicating that 70% of the AI population resides in urban areas; therefore, most of the clinicians would be providing BH services in the urban sectors (IHS, 2018). All participants were over 18 years of age and signed consent forms to participate in the study.

Table 3

Participants' Demographic Data

	Urban Program	Tribal Program
Sample (*n* = 24)		
Behavioral health directors	1	3
Mental health clinicians	7	8
Cultural experts	1	4
Gender		
Male	2	6
Female	7	9
Ethnicity		
American Indian	5	8
Latino	0	2
White	4	5
Education		
High school diploma	0	3
Associate's degree	1	0
Bachelor's degree	0	1
Master's degree	6	11
Doctorate	2	0

Data Collection

IRB approval (ASU/tribal/urban) was obtained at the end of October 2019. Interviews were scheduled over a 6-week period (November 8, 2019-December 10, 2019) with BH directors, mental health clinicians, and cultural experts at the three BH organizations. The interviews were 60 minutes in length, and the majority of them (23 participants) were face-to-face at the participant's place of employment. One interview was at a restaurant because the interviewee requested that site. I wanted to honor their choice of location to do the interview. Twenty-three interviews were completed as of

December 2019. I had to schedule my last cultural expert interview on January 2020 because of the holiday and traditional calendar of events.

Audio recordings, notes, and transcriptions of the participants' interviews and demographic data were stored in a locked filing cabinet. Transcriptions from the interviews were stored on a password-protected computer, and all data were de-identified. I had the master list of names of the participants, and it was in a locked filing cabinet.

Semi-Structured Interviews

I piloted the interview questions with a community stakeholder. The process helped me organize and eliminate redundant questions and provided an opportunity to do a test run of the interview questions.

A semi-structured interview was used with the practitioners (BH directors and mental health clinicians). The demographic questions included gender, race, age, level of education, employment status, area of expertise in behavioral health, type of clinical license obtained, how many years they have provided mental health services, how many years they have provided services to AI clients, and how many years they have worked in Indian country (see Appendix B). There were 14 open-ended questions related to (1) attitudes towards EBTs, (2) process to adapt EBTs, (3) whether the adaptations were useful, (4) how culture plays a role in adaptation of EBTs, (5) what internal/external organizational characteristics facilitate adoption of EBTs, (6) what internal/external organizational characteristics create barriers to adoption of EBTs, and (7) what protective

factors or resiliency characteristics they recognize in their client population (see Appendix C).

The cultural expert interviews had the same demographic questions as the practitioners (see Appendix B). The interviews for the cultural experts included questions about (1) attitudes towards EBTs, (2) process to adapt EBTs, (3) how culture plays a role in adaptation of EBTs, (4) what internal/external organizational characteristics facilitate adoption of EBTs, (5) what internal/external organizational characteristics create barriers to adoption of EBTs, and (6) whether EBTs are a good fit for the client population (see Appendix D).

All interviews were scheduled face-to-face and audio-recorded with their consent (see Appendix E). Upon completion of the interviews, each participant received a $25 gift card for their time. All interviews were transcribed using an online transcription service, Transcribe Me (January 2020). I used Atlas ti (qualitative data analysis software) to code and analyze transcriptions. Atlas ti software organizes and analyzes the data to explore connections among themes, topics, and people and arranges the data to build a body of evidence to answer the research question. For the first cycle of coding, I used the InVivo method, which utilizes participants' language to code their perspectives and actions to ensure the information is captured accurately (Saldana, 2016).

Data Analysis

I used the constant comparative analysis (CCA) method (Glasser, 1965) to code the data because the purpose of the study was to describe the process participants used to adapt EBTs. I was exploring the relationship between how participants adapted EBTs and

how they included cultural ways into those adaptations. Therefore, CCA was an appropriate method to analyze the data.

There are four steps to the CCA method (Glasser, 1965; Padgett, 2017). The first step is open coding of the transcripts, which entails coding participants' words (Padgett, 2017). The second step is reviewing field notes and constantly comparing those notes with the initial codes to create categories (axial coding; Glasser, 1965; Padgett, 2017). The third step is constantly comparing the categories with other categories and reviewing memos as well as reflexive notes to see how the categories are related (selective coding; Glasser, 1965; Padgett, 2017). The memos provide insight into the categories' content and the development of the themes (Padgett, 2017). At this point in the process, a researcher is looking for saturation (new codes have not emerged), and the data are redundant (Glasser, 1965; Padgett, 2017). This is when categories are collapsed and integrated on the basis of their properties; it is referred to as the delimited theory process (Glasser, 1965). A researcher engaged in the CCA method is looking for new categories of data to emerge. The goal is to collapse the categories (delimited theory) to reduce the qualitative data into manageable selective data. The last step is to categorize the data into themes that develop theory. In Steps 1 to 3, the researcher is constantly comparing the codes to field notes, memos, reflexive notes, and categories to collapse the data into manageable parts, leading to a few themes.

After the initial coding phase, I had 136 codes. The research study was about how practitioners adapt EBTs, so I coded participants' adaptation responses as "cultural adaptation process." As I continued initial coding, I realized the participants had various

steps to their adaptation process that included speaking with "cultural experts" to ensure cultural adaptation congruence for the client population. It also included a "community-based approach." So cultural expert and community-based approaches were included as part of the cultural adaptation process. In the initial coding phase, I included "flexible approaches" because participants reiterated that clinicians need to be flexible to give clients enough time to tell their stories. In addition to flexible approaches, participants added that clinicians must be flexible and let the client lead the therapy session. That statement implied, for instance, that if the client's treatment plan is to reduce depressive symptoms and they are in a crisis situation at the time of their therapy session, the clinician must be flexible to do more crisis intervention work. I thought this was part of the adaption process of EBTs. After I coded all the transcripts, I reviewed my field notes and compared them to my codes. I realized the flexible approaches code was not part of the adaption process and that participants were referring to "clinical approaches." After this constant comparison analysis, I created the clinical approaches code.

After comparing my codes to my field notes, I was able to collapse my codes into 43 categories (axial coding). At this stage, I reorganized some of my codes into the clinical approaches category that included flexible approaches, "more time for clients to tell their story," and "creating a sense of belonging." I struggled with the category for cultural experts. Are they part of the cultural adaptation process or clinical approaches? At this point, I was comparing categories and their relationship to other categories (selective coding). I reviewed my memos and field notes again and realized that cultural experts were the foundation to creating culturally competent clinical skills and to the

cultural adaptation process of EBTs. So I pondered which skill set comes first: the culturally competent clinical skills or the cultural adaptation process? I had to repeatedly compare my categories to my notes and memos before I realized that in order to culturally adapt EBTs, clinicians must first have a foundation of culturally competent clinical skills to ensure a cultural fit. Therefore, the cultural experts are vital to building culturally competent clinical skills first and to the cultural adaption process to ensure the EBT is a cultural fit. In this selective process, categories are compared with other categories to examine interrelatedness and to reach saturation of the data. In the selective coding process, I collapsed the data into 27 categories.

The last stage is collapsing the categories into themes. The four themes that developed from this study were (1) attitudes towards EBTs, (2) building culturally competent clinical skills, (3) the process to adapt EBTs, and (4) the organizational facilitators and barriers to the adoption of EBTs. This entire process took six months (March 2020-August, 2020).

Strategies to Ensure Trustworthiness in the Study

Padgett (2017) describes six strategies from the extant literature to demonstrate trustworthiness and rigor for qualitative studies. Those strategies include (1) prolonged engagement, (2) triangulation of data, (3) peer debriefing and support, (4) member checking, (5) negative case analysis, and (6) audit trail. Padgett did not include transferability, which I will include for rigor and trustworthiness. These strategies are alternatives to internal validity, external validity, reliability, and objectivity in quantitative studies (Padgett, 2017). The goal is to demonstrate that this study carried out

fair and ethical guidelines and that the findings closely represent the participants' experiences (Padgett, 2017).

1. Prolonged engagement alleviates reactivity (how the researcher's presence can distort the participants' response and behaviors) and respondent bias if the researcher spends a long period of time in the field and is accepted (Padgett, 2017). Creating a trusting relationship between the researcher and participants reduces deception. Contrary to this, if the researcher spends extensive periods of time in the field, it can lead to researcher bias where the researcher goes "native" and loses interpretive distance, which can become problematic (Padgett, 2017).

I had worked with the three BH programs in the past as a clinical social worker. The BH directors were aware of my study because I had asked for their feedback on the study design and recruitment strategy. I had an established relationship with these programs so they trusted I would follow IRB guidelines and be fair and ethical. The BH directors provided a list of names of whom I could contact to participate in the study to reduce researcher bias. I knew seven participants because I had worked with them in the past. To reduce participant reactivity, I engaged in small talk to reconnect and talk about work and our personal lives. Next, I told participants I had to put my researcher hat on and start the interview. This gave the researcher and participants enough time to acknowledge each other and catch up personally and then start the interviews. Indian Country is small, so it was inevitable I would know some of the participants. To address respondent bias, I interviewed participants until I reached saturation (no new data emerged). Twenty-four participants were interviewed.

2. Triangulation is using two or more sources to achieve a comprehensive picture of the phenomenon being studied (Padgett, 2017). I used data triangulation whereby I relied on interview data, field notes, a self-reflective journal, and analytic memos to crystallize the information. An interdisciplinary strategy I used was interviewing BH directors and cultural experts to identify their adaptation process of EBTs so a variety of diverse points of view were captured.

I did not use analytic triangulation (involving another coder) because I could not hire a staff member for my study due to a lack of funding. Plus, the sample was considered a vulnerable, marginalized population, and I wanted to respect their confidentiality.

3. I received peer debriefing support from my dissertation committee. It kept me on track with my data collection and analysis. They provided other points of view during data analysis and offered constructive feedback to strengthen my data analysis and findings. They requested I pilot my interview questions and make any changes to the question order and prep for my interviews. They reminded me to immediately take field notes after each interview while the information was fresh in my memory.

4. Member checking was not an option during analysis because COVID-19 impacted the three AIBH programs, and they shut down for business for months. In September 2020, I invited all participants to a virtual presentation of the study's findings, and only three participants attended. I presented my findings to Community A's tribal administration and Community C's ED. For Community B, the tribal leaders requested I drop off a USB drive of my presentation of the study's findings. The tribal leader of

Community B had several priorities, and this was the best way to provide the information during the pandemic.

The tribal administrators of Communities A and C, as well as the three participants, appreciated the comparison of tribal BH programs to urban BH programs based on homogeneous populations and heterogeneous populations (see Chapter 5 for more information).

5. A negative case analysis offers an alternative explanation of a study's findings (Padgett, 2017). I did not have a complete negative cases analysis: Participant 13 stated that they thought EBTs were not a colonial approach because AIs have always looked for evidence through an Indigenous lens, but the other 23 participants agreed EBTs were a colonial approach. If I had more time, I would have probed Participant 13 to elaborate on their response.

6. My audit trail includes samples of de-identified raw data, memos, a self-reflective journal, and field notes. For my thematic analysis, I had a wall of flip charts that listed my analytical decisions and was referred to as "my wall." My wall was the verification system I used when coding the initial data, then moving towards axial and selective coding. During this process, I used flip charts to identify the steps in building culturally competent clinical skills and participants' adaptation process of EBTs. This provided clarity that these two skill sets were distinct.

7. Transferability is concerned with whether the study's findings transfer to other settings and/or contexts. It is not concerned with generalizability from the sample to the larger population. When I presented the findings to the tribal administrators and ED, they

found the comparison of tribal programs (homogeneous) and the urban program (heterogeneous) useful. They could clearly identify core competencies BH programs require to ensure culturally relevant care. The tribal administrators appreciated the important role cultural experts have in the community and BH programs. The three participants who attended the presentation of the aggregate results corroborated that there is a difference between tribal and urban BH programs and how clinicians employ different clinical approaches based on the clinical setting.

Summary

Using a qualitative research design based on TPR approaches was the appropriate method to answer the research question. Each community had their own research protocol to follow and how to share the study's findings. They all agreed that they wanted a copy of the completed manuscript before publication to give their feedback and approval. The TPR and CPBR research approaches emphasized following tribal protocols to honor tribal sovereignty and counteract negative experiences with research to create a collaborative research partnership. The study illustrated how it met the TPR and CBPR principles. The next chapter describes the study's findings.

CHAPTER 4

FINDINGS

Interviews with 24 participants highlighted behavioral health providers' experiences of building a culturally competent system of care for AI clients. I discovered four themes emerged: (1) attitudes towards EBTs, (2) building culturally competent clinical skills, (3) process for adapting EBTs, and (4) internal/external organizational facilitators and barriers to adopting EBTs. For Item 2, building culturally competent clinical skills, the person-centered approaches are arranged in alphabetical order because these skills entail a fluid process, not a static approach. Each section has corresponding quotes from participants to illustrate the themes that emerged. Listed below are the four themes and the corresponding codes.

Table 4

Study Participant Themes and Codes

Themes	Codes
Attitudes towards EBTs	1. EBT is a colonial approach because it does not recognize colonization's impact on AI communities. 2. EBTs lack cultural considerations. 3. EBTs must be adapted for a cultural fit to sustain client engagement.
Building culturally competent clinical skills	1. Use person-centered approaches that include (a) more time for client to tell their story, (b) building trust and rapport with client, (c) greeting clients in a culturally relevant manner to build a connection, (d) creating a sense of belonging to reduce stigma for accessing behavioral health services, and (e) flexible clinical approaches. 2. Hire cultural experts to ensure culturally appropriate treatment is provided. 3. Utilize culturally appropriate tools: assessments and interventions. 4. Clinical outcome measures include: renewed sense of gratitude for life, building cultural identity, trust/acceptance of services, and client referrals.

Themes	Codes
Cultural adaptation process	1. Identify community needs and risk/protective factors using a community-based approach to create buy-in. 2. Use an interdisciplinary approach to adapt the EBT (includes cultural experts) to translate key concepts relevant to the community. 3. Pilot the intervention and acquire feedback from the community, internal, and external partners about what was effective and ineffective.
Internal organizational facilitators to adoption of EBTs	1. Endorsement from all behavioral health program staff to adopt the EBT. 2. Cohesive team. 3. Clinical supervision with cultural experts as needed. 4. Hiring an evaluator to document the adaptation process and treatment outcomes for transparency and accountability purposes. 5. Access to diverse funding.
Internal organizational barriers to adoption of EBTs	1. Need for more time to adapt and evaluate the intervention outcomes. 2. Lack of administrative support. 3. Insufficient training to implement the EBT. 4. Competing program demands for monthly reports and use of assessment tools that were irrelevant for the target population. 5. Hiring of inexperienced staff who were inflexible with AI populations, which was detrimental to creating a cohesive team.
External organizational facilitators to adoption of EBTs	1. Access to technical and subject matter experts outside the organization was important.
External organizational barriers to adoption of EBTs	1. EBTs that were too rigid and did not allow adaptation would not work at AIBH programs. 2. Restrictions on purchasing food and cultural items for groups.

Attitudes Towards EBTs

In response to whether participants believed EBTs are a colonial approach, 23 participants agreed. Only one participant said EBTs are not a colonial approach, instead saying, "Natives have always looked for evidence," suggesting that American Indians have their own form of culturally informed treatment. Over half the participants stated that EBTs do not recognize the detrimental effects of colonization on AIs. Participant 22 said,

> The colonists came [over and said], "Oh, no. You all are terrible. You're wrong. You're evil. Whatever you did and [now] you've got to do this." And everything got messed up. And now we're coming back again, saying, "Well, actually, you know, why don't you try to get out there and connect to your culture.". . . And it felt like [the interventions] were already [here]. I mean the way people have explained it [to me] is we. . . have those traditions. Sometimes it's forgotten along the way due to historical trauma, intergenerational trauma, but now it's coming back full circle . . . but I try to remind people like, you have it in you, we just got to find it.

Over half the participants recognized that AI communities are disenfranchised due to colonial (domination) practices and policies (imperialism) and therefore do not often trust "outside" providers. As participants vividly described, colonizers took AI children to boarding schools and physically and sexually abused them. According to Participant 14,

> If I'm going to say it's a Western approach, well, what did the West do to the people here? Oh! They colonized. They imposed. They wrecked. They took slaves..... It's the Western approach [that took] children from their homes and put them in Indian schools and then beat the language out of them. You want to call it a Western approach? I think a harsher term is more effective.

Colonization almost eradicated the AI race. Some participants emphasized how outside providers need to understand the impact of colonial practices on AI communities

to grasp the depth of distrust they have for Western types of therapy and medicine. Currently, AI communities are burdened with complex trauma that includes physical and sexual abuse, historical trauma, depression, suicide, anxiety, domestic violence, homicides, substance abuse, and a severe sense of grief and loss. In the clinical world, these disparities are considered co-occurring disorders. Participant 2 said, "I want to say like 85% of the individuals that come through our doors are co-occurring." Participant 14 added,

> And you know what? If you're talking to, let's say some psychologists or therapists who haven't worked [in an AI community] and are having a discussion about Western approaches, and I [would] say, "that's a colonial approach!" That's much more likely to get a rise out of somebody and create a healthy conflictual conversation [on] Western approaches. It's colonial. You're stealing their shit and pretending that what you have is better. I don't think that's a good idea.

Respondents acknowledged the impact colonial institutions have on AI communities and how they nearly destroyed their "traditional" ways of life. The damage was immense and unforgettable, requiring AI communities to retreat to their cultural wisdom and practices to heal from the trauma to deal with society's current dilemmas. That is what makes AI communities unique—their cultural, spiritual protections passed down from generation to generation. Participant 24 said,

> Because of the atrocities [of] colonialism and historical trauma, we've kind of retreated . . . into our spiritual protections . . . and therefore we've stayed there. . . . We can keep [our spiritual protections], but also begin to explore. [Now we have] shootings in the schools . . . and bullying in the schools. There's trauma, rapes, and murders. There's death in our community. And that creates a trauma response . . . therefore you need to find the different tools to help your community heal through various modalities . . . we need to [use] our cultural practices and traditions, whatever those protective factors are. And that makes [us] unique.

Participants argued EBTs are too rigid and strict; thus, manualized materials may not culturally fit for AIs. EBTs must be flexible to incorporate cultural practices to resonate with AI clients. Adding cultural practices creates a connection between the clinician and client to engage in therapy and reduces any power differential in which the therapist knows more than the client. Participant 6 said,

> I think most evidence-based models do talk about adapting [EBTs] for the population that you're working with culturally. And if [the EBT is] so rigid that you can't do that, then they're likely not an evidence-based model. Or they're likely a one-hit wonder. And then we're going to move on from that model.

There are few culturally appropriate interventions for working with AI populations, leading participants to rely on clinical wisdom, years of experience, and cultural experts to integrate culturally responsive practices. Those practices include honoring AI culture and beliefs and using storytelling, intergenerational, and community-based approaches and the concept of wellness and recovery from an Indigenous perspective to ensure AI clients are receiving culturally appropriate care. EBTs have to incorporate these values to engage AI clients in mental health treatment, or else the interventions will not work. According to Participant 18,

> EBTs are a good fit, if...there's a [cultural expert] to ensure culturally appropriate treatment . . . we need [the] flexibility to adapt [EBTs] to include our cultural pieces we feel are needed, so blending is important.

Building Culturally Competent Clinical Skills and Approaches at AIBH Organizations

All participants described how to build culturally competent clinical skills in their behavioral health program. The first item, person-centered approaches, includes five clinical skills because they are fluid, not static. The person-centered approaches (a)

incorporate more time for clients to tell their story and (b) build trust and rapport with clients to create an authentic connection; clinicians must (c) greet clients in a culturally relevant manner to build a connection and a (d) sense of belonging to reduce stigma for accessing services. In addition to clinical skills, (e) clinical approaches must be flexible because the client guides the treatment process. Clinicians never know what the client is bringing to the session because clients' lives change daily; hence, clinicians need to use flexible approaches.

To provide culturally competent care, AIBH organizations must hire AI staff who are considered cultural experts in the community to build a culturally responsive system of care. These cultural experts provide insight into what interventions are most appropriate and how they will work with the client and the community's cultural belief systems and practices. Participants described that they want more culturally appropriate assessment tools and interventions that honor the client's personal view of healing and recovery. These tools must assess for client readiness to engage in treatment and the intervention that will be more effective given the client's belief system. Lastly, clinical outcome measures need to include the client's renewed sense of gratitude for life, measure client self-efficacy, and require trust and acceptance of providers' help and expertise.

Culturally Competent Clinical Skills

The clinicians stressed that person-centered approaches are essential, and the client chooses the approach to ensure a culturally relevant treatment process. Participant 12 said,

> One of the big ones is making sure it's about the client's goals and what they really want for treatment and at the pace they want it to be. So not wanting to push or go to private areas until they're really ready for it and that it's clearlytheir choice to go there. Make sure that it's really their choice and that I'm honoring their pace and their choice. So they're not again [being] forced into feeling, having their shame button pushed, or feeling less than, or disempowered, or something in that process. So wanting to be really sensitive to really following their pacing and their goals.

Next, participants discussed how clients need more time to tell their stories, especially if they are new to therapy. It takes time for clients to trust an outsider with intimate details of their lives. Allowing more time provides opportunities for clinicians and their clients to build trust and rapport. According to Participant 12,

> It's being sensitive to cues, if this isn't a good day to talk about that stuff or if I'm asking too many questions, then all of a sudden, I could see the defensiveness coming up, and they're feeling interrogated and I need to back off. So that was a teaching for me as well in terms of cultural differences. I think as mental health professionals and also culturally, we're often trained to ask a lot of questions, often very personal questions, all one right after the other, so the person can feel really exposed and kind of interrogated. So it's sometimes a tricky dance, because we still need to get the picture of a person's life and understand what's going on, but if they start to feel interrogated or like they're not getting a chance to tell their story, then that's a problem.

Building trust and rapport is a process that requires the clinician to find common ground, create shared experiences, and be an empathetic listener to build a therapeutic relationship with the client. Participant 20 said,

> Everything is so familial [here], right? So for you [as an outside clinician] to be accepted in, in a way that they're going to trust you, takes time. And [the client is] not going to go anywhere or give you anything, until they trust you . . . [and] to see the [clients] grow, and know that they . . . whether or not they've had me for a therapist or not, they still know me. They think of me as from here, because I've worked [here] for so long. Even though I'm the [outside clinician], they still think of me as, well, you work for the tribe, so you're different, you're safe, you're whatever. I had given up and I [got] to this very humble place where it's just like I get it. I get why they don't trust me. I'm just one more in a line of many and we have a lot of turnover, or at least [we] did in the past.

Greetings are vital at AIBH programs. When AIs meet someone new, it is common practice to ask, "Where are you from?" AIs want to know where an individual comes from because it creates a connection; the client is researching whether they are related to the clinician or know the same people. When asking that question, AIs are looking for tribal affiliation, clan, and the location of the individual's home community. Establishing a connection creates an authentic relationship. In the clinical world, therapists are taught not to share their personal background, which is a culturally incongruent practice in AI communities. Clinicians have to share who they are and where they come from to establish a relationship and connection with AI clients. Clinicians who share where they come from build a sense of belonging, so clients feel comfortable sharing their problems with the therapist. Once greetings are exchanged, clients can genuinely engage in services. Participant 1 said,

> The [cultural] practice is that you enter a home and you announce yourself going in and then you're greeted with a verbal "Come in." And even that is wellness, how you are received. And that's how we envision all of mental [health] programs in [our community] to be informed [of] that approach . . . and so making sure that they are received in that way at first contact and then eventually . . . just being informed culturally.

Participants discussed the various types of greetings used, including determining whether the client preferred a traditional (cultural way) or Western (mainstream) greeting. Participant 3 commented,

> [The client's] first time here is like, okay, just engaging in small talk, and that's just really just hearing them out and seeing how they talk to you. If they talk to you in nothing but [our Native language], then you know . . . [there's] the response, that you can greet them next time if they come through your door, [greet them] in a traditional response. Or if they just talk nothing but English to you [greet them in English].

A sense of belonging is created when greetings are personalized. Clients already feel vulnerable in sharing their stories, so clinicians create a safe environment that is nonjudgmental for clients to start their healing and recovery. Participant 7 said,

> I think what's missing from Western therapy is that relationship with the client . . . because there are no contingencies of okay, you're ethically bound [with] your licensure to do this and do that. They're able to refer to their clients as hey brother, hey sister, hey auntie, hey uncle in their Native tongue, and I've heard so many of my clients go in and say I just go there, even if I don't have a session, to . . . hear that I'm an auntie or . . . an uncle or that I belong. Just making that connection and personalizing it for [the] client has done a lot for [them].

Participants successfully used flexible clinical approaches that are strength-based to reduce shame and stigma for accessing services. An example of flexibility includes changing the therapy focus from addressing the client's depression to discussing whatever emergency they are dealing with at the moment that has impacted their state of well-being. The types of mental health crises clinicians saw were loss of loved ones, suicide attempts, trauma, and substance abuse. Participant 22 discussed this:

> So we have more flexibility doing . . . person-centered as a longer-term type of treatment. But that's not to say, I wouldn't use CBTs specifically if I [had] the feeling that somebody's in crisis mode. I get more concise, more directed and also knowing that they might not come back. But if I can go deeper and I can get them to come in for more than four sessions, I would rather just stretch it out with [them] and go deeper than . . . just skimming the surface.

In addition to using flexible approaches, hiring cultural experts vetted from the community is mandatory to build a culturally responsive system of care. They assist with culturally appropriate interventions and culturally appropriate care. Clinicians consulted with them about mental health diagnoses, interventions, and community supports to increase clients' well-being. Cultural experts understand the cultural beliefs

regarding mental illness, suicide, and why certain practices would be appropriate for the client based on their belief system. Cultural experts translate Western therapy concepts, so AI clients understand it from their cultural lens. Participant 19 said,

> In my mind, what is missing is somewhere in that gap to have someone who can take these [Western] concepts, understand needs of communities, and use these same concepts but teaching us how to communicate that in a Native way. They have to be linked together because you, the clinician might take this, let's use EMDR [eye movement desensitization and reprocessing], and use that modality in the way they've been trained and coming from private practice in the White culture they're like, "Yes, give me something new, and I've heard about this thing and you want me to tap and you want me to hear the click" and they're excited. Where a Native is coming, "How does that merge with who I am at my core?" Right? So you have to help them understand it and find some kind of connection to their culture before they can absorb it.

Cultural experts have a deeper understanding of tribal communities' cultural attitudes and practices, including clan systems, language, gender roles, storytelling, and social mapping. Clinicians who had difficulty connecting with clients consulted with cultural experts at their agency to enhance their cultural awareness, attitudes, and knowledge. Participant 15 commented,

> One of our [cultural experts] is our main guy here . . . and he will take a group of boys out that don't have dads in their lives or healthy father figures. In the community, the men, the dads, the uncles, the grandpas take in the young boys, the young men, and they teach them the cultural and traditional ways. And so these boys who don't have that father figure in their lives outside of here, they get to come here and find that with [our cultural expert]. And so [he] has taken kids out and they go out and they find the perfect branch to make a slingshot . . . or he'll go and get the material on his own personal time for them to make bows and arrows. We have a garden each year, and there's . . . a type of squash that you can make into . . . a drum or the rattles . . . so they'll grow some gourds out there, and then the kids get to carve them out and boil them or [the cultural expert] will boil them, but they talk about the process, and these are things in outside communities, you go to a therapy program and tell them that you're making slingshots and bow and arrows with your kids, forget it, right? But these are very culturally grounded approaches that our [cultural experts] bring to the table.

Working with cultural experts ensures that clinicians' interpretations of what they see in therapy are translated through a culturally accurate lens. Clinicians build their cultural knowledge about the groups' cultural characteristics, values, beliefs, and histories. That knowledge transforms into culturally responsive clinical skills to address behavioral health disparities and inequities to produce effective treatment outcomes. Most importantly, it validates the clients' worldview. According to Participant 15,

> I cannot, as a clinician, I cannot do the work that I do without my community members who are team members. Their insight, it holds so much value. And so, I don't know that this really fits a protocol description. But don't be ignorant in thinking that you know it all and you can come [in] and bring everything that you know to that [particular] community. In social work, you start where the client is at..... We're here Monday through Friday, 8 to 5, but our community members who are employees here, they're in the community for traditional days and cultural gatherings, and so when they see how a young man or a young girl who's needing just a little bit of extra guidance from somebody in that cultural or traditional perspective, they'll go and just acknowledge them on an off day.

To sustain a culturally competent AIBH program, they need to employ community members who have the cultural knowledge and practices to ensure continuity of care. Participant 20 said,

> I think having more Native people who are clinically trained, that's the desire for every Native community, their own people doing the work, right .....because that's been hugely helpful having a couple of people on our clinical team that are Native. [There is] one specifically here, she helps us understand the dynamics that have gone on forever.

Clinicians and the behavioral health directors, who had four years or more experience serving AI clients, built their cultural humility skills and increased their advocacy for quality mental health services. Participant 15 shared,

> You'll have to look at home, family system, community, leadership, government, state government. I mean you do. You start from the very beginning of it and then you go out and then you come back. And it's just a constant process of

> understanding because funding changes and [leadership] changes. And so, for me, the main part of it is, no matter what your degree says, no matter what level of education you have, no matter what you're bringing in with you, you're always a student here. No matter what, you have to come in with the mindset of "I'm here to learn, and I'm here to give." So you're coming in, to give to this community, and you're here to learn from this community. And yes, there's going to be times where you're asked to give professional or expert advice. And that's all fine and well, but in the back of your mind, you always have to have it in the back of your mind . . . be mindful that your expert advice that [may] apply out there, in the outside world, you might have to adapt your response a little bit to make it relevant to the people of this community.

Mental Health Interventions That Work With AI Clients

The participants who were mental health clinicians were familiar with EBT techniques such as cognitive-behavioral therapy (CBT), dialectical behavioral therapy (DBT), and motivational interviewing (MI). More than half the participants described narrative therapy as a culturally appropriate intervention with AI clients, yet it is not considered an EBT. This approach was frequently used because it includes a technique for the clients to re-author their story with new meaning, creating a healthier outcome. Other techniques participants used were trauma-informed practices, grief and loss processes, family systems approaches, suicide and substance abuse prevention, and crisis and person-centered interventions. Participant 10 explained,

> I work from a family systems perspective. I embrace that fully . . . I've utilized the genogram to kind of look at family histories and where things may have begun. A lot of [clients] are more visual. So, when they see the genogram where they can pinpoint where things started to be kind of out of harmony, then they can kind of help themselves to make better choices for themselves. I [also] use the universal Native American perspective of . . . the medicine wheel to identify clients' strengths. [Some clients] are trauma-induced. ..... So, it doesn't take away from their story, but it helps me think, okay, so maybe some of the DBT skills might be helpful to navigate that emotional regulation stuff. And then we build some of those small victories and get those personal relationships a little bit healthier. Then people start to thrive. So, yeah. I think clinical knowledge is very important.

Culturally Appropriate Tools

Participants spoke of using culturally appropriate assessment tools such as genograms to address conflict or trauma in the client's environment as a useful tool. Participants used the medicine wheel concepts: emotional, physical, intellectual, and spiritual compartments to create clients' treatment plans, identify clients' strengths, and note their resiliency characteristics. Participants also spoke about using visual aids, hands-on activities, analogies, and storytelling approaches to foster therapy engagement. Participant 24 said,

> I learned about genograms and I learned about trends in families, such as suicide, such as alcohol. And I learned to think in terms, if [those disparities] lived in the community, and identifying those, and looking at the risk factors that lived here for our children and our families. And then looking at . . . the protective factors. Really having an eye out for the risk factors, but really working on embedding the protective factors.

Clinical Assessment Tools

All three organizations used a variety of screening tools, the Patient Health Questionnaire-9 (PHQ-9) to assess for depression, the quality of life scale, and a variety of suicide ideation scales. Over half of the interviewees wanted their programs to use culturally appropriate assessment tools that not only measured mental health disorders but, more important, measured self-efficacy and wellness outcomes. Participant 7 said,

> Some of [the assessments] we have to administer to every client regardless of whether it's appropriate or not. I think that should change. I think it should be culturally appropriate, or they need to make some cultural adaptations if they want to collect that data. It's like some of the PTSD assessments we have to give out. A client could be doing very well in therapy, but the anniversary of their partner's death comes up, of course, their trauma skills are going to go up, of course, their grief, their depression is going to go up and increase, that's natural,

> and we should expect that. It doesn't mean that therapy isn't working or the work they've done, it hasn't been helpful.

A majority of the participants spoke about assessing client readiness to gauge the client's motivation to engage in services to change maladaptive behaviors. They made sure to identify client protective factors, such as social and family supports, strengths, and resiliency characteristics, to empower and enhance the client's self-efficacy. A third assessment they used was to identify the clients' enculturation and acculturation attitudes, beliefs, and practices. To assess for this, they asked the client about their cultural beliefs, practices, and attitudes towards the type of treatment they preferred. Do they want "traditional" cultural ways (enculturation), religious-affiliated, or a blend of traditional and Western medicine (acculturated) forms of treatment to address their mental well-being. The phase of acculturation is a vital period of collecting information to provide culturally appropriate treatment. Participant 3 said,

> Some clients that I've worked with may identify as Native American, but they don't necessarily identify as traditional or really, necessarily any different than any other person. So I think it's really important to kind of know who you're dealing with and where they're coming from and how they identify themselves and their culture and how they participate or not participate . . . that's one thing that's unique about reconnecting, or having individuals reconnect, is giving them insight or purpose to their recovery from a Native or traditional standpoint . . . like in AA books and materials . . . they talk about a higher power. Some individuals have a hard time with believing in God, or our Father, so I usually change the language to either where it's our Creator, as Native Americans, we believe in the Mother and the Father. And so a greater spirit. So I try and change or adapt my language to where they're more comfortable . . . It [allows] them to make that connection to believe in the higher power and it's just being really flexible and understanding that a lot of people [are] different. Sometimes they don't have a religion. I make it really broad for them.

Assessing client readiness involves the following, as Participant 11 explained:

> I think you have to go through the stages or identify your readiness. So how willing are you or identify . . . the dimensions of wellness. Like, is it mental, emotional, occupational wellness? Is it financial wellness? So I think [the client has] to pinpoint it and identify what [they're] willing to work on, and like I said, what [is their] readiness. So, I think that has to be a part of the procedure.

This is how clinicians assess for protective factors when clients share their stories, as Participant 2 described:

> I think of [Native] people and . . . the clients that come in, is they're very strong and they come from very strong people and their ancestors are very strong in that way. They . . . have strong cultures and ties. The familial support is very strong. It's a very small community. . . so I feel like that accounts for that resiliency. When we talk about protective factors, as long as you have one individual that cares about you, that says a lot, and you can see it here. Everyone knows each other. Everyone has some type of . . . like a relative. They can associate that relative and know "That's my people. That's my family" . . . even extended family and so I feel like those are definitely the protective factors that I see here. And of course, we talk about the language and the culture and the traditions . . . those are protective factors they all have as well.

Clinical Outcome Measures

Participants conveyed that many clinical outcome measures do not measure the clients' renewed sense of gratitude for life since addressing their mental health issues. Assessments often miss the client's story of success. Participant 7 commented,

> So maybe part of the measurement process could be just the client's story. Like I'm feeling better after 8, 10 weeks with therapy and with traditional healing practices or whatever, now I'm feeling . . . like myself. And that's justification enough . . . I think things don't have to be so hard, they can be so simple as a client saying I feel better, or I feel happier. I don't need you to fill out this assessment or the scale of where you are on your level of happiness. I can't judge that. If you are telling me you feel happier, I should be accepting of that regardless of what the scores reflect.

Clinical outcome measures need to include how clients build a strong sense of cultural identity. According to Participant 7,

> A lot of our work together isn't so much focusing on his symptoms, it's building a positive cultural identity, building cultural awareness and knowledge. And I think in some ways he's . . . in being here and being surrounded by a lot of cultures, Native cultures, he's had a positive relationship and has felt better about himself.

Other outcome measures are trust and acceptance. Clients who trusted and accepted mental health services felt comfortable sharing what interventions worked and what was irrelevant in therapy. A core construct in AI communities is building trust to engage in services, especially when the providers are considered outsiders. Participant 20 said,

> [Community members say], "I hear you're from the West." Yeah, and I'm still here So I think the acceptance has probably been in the last 2 years, and really this year where I'm like, wow—they do see me I get why they don't trust me. I'm just one more in a line of many [outsiders] and we [had] a lot of turnover . . . in the past. And when the [trust] started they text[ed] me [saying], "Thank you so much, you've changed things." And I just sit there and cry. Luckily, I'm usually at home or in the office, but I mean [the referrals are] coming fast and furious all of a sudden, and it's interesting.

Clinicians spoke about how community referrals increased, starting with tribal leadership, community members, and other programs because they trusted their services. The providers had trust and acceptance status in the community, which is a programmatic outcome of success. Participant 20 said,

> [When a tribal leader] sends their [family] here .....that's a huge deal. And [other programs] send people to me, when we've had challenges [where] they could not trust outsiders. But I've had a lot of people coming out of the woodwork in the last year .....when I actually looked and saw 80% are [self-referrals], that just tells me it's coming from the community. They come find me and they're like, someone referred you and said you're really good ..... and that's huge in a community. That's very humbling..... because I think the trust takes a long time and you have to be here.

Cultural Adaptation Process

All the participants acknowledged that they engage in efforts to culturally adapt interventions. They described it as a fluid process that coincides with flexible clinical approaches. Participants explained that their adaptation process needs to include (1) identification of community needs using a community-based approach to create buy-in, (2) use of an interdisciplinary approach to adapt the EBT and translate key concepts that are relevant to the community, and (3) pilot the intervention and acquire feedback from internal and external partners to improve the adapted EBT.

To identify community needs, AIBH organizations used a community-based approach to gain community members' input about what practices are needed to maintain a healthy, vibrant community. Acquiring feedback from elders, community members, providers, and stakeholders is essential. The feedback must include intergenerational perspectives that represent all age groups to identify what treatment is most effective. One method participants described using was the Gathering of Native Americans (GONA), a culturally-based planning process that is interactive and empowering in the way that it brings community members together to identify issues to address. According to Participant 24,

> You don't want to lead people into fixing them. You want them to want something that could help them ..... [So] we started to explore how our [elders] in the senior program could help our summer youth in bridging the lessons or bridging those natural supports, and how those natural supports can be taught by the elders to our children. And so we started ..... using GONA. Using GONA as part of a summer initiative, we would do a GONA for the elders to bring them together. To get them cohesive, we would do it for the youth themselves to get them cohesive, and then we would bring the groups together so that you would have a nice merge of the two groups, coming together wanting to learn from each other.

In adapting an EBT, programs must have community buy-in. AI communities are a collective group, and using a community-based approach is standard practice to engage the client population. Participant 23 said,

> Number one, ask the community what their wants are. Kind of treat it like a treatment plan. What do you guys . . . think would be most suitable? Here's what we have. You want to read them over, and see what you think of them, have somebody describe to you how this works? Typically, do you see it connecting or relating to [the] community? And having a variety of community [members] look at it because not everybody looks at it the same way. .....Identifying what the primary issues are, so like a needs assessment .....[so] you [need] the community's buy-in. You can't just put it on them .....So you have to have buy-in [from] your community.

After identifying the community needs, an interdisciplinary team is assembled to gather input from all behavioral health staff on what treatment approaches work and what needs to change. Input must be gathered from preventionists, peer support workers, cultural experts, clinicians, managers, and administrators. It is important to seek all provider input because AI communities use community-based approaches. Participant 4 said,

> So the core group really was the midlevel clinicians..... but we also included and incorporated the prevention team, our peer support specialists, our cultural liaisons. In some respect to suicide prevention and intervention work, we've also had the experience of including traditional healers within the community to talk about, I guess, cultural sensitivity and adaptation. In that sense, we've also had elders within the community. We've had, I guess I would include tribal leadership as a part of the conversation as well. Now [they] have taken ownership of the program and have their own recovery. Not just the recovery, but their own wellness in general.

Participants described that a network of internal and external partners is essential to adapt an EBT. The internal partners (tribal leadership, community providers, community members, and community stakeholders) and external partners (universities,

federal, state, and local partners) assisted with adapting and adopting EBTs. They helped market the intervention and found supplementary resources to sustain the program. Participant 18 said,

> The university brings to us . . . a lot of the scientific evidence, and then . . . for us [community], it's what we got from university is the understanding that there needs to be . . . our [own] local evaluation team comprised of people from the community . . . [This ensures] the university is understanding that these [cultural] things that need to be protected . . . and so building those [protections] in there [is essential]. Also, [the partnership] has brought us interns who have specialized care with certain mental illnesses and age groups.

Organizational Facilitators and Barriers to Adopting EBTs

A key theme in the interviews was that there are organizational facilitators (provides guidance) that make adoption of EBTs easier, and there are barriers that make adoption of EBTs difficult. The internal organizational facilitators were (1) endorsement from all behavioral health program staff, (2) a cohesive team to adopt the EBT, (3) clinical supervision, (4) hiring of an evaluator to document the evaluation process and clinical outcomes, and (5) access to diverse funding. The internal organizational barriers were (1) the need for more time, (2) lack of administrative support, (3) insufficient training to implement the EBT, (4) competing deadlines for various monthly reports, and the use of irrelevant assessment tools for the client population, and (5) hiring of inexperienced staff who would not tailor their clinical skills to the population, which was detrimental to creating a cohesive team.

The external organizational facilitator was (1) having sufficient access to technical and subject matter experts outside the organization. Some of the external organizational barriers were (1) EBTs that were too rigid and did not allow for

adaptation and (2) funding restrictions to purchase food or cultural items for their groups. These restrictions created financial hardship, so participants had to find other creative ways to purchase these items.

Characteristics That Promote Internal Organizational Facilitators for Adoption of EBTs

The internal organizational characteristics that facilitate the adoption of EBTs are the following: (1) Endorsement for AIBH programs from administrators, managers, and supervisors before implementing an EBT; (2) an interdisciplinary approach to adopting an EBT; (3) clinical supervisors, critical because the staff debriefs with them to discuss the challenges and triumphs of adopting EBTs, (4) a program evaluator to document the process of adaptation and track outcomes, and (5) diverse funding to sustain an EBT at the organization. AIBH organizations need administrative and program staff buy-in to implement and adopt an EBT. Participant 15 described a meeting:

> So we sat down as a treatment team .....We had three people [staff members from the community, the administrator, and the director who are from the community] ..... and then we [had] one person from the university who was well established with [the community]. So, we all sat down as a treatment team and went through the manual. So, it was a mix of outside professionals and community members who are employees [of] the tribe.

To adapt an EBT, an interdisciplinary approach is essential. Staff from prevention programs, mental health clinicians, substance abuse providers, and cultural experts were included to adapt the EBT. Participants need peer support to practice implementing the EBT and a safe place for constructive criticism to improve services. Participant 15 explained,

> If you look at each one of our team members, we have social workers, psychologists, psych interns, and . . . counselors. And we have community [experts] . . . that we go to for advice when we're having a really hard time reaching a certain family or certain client. [We ask the cultural experts] for further or deeper understanding of where that family or where that individual might be coming from and how can we best influence them or not . . . Sometimes when we get stuck . . . we'll come together as a treatment team and we'll have a discussion about the clinical perspective and the community perspective.

Clinical supervisors are key personnel for AIBH program staff because they candidly discuss the challenges and usefulness of cultural adaptations. Therefore, clinical supervisors must know how to adapt EBTs and include team members who have the cultural knowledge to ensure a cultural fit. Adoption of an EBT involves a merging of clinical and cultural wisdom. Clinical supervisors must be aware of how to incorporate community-based approaches. Participant 9 said,

> I was lucky enough to have [two clinical supervisors] as I was starting out. So, I feel just . . . having that feedback really helped to shape me as a clinician and being aware of cultural differences, cultural similarities, and . . . some [of the] do's and don'ts and just general ideas.

The participants felt strongly that their programs were strengthened by hiring evaluators to document the cultural adaptations and treatment outcomes. Evaluators provided an outside perspective to ensure the information and processes were captured correctly and translated the work for funders and community stakeholders. Evaluations increased transparency so staff could review the reports to improve clinical services. According to Participant 4,

> So we started to [get] closer to the end of our funding [and] we started to evaluate data. And so we were looking at data, looking at progress of clients coming through the program and noticed that . . . the first 4 years of our funding, we really were not seeing any progress with clients and/or any successes with the program. And so we felt like, we have 1 year to try to make a difference with those that we [are] serving, and we had to go back and look at what was

> happening before and what can we do to change that? And so that's what really kind of initiated this discussion. We also had the clients [provide] feedback about what worked and what didn't work for [them]. Having an outside evaluator is critical in the implementation because it's an outside person being able to say and tell you what's working, what's not working,…and offer feedback and/or suggestions, or…sometimes offer some effective and constructive feedback. Access to diverse funding (e.g., SAMHSA, CDC, NIH, DOJ, local, and state

funding) provides resources to pilot the adapted intervention and document the process, making adoption seamless. Participant 23 said,

> So we have contracts [at] our program. We're funded under [several federal grants for our] traditional wellness practices . . . in Indian Country. So that's how we're able to hire on more staff. But we also have other contracts like the specialty courts, like drug courts and . . . [funding allowed us to do] a pilot where [we] reviewed the challenges and the successes. [We asked] is it possible to tweak it? Did it not work well at all? What were those issues? Kind of looking at it in a . . . methodical . . . scientific way but based off of what the community wants.

Internal Organizational Barriers to Adoption of EBTs

Participants mentioned they need more time and administrative support to pilot the intervention to make adaptations and market the intervention to gain access to the community. They need more training to implement the EBT and requested constructive feedback to improve services. Participant 8 commented,

> A lot of training and practice. I think the clinicians I work with have pretty significant training regularly to check in with each other and practice on each other. I feel like sometimes the trainings you get are like, here . . . you trained for 2 days, now go out there and do it. And there's no follow-up. So I know they do [group training] at [my program] and the clinicians are in it for like a year [to build their skills].

Participants stated they had to manage numerous deadlines for reports, data collection, and clinical assessments, all of which had to be reorganized. Participants discussed issues with documentation, which was cumbersome, and reduced clinicians'

time and energy to focus on client engagement and retention of services. Participant 7 explained,

> I think a lot of the way we function is funding based. And for me, I think it would be nice if we weren't so funding based, because we're bound by reports and data collection. And having to administer inappropriate assessments to every individual, I think is a disservice to our clients.

Participants described a bureaucracy in which they had to manage funding streams from federal, state, and local resources, with each placing restrictions on what to purchase. Participant 17 said,

> Now that we have these programs, we have the federal programs coming to the [tribe] to help . . . so once [the programs] get [the funding] . . . there's so much policies that we need to follow, so whatever [is] required we follow . . . Back [in the day], . . . it was not like that. So now there's a big [competing] role . . . And you know, with [all these] programs [there] are [many] do's and don'ts of [each program] . . . [we] have to follow . . . [It's federal funders] versus community policies.

Inexperienced staff often choose models of care they are already familiar with rather than those based on community needs and strengths. There needs to be a core value that working in Indian Country requires a community-based approach and that community buy-in is an ethical value to be followed. Participant 19 said,

> The majority of EBTs have to be adapted for AIs to be a cultural fit. And I think from a clinician's side too of accepting that culture because if you can't accept it, if you're coming from your schooling or you've done it in private practice and the White culture, and then you're wanting to run with it here, and you don't have that ability to be patient and to adapt and be flexible, you probably shouldn't be in Native country. But I have seen it where clinicians come in and want to plow through and don't really last. Either they get burnt out really fast or they get walked on, one of the two.

New employees who have not worked with AI clients require immense training, and they must learn how to tailor their clinical skills to fit the client's needs. If they do

not actively practice these new skills, it creates challenges for the entire behavioral health team. Participant 6 said,

> I think sometimes just sort of that old school kind of 'Western treatment as usual' kind of approach . . . it's just hard to change that culture. So when we have providers that are still providers [of that] system . . . that are still very Western thinking, it is hard to change those [skills]. And we try to change those [skills] with a lot of trainings, but without being on the ground floor day in and day out, it's challenging.

Characteristic s That Promote External Organizational Facilitators for Adoption of EBTs

The external organizational facilitators needed to adopt an EBT are access to technical expertise and other subject matter experts to adopt EBTs.

Technical expertise is crucial from local universities and state departments to assist with training, research, and evaluation components. A diverse partnership increases opportunities to write additional grants to sustain programs. This partnership provides external networking with other AIBH programs to share their successes and challenges of adapting EBTs. According to Participant 15,

> We have a partnership with [a university] and [their] research team. So they help with the grant funding. They help with our research. So they're collecting data on the services that we provide within [the] program but also the prevention teams [as well]. So [the university] is a really big partnership that we have.

AIBH programs receive additional staff resources such as interns to provide mental health counseling because of their external partners. With any new partnership, the programs always keep at the forefront what is in the best interest of the tribe and the program's future goals to maintain their community support. Participant 24 said,

> Most of the mental health grants or most of the grants that we compete for, we have to show some form of evidence-based practice . . . So [as] a team . . . [we]

> look at the evidence-based practices. But at the same time it was important to note that we have a psychologist and [psych interns] who actually are trained in evidence-based practices and modifications [so we got their feedback] . . . We have to be mindful of our approaches and the types of instruments we use . . . we [need to] consider what is in the best interest of the tribe, and . . . to use the IRB in a manner to protect our community.

External Organizational Barriers to Adoption of EBTs

Two external barriers to adopting EBTs were identified. Participants reported that EBTs are rigid and do not allow for cultural adaptations. Also, funding restrictions that prohibit purchasing arts and crafts items and food that are used to engage clients in services create a barrier to services.

EBTs that are too rigid and inflexible will not allow for cultural adaptations; therefore, they do not work with AI clients. Participant 21 commented,

> I do have some difficulties sticking . . . to the rigidity of [an EBT] because I don't believe we're cookie-cutter people. And I don't think that holds true for most populations..... I don't think the clinician could be absolutely rigid to [the EBT] . . . I think you set people up for failure a lot of times of, well, you're not trying hard enough. And that's not good..... I mean, of course, there are built-in things in each modality to work with like treatment resistance or avoidance and things like that. But you need to be able to adapt those culturally, you need to be able to do those out of a solutions focus, out of something that's not punitive. I always tell people, punitive stuff doesn't work because if it did, I mean, the prison systems would be amazing..... punitive approaches just do not work and highly manualized stuff could be punitive.

Participants suggested that relaxing funding restrictions to purchase food and buy cultural items for group work is a program obligation to maintain community buy-in and access to services. AIBH organizations host meetings and provide meals to community members to access their feedback on what is needed in the community. Providing a meal is one less item community members have to worry about, and it provides opportunities

for community members to meet informally before starting the business agenda. Participant 3 said,

> I know one thing we used at [my previous work] is we would feed them. And so families would come when there's food because we did it in the evening. And so it was suppertime. And so when you're able to alleviate or take away one thing they have to worry about as being parents or providing for family . . . if you do that one thing and give them food and energy, then they're able to be more involved.

To provide culturally relevant and appropriate care, participants had to purchase arts and crafts items to make unique "cultural pieces." Due to funding restrictions, participants could only buy a certain amount of goods, so they found creative ways to meet their groups' cultural needs. According to Participant 1,

> I do arts and crafts [with my clients]. We make cornmeal patches, rattles, [and do] embroidery. So purchasing cultural items . . . I wanted to purchase some more gourds for our rattle-making, but we were only given the green light for like 15 [because] funding is a barrier . . . not having the tools you need is a barrier.

Conclusion

The four themes (attitudes towards EBTs; building culturally competent clinical skills; the process to adapt EBTs; internal and external organizational facilitators and barriers to adopt EBTs) illustrate how the AIBH programs built a culturally responsive clinical team to address the unique needs of their clients who sought behavioral health services. These culturally competent clinical skills take time to institute, and clinical supervision is critical to maintaining these skills. Utilizing a community-based approach creates buy-in and establishes trust and rapport to build a culturally competent system of care. The AIBH programs continue to include cultural practices into their treatment to engage their clients and ensure culturally appropriate care is provided.

The next chapter summarizes these findings and how they coincide with tribal critical race theory (Brayboy, 2005), the unique differences between tribal and urban BH programs, and how the cultural adaptation process is similar to Whitbeck's (2006) model.

CHAPTER 5

DISCUSSION

This qualitative research study aimed to identify how AIBH programs culturally adapt EBTs for cultural relevance. This chapter includes a discussion of the major findings related to attitudes towards EBTs and how these interventions are connected to tribal critical race theory. Moreover, it presents several studies that pertain to creating culturally competent clinical skills (Nebelkopf et al., 2011; Novins & Croy et al., 2016; Pommerville et al., 2016). Furthermore, the chapter explores the ways that the cultural adaptation process AIBH programs use is similar to Whitbeck's model of cultural specific prevention. In addition, I explain the organizational factors to adopt and sustain an EBT in AIBH programs and how that process relates to the exploration, preparation, implementation, and sustainment (EPIS) model (Aarons et al., 2011). Also included in the discussion is how the Institute of Medicine's (IOM) Core Competencies for Healthcare Professionals aligns with AIBH programs' culturally competent system of care. This chapter concludes with the study's limitations and implications, areas for future research, and a brief summary.

The study's research question was as follows: How do AIBH programs adapt EBTs for cultural relevance? The study had two aims: to identify organizational characteristics that contribute to adopting EBTs and to determine whether EBTs are a good fit for AIBH programs.

Attitudes Towards EBTs and Tribal Critical Race Theory (CRT)

The main tenet of Tribal CRT states that colonization (domination) is endemic to society, meaning Eurocentric knowledge and power structures dominate present-day United States (Brayboy, 2005). I asked all participants if they thought EBTs were a colonial approach. Twenty-three participants agreed EBTs were a colonial approach. One participant disagreed that EBTs were a colonial approach, stating that AIs have always looked for evidence through their Indigenous lens, not a Eurocentric lens. According to Brayboy (2006), Eurocentric thinkers dismissed Indigenous knowledge because they did not understand it; their goal was to change (colonize or civilize) AIs to be more like those in power in the dominant U.S. society. As one participant relayed, that is what boarding schools tried to do (i.e., assimilate/change/civilize) to AIs, erase their cultural knowledge, practices, and values, but those protective factors remained with AI communities. Tribal CRT recognizes that U.S. policies are rooted in imperialism (political and economic control) towards AIs, and there is a desire for material gain. It is rooted in history that Eurocentric settlers rationalized and legitimized stealing land from Indigenous peoples who already resided on those lands and rationalized placing Indigenous children in boarding schools (Brayboy, 2005). The removal of Indigenous peoples from their tribal land by the U.S. government disposed them of the rich resources the land provided Indigenous communities. Over half the participants recognized these atrocities AI communities encountered and understood why AI communities did not trust "outsiders."

Tribal CRT (Brayboy, 2005) reiterates that the concepts of culture, knowledge, and power take on a new meaning when examined through an Indigenous lens; this is

because the theory honors AI beliefs, customs, and traditions to foster self-determination and identification of what works for AIs. Participants realized the importance of including AI cultural practices, values, and attitudes into EBTs to make it culturally congruent to their client's worldview. The majority of participants stated they adapted EBTs to ensure a cultural fit, but more importantly, they wanted to validate Indigenous healing and wellness practices as forms of treatment equal to Western treatment. The exclusion process in developing EBTs (i.e., not honoring and including cultural knowledge and practices) can lead to feelings of oppression, discrimination, and racism.

The participants discussed how they built their cultural competency skills and applied them to adapting EBTs for AI clients. The practitioners (BH directors and mental health clinicians) had to view culture, knowledge, and power through an Indigenous lens (Tenet 5; Brayboy, 2005) to learn how to provide culturally appropriate care to AI clients. It is evident that tribal administration and AIBH programs have a unique relationship with the federal government (PL-638) as it pertains to operation of their programs on their land. This study's findings illustrate how the federal mandates to select an EBT not rooted in tribal philosophies, beliefs, practices, values, and traditions create a sense of assimilative practices and oppression that needs to be addressed (Tenets 6, 7, 8; Brayboy, 2005). The practitioners, cultural experts, tribal administrations, and community stakeholders address the issue by adapting EBTs to fit their community's worldview to ensure culturally appropriate care and to keep clients engaged in services. Honoring AI clients' stories, life experiences, and cultural knowledge moves clinical practice towards cultural awareness (Weaver, 1999). Building practitioners' cultural competency skills

with clear direction from cultural experts moves the needle towards culturally competent care, with the goal of producing social change in behavioral health systems (Weaver, 1999).

The mental health clinicians interviewed, explained that they had to use EBTs because their financial structures (federal, state, and local funding streams) mandated they do so (Gone & Trimble, 2012; Nebelkopf et al., 2011). To follow this mandate, but ensure fit, all three programs included in this study adapted EBTs to engage and align their interventions with AI values and customs to provide culturally appropriate care.

Building Culturally Competent Clinical Skills

Table 3 (see chapter 3) illustrates the components of building culturally competent clinical skills. Initially, I thought participants would identify their adaptation process of EBTs, but I discovered they first had to build their cultural competency clinical skills before adapting EBTs. Building person-centered approaches is a fluid process, not static; therefore, the subset of person-centered approaches are labeled with letters rather than numbers, which could imply a specific order.

1. The person-centered approaches include (a) more time for clients to tell their story, (b) building trust and rapport with clients, (c) greeting clients in a culturally relevant manner to create a connection, (d) build a sense of belonging to reduce stigma for accessing clinical services, and (e) flexible clinical approaches and interventions because the client guides the treatment process.

2. Hiring cultural experts because they know what interventions are culturally appropriate and how they will align with the client's cultural belief system and practices.

3. Using culturally appropriate assessment tools and interventions that honor the client's personal view of healing and recovery.

4. Using the following clinical outcomes to measure treatment effectiveness: (a) clients report a new sense of gratitude for life, (b) clients build cultural identity, (c) clients trust and accept behavioral health services, and (d) clinicians receive a community or self-referral, which is a sign of trust and acceptance in the community.

All of the clinicians and behavioral health directors (n = 19) were familiar with the following EBTs: motivational interviewing, cognitive behavioral therapy, and dialectical behavioral therapy. This finding correlates with three studies (Nebelkopf et al., 2011; Novins & Cory et al., 2016; Pommerville et al., 2016) in which the authors found AIBH programs used these EBTs in their programs too. Clinicians expressed that a majority of their AI clients had co-occurring disorders, meaning they had health-related diagnoses or substance abuse diagnoses in addition to a mental health disorder. These co-occurring disorders require clinicians to know about diabetes, substance abuse, suicide prevention, trauma-informed practices, historical trauma, grief and loss, and prevention strategies (Goodkind et al., 2010). To work in tribal and urban BH programs, clinicians need the knowledge and skills to work with these diagnoses as well as clinical supervision to ensure that culturally appropriate treatment is provided (Goodkind et al., 2010).

All participants emphasized that trauma-informed practices are needed to treat their clients because the common diagnoses were trauma histories, depression, anxiety, stress, substance abuse, and interpersonal relationship issues (Goodkind et al., 2010).

Clinicians also need to address these diagnoses with integration of other culturally relevant supports. Those cultural supports or adaptations include using genograms to identify trauma histories and talk about clan systems for social supports, talking to elders to understand cultural identity and traditions/customs that are practiced in tribal communities, using storytelling approaches to re-author the client's narrative with a healthy outcome, and using the Medicine Wheel (physical, social, emotional, and spiritual sectors) to identify strengths, protective factors, and resiliency factors. Cultural experts provide clients entrance to prayer, songs, stories, and special land sites for reflection in terms of meaning, purpose, and the history behind these healing mechanisms available to AI populations. Three studies (Gone, 2009; Gone & Calf Looking, 2011; Goodkind et al., 2012) verify that culture is a form of effective treatment to enhance self-efficacy and well-being.

Clinicians who serve a diverse age range must adapt the intervention to fit the client's age and cultural belief system. The two tribal BH programs saw a relatively homogeneous population (one tribe), and the urban BH program saw a heterogeneous population (over 100 different tribes). Several urban program clinicians saw clients at two to three different site locations per week and provided care across various age ranges: elementary, adolescents, and older adults.

Tribal program clinicians, however, had one site location to see clients, and the age range had a clear cutoff point: elementary, adolescents, or adults, not the vast age range urban clinicians had to see. In summary, urban clinicians had to be diverse in their clinical approaches because their clients came from different tribal groups. A majority of

the urban clinicians stressed the importance of culturally competent clinical supervision because they had to discuss what cultural integrations were effective. More of the urban clinicians requested direct access to their cultural experts to increase their cultural awareness, attitudes, and practice skills. The tribal BH clinicians had direct access to their cultural experts, which kept clients engaged in services and enhanced clinicians' cultural competency skills.

Time was essential in providing clinical care. The urban BH program worked with various AI groups, so their continuity of care looked different compared with tribal BH programs. The urban clinicians billed for services, so they had to honor time limitations and often had a wait-list for their services; whereas, tribal BH programs had administrative support to stretch their continuity of care because although billing was important, it was not the only factor. It was important to keep clients engaged. Therefore, tribal programs had more flexibility to continue services beyond the insurance billing cycle.

Trust is such a huge factor with AI communities, given the history of colonial practices, which led to historical trauma, oppression, and cultural trauma. Clinicians must be aware of these histories before providing services to build clients' sense of resiliency and well-being. To engage clients in behavioral health services, it is vital to create a therapeutic space that is culturally congruent, where clients feel at home and safe to share their thoughts and feelings about the disparities affecting their lives. The participants referred to it as a sense of belonging, where there is no power differential between the clinician and client, and the therapeutic space is nonjudgmental. Part of creating a sense

of belonging is to greet clients in a culturally congruent manner that includes clinicians sharing where they come from, not just their academic or career background.

Cultural Experts

According to Sue and Torino (2005), there are four principles of cultural competency: cultural awareness builds attitudes, increases cultural knowledge, and enhances cultural skills. Cultural awareness is when people become aware of their values, beliefs, and biases related to race and culture (Sue & Torino, 2005). As people become more informed of how other races perceive their culture and identity, this builds cultural awareness (Sue & Torino, 2005). As awareness increases, so does cultural knowledge about other racial and ethnic groups because individuals are gathering accurate information about the group's values, beliefs, and histories (Sue & Torino, 2005). This must be an active engagement process (Sue & Torino, 2005).

To increase cultural knowledge and awareness, all three organizations had cultural experts who were vetted by the community and integrated into their behavioral health and prevention teams to provide cultural guidance on what treatment was appropriate for their clients and communities. These experts assisted in building clinicians' cultural competency skills and validated Indigenous healing practices and some Western therapies. These cultural experts had the knowledge and skills to translate Western treatment such that AI clients could understand it within their cultural belief system. Because most of the cultural experts from the tribal program lived in the community, clients had access to them when the program was closed after normal business hours. Access to cultural experts created a sustainable program.

The tribal programs' cultural experts talked about having role conflict because they walked a fine line among tribal administration, religious leaders, and program administration. At times it was a challenge to help clients who were extended family members or related by clan; an important step to learn was knowing how much to share and when to refer the client to the religious leaders. Clinical supervisors had to work through this with cultural experts, so both were learning how to create boundaries to provide cultural guidance. Three of the five cultural experts expressed the desire to learn from other programs that employed cultural experts and identify how they addressed some of these system challenges.

The urban program's cultural experts stated they have to work with local and state political systems to provide culturally appropriate services for their court-ordered clients. It is difficult for departments of justice or city police departments to understand the significance of cultural healing or traditional wellness practices and why they are incorporated into a client's treatment plan because these services do not align with the criminal justice system. The urban program cultural experts and clinical supervisors had to be creative to translate these wellness practices into Western terminology that criminal justice programs would accept. Numerous adaptations occur on behalf of AIBH organizations to translate wellness concepts that other programs do not have to integrate. This lack of cultural consideration on the part of criminal justice programs is a sign of cultural insensitivity and needs to change. The tribal program participants did not discuss any discrepancies they had with their tribal court systems because it is expected that all programs provide culturally relevant services.

Utilize Culturally Appropriate Assessment Tools

Cultural Identity

Clinicians said they use some form of the assimilation and reconnection cycle from SAMHSA (TIP 61, 2018) to ensure a culturally appropriate greeting and identify the client's cultural identity. There are four factors to assess cultural identity using the assimilation and reconnection assessment tool. Clinicians have to inquire whether the client is traditional, bicultural, assimilated, or reconnecting to their AI heritage (SAMHSA TIP 61, 2018). This cycle is not static, and individuals can be at different places on this continuum (SAMHSA TIP 61, 2018). Those who are traditional are associated with their Native culture, those who are assimilated are associated more with mainstream culture, and those who are bicultural equally engage in their culture of origin and mainstream culture (SAMHSA TIP 61, 2018). Those who are reconnecting to their culture are making a deliberate effort to reconnect and invest in developing their AI identity (SAMHSA TIP 61, 2018). Reconnecting to culture can include participating in tribal-specific and/or Pan-American Indian cultural activities (SAMHSA TIP 61, 2018).

In the study, participants stressed the importance of assessing clients' cultural identity to create a sense of belonging. If a client is "traditional," they may prefer to be greeted in their Native language or be referred to as a relative, such as an Uncle or Auntie. If they are bicultural, they may prefer a "mainstream" greeting. All to say, clinicians must discuss this with their clients at the beginning of treatment.

Other Culturally Appropriate Tools

The adaptations included using culturally relevant tools such as the Medicine Wheel and presenting visual aids to translate EBT concepts into the client's Native language. Using storytelling approaches, genograms to outline trauma and violence histories, and social maps to identify support systems such as extended relatives and clan systems to aid the client in their healing and recovery process. Another tool is talking with elders, dancing, drumming, singing, and praying, along with holding ceremonies. These cultural approaches enhance individual's sense of well-being. They are considered culturally grounded approaches because their unique values, beliefs, traditions, and practices have been around since time immemorial (Whitbeck, 2006). These tools validate culturally driven services that aid in healing and increasing a sense of well-being, and all the participants spoke about using these tools with their clients.

Clinical Outcome Measures

Blending culturally based services with science-driven interventions validates cultural treatment outcomes that are effective for AI clients (Echo-Hawk, 2011; Gone, 2009). For instance, participants knew they provided effective treatment to clients when the clients shared that their symptoms of mental illness were reduced and they had a new sense of gratitude for life. Clinicians knew they built trust when clients honestly shared what interventions were effective and ineffective, which implied that clients accepted their help and expertise. When clinicians received a community or self-referral, this indicated a level of trust, and it takes a long time to build that in AI communities. These clinical outcomes need to be included in treatment measures to build cultural evidence

that trust and a new sense of gratitude for life increase clients' well-being and that culturally relevant care is provided.

Cultural Adaptation Process Used by Participants

It was evident that those who had two or more years of experience providing clinical mental health services and those who worked in Indian Country had more experience adapting EBTs and identified the process they used. Those who worked in Indian Country were more likely to work with a homogeneous population and, therefore, were more immersed in learning thoroughly about one culture, as opposed to working at an urban program where one has to learn about numerous tribal groups. All the participants underscored that to adapt and implement an EBT, the AIBH programs had to acquire community buy-in and feedback to make it a successful cultural fit. For the tribal BH programs, tribal administration support was essential to move forward. Participant 7 said that because 70% of AIs live in urban areas, EBTs are necessary but must be adapted. "As more of our elders are dying, now is the time to understand cultural adaptation processes to improve culturally congruent services" (Participant 7).

Cultural adaptations are a systematic modification of an EBT that considers language, culture, and context in a way that is compatible with the target population's worldview (Burlew et al., 2013; Castro et al., 2010). There are surface and deep structural adaptations (Burlew et al., 2013). A surface adaptation changes the apparent features of the EBT to fit the social and behavioral aspects of the target population, such as language, music, visual items, or print, to enhance the intervention and engagement process (Burlew et al., 2013; Cabassa & Baumann, 2013; Castro et al., 2010). It does not

modify the core intervention (Burlew et al., 2013; Castro et al., 2010). A deep structural adaptation involves revising the core elements of the EBTs to fit the target group's historical and cultural values (Burlew et al., 2013; Castro et al., 2010). The participants described using both types of adaptations.

The cultural adaptation process used by the three programs included (1) identifying community needs (risk and protective factors) using a community-based approach, (2) using an interdisciplinary approach to adapt the EBT, and (3) piloting the adapted intervention and acquiring feedback from internal and external partners regarding what was effective. The cultural adaptation process the three programs used is similar to the culturally specific prevention model by Whitbeck (2006). Table 4 outlines the adaptation process participants used and compares its three steps with Whitbeck's (2006) model.

Steps of the Cultural Adaptation Process the Participants Used

Step 1 of the AIBH programs' cultural adaptation process is similar to Steps 1 and 2 of Whitbeck's (2006) model, excluding the baseline survey. The AIBH program's Step 2 is similar to Whitbeck's Steps 1, 3, and 4. Step 3 of the AIBH program process is similar to Step 5 of Whitbeck's model.

Table 5

Cultural Adaptations Process Used by Participants Compared With Culturally Specific Prevention Model

Cultural Adaptation Process Used by Participants (2020)	Culturally Specific Prevention Model (Whitbeck, 2006)
1. Identify community needs (risk and protective factors) utilizing a community-based approach to create buy-in.	1. Meet with the AI community (including elders, tribal leadership, providers, and community advisory boards) and researchers to identify key risk/protective factors.
2. Use an interdisciplinary approach to adapt the EBT (includes cultural experts) to translate key concepts relevant to the community.	2. Do a baseline survey that identifies the extent of the problems and protective factors.
3. Pilot the intervention and acquire feedback from the community, internal, and external partners about what was effective and ineffective.	3. Work with the community and cultural experts to translate the key risk/protective factors that fit the cultural context.
	4. Develop measures of the key risk/protective factors that are unique to the cultural context.
	5. Conduct trials of the culturally specific intervention and do assessments.

For Step 1, the AIBH programs emphasized using a community-based approach, which meant including community members (parents, youth, elders, tribal administration, religious/spiritual leaders), cultural experts, and program staff to culturally adapt EBTs. This was the first step to create buy-in and identify how to engage the community in accessing mental health services. Utilizing a community-based approach decreases the principle that scientific knowledge is superior to cultural knowledge and Indigenous ways

of knowing; it sets both knowledge foundations as equivalent and informs all how to learn from one another (Whitbeck, 2006). Utilizing the community-based approach creates a sense of community ownership and validates that AI ways of knowing are equivalent to scientific knowledge (Whitbeck, 2006).

Step 2 uses an interdisciplinary approach to adapt the EBT. It requires other programs to help translate the key risk and protective factors for cultural relevance. The programs/staff to ask to be involved are prevention specialists, community health representatives, cultural experts, substance abuse providers, school mental health clinicians, and internal and external partners to assist with the adaptations. This step is key because it brings all the internal and external program partners to work on one objective: culturally adapt the EBT. During this process, all individuals learn how to translate the key risk and protective factors culturally and why it is important to change the labels to make it more relevant for the potential clients. Everyone is learning more about the community's culture, values, traditions, and systems needed to create a true sense of health and wellness. Thus, cultural and scientific knowledge is translated into culturally relevant terms so clients can clearly understand the EBT components.

Step 3, pilot the intervention, is essential to identifying what to keep and what to discard of the EBT. This step includes using an interdisciplinary approach in which the partners come together to share lessons learned from the pilot intervention. Having an evaluator is significant because they document the adaptation process and share their findings with the community and stakeholders. Evaluators provide an unbiased view; the programs emphasized that this creates transparency and accountability needed to adapt an

EBT. The two tribal BH program evaluators were from outside the community (either a university partner or subject matter expert) and were vetted and supported by tribal leadership. The urban program participants did not discuss the use of an evaluator.

Organizational Facilitators and Barriers to Adopt EBTs

To sustain the adoption of EBTs, participants identified organizational facilitators and barriers to retain EBTs. The four inner organizational facilitators were (1) endorsement from all behavioral health program staff to adopt the EBT, (2) weekly clinical supervision with cultural experts as needed, (3) the hiring of an evaluator to document the adaptation process and treatment outcomes for transparency and accountability purposes, and (4) access to diverse funding. The five inner organizational barriers were (1) needing more time to adapt and evaluate the intervention outcomes, (2) lack of administrative support, (3) insufficient training to implement the EBT, (4) various competing program demands due to the funding streams for monthly reports and use of assessment tools that were irrelevant for the target population, and (5) hiring inexperienced staff who had not worked with AI populations and were not flexible to adapt to the local environment, which was detrimental to creating a cohesive team.

The one external organizational facilitator was access to technical and subject matter experts outside the organization, which was important. Some of the external organizational barriers were (1) EBTs that were too rigid and did not allow for adaptation and, therefore, would not work at AIBH programs and (2) the existence of funding restrictions whereby participants could not purchase food or cultural items for their groups. The funding restrictions created financial hardship, so participants had to

find other creative ways to purchase cultural items that were important to facilitating group sessions with clients.

How the Facilitators and Barriers Relate to the Cultural Adaptation Process

All participants from the AIBH programs reiterated that community buy-in and feedback to adopt an EBT is the first step. To have community buy-in relates to Step 1 of the cultural adaptation process used by participants. Without community endorsement, it would be problematic to implement an adapted EBT. Part of the community-based approach includes buy-in from internal BH staff and other departmental employees (Step 2 of the cultural adaptation process) to ensure that programs are not competing for the same product because the work could be shared, especially in small communities that have limited resources. Participants who were successful at implementing adapted EBTs said they had weekly clinical supervision and direct access to cultural experts to assist with translation of Western therapy concepts into culturally relevant terms (Step 2 of the cultural adaptation process). In supervision, clinicians were encouraged to share why they thought an intervention did not work to identify barriers to treatment and how to overcome those with culturally congruent practices. Identifying barriers and making necessary changes to the intervention relates to Step 3 of the cultural adaptation process to ensure a cultural fit. The cultural experts are essential in clinical supervision because they have the cultural knowledge to translate what practices are a cultural fit for a client and to assess what is ineffective. For example, if a client is reconnecting to their Native roots and wants to learn about their cultural role as a man, woman, or two-spirit in their community, the cultural expert and the clinician work together to ensure they have

appropriate services and mentors to guide them in building their cultural identity. Reconnecting to one's Native roots takes time, patience, and numerous follow-ups to ensure this process is seamless and that the individual's cognitive, emotional, spiritual, and physical capacities are ready to engage in these services. Therefore, weekly clinical supervision with a cultural expert is imperative to guarantee culturally competent care. Some clinicians also stated that culturally appropriate clinical supervision that includes immediate access to cultural experts is imperative to provide quality care.

All behavioral health directors discussed the importance of transparency and accountability. Clinicians want to know whether their services are effective, so it is important to include culturally congruent outcome measures such as trust, acceptance, and satisfaction with services in the client's treatment plan. The tribal BH programs appreciated how their evaluator tracked their cultural adaptation process and treatment outcomes because it informed them of what was effective and how to improve their quality of care (Step 3 of the cultural adaptation process). The outcome measures informed clinicians on how to enhance their cultural competency and clinical skills. An external facilitator of guidance for the AIBH programs was access to federal, state, and local funding to hire evaluators and cultural experts, thus creating external partnerships with universities and subject matter experts who provided resources and opportunities for additional clinical training.

The internal barrier of needing more time and training to adapt an EBT affected team cohesion. The BH directors shared that it took at least ten years to hire the right clinical team, identify how to adapt an EBT through trial and error, and utilize evaluation

to improve services, a resource-intensive and time-consuming process. At a minimum, it took two years to adapt an EBT and have clinical outcomes to improve it and make it more effective (Step 3 of the cultural adaptation process). This excludes the time needed to hire culturally appropriate staff. Therefore, having realistic timelines to build culturally competent clinical skills and adaptations of EBTs is essential to enhance team cohesion and reduce staff burnout. It was clear that hiring inexperienced staff who had not worked with AI clients and were unable to tailor their clinical skills to the community's cultural values, beliefs, customs, and traditions (Brayboy, 2005) was detrimental to team cohesion and the programs' reputation.

It was evident that the three AIBH programs recognized when an EBT was too rigid and inflexible to adapt, and their next step was to select another intervention amenable to adaptation for their population. Of note, some participants shared that due to some funding streams, they were mandated to use certain clinical assessments with clients every 30 or 60 days; they wanted this process streamlined to increase their time with clients. Some of these funding streams put restrictions on the amount participants could spend on arts and crafts supplies to make cultural items and limited food purchases for community programming. This was an external barrier in that participants had to find creative ways to purchase these items independently or through different revenue streams.

Findings Related to th e EPIS Model

The facilitators and barriers the AIBH programs identified are pertinent because it outlined internal and external resources needed to adopt EBTs. To sustain adoption of

EBTs, AIBH programs can assert their type of cultural competency skills candidates need at their program to successfully adapt an EBT. AIBH programs need to identify the type of distinctive knowledge, skills, practices, and attitudes in their selection criteria to find the best candidates who are culturally appropriate and responsive to AI clients' unique needs (Aarons et al., 2011). Clearly defining competencies for the position of the clinical supervisor and identifying staff training needs are essential to finding the right supervisor for AIBH programs (Aarons et al., 2011). Having several internal and external stakeholders to navigate the complex nature of cultural adaptations and implementing EBTs are fundamental to creating a sustainable program (Aarons et al., 2011). These findings are relevant to Aaron's study (2011, et al.).

The IOM and AIBH Core Competencies for Providers

The IOM (2003) developed five core competencies for health professionals to increase their quality of care at their organization. All three AIBH programs received some form of federal (IHS, NIH, SAMHSA), state, and local funding to build their programs. I looked at the extant literature to find information on how to build BH programs or BH competencies, and I found the IOM core competencies. The IOM and the AIBH program competencies look similar, but the AIBH programs have culturally relevant approaches that fit their communities and clients. Table 5 outlines how the AIBH cultural competencies fit the IOM model.

Table 6

Comparison of IOM Core Competencies to AIBH Competencies

IOM Core Competencies (2003)	AIBH Competencies
1. Provide patient-centered care. Identify, respect, and care about patients' differences, values, preferences, and needs. Coordinate care, communicate with and educate patients. Share decision-making and management. Continuously advocate for prevention, wellness, and promotion of healthy lifestyles.	1. Utilize person-centered approaches. 2. Hire cultural experts.
2. Work in interdisciplinary teams. Teams cooperate, collaborate, communicate, and integrate care to ensure continuous and reliable care.	1. AIBH programs use community-based and interdisciplinary approaches to create buy-in and adoption of services.
3. Employ evidence-based practice. Integrate the best research with clinical expertise and patient values for quality care. Participate in learning and research activities to the extent it is feasible.	1. AIBH organizations have a cultural adaptation process for EBTs.
4. Apply quality improvement (identify errors in care; implement safe design principles; measure quality of care in terms of structure processes and outcomes related to patient and community needs; design and test interventions to changes processes and systems of care to improve quality of care).	1. AIBH clinical outcome measures (referrals, trust and acceptance in the community). 2. Culturally appropriate assessment tools (cycle of assimilation and reconnection, Medicine Wheel concepts) are used to improve services. 3. Hire evaluator to document cultural adaptation process and clinical outcomes.
5. Utilize informatics (communicate, manage knowledge, mitigate error, and support decision-making using information technology).	1. Utilize electronic medical records to document services and clinical outcomes. 2. Utilize community-based approaches to reduce error and increase knowledge and support for programs.

It was significant to discover how these competencies translate across both organizational sectors. My assumption is AIBH competencies resonate with their programming more as compared with the IOM competencies because the former is culturally relevant and useful for AIBH programs. The intersectionality of program development, organizational development, and core competencies might be of interest to AIBH program directors to share with funders to demonstrate that their program competencies derive from an AI community perspective yet reflect IOM competencies. This is an opportunity to do more research on AIBH organizational development and how it relates to other systems of care.

Social Work Implications (Practice, Research, Teaching)

This research study is significant to social work because it addresses improving the quality of care for Indigenous people who constitute vulnerable and marginalized groups. Social workers strive to promote social justice and change to end discrimination, oppression, poverty, and other forms of injustice (NASW, 2017). They seek to empower people to address their own needs. Therefore, increasing clinicians' competency skills and teaching them how to adapt EBTs is a step towards cultural competency. Learning how to adapt EBTs facilitates culturally responsive care and increases the well-being of diverse, underrepresented populations. Evaluating the adapted interventions contributes to the empirical knowledge for ethnic minority populations while highlighting their strengths and protective factors. Educating future social work clinicians on culturally competent clinical care adds to the signature pedagogy of social work field education. This study adds to the clinical practice literature and recognizes how culture helps

address mental health disparities and identifies what supports are needed to assist clients on their wellness journey.

A future research implication is to identify other cultural adaptation frameworks that are effective with ethnic minority groups. Evaluating the effectiveness of these adaptations and disseminating the results increases public knowledge of what is truly effective. Without empirically testing cultural adaptations, the social work field will not know what works for racial and ethnic minority populations, and lack of that information would reduce culturally competent care, which would ultimately diminish the overall quality of care.

Study Limitations

One limitation of this study is the small sample size, and therefore the results are not generalizable. I used purposive sampling because there were specific criteria (mental health clinicians and cultural experts who adapted EBTs) I was looking for. Using randomization was not appropriate because the participant pool was not large enough, given that it required working with vulnerable and marginalized populations. Also, the topic of culturally adapting EBTs is explored only minimally in the literature, so finding participants to interview required a purposive sampling frame.

A second limitation is that I previously worked with all three AIBH organizations in some capacity, and I knew seven participants, so they might have provided socially desirable answers. This was addressed by sharing results with the participants to answer any questions and clarify the results. A third limitation is that three participants from the urban BH center declined to participate because they felt they could not adequately

answer the research question. Their input might have differed from the majority of the study participants. A fourth limitation is that I did not interview any female cultural experts because the three AIBH programs did not employ any. A fifth limitation is sampling bias because I relied on the behavioral health directors to refer participants for the study; I did so because I wanted to honor tribal program's self-determination and self-identification as outlined in Tribal CRT (Brayboy, 2005)

Future Research

For future research, including diversity in gender of cultural experts will add to the credibility of studies on adaptations of EBTs. Researching other cultural adaptation processes that AIBH agencies can utilize will add to the empirical literature and clinical competency skills. Currently, there are over 15 cultural adaptation models (Burlew et al., 2013), and Whitbeck's (2006) culturally specific prevention model appears to resonate with the three BH programs' adaptation process. I propose there are other cultural adaptation models AIBH programs use, and researchers need to identify those models to enhance behavioral health services. There are likely other unique organizational facilitators and barriers to adopting EBTs that need further research to determine whether the information I gathered is reliable.

Summary

In summary, I learned that community-based approaches and cultural experts are fundamental to provide culturally appropriate services at AIBH programs. Cultural experts and culturally appropriate clinical supervision appear to be the backbone of culturally competent care for AIBH programs. I observed that building culturally

competent clinical skills should be addressed first, before pursuing any cultural adaptation of an EBT, because it takes an abundant amount of resources and time to adapt an EBT. To sustain EBTs, AIBH organizations need tribal leadership support, external partners with subject matter expertise, and diverse funding to sustain the program.

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APPENDIX A

STUDY RECRUITMENT FLYER

Dissertation Research Study

Purpose: There is a mandate to use evidence-based interventions to treat mental health disorders to improve clinical outcomes, but these interventions have not been constructed with American Indians (AI). There is little knowledge about the effectiveness of evidence-based treatments (EBT) with AI populations. The majority of the EBTs that are implemented with AI populations have been culturally adapted, so what process are mental health clinicians using to adapt EBTs to ensure cultural relevance.
Research Question: How do American Indian Behavioral Health (AIBH) agencies adapt EBTs for their clients?
Sample: Two rural and one urban AIBH organization. A total of 25 participants who are 18 years and older will participate. That is 16 mental health clinicians, 3 behavioral health directors, and 6 cultural experts.
Participants: Must be a mental health clinician (social workers or counselors) or a cultural expert who assisted with adapting an EBT.
Method: It is a qualitative research study that will utilize tribal participatory research principles. The study requires a face-to-face or phone interview that will be 60 minutes in length and audio-recorded. Participants will receive a $25 gift card upon completion of the interview.

Charlene Poola is Hopi-Tewa and Navajo and has provided mental health and substance abuse prevention services in the southwest for 20 years. She is a licensed clinical social worker (LCSW) and a doctoral candidate at Arizona State University. She has provided training on culturally appropriate services, mental health first aid, suicide prevention, and school mental health services. Her expertise is in finding culturally appropriate evidence-based treatments for American Indian behavioral health programs. She also provided clinical supervision to mid-level clinicians. Lastly, she has assisted tribes to apply for federal, local, and foundation grants for behavioral health services.

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE FOR PARTICIPANTS

Demographic Questions

1. What is your gender?
   □ Male □ Female □ Other (please specify)____ □ prefer not to say

2. What is your age?
   □ 18-24 years old □ 25-34 years old □ 35-44 year old
   □ 45-54 years old □ 55-64 years old □ 65-74 years old
   □ over 75 year old

3. What is your ethnicity?
   □ White □ Hispanic/Latino □ African American □ Asian American
   □ Native Hawaiian □ American Indian/Native American.
   What is your tribal affiliation: _____

4. What is the highest degree or level of education you completed?
   □ Less than high school diploma □ High school degree or equivalent
   □ Associate's Degree
   □ Bachelor's degree (i.e., BA, BS) □ Master's degree (i.e., MA, MS, MEd)
   □ Doctorate degree (i.e., PhD, EdD) □ Other (please specify)_____

5. What is your current employment status?
   □ Full time (40-35 hours a week) □ Part time (34-20 hours a week)
   □ Less than part-time (19 -1 hours a week) □ Volunteer □ Contract employee
   □ Other (please specify)_____

6. What is your area of expertise (please check all that apply)?
   □ Substance abuse □ Mental health services
   □ Substance abuse prevention □ Other (please specify):_____

7. Do you have one of the following licenses to provide clinical services? □ No
   □ LMSW □ LCSW □ LPC □ LPCC □ LMFT
   □ LMHC □ CADAC □ LADAC □ Other (please specify): _____

7. How many years of experience do you have providing mental health services?
   _____

8. How many years of experience do you have providing mental health services to American Indian clients? _____

9. How many years have you worked in Indian Country?_____

APPENDIX C

INTERVIEW GUIDE FOR PRACTITIONERS

Interview Questions – Mental Health Clinicians and Behavioral Health Directors
Research Question: How do AIBH agencies adapt EBT for cultural relevance?

1. Can you tell me about your workplace? Your role here? How long have you worked here?

2. Are you familiar with the term evidence-based treatment (EBT) and evidence-based practice (EBP) process? Sometimes folks confuse both terms. Let me describe both - the EBP process is where the client is an active participant in the decision making process of his/her care. It's a process that uses scientific evidence to find an appropriate intervention that takes into account the client's preferences, values, clinical state, and environment in combination with clinical wisdom. An EBT is an intervention that demonstrates effective outcomes in at least two experimental studies and becomes a clinical treatment manual. An example of an effective outcome is reducing depressive symptoms.

    a. For this interview the focus is on EBTs. Can you give me an example of an EBT you have used? What do you think about it?

3. Can you tell me how you use EBTs in your organization? (PROBE: If you were training someone new to EBT, how would you describe it?)

4. Have you ever adapted an EBT? If so, what was your process - tell me step by step how you adapted it. If <u>not</u>, why haven't you adapt it? Who was involved in the adaptation (i.e., cultural expert, community members, tribal leadership)? Who is invited to adapt an EBT? How are those decisions made?

5. Describe a situation when using an adapted EBT was useful? When it was <u>not</u> useful?

6. Does culture play a role in implementing or adapting an EBT? If so, how? (Does the EBT provide room to include cultural adaptations or is it culturally incongruent). If not, why not?

7. Are you aware of any culturally grounded approaches (these are approaches that the community developed)? Tell me more? Was that a good approach to use with clients? Have you created a culturally grounded approach?

8. What external factors (socio-political, funding, client advocacy, interorganizational networks) support adapting an EBT?

9. What are some of the internal factors (organizational characteristics: leadership, practitioners skills and experience; organizational culture/climate; adopter characteristics) that support adapting an EBT?

Are there any other barriers and facilitators to implementing EBTs that have not been shared?

10. In a perfect world, what would be the protocol to adapt EBTs? What does that look like?

11. In your opinion, are EBTs a good fit for AIBH organizations? How so? Could you provide an example?

12. Are EBTs effective for your client population? How so? Can you provide an example?

13. Are EBTs a colonial approach?

14. What protective factors or resiliency characteristics do you recognize in your clients?

15. Ok, this concludes our interview, is there anything else you would like to add?

Probing Questions:

1. Can you tell me more?
2. What should I take from that example?
3. What does that mean?
4. I noticed you were hesitant to answer that question, can you comment on this?
5. You smiled a lot when you mentioned this…
6. What are the most memorable moments of that story? How does that happen, how does that work, what does that look like?

APPENDIX D

INTERVIEW GUIDE FOR CULTURAL EXPERTS

Interview Questions - Cultural Experts

How do AIBH agencies adapt EBTs for cultural relevance?

1. What is your role at the behavioral health center? How long have you been at the agency?

2. Have you done this type of work before? How many years have you provided cultural support/guidance in this setting?

3. How does culture play a role in mental health or wellness? Is there ever a time when culture does <u>not</u> play a role?

4. Since this study is about adapting EBT, what was the process used to adapt EBT at this agency? Was it useful (please describe)? If not useful, why?

5. What type of <u>internal</u> support (organizational characteristics: leadership, practitioners skills and experience; organizational culture and climate; adopter characteristics) did you have to adapt EBTs? Interviewer try not to provide examples.

6. What type of <u>external</u> (socio-political, funding, client advocacy, interorganizational networks) supports did you have to adapt EBTs?

7. What were some of the barriers (internal and external) to adapt EBTs?

8. What were some of the facilitators to adapt an EBT? What type of organizational culture is best to adapt an EBT?

9. Are EBTs a colonial approach?

10. Are EBTs a good fit for the client population? Why or why not?

Ok, this concludes our interview, is there anything else you would like to add?

APPENDIX E

CONSENT FORM

Consent Form

How do American Indian Behavioral Health Agencies
Adapt Evidence-Based Treatment Study

I am a graduate student under the direction of Professor Felicia Mitchell at Arizona State University School of Social Work. I am conducting a research study to identify how American Indian behavioral health agencies adapt evidence based treatments (EBTs) for their clients. There is little research on how the adaptation process occurs and who is involved therefore your participation is important.

I am inviting you to participate in the study, which will entail a one hour in-person or phone interview on what your thoughts, attitudes, and process is to adapt EBTs. To participate in the study you must be 18 years or older and be a mental health clinician, cultural expert, or a program director at the current behavioral health agency. For your participation you will receive a $25.00 gift card.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

A possible benefit of your participation are the responses you provide, will add to the empirical literature that explains what process is used to adapt EBTs to ensure culturally relevancy and appropriate treatment for American Indian clients. There are no foreseeable risks or discomforts to your participation.

Your responses will be kept confidential. The results of this study may be used in reports, presentations, or publications but your name will not be used. If applicable, the results will only be shared in aggregate form.

I would like to audio record this interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be recorded; you can change your mind after the interview starts, just let me know.

If you have any questions concerning the research study please contact Professor Felicia Mitchell at 602-496-0800 or Felicia.Mitchell@asu.edu. If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance at (480) 965-6788. Please let me know verbally if you would like to participate in this study.

By signing below you are agreeing to be part of the study. Thank you!

Name: _____
Signature:_____ Date:_____

APPENDIX F

ARIZONA STATE UNIVERSITY IRB APPROVAL LETTER

ASU Knowledge Enterprise Development

EXEMPTION GRANTED

Felicia Mitchell
WATTS: Social Work, School of
-
Felicia.Mitchell@asu.edu

Dear Felicia Mitchell:

On 10/16/2019 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	How do American Indian behavioral health (AIBH) agencies adapt evidence-based treatments to ensure cultural relevance?
Investigator:	Felicia Mitchell
IRB ID:	STUDY00010756

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 10/16/2019.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Charlene Poola
Elizabeth Segal
Felicia Mitchell
Hyunsung Oh
Charlene Poola