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The S.P.I.R.I.T. Program: Spirituality Promotion Interdependence Resiliency Inclusive Therapy

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The S.P.I.R.I.T. Program:

Spirituality Promotion Interdependence Resiliency Inclusive Therapy

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This scholarly project, submitted by Alycia Heisler, MOTS and Brianna Safranski, MOTS in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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TABLE OF CONTENTS

LIST OF TABLES

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ABSTRACT

Purpose: Native American children and adolescents are some of the most underserved people in the United States (Warzak, Dogan, & Godfrey, 2011). Common mental health problems this population typically experiences are depression, suicidal thoughts or ideation, traumatic experiences, substance use, and results of historical trauma (Brockie, Dana-Sarco, Wallen, Wilcox, & Campbell, 2015). They have the highest rates of these mental health problems, more than any other ethnic group (Evans-Campbell, Walters, Pearson, & Campbell, 2012). There is a need for preventative programs to be implemented with elementary school-aged Native American children and adolescents (Ohl, Mitchell, Cassidy, & Fox, 2008; Stigler, Neusel, & Perry, 2011; Urbaeva, Booth, & Wei, 2017). Many programs with Native Americans have been previously unsuccessful due to the lack of culturally relevant interventions and the spiritual aspect (Brockie et al., 2015; DeMars, 1992; Urbaeva et al., 2017).

Methodology: Data bases searched include: Academic Search Premiere, EBSCOHost, ERIC, CINAHL, PsychInfo, PubMed, Google Scholar, and reliable government websites. The key terms and phrases used for searching include: Native American(s), mental health, education, school programs, prevention, prevention programs, occupational therapy, cultural programs, protective factors and others. The information gathered helped inform the literature review for the background, history, and needs of Native Americans. From this literature search, a gap in literature regarding a need for culturally relevant, prevention-based programs in the educational setting for Native American youth was identified.

Results: A culturally relevant program for occupational therapists to promote mental health wellness with Native American children was designed. The Canadian Model of Occupational Performance and Engagement (CMOP-E) guided the development of this project as it focuses on the spirituality as the center of the person, which aligns with the goal of a culturally relevant product. In addition, the CMOP-E helped to tie the relevance back to occupational therapy and result in a positive change in occupational performance and engagement. Five units emerged based on findings from the literature review and CMOP-E: spiritual, mental, emotional, relational, and physical health. Each unit has three session outlines with suggested adaptations, along with additional resources and activity ideas so that it can be implemented in various settings. These sessions should be expanded as the occupational therapist increases competency. The sessions were designed as a starting point. A common factor within the units was to identify and build on protective factors to promote strength-based approaches, rather than problem-focused.

Conclusions: Native American children and adolescents have the potential for exposure to a variety of mental health challenges and, if addressed earlier, positive mental health and quality of life. Programs targeting Native Americans need to be culturally relevant to be successful. Schools are an opportunity to reach the most children and adolescents. Occupational therapists are able to work within schools. However, there is a lack of programs or curriculums to guide culturally relevant occupational therapy interventions. The results of this product will guide occupational therapists working with Native American students to provide culturally relevant interventions and improvement in mental health. An important concept for Native American populations is building protective factors. This program has an emphasis on building protective factors, which hopefully allows for better outcomes in quality of life and reduction of risk factors in Native Americans.

CHAPTER I

INTRODUCTION

Native American children are some of the most underserved people in the United States (Warzak, Dogan, & Godfrey, 2011). Common mental health problems this population typically experiences are depression, suicidal thoughts or ideation, post-traumatic stress disorder, and substance use (Brockie, Dana-Sarco, Wallen, Wilcox, & Campbell, 2015). Native American adolescents and young adults are one and a half times more likely to attempt suicide, and have psychological distress compared to the national average (Centers for Disease Control and Prevention, 2015; National Center for Health Statistics, 2007). In addition, suicide is the second leading cause of death for Native Americans age ten to thirty-four (Centers for Disease Control and Prevention, 2015). In 2006, more than one third of patients seen by Indian Health Services were due to mental health issues (Urban Indian Health Commission, 2007).

There is an overall lack of cultural needs addressed in programs for Native Americans. Typically, Western medicine is illness-centered and addresses only the problem or illness at hand (Peacock & Wisuri, 2002). There is little to no consideration for the person in terms of values, beliefs, spirituality, and other aspects affected by the illness, which are important aspects of Native American culture (Peacock & Wisuri, 2002). Mental health programs are especially lacking in addressing the cultural needs of Native Americans (Bigfoot & Schmidt, 2010). The practitioners tend to lack education regarding the specific culture and background of Native Americans, which interferes with their ability to provide client-centered, culturally relevant care (BigFoot & Schmidt, 2010).

To address the general population suicide rates, there have been programs developed for suicide prevention among adolescents and young adults in community settings (U.S. Department of Health and Human Services, 2010). There is a need for more preventative programs to be implemented with elementary school-aged children in addition to the current ones for adolescents and young adults (Ohl, Mitchell, Cassidy, & Fox, 2008; Stigler, Neusel & Perry, 2011; Urbaeva, Booth, & Wei, 2017). Given that Native Americans have higher rates of suicide than other populations, preventative measures are especially important with this population (Center for Disease Control & Prevention, 2015). Prevention measures also are found to decrease the rate of Native American youth in juvenile detention centers, which in turn reduces the suicide rates (Horwitz, 2014). More programs targeting suicide prevention need to be addressed with Native Americans.

Accessibility is another important factor to include when developing programs for Native Americans (Gray & McCullagh, 2014). School is an area that is best suited for program implementation for children and adolescent programs (Bazyk et al., 2009). Additionally, after-school programs and extra-curricular activities are a protective factor for Native American youth (Henson, Sabo, Trujillo, & Teufel-Shone, 2017). Protective factors are "conditions or variables capable of directly affecting adolescents and increasing the likelihood of positive health outcomes" (Henson et al., 2017, p. 6). Generally, school-based programs for Native American youth need to have a cultural element to have successful results (DeMars, 1992).

A literature review was conducted using Academic Search Premiere, EBSCOHost, ERIC, CINAHL, PsychInfo, PubMed, Google Scholar, as well as hard copy resources. The topics are history, historical trauma, reservations, common belief and values, common mental health

problems, general needs, educational needs, current practices used in schools to address mental health, and the role of occupational therapy in mental health.

The purpose of this scholarly project was to develop a preventative, culturally relevant program for Native American children to promote mental health. It is designed to be implemented by occupational therapists. While there are many Native American people across the country, the focus of this project will be on the tribes located in the upper Midwest. Thus, it is important to note, the results of this scholarly project may not suit the specific needs of all Native American youth (Gerlach, 2008). Potential factors that may influence the application of the product include time, population, resources, availability of occupational therapists, and funding.

Key Terminology

Terminology	Definition	Citation
Culture	"knowledge, beliefs, values, customs, and behaviors shared by people in a particular society"	Cockerham, 2007, p. 115
Forced assimilation	A way the U.S. government attempted to eliminate Native American people in terms of their culture as a whole, on federal and state levels	Davis, 2013
Boarding schools	Schools on reservations that Native American children were forcibly sent away to, as a way to further isolate them and remove their cultural identity	Davis, 2013
Indian Civilization Act of 1824	An act passed in order to provide funds for Native Americans to be sent to formal schools. However, in reality, the Indian Civilization Act of 1824 caused long-lasting culture loss and disruption of the family structure for many who attended the boarding schools.	Peacock & Wisuri, 2002
General Allotment Act of 1887 (Dawes Act)	Act developed by the United States government that forced Native Americans to live on plots of land that they were not allowed to sell for at least twenty-five years	Kidwell & Velie, 2005

Historical Trauma	Historical trauma is a type of trauma experienced by a group of people who share similar values, beliefs, and interests. It is "cumulative emotional and psychological wounding across generations, including the life span, which emanates from massive group trauma" (Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283)	Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283; Substance Abuse Mental Health Service Administration, n.d.
Oppression	As the result of historical trauma, traumatized people may begin to internalize the views of the oppressor and perpetuate a cycle of self-hatred that manifests itself in negative behaviors. Emotions such as anger, hatred, and aggression are self-inflicted, as well as inflicted on members of one's own group. For example, self-hatred among Blacks/African Americans who act out their aggression on people who look like them.	Substance Abuse Mental Health Service Administration, n.d., p. 1
Spirituality	" A pervasive life force, source of will and self-determination, and a sense of meaning, purpose and connectedness that people experience in the context of their environment. Spirituality among Native Americans is also viewed as interconnected with health" (Canadian Association of Occupational Therapists, 1997, p. 183). Spirituality differs among Native American tribes but does have commonalities of belief in an existential power, universe elements are dependent upon and influence each other, honorable behavior, and inclusion of spiritual ceremonies or practices (Limb & Hodge, 2008).	Canadian Association of Occupational Therapists, 1997, p. 183; Limb & Hodge, 2008
Culturally relevant (interventions)	Culturally relevant interventions consist of a combination of definitions including culturally responsive teaching and cultural competence. Culturally responsive teaching is defined "as using the cultural knowledge, prior experiences, frames of reference, and performance styles of ethnically diverse students to make learning encounters more relevant to and effective for them" (Gay, 2010, p. 31). Manson and Altschul (2004) developed a cultural diversity series and wrote, "mental health systems must be aware of significant differences in lifestyle and worldview among diverse populations, while	Gay, 2010, p. 31; Manson & Altschul, 2004, p. X

	valuing and responding to the distinct needs of each client" (p. X).	
Protective factors	"Protective factors are conditions or variables capable of directly affecting adolescents and increasing the likelihood of positive health outcomes."	Henson, Sabo, Trujillo, & Teufel-Shone, 2017, p. 6
Connectedness	"The interrelated welfare of the individual, one's family, one's community, and the natural environment."	Mohatt, Fok, Burket, Henry & Allen, 2011, p. 444
Resiliency	"The ability to cope with stress; a positive capacity of an individual to responds under pressure."	Thornton & Sanchez, 2010, p. 455
Circle of Courage	A framework that focuses on four traits that foster and promote resiliency. The four traits are belonging, mastery, independence, and generosity.	Brendtro, Brokenleg, & Van Brockern, 1990; Feinstein, Driving-Hawk, and Baartman, 2009; Lee and Perales, 2005
Mental health	"Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium"	Galderisi, Heinz, Kastrup, Beezhold, & Sartorius, 2015, p. 231-232
Mental illness	"mental illnesses are health conditions involving changes in thinking, emotion or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities"	American Psychiatric Association, 2015, para. 1
Occupational therapy	Occupational therapy is a profession that utilizes everyday life activities (occupations) to enable engagement, maximize independence, and maintain health of clients They work with individuals, groups, or organizations with a variety of physical, psychosocial, or developmental needs.	American Occupational Therapy Association, 2014

Native American children & youth	A descendant or enrolled member of a Native American tribe who is under the age of 18 years old	Heisler & Safranski, 2018
Medicine wheel	A circle or hoop-shaped image depicting connections, symbols, animals, teachings, directions, or colors. Used in Native American teaching, ceremonies, and practices.	BigFoot & Schmidt, 2010
Circle of Courage – Mastery	A construct related to knowledge and success	Brendtro, et al., 1990; Feinstein, et al., 2009
Circle of Courage – Generosity	A construct involving giving to others and not being selfish	Brendtro, et al., 1990; Feinstein et al., 2009
Personal history	"A personal timeline is a graph or diagram that visualizes significant moments in a person's life." (Reference.com, 2017, para. 1). It acts like a protective factor (Henson et al., 2017).	Henson, et al., 2017; Reference.com, 2017, para. 1
Emotional health	Feelings, thoughts, and behaviors that influences well-being and mental health	Healthy Place, 2017
Affective	One component that makes up a person according to the Canadian Model of Occupational Performance and Engagement (CMOP-E). "Relating to moods, feelings, and attitudes."	Polatajko, Townsend, & Craik, 2010; "Affective", n.d.
Maladaptive coping skills	Strategies to deal with problems that may be harmful to one's health, including aggression, suppression, or passive-aggression.	Vantage Point, 2017
Relational (Relationships)	"Concerning the way in which two or more people or things are connected."	"Relational", n.d.
Social Environment	"Particular social features (i.e., social groups and occupational tasks) of the specific context in which one does something that impacts upon what one does and how it is done."	Schell, Gillen, & Scaffa, 2014, p. 1241
Interdependence	A system of people who feel connected as members of the greater whole, rather just an individual.	Kawulich (2008) in (Garrett, et al., 2014)
Physical health	Includes fitness and health via eating healthy and exercising. Considered to be the most visible of all areas of health.	"Physical health", 2018
Sensory components	Systems including sight, hearing, taste, touch, and smell that affect how information is processed	"Sensory system", 2013

Chapter II is a literature review of relevant concepts and research, as well as an exploration of a theoretical framework. The theoretical framework chosen to guide this scholarly project is the Canadian Model of Occupational Performance and Engagement (CMOP-E). Chapter III is the methodology section where the decision-making strategies and processes used to construct this scholarly project are discussed. Chapter IV is the discussion of the product developed as a result of a review of literature and the influence of theory the entire project follows. Finally, Chapter V is the summary section where strengths and weaknesses of the product, outcome measures, and future suggestions are explored.

CHAPTER II

LITERATURE REVIEW

Introduction

Culture is defined as "knowledge, beliefs, values, customs, and behaviors shared by people in a particular society" (Cockerham, 2007, p. 115). Native American culture is similar to any world culture in that it is comprised of common beliefs, values, traditions, and a rich history. Although the Native American culture shares similarities with other cultures, it has a significant difference in how the culture has been lost, and how the people continue to work to regain the culture back over time.

"Culture is a powerful tool, so it is no coincidence that colonial officials and the U.S. Government created policies that suppressed Native tribal cultures from first contact to well into the 20th century. Indians were assimilated into the dominant European 'civilization'" (PBS, n.d., ¶3). The policies were used to dismantle and oppress the Native Culture, which targeted the areas of economics, political, cultural, social, psychological, and educational contexts (PBS, n.d.).

Due to the forced assimilation, it became difficult for Native Americans to hold onto their traditions as they were forced to move to reservations. The land selected to become reservations was often desolate and lacking resources. They traditionally fed their families by hunting, fishing, and gathering fruits and vegetables they found (Peacock & Wisuri, 2002). This was not supported by the type of land the government deemed to be a reservation.

Another loss of tradition was impacted by children being forced to attend boarding schools. In these boarding schools, the children were punished if they expressed any aspect of

their Native identity (Kidwell & Velie, 2005). Their whole identity in who they were, and the definition of their culture was shifted and was forcefully lost over time for many (Davis, 2013). To understand the impact more fully, relevant events are explored regarding Native American history.

History

Native Americans have had a rich history in the United States (US) both with and without the US government's involvement. They followed the beliefs of honoring elders, women, animals, and the Creator (Peacock & Wisuri, 2002). Continuing to practice these cultural beliefs became difficult as the government became increasingly involved in Native Americans' affairs. Historical events such as the boarding school era, the assimilation era, the General Allotment Act of 1887, and the general transmission of diseases are the main events that have since left a mark on Native Americans in a way that continues to influence their mental health today. The effects can be seen in multiple levels including children, the family, and their overall health.

Children

Historical events have taken place including the passing of laws and signing of treaties, which has affected Native American people across time. The Indian Civilization Act of 1824 was passed in order to provide funds for Native Americans to be sent to formal schools (Peacock & Wisuri, 2002). However, in reality, the Indian Civilization Act of 1824 caused long-lasting culture loss and disruption of the family structure for many who attended the boarding schools (Peacock & Wisuri, 2002). Children were taken away from their parents at a critical time in their lives when they were not ready to be away. Separating children away from their families against their will and uprooting them from the only life they have ever known is referred to as historical trauma that influences mental health problems generations later as seen today. In addition to the

disruption of family ties, psychological, physical, and sexual abuse occurred at the boarding schools (Evans-Campbell, Walters, Pearson, & Campbell, 2012).

Native American children were forced to assimilate to the White culture and would be punished if caught practicing or speaking any aspect of their culture while in school (Meza, 2015). This was part of the assimilation era that enacted policies with the goal of eliminating Native language. Because language was an integral part of their ability to practice culture and spirituality, this was yet another means of eliminating out Native culture. Other effects included a lack of being able to communicate with family members or tribal elders in the traditional language, which disrupted the ability to practice their culture and language, resulting in identity loss (Peacock & Wisuri, 2002).

Family

The General Allotment Act of 1887, or the Dawes Act, forced Native Americans to live on plots of land that they were not allowed to sell for at least twenty-five years (Kidwell & Velie, 2005). The government's intent in forcing Native Americans to live on these plots of land for so long was so they could have enough time to learn how to farm well enough to be "self-sufficient" (Kidwell, & Velie, 2005, p. 67). Many were forced to farm when they were never farming people; they were previously self-sufficient as hunters and gatherers prior to European influence (Kidwell & Velie, 2005). What the Dawes Act ultimately did was uproot and separate Native Americans from their familiar way of life, and each other (Grobsmith 1981; Kidwell & Velie, 2005). Plots could be located in other states, forcing families to split up (Grobsmith, 1981). Overall, the government forcibly and completely changed their way of life.

Health

Another way that Native American's life was changed due to the arrival of Europeans, was through the transmission of diseases. Europeans who interacted with the Native Americans brought destructive diseases like small pox, which acted like a genocide to some tribes and completely eliminated them (Kidwell & Velie, 2005). For others, it greatly reduced the population size and resulted in broken trust between the tribes and the European settlers (Kidwell & Velie, 2005). They believed that they were being punished for having traded material goods and shared aspects of their culture with the settlers (Kidwell & Velie, 2005). Therefore, trust was broken, and tribes were decimated as a result of the spread of disease. While there are other relevant historical events related to Native Americans, the boarding school era, the assimilation era, the General Allotment Act of 1887, and the spread of disease by European settlers were several primary events that have contributed the most to the cultural loss, mental health problems, and historical trauma experienced by Native Americans (Grobsmith, 1981; Kidwell & Velie, 2005). Historical trauma, specifically, is influenced by historical events and continues to negatively affect Native Americans.

Historical Trauma

Historical trauma is a type of trauma experienced by a group of people who share similar values, beliefs, and interests (Substance Abuse and mental Health Service Administration, n.d.). Historical trauma is "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma" (Brave Heart, Chase, Elkins, & Altschul, 2011). It can be experienced across generations, even if the descendants never experienced the trauma first (Substance Abuse and mental Health Service Administration, n.d.).

As a result of this historical trauma, the intergenerational effects on mental health and identity are still prevalent in Native Americans today (Evans-Campbell, 2008).

Historical trauma is a concept comprised of three main steps. The first step involves a culture that takes control of another group of people via genocide, slavery, war, or colonialism (Pember, 2016). Next, being under control of the dominant culture affects the other group psychologically and physically. Finally, the trauma experienced by the first group and the ineffective coping strategies used by that group are passed on to future generations (Pember, 2016). Historical trauma can last for multiple generations, affecting physical and mental health (Evans-Campbell et al., 2012). Native Americans have had historically negative experiences with the government and have experienced a lot of mistrust for White people because of these experiences. According to Meza (2015), "[t]he United States government has attempted to accommodate, assimilate, and terminate the Indian since declaring its independence" (p. 353). The Native American people, as a whole, have a history of being oppressed (Urbaeva et al., 2017). Historical trauma occurred throughout history and in various primary components of their culture via oppression.

Spirituality

A primary area of oppression was spirituality. In 1883, practices of traditional ceremonies were banned for Native Americans (Brave Heart et al., 2011). Despite the addition of The American Indian Religious Freedom Act of 1978, some traditional burial practices are still prohibited (Brave Hart et al., 2011). The denial of traditional practices for mourning combined with the historical trauma such as genocide has impacted future generation's mental health and ability to form a positive cultural identity (Brown, Dickerson, & D'Amico, 2016).

Language and Identity

A second area of oppression is in the area of language and its necessity for cultural survival. Today, tribal leaders are struggling to maintain the culture and language of their ancestors, which endangers tribal sovereignty (Meza, 2015). This is in part due to the fact that some tribes are unable to be recognized as a tribe by either federal or state government (Limb & Hodge, 2008). Tribes that are not federally recognized do not receive the same services and access to resources as federally recognized tribes do, limiting their ability to revive their language and culture. The languages themselves are dwindling and are a crucial part of their culture (Kidwell & Velie, 2005). In addition, Meza (2015) asserts that "[p]reserving Native American culture and language will not only improve the individual Native American student's success, but culture and language preservation will also preserve tribal sovereignty" (p. 356). There are now bills and laws in place in the country that specifically state to provide "culturally relevant" schooling to Native American students in schools such as the No Child Left Behind Act, the Student Success Act, and Title VII programs (Meza, 2015).

Education

A third area of oppression is elimination of culture through education. Native American children's experiences in schools in the past have not been pleasant. Historically, many were sent to boarding schools, which were outside of the reservations (Davis, 2013). As mentioned previously, the children in boarding schools would be forced to eliminate their Native American identity including forced use of the English language (Meza, 2015). Children were also forced to cut their hair and change their name to a more English-sounding name (Meza, 2015). Because Native American culture involves so much of the Native language, much of the culture was lost

as a result of being forced to forget their Native language and assimilate to the English language.

Historical trauma has been suggested to have lasting effects at the individual, the family, and community levels (Evans-Campbell, 2008). The levels are interwoven and connected with the others. For example, parents who grew up in boarding schools were deprived of experiencing and learning about traditional parenting practices (Horejsi, Craig Heavy Runner, & Pablo, 1992). As a result, the historical trauma may contribute to the family violence among Native American families (Evans-Campbell, 2008). At the community level, the loss of traditions, values, and rites of passage have led to weakened social structures among communities with higher rates of suicide and alcoholism (Duran & Duran, 1995; Whitbeck, Adams, Hoyt, & Chen, 2004)

Historical trauma accumulates over time and takes a toll the mental health of an individual and community. Historical trauma has been linked to the mental health diagnoses of Posttraumatic Stress Disorder (PTSD) and depression (Pember, 2016). Regardless of when the historical trauma took place, it can directly affect Native Americans today. The effects can be seen throughout history from the initial implementation of reservations to current reservation life.

Reservations

The majority of Native American reservations were established as a result of the General Allotment Act of 1887 in the late eighteen-hundreds (Grobsmith, 1981; Kidwell & Velie, 2005). Plots of land were given to individual tribal members. Conditions on the reservations were poor, and Native Americans were forced to become farmers when their preferred way of life and part of their culture revolved around being hunters and gatherers (Kidwell & Velie, 2005). Farming, as a way of life, was also largely unsuccessful. They were forced to live on unlivable land that was unwanted by others (Child, 2012). Because not all Native Americans spoke English fluently,

they did not fully understand what was occurring, and they really had no choice in the matter (Child, 2012).

Today, tribal communities are working to reclaim and strengthen their Native American culture, language, and tribal lands. For example, Native American tribes are implementing language immersion programs as a way to promote Native language to current generations (McCarty, 2014). As a way to protect their tribal lands, Native Americans, along with non-Natives, participated in protests against oil pipelines to be installed on tribal lands (Schilling, 2017). Despite their efforts, pipeline construction did continue, and oil spills occurred. Native Americans still strive to fight for their rights involving their culture, language, and land.

Currently, living conditions are below average on reservations, including high levels of poverty and unemployment. Many have left reservations for employment and opportunities for security for their families. The majority of Native Americans live off of reservations in urban areas but continue to have cultural and spiritual needs ignored (Limb & Hodge, 2008). Although reservation life did not align with Native Americans' values and beliefs, they were still able to hold onto some aspects of their culture.

Common Beliefs and Values

Some of the common beliefs and values relevant to Native Americans today include the importance of independence and interdependence, the value of the earth, health and wellness, and spirituality (Densmore, 1979; Kidwell & Velie, 2005). Family, in Native American culture, involves both the immediate and extended family as well as the community (Urbaeva, et al., 2017). One traditional norm is that children will receive a lot of independence because parents want their child to make their own decisions and have to live with the consequences (Urbaeva et al., 2017). Interdependence is also a key component of Native American family culture. The

group is more important than the individual, and there is a sense of responsibility when it comes to taking care of the whole family unit (Urbaeva et al., 2017).

Another belief is that the earth and land are treated as sacred (Peacock & Wisuri, 2002). Native Americans saw how plants grew from the earth, which gave them food, and that when animals died, they fell to the ground, which is why they felt a strong connection to the earth and treated it with care. They did not own the land; they felt no one could own it. They would travel across the land to use what they needed when they needed it and then would move on to the next place. The concept of owning land did not make sense to them. Therefore, when the General Allotment Act of 1887 was passed, and they were forced to live on parcels of land they "owned" to farm it, they did not understand or appreciate it, as the government anticipated they would (Peacock & Wisuri, 2002).

Health and Wellness

Health and wellness were important to Native Americans. They ate healthy foods they found or hunted; however, the influence of the federal government giving them rations of food they were not used to eating resulted in difficulty processing the new foods (Peacock & Wisuri, 2002). As a result, health problems developed and are still a present issue. Diabetes is one specific health problem that is commonly found in Native American populations. In addition, traditional foods such as fry bread or wild rice hot dish are typically found to be high in fat. Eating foods high in fat can result in high cholesterol, heart disease, and obesity.

Health is believed to be an interwoven concept of harmony between the mind, body, and spirit (Limb & Hodge, 2008). The disturbance of one area will inevitably affect the others. For instance, if people harbor feelings of ill-will towards others, the chances of contracting an illness is likely (Peacock & Wisuri, 2002). Thus, illness is viewed differently than typical Western

thoughts are the thoughts are that illness is the product of a problem that needs to be fixed. Instead, illness is a combination of an imbalance between the mind, body, and spirit (Limb & Hodge, 2008).

Spirituality is a critical component of Native Americans' lives, and leaving it out of interventions or assessments is a hindrance to their progress. Not addressing all these areas may have a direct influence on the challenges they face today. Limb & Hodge (2011) discuss the importance of keeping spirituality in therapy sessions with Native American children. In addition, Pember (2016) wrote, "[i]f clinical mental health interventions are to be successful among Native peoples, the therapy must be tied to its spiritual root" (p. 7). Therefore, spirituality needs to be considered when working with Native Americans in any setting that addresses health and wellness.

Mental Health Services

Typically, Western interventions revolve around the physical, emotional, or biological issues that people experience, and not the spiritual (Peacock & Wisuri, 2002). They assume that medical providers will attempt to make them adopt Western therapy techniques instead of working with them to utilize their culture and spirituality (Gerlach, 2008). This can result in mistrust with mental health providers. Due to this, some Native American families are unlikely to seek out mental health services for their children or themselves (American Psychiatric Association, 2010). There are resources available specifically to Native Americans, such as Indian Health Services, that incorporate cultural components (BigFoot, Willman-Haque, & Braden, 2008; Dorgan et al., 2014).

Some reservations have an Indian Health Services clinic where mental health providers, like psychologists, are available (U.S. Department of Health and Human Services, 2018). Native

Americans can go to the clinic to see a mental health provider to address their mental health problems on an outpatient basis. Approximately 82 percent of Indian Health Services clinics had mental health providers; however, the specific type of mental health services may not be available (U.S. Department of Health and Human Services, 2011). Additionally, not every reservation has a clinic, therefore, not every reservation has access to a mental health provider (Horwitz, 2014). While there are individuals on reservations that have positive coping skills such as seeking out mental health providers at Indian Health Services, these services are not guaranteed.

Common Mental Health Problems

As a result of historical events, political laws and acts, and social factors like oppression and racism, Native Americans have a plethora of issues to address. Oppression, racism, and self-hate are some of the many current issues that Native Americans face, often on a daily basis (Peacock & Wisuri, 2002). This can take a toll mentally and emotionally. Native Americans can experience "feelings of isolation, exclusion, and frustration that contribute to…high rates of alcoholism and substance abuse, crime, suicide, poverty, and unemployment" (Theriot & Parker, 2007, p. 87). Additionally, experiencing trauma as a child can increase chances of experiencing "addiction, depression, intimate partner violence, suicide, diabetes, liver disease, poor fetal health" and others in the future (Pember, 2016, p. 6). Therefore, there are still ongoing mental health problems because of what has taken place historically and in how Native Americans are treated and viewed by society today.

Native Americans "have the highest rates of mental health disorders in the United States" (Evans-Campbell et al., 2012, p. 421). Negative self-esteem is another contributor to mental health problems. Internalized oppression means believing in being inferior to another group long

enough to develop a negative self-image (Peacock & Wisuri, 2002). It can make Native Americans feel hopeless and helpless if they accept this as being true. As a way to cope with this internalized oppression, many Native Americans have turned to drug abuse, suicide, and alcohol abuse (Peacock & Wisuri, 2002). Common mental health problems discussed in this section are trauma, substance use, depression, and suicide.

Trauma

Trauma is one common mental health problem experienced in Native American populations. Native youth are 2.5 times more likely to experience a traumatic event than non-Native children (BigFoot, et al., 2008). One study that surveyed two reservations found that 57% of adolescents ages 15-24 reported at least one traumatic event occurred throughout their lifetime. Traumatic events include rape, sexual assault, violent crime, and domestic violence to name a few (Horwitz, 2014). The most common traumatic events reported were threat of injury and witnessing an injury (Deters, Novins, Fickenscher, & Beals, 2006). Sexual abuse was the least common traumatic event reported but has the highest rates of Post-Traumatic Stress Disorder (PTSD) symptomology (Deters et al., 2006).

In addition, traumatic events with trauma symptoms was more prevalent in Native American youth who were in a residential substance abuse recovery program. A study completed by Deters, Novins, Fickenscher, and Beals (2006), found that an average of 4.1 traumatic events were reported among the Native American adolescents in the program. Trauma among Native Americans is not limited to youth. One study completed by Manson, Beals, Klein, Croy, and the AI-SUPERPFP TEAM, (2005) had a sample from two large Native American tribes with ages spanning from 15-57 and found that 62.4% to 69.8% of respondents indicated they experienced a form of a traumatic event.

Experiencing trauma can lead to a potential diagnosis of post-traumatic stress disorder if the DSM-V criteria are met (American Psychiatric Association, 2013). Approximately 22-25% of American Indian juveniles experience PTSD (The Denver Post, 2016; Dorgan et al., 2014). Compared to the general adult population, Native American adults tend to have high rates of post-traumatic stress disorder (Evans-Campbell et al., 2012). Approximately twice as many Native American adults develop PTSD compared to the general population (American Psychiatric Association, 2009). These rates of PTSD are approximately three times higher than the national average and are the same as war veterans who have returned from the Middle East (The Denver Post, 2016; Dorgan et al., 2014).

Due to the complex historical trauma that Native Americans experience, it is likely that the numbers of those with PTSD is actually greater (Evans-Campbell et al., 2012; Pember, 2016; Substance Abuse and Mental Health Administration, 2014). Another explanation is that the criteria for PTSD does not encompass the effects and components of historical trauma (Goodkind, LaNoue, Lee, Freeland, Freund, 2012). The combination of unresolved historical trauma, and exposure to traumatic events is linked to increased substance use and behavioral disorders in Native American youth (Goodkind et al., 2012).

Substance Use

Substance use is another mental-health related issue that is prevalent in Native American children. They are the ethnic youth group with the highest rates of substance and alcohol use (Evans-Campbell et al., 2012). Substances typically used by Native American youth include marijuana (7.1%), cigarettes (4.8%), alcohol binge drinking (3%), and illicit drugs (8.3%) (Substance Abuse and Mental Health Services Administration, 2017). Alcohol use, specifically, stems from the historical trauma experienced by previous generations, providing an explanation

as to why Native American adolescents tend to use alcohol at an earlier age than non-Native adolescents (Substance Abuse and Mental Health Services Administration, 2014; Urbaeva et al., 2017).

Communicating about norms and alcohol use can affect alcohol use in adolescents. Parental involvement or lack thereof, can influence the extent to which adolescents use substances (Urbaeva et al., 2017). Trying to cope with these issues when faced with poverty and limited access to resources makes it difficult to use and develop healthy coping skills. Feeling hopeless and stuck in the cycle of poverty also affect Native Americans' mental health and can lead them to using maladaptive coping skills such as alcohol and substance use (Brockie et al., 2015). Obtaining alcohol and substances is easy as they are typically readily available. Being exposed to this at a young age can also have a lasting impact if left unaddressed. Native American youth may feel ill equipped to confront these issues, especially if the adults in their family have poor coping skills. When these poor coping skills are modeled by adult role models in their life, it is difficult to break the cycle.

The opioid epidemic is a specific substance use issue affecting Native American communities at a staggering rate. Native Americans and non-Hispanic whites had the highest rates of opioid overdose (Rudd, 2017). As a response, Indian Health Services appointed the National Committee on Heroin, Opioids, and Pain Efforts (Rudd, 2017). This committee was developed in order to improve accessibility to substance use treatment options that align with Native American culture, promote effective and appropriate pain management options, and decrease opioid deaths (Rudd, 2017). Programs and policies are being developed to combat the opioid epidemic that is taking over Native American communities.

Generally, substance use acts as a maladaptive, self-medicating coping skill that is passed down through generations (Urbaeva et al., 2017). It is likely for Native American youth to be exposed to using substances as a coping strategy, if it is a coping strategy used by peers or family members around them (Urbaeva et al., 2017). It is suggested that they are self-medicating because this is a strategy used by those around them who are dealing with the effects of historical trauma with limited access to healthier options (Horwitz, 2014). Additionally, Native American youth and adolescents did not perceive substances to be harmful to use, explaining why many of them would engage in substance use (Substance Abuse and Mental Health Services Administration, 2017). Boredom and unstructured time are common experiences among Native American youth on reservations, contributing to the reasons why Native American youth would use substances (Heavyrunner-Rioux & Hollist, 2010). Due to the lack of positive coping strategies modeled to some Native American youth, it is important to intervene early, such as in schools to incorporate healthy coping skills and strategies to build resiliency (Henson et al., 2017). Such healthy coping skills and strategies should be built upon protective factors, which are explored in depth later in the literature review.

Depression

Depression is a common mental health problem experienced by Native American children. In 2013, the rate of depression in Native American youth was approximately 39 percent, which was the highest among Latinos, African Americans, non-Hispanic white, and Asian populations (Mays, 2015). This number has increased since 2001 when the prevalence of Native American children with depression was 36 percent (Forrest, Leeds, Williams, & Lin, 2001). Even in 2001, Native American children had the highest rates of depression when compared to other ethnicities (Forrest et al., 2001). For adolescents, the rate of depression is also

the highest among other races at 13 percent (Urban Indian Health Institute, 2012). The rates of Native American children developing depression has increased over time, which can be explained by exploring related risk factors.

The risk factors associated with developing depression include substance use, feeling isolated, low socioeconomic status, experiencing discrimination, experiencing family violence or trauma, and experiencing complex trauma, (Mays, 2015). When children or adolescents are diagnosed with depression and it is left untreated or is only partially treated, the chances of developing chronic and recurrent adult depression increases (Mays, 2015). If untreated, then the chance of death by suicide also increases. Untreated depression is the highest risk factor causing Native American youth to die by suicide (Mays, 2015). There is a link between depression and suicide in Native American youth.

Suicide

Suicide is complex and is, unfortunately, a prevalent issue experienced by Native American children. Death by suicide occurs as a result of a variety of factors including mental health problems, such as depression, and substance use (U.S. Department of Health and Human Services, 2010). Suicide is the second leading cause of death among Native Americans from ages 10-34 (Centers for Disease Control and Prevention, 2015). The suicide rates for Native Americans is one and a half times higher than the general population (Center for Disease Control and Prevention, 2015). While there are many Native Americans that live in urban areas, the ones who live in rural areas have a higher risk for suicide due to isolation, low socioeconomic status, and lack of resources (Gray & McCullagh, 2014).

Several risk factors are incorporated into the high suicide rates for Native Americans. Risk factors for suicide, identified by Gray and McCullagh (2014), include: alcohol/substance

abuse, bullying, gang involvement, gun availability, mental health problems, history of abuse, socioeconomic factors (poverty and low educational resources), and experiencing suicide from family/friends. Historical trauma, feeling isolated, chronic illness, impulsivity, and family history of mental health problems are other risk factors contributing to suicide (U.S. Department of Health and Human Services, 2010). Risk factors are interrelated and cumulative; the greater the risk factors, the greater the chances are of dying by suicide (U.S. Department of Health and Human Services, 2010). One theory as to why suicide rates are so high in Native Americans, is due to the loss of cultural identity and loss of community (Gray & McCullagh, 2014; U.S. Department of Health and Human Services, 2010). These two issues are related to the historical trauma that occurred generations ago, and yet are still causing issues in today's Native American children.

The common mental health problems experienced by Native American children include trauma, substance use, depression, and suicide (Theriot & Parker, 2007; Pember, 2016). While some mental health problems have occurred for generations, new ones like opioid use are on the rise (Rudd, 2017). Each mental health problem can be linked to a variety of risk factors, indicating specific areas that need to be addressed. Native American children also have other, general areas of need apart from their mental health needs.

General Needs of Children

Native American children tend to have general areas of need that affect their physical, psychological, and socio-emotional health. In order to better understand the importance of having basic needs met, a humanistic learning theory needs to be explored (Braungart, Braungart, & Gramet, 2011). Maslow's hierarchy of needs is a humanistic learning theory designed to explain the connection between motivation and learning (Braungart al., 2011).

Maslow's hierarchy of needs is separated into five categories. The foundation includes having basic, physiological needs met such as food, sleep, and shelter (Braungart al., 2011). The next level is safety, which includes a sense of security regarding health, family, and general resources (Braungart al., 2011). The third level is about feeling a sense of belonging and love (Braungart al., 2011). People want to experience this with their friends, family, or other loved ones. The fourth level is about esteem, respecting one's self, respecting others, and feeling confident (Braungart al., 2011). The fifth and final level is self-actualization, where people are able to problem-solve, accept others without judgement, be creative, and be moral when making decisions (Braungart al., 2011). People are able to move through the hierarchy levels when they meet the needs of each level. Mental health, physical health, and other life situations can impact whether people move up or down the hierarchy.

When basic life needs of the foundational level of Maslow's hierarchy of needs are unmet, they are unable to learn and move through the levels of the hierarchy (Braungart al., 2011). Native American youth who are living in poverty may experience inconsistent meals and a lack of adequate sleep. Following Maslow's hierarchy of needs, if these children's basic needs are unmet, they are unlikely to reach the levels of safety, belonging and love, esteem, and self-actualization (Braungart al., 2011). Learning becomes difficult when children are unable to surpass the foundational level. While there are exceptions to this theory and a lack of reliable and valid research in support of its claims, Maslow's hierarchy of needs provides a visual to help explain why children may not be able to learn all that is required to meet their educational standards (Braungart al., 2011).

Educational Needs

Historically, when European settlers arrived, the purpose of educating Native American children was to rid them of their culture and language and force them to assimilate to European ways (Meza, 2015). Native American children who were sent to boarding schools typically had traumatic experiences (Meza, 2015). They were physically punished in schools if they spoke their Native language, resulting in psychological and emotional damage (Davis, 2013; Meza, 2015). The impact of this trauma spans across generations, affecting the school performance of Native American youth today.

Academic wise, Native Americans have several factors to overcome in traditional schooling systems. One issue that Native Americans face is the low graduation and dropout rates. Native American students are more likely to drop out of school than White students (Thornton & Sanchez, 2010). Schools are required to support multicultural competence, but current approaches are inadequate to address the needs of specific cultural groups (Robinson- Zañartu, Butler-Byrd, Cook-Morales, Dauphinais, Charley, & Bonner, 2011). This can be attributed to lack of resources, and inadequate training or preparedness of school staff to address multicultural needs (Robinson-Zañartu et al., 2011).

Programs exist whose aim is to help better the lives of Native American youth, and one example is the Bureau of Indian Education (BIE). The BIE aims to ensure that children are given access to education that considers both the economic and cultural needs of the tribe (bie.edu, 2017). Some of their programs include the Sovereignty in Indian Education Enhancement Program, the Tribal Education Department Grant Program, and the Family and Child Education program (bie.edu, 2017). These programs are designed to provide tribal BIE schools with resources they need and to ensure that children are getting their educational needs met.

Approximately 8% of Native American students attend a school that is funded by the BIE (Faircloth & Tippeconnic, 2010). The BIE funds 184 schools on 63 reservations in 23 different states throughout the US, including Midwest states of Minnesota, North Dakota, South Dakota, Iowa, Montana, and Michigan (Freeman & Fox, 2005). However, they are not all meeting the expectations for cultural and educational needs. Areas of improvement in the BIE include increasing resources, ensuring that schools are up to health codes, and improving the low graduation rates (Santhanam, 2016). Given that schools, funded or operated by the BIE, are often based in rural areas, the lack of resources may be correlated to rural areas (Faircloth & Tippeconnic, 2010). While there are several tribal schools throughout the US, there are still Native American students who attend non-tribal schools to receive their education. It is estimated that 46% of Native Americans who attend non-tribal schools, go to rural schools, which is more than non-Native American students (Faircloth & Tippeconnic, 2010).

Meza (2015) states that the overall performance of Native American children in schools is significantly lower than the rest of the students. Native Americans tend to have lower reading and math skills, resulting in lower test scores in these areas (Meza, 2015). For example, eighty-one percent will commonly read at a grade level below their actual grade level (Meza, 2015). Approximately half will graduate from high school, and they are the "least likely ethnic group to attend college" (Meza, 2015, p. 360). Overall, Native American youth are at risk for poor performance in school and low graduation rates (Meza, 2015). These risk factors can result in mental health issues. Due to this, it is important to examine what interventions are currently in place within the school system.

The combination of the effects of historical trauma and mental illness risk factors affects school performance. For example, historical trauma from boarding schools, caused a loss of

cultural education needs (Davis, 2013). Loss of culture, and historical trauma has led to increased substance use and other mental health disorders (Brave Hart et al., 2011). A lack of mental health services in rural areas where Native Americans live provides an opportunity for prevention-based interventions to be implemented in schools. Therefore, schools are appropriate settings to provide culturally relevant interventions regarding the mental health and educational needs of Native American youth.

Current Practices Used in Schools to Address Mental Health

There are three tiers in school systems to determine the level of assistance students need in terms of interventions to aid in their learning (National Center for Learning Disabilities, 2018). Tier I interventions are designed to provide additional supports to students in the classroom so that they do not have to go to another classroom. An eight-week program is the average amount of time students will spend in Tier I before checking their progress and determining if they need additional or fewer supports. If this is the case, then students who continue to struggle after receiving Tier I services can then be placed in Tier II services.

Tier II included targeted interventions where students will leave the general classroom to receive services in a small group. Again, after a grading period the students' progress will be checked to determine if more services are needed. If so, then a Tier III intervention would be the next step.

Tier III interventions are designed to provide intensive, individualized interventions. If students are not making desired progress after receiving Tier III interventions, then a special education evaluation and referral are recommended. (National Center for Learning Disabilities, 2018). Traditional school systems have failed to incorporate the cultural needs for students and

has resulted in an over-representation of Native American youth in the special education system (National Center for Education Statistics, 2008).

In 2006, 14% of Native American students had special education services, higher than any other racial group (National Center for Education Statistics, 2008). While this is typically a good thing, Native American students are more likely to be over-represented in the special education system than non-Native American students (Robinson-Zañartu et al., 2011). Native American students are especially more likely to be under special education services or identified as having a disability in schools that have less than 25% Native American students (Robinson-Zañartu et al., 2011). With the combination of lack of resources, unmet multicultural needs, and over-representation in special education there needs to be more emphasis on multicultural curriculums (Robinson-Zañartu et al., 2011). Interventions need to cater to the cultural needs of the population, and there are some examples of such intervention programs.

Interventions

As stated previously, the Tier system is used in schools to delineate the need for intervention services ranging from Tier I universal services to Tier III of specific targeted interventions (National Center for Learning Disabilities, 2018). A variety of interventions have been used to address mental health specifically for adolescents and young adults. There are benefits and drawbacks to each of them, with one particular benefit being that there is evidence that there is a need for culturally relevant interventions.

Culturally relevant. Brockie et al. (2015) suggested that future interventions should be culturally relevant, meaning they address or include the values and beliefs of the target population. This notion would pertain to interventions for any cultural group; however, it suggests looking at the specific values and beliefs to add meaning to the activities. In addition,

motivation would increase for the clients if the intervention related to values, beliefs, or spirituality. Values such as honoring elders, being peaceful in both mind and spirit, honoring and learning from animals, speaking Native language, and being kind and generous can be included (Peacock & Wisuri, 2002).

One example of using cultural values in addressing specific issues was identified by Urbaeva et al. (2017). It involved using the relationship between the culture and being able to socialize with family in helping prevent alcohol use (Urbaeva et al., 2017). Another example is a school in Utah was able to implement the Title VII Indian Education program, which included having students participate in traditional dances and songs related to their culture (Meza, 2015). The graduation rate grew from thirty-seven to ninety-two percent after four years of implementing the program. This indicates that including students' culture can have a positive impact on their success in educational settings.

Using culturally relevant methods, DeMars (1992) developed a culturally relevant occupational therapy life skills curriculum for Native American youth. In the process of creating a culturally relevant program, developing a strong rapport with tribal elders through therapeutic use of self and psychosocial interviewing skills helped facilitate a collaborative process, which was essential for the success of the program (DeMars, 1992). One of the components of the program was incorporating history classes to foster pride in the culture and overcome the effects of historical trauma and lack of cultural identity.

Prevention. There is a need for more prevention interventions for Native American youth. Prevention programs can be classified as either Tier I or Tier II interventions. As Tier II focuses on identifying risks early on, it could help prevent and address issues before they get out of hand. One common topic for prevention-based programs is alcohol prevention programs that

are implemented in schools. In elementary schools, the goal of alcohol prevention programs is to target risk factors such as early aggression that could develop into alcohol use later in life (Stigler et al., 2011). Given that Native American youth have higher rates of substance use, alcohol prevention programs in schools is a possible solution to reduce the rates of substance use.

Another way to implement prevention programs is through after school programs. Providing children with structured activities after school is a protective factor against suicide as well as promoting positive academic performance (Henson et al., 2016). Protective factors are explored later in the paper. An example of a successful after-school program is the Pyramid Club developed by Ohl, Mitchell, Cassidy, and Fox (2008). This study was not implemented with Native American populations, however did target similar issues facing Native American youth. The Pyramid Club targeted elementary school-aged children who had poor socio-emotional health and found a positive improvement in the social-emotional health of the at-risk children (Ohl et al., 2008).

Prevention interventions also have successful outcomes when both the children and the families are targeted. Family interventions can be implemented in a variety of settings such as in conjunction with schools, and at home. Urbaeva et al. (2017) identified that involving the family in school settings can help prevent substance use. Having the school coordinate with the family to communicate with the adolescent about the dangers of alcohol is shown to impact the adolescent's substance use (Urbaeva et al., 2017). An intervention suggestion to implement at home from Urbaeva et al. (2017) was to apply parent monitoring, where parents become increasingly involved in the adolescent's life. Doing so would decrease the likelihood of the adolescents engaging in substance use behaviors (Urbaeva et al., 2017).

Currently, there are intervention programs implemented to address mental health in adolescents and young adults as an intensive method (Tier III); however, there is still a lack of interventions to address the mental health needs of the at-risk children (Tier II) (Gerlach, 2008; Urbaeva et al., 2017). There have been prevention-based programs that target alcohol use and social-emotional health, but there is room for more prevention services to be expanded into other areas as well (Ohl et al., 2008, Stigler et al., 2011; Urbaeva et al., 2017). Research indicates, for prevention interventions to be successful with Native American youth, interventions need to be culturally relevant, and inclusive of parents and guardians (Brockie et al., 2015; DeMars 1992; Urbaeva et al., 2017). Future interventions addressing mental health can be enhanced if protective factors are incorporated, which is explored in the next section.

Protective Factors

While it is true that Native Americans have obstacles to overcome such as historical trauma, resulting mental health issues, and lack of academic resources, Native Americans have shown an incredible ability to overcome obstacles. In fact, Native American's are arguably better suited for overcoming obstacles than any other race. One of the reasons for this is protective factors. According to Henson, Sabo, Trujillo, and Teufel-Shone (2017), "protective factors are conditions or variables capable of directly affecting adolescents and increasing the likelihood of positive health outcomes" (p. 6). A combination of protective factors helps to develop healthy behaviors to overcome risk factors and adversity (Henson et al., 2017). Native Americans have experienced adversity and have several risk factors for negative health outcomes. However, they also have protective factors that should be acknowledged and built upon to foster healthy behaviors and increase positive health outcomes. Two large protective factors within the Native American culture include connectedness, and resilience.

Connectedness. Connectedness is a protective factor among Native Americans that is achieved through the individual feeling connected to family, community, and the natural environment (Mohatt, Fok, Burket, Henry & Allen, 2011). The idea of connectedness, like sense of wellness, is important to understand for Native American culture. Connectedness has shown to be a protective factor against substance abuse and suicide, which are two important topics to address in Native American populations (Mohatt et al., 2011). With Native American youth being one and a half times more likely to attempt suicide than the national average (Centers for Disease Control and Prevention, 2015), as well as earlier ages and more often substance use (Heavyrunner-Rioux & Hollist, 2010), protective factors need to be utilized more often when developing programs to address these issues.

According to Garrett et al. (2014), developing culturally sensitive programs to promote Native American youth development is supported for reducing health disparities and promoting resilience. As mentioned previously, Native Americans have a history of trauma, high rates of low socioeconomic status, and poverty (Theriot & Parker, 2007). These factors add up to the definition of at-risk youth (Thornton & Sanchez, 2010). With at-risk youth, promoting resilience is an important factor that allows for at-risk youth to respond to negative life circumstances or events in a positive way (Thornton & Sanchez, 2010).

Resilience. Resilience is an important factor for Native Americans and is considered another protective factor that should be emphasized when working with Native Americans, along with connectedness (Mohatt et al., 2011; Thornton & Sanchez, 2010). The American Psychiatric Association has developed a list of successful ways to promote resiliency including accepting change as a part of life, completing self-care tasks, having hope, having a positive outlook, keep crises in perspective, building social circles, and involving spirituality (Pember, 2016). In

addition, resilience is often fostered to Native American youth through the school system, as it can provide a structured intervention readily available to at-risk youth (Thornton & Sanchez, 2010).

Thornton and Sanchez (2010) suggested that resilience can be learned. With that in mind, it is important that programs targeting resilience in at-risk youth require training for teachers and school stakeholders on how to incorporate and promote resilience in students (Thornton & Sanchez, 2010). While resiliency can have individual personality factors, it can also be shaped by educators in the school system (Thornton & Sanchez, 2010). One study wrote about the components of interventions that promote resiliency and found that programs for resiliency should include developing long-term processes that focusing on a child's strengths (Thornton & Sanchez, 2010). Recognizing the strengths of Native Americans versus focusing on the deficits is crucial to developing a program to achieve positive outcomes (Garrett et al., 2010).

The Circle of Courage is a model of positive youth development that focused on four traits that foster resiliency (Brendtro, et al., 1990). It was developed by Brendtro, Brokenleg, & Van Bockern (1990) to combine tribal cultural wisdom and clinical knowledge of working with Native American populations. The four traits of the Circle of Courage are belonging, mastery, independence, and generosity. The four terms are defined by Feinstein, Driving-Hawk, and Baartman (2009):

> "A sense of belonging is established when students form relationships within family, school, and community. Independence is developed as students turn from irresponsible behavior to responsible behavior. Mastery is cultivated in experiences that facilitate success and knowledge. Key components in promoting a sense of mastery are active learning, cooperative learning groups, and stress-free, fun surroundings. A spirit of

> generosity is based in unselfish and giving behavior. Students are encouraged to see the world through others' eyes, enhancing their ability to be empathetic, ultimately leading to altruistic behavior" (p. 13).

According to Lee and Perales (2005), programs that use the Circle of Courage framework's four values can lead to positive benefits for youth and increase successes for youth. Other protective factors that promote resiliency include academic achievement, opportunity for valuable education and future careers, participation in extra-curricular activities, and family support of school participation (Feinstein et al., 2009). Suggestions for future school programs to promote resiliency include having goal setting for education and careers, encouraging extra-curricular involvement, support from teachers and parents on student's emotional and social needs, and building in Native American pride for culture in the curriculum (Feinstein et al., 2009).

Other general protective factors were found exploring the literature. A literature review completed by Henson et al. (2017), found 18 studies that identified protective factors among Native Americans. The authors grouped the protective factors identified into five groups: Individual, relationship, community, socio-ecological, and multi-level protective factors (Henson et al., 2017). In addition, identified protective factors for a specific health or social outcome for Native American adolescents from 10-21 years old were put together. Relevant protective factors focusing on academic success, and mental health factors (depression, emotional health, and suicide attempts) include themes of high self-esteem, family support, participation in extracurricular activities, adult/tribal caring and support, religiosity (spirituality), identifying personal strengths, and positive feelings about school (Henson et al., 2017).

Summary

To summarize, the mental health needs of Native American children are complex, rooted in the historical trauma associated with boarding schools and various government acts. Although they may not have experienced it firsthand, they are still able to experience the negative side effects as they are passed down through the generations. These include mental health problems such as trauma, substance use, depression, and suicide. Current intervention programs have noted the importance of including culturally relevant practices when working with Native Americans. Including their specific values, beliefs, language, and family will be beneficial in adding to the protective factors and resiliency Native American children desperately need.

Even though many of today's Native American youth did not experience boarding schools firsthand, their parents and grandparents did (Horwitz, 2014). The adults in their lives who went to boarding schools are dealing with the historical trauma and various mental health problems associated with that specific, negative experience (Davis, 2014; Kidwell & Velie, 2005). Many may have turned to maladaptive coping skills, such as substance use, because of a lack of mental health services in the rural areas they typically live in (Substance Abuse and Mental Health Services Administration, 2014; Urbaeva et al., 2017). Since it is common for Native American youth to live with or be close to their parents and grandparents they may be exposed to these maladaptive coping skills. Living with adults with mental illness can result in a lack of having their basic needs met, making it difficult to be ready to learn (Braungart et al., 2011). In addition, there is a common finding of mistrust between Native Americans and the U.S. government as a result of broken promises for education, health care, and housing (Horwitz, 2014). This sense of mistrust can also be passed on to the next generation and can affect their performance in school and can lead to mental health problems. It is appropriate for these mental

health problems to be addressed in schools. A profession that works within mental health, schools, teaches coping skills, uses cultural competency, and works along the Tier continuum, is occupational therapy. Occupational therapists do possess the skills to provide interventions that promote mental health and wellness, and with these resources they can provide increased culturally relevant interventions to Native American children.

The Role of Occupational Therapy in Mental Health

Mental health is one area of health and wellness addressed by occupational therapists. Occupational therapy's roots are in mental health as that is where the profession began a century ago. The American Occupational Therapy Association [AOTA] (2016) provides information on how the three-tier system works in the school system. An occupational therapy practitioner in the schools can utilize the response to intervention tiered system to support academic achievement and social participation within individuals, groups, and the whole classroom or school (AOTA, 2016). Tier II programs, which target the at-risk students, have been found to have high efficiency and rapid response in both academic and behavioral system results (AOTA, 2016).

In addition, there is evidence to support specific occupational therapy methods in schools along the three tiers of intervention. One systematic review found that for tier one, occupational therapy practitioners are able to incorporate occupation-based and activity-based interventions that focus on developing social-emotional learning, and social skills to reduce problem behaviors (Arbesman, Bazyk, & Nochajski, 2013). Occupational therapy practitioners are also well suited for developing after-school art programs for children and adolescents from low socioeconomic backgrounds due to their knowledge in play, leisure, activity analysis, group dynamics, program development (AOTA, 2014; Arbesman et al., 2013). The after-school art programs led to an increase in academic achievement (Arbesman et al., 2013). As mentioned previously, academic

achievement, and extracurricular activities were considered indicators of resiliency, a protective factor (Feinstein et al., 2009). Therefore, occupational therapy practitioners would be a valuable asset in the development of school programs to promote mental health in Native Americans.

Occupational therapists are prepared to address mental health with clients based on academic preparation established by the Accreditation Council or Occupational Therapy Education (ACOTE) standards for accredited programs. Included in these accreditation standards is to be able to plan and implement interventions that address the cognitive, and psychosocial aspects that interfere with well-being and quality of life (AOTA, 2012). Occupational therapists must also be able to understand issues related to diversity and utilize the latest evidenced-based research (AOTA, 2012). Occupational therapists are trained to examine how a client's mind, body, and spirit affect the ability to participate in daily tasks (AOTA, 2014). Health and well-being are two terms that occupational therapists strive to maximize for their clients when engaging in everyday activities (AOTA, 2014). Mental health and mental well-being are recognized as a part of each of those terms.

Occupational therapists use a practice framework which defines each aspect of the practice in detail (AOTA, 2014). The Occupational Therapy Practice Framework discusses the aspects of the client that occupational therapists examine in order to best help them and provide the best care, regardless of their diagnosis. Terminology that describes the occupational therapy focus include client factors, process skills, and performance patterns. Client factors are a construct occupational therapists use to examine a client's values, beliefs, and spirituality and how they can impact occupational engagement and performance (AOTA, 2014). Categories of client factors include specific mental functions (memory, emotions, perception, attention, etc.) and global mental functions (orientation, temperament, and personality, etc.) (AOTA, 2014).

Process skills are a subcategory of performance skills, which include chooses, attends, handles, continues, adjusts, and navigates to name a few (AOTA, 2014). These process skills are important when examining how a client performs a daily task or activity in terms of what they may be doing well and what may be causing them to struggle. Performance patterns are another way of examining how clients perform their meaningful, daily tasks. These include habits, routines, rituals, and roles (AOTA, 2014). Depending on what mental health problems may be occurring, the client may struggle to perform daily tasks, and all of these terms can help occupational therapists pinpoint areas of improvement and strength areas. Therefore, occupational therapy practitioners would be a valuable asset in the development of school programs to promote mental health in Native Americans.

Product

The purpose of this scholarly project was to develop a preventative, culturally relevant program for Native American children to promote positive mental health and wellness. It is designed to be implemented by occupational therapists. While there are many Native American people across the country, the focus of this project will be on the tribes located in the upper Midwest. Thus, it is important to note, the results of this scholarly project may not suit the specific needs of all Native American youth (Gerlach, 2008). Potential factors that may influence the application of the product include time, population, resources, availability of occupational therapists, and funding.

Theory/Model of Practice

The Canadian Model of Performance and Engagement (CMOP-E) is the model that best fits with the purpose of this project. It involves three core concepts of the person, the environment, and occupation (Polatajko, Townsend, & Craik, 2010). The person consists of

spirituality, physical, affective, and cognitive components. The environment consists of physical, cultural, social, and institutional components. The occupation is broken into three areas of self-care, leisure, and productivity.

At the core of this model is occupation, the meaningful activities people do in their daily lives. In addition to those three concepts is the idea of engagement, both having and performing in occupations (Polatajko et al., 2010). Spirituality is a component of the person that is experienced via occupations (Polatajko et al., 2010). In the CMOP-E, spirituality can include religion; however, it can involve other aspects as well. For instance, a sense of purpose and motivation are drawn from spirituality and they add to who a person is (Polatajko et al., 2010).

Previous articles have been written on the use of the CMOP-E model with children and adolescents with an emphasis on mental health and spirituality. Hall, McKinstry, and Hyett (2016) discussed the use of the CMOP-E model in their article, which explored the perceptions of youth regarding positive mental health. Through the lens of this model, occupational therapists suggest that "positive mental health is the product of meaningful engagement in occupation within a supportive environment which promotes personal development, skill acquisition, goal attainment and socialization" (Hall et al., 2016, p. 475). The three concepts of the model, person, occupation, and environment, are used via the CMOP-E to organize findings and expand on how positive mental health is viewed. In addition, Hall et al. (2016) found that positive mental health was attainable when engaging in meaningful leisure occupations as they were a way to relieve stress, express one's self, and interact with peers. Developing social relationships with both family and friends acted as a coping skill to decrease hopelessness and increase resiliency (Hall et al., 2016).

The result of this scholarly project is a culturally relevant guide for occupational therapists to promote the positive mental health of Native American children in school: *The S.P.I.R.I.T. Program*. The program will provide Native American students with skills and strategies based on their cultural values, beliefs, spirituality, and ultimately more meaning than other available programs. Fortunately, spirituality is a concept that occupational therapists are able to include in their interventions when working with clients. Addressing mental health with school-aged children is within the occupational therapy scope of practice (Mahaffey, 2016). The following is the table of contents for the Chapter IV product section of this scholarly project.

Chapter IV is an introduction of the product, how to use, and its intended purpose. It also includes a full copy of the program designed for this scholarly project.

CHAPTER III

METHODOLIGY

The topic for this scholarly project evolved through an interest in school-based occupational therapy. Originally, the authors were interested in creating a Tier I or Tier II school program for elementary school aged children. It was later decided that this project would be more meaningful if applied to a population that is underserved and has a need to have more Tier I or Tier II interventions compared to others. After completing a project in a previous class, the authors discovered that Native Americans have a variety of mental health needs based on their history and lack of services. One of the authors has Native American ancestry, thus has first-hand experience and information regarding this population. In addition, a previous project completed by the authors focused on the development of a school-based mental health curriculum for rural schools. Together, the previous project and class informed the population (Native American), emphasis on mental health, and incorporated the interests of Tier I or Tier II interventions in a school.

The development of this scholarly project required gathering information from the literature. The method for gathering information began by conducting an exploratory and thorough search of the following data bases: Academic Search Premiere, EBSCOHost, ERIC, CINAHL, PsychInfo, PubMed, Google Scholar, and hard copies of resources. In addition, a search of reliable websites such as the Substance Abuse Mental Health and Services Administration (SAMHSA), the National Institute of Mental Health (NIMH), the National Institute of Health (NIH), and the National Center for Biotechnology Information (NCBI),

provided information for statistics, interventions, and health information regarding Native Americans. The key terms and phrases used for searching include: Native American(s), history, trauma, mental health, education, school, school programs, prevention, prevention programs, occupational therapy, cultural programs, interventions, and others. The information gathered helped inform the literature review for the background, history, and needs of Native Americans. From this literature search, a gap in literature regarding a need for culturally relevant, prevention-based programs in the educational setting for Native American youth was identified.

The needs identified from the literature include that Native Americans "have the highest rates of mental health disorders in the United States" (Evans-Campbell et al., 2012, p. 421). The common mental health problems experienced by this population are trauma, substance use, depression, and suicide (Theriot & Parker, 2007; Pember, 2016). Occupational therapists possess the skills to address these mental health problems as occupational therapy addresses the mind, body, and spirit (AOTA, 2014). Incorporating cultural values is also a skill that occupational therapists have, as it relates to several models of practice, especially the Canadian Model of Occupational Performance and Engagement (Polatajko et al., 2010).

The Canadian Model of Occupational Performance and Engagement is an appropriate model to use when addressing mental health in children and adolescents (Hall et al., 2016). Concepts from the Canadian Model of Occupational Performance and Engagement include the person, occupation, and environment (Polatajko et al., 2010). These concepts are connected to the five dimensions of spirituality, mental, emotional, relational, and physical health in an article by BigFoot and Schmidt (2010). While the CMOP-E was ultimately selected for this scholarly project, other models of practice were also considered.

Other models of practice were considered and ruled out as they did not fully encompass the needs of the population. For example, the Person, Environment and Occupational Performance (PEOP) model and Model of Human Occupation (MOHO) contain similar constructs that would align with Native American youth with mental health problems. The PEOP model considers spiritualty as a factor of the person, with occupational performance at its center (Turpin & Iwama, 2011). Additionally, culture is a component of the environment, which is an important to consider with this population (Turpin & Iwama, 2011). The MOHO incorporates volition or motivation which could be beneficial in explaining how Native American youth can develop (Turpin & Iwama, 2011). While culture is not explicitly stated as a construct, it can be described in combination with values, interest, and the social environment. While both of these models have some aspects that match with the mental health needs of Native American youth, they do not have spirituality at the center of the model like the CMOP-E does. Spirituality is an essential aspect of Native American culture, which coincides with the CMOP-E. Overall, due to the conceptualization of the person and the emphasis on spirituality, the CMOP-E was determined to be the best suited model for the development of this project.

The final decision for the product involved considering the gap identified in literature and the purpose of the scholarly project to develop an occupational therapy focused product. When deciding on the product, the authors discussed three options, all related to Native American children in schools: developing culturally relevant Tier II interventions for occupational therapists to use in a school setting with Native American youth, a resource tool for teachers who work with Native American youth, or a culturally relevant program for occupational therapists who work with Native American children in school. Solely developing Tier II interventions was ruled out, as it would not provide enough background information for the occupational therapists

in terms of culture and how to develop culturally relevant interventions. The second option regarding educating teachers on implementing culturally relevant interventions in the classroom was ruled out because a tribal leader or elder may be a more appropriate resource to do this. Ultimately, after developing a pros and cons list for each option, the authors decided to develop a culturally relevant program for occupational therapists to use to promote mental health in at-risk, school-aged Native American children.

The product is meant to educate and guide occupational therapists to make interventions culturally relevant to the population to increase effectiveness and build protective factors in the youth. The product of the scholarly project is a program designed with one unit per topic (spirituality, mental, emotional, relational, and physical health), for a total of five units. The units will have a step-by-step process with session outlines and descriptions about each topic. Session outlines are designed for each unit with suggested culturally relevant interventions to help promote mental health in Native American children. It will be left open enough regarding population, settings, and topics for units, to not limit the circumstances this can be used for. Participating in culturally relevant interventions can result in positive outcomes, which is the goal of the product (DeMars, 1992).

CHAPTER IV

PRODUCT

The purpose of the scholarly project product is to provide a Tier II mental health program for occupational therapists working with Native American students. This program is designed to be culturally relevant and promote protective factors within Native American students. Overall, the general goal is to improve the mental health of Native American students, using culturally relevant sessions to improve overall occupational functioning and resiliency.

The name of the product is *The S.P.I.R.I.T Program*. This an acronym for: Spirituality Promotion Interdependence Resiliency Inclusive Therapy. These terms in the title describe the focus of the program. This program is designed as a five-unit program addressing various person factors that influence mental health. The five units are spiritual, mental, emotional, relational, and physical health. The units are in the recommended order. Along with each unit, is three sessions for examples of how to use culturally relevant interventions with Native American students. The Circle of Courage (Brendtro, et al., 1990; Feinstein et al., 2009; Lee & Perales, 2005), an article by BigFoot and Schmidt (2010), and the medicine wheel, are common themes used throughout the units and helped develop the sessions.

The unit outlines have the introduction to the purpose of the unit, key terms, goals for the therapist and the students, adaptations, outcome criteria, resources, and also provide additional activity ideas that are not included as session outlines. There are also elements of the occupational model chosen for this program, which is explained in the following paragraph. Each session has steps for the activity, precautions, supplies, session goals, cultural components,

rationale, outcome criteria, resources, and suggested group or timeline considerations for the occupational therapist. Finally, after each session in the units there are the resources needed as well as outcome measures for the occupational therapist to use to measure the effectiveness with the students.

The Canadian Model of Occupational Performance and Engagement (CMOP-E), was used as the guiding occupational model for the program. Using a model helped incorporate occupational therapy concepts into the program and orient the occupational therapist using the program. The reason the CMOP-E was chosen was because of the increased emphasis on spirituality, as it is viewed as the center of the person (Polatajko et al., 2010). This fit well with the desired population, since spirituality is an important aspect in Native American life (Kidwell & Velie, 2005).

To use this program, it is recommended that the occupational therapist conduct a needs assessment. This will inform the best time to implement the program as well as general needs of the students. For example, this program could be implemented during school time, or after school if applicable. The program does not include every possible session or culturally relevant intervention in order to allow the occupational therapist using it to have freedom to adapt the units. This program was made general enough to provide ideas on how to incorporate culturally relevant and meaningful activities. However, the occupational therapist should also recognize that the needs of the students may differ than the suggested sessions, so should adapt accordingly. Overall, the hope is that this program will assist occupational therapists to provide client-centered practice and promote mental health in at-risk Native American students.

The S.P.I.R.I.T. Program:

Spirituality Promotion Interdependence Resiliency Inclusive Therapy

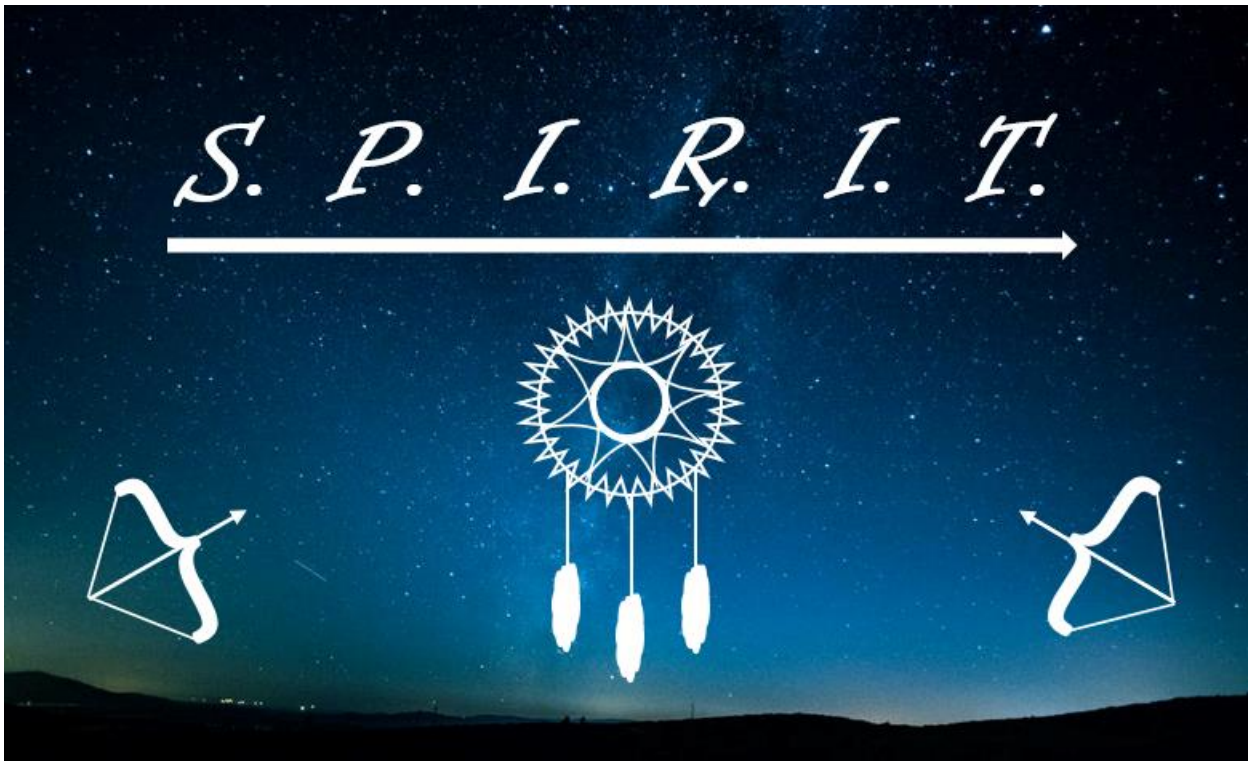

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TABLE OF CONTENTS

Introduction

Because of historical events, political laws and acts, and social factors like oppression and racism, Native Americans have a plethora of issues to address. Oppression, racism, and self-hate are some of the many current issues that Native Americans face, often on a daily basis (Peacock & Wisuri, 2002). This can take a toll mentally and emotionally. Native Americans can experience “feelings of isolation, exclusion, and frustration that contribute to…high rates of alcoholism and substance abuse, crime, suicide, poverty, and unemployment” (Theriot & Parker, 2007, p. 87). Additionally, experiencing trauma as a child can increase chances of experiencing “addiction, depression, intimate partner violence, suicide, diabetes, liver disease, poor fetal health” and others in the future (Pember, 2016, p. 6). Therefore, there are still ongoing mental health problems because of what has taken place historically and in how Native Americans are treated and viewed by society today.

Native Americans "have the highest rates of mental health disorders in the United States" (Evans-Campbell, Walters, Pearson, & Campbell, 2012, p. 421). Negative self-esteem is another contributor to mental health problems. Internalized oppression means believing in being inferior to another group long enough to develop a negative self-image (Peacock & Wisuri, 2002). In a way, it makes Native Americans feel helpless once they accept this as being true. As a way to cope with this internalized oppression, many Native Americans have turned to drug abuse, suicide, and alcohol abuse (Peacock & Wisuri, 2002). Common mental health problems discussed in this section are trauma, substance use, depression, and suicide.

Trauma

Trauma is one common mental health problem experienced in Native American populations. Native youth are 2.5 times more likely to experience a traumatic event than non-Native children (BigFoot, Willmon-Haque, & Braden, 2008). One study that surveyed two reservations found that 57% of adolescents ages 15-24 reported at least one traumatic event occurred throughout their lifetime. Traumatic events include rape, sexual assault, violent crime, and domestic violence to name a few (Horwitz, 2014). The most common traumatic events reported were threat of injury and witnessing an injury (Deters, Novins, Fickenscher, & Beals, 2006). Sexual abuse was the least common traumatic event reported but has the highest rates of Post-Traumatic Stress Disorder (PTSD) symptomology (Deters et al., 2006).

In addition, traumatic events with trauma symptoms was more prevalent in Native American youth who were in a residential substance abuse recovery program. A study completed by Deters, Novins, Fickenscher, and Beals (2006), found that an average of 4.1 traumatic events were reported among the Native American adolescents in the program. Trauma among Native Americans is not limited to youth. One study completed by Mansen, Beals, Klein, Croy, and the AI-SUPERPFP TEAM, (2005) had a sample from two large Native American tribes with ages spanning from 15-57 and found that 62.4% to 69.8% of respondents indicated they experienced a form of a traumatic event.

Experiencing trauma can lead to a potential diagnosis of post-traumatic stress disorder if the DSM-V criteria are met (American Psychiatric Association, 2013). Approximately 22-25% of American Indian juveniles' experience PTSD (The Denver Post, 2016; Dorgan et al., 2014). Compared to the general adult population, Native American adults tend to have high rates of post-traumatic stress disorder (Evans-Campbell et al., 2012). Approximately twice as many

Native American adults develop PTSD compared to the general population (American Psychiatric Association, 2009). These rates of PTSD are approximately three times higher than the national average and are the same as war veterans who have returned from the Middle East (The Denver Post, 2016; Dorgan et al., 2014).

Due to the complex historical trauma that Native Americans experience, it is likely that the numbers of those with PTSD is actually greater (Evans-Campbell et al., 2012; Pember, 2016; Substance Abuse and Mental Health Administration, 2014). Another explanation is that the criteria for PTSD does not encompass the effects and components of historical trauma (Goodkind, LaNoue, Lee, Freeland, Freund, 2012). The combination of unresolved historical trauma, and exposure to traumatic events is linked to increased substance use and behavioral disorders in Native American youth (Goodkind et al., 2012).

Substance Use

Substance use is another mental-health related issue that is prevalent in Native American children. They are the ethnic youth group with the highest rates of substance and alcohol use (Evans-Campbell et al., 2012). Substances typically used by Native American youth include marijuana (7.1%), cigarettes (4.8%), alcohol binge drinking (3%), and illicit drugs (8.3%) (Substance Abuse and Mental Health Services Administration, 2017). Alcohol use, specifically, stems from the historical trauma experienced by previous generations, providing an explanation as to why Native American adolescents tend to use alcohol at an earlier age than non-Native adolescents (Substance Abuse and Mental Health Services Administration, 2014; Urbaeva et al., 2017).

Communicating about norms and alcohol use can affect alcohol use in adolescents. Parental involvement or lack thereof, can influence the extent to which adolescents use

substances (Urbaeva et al., 2017). Trying to cope with these issues when faced with poverty and limited access to resources makes it difficult to use and develop healthy coping skills. Feeling hopeless and stuck in the cycle of poverty also affect Native Americans' mental health and can lead them to using maladaptive coping skills such as alcohol and substance use (Brockie et al., 2015). Obtaining alcohol and substances is easy as they are typically readily available. Being exposed to this at a young age can also have a lasting impact if left unaddressed. Native American youth may feel ill equipped to confront these issues, especially if the adults in their family have poor coping skills. When these poor coping skills are modeled by adult role models in their life, it is difficult to break the cycle.

The opioid epidemic is a specific substance use issue affecting Native American communities at a staggering rate. Native Americans and non-Hispanic whites had the highest rates of opioid overdose (Rudd, 2017). As a response, Indian Health Services appointed the National Committee on Heroin, Opioids, and Pain Efforts (Rudd, 2017). The committee was developed to improve accessibility to substance use treatment options that align with Native American culture, promote effective and appropriate pain management options, and decrease opioid deaths (Rudd, 2017).

Generally, substance use acts as a maladaptive, self-medicating coping skill that is passed down through generations (Urbaeva et al., 2017). It is likely for Native American youth to be exposed to using substances as a coping strategy, if it is a coping strategy used by peers or family members around them (Urbaeva et al., 2017). It is suggested that they are self-medicating because this is a strategy used by those around them who are dealing with the effects of historical trauma with limited access to healthier options (Horwitz, 2014). Additionally, Native American youth and adolescents did not perceive substances to be harmful to use, explaining why many of

them would engage in substance use (SAMHSA, 2017). Boredom and unstructured time are common experiences among Native American youth on reservations, contributing to the reasons why Native American youth would use substances (Heavyrunner-Rioux & Hollist, 2010). Due to the lack of positive coping strategies modeled to Native American youth, it is important to intervene early, such as in schools to incorporate healthy coping skills and strategies to build resiliency (Henson et al., 2017). Such healthy coping skills and strategies should be built upon protective factors, which are explored in depth later in the literature review.

Depression

Depression is a common mental health problem experienced by Native American children. In 2013, the rate of depression in Native American youth was approximately 39 percent, which was the highest among Latinos, African Americans, non-Hispanic white, and Asian populations (Mays, 2015). This number has increased since 2001 when the prevalence of Native American children with depression was 36 percent (Forrest, Leeds, Williams, & Lin, 2001). Even in 2001, Native American children had the highest rates of depression when compared to other ethnicities (Forrest et al., 2001). For adolescents, the rate of depression is also the highest among other races at 13 percent (Urban Indian Health Institute, 2012). The rates of Native American children developing depression has increased over time, which can be explained by exploring related risk factors.

The risk factors associated with developing depression include substance use, feeling isolated, low socioeconomic status, experiencing discrimination, experiencing family violence or trauma, and experiencing complex trauma, (Mays, 2015). When children or adolescents are diagnosed with depression and it is left untreated or is only partially treated, the chances of developing chronic and recurrent adult depression increases (Mays, 2015). If untreated, then the

chance of death by suicide also increases. Untreated depression is the highest risk factor causing Native American youth to die by suicide (Mays, 2015). There is a link between depression and suicide in Native American youth.

Suicide

Suicide is complex and is, unfortunately, a prevalent issue experienced by Native American children. Death by suicide occurs because of a variety of factors including mental health problems, such as depression, and substance use (U.S. Department of Health and Human Services, 2010). Suicide is the second leading cause of death among Native Americans from ages 10-34 (Centers for Disease Control and Prevention, 2015). The suicide rates for Native Americans is one and a half times higher than the general population (Center for Disease Control and Prevention, 2015). While there are many Native Americans that live in urban areas, the ones who live in rural areas have a higher risk for suicide due to isolation, low socioeconomic status, and lack of resources (Gray & McCullagh, 2014).

Several risk factors are incorporated into the high suicide rates for Native Americans. Risk factors for suicide identified by Gray and McCullagh (2014) include alcohol/substance abuse, bullying, gang involvement, gun availability, mental health problems, history of abuse, socioeconomic factors (poverty and low educational resources), and experiencing suicide from family/friends. Historical trauma, feeling isolated, chronic illness, impulsivity, and family history of mental health problems are other risk factors contributing to suicide (U.S. Department of Health and Human Services, 2010). Risk factors are interrelated and cumulative; the greater the risk factors, the greater the chances are of dying by suicide (U.S. Department of Health and Human Services, 2010). One theory as to why suicide rates are so high in Native Americans, is due to the loss of cultural identity and loss of community (Gray & McCullagh, 2014; U.S.

Department of Health and Human Services, 2010). These two issues are related to the historical trauma that occurred generations ago, and yet are still causing issues in today's Native American children.

The common mental health problems experienced by Native American children include trauma, substance use, depression, and suicide (Theriot & Parker, 2007; Pember, 2016). While some mental health problems have occurred for generations, new ones like opioid use are on the rise (Rudd, 2017). Each mental health problem can be linked to a variety of risk factors, indicating specific areas that need to be addressed. Native American children also have other, general areas of need apart from their mental health needs.

General Needs

Native American children tend to have general areas of need that affect their physical, psychological, and socio-emotional health. To better understand the importance of having basic needs met, a humanistic learning theory needs to be explored (Braungart, Braungart, & Gramet, 2011). Maslow's hierarchy of needs is a humanistic learning theory designed to explain the connection between motivation and learning (Braungart et al., 2011).

Maslow's hierarchy of needs is separated into five categories. The foundation includes having basic, physiological needs met such as food, sleep, and shelter (Braungart et al., 2011). The next level is safety, which includes a sense of security regarding health, family, and general resources (Braungart et al., 2011). The third level is about feeling a sense of belonging and love (Braungart et al., 2011). People want to experience this with their friends, family, or other loved ones. The fourth level is about esteem, respecting one's self, respecting others, and feeling confident (Braungart et al., 2011). The fifth and final level is self-actualization, where people are able to problem-solve, accept others without judgement, be creative, and be moral when making

decisions (Braungart et al., 2011). People are able to move through the hierarchy levels when they meet the needs of each level. Mental health, physical health, and other life situations can impact whether people move up or down the hierarchy.

When basic life needs of the foundational level of Maslow's hierarchy of needs are unmet, they are unable to learn and move through the levels of the hierarchy (Braungart et al., 2011). Native American youth who are living in poverty may experience inconsistent meals and a lack of adequate sleep. Following Maslow's hierarchy of needs, if these children's basic needs are unmet, they are unlikely to reach the levels of safety, belonging and love, esteem, and self-actualization (Braungart et al., 2011). Learning becomes difficult when children are unable to surpass the foundational level. While there are exceptions to this theory and a lack of reliable and valid research in support of its claims, Maslow's hierarchy of needs provides a visual to help explain why children may not be able to learn all that is required to meet their educational standards (Braungart et al., 2011).

Purpose & Rationale

The goal of this program is to provide a culturally relevant program for occupational therapists who work with Native American students in schools. It incorporates the cultural values, beliefs, and spirituality of Native American culture, and ultimately provides more meaning than other available programs. This program is needed for a variety of reasons. First, there tends to be a Western focus when it comes to addressing mental health in the United States, which focuses on the individual only. A Western approach is not an effective approach for occupational therapists to implement with all clients, as it is not entirely client-centered care, nor culturally inclusive. Native American culture tends to include extended family, immediate family, and community members in the concept of family (Urbaeva et al., 2017). Therefore, focus only on the individual, is not the best approach.

Second, current interventions intended to address mental health lack cultural relevance to Native American children. Native Americans tend to feel mistrust when seeing Western mental health providers (Gerlach, 2008). Mental health services that do not have cultural relevance to Native Americans contributes to the growing mental health issues and lack of services provided to Native Americans (Goodkind, LaNoue, Lee, Freeland, & Freund, 2012; U.S. Department of Health and Human Services, 2011). This highlights the need for culturally relevant services.

There are specific resources of evidence-based interventions for culturally appropriate treatment, that have shown positive results of treatment with Native Americans. The Honoring Children Series from the Indian Country Child Trauma Center, provides opportunities for

education on culturally adapted mental health therapies, based off traditional therapy models such as CBT (BigFoot & Schmidt, 2010). Literature supports use of culturally relevant interventions when working with Native Americans, for better outcomes, compared to using traditional non-cultural interventions (Brockie et al., DeMars, 1992; Urbaeva et al., 2017). In addition, current literature exists targeting interventions and strategies to help Native American adolescents and young adults. One example that has been developed to help Native American adolescents is the Circle of Courage. This culturally relevant framework is used to foster resiliency using four traits: belonging, mastery, generosity, and independence (Brendtro, Brokenleg, Van Bockern, 1990). There is a lack of interventions for Native American children, specifically those in elementary schools who may be experiencing mental health problems.

Occupational therapists (OTs) receive education regarding cultural competency and understand the importance of being client-centered; however, they may lack the specific knowledge regarding Native American culture. It is crucial that OTs understand the culture and change the way mental health interventions are implemented, in order to provide effective care for Native American children in schools. A crucial aspect of Native American cultural values and beliefs is spirituality. Spirituality to Native Americans is seen as a connection to land and other inanimate and animate objects, dreams, praying to the Creator, and participating in ceremonies (BigFoot & Schmidt, 2010; Kidwell & Velie, 2005; Pember, 2016). This is a general definition of spirituality; it varies among tribes and individual Native Americans. Spirituality is a concept used in the Canadian Model of Occupational Performance and Engagement (Turpin & Iwama, 2011). Using this model to guide occupational therapy practice is important as it incorporates spirituality in interventions.

Occupational therapists who work in schools need their interventions to focus on enhancing educational performance. OTs would benefit from addressing mental health in their interventions, which would also enhance the Native American children's educational performance. This, in turn, would help the children reach their educational goals and likely increase their self-esteem, confidence, and ability to use protective factors. Outcomes such as these would then positively influence the Native American children's mental health. Therefore, the relationship between the OTs and their education-based interventions and the mental health of Native American children influence each other and are interconnected.

Protective Factors

While it is true that Native Americans have obstacles to overcome such as historical trauma, resulting mental health issues, and lack of academic resources, Native Americans have shown an incredible ability to overcome obstacles. In fact, Native American's are arguably better suited for overcoming obstacles than any other race. One of the reasons for this is protective factors. According to Henson, Sabo, Trujillo, and Teufel-Shone (2017), "protective factors are conditions or variables capable of directly affecting adolescents and increasing the likelihood of positive health outcomes" (p. 6). A combination of protective factors help to develop healthy behaviors to overcome risk factors and adversity (Henson, Sabo, Trujillo, & Teufel-Shone, 2017). Native Americans have experienced adversity and have several risk factors for negative health outcomes. However, they also have protective factors that should be acknowledged and built upon to foster healthy behaviors and increase positive health outcomes. Two large protective factors within the Native American culture include connectedness, and resilience.

Connectedness. Connectedness is a protective factor among Native Americans that is achieved through the individual feeling connected to family, community, and the natural

environment (Mohatt, Fok, Burket, Henry & Allen, 2011). The idea of connectedness, like sense of wellness, is important to understand for Native American culture. Connectedness has shown to be a protective factor against substance abuse and suicide, which are two important topics to address in Native American populations (Mohatt, Fok, Burket, Henry & Allen, 2011). With Native American youth being one and a half times more likely to attempt suicide than the national average (Centers for Disease Control and Prevention, 2015), as well as earlier ages and more often substance use (Heavyrunner-Rioux & Hollist, 2010), protective factors need to be utilized more often when developing programs to address these issues.

According to Garrett, Parrish, Williams, Grayshield, Portman, Rivera, and Maynard (2014), developing culturally sensitive programs to promote Native American youth development is supported for reducing health disparities and promoting resilience. As mentioned previously, Native Americans have a history of trauma, high rates of low socioeconomic status, and poverty (Theriot & Parker, 2007). These factors add up to the definition of at-risk youth (Thornton & Sanchez, 2010). With at-risk youth, promoting resilience is an important factor that allows for at-risk youth to respond to negative life circumstances or events in a positive way (Thornton & Sanchez, 2010).

Resilience. Resilience is an important factor for Native Americans and is considered another protective factor that should be emphasized when working with Native Americans, along with connectedness (Mohatt, Fok, Burket, Henry & Allen, 2011; Thornton & Sanchez, 2010). The American Psychiatric Association has developed a list of successful ways to promote resiliency including accepting change as a part of life, completing self-care tasks, having hope, having a positive outlook, keep crises in perspective, building social circles, and involving spirituality (Pember, 2016). In addition, resilience is often fostered to Native American youth

through the school system, as it can provide a structured intervention readily available to at-risk youth (Thornton & Sanchez, 2010).

Thornton and Sanchez (2010) suggested that resilience can be learned. With that in mind, it is important that programs targeting resilience in at-risk youth require training for teachers and school stakeholders on how to incorporate and promote resilience in students (Thornton & Sanchez, 2010). While resiliency can have individual personality factors, it can also be shaped by educators in the school system (Thornton & Sanchez, 2010). One study wrote about the components of interventions that promote resiliency and found that programs for resiliency should include developing long-term processes that focusing on a child's strengths (Thornton & Sanchez, 2010). Recognizing the strengths of Native Americans versus focusing on the deficits is crucial to developing a program to achieve positive outcomes (Garrett et al., 2010).

The Circle of Courage is a model of positive youth development that was developed to foster resiliency using four traits (Brendtro et al., 1990). The four traits are belonging, mastery, independence, and generosity. The four terms are defined by Feinstein, Driving-Hawk, and Baartman (2009):

> "A sense of belonging is established when students form relationships within family, school, and community. Independence is developed as students turn from irresponsible behavior to responsible behavior. Mastery is cultivated in experiences that facilitate success and knowledge. Key components in promoting a sense of mastery are active learning, cooperative learning groups, and stress-free, fun surroundings. A spirit of generosity is based in unselfish and giving behavior. Students are encouraged to see the world through others' eyes, enhancing their ability to be empathetic, ultimately leading to altruistic behavior" (p. 13).

According to Lee and Perales (2005), programs that use the Circle of Courage model's four values can lead to positive benefits for youth and increase successes for youth. Other protective factors that promote resiliency include academic achievement, opportunity for valuable education and future careers, participation in extra-curricular activities, and family support of school participation (Feinstein, Driving-Hawk, & Baartman, 2009). Suggestions for future school programs to promote resiliency include having goal setting for education and careers, encouraging extra-curricular involvement, support from teachers and parents on student's emotional and social needs, and building in Native American pride for culture in the program (Feinstein, Driving-Hawk, & Baartman, 2009).

Other general protective factors were found exploring the literature. A literature review completed by Henson et al. (2017), found 18 studies that identified protective factors among Native Americans. The authors grouped the protective factors identified into five groups: Individual, relationship, community, socio-ecological, and multi-level protective factors (Henson et al., 2017). In addition, identified protective factors for a specific health or social outcome for Native American adolescents from 10-21 years old were put together. Relevant protective factors focusing on academic success, and mental health factors (depression, emotional health, and suicide attempts) include themes of high self-esteem, family support, participation in extracurricular activities, adult/tribal caring and support, religiosity (spirituality), identifying personal strengths, and positive feelings about school (Henson et al., 2017).

Theory

The Canadian Model of Performance and Engagement (CMOP-E) is the model that best fits with the purpose of this project. It involves three core concepts of the person, the environment, and occupation (Polatajko, Townsend, & Craik, 2010). The person consists of spirituality, physical, affective, and cognitive components. The environment consists of physical, cultural, social, and institutional components. The occupation is broken into three areas of self-care, leisure, and productivity.

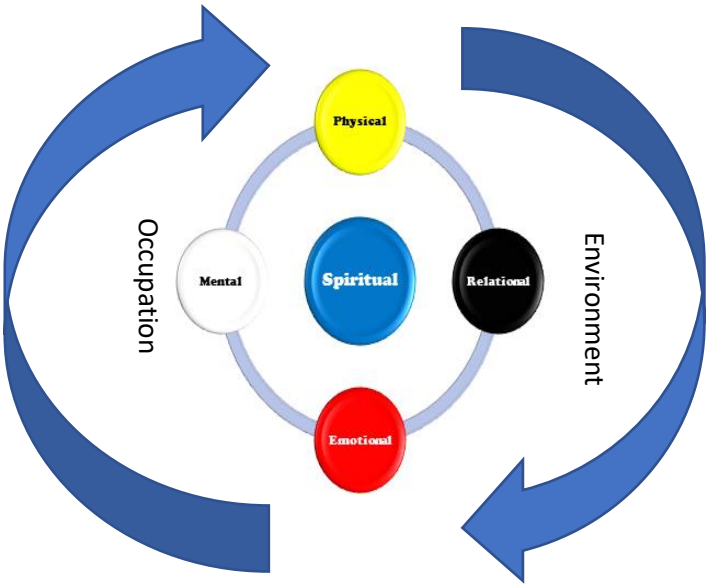
Spirituality is a component of the person that is experienced via occupations (Polatajko et al., 2010). In the CMOP-E, spirituality can include religion; however, it can involve other aspects as well. For instance, a sense of purpose and motivation are drawn from spirituality and they add to who a person is (Polatajko et al., 2010).

Previous articles have been written on the use of the CMOP-E model with children and adolescents with an emphasis on mental health and spirituality. Hall, McKinstry, and Hyett (2016) discussed the use of the CMOP-E model in their article, which explored the perceptions of youth regarding positive mental health. Through the lens of this model, occupational therapists suggest that "positive mental health is the product of meaningful engagement in occupation within a supportive environment which promotes personal development, skill acquisition, goal attainment and socialization" (Hall et al., 2016, p. 475). The three concepts of the model, person, occupation, and environment, are used via the CMOP-E to organize findings and expand on how positive mental health is viewed. In addition, Hall et al. (2016) found that

positive mental health was attainable when engaging in meaningful leisure occupations as they were a way to relieve stress, express one's self, and interact with peers. Developing social relationships with both family and friends acted as a coping skill to decrease hopelessness and increase resiliency (Hall et al., 2016).

Overall, the concepts and visual design of the Canadian Model of Occupational Performance and Engagement align with the person factors of Native Americans used from the article by BigFoot and Schmidt (2010).

Canadian Model of Occupational Performance	Spirituality	**S.P.I.R.I.T. Program**
The person factors from the CMOP-E that are similar include spirituality, physical, affective, and cognitive (Polatajko et al., 2010). **Physical:** Relating to the sensory and motor functions. Includes health eating and exercise. The most visible area of health ("Physical health", 2018) **Affective:** "Relating to moods, feelings, and attitudes." ("Affective", n.d.) **Cognitive:** Relating to the function of thinking ("Cognitive", 2018) The CMOP-E has the environment and occupation as interacting with the person, as indicated by the arrows on the visual below (Polatajko et al., 2010).	Spirituality is at the center of both of these and, thus, is at the center of the visual model used to represent each unit and session of the program.	The person factors from BigFoot and Schmidt (2010) are spirituality, mental, emotional, relational, and physical. **Physical:** Relating to the body and physiological abilities. Correlates to physical in CMOP-E. **Emotional:** Relating to the feelings and emotions of a person. Correlates to affective in CMOP-E. **Mental:** Relating to the functions of the mind including thinking and memory. Correlates to cognitive in CMOP-E. **Relational:** Relating to the social and familial relationships of an individual. This was added due to the value on relationships of Native American culture



How to Use

Before implementing the program, the occupational therapist should implement a needs assessment to determine the needed topics, and best possible organization of the program (e.g. time and schedule). The program was designed and arranged in a sequential order, targeting the physical, spiritual, emotional, mental, and relational aspects of the person, while also considering their environment and meaningful occupations related to Native American children. It is intended to be used as a Tier II intervention program to promote the mental health of Native American children who are at risk of developing mental health problems. This program is not medically based nor is it deficit-based. It was designed as a proactive, preventative program to introduce protective factors and enablement skills with Native American children.

There is a suggested order of units and corresponding sessions to implement. Each unit targets a specific component of the person. The focus of the unit is indicated by the enlarged circle on the visual. The suggested progression of units is spirituality, mental health, emotional health, relational, and physical health. These units were ordered in this manner based on the Canadian Model of Occupational Performance and Engagement with spirituality being at the core of the person and being an important cultural component in Native American culture (Turpin & Iwama, 2011).

Within each unit, there will be three examples of session outlines of the activity ideas. Each unit will have a session that incorporates a trait of the Circle of Courage. The reason behind this was to use an evidence-based, culturally relevant model that has builds protective factors.

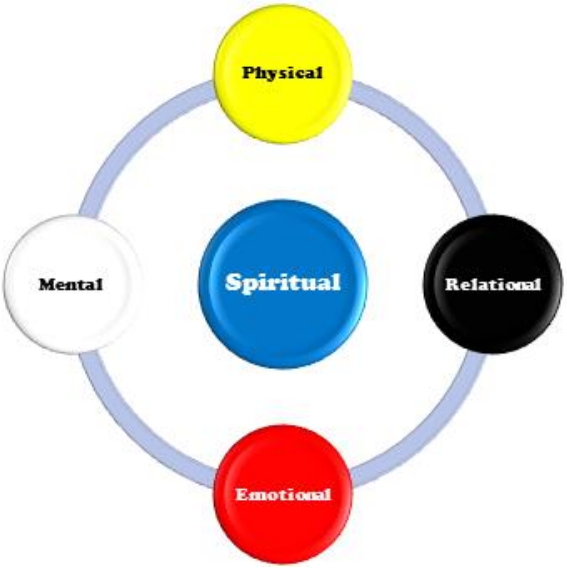
Three sessions were written to provide an example of how to adapt interventions to fit culturally relevant components, as well as leave enough room for occupational therapists to make clinical judgments of what is needed to address with the client. In addition to the provided sessions, there are listed activity ideas in the unit outline. This is intended to provide ideas for the occupational therapist to use in conjunction with the topic of the unit. The suggested progression of units is:

1. **Spirituality**: Incorporating spiritual components in the sessions is crucial. Spirituality is a critical component of both the CMOP-E and Native American cultural values. Addressing this first, is important in providing client-centered, culturally relevant care for Native American children. Additionally, it will provide the base for future concepts in the units to tie back to spirituality, allowing for the cultural aspect to be met effectively.
2. **Mental health**: Promoting mental health is the focus of this program. Native American children are likely to encounter mental health problems such as depression, substance use, trauma, and suicide (Brockie et al., 2015; Pember, 2016). Using the mental health sessions, Native American children can develop feelings of belonging, mastery, independence, and generosity (Lee & Perales, 2007). Providing culturally relevant interventions can enhance the development of protective factors such as resiliency and connectedness.
3. **Emotional health**: Emotional health is closely linked to mental health, which is why it was presented next. Native American youth may experience internalized oppression or trauma as it affects their older family members (Pember, 2016; SAMHSA n.d.). Their emotions can be affected by these experiences, so it is important to incorporate resiliency in the sessions as well as coping skills.

4. **Relational**: Relational health is the fourth unit, where independence, interdependence, and connectedness are included. As mentioned above, focus on the individual is not the best approach when working with this population (Urbaeva, et al., 2017). Therefore, inclusion of this component, is meant to incorporate the value of family and interdependence in the Native American culture.
5. **Physical**: The fifth unit is on physical health which, while there may be physical health problems, this is not the primary issue for this program. In the physical health unit, we discuss the ways in which physical health and wellness may be compromised as it relates to mental health problems.

While each unit is presented individually, there are connections to other topics within the sessions. In the visual depiction, there is still a line connecting all the topics while spirituality remains at the center. The purpose of this image is to show that all of the unit concepts are connected and interrelated. The visual representation of how these units are interwoven is depicted below.

Diagram 1: Program VIsual



Possible Program Adaptations

1. **Needs Assessment**: While this program is presented in a recommended sequential order, you can adapt it to fit the needs of the client. Conducting a needs assessment at your specific school would be beneficial in determining the specific needs of the Native American children you serve. Each school and school district are unique just like each child is unique. Asking the parents and teachers at the school what they see as the areas of need in terms of mental health for the children will help guide which sections of the program to use. Additionally, a needs assessment would help determine if parents and teachers would be interested in having you implement these sessions at school during the school day or after school. There are benefits and drawbacks to both options; however, you will receive more support and a greater turnout if you implement the program at a time that works best for all parties involved.
2. **Parent or Guardian Involvement**: Parent or guardian involvement is a component that you can choose to implement. Since Native American family units tend to involve the immediate family, extended family, and sometimes community members, it is important to also include the family in the sessions. If you are ***providing sessions to the children in school***, one suggestion would be to send homework home with the children after implementing a session. Completing homework at home will foster communication between the child and his or her family, allow for generalization of new learning, and will foster a protective factor of connectedness within the family unit. If you decide to ***implement the program after the school day***, you could invite the child's family to the sessions. Their siblings or cousins who would learn the content would simulate peer learning, which can enhance the learning of your elementary school-aged client. Parents,

guardians, and other family members can benefit from these sessions, as there is information that pertains to them as well. The culturally relevant information may be new or old to them, and they may be able to add their own experience or knowledge to enhance the child's learning.

3. **Tier Focus**: While this program is designed as a Tier II intervention, it could be adapted to be Tier I or Tier III. As a Tier I adaptation, you could work with the teachers and staff at your school to educate them on techniques from the program to implement in their classrooms. You could hold an in-service, after school meeting, or a conference to explain the program to the teachers and other staff. This could occur on a weekly basis where you introduce one session per week, and then continue until the program is complete. A Tier III intervention would be one on one with each client, providing intensive treatment to meet their individual needs. The format of this program would help to guide the tier III interventions regarding the unit topics, because it still addresses the cultural need and relevant topics. The sessions, can be able to be adapted to be used individually or as groups, and be used outside of the school setting for those with identified mental health needs.
4. **Grading the Activity**: Some children who are Native American may not participate in traditional practices, so these activities may not be as meaningful or effective. It is important to meet the students where they are at developmentally, so some of the session activities or content may need to be graded up or down to provide the just-right challenge. In addition, you may not have the materials required to complete each of the sessions. You can adapt the activity to be used with the resources or materials you do have. Children are also prone to having days or times when they are presenting

inappropriate behavior. In this case, the next activity in the program may not be the best choice, so use your judgement and clinical reasoning to determine if the session or activity is appropriate. In other words, the units can be used out of order and can be adapted to best meet the needs of the Native American children you are working with.

Outcomes

The outcomes of this program aim to promote better mental health in Native Americans and promote protective factors to address the areas of need within this population. This program will have two sets of outcome measures. The first set is an outcome pretest/posttest to be used at the beginning and end of each unit to determine the client's perceptions of improvement. This is a measure meant to inform the occupational therapist of the direct outcomes associated with each unit.

The second outcome measure is the Canadian Occupational Performance Measure (COPM). It is an assessment tool designed to be an outcome measure based on the Canadian Model of Occupational Performance and Engagement. The COPM examines clients' perceptions regarding their performance and satisfaction with their meaningful occupations (Canadian Occupational Performance Measure, 2018). Clients are also able to rate the importance of the occupations they discuss, which can be organized into one of the three categories on the form: self-care, productivity, and leisure (Canadian Occupational Performance Measure, 2018).

The area of mental health affects performance in all areas of life, and quality of life. The COPM will measure the overall effectiveness of improving satisfaction and performance in the client's occupations. Ideally, a successful program will result in improved mental health, as well as occupational performance in general. The COPM will be the unit of measurement for this aspect. In other words, the COPM would provide information on the child's perceptions of their

performance at the beginning of the program, and at the end of the program. In summary, the COPM is an appropriate outcome measure of occupational performance and engagement, as it is an outcome measure that complements the Canadian Model of Occupational Performance and Engagement.

Key Terminology

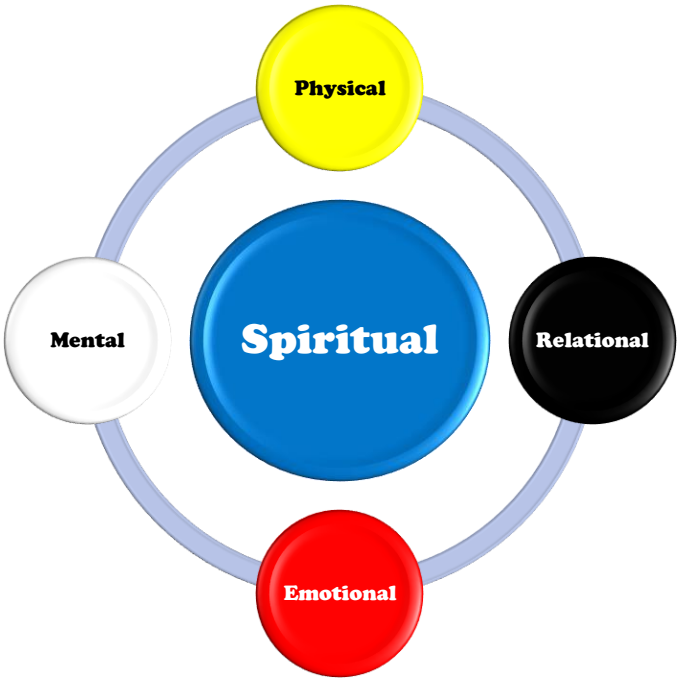
Terminology	Definition	Citation
Culture	"knowledge, beliefs, values, customs, and behaviors shared by people in a particular society"	Cockerham, 2007, p. 115
Forced assimilation	A way the U.S. government attempted to eliminate Native American people in terms of their culture as a whole, on federal and state levels	Davis, 2013
Boarding schools	Schools on reservations that Native American children were forcibly sent away to, as a way to further isolate them and remove their cultural identity	Davis, 2013
Indian Civilization Act of 1824	An act passed that provided funds for Native Americans to be sent to formal schools. However, in reality, the Indian Civilization Act of 1824 caused long-lasting culture loss and disruption of the family structure for many who attended the boarding schools.	Peacock & Wisuri, 2002
General Allotment Act of 1887 (Dawes Act)	Act developed by the United States government that forced Native Americans to live on plots of land that they were not allowed to sell for at least twenty-five years	Kidwell & Velie, 2005
Historical Trauma	Historical trauma is a type of trauma experienced by a group of people who share similar values, beliefs, and interests. It is "cumulative emotional and psychological wounding across generations, including the life span, which emanates from massive group trauma" (Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283)	Brave Heart, Chase, Elkins, & Altschul, 2011, p. 283; Substance Abuse Mental Health Service Administration, n.d.
Oppression	As the result of historical trauma, traumatized people may begin to internalize the views of the oppressor and perpetuate a cycle of self-hatred that manifests itself in negative behaviors.	Substance Abuse Mental Health Service

	Emotions such as anger, hatred, and aggression are self-inflicted, as well as inflicted on members of one's own group. For example, self-hatred among Blacks/African Americans who act out their aggression on people who look like them.	Administration, n.d., p. 1
Spirituality	"A pervasive life force, source of will and self-determination, and a sense of meaning, purpose and connectedness that people experience in the context of their environment. Spirituality among Native Americans is also viewed as interconnected with health" (Canadian Association of Occupational Therapists, 1997, p. 183). Spirituality differs among Native American tribes but does have commonalities of belief in an existential power, universe elements are dependent upon and influence each other, honorable behavior, and inclusion of spiritual ceremonies or practices (Limb & Hodge, 2008).	Canadian Association of Occupational Therapists, 1997, p. 183; Limb & Hodge, 2008
Culturally relevant (interventions)	Culturally relevant interventions consist of a combination of definitions including culturally responsive teaching and cultural competence. Culturally responsive teaching is defined "as using the cultural knowledge, prior experiences, frames of reference, and performance styles of ethnically diverse students to make learning encounters more relevant to and effective for them" (Gay, 2010, p. 31). Manson and Altschul (2004) developed a cultural diversity series and wrote, "mental health systems must be aware of significant differences in lifestyle and worldview among diverse populations, while valuing and responding to the distinct needs of each client" (p. X).	Gay, 2010, p. 31; Manson & Altschul, 2004, p. X
Protective factors	"Protective factors are conditions or variables capable of directly affecting adolescents and increasing the likelihood of positive health outcomes."	Henson, Sabo, Trujillo, & Teufel-Shone, 2017, p. 6
Connectedness	"The interrelated welfare of the individual, one's family, one's community, and the natural environment."	Mohatt, Fok, Burket, Henry & Allen, 2011, p. 444
Resiliency	"The ability to cope with stress; a positive capacity of an individual to responds under	Thornton & Sanchez, 2010, p. 455

	pressure."	
Circle of Courage	A framework that focuses on four traits that foster and promote resiliency. The four traits are belonging, mastery, independence, and generosity.	Brendtro, Brokenleg, & Van Brockern, 1990; Feinstein, Driving-Hawk, and Baartman, 2009; Lee and Perales, 2005
Mental health	"Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium"	Galderisi, Heinz, Kastrup, Beezhold, & Sartorius, 2015, p. 231-232
Mental illness	"mental illnesses are health conditions involving changes in thinking, emotion or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities"	American Psychiatric Association, 2015, para. 1
Occupational therapy	Occupational therapy is a profession that utilizes everyday life activities (occupations) to enable engagement, maximize independence, and maintain health of clients They work with individuals, groups, or organizations with a variety of physical, psychosocial, or developmental needs.	American Occupational Therapy Association [AOTA], 2014
Native American children & youth	A descendant or enrolled member of a Native American tribe who is under the age of 18 years old	Heisler & Safranski, 2018
Medicine wheel	A circle or hoop-shaped image depicting connections, symbols, animals, teachings, directions, or colors. Used in Native American teaching, ceremonies, and practices.	BigFoot & Schmidt, 2010
Circle of Courage – Mastery	A construct related to knowledge and success	Brendtro, et al., 1990; Feinstein, et al., 2009

Circle of Courage – Generosity	A construct involving giving to others and not being selfish	Brendtro, et al., 1990; Feinstein et al., 2009
Personal history	"A personal timeline is a graph or diagram that visualizes significant moments in a person's life." (Reference.com, 2017, para. 1). It acts like a protective factor (Henson et al., 2017).	Henson, et al., 2017; "Personal timeline", 2017, para. 1
Emotional health	Feelings, thoughts, and behaviors that influences well-being and mental health	Healthy Place, 2017
Affective	One component that makes up a person according the to Canadian Model of Occupational Performance and Engagement (CMOP-E). "Relating to moods, feelings, and attitudes."	Polatajko, Townsend, & Craik, 2010; "Affective", n.d.
Maladaptive coping skills	Strategies to deal with problems that may be harmful to one's health, including aggression, suppression, or passive-aggression.	Vantage Point, 2017
Relational (Relationships)	"Concerning the way in which two or more people or things are connected."	"Relational", n.d.
Social Environment	"Particular social features (i.e., social groups and occupational tasks) of the specific context in which one does something that impacts upon what one does and how it is done."	Schell, Gillen, & Scaffa, 2014, p. 1241
Interdependence	A system of people who feel connected as members of the greater whole, rather just an individual.	Kawulich (2008) in (Garrett, et al., 2014)
Physical health	Includes fitness and health via eating healthy and exercising. Considered to be the most visible of all areas of health.	"Physical health", 2018
Sensory components	Systems including sight, hearing, taste, touch, and smell that affect how information is processed	"Sensory system", 2013

Unit I: Introduction - Spirituality



Introduction	***Spirituality*** is an essential component to Native American lives. It is one of the common beliefs and values for health and wellness. To Native Americans, health is an interwoven concept of mind, body, and spirit (Limb & Hodge, 2008). When a person is not well, it is viewed as an imbalance in the mind, body, and spirit together. To promote healing, foster the connection between spirituality, physical health, and nature (Warzak, Dogan, & Godfrey, 2011). Spirituality to Native Americans is seen as a connection to land and other inanimate and animate objects, dreams, praying to the Creator, and participating in ceremonies (BigFoot & Schmidt, 2010; Kidwell & Velie, 2005; Pember, 2016). Using the CMOP-E, an occupational therapist leading this unit should recognize that spirituality is at the center of the person (Turpin & Iwama, 2011). Spirituality is a component of the person that is experienced via occupations (Polatajko, Townsend, & Craik, 2010). In the CMOP-E, spirituality can include religion; however, it can involve other aspects as well. For instance, a sense of purpose and motivation are drawn from spirituality and they add to who a person is (Polatajko et al., 2010).

	This unit incorporates spirituality exploration to promote culturally-relevant care for Native Americans. As spirituality is a component of health in Native American culture, it is essential to include in interventions. The occupational therapist using this program, needs to recognize that spirituality is individual to the person, and differs within the same culture. In order to explore and discuss spirituality, the OT will need to build rapport with the clients.	
Terms	**Term**	**Definition**
	Spirituality	"A pervasive life force, source of will and self-determination, and a sense of meaning, purpose and connectedness that people experience in the context of their environment." Spirituality among Native Americans is also viewed as interconnected with health" (Canadian Association of Occupational Therapists, 1997, p. 183). Spirituality differs among Native American tribes but does have commonalities of belief in an existential power, universe elements are dependent upon and influence each other, honorable behavior, and inclusion of spiritual ceremonies or practices (Limb & Hodge, 2008).
	Medicine Wheel	A circle or hoop-shaped image depicting connections, symbols, animals, teachings, directions, or colors. Used in Native American teaching, ceremonies, and practices (BigFoot & Schmidt, 2010).
	Protective Factors	"Protective factors are conditions or variables capable of directly affecting adolescents and increasing the likelihood of positive health outcomes" (Henson et al., 2017, p. 6).
	Resiliency	"The ability to cope with stress; a positive capacity of an individual to responds under pressure" (Thornton & Sanchez, 2010, p. 45).
	Circle of Courage – Mastery (in spirituality)	A construct related to knowledge and success (Brendtro, et al., 1990; Feinstein, et al., 2009)
	Circle of Courage – Generosity	A construct involving giving to others and not being selfish (Brendtro, et al., 1990; Feinstein, et al., 2009)
Goals	Therapist Goals: 1) Define and discuss importance of spirituality	

	2) Use spirituality as a concept in sessions to demonstrate cultural competence as a therapist Student Goals for Unit: 1) Define and discuss importance of spirituality 2) Explore spirituality activities to promote spiritual awareness 3) Be able to apply spirituality concepts in life for better health and wellness
CMOP-E components	**1) Person** a. Spirituality: Core of the person b. Resiliency: Fostering traits in the person to develop resiliency c. Medicine wheel: Looking at the affective, physical, and cognitive portions of the person with different terms (of the medicine wheel) and helping promote self-awareness in the student **2) Occupations**: using participation in valued activities to promote both spirituality and develop resiliency traits **3) Environment**: incorporating the cultural context and being within an in vivo context creates a positive environment to help identify supports and barriers in the environment **4) Enablement**: using enablement skills to view the Native American students in a strength-based way, to promote positive skills, rather than reinforce negative behaviors
Adaptations	Adapt activities for the age level. Developmental level needs are to be assessed and addressed to meet the student where she/he is. Generally, younger students need more structure and have less self-awareness abilities. Activities should be concrete, simple, and straight-forward. Timing should not exceed 30 minutes for students ages 6-11 (Bastable et al., 2011).
Outcome Criteria	At the end of each unit there is a pretest/posttest that measures the outcomes of this unit. It is designed as a Likert-scale to see the improvement in the client's perception of spirituality. Note: The COPM is the entire program's outcome measure. It used only twice. 1). Once at the beginning of the implementation for baseline of occupational functioning of the client, and; 2) once at the end of the program to determine improvement in the client's occupational performance and engagement as a result of participation in this program. Therefore, the COPM should be administered before the start of this unit.
Additional Activity Ideas & Rationale	• Exploring earth & land connection • Smudging • Listening to stories, telling stories • Participate in history classes to foster pride • Other Circle of Courage topics: generosity, belonging, independence

	Rationale: Doing activities that promote pride in Native American history was found to foster pride in culture, and help rebuild the lost cultural identity that Native Americans have endured from historical trauma (DeMars, 1992).
Resources	Bastable, S. B., Gramet, P., Jacobs, K., & Sopczyk, D. L. (2011). *Health professional as educator: Principles of teaching and learning*. Sudbury, MA: Jones and Bartlett Learning. BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. BigFoot, D. S., Willmon-Haque, S., & Braden, J. (2008). Trauma exposure in American Indian/Alaska Native Children. Indian Country Child Trauma Center, 1-6 Retrieved from www.nrc4tribes.org/files/Trauma%20Exposure%20in%20American%20Indian-Alaska%20Native%20Children.pdf. Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Canadian Association of Occupational Therapists. (1997). *Enabling occupation: An occupational therapy perspective*. Ottawa, ON: CAOT Publications ACE. DeMars, P. A. (1992). An occupational therapy life skills curriculum model for a Native American tribe: A health promotion programs based on ethnographic field research. *American Journal of Occupational Therapy*, *46*(8), 727-736. Retrieved from http://ajot.aota.org/ Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention*, 38(1-2), 5-26. doi: 10.1007/s10935-016-0455-2 Kidwell, C. S. & Velie, A. (2005). *Native American Studies*. University of Nebraska Press: Lincoln, NE. Lee, B., & Perales, K. (2007). Circle of courage: Reaching youth in residential care. *Residential Treatment for Children & Youth*, *22*(4), 1-14. Retrieved from https://doi.org/10.1300/J007v22n04_01 Limb, G., & Hodge, D. (2008). Developing spiritual competency with Native Americans: Promoting wellness through balance and harmony. *Families in Society: The Journal of Contemporary Social Services*, *89*(4), 615-622. doi: 10.1606/1044-3894.3816 Pember, M. A. (2016). *Intergenerational trauma: Understanding Natives' inherited pain*. Retrieved from www.indiancountrytodaymedianetwork.com. Polatajko, H.J., Townsend, E.A. & Craik, J. (2010). Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health,

Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36 Retrieved from https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf.

Thornton, B., & Sanchez, J. E. (2010). Promoting resiliency among Native American students to prevent dropouts. *Education*, *131*(2), 455-465. Retrieved from https://eric.ed.gov/?id=EJ930615

Turpin, M. & Iwama, M. (2011). *Using occupational therapy models in practice: A field guide*. Edinburgh, UK: Elsevier

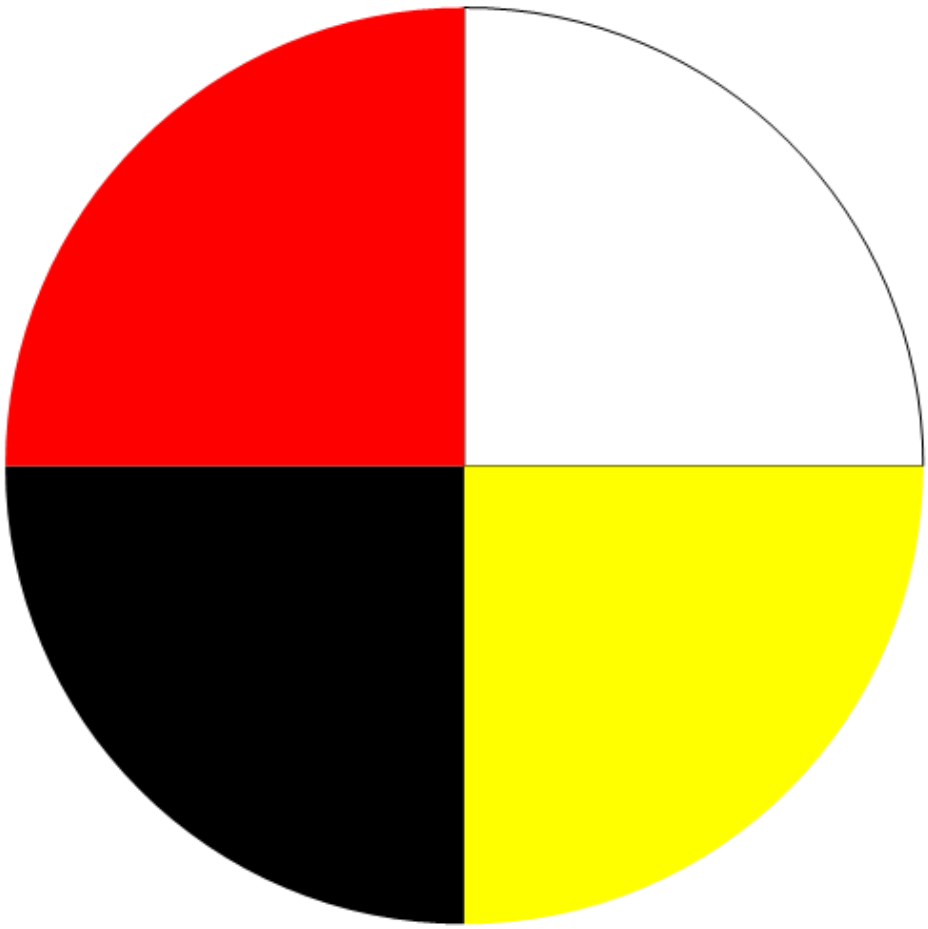
Warzak, W. J., Dogan, R. K., Godfrey, M. (2011). *Developing a culturally sensitive curriculum: Teaching Native American children about psychological and behavioral health*. Retrieved from ERIC database. (ED529907).

Session 1: Make a Medicine Wheel

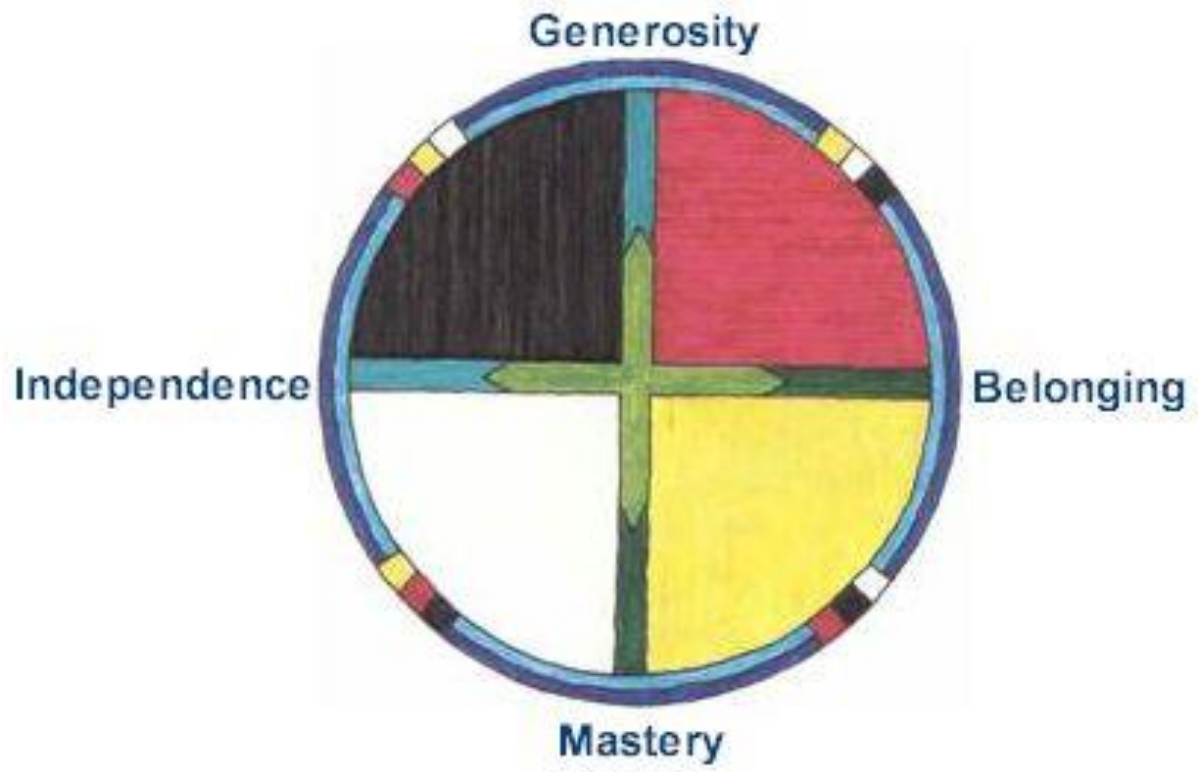
Purpose	The medicine wheel has been a tool used by Native Americans throughout history to promote health and healing (U.S. National Library of Medicine, n.d.). The medicine wheel is divided into four quadrants, with one section for each direction (North, South, East, and West) and symbolically represents different dimensions of health and cycles of life (U.S. National Library of Medicine, n.d.). There are many variations of medicine wheels and have been represented in many art forms (Gilgun, 2004). The use of a medicine wheel in this session is to show value of Native American culture and tools. Using a medicine wheel to focus on health promote both spirituality and culture relevance in therapy will result in more meaning attached to the session. The four quadrants used for the medicine wheel in this session are Physical, Mental, Emotional, and Spiritual. The quadrants are also units in this program, however, this session is included in the spirituality unit due to the history and use of a medicine wheel throughout Native American life. In addition, it provides an introduction and a basis to the other units. For example, the therapist can use the client's medicine wheel as a topic of conversation while in each unit.
Preparation/ Supplies	Paper with Medicine Wheel, markers/pencils ***Note: a picture of a medicine wheel is provided at the end of this session**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** Session should take anywhere from 30 minutes to an hour depending on age range
Goals	By the end of the session: 1. Students will create a medicine wheel to further understanding of spirituality 2. Students will discuss ideas for overcoming challenges identified (protective factors)
Rationale of Activity	Making a medicine wheel is a way to conceptualize mind, body, emotions, and spiritual connection. This will help for the youth to be able identify and explore possible healthy, strength-based, opportunities that are available to them.
Cultural Components	Medicine wheel is a holistic healing tool. It is designed to help achieve balance in life, which ties back to Native American's health & wellness views of harmony between mind, body, and spirit. Medicine wheels have been

	depicted using directions, colors, symbols, animals, connections, and movement (BigFoot & Schmidt, 2010).
Precautions	Challenges may bring up feelings that are difficult to process during a group activity.
Steps	1) Introduce medicine wheel components 2) Explain activity: identifying challenges in life in each section 3) Have students label one section of the medicine wheel with Physical, Emotional, Mental, and Spiritual 4) Facilitate discussion on opportunities to overcome the challenges identified in step 2 and steps needed to reach it 5) Have students fill out the medicine wheel with ideas to overcome the challenges in each area 6) Keep the medicine wheels the students create to use as reference points in later units.
Adaptations	If using when younger students, rename the categories to simpler terms. Example: Mental = Thinking Physical = Body feelings Spiritual = Beliefs Emotional = Feelings Terms can carry over into other sessions, depending on discussion
Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about spirituality b. Allow students to create their own medicine wheel c. Provide strategies to act as protective factors to overcome strategies Promote engagement and performance in spiritual occupations from understanding spiritual health
Resources	BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Gilgun, J. F. (2004). The 4-D: Strengths-based assessment instruments for youth, their families, and communities. *Journal of Human Behavior in the Social Environment, 10*(4), 51-73. doi: 10.1300/J137v10n04_04 Turpin, M. & Iwama, M. (2011). *Using occupational therapy models in practice: A field guide*. Edinburgh, UK: Elsevier U.S. National Library of Medicine, (n.d.). *Medicine ways: Traditional healers and healing*. Retrieved from https://www.nlm.nih.gov/nativevoices/exhibition/healing-ways/medicine-ways/medicine-wheel.html

Activity for Session 1:



Visual: Circle of Courage Medicine Wheel



Brendtro, L., Brokenleg, M., & Van Bockem, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN: Solution Tree.

Session 2: Circle of Courage: Resiliency

Purpose	Resiliency is a product of four components: mastery, independence, generosity, and belonging (Brendtro et al., 1990; Feinstein, Driving-Hawk, & Baartman, 2009). It can be defined as "human capacity and ability to face, overcome, be strengthened by, and even be transformed by experiences of adversity" (Feinstein et al., 2009, p. 12, as cited by Cesarone, 1999, p. 12). Resiliency is needed as a protective factor for Native American youth due to the number of mental illnesses they are likely to face such as depression, substance use, trauma, and suicide (Henson, et al., 2017; Urbaeva, et al., 2017).
Preparation/ Supplies	To prepare for this activity, please read the outlined steps and the additional resources to ensure you understand the content well enough to discuss it with clients. Think about your own experiences and come up with examples from your own life to aid in the understanding of the concept of mastery in terms of spirituality. Consider what you deem as spiritual in your life and how it may or may not relate to what Native Americans may consider as spiritual. ***Note: supplies for the activity is provided at the end of this session**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** 2-4, 30 minute sessions
Goals	By the end of the session: 1. Students will be able to define resiliency in their own words 2. Students will be able to list the four factors of resiliency 3. Students will select at least 2 strategies to use to promote their individual resiliency
Rationale of Activity	Concepts from the Circle of Courage are vital to this program and are appropriate to introduce in the first unit of the program. The Circle of Courage introduces four concepts that will be embedded in the rest of the units and sessions in the program (Brendtro et al., 1990; Feinstein et al., 2009; Henson et al., 2017). Additionally, there is a mastery session in each unit to introduce skills and content directly related to the unit topic. Belonging, mastery, independence, and generosity are protective factors that work with the concepts of traditional Native American culture to help

	increase their resiliency (Brendtro et al., 1990; Feinstein et al., 2009; Henson et al., 2017).
Cultural Components	Culture is embedded in this session through the protective factors from the Circle of Courage. Native American values of family, connectedness, helping others, and success are reflected in belonging, generosity, independence, and mastery.
Precautions	Asking about difficult or challenging experiences in the warm-up may bring up strong emotions that may interfere with the session.
Steps	1) Introduction/Warm-up: Ask students to think about a difficult experience they had or that they had to go through. Ask them how they got through that difficult time. Did they have help? What did they do? What did they say? 2) Define/explain resiliency in simple terms (i.e. it is how you are able to get through a bad situation by doing something good). 3) Discuss the four components of resiliency and protective factors: belonging, mastery, independence, and connectedness as they relate to being school students. (These will all be included and interwoven into future sessions, with some sessions directly addressing them. Therefore, you can be brief in this explanation as long as students demonstrate they understand through defining/describing the terms). ○ **Belonging**: developing relationships with family members, community members, and school staff, faculty, and other peers (Brendtro et al., 1990). ○ **Independence**: demonstrating responsible behavior (Brendtro et al., 1990; Feinstein et al., 2009) (doing what is asked of you, following directions, turning work in on time, helping others, etc.) ○ **Mastery**: feeling knowledgeable and successful in a calm, relaxing environment while working together (Brendtro et al., 1990; Feinstein et al., 2009) ○ **Generosity**: helping others, doing kind things for others, trying to understand what others are feeling or going through (Brendtro et al., 1990; Feinstein et al., 2009). 4) Discuss each factor with the students allowing for questions or additional examples. 5) Examples of strategies that promote resiliency are: individual protective factors, relationship protective factors, multi-level protective factors (Henson et al., 2017) ○ **Individual examples** (Henson et al., 2017): eating healthy foods consistently, having a positive mood and self-image, self-efficacy (how confident you feel you are in your ability to complete tasks) ○ **Relationship examples** (Henson et al., 2017): role models, people you look up to), community support, talking to friends or family, feeling connected to school, having a friend/s who help

	others (set a good example by volunteering, have goals, participate in extracurricular activities ○ **Multi-level examples** (Henson et al., 2017): cultural connectedness, participating in traditional activities (powwows, ceremonies, tribal language) 6) Have students provide an example from each of the three types (individual, relationship, and multi-level) that they can use or that they currently use to help promote their resiliency 7) Ask students what resiliency means and what the 4 factors are 8) Conclusion/ Wrap-up: Restate the importance of resiliency and how there are strategies they can do every day to help them become more resilient.
Adaptations	For older students (9+): While this is mainly discussion-based, you could adapt it to become a worksheet or activity where students complete matching after you explain the terms. Additionally, you could make it a problem-solving activity where you suggest a situation with a problem, and they use the protective factors to determine what strategies they would use in that situation.
Outcome Criteria	The outcomes of this session should: a. Allow students to define resiliency and understand its meaning b. Identify all four components of resiliency c. Create strategies to promote each student's resiliency Promote resiliency and overall occupational performance from understanding spiritual health
Resources	Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and Native American teenagers. *Reclaiming Children and Youth, 18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921 Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention, 38*(1-2), 5-26. doi: 10.1007/s10935-016-0455-2 Urbaeva, Z., Booth, J.M., & Wei, K. (2017). The relationship between cultural identification, family socialization and adolescent alcohol use among Native American families. *Journal of Children and Family Studies, 26*(10), 2681-2693. doi: 10.1007/s10826-017-0789-2.

Activity for Session 2:

Resiliency Bingo

Belonging	Independence	Generosity	Mastery
Being kind to my family members	Doing what your parents and elders ask of you	Offering to help others	Getting good grades
Speak with neighbors using Native language	Follow directions the first time	Random acts of kindness	Helping or tutoring others with schoolwork
Spend time with friends at extra-curricular activities	Turn homework in on time	Understand what others are going through	Teaching others about beading, drumming, etc.
Respect teachers and school staff	Start an art project by myself or with friends	Volunteering for community events like powwow	Winning in my age category at the powwow

Session 3: Circle of Courage - Mastery (Spirituality)

Purpose	The purpose of this session is to use the Circle of Courage as a framework to provide education on mastery in terms of spirituality. The specific from the Circle of Courage focused on in this session is Mastery. Mastery means feeling competent in many areas, including in spirituality, to feel successful and facilitate knowledge (Brendtro et al., 1990; Feinstein et al., 2009). Thus, feeling a sense of mastery in the area of spirituality would involve feeling successful and knowledgeable about one's ability to express and participate in spiritual events or activities (Brendtro et al., 1990; Feinstein et al., 2009). Mastery of spirituality is not expected by the end of the session, rather the purpose is to introduce and familiarize clients with the concepts for lifelong success.
Preparation/ Supplies	To prepare for this activity, please read the outlined steps and the additional resources to ensure you understand the content well enough to discuss it with clients. Think about your own experiences and come up with examples from your own life to aid in the understanding of the concept of mastery in terms of spirituality. Consider what you deem as spiritual in your life and how it may or may not relate to what Native Americans may consider as spiritual.
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** 1-2 sessions, 30 minutes each
Goals	By the end of the session: 1. Students will define what spirituality means to them 2. Students will describe something that has spiritual value 3. Students will explain a situation where they experienced mastery in spirituality 4. Students will develop a goal to foster spiritual mastery
Rationale of Activity	Protective factors are essential to address with Native Americans, as it promotes more strengths than focusing on negatives. Resiliency can be taught and promoted in educational contexts (Feinstein, et al., 2009). The Circle of Courage is a framework that will help to foster resiliency (Lee & Perales, 2005). Mastery is one of the concepts of the Circle of Courage protective factors, and spiritual mastery will aid in increasing resiliency.
Cultural Components	Native American cultural values are embedded in this session in how they tend to value spirituality. The Circle of Courage protective factors also relate to

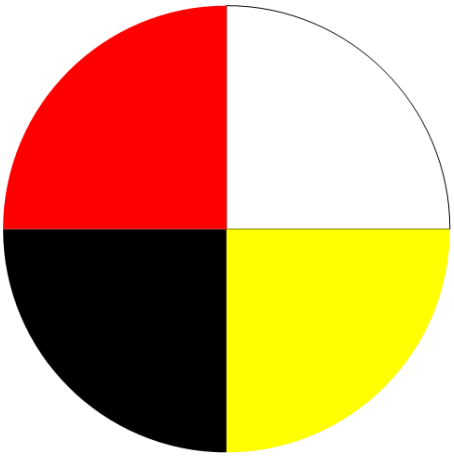
	cultural values and beliefs of Native Americans (Feinstein et al., 2009; Henson et al., 2017).
Precautions	Discussing examples of these concepts may bring up strong emotions in the clients. You may need to pause the session to discuss these feelings or you may need to stop the session altogether to have the student seek out a counselor to further discuss these experiences if you feel that it is outside of your scope of practice.
Steps	1) Define spirituality and mastery and explain the connection between the two terms ○ **Spirituality** - connection to land and other inanimate and animate objects, dreams, praying to the Creator, and participating in ceremonies (BigFoot & Schmidt, 2010; Kidwell & Velie, 2005; Pember, 2016) ○ Ask clients to define/describe what spirituality means to them individually and what they do to demonstrate spirituality ○ **Mastery** – success and knowledge (Feinstein et al., 2009) ○ Mastery of spirituality would mean understanding what spirituality means and being able to successfully participate and demonstrate it. 2) Discuss examples and then ask the student to come up with an example of spiritual mastery: ○ **Spiritual mastery**: Knowing and successfully defining and doing spiritual activities ○ **Examples**: listing activities with spiritual meaning (praying to Creator, attending powwows, family traditions) and being able to complete them the way they are meant to be done 3) Work together to develop a goal related to spiritual mastery ○ This can be individually-based, family- or community-based ○ The purpose of this is to have clients think ahead to continue working towards spiritual mastery
Adaptations	If you are working on handwriting in a school setting for example, you can make this into a writing activity. You can have the client write his or her goal of spiritual mastery on paper. If appropriate, have the student draw what spirituality means to them and you can assess their pencil grasp, coloring quality, etc.
Outcome Criteria	The outcomes of this session should: a. Promote students' knowledge about spirituality and mastery b. Facilitate exploration of students' spiritual activities c. Promote problem-solving strategies of how and when to use spiritual mastery d. Provide students with personal goals to promote their own spiritual mastery

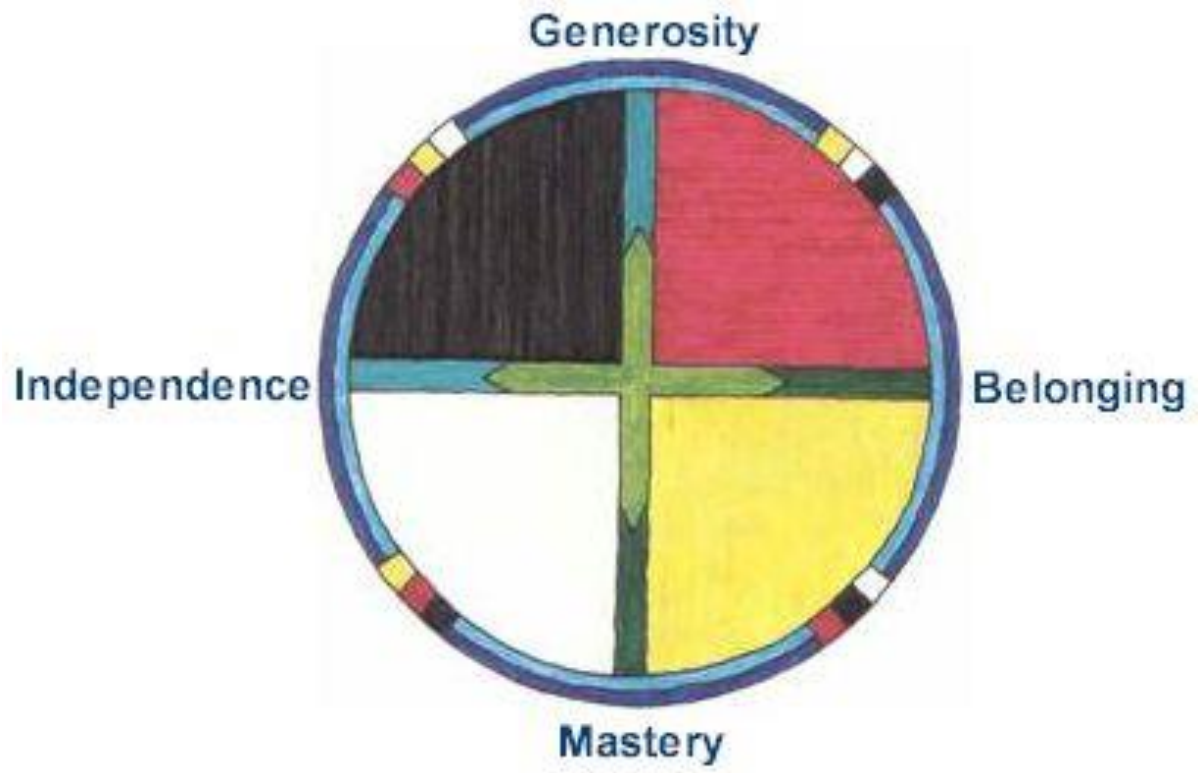
	Promote positive mental health and occupational performance from understanding spiritual health and mastery
Resources	BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and native American teenagers. *Reclaiming Children and Youth*, *18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921 Kidwell, C. S. & Velie, A. (2005). *Native American Studies*. University of Nebraska Press: Lincoln, NE. Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention, 38*(1-2), 5-26. doi: 10.1007/s10935-016-0455-2 Lee, B., & Perales, K. (2007). Circle of courage: Reaching youth in residential care. *Residential Treatment for Children & Youth*, *22*(4), 1-14. Retrieved from https://doi.org/10.1300/J007v22n04_01 Pember, M. A. (2016). *Intergenerational trauma: Understanding Natives' inherited pain*. Retrieved from www.indiancountrytodaymedianetwork.com.

Activity for Session 3

- **Make a dreamcatcher**

- **Fill out medicine wheel/add to spirituality concepts**





Brendtro, L., Brokenleg, M., & Van Bockem, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN: Solution Tree.

Spirituality Outcome Measure

For Client's ages 10-18:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what spirituality is:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

2) I know how important spirituality is for my health

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

3) I understand how my spiritual needs affect my life

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

4) I am able to select spiritual activities I enjoy doing

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

5) List 2 spiritual activities you enjoy:

1)

2)

For students 5-10:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what spirituality is:

No **Not Sure** **Yes**

2) I know how important spirituality is for my health:

No **Not Sure** **Yes**

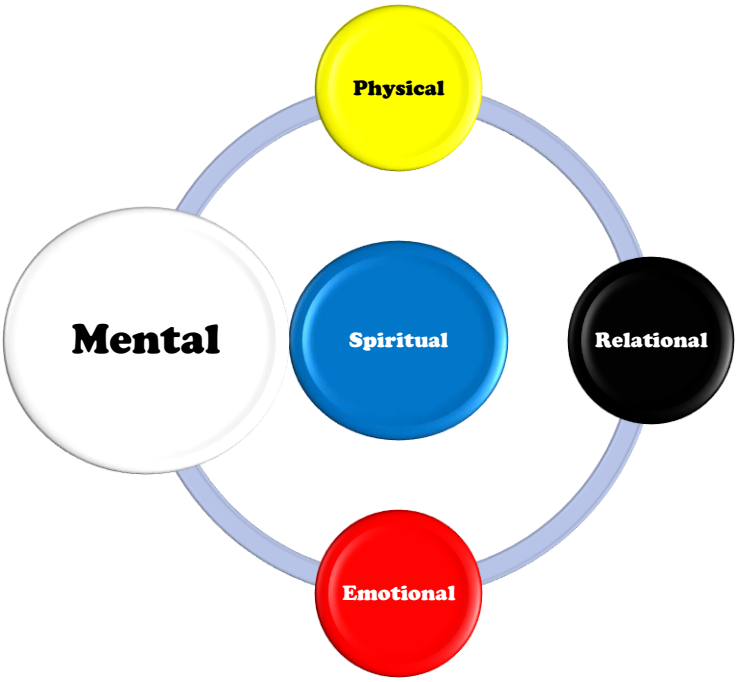
3) I understand how my spiritual needs affect my life

No **Not Sure** **Yes**

4) I can pick spiritual activities I enjoy doing

No **Not Sure** **Yes**

Unit II: Mental Health



Introduction	Mental health is a main component of this program. It is necessary to address mental health due to the high rates of depression, suicide, trauma, and substance use in Native American children (Evans-Campbell, Walters, Pearson, & Campbell, 2012). Additionally, their family members may suffer from a mental illness such as posttraumatic stress disorder due to historical trauma and internalized oppression (Horwitz, 2014; Peacock & Wisuri, 2002). Being exposed to this can result in exposure to substance use, abuse, violence, and crime (Horwitz, 2014; Theriot & Parker, 2007). Native American children would benefit from sessions with culturally relevant interventions to address their mental health needs. The CMOP-E is an appropriate model to use when addressing mental health with children (Hall, McKinstry, & Hyett, 2016). It helps to explain how "positive mental health is the product of meaningful engagement in occupation within a supportive environment which promotes personal development, skill acquisition, goal attainment and socialization" (Hall et al., 2016, p. 475). An example of why this is important to address with this population is that

<table>
<tr><td></td><td colspan="2">engaging in meaningful leisure occupations is a way to relieve stress, express one's self, and interact with peers (Hall et al., 2016).</td></tr>
<tr><td>Terms</td><td>Terms</td><td>Definition</td></tr>
<tr><td></td><td>Mental Health</td><td>"Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium" (Galderisi, Heinz, Kastrup, Beezhold, & Sartorius, 2015, p. 231-232).</td></tr>
<tr><td></td><td>Protective Factor: Resiliency</td><td>"The ability to cope with stress; a positive capacity of an individual to responds under
pressure" (Thornton & Sanchez, 2010, p. 45).</td></tr>
<tr><td></td><td>Personal History</td><td>"A personal timeline is a graph or diagram that visualizes significant moments in a person's life." ("Personal timeline", 2017, para. 1). It acts like a protective factor (Henson et al., 2017).</td></tr>
<tr><td>Goals</td><td colspan="2">Therapist goals:
1) Define resiliency and acknowledge its significance in mental health with Native American populations
2) Prepare and implement a culturally relevant intervention session to promote resiliency and mental health

Student goals:
1) Demonstrate increased knowledge of mental health and resiliency
2) Identify two coping skills with cultural relevance or meaning
3) Apply 2 coping skills outside of the school setting</td></tr>
<tr><td>CMOP-E components</td><td colspan="2">1) Person:</td></tr>
</table>

	a. Person components related to mental health include affective, cognitive, and spirituality (Polatajko et al., 2010). Affect, or how one is feeling, can be influenced by what one is thinking. The link between affect and cognition in the person can be seen when implementing mental health strategies. Spirituality is still incorporated into the unit of mental health as it is a part of Native American culture. b. Resiliency can influence person factors and mental health, providing Native American youth with skills they need to face challenges **2) Environment:** a. **Social Environment**: People within the social environment can affect mental health in a positive or negative manner. Developmentally, children and adolescents are influenced by their peers. b. **Physical environment**: The space and resources in the environment can affect mental health. Memories or emotions can be the result of being in a specific, physical environment. **3) Occupation:** The use of participation and engagement in meaningful activities will promote mental health and the development of resiliency traits. Oftentimes, self-care, productivity, and leisure tasks can be neglected when dealing with a mental health problem. Promoting healthy engagement and balance in these areas can help promote mental health. **4) Enablement:** The use of enablement skills, especially collaborating and coaching, will help promote resiliency and mental health in Native American students. Establishing rapport and having open communication can foster a collaborative approach to working together. Coaching and encouraging will provide the support the students' need.
Adaptations	Adapt activities for the age level. Developmental level needs to be assessed and addressed to meet the student where they are. Generally, younger students need more structure and have less self-awareness abilities. Activities should be concrete, simple, and straight-forward. Timing should not exceed 30 minutes for students ages 6-11 (Bastable et al., 2011). As mental health is a difficult concept for children to comprehend, consider describing it in simple terms using a simple example. Explain how it relates to thinking and feeling. For example, say that "just like how you need a healthy body to run fast and jump high, you need a healthy mind. We will work

	together to find ways to keep your mind healthy". Another term to use instead of mental health is "happy mind."
Outcome Criteria	At the end of this unit there is a pretest/posttest that measures the outcomes of this unit. It is designed as a Likert-scale to see the improvement in the client's perception of mental health.
Additional Activity Ideas & Rationale	• Sensory strategies or techniques to enhance mental health • Practice and learn Native language • Reading books on Native American culture and history • Other Circle of Courage topics: generosity, belonging • BigFoot & Schmidt's (2010) article on Honoring Children, Mending the Circle • LaFromboise (1996) curriculum with activities addressing depression, suicide, and other areas of mental health for adolescents and young adults. • BigFoot and Schmidt (2010) developed culturally relevant CBT • Current or future aspirations/goals (Henson et al., 2017) • Basket weaving, pottery making, beadwork, jewelry making **Rationale**: Activities that promote connectedness and resiliency can help promote protective factors that students have related to mental health. ensuring that the activities have a culturally relative component will increase their effectiveness.
Resources	Bastable, S. B., Gramet, P., Jacobs, K., & Sopczyk, D. L. (2011). *Health professional as educator: Principles of teaching and learning*. Sudbury, MA: Jones and Bartlett Learning. BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Evans-Campbell, T., Walters, K. L., Pearson, C. R., & Campbell, C. D. (2012). Indian boarding school experience, substance use, and mental health among urban two-spirit American Indian/Alaska Natives. *The American Journal of Drug and Alcohol Abuse*, 38(5), 421-427. doi: 10.3109/00952990.2012.701358.

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231-233. doi: 10.1002/wps.20231

Hall, S., McKinstry, C., & Hyett, N. (2016). Youth perceptions of positive mental health. *British Journal of Occupational Therapy, 79*(8), 475-483. doi: 10.1177/0308022616632775.

Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention, 38*(1-2), 5-26. doi: 10.1007/s10935-016-0455-2

Horwitz, S. (2014). *The hard lives-and high suicide rate- of Native American children on reservations*. Retrieved from https://www.washingtonpost.com/world/national-security/the-hard-lives--and-high-suicide-rate--of-native-american-children/2014/03/09/6e0ad9b2-9f03-11e3-b8d8-94577ff66b28_story.html?utm_term=.7bc8d903c179.

LaFromboise, T.D. (1996). *American Indian life skills curriculum*. Madison, WI: The University of Wisconsin Press.

Peacock, T., & Wisuri, M. (2002). *Ojibwe: Waasa Inaaabidaa: We look in all directions*. Minnesota Historical Society Press: St. Paul, MN.

Polatajko, H.J., Townsend, E.A. & Craik, J. (2010). Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36 Retrieved from https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf.

Theriot, M. T. & Parker, B. (2007). Native American youth gangs: Linking culture, history and theory for improved understanding, prevention and intervention. *Journal of Ethnicity in Criminal Justice 5*(4), 83-97. doi: 10.1300/J222v05n04 04

Thornton, B., & Sanchez, J. E. (2010). Promoting resiliency among Native American students to prevent dropouts. *Education*, *131*(2), 455-465. Retrieved from https://eric.ed.gov/?id=EJ930615

Session 1: Personal History

Purpose	The purpose of developing a personal history is that it can act like a protective factor. History is linked to fostering pride, identity, and self-esteem (DeMars, 1992). Helping clients identify and understand more about their own personal history can help increase their resiliency and connectedness (Henson et al., 2017). Enhancing protective factors will help children move up Maslow's hierarchy, enhancing their ability to perform academic tasks (Braungart, Braungart, & Gramet, 2011). (Exploring History Fostering Pride article, DeMars, 1992)
Preparation / Supplies	Paper, pencil/pen, colored pencils, crayons, markers, tape or stapler Optional: computer, internet access to print pictures or images ***Note: examples for paper handouts provided at the end of this session**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline**: 2-3, 30-minute sessions
Goals	By the end of the session: 1. Students will define or describe history and its importance in his/her personal life 2. Each student will develop a personal history/timeline 3. Students will define and explain their own personal history 4. Students will describe 1-2 ways that their family, friends, or community members can support them or vice versa
Rationale of Activity	Developing a personal history is a necessary activity to help students learn about their family or community's history and culture so that they are better able to understand and learn who they are. Native American culture typically revolves around the individual, their family, and their community (Urbaeva et al., 2017). An activity like this will involve working with the child's family, which will foster communication with family or community

	members. Fostering communication to work on an activity like this will, in turn, foster a sense of connectedness, which is a protective factor (Gerlach, 2008; Henson et al., 2017).
Cultural Components	History plays an important role in Native Americans' lives because it still affects many today, generations later. Historical trauma may affect those who experienced it firsthand at boarding schools, or they may be experiencing the negative, residual effects that have been passed down. Traumatic experiences like this can have a negative impact on student's mental health. Native American culture, however, has factors that can promote resiliency against these effects. Exploring their family or community's history and cultural values and beliefs of Native Americans in general, can promote feelings of connectedness and an overall feeling of empowerment.
Precautions	Strong emotions may arise because of some of the history the child learns about his/her family. It will be important to be prepared to address these emotions. The child may bring up topics regarding substance use, trauma, or other situation and it may be beneficial to involve a counselor to help the child process through these.
Steps	This activity may span across multiple sessions 1) Introduce concepts and terminology of personal history. Explain why history is important and how it can make you feel more connected to family members, friends, and community members. The concept of "family" can mean more than just those who are biological relatives; it can extend to friends and community members. 2) Introduction: "What you have experienced in the past influences who you are today (LaFromboise, 1996). People around you have also helped you become who you are today, and have been there for the important events in your life. So, we are going to make a picture of your personal life history." ○ Collage ○ Journal ○ Timeline ○ Maslow's pyramid 3) Have the child/ help the child write down the important people in his/her life 4) Write the important events in his/her life

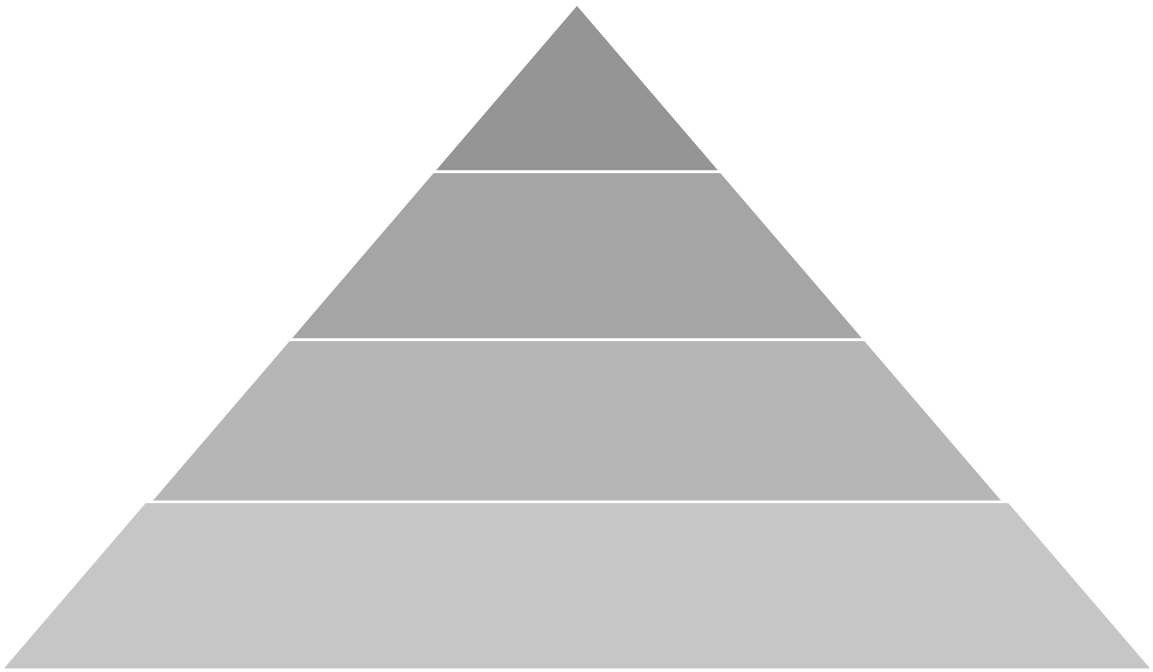
	5) Draw and discuss the timeline of the events and how they connect to the child. 6) Have the child draw his/her personal timeline of events, drawing pictures or using words to describe the events and draw the people involved in those events. Suggest that the child thoughtfully choose colors, shapes, and images to portray meaning. 7) Conclusion: Reiterate the important people in the student's life that were there for the important events in his/ her life thus far. Encourage the child to continue to add to the timeline as they get older.
Adaptations	This activity may take multiple sessions, you can allow the child to complete sections of the activity like homework. This would give them time to interview family members.
Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about history and how it can affect a person b. Produce a personal history diagram to act as a protective factor c. Create strategies to promote social support and resiliency Promote positive mental health and occupational performance from understanding personal and family history
Resources	Braungart, M. M., Braungart, R. G., & Gramet, P. R. (2011). Applying learning theories to healthcare practice. In Bastable, S. B., Gramet, P., Jacobs, K., & Sopczyk, D. L. (Eds.), *Health professional as education: principles of teaching and learning* (pp. 55-101). Sudbury, MA: Jones & Bartlett Learning. DeMars, P. A. (1992). An occupational therapy life skills curriculum model for a Native American tribe: A health promotion programs based on ethnographic field research. *American Journal of Occupational Therapy*, *46*(8), 727-736. Retrieved from http://ajot.aota.org/ LaFromboise, T. D. (1996). *American Indian life skills development curriculum*. Madison, Wi: The University of Wisconsin Press Gerlach, A. (2008). "Circle of caring": A first nations worldview of child rearing. *Canadian Journal of Occupational Therapy, 75*(1), 18-25. Retrieved from http://journals.sagepub.com/doi/abs/10.1177/000841740807500107

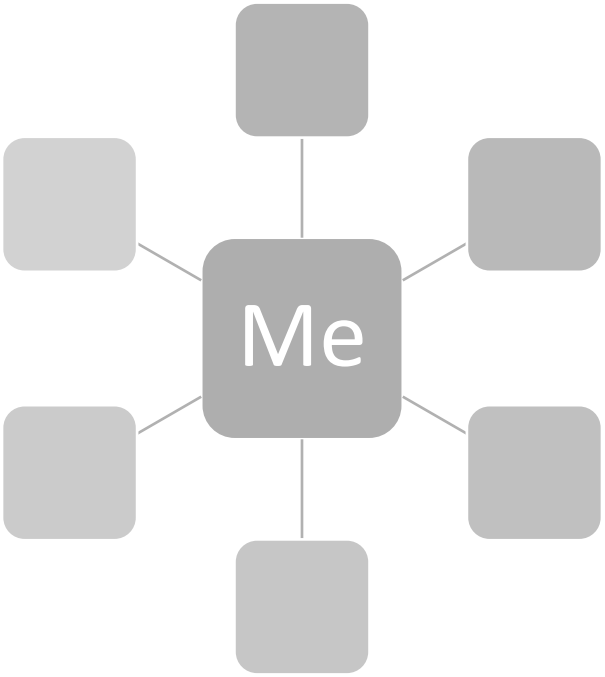
Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention, 38*(1-2), 5-26. doi: 10.1007/s10935-016-0455-2

San Diego County District Attorney. (n.d.). *Girls only! Toolkit*. Retrieved from http://www.sdcda.org/office/girlsonlytoolkit/toolkit/got-14-diversity.pdf

Urbaeva, Z., Booth, J.M., & Wei, K. (2017). The relationship between cultural identification, family socialization and adolescent alcohol use among Native American families. *Journal of Children and Family Studies, 26*(10), 2681-2693. doi: 10.1007/s10826-017-0789-2.

Activity for Session 1:





Session 2: Coping Skills

Purpose	Introducing coping skills is a way to help Native American students deal with mental health problems they may encounter. Coping skills can help students address anxiety and stress that they may encounter in their lives. Developing culturally relevant coping skills is a way to include a meaningful, client-centered approach. Doing so will hopefully aid in promoting mental health so that students can enhance their educational performance. Oftentimes, Native American children experience trauma due to historical trauma experienced by their relatives, or they may experience these feelings because of post-traumatic stress disorder (Deters, Novins, Fickenscher, & Beals, 2006). They may turn to negative coping skills, such as substance or alcohol use, used by their role models or older family members (Urbaeva et al., 2017). Therefore, it is critical to Introduce healthy coping skills as an alternative to the negative ones they may have already been exposed to.
Preparation/ Supplies	Read this outline and any of the additional resources prior to implementing the session. Practice the coping strategies beforehand to become familiar with them. Think about times when you have or would use these strategies in your own life. Ensure that you have established enough of an understanding of the material and the coping strategies that you are able to explain aspects to clients if they ask. Paper, pencil, colored markers/pencils/crayons ***Note: an example of coping skills bingo paper is provided at the end of this session**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** 1, 30-minute session

Goals	By the end of the session: 1. Students will list 1-2 coping strategies 2. Students will identify 1 coping skill to use when given a description of a stressful or anxiety-provoking situation 3. Students will identify and describe 2 situations in which they can use coping skills in their lives.
Rationale of Activity	Introducing age-appropriate, culturally relevant coping skills will help students manage stressful or anxiety-provoking situations in their lives. Coping skills that are already established may be too difficult for students to comprehend and fully grasp. It is important to discuss coping skills in a fun and meaningful way that meets students where they are at developmentally. Doing this will increase their ability to utilize these skills to promote their mental health and resiliency. Being able to increase resiliency and improve mental health by using coping skills will help students to feel calm so that they can focus on their school work to enhance their educational performance.
Cultural Components	Maladaptive coping skills such as substance or alcohol use are common in Native American populations (Urbaeva et al., 2017). These substances are not part of the traditional cultural values and beliefs. In fact, an addiction can affect mental health, spirituality, and the physical body (Moghaddam, Momper, & Fong, 2014). These holistic effects would then detract from participation in spirituality. There is a link between mental health and spirituality and addressing one will influence the other.
Precautions	The client may be hesitant or resistive to using these coping skills or strategies. Reassure that they are in a safe place with you. Consider asking them what is making them feel this way.
Steps	1) Warm-up: Ask what the student currently does to calm down when he/she is feeling upset or anxious. (If they are unsure what it means to be anxious, you can explain that it can feel like butterflies in your stomach, you might get sweaty, your heart might beat faster, etc.) 2) Ensure students know that they are in a safe place with you. 3) Instruct and explain the importance of relaxation. Thinking and feeling are connected and can also impact physical health (BigFoot & Schmidt, 2010).

4) *Practice each of the following coping skills:* Practice them until the child demonstrates competency or when they successfully complete all the steps. Allow for additional practice of each strategy if needed, and time for questions:
    - **Mindfulness**: "If you have bad or scared thoughts, you can leave them outside this place. Think about who you are, close your eyes, breathe in, feel how you are sitting..." (BigFoot & Schmidt, 2010, p. 852). Appreciate the present moment; focus on the here and now. Allow students to sit quietly in a calm, quiet environment. You can turn the lights off if you ensure the student will stay awake.
    - **Visual Imagery**: Engage sensory system: sight, sound, smell, feel, taste. With eyes closed either sitting or lying down. Read in a slow, calm voice:
        - "Picture a safe place out in nature (I.e. quiet forest, calm lake, etc.) You can feel the cool/warm breeze, you can hear the quiet rustle of leaves, birds are chirping in the distance. It's a warm summer day. You feel the sun's warmth on your face. The grass beneath you is cool and comforting. You can smell the fresh grass and the flowers. You are safe. You are calm. You are happy."
        - LaFromboise (1996) uses nature-related terms and images in a visualization activity. Each step of what you would narrate is listed out and helps students relax.
    - **Writing/Drawing:** Instead of talking about feelings first, allow the child to draw or write what they are feeling (LaFromboise, 1996). If the child is in a calm state of mind, have a discussion about what was drawn, explaining that you are there to help and that you want to understand what he/she is going through. Then, you may be able to ask probing questions regarding what the child drew in order to help them facilitate putting emotions into words. Additionally, encourage the use of the student's Native language if that is a better way to get across what he or she is experiencing. (Do not be offended if the child is unable to put into words what he or she is feeling; it can be difficult for Native Americans to discuss their emotions, as they tend to keep them inside as a part of their culture.)
    - **Talking to Someone**: Encourage the child to speak to their Elders who have more wisdom than they do. Encourage them to talk to their positive role models (people they look up to or admire),

	parents, aunts, uncles, or grandparents to share what they are feeling and to ask for advice on how to deal with it. Placing a high value on family suggests that what their family says may influence what they do about it. Tell them that they can also consider you as a resource to talk to in addition to other staff or faculty at the school (i.e. a counselor). ○ **Make a List**: Work with the child to make a list of activities they can do when feeling sad, anxious, or stressed. These activities can be done indoors, outdoors, and in each season. Brainstorm a list together for all of these situations. (Examples: walking outdoors, talking to an Elder, doing a craft, playing a ball game with cousins). When finished make a copy for the child to take home, and encourage him or her to add new ideas or activities as needed. When the child does one of the activities, have them draw a star next to it or place a sticker by it so they can see what they have tried, what words, etc. ○ **Music**: Listen to calming Native American flute music or drum music if students find that to be calming. You can pair the music with the other activities as well (LaFromboise, 1996) 5) *After practicing each strateg*y: Ask the child what they liked/did not like about each strategy. 6) Provide examples of when it would be beneficial to use each of these (Before playing a new game with family, when a family member moves away, if it is loud when family comes to visit, etc.). Ask the child to suggest a coping skill to use after you have suggested a situation. 7) Ask the child to think about a situation in his/her own life when he or she could use each of the coping strategies. 8) Provide an example of a stressful situation the student may encounter. For instance: "When you get home after school, you have family coming over for supper, and your family needs help in cleaning and cooking to prepare for guests. You still have homework to do for class tomorrow and the neighborhood kids and you made plans to play together. What do you do?" Help the student problem-solve the scenario and use verbal or visual cues to remind them of the coping strategies you just went over. 9) Explain that you may cover these strategies again at another time, and that you would to hear about a time when the child used these coping skills at home or at school.
Adaptations	Depending on the student's level of insight, you may need to provide examples of when it would be an appropriate situation for them to use the

	coping skills in their lives. If they are unable to state a time when they could use these coping skills at home, have them explain a time at school that would be appropriate. It may be better to address these skills over multiple sessions depending on the student's attention span or distractions in the environment. You may need to plan to use a quiet space to practice these coping skills in a future session. Additionally, if the child brings up an issue or situation in the moment where he/she describes feeling anxious or stressed, then you may want to do coping skills side-by-side with the child to help him or her calm down.
Outcome Criteria	The outcomes of this session should: 1. Develop a list of strategies students can use to deal with stressful situations 2. Practice each of the coping strategies step-by-step 3. Apply the coping skills to a specific scenario or real-life example Promote positive mental health and occupational performance from understanding and practicing coping strategies
Resources	BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Deters, P. B., Novins, D. K., Fickenscher, A., & Beals, J. (2006). Trauma and posttruamatic stress disorder symptomatology: Patterns among American Indian adolescents in substance abuse treatment. *American Journal of Orthopsychiatry, 76*(3), 335-345. doi: 10.1037/0002-9432.76.3.335. LaFromboise, T.D. (1996). *American Indian life skills curriculum*. Madison, WI: The University of Wisconsin Press Urbaeva, Z., Booth, J.M., & Wei, K. (2017). The relationship between cultural identification, family socialization and adolescent alcohol use among Native American families. *Journal of Children and*

Family Studies, 26(10), 2681-2693. doi: 10.1007/s10826-017-0789-2.

Activities for Session 2:

Coping Skills Bingo

Go for a nature walk	**Talk to a friend**	**Talk to an elder**	**Ask a teacher for help**
Drum and dance	**Listen to calming flute music**	**Write down feelings and thoughts in a journal**	**Draw feelings or thoughts**
Pray in Native language	**Do visual imagery steps**	**Deep breathing**	**Play a game outside with friends**
Practice beadwork	**Make a dreamcatcher**	**Do a craft with a friend**	**Eat a healthy snack**

Coping Skills for Me

Coping Skill	What I liked	What I didn't like	When I can use it
Mindfulness			
Visual imagery			
Write/draw			
Talk to someone			
Make a list			
Listen to music			
Other:			

Session 3: Mastery/Independence

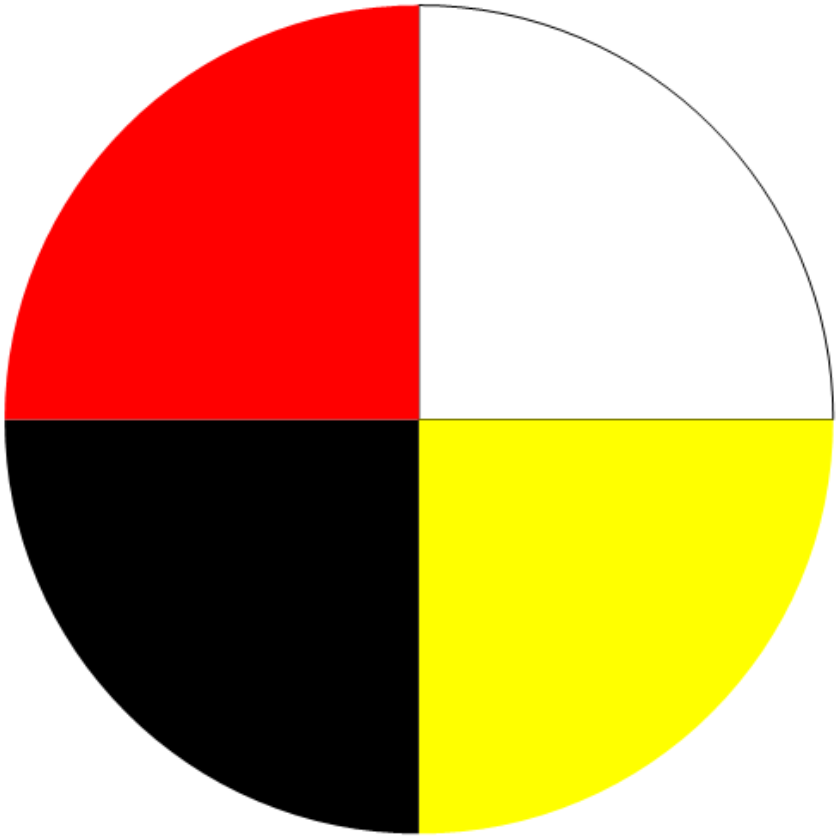
Purpose	Mastery is a protective factor that promotes resiliency (Brendtro et al., 1990; Feinstein et al., 2009). In order to foster mastery in mental health, clients need to feel knowledgeable and successful when it comes to their personal mental health (Brendtro et al., 1990; Feinstein et al., 2009). It is assumed that mastery of independence is a lifelong pursuit, and that this session is an introduction to the topic. Clients can begin to develop goals specifically for mastery of mental health so that they have a strategy when they encounter difficult situations.
Preparation/ Supplies	Read the session outline and additional resources so that you have a full understanding of the concept of independence as it relates to Native American culture and the Circle of Courage. ***Note: a picture of the Circle of Courage and goal worksheet is provided at the end of this session**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** 1, 30-minute session
Goals	By the end of the session: 1. The child will define and describe mental health and mastery 2. The child will describe at least one time they demonstrated independence 3. The child will develop at least 2 goals (1 for at school and 1 for outside of school) to foster mastery in mental health
Rationale of Activity	Mastery is a protective factor that will foster resiliency in Native American children (Brendtro et al., 1990; Feinstein et al., 2009; Henson et al., 2017). Mastery is also a part of Native American culture in that they want to be successful in what they do, which enhances this session's cultural

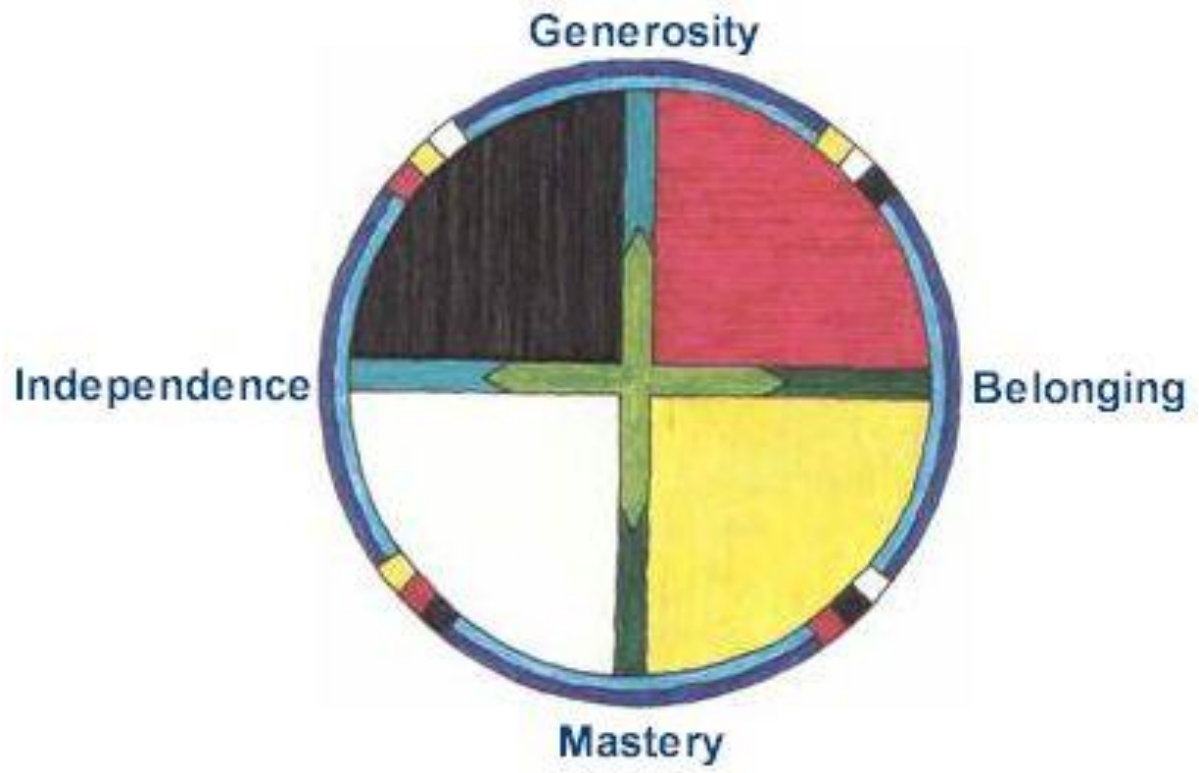
	relevance. This session is meant to take place last in the unit since it combines concepts discussed in previous sessions in the unit.
Cultural Components	Incorporating mastery is a protective factor for Native Americans, related to their cultural values and beliefs. Discussing mental health strategies/ coping skills from previous sessions incorporates cultural components as well.
Precautions	Students may become disruptive and off-task during the session. You may need to do a gross motor activity beforehand to promote their focus and concentration. These concepts may also be difficult for younger students to understand, so be prepared to explain the concepts in simpler terms.
Steps	1) Introduction/Warm-up: Ask students what they think mastery of mental health means? If they have heard it, can they provide an example (meaning to have the knowledge to take care of your own mental health and wellbeing and/or get help when needed)? 2) Provide definition of mastery: demonstrating success and knowledge (Brendtro et al., 1990; Feinstein et al., 2009). 3) Discuss examples of mastery behavior - Ask the client to describe a time he or she demonstrated mastery of mental health (I.e. used a coping strategy from previous session) • Knowing when to use a healthy coping skill and demonstrating how to use it. • Knowing when to ask for help 4) Develop goals by collaborating to foster mastery of mental health ○ Examples: in the classroom, or at home ○ In classroom: deep breathing ○ At home: journaling 5) Conclusion/Wrap-up: ask if clients have any questions and what they learned from this discussion about mastery of mental health
Adaptations	Incorporate handwriting if appropriate by having students write down their goals. Discuss this material while working on a craft or other project if the client can focus on doing a task while listening and discussing.
Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about mental health and mastery b. Apply mastery skills to examples c. Develop personal goals and strategies to enhance mastery in mental health

	Promote mastery and occupational performance from understanding mental health
Resources	Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and native American teenagers. *Reclaiming Children and Youth*, *18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921 Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention*, *38*(1-2), 5-26. doi: 10.1007/s10935-016-0455-2 Lee, B., & Perales, K. (2007). Circle of courage: Reaching youth in residential care. *Residential Treatment for Children & Youth*, *22*(4), 1-14. Retrieved from https://doi.org/10.1300/J007v22n04_01

Activities for Session 3:

- **Add mental health concepts in personal medicine wheel**





Brendtro, L., Brokenleg, M., & Van Bockem, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN: Solution Tree.

Mastery Goals Worksheet	
Mastery Goals **(What I want to do)**	**Plan to meet goals** **(How I will do it)**
•	• • •
•	• • •
•	• • •

Mental Health Outcome Measure

For Client's ages 10-18:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what mental health is

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

2) I know how important my mental health is

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

3) I understand how my mental health needs affect my life

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

4) I am able to select positive mental health activities I enjoy doing

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

5) List 2 mental health activities you enjoy:

1)

2)

For students 5-10:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what a happy mind is

No **Not Sure** **Yes**

2) I know how important it is to have a happy mind

No **Not Sure** **Yes**

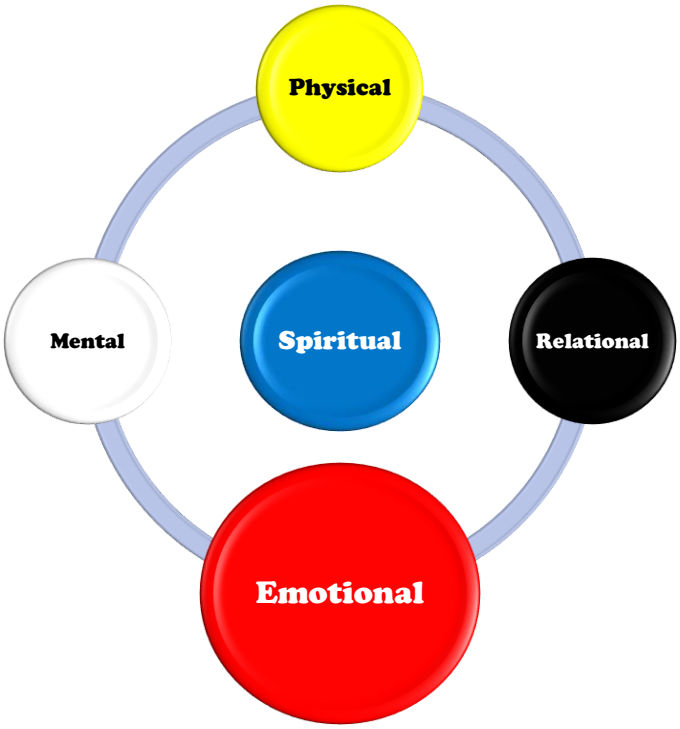
3) I know that the way my mind feels affects how I act

No **Not Sure** **Yes**

4) I can pick activities that are make my mind happy

No **Not Sure** **Yes**

Unit III: Emotional



Introduction	This unit focuses on promoting emotional health. The definition of mental health used for this program is how mental health includes the "ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events" (Galderisi, Heinz, Kastrup, Beezhold, & Sartorius, 2015, p. 231-232). The importance of having the ability to understand one's emotions, as well as figure out coping strategies is important for mental health. Factors such as historical trauma, being subject to oppression, racism, and the influence of mental health issues have led to poor emotional health in Native Americans (Peacock & Wisuri, 2002). In addition, a lack of positive emotional coping strategies has led to high rates of maladaptive coping skills such as substance use (Brockie et al., 2015). Using the CMOP-E, an occupational therapist leading this unit should recognize that one component of the person is affective (Turpin & Iwama, 2011). Affective is one performance component that makes up the person, meaning that a person's performance in occupations has affective considerations (Turpin & Iwama, 2011). The affective component of the person is the emotions and feelings a person experiences. The occupational

<table>
<tr><td></td><td colspan="2">therapist, using this program, should recognize that each individual would have different affective components to consider when implementing this unit.

This unit incorporates exploration of positive emotional expression and coping strategies. It also will promote culturally-relevant care for Native Americans through continued emphasis on expanding protective factors and use of the Circle of Courage. Ultimately, this unit focuses on understanding the client's emotions and working to improve emotional health, which will improve overall mental health.</td></tr>
<tr><td>Terms</td><td>Terms</td><td>Definition</td></tr>
<tr><td></td><td>Emotional health</td><td>Feelings, thoughts, and behaviors that influences well-being and mental health (Healthy Place, 2017).</td></tr>
<tr><td></td><td>Mental health</td><td>"Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium" (Galderisi et al., 2015, p. 231-232).</td></tr>
<tr><td></td><td>Affective</td><td>One component that makes up a person according the to Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko et al., 2010).

"Relating to moods, feelings, and attitudes" ("Affective", n.d.).</td></tr>
<tr><td></td><td>Emotional health</td><td>Feelings, thoughts, and behaviors that influences well-being and mental health (Healthy Place, 2017).</td></tr>
<tr><td></td><td>Maladaptive coping skills</td><td>Strategies to deal with problems that may be harmful to one's health, including aggression, suppression, or passive-aggression (Vantage Point, 2017).</td></tr>
<tr><td>Goals</td><td colspan="2">Therapist goals:
1) Be able to recognize the connection of positive emotional health on overall mental health
2) Evaluate client's current emotional health and determine both positive areas and improvement areas to promote better mental health.</td></tr>
</table>

	3) Prepare and implement culturally relevant interventions to build on protective factors and address areas of need regarding emotional health. Student goals: 1) Describe the effects emotions have on behavior and mental health. 2) Be able to compare positive versus negative emotions and coping strategies. 3) Develop strategies to promote emotional health in all areas of life.
CMOP-E components	**1) Person:** a. The person component addressed primarily in this unit is affective. The affective component of the person is the emotions and feelings of a person. This unit focuses on emotional health and using strategies that incorporate spirituality to promote better overall mental health in Native American students. b. As mentioned above, spirituality is another component addressed using spiritually meaningful activities. The CMOP-E has spirituality at the center of the person, so a person will have more success with activities that provide meaning to their lives (Turpin & Iwama, 2011). **2) Environment:** a. **Social Environment**: The CMOP-E recognizes the importance of addressing social change, especially when social inequalities are present (Townsend & Polatajko, 2007). Social inequality is present among Native Americans due to the history of oppression (Peacock & Wisuri, 2002). The occupational therapist working in this unit should be aware that the effect of the social environment, can influence a person's affect. In addition, a possible intervention is to promote occupational inclusive environments in the school itself. b. **Physical environment**: The physical environment can affect the amount of resources available, which can influence the types of coping strategies available. **3) Occupation:** Occupations that are spiritually fulfilling (meaningful) to the person will improve the person's emotional health (affect). Participating in meaningful activities will elicit emotions, and the goal of this unit is to improve emotional health. Therefore, using occupations that are meaningful to the client will promote positive emotional health and overall mental health. **4) Enablement:** The enablement skills that should be utilized in this unit include coaching, collaborating, educate, and engage. The use of these skills will promote a positive rapport and outcome for the client. In addition, the occupational therapist could use advocate within the school to advocate for an environment that is occupationally inclusive.

Adaptations	Adapt activities for the age level. Developmental level needs to be assessed and addressed to meet the student where they are. Generally, younger students need more structure and have less self-awareness abilities. Activities should be concrete, simple, and straight-forward. Timing should not exceed 30 minutes for students ages 6-11 (Bastable et al., 2011). The terminology used can be adaptive for younger ages or developmental levels. The word emotions can be feelings, and expanded into happy feelings, sad feeling, mad feelings, and others.
Outcome Criteria	At the end of this unit there is a pretest/posttest that measures the outcomes of this unit. It is designed as a Likert-scale to see the improvement in the client's perception of mental health.
Additional Activity Ideas & Rationale	• BigFoot and Schmidt (2010) discuss the American Indian Life Skills Development Curriculum by Fromboise, 1996) who helped youth identify and decrease self-harming behaviors • Conflict resolution skills act as a protective factor (US Dept Health Hum Services, 2010)
Resources	Affective. (n.d.). In *Oxford English dictionary online*. Retrieved from https://en.oxforddictionaries.com/definition/affective BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Brockie, T. N., Dana-Sacco, G., Wallen, G. R., Wilcox, H. C., & Campbell, J. C. (2015). The relationship of adverse childhood experiences to PTSD, depression, poly-drug use and suicide attempt in reservation-based Native American adolescents and young adults. *American Journal of Community Psychology, 55* (3-4), 411-421. doi: 10.1007/s10464-015-9721-3. Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231-233. doi: 10.1002/wps.20231 Healthy Place. (2017). *What is emotional health? And how to improve it?* Retrieved from https://www.healthyplace.com/other-info/mental-illness-overview/what-is-emotional-health-and-how-to-improve-it/ Lee, B., & Perales, K. (2007). Circle of courage: Reaching youth in residential care. *Residential Treatment for Children & Youth, 22*(4), 1-14. Retrieved from https://doi.org/10.1300/J007v22n04_01 Peacock, T., & Wisuri, M. (2002). *Ojibwe: Waasa Inaaabidaa: We look in all directions*. Minnesota Historical Society Press: St. Paul, MN. Polatajko, H.J., Townsend, E.A. & Craik, J. (2010). Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health,

Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36 Retrieved from https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf.

Townsend, E. A., & Polatajko, H. J. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation*. Ottawa: Canadian Association of Occupational Therapists.

Turpin, M. & Iwama, M. (2011). *Using occupational therapy models in practice: A field guide*. Edinburgh, UK: Elsevier

Vantage Point. (2017). *What is adaptive and maladaptive coping?* Retrieved from https://vantagepointrecovery.com/adaptive-maladaptive-coping/

Session 1: Emotion Management

Purpose	The purpose of this session is to introduce skills for managing tough emotions. This session will involve guiding the clients to understand what emotions are, and how the emotions affect them individually. For this session, the occupational therapist may want to bring out the medicine wheel created earlier in the program. This will incorporate the cultural aspect into what is typically a coping skills group and allow the clients a chance to add more strategies to the emotional piece on the wheel. Use the emotion piece of the medicine wheel to begin discussion about understanding of emotions and a person's needs for healthy emotions. This session example focuses on anger management, but a session on any emotion would be appropriate to facilitate understanding and begin healthy management of emotions. A tool to assist the occupational therapist using this session is the activity from *100 Interactive Activities for Mental Health and Substance Abuse Recovery* called "The Volcano" (Butler, 2001).
Preparation/ Supplies	Medicine wheels created by the clients in Unit 1 *100 Interactive Activities for Mental Health and Substance Abuse Recovery* - The Volcano (p. 10) (handouts available from this book) Pens/Pencils/Markers, cut-outs from book
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** This activity should take 30-45 minutes. More time may be needed for a larger group.
Goals	By the end of the session: 1. The child will describe the effects of the emotion anger. 2. The child will identify times when the positively and negatively handled anger. 3. The child will develop 2 strategies to deal with anger in a health way.

Rationale of Activity	This activity helps provide a visual of anger exploding out, like a volcano. The volcano gives a representation to show the different variables that contribute to anger and helps facilitate a discussion to promote positive ways to help anger. The use of the medicine wheel the students made in an earlier session helps bring the emphasis of culture back into the session. The students can add any strategies developed during this session into their medicine wheel.
Cultural Components	Tying back to the medicine wheel promotes the use of traditional Native American aspects. Recognizing the emotional effects of Native American's history and experiences, helps inform the session and address the client's emotions. An adaptation to this session is to use a river metaphor instead of volcano, which can help incorporate the value of land.
Precautions	Each individual experiences emotions differently. Talking about events that bring out negative emotions can cause negative reactions. Be cautious with the topics used during discussion, and respect if students do not want to share in a group.
Steps	1) Review the Emotional piece on the medicine wheel that the students created in Unit one. Use it as a discussion to: o Define emotions o Discuss what influences emotions o Discuss positive and negative effects of emotions o Examples of positive and negative emotion effects 2) Introduce "The Volcano" activity 3) Describe what variables contribute to anger and "erupting" 4) Have students complete their own volcano worksheet 5) Facilitate discussion about positive and negative ways to deal with and express anger 6) Help students build on current positive factors and identify areas of need related to anger management strategies 7) Have students update their medicine wheel with new strategies
Adaptations	Instead of volcano, can use water analogy, and when you will overflow because of all the emotions (so have a river with streams of all emotions coming into it, and eventually overflows). This session can be adapted to focus on any type of emotion management. Watch the movie *Inside Out*. Pause at certain points and have discussion.

Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about emotions and how they effect a person b. Identify current positive and areas of need for emotion management c. Create strategies to address anger in a positive way d. Promote positive mental health and occupational performance from understanding emotional health
Resources	Butler, C. A. (2001). *100 Interactive Activities for Mental Health and Substance Abuse Recovery.* Melville, NY: Wellness Reproductions & Publishing.

Session 2: Circle of Courage - Generosity

Purpose	This session addresses another area of the Circle of Courage. As stated above, the Circle of Courage helps build resiliency, which is a protective factor among Native Americans (Brendtro et al., 1990; Feinstein et al., 2009). Generosity in the Circle of Courage means contributing to others, having empathy, and compassion (Brendtro et al., 1990 Brendtro et al., 2014). It also states that a person cannot have real happiness without giving to others (Brendtro et al., 1990; Brendtro et al., 2014). This session will begin by introducing the concept of generosity and the benefits of it to the students. It will then be led by the students to develop ideas, plans, and carryout the plans that revolve around being generous. This session's purpose is to continue to build protective factors that revolve around emotions. Doing generous acts brings out positive emotions, and as stated above brings out happiness (Brendtro et al., 1990; Brendtro, et al., 2014).
Preparation/ Supplies	Visual of the Circle of Courage Paper with Generous activity ideas Pens/pencils ***Note: A picture of the Circle of Courage and an example of what the paper for generous activity ideas may look like is provided at the end of this session.**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** This activity will take two sessions. The first session will take 30-45 minutes, and the second session will take about 15 minutes to discuss results of the completion of the activities. The second session may be done at the beginning of another session for time considerations.
Goals	By the end of the session:

	1. The student will define generosity and describe the importance of it 2. The student will identify activities that incorporate generosity 3. The student will implement the generosity activities and identify emotions felt after completion
Rationale of Activity	Generosity is another component of the Circle of Courage, which is a Native American developed framework to build resiliency. Resiliency is a protective factor that is important to build in at-risk Native American youth. It is also important that this program uses culturally-relevant interventions to provide more meaningful activities that support Native American culture. The more protective factors promoted in Native Americans, the more likely to have success in areas of life. This activity helps to build skills in doing generous acts for positive emotional health. Building positive emotional health is needed to promote mental health, which is the purpose of this program.
Cultural Components	The Circle of Courage is a Native American developed framework designed to use within Native American cultures.
Precautions	Generosity focused activities should be chosen with care. Make sure safety is emphasized.
Steps	1) Introduce the Circle of Courage and describe Generosity and how it relates to healthy emotions and promotes mental health 2) Facilitate discussion on the positive effects of generosity 3) Tie back to promoting resiliency 4) Have students brainstorm activities that are generous and reasonable to complete 5) Have students each pick an activity, and develop a schedule and plan to implement the generous activity 6) If done in individual format, help the student complete the activity 7) Have students write down emotions they felt after completing the activity and use as discussion at next session.
Adaptations	Generous activities that are chosen can be adapted to age level or setting. For example, can help students develop generous activities that are available at the school, the community, or at home. Generosity is also taught through modeling, so an adaptation is consciously modeling generosity to the students. Generosity with elders and classmates worksheet
Outcome Criteria	The outcomes of this session should:

	a. Facilitate knowledge about how generosity can positively influence emotions b. Increased protective factors through strategies using generosity to promote mental health c. Increased healthy emotions and resiliency through participating in generous activities d. Ability to identify activities that lead to positive emotions
Resources	Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Brendtro, L. K., Mitchell, M. L., & Jackson, W. C. (2014). The Circle of Courage: Critical Indicators of Successful Life Outcomes. *Reclaiming Children and Youth*, *23*(1), 9-13. Retrieved from https://eric.ed.gov/?id=EJ1038854 Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and native American teenagers. *Reclaiming Children and Youth*, *18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921 Lee, B., & Perales, K. (2007). Circle of courage: Reaching youth in residential care. *Residential Treatment for Children & Youth*, *22*(4), 1-14. Retrieved from https://doi.org/10.1300/J007v22n04_01

Activity for Session 2:

GENEROUS ACTIVTITY IDEAS FOR….

MY FAMILY:

1) _____

2) _____

3) _____

4) _____

5) _____

CLASSMATES:

1) _____

2) _____

3) _____

4) _____

5) _____

COMMUNITY:

1) _____

2) _____

3) _____

4) _____

5) _____

OTHERS:

1) _____

2) _____

3) _____

4) _____

5) _____

The two activities I want to do by tomorrow are:

1) _____

2) _____

MY JOURNAL

How did completing the generous activity make me feel?

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Why did it make me feel that way?

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Ways I can keep doing generous things:

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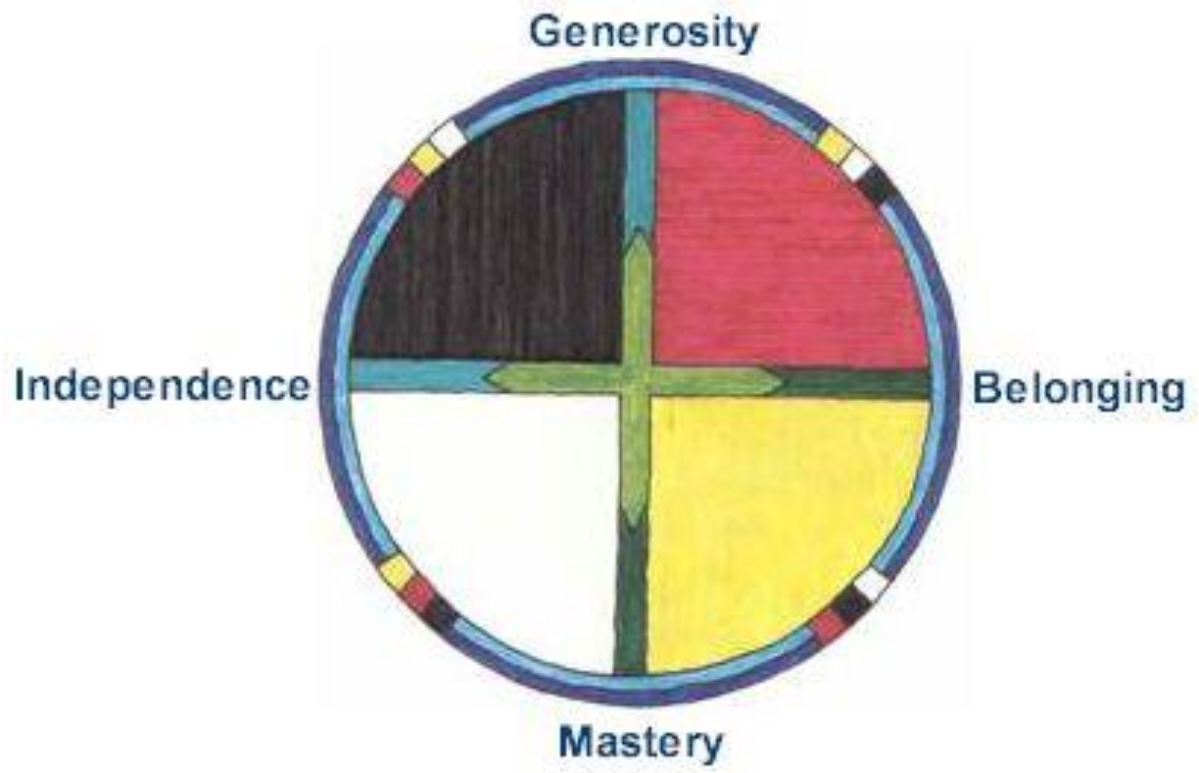

Brendtro, L., Brokenleg, M., & Van Bockem, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN: Solution Tree.

Session 3: Safety Plan & Contract

Purpose	The purpose of this session is develop a safety plan and contract. This is derived from a Wellness Action Recovery Plan (WRAP) (Copeland, 2002). Typically, a WRAP plan is used for people with identified psychiatric problems (Copeland, 2002). However, given that this program is designed to be used with at-risk populations, a full WRAP plan is not relevant. Instead, the parts of the WRAP plan that can be used for populations without an actual diagnosis will be used, and some steps will be modified to fit the population. The use of a safety contract will be implemented as well. The parts of the WRAP plan that can be incorporated with populations without a diagnosis will be sections 1 – 3, and section 4 & 5 will be adapted to fit the population. Additionally, the safety contract will be used to promote a commitment to safety. The first part of the WRAP plan, not included in the sections, is to develop an Wellness Toolbox, which is a list of activities that the person has done in the past, or can do in the present to stay well, and things to do when not well to become well again (Copeland, 2002). This is a list that will be used to develop the other parts of the safety plan, which can be located at the front of the binder (Copeland, 2002). **1) Section one is a daily maintenance list**, which has three parts to it (Copeland, 2002). The first part is a description of how the person feels when they are well, part two is everything a person needs to do in a day to feel well, and part three is a list of everything a person should consider doing in a day (Copeland, 2002). The difference between this and the Wellness Toolbox is the list is of things the person needs to do *every day* to feel well. **2) Section two is dealing with triggers**, and it involves identifying triggers and potential solutions to react to the triggers (Copeland, 2002). **3) Section three is dealing with early warning signs**, and it includes identifying early warning signs that the situation could worsen and actions to address the early warning signs (Copeland, 2002). This section focuses on putting a name to the warning signs such as anxiety, getting frustrated, and uncaring (Copeland, 2002). 4) **Section four is when symptoms continue to worsen** and making a list of indicators that symptoms have worsened and possible actions to take to address the symptoms (Copeland, 2002).

	5) **Section five is normally crisis planning** for when the person no longer can make decisions for themselves and designates a plan for people to carry out to assist the individual (Copeland, 2002). ***This will be modified to picking a person that the student feels they trust to talk with.*** The **safety contract** will be developed by the students individually and sign for safety. The key for this type of contract is the focus on **prevention**. It should emphasize to **prevent** the development of maladaptive coping skills. For example, the students should think of a contract that states how they want to use positive coping skills instead of *starting* maladaptive coping skills. If the occupational therapist is using this with teenagers who have likely participated in maladaptive coping skills such as substance use, the safety contract should instead emphasize to choose positive strategies over already explored maladaptive strategies. The purpose of this session in the emotional unit is to recognize that emotions can lead to the development of either positive or negative coping strategies. This session is to help explore ideas for positive strategies, as well as acknowledge that it can be difficult to deal with strong emotions.
Preparation/ Supplies	Binders for each student Empty lined paper for students to list triggers, strategies, and warning signs. Pens/Pencils Paper for safety contracts ***Note: A an example of what the papers for the Safety Plan and Safety Contract may look like is provided at the end of this session.**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. • This particular session is best suited for older students. It can be used for younger students (11 and under, but needs to be adapted to developmental level) Note: Can be done individually instead of in group as well.

	Timeline: This may take several sessions of 30-45 minutes. The steps worked on for the safety plan and contract can be broken up into multiple sessions. Additionally, other session content such as coping skills in mental health may be utilized as ideas for the safety plan.
Goals	By the end of the session: 1. The student will explain how emotions can lead to actions, and how those actions can be positive or maladaptive 2. The student will identify their current positive and negative coping habits 3. The student will complete sections 1-3 of the WRAP and discuss strategies for addressing emotions in a healthy way 4. The student will express increased understanding of emotional health. 5. The student will develop a safety contract that promotes mental health
Rationale of Activity	This activity is in line with the prevention aspect of the program. It helps the students develop strategies to prevent the worsening of risk factors and helps promote positive strategies. This type of session is also important to acknowledge that choosing adaptive strategies is powerful and having options is important.
Cultural Components	The types of strategies chosen to address risk factors, warning signs, as well as chosen daily maintenance activities will likely involve culture specific activities. The therapist can incorporate culturally relevant activities by providing suggestions such as the brainstormed generosity activities in the previous session.
Precautions	Some older students may already have experimented with maladaptive coping strategies or may have had it modeled by their parents in response to strong emotions. It is important to ensure that the student does not promote the behavior as a positive experience.
Steps	1) Begin with explanation of the connection between emotions, behaviors, and promoting emotional health 2) Introduce the 3 sections of the WRAP 3) Facilitate development of the individualized WRAP plan for each students 4) Describe the safety contract for prevention and promotion of positive choices

	5) Facilitate development of the safety contract individually 6) Discuss application and emphasize importance of choosing to engage in positive strategies and how it leads to improved emotional health and mental health
Adaptations	This session should be adapted for ages. The session used as written would be best suited for students ages 12-18. To adapt this for students ages 7-11, use age appropriate language and may want to exclude the third section of the WRAP and instead focus on only sections one, two, and the safety contract.
Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about how emotions, emotional health, and strategies to promote mental health b. Increased awareness of risk factors and triggers c. Increased development of positive strategies and prevention of maladaptive strategies
Resources	Copeland, M. E. (2002). Wellness recovery action plan: A system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings. *Occupational Therapy in Mental Health*, *17*(3-4), 127-150. doi: 10.1300/J004v17n03_09

Activity pages for Session 3

My Safety Plan

Wellness Toolbox:

This is a list of tools that I have used in the past, present, or want to use in the future to feel well. They can be used when I am not well to feel better.

Things I have used in the past that work:

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Things that I use now to feel well:

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Things that I want to use in the future when I feel unwell:

Daily Maintenance List:

There are 3 parts to this step:

Step 1: Describe how you feel when you feel well.

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Step 2: List of activities that need to be done every day to feel well.

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Step 3: Reminders of what needs to be done

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Triggers:

List of things that if happen, cause symptoms or bad feelings to appear.

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Plan on how to address triggers:

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Early Warning Signs:

List of Early warning signs when steps to address triggers have not worked.

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Plan to address the Early Warning Signs:

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When Things Have Worsened:

List of ways to identify when things are worsening:

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My Plan and People I can go to:

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My Safety Contract

I promise that I will _____

_____

This is important to me because _____

_____

_____

In the future, I want to handle stress and negative feelings by _____

_____

_____

Ways that I can work towards this or people that can help me are _____

_____

_____

_____ _____

Signature **Date**

Emotional Outcome Measure

For Client's ages 10-18:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what emotions are:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

2) I know how important expressing emotions are for my health

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

3) I understand how my emotional needs affect my life

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

4) I am able to select emotionally satisfying activities I enjoy doing

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

5) List 2 emotional activities you enjoy:

1)

2)

For students 5-10:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what feelings are:

No **Not Sure** **Yes**

2) I know how important showing my feelings in a good way is for my health:

No **Not Sure** **Yes**

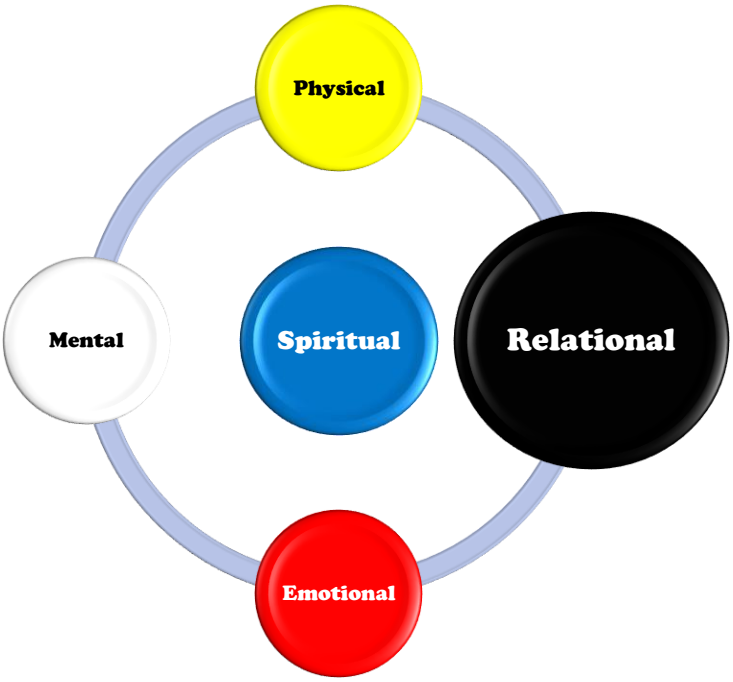
3) I understand how my feelings affect my life

No **Not Sure** **Yes**

4) I can pick activities that make me feel happy

No **Not Sure** **Yes**

Unit IV: Relational



Introduction	***Relational*** in this program is viewed as the social aspects that make up and surround the individual. Relational and relationships may be used interchangeably. The *social environment* is the broad environment that relational aspects take part in. The social environment according to the CMOP-E is one factor of the environment that the person is imbedded in along with physical, cultural, and institutional (Townsend & Polatajko, 2007). With Native Americans, the relational piece is a large factor of cultural relevance. *Interdependence*, which is the focus on the group as a whole, is just as important as the individual (Densmore, 1979; Kidwell & Velie, 2005). Since Native Americans value interdependence as well as independence, leaving relational out of therapy would be doing a disservice to the client, as well as make the therapy process less effective. Incorporation of the relational aspect is necessary for students. Students during childhood and adolescence are constantly influenced and learning from their peers (Bastable et al., 2011). Additionally, influence of the family has been found to be a protective factor against substance use, and promote

<table>
<tr><td></td><td colspan="2">academic success (Henson et al., 2017). Therefore, incorporation of relational aspects including peers and family is important in the program.

Facilitating protective factors is a key component to this program. One important protective factor with Native Americans is connectedness. Connectedness is achieved through the individual feeling connected to family, community and the natural environment (Mohatt, Fok, Burket, Henry & Allen, 2011).</td></tr>
<tr><td>Terms</td><td>Terms</td><td>Definition</td></tr>
<tr><td></td><td>Relational (relationships)</td><td>"Concerning the way in which two or more people or things are connected" ("Relational", n.d.).</td></tr>
<tr><td></td><td>Social environment</td><td>"Particular social features (i.e., social groups and occupational tasks) of the specific context in which one

does something that impacts upon what one does and how it is done" (Schell, Gillen, & Scaffa, 2014)</td></tr>
<tr><td></td><td>Interdependence</td><td>A system of people who feel connected as members of the greater whole, rather just an individual. Kawulich (2008) in (Garrett, et al., 2014).</td></tr>
<tr><td></td><td>Connectedness</td><td>"The interrelated welfare of the individual, one’s family, one’s community, and the natural environment" (Mohatt et al., 2011, p. 444).</td></tr>
<tr><td>Goals</td><td colspan="2">Therapist Goals:

1) The therapist will be able to identify and describe the importance of relationships to clients.
2) The therapist will formulate goals, objectives, and interventions to address the needs of the clients regarding positive relationships.
3) The therapist will build cultural competency through engagement in culturally relevant interventions.

Student Goals:

1) The students will define relational aspects and explain the benefits of positive relational aspects.
2) The students will identify both positive and negative influences of their relationships.</td></tr>
</table>

	3) The students will choose strategies to promote healthy relationships.
CMOP-E components	**1) Environment:** a. **Social Environment**: The social environment is a component of the CMOP-E. The relational unit defines relational aspects of a person's relationships and the social environment. To best understand how to view the social environment, use it in regards from the CMOP-E. The person is embedded in an environment, including social environment factors, and the environment has the ability to facilitate or hinder occupational performance (Turpin & Iwama, 2011). Therefore, the OT should recognize that there will be positive and negative influences from the client's social environment that can be addressed to promote mental health. b. **Culture**: Additionally, culture is an environmental component in the CMOP-E. This unit recognizes that culture is important and uses the client's cultural environment for the most effective results. **2) Occupations**: Social participation is an important occupation for mental health and well-being. This unit recognizes relational health involves positive social participation with both the client's family and friends. The OT should work to use occupations that promote social participation as well as incorporate family and friends. **3) Person**: a. **Affective:** For this unit, understand that a person's emotions towards their relationships influences their overall performance in occupations. **4) Enablement**: using enablement skills to view the Native American students in a strength-based way, to promote positive skills, rather than reinforce negative behaviors
Adaptations	Adapt activities for the age level. Developmental level needs to be assessed and addressed to meet the student where they are. Generally, younger students need more structure and have less self-awareness abilities. Activities should be concrete, simple, and straight-forward. Timing should not exceed 30 minutes for students ages 6-11 (Bastable et al., 2011). Some of the sessions provided in this unit for examples may be too difficult for younger ages. For example, students with less insight will have difficulty identifying areas they need to improve on. Also, gardening may need to incorporate adaptations for developmental levels or physical abilities.

Outcome Criteria	At the end of this unit there is a pretest/posttest that measures the outcomes of this unit. It is designed as a Likert-scale to see the improvement in the client's knowledge about relationships and ability to pick out activities that promote good relationships.
Additional Activity Ideas & Rationale	• Community-based events for family • Practice and learn Native language together • Participating in powwows • Circle of Courage topics: generosity, belonging, mastery, independence • Circle of Courage • Develop schedule for family activities • Trivia card game with historical facts/images • Peer group to foster peer connectedness
Resources	Bastable, S. B., Gramet, P., Jacobs, K., & Sopczyk, D. L. (2011). *Health professional as educator: Principles of teaching and learning*. Sudbury, MA: Jones and Bartlett Learning. Densmore, F. (1979). *Chippewa customs*. St. Paul, MN: Minnesota Historical Society Press. Garrett, M. T., Parrish, M., Williams, C., Grayshield, L., Portman, T. A. A., Rivera, E. T., & Maynard, E. (2014). Invited commentary: Fostering resilience among Native American youth through therapeutic intervention. *Journal of Youth and Adolescence*, *43*(3), 470-490. doi: 10.1007/s10964-013-0020-8 Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention, 38*(1-2), 5-26. doi: 10.1007/s10935-016-0455-2 Kidwell, C. S. & Velie, A. (2005). *Native American Studies*. University of Nebraska Press: Lincoln, NE. Mohatt, N. V., Fok, C. C. T., Burket, R., Henry, D., & Allen, J. (2011). Assessment of awareness of connectedness as a culturally-based protective factor for Alaska native youth. *Cultural Diversity and Ethnic Minority Psychology*, *17*(4), 444-455. doi: 10.1037/a0025456. Relational. (n.d.). In *Oxford English dictionary online*. Retrieved from https://en.oxforddictionaries.com/definition/relational

Schell, B. A. B., Gillen, G., & Scaffa, M. E. (2014). *Willard & Spackman's occupational therapy.* Baltimore: Lippincott Williams & Wilkins, a Wolters Kluwer business.

Townsend, E. A., & Polatajko, H. J. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation*. Ottawa: Canadian Association of Occupational Therapists.

Turpin, M. & Iwama, M. (2011). *Using occupational therapy models in practice: A field guide*. Edinburgh, UK: Elsevier

Session 1: Belonging

Purpose	This session is another incorporation of the Circle of Courage. Belonging is another trait in the Circle of Courage that facilitates resiliency. Belonging is "established when students form relationships within family, school, and community (Feinstein et al., 2009). A sense of belonging is just as important to physical health, and those who do not have an adequate sense of belonging will turn to negative relationships, and risky behaviors for attention (Brendtro et al., 1990; Brendtro et al., 2014). This session will educate the students on the belonging needs of a person, and how to develop positive relationships. As this is a session based on the Circle of Courage, the purpose is to also promote the protective factor resiliency, which improves mental health.
Preparation/ Supplies	Visual of the Circle of Courage Paper for belonging activities Pencils/pens ***Note: A picture of the Circle of Courage and an example of what the paper for belonging activities may look like is provided at the end of this session.**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** This session will take one 30-45 minute session, and another 15 minutes in a follow up session to cover the application of the session.
Goals	By the end of the session: 1. The student will explain what a sense of belonging is and why it is important 2. The student will identify examples of how they felt when they felt a sense of belonging, and when they did not feel a sense a belonging. 3. The student will develop activities that promote a sense of belonging in the areas of group, family, friends, and community

	4. The student will choose and activity to complete with their family and identify the effect on their sense of belonging in their journal.
Rationale of Activity	Humans need a sense of belonging and the ability to connect with others (Brendtro, et al., 2014). This session promotes the building of resiliency using the Circle of Courage, and it promotes mental health by increasing a sense of belonging in the students. It helps educate students on the importance on healthy relationships (the focus of this unit) and uses inclusion of the family. Inclusion of the family helps focus on the interdependence aspect that is important to Native Americans.
Cultural Components	The Circle of Courage, inclusion of interdependence factors by including the family, and promotion of resiliency are all important cultural considerations in this session.
Precautions	The family that the students choose should be realistic and feasible. For example, the student may list an activity that involves travel and extra time. An activity that can be easily completed together at home one night should be picked.
Steps	1) Begin by reintroducing the Circle of Courage and the how it promotes resiliency for better mental health 2) Explain the importance of a sense of a belonging 3) Facilitate a discussion with the students about how they feel when they have a sense of belonging, and how they feel when they are left out. 4) Educate how a sense of belonging can occur at the levels of groups, family, friends, and community 5) Begin activity: a. Provide each student with packet. The first page in the packet should have categories of group, family, friends, and community with blank lines for students to fill out activities under each. The second paper should have a section for journaling about the effects of completing the activity. b. Have each student brainstorm activities in each category that promote a sense of belonging c. Have each student share at least one activity from their lists and why they would like it d. After sharing, have each student write down or circle an already listed activity that they want to complete with their family that night, and instruct them to journal about it with their family after completion. e. Use journal as a discussion point next session.

Adaptations	Can have students list out activities as a group instead of individually for younger ages. Can choose an activity that does not involve brainstorming and instead provides an example of how it feels to be included and how it feels to be excluded as a learning activity.
Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about how a sense of belonging promotes positive feelings and resiliency b. Increased positive relationship with their family for better sense of belonging c. Increased awareness of a sense of belonging on mental health
Resources	Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Brendtro, L. K., Mitchell, M. L., & Jackson, W. C. (2014). The Circle of Courage: Critical Indicators of Successful Life Outcomes. *Reclaiming Children and Youth*, *23*(1), 9-13. Retrieved from https://eric.ed.gov/?id=EJ1038854 Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and native American teenagers. *Reclaiming Children and Youth*, *18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921

Activity for Session 1:

SENSE OF BELONGING:

Group activities to improve belonging:

1) _____
2) _____
3) _____
4) _____
5) _____

Family activities to improve belonging:

1) _____
2) _____
3) _____
4) _____
5) _____

Friend activities to improve belonging:

1) _____
2) _____
3) _____
4) _____
5) _____

Community activities to improve belonging:

1) _____
2) _____
3) _____
4) _____
5) _____

MY JOURNAL

1) How did I feel before I started the activity with my family?

_____

_____

_____

2) How did I feel after I finished the activity with my family?

_____

_____

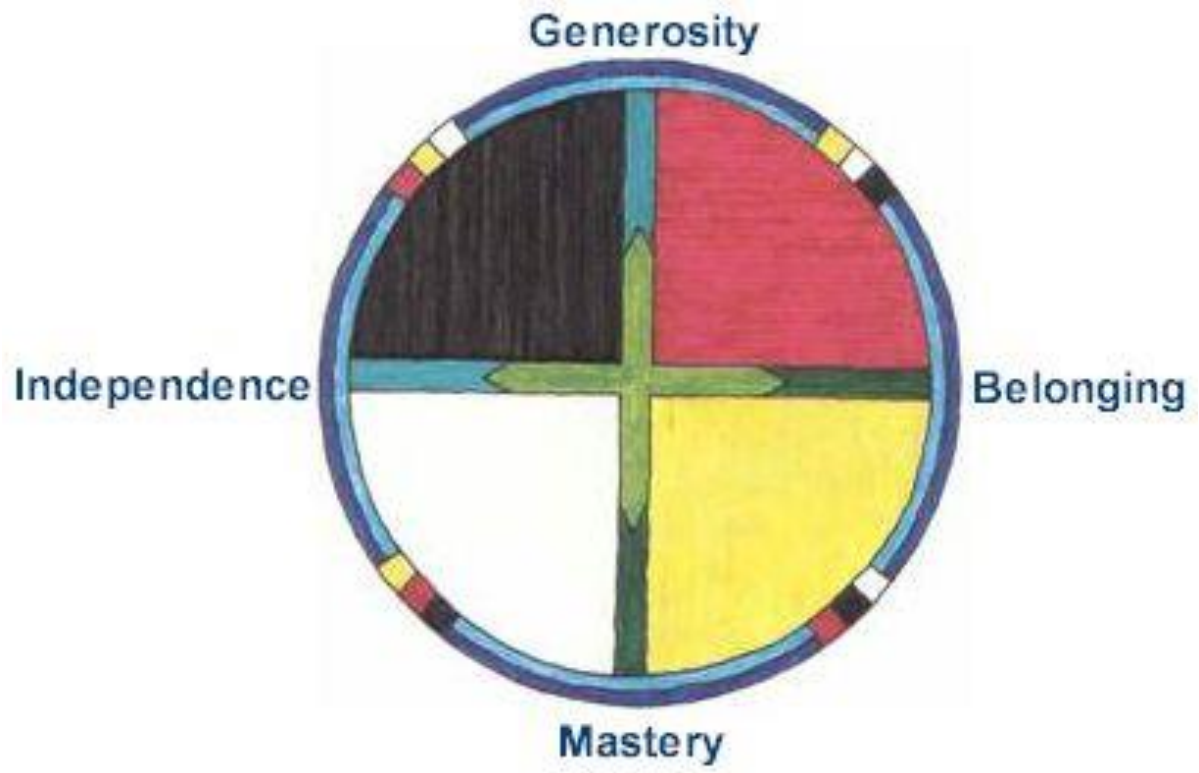
_____

3) Describe how your sense of belonging with your family after the activity.

_____

_____

_____



Brendtro, L., Brokenleg, M., & Van Bockem, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN: Solution Tree.

Session 2: Connectedness

Purpose	The purpose of this session is to promote the development of another protective factor that was identified as relevant to Native Americans in the literature. Connectedness is a protective factor among Native Americans that protects against substance abuse and suicide (Mohatt et al., 2011). It is "achieved through the individual feeling connected to family, community, and the natural environment (Mohatt et al., 2011). This is similar to the first session of belonging; however, the difference lies in that belonging is a factor of the Circle of Courage to promote resiliency. Connectedness is a protective factor in itself. This session will focus on defining connectedness, explaining the importance of connectedness as a protective factor and how it can reduce substance abuse and suicide risk. There will be an activity incorporate that promotes development of connectedness. Different activities can be chosen to facilitate connectedness, but for this example, the use of a planting a plot of garden will be used to feel connected to the natural environment.
Preparation/ Supplies	Gardening supplies: seeds, soil (if needed), tools, watering cans, etc...
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** This session will take extra preparation before initiating with the students. The initial session with the students may take 45 minutes to an hour. Subsequent sessions may take less time for tending to gardens.
Goals	By the end of the session: 1. The student will explain what connectedness is, what it protects against, and how it promotes good relationships 2. The student will identify how gardening promotes connectedness 3. The student will express an increase in connectedness to the land.
Rationale of Activity	This activity promotes connectedness to the natural environment through gardening. The students can also learn about Native American history with

	gardening while actually building a garden, which promotes pride in their culture. Connectedness is a protective factor among Native Americans shown to reduce risk of substance abuse and suicide in literature (Mohatt et al., 2011). This unit focuses on relationships, which this session promotes to the land and can be adapted to promote relationships with family and community as well.
Cultural Components	Connectedness is a protective factor that is relevant to Native Americans. In addition, Native Americans have a value of the earth and land, and gardening is a tool to promote that value as an intervention.
Precautions	This may take permission and extra requirements to be completed by the occupational therapist using this session.
Steps	**Steps to complete before using this session:** 1) Obtain permission from necessary people to have students plant a garden 2) Locate a spot that has permission to plant a garden 3) Get supplies to plant a garden **Steps of the Session:** 1) Define/redefine protective factors and educate the students on the importance of protective factors in facilitating mental health and reducing risk factors. 2) Define connectedness and facilitate discussion with students about how important connectedness is to them 3) Begin gardening activity 4) While students are gardening ask students to share what they know about Native American history with valuing the earth and land 5) After completing gardening, facilitate a discussion how connection to the land promotes connectedness.
Adaptations	This activity can be adapted to include the community or family but would require permission and work by the occupational therapist to get participation. For example, the occupational therapist could ask the student's family members or the Elders of the tribe to participate in planting a garden with the students. This would facilitate connectedness to family and community and could even be made into a project of developing a community garden.

	Other activities besides gardening could be used to promote connectedness. Could do a Zen garden (indoor option) or plant outdoors depending on the weather (outdoor).
Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about connectedness b. Increased awareness of effect of connectedness on mental health c. Increased connectedness to the natural land (and relationships), which is an increase in protective factors
Resources	Mohatt, N. V., Fok, C. C. T., Burket, R., Henry, D., & Allen, J. (2011). Assessment of awareness of connectedness as a culturally-based protective factor for Alaska native youth. *Cultural Diversity and Ethnic Minority Psychology*, *17*(4), 444-455. doi: 10.1037/a0025456.

Session 3: Mastery

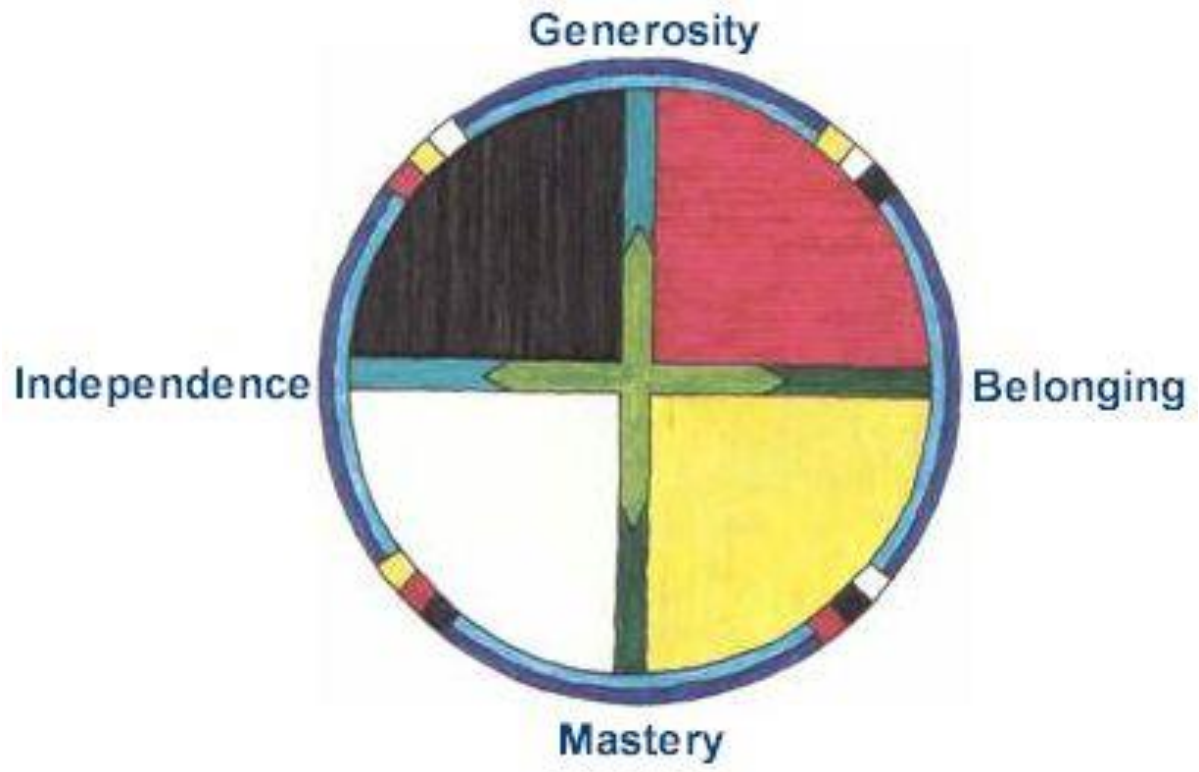
Purpose	This is another session dedicated to the Circle of Courage trait of mastery, which is to promote a sense of success and achievement (Brendtro et al., 1990; Feinstein et al., 2009). This session is in the relational unit because it is addressing a sense of mastery in the area of social mastery (relationships). This session is needed to help promote students feel successful in their social lives, which is especially important among adolescents. According to Bastable et al. (2011), one of the levels on Maslow's Hierarchy of needs is a sense of belonging and love. A feeling of mastery in the social areas of life is needed to fulfill this need level.
Preparation/ Supplies	Circle of Courage Visual Paper with label of goals, steps, supports, barriers on it Pencils/pens ***Note: A picture of the Circle of Courage and an example of what the paper for goals may look like is provided at the end of this session.**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** This session should take around 45 minutes. It may take more or less time depending on how large of a group is present.
Goals	By the end of the session: 1. The student will explain how mastery of social relationships improves mental health 2. The student will develop goals to achieve a sense of mastery in social relationships and strategies to reach those goals 3. The student express increased understanding of what mastery is and how it affects resiliency and mental health
Rationale of Activity	This activity helps students to understand why a sense of mastery is important to mental health. It supports the development of positive social (relationship) goals and the ability to identify steps to reach goals. In

	addition, it is using the Circle of Courage again as a framework to develop resiliency, which promotes mental health in Native Americans.
Cultural Components	The Circle of Courage is a model developed promote resiliency in Native Americans.
Precautions	Goals chosen by students should be positive so the occupational therapist should ensure that students are taking it seriously.
Steps	1) Reintroduce the Circle of Courage and the purpose to promote resiliency 2) Facilitate a discussion on a sense of mastery in social lives (relationships) and the importance of feeling fulfilled in their social lives. 3) Have the students develop goals that they need to achieve in order to feel successful (mastery) in their social lives 4) Have the students identify steps to reach those goals and what barriers may be present 5) Facilitate a discussion about ways to overcome barriers 6) Tie discussion back to importance of feeling a sense of mastery in relationships and why it is important to mental health
Adaptations	Can choose an activity that uses active participation of facilitating mastery in relationships (social). For example, if the students are at-risk because of decreased social skills, can lead a social skills group.
Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about mastery in social relationships b. Increased awareness of effect of social relationships on resiliency, and mental health c. Increased ability to identify positive supports and strategies to overcome barriers to reach social mastery goals
Resources	Bastable, S. B., Gramet, P., Jacobs, K., & Sopczyk, D. L. (2011). *Health professional as educator: Principles of teaching and learning*. Sudbury, MA: Jones and Bartlett Learning. Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and native American teenagers. *Reclaiming Children and Youth*, *18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921

Lee, B., & Perales, K. (2007). Circle of courage: Reaching youth in residential care. *Residential Treatment for Children & Youth*, *22*(4), 1-14. Retrieved from https://doi.org/10.1300/J007v22n04_01

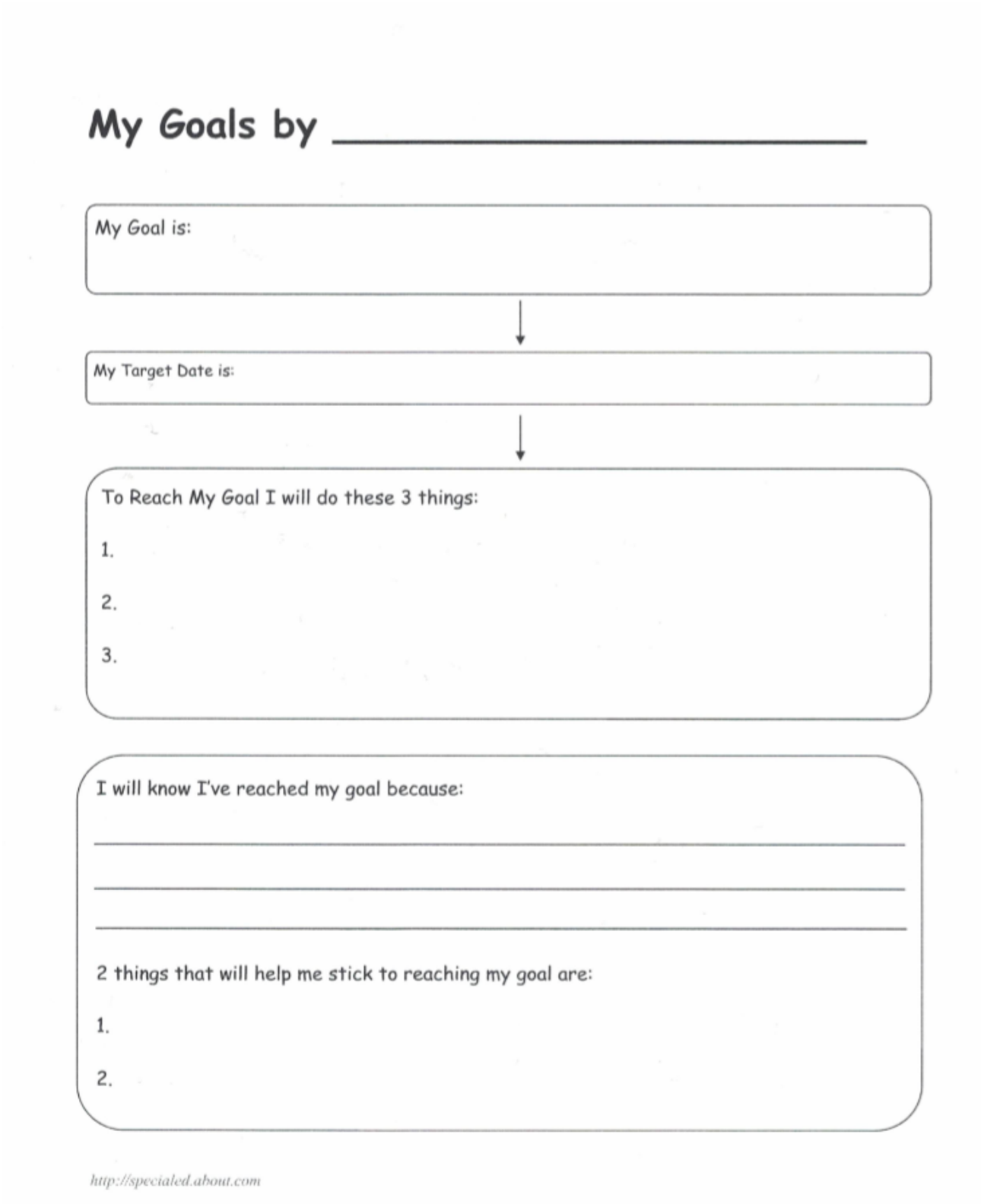
Visual for Session 3:

***Use for discussion on mastery in social life. Can have students fill out the mastery section of the medicine wheel for how to feel success socially.**



Brendtro, L., Brokenleg, M., & Van Bockem, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN: Solution Tree.

Activity for Session 3:



My Goals by _____

My Goal is:

My Target Date is:

To Reach My Goal I will do these 3 things:

1.

2.

3.

I will know I've reached my goal because:

_____

_____

_____

2 things that will help me stick to reaching my goal are:

1.

2.

http://specialed.about.com

*Link for downloadable sheet: PDF Goal Worksheet

Relational Outcome Measure

For Client's ages 10-18:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what relational/relationship(s) is:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

2) I know how important positive relationships are for my health:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

3) I understand how my need for fulfilling relationships affect my life:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

4) I am able to select activities I enjoy doing with my family:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

5) I am able to select activities I enjoy doing with my friends:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

6) List 2 activities you enjoy doing with a group:

1)

2)

For students 5-10:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what relationships are:

No **Not Sure** **Yes**

2) I know how important good relationships are for my health:

No **Not Sure** **Yes**

3) I understand how my relationships affect my life

No **Not Sure** **Yes**

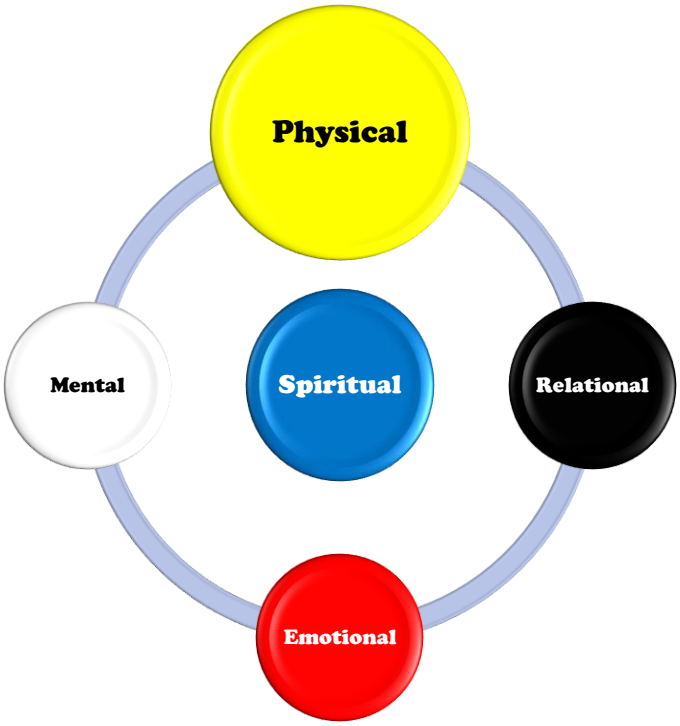
4) I am able to select activities I enjoy doing with my family

No **Not Sure** **Yes**

5) I can pick activities I enjoy doing with my friends

No **Not Sure** **Yes**

Unit V: Physical



Introduction	Physical health is the final unit in this program. While presented last, it still has high value and potential to have a positive impact on Native American children. Physical health relates to physical health in that it can be affected when experiencing historical trauma (Evans-Campbell et al., 2012). To promote healing, foster the connection between physical health, spirituality, and nature (Warzak, Dogan, & Godfrey, 2011). The person in the CMOP-E has a physical component. It can be considered in terms of physical health, cognition, affect, and spirituality (Polatajko et al., 2010).	
Terms	**Terms**	**Definition**
	Physical health	Includes fitness and health via eating healthy and exercising. Considered to be the most visible of all areas of health. ("Physical health", 2018).
	Mastery	A construct related to knowledge and success (Brendtro, et al., 1990; Feinstein, et al., 2009).

	Sensory components	Systems including sight, hearing, taste, touch, and smell that affect how information is processed ("Sensory system", 2013).
Goals	Therapist goals: 1) Define physical health and recognize its importance for overall health 2) Implement culturally relevant interventions to promote physical health Client goals: a) Participate and engage in physical interventions b) Describe the importance of physical health and how it relates to overall health and wellbeing	
CMOP-E components	**1) Person:** Physical health is a component of the person in the CMOP-E **2) Environment:** a. **Physical environment**: Having the equipment and space necessary to complete interventions with a physical focus. b. **Social environment**: Being able to complete interventions with a peer, relative, or community member. **3) Occupation:** Participating in interventions to improve physical health can be an example of a leisure occupation, if the client values it. Improving physical health can affect performance and engagement in areas of occupation including self-care, productivity (education), and leisure. **4) Enablement:** Enablement skills that may be useful when implementing sessions in this unit are educating on the importance and benefits of physical health; coaching and encouraging clients to participate and engage in physical health; and collaborating with clients to develop meaningful, culturally relevant physical health interventions (Turpin & Iwama, 2011).	
Adaptations	Adapt activities for the age level. Developmental level needs to be assessed and addressed to meet the child where they are. Generally, younger children need more structure and have less self-awareness abilities. Activities should be concrete, simple, and straight-forward. Timing should not exceed 30 minutes for students ages 6-11 (Bastable et al., 2011). Grade the activity up or down depending on the client's physical abilities. Some tasks may be too challenging in terms of motor planning or sequencing steps. They may benefit from breaking the activity down into fewer steps,	

	using visual cues, using verbal cues, demonstration, or repeated practice of each step.
Outcome Criteria	At the end of this unit there is a pretest/posttest that measures the outcomes of this unit. It is designed as a Likert-scale to see the improvement in the client's perception of physical health.
Additional Activity Ideas & Rationale	• Circle of Courage topics: generosity, belonging, mastery, independence • Participating or dancing in a powwow • Trying new activities in the community with family or friends • Handball game - peer interaction, family • Sensory skills – nature walks, animal examples, make drum and dance • Traditional dance • Running • Sports • Exercising **Rationale**: Physical health is a part of the person in the CMOP-E and is considered in the article by BigFoot and Schmidt (2010). While it is placed last in the unit, it is vital to overall health and wellness. If clients are struggling in other areas like mental, emotional, relational, or spiritual health, then they are likely to experience issues in their physical health. Therefore, it is important to introduce physical health-related strategies to act as protective and preventative factors.
Resources	Bastable, S. B., Gramet, P., Jacobs, K., & Sopczyk, D. L. (2011). *Health professional as educator: Principles of teaching and learning*. Sudbury, MA: Jones and Bartlett Learning. BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Evans-Campbell, T., Walters, K. L., Pearson, C. R., & Campbell, C. D. (2012). Indian boarding school experience, substance use, and mental health among urban two-spirit American Indian/Alaska Natives. *The*

American Journal of Drug and Alcohol Abuse, 38(5), 421-427. doi: 10.3109/00952990.2012.701358.

Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and native American teenagers. *Reclaiming Children and Youth*, *18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921

Physical health. (2018). *What is physical health?* Retrieved from https://www.reference.com/health/physical-health-7fa916b66aac73e8?aq=physical+health&qo=cdpArticles#

Polatajko, H.J., Townsend, E.A. & Craik, J. (2010). Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36 Retrieved from https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf.

Sensory system. (2013). In *Psychology Dictionary*. Retrieved from https://psychologydictionary.org/sensory-system/

Turpin, M. & Iwama, M. (2011). *Using occupational therapy models in practice: A field guide*. Edinburgh, UK: Elsevier

Warzak, W. J., Dogan, R. K., Godfrey, M. (2011). Developing a culturally sensitive curriculum: Teaching Native American children about psychological and behavioral health. Retrieved from ERIC database. (ED529907).

Session 1: Traditional Games

Purpose	Participating in traditional Native American games enhances physical health. Playing games is an appropriate activity for students, developmentally, to foster their physical health. It is possible to incorporate a spiritual component into physical health, providing more meaning and cultural relevance to the interventions. Fostering physical health can improve mental and emotional health, increasing the Native American student's overall health and wellness.
Preparation/ Supplies	Tennis ball, sticks (long and short), lacrosse rackets Read the game descriptions and additional resources to become familiar with the games. Choose materials that you currently have or that are easy to obtain to modify the game. Plan the session around a time where the weather will cooperate to do the activities outdoors, if possible. Plan the session during a time when the gym is available.
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** 1, 30-minute session
Goals	By the end of the session: 1. The child will identify and describe at least 2 games they can play to enhance physical health 2. The child will practice at least 2 culturally relevant games to enhance physical health
Rationale of Activity	Traditional, cultural games provide more meaning and relevance to Native American students than games that are not culturally relevant. Introducing culturally relevant games is likely to increase a spiritual connection, motivation, and enable them to improve their physical health. Physical health is a component of the person in the CMOP-E and the article by BigFoot and Schmidt (2010) (Polatajko, Townsend, & Craik, 2010). Addressing physical health is a critical component addressing the whole person.

Cultural Components	Incorporating traditional games into interventions is a way of facilitating physical health in a culturally relevant manner. Involving family and friends to play the games with the child also incorporates the value of family. There is a historical factor in the suggested games, promoting a feeling of connectedness to one's ancestors who may also have participated in these games.
Precautions	There is a chance that the students could get hurt when playing these games. Be prepared: know where the first aid kit is, where the school nurse is, etc. in case of an injury.
Steps	1) Introduction/Warmup: Ask the students what games they like to play for fun. Talk about why they like the games or what they enjoy the most about the games. Ask how they learned to play the game and who taught them. Have them teach you the game, if appropriate, either during this session or at another time. 2) Describe each game before actively participating. Ask if the students have heard of them before or if they know anything about them. ○ **Lacrosse game**: Use a ball and a scoop-shaped racket to catch and carry the ball. Two teams oppose each other with goal at each end. The goal on each side consists of a single stick 2-3 feet high. The purpose of the game is to get the ball past the goal or to hit the goal with the rackets, and not hands. (Densmore, 1979). ○ **Women's ball game**: The purpose of the women's ball game is to score goals. Played with two opposing teams, a pair of short sticks tied together, and a pair of longer sticks also tied together. Requires running and tossing the short sticks across the field (typically 300 feet long). A goal is made when the short sticks hit the lone goal post, a stake in the ground (Densmore, 1979). 3) Encourage the students to play these games with their friends at recess, or their friends or family at home outside of school. 4) Conclusion/Wrap-up: Ask the students to recall the games they played, what they liked/disliked. Ask them to explain the games to you so that you can ensure they remember the steps correctly, when they explain it to their friends and family later on.
Adaptations	Setting up these games to play one-on-one involves a smaller playing field and altering the game rules. Depending on the student's motor coordination skills, aspects of the games may need to be modified to be the just right challenge for the students. Additionally, the materials may need to be modified if you are unable to acquire them, or if the child is unable to properly handle them (I.e. use straws, pom-poms, ping pong balls, rulers, hockey sticks, etc.).

Outcome Criteria	The outcomes of this session should: a. Facilitate knowledge about culturally relevant games to act as protective factors and enhance physical health b. Practice culturally relevant games to enhance physical health Promote physical health and occupational performance from understanding and practicing culturally relevant, traditional games.
Resources	BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Densmore, F. (1979). *Chippewa customs*. St. Paul, MN: Minnesota Historical Society Press Polatajko, H.J., Townsend, E.A. & Craik, J. (2010). Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36 Retrieved from https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf. U.S. Lacrosse. (2016). *History*. Retrieved from https://www.uslacrosse.org/about-the-sport/history

Session 2: Leisure Exploration

Purpose	Leisure exploration with an emphasis on physical health allows students to explore a variety of activities of interest. It allows them to be exposed to activities they may not have known while also addressing physical health. Leisure or play is a critical occupation that children participate in regularly (Bergen, 1988). The activities selected have cultural relevance for Native American students, in the hopes of fostering connectedness to their heritage and resiliency as a protective factor (Henson et al., 2017).
Preparation/ Supplies	Paper, pencil, clipboard Beads, string Computer/internet access Prepare knowing how to bead or dance. Best plan, find someone in the community willing to assist in teaching these skills. ***Note: a picture of examples are provided at the end of this session**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** 1-2, 30-minute sessions
Goals	By the end of the session: 1. Child will identify and state at least two activities of interest to explore 2. Child will practice at least two activities of interest to promote leisure exploration and physical health
Rationale of Activity	Addressing physical health from a play or leisure perspective provides more meaning for children. Allowing them to explore activities and try them allows them the opportunity to experience new activities they may not be familiar with. Play or leisure is an area of occupation included in the CMOP-E (Polatajko et al., 2010; Turpin & Iwama, 2011).

Cultural Components	Historically, culturally-based activities that Native Americans participated in included beadwork, dancing, and honoring the connection with the earth and the land (Peacock & Wisuri, 2002). Being able to complete these activities with peers or family members enables connectedness and the value of family (Henson et al., 2017; Urbaeva et al., 2017).
Precautions	There is a chance that the students could get hurt when completing these activities. Be prepared: know where the first aid kit is, where the school nurse is, etc. in case of an injury.
Steps	1) Introduction/Warm-up: Define and discuss leisure and how it can improve physical health and wellness. (Leisure means activities or things you like to do for fun). Ask the child to think of other leisure-related, culturally relevant activities that they would like to try and to let you know about them, so you can plan them for future sessions. Asking them to come up with the activities demonstrates a client-centered approach with a collaborative emphasis. ○ **Nature Walk**: Going on a nature walk increases the connection with the earth and land, which is a value of Native American culture. Be sure to note all the sensory input involved and point them out to the child. Ask what they smell, feel, hear, taste (if applicable) and see. Let the child bring a notebook or clipboard and pencil to sketch what they see. If they are unsure of what a particular plant is, they can draw it and then research it later by asking family members or looking online. ○ **Beading**: Make beaded earrings, bracelets, necklaces or other jewelry. These are often done with small beads and thin string. Ask if the child has made them before and offer to have him or her teach you about it. Otherwise, there are simple tutorials on YouTube (https://youtu.be/BiSX4zJZzDk). Some require more tools than others, so check that you have the right equipment beforehand. ○ **Practicing traditional dances**: Dancing and powwows are a part of Native American culture. Ask the child if he or she has ever attended or been involved in a powwow. If so, ask if he or she would describe the experience or demonstrate the skills. Typically, there are several styles of dances involved in powwows for boys and girls from traditional, fancy, shawl, and jingle for the girls, and traditional, fancy, chicken, and grass for the boys. There are different age ranges for the categories of dances when the dancers compete in powwows.

Adaptations	Some activities are geared towards fine motor skills (beading) while others involve more gross motor (dancing). Be sure that the activities match with the skills the students have or are working on. Grade the activity up or down to meet their needs and skill levels. Some activities are best suited to take place outdoors, however, the weather or the facility may not allow this. Therefore, it may be best to wait until the weather is warm enough to do this. For example, the nature walk activity is meant to be held outdoors. If there are trees or plants around the school, you can walk around the school grounds and you don't have to travel.
Outcome Criteria	The outcomes of this session should: a. Explore culturally relevant leisure activities to promote physical health b. Participate and practice culturally relevant leisure activities for enhanced physical health Promote physical health and occupational performance from leisure exploration
Resources	Bergen, D. (Ed.). (1988). *Play as a medium for learning and development: A handbook of theory and practice*. Portsmouth, NH: Heinemann. Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents: A literature review. *The Journal of Primary Prevention, 38*(1-2), 5-26. doi: 10.1007/s10935-016-0455-2 Peacock, T., & Wisuri, M. (2002). *Ojibwe: Waasa Inaaabidaa: We look in all directions*. Minnesota Historical Society Press: St. Paul, MN. Polatajko, H.J., Townsend, E.A. & Craik, J. (2010). Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36 Retrieved from https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf. Turpin, M. & Iwama, M. (2011). *Using occupational therapy models in practice: A field guide*. Edinburgh, UK: Elsevier Urbaeva, Z., Booth, J.M., & Wei, K. (2017). The relationship between cultural identification, family socialization and adolescent alcohol use among

Native American families. *Journal of Children and Family Studies, 26*(10), 2681-2693. doi: 10.1007/s10826-017-0789-2.

Activities for Session 2:

- **Make beaded earrings or other beadwork**

- **Participate in traditional dance or powwows**

Session 3: Mastery & Program Wrap-Up

Purpose	Mastery is defined as successes and knowledge (Feinstein et al., 2009, p. 13). Mastery in terms of physical health and wellness involves knowing what physical health is, and how to improve it. After completing the previous sessions on physical health, mastery is a natural progression that takes place next.
Preparation/ Supplies	A binder or folder to hold all program-related materials for the student to take home. Be sure to read the session outline completely as well as any additional resources listed to understand the concepts so that you can explain them to your clients. Review previous sessions in the unit to recall games and other leisure exploration opportunities. ***Note: a handout for the conclusion/wrap up of the program is provided at the end of this session**
Group size & Timeline	**Group size:** • 3-10 • Age should be taken into account. The younger the clients, the smaller the group size. Note: Can be done individually instead of in group as well. **Timeline:** 1-2, 30-minute sessions
Goals	By the end of the session: 1. Students will define mastery as it relates to physical health 2. Students will provide at least one example of how they have demonstrated mastery related to physical health 3. Students will develop 2 goals related to physical health to promote mastery 4. Students will compile all handouts from the program into a binder to foster continued resiliency after completing the program
Rationale of Activity	Mastery is a protective factor that can promote resiliency in Native American children (Brendtro et al., 1990; Feinstein et al., 2009). Introducing mastery of physical health and wellness to Native American youth addresses one component of the image described by BigFoot and Schmidt (2010) when

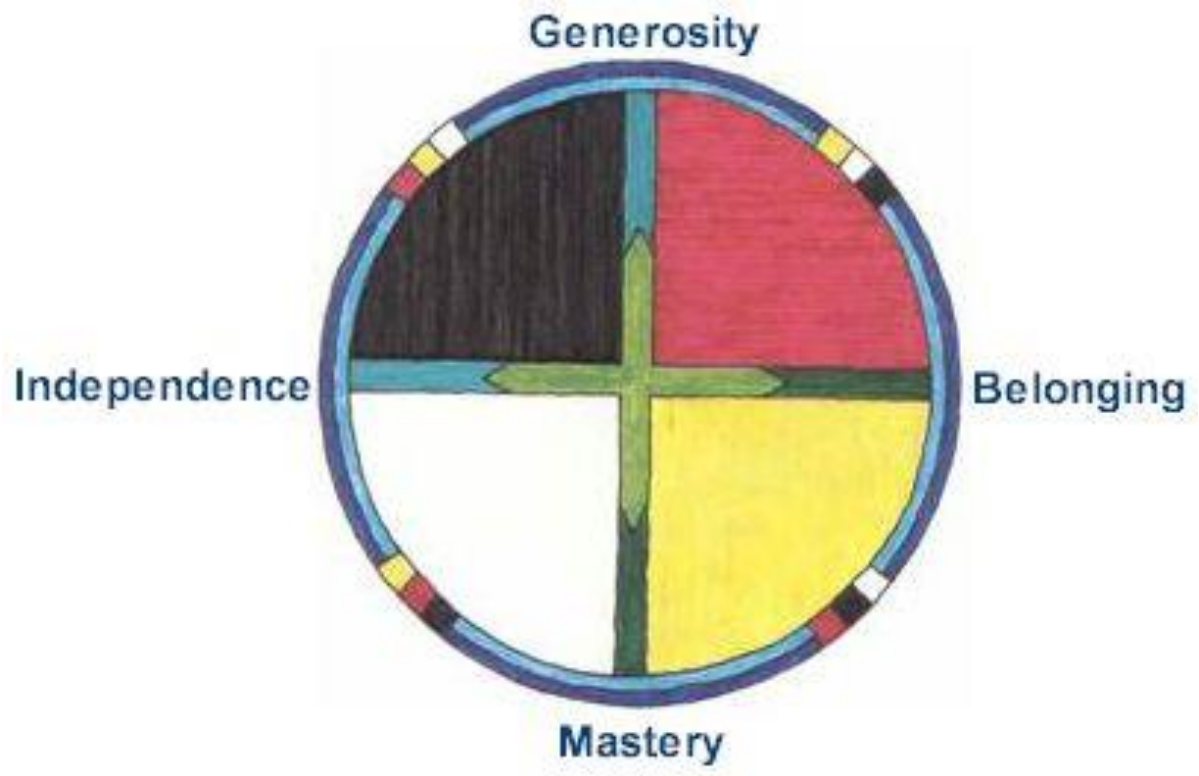
	considering the whole person. Additionally, demonstrating mastery of physical health and wellness is related to the physical component of the person in the CMOP-E (Polatajko et al., 2010). Therefore, addressing mastery in terms of physical health is appropriate because it relates to protective factors, resiliency, and the CMOP-E.
Cultural Components	Physical health is a cultural component of Native American culture as it is something they value. Historically, they would develop natural medicines or remedies to promote health (Densmore, 1979). Mastery is a protective factor related to resiliency in Native Americans (Feinstein et al., 2009). Discussing culturally relevant strategies to promote physical health incorporates specific cultural values and beliefs.
Precautions	Clients may become disruptions and distract others from learning the content. Be sure to watch for this and to
Steps	1) Warmup/ Introduction: Ask clients to define physical health and mastery separately, and then ask what they think what a combined definition would mean 2) Discuss mastery of physical health to foster a better understanding o Knowing what physical health is and how to successfully participate in it 3) Ask clients to provide examples of ways in which they have enhanced mastery in their own physical health (feel free to provide one of your own examples if clients would benefit from an example) o Discuss previous cultural strategies from leisure exploration or traditional games if they have tried them yet or if they want to try them in the future 4) Collaborate to develop goals of how clients will work on developing mastery of their physical health both at home and at school 5) Reflect on all sessions from the program while compiling handouts and resources in a binder for the student to take home. Take time to organize and decorate binder if appropriate. Have the child work on hole punching paper materials if applicable. Discuss progress made by looking at previous outcome measures. Ask student to reflect on progress made throughout program and list specific progress you have noted the student has made. 6) Conclusion/wrap-up: Thank the student for their participation and hard work in the program. Ask if there are any questions and ask students to reiterate what their goals are/ what they will be working on now that they have completed the program. 7) Complete the COPM as the outcome measure of the program.

Adaptations	If you are working on handwriting or drawing as goals for your clients, have the clients write the goals down or draw them on paper. Additionally, provide examples from your own life to facilitate rapport and discussion with clients. You can discuss mastery of physical health while completing another craft or task if the client is able to pay attention.
Outcome Criteria	The outcomes of this session should: a. Facilitate mastery with physical health to act as a protective factor b. Create goals to foster resiliency in the future in all protective factors c. Compile strategies from all protective factors for continued resiliency in various environments Promote mastery and resiliency to enhance occupational performance
Resources	BigFoot, D. S. & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology, 66*(8), 847-856. doi: 10.1002/jclp.20707. Brendtro, L., Brokenleg, M., & Van Bockern, S. (1990). *Reclaiming youth at risk: Our hope for the future*. Bloomington, IN: National Educational Service. Densmore, F. (1979). *Chippewa customs*. St. Paul, MN: Minnesota Historical Society Press Feinstein, S., Driving-Hawk, C., & Baartman, J. (2009). Resiliency and native American teenagers. *Reclaiming Children and Youth*, *18*(2), 12-17. Retrieved from https://eric.ed.gov/?id=EJ867921 Lee, B., & Perales, K. (2007). Circle of courage: Reaching youth in residential care. *Residential Treatment for Children & Youth*, *22*(4), 1-14. Retrieved from https://doi.org/10.1300/J007v22n04_01 Polatajko, H.J., Townsend, E.A. & Craik, J. (2010). Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36 Retrieved from https://vula.uct.ac.za/access/content/group/9c29ba04-b1ee-49b9-8c85-

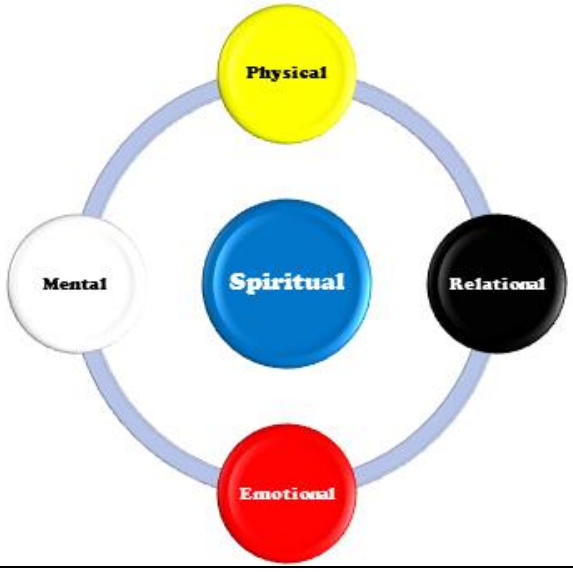
	9a468b556ce2/Framework_2/pdf/The%20Canadian%20Model%20of%20Occupational%20Performance%20and%20Engagement.pdf

Activity for Session 3:

Compile all resources from the program for student to keep.



Brendtro, L., Brokenleg, M., & Van Bockem, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN: Solution Tree.



Student Name:			
	What I learned	**What are my goals**	**How will I meet my goals**
Spirituality			
Mental health			
Emotional health			
Relational health			
Physical health			

Physical Outcome Measure

For Client's ages 10-18:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I understand what physical health is:

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

2) I know how important being physical is for my health

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

3) I understand how my physical body abilities affect my life

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

4) I am able to select physical activities I enjoy doing

Strongly Disagree **Disagree** **Neutral** **Agree** **Strongly Agree**

5) List 2 physical activities you enjoy:

1)

2)

For students 5-10:

Instructions: Read each question and **circle the choice** that you feel best applies.

1) I know how important knowing about my body is for my health:



No **Not Sure** **Yes**

2) I understand how my body's reactions affect my life



No **Not Sure** **Yes**

3) I can pick active activities I enjoy doing



No **Not Sure** **Yes**

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CHAPTER V

SUMMARY

Purpose

The purpose of this scholarly project was to create an occupational therapy culturally relevant program that can be used to address the unmet mental health needs of Native American students. In addition, the authors wanted to create a program that is for at-risk students, to promote protective factors and better occupational functioning. Native Americans are one of the most underserved groups, and typical Western interventions are viewed as not as effective by Native American consumers (Limb & Hodge, 2008; Warzak et al., 2011).

The S.P.I.R.I.T. Program includes units, session outlines, resources, and additional activity ideas for occupational therapists to implement to promote mental health, occupational performance, and protective factors. The program does not include all possible options of interventions, instead the sessions are provided as a starting point for occupational therapists. As the occupational therapist increases cultural competency, this program is designed to be adaptable by the occupational therapist to meet needs of the Native American children they will work with. The units and sessions of *The S.P.I.R.I.T. Program* incorporate the use of culturally relevant interventions. This was emphasized was because the literature supported the use of culturally competent care for better results with Native American populations (Brockie et al., 2015; DeMars, 1992; Urbaeva et al., 2017).

The goal of each unit is to promote protective factors and performance in the areas of spirituality, mental health, emotional health, relational (relationships), and physical health. Within each unit, there is a session that focuses on building traits from the Circle of Courage.

The Circle of Courage is a framework that was designed to promote resiliency (Brendtro, et al., 1990; Feinstein et al., 2009). Therefore, there is a session in each unit that is designed to promote resiliency, which is a protective factor in Native Americans (Feinstein et al., 2009; Mohatt et al., 2011; Thornton & Sanchez, 2010). Protective factors such as resiliency and connectedness are important when working with Native American populations because protective factors foster healthy behaviors and increase positive health outcomes (Henson et al., 2017).

This program is also designed to be adaptable. Each unit has suggested other additional activity ideas that can be used when the occupational therapist decides there is a need for it. In addition, it is recommended that the occupational therapist conducts a needs assessment to determine areas of need, and feasible time frames to implement the program. For example, an adaptation could be to implement the program during school or after school depending on the results of the needs assessment. Overall, the goal is to promote mental health, occupational performance, and protective factors within at-risk Native American students using culturally relevant interventions.

In order to determine the effectiveness of the program, there are Likert scale outcome measures for each unit. The outcome measures are designed to assess the students' perceptions of changes in satisfaction. In addition, the Canadian Occupational Performance Measure (COPM) will be used at the beginning and conclusion of the program to determine overall change in students' occupational performance. The COPM is an assessment tool from the Canadian Model of Occupational Performance and Engagement that is used as an outcome measure.

Limitations

While the program has several benefits, it also has limitations.

1. First, the program has an emphasis on protective factors, but it does not include all available protective factors for this population.
2. Second, to be used, the program needs to be used in areas with a high number of Native American students; however, there are not a lot of occupational therapists available on areas such as reservations.
3. A third limitation is that the cultural relevance of the program may not be applicable to all Native Americans.
4. A fourth limitation of this program is that it is assumed that occupational therapists will be culturally competent when implementing the program. Cultural competence is not determined prior to implementing this program.
5. A fifth limitation is that the occupational therapist needs to be aware of billing procedures and providing mental health-based interventions within the school may not be covered. If this is the case, the program could be implemented by another occupational therapy company instead of schools.
6. Finally, it may be difficult to implement all of the units due to the time needed.

Recommendations

The following are recommendations for the future outlook of this program.

1. One recommendation is to continue to add session ideas of culturally relevant interventions. This would provide more session options and relevant topics to address with the students.

2. A second recommendation would be to conduct a pilot study of the effectiveness of the program. Doing so would establish a foundation to determine the effectiveness of the program.
3. Finally, this study could be adapted to reach other at-risk populations with a need for culturally relevant care.

Conclusion

After conducting a thorough review of literature, a gap in culturally relevant interventions for Native American children was discovered. Based on an occupation-based model and information from the literature *The S.P.I.R.I.T. Program* was developed. Specifically, the Canadian Model of Occupational Performance and Engagement, the medicine wheel, an article by BigFoot and Schmidt (2010), and the Circle of Courage (Brendtro et al., 1990) inspired the program's image, units, and sessions. *The S.P.I.R.I.T. Program* is designed to be a culturally relevant program that was developed to promote resiliency, occupational performance, and protective factors in Native American students. Occupational therapists are well suited to implement culturally relevant programs to address mental health needs with students. Therefore, it is the hope of the author's that *The S.P.I.R.I.T. Program* addresses the unmet needs of Native American students in the hopes of improving their mental health.

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Appendix A

Permissions

Permission to Use Image

BD

Bigfoot, Dee (HSC) <Dee-Bigfoot@ouhsc.edu>

Reply all

Mon 2/26, 2:03 PM

Heisler, Alycia;
Safranski, Brianna;
Braden, Janie M. (HSC) <Janie-Braden@ouhsc.edu>

Inbox

Hi,
I missed your first request. Certainly you are welcome to use the model.

Please send me a copy with any paper or poster you might develop.

I wish you much success.

dbf

HA

Heisler, Alycia

Mon 2/26, 1:28 PM

Dear Professor BigFoot,

I am re-sending this email in the hopes of contacting you, as there is a chance you may not have received it the first time:

My name is Alycia Heisler and I am an occupational therapy student from the University of North Dakota. I am working on my scholarly project along with my project partner, Brianna Safranski. We are developing a program to help occupational therapists who work in schools

with Native American youth to educate them on how to provide culturally-relevant interventions.

I am writing to you to ask for permission to use Figure 1 in your 2010 article, Honoring Children, Mending the Circle: Cultural Adaptation not Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children. We would like to adapt it to use in our scholarly project to guide our curriculum. We would of course cite and provide credit to you in the project.

I look forward to hearing from you!

Sincerely,
Alycia

HA

Heisler, Alycia

Thu 2/15, 9:55 AM

Dear Ms. BigFoot,

My name is Alycia Heisler and I am an occupational therapy student from the University of North Dakota. I am working on my scholarly project along with my project partner, Brianna Safranski. We are developing a program to help occupational therapists who work in schools with Native American youth to educate them on how to provide culturally-relevant interventions.

I am writing to you to ask for permission to use Figure 1 in your 2010 article, Honoring Children, Mending the Circle: Cultural Adaptation not Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children. We would like to adapt it to use in our scholarly project to guide our curriculum. We would of course cite and provide credit to you in the project.

I look forward to hearing from you!

Sincerely,
Alycia

Appendix B

Circle of Courage

SB

Safranski, Brianna

Reply all

Sun 3/25, 1:57 PM

Larry Brendtro <larry.brendtro@gmail.com>

Sent Items

Perfect, that is good to know. Thank you so much for getting back to me.

Sincerely,

Brianna Safranski

LB

Larry Brendtro <larry.brendtro@gmail.com>

Sat 3/24, 8:41 AM

The Circle of Courage medicine wheel is based on Indigenous images and no copyright or trademark. permission is needed. Most citatations simply state the description of the of the Circle of Courage model in professional literature: Brendtro, L., Brokenleg, M.., & Van Bockern, S. (1990, 2002). *Reclaiming Youth at Risk: Our Hope for the Future*. Bloomington, IN; Solution Tree

Larry K. Brendtro

Circle of Courage Image Permission

SB

Safranski, Brianna

Reply all

Fri 3/23, 12:07 PM

info@reclaimingyouthatrisk.org;
Heisler, Alycia;
Fox, LaVonne

Hello,

My name is Brianna Safranski and I am an occupational therapy student from the University of North Dakota. I am working on my scholarly project along with my project partner Alycia Heisler and our adviser Dr. Fox. We are developing a program to help occupational therapists who work in schools with Native American youth to educate them on how to provide culturally-relevant interventions.

I am writing to you to ask for permission to use the image of the Circle of Courage in our product section. Our product section we have created includes sessions that focus on promoting factors from the Circle of Courage to promote resilience. We would like to include a picture for a visual of the Circle of Courage, as it is a wonderful resource. We would of course cite and provide credit to the authors of the Circle of Courage (Reclaiming Youth at Risk).

If there is anything else I need to do to obtain permission, let me know. Thank you.

Sincerely,

Brianna Safranski & Alycia Heisler