A culturally adapted peer support curriculum in Mental Health and Substance Abuse Treatment of American Indian/Alaska Native people.

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Abstract

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Pamela M. End of Horn

University of Pennsylvania
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Introduction

There is a need for a culturally adapted curriculum within peer support services that addresses mental health and substance abuse issues specific to the American Indian/Alaska Native (AI/AN) population. Mental health and substance use disorders affect the American Indian/Alaska Native population at an alarming rate. In 2019, 350,000 AI/AN adults ages 18 years and older were diagnosed with a mental health, substance use disorder and/or co-occurring disorder (U.S. Department of Health and Human Service, Substance Abuse and Mental Health Services, 2020a). In addition, AI/AN people have a disproportionate burden due to high rates of morbidity and mortality. As a result, AI/AN people experience lower health status than any other ethnic minority group with lower life expectancy, numerous barriers such as inadequate education, poverty, discrimination and prejudice, lack of services, and cultural differences (U.S. Department of Health and Human Service, Indian Health Service, 2018). Due to high mortality rates of AI/AN people resulting from high rates of co-morbid health, mental health, and substance abuse disorders (U.S. Department of Health and Human Services, 2014), effective peer support services are vital to rural tribal communities.

Currently, the use of peer support services within mental health and substance abuse treatment is sporadic among the 574 federally recognized tribes within the U.S. (U.S. Department of Interior, Bureau of Indian Affairs, 2017). To date the following tribes have initiated peer support services: Eastern Shoshone, Crow Tribe, Northern Arapaho (Transitional Recovery and Culture Project, 2021), Pueblo of Acoma (Acoma Behavioral Health Services, 2021), Eastern Cherokee (Family Safety, 2021), Squaxin Island Indian Tribe, Norton Sound Health Corporation, and Southern Ute Indian Tribe (U.S. Department of Health and Human Service, Indian Health Service, 2021). Services focus on activities such as coaching, recovery-
based activities, psychoeducational activities, and resource brokering (Solomon, 2004). Tribal communities have expressed interest in augmenting mental health and substance abuse treatment services with peer support to include traditional helping relationships such as parental support systems, role modeling, mentoring, and emotional support (Gidugu, Rogers, Harrington, Maru, Johnson, Cohee, & Hinkel, 2015). Peer support services have been found to be moderately effective when it is included as part of mental health services (Simpson, Flood, Rowe, Quigley, Henry, Hall, & Bowers, 2014; Vally & Abrahams, 2016) but lack of cultural competency was noted as a barrier to engaging culturally diverse populations (Jonikas, Kiosk, Grey, Hamilton, McNulty, and Cook, 2010). Within the current training used by tribal communities, *Recovery to Practice*, (U.S. Department of Health and Human Services, 2015a) module four focuses on the culture and self-awareness on the part of the peer provider but offers only general information related to culture. Overall, the curriculum *Recovery to Practice* does not address cultural components such as language, ceremonies, customs, or beliefs related to AI/AN people. Kaufman, Kuhn, and Stevens (2016) noted cultural competency as a core competency within state peer support curriculums, but an AI/AN population specific curriculum has yet to be identified.

The lack of a culturally adapted curriculum specific to AI/AN people could be a hindrance to the application of peer support in rural tribal communities. Among tribal communities, culture is viewed as prevention and treatment in that cultural reproduction and ethnic identity is vital to wellness (LaFromboise & Bigfoot, 1988; Wexler, 2006). LaFromboise and Bigfoot (1988) posited that changing of problematic thoughts and feelings by reframing through the use a culturally based framework of interconnectedness could aid in decreasing stress and offering a basis from which AI/AN people could begin to develop healthy, culturally
based coping strategies. Peer providers unaware of the cultural need for interconnectedness may not be as effective in setting up support, building rapport, or joining with the patient in offering services and meeting the needs of the patient. The development of a culturally adapted curriculum for peer support services specific to the AI/AN people could play a vital role not only by increasing cultural competence, but also increasing cultural proficiency through reproducing cultural norms by intervening in culture loss and increasing biculturalism and community interconnectedness. Peer providers from and within the tribal community can assist in focusing on specific tribal knowledge, and practices related to the act of helping. Inclusion of cultural activities such as use of language through song, and ceremonies can increase tribal identity and foster mental health and substance use recovery.

A cultural adaptation of mental health services was identified as a framework for culturally adapting Peer Support Services. The *Hoe Nuku Roa Framework* developed by Sir Mason Durie (Durie, 1995) of the Maori people in New Zealand is based on the Maori culture with focus on land, environment and interconnectedness paired with health dimensions of spirituality, thoughts and feelings, physical health, and family. The framework consists of eight culturally based health factors of spirituality, physical, mental, family, uniqueness, vitality, inspiration from ancestors, emotions, and connection. The framework was developed to focus on the ethnic and cultural identity of the Maori people for inclusion within healthcare services.

The Maori people consist of 70 tribes across New Zealand and tribal membership is self-determined. Due to the impact of colonialism and voluntary assimilation of the Maori people, the Maori culture was identified as highly relevant within the dominant society of New Zealand. To address the presence and inclusion of the Maori people, the assumptions of diversity, dynamic
change, multiple affiliations of the Maori people and self-identification were created to provide culturally appropriate and competent services within New Zealand (Durie, 1995).

The Maori culture is not static, and the Maori people were best able to identify elements of self-determination, tribal values, beliefs, traditions, positions and use of language. The result was a theoretical and conceptual framework based on empowerment, client centered care and social learning theory. All mental health services were grounded in the developed frameworks with individual tribes identifying local inputs and outputs related to healthcare factors, metrics, and service provision. This type of culturally informed framework is necessary for an integrated approach to healthcare for the Maori people resulting in a bridge between Maori culture from contemporary to traditional across New Zealand (Durie, 1995). Application of the Hoe Nuku Roa Framework to peer support service could begin to address needed cultural components lacking in the current curriculum. Cultural adaptation of the curriculum could offer AI/AN people an intervention tailored to meet their specific issues and needs.

**Background and significance**

The terms “American Indian” and “Alaska Native” refer to individuals who are descendants of the indigenous people of North America and who are affiliated with one or more of the 574 U.S. federally recognized tribes (U.S. Census Bureau, 2012; U.S. Department of Interior, 2017). American Indians and Alaska Natives comprise a total of 5.2 million people or 1.7% of the total U.S. population and the population is growing (U.S. Census Bureau, 2012). Forty-one percent of the AI/AN population reside in the western half of the 48 contiguous states with portions of the AI/AN population located in rural, geographically isolated areas with limited access to infrastructure, resources, or services available in urban populated areas within the U.S. (U.S. Census Bureau, 2012; U.S. Department of Health and Human Services, 2017).
According to the U.S. Department of Health and Human Services (2014), the AI/AN population experiences high rates of death from heart disease, cancer, diabetes type II, chronic liver disease, and unintentional injuries or accident as well as substance use disorders and other mental health issues which result in high mortality rates (U.S. Department of Health and Human Services, Indian Health Service, 2014; U.S. Department of Health and Human Service, Indian Health Service, 2018). The Congressional Research Service (Bagalman & Heisler, 2016) found the AI/AN population have higher prevalence rates for Suicide, Substance Use Disorders, Post Traumatic Stress Disorder, and Childhood Conduct Disorder. In addition, the American Psychiatric Association (2017) noted 21% of the AI/AN population ages 18 years and older reported mental illness in the past year compared with 17.9% for the general population and that 9% had a co-occurring mental illness and substance use disorder in the past year.

The rurality of AI/AN people living in tribal communities contributes to barriers in accessing quality mental health services. Key barriers include lack of services, lack of awareness of mental health, stigma related to mental health, mistrust of health care providers, lack of quality of care, lack of infrastructure, and lack of culturally appropriate intervention strategies (American Psychiatric Association, 2017). In addition, the impacts of historical trauma related to colonialism, genocide and culture loss are identified as a contributing factor related to mental health issues (Wexler, 2006; Lafromboise & Bigfoot, 1988). Whitbeck, Adams, Hoyt, and Chen, (2004) noted AI/AN people who experience higher levels of historical cultural loss may be more responsive to more proximal stressors and that the combination of historical and contemporary stressors can exact a higher toll on physical and emotional wellbeing. The development of healthy, culturally based coping strategies could aid in identifying roles and status of the individual within the family and community which could lead to a decrease in mental health
issues and an increase in biculturalism and establishment of an ethnic identity. LaFromboise, Hardin, Coleman, and Gerton (1993) noted bicultural experiences were related to being grounded in identified cultures which maintained and enhanced ethnic identity. Ethnic identity aids in managing challenges related to living between and within multiple cultures.

Ethnic identity plays an integral role to the construct of culture among AI/AN people (LaFromboise, Hardin, Coleman, & Gerton, 1993). Culture is the lens by which AI/AN people perceive and interact with the world. As AI/AN people are part of two distinct cultures, tribal and the dominant culture within the U.S., understanding the complexities within and between both is vital to provision of services as well as obtaining services within healthcare systems. The knowledge of and experience in traditional healing practices and other protective factors related to cultural context is important in the treatment of AI/AN people and communities as AI/AN people are more likely to seek help from community resources versus western medicine-based healthcare systems (American Psychiatric Association, 2017). For AI/AN people tribal languages, ceremonies, customs, and values are integral to healthcare services related to the community and family support (Beals, Novins, Whitesell, Spicer, Mitchell, & Manson, 2005; Brown, Dickerson, & D’Amico, 2016). The importance of including ethnic identity in healthcare services can aid in the lessening of cultural disconnection between the community and the healthcare system by creating a cohesive community environment where AI/AN people can increase bicultural experiences and obtain needed healthcare services (Brown, Dickerson, & D’Amico, 2016; Moran, Fleming, Somervell, and Manson, 1999).

**Family support**

The family plays an integral role within the community’s interconnectedness with cultural attributes such as language, ceremonies, values, morals, and practices which are taught
within and across families. Whitlock, Wyman, and Moore (2014) found in the general population that family was identified as a vital connectedness attribute in addition to schools, peers, and community. Family members, adults and peers who were perceived as supportive and engaged led to beneficial effects. Bolstering of support by parents, school, and family in areas where AI/AN people may be lacking, such as with peers, may increase the preventative effects through integrated support systems (Kidd et al., 2006).

Tribal cultures were traditionally based on interconnected familial systems. In a review of the empirical literature, Smokowski, David-Ferdon, and Stroupe (2009) noted family connections as a significant cultural asset. Family systems were responsible for continuation of the tribe’s societal norms related to ceremonies, language, and customs. Oetting, Swaim, & Chiarella (1998) developed a scale to measure orthogonal cultural identification among American Indian and Mexican American Youth. The scale was based on broad range of Mexican youth and American youth based in two schools. The sample size consisted of 2,048 students grades 7 to 12. The results of the study found personal, and family cultural identity was likely to be highly related indicating cultural identification being strongly rooted within the family. Bicultural ethnic identity is complicated among the AI/AN population due to multiple tribal affiliations, intertribal marriage, distinct tribal languages, and customs in addition to the culture of heritage and the dominant culture (Moran, Fleming, Somervell, & Manson, 1999). Due to colonialism and the resulting trauma, traditional cultural norms were either disrupted or destroyed resulting in AI/AN people living alongside two cultures but not fully integrated within either. Family support could offer aid in addressing mental health needs and building integration with the tribal culture.
Family support is defined as mutual assistance, both direct and indirect, which affects mental health, feelings of self-worth, and promotes growth in emotional, psychological, and intellectual development (Colarossi & Eccles, 2003). Colarossi and Eccles (2003) noted family support was unrelated to peer support and peer support was an additive effect within mental health. Unfortunately, family peer support models within the dominant society are underdeveloped. Paraprofessionals have historically aided in recruitment and retention but were not part of service delivery. Peer support can offer a unique strength to work with families in relation to trust, credibility and engagement (Kimberly, Mary, Barbara, Hoagwood, Cavaleri, & Hughes, 2010). A culturally adapted peer support model within the AI/AN population could begin to engage with families in healthcare services.

Family focused programs for peer services can emphasize offering information, education, and advocacy as well as mentoring within the culture. Cavaleri, Olin, Kim, Hoagwood, and Burns (2011) reviewed the empirical literature and found support services for parents produce better outcomes for children at risk than treatment alone. Augmenting services for parents also resulted in improved mental health and wellbeing. Additional findings included increased self-efficiency, reduced stress, increased perceived social support skills, treatment engagement and reduced barriers to care (Cavaleri, Olin, Kim, Hoagwood, & Burns, 2011). Overall results showed enhanced quality of life, improved perceptions, improved decision making regarding healthcare and positive therapeutic alliance. Some results showed lower rates of stress, depression, as well as an increase in social support. Peer support which includes families can give emotional support, support in navigating systems, psychoeducational information on mental health conditions and educate on how to manage and enhance wellbeing of family members (Acri, Zhang, Adler, & Gopalan, 2017). Adaptions to the curriculum can add
needed cultural references such as ceremonies, language, and customs in order to facilitate access to services.

Due to families within the AI/AN population experiencing rurality, limited mental health programs and high rates of health disparities, the period for services engagement by helping professionals is an area of concern (U.S. Department of Health and Human Services, Indian Health Service, 2014). Frequently AI/AN people face barriers to obtaining services which can include limited transportation, limited funds, and high rates of substance abuse. Considerations should be given for longer engagement periods with participants, inclusion of programmatic cultural modifications and training (Tondora, O’Connell, Miller, Dinzeo, Bellamy, Andres-Hyman, & Davidson, 2010) as well as focusing on ways to retain participants through involvement of family members in accessing services (McCurdy, & Daro, 2001).

**Ethnic identity**

Friesen, Cross, Jivanjee, Thirstrup, Bandurraga, Gowen and Roundtree (2015) noted ethnic identity as a collectivistic orientation where interdependence with family, extended family and community are viewed as beneficial and vital to health and wellness of the individual. Ethnic identity encompasses cultural environmental influences based on a local, regional, and national context with the type, dynamics and sources of influence of the identity and is based in the perception of strength of connection to the identified ethnic group (Markstrom, 2011; Moran, Fleming, Somervell, and Manson, 1999). Ethnic identity related to AI/AN cultures has been identified as a protective factor due to the holistic nature of the AI/AN worldview with mental, physical, spiritual, and contextual parts represented (Brown, Dickerson, & D’Amico, 2016; Friesen, Cross, Jivanjee, Thirstrup, Bandurraga, Gowen, & Roundtree, 2015). Each part plays an integral role within not only the person’s life but also with the family and community. These
interrelated factors are necessary for health and wellness-based functionality. Ethnic identities are based in the how and to what extent an individual has between and within cultures. Reciprocal relationships between an individual and the land, environment, and family descendants (Durie, 1995) are influential in the establishment of ethnic identity (LaFromboise, Coleman, and Gerton, 1993).

The AI/AN ethnic identity is seen as positive and protective for many AI/AN people (Friesen, Cross, Jivanjee, Thirstrup, Bandurraga, Gowen, & Roundtree, 2015). AI/AN people adhere to specific dimensions of ethnic identity related to self-categorizations and labeling related to genealogy. Self-categorizations focus on distinct tribal affiliations, location, descent, and blood quantum in addition to physical location of the tribe within the U.S. Each category is a social and political construction determined not only by tribes but also the U.S. Government based on the core factor of genealogy (Markstrom, 2011). Ethnic identity overall is related to the connection of tribally specific features, relationships, social interactions and institutions, tribal customs, values, behaviors, and language as well as tribally based norms and rights. Moran, Fleming, Somervell, and Manson (1999) developed a measure of ethnic identity among 2,077 American Indian adolescents in grades 9 to 12. The results provided support for ethnic identity among American Indian youth in recognizing the interaction of biculturalism in relation to tribal and dominant society. Relating the ethnic identity to genealogy and how the interconnected aspects of family, ceremonies, language, and customs within one or more cultures can aid in creation of connection within and between cultures enhancing help seeking and service provision.
Biculturalism

Bicultural efficacy is the belief that individuals can develop and maintain effective interpersonal relationships in two cultures effectively and in a satisfying manner without compromising a sense of ethnic identity (LaFromboise, Coleman, & Gerton, 1993). Nguyen and Benet-Martinez (2013) conducted a meta-analysis of biculturalism and adjustment and found that flexibility and social support networks within the ethnic and dominant culture may buffer an individual from psychological or sociocultural maladjustment indicating that biculturalism is strongly related to adjustment. Results from Moran et al. (1999) support a bicultural approach to ethnic identity among AI/AN people. Biculturalism is defined as AI/AN individuals who live in two worlds, one that is an ethnic community and the other that is the dominant culture. It was noted that those within the AI/AN population who live in a bicultural world, their own community, and the dominant culture, scored higher for well-being than those who identified separation or assimilation with individual cultures. Nguyen and Benet-Martinez (2013) noted biculturalism as positively related to adjustment and this relationship is stronger than those between adjustment and either ethnic or dominant cultural orientation. Biculturalism was noted to be crucial within plural societies and the global community.

The history of AI/AN people related to colonialism, genocide, forced relocation, dislocation, foster care and boarding school focusing on forced assimilation practices play an integral role in the disruption of an AI/AN ethnic identity. The ethnic identity of AI/AN people is based on the tribal history keeping traditions and the impacts of such practices (Yellow Horse-Brave Heart & DeBruyn, 1998). As a result, tensions between the ethnic and the dominant culture may impact biculturalism among AI/AN people (Nguyen & Benet-Martinez 2013). Due to this complex history, interactions related to AI/AN people are unique and complex requiring
interventions based in contexts related to the impacts on the culture both within the dominant society as well as within tribal communities (Brown, Dickerson, & D’Amico, 2016).

**Cultural competency and cultural adaptation**

Culture is viewed as a value laden (American Psychological Association, 2003; Valsiner, 2003) belief system that takes into consideration customs, norms, practices, social institutions, and psychological processes that contribute to a world view. Culture is dynamic, it adapts and changes over time through short or long-term events or due to shifting societal structures. Elements of the culture at the micro, mezzo and macro levels meet people’s experientially created and identified needs. Shifts related to daily and long-term practices can be susceptible to change but can also be resilient in the face of adaptation due to necessity. Culture is not static but rather adaptive and reproducible (Hoffman, 2016). In short, culture is simply a group of people that belong to a culture and to which a culture belongs (Valsiner, 2003).

Different elements of a culture, such as language and beliefs, can affect healthcare services making cultural competency crucial in healthcare provision among AI/AN people. Integration of cultural competency includes mission, values, diversity statements, diversity and inclusiveness plans, cultural competency training for staff, course content and curricular components, and assessment of perception of diversity (Lopez-Littleton & Blessett, 2015). Cultural competency values include valuing diversity, conducting cultural self-assessments, understanding the dynamics of difference, incorporating cultural knowledge, and adapting to diversity (U.S. Department of Health and Human Services, 2017). Elements that work in tandem with cultural competency values are attitude, practice, policy, and structure. Cultural competency occurs across a continuum from cultural destructiveness to cultural proficiency.
Included within the continuum is cultural blindness, cultural pre-competence and cultural competence (Heflinger & Nixon, 1996).

Benuto, Casas and O’Donohue (2018) conducted a review of the literature of 235 sources focused on multicultural education as it relates to mental health. The results noted limited research for cultural competency training and patient outcomes, yet multicultural education interventions based on self-reports post training were associated with an increase in cultural competency development and provided direction for future training. The goal of cultural competency is provision of services by creating individualized systems of care (Heflinger & Nixon, 1996). Whaley and Davis (2007) noted cultural adaptation as a method in making mental health services culturally appropriate and meeting the need to expand the definition of “evidenced based practice” to maximize external validity. The inclusion of ethnic identity with emphasis on cultural distinctiveness can address gaps in services for AI/AN people, outcomes related to being AI/AN and gradients of hardship (Durie, 2005b) as well as shift the focus from disparities to strengths based (Durie, 2011a).

Jonikas, Kiosk, Grey, Hamilton, McNulty, and Cook (2010) found that a lack of cultural competency was a barrier to peer support services. Participants reported peer run programs were unable to reach out to diverse communities and lacked information about other cultures which contributed to the feeling of not belonging. Jonikas et al. (2010) identified a need for cultural competency within peer run programs as well as strategies to engage diverse populations. In addition, peer support services have been found to be only moderately effective when part of mental health services (Simpson, Flood, Rowe, Quigley, Henry, Hall, & Bowers, 2014; Vally, & Abrahams, 2016). Considerations should be given to the application of peer support within the AI/AN population to ensure appropriateness of fit, significance and appropriateness of outcomes.
Low (2002) developed a conceptual framework for nursing within the Native American culture and noted that the cultures of AI/AN tribes differed within and across regions of the U.S. Each tribe had its own culturally based identity based on ecology, climate, geography, territory, linguistics, affiliations with other tribes and sharing of information with and among other tribes. Each tribe had individual identified customs which varied significantly within and across regions. Customs were based in origin, language, beliefs, socioeconomic status, gender, sexual orientation, age, marital status, ancestry, history, gender identity, geography, matrilineal or patrilineal practices, songs, prayers, ceremonies, and practices. Cultural and ethnic identity among AI/AN people is unique and related to an individual’s family history and genealogy. Most often specific tribal affiliation and tribal location within the U.S. are key to ethnic identity as an AI/AN person. The AI/AN person is as much a part of as they are a product of their environment. Environmental factors such as geographical isolation from the dominant society and limited exposure to ethnic culture can impact connection and interconnection within either or both cultures.

Cultural revitalization and reproduction

The world view held by AI/AN people consists of belonging as a component of connectedness and interconnectedness not only to family and tribal affiliation but also the environment (Durie, 2005a; Durie 2005b; Durie 2011a; Durie, 2011b). These components are evident in the holistic focus of the person within their environment (Durie 2011a; Durie, 2011b). All components are connected through interactions highlighting belonging to a system of mental, physical, emotional, and spiritual dimensions. Belonging is not only a need but also the element of connectedness and interconnectedness to people, places, and things (Hill, 2006). Lowe (2002) found connectedness within the AI/AN people maintain core dimensions of caring, tradition,
respect, holism, trust, and spirituality. Connectedness is a fundamental focal point and intention within the AI/AN value system. Due to the impacts of colonialism and genocide, the AI/AN people are shifting societal structures in adapting to change agents through necessity, but culture persists as it reforms (Hoffman, 2016).

Valsiner (2003) noted culture was existing knowledge of core conceptual structures developed through activities of people. Culture is viewed as transferrable by either unidirectional or bi-directional construction between people resulting in both closeness to and distance from. The perception and interactions of people with differing cultures or lack thereof can shape world views. Emphasis on universal human behavior with contact between groups can de-emphasize group membership, encourage understanding of similarities and differences which can aid in developing interactions which are helpful and can lead to exploration of other’s perspective and world views (Valsiner, 2003). In addition, cultural reproduction can instill connection and a sense of belonging.

Lee (2008) found that displaced cultures can reproduce cultural elements through strategies and approaches focused on preserving and enriching the culture. People of changing cultures can reinvigorate their culture through the use of traditional stories, songs, dances and prayers which can be used at specific points of connection within a community such as a birth or death. Traditional stories, songs, dances, and prayers can also be reproduced through media such as videos, film, and music for people of the community to consume to increase belonging and connection within the culture.

In addition, dissemination of cultural practices via the internet can reach displaced members of the culture to provide connection and identification with the culture (Durie, 2004) as well as expose AI/AN people to cultural elements to inform and reduce bias. All the information
can be part of an ongoing cultural reproduction related to production of artifacts, crafts and items related to traditional ceremonies and traditions. Such items can represent the sense of identity for the people of the culture and reflect vital cultural components needed for cultural and ethnic identity formation and maintenance. Durie’s (1995) developed framework, *Hoe Nuku Roa*, employs cultural practices and components within healthcare delivery to increase service effectiveness. These components focused on cultural reinvigoration and serves as a model on how cultural components can be integrated into healthcare services for the benefit of indigenous populations. Through the development of a similar framework for AI/AN people, cultural reproduction can focus on functionality, connectedness, and interconnectedness through the adaptation of Peer Support Services which could increase service provision within tribal communities and among AI/AN people.

**Peer support services**

Peer Support Services focus on consumer- or peer-provided services and gives social and emotional support through mutuality and self-efficacy. Using lived experience, a peer provider works with clients to promote choice, self-determination, and empowerment. (Solomon, 2004; U.S. Department of Health and Human Services, 2015b). Peer Support Services have been integrated within healthcare systems across 36 U.S. States since the 1970’s (Myrick & Del Vecchio, 2016). Peer providers can also be found within the Department of Veterans Affairs and in the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) through peer provider services, curriculum training, technical assistance, and subject matter expertise (U.S. Department of Health and Human Services, 2013). With the implementation of Affordable Care Act (ACA) in 2010, Peer Support Services have found applicability across healthcare systems as reimbursement for peer providers
are included in the key objectives related to the ACA such as being community based, peer focused and improving the quality of healthcare (Call to Action: Integrating Peer Support in Prevention, & Health Care Under the Affordable Care Act, 2014).

Peer providers can be found working in medical units, mental health and substance abuse treatment programs and are known as health navigators, informed supporters, peer support specialists, peer mentors, peer counselors, recovery support specialists, recovery coaches, client liaisons, peer bridgers, family support navigators, peer companions, consumer case managers and peer specialists (Myrick & Del Vecchio, 2016; Proudfoot, Jayawant, Whitton, Parker, Manicavasagar, Smith, & Nicholas, 2012; Solomon, 2004). Peer providers act as part of treatment team augmenting care for healthcare conditions and medical issues from pain management (Matthias, Kukla, McGuire, Damush, Gill, & Bair, 2016) to breast feeding (Long, Funk-Archuleta, Geiger, Mozar, & Heins, 1995) as well as mental health services for specific psychiatric disorders and conditions (Gidugu, Rogers, Harrington, Maru, Johnson, Cohee, & Hinkel, 2015; January, Duppong Hurley, Stevens, Kutash, Duchnowski, & Pereda, 2016; Proudfoot, Jayawant, Whitton, Parker, Manicavasagar, Smith, & Nicholas, 2012; Scott, Doughty & Kahi, 2011; Vally & Abrahams, 2016).

A meta-analysis conducted by Chinman, George, Dougherty, Daniels, Ghose, Swift & Delphin-Rittmon (2014) noted Peer Support Services as moderately effective within the general population due to many of the studies reviewed having issues in methodology and outcome measurements. The meta-analysis noted more research was needed. Walker and Bryant (2013) found that peer providers required additional supervision and support to address prejudice, stigma, and discrimination. Moran, Russinova, Gidugu, and Gagne (2013) found that peer providers faced numerous challenges within the workplace including lack of clear job
A CULTURALLY ADAPTED PEER SUPPORT CURRICULUM

description, job duties, skills, encountering stigma, overwork, symptom reoccurrence, lack of appreciation, role conflict and issues with confidentiality regarding receiving services where the peer was both employed and obtained services. Silver and Nemec (2016) identified the role of peer providers requiring standardized credentialing standards for use across healthcare systems and the expansion, advancement, and evaluation of peer providers regarding effectiveness within different populations was vital to the continued utility of Peer Support Services.

Despite the identified limitations, Peer Support Services and peer providers have been found to improve health outcomes, increase access to healthcare services, improve management of health related and mental health conditions as well as positively impact patient engagement (Dennis, 2003; Myrick & Del Vecchio, 2016; Vally & Abrahams, 2016; Vayshenker, Mulay, Gonzales, West, Brown, & Yanos, 2016). Peer providers have the potential for effective impact within healthcare.

Within AI/AN communities, Peer Support Services are offered on a limited basis. Aspects of Peer Support Services compliment services provided by AI/AN mental health and substance abuse services and have characteristics of traditional helping relationships such as parental support systems, role modeling, mentoring, navigating and emotional support (Gidugu, Rogers, Harrington, Maru, Johnson, Cohee, & Hinkel, 2015). The services of peer providers focus on the tenets of health navigation, coaching and advocacy for patients and their family (Solomon, 2004). The training of the peer providers is specific to the Recovery to Practice (U.S. Department of Health and Human Services, 2015) curricula which includes a lay introduction of culture as it relates to mental health. Development of culturally adapted Peer Support Services specific to the AI/AN family and community could play a vital role through culture reproduction and increasing community connectedness and interconnectedness.
Connectedness was identified as an important effect within prevention and early intervention efforts. (Opperman et al., 2015). Walker, Ashby, Hoskins, and Greene, (2009) found that social environments where questioning and listening occurred offered an effective response in decreasing stress and aiding in reframing of interpersonal problems within the family. Cultural activities were found to give therapeutic benefits for AI/AN people who report acculturation stress and cultural disconnection. (Brown, Dickerson, & D’Amico, 2016). Providing culturally adapted peer support services to facilitate culturally based coping strategies to patients and their families within an AI/AN community could prove beneficial to a large portion of the tribe by aiding in development of an ethnic identity within the AI/AN community as well as to the larger society.

The AI/AN people’s holistic worldview represents an opportunity to expand on the theoretical framework of Durie (1995) which is based on emotional, physical, psychological, and spiritual dimensions not only of the person but also tribal community. When taking into consideration the connectivity, interconnectedness, and ethnic identity of AI/AN people, a theoretical framework must include elements related to person to person and person in community interactions to derive beneficial and needed outcomes. These elements must focus on the interaction of the individual through micro, mezzo, and macro levels within their environment.
Theoretical Frameworks to Guide Curriculum Adaptation

Social learning theory

Bandura et al. (1971) found that learning occurs in a social context. Within Peer Support Services learning is bi-directional from a social interaction of patient to peer and peer to patient. The interaction between peer and patient can aid in learning through observation, modeling and through interactive behavior itself. New behaviors can be created from the social interaction between peer and patient, which can empower the patient to obtain support, find resources and obtain aid where before the patient may have been isolated or lacked connection and resources.

Within Peer Support Services, peer providers can be a powerful change agent in the promotion of and access to healthcare (Simoni, Franks, Lehavot, & Yard, 2011). Social Learning Theory, which the intervention of peer support focuses on, can be used to aid AI/AN people through mutual support of peer and patient by understanding the impact of historical trauma due to colonialism, poverty, and disease burden. The outcomes of the intervention can focus on empowering the patient in relation to the myriad of intersections related to culture, gender, race, ethnicity, socioeconomic status, and health consciousness.

A culturally adapted curriculum based in applied theories and educationally based, such as Peer Support Services, can empower peer providers and AI/AN people (Aschenbrener & Johnson, 2017). Bolea (2012) found that cross cultural immersion experiences can aid in obtaining cultural sensitivity and competency. Such immersive experiences highlight the importance of learning in a social context. Participants who took advantage of cross-cultural experience led to development of understanding as well as an increase in service provision to AI/AN people. Peers can aid patients who are part of a vulnerable population to cross barriers to obtain needed and vital information, resources and services through social interaction and social
learning by minimizing the tenets which lead to discrimination, bias and stigma through cultural competency and awareness.

Cooley (1977) found that understanding of similarities and differences within and across cultures can aid in the identification of adaptive skills and interventions related to culturally based traditions and customs. A cultural adaptation may be readily accepted by the populations which would allow for dissemination of current interventions based within both a dominant society and tribal culture. Adaptation of Peer Support Services through embedding of cultural competency and sensitivity can aid peers providing services to AI/AN people by emphasizing strengths related to the AI/AN culture. Recognition of the cultural strengths can aid peers in becoming cultural aware and practicing from a culturally focused perspective (Chavis, 2012).

**Intersectionality**

Developing a culturally adapted curriculum that focuses on culturally competent practices and biculturalism can aid in understanding how culture shapes and impacts the life of AI/AN people through established cultural history, values, traditions, and norms including advantages and disadvantages related to cultural proximity (Jani, Pierce, Ortiz, & Sowbel, 2011). Consideration must be given to terminology, identities, subject formation, models used and how to focus on interactions when shifting paradigms (Dhamoon, 2011).

Patient identities related to the impact of culture on sex, gender, and class should be included in curriculum adaption to improve operationalization for diversity (Muntinga, Krajenbrink, Peerdeman, Croiset, & Verdonk, 2016). Incorporation of gender in relation to the ethnic identity of AI/AN people can inform applied theories and aid in the incorporation of intersecting identities within curriculum development (Shields, 2008). Gender egalitarianism, ambiguity, and power relations among AI/AN people are complex and in conflict with dominant
society gender dichotomy. Many tribes are matrilineal and keep strict sex role identification. This focus can lead to misunderstandings on part of the peer provider as well as cultural insensitivity, prejudice, and stigma. Peer providers’ recognition of the differences and intersections between biological sex, gender, power, and oppression, could empower and aid versus furthering conflicting systemic models of oppression through interaction, learning and service provision (Jacobs, 2014). Peer providers can also aid AI/AN people in developing connections within cultural contexts to achieve competency and increase connection and belonging.

**Humanization of healthcare**

Humanization in healthcare is the use of a person-centered approach and asserts the intrinsic dignity of all human beings and the rights stemming from this fact. It is a value by which the care is based in scientific evidence while incorporating aspects of the patient’s dignity and humanity. Trust and empathy are actively built, and focus is placed on the patient’s wellbeing to achieve the best outcomes (Velasco Bueno & Heras La, Calle, 2020).

The roots of humanization can be traced to Edmund Husserl, the founder of the phenomenological movement. Husserl (1970) asserted the nature of human-world intimacy to be made more explicit. He named this the lifeworld, the beginning place-flow from which we divide up our experiences into more abstract categories and names. It is a world that appears meaningfully to consciousness in its qualitative, flowing given ness, not an objectiveness, not an objective world “out there” but a humanly relational world, full of meanings (Todres, Galvin, & Dahlberg, 2007).

Backes, Koerich, and Erdmann (2007) identified humanization occurs through the valuation of the human being. Factors included in humanization: flexible visiting policies for
inpatient settings, communication, well-being of the patient, presence, and participation of relatives, caring for the healthcare professional, prevention, management and monitoring, humanized architecture and infrastructure, and end of life care (Velasco Bueno & Heras La, Calle, 2020). Cheraghi, Esmaeili, and Salsali (2017) linked humanization to patient centered care which focus on patient acceptance, assessment, and identification, understanding the patient, and patient empowerment.

Patient empowerment is the encouraging of patients to have control of their healthcare to affect outcomes and is also a tenet of patient centered care. By applying the core values of honesty and integrity, caring compassion, altruism and empathy, and respect for others, positive relationships between provider and client can be improved and encouraged (Cheraghi, Esmaeili, Salsali, 2017). The facilitation of positive relationships that encourage connection allows for development of trust, vulnerability, care, learning and openness. Such interactions foster engagements that can be based in cultural norms and practices (Sylliboy & Hovey, 2020). Patient participation can be increased and enable healthcare systems to become patient centered which could aid in furthering overall patient care (Castro, Van Regenmortel, Vanhaecht, Sermeus, & Van Hecke, 2016).

With the establishment of culturally competent interventions through adaptation and integration of culture, feelings of visibility, cultural safety, autonomy, involvement, and humane treatment of AI/AN people could be increased (Hole, Evans, Berg, Bottorff, Dingwall, Alexis, & Smith, 2015; Holmström, & Röing, 2010). Encouragement of self-determination through the application the concepts related to the humanization in healthcare and patient centered care can bridge the gap between western medicine-based healthcare practices and tribal programs to promote development of processes based in cultural and community standards. Recognizing
local cultural impacts and providing treatment to meet needs could aid AI/AN people to obtain a broad range of services specifically geared to their needs and improve mental health and substance abuse treatment outcomes (Chino & Debruyn, 2006). The act of sharing stories can be medicine and thus healing. Sharing their hurt, pain and journey through stories which can give more control to the AI/AN people in their healthcare and allow for outcomes aligned with traditional views of medicine (Sylliboy & Hovey, 2020)

**Cultural revitalization and reproduction**

Valsiner (2003) asserts that a person belongs to a culture and a culture belongs to a person. The concept of culture is a process which is both internalized and externalized; thereby highlighting the mutuality of the person and world. Culture can be seen as patterns of learned behavior which contain parts related to social organization and is displayed through individual and group behaviors (Wallace, 1956).

Change in culture can stem from unsatisfactory systemic elements resulting in members of the culture moving to infuse classical or contemporary traits. This change can occur through evolution, drift, diffusion, historical change, and acculturation and follow functional stages of pathway reformulation, communication, organization, adaptation, cultural transformation, and routinization. The stages can reoccur as new traits, either from historical or contemporary sources, are introduced. Difficulty arises when accepting tradition is not respected or respected in return (Wallace, 1956). Cultural revitalization is a phenomenon where major cultural system innovation is a uniform process (Wallace, 1956). Cultural revitalization is a deliberate, organized, conscious effort by members of a culture to induce change.

Revitalization movements have occurred throughout history and are a result of extreme stress and disillusionment with the current cultural landscape (Wallace, 1956). Cultural identities
are socially constructed and are emotionally motivated by the influence of structuring identity over many generations. The cultural identity of many Natives has been maintained across many years of colonialism. Patterns of familial relations influence the roles found within ancestral beliefs and societal structures. American Indian/Alaska Native identity persisted through the use of traditional and cultural practices maintained by Native women. The use of oral traditions within tribal communities celebrated by matrilineal communities transmitted contemporary Tribal identity. Factors such as family genealogy and social networks are the foundation of cultural practices (Tveskov, 2007).

Tribal identity is a shifting content and focus among Native people. Often tribal identity is formed and reformed through innumerable intersections of experiences and other identities. Alienation and displacement of people from traditional lands, kinship and familial networks heavily impacts the development and maintenance of Tribal identity. All too often this disruption occurs at a young age causing difficulties within individuals in recognizing their tribal identity and accepting their culture (McIlwraith, 1996).

Through cultural healing concepts such as pride, survival, healing, struggle and discovery can become a way for expression of Tribal identity and exercising of political, educational, heritage, physical and emotional healing of the culture and people. Tribal identity includes the connections between identity and place, between the past and present, and acknowledgement of one’s own identity (McIlwraith, 1996). Cultural revitalization efforts, such as language and cultural education are effective in transmitting knowledge, value systems, and contribute to resilience within Natives lives to promote recovery from historical trauma (Shea et al., 2019).

Ethnic resistance is an effort to foster self-determination and initiate cultural revitalization by way of accepting new cultural elements without losing Tribal identity (Mager &
Monk, 2017). Sharing of cultural practices through contemporary practices related to media play an integral role in cultural revitalization. Production and circulation of cultural practices, language, and knowledge-based media can assist in the revitalizing cultural aspects within tribal communities. Person to person communication is valued and integral to sharing of cultural practices and the inclusion of media allows for sharing of knowledge across distances for individuals far from the community to participate and learn cultural practices, language, and knowledge (Wagner, 2018). Technology plays a role in the process of sharing language, texts, songs, and dances through media. Cultural affiliation is not blood bound but rather determined through learning of the cultural practices and knowledge. Embracing values and knowledge enables sharing, cultural healing, and reproduction of culture (Uzawa, 2019).

Looking forward to future generations projects an optimistic perspective of ensuring the continuation of cultural practices through conversion of past knowledge into contemporary awareness. Conversion produces revitalization and focuses not only self-preservation but construction of a contemporary tribal awareness through an imagined community. Such efforts uphold cultural reproduction through cultural change to instill cultural revitalization. The tribe’s distinctive traits and identity endure and assures the continuation of the tribe. The best historical characteristics of the tribe are made into focal points to a better the future for the tribe and people (Willow, 2010).

Narrative is one of the oldest forms of communication and functions in the cultural reproduction process as it drives communication. Narrative makes explicit the implicit nature of cultural values such as what is seen, felt, and acted upon. Often cultural values arise spontaneously from produced and reproduced narratives which are communicated. As such, cultural reproduction occurs through ordinary and mundane social interactions where the
narrative is a communication of shared values and meanings in a society. These communications are internalized and give rise to the formation of collective realities that go on to shape psychological tendencies and determine culturally appropriate behaviors, values, and norms. This allows for cultural reproduction to occur and aid in the dissemination of existing cultural values and norms across times, generations, and societies (Imada & Yussen, 2012).
Curriculum development

An outline for a culturally adapted curriculum for AI/AN people, which includes the theoretical frameworks of social learning theory, intersectionality, humanization of healthcare, and cultural revitalization and reproduction, was developed to address the knowledge gap of a lack of cultural competency in peer support services. The development of the curriculum includes participatory based research methods to inform and culturally adapt Peer Support Services to AI/AN people in tribal communities. The curriculum can also serve as a framework for other AI/AN communities to utilize Peer Support Services to meet the unique needs of individual Tribes. Cultural representative interaction within individual interviews was used for understanding contemporary and traditional culture, cultural knowledge, and traditional practices of wellness and healing. Tribal representation was vital in ensuring recognition of the dynamic nature of AI/AN people and cultures.
Methods

Population and settings

The data for development of the culturally adapted curriculum was obtained through interviews with nine Tribal Elders from eight tribes. Tribal representation spanned the contiguous U.S. with three participants residing in the State of New Mexico and two in the State of Florida. All Tribal Elders were members of their identified tribal community (See Table 1). Two resided off tribal community but commuted frequently. The Tribal Elders were selected via a nonprobability convenience sampling using recommendations from tribal members, tribal leaders and tribal officials who participated in various national tribal advisory committees. Tribal Elders who were interviewed were known for their involvement in tribal related activities such as education, healthcare, and activism and were known elders within their tribal communities. Each Tribal Elder were identified for their knowledge of their tribal culture, history, and practices.

The interviews occurred via Zoom, a video conferencing application, following a semi-structured format and protocol (see Appendices A). The interview with each tribal elder was 59 minutes in length on average. All data was recorded and transcribed for further analysis. Upon completion of the tribal elder interviews, themes and categories were open coded using content analysis to begin synthesizing concepts from the literature review to create a conceptual framework featuring identified themes and categories. Each theme and category described using quotes and responses obtained from the interviews to determine and inform a draft of the culturally adapted curriculum outline.
Table 1.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Tribal Affiliation</th>
<th>Residence Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Navajo</td>
<td>New Mexico</td>
</tr>
<tr>
<td>2.</td>
<td>Mi’kmaq</td>
<td>Delaware</td>
</tr>
<tr>
<td>3.</td>
<td>Cherokee</td>
<td>Oklahoma</td>
</tr>
<tr>
<td>4.</td>
<td>Navajo</td>
<td>New Mexico</td>
</tr>
<tr>
<td>5.</td>
<td>Eastern Band of Cherokee</td>
<td>Florida</td>
</tr>
<tr>
<td>6.</td>
<td>Yurok Tribe</td>
<td>California</td>
</tr>
<tr>
<td>7.</td>
<td>Santa Domingo Pueblo</td>
<td>New Mexico</td>
</tr>
<tr>
<td>8.</td>
<td>Sault Sainte Marie Band of Chippewa Indians</td>
<td>Florida</td>
</tr>
<tr>
<td>9.</td>
<td>Turtle Mountain Band of Chippewa Indians</td>
<td>North Dakota</td>
</tr>
</tbody>
</table>

Data collection: Interviews

The author obtained approval through the University of Pennsylvania Institutional Review Board. Data was collected from April 2019 to March 2020. All participants provided written informed consent prior to data collection. Demographic information was obtained at the time of the interview.

Face to face interviews:

Upon receipt of completed consent forms, participants attended a face-to-face interview via a video conferencing application. A semi-structured interview guide was prepared to ensure culturally relevant factors were captured (see Appendix A). Examples of questions include: What is your tribe’s creation story? What historical information is vital to know when services are provided to your tribe? What is the traditional name of your tribe and people? What language is traditional? Probing questions were included in the interview guide to focus on specific factors related to cultural characteristics such as practices, and knowledges to elicit in-depth and detailed information.

The face-to-face interviews lasted for 59 minutes on average. Interviews lasted a minimum of 49 minutes to a maximum of 71 minutes in length. Participants were offered $20 in
compensation in appreciation for their participation. Of the nine participants, two accepted compensations, one requested the compensation be donated and six declined.

**Sample**

Nine participants took part in this study (Table 3). The mean age was 56 years with a higher female gender ratio (55%). Participants tended to be 40 to 59 years of age (66%). Participants had a minimum age of 42 years and maximum age of 71 years.

<table>
<thead>
<tr>
<th>Socio-demographic variable</th>
<th>Sample (N = 9)</th>
<th>Tribal Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Age range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 – 49</td>
<td>3 (33%)</td>
<td>Turtle Mountain Band of Chippewa Indians, Yurok Tribe, Santa Domingo Pueblo</td>
</tr>
<tr>
<td>50 – 59</td>
<td>3 (33%)</td>
<td>Navajo, Sault Sainte Marie Band of Chippewa Indians, Eastern Band of Cherokee</td>
</tr>
<tr>
<td>60 – 69</td>
<td>1 (11%)</td>
<td>Navajo</td>
</tr>
<tr>
<td>70 – 79</td>
<td>2 (22%)</td>
<td>Cherokee, Mi’kmaq</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5 (55%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3 (33%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 (11%)</td>
<td></td>
</tr>
</tbody>
</table>
Data analysis and plan

All interviews were recorded using Zoom, a video conferencing application, and transcribed using Temi and online transcription service to ensure accuracy. All transcripts were reviewed along with the original recordings to ensure accuracy. Data was analyzed using content analysis. The content analysis focused on subcategories which emerged within the data based on the identified theoretical frameworks of social learning theory, intersectionality, humanization of healthcare, and cultural revitalization and reproduction. The subcategories were then grouped into categories focusing on cohesion of meaning and intent. Categories were then grouped into larger themes to frame related categories and organize information in a coherent framework.

The interview focused on cultural elements related to tribal cultural beliefs and language related to Peer Provider Services. Prominent themes were identified from preliminary review and distilled five times over the course of 6 months to account for language variations between dominant society and tribal communities. Transcripts were coded for a sense of the whole to individual units of analysis to determine meaning of unit then condensed to abstract coding labels. A coding chart, example is in Table 2, was used to summarize data according to units, sub-categories, categories then themes. Themes were the overall abstracted code that combined all features of a grouping of data.
<table>
<thead>
<tr>
<th>Unit</th>
<th>Sub-categories</th>
<th>Categories</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trying to combine like basically best practices and working with someone who may be thinking about suicide, and you know, encouraging others to have some sort of system in place that matches up well with them culturally as well.</td>
<td>Cultural Rejuvenation, Traditional Knowledge, Traditions, Practices</td>
<td>Cultural Rejuvenation</td>
<td>Practice</td>
</tr>
<tr>
<td>We don't have like a chief or anything like that, but there's certain individuals that are thought upon as cultural leaders within our tribe. And so one of the things that we did was to bring people in.</td>
<td>Local Tribal Social Norms, Traditional Practices, Kinship, Local Tribal Community Structure</td>
<td>Traditional Knowledge and Practices</td>
<td>Community</td>
</tr>
<tr>
<td>I think that would be optimal if I was in the situation where I was looking for someone to provide me guidance, I would love it if the person had a really similar backgrounds made with those types of, uh, substance use background and then a really good grasp on the culture.</td>
<td>Intersectionality of lived experience with substance abuse and mental health</td>
<td>Peer Provider</td>
<td>Role</td>
</tr>
<tr>
<td>I think that's an issue of confidentiality. I think a lot of us don't trust the, the confidentiality story</td>
<td>Confidentiality, Impact of Sexuality within Confidentiality, Repercussions of lack</td>
<td>Confidentiality, Tribal Social Norms</td>
<td>Knowledge</td>
</tr>
</tbody>
</table>
that would get me to go on to a clinic or we talked to a peer provider or almost any situation and we have to learn to trust that I think over time. And I think that's why laws like HIPAA are important and people need to be made aware like, Hey, I'm your peer supporter today and let me just let you know up front that we have these laws.

| of Confidentiality, Ethics of Being a Helper |  |

**Trustworthiness and transferability**

The following strategies were used to ensure trustworthiness of the study. The methodology of content analysis was adopted and maintained throughout the interview process (Elo & Kyngas, 2007.) Familiarity of Tribal Elder’s culture was sought through consultation with tribal members, tribal leaders and tribal officials who referred a Tribal Elder for participation. Only those Tribal Elders who and explicitly agreed to participate were included in the study. Tribal Elders were encouraged to be open and honest in their disclosure as information was protected under confidentiality. Confidentiality was also assured through disclosure of processes safeguarding information as outlined within the consent form and was verbally conveyed at the beginning of the interview. Checks of accuracy of information shared were also built into the interview process through active listening and reflection to ensure words that were conveyed matched intended meaning. Tribal Elders were encouraged to share detailed cultural
information to provide insight into meaning of phenomena under observation with direct quotes used to highlight findings. Transferability was assured through the development and adherence to detailed research activity plans including protocol, data management, and analysis processes. This ensures the study can be replicated in different groups, across differing settings and in other geographic locations.
Results

Four themes were derived from twelve categories identified by participant interviews (see Table 4). The theme of attributes of peer providers encompasses shared background and experience of the role as well as communication and engagement skills of the peer provider. The theme tribal community contains the categories of tribal identity, tribal history and organization, tribal social norms and traditional knowledge and practices. The theme knowledge focuses on confidentiality, barriers, and mental health-related issues whereas the theme practice encompasses engagement as one community, traditional practitioner, and cultural rejuvenation.

Table 4.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attributes of peer providers</td>
<td>Shared background and experience</td>
</tr>
<tr>
<td></td>
<td>Communication and engagement Skills</td>
</tr>
<tr>
<td>Tribal community</td>
<td>Tribal identity</td>
</tr>
<tr>
<td></td>
<td>Tribal history and organization</td>
</tr>
<tr>
<td></td>
<td>Tribal social norms</td>
</tr>
<tr>
<td></td>
<td>Traditional knowledge and practices</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Confidentiality</td>
</tr>
<tr>
<td></td>
<td>Barriers</td>
</tr>
<tr>
<td></td>
<td>Mental health-related issues</td>
</tr>
<tr>
<td>Practice</td>
<td>Engagement as one community</td>
</tr>
<tr>
<td></td>
<td>Traditional practitioner</td>
</tr>
<tr>
<td></td>
<td>Cultural rejuvenation</td>
</tr>
</tbody>
</table>

The interviews of Tribal Elders highlighted the use of language as a social construct. Although the interviews were conducted in English, the meaning of the terms used were deeply rooted in the lived experiences of each Tribal Elder. As such, the terms identified carried a rich, tribally specific contextualization. The data derived from the interviews were filled with in-depth meaning that conveyed nuances related to the individual Tribal Elder as a tribal member within their tribal community but also as a person within an overall tribal and Native context. Due to the deep and meaningful context, four categories under three themes will be focused on to provide
an in-depth analysis to contextualize the application and implications of the data obtained and analyzed. Each category was defined in Table 5 for reference and then later expanded upon. The analyzed data enriched the theoretical framework through expansion of concepts to include tribal cultures, communities and lived experiences.

Table 5.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attributes of peer providers</td>
<td>Communication and engagement skills</td>
<td>Use of tribally specific language for sharing of culture related activities, practices, knowledge, experiences to connect to others.</td>
</tr>
<tr>
<td>Tribal community</td>
<td>Traditional knowledge and practices</td>
<td>Acknowledgement of the connection to the tribe, tribal community, kinships, families, and culture through culturally based activities focusing on the holism of the person to and within the tribe.</td>
</tr>
<tr>
<td>Practice</td>
<td>Engagement as one community</td>
<td>Relating to the collectivistic nature of tribal communities through acknowledgement of the person as part of the community with responsibilities to the community through activities and behaviors that focus on connection.</td>
</tr>
<tr>
<td>Practice</td>
<td>Cultural rejuvenation</td>
<td>Use of behavior-based activities to grow and expand culturally related practices, share knowledge, engage in and with the tribal community and to share the tribal nation with future generations.</td>
</tr>
</tbody>
</table>

Communication and engagement skills

Within the theme of attributes of peer providers, communication and engagement skills focus on the act of sharing and how sharing can impact connection including the skills needed to connect within a tribal community. The category of communication and engagement skills is
defined as the use of tribally specific language for sharing of culture related activities, practices, knowledge, experiences to connect with others. Tribal Elders highlighted the use of traditional languages as a means of connection between people and to a tribal community, family, kinships, and tribal identity. Speaking a traditional language to others, even if they are not speakers of the language, shows connection among and between AI/AN people through shared experiences, beliefs, and practices.

“Our language is our culture.” – Mi’kmaq, Woman, age 72

The following story highlights the use of a traditional language to share traditional practices and acknowledges the connection between groups of AI/AN people. In addition, the Tribal Elder encourages the use of traditional languages within other communities to inspire connection and find meaning in sharing cultural knowledge.

“I spoke to them in my language, and I forgot to interpret for them. And so, when I told them my name, why I was there, our tribal leaders and their prayers and blessings, all of that, I said it in my language. I saw a little girl crying, you know, she had tears running down her eyes as she looked at me speaking my language. And so, there’s like a deeper connection with people that do speak through their language as well. So maybe you could also find a way to come on you know, see if they can adapt it in their communities to use language.” – Santa Domingo Pueblo, Woman, age 49

Tribal elders described skills related to communication and engagement with statements of, “say something,” “soft skills,” “non-judgmental,” “explanation,” and “get through.” The skills highlighted are essential in tribal communities. Speaking, not only in a traditional language but overall, is important. When a Tribal Elder speaks, they are explaining their lived experience to “get through” to those listening. The words used are often chosen to be “non-judgmental,”
exhibit community connection based in social norms and find meaning through lived experiences. These skills are what the Tribal Elders identified as soft skills or personal characteristics of the speaker to affect others and to promote and guide connection.

Connection within a tribal community is based on networks of family and kinships. Social learning theory emphasizes modeling of behaviors and attitudes (Bandura et al., 1971). This aspect is reflected in the way a tribal community uphold and listens to a Tribal Elder when they speak. Often social norms are encouraged such as asking a Tribal Elder to speak, lowering of the gaze, maintaining silence, and not speaking while a Tribal Elder speaks. These social norms are vital to engaging with AI/AN people as well as with the tribal community. The skills of speaking in a socially acceptable manner can impact how a person is heard, respected and if they are accepted within in a tribal community.

“I think respect includes the idea of being patient. To respect someone. I need to honor their life experiences. I need to give them space to feel comfortable. So, I need to give them spiritual, physical, respect.” – Sault Sainte Marie Band of Chippewa Indians, Man, age 54

Social norms are vital to connection and play an integral role within the tribal community. When considering social norms, the role of the peer provider and how that peer provider communicates and uses engagement skills within the tribal community have a significant overlap. Tribal Elders highlighted the need for the proposed curriculum to include providing the individual Tribe space to include tribally specific social norms, tribally identified values and beliefs, acceptable social behaviors, and unacceptable social behaviors. The module will focus on the peer provider within the context of the tribal community and include tips of how the peer provider can engage in communication and engagement in culturally appropriate
ways that would allow for connection. The module will also focus on tribally specific characteristics which can impact communication and engagement which include dress, mannerisms, facial expressions, and what to expect when interacting within the community as well as what to avoid.

**Traditional knowledge and practices**

Under the theme of tribal community, traditional knowledge and practices is defined as acknowledgement of the connection to the tribe, tribal community, kinships, families, and culture through culturally based activities focusing on the holism of the person to and within the tribe. The commonality of the Tribal Elder’s use of culture is based in the systemic structure of interrelated characteristics found within the community to which a Native person belongs and that which belongs to the Native person (Valsiner, 2003). Such characteristics can be found within the traditional language of the tribe. The application of that term can have specific connotations that spans multiple areas of life as a Native person and is dependent upon the interplay of translation between the traditional language of the tribe and English. This gives terms a wider, richer meaning. Often more than one English term is needed to convey the nuances of the characteristic to capture the inherent meaning present in the traditional language of the tribe.

“Beauty is what was said, you know, so I think the word, beauty was put in there but when you really talked to some of the traditional teachers, what they say is all things were made brought back to balance. So, when you talk about balance and, you know, yet, yes, that means beauty, but harmony is a better word. So that’s why I say harmony has been restored, harmony has been restored, our name has been restored, harmony has been restored, and is repeated four times.” – Navajo, Woman, age 61
The social construct of language was evident during the interviews with each Tribal Elder. Each Tribal Elder had to convey not only meaning and context but the nuance of the interaction with the traditional knowledge or practice being discussed. The use of the term’s beauty, harmony and balance was used to convey healing within a holistic framework. Healing not only is a curative process but the realignment of parts of the person which fell out of alignment to achieve a realignment, a wholeness. A Native person is not just a mind, or a body or a spirit. In the holistic framework discussed within Tribal Elder interviews, a Native person is one who walks in the world with all parts working in tandem, all parts being present, all parts important to the journey and all parts taking part in the journey.

In addition, the Native person is not individualistic rather they are party to the collective that is the four directions of the world. The directions of north, south, east, and west symbolize elements of the tribal culture which can vary to mean stages of life, death to birth, beginning to end, time and space, as well as seasons, locations and all the connections within and between. The reference of repeating elements of traditional knowledge and practices four times acknowledges the place of the Native person in the world as well as the recognition of being a Native person living in the world.

The traditional knowledge and practices shared by each Tribal Elder references the many shared activities each tribe maintains and what they identified as their culture.

“We’re doing remarkable things using our own ways of knowing. Or traditional views, our songs, our stories, our dances, our gatherings. What we do is heal. Laughter is healing. We know we give to each other, and we deplete each other, our spirits get depleted and then when we get together it fills back up again. Those are the powerful
things. You know, when you're working with someone who you don't have to explain every single thing too.” – Mi’kmaq, Woman, age 72

Although tribes are unique and vary across the US, there are similarities. Those similarities are enough to give a Native person a sense of belonging among Natives not of their own tribe but are able to have their tribal identity acknowledged, recognized, and appreciated. The similarities allow for a mutuality that crosses local, state, and even regional differences. These characteristics are such that a Native person of any tribe can identify with, acknowledge, understand, and share in as it is part of the lived experience of being a Native person. This allows for a deeper level of communication without need to explain but can be built upon.

The main focal point is the connection to family. Family, not just blood relatives, but chosen relatives who act as teachers and guides sharing their knowledge in specific and often ceremonial ways.

“Well, I would say it's more or less like converse from the elders on down because if someone that's facilitating a ceremony and sitting in that sacred area, that individual will be the one that will be sharing the teachings. And then, but on the flip side of that, if you attend a family ceremony event it's usually the grandmother to aunts and uncles who are, who are speaking to their children or grandchildren. So, it all depends on how the family is, I would say. But, from my own observation of my personal experience to attend ceremonies which are mainly family is that elders, my relatives that are elders, are the ones that sit there and teach and speak to the children and grandchildren. So, they, more or less are like in the position with knowledge to share.” – Turtle Mountain Band of Chippewa, Woman, age 42
Sharing is a central tenet to traditional knowledge and practices. Not only in the act of sharing but also how sharing is to be initiated and completed, where sharing occurs, at what time of year and by who is sharing. Certain traditional knowledge and practices are not shared outside specific parameters, outside specific ceremonies or beyond specific persons. Instead learning wisdom and teachings occurs at specific times, in specific ways, in specific locations by specific people. Although the wisdom and teachings are shared freely, it is not shared haphazardly rather it is shared with intention.

“\textit{I think when I go home and when I engage in ceremonial events it's always great to see elders there and it's more, embracing to see elder speak, especially in a ceremonial setting, speaking in their tribal language and sharing their wisdom and life experiences and teachings. So just listening, to be more in tune to sit and listen, absorb what’s being shared.}” – Navajo, Two Spirit, age 51

**Engagement as one community**

The category of engagement as one community is contained under the theme of practice. Engagement as one community is defined as relating to the collectivistic nature of tribal communities through acknowledgement of the person as part of the community with responsibilities to the community through activities and behaviors that focus on connection.

Tribal elders highlighted the following characteristics as necessary for engagement as one community, “closed ceremony,” “giving time,” “rapport,” “storytelling,” “community versus individual focus,” “inclusivity,” “personhood,” “acknowledgement,” “importance of language,” “sharing,” “power,” “cultural connection,” “culture-based communication,” and “oral history.”

Tribal Elders focused on the importance of language and how language frames many of the interactions within the tribal community and the tribe as a whole. Traditional languages often
had elements that held to a collectivistic orientation. Often the traditional language itself maintained the collectivistic orientation simply through how the language was literally spoken and conveyed meaning.

“I learned in Ojibwe, there's no way in a group to say ‘Would you like to go have lunch with me?’ It's always a plural. I have to invite the whole group. I can't pick anyone out in a group and ask them for something. It's whole or none. So, I think that was a really interesting way to talk about the way communities work. So, I had to know that basic concepts of knowledge so that influences the way culture works.” – Sault Sainte Marie Band of Chippewa Indians, Man, age 54

Often the traditional language was used to tell culturally relevant stories. These stories give Native people not only a basis for beliefs, values, customs, and morals but also guidance on how to connect to others. Storytelling was the vehicle on how to offer lessons, give insight, assist in decision making, empower, encourage self-determination and other personal attributes that would aid the Native person to grow, be challenged, and learn.

“I always kind of fall back to storytelling and not necessarily the telling of tribal story. Maybe even sharing a little bit of my own story, sharing the story that a friend has given me permission to share. Or it could be a travel story. We have so many tribal stories that do help and guide people in that is their intent. For many years they were used to teaching guide people. And so, I think I would try a little storytelling in this therapeutic setting and I actually have done that quite often. And so, I would feel comfortable doing some storytelling and just seeing how, how they respond to that, as if it seems to be thinkable and they seem to want to know more then we could take the next therapeutic steps from that position.” – Cherokee, Woman, age 71
Storytelling, giving a narrative accounting, is a deeply rooted culture-based form of communication and expression (Sylliboy & Hovey, 2020). Sharing your story is an important expression of lived experience, sharing another’s story with their approval and awareness is a powerful expression of connection through lived experience. Personal stories, stories of family and community become the threads that bind the community together. Tribes are not only groupings of families but of the oral history of those families and their interconnectedness. The stories become ties that bind the purpose and meaning of family to the community and to the tribe. Everyone is connected to the oral history as the stories are being shared, told, and retold.

“And there was this tree, and it had all these buckets around it and a woman I know said, should we clean that up and I said, you know what, we need to talk with the local elder because there’s a reason they’re right there. They aren’t ours to pick up. You know, we have to be civil. Later on, we found out that they were part of their ceremony of when they lost someone, when they were in mourning, and buried a person, it’s their crying tree. So, I just said, you know, I don’t think we should touch that. There are some things we don't get to touch and so it's just not understanding that it's a good thing or that a peer provider would know. They need to ask if there are things they need to be aware of.”

– Turtle Mountain Band of Chippewa, Woman, age 42

Stories not only inform but they also convey the practices of the community and tribe. Shared stories help inform and guide individuals interacting within the community of the experience of the Native people and tribe. Many of the stories are passed generation to generation, many are changed to meet modern realities, many still are maintained in their original form. The importance of oral history, narrative and storytelling highlight the profound interrelatedness of the tribe as whole. Stories are meant to be shared. Stories can be requested.
Stories give life to the past and stories give honor to those who experienced life. Engagement as one community is tied to the oral history of the person in the tribe and the tribe in the world.

**Cultural rejuvenation**

The category of cultural rejuvenation is contained within the theme of practice. Cultural rejuvenation refers to the use of behavior-based activities to grow and expand culturally related practices, share knowledge, engage in and with the tribal community and to share the tribal knowledge with future generations. Cultural rejuvenation focuses on bringing the past to the present and shaping the current culture to meet future needs.

“So that part of history has become very much part of our present period there is also the walks, the Trail of Tears commemorative walks. So, I think that element of grief and loss that was there during the 1860’s when that particular walk took place, I think there still a lot of that here because it's a talked about every day. It's in the tribal news every day, things that are happening. We have a group here called the first families in that group; you trace your lineage back to the first families that were there. And we do activities and things to keep their memories alive. And we try to pull that into our everyday lives, you know, teaching our children to see at least one word today. They may not be fluent in the language then at least say a word or know your name. Things like that. And I'm not sure that that answers your question, but I think that just the trauma that happened even though it may not impact people as much today it's still in our hearts. It's still there.”

-Cherokee, Woman, age 71

Knowledge of tribal history and how it impacts the present culture is vital to tribal communities. Much of tribal history is rooted in cultural activities which occurred prior to and hidden during colonialism. Tribal Nations were not allowed to practice tribal customs related to
spirituality until passage of the American Indian Religious Freedom Act (AIRFA) of 1978 (42 U.S.C § 1996). Due to AIRFA, many tribes were able to openly practice traditional dances, songs, customs, and other spirituality related activities. Since 1978 many tribes have experienced a resurgence of traditional cultural practices with a focus on growing and expanding those practices to ensure continuation in future generations.

Tribal Elders identified the characteristics of cultural rejuvenation as, “cultural awareness,” “cultural matching,” “culture seeking,” “asking,” “culture-based modifications,” “language immersion,” “choice,” “individualization,” “cultural guidance,” “language is culture,” and “attending ceremony.” The role of the peer provider was identified not only as a helper but a healer, participant of and teacher in the culture of the tribe. The peer provider was seen as a vital linkage between what the tribe’s needs regarding mental health and substance abuse services and what healthcare services can provide. The peer provider could be the person who could assist in providing equivalent translations between western medicine and traditional practices while respecting, engaging in, and sharing cultural practices.

“There was a situation with some of the tribes in the Southwest where we were talking about getting our HIV testing but they're like oh, some of our communities don't even want to say that word because if we speak it out loud it could bring it to us. So, they came up with the slogan about ‘getting it done’ and everyone knew what ‘getting it done’ meant getting your HIV test, but it was a way that they chose, they still got the message out. People still knew what it meant. And I had to be patient and sit back and think, just talk about it. But I learned from them. We don't have to say the words, but everyone knows what we mean, and we've got posters around and social media and people know it ‘getting it done’ means.” – Navajo, Woman, age 61
Tribal Elders recognized language as vital to the growing and development of tribal identity and encouraged inclusion of activities to affirm and develop tribal identity (Elfman, 2016). Tribal identity includes the connections between identity and place, between the past and present, and acknowledgement of one’s own identity (McIlwraith, 1996). Acknowledgement of the impact of the past was vital in preparing for the future. Tribal Elders focused on how oral history encourages connection through the stories shared.

“It's our relationship with our youth and our elders and those in between. It's our relationship with creator and the ancestors. It's understanding that what we do today and what we're sitting here doing today is going to impact seven generations into the future. Those things are important.” – Mi’kmaq, Woman, age 72

The impact of current day traditional knowledge and practices serves to encourage identification with an imagined community and to uphold traditional beliefs which may not be part of a Native person’s day to day experience. Use of the tribe’s unique and distinctive traditional practices can assure the continuation of the tribe (Willow, 2010). Many of the practices are shared in an organized, consistent manner to induce connection with a shared history while creating opportunity for change in future generations (Wallace, 1956).

“We always say that you were prayed for generations ago because they knew you would be here. So, prayer was said for you already. They felt you were blessed, then you were willed, you’re a blessing in this life before your life even came to be, back then generations ago.” – Navajo, Woman, age 61
Discussion

This qualitative study generated data rich in meaning. The data generated through interviews of American Indian/Alaska Native Tribal Elders conveys tribally based context and understanding of peer providers and peer support services within mental health and substance abuse services. Specific findings from this study warrant discussion.

Previous studies addressing culture competency within Peer Support Services curriculums for diverse populations is lacking. Jonikas et al. (2010) noted the lack of cultural competency as a barrier to engaging diverse populations. Full adaptation of a peer support services curriculum was absent within the current literature. Moreover, the lack of a culturally adapted curriculum can act as hindrance in the implementation of peer providers and peer support services within tribal communities.

The study was qualitative focusing on interviews of AI/AN Tribal Elders using a theoretical framework on which to begin to understand how to develop a culturally adapted peer support services curriculum. Tribal Elders interviewed drew upon cultural beliefs regarding helpers and helping. The role of peer provider was viewed as having limitations but encompassing potential to be more than information sharing but rather engaging, learning, and growing within a tribal community. This perspective was unique in that the role of the peer provider was seen as a vehicle for not only connecting to healthcare for mental health and substance abuse services but also for cultural rejuvenation. The Tribal Elders viewed the role of the peer provider as a connection between the community and healthcare services. The peer provider was not only connecting the community to healthcare but also connecting healthcare back to the community by focusing on intra-individual differences and leading to bidirectional change (Valsiner, 2003).
The findings highlight the need to collaborate and partner with the tribe and tribal community. Application of a culturally adapted curriculum would require providing individual tribes space to include tribally specific social norms, tribally identified values and beliefs, as well as acceptable and unacceptable social behaviors. The curriculum should also include space for tribes to focus on specific characteristics which could impact communication and engagement such as dress, mannerisms, facial expressions, and what to expect when interacting within the community. The curriculum would require the tribe to have an active role within the facilitation and implementation of peer support services through provision of information, resources and knowledge regarding local culture, customs, and history. The role of the peer provider would be that of being part of and an integral component of the community versus the current view of peer provider services as mental health and substance use specific services separate from the community. This would be an expansion of the role and services which is not currently part of the evidence base.

Inclusion of traditional knowledge and practices within the curriculum should follow an intersectional framework which can take into consideration the interplay of gender norms, gender roles, lived experiences, age, biological sex as well as power (Jacobs, 2014). Traditional knowledge and practices do not follow simple lines of delineation but rather align to a multifaceted approach. Among Tribal elders interviewed, traditional knowledge and practices carried the following characteristics, “ceremony and traditions,” “organic recovery systems,” “family systems,” “elders,” “understanding of time,” “valued activities,” “prayer,” “intergenerational connection,” “inclusion,” “balance,” “purpose,” “resilience,” “community affiliation,” “future impact,” “listening,” and “speaking language.” The curriculum should focus on specific elements highlighted by the tribe as the most salient and needed to work within the
community. The role of peer provider is not to be an expert in the tribal knowledge and practices but to be aware of the tribal knowledge and practices to best help the tribe and Native person while engaging with the community. The role of the peer provider is that of helper not expert, and not an outsider coming into the community but rather an insider who moves between when and where needed.

The curriculum can also harness technology in peer support services through inclusion of promoting and sharing of traditional tribal language, texts, songs, and dances through media (Uzawa, 2019). The use of traditional tribal language within the promotion and delivery of peer support services can aid in cultural rejuvenation of the tribe as well as increasing connection of Native people within and across Tribal Nations and tribal communities. Often the use of language by Native people is contextually based within their own experience related to their Tribal Nation and tribal community. Expansion of how language is used within that Tribal Nation and tribal community via media can assist peer providers in their work to understand and help Native people in a way that is familiar. In addition, preservation of photographic and audio recordings can provide a safeguard of the tribe’s knowledge and practices for future generations as well as assist peer providers in connecting with the tribal community (Yunxia & Prott, 2016). Media can further the tribe’s reach to members who live off or outside of the tribal community. The media can be included and shared via online social media platforms that can be accessed as needed by tribal members. The media can also act as cultural awareness to people who are not aware of or knowledgeable of the tribe. The use of media can have a direct impact on cultural rejuvenation efforts of the tribe by expanding the tribe’s online presence and reach as well safeguarding the tribe’s knowledge, practice, and customs for future generations.
The study findings suggest that peer provider services among the AI/AN population would differ from current curriculums. Current curriculums focus primarily on mental and substance abuse illnesses with overviews of other healthcare related elements such as confidentiality and engagement. Most include a module or chapter on cultural competency from the perspective of the peer provider’s culture. Few include space for awareness of the healthcare service population or community where services are provided (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, 2015a; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, 2020b). A culturally adapted curriculum would focus first on the community where services are being provided and second on the person providing the services but with an emphasis on how that person could relate and experience the intersections of their lived experiences as they apply to the tribal community. In addition, the role of the peer provider could include matching between the peer provider and client based on more than mental health and/or substance use disorder. Matching could be based on language, gender role, tribal or community affiliation, location and other criteria identified as important to the population served.

The study findings highlight the importance of engaging diverse populations through participant informed approaches. The adaptation of a peer support services curriculum can allow for the inclusion of people with lived experiences from diverse populations as well as further the reach of peer providers services. The inclusion of diverse population lived experience can further the knowledge base of peer provider services and challenge the currently held understanding of the role of peer providers. The expansion could potentially impact the effectiveness of peer support services which have been found to be moderately effective when included as part of mental health services (Simpson, Flood, Rowe, Quigley, Henry, Hall, & Bowers, 2014; Vally &
Abrahams, 2016). Increasing effectiveness of peer support services can increase use of peer providers in ways not currently used as well as create new approaches for peer providers in areas and services not currently employing peer providers. Implications for real world service delivery can include Peer Providers acting as bridges for meeting needs such as identifying the need for translation services prior to service delivery or overcoming barriers to accessing services related to billing or understanding of benefits.

The findings highlight significant barriers to adaptation of a peer support services curriculum for American Indians/Alaska Natives. The interviews of American Indian/Alaska Native Tribal Elders highlighted the differences in the social discourse of language and meaning. The Tribal Elders spoke English fluently, but the meanings of the words were contextually driven based on individual tribal culture and awareness. The English words used included nuances based in each Tribal Elder’s lived experience as an American Indian/Alaska Native. The Tribal Elders represented a wide and diverse group of Native people. The experiences differed based on that Tribal Elder’s specific tribe. Those differences were based in traditional and contemporary awareness of traditional tribal culture, use and understanding of traditional languages, urban and rural location, connection to and with tribal communities, federal trust lands, and reservations as well as connection to other tribal members. Each Tribal Elder was a unique individual representation of a Tribal Nation and provided an overarching Native perspective and awareness of what it means to be Native. These differences must be accounted for within the adapted curriculum to speak to the experiences of each Tribal Nation.

The use of peer provider services within tribal communities can face challenges due to stigma and discrimination related to mental health and substance use disorders. Tribal communities can lack infrastructure for mental health and substance use services which would
contribute to literacy and awareness of mental health and substance use disorders. The lack of literacy and awareness can result in Native people not using or not accepting services related to mental health or substance use disorders. Many Native people prefer to use traditional healers to regain balance and wellness within a healing context. Peer providers would need awareness and understanding of traditional medicine and how traditional medicine can interface with western medicine to provide culturally based care. A culturally adapted curriculum would require involvement of traditional practitioners to increase literacy and awareness of mental health and substance use disorders as well as decrease stigma and discrimination related to mental health and substance use disorders.

Many Tribal Nations face numerous barriers to healthcare such as a lack access to quality care, aging infrastructure, poor funding of health care services, physical and social barriers to accessing services, lack of transportation, disparities in accessibility and quality of care, lack of technology, and fewer quality providers (Manson, 2000; Cromer, Wofford & Wyant, 2019). Peer provider services would require a significant investment by the Tribal Nation to develop and implement peer providers within their healthcare system. Funding would be vital not only to develop and implement but to sustain peer support services. Reimbursement for peer support services would be needed through third party billing as well as state and federal reimbursement services. Currently 39 US States allow Medicaid billing for peer support services (Open Minds, 2018). Tribal Nations and communities located outside of those US States would require funding to sustain peer support services.

Lastly, the study findings highlight the unmet need for peer provider services which engage diverse populations with unique and challenging needs. Additional studies focusing on other diverse populations should be developed to identify other avenues for expansion of peer
supports services. Furthermore, peer support services within diverse populations is a gap that has long been unaddressed and is in need of research attention. Future studies should examine how the role of peer provider is viewed within other populations and how the role can address health disparities as well as gaps within healthcare services.
Limitations

The following limitations should be noted in the interpretation of the study findings. The study was specific to the American Indian and Alaska Native population but not individual tribally specific. The findings are non-generalizable to other populations. Excluded from the development of the curriculum were Tribal Elders who self-identified as not involved with their tribal nation or lacked awareness of their tribal nation related culture. Requests for participant recommendation via snowball sampling was specific to tribal members who were actively aware, knowledgeable, and involved in their identified tribe, tribal community, and who identify as AI/AN. As a result, the findings may not be representative of tribal nations whose culture has been impacted by colonialism to such a degree that culture-based characteristics is lacking. Study participants were from differing tribal nations resulting in a generalized adapted curriculum that would account for variations but may lack the specificity needed by individual Tribal Nations.
Implications

The study findings have important implications for clinical and research practices related to American Indians/Alaska Natives and peer support services. Emphasis should be placed on understanding language as social discourse, tribal knowledge, and practices as well as cultural rejuvenation.

American Indians and Alaska Natives use language which runs parallel to the dominant society within the US. Despite living in proximity and speaking English, the meaning and contextual differences are prevalent. The use of English takes on nuances which are rooted in historical contexts of each unique tribal nation. This gives a variation to the meaning and how terminology is used. Definition of terms, the use of terms in certain contexts and the way in which a term is used can vary from tribal nation to tribal nation. This variance can impact the understanding of the tribal nation’s culture, practices, and knowledge and can impact adaptation of a peer support curriculum for AI/AN people in mental health and substance use services.

Including tribal nation’s information such as history, language, and cultural practices to a culturally adapted curriculum on an individual tribal nation basis can add nuance and richness to the curriculum as well as acknowledge the uniqueness of each tribal nation. Tribal nations can in turn develop the curriculum in a way which would be meaningful, helpful, and impactful to their people and community.

Understanding of how language is used among AI/AN people can impact how research is conducted. Narrative is a vital component not only within gaining information but also in connection and engagement with tribal nations and AI/AN people. Furthermore, clinicians and researchers working with AI/AN people should be aware of the impact of the tribal nation’s culture on the individual as well as how the individual fits in with the tribal nation, tribal
community, and family network. These connections can impact clinical and research approaches as AI/AN people may not be interested in engagement on an individualistic basis but may be apt to participate from a collectivistic perspective.

Tribal Nations maintain unique cultural knowledge and practices. Culturally adapted curriculums must include sections where the tribal representatives such as tribal elders, traditional practitioners, and tribal leaders can provide important and pertinent information related to the tribe. Such information can include common language practices, prayers, songs, dances, and socially expected behaviors such as shaking hands, standing when leaders and elders are speaking as well as how to engage with elders, and leaders. Other tribally specific knowledge and practices can be included which are important to engagement and connection within the community. Sacred sites, sacred areas, as well as taboo subjects and topics must be included for helpers to navigate the complex and complicated social nuances found within tribal communities. In addition, family and kinship networks must be included as traditional familial systems within tribal communities may not reflect the dominant society of the U.S. which focuses on the mother, father, and children. Family and kinship can be uniquely defined and include non-related individuals such as adopted family members and honorary family members as well as friends of the tribe. The inclusion of this information can inform peer providers as well as help transition the role of the peer provider from an agent of healthcare to helper within the community.

The role of connection among AI/AN people is rooted within traditional practices. Recognizing the importance of AI/AN people’s connection to a community can aid clinicians and researchers in understanding the systemic impacts of both clinical work and research studies. A person utilizing a community approach can target underlying issues related to mental illness
and substance use as well as harness treatment approaches which may meet previously unmet needs in a way that is culturally aware, sensitive, and humble.

The use of traditional languages, traditional knowledge and practices can further assist individual Tribal Nation’s cultural rejuvenation efforts. Each tribe is unique in their path to rejuvenation of their individual culture. Some may have intensive focus on the dissemination of cultural efforts such as language immersion. Others may have stalled in their efforts and other may lack initiatives. Using and highlighting elements of an individual Tribal Nation’s culture could further the tribe’s actions, increase or re-initiate their efforts. As tribes grapple with contemporary issues such as mental illness and substance use, culture is increasingly identified as prevention and treatment for AI/AN people. By including language, and traditional knowledge and practices, culture can be actively used in the prevention and treatment of mental illness and substance use.

The study’s findings highlight important topics for future research consideration. First, the impact of culture in relation to incentives in research. As AI/AN people place value on their identified community, focus on incentives for participants may be on meeting community needs versus individual monetary compensation. Second, acknowledgement and understanding of culture loss for AI/AN people is an impactful experience and can highlight the impact of assimilation on AI/AN people. Approaches for sampling of AI/AN people should be developed to address the impact of assimilation and how assimilation and lack of knowledge of cultural practices can negatively impact AI/AN people who may be considering or be considered for participation in research. Lastly, qualitative studies are needed to investigate tribal nation similarities and differences in application of peer support services as well as how to define the role of a peer provider within a tribal community. Studies should focus on how different
individual tribes define and apply peer providers then determine and reconcile differences while promoting similarities in order to re-define peer provides within a Tribal Nation context.
Conclusion

The goal of this qualitative study was to develop how to culturally adapt a peer support service curriculum for American Indian/Alaska Native people in mental health and substance use disorder services. The study findings underscore the importance of the inclusion of culture in providing peer support services to meet the needs of diverse populations. Curriculums should be developed to increase awareness and knowledge of the role of peer providers within mental health and substance use disorder services for diverse populations. Culturally adapted curriculums are imperative to address the needs of diverse populations. Areas for future research are discussed.
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Appendices A

**Interview Guide for the Individual Interviews**

Participant Information

ID Number:

Program Number:

Date of Interview (Month/Day/Year):

Time Interview Started (Use 24-HR Time):

Time Interview Ended (Use 24-HR Time):

Location of Interview:

Interview Completion Type:

**Reminders for Interviewer**

- Turn on audio recording for the entire interview to ensure accuracy of information and transcribe information upon completion of the interview.
Introduction for Individual Interviews

Hello, my name is Pamela End of Horn and I am working on my dissertation with the University of Pennsylvania. I would like to thank you for helping me today.

Before we start the interview, I would like to review the consent form and the purpose of the study. (Go over consent form with participant. When finished, provide two copies for signature. Give one copy to the participant and keep one copy.)

The purpose of the interview is to obtain information on how to culturally adapt Peer Support Services to American Indian/Alaska Native people. The interview format will be semi-formal, and the information obtained will be used to adapt the peer support curriculum, Recovery to Practice. A copy of the culturally adapted curriculum will be made available to you as well as to the tribe upon completion. Please feel free to ask questions at any time during the interview. The interview will take approximately two hours and will include a 2 hour follow up interview to ensure accuracy. As indicated in the consent forms your participation is voluntary and you are free to end the interview at any time. Your information is confidential, but I must inform you that I am a mandated reporter and any disclosure of harm to yourself, others or a child I will have to disclose. I would like to go over how your data will be maintained including where it will be securely stored and who will have access to it.

Note of Appreciation

Thank you for giving me the opportunity to conduct an interview with you to learn about American Indian/Alaska Native cultural values, norms, customs, and language in order to culturally adapt the Recovery to Practice Peer Support Curriculum. Do you have any questions? Please feel free to stop the interview at any time if you need a break or to ask questions. If you are comfortable, we will begin.
Socio-Demographic Information

Gender:

Age:

Tribal Affiliation:

Current resident location:
Interview Questions

1. What is your tribe’s creation story?
   a. Language?
   b. Customs?
   c. Traditions?
   d. Ceremonies?
   e. Songs?

2. What historical information is vital to know when services are provided to your tribe?

3. What is the traditional name of your tribe and people?

4. What language is traditional?

5. How is healing defined?
   a. Wellness?
      i. What does wellness include?
      ii. What does wellness not include?
   b. Spirituality?
   c. Thoughts and feelings?
   d. Physical Health?
   e. Family?
   f. Uniqueness?
   g. Vitality?
   h. Emotions and feelings?

6. What is important about the land and the environment to the tribe and tribal members?

7. How is culturally based wellness promoted within your tribe?
8. What are tribal values, beliefs, morals, customs, ceremonies, or songs which communicate wellness?

9. How would you define culture in accordance with your tribe?

10. How would you define identity?

11. How would a person be recognized as part of the tribe?

12. What information about your tribal values, beliefs, morals, customs, ceremonies, or songs is needed to know to understand tribal way of life?

13. What assumptions made that you are aware of that gives a false misrepresentation of tribal life and being AI/AN?

14. What are the values of your tribe?

15. What are the morals?

16. What are the beliefs?

17. How is respect shown?

18. How is integrity shown?

19. How is trust gained?

20. What ethics are part of your tribal values, beliefs, morals, customs, ceremonies, or songs?

21. How are traditional helpers identified within the tribe?

22. How are boundaries viewed within your tribal values, beliefs, morals, customs, ceremonies, or songs?

23. How is confidentiality defined within the tribe?

24. How should a person behave within the culture?

25. How does gender and roles influence behavior?
Appendices B

University of Pennsylvania
Informed Consent Form
Phase One

**Title of the Research Study:** A Culturally Based Peer Support Curriculum for the American Indian/Alaska Native population.

**Protocol Number:**

**Principal Investigator:** Pamela End of Horn, 1801 Chapman Ave Apt 219, Rockville, MD 20852, 240-397-3526, pend@upenn.edu

**Co-investigator:**

**Emergency Contact:**

You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision, you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if you decide to participate. The researcher will talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends, family doctor and family. Your doctor is not an investigator in this research study. You do not have to participate in any research study offered.

If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

**What is the purpose of the study?**

The purpose of the study is to learn more about

- Culturally adapting Peer Support Services to American Indian/Alaska Native people.

**Why was I asked to participate in the study?**

You are being asked to join this study because.

- Your participation can aid in culturally adaptation of peer support curriculum to American Indian/Alaska Native people in order to provide culturally informed and competent services.

**How long will I be in the study?**
The study will take place over a period of 1 year. This means for the next 12 months we will ask you to spend 4 hours participating in phase one this study. Each session will last approximately 2 hours.

- Subjects will participate in an interview for two hours including an additional interview for a total of 4 hours.

Where will the study take place?

You will be asked to log in or call the web based video teleconference service.

- Subjects will click on the provided link or call the provided teleconference line and enter an access code. Subjects will be greeted by the interviewer who will provide an overview of the study, review consent forms, review purpose and answer questions.

What will I be asked to do?

- Participants will log in or call the web-based video teleconference service on an identified date and time.
- During each interview, questions based on the curriculum will be reviewed and information will be obtained.
- Participants will be given educational materials related to the Peer Support curriculum in order to facilitate additional information based on tribal culture. Follow up interviews will focus on expanding answers to the questions.
- Participate and allow full face photographic images and any comparable images to be video tapped and verbal responses captured and transcribed.

What are the risks?

- The following risks have been identified as a possible outcome to participation.
  - Breach of confidentiality which could result in community being aware of identification and communication of traditional practices.
  - Physical or emotional discomfort related to conveying tribal beliefs, customs, and ceremonies which may not have been previously shared outside of the tribe.
  - Experiencing tired voices or physical discomfort related to speaking on the phone or sitting at a computer for an hour.

How will I benefit from the study?

There is no benefit to you. However, your participation could help us to adapt the Peer Support curriculum to American Indian/Alaska Native people, which can benefit you indirectly. In the future, this may help other people to adopt the curriculum and expand knowledge related to Peer Support Services among tribes.

What other choices do I have?

Your alternative to being in the study is to not be in the study.

What happens if I do not choose to join the research study?
You may choose to join the study, or you may choose not to join the study. Your participation is voluntary. There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you or would come to you in the future. Your therapist, social worker, nurse, doctor or mental health technician will not be upset with your decision.

If you are currently receiving services and you choose not to volunteer in the research study, your services will continue.

**When is the study over? Can I leave the study before it ends?**

The study is expected to end after all participants have completed all interviews and all the information has been collected. The study may be stopped without your consent for the following reasons:

- The Principle Investigator feels it is best for your safety and/or health-you will be informed of the reasons why.
- You have not followed the study instructions
- The Principle Investigator, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so.

If you no longer wish to be in the research study, please contact Pamela End of Horn, at 240-397-3526 and take the following steps:

- During the hours of 8:00 AM to 4:30 PM (Eastern), please speak to Pamela regarding your declining further participation.
- After the identified hours please leave your name, number and leave a message saying you are declining further participation with the study.

**How will confidentiality be maintained and my privacy be protected?**

We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

- All disclosures will be kept confidential and all information will be kept in a secure and locked location. In addition, your information is also only accessible by the primary investigator and investigator with a need to know and records of who has accessed your records is available to you upon request. Your confidentiality is our highest priority.
- In addition, the Institutional Review Board at the University of Pennsylvania will have access to the records, but your personal information will be removed, and a serial number will be used. Only the investigator will have access to the spreadsheet that links the serial number to your name. The spreadsheet will be kept on a computer system in a secured folder which only the the primary investigator and investigator staff will have access. The computer system is maintained behind a locked door accessible by staff with a need to know. The computer system antivirus is run on a daily basis and updated immediately upon notification of the availability of an update to the software.
What happens if I am injured from being in the study?  
(for research that poses greater than minimal risks to participants.)

- Please contact Pamela End of Horn at 240-397-3526 as soon as possible.
- Report immediately to your local Emergency Department for assessment and treatment.
- If necessary, is the subject’s responsibility to call 9-1-1 or report to the local Hospital Emergency Department. It is the subject’s responsibility to obtain health care as soon as possible and notify the PI when able.

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them. There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher’s name and phone number are listed in the consent form.

Will I have to pay for anything?

- Costs incurred for telephone or internet usage will be the responsibility of the subject.

Will I be paid for being in this study?

- Participants will receive a tangible incentive of $20 per interview and $20 for a follow up interview for a total of $40 per participant.
- Compensation will be provided after completion of enrollment, initial and follow up interviews. Compensation will be in the form of a gift card.

Please note: In order to be compensated for your participation in this study, you must provide your name. Additionally, please note that the University of Pennsylvania is required to report to the IRS any cumulative payments for participation in research studies that exceed a total of $600 in a calendar year.

Who can I call with questions, complaints or if I’m concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you sign this document, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject:  
Print Name of Subject:  
Date:
Appendices C
Sample Memorandum

Qualitative Interview 4
Beginning Time 7:00 pm
Ending Time 8:10 pm

7:00 pm – Introduction
7:04 pm – First Question

- Creation story, language, ceremonies to LGBTQ2S. Genders focus on healing.
- Songs are also healing.
- Historical information is vital for the Navajo creation.
- Story shows matrilineal society
- Men and women live apart.
- Societies come back together two spirit lore, a place within both the societies.
- Traditional Dine or Navajo,
- All human beings from five fingered people
- Language describes I'm from the Holy people.
- What are the dirty words there? (Examples)
- Language was given by Holy people and is descriptive
- Very descriptive to describe state animal, no dirty words.
- Language is traditional.
- Language is culture
- Healing defined all beauty and harmony has been restored.
- Number four is a sacred number.
- Harmony beauty included in wellness
- Depression will be a disharmony.
- Balance is to be this harmony
- Spiritual wellness is part of life.
- Thoughts are mental emotional one, and the thoughts
- Expressed in a physical sense
- Physical health is a regiment such as walking, being up early, exercising, doing tours, breathing and playing, bringing in food to native bodies.
- Food was all natural, such as roots, and teas plays into social society.
- Worked in family with siblings, such as teaching younger siblings, children raised under the same roof yet are so different taught the same way yet develop their own personality.
- Sweat lodge men and women talk about teachings of mother earth to go back and relearn up to individual to learn or not
- Example sweat lodge for menopausal women.
- What is the teachings to become an elder
- Young men four nights, four days for Rite of passage
- he is taught about his whole role.
- Challenges are covered like substance use as well as healthy and unsafe behaviors to stand up to the “bad evil giants” and resist bad behaviors.
• When a woman is the same way, what it means to take care of the body
• Cultural teachings provide guidance that is integrated into mental health treatment.
• Traditional teachings, Navajo language prayers process include environmental family, food societies
• Define ourselves is to be defined by our clan in kinship, very large within family society and clan identification
• Clan system, vital to recognition
• Needed to understand as a support of human beings, which is needed also needed is cross cultural bonding
• More providers trained by tribal health providers to understand
• Language is descriptive.
A CULTURALLY ADAPTED PEER SUPPORT CURRICULUM

Appendices D

Curriculum Outline

I. Introduction
   A. Purpose
   B. Overview
   C. Theoretical Framework

II. Application
   A. Eligibility
   B. System Requirements
   C. Supervision Requirements
   D. Caseload
   E. Financial Considerations
   F. System Change

III. Training Overview
   A. Modules
   B. Materials
   C. Expectations

1. Format
2. Assignments
3. Self-Learning

III. Modules
   A. Module 1:
   Attributes of Peer Providers

1. Shared Background and Experience
   i. Introduction
   ii. Objectives
   iii. Definition
   iv. Examples
   v. Principles

2. Communication and Engagement Skills
   i. Introduction
   ii. Objectives
   iii. Definition
B. Module 2: Tribal Community

1. Tribal Identity
   i. Introduction
   ii. Objectives
   iii. Overview
   iv. Definition
   v. Examples
   vi. Exercise

2. Tribal History and Organization
   i. Introduction
   ii. Objectives
   iii. Overview
   iv. Case Examples
   v. Exercise

3. Tribal Social Norms
   i. Introduction
   ii. Objectives
   iii. Overview
   iv. Examples
   v. Exercise

4. Traditional Knowledge and Practice
   i. Introduction
   ii. Objectives
   iii. Overview
   iv. Examples
   v. Exercise

C. Module 3: Knowledge

1. Confidentiality
   i. Introduction
   ii. Objectives
   iii. Definition
   iv. Examples
   v. Principles

2. Barriers
   i. Introduction
A CULTURALLY ADAPTED PEER SUPPORT CURRICULUM

3. Mental Health-Related Issues
   i. Symptoms
   ii. Demographics
   iii. Risks
   iv. Treatments
   v. Resources

D. Module 4: Practice
1. Engagement as One Community
   i. Introduction
   ii. Objectives
   ii. Overview
   iv. Example
   v. Skills
   vi. Guidelines
2. Traditional Practitioner
   i. Introduction
   ii. Objectives
   iii. Definition
   iv. Examples
   v. Guidelines
3. Cultural Rejuvenation
   i. Introduction
   ii. Objectives
   iii. Definition
   iv. Examples
   vi. Recommendations

IV. Evaluation
   A. Scales
   B. Outcome Measures
   C. Metrics

V. References
VI. Resources