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ORIGINAL ARTICLE

Decolonizing Mental Health Services for Indigenous Clients: A Training Program for Mental Health Professionals

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Highlights

- This brief 90-minute training program can be delivered in a wide variety of professional settings.
- This program increases clinician's knowledge, awareness, and skills to work with Indigenous clients.
- The program is described in detail so that readers can learn from it and implement it widely.

Abstract Culturally appropriate mental health services are essential for Indigenous people who suffer the greatest mental health disparities of any ethnic group in the U.S. However, few mental health professionals receive training to work with this population. To fill this gap, a 90-minute training was created to increase knowledge of and empathy for Indigenous people and culture and therefore, improve mental health services for Indigenous patients. This training is grounded in cultural competency, cultural humility, and decolonialism. The training is presented here for mental health professionals, agencies, and administrators to use as a guide. The training aims to increase knowledge, awareness, and skills and has been implemented in a variety of settings receiving positive feedback from participants and administrators.

Keywords Decolonization · Indigenous · Mental health · Knowledge · Empathy · Cultural competence

Introduction

The purpose of this paper is to present a brief training program for mental health professionals who work with Indigenous clients. This brief training is meant to increase knowledge and empathy and disrupt biases and stereotypes about Indigenous people. We begin with an overview of the health disparities experienced by Indigenous populations and the complicity of healthcare providers in those disparities. Then, we describe the development of the training program according to multicultural competence, cultural humility, and decolonization. Finally, we present an overview of the program so that other educators and trainers can replicate and expand upon our prior success in implementing this training.

Background

Indigenous people suffer from the largest mental health, substance use, and physical health disparities of any other racial and ethnic group in the United States (American Psychiatric Association, 2010; Indian Health Services, 2016). Indigenous adults have higher rates than non-Hispanic Whites in the following areas of mental health: serious psychological distress; feelings of sadness, hopelessness, and worthlessness; feelings of nervousness or restlessness; and suicide (U.S. Department of Health and Human Services, 2017); and are more likely than persons from other racial and ethnic groups to have needed treatment for substance use in the past year (17.5% vs. 9.3%) (SAMHSA, 2012).

Indigenous women are 1.2 times and men are 1.3 times as likely as non-Hispanic White counterparts to have experienced violence in their lifetime, and Indigenous women are 1.7 times as likely to have experienced violence in the past year compared to their counterparts (Rosay, 2016) this rate is 50% higher than the second most victimized group (Perry, 2004). Indigenous women

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are 2.5 times more likely to experience sexual violence in their lifetime (Tjaden & Thoennes, 2000). Violent deaths, including unintentional injuries, homicide, and suicide, account for 75% of all deaths among 20 to 29-year-old Indigenous young adults (Office of the Surgeon Genderal, 2001). Adverse childhood experiences (ACEs), such as exposure to violence and substance abuse, result in increased prevalence rates of depression, anxiety, ADHD, school problems, grade failures, and an increased need for medication and counseling in Indigenous children (Brockie, Dana-Sacco, Wallen, Wilcox, & Campbell, 2015; Kenney & Singh, 2016). These differences are attributed to social and economic-related factors and indicate a need for more attention to the social determinants of health disparities (Kenney & Singh, 2016; West, Williams, Suzukovich, Strangeman, & Novins, 2012).

Research has found that the primary determinants of racial disparities within health care are health providers and health systems (Goodkind et al., 2010; Van Ryn & Fu, 2003) Many mental health professionals are ill-equipped to work with Indigenous families due to lack of knowledge about the population, use of stereotypes and bias from mainstream culture, lack of training in and out of graduate school, and lack of access to theories that avoid settler-colonial belief systems, which are directly in contrast with the belief system of many Indigenous families (Gone, 2007, 2008, 2010; Wendt & Gone, 2012). Indigenous clients are more likely to receive treatment that devalues their cultural health beliefs and health professionals are more likely to misinterpret Indigenous people, resulting in bias and discrimination (Nelson, 2002). This misinterpretation can be the result of a socially sanctioned power differential, in which the mental health professional with more sociopolitical power imposes their definitions of pathology and healing (based on their worldview) onto a client with less sociopolitical power (Sue, 2015). In this case, mental health professionals belong to a Western paradigm of knowledge and healing, and as members of this dominant paradigm, have the power to intentionally or unwittingly reject or devalue beliefs outside of the Western paradigm. Furthermore, the hierarchy of psychotherapy research itself can further marginalize oppressed groups by maintaining the status quo (Sue, 2015). Unfortunately, most professional ethical guidelines inadequately address the potential for harm to marginalized clients due to implicit bias, stereotyping, and dominant social systems, such as heteropatriarchy and racism (Davidson & Hauser, 2015; Sue, 2015). Overall, health professionals have a strong impact on health outcomes for Indigenous clients (Bates, Rankin-Hill, & Sanchez-Ayendez, 1997; Walls, Gonzalez, Gladney, & Onello, 2015). Therefore, training that identifies colonialism and promotes decolonialism are essential to the provision of culturally sensitive and appropriate care for Indigenous people.

Community mental health has a particular emphasis on social justice, decolonial methodology, and issues of intersectionality that may be critical to providing equitable care to Indigenous families and communities. A decolonizing lens "brings into clearer view ways in which power/privilege/oppression are reproduced and contested through racialized and ethnicized practices and discourses; that is, how social inequality is maintained and challenged through culture" (Cruz & Sonn, 2011, p. 204). However, both white privilege and religious conservatism are roadblocks to becoming social justice advocates (Todd, McConnell, & Suffrin, 2014), a critical competency of community mental health professionals (Langhout, 2015). In particular, in the field of community psychology, "the goal is to develop and support scholar activists who will engage in the work of transforming social structures" (Langhout, 2015). One article provided recommendations for the future of community psychology including the increased use of critical pedagogy, critical race theory, and Indigenous methods (Todd et al., 2014), but there are few recommendations about how to apply these theories in student or professional training.

Development of the Training Program

In response to the need for culturally appropriate mental health care for Indigenous clients, the authors–all licensed marriage and family therapists and citizens of state and federally recognized tribes in what is now the United States–developed a 90-minute workshop. The creation of the workshop was grounded in multicultural counseling competencies (Sue, 2001; Sue, Arredondo, & McDavis, 1992), cultural humility (Rincón, 2009; Tervalon & Murray-Garcia, 1998), and a decolonizing framework (McDowell & Hernández, 2010).

The objectives of multicultural training and education have been well-established, particularly in the counseling literature (Sue, 2001). Most commonly, the objectives are organized into three dimensions: (a) knowledge, (b) awareness, and (c) skills. The first dimension, *knowledge*, refers to a person's understanding of his or her own culture, the cultures of others (specifically those being served), and the effects of sociopolitical influences. The second dimension, *awareness*, refers to a person's awareness of his or her own biases and assumptions about others, an effort to correct those biases, and an understanding of how biases can interfere with clinical practice. The third dimension, *skills*, refers to the specific skills needed by a person to practice ethically and effectively with culturally diverse clients. Below, we will describe

specific strategies and activities used to achieve these learning objectives.

The addition of a cultural humility perspective enriches the traditional multicultural competence model because it emphasizes process over content (Tervalon & Murray-Garcia, 1998). The risk with a strictly competence-based model is that one could be presumed "competent" to work with a particular population after acquiring a certain level of knowledge, awareness, and skills. However, culture is not static and cannot be narrowly defined, rather, it is dynamic, contextual, emergent, and multifaceted (Dean, 2001; Rincón, 2009). Therefore, the goal of becoming culturally humble must be seen as a lifelong process and one that is never fully attained (Tervalon & Murray-Garcia, 1998). A cultural humility perspective requires us to engage in continual self-reflection and critique so that we can create nonpaternalistic partnerships with our clients and their communities, in which their own knowledge, values, and ways of being are privileged (Hook, Davis, Owen, Worthington, & Utsey, 2013). We used Rincón's (2009) model of cultural humility that is comprised of six key components: (a) self-reflection and self-critique that includes analyzing biases and assumptions; (b) understand that no culture is better than another; (c) admit when we do not know about the culture or context of our clients; (d) seek out knowledge and resources about the contexts of our clients; (e) see the client as the expert on their own culture, values, and beliefs; and (f) place assumptions aside. These components create a framework for increasing knowledge, awareness, and skills that is augmented by a decolonizing perspective.

A decolonizing framework seeks to: (a) criticize and challenge colonialism, (b) legitimize Indigenous knowledge, and (c) center liberatory healing practices (McDowell & Hernández, 2010; Mihesuah & Wilson, 2004; Nelson & Prilleltensky, 2010). The term, colonialism, refers to the practice of a dominant group exerting political, economic, and social power and imposing values and practices on another group, for the benefit of the dominant group. In the case of people Indigenous to the U.S., we are referring to the historical and current settler-colonialism by people of European descent. Decolonization does not mandate discarding the values and practices of Western culture and it is not a process exclusive to those who have been explicitly colonized. Rather, anyone can attempt to decolonize their ideologies, beliefs, and ways of being by being critical of dominant paradigms and consciously privileging Indigenous knowledge. For example, mental health professionals ought to be critical of their own profession, as the medical model and its conceptualization of mental health are Western constructs that create an inherent power structure of the doctor over the patient. A decolonial perspective questions the need for mental health treatment at all. Rather than dismantle the current system of mental health, this training seeks to integrate competency, humility, and decoloniality through a brief 90-minute training program, which will be described in the follow section.

The Training Program

Using decolonizing and cultural humility frameworks, we created a training to increase knowledge, awareness, and skills related to Indigenous mental health care. Here, we provide the activities, strategies, and resources used to reach these learning objectives.

Knowledge

Although the cultural humility model eschews the notion that one can ever learn enough to be truly competent in a culture, it does encourage clinicians to seek out knowledge and resources regarding their clients' cultural backgrounds. Further, a decolonizing perspective requires sufficient historical and contemporary knowledge to be able to criticize and challenge colonialism. Learning the history of Indigenous peoples sheds light on why current disparities exist today and removes bias and stigma and creates understanding and accountability. Therefore, our training begins with an acknowledgement of ancestral lands in order to introduce the idea of colonialism as essential to their knowledge base. We present two maps of the state in which the training is being conducted–one showing the ancestral homelands of Indigenous people and one showing their current reservation lands. From this, participants become familiar with both the fact that Indigenous people currently live in their community and the fact that vast amounts of land were ceded in treaties with the U.S. government.

Next, we briefly discuss our use of language when discussing Indigenous people. The term recognized by the federal government is American Indian, even though that name is based on the inaccurate assumption made hundreds of years ago by Europeans who thought they had traveled to India. Many people prefer the term, Native American, because it is more accurate than American Indian, but this term can still be problematic to some, because Indigenous people may not consider themselves native to America–a name given by Europeans to a land that had many names already. We use the term Indigenous to describe a large and diverse population of people whose ancestors lived on this continent long before it was named America. Because the term, Indigenous, is not confined to a particular place, but rather means something different depending on where you are, we feel it also

connects North American Indigenous people to other Indigenous people across the globe. That being said, we do not mean to imply that Indigenous people are one homogenous group that should be called by one name. Whenever possible, Indigenous people should be identified by their tribe, nation, or clan-in their native language, because these groups are very diverse and hold unique identities.

A core component of cultural humility is to seek knowledge and resources about the contexts of clients (Rincón, 2009). Of course, the ideal way to do this is to ask your clients about their unique context. However, we feel that it is important to have your own working knowledge of the histories of various marginalized groups, above and beyond the narratives in dominant society. Therefore, we present a contextual framework for decolonizing work with Indigenous clients that includes information about historical trauma, the intergenerational transmission of trauma, and how these influence current health disparities.

The knowledge section of the intervention included (a) describing accurate information about the actions of the US toward Indigenous people, (b) bringing Indigenous voices to the forefront of the telling of their own history and stories, and (c) relating historical events to modern day disparities and inequities. For instance, the historical traumas inflicted on Indigenous people were the result of policies aimed at forced assimilation and genocide including: mass murder, relocation of people from their homelands, removal of children from their families, and illegalizing spiritual practices and use of language, for example. Dr. Maria Yellowhorse Brave Heart (1998) coined the term historical trauma that refers to "cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma." (p. 288). Key policies and eras we covered include the following:

- The *Indian Removal Act* (1830), which resulted in the loss of cultural and spiritual practices, at least 10,000 Cherokee lives, and hundreds of thousands of square miles of land (Perdue & Green, 2007).
- The *Allotment Era* (1887–1934), in which 90% of existing Cherokee land was taken forcibly and Cherokee language and customs were prohibited (Stremlau, 2011).
- The *Termination Polic*y era (1945–1968), in which approximately 2,500,000 acres of trust land were removed from protected status and sold to non-Indigenous people, and 12,000 Indigenous people lost their tribal affiliation (National Congress of American Indians, 2015).
- The *Indian Relocation Act of 1956,* relocated over 100,000 Indigenous people to urban areas to fill low-paying vocational and wage work. However, many participants of this program could not find full-time work placing American Indian families in an environment of urban poverty (Mizutani, 2013).
- The *Boarding School Era* (1880–1980), in which children were removed from their families, placed in distant boarding schools, and forbidden to speak their native tongue and practice their religious traditions (Churchill, 2004). Children suffered severe abuse as well as disease and deaths of epidemic proportions.
- *Forced Sterilization* (1973–1976) took place in four of the 12 Indian Health Service regions and resulted in the sterilization of at least 3,406 Indigenous women without their consent (Lawrence, 2000).

Colonial oppression and genocidal policies and actions have had devastating effects on generations of Indigenous families, including: loss of cultural practices and oral history (Deloria, 1969; Weaver, 1998a, b), loss of traditional parenting practices and familial ties (Brave Heart, 2003), impingement on cultural and emotional strength (Gray, 1998), secondary posttraumatic stress disorder (Duran & Duran, 1995), intergenerational impact of historical trauma (Myhra, 2011), and psychological trauma and substance abuse across generations (Myhra & Wieling, 2014a, b). Furthermore, historical trauma has been linked to mental health outcomes such as depression (Whitbeck, Adams, Hoyt, & Chen, 2004; Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009), anxiety (Brave Heart, 2003), suicidality (Brave Heart, 2003), anger issues (Whitbeck et al., 2004), substance abuse (Walls & Whitbeck, 2012), and intimate partner violence (Duran & Duran, 1998). Indigenous children are five times more likely to experience four or more adverse childhood experiences (Koss et al., 2003) which are linked to poor mental and physical health outcomes in adulthood, such as depression, substance abuse, obesity, cardiovascular disease, and diabetes (Dong et al., 2004; Felitti et al., 1998; Scott et al., 2011). All of these traumas have a cumulative effect on the health of Indigenous people, resulting in an average lifespan that is 10 years shorter than non-Indigenous people (Indian Health Service, 2016).

It is critical to teach the history of Indigenous people to understand the context for present-day oppression and health disparities. Many mental health professionals are unaware of the history of Indigenous people and so may struggle to understand how historical traumas can accumulate and impinge on the well-being of this large and diverse group of people. For example, after learning about the policies enacted under Andrew Jackson, a clinician might understand how an Indigenous person could perceive his face on a 20-dollar bill as a microaggression and a daily reminder of a painful history.

The impact of historical trauma may also show up in therapy indirectly through coping strategies that have been employed and passed down through generations. For example, an Indigenous person may be disconnected from trauma experienced directly in their own life if previous generations have also used disconnection or disassociation as a way of managing trauma. A clinician may observe avoidant patterns of communication, denial, anger, and emotional detachment in families with historical trauma (Benjamin & Carolissen, 2015). Understanding the nature of historical trauma allows the clinician to understand an Indigenous client's thoughts, feelings, and behaviors in a larger context, where they are seen as ways of surviving rather than symptoms.

Awareness

Both multicultural counseling objectives and the cultural humility model emphasize the importance of self-reflection and self-critique, particularly when it comes to biases and assumptions. A continued and intentional examination of these often-unconscious beliefs is necessary in order to begin the work of decolonization by centering and legitimizing the knowledge, values, and practices of indigenous people. Experiential activities are key to this process. Experiential learning requires learners to be direct and active participants, which is a shift from traditional models of teaching in which learners are expected to be passive (Dewey, 1938; Freire, 1970). Because biases and privileged identities are personal to each participant, they cannot be taught didactically, but must be explored and experienced by each person (Hartwell et al., 2017; Weaver, 1998a, b) Therefore, we ask participants to reflect in writing, in pairs or small groups, or with the whole group several times throughout the training.

The first reflective exercise is early in the presentation–just after presenting learning objectives, acknowledging ancestral homelands, and discussing terminology. Participants are asked to make two lists: (a) assumptions they have about Indigenous people/culture or about doing therapy with Indigenous clients, and (b) things they do not know about Indigenous people/cultures or about doing therapy with Indigenous clients. Participants are reassured that there are no right or wrong answers and they can choose to share as much or as little of what they wrote with others. After a few minutes of free writing, participants discuss their lists in pairs or small groups. Then, together as a large group, we share some of what was written and discussed and the presenter makes a list on the board. This process helps participants to recognize the prevalence of many harmful stereotypes, assumptions, and the invisibility of Indigenous people.

Following the presentation of historical trauma, intergenerational transmission, and health disparities (described above in the knowledge section), we ask participants to pause and reflect once again. This is important for two reasons. First, much of the information presented about historical trauma is new to participants and very upsetting. Often, people have strong emotional reactions to the material that they need time to process. Second, it is important to analyze how this new information relates to their original list of assumptions and questions. Therefore, we asked participants to write in response to two questions: (a) What are your thoughts or reactions to what you learned about colonization? and (b) Did your learning confirm, challenge, or inform your list of assumptions and things not known? Similar to the first exercise, participants write, share in pairs or small groups, and then discuss with the entire group.

After the history of colonization has been presented and processed, an important next step is to discuss the ways that Indigenous people are actively decolonizing themselves. We discuss ways that tribes are privileging and revitalizing their own cultural values and practices, such as creating resources to ensure that tribal members can learn, practice, and preserve their own language (Wapachee & Little, 2016). Indigenous artists teach others about crafts such as beadwork, moccasin-making, or bow-making (Louwagie, 2016). Some tribes have begun or continue to exercise their treaty rights in regard to hunting, fishing, and foraging despite barriers (Cedar Tree Institute, 2016; Red Lake Nation, 2017). These efforts provide a stronger sense of cultural identity, which research has linked to improved physical health (Wilson & Rosenberg, 2002), positive mental health for youth (MacDonald, Ford, Willox, & Ross, 2013) and adults (Garroutte, Goldberg, Beals, Herrell, & Manson, 2003), reduced substance use for youth (Yu & Stiffman, 2007), and adults (Stone, Whitbeck, Chen, Johnson, & Olson, 2006), and improved academic performance (Whitbeck, Hoyt, Stubben, & LaFromboise, 2001). Further, it is important for non-Indigenous clinicians to recognize that Indigenous people are active agents in their own lives and well-being and are not looking for charity, service, or advice from those who have been privileged by a colonial society.

Clinicians working with Indigenous clients must continually practice from a place of cultural humility, in which the client's culture is valued and privileged (Hook et al., 2013). In order to do this, clinicians must gain ethnocultural empathy, or the ability to understand the perspectives and feelings of members of a different ethnic group (Wang et al., 2003). Because empathy is an essential component to changing biased attitudes (Batson et al., 1997), and improving client care (Mercer & Reynolds,

2002), our training was designed to increase ethnocultural awareness and empathy. In addition to the self-reflection necessary for culturally humble practice, clinicians also require culturally appropriate skills.

Skills

For the purposes of this training, we focused on skills of self-reflection and self-critique, as well as the ability to identify culturally appropriate interventions. In previous sections, we described activities used to foster self-reflection and to identify decolonizing practices within Indigenous communities. In this section, we present various models, approaches, and interventions within the current colonial system of mental health that have been adapted or may be appropriate for use with Indigenous clients and families.

Evidence-based interventions and empirically supported theories are typically not developed or adapted for Indigenous clients and thus are not necessarily appropriate forms of therapy for Indigenous clients because these practices may in fact perpetuate settler-colonial values and institutional racism. Mental health professionals in the U.S. overwhelmingly utilize a Western, individualistic viewpoint, a product of the political, social, and economic environment in which they were trained and now practice (Duran, Firehammer, & Gonzalez, 2008). This lens does not match the systemic lens that some Indigenous individuals and families use to view the world, and therefore, are oppressive and ultimately ineffective in supporting or empowering positive change in these communities (Constantine & Sue, 2006). Indigenous communities already have many family and community-centered activities that are effective at promoting health and wellness (e.g., storytelling, ceremonies, singing, herbal remedies, healers. etc.) that ought to be centered and acknowledged by Western practitioners. When an Indigenous individual or family seeks mental health treatment, there are several therapeutic models and interventions that have been successfully used by both Indigenous and non-Indigenous professionals to increase mental health outcomes and reduce health risks. We briefly discuss these models in our program to highlight how Indigenous ways of knowing can be integrated into a Western mental health paradigm.

The Indigenous Liberation Perspective (ILP) is an important place to start because it offers mental health professionals a chance to highlight Indigenous knowledge and move away from a disease model (Duran et al., 2008). ILP highlights the Indigenous concept of the soul wound, which is understood to be a result–whether directly or indirectly–of historical trauma and oppression. It also focuses on healing the soul wound through acknowledging historical trauma and adapting Western methods to meet the goals of an Indigenous client, which may not be focused on symptom reduction but on healing. ILP encourages a shift away from the typical therapist-client hierarchy to a more client-centered and empowering approach. Although client-centered models are not new to the mental health field (Romana, 2006), this particular approach can support decolonization by promoting healing from the wounds of assimilation, accommodation, looking down on, saving, helping, and pitying. Studies have found that this approach reduced the perceived burden of sociopolitical oppression and injustices and reduced symptoms, such as depression and anxiety (Combs & Freedman, 2012; Sheppard, 2002).

Clinicians have integrated the ILP and other decolonial perspectives with existing models or theories for doing therapy in such a way that they privilege and empower the experiences of Indigenous clients. Examples of this include motivational interviewing (Miller et al., 2008; Venner, Feldstein, & Tafoya, 2007), cognitive-behavioral therapy (Jackson, Schmutzer, Wenzel, & Tyler, 2006), solution-focused therapy (Meyer & Cottone, 2013), and systems theories (Limb & Hodge, 2011; Oetzel & Duran, 2004). Narrative medicine (Mehl-Madrona, 2007) integrates physical health care with an Indigenous perspective that moves the provider away from being an expert advice-giver and toward being an expert listener. This approach uses stories, worldviews, and belief systems to help clients heal from physical ailments. Other successful projects in Indigenous communities focus on strengthening family and community bonds, highlighting or revitalizing traditional practices and beliefs, as well as promotion of sovereignty and self-determination (Kral, Idlout, Minore, Dyck, & Kirmayer, 2011; Rasmus, 2014).

Another approach to creating and validating decolonizing interventions is to adapt existing evidence-based treatments (EBTs) to fit Indigenous practices and belief systems. We provide several examples of these in the training and will highlight one here. Honoring Children, Mending the Circle involved Indigenous community members, healers, and leaders in adapting trauma-focused cognitive-behavioral therapy to reduce posttraumatic stress in Indigenous children (Bigfoot & Schmidt, 2010). The goal of trauma-focused cognitive-behavioral therapy is to correct distorted cognitions and reduce negative attributions of self and others. Similarly, Indigenous cultures emphasize the relationship between thoughts, emotions, and physical reactions and have established practices, activities, and ceremonies that aid community members in making these connections. In this adaptation, these goals are reached by utilizing traditional beliefs and practices, such as listening to children, telling stories, and identifying and expressing emotions. For a more extensive review of culturally tailored EBTs for Indigenous communities, please

refer to Gone and Alcántara (2007). This review highlights EBTs that integrate traditional ways of knowing and healing with culturally appropriate treatment goals and community members as stakeholders or treatment providers.

In the training program, we emphasize the legitimacy and centrality of Indigenous practices and belief systems and highlight how the delegitimization of these is, in fact, colonial and harmful. We also provide many examples of the ways that Indigenous communities heal themselves and do not require Western intervention. However, for those clinicians who do work with Indigenous clients, it is essential that they have a foundation for decolonizing their own practice, and for integrating Indigenous ways of knowing into the Western mental health system. By highlighting Indigenous healing and liberation practices as well as examples of integrating Indigenous and Western healing, we provide participants with the tools to center and collaborate with their Indigenous clients.

Summary

Although Indigenous people suffer from mental health and substance abuse issues at a higher rate than any other group, mental health professionals seldom receive training on this population (U.S. Department of Health and Human Services, 2009, 2017). These health disparities are due to a history of colonization resulting in intergenerational trauma. Mental health professionals are a product of the colonization process and ought to be critical of their own interventions, including this one. In an attempt to fill this training gap and introduce a critical perspective, we created a brief program that addresses basic knowledge of Indigenous people and histories, self-reflective exercises, and therapeutic interventions that privilege Indigenous knowledge and decolonize therapeutic practices. To our knowledge, no such Indigenous-health training has been developed and disseminated for wide use.

To date, we have given this training at national conferences, university classrooms, and community mental health agencies. These experiences and formal feedback suggest that this training can be adopted in a variety of settings. Agencies or training programs may choose to integrate this training into their typical on-boarding or orientation process. Although we did not experience resistance to the training, some participants may have a reaction to the history of colonization or its impact on indigenous people. Therefore, the training should be delivered by well-trained facilitators who have experience with challenging norms and dominant discourse in a productive and compassionate manner.

As Indigenous women, we have all experienced bias and microaggressions during our own health care visits. As Indigenous mental health providers, we have heard the painful stories of our Indigenous clients when recalling their experiences with other providers and we have watched the unintended, yet still damaging missteps of our colleagues. Creating and disseminating this training has been a meaningful part of our own decolonization process.

Mental health is no longer simply an act of implementing psychological theories, given the knowledge we now have of the impact of social inequities on health outcomes. Mental health is an inherently political practice to create mental health equity and its practitioners have begun to take up the cause (Bess, Prilleltensky, Perkins, & Collins, 2009). Mental health professions often reflect the systemic injustices of the larger society, therefore practitioners must gain knowledge and skills in both mental health delivery and social justice advocacy to address mental health disparities.

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