Engaging Indigenous Community Partners in Commonwealth of the Northern Mariana Islands (CNMI)

988 READINESS AND CRISIS SERVICES

The Community Guidance Center of the CNMI Healthcare Corporation (CCHC) has worked actively to ensure that substance use treatment and behavioral health services are clearly listening to and engaging people with lived experience. This is most evident in their current TTI efforts to develop and launch a National Suicide Prevention/988 Lifeline center staffed by crisis response workers who are certified peer support specialists. Their work embodies the message “nothing about us without us,” which underscores the significance of collaboration, empowerment, and inclusion of populations of focus when designing and implementing services.¹

As CCHC continues to collaborate with local Chamorro and Carolinian communities in planning for 9-8-8 rollout and implementation, these efforts will ensure that the expertise of Indigenous natural helpers, knowledge, and traditions are infused in the behavioral health approach.

When enhancing behavioral health services for Chamorros and Carolinians, government officials will

¹ p6 Partnering with Tribal Governments to Meet the Mental Health Needs of American Indian/Alaska Native Consumers
continue consulting with various communities representing the ethnic, religious, linguistic, and cultural diversity found on the islands. Behavioral health officials will continue celebrating the many facets of the Chamorro and Carolinian culture as protective factors for resilience and a pillar of behavioral health wellness.

**Ties to traditional cultural values, community involvement, education, and culturally rooted services and supports can all be fostered as protective assets in Indigenous-driven services.**

When programs and interventions are culturally anchored and developed with local input and partnerships, they can foster supportive communities, strengthen families, and empower individuals with tools and skills to manage their behavioral health needs.² It is crucial to engage natural leaders, Indigenous community partners, and people with lived experiences (peers) to identify gaps in service provision and gain feedback on how the medicalized Western model of behavioral health may not meet their specific needs.

**When developing services for the diverse ethnic groups living in CNMI, it is paramount to provide services through a lens of trauma-informed care, decolonization, and celebration of the myriad of Indigenous cultural values found in any given region.**

There is no universal approach or service that will resonate with every individual in CNMI, so it is essential to seek feedback from various groups about which mental health services, religious values, and cultural practices will be most powerful when integrated with the behavioral health system. Culture is a cornerstone of resilience and wellbeing and must avoid the “international bias that neglects the diversity of ethnic population compositions outside of Western sovereign states.”³

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² [https://doi.apa.org/manuscript/2018-37731-013.pdf](https://doi.apa.org/manuscript/2018-37731-013.pdf)

³ [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6726839/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6726839/)
UNDERSTANDING INTERGENERATIONAL TRAUMA

A decolonizing approach to behavioral health means that colonialism is seen at the center of the historical trauma and pain of the oppressed, and cultural and community strength is at the heart of healing.

U.S. colonialism has radically altered the social, economic, ecological, and political living conditions of AANHPI populations, not unlike the American Indian/Alaska Native population. Indigenous Chamorro and Carolinian communities had to face profound trauma, uniquely characterized as multi-generational and historical, directly as a result of the legacy of repeated colonization over centuries from Spain, Germany, Japan and the US, without the cultural safety nets of traditional healers and community support.4

By the mid-20th century, Chamorros and Carolinians on the Northern Mariana Islands had already endured centuries of cultural and religious erasure, imposed conversion to Christianity, repeated forced relocation, exploitation of land, colonization by Spain, Germany, and Japan, and significant reduction of the Indigenous population through displacement and colonial violence. Their Indigenous faiths and cultural practices were largely eradicated, the language suppressed, and lifestyles altered to fit ‘civilized’ European standards.5

Today, in a commonwealth of the United States with mixed influence from various global cultures, Chamorros and Carolinians in CNMI continue to face forced assimilation, must grapple with generational trauma and identity erasure, and are systemically disenfranchised by ingrained power structures.6 Even today, the pressure on the Chamorros and Carolinians, and other Indigenous people to assimilate into the mainstream culture is an ongoing biproduct of the historic colonization. Traditional Western behavioral health services are often culturally inappropriate; they may overlook the effects of colonial violence on generational mental health and fail to affirm Indigenous culture and community as resilience factors. Despite the overwhelming history of land theft, and ethnic genocide that Chamorro and Carolinian people have

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5 https://www.britannica.com/place/Northern-Mariana-Islands/German-and-Japanese-control

Developed by the Transformation Transfer Initiative (TTI) FY2022.
suffered, their community has shown unimaginable resilience and resistance, keeping their Indigenous language alive and a connection to traditional values as they become an increasingly smaller demographic in the region.

Behavioral health services in CNMI admirably promote the healing strengths of indigenous culture and practices. Ideally, these services will continue to honor the various interpretations of mental health found across CNMI, which are often influenced by the complex intersections of faith and religion, language, cultural practices, migration history, societal stigmas and beliefs, and complex historical trauma. Thus, behavioral health officials in CNMI should continue to seek feedback, guidance, and collaboration from all facets of their Indigenous communities: community leaders and Elders, individuals who use mental health services, their family members, and providers, to enhance behavioral health services and programs to reflect the traditions, values, and beliefs of those being served. Before scaling up services available to Indigenous communities, it is essential to verify the effectiveness of interventions and ensure that they are rooted in the strengths, not the deficits, of a community.⁷

The launch of 9-8-8 presents an unprecedented opportunity to build relationships with local Indigenous communities and other populations that have historically been underrepresented in and excluded from the behavioral healthcare system.

Enhanced collaboration and learning with Chamorros and Carolinians in developing these services will improve accessibility, comprehensiveness, and cultural appropriateness of resources available to individuals in crisis or seeking behavioral healthcare.