This report was approved by the Navajo Nation Human Research Review Board on May 20, 2008. Please do not make alterations to the report or reproduce without approval.
Acknowledgements

This report was written by a core working group of Project TRUST members, who represent a diverse array of organizations involved with Native American youth and their families. The report was funded by the New Mexico Department of Health Office of School & Adolescent Health as part of a suicide prevention initiative.

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We wish to acknowledge the Project TRUST members who participated in facilitating the community advisory meetings and analyzing the data: Gloria Collins (Lakota), Myra Gould (Diné), and Christopher Lee (Diné). In addition, we appreciate the time, effort, and contributions of our youth facilitators: Charvel Baldwin (Diné), Krystal Curley (Diné), Erin O’Keefe (Diné), Jacob Salabiye (Diné), and Casey Tom (Diné). We are also indebted to the Diné traditional practitioners who gave us guidance: T.J. Anderson, Ray Daw, Lincoln Nez, and Aricke Willie. Finally, we would like to recognize the many additional Project TRUST members and partners who contributed to our process and report. They are:

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- New Mexico Department of Health, Public Health Regions 1/3
■ New Mexico Alliance for School-Based Health Care
■ Northwest New Mexico School-Based Health Care Champions
■ University of New Mexico Center for Health Promotion and Disease Prevention
■ University of New Mexico Center for Rural & Community Behavioral Health
■ New Mexico Alliance for School-Based Health Care’s “4-Youth” Project, a Kellogg funded School-Based Health Care Policy Program for Native American Youth
■ Value Options NM, Service Systems Relations
■ Navajo Nation Division of Health, Department of Behavioral Health Services
■ Gallup Indian Medical Center, Behavioral Health Services
■ Gallup-McKinley County Schools Counseling
■ UNM-ACL Teen Centers
■ Northern Navajo Teen Life Center
■ Crownpoint & Thoreau School-Based Health Centers
■ McKinley Coalition for Healthy & Resilient Youth
■ McKinley Community Health Alliance

We also thank the community members and service providers in Crownpoint, Gallup, Shiprock, and To'Hajiilee who shared their stories, knowledge, and experiences with us. We are grateful for guidance and approval from: the Navajo Nation Human Research Review Board and the University of New Mexico Human Research Review Committee. Finally, we appreciate resolutions of support from: Northern Navajo Agency Council, Eastern Navajo Agency Council, Central Consolidated School District 22 (Shiprock), To'Hajiilee Community
School Board, Gallup McKinley County Schools Board of Education, Shiprock Service Unit Health Board, and Gallup Diné Healthcare Advisory Board.
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Executive Summary

Native American youth represent the resiliency and continued survival of many Nations and Tribes. They symbolize the hope, dreams, and cultural continuity for future generations to come. It is with this understanding that Project TRUST members embarked on an effort to examine those things that have influenced both positive and negative challenges to providing behavioral health care for Native American adolescents. A key concept in facilitating this examination was approaching the "real" experts - our community - and asking them why they thought the aftermath of colonialism, including historical trauma and current institutional inequalities, has resulted in numerous health disparities for Native American youth. For instance, Native American youth have the highest rate of suicide among 15-24 year olds in the United States (34 per 100,000 compared to 11 per 100,000 for overall U.S. population). It was important to work with the community and seek their guidance to help us address this and other glaring health disparities rooted in both current and past oppression by the federal policies of the U.S. government experienced by Native American individuals, families, communities, and nations for the past 500 years, rather than impose upon them yet another theory for "fixing" their problems.

Efforts to understand and redress these disparities face a fundamental challenge – the divergence of western and traditional Native American approaches to mental health care and healing, and the primacy given to western practices in service provision, policy, and funding. Native American traditional practices and ceremonies have been effective since time immemorial, but federal policies at different times have prohibited them, disregarded them, perpetuated questions about their credibility and validity, and resulted in their loss across generations in some communities. The result is a “replacement” system of care that is not actually meeting the mental health needs of Native American youth, and may in fact be harmful. Eliminating the behavioral health disparities experienced by Native American youth requires recognition of the past. It also requires recognition of the effectiveness of traditional practices and an integration of
Native American cultural (including spiritual) perspectives on mental health and well-being. An understanding of western influence on Native American individuals, families, communities, and nations is also essential, as well as a willingness to transform on multiple levels, including the individual, family, community, tribe, systems of care, and larger social structures. As a Native American Project TRUST member explains:

But mainly, the one thing that always kept coming up when the suicide and mental health started coming into the conversation, we said, ‘Well, what do we do? When we send kids to get treatment or get some kind of help, what are we doing? Are we re-traumatizing our youth without the historical understanding of where a lot of these issues are coming out in the community?’ And we realized we don’t want to re-traumatize our youth when we keep sending them for different help and they’re saying that there’s a lot of trust issues and they don’t want to go in for treatment… The kids don’t trust, I think, and this is my thought, they don’t trust, because they can’t tell you the whole story. They’re not quite sure how to start the whole story, the history of what happened to them and their families, and their relatives from generations back—grandmas and grandpas.

In order for beneficial “treatment” to occur, we have to recognize the power of the cultural practices and beliefs within Native families and communities that have contributed to their survival, recovery and resiliency over thousands of years. A cultural awareness and understanding must be cultivated among behavioral health providers and Native American communities, which can only be accomplished if certain complexities are recognized, addressed, and thoughtfully understood.

First, it is imperative to recognize that all tribes have traditional cultural healing practices and teachings, but because of federal policies that contributed to historical trauma, not all community members have access to them. Another complexity and responsibility is the emotional and spiritual consequences of
raising the issue of historical trauma, and how to ensure that Native American youth and their families are supported and taken care of in this process.

This report represents our efforts to promote the mental health and well-being of Native American youth, their families, and their communities through the development of policy, practice, and research recommendations that emphasize the importance of traditional cultural teachings and healing practices. We are a partnership of service providers, community members, community organizers, youth, university faculty and staff, and organizations who formed Project TRUST because we feel that existing behavioral health services are not meeting the needs of Native American youth, their families, and communities. We are frustrated because we recognize that the dedication and commitment that we and many other well-intentioned service providers have is not translating into improved behavioral health for many of our Native youth.

We have identified several key issues, including: lack of awareness of the impact of historical trauma and institutional racism on the mental health of Native youth, and lack of integration of this understanding into behavioral health services; evidence-based practices being imposed on Native youth that are not developed with and for Native communities; absence of traditional healing practices and cultural teachings in many behavioral health services; exclusion of youth and their families from behavioral health service planning and policy development; a behavioral health system that is under-funded and ineffective; and social structures that continue to re-distribute resources to a tiny segment of the population. As a result of these factors, many Native youth have a deep mistrust of western behavioral health services and providers.

We named our partnership Project TRUST because we believe that this lack of trust is the underlying issue. We expanded this supposition by identifying the related key issues that need to be addressed to promote healing and create trust:

- Truths about historical trauma and current inequities that impact the mental health and well-being of Native youth and their families
Responsiveness to issues and needs identified by Native youth and their families from their perspective

Understanding of the effectiveness of traditional indigenous healing practices and cultural teachings

Self-Determination of youth and families to guide their behavioral health services

Transformation of individuals, families, communities, systems of care, and social structures

We realized that we needed more information about these issues from traditional practitioners, existing behavioral health research and literature, and Native youth and their families and communities. After completing a comprehensive literature review on mental health of Native youth, strengths and resiliency, historical trauma, evidence-based/promising practices, and culturally competent processes for working with Native American youth, we conducted community advisory meetings with 71 Native American youth, parents, and elders, and surveys of 25 service providers. Next, we consulted with several traditional practitioners to get their guidance on developing policy and practice recommendations to promote the mental health of Native American youth, and their feedback on our preliminary report. Based on what we learned, we developed recommendations for providers, policy makers, and researchers.

Our report summarizes the literature we have reviewed, the experiences of Native youth, adults, and providers who participated in our advisory meetings and surveys, guidance from traditional practitioners and experts, and the real-world input of Project TRUST partners. This report culminates in 32 policy, provider, and research recommendations, which focus on recognizing and addressing historical trauma; making behavioral health services more responsive to issues and needs identified by Native youth and their families; incorporating traditional healing practices, cultural teachings, and spirituality into services; shifting focus from evidence-based practices to practice-based evidence; connecting prevention and treatment efforts; recognizing inherent sovereignty
and self-determination at multiple levels; and fostering transformation of individuals, families, communities, systems of care, and social structures. It is our hope that this report will encourage our numerous partners and others to advocate for and implement these changes because, as a Native American Project TRUST member explains:

Doing this together is the only way it's gonna get done. You know, we can’t do this individually. It’s not gonna happen through individual treatment and care because you have to send them back to a sick community. And so, how do they function in that barely functional system? Because what I want are beautiful, healthy Native communities that thrive and are successful, and are not only resilient, but are really, really strong and powerful. And that fits in line with the way our culture is, the way we were taught and the way we’re taught everyday, how we’re supposed to represent ourselves.
I. Background

The Project TRUST partnership was officially formed in 2006. However, several partners had already been working together for many years prior to 2006, to address behavioral health issues faced by Native youth. Most recently, in 2005, the New Mexico Department of Health (NMDOH) and the Coalition for Healthy & Resilient Youth (CHRY) produced the film *Rez Hope*, which is a film written and directed by Diné filmmaker Norman Brown, based on New Mexico Youth Risk & Resiliency Data. Young people from CHRY were involved in all aspects of the development of this film from script editors, to actors, and crew. The film depicts Native American youth who are dealing with real world issues including substance abuse, intimate partner violence, depression, and youth suicide. It also emphasizes the strengths of traditional Native American cultures in addressing these issues.

NMDOH and CHRY found *Rez Hope* to be an effective tool for stimulating dialogue among young people, parents, elders, teachers, providers, and others in a variety of school and community settings. One of the major impetuses for Project TRUST was the need to build upon the success of *Rez Hope* to work towards identifying concrete policy and practice changes that address the fundamental issues highlighted in the film and raised by viewers, including oppression that caused historical and intergenerational trauma, and how this impacts the current mental health systems of care for Native youth. The limitations of current behavioral health services for Native youth are important and pressing issues that need to be addressed through the lens of historical trauma and intergenerational trauma. In the words of two Project TRUST members:

How are we going to ask young people to lead us if we don’t even know what’s making us sick or keeping us sick? What are we doing? What aren’t we doing? How are we perpetuating all this stuff? How do we stop the cycle?

—Native American Project TRUST member
He started telling me the truth about his life and the trauma that he’d experienced in his life. And I listened and was really happy that he was finally opening up about it, but after listening I said, ‘I’m really glad that you’re willing to talk with me about this, but I feel like I’m beyond my expertise. And so, I really think you need to talk to someone.’ And I knew he was in counseling at the time, and I said, ‘So have you ever talked with your counselor about these things?’ And he honestly looked at me…literally looked at me like I had three heads and said, ‘Why would I tell him that? He doesn’t care about me.’ …I happened to know his counselor, who did care about him on some level. But obviously there wasn’t the trust…the trust issue was just huge.

—Non-Native Project TRUST member

These sentiments express the underlying issues and the urgent need to address them. The sections that follow detail the perspectives of community members and service providers who participated in our community advisory meetings and survey, the guidance we received from traditional practitioners, our review of relevant literature, as well as our recommendations.
II. Method

Project TRUST partners began meeting in March 2006 to plan our efforts, and we spent the next year conducting background research, developing our method, and obtaining community and institutional support and approvals. We presented to and received resolutions of support from:

- Northern Navajo Agency Council
- Eastern Navajo Agency Council
- Central Consolidated School District 22 (Shiprock)
- To’Hajiilee Community School Board
- Gallup McKinley County Schools Board of Education
- Shiprock Service Unit Health Board
- Gallup Diné Healthcare Advisory Board

We also received approval from the Navajo Nation Human Research Review Board and the University of New Mexico Human Research Review Committee.

Between March and June 2007, we conducted community advisory meetings in four communities (Crownpoint, Gallup, Shiprock, To’Hajiilee), and a survey of service providers who work with Native American youth in those areas (see Tables 1 and 2 for description of participants). In addition, we held a focus group with our partners. See Appendix A for the community advisory meeting questions, Appendix B for the service provider survey questions, and Appendix C for the focus group questions.

Table 1. Summary of Community Advisory Meeting Participants (N = 71)

<table>
<thead>
<tr>
<th>Meeting Location</th>
<th>Adults</th>
<th>Youth (ages 11-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Gallup</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Shiprock</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>To’Hajiilee</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Crownpoint</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>36</td>
</tr>
</tbody>
</table>
The qualitative data collected from the community advisory groups and service provider surveys was content analyzed using a modified grounded theory approach. Analyzing data using grounded theory involves allowing themes to emerge from the data, rather than basing analysis on our ideas or beliefs about a topic (Corbin & Strauss, 1990). Six Project TRUST partners affiliated with the University of New Mexico participated in the initial analyses, including three women (Tewa/Hopi social worker, Lakota clinical psychologist, Anglo community psychologist), and three men (Diné program specialist, Diné undergraduate psychology major, and Anglo program manager). All data was analyzed separately by two partners, who then shared their findings with the group of six and discussed them until consensus was reached. Themes that were found to be repeated were identified and then grouped into larger, related categories. A list of themes was created and then notes and surveys were read for a third time and coded against the list. Once thematic coding was completed, individual codes were aggregated into more substantive themes, which reflected the underlying

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total</th>
<th>Ethnicity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>9</td>
<td>White</td>
<td>11</td>
</tr>
<tr>
<td>Social Worker</td>
<td>4</td>
<td>Native American</td>
<td>6</td>
</tr>
<tr>
<td>MH Therapist</td>
<td>4</td>
<td>African American</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2</td>
<td>Hispanic</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist</td>
<td>2</td>
<td>Asian American</td>
<td>1</td>
</tr>
<tr>
<td>Public Health</td>
<td>1</td>
<td>Native &amp; White</td>
<td>1</td>
</tr>
<tr>
<td>Not specified</td>
<td>3</td>
<td>Not Specified</td>
<td>1</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8</td>
<td>Years Working with Native American</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>Youth</td>
<td></td>
</tr>
<tr>
<td>Not Specified</td>
<td>1</td>
<td>5 years or less</td>
<td>5</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td>6–10 years</td>
<td>4</td>
</tr>
<tr>
<td>26–40</td>
<td>8</td>
<td>11–15 years</td>
<td>7</td>
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<td>41–55</td>
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<td>16+ years</td>
<td>8</td>
</tr>
<tr>
<td>56+</td>
<td>3</td>
<td>Not Specified</td>
<td>1</td>
</tr>
<tr>
<td>Not Specified</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Summary of Provider Survey Participants (N = 25)
issues or factors. Preliminary analyses of the qualitative data were presented to the other Project TRUST partners for further analysis and interpretation.

After completion of these analyses, we had several meetings and consultations with traditional practitioners to obtain their guidance on our process, analyses, and recommendations. Issues we discussed with them included: the relevance of historical trauma, how to address and heal historical trauma in culturally appropriate ways, how to build upon the strengths that Native people have to deal with the challenges they face, the psychological benefits of traditional healing practices, and recommendations for behavioral health providers who work with Native youth.
III. Community and Traditional Practitioner Guidance

The objective of Project TRUST is not to provide services, but to develop policy, practice, and research recommendations that improve behavioral health care for Native youth, their families, and their communities. Our discussions with traditional practitioners, community members, and service providers, have confirmed that recommendations must center on the premise that the western health care system should support the effective healing practices and teachings that already exist in Native American communities. Behavioral health care in Native communities should not be something that Native American cultural teachings and practices must get integrated into; on the contrary, to be effective, western behavioral health systems must find ways to support Native healing practices.

When we address this sensitive issue, we cannot assume that all people share the same perspective. However, the input and guidance from community members and traditional practitioners has been clear: Native people already have their own systems, their own ways of healing spiritually, mentally, and physically. This inherent body of traditional knowledge precedes western approaches to care. Before the United States existed, there were bodies of fundamental values, principles, and laws that Native people knew and survived on for many years. However, many traditional healing ways were forcibly interrupted and western behavioral health treatments were introduced. Thus, given the process of colonization that occurred, the solution cannot be conceived of as the integration of two equal systems of care. Instead, it must involve primacy being given to traditional teachings and practices and an overall emphasis on the restoration of harmony.

Although the objective of Project TRUST is the development of recommendations to improve behavioral health care for Native youth, their families, and communities, the community advisory process that Project TRUST partners engaged in with community members and traditional practitioners has been an important, positive step toward beginning the process of healing and restoring harmony. As one of our traditional practitioners explained to us:
Having the conversation is the beginning of something positive…Even an individual coming into this is part of the process of healing, the acknowledgement…And even the shifts of thought patterns or how an individual sees himself, that is something positive that goes in the direction of healing.

The same practitioner also delineated how the Project TRUST community meetings and listening to community voices fit into the healing process:

Culturally, speaking about historical trauma starts with the individual, then the family and community, and then the Nation as a whole.

Another traditional practitioner emphasized the importance of our allowing unique processes and discussions to emerge:

Make sure talk about historical trauma is grounded in the community. Each community is different.

Community members expressed similar sentiments. For instance, one adult said,

This movie [Rez Hope] and meeting are really good for me because I need to talk about it. Because you go to work and you don’t get a chance to talk about your problems.

Project TRUST members who helped facilitate the community advisory meetings also talked about the powerful impact the meetings had on participants. As they explain:

For a long time young people really thought they didn’t have a choice, they couldn’t say anything, they couldn’t do anything. And I think with the work we’re doing in Project TRUST, being guided through this process, this community process, we’re getting some young people who are really
starting to see their value, and their experience and how they can use that for other young people.

—Native American Project TRUST member

I think our community advisory meetings have sort of demonstrated that it’s powerful to create the environment that those conversations can happen…it’s obvious that people really want to have those conversations. They actually have said, ‘When can we have another meeting?’

—Non-Native Project TRUST member

I think that the community process is different from bringing the program in and saying this is how it’s gonna get done.

—Native American Project TRUST member

Traditional practitioners also supported the importance of community advisory processes in empowering Native youth and their families and communities to solve their own problems and achieve positive mental health. As one traditional practitioner said:

It's important to remind individuals and communities of their ability and insight to overcome this.

This statement reinforces the important point that tribal communities have inherent strengths that give them the ability to overcome and address their issues.

Clearly, communities are an essential component of the healing process. However, we also know that existing behavioral health care systems that serve Native youth, families, and communities, have the potential to be helpful, if they can provide services in culturally appropriate ways that support traditional beliefs, teachings, and practices. The next section of the report examines the concept of cultural “competency” and other concepts related to culturally appropriate care.
IV. “Cultural Competency” and Related Concepts

The integration of western and traditional Native American approaches to mental health care and healing results is a challenge to western behavioral health systems in their attempts to provide culturally “competent” care. This is in part because of the history of forced colonization of Native people, which has led western behavioral health care systems to ignore traditional healing practices and approaches to mental health care and healing for Native Americans. Therefore, achieving culturally appropriate care for Native youth requires an ongoing examination of general concepts of cultural competency, as well as specific focus on traditional practices and beliefs.

The traditional practitioners who guided us continually reinforced these ideas. For instance, one practitioner focused on traditional teachings and behaviors that may even be taken for granted. He said:

It's important to emphasize the psychological benefits of traditional indigenous practices. Even eating together is a form of Ke' [Diné concept of sacredness of all relations which forms the foundation of Diné culture].

Other Diné traditional practitioners reinforced this idea in their discussion of Ke’. As one explained:

Ke’ is holistic healing and how we come together and acknowledge each other. And if you have that, you can understand that you’re home. Ke’ creates other people who are willing to share. The point is how we are connected to each other and to youth and how they are related to everything in the world. With the Ke’ system, you can express a lot; that’s where the psychological benefit comes about, the powerful positive impact on you. And there is great psychological benefit in knowing you
are related and connected to people in the world. It minimizes distance and brings people together.

Community members also mentioned cultural knowledge, values, customs, and traditions as important. Youth and parents emphasized that Native and non-Native providers need to understand Native cultures and Native youth cultures in order to work effectively with Native clients. There is power in Native American cultural teachings and one’s relationship with the world. One adult explained how powerful this was in her own life:

I was an alcoholic before. This provider used to really get down on me strongly about the four directions and traditional practice. 'lina is something in you. You need to take care of your body, what you eat, what you put in it. lina is life. Do you want to live long or end your life with alcohol and drugs? Think about yourself in a positive way, not a negative way.' A medicine man and counselor taught me that. This is my 15th year I haven’t done alcohol. I still go out with my friends but I’m the designated driver.

Many of the providers we surveyed also highlighted the importance of culturally appropriate care and integrating western and traditional practices:

[Providers need to] understand the cultural context and know the limitations of western practices.

—Anglo Provider

Culture includes traditions, language, stories, spiritual worldviews, communication styles, food, family and relative configurations among many other things.

—Anglo Provider

Learn from long time providers, particularly Navajo staff.

—Anglo Provider
Stand back and learn before jumping in and thinking you’re going to make quick changes without understanding the culture.

—Native American/Anglo Provider

[We need to offer] services that mold to the client and are not cookie cutter approaches, services that allow for cultural inclusion.

—Anglo Provider

There was agreement that cultural competency/appropriateness was important. The next essential question is: What does cultural competency mean? Is cultural competency even the correct term for what traditional practitioners, community members, and service providers describe? Wallerstein and Duran offer an alternate concept: cultural humility, which is different than cultural competence (Wallerstein & Duran, 2006). They suggest that although cultural competency may be unattainable, cultural humility is achievable. They cite (Tervalon & Murray-Garcia, 1998), who explain that cultural humility is “a lifelong commitment to self-evaluation and self-critique’ to redress power imbalances” (Wallerstein & Duran, 2006). This is important, particularly for non-Native providers and researchers who work with Native youth.

However, given that there is much less written about cultural humility, it is also important to explore the concept of cultural competency. The U.S. Department of Health and Human Services defines cultural competence as:

Attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations.

There are several standard components of cultural competency discussed in the literature: organizational cultural competence (e.g., leadership understanding and commitment, institutional policies, practices, and systems, cultural competence committee focused on diversity and cultural awareness, system wide standards/competent policies, and dissemination of best practices); consumer inclusion (e.g.,
patients/consumers/community actively participate in definition of their culture and culturally competent practices; community collaborative partnerships; inclusion of family member perspectives in mental health treatment plans and treatment objectives; linguistic competence (e.g., organizational language assistant services, bilingual/bicultural or multilingual/multicultural staff); diversity training (e.g., ongoing cultural and linguistic appropriate service deliveries, education increasing in academe, dismantling racism and stereotyping, communication models), assessment and evaluation (e.g., individual assessment of attitudes, beliefs, and opinions, organizational assessment on policies and standards, focus on lessons learned, and implementation of grievance resolution processes to resolve cross-cultural conflicts), and staffing (e.g., most people agree that it is important to have a staff that is reflective of the diversity of your clients, although this does not mean that a Native client must see a Native provider).

Another important resource on cultural competency is the California Institute for Mental Health Center for Multicultural Development. They conducted the Seven County Study, which worked to conceptualize cultural competence at the policy, organizational, and clinical levels, identify best practices including ethnic-specific clinics, highlight challenges and barriers to cultural competence, and present strategies to overcome the barriers. They present eight dimensions of what they call culturally-sensitive treatments, which are: language, persons of intervention, metaphors of intervention, content, concepts, goals of treatment, methods, and context. They then evaluate evidence-based practices on these domains (see their website for complete definitions and details). They also make the important point that cultural competence is really a set of values that is communicated and structured through policies. (See www.cimh.org/projects/Eliminating_Disparities.cfm).

Beyond these general guidelines, there is some literature that explores cultural competency as it specifically relates to Native Americans. For instance, Weaver suggests that cultural competence for clinicians working with Native Americans includes: being knowledgeable about a client’s cultural context, history, and worldview; having awareness of one’s own personal assumptions and biases; and
using culturally appropriate intervention strategies (Weaver, 1997). In terms of cultural competency in therapy, many psychologists have recognized that historical racism may have negative impacts on Native clients’ trust in therapeutic relationships with non-Natives, which is problematic because trust forms the foundation of effective therapy (Belcourt-Dittloff & Stewart, 2000).

Gone discusses mental health cultural competency that reaches beyond the superficial level. Rather than focus on matching therapist and client by race, gender, class, or adjusting the communication and interaction style, and being aware of level of acculturation of client, Gone questions the underlying assumptions of western therapy (e.g., that talk is the most important means for improving emotional/psychological health, that secular professionals are the best people to seek help from, that specialized help for behavioral health issues should be separate from other types of help, that intrapsychic exploration is beneficial). He questions whether psychotherapy is an appropriate method at all for Native people. However, as a Native mental health provider, he suggests four principles for avoiding what he calls “cultural proselytization”: 1) provider’s awareness of their own culture and how it impacts their professional practice; 2) understanding clients’ cultural contexts and perspectives; 3) work collaboratively with traditional healers and other community members; and 4) assess process and outcome of therapeutic efforts both in terms of positive and unintended negative outcomes or difficulties in process (Gone, 2004).

The issue of cultural competency beyond the superficial level is a concern raised by many Project TRUST partners:

We also kind of were realizing, for a long time that even when people would talk about culturally appropriate care, it’s like, the whole piece that was missing there was just like no context around historical trauma or institutional racism. For instance, on the [large behavioral health service provider for Native Americans] website, they talk about not looking people in the eye, or not having a very strong handshake. It’s this really stereotyping…superficial kinds of things that, even when people
have orientations in their work, that’s what it is. It’s more superficial. It
doesn’t really get to the context of historical and generational trauma
and institutional racism.

—Native American Project TRUST member

They just need to understand that we are of one culture, but we’re all
very different and we have diverse practices, and they just need to be
respectful of that. Maybe that’s something that I’d like to see incorporated
in providers’ training. You know, getting into the universities, and having
them offer classes to their students on intergenerational trauma,
multigenerational trauma and how does that impact health disparities
and how can you become a better provider if you understand that in any
community.

—Native American Project TRUST member

LaFromboise also discusses the lack of compatibility between western
therapeutic approaches and Native Americans. She mentions several conflicting
values, most importantly that western therapy is too individually-focused and
that it de-legitimizes traditional healers and practices. However, she recognizes
that many Native Americans tend to combine western and traditional healing
approaches (LaFromboise, 1988).

In Canada, the Canadian Institutes of Health Research (comparable to the
National Institutes of Health in the U.S.) has an entire Institute of Aboriginal
Peoples’ Health. They recently published comprehensive guidelines, called CIHR
Guidelines for Health Research Involving Aboriginal People (Canadian Institutes of
Health Research, 2007), which outlines 15 Articles that address issues of cultural
competence and ethics, including: sacred space and traditional knowledge,
community control and approval, participatory research, community and
individual consent, confidentiality and privacy, protection of cultural knowledge,
intellectual property rights, benefit sharing, empowerment and research
capacity development, cultural protocol, language and communication, initial and
secondary use of data, and interpretation and dissemination of results).
Another aspect of cultural competency for Native youth involves general strategies for engaging youth. The National Child Traumatic Stress Network has numerous suggestions for engaging youth in substance abuse treatment:

- To identify and encourage youth to seek help, offer multiple types of assistance (e.g., employment, relationships, family) rather than focusing only on mental health, emotional issues, or substance abuse. Be a resource for multiple problems.
- Consider trying to identify youth through broad-based school screening programs.
- Clinicians should: make reminder calls, be especially welcoming at first session, use their cultural knowledge to establish trust (culture includes not only racial/ethnic group, but also sexual orientation, homelessness, disability, socioeconomic status), devote time to intensive outreach (get contact information from youth and several others involved with their care, and make follow-up calls to emphasize to youth that you care and want to see them again).
- Slesnick, Meyers, Meade, & Segelken (2000) discuss strategies for engaging substance-abusing homeless adolescents that are useful in general:
  - meet youth “at their level”, show you understand their language and culture, present treatment in a non-threatening, appealing manner
  - don’t ask too many personal questions at first
  - don’t blame the adolescent but instead reframe current situations in terms of relational or situational factors
  - convey a sense of hope that change is possible,
  - respect youth’s concerns, especially around confidentiality

1 We would suggest this packet for clinicians (www.nctsn.org).
• attend to practical barriers to treatment, including transportation, scheduling, child care, and caregivers’ treatment needs.

• get families involved – we know that adolescents whose caregivers are involved with treatment with have better outcomes (Dakof, Tejeda, & Liddle, 2001)

• try to encourage family motivation by finding out what changes they would like to see

• validate parents past and current efforts to help their adolescent

• acknowledge parental stress, provide support and guidance for parents, as well as education about mental health issues

• be aware of complex family dynamics and who in their life will be able to best support and encourage them to stick with treatment

- Adolescents and their families need to feel that the clinician is an ally – need to have common goals and believe that the treatment will help

- Clinician needs to establish rapport, set clear boundaries, find out what the adolescent wants to talk about, foster autonomy by trying to offer them guidance in solving their problems as they want to

- Use assessment instruments that aren’t face-to-face (youth will disclose more and not feel as threatened when completing self-report measures)

- Discuss limits of confidentiality and adhere to what you promise

- Leave the door open if a youth wants to terminate treatment
Many Project TRUST partners identified an additional challenge related to culturally appropriate care, which involves the very wide spectrum of beliefs among Native people, ranging from people who speak their Native language and follow traditional spiritual practices and values, to others who have a Native cultural identity but are Christian, to those who are fully immersed in the dominant culture and do not speak their native language or practice traditional religion. Project TRUST partners wondered how we can ask all providers, Native and non-Native, to be culturally competent when historical trauma has created such a diversity of beliefs. We concluded that the key to working effectively with this diversity of beliefs involves alerting providers to this spectrum (and its causes), maintaining cultural humility, and engaging in genuine listening. For instance, a provider working with a Native youth may not understand how multigenerational trauma has influenced this youth’s self-identification within his world and how this youth is feeling in this context. Listening, maintaining cultural humility and recognizing historical trauma is the first step to properly engaging this youth on a path to wellness.

One of the resulting complexities is how to recognize when someone has self-insight and is choosing a particular path versus when internalized oppression may be impacting the person’s identity. As one traditional practitioner explained:

“We have learned to function effectively in western processes such as hierarchy, but it’s not necessarily culturally appropriate. What has been used to oppress us, we don’t want to perpetuate on our people.”

It is not necessarily appropriate for non-Native providers to question this, instead maintain cultural humility and remember the effects of historical trauma. A Native provider and/or traditional healer, on the other hand, might be able to assist a Native youth with this issue, if they have an understanding of the impacts of historical trauma, such as internalized oppression.

Finally, Project TRUST partners also emphasized that cultural competence for any providers who work with Native populations must include an integration
of spirituality (or at least recognition of its centrality) in treatment. Although the dominant culture in the U.S. frequently values the separation of religion or spirituality from government-funded services and western medicine, this typically is the opposite with Native populations where spiritual practices are fully integrated with tribal funded services and treatment modalities. For example, Native providers maintain the importance of approaching Native youth holistically. Many providers are reconceptualizing what it means to heal and are realizing that healing requires a spiritual component.
V. Native American Adolescent Mental Health

Native American youth face appalling socio-economic and health disparities and discriminatory practices or challenges, as well as the pressures of balancing contradictory western and traditional cultures. Research suggests that the most resilient Native youth are those who are culturally and spiritually grounded. For instance, several researchers have found that higher enculturation (the degree to which individuals are embedded within their own culture) can act as a protective factor against negative mental health outcomes and substance abuse in Native American populations (Gray & Nye, 2001; Spicer, Novins, Mitchell, & Beals, 2003). Whitbeck found that enculturation is related to less alcohol abuse among Native American adults; more pro-social behavior among Native American adolescents; and enculturation can buffer the effects of depressive symptoms among Native American adults (L.B. Whitbeck, Hoyt, McMorris, Chen, & Stubben, 2001; L.B. Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002; L. G. Whitbeck, X. Chen, D. R. Hoyt, & G. W. Adams, 2004). In research related specifically to youth, Yoder and colleagues found that Native American youth (ages 9-16) who have higher levels of involvement and identification with their Native American culture are less likely to have suicidal thoughts (Yoder, Whitbeck, Hoyt, & LaFromboise, 2006).

Rieckmann, Wadsworth and Deyhle (Rieckmann, Wadsworth, & Deyhle, 2004) found that Diné cultural identity is a protective factor against depression among Diné adolescents ages 14-20, through its relationship with positive explanatory style (which has to do with attributions about what causes stressful events and dimensions of control, salience, predictability, novelty, duration, and causality). At the tribal level, Chandler and Lalonde found that Canadian First Nation tribes with higher cultural continuity (e.g., presence of cultural facilities, self-government) had significantly lower rates of suicide among their youth (Chandler & Lalonde, in press).

Use of traditional health practices among American Indians (e.g., indigenous herbs, sweat lodges) and traditional spiritual orientations have also been linked
to positive health outcomes (Buchwald, Beals, & Manson, 2000; Garrouette et al., 2003; Marbella, Harris, Diehr, Ignace, & Ignace, 1998). For instance, Garrouette et al. (2003) found that commitment to cultural spiritual orientation was significantly related to decreases in attempted suicide among 1456 American Indians ages 15-57. Walters and Simoni developed an empirically-based indigenist model of trauma, coping, and health outcomes for American Indians that suggests that historical trauma, discrimination, and traumatic life events are stressors that impact substance abuse, PTSD, and depression, but which are mediated by cultural buffers that include enculturation, traditional health practices, identity, and spiritual coping (Walters & Simoni, 2002).

Montgomery and colleagues interviewed 14 American Indian college students and found that success in higher education settings was facilitated by integrating traditional ways of life and beliefs into their academic experiences (Montgomery, Miville, Winterowd, Jefferies, & Baysden, 2000). One recent study suggests that among 980 Native American adults, older adults, women, and married adults who participated in traditional activities and traditional spirituality were more likely to cease their use of alcohol (Stone, 2006). Finally, bicultural competence, which is the ability to alternate between one’s own ethnic identity and White identity, depending on the demands of the context, has also been shown to be a protective factor (LaFromboise, Coleman, & Gerton, 1993).

Traditional practitioners also emphasize the importance of being connected to cultural traditions and teachers. One of the practitioners who provided us with guidance explains:

I think that people who have the most problems are those who are not grounded in any way of being or tradition. That’s why we lose so many young people. Substance abuse is a consequence of acculturation and assimilation.

One of the most comprehensive examinations of resiliency among Native American youth is Goodluck’s report Native American Children and Youth Well-
Being Indicators: A Strengths Perspective (Goodluck, 2002). First, she critiques the problem-solving model of treatment, which “looks for problems first and foremost” (p. 8). In this model, a professional is viewed as “the expert” and the client is seen as the person who needs help. The focus of this model is on identifying the problem, assessing how to solve it, looking for solutions, and evaluating interventions to solve it. Instead, she suggests a strengths perspective, which is quite different because the emphasis is on understanding an individual's story in his or her own language. The helping professional is seen as a facilitator who helps the client identify a vision for their life, as well as their strengths and goals. From Goodluck’s research, she identified 10 areas of Native American strengths:

- importance of spirituality
- power of the group
- relevance of identity
- political relationships
- “our voice” [language and stories]
- environment
- the next generation
- values
- education
- methods of survival

From these themes of strength, Goodluck identified three domains of Native American well-being indicators (helping each other, group belonging, and spiritual belief system and practices), and behaviors within each domain.

Another resource that focuses on positive is The Context and Meaning of Family Strengthening in Indian America (Besaw et al., 2004). They present several case studies in effective family strengthening, including wellness centers, community
centers, and schools. They also developed a useful ecological model (p. 14) that takes into account the multiple layers of context that impact American Indian youth as they grow and develop and also highlights the interconnectedness of the individual, family, community, tribal, and larger societal levels. In addition, they discuss many of the important contexts in depth, including the importance of self-determination at the personal, collective, and political levels, challenges in developing institutional capacity among many tribes, different definitions of family in American Indian tribes, and the important roles of spirituality, land, and place. They also discuss important components of effective family strengthening practices:

- they are self-determined
- have buy-in from tribal communities and formal leadership
- they are institutionalized with formal structures
- they are spiritual at their core
- they explicitly build on and strengthen traditional cultural practices
- they focus simultaneously on individuals and the community
- they explicitly strengthen children’s and family’s social networks
- they purposively invest in the professional and educational skills of their staff

Unfortunately, the policy makers of federal and state government systems do not often understand the importance of funding programs that include these practices. This is unconscionable given that Native American youth experience numerous behavioral health disparities related to suicide, mental health disorders, substance abuse, and violence exposure. For instance, Native American youth have the highest rate of suicide among 15 to 24 year-olds (Health United States, 2004). Furthermore, suicide has been the second leading cause of death for Native American youth ages 15 to 24 for the past 20 years – current rate is
34 per 100,000 (compared to 11 per 100,000 for general U.S. population). Of people in Native American communities who commit suicide, more than half have never been seen by a mental health professional (American Academy of Child and Adolescent Psychiatry, 2006). Among American Indian high school students in New Mexico, 26% report having made a suicide plan, and 21% report having attempted suicide in the previous year (2005 YRRS). In a study of 736 American Indian youth ages 10-12, Whitbeck and colleagues found that 23% met the criteria for at least one mental disorder, which suggests not only a current disparity but also a risk for subsequent disparities in terms of predicting later substance use and mental health problems (L.B. Whitbeck, Hoyt, Johnson, & Chen, 2006).

Over many years and across different American Indian populations, Beauvais has found that American Indian youth are more likely to have substance abuse risks than non-American Indian youth, including starting to drink at a younger age, drinking more heavily, using drugs in combination with alcohol, and experiencing negative consequences of using substances (Beauvais, 1992, 1996). American Indian youth are also more likely to meet the criteria for alcohol abuse/dependence and to have co-morbid alcohol use and psychiatric disorders (Beals, Novins, Mitchell, Shore, & Manson, 2002; Beals et al., 1997). Alcoholism death rates for Native American youth ages 15 to 24 are 3.7 deaths per 100,000 (compared to 0.3 per 100,000 for overall U.S. population) (American Academy of Child and Adolescent Psychiatry, 2006).

Another area of disparity involves trauma exposure and trauma-related symptoms. High rates of traumatic loss and trauma exposure, linked to oppression, racism, low socioeconomic status, and elevated mortality rates, have been found among Native American youth (Jones, Dauphinais, Sack, & Somervell, 1997; Manson et al., 1996; Robin, Chester, & Goldman, 1996). Jones and colleagues (Jones et al., 1997) found that 61% of the 109 American Indian youth in their study had experienced at least one traumatic event, and that exposure to and experiences of trauma among American Indian youth were related to increased behavioral disorders and substance abuse and dependence. In a community-based
sample of 618 American Indian adolescents ages 15–24, 57% had experienced at least one traumatic event during their lives, and 12% of those traumatized met the criteria for PTSD\(^2\) (Gnanadesikan, Novins, & Beals, 2005).

Unfortunately, the high rates of trauma experienced by Native American youth have been linked to negative substance use outcomes. Kilpatrick and colleagues found that experiencing violence (physical or sexual abuse or assault) increased alcohol, marijuana, and hard drug abuse/dependence by a factor of two and witnessing violence tripled the risk of all substance use disorders. Furthermore, when controlling for victimization and other variables, Native American youth ages 12–17 had similar substance use risks as Caucasian youth, which suggests that violence victimization and other disadvantaging factors play large role in high rates of substance use disorders (Kilpatrick et al., 2000). Among 89 American Indian youth ages 13–18 in a residential substance abuse treatment program, the research found higher than average rates of suicide, drug and alcohol problems, physical abuse, depressive symptoms, and alienation. The youth had experienced an average of 4.1 lifetime traumas; the most common ones were threat of violence and witnessing violence (Deters, Novins, Fickenscher, & Beals, 2006).

Other research on substance abuse among Native American youth demonstrates the complexity and severity of this issue. For example, in a study of 89 American Indian adolescents in a tribally operated residential substance abuse treatment program, researchers found that youth used multiple substances (mean of 5.26) and that 82% had co-morbid psychiatric disorders (most common conduct disorder) (Novins, Fickenscher, & Manson, 2006). There is also research that examines specific trajectories of substance use for American Indian adolescents (Novins & Baron, 2004). They found that risk peaked at age 18, and also that substance use varied by community and season of the year. This variance suggests that policy and practice changes that target youths’ environments and communities could have positive impacts on decreasing substance abuse.

\(^2\) Several researchers have noted that there may be cultural biases in the PTSD criteria and that the notion of PTSD may not adequately represent the full impact of the pervasive multigenerational community trauma experienced by American Indian populations (Jones et al., 1997; Manson et al., 1996; Robin et al., 1996).
There is very limited research on lesbian, gay, bisexual, and two-spirit Native youth. However, a study of Native American adults who were lesbian, gay, bisexual, and two-spirit found higher rates of childhood physical abuse, more historical trauma in their families, higher levels of psychological symptoms, and more mental health service utilization (Balsam, Huang, Fieland, Simoni, & Walters, 2004).

Native American youth are also impacted by the mental health of their caregivers. For instance, a recent study of mental health disorder prevalence rates among 861 Native caregivers of children ages 10-12 from a Northern Midwest tribe in U.S. and Canada (ages 17-77) found that 74.6% met life time criteria for one of five disorders studies (alcohol abuse, alcohol dependence, drug abuse, major depressive episode, generalized anxiety disorder). Adult female caretakers were almost five times more likely to meet lifetime criteria for alcohol use than general population. Whitbeck and colleagues also found a relationship between female parent/guardian depression and the alcohol use and mental disorders of their children. Parent practices is thought to be one mediating factor in this (L.B. Whitbeck et al., 2006). Another recent study found that exposure to substance use through parents is significantly related to substance use among American Indian adolescent girls (Kulis, Okamoto, Rayle, & Sen, 2006).

Finally, it is important to note that in addition to the disproportionate burden of mental health problems experienced by Native American youth, there is a lack of epidemiology and surveillance (U.S. Public Health Service Office of the Surgeon General, 2001). Even when these data are collected, they are often not sufficiently analyzed or reported, citing the size of the population as rationale. While the term "statistically insignificant" may seem relevant to epidemiologists, it feels dismissive and like an excuse to many. This is critical because it perpetuates the disparities by allowing them to remain "invisible" to funders, policy-makers, and the population as a whole.

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3 There are some recent notable exceptions to the paucity of rigorous epidemiological research with Native American populations, including the American Indian Services Utilization and Psychiatric Epidemiology Risk and Protective Factors Project (see [http://aianp.uchsc.edu/hcaiannhr/research/superfp.htm](http://aianp.uchsc.edu/hcaiannhr/research/superfp.htm)).
VI. Context: Historical Trauma & Institutional Racism

When examining these mental health challenges faced by Native youth, it is important to understand the context from which these disparities have emerged, namely historical trauma and institutional racism. Many researchers have emphasized that understanding Native people’s history and the trauma that it has resulted in is essential to healing for Native people (B. Duran, E. Duran, & M. Y. H. Brave Heart, 1998). There are numerous terms that have been used to explain this legacy of suffering. These include: colonial trauma, multigenerational trauma, intergenerational trauma, collective trauma, cumulative psychic wounding, unresolved trauma, and effects of historical racism. Duran and Duran also use the term soul wound. This term is used because many Native people conceptualize the effects of colonization as a spiritual injury (E. Duran & Duran, 1995).


Brave Heart first theoretically attributed PTSD symptoms and unresolved grief and depression to historical trauma. Symptoms identified for Lakota historical trauma response, Jewish Holocaust survivor syndrome, and survivor’s child complex include: anxiety; intrusive trauma imagery; depression; survivor guilt; higher mortality rates from cardiovascular disease, suicide, and other violent death; identification with ancestral pain and deceased ancestors; psychic numbing and poor affect tolerance; and unresolved grief (Brave Heart, 1998). In subsequent work, Brave Heart suggests that historical trauma theory is more
inclusive and relevant to American Indians than PTSD, which doesn’t capture enduring widespread, intergenerational components of historical trauma (Brave Heart, 2003).

Historical trauma may be transmitted across generations, both psychologically through processes of transposition and identification with ancestors’ past suffering, and possibly biologically (van der Kolk, 1994). Whitbeck and colleagues operationalized historical trauma in a scale of historical loss and documented its impact on the mental health and substance use, and symptoms of anger, avoidance, and depression among American Indians (L. B. Whitbeck, G.W. Adams et al., 2004; L. B. Whitbeck, X. Chen et al., 2004). Another related term that many people use to discuss the intergenerational transmission of trauma is internalized oppression, through which American Indians may replicate dominant power structures within their families (Poupart, 2003).

More recently, researchers have explored the multiple ways in which to conceptualize historical trauma and its impact on mental health. Walters and Chae (2007) discuss historical trauma as:

- An etiological or causal factor (e.g., historically traumatic events that may lead to negative outcomes)
- An outcome (e.g., historical trauma response, as outlined by Brave Heart, 1998)
- A mechanism or pathway (e.g., storytelling in families)
- A factor that interacts with proximal (current) stressors (e.g., historical trauma loss – which measures the prevalence and immediacy of thoughts pertaining to historical loss, see Whitbeck, Chen, et al., 2004).

For an in-depth discussion of the recent research on historical trauma and its impacts on American Indian/Alaska Native individuals, families, and communities, see Evans-Campbell (2008).
What is sometimes obscured in academic discussions about the conceptualization of historical trauma, is its relationship to past and current institutional racism, unique to each tribal community, including purposeful and manipulative federal policies that legitimized genocide, terminated tribal identity, loss of land or resources, forced relocation and assimilation, cultural destruction, forced removal of children, and livestock reduction. It is because of these events that historical trauma is also referred to as colonial trauma. The United States government’s policies included an explicit policy of cultural genocide and termination of cultural identity, with the objective of destroying the traditional beliefs and practices of Native peoples in order to assimilate them into western society and to take their resources and land for their own gain. These racist and genocidal actions and policies against Native Americans have resulted in substantial historical trauma. There are also present structural inequalities that continue to be perpetuated by current racist policies and practices, in the areas of education and health for Native youth.

Funding disparities for Native communities are a glaring present-day example of such inequalities. There is no doubt that funding disparities are one indication of a long history of broken promises that impact the ability of tribes and systems that serve Native American youth to address health disparities for Native youth. For instance, per capita funding for Native American health care (through the Indian Health Service) is 60% less than is spent on the average American. Furthermore, the U.S. government spends less per capita on health care for Native Americans than it does on Medicaid recipients, prisoners, veterans, or military personnel (U.S. Commission on Civil Rights, 2003). In addition, funding for behavioral health care through Indian Health Service (IHS) is less than $30 per year spent per person served by the system, including hospitalization (MacArthur Foundation Mental Health Policy Research Network, 2008). These facts do not help Native Americans believe or find hope in their current systems of care, because it highlights to Native individuals, families, and communities that they are at the “bottom of the list” for health care funding, yet suffer the most horrible health disparities in the country.
Most Americans are not aware that one of the conditions of the treaties the United States government signed with some Native American tribes was the provision of healthcare to all of their descendants. The emotion stirred by the lack of regard for treaty rights is another stream that feeds into historical trauma for many Native Americans.

A related issue involves other forms of current discrimination, such as microaggressions, which Walter and Chae (2007) define as ongoing and current trauma that involves appropriation of traditional and cultural practices by non-Natives, romanticization and eroticization of American Indian men and women, invisibility, and religious defamation. Some examples they give include: being asked if you are a “real Indian” by a non-Native person, hearing discussions by persons in authority about Indians as if they no longer exist, being told by non-Natives that they felt a spiritual connection to Indian people. Research has linked current discrimination to depressive symptoms among American Indian adults and to internalizing and externalizing symptoms and substance use among American Indian adolescents (L.B. Whitbeck et al., 2001; L.B. Whitbeck et al., 2002).

Thus, American Indian youth live in a multi-layered, multi-jurisdictional world and face multiple stressors or traumas, including historical trauma, poverty, current institutional racism, microaggressions, traumatic life events (witnessing or experiencing violence), and physical and sexual abuse or assaults. Some researchers have worked to explicate the specific mechanisms through which historical trauma is transmitted across generations. For instance, Stone (n.d.) provides a comprehensive discussion of historical traumas (dispossession, biological warfare, disruption of culture, Indian wars, boarding schools, termination, relocation, gangs and drugs), and how he believes they have negatively impacted parenting practices within American Indian communities, which in turn has negatively impacted the neurodevelopment of American Indian children.

One of the important concepts Stone introduces is “compromised behavioral immunity.” He explains that children who have had inadequate caregivers during
their early development are often less resilient as adults. Thus, these children have compromised behavioral immunity and may be more likely to develop psychiatric symptoms from traumas they experience as adults, such as war or sexual assault. Stone links inadequate parenting practices to the past 500 years of colonization of Native people. For instance, many Native children were forcibly sent to boarding schools, where they were treated very harshly. Not only were these children deprived of time and parenting from their families (and thus did not learn traditional parenting techniques), but also they were exposed to and learned punitive practices and abuses. In turn, these children become adults and may not be able to be supportive caregivers to their own children, which can lead to compromised behavioral immunity in the next generation. Taken together, Stone clearly illustrates the ongoing cycles of intergenerational postcolonial stress. At present, we are living in a post boarding school era of parents who lack parenting skills to address the many stressors Native youth experience today. Further, in many Native communities, the extended family mentoring and support systems have been affected and/or obliterated.

Historical trauma has also had a significant impact on the physical health of Native Americans because it has contributed to the development of unhealthy coping mechanisms (e.g., smoking, drinking, eating unhealthy food) and social/community norms that sanction these lifestyles. These behaviors were not a part of traditional Native cultures, but have been normalized in many communities as the result of western influence and stress. The result is increasing health disparities around diabetes, cancer, cardiovascular disease, and other health conditions for Native Americans.

Historical trauma was also frequently discussed in our community advisory meetings and provider surveys. Most participants seemed to understand historical trauma and its impact on the mental health and well-being of Native youth, particularly parents and youth and some providers:

When I talk to the elders, the elders are so used to being abused. I don’t think our people used to be like that. They used to be proud,
riding horses. But then there was the Long Walk and our people were imprisoned. They did anything they could to get back, then there was livestock reduction, then kids taken away. Where they are now, they are beaten, they don’t think they deserve to be treated with dignity. And I find myself falling into that trap. My dad drank and beat my mom, then I married an alcoholic and was abused, and my children are falling into that. I see that it can be fixed by prayers — either western Christian or traditional. We can overcome it. I find myself yelling at my grandchildren because we were treated like that at boarding schools, “get in here, do this.” We can go back and fix it in our families. My sister and I didn’t know anything about raising families because look at the way we were treated in boarding schools.

—Adult Community Advisory Meeting Participant

When I talk to elderlies about the Long Walk and these things, they say it is true. We need forgiveness because otherwise there is so much hate and picking up the bottle.

—Adult Community Advisory Meeting Participant

For my daughter, she’s been through these programs so many times, they don’t help. My daughter feels they don’t care. She tells me that I don’t care, that I just care what other people think. You begin to wonder if it is your fault. I take the blame. I grew up in boarding school, I thought alcohol was fun. My home was not happy for my five kids. I saw that what we did as parents was the problem.

—Adult Community Advisory Meeting Participant

Even when your grandparents teach you all this Navajo-stuff---when you go through years of discrimination---you end up hating yourself for who you are.

—Youth Community Advisory Meeting Participant
This paradigm [historical trauma] is a powerful model for understanding behavioral health needs of a Native American community.

—Anglo provider

Generational trauma has an effect as the ‘older’ folks whom were affected use substances to self-medicate and youth see this trend.

—Native provider

The anger and mistrust has no place to go so it gets projected out to each other, especially the kids.

—Native provider

Ways of coping with loss has been substituted with alcohol, drugs, violence, depression, etc. These are witnessed and learned by children.

—Native provider

Eighteen of the 25 providers we surveyed said their knowledge about historical trauma affects their work with Native American youth and their families.

It is also important to acknowledge that for some Native people, talking about historical trauma is not culturally appropriate. As one Project TRUST member explained:

Traditional practitioners did that [traditional ceremonies to heal the trauma] back after the Long Walk when people crossed back in the boundaries of the Navajo Nation. And somehow it was taboo and forbidden, that we’re not supposed to go back or cross that line because that has been cleaned up already. So now that individuals have gone back, it’s on them to deal with it and clean it. My mother-in-law said you have to be careful how you approach this, because who is going to help you? Also she said to clean up before and after you so you don’t get stuck. I do believe there is historical trauma and I can feel these things as an individual and I can guide myself and my children through this process.
and know that it exists. But I don’t know if I can force this on other people.

The traditional practitioners we consulted with raised similar concerns:

It’s like a crystal, they don’t want it to be damaged or cracked again so they [traditional practitioners] are very cautious. And that crystal they didn’t make themselves, it was given to them by the Holy People. That’s why I said historical trauma has been taken care of, but then maybe there are more policies that are creating more trauma. You have to critically think about that. That’s what we are dealing with.

When historical trauma came up, a lot of wounds have been reopened and people have to go through processes again. But some traditional practitioners who deal with it are gone because people had specific ways to deal with it, so we’re kind of in a limbo right now. If you’re really educated in traditional ways, you can see that something is still there, and there is a process that we’re still going through as a Nation and a clan.

Another reason that people are often reluctant to address historical trauma is because of the mistrust that has resulted from 500 years of oppression. One of our traditional practitioners said:

As a Nation, a lot of promises have been made to the Natives but a lot of them never came through so we are resistant. Because if those things had been fulfilled, then yeah, but they haven’t been fulfilled.

A related barrier to raising the issue of historical trauma involves the protection of cultural pride. Accepting historical trauma means acknowledging the losses that have occurred due to historical trauma. In addition, historical trauma is inseparably connected to racism, which people often do not want to talk about and may believe cannot be changed.
Although these concerns are real, traditional practitioners and other Project TRUST members also believe that more healing needs to occur. There is a growing recognition that changes to cultural traditions and social norms, which have occurred because of historical trauma, have also resulted in the need for many communities and individuals to address historical trauma. This is also important because the trauma caused by oppressive governmental policies continues to occur. A traditional practitioner clarified this:

For Navajo, traumas are still happening. First, is what happened to us, then how are we going to deal with it? Then another trauma comes along. So do we do this or we don't? If we forget, what's going to happen?

We are very conscious that if historical trauma is raised, it must be done responsibly. Our traditional practitioner consultants also reinforced the seriousness of addressing historical trauma and the importance of having appropriate supports and healing in place:

In traditional ceremonies, you are always prepared for those who are going to be moved by prayers, songs, people, emotions, spiritual. So an individual may not know but when they enter a situation different aspects of their personality become vulnerable (spiritual, emotional, physical, mental). I think that's where you [Project TRUST] are at right now. Again, I think, not to say that there is a standard structure framework, but I think it would vary depending on individual and community. I think you would have to have three approaches that would give you a multi-dimensional grasp on what is going on so you are prepared for whatever outcome you may have, community-based. And depending on what background they are coming from, to have those things prepared for the individual.

A lot of people leave out how to deal with responses and healing. I am glad you [Project TRUST] are talking about it because that is critical. The challenge is how to work out how to deal with the anger, sadness and confusion, which are the three main responses that come out when
people begin to understand the things that happened from the past as a result of policies. I think when you prepare that way, then you have healing ready. That is a must. If we don’t do that, and we go out and talk about the policies, trigger people’s responses, and then leave, we create more harm.

While there is hesitancy to talk about historical trauma because of traditional cultural beliefs, our experience with communities has validated that it is important and provides healing for community members. As a Native American Project TRUST member stated:

We have found that it is a long process that begins with understanding, identification, and acceptance of historical trauma. First youth and younger parents relate to it and want to address it, while elders are reluctant. But once we talked about Ke’ and had that foundation, then elders said, well yes we did have these experiences and survived them. You can’t tell people; they have to develop understanding and then they can work to change things.

The same Project TRUST member continued:

We really have to take out the aspect of how we feel as individuals. If we deal with it at a micro-level, we have all these obstacles. But at a macro-level, if you work with a community and not have outsiders identify and define it, but have community members define historical trauma, decide if it exists, and build from there. Then ask them how their family deals with it and they start thinking about it. Then bring in a few more families. We can’t give a definition that is a western definition. That is shooting ourselves in the foot. We need to take a step back and think about how we address it. And of course traditional practitioners have to come together to approach it too.

Another Native American Project TRUST member added:
For me, I can feel on a day that something is not right and then I fix it right then. That is what we need to educate people on. We need to give the information so they can use it if they want to heal but it is up to them. That’s what I give my kids. That’s what I have been able to do is educate and that’s it.

Traditional practitioners agreed. As one explained:

Leave it to the community to identify [historical trauma] but bring our information to the process...emphasize overcoming trauma by using various Native strategies like stories, songs, cultural teachings, something familiar to the area, that the community can really relate to. Because once you have identified the trauma in a person, there are usually methods to bring the person back to a comfortable place.
VII. Culturally Appropriate Behavioral Health Treatments & Interventions

Given the behavioral health disparities experienced by Native youth, as well as the negative legacies of colonization and historical trauma, American Indian community members and the literature on American Indian mental health have identified a need for the development of culturally-based mental health interventions and the importance of recognizing American Indian history and intergenerational trauma in prevention and intervention strategies (Brave Heart, 2003; Manson et al., 1996; Robin et al., 1996). However, identifying what culturally appropriate care for Native American youth actually means, is challenging. This section begins with an exploration of the intervention and treatment approaches for Native American youth that have been documented in the research literature, followed by evaluation and examination of what may be missing.

First, it is important to note that studies documenting the efficaciousness of mental health treatments have been done almost entirely on White populations. There were no American Indians or Alaskan Natives among the 9266 participants in the efficacy studies used to develop the major treatment guidelines for bipolar disorder, schizophrenia, depression, and attention deficit/hyperactivity disorder, and only 7% of the participants were Black, Latino, or Asian American/Pacific Islander (U.S. Public Health Service Office of the Surgeon General, 2001). Miranda and colleagues were unable to find any studies evaluating outcomes of mental health care for American Indians, thus raising the question of whether it is appropriate to promote the use of evidence-based treatments in these populations (Miranda et al., 2005).

There are also critiques of the overemphasis on evidence-based practices more generally (e.g., see Kemm, 2006). What does “evidence-based practice” mean? There are several different definitions, but in general, the intervention must have shown positive effects in a randomized controlled trial (RCT), have a manual, and the positive effects must have been replicated in other studies. Kemm raises issues of the expectation of RCTs in public health interventions where the
community rather than the individual is the unit of intervention (Kemm, 2006). Another limitation of relying on RCTs is that the result is that most evidence comes from artificially controlled research, which does not address the realities of practice (Green, 2006). It is also important to note that promotion and implementation of evidence-based practices is another form of institutional racism because almost none have been developed with Native communities. This reality is clearly perceived by many Native American providers and community members, but is not often recognized by non-Native providers, researchers, funding sources, and policymakers. Furthermore, the practices developed by Native American providers that are often deemed non-“evidence-based” are often not funded by important policy makers.

A helpful review of evidence-based practices by Cruz and Spence (2005) attempts to broaden the discussion on evidence-based practices. They suggest that we consider four types of best practices: 1) science-validated programs evaluated using scientific methods, 2) science-replicated programs implemented more than one time, 3) cultural-validated programs designed according to the “Indian Way,” and 4) cultural-replicated Native American programs passed on to others (Cruz & Spence, 2005). They mention that SAMHSA lists two Native American programs as effective (American Indian Life Skills and Project Venture) and one as promising (Storytelling for Empowerment). They also mention Skills for Adolescence as a model program that was used in four Native American communities (including Gallup-McKinley School District).

Most mental health interventions for American Indian youth focus on substance abuse and suicide prevention (May, Serna, Hurt, & DeBruyn, 2005; Miranda et al., 2005). This research demonstrates that American Indian youth will participate in non-stigmatized group interventions. Group interventions are also important because individual interventions may pathologize American Indian individuals (Ryan, 1976) and fail to utilize resources and strengths in their communities (Rappaport, 1981), particularly natural support networks in collectively-oriented cultures. It is important that interventions consider the traumatic circumstances many American Indians have endured, while also focusing on their cultural
strengths and resources. Interventions for Native American youth that have demonstrated positive effects are summarized in Appendix D. For a description of behavioral health measures that have been developed for and/or tested with Native American youth, see Appendix E.

Although it was implemented with Native American adults, it is important to mention the ground-breaking interventions developed by Maria Yellow Horse Brave Heart. She developed and implemented two psycho-educational interventions to address historical trauma – one for 45 Lakota service providers and community leaders and one for 10 Lakota parents. The goals were to facilitate a sense of mastery and control in spite of oppression and historical trauma. The interventions included exposure to historical traumatic memories and opportunities for cognitive integration, small and large group processes to provide opportunities for verbalizing traumatic experiences, and the use of traditional Lakota ceremonies and culture. Outcomes of the first intervention included: increased participant awareness of traumatic Lakota history and grief associated with the trauma; cathartic relief from sharing their feelings in the group; reduction in symptoms of grief; increased positive identity as Lakota and commitment to healing; near elimination of feelings of helplessness and hopelessness; and large decreases in guilt, shame, sadness, and anger. The parenting intervention included components on Lakota child development and Lakota-centric parenting skills. Qualitative evaluation revealed that parents learned about the impact of historical trauma on parenting, were re-connected to Lakota culture and values, strengthened their extended kinship networks, and felt more empowered (Brave Heart, 1998, 1999b).

In terms of where youth seek help for behavioral health issues, research finds:

- In a study of 401 Southwestern American Indian youth, Stiffman and colleagues found that youth are least likely to receive mental health services from specialist providers and traditional healers. They did however receive help from informal adult family and
friends, peers, and non-specialist professionals (Stiffmann, Striley, Brown, Limb, & Ostmann, 2003).

Researchers who interviewed 865 American Indian parents/caregivers in the northern Midwest found that the adults strongly preferred traditional cultural services for mental health and substance abuse problems rather than formal behavioral health services (Walls, Johnson, Whitbeck, & Hoyt, 2006). Respondents also believed that traditional cultural and informal services were more effective. In order of effectiveness were: talking to a family member, talking to an elder, offering tobacco and praying, traditional healer, traditional ceremony, healing circle, sweat lodge, counselor on reservation, pipe ceremony, doctor on reservation, psychologist on reservation, IHS, doctor off reservation, psychiatrist on reservation, nurse on reservation...They also found that adults preferred formal services on the reservation to formal services off the reservation. The authors argue that this relates to both issues of trust and the appropriateness of western approaches for American Indian cultures.

Participants in our community advisory meetings and provider survey identified the following sources of behavioral health help for Native American youth in their communities (not in ranked order):

- Criminal Justice System (Police, Courts)
- Social Service System
- School Counselors
- Spiritual Healers (Traditional Practitioners, Pastors, Churches)
- Traditional Practices (Sweatlodge, Ceremonies)
- Families (Parents, Grandparents)
- Friends
Mutual Help Groups (e.g., AA)
Youth Programs (e.g., National Indian Youth Leadership Program)
Behavioral Health System (e.g., IHS, GIMC)
Substance Abuse Services (e.g., NCI)

Despite these important efforts, researchers and our community participants recognize that there is a great deal of work to be done in order to help Native youth heal and be healthy:

Both of them [service providers] have been in this area, are non-Native people who have made a lifelong commitment to serving Native youth and Native people in this area and yet, it’s like the light bulb went on for them that what they’re doing wasn’t really working, and yet at the same time what they wanted, what they asked us was, ‘OK, we get it. Now what are we supposed to do differently? How do we, how do we do it so it is different?’ And you know, we couldn’t answer the question really.

—Non-Native Project TRUST member

This trauma, this racism, it gets replicated in therapeutic contexts, interpersonally, without people really being aware of it. I think people with really good intentions replicate those relationships all the time.

—Non-Native Project TRUST member

Providers had suggestions for addressing these issues:

Do your own therapy first so you can help others heal.

—Native American Provider

We need behavioral health personnel who are familiar with living situations of patients, the local economy, and family structure.

—Anglo Provider
Introduce this [HT] into therapy; try to teach youth about this phenomenon in order to assist them in understanding the intensity and in-depth feelings. Also looking at family members with a deeper understanding of their struggles.

—Anglo Provider

I teach parents [about HT] in parenting groups and it shifts some of the blame away from themselves and offers hope for change for the next generation, lowers unrealistic expectations they may have on themselves. It gives a context for healing.

—Anglo/Hispanic Provider

Get the entire community invested.

—Native American Provider

Parents emphasized the importance of family involvement:

Become involved with your kids, positively. Let them know their/your expectations and boundaries. Share your knowledge with them.

—Adult Community Advisory Meeting Participant

Listen to others and elders and respect others.

—Adult Community Advisory Meeting Participant

Teach culture to youth to remind them that their life is important.

—Adult Community Advisory Meeting Participant

These insights from providers and family members are important to incorporate into efforts to develop culturally-appropriate care for Native youth.

Project TRUST members also identified a limitation of current prevention efforts with Native American youth. Based on our experience and review of current prevention programs, it seems that most prevention programs targeted towards
Native American youth focus on interpersonal skills development (e.g., refusal skills, anger management skills). While these are important, it is also essential to develop and implement prevention programs that emphasize positive youth development and civic engagement. These types of programs would prepare youth for policy advocacy and develop their competencies as citizens and leaders.

An example of this type of program is the New Mexico Alliance for School Based Health Care’s Policy program “4-Youth,” which recruits Native youth from four communities to participate in policy development for their School Based Health Center. The goal of this project as it pertains to the youth is to address the systems of laws, regulatory measures, courses of action and funding priorities for their respective communities. At present, New Mexico is one of nine states that are currently participating in the Kellogg SBHC policy project. The results of this project for the Native youth have been excellent. For example, in the Pueblo of Laguna, the youth advocated for Native youth peer-to-peer suicide prevention funding statewide during the New Mexico Legislative session in 2007 and were successful because they wanted to do something about the suicide rates in tribal communities (for more information, see www.nmasbhc.org).

Finally, Duran and Duran suggest that healing for Native Americans is difficult because the world community has not validated the trauma or offered “an escape route” (American Indians are still living with the oppressors). They assert that individual western therapeutic approaches can be harmful because they “incompletely…capture the truth of Native American tribal lives and pathology” (E. Duran & Duran, 1995), p. 69). They, and many other authors, recognize that it is important to integrate indigenous healing practices with western models of therapy. They recommend “hybrid therapy – community clinic model” where western-trained Native Americans work with Native healers. This should include education by the medicine people so that participants learn about what they are doing and can reconnect to traditional beliefs. Duran and Duran also recommend healing rituals for the entire community, like Brave Heart’s model. Remembering and mourning collectively is important for many reasons. For one, the perpetrators of violence make every effort to silence people’s stories,
discredit them, and prevent people from remembering. Thus, an important part of healing involves remembering, sharing stories, and creating community events such as memorial walks (Faimon, 2004).
VIII. Individual & Systemic Challenges to Behavioral Health Care

One of the important questions we are asking in Project TRUST is: Are services responsive to issues and needs identified by youth and their families? Researchers have asked this question also. Among 3,084 American Indians ages 15-54, the main obstacles to utilization of mental health and substance abuse treatment were self-reliance, privacy, quality of care, and communication and trust (B. Duran, Oetzel, J., Lucero, J., and Jiang Y., 2005). The American Indian Multisector Help Inquire study found that Native American youth receive mental health services from multiple informal providers, which makes coordination and continuity of care challenging. Geographical remoteness, poverty, and transportation are also barriers, as well as shortage of qualified treatment providers (American Academy of Child and Adolescent Psychiatry, 2006). For instance, there are only 101 western mental health professionals per 100,000 Native Americans, as compared to 173 per 100,000 white people in the United States (U.S. Commission on Civil Rights, 2004).

On the other hand, a recent study by Freedenthal and Stiffman found that 76% of American Indian adolescents who had thought about or attempted suicide sought help. More than one-third (38%) sought help from both formal and informal sources (e.g., mental health professional and family or friends). However, the 24% of youth who did not seek help when they were thinking about suicide, identified mostly internal reasons for not seeking help, including feeling they did not need help, wanting to avoid stigmatization, fearing the consequences of disclosure (e.g., being hospitalized), and feeling alone (Freedenthal & Stiffman, 2007).

These findings are supported by what our participants said. They identified the shortage of providers (including western mental health and substance abuse providers and traditional practitioners) as a key obstacle to care:
She [daughter] uses drugs so can only receive substance abuse services in the community, and we need a focus on mental health. We do not have a mental health clinician here – there is no one.

—Adult Community Advisory Meeting Participant

Once a provider identifies the need and then has no services to offer – very frustrating.

—Italian-American Provider

The hospital does not offer option of traditional healing ceremonies or sacred sanctuaries such as a Hogan or sweat lodges.

—Anglo Provider

Not enough programs on the reservation.

—Adult Community Advisory Meeting Participant

I see [behavioral health insurance] denying services to youth in rural areas due to lack of providers or previous treatment.

—Anglo Provider

In addition to the limited number of providers, many people felt that there was inadequate behavioral health training for school and health care providers, and not enough time allocated for services:

We need more time to counsel youth, address issues with them, and travel to where they are located.

—Native American/Anglo Provider

Participants also identified the overall lack of resources available for care as a major barrier:
Counseling is like a drop in the bucket to all the problems we're facing. There's no funding...Need more than 30 days to work with a person.

—Adult Community Advisory Meeting Participant

**Transportation** was another access issue frequently mentioned by providers and families:

No funds provided for travel back for patient or their families.

—Anglo Provider

Gas prices go up and attendance goes down.

—Anglo Provider

No transportation.

—Youth Community Advisory Meeting Participant

Issues of **communication and trust** were the most highlighted obstacles to care, including a lack of kid-friendly behavioral health providers. Participants talked about communication problems and lack of trust in several different ways. Some people expressed this in terms of feeling that providers do not care:

There are very few people in these resources that are truly there to help. When you get one who cares, it helps.

—Adult Community Advisory Meeting Participant

Providers just don’t care.

—Adult Community Advisory Meeting Participant

Youth expressed their lack of trust in providers very strongly:

Hard to imagine some will care. It is just their job, not sure if they really care.

—Youth Community Advisory Meeting Participant
They need to mind their own business.

—Youth Community Advisory Meeting Participant

I don’t like counselors, I call them shrinks. They make you feel like you’re the enemy.

—Youth Community Advisory Meeting Participant

They keep asking the same questions over and over, but in a different way---it’s like didn’t you hear me say I don’t want to talk about it?

—Youth Community Advisory Meeting Participant

Makes you uncomfortable, course, they think they know you.

—Youth Community Advisory Meeting Participant

It would probably help if they at least acted like they cared.

—Youth Community Advisory Meeting Participant

I want to be treated nice.

—Youth Community Advisory Meeting Participant

When you see a counselor, they look at the folder, like the folder is going to fix the problem. They need to get to know you. I would talk to a family member because I trust them, not a psychiatrist, I would feel uncomfortable.

—Youth Community Advisory Meeting Participant

Adults echoed the concerns of youth:

We need to be treated like human beings.

—Adult Community Advisory Meeting Participant
There needs to be more confidentiality, respect, and ask for private room when doing intake. And don’t judge.

—Adult Community Advisory Meeting Participant

Many providers were aware of the mistrust expressed by youth:

They [youth] do not feel important. They do not feel we have the time for them or we care about them and this again is due to lack of providers and resources. There is always more to do.

—Anglo Provider

They [youth] often wish connection with adults but wish to avoid difficult issues. It may have to do with lack of support at homes and they don’t want to leave the office with newly discovered pain.

—Anglo/Hispanic Provider

Huge trust issues that affect long-term therapeutic relationships.

—Anglo Provider

I don’t know. I only know that we have to address the toddler who tells provider, ‘fuck you’ and throws the finger.

—Native American Provider

Youth said that they would talk to and trust:

Someone who’s real, someone who doesn’t act all perfect, someone who’s been through the same thing as you.

—Youth Community Advisory Meeting Participant

For instance, several youth specifically named a young counselor in town who was in recovery himself as being someone that they would go to for help. This suggests that innovative peer to peer supports are needed in rural and frontier areas to meet the needs of these youth.
Other participants suggested that high rates of staff turnover made communication and trust difficult to develop:

I was comfortable but the counselor quit, and then I wasn’t comfortable in going to the Teen Center anymore.

—Youth Community Advisory Meeting Participant

People do contract work and have to meet someone else again. Have to always come back again. The more you know about us, the more we will tell and will trust, then we won’t shut up. Need to build relationship.

—Adult Community Advisory Meeting Participant

To be effective need to stay more than five years.

—Anglo Provider

Trust is also predicated on providers behaving in ways that are consistent with the help they give, including role modeling behavior of providers. For instance, several participants commented on the inconsistent words and actions exhibited by providers in their communities:

Staff need to be role models. I don’t think they should be at the bar the night before and then expected to counsel the youth the next day. That I see a lot of.

—Adult Community Advisory Meeting Participant

Counselors don’t walk their talk.

—Adult Community Advisory Meeting Participant

Another important concern related to trust that many participants raised was lack of privacy and confidentiality, which can make youth feel further stigmatized in their communities:
Another thing I hear mostly from young parents is that when they go to [large behavioral health provider for Native Americans], there’s no confidentiality. Everybody knows everybody in a small community. By the time you go to an appointment and go home, everyone knows you have a problem.

—Adult Community Advisory Meeting Participant

When you do get in services, they ask a lot of questions and parents don’t like to share, making it hard to go back.

—Adult Community Advisory Meeting Participant

They don’t want everybody to know what is going on.

—Youth Community Advisory Meeting Participant

Other participants, including both parents and providers, identified stigma and labeling as fundamental obstacles to care:

Fear of getting labeled and lack of trust going to these services.

—Adult Community Advisory Meeting Participant

Stigma.

—Many Providers

Finally, trust and communication are based on establishing connection and feelings of safety and acceptance. Some participants felt that this was more likely if Native providers were available:

The color of the provider. Navajo providers care the most.

—Adult Community Advisory Meeting Participant

Not enough Native American providers.

—Jamaican Provider
Several parents and providers also felt that youth are sometimes **obstacles to themselves**, either because they do not believe they have a problem, do not want help, or lack initiative:

I tried a lot of programs but my daughter didn’t complete them.

—Adult Community Advisory Meeting Participant

A lot of kids don’t know how to handle the help or don’t know they need it.

—Adult Community Advisory Meeting Participant

Those who are in greatest needs don’t come in or follow through with treatment.

—Anglo Provider

Youth not wanting services and don’t recognize the need for services.

—Native American Provider

Often parents and providers are unaware of the impact of historical trauma on the socializing of inappropriate family and community norms as protective factors. Harmful behaviors such as drinking alcohol, using drugs, cutting, and eating disorders can be used by an individual to numb their emotions and their physical self from the pain and hopelessness of uncontrollable social predicaments such as homelessness, joblessness, poverty, racism, and discrimination. The individual may feel that these behaviors are protecting him or her from engaging in even more dangerous choices like suicide and homicide. When a parent or provider tries to help a young person stop these inappropriate “protective” behaviors, it can feel very threatening and dangerous to the young person, and thus the result may be resistance or non-completion of treatment.

On the other hand, youth often identified **parents as obstacles**, and identified the need for parents to be listeners and helpers:
If our parents had been there for us, we’d probably know who we could trust.

—Youth Community Advisory Meeting Participant

Some parents and providers agreed:

It’s not working because we [parents] are the problem. We don’t talk with them. We don’t listen to them. We just judge them.

—Adult Community Advisory Meeting Participant

Parents aren’t willing to attend treatments with kids, so the kids go back to what they were doing.

—Adult Community Advisory Meeting Participant

Lack of parental involvement.

—Native American Provider

Unsupportive parents/family, global family dysfunction. So many youth mental health problems arise out of their dysfunctional home situations.

—Anglo Provider

Parents often blaming and don’t see their roles in child’s problems.

—Anglo/Hispanic Provider

Not surprisingly, both parents and youth identified family communication issues as obstacles to care:

A lot of elders can’t really communicate to their children and grandchildren anymore. When I talk to my grandchildren in Navajo, they say, ‘What did you say?’

—Adult Community Advisory Meeting Participant
Young people don’t listen.

—Adult Community Advisory Meeting Participant

Older people don’t talk to us, they just get after us.

—Youth Community Advisory Meeting Participant

These communication concerns are also related to the loss of traditional values identified by many participants:

I think people are too busy and things are moving too fast. When we lived in the Hogan, we all had our chores and we knew what to do. We all felt safe and we knew our mom and dad and brothers were there. But now we live in houses and we’re separate and we don’t eat together. Lack of communication. When you start talking about things like this, they tell you, ‘oh that’s old stuff.’

—Adult Community Advisory Meeting Participant

In addition to loss of traditional values, some Native providers identified mainstream pressures as barriers to care. One provider discussed pervasive media influences, such as television, video games, and cell phones. She said:

Sometimes I think they [youth] are not sure what is real anymore. What some might see daily, like poverty, is not portrayed [in the media]. Their world being so different is hard to compare to what they have access to via their toys.

—Native Provider

Family communication issues, dysfunction, and loss of traditional values are directly related to past mistreatment and trauma experienced by Native people. For instance, as discussed previously, the parenting skills of many people who were forced to attend boarding schools were compromised because they never had the opportunity to learn traditional parenting practices and because they
were abused. Thus, the cycle of multigenerational trauma is more likely to be perpetuated. As one provider explained:

When a home is stricken with poverty, domestic violence, and alcoholism and a young person has made gains in their mental health and substance abuse in the office, the issues still remain the same in the home environments. They return to an unchanged environment.

—Anglo Provider

We also found that some providers did not understand historical trauma, and instead “blamed the victim.” This is an additional barrier to culturally appropriate care. For example, one provider said:

[Historical trauma is] Culture of helplessness which blames dominant culture for the ills of problems. This suggests that oppressed people remain under control of dominant culture.

—Anglo provider

Parents, youth, and providers also identified systemic obstacles to care, such as fragmentation and lack of services:

The resources are there but they don’t work together.

—Adult Community Advisory Meeting Participant

When you report an incident, it’s just written up and filed away. Nothing gets done with Social Services, the Police Department, or Family Harmony. It’s nice to have these services, but like she says, a lot of stuff falls through the cracks.

—Adult Community Advisory Meeting Participant

Not enough community agency collaboration.

—Native American Provider
Without better treatment teams of professionals, it is almost impossible to begin to address the complex, overwhelming needs of the patients and families.

—Anglo Provider

A common challenge for providers involves working with a Native youth who clearly needs mental health services, but is not suicidal, and thus may not meet the criteria for in-patient admission. The provider has nowhere to refer such a youth, and this lack of service availability can lead to deterioration and sometimes tragedy that could have been prevented.

These systemic problems can also result in “learned helplessness” among providers and systems of care. The concept of learned helplessness was first used to describe the development of passivity among dogs, who were intermittently shocked in response to their attempts to escape a cage. Eventually, the dogs would stop trying to avoid the shocks even if an open escape route existed because they had “learned” that their attempts would not succeed (see (Seligman & Maier, 1967). Subsequently, this concept has been extended and applied to a variety of people, including those with depression, prisoners of war, institutionalized patients, and women who have experienced intimate partner violence (see (Seligman, 1975; L.A. Walker, 1984). Instead, in a critique of the application of the learned helplessness concept to battered women, Gondolf and Fisher suggest that learned helplessness may be more appropriately applied to well-intentioned providers:

If learned helplessness is a valid conception, it is ironically prevalent in the system of helping sources. It is more likely that agency personnel suffer from insufficient resources, options, or authority to make a difference, and therefore are reluctant to take decisive action (Bass and Rice, 1979; (McEvoy, Brookings, & Brown, 1983); McShane, 1979). Too often, community services respond singularly to a problem rather than in some coordinated and mutually reinforcing fashion. This too cannot help
but cause a sense of diffusion and duplication (Gondolf & Fisher, 1988, pp. 22–23).

Thus, Gondolf and Fisher suggest that it is the helpers (and the dysfunctional systems within which they are located) that need “treatment.” Lack of resources, options and information by providers is often affected by the funding streams in Indian health. Due to the funding disparities of federal and tribal behavioral health programs, this learned helplessness among providers may very well be an issue of concern.

Finally, in addition to “sick” systems of care, many providers who work with Native youth face the additional challenges of compassion fatigue, vicarious traumatization, and secondary traumatic stress. Although these terms are often used interchangeably, they are distinct concepts. Vicarious traumatization is used to describe harmful changes in therapists’ views of themselves, others, and the world due to their exposure to trauma. This concept was first discussed by McCann and Pearlman to explain the cognitive changes that therapists experience as a result of their work with traumatized clients (McCann & Pearlman, 1990). Specifically, vicarious traumatization often results in changes in therapists’ beliefs about safety, trust, esteem, intimacy, and control (Baird & Kracen, 2006), and is seen as a normal, cumulative, and permanent response.

Secondary traumatic stress, on the other hand, describes a syndrome similar to PTSD that therapists (or family members of trauma survivors) may develop as a result of their exposure to the trauma of their clients. Figley first described this syndrome, which instead of involving cognitive changes among therapists, includes symptoms such as exhaustion, hypervigilance, avoidance, and numbing (Figley, 1995). Secondary traumatic stress is closely related to the more nebulous term compassion fatigue, which is actually the term Figley (1995) first used to describe these PTSD-like symptoms.

Another distinction between vicarious traumatization and secondary traumatic stress is that vicarious traumatization usually develops slowly over the course of
prolonged exposure to trauma experiences of clients, while secondary traumatic stress can occur after a relatively short exposures of a therapist (e.g., as a member of a emergency disaster response team). Both vicarious traumatization and secondary traumatic stress are relevant to providers who work with Native youth because of the high rates of violence experienced by Native youth, as well as the impact of historical trauma. Providers may become exhausted physically, emotionally, and/or spiritually because of chronic exposure to the trauma and emotional pain of the youth they serve. The result is often burnout, which is characterized by emotional exhaustion, disconnection from other people, and lack of sense of accomplishment from one’s work (Maslach, 1982). Burnout, in turn, can lead to high rates of turnover among providers. Native providers are also burdened by historical trauma and thus may be or may become “wounded healers.”

Native providers may be particularly at risk for vicarious traumatization, secondary traumatic stress, compassion fatigue, and burnout because research has shown that providers who have a personal history of trauma are more likely to develop vicarious traumatization and may be more likely to develop secondary traumatic stress (Baird & Kracen, 2006). In addition, providers who are exposed to a larger amount of traumatic material from their clients are more likely to develop secondary traumatic stress (Baird & Kracen, 2006). Furthermore, providers who believe that it is important for their clients to work through their trauma, but are unable to help their clients do so (which may often be the case for providers who work with Native youth), are more likely to develop compassion fatigue, burnout, and distress (Deighton, Gurris, & Traue, 2007). On the other hand, we also know that providers who have stronger perceived coping abilities are less likely to develop vicarious traumatization or secondary traumatic stress, and providers who have supervision are less likely to develop vicarious traumatization (Baird & Kracen, 2006). Taken together, this evidence suggests that we need to be especially cognizant of the mental health and well-being of Native providers, as well as other providers who work with Native youth. In particular, we need to offer training to providers that focuses on coping strategies for
dealing with the trauma exposure, as well as ensure that providers have adequate support and supervision. Given the challenges faced by providers, it is important to remember that to care for our youth, we must also take care of our healers.
IX. Recommendations

We recognize and appreciate the wealth of knowledge that traditional practitioners, community members, and service providers have shared with us, as well as what we have learned through our review of the literature. Based on these efforts, we organize our recommendations into three categories: policy, provider, and research recommendations.

POLICY RECOMMENDATIONS

Policy Recommendation #1: Apology from U.S. Government

Acknowledgement of past mistreatment is a very important component of healing. In the interest of promoting the well-being of all Native people, the United States should issue a formal apology. As an example, the Canadian government apologized to its 1.3 million indigenous people in 1998. In 2008, the Australian government apologized to its indigenous people and pledged to develop policies to redress past oppression and mistreatment.

Policy Recommendation #2: Reparations from U.S. Government to Fulfill Treaty Obligations to Restore Trust

An apology is an important first step toward emotional healing but it is not enough to restore trust. It must be made real by action and changes in behavior, policies, and funding. The remaining recommendations in this report represent the types of actions that would support an apology and demonstrate its sincerity. One essential component of reparations would be to make funding levels adequate to address the level of need for health care, education, and other social services among Native Americans. Canada has committed $245 million to a healing fund. In addition, at the end of 2006, a class action suit filed by Canadian boarding school survivors resulted in average individual payments of $24,000, an additional $125 million to the healing fund, $60 million for a truth and
reconciliation process to document the history and legacy of the government-run boarding schools, and $20 million for commemorative projects.

**Policy Recommendation #3: Expand Mechanisms for Reimbursement for Traditional Healers**

An emphasis of this report has been on the importance of traditional cultural healing practices and cultural teachings for promoting the recovery and healing of Native American youth. In order to legitimate and support these practices, federal, state, and local behavioral health systems must have authorization and mechanisms for paying traditional practitioners or cultural teachers for their services. There are already several examples of developing mechanisms, which may be useful to examine for further expansion. For instance, the Navajo Nation has a framework in place that reimburses traditional healers, the Access to Recovery program pays for traditional services and alternative forms of healing throughout the state of New Mexico, and the Albuquerque VA has a program to reimburse traditional healers for its clients.

**Policy Recommendation #4: Create and Fund Infrastructure to Connect Behavioral Health and Primary Care Health Services**

Native people’s approach to health tends to be holistic. Therefore, health services and care should reflect this value. Manson and Altschul recommend integrating care for children, adolescents, and elders and using a “carved-in” approach where behavioral health and primary care health services are available together (Manson & Altschul, 2004). They suggest that behavioral health carve-outs that separate funding for behavioral health services from general health care may not be appropriate for Native people. In addition, integrated services help reduce the stigma associated with seeking mental health care and diminish concerns around loss of confidentiality. Therefore, it is important to fund integrated systems that are devised by each specific Native community to address their behavioral health needs in a collaborative effort, working in partnership with all providers and funding systems. A related issue is the need to address the disconnect between mental health and substance abuse services in many tribal communities, which
has resulted because some tribes subcontract to provide their own substance abuse services, but do not receive funding for mental health services. The result is often that services for mental health and co-occurring disorders are not available.

**Policy Recommendation #5: Shift Emphasis from Evidence-Based Practices to Practice-Based Evidence**

Native communities have healing practices that have worked for thousands of years. If policymakers and providers truly want to be culturally appropriate, it is essential that they become culturally humble and more conscious of what people are doing in communities that works. We need to support these efforts and help communities develop or demonstrate evidence for their programs. Fund the implementation and evaluation of “promising” and community based practices for Native communities.

**Policy Recommendation #6: Acknowledge Spirituality in Healing Processes**

Because many Native people do not separate the spiritual from the physical, emotional, or mental, it is essential to ensure that spirituality can be incorporated into prevention and treatment for Native youth. Spirituality will involve different beliefs or practices for different Native youth, ranging from traditional beliefs to Christianity or other western religions. As one Native provider told us, “Many people asked me to pray for them but many times I was told this is federal funding so no Christianity. This was a barrier. People need to understand the importance of spirituality to Native people.”

**Policy Recommendation #7: Ensure Genuine Sovereignty through Government to Government Relations with Tribes**

Acknowledge the inherent sovereignty of tribal governments. This means that there is an acknowledgement of the indigenous systems of government, health care, healing, and education that have existed since time immemorial, prior to the immigration of non-Natives to these lands. Self-determination has always existed for Native peoples. The federal government should re-issue a high level policy
statement about recognizing the inherent sovereignty of tribes. This statement should direct all government agencies (federal, state, and local) to recognize this and to engage in government to government relations with all tribes. Ensure that there is meaningful consultation on health issues of common concern between tribes and non-tribal governments before policies are implemented.

**Policy Recommendation #8: Support Youth Involvement in Policy-Making**

Effective policy changes at federal, state, and tribal levels are strongest when youth are involved in matters that affect them. Youth voices should be thoughtfully heard when policies are implemented that affect their access to, and funding for, health care, particularly behavioral health care. Youth are knowledgeable about their own health care in their communities and can positively effect change that would make the systems more cost effective and efficient for all involved. Funding and support for youth advisory groups is an important example, as well as providing youth development training for young people.

**Policy Recommendation #9: Require Behavioral Health Systems (and larger social structures) to Take into Account Historical Trauma and the Current Realities of Native Youth**

In order to truly improve the mental health and well-being of Native youth and their families, transformation at multiple levels is necessary. In terms of current behavioral health systems, it is important to examine how policy makers at the state level institute policies that do not fund culturally appropriate practices, and how managed care requirements may impede the cultural appropriateness of behavioral health care for Native people. This includes what services are funded and how credentialing and licensing issues impact the people who Native clients are likely to interact with. In addition, funding of these programs must be transformed. As a Native American Project TRUST partner explains: “When we ask for five million [dollars] for prevention programs for Native youth in Indian country, they have to understand that it also involves transportation. It also involves culturally appropriate programs that may not be evidenced-based.” And
the incorporation of traditional teachings and traditional customs, because I find that a lot of times these policymakers and even legislators think that traditional thinking is kind of hokey. It’s what one guy said to me about sweat lodges. But they don’t understand the historical impact or the history, the federal policy of termination and assimilation that occurred with all Native people.”

**Policy Recommendation #10: Create a “Trauma-Informed” System of Care**

The Oregon Department of Human Services has adopted a policy that is particularly applicable to behavioral health service systems for Native American youth and their families. It states, “Trauma-informed services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. A trauma-informed system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that trauma plays in the lives of people seeking mental health and addictions services. A trauma-informed system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent re-traumatization and will facilitate consumer participation in treatment. In also requires collaborative relationships with other public and private practitioners with trauma-related clinical expertise.”

**Policy Recommendation #11: Improve Access to Behavioral Health Care**

Transforming the service system also involves ensuring that funding and services are adequate such that all Native people who need them can access them. As one adult said, “Providers need more funding, more counselors, more feedback and input. These problems are all over the country. With more staff and more money from the government, we could address them better.”
Policy Recommendation #12: Build Alliances to Work toward System Transformation

We must strive to build constructive alliances that will enable us to analyze and transform the present system, which continues to perpetuate increasingly inequitable distribution of resources and funding. To achieve genuine mental health and well-being among Native youth and their families, we must work together to promote the conditions that support healthy lifestyles, healthy families, healthy neighborhoods, healthy communities, healthy nations, and healthy international relationships.

Policy Recommendation #13: Recognize Healing as a Process Not an Outcome

Recognizing that healing is a process, requires that funders shift their emphasis from short-term outcomes to long-term impacts, such as community development. As one Non-Native Project TRUST member stated, “The patience that’s required to do community engagement and really respectful consultations is often missing.” This patience is necessary at the level of providers, funders, and the behavioral health system.

Policy Recommendation #14: Provide Additional Funding to Support Teen Centers, school behavioral health providers and School-Based Health Centers

It is essential to support and create settings where youth have positive interactions with adults (e.g. Teen Centers). One of the most important aspects of promoting resiliency in youth involves mentorship and connection with adults. Youth need to feel that they are valued and that people care about them and will accept them for who they are. Adults need to connect with youth before they get to the stage of needing professional intervention. There is a difference between listening in a therapeutic context versus listening during positive activities. In addition, the creation of Teen Centers (or expansion of school-based health centers) to include recreational activities and employment services will provide non-stigmatized settings where youth can develop positively and can connect to
mental health services, if necessary. School-based health centers could develop a more sustainable infrastructure through continued refinement of policies for them to receive Medicaid reimbursement.

Policy Recommendation #15: Provide Funding for Programs that Connect Prevention and Treatment

Prevention should be a high priority because most Native people are healthy. Furthermore, prevention allows for individual and collective strengths of Native communities to be emphasized and explored in more depth (U.S. Public Health Service Office of the Surgeon General, 2001). In addition, research has shown that Native youth are much more likely to participate in non-stigmatized, prevention interventions. Including components of treatment and healing in prevention programs makes particular sense if we acknowledge that multigenerational trauma and institutional racism affect all Native people.

Policy Recommendation #16: Create Alternative Licensing and Credentialing for Native Service Providers

Provide for alternative licensure requirements for those Native providers who lack a degree but have real world experience over many years, and who speak their Native language, in order to be reimbursed for services at a higher rate or comparable to licensed providers. This would allow for programs that serve Native Americans to build their infrastructure and support Native healing concepts in this system of care.

Provider Recommendations

Provider Recommendation #1: Modify Cultural Competency Training to Address Historical Trauma and Institutional Racism

Currently, many cultural competency training efforts focus on issues of language and translation, different styles of interaction, and variations in health beliefs. While we recognize the importance of these issues, it is essential that cultural
competency training for providers who work with Native youth include explicit
discussion of historical trauma and institutional racism, their impact on health
disparities, and how to apply this knowledge appropriately with each client they
see.

**Provider Recommendation #2: Modify Cultural Competency**
**Training to Include Healing for Providers**

Cultural competency training also needs to include opportunities for providers
to address their own mental health and healing. Providers face not only the
negative effects of historical trauma and institutional racism (which affects all
people), but also the potential for developing vicarious traumatization, secondary
traumatic stress, and/or burnout because of their high levels of exposure to
trauma through their clients.

**Provider Recommendation #3: Improve Coordination**
**across Agencies & Programs**

Both providers and community members raised concerns about youth being
abandoned or lost when they seek help. Once a youth is able to take the
important step of asking for help, they should be able to receive services quickly
and conveniently. Providers need to have mechanisms for communication across
agencies. Wrap-around concepts of services may be particularly effective in small
Native communities. Another effort would be a clinical home model that takes
into consideration rural and frontier areas.

**Provider Recommendation #4: Develop Services in**
**Collaboration with Community Members**

Self-determination also includes the right of Native families to participate in the
development of behavioral health services and decision-making about services
offered. People who use behavioral health services often see providers as the
“experts.” However, it is essential that we involve people in solving their own
problems. This is facilitated by creating mechanisms for family-guided services and programs (i.e., peer support programs).

**Provider Recommendation #5: Develop Creative Opportunities to Build on Current Workforce Development**

Encourage and support Tribal efforts to build up current behavioral health programs and workforce by providing onsite clinical oversight for educational and clinical supervision, financial assistance to pursue higher education, licensure, and/or appropriate credentialing to enhance quality in service delivery. This may include use of distance learning technology. It is also important to continue to build upon existing financial incentive programs for providers to work in Native American communities, being sure to include mid-level behavioral health providers. One example may be a tax credit for rural behavioral health professionals.

**Provider Recommendation #6: Emphasize Community Engagement and Consumer Driven Care**

Support the people who are receiving or eligible to receive behavioral health services. They know more about what works and what does not work and can be helpful in systems design from a community level perspective. Fund coalitions and organizations that promote community engagement and that support people to voice their concerns. In addition, learn about and employ the language of consumer-driven care, which emphasizes recovery and resilience.

**Provider Recommendation #7: Raise Personal Consciousness/Awareness Regarding Native Peoples**

If providers want to be effective in the work that they do, they need to raise their awareness of the health disparities of Native youth on all levels (federal, state, local). Another aspect of historical trauma involves the invisibility of Native peoples and cultures as they exist today. Providers need to read and understand *Broken Promises*, learn about the populations of Native Americans,
the historical influence Native people have had, and the current disparities they experience. As one Native American Project TRUST member explained, “Native Americans in this culture are invisible. You know, they do minority studies, with Blacks, Hispanics, or Asians. You never see Natives on those things. We just don’t exist. They don’t ask us questions. They don’t ask us what’s going on. We’re a population of people who are walking around, and people still ask questions. You can go back East and people will still ask questions about, ‘Do you still live in teepees?’ You know, I’m Navajo. You don’t even know…” Cultural humility is a key attitude for providers, who must be open to the limitations of their knowledge and training, and to the different perspectives and approaches to healing within Native communities.

**Provider Recommendation #8: Increase the Knowledge and Capacity of Providers to Work Effectively with Youth**

Youth have their own cultures and sub-cultures. Providers need to know these to work effectively with youth. In fact, most of the youth we talked to said that providers need more training to understand Native youth. Provider training should include knowledge about maturational processes and age-appropriate activities and treatments, guidance about the diversity of young people, and effective approaches for connecting with and engaging youth and developing relationships with youth and their communities. Providers also need training and awareness about how the power differential between adults and youth and between providers and “clients” can be a barrier to care, as well as the importance of building trust. This training should be guided by young people and people who understand youth, and should be funded by policy makers.

**Provider Recommendation #9: Be Aware of Both Traditional and Western Approaches and How They Can Support and Inform Each Other**

It is important to recognize that effective western behavioral health practices may have benefit for Native youth, particularly if they are used in conjunction with or in a complementary way to traditional practices. Walls and colleagues makes several specific suggestions around this issue, including that we should
IX. Recommendations

Provider Recommendation #10: Reconnect Families to Traditional Parenting Practices and Values

One of the legacies of boarding schools has been a loss of traditional parenting practices for many Native families. Both prevention and treatment of behavioral health issues among Native youth will be strengthened if Native parents have opportunities to accept and reconnect or deepen their understanding of effective traditional parenting techniques. There are several family curriculums that have been developed specifically for this purpose (see Appendix D).

Provider Recommendation #11: Train Providers in Motivational Interviewing (Individual self-determination)

At the individual level, self-determination can be fostered through motivational interviewing. This technique has been used effectively in numerous behavioral health settings to facilitate positive change that is directed by the youth or family themselves. Motivational interviewing encourages people to make their own decisions and it works towards dismantling power imbalances in therapeutic relationships. According to several traditional practitioners, motivational interviewing is also consistent with traditional guidance in numerous ways, including their shared emphases on self sufficiency, supporting positive hope, rolling with resistance, and expressing empathy. These key factors are the basis from which both motivational interviewing and traditionally-based
therapies approach healing and wellness. Motivational interviewing also embraces the concept of *T’aad hwo ajit’eego* (*It’s up to you*), a Diné traditional philosophy and the theme of the national Indian Health Service program for family fun run and walks to encourage physical activity.

**Provider Recommendation #12: Align Behavioral Health Approaches to Include Youth, Parents, Extended Families, and Communities**

Brave Heart and DeBruyn emphasize that community healing, along with individual and family healing, are essential in order to heal historical unresolved grief and its manifestations in mental health and substance use problems (Brave Heart & DeBruyn, 1998). To break the cycles of intergenerational transmission of trauma, we have to understand historical circumstances and how they are affecting current circumstances and social norms, and we have to mobilize and involve entire communities in these processes. The youth we spoke with also said they would be more open to providers if parents were involved in the youth’s treatment, including providing comfort and showing a sense of caring. Funding and support for community healing efforts is also important.

**RESEARCH RECOMMENDATIONS**

**Research Recommendation #1: Advocate for Research to Be Based on an Indigenous Research Agenda**

Research can be transformed by supporting an indigenous research agenda, such as Smith’s model that has self-determination at its core and includes, healing, decolonization, transformation, and mobilization at multiple levels (Smith, 1999). This transformation requires community-based participatory research (CBPR) approaches that engage communities as equal partners in the research process. Joseph Gone has recently written a thorough discussion of the relevance of community psychology approaches for promoting the mental health and well-being of Native peoples (Gone, 2007).
Research Recommendation #2: Develop Innovative Research Methods and Methodologies

Furthermore, we need to improve upon our research methods and methodologies so that we are able to measure the healing we hope to foster. We may not know what questions to ask to detect healing. For instance, a person, family, or community may be going through transformation but we may not observe it or know how to measure it. There is currently a major limitation in the way we evaluate programs because we are often not measuring the correct constructs, are not allowing participants to give voice to their own experiences through qualitative approaches, and are usually not able to look at long-term changes.

Research Recommendation #3: Insist on Appropriate Academic and Training Programs

Although non-Native providers can work effectively with Native youth, it is essential to have more Native providers. To increase the number of qualified Native mental health professionals, we must transform the academic system of research and training. LaFromboise suggests that academic institutions increase the number of Native psychologists they enroll and train, include indigenous healing methods and non-western perspectives in psychology training programs, include community-based practicum in psychology training programs, and build on clients’ strengths in therapy, including their natural support systems (LaFromboise, 1988). Furthermore, it is imperative that academic programs be genuinely supportive of and responsive to the perspectives of Native students. These are not only issues for academic institutions but also for workforce development as a whole.

Research Recommendation #4: Create a Research Clearinghouse or Related Mechanism to Promote Access to Research on Native American Behavioral Health for Those Outside of Academic Environments

In order to create equal partnerships with communities, researchers and their academic institutions must ensure that their research is widely accessible to
non-academics. A national or statewide research clearinghouse is one idea for improving access to research.
X. DISCUSSION

Because of the gap in literature and because of the gap in research that when this approach was taking place coming from young people themselves and the families that we’re all asking questions and that we all agree to disagree on all these incredible issues. It’s gonna take us somewhere in a good direction, and it’s gonna help many, many other Native communities in the country. Historical trauma has affected every indigenous group. So, what is happening here is taking a precedent. It’s gonna be set as a model. And, in a sense, it’s a historic moment for research, so I’m really proud of the founders [of Project TRUST].

—Native American Project TRUST member

This paper summarizes the literature we have reviewed, the experiences of our community experts including Native youth, adults, and providers who participated in our advisory meetings and surveys, the input of Project TRUST partners, and guidance from traditional practitioners. It culminates in 32 policy, provider, and research recommendations, which focus on recognizing and addressing historical trauma; making behavioral health services more responsive to issues and needs identified by Native youth and their families; incorporating traditional healing practices, cultural teachings, and spirituality into services; shifting focus from evidence-based practices to practice-based evidence; connecting prevention and treatment efforts and behavioral health with primary care; recognizing inherent sovereignty and self-determination at multiple levels; and fostering transformation of individuals, families, communities, systems of care, and social structures. We are counting on our numerous partners to help us advocate for and implement these recommendations.

In this section, we provide some concluding thoughts and discussion, as well as present the limitations of our work, challenges we faced, and lessons learned. We feel that the voices of community members, service providers, and traditional practitioners are powerful and that we have already learned a great deal from
them. It is clear to us that there are many common sentiments, values, and beliefs shared by youth, adults, and providers. However, there are also some important differences. For instance, youth clearly feel disconnected from most providers and services in a manner and to a degree not expressed by parents or providers. It is imperative that this disconnection and lack of trust be acknowledged and addressed.

In addition to the issue of trust, an overarching theme we identified was the systemic nature of most of the problems. Services are fragmented and grossly under-funded. Families, communities, and service systems need additional resources. We also noticed that most participants did not discuss mental health explicitly, but focused more on trust, relationships, and substance abuse.

We learned many important lessons throughout the Project TRUST process, the first of which is that we are engaged in a healing process that takes time. This is an important consideration for funders and program planners. For us, this was also a very emotional process. We found that our partnership provided a support system to help members deal with the pain, frustration, and other difficulties. To create real change, we have to be open to the emotionality of the process rather than keeping the discussion at a purely intellectual level. We would not have been able to do this work without relationships with each other built on trust. We also recognized that there are some people who say “get over it and move on” about historical trauma. We respect that this is a controversial topic and that everyone must make their own decision about how they address or do not address it. We hope our examination of this topic clearly outlines how this has influenced both positively and negatively on the challenges to providing behavioral health care to Native American youth, as well as how it provides communities with opportunity to begin or continue healing processes.

Another important lesson for us emerged out of our efforts to engage youth in our community advisory meetings. We ended up adapting our original discussion questions for youth to include experiential activities and personal stories shared by the youth facilitators, in order to foster the participation of
youth. Based on our experience, it seems that with adults, anonymity promotes openness, while developing a bond or relationship seems to promote more openness from youth. Youth can sense when people are genuinely interested in helping them and will be more likely to open up to them. In addition we learned that involving youth as facilitators of the community advisory meetings, also meant that we had to be attentive to supporting our youth facilitators, both emotionally and in terms of the further development of their competencies. We are still learning about how to give youth a true voice, but it is clear that even if we open the door a little crack, youth come through because they are waiting for opportunities to be heard. Finally, we recognized that we do not have all of the answers, so we are left with questions that we want to continue to explore, such as how can we best support traditional practices with the western behavioral health system of care? How do we engage the multiple systems that impact the well-being of youth and their families, such as social service and judicial systems? How do we reawaken the spirit of our people and help communities recognize their strengths and capacity for transformation?

Project TRUST members also learned from each other, and were transformed throughout the process. One Project TRUST member explains how her views on research changed:

I kept saying, ‘I don’t do research on my people.’ And he [another Project TRUST member] got after me and…not got after me, but just kind of said, ‘You know, I’d really have to disagree with you,’ cause if we don’t do it, then we’re gonna always have it being done wrong. We need to step up and do it the right way. And it’s okay to do research.’

—Native American Project TRUST member

Other Project TRUST members described the affirmation of their traditional beliefs that they experienced through their involvement in the project:

For me, the times I’ve been with the group and reading, it has been confirmation of what I’ve been taught by my parents and grandparents
that the traditional way really works if you follow it and embrace it. And I try to pass that on to my kids, although I won’t see that results for 20-30 years from now.

—Native American Project TRUST member

In any given community, there’s strengths, there’s knowledge that’s carried on through the ages and generations. And it’s interesting that the troubles our kids are having now, if we would only get back to that knowledge. It was interesting and enlightening. We didn’t need the internet, we didn’t need more letters behind someone’s name to tell us what work needed to be done or what our kids needed, we just needed to look within to understand what is happening with families and communities. The answers are still within the communities, within the folks that are living it. I think that was transformational that we just needed to get back to that to help communities and residents and improve the future.

By participating in this process and paper, it has put some hope back into my heart that we have an opportunity to change our communities into strong, resilient, healthy, beautiful communities. There’s a place where you get tired and feel that you are just spinning your wheels, but being involved in this process has helped push me to continue working in the direction I am going and to do it with hope.

—Native American Project TRUST member

In terms of generational trauma, it’s been a long process and just thinking about it realizing that it is going to be a long community process to healing. It’s an important step but there’s a lot more to do out there so helping people to understand that. It also is reaffirming how important what my grandmas and grandpas said. We get so caught up in this western world and trying to raise our kids, but it is so important to remember what we learned from our grandparents. And it took me a while to get back this.

—Native American Project TRUST member
Other Project TRUST members gained a deeper understanding of the effects of historical trauma and how it can be addressed:

My understanding of historical trauma has always been from a legal perspective in terms of federal policy... This project has really transformed my understanding of historical trauma in a psychological way and how systems react when people get caught up in legal/judicial systems. So it has expanded my understanding from a mental perspective that I wish I had many years ago when I was prosecuting cases in the Navajo Nation. Because I saw a lot of death, alcohol abuse, but I never put the mental health issues together with that. If I had, I would have done things differently, tried to get more supports and mental health services for people.

—Native American Project TRUST member

What really needs to happen is kind of like an anti-racism agreement. Some people need to step up and other people need to step back. And the way I see it is that the dominant culture needs to step back because our approach isn’t working. Because we know that there is something deep within that will work.

—Non-Native Project TRUST member

Overall, Project TRUST members are optimistic about what has been accomplished and what can be accomplished in the future:

When one is asked about historical trauma, we want to generalize it in terms of a definition, but through the experience I’ve had, there’s going to be so many categories, many layers of pain and suffering for each generation. And there’s going to be an understanding of treatment for addressing these topics and issues. It seems like right now we are grasping what historical trauma is. As we go into the deeper layers, only then will we have the full definition and understanding. I’m pleased to see
it and we don’t have any restraints or hidden agendas that are going to get in our way. So I see it is a positive direction that everyone needs to move forward.

—Native American Project TRUST member

We make the road by walking, but only by walking together. We may not know the answers, but we can find them together.

—Non-Native Project TRUST member

Our goal has been to help providers see that if they want to be effective, they are going to have to learn some things and change the way they do things and most fundamentally understand that the answers aren’t on their diploma or the letters behind their name but are in the communities themselves and until they see that, they are just going to create more barriers and challenges to care.

—Non-Native Project TRUST member

Finally, we reflected on how to improve the community advisory process. As several Project TRUST members said:

We need to move them [community members] from, ‘Well, this is why we’re like this.’ to ‘Well, what do we do to change that?’ Making that transition, creating that bridge, because I think that’s a tell-tale sign when people are always saying, ‘When are you guys coming back? When are you gonna do this again?’ It tells me two things. One, they have a lot of stuff they want to share and a lot of knowledge and expertise, and yet, they don’t feel empowered enough to do that amongst themselves. And they need something that’s there to help facilitate that, so I think that’s something that’s really critical as we move forward.

—Native American Project TRUST member

Mental health is essential to the overall health of our Native American youth. It is critical that mental health care for them be youth-driven
and community-driven to eliminate the disparities in services for youth. This includes listening to their voices, understanding their community histories and acknowledging the multi-cultural issues they face today.

—Native Project TRUST member

We would like to conclude by highlighting one of the fundamental tensions throughout this paper and throughout our efforts, which was succinctly articulated by a Project TRUST member in one of our first meetings. He asked, “Are we trying to help youth navigate a system that no longer works or transform the system?” Our answer is both. Because our youth are struggling now, it is imperative to provide immediate services and programs that address their behavioral health needs. On the other hand, we recognize that the well-being of Native families cannot be secured without genuine transformation of systems of care. What does this mean? Transformation implies a series of changes that result in something profoundly different from what existed before. Thus, transformation of the current system to a more culturally responsive or culturally competent community-wide system requires an analysis of the present system, including an examination of the basic assumptions that form the foundation of it.

Although we have argued for the importance of cultural humility among providers, researchers, and policy makers who work with Native youth and their families, real transformation will require going beyond this stance to establish a pedagogical (teaching/learning) approach that involves critical analysis and collective struggle. We must strive to build constructive alliances, enlist the perspectives of all community members, and engage in a more intentional analysis of the present system. For instance, it is clear that the system we are purportedly helping Native youth “adjust to” is one that continues to have the basic function of re-distributing the resources to a smaller and smaller segment of the population. This leaves us with a concern for what happens once a Native youth (or any person) is on the road to sobriety or has dealt with their particular mental health issue. Will they have adequate resources and opportunities to fulfill their hopes and dreams? To survive? Should there not be other options
for individuals other than learning to adjust to the status quo? We believe it is in everyone’s interest to begin to develop healthy lifestyles, healthy families, healthy neighborhoods, healthy communities, healthy nations, and healthy international relationships. This would also be a closer reflection of applying traditional Native values to heal ourselves and the world, and would give us each an opportunity to live meaningful lives.
Appendix A: Community Advisory Meeting Questions

1. What behavioral health (mental health/substance abuse) services are available to young people (like Josh, Tammy, & Go-Go) in your community?
   - Where could Josh go for his meth/crack addiction?
   - Where could Tammy go for her depression/thoughts of suicide?
   - Where could Go-Go go for his alcohol problem/not liking his name?
   - If someone you cared about had the same kinds of problems who would you go to or send them to?

2. Do the behavioral health services in your community work for you (and/or your family)? Why or why not?
   - Do young people use these services and are the helpful? Why or why not?
   - Are young people usually made to go or do they go on their own? Why or why not?
   - Suppose you or someone you know got referred, did it work for you/them? Was it helpful?

3. What barriers have you and/or your family (or might Josh, Tammy, or Go-Go have) experienced when seeking these behavioral services?
   - Have you or some you know had the same or similar experience? Please explain the experience?
   - What was it like for you? Why didn’t you go back?

4. Why do you think Native American youth (like Josh, Tammy, or Go-Go) might not seek or complete behavioral health counseling or treatment as advised by a medical or behavioral health service provider?
• Why do you think Native American young people don’t go or go back? Even when they’re referred?

5. What would help medical or behavioral health service providers do a better job at reaching and meeting the needs of Native American youth?

• How can service providers like JPPP Officers, Law Enforcement, Pastors, Councilors, Teachers, and Doctors etc. be more helpful/supportive for you or someone you know?

• How do you know that you can “trust” the person who says they want to help you?

6. What do you know about historical and intergenerational trauma?

• Do you think this impacts Native American youth today?

• If yes, how do you think it impacts Native American youth today?

• How does your family/community/tribal history affect your life? (Examples: Long Walk, Boarding School, Parenting, Holocaust, Slave Trade, Language, etc.)

• Do you speak your native language? Why or why not?

7. What is “culturally-appropriate” behavioral health care for Native American young people and their families?

• As a Native American young person reaching out for help, how would you like to be treated?

• What would make you feel comfortable and come back to receive the help you need?

• Would you want your family included?

• Is it better to include families? Why or why not?
8. What advice would you give to medical/behavioral health providers and/or policy-makers who want to provide positive and supportive behavioral health care for Native American youth?
Appendix B: Service Provider
Survey Questions

Project TRUST is very interested in what you think and is seeking your thoughts and insights as to how we can work towards the goal of more culturally appropriate and client-centered approaches to behavioral health care for Native American youth and their families.

1. In your work with Native American (NA) youth and their families, do you think you are meeting or addressing their behavioral health (mental health & substance abuse) needs?
   - Why or why not?
   - What barriers impede the services that you or your agency provides in meeting the behavioral health needs of the NA youth?

2. What do you think will make you even more effective in your work with the NA youth? (Is it more training, more time with patients, less of something, what tools, etc.?)

3. Why do you think NA youth do not seek behavioral health counseling, complete treatment or return for therapy?

4. What do you know about historical and the role of intergenerational trauma as it relates to Native Americans?
   - Does it impact the NA youth of today?
   - If yes, how do you think it impacts the youth of today?
   - Does your knowledge about historical trauma and or intergenerational trauma impact the day-to-day work that you do with the NA youth and their families?
• How do you think your knowledge of historical trauma and/or intergenerational trauma affect the daily work that you do (if it does)?

5. What are culturally appropriate behavioral health services for NA youth and their families?

6. If you are a provider of greater than 2 years in the area, what advice would you give a new provider who is interested in joining your department or practice to be effective?

(OPTIONAL)

Your Profession: ____________________________________________

Number of years working with NA Youth and Families __________________

Gender _______ Age _______ Ethnicity ___________________________
Appendix C: Project TRUST Partner Focus Group Questions

1. When did the partnership first begin to form?
2. Who were the “founders”?
3. What brought each one of you here?
4. Why is this partnership important to you?
5. What have you learned throughout the partnership process?
6. What do you hope the partnership will accomplish?
7. How is this partnership similar to other groups you’ve been involved with?
   How is it different?
8. What questions do you want to ask the group?
Appendix D: Behavioral Health Interventions for Native American Youth

People Awakening Projects: A resilience model for substance abuse prevention among Alaska Native youth (Mohatt & Thomas, 2005). They focus on building resilience in children ages 12 to 18 (grades 7 to 12) and their families. They emphasize tradition AND the ability to navigate and thrive in current society.

Canoe Journey, Life’s Journey: A Life Skills Manual for Native Adolescents (La Marr & Marlatt, 2005) is an 8-session substance abuse prevention curriculum for Native adolescents.

The Seventh Generation Program, which blends evidence-based “mainstream” prevention components with traditional, culturally appropriate components has recently been shown to be an effective alcohol prevention program for urban American Indian youth (Moran & Bussey, 2007).

Listening to One Another substance abuse prevention curriculum, which is a 14-week family curriculum that was developed by the Anishinabe tribe and Les Whitbeck at the University of Nebraska-Lincoln. The curriculum involves youth, parents, and elders, and has demonstrated promising results.

May and his colleagues describe a public health approach to suicide prevention – a 15 year program with one tribe that resulted in significant decreases in suicidal gestures and attempts (but not deaths from suicide). They focused on 10-19 year olds with boosters for 20-24 year olds. They took a community systems approach and used a community planning process to identify tribal-specific risk factors, identify high risk individuals and families, implement preventions efforts with high risk individuals and families, provide direct mental health services to high risk individuals and families, and increase community education and awareness. Their efforts also included surveillance, screening at conventional and non-conventional settings, and training people as natural helpers (May et al., 2005).
The *Circles of Care* initiative provided funding in nine communities for American Indian and Alaska Native families and their communities to participate in the development of mental health services for their children – see special issue of *American Indian and Alaska Native Mental Health Research* (2004, Vol. 11, No. 2). Freemand and colleagues describe Circle of Care: “In September 1998, nine American Indian/Alaska Native (AI/AN) tribal grantees began a three-year journey to design culturally appropriate systems of care for children suffering from serious emotional disturbances. The project, called Circles of Care (CoC), was the joint effort of the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Indian Health Service (IHS), and the Office of Juvenile Justice and Delinquency Prevention, a collaboration that resulted in $2.55 million in grant funds and support from two technical assistance centers. The National Indian Child Welfare Association (NICWA) provided program level technical assistance, in collaboration with IHS. The University of Colorado Health Sciences Center provided evaluation technical assistance, in collaboration with the National Institute for Mental Health sponsored National Center for American Indian and Alaska Native Mental Health Research” (Freeman, Iron Cloud-Two Dogs, Novins, & LeMaster, 2004).

*Cheyenne River Sioux Tribe Restoring the Balance Project* (funded by SAMHSA) surveyed youth, adults, and service providers about mental health problems and services needed to address them. Highest priority solutions were: increased adult involvement with youth, additional counselors/counseling services, employment, recreational activities, substance abuse counseling and awareness. Prevention also key. They formed a Teen Center – with internet access, traditional Native language and arts classes, library, basketball courts, and counseling. This is important to get kids “in the door” with activities, and then they can provide health and mental health services and prevention too (Garreau, 2005).

*One Sky Center* is an American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services. The director provides a discussion of traditional health practice (THP) and its importance. “...to respond
to the behavioral health needs of Native youth, children, and families, a culturally tailored and community specific approach combined with evidence-based best practices in behavioral health must be initiated at a community level in Indian Country” (D. Walker, 2005), pp. 5-6). This article reviews three helpful culturally relevant, community specific programs for handling suicide related crises and/or preventing them.

Other helpful discussions of promising practices for Native American youth:

Suicide prevention among Native American youth (Carmona, 2005).

Substance abuse prevention literature relevant to Native American youth (Hawkins, Cummins, & Marlatt, 2004). They suggest:

Community empowerment approaches (limited empirical support), peer-led interventions (no empirical support), bicultural competence interventions (strong empirical support, see Schinke et al. 1988; Schnike et al., 2000; Moran & Reaman, 2002)

Their main recommendations are to conceptualize prevention and behavior change as part of a continuum, use a stepped-care approach in which treatment or prevention begins with less intensity and is increased as necessary, use a biculturally focused life skills curriculum, and collaborate with community throughout development and implementation of prevention efforts.

Cultural interventions that have been used in American Indian prevention programs, include tribal ceremonies and rituals such as sweat lodges or smudging, tribal crafts such as sewing quilts and making cradle boards, and traditional forms of living such as fishing and horsemanship (Sanchez-Way & Johnson, 2000).

Another helpful source is (Manson & Altschul, 2004). They describe six innovative approaches to mental health care in American Indian and Alaska Native communities, including: the Rural Health Service Certificate Program, SAMHSA-funded experiments to provide coordinated services, Circles of Care Initiative,
Comprehensive Community Mental Health Services for Children and Their Families Program, the Kmiqhitahasultipon Program of the Passamaquoddy Tribe, and the Sacred Child Project.

Some researchers have worked on specific therapeutic models and tried to adapt them for American Indians (e.g., Cognitive-Behavioral Therapy (Jackson, Wenzel, Schmutzer, & Tyler, 2006)) but even title here (with American Indian individuals) suggests a lack of recognition of importance of family and community.

Other interventions that are in the developmental stage but have not demonstrated positive effects yet:

Teen Health Resiliency Intervention for Violence Exposure (THRIVE), which aims to examine the trauma experiences and mental health of American Indian youth served by school-based health centers (SBHCs) and to adapt, implement, and assess the effectiveness of an evidence-based behavioral intervention – Cognitive Behavioral Intervention for Trauma in Schools (CBITS) – for American Indian youth. CBITS has been adapted to be culturally and geographically appropriate for youth from one Diné and two Pueblo communities. The intervention was implemented with four groups of adolescents aged 12-16. Preliminary results show significant reductions in PTSD symptoms and anxiety among participants.

The Nihii’iina program is a community-based intervention to address the multiple layers of trauma (including historical trauma) experienced by American Indian youth and their parents. Its objectives are to develop, pretest, and formalize a community-based intervention to prevent mental health disorders and substance abuse by healing historical trauma and promoting enculturation among Diné youth and their parents and guardians. Contact Jessica Goodkind (jgoodkind@salud.unm.edu) or Lance Freeland (lfreeland@salud.unm.edu) for more information.
Appendix E: Behavioral Health Measures for Native American Youth

References for measures that have been tested and recommended for Native American youth behavioral health:

Reasons for Living Inventory for Young Adults (Crofoot Graham, 2002; Gutierrez et al., 2002) is a strengths-based measure for assessing suicide risk.

Suicide Ideation Questionnaire (Keane, 1996) is predictive of suicide attempts among American Indian youth.

Discussion of three depression measures for American Indian adolescents (Center for Epidemiologic Studies Depression Scale, Youth Self Report, and Tri-Ethnic Center’s for Prevention Research Depression Scale) (Thrane, Whitbeck, Hoyt, & Shelley, 2004)

Orthogonal Cultural Identification Scale (Oetting, Swaim, & Chiarella, 1998)

Traditionalism Scale for Parents and Traditionalism Scale for Children (Morris, Crowley, & Morris, 2002)

Ethnic, Culture, Religion/Spirituality scale (Long & Nelson, 1999)

Works Cited


Manson, S. M., & Altschul, D. B. (2004). *Meeting the mental health needs of American Indians and Alaskan Natives*: National Association of State Mental Health Program Directors (NASMHPH) and National Technical Assistance Center of State Mental Health Planning (NTAC).


