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ORIGINAL PAPER

Promoting Healing and Restoring Trust: Policy Recommendations for Improving Behavioral Health Care for American Indian/Alaska Native Adolescents

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Abstract American Indian/Alaska Native youth represent the strength and continued survival of many Nations and Tribes. However, they currently experience numerous health disparities and challenges, including the highest rate of suicide among 15–24 year-olds in the United States. Our comprehensive review of the literature on the mental health of AI/AN youth highlighted seven focal causes of behavioral health disparities: (1) high levels of violence and trauma exposure and traumatic loss, (2) past and current oppression, racism, and discrimination, (3) underfunded systems of care, (4) disregard for effective indigenous practices in service provision, policy, and funding, (5) overreliance on evidence-based practices, (6) lack of cultural competence among systems of care and providers, and (7) barriers to care. Seven policy recommendations that recognize the importance of moving beyond exclusive reliance on western models of care and that seek to foster transformation of individuals, families, communities, behavioral health service systems of care, and social structures are presented, supported, and discussed.

Keywords Adolescent · Alaska Native · American Indian · Behavioral health · Evidence-based intervention · Historical trauma · Mental health services · Native American · Policy

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Recent important mental health policy documents published by The President's New Freedom Commission on Mental Health (The President's New Freedom Commission on Mental Health 2003), Institute of Medicine (Committee on the Future of Rural Health Care 2004; Institute of Medicine 2001; Smedly et al. 2003), U.S. Surgeon General (U.S. Public Health Service Office of the Surgeon General 2001a, b), and NIMH (National Institute of Mental Health 1999, 2000) call for the reduction of racial and ethnic disparities in mental health care, particularly in rural areas, by decreasing barriers and delivering culturally relevant services that are evidence based and patient and family driven. Unfortunately, racially and economically marginalized populations in the U.S., including American Indian and Alaska Native youth, continue to bear larger burdens both in terms of higher prevalence of mental health and

substance abuse disorders and lack of access to appropriate, quality care.

American Indian and Alaska Native youth embody the resiliency and survival of indigenous Nations and Tribes throughout the United States, and they symbolize the hope, dreams, and cultural continuity for future generations to come. However, they are hindered in their ability to fulfill these important roles by numerous behavioral health disparities and challenges. American Indian and Alaska Native adolescents 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), and suicide has been the second leading cause of death for Native American youth ages 15–24 for the past 20 years (Health US 2004). Furthermore, 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 et al. 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 et al. 2002; Beals et al. 1997). Alcoholism death rates for Native American youth ages 15–24 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).

Other research on substance abuse among AI/AN youth demonstrates the complexity and severity of this issue. For example, a study of 89 American Indian adolescents in a tribally operated residential substance abuse treatment program found that youth used multiple substances (mean of 5.26) and that 82% had co-morbid psychiatric disorders (most common conduct disorder) (Novins et al. 2006). There is also research that examines specific trajectories of substance use for American Indian adolescents (Novins and 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.

Finally, it is important to note that in addition to the disproportionate burden of mental health problems experienced by AI/AN youth, there is a lack of epidemiology and surveillance (U.S. Public Health Service Office of the Surgeon General 2001b).[1] 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, policymakers, and the population as a whole. In order to eliminate these disparities, it is essential to identify their causes and address them, while simultaneously working to improve the behavioral health care system for AI/AN youth.

Our comprehensive review of the literature on the mental health of AI/AN youth highlighted seven focal causes of behavioral health disparities:

1. *High levels of violence and trauma exposure and traumatic loss* have been linked to PTSD, other forms of psychological distress, and substance abuse among AI/AN youth (Deters et al. 2006; Gnanadesikan et al. 2005; Jones et al. 1997; Kilpatrick et al. 2000).
2. An emerging literature is beginning to link psychological distress and substance use among American Indian adolescents to *past and current oppression, racism, and discrimination* (Whitbeck et al. 2001, 2002, 2004a, b).
3. *Underfunded systems of care for AI/AN behavioral health* affect accessibility and quality of care for AI/AN youth. 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).
4. One of the most fundamental challenges to reducing health disparities and improving behavioral health care for AI/AN youth is the divergence of western and traditional indigenous approaches to mental health care and healing, and the *disregard for effective indigenous practices in service provision, policy, and funding*. Traditional AI/AN practices and ceremonies have been

[1] 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/ncaianmhr/research/superpfp.htm).

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. Use of traditional health practices among AI/AN populations (e.g., indigenous herbs, sweat lodges) and traditional spiritual orientations have been linked to positive health outcomes in numerous studies (Buchwald et al. 2000; Garroutte et al. 2003; Marbella et al. 1998). Research also suggests that the most resilient Native youth are those who are culturally and spiritually grounded (Gray and Nye 2001; Rieckmann et al. 2004; Spicer et al. 2003; Whitbeck et al. 2001, 2002, 2004, Yoder et al. 2006).

5. The focus on evidence-based practices (EBPs) in mental health care and substance abuse by treatment federal, state, and local regulatory bodies, reimbursement mechanisms, and other funders has involved an important effort toward ensuring that all people receive quality care that has been scientifically tested and that has demonstrated effectiveness. However, the *reliance on and/or exclusive funding of EBPs* raises problematic issues when focusing on behavioral health care for AI/AN youth and their families.[2] The fundamental concerns are the lack of inclusion of AI/AN participants in behavioral health intervention research (and thus no evidence-base for these populations) and the previously described exclusion of traditional healing practices among these studies (Miranda et al. 2005; U.S. Public Health Service Office of the Surgeon General 2001b).
6. The seemingly divergent emphases on traditional indigenous practices and evidence-based practices as well as issues of trust and power related to U.S. mistreatment of AI/AN populations present a *challenge to western behavioral health systems and providers in their attempts to provide culturally "competent" care to AI/AN youth*. Many Native researchers and providers recognize the lack of cultural competency for AI/AN youth within current systems (Besaw et al. 2004; E. Duran and Duran 1995; Faimon 2004; Gone 2004; LaFromboise 1988).
7. Finally, there are several related *barriers to care* which impact the mental health of AI/AN youth and their access to care, including geographical remoteness, poverty, transportation, and shortage of qualified treatment providers (American Academy of Child and Adolescent Psychiatry 2006), as well as the concerns about privacy, quality of care, and communication and trust (Duran et al. 2005).

In addition to our comprehensive review of the literature, we conducted advisory meetings with 71 American Indian youth, parents, and elders; surveyed 25 service providers; and engaged in ongoing consultation with four traditional practitioners. Given our concern about the exclusion of indigenous healing practices and perspectives in current research and funding, it was important to engage with multiple sources of information in order to inform our conclusions and recommendations. For a detailed description of our findings, please see Goodkind et al.(2008).

In summary, we found that American Indian/Alaska Native youth face multiple stressors and traumas, including: poverty, current institutional racism, micro-aggressions, and traumatic life events. Furthermore, the current structures and emphases of behavioral health systems of care do not adequately address these challenges or integrate effective indigenous health practices. To redress these limitations of current behavioral health care in the United States, we propose seven policy recommendations.

Policy Recommendations

Recommendation #1: Expand Mechanisms for Reimbursement for Traditional Healers

A central finding of numerous studies has been the importance of traditional cultural healing practices and cultural teachings for promoting the mental health, 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 that 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 forms of healing throughout the state of New Mexico, and the Albuquerque VA has a program to reimburse traditional healers for its clients.

Rationale:

- Use of traditional health practices among AI/AN populations (e.g., indigenous herbs, sweat lodges) and

[2] There are also critiques of the overemphasis on evidence-based practices more generally. Kemm raises issues regarding the expectation of randomized control trials (RCTs) to test 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).

traditional spiritual orientations have been linked to positive health outcomes in numerous studies (Buchwald et al. 2000; Garroutte et al. 2003; Marbella et al. 1998).

- Research also suggests that the most resilient Native youth are those who are culturally and spiritually grounded (Gray and Nye 2001; Rieckmann et al. 2004; Spicer et al. 2003; Whitbeck et al. 2001, 2002, 2004; Yoder et al. 2006; Zimmerman et al. 1998).
- A large study of American Indian adolescents and adults found that between 34 and 49% of those with a history of depressive or anxiety disorders sought help from traditional healers (Beals et al. 2005). Another large study of American Indian parents/caregivers found that they strongly prefer traditional cultural services for mental health and substance abuse problems rather than formal behavioral health services and that they believe traditional cultural services are more effective (Walls et al. 2006).
- Many Native people do not separate the spiritual from the physical, emotional, or mental (Gone and Alcantara 2007). Therefore, 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 indigenous beliefs to Christianity or other western religions.

Recommendation #2: Fund Infrastructure to Connect Behavioral Health and Primary Care Health Services

Native people's approach to health tends to be holistic (Gone 2004; Gone and Alcantara 2007). Therefore, health services and care should reflect this value. One way to connect behavioral health and primary care services for AI/AN youth is to *provide additional funding to support teen centers and school-based health centers (SBHCs)*. 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 also develop a more sustainable infrastructure through continued refinement of policies for them to receive Medicaid reimbursement.

Rationale:

- Behavioral health carve-outs that separate funding for behavioral health services from general health care may not be appropriate for Native people (Manson and Altschul 2004).
- A study of American Indian adolescents with suicidal thoughts and behaviors found that embarrassment and stigma were central reasons youth did not seek help (Freedenthal and Stiffman 2007). Integrated services and mental health services offered in primary care settings and schools help reduce the stigma associated with seeking mental health care, are more easily accessed, and can diminish concerns around loss of confidentiality (Pumariega et al. 2005).
- Several studies have documented the important role SBHCs have in improving access to care for youth with mental health and substance abuse problems. For instance, in a 3-year study, adolescents with access to SBHCs were over 10 times more likely to access mental health or substance abuse care than adolescents without access to SBHCs (Kaplan et al. 1998). Another large study of adolescent users of SBHCs found that youth had a higher use of medical, mental health, and probably substance abuse counseling services than did adolescents in the general population (Anglin et al. 1996).
- The comprehensive nature of SBHC services can also 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 in some tribal communities.

Recommendation #3: 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 more conscious of what people are doing in their own communities that works. It is important to support existing efforts and help communities develop or demonstrate evidence for their programs. This requires *funding implementation and evaluation of "promising" and community based practices for AI/AN communities*.

Rationale

- Important papers from White Bison (2001) and the Oregon Department of Human Services (Cruz and Spence 2005) have developed more inclusive models for evaluating best practices that incorporate: (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.
- An innovative, rigorous methodology, practice-based evidence for clinical practice improvement (PBE-CPI), has been shown to provide evidence for better practices more quickly than randomized controlled trials or sophisticated statistical methods (Horn and Gassaway 2007). This type of model provides important outcome information about current, real-world practice, as opposed to artificial practices of screening, selection and intervention control in randomized controlled trials.

Recommendation #4: Require Behavioral Health Systems to Take into Account the Current Realities of Native Youth

In order to adequately address the behavioral health needs of AI/AN youth, it is essential to *incorporate mechanisms and supports within behavioral health systems that address the multiple stressors AI/AN face.* Furthermore, behavioral health programs in rural areas are often more expensive because transportation and other logistical considerations must be addressed.

Rationale:

- For instance, in addition to behavioral health disparities, American Indians and Alaska Natives have significantly lower mean household income and levels of education, higher mortality rates (including infant mortality), and higher rates of school drop-out, teen pregnancy, unemployment, and physical health disparities (U.S. Public Health Service Office of the Surgeon General 2001b). In 1999, the poverty rate for families with children in the U.S. was 13.6 (and 9.4% for white families with children), while 27.0% of American Indian and Alaska Native families with children were in poverty (Snipp 2005).
- As a Native American behavioral health community leader explained:

> "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 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 of the federal policy of termination and assimilation that occurred with all Native people" (Goodkind et al. 2008).

Recommendation #5: Provide Funding for Programs that Connect Prevention and Treatment

Prevention should be a high priority because most Native people are healthy Also, 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 2001b). *Including components of treatment and healing within prevention programs makes particular sense* given the high rates of mental health challenges, trauma exposure, and other disproportionate stressors faced by most AI/AN youth and the recognition that past oppression and current institutional racism affect all Native people.

Rationale:

- AI/AN youth are more likely to participate in non-stigmatized, prevention interventions (Miranda et al. 2005); therefore treatment or healing approaches included in prevention interventions will provide the opportunity to reach more youth.
- A meta-analysis of 177 mental health prevention studies found that most types of primary prevention programs achieve significant positive effects. In addition, most prevention interventions not only significantly reduced problems but also significantly increased competencies, and affected functioning in multiple adjustment domains (Durlak and Wells 1997).

Recommendation #6: Create Alternative Licensing and Credentialing for Native Service Providers

Providing alternative licensure requirements for AI/AN providers who lack a degree but who have real world experience over many years and who speak their native language would allow them to be reimbursed for services at a rate 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.

Rationale:

- Extreme shortages of licensed mental health providers exist in many AI/AN communities (American

Academy of Child and Adolescent Psychiatry 2006). For the two-thirds of American Indian children who live in urban areas (Snipp 2005), access to mental health care is also limited by underfunding of the Indian Health Service and lower rates of insurance.

- Many American Indians prefer traditional cultural services and informal supports within their communities for mental health and substance abuse problems rather than formal behavioral health services (Walls et al. 2006). Thus, mechanisms for certifying, licensing, and reimbursing these types of services and supports are important.
- The Alaska Native Tribal Health Consortium has developed and implemented a Behavioral Health Aide Program that involves a tiered system of local behavioral health workers who are trained, certified, and supervised to address mental health and substance abuse issues in rural and remote Alaska Native Villages. This model is currently being adapted in preparation for implementation in New Mexico.

Recommendation #7: Apology from U.S. Government

An important foundation for healing and reducing behavioral health disparities experienced by AI/AN youth would be an acknowledgement of past mistreatment. Thus, in the interest of promoting the well-being of all Native people, the *United States could issue a formal apology*. This would not be unprecedented. For 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. There are several current efforts within the U.S., including proposed Congressional legislation, to make a formal apology.

Rationale:

- Research supports the importance of apology for increasing victims' capacity to forgive (McCullough et al. 1998), which is important because forgiveness has been linked to improved mental and physical health across numerous populations (Berry and Worthington 2001; Maltby et al. 2001; Toussaint et al. 2008a, b, 2001; Witvliet et al. 2001).
- Regehr and Gutheil (2002) conclude that although "the current empirical evidence is insufficiently solid to support the proposition that apology by oppressors, perpetrators, and defendants is a panacea leading to healing of trauma under all circumstances…in particular situations, such as civil harm brought to bear on groups of people, apology may be a necessary if insufficient step toward some restitution for the injury" (pp. 429–230). Thus, although an apology is an important first step toward emotional healing, it is not enough to restore trust. It must be made real by action and changes in behavior, policies, and funding, such as those suggested in Recommendations 1–6.

Discussion

An overarching theme throughout our literature review and policy recommendations is the systemic nature of most of the problems with current behavioral health care. Services are fragmented and grossly under-funded. Families, communities, and service systems need additional resources. Our conclusions are that these resources should be predicated on an understanding 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. A 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 exists. It is important for providers and systems to be aware of this diversity of beliefs and practices and to avoid assumptions. However, it remains important to recognize that many 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. 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.

Thus, the well-being of AI/AN youth and their families cannot be achieved without *genuine transformation of systems of care*. 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. This requires 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.

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