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Rebuilding TRUST: A Community, Multi-Agency, State, and University Partnership to Improve Behavioral Health Care for American Indian Youth, their Families, and Communities

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Abstract

American Indian/Alaska Native youth represent the strength and survival of many Nations and Tribes. However, the aftermath of colonialism has resulted in numerous health disparities and challenges for Native youth, including the highest rate of suicide in the United States. With the aims of elucidating the causes of behavioral health disparities, eliminating them, and improving behavioral health care for Native youth, a partnership of providers, community members, and university faculty and staff completed a comprehensive literature review; conducted advisory meetings with 71 American Indian youth, parents, and elders; surveyed 25 service providers; and engaged in ongoing consultation with traditional practitioners. Results from the multiple sources were synthesized and are reported with 20 policy, provider, and research 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.

Introduction

Trust is at the core of most healing or therapeutic relationships (Horvath & Symonds, 1991; Marshall & Serran, 2004; Martin, Garske, & Davis, 2000). During the past 500 years, many American Indian and Alaska Native peoples have learned to distrust the people who came to their land as colonizers and the institutions they created, as a result of oppressive actions and policies, numerous treaties that have been violated, and promises that have been broken. Distrust has also been earned by European-American service providers, educators, and researchers who have intentionally or inadvertently imposed their values, beliefs, and systems of care upon individuals, families, and communities for whom these services or practices may be ineffective and/or harmful. For American Indian youth, their trust in adults or other authority figures may be further challenged by the developmental processes in which they are engaged. While skeptical mistrust may be warranted, considering ways to build a foundation of trust and safety between American Indian youth and the behavioral health care systems with which they can or do interact is essential for their well-being. This is particularly important given the behavioral health disparities experienced by American Indian and Alaska Native (AI/AN) youth, foremost of which is the high rate of suicide among 15-24 year old AI/AN youth in the United States (34 per 100,000), compared to 11 per 100,000 for overall U.S. population of 15-24 year olds (U.S. Department of Health and Human Services, 2004).

To address this glaring health disparity, a partnership of service providers, community members, community organizers, youth, university faculty and staff, and behavioral health organizations was formed.[1] High levels of frustration among partners were evident because of the recognition that the dedication and commitment of well-intentioned service providers was not translating into improved behavioral health for many AI/AN youth. The partnership gave itself the name Project TRUST because lack of trust was perceived as a fundamental underlying issue. TRUST was expanded as an acronym that identified related key issues that needed to be addressed through policy and practice changes in order to promote healing and create trust:

- **T**ruths about historical trauma and current inequities that impact the mental health and well-being of Native youth and their families
- **R**esponsiveness to issues and needs identified by Native youth and their families from their perspective
- **U**nderstanding of the effectiveness of traditional indigenous healing practices and cultural teachings

[1]Project partner organizations are: Crownpoint & Thoreau School-Based Health Centers, Gallup Indian Medical Center Behavioral Health Services, Gallup-McKinley County Schools Counseling, McKinley Coalition for Healthy & Resilient Youth, McKinley Community Health Alliance, Navajo Nation Division of Health Department of Behavioral Health Services, New Mexico Alliance for School-Based Health Care's "4-Youth" Project (a Kellogg funded School-Based Health Care Policy Program for American Indian Youth), New Mexico Department of Health Office of School and Adolescent Health, New Mexico Department of Health Public Health Regions 1/3, Northern Navajo Teen Life Center, Northwest New Mexico School-Based Health Care Champions, University of New Mexico Acoma-Canoncito-Laguna Teen Centers, University of New Mexico Center for Rural & Community Behavioral Health, University of New Mexico Prevention Research Center, and Value Options New Mexico Service Systems Relations.

- **S**elf-Determination of youth and families to guide their behavioral health services
- **T**ransformation of individuals, families, communities, systems of care, and social structures

A key goal of our efforts was to approach the "real" experts - our communities - and ask them about the lack of trust and why they thought American Indian youth experience such large health disparities. It was important to work with youth and their communities and to seek their guidance in understanding these high suicide rates and other health disparities, which we believe are rooted in both current and past oppression experienced by American Indian individuals, families, communities, and nations for the past 500 years, rather than impose upon them yet another theory for "fixing" their problems.

We also approached our work with a focus on an important context within which these behavioral health disparities among AI/AN youth and their mistrust of western behavioral health systems exist – namely the divergence of western and traditional American Indian approaches to mental health care and healing, and the primacy given to western practices in service provision, policy, and funding. American Indian 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 American Indian youth, and may in fact be harmful. Eliminating the behavioral health disparities experienced by American Indian youth requires recognition of the past. It also requires recognition of the effectiveness of traditional practices and an integration of American Indian cultural (including spiritual) perspectives on mental health and well-being. An understanding of western influence on American Indian 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 an American Indian member of our collaborative effort explained:

> 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 American Indian 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 American Indian youth and their families are supported and taken care of in this process.

In order to eliminate the behavioral health disparities experienced by AI/AN youth and to promote their mental health and well-being, it is imperative to understand this historical context and to foster change on multiple levels, including the individual, family, community, tribe, systems of care, and larger social structures. We outline a partnership process and framework to address the mental health and well-being of American Indian youth, their families, and their communities through an understanding and integration of historical trauma in behavioral health practices and policies. We summarize the literature we have reviewed, the experiences of AI/AN 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. We end with 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 AI/AN 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 effort will encourage our numerous partners and others to advocate for and implement these changes because, as an American Indian 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 every day, how we’re supposed to represent ourselves.

Method

We began our process with a comprehensive literature review on the mental health of AI/AN youth, strengths and resiliency, historical trauma, evidence-based/promising practices, and culturally competent processes for working with AI/AN youth. Next, we conducted community advisory meetings with 71 American Indian youth, parents, and elders, and surveys of 25 service providers. We also consulted with four traditional practitioners to obtain their guidance on developing policy and practice recommendations to

promote the mental health of AI/AN youth, and their feedback on our preliminary report. Finally, we conducted a focus group with ourselves (Project TRUST members) to document our experiences and reflections. Prior to beginning this study, we obtained approval from the School Boards in the four communities where the community advisory council meetings were held, the Northern and Eastern area agencies of the Navajo Nation, the Navajo Nation Department of Behavioral Health Services, the Navajo Nation Human Research Review Board, and the University of New Mexico Human Research Review Committee.

Community Advisory Meetings

Between March and June 2007, we conducted community advisory meetings in four communities (see Table 1 for description of participants).[2] The community advisory meetings were each two hours in length and began with a small meal. This was followed by a viewing of *Rez Hope,* a film written and directed by Diné (Navajo) filmmaker Norman Brown, which depicts American Indian adolescents who are dealing with issues including substance abuse, intimate partner violence, depression, and suicidality. The film also emphasizes traditional American Indian cultural strengths in addressing these issues. After viewing the film, the facilitators (American Indian youth and adult members of the Project TRUST partnership) posed several questions to parents and youth together (e.g., Do the behavioral health services in your community work for you and/or your family? Why or why not?), and then split parents and youth into separate groups for additional questions and discussion (e.g., Why do you think American Indian youth might *not* seek or complete behavioral health counseling or treatment as advised by a medical or behavioral health service provider?). At least one clinician was present at each community advisory meeting, and at least two additional Project TRUST members took detailed notes during each meeting.

Provider Surveys

During the same time period, we conducted a survey of service providers who work with American Indian youth in the same four communities (see Table 2 for demographic information about respondents). The survey contained six open-ended questions that asked respondents to describe how effective they perceived their work with American Indian youth to be, as well as barriers to behavioral health care, what culturally-appropriate behavioral health care for American Indian youth involves, and advice they would give to other providers. The surveys were distributed through behavioral health provider organizations and other health care facilities (e.g., school-based health centers) in all four communities. We asked our partners to track how many surveys they distributed and how many were returned. Our response rate was approximately 55%.

Data Analysis

Six Project TRUST partners affiliated with the University of New Mexico participated in the initial content analyses of the qualitative data collected from the community advisory

[2]The four communities included three rural, reservation communities and one urban, non-reservation community. Although the advisory meetings were conducted within the state of New Mexico, our review of the literature and our national experience suggest that the issues raised are widely applicable throughout the United States.

meetings and service provider surveys, including three women (Tewa/Hopi social worker, Lakota clinical psychologist, White community psychologist), and three men (Diné program specialist, Diné undergraduate psychology major, and White 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 issues or factors. Preliminary analyses of the qualitative data were presented to the other Project TRUST partners for further analysis and interpretation.

Traditional Practitioner Guidance

After completion of these analyses, we had a series of four meetings and consultations with traditional practitioners to obtain their guidance on our process, analyses, and preliminary 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 of Native people to deal with challenges they face, the psychological benefits of traditional healing practices, and recommendations for behavioral health providers who work with Native youth.

Partner Focus Group

A final step in our methods was to facilitate a focus group discussion among our own members to reflect on our process and findings. We recorded, transcribed, and analyzed this partner discussion that included 11 participants. Triangulating all five sources of data (literature review, community advisory meetings, provider surveys, consultation with traditional practitioners, and focus group with Project TRUST partners), we identified seven focal causes of behavioral health disparities and ineffective behavioral health care for AI/AN youth: 1) high levels of violence and trauma exposure, 2) historical trauma and institutional racism, 3) underfunded systems of care, 4) disregard for effective traditional practices, 5) overreliance on evidence-based practices, 6) lack of cultural competence among systems of care and providers, and 7) barriers to care. With an explicit focus on placing equal value on community members' perspectives, traditional practitioners' expertise, and existing literature, our results integrate these various sources of knowledge within a discussion of each identified cause. Based on our understanding of these causes, we developed 20 policy, practice, and research recommendations.

Results

Violence and Trauma Exposure

A growing body of evidence suggests that behavioral health disparities experienced by American Indian and Alaska Native youth are related to disparities in violence and trauma exposure. High rates of traumatic loss and trauma exposure have been found among AI/AN youth (Jones, Dauphinais, Sack, & Somervell, 1997; Manson, et al., 1996; Robin, Chester, & Goldman, 1996). In addition, higher rates of witnessing traumatic events, experiencing

trauma to loved ones, and being victimized by physical attacks than the overall U.S. population have been found among a random sample of 3,084 members of two American Indian tribes (Manson et al., 2005). These high rates of traumatic loss and trauma exposure have been linked to PTSD,[3] substance abuse, and other forms of psychological distress among AI/AN youth (Gnanadesikan, Novins, & Beals, 2005; Jones, et al., 1997). 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, American Indian youth ages 12-17 had similar substance use risks as Caucasian youth, which suggests that violence victimization and other disadvantaging factors play a large role in high rates of substance use disorders (Kilpatrick, et al., 2000).

Historical Trauma and Institutional Racism

When examining the high rates of violence exposure, mental health challenges, and health disparities faced by AI/AN 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, Duran, & 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). An emerging literature is beginning to link psychological distress and substance use among American Indians to multigenerational and community trauma, through an explication of the concept of historical trauma (Whitbeck, Adams, Hoyt, & Chen, 2004; L. B. Whitbeck, X. Chen, D. R. Hoyt, & G. W. Adams, 2004).

The historical trauma concept emerged from studies of children of Holocaust survivors (Kellerman, 2001), and has been applied to the genocide and ethnic cleansing of American Indians (Brave Heart, 1999, 2003; 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 and Jewish Holocaust survivor syndrome: 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, she suggests that historical trauma is more relevant to American Indians than PTSD, which doesn't capture enduring widespread, intergenerational components of historical trauma (Brave Heart, 2003).

[3]Several researchers have noted potential cultural biases in the PTSD criteria, and have suggested that the notion of PTSD may not adequately represent the full impact of the pervasive multigenerational community trauma experienced by AI populations (Jones et al., 1997; Manson et al., 1996; Robin et al., 1996).

Historical trauma was frequently discussed in the community advisory meetings and provider surveys. Most participants seemed to understand historical trauma and its impact on the mental health of Native youth. As an adult community advisory meeting participant explained:

> 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… 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.

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 (Whitbeck, Hoyt, McMorris, Chen, & Stubben, 2001; Whitbeck, McMorris, Hoty, Stubben, & LaFromboise, 2002). As a youth community advisory participant stated: "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."

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, state, and local policies, as well as actions taken by religious institutions, 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. 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. 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.

Underfunded System of Care for AI/AN Behavioral Health Care

Funding disparities for Native communities are a glaring present-day example of such inequalities. It is clear that funding disparities are one indication of a long history of broken promises that impact the ability of tribes and systems that serve American Indian/Alaska Native youth to address health disparities for Native youth. For instance, per capita funding for American Indian 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 American Indians 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 American Indians 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 some of the most severe health disparities in the country.

Service providers who responded to our survey frequently mentioned the underfunded system of behavioral health care for Native youth. As one explained, “Once a provider identifies the need, and then has no services to offer, it’s very frustrating.” Most Americans are not aware that one of the conditions of the treaties the U.S. government signed with some American Indian 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 American Indians.

Disregard for Effective Traditional Practices

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 American Indian populations (Gray & Nye, 2001; Spicer, Novins, Mitchell, & Beals, 2003). Whitbeck found that enculturation is related to less alcohol abuse among American Indian adults; more pro-social behavior among American Indian adolescents; and enculturation can buffer the effects of depressive symptoms among American Indian adults (Whitbeck, et al., 2001; Whitbeck, et al., 2002; L. G. Whitbeck, X. Chen, D. R. Hoyt, & G. W. Adams, 2004). Yoder and colleagues found that American Indian youth (ages 9-16) who have higher levels of involvement and identification with their AI culture are less likely to have suicidal thoughts (Yoder, Whitbeck, Hoyt, & LaFromboise, 2006). Rieckmann, Wadsworth and Deyhle found that Diné cultural identity is a protective factor against depression among Diné adolescents ages 14-20 (Rieckmann, Wadsworth, & Deyhle, 2004).

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; Garroutte, et al., 2003; Marbella, Harris, Diehr, Ignace, & Ignace, 1998). For instance, Garroutte and colleagues found that commitment to cultural spiritual orientation was significantly related to decreases in

attempted suicide among 1456 American Indians ages 15-57 (Garroutte, et al., 2003). 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). Another recent study with 980 American Indian adults suggests that those who participated in traditional activities and traditional spirituality were more likely to cease their use of alcohol (Stone, 2006).

Taken together, the research findings on the importance of traditional cultural practices, values, and beliefs for well-being support what many AI/AN elders and other community members already know. It is also important to note that 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. The authors argue that this relates to both issues of trust and the appropriateness of western approaches for American Indian cultures.

Uncritical Use of Evidence-Based Practices

One of the reasons traditional indigenous practices tend to be disregarded within U.S. behavioral health systems of care is the emphasis placed 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. The focus on EBPs 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.[4] 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. Studies documenting the efficaciousness of mental health treatments have not included any AI/ANs. For instance, there were no AI/ANs 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 (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 AIs, thus raising the question of whether it is appropriate to promote the use of evidence-based treatments in these populations (Miranda, et al., 2005). In fact, the promotion and implementation of evidence-based practices can be seen as another form of institutional racism because almost none have been developed and/or tested with Native communities. This reality is clearly perceived by many AI/AN providers and community members, but is

[4]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).

not often recognized by non-Native providers, researchers, funding sources, and policymakers. A provider who responded to our survey explained, "[Providers need to] understand the cultural context and know the limitations of western practices."

Lack of Cultural Competency

The seemingly divergent emphases on traditional indigenous practices and evidence-based practices present a challenge to western behavioral health systems in their attempts to provide culturally "competent" care. Integration of western and traditional AI approaches to mental health care and healing may be possible, but it is rare, in large part because the history of forced colonization of Native people has led western behavioral health care systems to ignore traditional healing practices and approaches to mental health care and healing for American Indians. 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 the Project TRUST partnership 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. They focused on the power in American Indian 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. '*Iina* is something in you. You need to take care of your body, what you eat, what you put in it. *Iina* 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.

There was agreement that cultural competency/appropriateness was important. The next essential question we asked was: What does cultural competency mean? Is cultural competency even the correct term for what traditional practitioners, community members, and service providers describe? Tervalon and Murray-Garcia (1998) offer an alternate concept – cultural humility, which implies ongoing self-reflection and critique, efforts to decrease the power differential between providers and their clients, and formation of genuine partnerships to improve health through improved services and advocacy, rather than endorsing the idea that cultural competency requires only the acquisition of certain knowledge about diverse populations.

In addition to cultural humility, several standard components of cultural competency commonly acknowledged are: organizational cultural competence (e.g., leadership commitment; institutional policies, practices, and systems; system wide standards; and dissemination of best practices); consumer inclusion (e.g., patients/consumers/community actively participate in definition of their culture and culturally competent practices; inclusion of family member perspectives in mental health treatment plans and objectives); linguistic competence (e.g., organizational language assistant services; bilingual/bicultural staff); diversity training (e.g., dismantling racism and stereotyping; and communication models), assessment and evaluation (e.g., individual assessment of attitudes, beliefs and practices; organizational assessment of policies and standards; focus on lessons learned; and implementation of grievance resolution processes), and staffing (e.g., most people agree that it is important to have a staff that is reflective of the diversity of clients, although this does not mean that a Native client must see a Native provider).

There is also some literature that explores cultural competency as it specifically relates to AI/AN populations. For instance, Weaver suggests that cultural competence for clinicians working with American Indians 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 therapeutic cultural competency, 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 behavioral 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, and 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) working collaboratively with traditional healers and other community members; and 4) assessing process and outcome of therapeutic efforts both in terms of positive and unintended negative outcomes or difficulties in process (J.P. Gone, 2004).

LaFromboise also discusses the lack of compatibility between western therapeutic approaches and American Indians. She mentions several conflicting values, most importantly that western therapy is too individually-focused and that it de-legitimizes traditional healers and practices (LaFromboise, 1988).

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 to assist all providers, Native and non-Native, to be culturally competent when historical trauma has created such a diversity of beliefs. Our multiple sources of data suggest that the key to working effectively with this diversity of beliefs involves alerting providers to this spectrum (and its causes). 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.

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.

Duran and Duran suggest that healing for American Indians is difficult because the world community has not validated the trauma or offered "an escape route" (e.g., 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 American Indian tribal lives and pathology" (E. Duran & Duran, 1995), p. 69). They recommend "hybrid therapy – community clinic model" where western-trained American Indians 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 entire communities. Remembering and mourning collectively is important because 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 sharing stories and creating community events such as memorial walks (Faimon, 2004).

Barriers to Care

In addition to the six issues discussed previously, there are several related barriers to care which impact the mental health of AI/AN youth and their access to care. For instance, the main obstacles to utilization of mental health and substance abuse treatment identified by 3,084 American Indians ages 15-54 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 American Indian 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). It is important to address these barriers, because American Indian/Alaska Native youth want and need quality care. For example, a recent study 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).

The barriers to care identified in the literature 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)
>
> The hospital does not offer option of traditional healing ceremonies or sacred sanctuaries such as a Hogan or sweat lodges.
>
> (White 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. Participants also identified the overall lack of resources 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)

Issues of communication and trust were the most highlighted obstacles to care. 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.
>
> It would probably help if they at least *acted* like they cared.

> 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.

Providers were also aware of the mistrust expressed by youth. As one White provider explained:

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

Other participants suggested that high rates of staff turnover made communication and trust difficult to develop. 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)

It is important to recognize that provider turnover is closely linked to the lack of resources within behavioral health care systems, which can result in learned helplessness among providers (Gondolf & Fisher, 1988), and to providers' vicarious traumatization (McCann & Pearlman, 1990) and/or secondary traumatic stress (Figley, 1995) due to high rates of trauma experienced by their clients. Thus providing adequate support, supervision, and training for providers is essential.

In summary, we found that American Indian/Alaska Native youth live in a multi-layered, multi-jurisdictional world and face multiple stressors and traumas, including: historical trauma, poverty, current institutional racism, microaggressions, and traumatic life events (witnessing or experiencing violence). Furthermore, the current structures and emphases of behavioral health systems of care do not adequately address these multiple challenges or integrate effective indigenous health practices. These findings highlight the legacy of historical trauma in Indian Country not only in terms of its impact on the mental health and well-being of AI/AN youth, but also its effect on the resources for healing that are available to AI/AN youth. To redress these limitations of current behavioral health care in the United States, we utilized our results to develop a series of policy, provider, and research recommendations that seek to address the seven causes of behavioral health disparities we identified. We created recommendations for policy makers, providers, and researchers because creating sustainable improvements requires change among providers who work directly with AI/AN youth, policies that fund treatment, and research that informs the development and funding of behavioral health care.

Policy Recommendations

#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 could issue a formal apology.

#2: Reparations from U.S. Government

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 subsequent recommendations 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 AI/ANs.

#3: Expand Mechanisms for Reimbursement for Traditional Healers

In order to legitimate and support traditional cultural healing 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.

#4: Shift Emphasis from Evidence-Based Practices to Practice-Based Evidence

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. Thus, it is important to fund the implementation and evaluation of “promising” and community based practices for Native communities.

#5: 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.

#6: Require Behavioral Health Systems to Take into Account Historical Trauma and the Current Realities of Native Youth

In terms of current behavioral health systems, it is important to examine how policy makers at the state and federal levels 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.

#7: Provide Additional Funding to Support Teen Centers and School-Based Health Centers

It is essential to support and create settings where youth have positive interactions with adults. 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.

#8: 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, 2001). In addition, 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.

#9: Create Alternative Licensing and Credentialing for Native Service Providers

Providing alternative licensure requirements for those Native 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 American Indians to build their infrastructure and support Native healing concepts in this system of care.

Provider Recommendations

#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.

#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, but also the potential for developing vicarious traumatization, secondary traumatic stress, and/or burnout because of high levels of exposure to trauma through their clients.

#3: 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 AI/AN communities, being sure to include mid-level behavioral health providers. One example may be a tax credit for rural behavioral health professionals.

#4: 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. For example, co-trainings that bring traditional practitioners and western providers together to share their perspectives on particular behavioral health issues may be useful. Other strategies to consider include creating a resource list of traditional practitioners and a mechanism for connecting western providers to traditional healers.

#5: 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.

#6: 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.

#7: Align Behavioral Health Approaches to Include Youth, Parents, Extended Families, and Communities

To break the cycles of intergenerational transmission of trauma, we have to understand how historical events 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 their treatment,

including providing comfort and showing a sense of caring. Funding and support for community healing efforts is also important.

Research Recommendations

#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. For a thorough discussion of the relevance of community psychology approaches for promoting the mental health and well-being of Native peoples see Gone (2007).

#2: Develop Innovative Research Methods and Methodologies

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. In addition, research that explores the ways in which western psychotherapy and traditional healing practices can be effectively integrated is essential (Joseph P. Gone, 2010).

#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. 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.

#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.

Discussion

This paper summarizes the literature we have reviewed, the experiences of our community experts including AI/AN 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 20 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 AI/AN 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.

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.

Although our literature review included research conducted with American Indians from numerous tribes in the U.S., most of the youth, parents, elders, and traditional practitioners in our study were Diné (Navajo). Thus, we cannot assume that our findings apply to all AI youth and families. However, the convergence we identified between the research literature and our focus group, survey, and consultation results suggests that the seven main causes of behavioral health disparities we present may be applicable to many AI youth and families, and therefore the recommendations we developed to address these factors are broadly construed. Future research should explore the relevance of the recommendations for other AI youth, with particular attention to the experiences of urban AI youth and youth from smaller tribes. It is also important to note that the reliability and validity of our qualitative data analyses was affected by our research team. For this reason, we involved six research team members from different backgrounds and with different areas of expertise in the coding process, including AIs from several different tribes and non-Natives, providers, researchers, and non-research staff. However, other coders may have found different themes within the data. To further address this limitation, we shared our preliminary themes with all Project TRUST partners, as well as with community members and traditional practitioners who participated in the study, in order to check the authenticity and validity of our findings.

We learned many important lessons throughout the Project TRUST process, the first of which 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.'
>
> (American Indian Project TRUST member)

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

> 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… 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.
>
> (American Indian 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.
>
> (American Indian 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… 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.
>
> (American Indian 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:

> 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 one Project TRUST member said:

> 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.
>
> (American Indian Project TRUST member)

We recognize 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 the well-being of AI/AN youth and the challenges to providing behavioral health care to AI/AN youth, as well as how it provides communities with opportunity to begin or continue healing processes. Although complex and contested, framing the behavioral health disparities experienced by AI/AN youth through the concept of historical trauma may be one way in which to resist blaming AI/AN individuals, families, and communities for these disparities and to articulate the socio-political foundations of suffering and potential multi-layered, social, non-western approaches to healing. This is important because historical trauma foregrounds local, state, and federal government and religious institution policies and actions that intentionally attempted to destroy AI/AN peoples and cultures, while also emphasizing the resiliency of those who survived these attempts.

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

Meeting Location	Adults			Youth (ages 11-17)		
	Male	Female	**Total**	Male	Female	**Total**
Gallup	6	7	13	5	1	6
Shiprock	0	8	8	5	5	10
To'Hajiilee	2	11	13	1	6	7
Crownpoint	1	10	11	0	3	3
TOTAL	9	36	**45**	11	15	**26**

Table 2
Summary of Provider Survey Participants (N = 25)

Provider Type	Total	Ethnicity	Total
Physician	9	White	11
Social Worker	4	American Indian	6
MH Therapist	4	African American	3
Psychiatrist	2	Hispanic	2
Psychologist	2	Asian American	1
Public Health	1	Native & White	1
Not specified	3	Not Specified	1
Gender			
Male	8	**Years Working with AJ7AN Youth**	
Female	16		
Not Specified	1	5 years or less	5
Age		6-10 years	4
26-40	8	11-15 years	7
41-55	12	16+ years	8
56+	3	Not Specified	1
Not Specified	2		