HHS Public Access

Author manuscript

Psychol Serv. Author manuscript; available in PMC 2020 November 02.

Published in final edited form as:

Psychol Serv. 2021 February ; 18(1): 84–92. doi:10.1037/ser0000358.

Increasing Culturally Responsive Care and Mental Health Equity With Indigenous Community Mental Health Workers

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Abstract

There are 600 diverse American Indian/Alaska Native communities that represent strong and resilient nations throughout Indian Country. However, a history of genocidal practices, cultural assaults, and continuing oppression contribute to high rates of mental health and substance use disorders. Underresourced mental health care and numerous barriers to services maintain these disparities. Indigenous community mental health workers hold local understandings of history, culture, and traditional views of health and wellness and may reduce barriers to care while promoting tribal health and economic self-determination and sovereignty. The combination of Native community mental health workers alongside a growing workforce of Indigenous mental health professionals may create an ideal system in which tribal communities are empowered to restore balance and overall wellness, aligning with Native worldviews and healing traditions.

Keywords

American Indian; Alaska Native; indigenous; mental health; community health worker

> "It all comes back to our heritage and our roots. It is so vital that we retain our sense of culture, history, and tribal identity."
>
> —Wilma Mankiller, Cherokee Nation of Oklahoma
> (Mankiller & Wallis, 1993, p. 246)

American Indian (AI)/Alaska Native (AN) communities represent strength and resilience within a history of attempted genocide, cultural assault, and ongoing systemic oppression. A myriad of factors including historical trauma, continuing discrimination, barriers to services (including culturally effective services), and the failure of the federal government to uphold its trust responsibility to AI/AN communities contribute to persistent substantial mental health and substance use disparities for Native communities. The purpose of this article is to advocate for the employment of indigenous community mental health workers to expand and improve mental health services and systems of care within AI/AN communities—an approach that underscores community resilience and strengths. We describe promising outcomes from Native communities currently using this model and discuss advantages of

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community mental health workers in delivering care, including increasing tribal health and economic self-determination and sovereignty, reducing barriers and stigma related to seeking care, increasing availability of services and culturally effective care, and reflecting and empowering the Native value of community as essential to maintaining and sustaining population health. A system of care that includes indigenous community mental health workers in addition to Native psychologists, psychiatrists, and other mental health professionals has great potential in improving overall wellness and restoring balance in Indian Country.

Current Context of Native Nations in the United States

Demographics

The 2016 U.S. Census yielded data showing 5.6 million people self-identified as AI or AN. Within this group, approximately 2.7 million identified as only AI or AN (U.S. Census Bureau, 2016). The majority of AI/ANs live outside federal or state reservations, trust lands, or tribally designated areas, leaving 22% who live on reservations or other trust lands (Norris, Vines, & Hoeffel, 2012; U.S. Department of Health and Human Services, Office of Minority Health, 2017). Approximately one third of AI/ANs are younger than 18; the median age for AIs living on reservations is 26 years old compared to 37 among non-Natives in the general population (National Congress of American Indians, 2018a; U.S. Census Bureau, 2018). The terms *Indigenous, American Indian*, and *Alaska Native* encompass individuals from diverse, strong communities who practice different Native spiritual and cultural traditions, speak different languages, reside in different settings, and have different approaches to forming their own cultural identities, often shaped by a wide range of contextual, historical, and relational factors (Gone, 2004; Harris, Carlson, & Poata-Smith, 2013).

Tribal Sovereignty and Self-Determination

The 573 federally recognized tribes and hundreds of state-recognized tribes are sovereign nations within the United States (National Congress of American Indians, 2015, 2018b). Self-governance allows for significant policy and programmatic-driven decisions by and for tribal communities in a variety of domains, including health care and economy (The Harvard Project on American Indian Economic Development, 2008). In spite of sovereign nation status, tribal communities still reside within a federal system that has historically undermined their self-determination (Gone & Trimble, 2012) and are challenged by difficult structural and social conditions that differ from the general experiences of others in the United States. These conditions contribute to important contextual factors that influence mental health and overall well-being of AI/AN communities.

Addressing Mental Health with American Indian/Alaska Native Communities

Underresourced Mental Health Care

The United States has a legal responsibility to provide health care services to AI/ANs as part of the government-to-government relationship with tribal nations dating back to the history of treaties signed with tribes (Indian Health Service [IHS], 2015; Warne & Frizzell, 2014).

The IHS is housed within the Department of Health and Human Services and tasked with upholding federal responsibility and providing health care services to tribal communities (IHS, 2018a). Unfortunately, the IHS is considered a discretionary program with funding decisions reliant on Congress and subject to political influences (Warne & Frizzell, 2014). Historical and contemporary relationships with the federal government have impacted the health status of AI/ANs. As Warne and Frizzell (2014) state, "U.S. history [and current policy] has borne out a unique relationship between AI/AN tribes and the federal government, including forced acculturation, warfare, and severely underfunded health services, leading to severe AI/AN health disparities" (p. S266). In 2014, the per capita allocation for patient care afforded by IHS was approximately one third of per person health care spending nationally and 40% of per prison inmate federal spending, even though tribal communities suffer far greater health disparities, largely due to a history of abuse and neglect systematically carried out by the federal government (National Congress of American Indians, 2017; U.S. Government Accountability Office, 2017). The severity of need and potential consequences were highlighted in the U.S. Commission on Civil Rights (2003) report stating the meager IHS budget

> can only lead one to deduce that less value is placed on Indian health than that of other populations. If funding levels continue to stagnate, the health status of Native Americans will continue to decline, resulting in even greater needs in the future. (p. 49)

Mental Health Inequities in Native Communities

AI/ANs face some of the greatest challenges to their health, mental health and well-being of any ethnic or racial group in the United States. Mental health related mortality is a priority. A recent study (Shiels et al., 2017) of death certificate data from the U.S. National Center for Health Statistics showed that premature deaths among AI/ANs was highest and increased each year from 1999 to 2014, primarily due to consequences of mental health and substance use disorders such as liver disease and cirrhosis, suicide, and injuries. An estimated 6,600 excess premature deaths occurred in AI/ANs ages 25 to 49 during this time frame.

Morbidity from mental health concerns are similarly elevated and help to elucidate a more nuanced and complicated picture. Mental health-related morbidities are 1.7 to seven times higher among Native youth and adults for conditions including, but not limited to, substance use and posttraumatic stress disorders, and suicide (see Sarche & Spicer, 2008). In a longitudinal study of indigenous adolescents from four reservations in the Midwestern United States and four Canadian reserves, results showed prevalence rates for mental health and substance use disorders increased significantly from age 10 to 12 to when youth reached age 12 to 15 (Whitbeck, Yu, Johnson, Hoyt, & Walls, 2008). Results showed an eightfold increase in youth meeting criteria for a substance use disorder; major depressive episode prevalence more than doubled between the two time periods. Conduct disorder and lifetime substance use disorder rates were two to three times higher among this group of indigenous youth compared to the general population (Whitbeck et al., 2008). Intergenerational burden of mental health and substance use disorders was also apparent in high prevalence rates of one lifetime mental health or substance use disorder (43%) or two or more lifetime disorders (31.6%) among these youth's caregivers (Whitbeck et al., 2008). Another study by Brave

Heart and colleagues (2016) with urban AI/ANs demonstrated that approximately 70% and 63% of AI/AN men and women respectively, compared to 62% and 53% of non-Hispanic White men and women, met criteria for a lifetime psychiatric disorder. Almost half of AI/ANs met diagnostic criteria for a psychiatric disorder in the past year; AI/AN women experienced larger gaps with their counterparts then men (Brave Heart et al., 2016). However, differences between groups decreased when analyses adjusted for sociodemographic characteristics. Taken together, despite disparities, there is great heterogeneity in mental health and substance use disorders by age, region, gender, and tribal context. There is also a great need to understand historical and current stressors as root causes that impact mental health, well-being, and the unique role that strengths play in overcoming these inequities within AI/AN communities.

Mental Health and Substance Use Treatment in Tribal Communities

Mental health and substance use as priority areas in Native communities have prompted an increase in literature on treatment. Theoretical and empirical articles have attempted to understand treatment utilization, barriers to seeking mental health care, and treatment preferences. Research has been mixed about treatment utilization. In a recent national sample that included significant urban representation, AI/ANs were more likely to seek mental health treatment compared to non-Hispanic Whites with variations by gender and psychiatric presenting complaint (Brave Heart et al., 2016). However, in a study of Northern Plains and Southwest tribal communities, mental health treatment utilization for biomedical services and traditional healing was low (Fortney et al., 2012). It is challenging to draw conclusions from the current literature given the heterogeneity of AI/AN samples (e.g., geographic region, tribal identity, urban vs. rural vs. reservation residence) and methods (e.g., national vs. local sampling).

Stigma has emerged as one of the most consistent barriers to care across several studies for Native communities. AI/ANs have described stigma about seeking services related to concerns about being weak and how others will view them (Duran et al., 2005; Freitas-Murrell & Swift, 2015; Johnson, Bartgis, Worley, Hellman, & Burkhart, 2010; Venner et al., 2012). Other barriers include concern about maintaining privacy about their presenting psychiatric complaint, trusting providers, as well as lack of transportation, time, financial resources, and social support (Duran et al., 2005; Venner et al., 2012).

AI/AN ethnic identification may also have implications for choosing to engage in mental health treatment. In a study of AN college students, those with higher levels of Caucasian identity demonstrated positive attitudes (i.e., openness in therapy, willingness to seek help, and stigma) about seeking mental health therapy (Freitas-Murrell & Swift, 2015), whereas in a separate study of AI college students, those with strong tribal identification reported negative attitudes (i.e., self-reported need for therapy, stigma, openness in therapy, and confidence in service providers; Price & McNeill, 1992). However, these two studies used different measures assessing attitudes about seeking mental healthcare and this may explain the discrepancy in results. In addition, research has shown that AI/AN individuals may prefer Native providers for mental health treatment (e.g., Aronson, Johnson-Jennings, Kading, Smith, & Walls, 2016; Venner et al., 2012). These findings may be attributable to a

lack of and need for culturally sound and effective care that honor Native epistemologies underlying health and wellbeing (Duran et al., 2005; Goodkind, Gorman, Hess, Parker, & Hough, 2015; Gone & Alcántara, 2007; Gone & Trimble, 2012; Hodge, Limb, & Cross, 2009; LaFromboise, 1988; Venner et al., 2012).

Indigenous Views of Mental Health, Healing, and Wellness

Numerous authors have identified colonialism (i.e., European contact, land theft, genocidal acts, forced assimilation), its lasting effects (e.g., historical trauma or historical loss; Brave Heart & DeBruyn, 1998; Whitbeck, Adams, Hoyt, & Chen, 2004) and continuing oppression (e.g., discrimination) as root causes of indigenous mental health inequities (Brave Heart, 2003; Duran & Duran, 1995; Goodkind et al., 2015; Gone & Trimble, 2012; Smith, 1999). Colonialism and continued discrimination impact specific tribes differently (e.g., historical events and current context of racism). There is also a general sense of shared suffering (Brave Heart, Chase, Elkins, & Altschul, 2011) that may be reflected in population-level mental health disparities.

Research has shown a direct link between historical trauma (also called historical loss) and depression, anxiety, substance abuse, and indirectly to suicide ideation (e.g., Armenta, Whitbeck, & Habecker, 2016; Grayshield, Rutherford, Salazar, Mihecoby, & Luna, 2015; Tucker, Wingate, & O'Keefe, 2016; Tucker, Wingate, O'Keefe, Hollingsworth, & Cole, 2016; Whitbeck, Chen, Hoyt, & Adams, 2004; Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009; Wiechelt, Gryczynski, Johnson, & Caldwell, 2012). Burgeoning viewpoints assert that if colonialism and intergenerational historical loss are recognized as the identified problem, it follows that interventions with AI/ANs should be focused on cultural reassertion and revitalization at the individual and community level (Brave Heart et al., 2011; Gone & Trimble, 2012; Goodkind et al., 2015). In a qualitative study, AI elders discussed that healing from intergenerational historical trauma involves tribal cultural reclamation, including speaking one's native language, and spirituality (Grayshield et al., 2015).

When considering culturally appropriate mental health care, it is vital to understand cultural views, traditions and practices related to healing and wellness—which far predate contact with Europeans (Goodkind et al., 2010; Hodge et al., 2009)—directly from and for tribal community members (Gone, 2004; Gone & Trimble, 2012). AI/AN beliefs and practices vary by tribe and may include prayer, ceremony, storytelling as a method of passing on traditions, interactions with a traditional healer, and daily practices to sustain balance and wellness (Gone, 2010; Goodkind et al., 2015; Whitbeck, Walls, & Welch, 2012). A recent study of Dine youth, caregivers, and elders revealed "connections to the land were a vital cultural strength on which to build efforts to promote mental health, wellbeing, and healing" (Goodkind et al., 2015).

Western mental health care is epistemologically different from AI/AN traditional belief systems in a number of ways (Duran & Duran, 1995; Gone, 2010; Hodge et al., 2009). Several tribal communities have adopted mental health/substance use prevention/ intervention programs driven by culture and included in discussions pertaining to the

continuum of local community validated practices to practice based evidence with cultural validation to evidence based practice (see First Nations Behavioral Health Association, 2009). Related, there has been a call for institutional health care systems supporting Native traditional practices (Goodkind et al., 2010). A convening of traditional healers, researchers, and clinicians provided a definition of traditional healing and traditional healer, in addition to points of integration for AI/AN practices with mental health services (Moorehead, Gone, & December, 2015). Common themes to define traditional healing included relationality (e.g., relation to family, community, higher spiritual power, environment), personal characteristics (e.g., trust in traditional healing process, humor), and continuing culture, history, and teachings. A traditional healer was described as someone who engages in their own wellness, holds traditional and cultural knowledge usually through learning from other healers or elders, believes that an individual holds the ability to heal him or herself, and serves the whole community (Moorehead et al., 2015). Points of integrating traditional healing and western mental health care emphasize working together on culturally based programs, respect for each system of care, and the importance of communication between the two (Moorehead et al., 2015). These views, combined with research demonstrating positive outcomes for those who seek traditional healing, has led to policy recommendations to allocate funding to tribal programs to support cultural traditions and reimburse traditional healing (see Goodkind et al., 2010; Payne, Steele, Bingham, & Sloan, 2018). Harnessing cultural strengths to promote and sustain wellness, while carrying these traditions forward for future generations, may provide the keystone to culturally informed mental health care for AI/ANs.

Overrepresented While Underrepresented

AI/ANs are overrepresented in statistics defining mental health disparities, while simultaneously underrepresented in the availability of mental health professionals (Thomason, 1999). There is also a pronounced need for AI/AN mental health providers (Thomason, 1999). Tribal community members voicing preferences for Native providers and research demonstrating effective culturally informed interventions has led to a call for increasing AI/ANs in mental health fields (Aronson et al., 2016; Gone, 2004; Gone & Trimble, 2012; LaFromboise, 1988; Thomason, 1999). A report by the U.S. Department of Health and Human Services (2001) revealed there are approximately 101 mental health providers (i.e., counselors, psychiatric nurses, social workers, psychiatrists, and psychologists) per 100,000 AI/ANs compared to 173 per 100,000 White Americans. Recent data estimates there are approximately 260 indigenous Psychologists across North America (J. Gone, personal communication, March 17, 2018). The paucity of Native psychologists leads to a lack of academic role models for Native students interested in mental health professions (LaFromboise, 1988; Thomason, 1999). AI/AN researchers also carry with them unique knowledge of culturally sound and ethical research methodologies to protect communities against harm (Walters & Simoni, 2009). Federal grants have supported recruiting and retaining AI/AN doctoral psychology students, including the Indians into Psychology Doctoral Education program at the Universities of North Dakota and Montana, American Indians into Psychology at Oklahoma State University, and Alaska Natives into Psychology at the University of Alaska (Trimble & Clearing-Sky, 2009). Growing the base

of AI/AN psychologists is necessary to bring indigenous views and practices to accelerate progress to mental health equity for Native peoples. Many newly trained AI/AN psychologists have the ability to choose academic research positions to address inequities through research and policy over providing direct clinical service. Thus, it may take decades to reach a sufficient number of trained AI/AN clinicians to attend to treatment needs in their own or other tribal communities.

Indigenous Community Mental Health Workers

While efforts continue to expand the AI/AN professional mental health treatment workforce, there are alternative approaches to concurrently fill gaps. A promising strategy is to use task-shifting (Becker & Kleinman, 2013; Kakuma et al., 2011; World Health Organization, 2008). Task-shifting is "a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications" (World Health Organization, 2008, p. 7). This approach helps address critical health priorities and provider shortages. Task-shifting is not a stand-alone solution and should be used in combination with additional approaches to increase providers (World Health Organization, 2008). For example, paraprofessionals or local lay providers may be trained in evidence-based mental health practices (EBPs) and provide mental health interventions in community settings (e.g., home, school, summer camps). In low resource settings globally, there is now robust evidence to show that task-shifting delivery of evidence-based mental health care to community health workers, including delivery of EBPs, can be implemented with fidelity and are effective for treatment of common mental health disorders, including depression, posttraumatic stress, and substance use disorders (Singla et al., 2017; Van Ginneken et al., 2013). In fact, there are 27 randomized controlled trials (Van Ginneken et al., 2013) of task-shifted mental health interventions that have been delivered in a variety of settings including with refugees, in settings of ongoing conflict (Weiss et al., 2015), among HIV affected populations (Kane et al., 2017; Murray et al., 2013), in low-resource contexts generally (Chowdhary et al., 2016; Rahman, Malik, Sikander, Roberts, & Creed, 2008), and with other trauma affected populations (Bass et al., 2013; Bolton et al., 2014). There are now growing calls for using this approach to address treatment gaps in the United States (Hoeft, Fortney, Patel, & Unützer, 2018; Kazdin, 2017; Kazdin & Rabbitt, 2013; National Institutes of Mental Health, 2016; World Health Organization, 2008).

There is a ready workforce of passionate, experienced, empathic and motivated indigenous paraprofessionals who are eager to address their communities' priorities (Barlow & Walkup, 1998; Chernoff & Cueva, 2017; Gampa et al., 2017). Throughout this article, we use the terms *paraprofessional* and *community mental health worker* to describe AI/AN health workers engaged in task-shifting. We use the terms *Community Health Aide, Behavioral Health Aide*, and *community health worker* pertaining to specific funded programs and/or use the same terminology used by published literature when providing existing examples. Tribal nations in the United States have been unrecognized innovators in using this approach for decades (e.g., Barlow, 2013; Barlow et al., 2013; Walkup et al., 2009). As an example, the Alaska Community Health Aide Program was conceptualized in the 1950s, formalized in the 1960s, and since 1968 has continuously been funded by Congress (Alaska Community Health Aide Program, n.d.). AI/AN community mental health workers may serve a variety of

roles including patient navigation and case management of existing services, provide adjunctive culturally appropriate psychoeducation to families, and help tap local cultural assets and resources to promote mental wellness (Barlow & Walkup, 2008; Cueva, Cueva, Dignan, Lanier, & Kuhnley, 2014; Kelley, DeCourtney, & Owens, 2014). Appropriately trained indigenous community health workers have the benefit of sharing a common history and similar challenges with the individual whom they serve. In contrast to Native scholars who may have to leave their home community to pursue a mental health degree, indigenous community mental health workers have always been embedded within the community. They possess familiarity with community dynamics, kinship patterns, spiritual values, attitudes, language and communication styles, and patient expectations (Miller & Pylypa, 1995; Roman et al., 2007; Gampa et al., 2017). This common ground can facilitate rapport, trust and retention (Kelley et al., 2014)—critical factors in mental health intervention effectiveness—and illuminate culturally meaningful content. Native community mental health workers also have natural capacity to navigate cultural mores and bilingual language demands that allow them to operate effectively in multigenerational contexts, potentially increasing engagement, compliance and ultimately, therapeutic effect (Barlow, 2013; Gampa et al., 2017).

Indigenous community health workers are providing valuable services across health, wellness, and community support, including, but not limited to, cancer prevention (e.g., Cueva et al., 2014), oral health (e.g., Braun et al., 2016), and connecting patients to health or community resources (e.g., transportation services; Gampa et al., 2017). Research on AI/AN mental and behavioral health interventions has shown task-shifting to Native community mental health workers to be feasible, acceptable and effective. The Johns Hopkins Center for American Indian Health has developed an early childhood home-visiting intervention, called "Family Spirit," that employs Native paraprofessionals to serve teen mothers with high unmet behavioral and mental health needs from pregnancy until their child's third birthday. This program has documented significant impacts on reducing maternal risk for depression and illicit substance use, while improving children's social, emotional and behavioral development in ways that predict lower risk for behavioral and mental health problems later in life (Barlow et al., 2013; Barlow et al., 2015; Walkup et al., 2009).

Over the past decade, Substance Abuse and Mental Health Services Administration funded programs have demonstrated the significant role Native community mental health workers can provide in suicide prevention (The National Tribal Behavioral Health Agenda, 2016). As an example, AI community mental health workers have delivered a culturally adapted evidence-based intervention to youth who have attempted suicide and their family members (see Cwik et al., 2016). Benefits of Native community mental health workers leading this work included increased cultural awareness and understanding during the intervention, as well as openness/comfort in meeting about this sensitive topic, thereby reducing stigma (Cwik et al., 2016). Practical barriers to mental health care (e.g., wait times; lack of transportation) were also ameliorated through community mental health workers visiting home or another private location. AI youth who received the intervention had reduced depression symptoms, reduced suicide-related outcomes, and more positive attitudes toward seeking mental health care. Further, AI youth reported that the community mental health workers were respectful, knowledgeable, professional, and helpful (Cwik et al., 2016).

Within AI/AN communities, there are a number of unique challenges for community mental health workers. Social and cultural beliefs relating to family and kinship relationships of the paraprofessional and client may introduce complexity to who can provide care, who is involved in care-related decisions, trust, and confidentiality (Chernoff & Cueva, 2017; Miller & Pylypa, 1995). Related, community health workers must navigate a spectrum of diverse traditional cultural, spiritual, or religious beliefs within a single community (Gampa et al., 2017). Although growing up and living in a tribal community/village may have advantages for providing shared context and understanding, there are also matters pertaining to maintaining wellness of community health workers. When living and working in a small tribal community, it may prove extremely difficult for community health workers to disconnect their work from their daily personal life (Chernoff & Cueva, 2017). During times of loss, serving dual roles as a community member also experiencing this loss and providing support to grieving families may conflict (Gampa et al., 2017). These experiences compounded with feelings of isolation and lacking professional social support/coping can take an emotional toll or lead to burn out (Chernoff & Cueva, 2017; Gampa et al., 2017). Further, community health workers may desire increased education and training to broaden their scope in addressing community priorities (Chernoff & Cueva, 2017).

Overall, the above potential barriers could be addressed proactively prior to a tribal community or health system implementing indigenous community health workers and should continuously be assessed for to foster effective care and wellness for communities. Community health workers may participate in training programs underscored by indigenous ways of knowing. For example, a cancer education training program guided by incorporating art, movement, and culture, was delivered to a variety of AN community health workers, including Behavioral Health Aides. Results of qualitative interviews and quantitative surveys demonstrated increased knowledge about cancer prevention, sharing arts and culturally based methods of education during patient interactions, and decreased stigma around community health workers talking to patients about cancer and promoting behavior changes to prevent cancer four years posttraining (Cueva et al., 2014). Notably, community health workers reported their own positive health-promoting behavior changes as a result of participating in training and sharing this information with their families and local communities. This single example illustrates ways in which community health workers' training and impact can reverberate and foster culturally based wellness for themselves, their families, and entire villages/communities. Other tribal agencies and programs may follow this model guided by local indigenous epistemologies and practices and provide training on the barriers discussed above—how community health workers can best provide care and connections to other forms of care across diversity of cultural and spiritual identity; how to engage in self-, family-, and community-care given their coinciding unique roles; and coping with feelings of isolation, grief, loss. Further, ongoing educational/training opportunities should be provided to community health workers. If a community is located near Tribal Colleges and Universities (see U.S. Department of Education & the White House Initiative on American Indian and Alaska Native Education, 2018), there may be points of collaboration to promote education and training of community mental health workers. Examples of trainings and courses that encourage community health worker participation include the summer research institute at the Northwest Portland Area Indian Health Board

(Oregon Prevention Research Center, 2018) and AI public health courses at the Johns Hopkins Center for American Indian Health (2018).

Within mental health more generally, use of paraprofessionals from the community may increase professional capacity, help with acceptability of treatments (Filene, Kaminski, Valle, & Cachat, 2013; Mendenhall et al., 2014), contribute to increased uptake and retention, and enhance scale-up and sustainability of critical mental health interventions for underserved groups (Hoeft et al., 2018). Specific to Native communities, the training and employment of Native community mental health workers can increase the cultural appropriateness of care and decrease stigma and other access barriers to mental health care (e.g., Cueva et al., 2014; Cwik et al., 2016). In addition, it may offer a source of local workforce and economic development, reinforcing tribal self-determination. Further, it may produce continuing education interests for community mental health workers. Together, these byproducts of employing indigenous mental health workers could lend more generally to primary prevention in AI/AN communities to increase economic and financial opportunities while working to promote mental health and well-being (Barlow & Walkup, 1998; Cwik et al., 2016).

Discussion

The federal government upholding trust responsibility to AI/AN health care is falling short while significant mental health inequities persist in tribal communities. The needs of Native communities require imminent solutions given continued mental health and substance use disparities and underresourced services. According to The National Tribal Behavioral Health Agenda (2016), mental and behavioral health issues necessitate a "communitywide response" with tribal ownership being vital. Tribal empowerment, mobilization, and capacity building underlie tribal sovereignty and represent methods that will provide an appropriate response to the needs of communities (Chino & DeBruyn, 2006).

Capacity building within tribal nations is highlighted as a funding priority for the Department of Health and Human Services (U.S. Commission on Civil Rights, 2003) and has been emphasized as a strategy to overcome AI/AN mental health inequities (The National Tribal Behavioral Health Agenda, 2016). The goal should be that Native community members have equal capacity and opportunity to fill all necessary roles in the ideal mental health care system (Barlow, 2013). The combination of a growing workforce of Native mental health professionals (e.g., psychologists) alongside indigenous community mental health workers has the ability to widen scope, increase local and cultural assets, improve a continuum of care, and work to reduce disparities. Indigenous communities interested in developing and implementing a community mental health worker program can obtain information from community-driven examples and peer-reviewed literature describing existing programs (e.g., Alaska Community Health Aide Program, n.d.; Barlow et al., 2013; Cueva et al., 2014; Cwik et al., 2016; Sehn et al., 2018). In addition, there are reports that reference how this program is being funded by Medicaid in certain states (see Alaska Center for Rural Health, 2003) and opportunities for resources, funding, and training through IHS (see IHS, 2018b).

Indigenous community mental health workers delivering care provides a number of distinct advantages. By creating a local workforce, indigenous community mental health workers also represent self-determination and sovereignty over economy and health care. In addition, Native community mental health care workers possess knowledge and understanding of local history, culture, community, and spirituality which may help maintain rapport and retention in care with community members. Further, familiarity with interconnections between physical, mental, emotional, spiritual, and the environment support Native worldviews of health and wellness (The National Tribal Behavioral Health Agenda, 2016) that may be incorporated into care. This model has the ability to address previously identified barriers to treatment for AI/ANs including stigma (Duran et al., 2005; Freitas-Murrell & Swift, 2015; Johnson et al., 2010; Venner et al., 2012), practical barriers such as transportation (Cwik et al., 2016; Venner et al., 2012), and preference for a Native provider (Aronson et al., 2016; Venner et al., 2012). Finally, indigenous community mental health workers delivering interventions related to maternal and child health and suicide prevention have already shown positive outcomes related to mental health promotion, reduced substance use, and improved attitudes toward healing mental health issues (Barlow et al., 2013; Barlow et al., 2015; Cwik et al., 2016; Walkup et al., 2009).

Native community health workers significantly contribute to the wellness of an individual they meet with and the entire community (Gampa et al., 2017). This is noteworthy, as "relationship is the cornerstone of tribal community, and the nature and expression of community is the foundation of tribal identity" (Cajete, 2000 p.86). By promoting community-level solutions to health and wellbeing, tribal communities may reclaim collective strength and effectiveness (Chino & DeBruyn, 2006). Indigenous community mental health workers are proving to be a promising solution to overcoming mental health inequities while reinforcing community-focused cultural values and healing traditions. A coalition of Native community mental health workers alongside Native mental health professionals may be the keystone to an ideal system to eliminate mental health disparities and restore balance and wellness throughout Indian Country.

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