Native Education Collaborative

Making Native Education Our Shared Priority

Behavioral Health

CCNETWORK National Center

Behavioral Health

The National Comprehensive Center

The National Comprehensive Center (NCC) is one of 20 technical assistance centers supported under the U.S. Department of Education's Comprehensive Centers program from 2019 to 2024. The NCC focuses on helping the 19 Regional Comprehensive Centers and state, regional, and local education agencies throughout the country to meet the daunting challenge of improving student performance with equitable resources.

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Introduction

The National Center assembled a panel of experts in the field of American Indian and Alaska Native education from a broad constituency base to help determine current needs and interests in the field. Interviews conducted with the panel produced the following primary thematic categories:


Native culture and language


College and career readiness and access


Tribal consultation and sovereignty


Physical and behavioral health


Teachers and leaders


Promising programs and practices

The National Center's American Indian and Alaska Native Education Project developed the following briefs for each category to positively impact the learning lives of Native children and youth. These briefs are meant to enhance the effectiveness of state education agencies' work on Native education. Though tribal communities are very diverse, for the purposes of these briefs, the terms *American Indian and Alaska Native, Native, indigenous,* and *tribal* are used to refer to Native communities.

Behavioral Health

There is a pressing opportunity to increase and improve behavioral health care services for Native youth. This brief describes several approaches to address the health needs of Native communities, including culturally responsive behavioral health supports, circles of care, and wrap-around services.

Behavioral Health Program Opportunities for Native Youth

Effective behavioral health programs demonstrate how integrated, trauma-informed, and culturally relevant approaches are already proving successful in countering risk factors and addressing health outcomes for Native youth. According to the sources collected for this brief, an integrative, holistic approach must be implemented to effectively address the needs of Native youth. The following approaches are considered critical underpinnings in implementing an integrative care approach for Native youth.

Cultural and historical grounding is necessary to ensure that Native youth have a deep understanding of the root conditions underlying the critical behaviors, such as historical trauma; adverse childhood experiences; recent trauma; poverty; racism; and other social, psychological, or developmental concerns or context. It integrates care approaches that value the community served, the Native worldview, and traditional practices, where appropriate.

Trauma-informed approaches recognize that most youth with behavioral health challenges have experienced trauma in their lives. A trauma-informed care approach recognizes signs and symptoms of trauma among youth, families, or communities. An integrated approach can address trauma in policies, procedures, and practices so tribal community members are not re-traumatized in the delivery of services. Care is taken to provide safety, security, and control within the service delivery setting. These efforts may consider current, past, intergenerational, and historical trauma.

Evidence-based interventions (EBIs) are behavioral health programs or practices that can be part of an integrated care service strategy if the EBI is a cultural fit with the cultural values, beliefs, and lifestyle of Native youth. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry for Evidence-based Programs and Practices (NREPP) has a list of EBIs. Some EBIs have been successfully implemented as part of the local tribal integrated care approach, including suicide prevention strategies such as Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), and SafeTALK (Tell, Ask, Listen, and Keep Safe).

Practice-based and culture-based interventions are often the foundation of integrated care approaches in Native communities. They create opportunities for interventions to be significantly adapted to varied communities and cultures and include high levels of community and stakeholder involvement. These field-driven practice approaches provide alternatives to the rigorous requirements of evidence-based practices while retaining evaluation criteria.

Donovan et al. (2015) state that "AI/AN [American Indian and Alaska Native] communities today demonstrate resilience, strength, and endurance despite centuries of postcolonial efforts to eradicate and assimilate them." Resilience is closely intertwined with trauma, and defined as "the capacity for adapting successfully and functioning competently, despite experiencing chronic stress or adversity following exposure to prolonged or severe trauma" (Cicchetti and Valentino, 2006, p. 165). Historically, Native communities share a history of genocide, assimilation, and oppression. Sweeping epidemics, war, involuntary relocations, and industrial boarding schools devastated Native communities and greatly compromised their traditional livelihoods.

These historical traumas are directly linked to accumulative, unresolved grief within Native communities today, and offer key insights into the causes of the communities' dire health disparities (Yellow Horse Brave Heart, Chase, Elkins, and Altschul, 2011). The 2012 National Study on Adverse Childhood Experiences (ACEs) found that Native children were diagnosed with the highest rates of behavioral health issues and other serious emotional disturbances, including post-traumatic stress disorder, ADHD, depression, and anxiety, in comparison to all other demographics. Similarly, ACEs scores from the same study determined that Native youth are more likely to live in families that have difficulty covering basic needs, like food or housing, and are disproportionately affected by childhood abuse, neglect, and family violence. Additionally, in 2017, the Centers for Disease Control and Prevention reported suicide as the second-leading cause of death for Native youth ages 10 to 18.

Despite the need for behavioral health services, Native communities face capacity and other human resource staffing issues. These challenges are further complicated by limited health care resources, community distrust in the medical system, and required travel distances to obtain services due to their

often rural and isolated locations. These barriers prevent Native youth from accessing clinically, socially, and culturally appropriate care (Cross, Earle, Echo-Hawk Solie, and Manness, 2000).

Cultural Behavioral Health Supports for Native Youth

BigFoot and Schmidt (2010) assert that mental health interventions are generally designed to serve the general population before they are evaluated for efficacy within minority communities. However, this approach could result in meaningless adaptations of these interventions for the intended population. The authors state that behavioral health care support must show significant cultural integrity in the development and dissemination of treatments (BigFoot and Schmidt, 2010, p. 849). Wexler (2010) note that the Euro-American framework common among behavioral health services can subordinate Native practices. For example, she notes that, "the reliance on rationality, realism, and objectivity in the framing of social and health issues is in itself a cultural phenomenon" (p. 160). BigFoot and Schmidt (2010) add, for minority populations, for instance, "cultural beliefs and norms regarding such issues as sexuality, gender roles, parenting practices, and intimate and social relationships are likely to factor significantly in the therapeutic process."

Wexler (2010) stresses the importance of evaluating tacit cultural commitments within professional behavioral health practices and interventions, as they can "shape the ways in which mental health and associated services are conceived, rendered and evaluated" (p. 160).

> Culturally responsive programming should be based on the sensibilities, social organization and current channels of influence in the participating communities. (Wexler, 2010, p. 165).

Notably, Wexler warns that "ignoring the cultural factors that shape professional interactions can create service systems that are, at best, contrived and ineffectual and, at the other extreme, imperialistic" (p. 161). BigFoot and Schmidt (2010) add that, historically, the use of poorly adapted mental health treatments within minority populations have now "led to widespread distrust and reluctance in such populations to seek mental health services" (p. 849).

This outcome points to an opportunity within the Seven Generations outlook for current generations to strengthen future generational outcomes. Wildcat (2009) relays the notion of Seven Generations, based on Native scholar Vine Deloria's description:

> "At all times and in every place, each of us is a unique expression of the seventh generation of our families and, more broadly, our people. In our lives, each of us constitutes the seventh generation in the sense that our actions ought to represent what we have learned from three previous generations: parents, grandparents, and great-grandparents, and simultaneously we must be mindful of how our present actions will influence the lives of three future generations: our children, grandchildren, and great-grandchildren." (p. 122)

This unique position between the past and future three generations provides a double involvement in history, meaning that "we are simultaneously shaped by history and shapers of the future history" (p. 122). The seven generations outlook shows how traumatic experiences of the past generations shaped the present-day disparities and how current generations have the power to shape future outcomes through culturally responsive behavioral health care support.

Integrating Traditional Practices into Behavioral Health Care

Prior to colonization, tribes held vast knowledge of plants and their medicinal uses, performed ceremonies, and shared traditional teachings, all of which supported wellness within the individual. SAMHSA notes a growing interest from Native youth in relearning and participating in these traditional practices. "AI/AN youth are blending traditional and modern best practices across the spectrum of behavioral health care services as they grow increasingly engaged in efforts to incorporate traditional practices—such as healing circles, sweat lodges, and ceremonies—into community programs" (SAMHSA, 2015). SAMHSA (2015) states that "bringing the healing power of traditional practices into modern services is at the heart of AI/ANs efforts in behavioral health." In parallel, Donovan et al.'s 2015 study of culturally grounded interventions in the Pacific Northwest supports the integration of traditional practices into behavioral health:

> "Community-derived, culturally grounded prevention curricula represent promising practices. Integrating evidence-based components of positive youth development and tribal-specific culture, traditions, and values, the curricula have the potential of reducing substance use; increasing hope, optimism, and self-efficacy; and facilitating cultural identity" (Donovan et al., 2015)

As culturally integrated behavioral health supports have shown promise in supporting the holistic development of Native youth today, and Native youth have grown increasingly interested in re-learning and returning to traditional ways of being, thinking, and relating to the world, culturally integrated

behavioral health supports offer healing to Native communities while also validating traditional values and culture.

Tribal Best Practices

While cultural integration of behavioral health care programming has proven successful within Native communities, Kelley, Witzel, and Fatupaito (2019) explain that there is very little supporting literature for these best practices, as most are not published. The authors add that "there is limited information about how TBPs [tribal best practices] are used to prevent substance use in American Indian youth" and "ongoing differences in how funding agencies and programs define and support TBPs have led to inconsistencies, challenges, and confusion about what actually constitutes a TBP." To address this issue, Kelley, Witzel, and Fatupaito (2019) collaborated with three Northern Plains tribal prevention programs to document each community's TBPs.

Assessment criteria for tribal best practices (Kelley, Witzel, and Fatupaito, 2019):

- activities performed,
- recruitment methods,
- target population,
- risk factors addressed,
- protective factors addressed,
- desired outcomes,
- traditional values, and
- tribal/community approval.

The authors note that this assessment aimed to meet funding agency demands for evaluation. However, communities have used these TBPs to address substance use and build resilience among Native youth for thousands of years, though they had not been documented before. "Empirical evidence was not the goal of these TBPs; tribes know these practices work" (Kelley, Witzel, and Fatupaito, 2019).

Circles of Care and Wrap-Around Services for Native Youth

Circles of Care and wrap-around services present opportunities for Native communities to build culturally based services that reflect an authentic community voice and provide needed organized systems of care for Native children. These services work well within Native communities, as Native worldviews and ways of being have always functioned like systems of care. Traditional worldviews are relational, viewing life in terms of harmonious cycles, seasons, and relationships. Native people knew that everything was connected, including each individual's physical, mental, emotional, social, and spiritual health.

Despite large numbers of health disparities and limited access to adequate behavioral health care services, the strength of Native communities and their traditional spiritual practices have begun to influence predominant western mental health care practices. This influence is paving the way for further

collaboration, which is a critical aspect of healing and wellness within Native communities. Two care philosophies that center on collaboration are Circles of Care and wrap-around services. These philosophies can support children with behavioral health and other serious emotional disturbances.

Circles of Care

Circles of Care are organizational philosophies that involve collaboration across agencies, families, and youth to improve access and expand the array of coordinated, community-based, culturally and linguistically competent services and supports. In these systems, professionals work alongside families and community members to formulate the best care strategies for their children.

Wrap-around Services

Wrap-around services include a definable planning process designed to help the youth thrive within their own family and community while avoiding out-of-home placement for the youth. The planning process involves a community care team that consists of the youth, their natural support system, and formal supports. Walker et al. (2004) suggests that the wrap-around planning process should include four phases: engagement, initial plan development, plan implementation, and transitioning, as laid out in Table 1.

Table 1. Planning process for wrap-around service

Planning process for wrap-around services (Walker et al., 2004):	
Phase	**Description**
Phase One: Engagement	This phase typically lasts 1 to 2 weeks and is characterized by staff meetings with the child's family to explain the wrap around process, hear the family's story, explore the family's cultural preferences and strengths, and identify additional informal supports.
Phase Two: Initial Plan Development	In this phase, the family invites relatives, friends, spiritual community members, other community members, probation officers, school teachers, and other supportive people from the child's life to form a wrap around team and initiate the formation of a family plan of care. This team then works to identify the child and family's strengths, challenges, and values and other influential people within their lives. The team then collaboratively produces a family vision, develops goals to actualize the vision, and establishes action steps and services to accomplish their goals.
Phase Three: Plan Implementation	During this phase, the team develops and asses the implementation plan for the family plan of care. Family meetings focus on reviewing accomplishments, assessing whether the plan of care has worked, adjusting action steps for goals

Planning process for wrap-around services (Walker et al., 2004):	
Phase	**Description**
	not being met, and assigning new tasks to team members to reach the family's vision.
Phase Four: Transitioning	During the final phase, plans are made to purposefully transition from formal wrap around services to informal and natural support from the child, family, and family's community. Successful transition requires a plan for the family to cope with stressors that will occur after the formal wrap around process has ended.

Stroul and Freidman (1986) developed a framework for a system of care, shown in Table 2, that includes core values and guiding principles for implementing services. It was originally designed for children with emotional disturbances, but it is applicable to other populations, as well.

Table 2. System of care framework

System of care framework (Stroul and Freidman, 1986):	
System element	**Implementation recommendations**
Core values	• **Child and family** The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided. • **Community** The system of care should be community based, with the focus of services, management, and decision making responsibilities resting at the community level. • **Cultural competence** The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
Guiding principles	• **Comprehensive services** Children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs. • **Individualized services** Children should receive individualized services in accordance with the unique needs and potentials of each child that are guided by an individualized service plan. • **Appropriate environments** Children should receive services within the least restrictive, most normative environment that is clinically appropriate.

System of care framework (Stroul and Freidman, 1986):	
System element	**Implementation recommendations**
	• **Families** The families and surrogate families of children should be full participants in all aspects of the planning and delivery of services. • **Linked services** Children should receive services that are integrated, with linkages between child serving agencies and programs and mechanisms for planning, developing, and coordinating services. • **Case management** Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs. • **Early identification and intervention** Early identification and intervention for children should be promoted by the system of care to enhance the likelihood of positive outcomes.

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