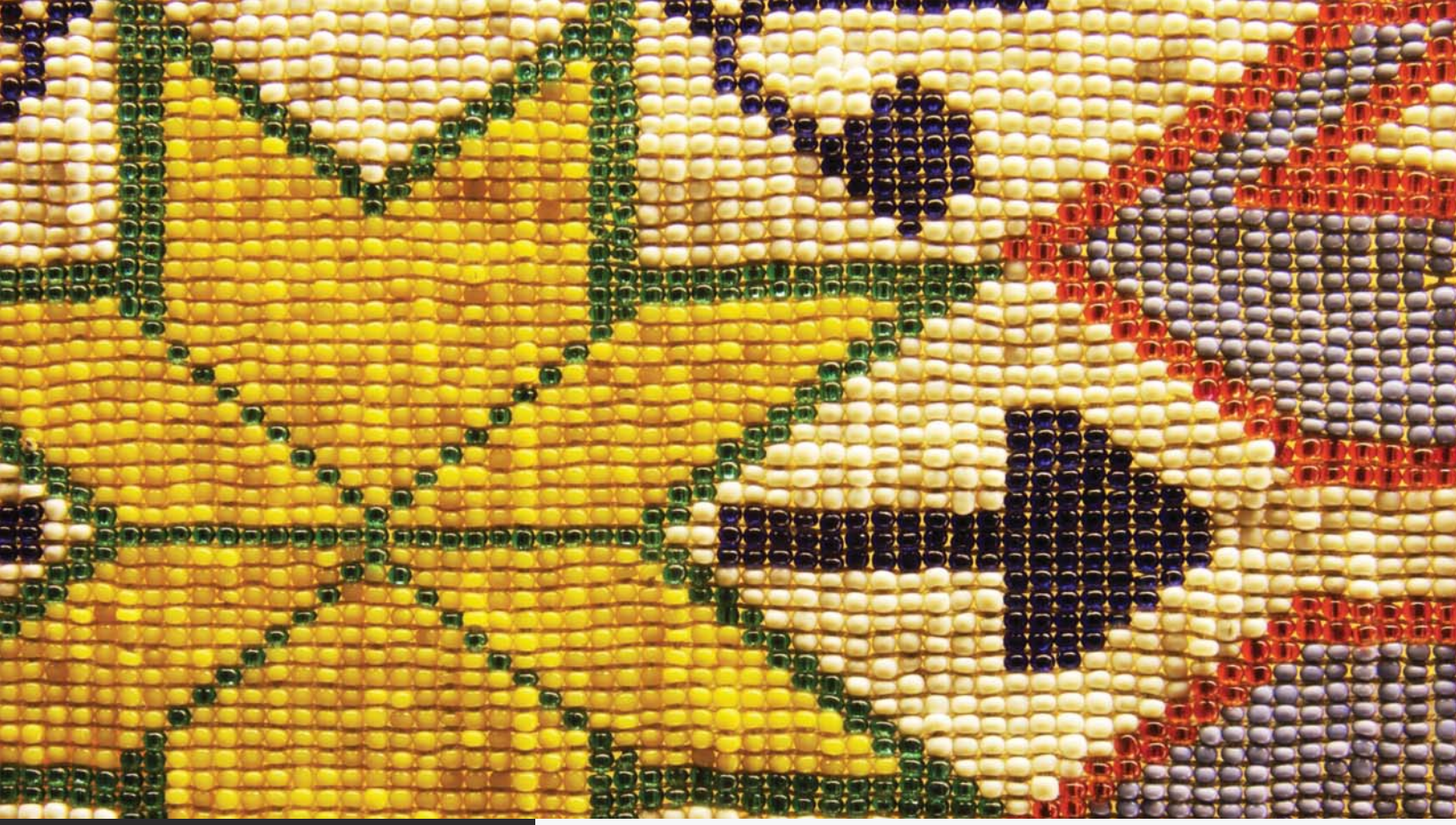
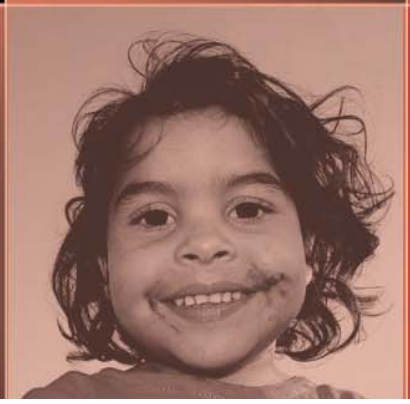


Urban Indian Health Institute
A Division of the Seattle Indian Health Board

Addressing Depression Among American Indians and Alaska Natives: A Literature Review

August 2012

The mission of the Urban Indian Health Institute is to suport the health and well-being of urban Indian communities through information, scientific inquiry and technology.



This report was prepared by Megan Fairweather MA, Julie Loughran MPH, Caleb Dunlap BA, Emma Strick BA and Emma Robson BA.

Recommended Citation:

Urban Indian Health Institute, Seattle Indian Health Board. (2012). *Addressing Depression Among American Indians and Alaska Natives: A Literature Review.* Seattle, WA: Urban Indian Health Institute.

TABLE OF CONTENTS

Please contact the Urban Indian Health Institute with your comments by e-mailing info@uihi.org, calling 206-812-3030 or visiting us online at www.uihi.org.

ACKNOWLEDGEMENTS

The UIHI would like to thank all those who dedicate their lives to improving the emotional, spiritual, social and physical well-being of urban American Indians and Alaska Natives. We know that this report does not capture all of the important work that you do but we hope this report can benefit your ongoing efforts.

A special thanks to Dr. Bonnie Duran for her assistance and guidance in developing this report. Bonnie M. Duran Dr.P.H. is an Associate Professor at the University of Washington (UW)-School of Public Health, Department of Health Services and Director of the Center for Indigenous Health Research at the UW Indigenous Wellness Research Institute.

This publication was made possible by Grant Number MPCMP101055-01-00 from the Department of Health and Human Services, Office of Minority Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Office of Minority Health.

Page intentionally left blank.

EXECUTIVE SUMMARY

INTRODUCTION

The purpose of this report is to highlight and review literature, programs and activities focused on depression and other common mental health conditions in American Indian and Alaska Native (AI/AN) communities in the United States. In 2010 the Urban Indian Health Institute (UIHI) initiated its Health Equity Project in order to examine the health disparities affecting urban AI/AN communities. This report represents a synthesis of academic (articles in scholarly, typically peer-reviewed journals) and grey literature (from a variety of sources including websites, online documents, government reports and presentations). This combination of findings is uncommon in typical reviews of depression and mental health among AI/ANs, which tend to focus on peer-reviewed academic literature.

This report provides background information on the prevalence of and factors associated with depression and common mental health conditions in AI/ANs as well as a description of mental health care standards, utilization trends and barriers to care. The procedures and inclusion criteria used in this literature review are detailed in the methods section. Due to the limited availability of outcomes and evaluation information in the sources identified, the results here do not present evidenced-based or best practices for depression but rather focus on the themes identified regarding implications for care as well as descriptions of programs in practice and useful resources. For organizations serving urban AI/ANs, it is intended that this information be useful for program planning purposes and proposal development.

BACKGROUND

While there is not a definitive assessment of the prevalence of depression and other common mental health conditions among all AI/ANs, available data point to disproportionately high rates of depression in AI/ANs compared other ethnic groups. Psychological distress, as evidenced by poor mental health and depression, is associated with historical and intergenerational trauma. The highly prevalent nature of emotional trauma helps explain the disproportionate rate of psychological distress in AI/AN communities. Serious co-occurring conditions including alcohol or substance abuse and greater incidence of chronic illness like diabetes are associated with an increased number of poor mental health days.

The Indian Health Service (IHS) provides screening guidelines for depression as one of the quality measures used for the Government Performance and Results Act. For those who screen positive for depression, the IHS suggests several treatment options. However, the barriers to accessing mental health care that AI/ANs face are complicated. Complex factors play a role in the disparity of utilization of mental health services among AI/ANs including insufficient resources, socio-economic factors (e.g., poverty, unemployment, housing stability, access to transportation), adequate availability of culturally relevant treatment sources and cultural preferences. While the prevalence of depression and co-occurring conditions is recognized and screening is recommended, the system of care to address these mental health conditions is often lacking.

METHODS

UIHI project staff developed search terms to obtain relevant and comprehensive search results in consultation with a reference librarian at the University of Washington. These search terms defined the population of interest (AI/ANs in the United States), the conditions of interest (depression, mental disorders, mental illness, mood disorder and anxiety) and the type of

EXECUTIVE SUMMARY

information sought (programs, activities and evaluations). In October and November of 2011, UIHI project staff conducted initial searches of both academic and grey literature databases. The searches resulted in a high volume of sources, which staff then reviewed and eliminated systematically, based on previously determined inclusion criteria.

RESULTS

Original academic and grey literature searches identified 1413 sources; 591 were found through academic databases and 822 were found through grey source databases or search engines. An additional seven sources included in this report were referred to in the original searches. Of the 1420 sources identified, 299 sources were excluded as duplicates and 1042 sources were excluded based on review criteria, for a total of 79 sources listed in this review.

The results of this environmental scan identified eight common themes regarding implications for improving depression and mental health care for AI/ANs. These themes included: 1) focusing on family and community, 2) incorporating traditional knowledge and practices into care, 3) emphasizing active skills building, 4) integrating and linking prevention and treatment care systems, 5) expanding cultural competency of both providers and health care systems, 6) developing flexible provider-client/patient relationships with adaptive treatment approaches, 7) implementing environmental and structural changes to affect surrounding conditions, and 8) developing policies, systems, and advocating for adequate funding to improve health care and economic opportunities for AI/AN people.

Additionally, these results include program or activity descriptions. Many of the programs and activities identified demonstrated these themes in practical application. Lastly, the review identified resources on depression, suicide prevention and mental health care for AI/AN communities. These resources are listed at the end of the results section.

DISCUSSION

Considerations regarding the overall report are highlighted including limitations and recommendations. Key recommendations and items for consideration include:

- The shortcomings of the mental health care system along with systemic and cultural barriers to care impede service utilization and access for AI/ANs.
- Discord exists between Western mental health care services and culturally based approaches for both research studies and in public health practice. This discord may be eased by increasing support for traditional or culturally-based treatment approaches by recognizing these strategies as reimbursable services. Additionally, both Western and traditional approaches require increased evidence of effectiveness through research and evaluation of practices in the field.
- Future research is required to address gaps in public health knowledge about mental health care among AI/ANs, especially research focused on pathways and barriers to care, financial infrastructure for AI/AN mental health care and testing of mental health programs and interventions in AI/AN communities.
- Investments must be made in providing evaluation of activities already in use among urban AI/ANs to establish practice-based evidence rather than expecting evidence-based practices that were not developed or tested in AI/AN communities to work effectively.

EXECUTIVE SUMMARY

- A systems approach featuring collaborative efforts, integration of services and support mechanisms needs to be advanced through local, state and national policy.
- Socioeconomic factors impacting AI/ANs and their mental health status need to be addressed through policy changes, economic opportunities, and social supports that provide integrated prevention, treatment and follow-up care as well as ancillary services such as life-skills building, economic opportunities and stable housing resources.
- In summary, the striking disparities in the prevalence of depression and common mental health conditions among AI/ANs require more comprehensive, systematic approaches than just the implementation of best practices through medical clinics. A health care system is needed that provides a new perspective on integrating the concept of mental health with holistic well-being including family, community, socioeconomic, and social supports.

INTRODUCTION

The goal of this report is to provide an overview of behavioral health programs for American Indians and Alaska Natives (AI/ANs) that address depression and other common mental health conditions. This report highlights findings from research, case studies, and mental health experts from the field. It is our hope that describing eight themes that have implications for care will support health care providers, policy makers and advocates in promoting effective mental health services for urban AI/ANs with the overall objective of achieving health equity for all AI/ANs.

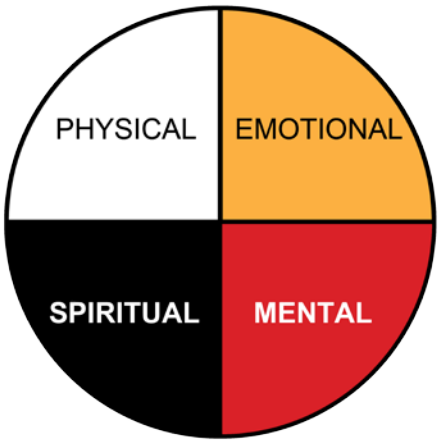
Responding to the persistent inequities in health outcomes among urban AI/ANs, the Urban Indian Health Institute (UIHI) launched its Health Equity Project in 2010. With support from the U.S. Office of Minority Health, the project focuses on identifying and disseminating culturally appropriate successful models of care in urban AI/AN communities to prevent and reduce disease. The Health Equity Project focuses on two diseases identified by Healthy People 2020 as critical focal areas for health improvement in urban AI/AN communities: cardiovascular disease and depression. In addition a third health topic, chemical dependency and substance abuse, was identified by Urban Indian Health Organizations as a priority. The Health Equity Project provides tools, trainings, information and facilitates partnerships to support Urban Indian Health Organizations in delivering promising programs to their clients.

The importance of documenting and recognizing effective, culturally appropriate efforts to reduce morbidity and mortality in minority communities is essential to achieve Healthy People 2020 goals and to realize the overall outcome of health equity for all.

The critical health focus area of this report is on depression and other common mental health conditions. Depression is not just a case of “feeling blue” or sad for a time; depression can impact a person’s ability to function, maintain relationships and enjoy life for an extended period of time. Depression may also reoccur throughout a person’s lifetime, even after successful treatment of earlier episodes. Untreated depression is the leading cause of suicide, which is alarmingly high among AI/ANs.[3] An estimated 90% of individuals who die by suicide have a mental illness, a substance abuse disorder or both.[4] AI/AN communities suffer from higher rates of depression and co-occurring conditions than any other ethnic group.[5-7]

Socioeconomic status, social support, cultural preferences for care and historical traumas, play a role in depression as well as in the perception of illness and treatment decisions. A Native concept of health traditionally embodies a holistic perspective in which mental health is viewed as a part of the overall health and well-being of the individual. One example to illustrate this point is the Medicine Wheel (Figure 1). The Medicine Wheel represents balance, harmony and interrelatedness of the physical, the mental, the emotional and the spiritual aspects of life. In contrast, Western mental health approaches typically use a more categorical, segmented and individualistic view of mental and physical health. These disparate health perspectives create incongruity in approaches to health between the mental health care

Figure 1. Medicine Wheel



INTRODUCTION

system and the AI/AN clients it intends to serve. In addition, a great disparity exists in accessing mental health care among AI/ANs fueled by cultural insensitivities and barriers to care created by the current mental health system infrastructure for AI/ANs.

This report was developed by the Urban Indian Health Institute primarily for the Urban Indian Health Organizations and others serving the health needs of urban Indians in the United States. These organizations and groups are described here in more detail. A general overview of mental health care for AI/ANs begins in the background section of this report.

URBAN AMERICAN INDIAN AND ALASKA NATIVES

American Indians and Alaska Natives (AI/ANs) living in urban areas are a diverse and growing population. Over the past three decades, AI/ANs have increasingly relocated from rural communities and reservations to urban centers. Urban AI/ANs are a very diverse group and include members, or descendents of members, of many different tribes. Represented tribes may or may not be federally recognized. Individuals may or may not have historical, cultural or religious ties to their tribal communities. Because urban Indians may not be connected to their tribal communities, their mental health may be impacted more by this disconnect. The population as a whole is highly mobile; individuals may travel back and forth between their tribal communities or reservations on a regular basis. Others may feel the loss of not having a reservation home. Generally, urban AI/ANs are spread out within the urban center rather than localized within one or two neighborhoods. Thus they are often not easily seen or recognized by the wider U.S. population. This “invisible” population makes up more than 67% of all AI/ANs living in the United States.[8]

HEALTH CARE FOR AMERICAN INDIANS AND ALASKA NATIVES

Numerous treaties, court cases, Executive Orders and laws such as the Snyder Act of 1921 and the Indian Health Care Improvement Reauthorization and Extension Act of 2009, define and affirm the U.S. federal governments’ responsibility to provide health care services to members of federally recognized Indian tribes and Native Entities of Alaska, regardless of whether they live in urban or reservation areas. This responsibility has been delegated to the Indian Health Services (IHS), an agency within the federal Department of Health and Human Services. The IHS is divided into three distinct health delivery models characterized as the I/T/U. The “I” refers to hospitals and clinics run directly by the Indian Health Service. The “T” applies to individual tribes or consortia of tribes that operate tribally managed hospitals and clinics under Indian self-determination and self-governance. The “U” signifies a discrete program created to assist urban Indian communities in building capacity to improve access to health care for urban Indians. In 2010, Tribally-run health services and IHS facilities received approximately 53% and 43% of the IHS budget respectively, while urban programs received only 1%.[9] This funding discrepancy contributes to a number of factors limiting AI/AN access to health services. Additionally, eligibility criteria for IHS and Tribally-run services are more limiting than at Urban facilities, often excluding urban AI/ANs who are either not enrolled in tribes, are members of State-recognized tribes, or are members of tribes that are not recognized by the U.S. federal government.

INTRODUCTION

URBAN INDIAN HEALTH ORGANIZATIONS

Urban Indian Health Organizations (UIHOs) are private, non-profit corporations that serve American Indian and Alaska Native people in select cities by providing a range of health and social services, from outreach and referral to full ambulatory care. UIHOs are funded in part under Title V of the Indian Health Care Improvement Act and receive limited grants and contracts from the federal Indian Health Service (IHS). UIHOs are located in 19 states serving individuals in approximately 100 U.S. counties, in which over 1.2 million AI/ANs reside, according to the 2010 U.S. Census. UIHOs provide traditional health care services, cultural activities and a culturally appropriate place for urban AI/ANs to receive health care.

URBAN INDIAN HEALTH INSTITUTE

The UIHI was established as a division of the Seattle Indian Health Board to study and document the striking health disparities affecting the urban AI/AN population. The UIHI is one of 12 tribal epidemiology centers (TECs) and the only TEC providing surveillance, research and analysis of data focused on the nationwide urban AI/AN population. The UIHI provides data and technical assistance to 33 UIHOs across the country. The mission of the UIHI is to support the health and well-being of urban Indian communities through information, scientific inquiry and technology.

IN THIS REPORT

The UIHI recognizes that there are many information sources regarding health promotion efforts in AI/AN communities beyond academic or peer-reviewed journals. In an effort to comprehensively capture those practices and lessons learned in AI/AN communities we included both databases of academic literature as well as “grey” literature (on-line, open source, government reports, etc.). Additionally, some organizations that have done innovative work in preventing and treating depression and other common mental conditions among AI/ANs may not be captured in this report due to limitations of the methods as well as limited dissemination of these novel efforts.

The remainder of this report is organized into several main sections. The background provides an overview of depression as well as the factors influencing AI/AN mental health, including prevalence and current barriers to care. The methods section outlines the process and sources used for the literature review. The results from this extensive review of the available literature include expert opinions, research findings, activities and programs. The discussion highlights themes from the literature review in addition to recommendations for future practices, policies and research projects. A companion UIHI report describes the current work of UIHOs across the county, and the important role of the UIHOs in meeting the behavioral health needs of the communities they serve. This companion report is titled, “A Profile of Urban Indian Health Organization Programming to Support Behavioral Health.”

BACKGROUND

DEPRESSION AND COMMON MENTAL DISORDERS

Characterized by depression or mania, mood disorders include many mental health conditions such as major depressive disorder and bipolar disorder, among others.[10, 11] In Western medicine as practiced in the United States, depression and other common mental health conditions such as mood and anxiety disorders are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. The DSM provides a common language and standard diagnostic criteria for the classification of mental disorders and is the basis for insurance reimbursement for mental health services.

Mental health problems, however, may be conceptualized differently in AI/AN communities than in mainstream Western culture.[12, 13] Differential conceptualization of emotional well-being has implications for the assessment and diagnosis of mental health issues in this population.[12] The DSM has been criticized for being Euro-American centric and for drawing categorical lines that may not apply across cultures, as well as for creating what some argue, are arbitrary categorical divisions of diagnoses.[14-16]

We did not limit inclusion of literature in this scan to the DSM criteria, but rather took a generalized approach and included terms such as depression, mental disorders, mental illness, mood disorder and anxiety into our search procedures. This does not, however, discount the significant and important role the DSM plays in establishing standards for screening and treatment of depression and other behavioral health conditions.

CURRENT PREVALENCE OF DEPRESSION AND ASSOCIATED FACTORS

Significant disparities exist in the prevalence of mental health conditions among AI/ANs and other races. While there is not a definitive assessment of the prevalence of depression and other common mental health concerns among all AI/ANs, available data point to disproportionately high rates of depression in AI/ANs. In 2006, among U.S. adults ages 18 and over who reported only one race, AI/ANs had the highest rate of a serious psychological distress within the last year (25.9%), and the highest rate of a major depressive episode (MDE) within the last year (12.1%).[5] Similarly, among U.S. adolescents ages 12 to 17, AI/ANs had the highest lifetime MDE prevalence (13.3%) and the highest MDE prevalence in the last year (9.3%).[5] One large study found lower rates of lifetime MDE in both AI men and women sampled from two AI tribes compared to MDE rates of all U.S. men and women participants of the National Comorbidity Survey[+].[17] This comparison study did report higher lifetime rates of post traumatic stress disorder (PTSD) and any anxiety disorder among AI men and women compared to all the men and women included in the National Comorbidity Survey.[17] Major limitations of this study were different time periods of data collection and different sampling methods for AI/ANs than for the general U.S. Population.

Signs of mental distress are also visible among AI/ANs across all UIHO service areas; for example, between 2005-2010, 15.1% of AI/ANs residing in UIHO service areas reported at least 14 poor mental health days in the past 30 days, compared to 9.9% of all races.[18] Untreated or incompletely treated depression is the leading cause of suicide in the United States.[3] Studies

[+] Originally conducted in 1990-92 and replicated in later years, the National Comorbidity Survey served as the first nationally representative mental health survey in the United States.

show that both AI/AN adults and adolescents suffer from high rates of suicide.[3] In 2011, the suicide rate for all AI/ANs was 14.68 per 100,000 compared with the overall U.S. rate of 11.15 per 100,000.[19] Suicide among AI/AN youth is especially high.[19] AI/AN male adolescents have been reported to have the highest rate of suicide deaths.[20] AI/AN female adolescents have the highest rate of suicide attempts compared with other races.[20]

An important factor in the mental health of AI/ANs is the experience of historical trauma and the transfer of unresolved loss and grief across generations. Years of injustices and discrimination including violent conflicts with invading Europeans and destructive colonialism (including the introduction of diseases; loss of land, plants and animals; the reservation system; betrayal of treaties; the abuses and cultural annihilation of the boarding school era; and federal assimilation policies) have contributed to the historical trauma and multigenerational unresolved grief.[21, 22]

The impact of trauma is extensive; any trauma affects not only the victim but their family, friends and community.[23] Research among several reservations in the United States and Canada revealed a significant portion of indigenous adolescents and adult caretakers had persistent thoughts of historical losses.[24, 25] These studies showed evidence that daily and weekly thoughts of historical loss are associated with emotional responses that included sadness, depression and anger, among others. These historical traumas contributed to continued distrust of the health care system by AI/ANs.

Co-occurring Conditions

Based on observations in practice, co-occurring disorders, including links between mental illnesses and physical conditions, are a common finding among urban AI/AN clients at UIHOs. In addition to the high prevalence of depression and suicide among AI/ANs, depression or poor mental health among AI/ANs has been linked with other serious conditions such as alcohol or substance abuse, diabetes and anxiety. In a study of the Behavioral Risk Factor Surveillance System data, a diabetes diagnosis and heavy use of alcohol were associated with five or more poor mental health days in the month.[26] A study among AI/AN boarding school adolescents found that stressful life events contributed to the co-morbidity of depression with alcohol and marijuana use. Alcohol and marijuana use or dependence in combination with depression increased with age.[6] A study conducted in an IHS primary care setting serving both urban Indians and surrounding tribes found a high co-morbidity of mood and anxiety disorders existed among AI/AN women with any lifetime substance abuse disorders.[7] These co-morbidity rates among AI/AN women were higher than rates in non-AI/AN women reported in other studies.[7]

Mental Health Practices and Needs

Effective treatment for severe mental health disorders including depression requires a care plan that accounts for environmental conditions as well as cultural background. Treatment plans are also more effective when coordination among multiple types of treatment options occurs. The prevalence of mental health conditions and the evidence of co-occurring conditions, along with other findings, indicate that the most critical mental health needs of AI/ANs include addressing depression, anxiety, suicide and substance use.[12, 27, 28]

The IHS uses the Government Performance and Results Act (GPRA) measure of depression screening as the basis for depression services.[29] This measure is consistent with the U.S. Preventive Services Task Force recommendation that all adults aged 18 and older should be

screened for depression annually, although only in situations when services or systems can ensure appropriate follow-up in terms of diagnosis, referrals and/or treatment.[30] Patient visits in the primary care setting for other concerns offer opportunities to identify those with, or at risk for, depression. Primary care screening can identify depression in those who may not otherwise seek mental health treatment.

A two-stage screening process is recommended, starting with universal screening of adults with the two item Patient Health Questionnaire (PHQ-2), followed by the nine item version (PHQ-9) only for those who screen positive in the first screening stage.[30, 31*] For those who screen positive for depression following the PHQ-9, IHS recommends discussing treatment options with the patient including: watchful waiting, counseling that includes multiple therapy approaches (individual, group, specialized therapies, etc.), medication, or a combination of treatments. IHS recommends that those with depression be referred from primary care to behavioral health services when displaying suicidal ideation, psychotic symptoms, manic symptoms, current substance abuse or severe psychosocial problems.[32]

Care Utilization and Barriers to Care

Barriers to mental health for AI/ANs are complex and multi-faceted. Even though AI/ANs report poorer mental health, their use of mental health care services is similar to or less frequent than that of whites.[5, 33] Noted mental health system inadequacies include insufficient resources (financial, staffing and infrastructure), limited appointment availability and limited facility hours.[23] While much attention is rightly given to increasing the cultural competency of individual providers, attention must also be paid to the cultural competency of the system itself including bureaucratic regulations, top-down controls by state and federal governments, funder priorities that may differ from patient needs, and the structure of provider-patient interactions (such as time limitations, billable services and diagnostic frameworks). The lack of adequate funding further restricts the availability of services and the need for balancing treatment demands with service capacity. Funding shortfalls also limit the availability of qualified AI/AN mental health providers. In addition, the excessive burden on practicing providers as well as the bureaucratic paperwork requirements can lead to burn-out and high turnover. Additionally, environmental factors (economic, physical and personal/social challenges) affecting AI/ANs may impact access to mental health services.[23] Substantive mental health needs are not always matched with a sufficient level of resources or provider staffing to meet those needs in the complex and fragmented system of care for AI/ANs.[2, 34]

Cultural identity, background and preferences may also impact AI/ANs' use of Western mental health care. For example, AI/ANs have been reported to seek care from traditional or spiritual healers at higher rates (33.7-48.9%) than from specialty mental health care providers (34.6-40.1%).[17, 35] Preference for traditional services for both mental health and substance use issues has been reported as well.[17, 35]

Cultural barriers to care have been discussed extensively in the literature and include: 1) lack of trust in the provider and health care system, 2) privacy concerns, 3) cultural stigma regarding

* Although it is not universally endorsed, a TeenScreen tool developed by Columbia University is also recommended and validated for depression and suicide screening in adolescent populations.

mental health services and 4) cultural norms of politeness and respect that may result in not directly discussing signs of depression even informally among family or friends.[3, 36-39] Cultural preferences for restoring well-being may be in contrast with the Western mental health care treatment model and may be another reason AI/ANs do not seek medical or therapeutic treatment for depression.[3]

In summary, given the impact of historical trauma, unresolved grief, inadequacies in the mental health care delivery system and economic challenges both within the health system and for individuals, it is not surprising that AI/ANs experience a high prevalence of serious co-occurring behavioral health conditions. Walters and Simoni (2002) proposed an "Indigenist Stress-Coping Model" that described how life stresses or trauma (historical, discrimination, traumatic life events and abuse) impact health outcomes experienced by AI/ANs (mental health/depression/anxiety, alcohol and substance use/abuse or dependence, morbidity and HIV risks). The "Indigenist Stress-Coping Model" presented a pathway where the effects of trauma can be moderated by cultural buffers (identity, enculturation, spiritual coping and traditional health practices) to diminish stress effects and improve emotional and physical health.[40] The remainder of this report describes a review of the literature and provides findings in order to share knowledge from both practitioners and past studies of mental health care services among AI/ANs.

METHODS

PROCESS

Initial database searches (described below) were conducted in October and November of 2011. The review process included several elimination rounds to narrow results to the most relevant findings according to the inclusion criteria (detailed later in this section). Project staff followed the steps below during the review and elimination process:

1. Review of all titles;
2. Review of remaining abstracts or brief descriptions; then
3. Review of remaining full articles, materials, project descriptions, reports, etc.

TERMS

The project team consulted with a reference librarian at the University of Washington to develop an optimal search strategy and search terms focusing on the population of interest, condition of interest and type of information sought. For the population component, the search terms included: “American Indian” OR “Alaska Native” OR “Native American.” The condition component search terms were “depression” OR “mental health” OR “mental disorders” OR “mental illness” OR “mood disorder” OR “anxiety.” For the type of information, the search terms included: “prevention” OR “treatment” OR “management” OR “intervention” OR “evaluation.” Each of these search term families were connected by AND to ensure that results consisted of at least one key word from each of the components. These search terms provided the balance between focus and breadth to ensure results were both relevant and comprehensive. When available in a given database, advanced search techniques were employed to optimize the key word search.

INCLUSION CRITERIA

To be included in the review, project staff determined if each of the findings met the following criteria:

1. Specifically tailored for AI/ANs;
2. Information included an activity, task or materials for health care providers, patients, and/or community members in an effort to prevent, treat, or manage depression and/or common mental disorders;
3. Activity, task or material addressed depression or other common mental disorders specifically;
4. Information was not a duplicate of another source already identified in the search between databases;
5. Information was available to UIHI either through an IHS library account or was free of charge on the internet in English; and
6. Activity, task or material occurred in the United States.

METHODS

DATABASES

Academic

Academic sources include those writings that are available in scholarly journals most, but not all, of which are reviewed by peer experts. A variety of databases provide access to academic articles. In consultation with a reference librarian, project staff selected the following databases to conduct searches in: PubMed, CINHAL, Scopus, Web of Science and PsycINFO. Project staff utilized this combination of databases to provide the widest coverage with the minimum overlap of findings.

Grey

Much of the innovative work being done in AI/AN communities is not available in academic sources due to a practice-based and service delivery focus, rather than devoting extensive time to the manuscript writing and publication process. Therefore, project staff also conducted searches for grey sources. Grey sources come in a number of forms including websites, online documents, working papers, government or technical reports, oral presentations and conference proceedings. The following are the databases searched for grey sources: Indian Health Services, Substance Abuse and Mental Health Services Administration, Native Health Database, New York Academy of Medicine's Grey Literature Report and Google. Only the first 200 results in the grey source searches were reviewed. This number represented the average number of results per database in the academic search. This limit was set to prevent bias between grey and academic sources and to control for the disproportionally high number of results from Google.

Additional Sources

If a new reference was identified during review of the articles and materials through the process described above, project staff located the source document to review for inclusion.

RESULTS

OVERVIEW

UIHI's environmental scan included both a review of academic sources (articles in scholarly, typically peer-reviewed journals) and also grey sources (from a variety of sources including websites, online documents, working papers, government or technical reports, presentations, and conference proceedings). This report represents a synthesis of academic and grey literature findings uncommon in typical reviews of depression and mental health among AI/ANs, which tend to focus just on peer-reviewed academic literature.

Limited, if any, outcomes or evaluation information was available in many of the sources identified through this review, a finding also noted by others.[41] Due to this limitation, these results do not present evidenced-based or best practices for depression but rather focus on two main categories of findings: 1) implications for care based on provider, key informant or researcher knowledge and perspectives on the mental health needs and treatment preferences of AI/ANs; and 2) programs or activities describing study or program design, outcomes or lessons learned. Additionally, this review identified resources on depression, suicide prevention, and mental health care for AI/AN communities which are included in a Resources section. These results provide UIHOs and other urban AI/AN serving organizations with mental health recommendations, programs that have been used in AI/AN communities and related resources for further investigation based on interests and needs.

UIHI identified 1413 sources; 591 were found through academic databases and 822 were found through grey source databases or search engines. An additional seven sources included in this report were referred to in the original searches. Of the 1420 sources identified, 299 sources were excluded as duplicates and 1042 sources were excluded based on review criteria, for a total of 79 sources listed in this review.

IMPLICATIONS FOR CARE

A substantial amount of information surfaced during the review of the literature illuminating the recommendations of various professional, research and community experts who have experience or knowledge of the mental health needs and treatment preferences of AI/ANs. These recommendations are grouped here under the category "Implications for Care." Rather than describing specific research, case studies or personal reflections, this section presents the themes that ran throughout the findings in this category. Using this approach, the UIHI hopes to minimize inappropriate generalization from findings of small studies and other limitations of these sources. Some sources stem from rural or reservation-based settings and others are from urban settings. A reference list of all sources used is available at the end of this report. Further investigation of these sources is encouraged for more comprehensive coverage of the issues discussed in this document.

While the findings in the implications for care category are diverse, all center around community-based, traditional and system approaches to preventing, healing, and addressing depression and other common mental health issues. Below, each of the themes are described with an emphasis on the implications for mental health care delivery for AI/ANs.

RESULTS

Theme 1: Focus on and include the whole family or community, not just the individual, in prevention and treatment.

Many sources noted the importance of including or focusing on family, extended family and community in the prevention and treatment of depression and other common mental illnesses, especially as this aligns with AI/AN relational perception of self.[20, 36, 42-56] In one study, focus group participants identified the tension between Western individualism and the AI community centered or collective perspective.[49] In addition to building interventions that strengthen family and community ties, Tolman and Reedy (1998) recommended involving peers in health promotion and service delivery to acknowledge their important role and have them advise intervention plans.[57]

- ***Community education***

  In structured interviews with youth, the most common reported reasons for not seeking help, either from mental health professionals or informal support of friends and family, were internal factors such as embarrassment, lack of recognition of the problem, self-reliance and a belief that no one could help.[36] Based on these findings, Freedenthal and Stiffman (2007) suggest that interventions should address these internal barriers. For example, provide education to the community to reduce stigma associated with mental illness and depression.[36] Several other sources also recommended increased information and community education about depression, mental illness and/or suicide in the community as a means to decrease stigma and increase awareness, social support and knowledge of resources.[20, 50, 58] Raising awareness about free anonymous resources, such as crisis hotlines, through flyers, screening of primary care patients, and columns in the local paper has helped engage people in services and decrease stigma, situating help seeking as a sign of strength.[59, 60] Beyond depression education, prevention efforts can focus on violence, illicit drug use and the historical experience of oppression of Native Peoples.[49]

  Additionally, Goldston et al. (2008) highlight the importance of "gatekeepers" (including professionals, paraprofessionals, teachers, parents, traditional healers, police, etc.) recognizing signs of suicidality that may manifest differently among AI/ANs than in other racial and ethnic groups.[20] Increasing the knowledge of these gateway providers to identify mental health and substance issues as well as increasing their knowledge of community resources to address those issues is critically important.[61, 62]

- ***Interventions and research need to be community-driven***

  Sources noted the need for the community to develop and implement solutions, rather than these coming from the outside.[57, 58, 63, 64] At a 1990 conference, mental health providers recommended that research needs to involve members of the culture being served in the research from the beginning and in-depth throughout.[64] In another example, focus group participants suggested drawing on community strengths for interventions including cultural heritage (language, arts and crafts, ceremonies, etc.) as a means to reconnect to community, the importance of a sense of belonging to a larger community, strengthening the family bond and elders imparting knowledge to younger generations.[49]

Goldston et al. (2008) posited that culturally-specific and sensitive interventions developed by or in close collaboration with the community will be more successful and will lead to greater community investment.[20] Goldston et al. also suggested interventions that build on community strengths and reinforce a positive cultural identity to increase self-esteem and coping skills.[20] Additionally, the authors noted that it is beneficial to implement comprehensive programs that address the multiple levels influencing behavioral health (community, environment, family, individual).[20]

- ***Therapy***

  Including family members in therapy sessions or conducting group sessions was suggested as a way to focus less on the individual and more on his/her relationships to others, which aligns better with a holistic and community-focused Native health approach.[49, 54, 63, 65] One example as applied to individual therapy includes Harper's (2010) suggestion of the Relational-Cultural Theory of therapy as an approach to therapy appropriate for AI/ANs because it situates functioning in complex relational networks, therefore may be congruent with AI/AN perceptions of self (not individual but as part of a greater whole).[42]

Theme 2: Incorporate traditional knowledge of health, spirituality and related traditional practices in prevention and treatment, in accordance to the patient's cultural identity and level of acculturation.

Much of the literature emphasized including traditional AI/AN practices, ceremonies and rituals, either in counseling sessions or by providing referrals to traditional practitioners.[42, 49, 57, 60, 63, 64] Others noted AI/AN perspectives on mental illness, highlighting the notion of balance and harmony.[51] Gary, Baker, and Grandboise (2005) recommended aiming for balance rather than alleviation of symptoms.[63] In a study of 1456 reservation-based AIs, researchers found a strong protective (inverse) association between cultural, spiritual orientation and suicide attempts, suggesting this orientation provides an accessible and powerful source of meaning and symbols to make more sense of the surrounding world and to counteract feelings of isolation.[66]

Culturally-based counseling approaches include traditional spiritual and healing ceremonies that vary from tribe to tribe as well as the use of prayer supported by sacred plants and objects that honor the clients worldview.[65] Traditional healers, as appropriate to the acculturation level of the patient, can serve many roles: as a co-therapist, trainer of the mental health professional, consultant, and reciprocal referral agent.[46] Niven, a social worker who practiced in Alaska, found success with her clients by integrating traditional values and activities into formal treatment plans.[59] For some clients, crafts work was done simultaneously with talk therapy, which was helpful in encouraging session participation by offering craft materials, showing the provider's respect for the traditional crafts and helping build a trusting relationship.[59] Participation in traditional activities, such as fishing, hunting, etc. provided healthy coping mechanisms and stress relief.[59]

Theme 3: Use prevention and treatment methods focusing on active skills building (communication, coping, stress and conflict management).

In addition to including family and support systems in counseling sessions, suggested methods include focusing on skills development specifically around coping, decision making and stress

management.[42] In one focus group study of AI/AN adults and elders, participants gave specific suggestions for preventing youth suicide: youth mentoring by elders who could help them problem solve, family education on parenting and financial management, and employment and economic development.[47] Participants emphasized the importance of engaging in skills building and education in the Native way, in other words through experiential learning, role modeling and storytelling.[47] This literature review indicates that skills development is important to improving the complex interpersonal and relational contexts that influence mental health.

In the Zuni suicide prevention curriculum, the authors suggested a school-based curriculum that focused on improving communication skills to support help-seeking behaviors as well as social support.[67] (For a description of the Zuni Life Skills Development Curriculum see the individual programs and activities descriptions section.) Additionally, the authors suggested prevention efforts focused on ways to avoid substance use, stress management techniques and life skills training.[67] Parent education and skills trainings are also suggested to compliment the school-based curriculum.[67]

Theme 4: Integrate screening and treatment with prevention or primary care (and in places not traditionally associated with mental illness, such as schools) and provide linkages in systems of care.

A number of sources noted a need for increased depression and/or suicide screening and identification of those at risk.[58, 61, 68-70] Developing infrastructure to integrate primary or physical health care with behavioral health care aligns with AI/AN holistic approaches to health and wellness, reduces stigma and privacy concerns, and may increase access to mental health care.[42, 71, 72] IHS supports the integration of mental health services with primary care services as well as establishing a broader range of services through larger networks of support and care.[2, 34] The World Health Organization report on integrating mental health care with primary care demonstrated the benefits of appropriately integrated care both in positive patient health outcomes and cost-effectiveness.[73] Similarly, interventions in youth centers or at schools also can decrease stigma and increase utilization of services.[20, 58] The importance of inter-agency and public-private collaborations was also stressed in the literature.[58, 60]

> "*Indian Health Service supports changing the paradigm of mental health services from being specialty and disease focused to being a part of primary care and the 'Medical Home'*." [2]
>
> – Robert G. McSwain, former director of the Indian Health Service

Theme 5: Expand and ensure cultural competency of mental health providers and related healthcare delivery systems.

- ***Educate and train mental health providers on cultural competency***

  Many sources noted the need for increased training and education of mental health providers about AI/AN history, cultures, beliefs, issues and context in order to provide effective therapeutic understanding and intervention.[20, 50, 51, 54, 60, 63-65] Brucker and Perry (1998) compiled literature on issues pertinent to treating AI/ANs in family therapy.[54] Specifically, the authors summarized literature and data on alcoholism, posttraumatic stress disorder, violence against women, racial genocide (i.e., historical traumas), depression and suicide in AI/AN youth to familiarize family therapists with the issues

AI/ANs may present in therapy.[54] Brave Heart and DeBruyn (1998) advocated for clinicians to develop cultural competence, self-awareness and the ability to manage transposition and grief.[21] The authors' provided a training model for group healing processes to resolve historical trauma and grief.[21] Sources also recommended non-Native care providers consult with Native providers and Native healers.[51, 53]

A report produced by the National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning, recommended that in addition to providers, health care systems would benefit from cultural competence in terms of policies, procedures and practices.[72]

- ***Broaden the mental health provider licensing and credentialing options to include traditional healers or lay person helpers as eligible providers able to receive reimbursement for culturally appropriate services***

  As noted earlier in the background Care Utilization and Barriers to Care section, findings have shown AI/ANs prefer traditional services and seek care from traditional healers at higher rates than from specialty mental health providers.[17, 35] Changing the treatment system to incorporate traditional healing for AI/ANs may help to respond to cultural preferences for care delivery. Recommendations included creating alternative licensing and credentialing for Native providers to recognize the expertise of traditional practitioners and increase their billing ability; these efforts would also help address the shortage of Native practitioners (See the next paragraph).[71, 72]

- ***Increase the number of AI/AN mental health providers***

  Sources noted the need to add more AI/ANs to the mental health workforce.[50, 60, 63] For example, participants at a conference for mental health providers suggested developing programs to actively recruit members of the distinct populations to work as providers and maximize the involvement of Natives in the leadership and management of mental health services.[64]

Theme 6: Provide flexibility in the provider-patient relationship as well as adaptations of standard treatment practices.

- ***Patient-provider relationship***

  Relationship building by providers includes establishing credibility and rapport; developing trust not just with the patient but also in the community.[46] As opposed to Western practice where the provider is separate from the patient's community life, Grandbois (2005) suggested that it is more appropriate in Native communities for the provider to be a part of the patient's non-therapy life, that family be included in therapy and not to impose bureaucratic barriers and restrictions (e.g., insurance eligibility, administrative rules).[51] Additionally, focus group participants explained the retraumatization of the diagnostic process, including the label of the diagnosis itself.[49] Diagnostic labels may negatively affect people's self-esteem, further disconnect AI/ANs from their cultural identity, and place a focus on disease not on wellness.[49] While these perspectives or experiences may be unique to some individuals or groups, both behavioral health and primary care providers will benefit from an awareness of these

perspectives when establishing care relationships with patients, families and communities.

Sources provided specific suggestions for improving the provider-patient relationship including: 1) allowing for time orientation considerations (i.e. being late or missing appointments,[54] not imposing time restrictions or requirements,[63] being flexible with the duration and frequency of treatment,[74] allowing longer spaces between speakers and allowing silence[54]); 2) slowing the pace of therapy; and 3) including visual and active learning exercises during the therapy session.[53] The use of storytelling or drawing can aid diagnosis with open ended questions rather than routine questioning.[53]

- ***Adaption of therapeutic techniques***

  There were conflicting findings regarding aspects of therapy that may or may not be modifiable for use with AI/ANs. Hodge et al. (2009) called for abandoning the Western mental health therapy model and adopting a Native model of wellness that focuses on the balance of spirit, body, mind, and context (family, culture, traditions). Based on the Native wellness perspective, the authors offered implications for care including: restoring balance between the four areas (spirit, body, mind, context); addressing challenges as relational not linear cause-and-effect; using self-discipline and cultural, spiritual or mental practices or therapeutic interventions such as ceremonies or remembering/storytelling; involving other AI/AN community members and/or healers in the process of restoring balance or harmony; and for Western therapists, developing working relationships with specialists in Native spirituality and culture.[13]

  Conversely, Jackson et al. (2006) suggested that the Western model of Cognitive Behavioral Therapy (CBT), a goal-directed systematic approach to changing negative or dysfunctional thoughts and behaviors, may be acceptable, with adaptations, to AI populations. The authors noted its adaptability stems from the fact that CBT is client-centered, promotes empowerment, attends to processes and behaviors (emphasizes action rather than verbal expression of emotions), has a present time orientation, acknowledges environmental factors and has a partnership approach.[74]

  An example CBT adaptation was a small study among AI/AN adolescents in the Southwest that examined the feasibility and acceptability of an adapted evidence-based trauma-focused intervention called Cognitive Behavioral Intervention for Trauma in Schools (CBITS) originally developed for urban youth in Los Angeles.[43] Based in schools, CBITS is both a group and individual intervention using standard cognitive behavior methods (education, relaxation, exposure and problem solving) to: 1) decrease symptoms of post-traumatic stress disorder, depression and behavioral problems, and 2) improve function, coping abilities, grades and attendance, and social and familial support.[75] The adapted intervention, Teen Health Resiliency Intervention for Violence Exposure (THRIVE) includes group sessions, parent meetings, teacher meetings and one to two individual therapy sessions. Adaptations from the original curriculum and materials ranged from superficial, such as removing Eurocentric examples and imagery, to more structural changes by using stories to share cultural teachings, using sweet grass in relaxation exercises and changing the order of sessions to build trust and family support.[43-45] Additionally, facilitators made referrals to traditional healers as appropriate

and discussed seeking help or support from elders.[43, 45] Community partnerships and input were important for designing and implementing these adaptations.[43, 44]

Several limitations were noted including confidentiality concerns, burdensome recruitment and assessment procedures, and variable attrition rates in different studies.[43, 45] While THRIVE was shown to be effective in achieving the stated objectives it may not be generally feasible and acceptable. However, the adaptation process, where the community's norms and priorities drove the curriculum changes offered an excellent example of adaption of an evidence-based practice for the AI/AN community (see Ngo et al., 2008 for the complete description of the CBITS curriculum development process). Information about free CBITS resources, training and implementation support can be found at http://cbitsprogram.org/.

Theme 7: Focus on environmental or structural changes to affect the conditions surrounding people as well as the interactions between people and their environments.

It is important for providers to understand and treat the individual as inseparable from his/her context or environment.[48] One source recommended that current systems of behavioral health care take into account the environmental realities of AI/ANs such as socioeconomic status, education levels, unemployment and physical health disparities.[71]

A source focused on decreasing suicidality recommended that interventions target the interaction between individuals and their environments rather than intrapersonal interactions.[48] Specific suggestions include person-focused skills training (e.g., coping skills), transaction focused skills training (e.g., communication or assertiveness skills) and environmental changes (e.g., eradicating poverty).[48]

Theme 8: Advocate for the development of policies, systems and increased funding to improve health care and economic opportunities for AI/AN people.

Advocacy to change systems and contexts is needed to address social determinants of health such as education, income, access to care, and prejudice.[63] Systems level changes (changes in the environment and society) to improve the conditions in which AI/ANs live are as necessary as changes made at the individual level.[42] There is a recognized need to increase funding and use broad-based approaches that bring together all sectors of society to address mental health needs and systems-oriented change to address depression and suicide.[58, 60] Diverse approaches suggested to address depression and suicide across societal sectors included increasing data collection, developing evaluation in practice, making more health and support services available, collaborating and involving community, incorporating and validating traditional and cultural services, conducting interventions at youth centers and schools, and developing strong and caring family-community networks.[58, 60]

Goodkind et al. (2010) recommended shifting the emphasis from evidence-based practice to practice-based evidence (current practices used routinely in real-world clinical settings), as many evidence-based practices (e.g., randomized controlled trials) are not tested in AI/AN populations.[71] Additionally, many practices are already in use that are effective but are lacking evaluation and validation by funders, therefore practice-based evidence can provide evidence more quickly than randomized control trials or other methods.[71] Goodkind et al. also called for

more funding for programs that connect prevention to treatment. Prevention programs increase outreach and education to a wider segment of AI/AN communities since many will not engage in treatment due to stigma but will participate in community prevention activities.[71] In addition, the Goodkind et al. report recommended focusing on prevention for youth with special attention to the collaborative potential of affiliating youth prevention services with special education, juvenile justice and social service agencies.

ACTIVITIES AND PROGRAMS

Findings in the Activities and Programs results category are organized into: 1) descriptions of individual programs and activities, 2) programs and activities highlighted by IHS sources, and 3) resources. Many of the programs and activities reflect one or more of the themes noted above under implications for care. These program descriptions provide examples of how the themes described above are implemented in practice.

Individual Programs and Activities Descriptions

Adolescent Suicide Prevention Project / Department of Behavioral Health of the Western Athabaskan Tribal Nation

May et al. (2005) described the evaluation results of what began in 1989 as the Adolescent Suicide Prevention Project and grew over the years into the Department of Behavioral Health of the Western Athabaskan Tribal Nation.[68] In addition to identifying and providing direct mental health services for those at risk for suicide, the program engaged in community education and awareness building, not just about suicide, but also life skills.[68] Neighborhood volunteers acted as “natural helpers” and provided education, referrals, and counseling to those who did not wish to speak to a mental health professional.[68] Mental health professionals also provided counseling and services, often in un-conventional settings in order to decrease stigma associated with seeking mental health services.[68] As the program grew, it integrated alcohol and substance abuse treatment services and other social services.[68] Based on public health theory and practices, program components included: local surveillance and careful record keeping, outreach, school and community based education, and integration of services.[68] Since 1998, suicidal gestures and attempts have decreased by 73%.[68] The number of completed suicides has not decreased significantly, though the trend is encouraging.[68] Since the overall suicidal behaviors consistently decreased during the prevention project period, the authors concluded that the delivery of the prevention programs in this community were successful.

Alaska Division of Behavioral Health

The State of Alaska has mandated two screening tools for programs receiving funding from the Division of Behavioral Health to promote early diagnosis and intervention of mental health problems. The screening tools ask direct questions about sadness, suicide, and disruption of daily activities due to depressive symptomology.[76] Alaska has also funded a suicide hotline, as well as reduced stigma around mental health issues and increased knowledge of services through print, radio and television advertising.[76] In addition, Alaska Behavioral Health developed a website that provides resources for those suffering from mental health problems and their families and friends.[76] Regionally, there are also preventive mental health care efforts at wellness conferences, health fairs, festivals, and dances.[76] Village-based counselors, Behavioral Health Aids and telemedicine are used to increase access to services in rural villages.[76] Public recognition of the need to address depression in order to prevent suicide has

helped facilitate the use of screening tools, despite the increased paperwork.[76] Future plans include an analysis of completed screening forms to improve the forms and their use in practice; however, no interim summary statistics were reported at the time of the source's publication.

Applied Suicide Intervention Skills (ASIST) Program

The ASIST program involves a two-day training program for caregivers (those in a position of trust in the community such as teachers, elders, health aids, clergy, etc.) to provide supportive, effective suicide prevention and intervention.[77] The Suicide Prevention Resource Center lists the program in its Best Practices registry[78] and ASIST training is available through the LivingWorks organization.[79] IHS notes the following benefits of the program: 1) reduction of stigma about discussing suicide, and 2) making suicide prevention something that can be practiced by community members (i.e., not limited to mental health care professionals).[77] The Alaska Native Tribal Health Consortium had their staff trained as ASIST workshop trainers to substantially lower the costs of conducting the workshops for caregivers.[77] Many programs have used, evaluated and/or adapted ASIST for their purposes as described in later sections of these results.

Circles of Care

Building upon the 1990 report to Congress, *Indian Adolescent Mental Health,* an advisory board of scholars, providers and leaders in AI/AN health worked for four years to develop the Circles of Care (CoC) funding mechanism. CoC represents a partnership between a number of federal agencies with the goals of reducing mental health disparities, increasing cultural competence in the mental health care delivery system and increasing the effectiveness of systems of care for children, adolescents and their families.[80] CoC funding recipients plan, design and assess the culturally appropriate systems of care for mental health services for AI/AN children with serious emotional disturbances and their families.[80] With technical assistance, grantees conduct a needs assessment that gathers information on local perceptions of mental health needs as well as current service accessibility and acceptability.

Findings from the first round of funding (1998-2001) indicate the needs assessment process itself decreased stigma associated with mental illness by providing locally relevant definitions of serious emotional disturbance, mobilizing communities through a strength-based conceptualization of need, establishing important collaborations and partnerships, and enabling grantees to secure further funding.[81, 82] Grantees used the findings from the assessment to inform their development of systems of care. Grantees addressed the barriers and needs in a number of ways from developing continuing education programs to improve training, quality and cultural competency of providers to the development of a satellite clinic site to address transportation and financial barriers to care.[83] One site developed a Family Support Circle to include extended family in the healing and care process.[83]

> "*Successful prevention efforts incorporate the notion of bicultural identity in practice, employing interventions tailored to the community and strengthening participant's ability to 'walk in two worlds'.*"[1]
>
> – E. Nebelkopf, J. King

Of the 23 grantees that have completed the Circles of Care program, nine have received direct funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement the systems they developed. Four others have

secured funding by partnering with other SAMHSA grantees, while others have used alternative strategies and resources to bring their plans to reality.[52]

Holistic System of Care (HSC)

The Native American Health Center in Oakland and San Francisco, California developed the Holistic System of Care (HSC) to prevent, treat and support recovery of urban AI/ANs with co-morbid conditions including alcohol or substance abuse, mental health issues and HIV/AIDS.[55] One of the original CoC grantees, the HSC combined evidenced-based and best practices, (such as the Gathering of Native Americans [GONA] curriculum for community healing and substance abuse prevention and recovery, motivational interviewing, and Positive Indian Parenting) with traditional AI/AN cultural practices, including smudging, traditional healers, pow wows, sweat lodge ceremonies, seasonal ceremonies and talking circles.[55] The integration of mental health, substance abuse, HIV/AIDS, medical and dental care provides comprehensive and holistic care that honors AI/AN perceptions of wellness, builds on community strengths and encourages empowerment.[55] Services include a focus on family, community and Native culture at every stage.[84] Additionally the HSC includes practical support to address environmental factors influencing mental health and substance abuse including life skills education, employment and housing services, positive peer role modeling and community service.[55] In earlier studies of the program, baseline and three month follow-up surveys showed improved quality of life in areas of mental health; at baseline 32% responded “definitely true” to the statement “I have been feeling bad lately”, at follow-up this dropped to only 3%.[84] In more recent results, six-month follow-up evaluation results showed statistically significant decreases in serious depression, serious anxiety or tension, attempted suicide and increased use of prescription psychological medication.[55] Program successes were attributed in part to the emphasis placed on including the community and family, as well as focusing on restoring balance through traditional practices and a multidisciplinary team of Native professionals that meet regularly to collaborate.[55, 84]

Medicine Wheel

Muehlenkamp et al. (2009) described the use and association of the medicine wheel as a culturally appropriate model for suicide prevention with AI/AN college students.[85] In an attempt to adapt mainstream and tribally-based suicide prevention efforts for use on a college campus where AI/AN students came from many different tribes, the program organizers based their model on the medicine wheel. They applied unifying themes across AI/AN cultures to inform content and activities as well as implemented the Sources of Strength[86] and QPR[87] (question, persuade, and refer) gatekeeper training curriculums. In suicide prevention workshops they encouraged discussions among participants that elicited specific experiences that made the discussion more culturally relevant. Pre and post workshop evaluations indicated participant satisfaction with the workshop content and some impact on student learning, especially regarding problem-solving skills. However, the program’s biggest challenge was participation. Only 24% (n=90) of the 368 AI/AN students at the school used any feature of the AI/AN suicide prevention program and only 1% (n=36) of AI/AN students participated in suicide prevention workshops. Participation challenges were attributed to difficulties in attracting students to program activities. Future plans to improve participation include integrating suicide prevention workshops in other AI/AN student activities, peer-to-peer networking, identifying students at risk through academic probation status and encouraging staff and faculty referrals. Information on

the Sources of Strength and QPR curriculums are available at the websites listed in the references section of this report.[86, 87]

Prevention of Suicide in Alaska's Tribal Health Care Setting

To limit access to lethal means of suicide, IHS' Injury Prevention Program implemented a gun locker and locked medicine cabinet program in southwest Alaska.[88] Through referrals made by local health aides, 19 medicine cabinets were installed by Emergency Medical Service volunteers in the homes of parents of youth at risk for suicide. Gun locker referrals were drawn by lottery. While a novel program, no long term follow-up of the ongoing use of the locking cabinets was conducted, preventing evaluation of the program's effectiveness.[88]

Project Life

In Northwest Alaska two hospital-based programs were conducted in collaboration with Project Life (funded by SAMHSA), a holistic program to support youth wellness and suicide prevention for the Maniilaq service area.[89] The program, which is based on Inupiat values, includes suicide prevention and intervention trainings as well as a multi-avenue media campaign to communicate positive community strength messages and change views of suicide in the community. The two hospital-based programs included: 1) a follow-up by postal contact with patients treated at an emergency department for a suicide attempt that intended to reduce barriers to help-seeking behaviors, and 2) a suicide/depression screening process conducted in the emergency and acute care hospital departments using two initial screening questions, followed by seven follow-up questions if the initial screen was positive.[88] The sources cited here described Project Life but did not provide outcomes or evaluation measures.

Southcentral Foundation Depression Collaborative

The Southcentral Foundation Depression Collaborative was an annual depression screening and intervention study in a primary care setting with consultation from and referral to a behavioral health clinic.[90] The two-part screening activity included: 1) the nine question Patient Health Questionnaire (PHQ-9) to screen for depression, and 2) semi-structured interviews of patients by certified medical assistants. (The PHQ is derived from the PRIME-MD instrument, both of which were tested in a mostly urban AI population).[91] Intervention for those diagnosed with a depressive disorder included recommendations for and information about self-care practices for depression such as physical activity and social support. Telephone or in-person follow-up was scheduled based on whether or not anti-depressant medication was prescribed. The behavioral health department created an anti-depressant medication identification/dispensing flow diagram. Seventy-eight percent of patients who received follow-up visits and/or antidepressants eventually had a PHQ score of less than six, indicating mild depression and minor impacts of depression on social and occupational activities.[90] Some challenges with the program that have been noted included significant time spent on follow-up and concerns about increased diagnoses exceeding clinic capacity to respond. Also, clinic and behavioral health providers expressed discomfort or concern about various aspects of conducting the screening and treatment.[90] For example, medical assistants were concerned about asking highly personal questions of patients, physicians were concerned about properly responding to behavioral health symptoms during short primary care visits, behavioral health providers were concerned about appropriate training of primary care providers to provide specialized depression treatment, and all were concerned about the impact of screening on their

organizations' capacity to respond to increased diagnoses. Even with these limitations, the intervention indicates screening and depression management may be a feasible method of reducing untreated depression in AI/ANs.

- **Denaa Yeets' (Athabascan for "Breath of Life") Program**

  In May 2006 the Southcentral Foundation began the Denaa Yeets' (Athabascan for "Breath of Life") Program.[88] This program provides case management, referrals to treatment programs and support services to Alaska Native adults at risk for self-harm. The program also seeks to engender a sense of self-worth through cultural identity and engagement in cultural activities such as talking circles, drum-making, fishing and potlucks.

Tohono O'odham Nation's Division of Behavioral Health

The Tohono O'odham Nation's Division of Behavioral Health (TOBH), formerly the Papago Psychology Service, was one of the first indigenous-developed and operated mental health systems and has served as a model for others.[92] TOBH provides a full range of behavioral health services to a tribal population of 29,000. Services include inpatient psychiatric referrals and aftercare (support services after treatment), outpatient counseling, an outpatient substance abuse program, aftercare sobriety campouts, Alcathons (all day Alcoholics Anonymous meetings or gatherings), Personal Growth, GONAs (for community healing and substance abuse prevention and recovery), acupuncture services, art therapy and ASIST workshops.[93] Traditional healing and cleansing ceremonies are provided by program staff and TOBH vendors. In addition, TOBH has skilled community response and crisis intervention teams.[93] Also, the Tohono O'Odham Nation operates the award-winning Tas Tonlik Ki program that provides transportation to serious and chronically mentally ill adults who participate in plant cultivation, maintaining a nursery, landscaping, meal preparation, ceremonies, groups and monthly psychiatry clinics.[94] As a long-running program, TOBH serves as an important example of establishing a community-developed and operated mental health and crisis intervention program.

Village Sobriety Project

The Village Sobriety Project integrated traditional Yup'ik and Cup'ik practices of healing alongside Western treatment services for mental health and substance abuse. The Village Sobriety Project obtained Medicaid reimbursement for cultural Yup'ik and Cup'ik activities such as tundra walks, hunting, berry picking, fishing, traditional arts and crafts, ceremonies and time with elders as a part of mental health and substance abuse treatment plans.[95] Justification that these traditional practices related to treatment goals provided sufficient documentation to receive Medicaid reimbursement for services.[95] The rationale relied on showing that if billable Western framework therapies included play and art therapy, along with cognitive therapy and rational-emotive therapy, then traditional and cultural activities were equally valid treatment approaches. These and other activities were identified as important to the process of healing and restoring balance by community members in focus groups.[95] These traditional modalities are done in tandem with Western treatment and can be used to the extent the patient chooses.[95]

RESULTS

Wind River Reservation-Wyoming State Hospital Collaborations

In an effort to increase AI utilization of Wyoming State Hospital (WSH), an inpatient psychiatric hospital, hospital administrators collaborated with members of nearby Wind River Reservation and Native patients to develop services more acceptable to AIs and to incorporate traditional activities used to heal and restore harmony.[57] Based on this collaboration, the tribe and hospital built a sweat lodge in a private area of the hospital grounds. Since its erection there have been regular sweats (four to five times a year) presided over by tribal elders or reservation officials.[57] The sweat lodge, in combination with a Dual Diagnosis program for persons with substance abuse and mental illness conditions, have resulted in: 1) improved utilization of the state hospital through increased referrals from the Reservation and IHS and increased AI inpatient admissions, 2) decreased length of stay for AI patients, 3) increased patient and tribal satisfaction, 3) improved health care outcomes for AI patients and 4) improved collaboration between the hospital, tribe and IHS.[57] Anecdotal reports from the authors noted that patients reported the integration of the sweat lodge into the care services contributed to their feeling cleansed and healthier; patients also reported the sweats helped them respond to treatment better and that they felt more ready to return to their community.

After these practices were put in place, WSH admission increased from an annual mean 4.77% AI admission rate prior to the sweat lodge initiation to 7.50% after initiation.[57] The researchers noted that this sustained increase was not evident for admissions in other racial categories during the same time period. This collaboration is an example of how discussions with key representatives from both hospital and tribal members can lead to positive changes in access to care and care delivery.

Zuni/American Indian Life Skills Development Curriculum

The Zuni Life Skills Development Curriculum and its adaptation for a more tribally-diverse population, the American Indian Life Skills Development Curriculum, are community-initiated, school-based suicide prevention interventions.[96] From 1980-1987 numerous suicides occurred in the Zuni community of New Mexico.[96] The Zuni Life Skills (ZLS) program was developed by the tribe to address suicide risks factors in adolescents.

The more tribally-diverse adapted model, the American Indian Life Skills (ALS) program, has continued to be used in other rural, reservation settings with culturally tailored modifications specific to local populations. The ALS has many lesson plans covering topics such as suicide risks and protective factors, recognizing warning signs, ending self-destructive behaviors, crisis intervention and prevention, goal setting, communication, problem-solving and other subjects.[96, 97] The curriculum is delivered three times a week in middle schools by teachers and counselors over the course of 30 weeks. Lessons are taught through interactive, experiential activities where students role-play and problem solve based on scenarios.[96, 97] SAMHSA lists the ALS program on its National Registry of Evidence-based Programs and Practices.[97]

Evaluations have indicated positive results, including students reporting feeling less hopeless and demonstrating a higher level of suicide intervention skills compared with a control group. Limitations of the studies of ALS include high attrition rates, concerns about the validity and reliability of the role-play scenarios and small sample sizes.[41, 97] Also, Lafromboise et al (2008) noted the ALS program needs application, evaluation and testing in urban settings.[96] More information about the availability of ALS is provided on SAMHSA's website.[97]

RESULTS

Programs and Activities Highlighted by IHS Sources

Current and past IHS Directors outlined strategic approaches to mental health care and preventing suicide. In statements before the Senate Committee on Indian Affairs and in the current IHS National Behavioral Health Strategic Plan, both former IHS Director McSwain and current IHS Director Roubideaux focused on holistic and cultural approaches, identifying and sharing best and promising behavioral health practices, promoting collaboration and cooperative partnerships, increasing access to services and enhancing epidemiological capacity.[2, 34] Underscoring these approaches are a respect for the role of community and cultural wellness, traditional knowledge, elders, spiritual leaders and positive youth development.[2, 34] Both IHS Directors highlighted the importance of a holistic approach to well-being as well as integration of behavioral health services into the structure of primary health services.[2, 34] IHS Directors also noted the growth of and potential for telebehavioral health services to increase access to care.[2, 98] Following are examples of some programs and activities cited by IHS sources that exemplify these principles.

- ***Behavioral Health Programs in Bemidji Area***

  Programs highlighted in the Bemidji IHS Area include the following:

  - **Bridge Program.** The "Bridge Program" operates as a partnership between the Red Lake IHS Hospital and the Minnesota Psychiatric Society (MPS). MPS member volunteer psychiatrists provided evaluations and consultation in the Emergency Department on weekends to expand the care coverage.[93]

  - **Miikanaake Program.** On the Fond du Lac Reservation, the Miikanaake Program (from Ojibwe —"to make a new road or trail") provides a brainwave optimization treatment program for those with a history of substance abuse, depression, or anxiety. Brainwave optimization uses relational electroencephalic (EEG) mirroring, a non-invasive technology, to gather brainwave data through sensors attached to the scalp by a trained practitioner. During guided visualization the brainwaves are translated into sounds from nature allowing the patient to observe brainwaves at optimal levels, thus training the patient to achieve balance and harmony between different areas of the brain. Brainwave optimization requires daily treatment sessions for one week with additional follow-up sessions as needed; regular counseling sessions are also advised. At six months following treatment of long-term substance abuse, the program demonstrated a 50% sobriety success ratio. Other than an individual personal success story, no specific success results were reported for depression or anxiety patients.[93]

  - **Northern Arapaho Tribe Methamphetamine and Suicide Prevention Initiative Program.** This program involves a multi-faceted approach by partnering with many organizations as well as integrating traditional practices such as sweat lodges and talking circles as supplemental to the clinical treatment practices.[93]

- ***California Area IHS***

  The California Area IHS (CAIHS) uses telemedicine to enable local clinics to deliver psychiatric care by a board-certified psychiatrist based at the University of California-Davis. These telemedicine behavioral health services enable clinics to seek

reimbursement for specialist provider care from MediCal that otherwise would not be available locally.[93] Other programs used in the CAIHS included the following:

- **Friendship House.** The Friendship House in San Francisco runs a youth program, funded through the IHS Methamphetamine and Suicide Prevention Initiative, with activities consisting of mentoring, sports, youth leadership development, health education, traditional counseling, life skills workshops, digital media workshops and traditional dance classes. Friendship House partners with other Native organizations to provide intensive mental health services. These activities support effective social and communication skills, problem solving, cultural identity and provide structure outside of school time to prevent drug use and suicide ideation.[99]

- **Toiyabe Indian Health Project**. In an effort to prevent suicide, the Toiyabe Indian Health Project in the Eastern Sierra region of CAIHS, uses the American Indian Life Skills (suicide prevention interventions) curriculum in close partnership with local area schools. The Toiyabe Indian Health Project also uses the ASIST program for training behavioral health staff and are expanding the ASIST training among personnel at other agencies, such as schools.[93]

- ***Nashville Area IHS***

  Evidenced-based practices in use in the Nashville Area include Trauma–Focused Cognitive Behavioral Therapy, Motivational Interviewing and the Practical Adolescent Dual Diagnosis Inventory.[100] Question, Persuade, Refer and Treat (QPR-T) is also used as an approach to suicide prevention to identify and manage suicide risk.[100]

  - The **Analenisgi Center** at the Eastern Band of Cherokee in the Nashville IHS Area runs a group sweat as a venue for group psychotherapy for people with anxiety.[101] The goal of the program is to reduce anxiety symptoms and improve coping skills.

- ***Portland Area IHS***

  The Spokane Tribe Health and Human Services Behavioral Health Program used the ASIST program with both behavioral health staff and children. In addition, the Spokane Tribe HHS Behavioral Health program has been working with a dietician to develop a community garden, with funding for seeds coming from the Women, Infants and Children program. With assistance from the dietician, mental health and alcohol/substance abuse clients create strategies for healthy eating, emphasizing access to fresh, locally grown produce for behavioral health clients and other Tribal members. Youth at a community center tend the garden and sell the produce at the garden's weekly farmer's market. This serves as an excellent example of a community-based program designed to integrate distinct healthy living approaches.[93]

- ***Tucson Area IHS***

  Programs highlighted in the Tucson Area IHS include the following:

  - **Native Pride Project.** Building on a previous successful partnership with the University of Arizona, the Tucson Indian Center worked with a Youth Coalition to develop the Native Pride Project (NPP) to encourage cultural arts and activities to protect against suicide risk factors. In collaboration with elders, artists, drum groups

and other community organizations NPP activities include pow wow singing, pottery, theater and creative movement.[94]

- **The Pascua Yaqui Child and Family Team** in the Tucson IHS area provides services for those experiencing mental health, alcohol/substance abuse and behavioral issues. Culturally relevant services include therapy conducted in many forms (individual, group, family and play therapy) and venues such as neighborhood schools. School-based counseling is a critical outreach and treatment service approach because children spend a majority of their time in school.[93]

- **The Tucson Indian Center (TIC)** serves the Tucson urban AI population with culturally appropriate wellness, social, economic and educational services.[93] TIC provides referrals to behavioral health resources including outpatient therapy, psycho-educational assessments, detox, inpatient substance abuse rehabilitation and White Bison Native American 12-Step meetings. Outreach for these services and general health promotion is conducted using the monthly Native Wellness Voice newsletter.[93]

- ***Other IHS Areas***

  The Navajo Area IHS is using telemedicine and telepsychiatry to overcome the obstacles of long distance transportation in rural areas as well as the recruitment of psychiatrists/psychologists.[93] The Phoenix Area Suicide Prevention Initiative uses best practice strategies to address suicide including ASIST, QPR and Assessing & Managing Suicide Risk (AMSR).[93, 102]

  Across the country, 11 Tribal and Federally operated Youth Regional Treatment Centers provide behavioral health care for AI/AN youth and their families in residential environments with a focus on substance abuse and dual diagnosis.[103] The holistic care integrates traditional healing, spirituality and identification with culture. Increasing the capacity of staff through training on Native American approaches to treatment and behavioral therapy has been an approach taken by some sites. Some programs developed systems enhancements that allow for telemedicine and family therapy sessions even when all family members can't be onsite. Many programs incorporate cultural crafts, group activities, peer support and connections with family and elders.[103]

Resources

In addition to the information, programs, and activities noted above and cited in the references, several other resources were indentified through the environmental scan. These resources include:

A Guide to Suicide Prevention for AI/AN– One Sky Center

This suicide prevention resource guide offers an introduction and background information on suicide in AI/AN populations, including contributing factors and warning signs. Other resources included in the guide are data sources, a list of relevant publications, assessment tools, consultant and technical assistance contact information as well as practice guidelines. The resource guide describes several programs and strategies for community suicide prevention.

RESULTS

The guide highlights a public health approach to preventing suicide that focuses on the community rather than the individual with key recommendations for prevention strategies taken from Mann et al. (2005)**:** 1) awareness and education for the general public to increase recognition of suicide risk and help seeking behaviors, 2) physician training to enhance screening and recognition of warning signs, 3) gatekeeper training for those who are in contact with potentially vulnerable people to direct those at risk to the appropriate resources, 4) screening to identify and direct to treatment those suffering from depression, 5) treatment including pharmaceutical and talk therapies, 6) restricting access to lethal means such as firearms, and 7) media guidelines that promote education and do not glamorize suicide.[70, 104] The guide highlights programs that provide these types of interventions, including a description of the program, generalizability to AI/AN populations, implementation essentials, programs costs and program contact information.

IHS American Indian and Alaska Native Suicide Prevention Website

This website provides links to materials, information, articles, tools and descriptions of some approaches being used in Indian country to address suicide.[105]

IHS Online Search, Consultation, and Reporting (OSCAR) System

The IHS OSCAR system allows you to search on best and promising practices by IHS Area, health indicators and key words.[101] A resource highlighted in OSCAR that is available nationally is the Center for the Treatment and Study of Anxiety which recommends Prolonged Exposure, a cognitive-behavioral treatment program of individual therapy with three components: education about common reactions to trauma, emotional reliving and gradual exposure to trauma triggers in an effort to minimize their impact.[101] Many of the programs described in earlier sections of this report were identified through the OSCAR System.

National Alliance on Mental Illness (NAMI)

The National Alliance on Mental Illness (NAMI) provides many resources along with education, family training and peer support programs, some of which are free or offered at reduced costs via NAMI state and affiliate organizations. For information see Support and Programs under www.nami.org.[106] NAMI also provides an American Indian and Alaska Native Resource manual.[107] While designed for use by NAMI offices, the information provided may be of use for community mental health centers or mental health professionals serving AI/AN populations.[107] The resource provides information on the importance of cultural competence and how to develop it, along with background information on AI/AN health disparities and AI/AN mental health research. This resource also includes *The American Indian and the Media: Indian Country Resource Guide – 100 Questions for 500 Nations* produced by the National Conference for Community and Justice.[107]

Summary of Best and Promising Mental Health Practices for Select Consumer Populations (2003)

Many of the programs featured in this report focus on family strengthening, communication and decision making with the goals of preventing substance abuse and violence.[56] One program highlighted is the Blue Bay Healing Center. Its services focus on suicidal thoughts/behaviors, parents, veterans, family communication, family violence, developing skills and hobbies, exploring educational opportunities, assertiveness skills and understanding one's cultural identity.[56]

Another program described in this report is the Mno Bmaadzid Endaad or Be In Good Health at His House program, which focuses on developing a seamless delivery system for health and human services, increasing the cultural competency of providers, and increasing awareness of the needs of children with serious emotional disturbances.[56]

Also highlighted is the Sacred Child Project that targets children with emotional disturbances on North Dakota reservations and works to create and provide mental health services consisting of: 1) wrap-around care coordination, 2) parent advocacy, 3) parent and community education, 4) tutoring, 5) mentoring, 6) traditional healing, 7) recreational activities, 8) cultural activities, 9) psychological services and assessments, 10) transportation, 11) emergency financial assistance for families, and 12) youth social development activities.[56]

TeenScreen

Columbia University developed the TeenScreen* Program to increase screening of youth in primary care, schools and communities to identify adolescents with mental health issues by "mainstreaming" mental health check-ups in youth-serving settings.[69] In primary care settings the evidence-based questionnaire takes five to 10 minutes and can be administered during well-child, sports physicals or other routine visits. For teens who score positive, further evaluation is conducted and, where appropriate, teens are either treated by the physician or referred to a mental health provider.[69] Parents are notified of screening results and educated about mental health needs, appropriate resources and community referrals.

The TeenScreen National Center for Mental Health Checkups provides free tools and resources to enable primary care providers, schools and community partners to offer adolescent mental health check-ups.[108] While not specifically designed or tested among AI/ANs the screening tools have been used in Native communities. These screening tools include a pediatric symptom checklist, a Patient Health Questionnaire modified for teens (PHQ-9 Modified) and a self administered questionnaire designed to screen teens for alcohol and substance use.[69] The screening tools can also be used at school-based clinics, shelters, juvenile justice facilities or other drop-in centers. TeenScreen also offers other free training materials and resource guides on their website at www.teenscreen.org.

Other Literature Resources

Several sources in the academic literature provided material that may be useful as general resource information. For instance, Bossarte et al. (2011) presented information on collecting and managing depression and suicide data using the Resource and Patient Management System (RPMS), which supports mental health and primary care, provided lists and templates to support work flow and remind staff of medications, labs and consultations. This resource discussed the use of the PHQ-9 screening tool and provided instruction on using RPMS for recording, managing and follow-up of cases of depression and suicidal behaviors.[109]

Second, Crofoot et al. (2008) provided a summary table of previous needs assessments for urban AI/AN populations in the Western United States that included behavioral health results.[110] While the authors were careful to note needs assessments and their own findings were not

* TeenScreen is not universally endorsed due to concerns regarding relationships to pharmaceutical companies, parental consent prior to screening and incentives for participation.

epidemiological studies and did not assess community strengths and weaknesses, this resource did provide a glimpse into the needs of urban AI/AN communities in the areas of mental health and substance abuse.

DISCUSSION

REVIEW AND CONSIDERATIONS

A clear need for effective programs and activities to address depression and other common mental disorders is evidenced by the high prevalence of these conditions, as well as of suicide and co-occurring conditions such as alcohol and substance use among AI/ANs. However, shortcomings in the mental health care system for AI/ANs are well recognized and both systemic and cultural barriers to care (e.g., stigma, cultural competency, etc.) must be overcome to eliminate mental health disparities.

The results of this environmental scan identified eight themes highlighting implications for depression and mental health care. Briefly, these themes included: 1) focus on family and community; 2) incorporate traditional knowledge and practices; 3) focus on active skills building; 4) integrate and link prevention and treatment care systems; 5) expand cultural competency of both providers and health care systems; 6) develop flexible provider-client/patient relationships with adaptive treatment approaches; 7) implement environmental and structural changes to affect surrounding conditions; and 8) develop policies, systems, and adequate funding to improve health care and economic opportunities for AI/AN people. Many of the programs and activities identified exemplified these themes and provided an illustration of practical application. Overall, the findings of this environmental scan indicate the need for a flexible and multifaceted approach to improving mental health care and outcomes for AI/ANs.

Discord between Western mental health care services and culturally-grounded approaches exists in both research and in practice. For example, there is potential conflict between the Western medical model and an AI/AN conceptualization of mental illness; AI/ANs may recognize an imbalance caused by external forces or lack of harmony whereas Western medicine focuses on internal and individual factors such as genetics, or other biologically based determinants.[63] Mental health services may be viewed as not relevant by AI/ANs, especially since they are focused on the individual and do not involve families, community, or spiritual healers. This discord presents a challenge for community health centers because billable services are often aligned with the Western model of care while the needs of their community fall equally along traditional or adaptive approaches to care. This discord may be eased by increasing support for traditional or culturally-grounded treatment approaches by recognizing these strategies as reimbursable services. Programs in Alaska have succeeded in obtaining reimbursements from Medicaid for cultural or adapted therapy approaches. The Village Sobriety Project described earlier in this report documented and demonstrated traditional Yup'ik and Cup'ik activities as valid behavioral health treatment options aligned with treatment goals that were as equally valid for Medicaid reimbursement as Western art and play therapies.[95] Alaska was the first state to successfully obtain reimbursement from Medicaid for telebehavioral health services in order to increase access to psychiatric services.[93]

Additionally, both Western and traditional approaches require increased evidence of effectiveness through research and evaluation of practices in the field. Evidence-based practices are rarely developed or tested in AI/AN communities, so it is unknown if they are acceptable or effective in these communities. As we continue to seek effective prevention and treatment modalities, investments should be made in providing evaluation of activities already in use among AI/ANs to establish practice-based evidence. This shift to practice-based evidence may also ease the tension between conventional approaches and AI/AN cultural perceptions of health as well as prevention and treatment approaches.

DISCUSSION

It is increasingly recognized that physical environments and socioeconomic factors impact health outcomes. Significant improvements are needed in policies, economic, environmental and social conditions for AI/AN communities in order to reduce disparities in mental health. Various aspects pertaining to these conditions include educational attainment, job and life opportunities, social support, less isolation or invisibility, safe neighborhoods, access to healthy foods, physical activity and access to safe spaces that encourage outdoor activities. Policies need to consider the impact of new legislation and implementation of government programs on underserved communities. The mental health care system needs to expand to match the needs of AI/AN communities. For example, the system would be more holistic by addressing the life skills trainings and social support essential to maintaining emotional well-being in AI/ANs and all people.

This report detailed a number of comprehensive programs that address the social, cultural, and emotional needs of AI/ANs in the context of a health concern like adolescent suicide; these programs merit greater study and, where appropriate, expansion into standard practice. The true test of the feasibility of such programs will be their comparative-effectiveness. In addition, program or service eligibility for funding initiatives and reimbursement as well as their acceptability and impact for communities and individuals are important measures of feasibility.

LIMITATIONS

Several limitations are noted regarding this environmental scan of depression and other common mental health conditions among AI/ANs. First, the intake period for searching for sources occurred in October and November 2011. Sources that may have been published or become publically available since that time have not been incorporated. Second, our exclusion criteria for sources may have eliminated sources due to a limited focus. For example, our criteria that the material addressed depression or other common mental disorders specifically may have excluded sources discussing co-occurring conditions where the other condition was the focus but included sideline mentions of depression (see the criteria detailed earlier in the Methods section). Third, many of the programs and activities identified provided limited or no outcome measurements or evaluations by which to assess their effectiveness. Gone et al.'s (2007) review of the scientific literature also found this substantial gap regarding reported outcomes and empirically assessed results for AI/ANs with serious mental health conditions.[41]

RECOMMENDATIONS

Given the tension between Western mental health treatment methods, such as CBT, and more culturally-grounded and developed approaches to treatment, it may be valuable to conduct research studies comparing the two treatment approaches to determine the merit of CBT or culturally-grounded treatment plans for AI/ANs. More definitive results may be able to indicate what services are most effective and therefore influence allowable reimbursements for services.

Further research is needed in the areas of pathways to care and help-seeking behaviors of AI/ANs in order to address barriers to care.[111] Also, studies of the mental health system structure and associated financing for AI/ANs are lacking in the literature.[111] Program data about suicide risks and protective factors are needed. Outcomes data such as completed and attempted suicides, suicidal behavior, help-seeking behaviors, risk identifications, treatment commencement, and anti-depressant prescription rates are needed to ensure allocation of funding resources for effective programs.[88, 112] This is particularly true for urban AI/ANs, which

necessitates more mental health programs that are specifically designed and tested for urban AI/AN settings. Investigating urban AI/AN mental health separately from reservation studies in targeted studies may identify the unique challenges and strengths of the two populations.[38] Researchers have also called for greater coordination and study of co-occurring conditions.[12]

Recommendations for policy development pertain to developing a comprehensive systems approach to addressing the mental health needs of AI/ANs. A healthy mind and body function best when social, environmental, and economical supports are accessible and suit the population in need. In addition, while the trend is to fund and implement evidenced-based practices, it is important to note that these practices are not truly evidenced-based for AI/ANs if they are not tested in AI/AN settings. More funding for studies, particularly in urban AI/AN settings, is needed to identify what truly works in practice. IHS supports the paradigm shift of moving mental health care from a specialty-based practice to an integrated part of primary care.[2] Policies, insurers and infrastructure for this model need to follow suit to provide integrated prevention, treatment and follow-up care as well as ancillary services such as life-skills building, economic opportunities and stable housing resources. Additionally, urban Indian programs could work together with state Medicaid programs to negotiate reimbursement for cultural services and activities as mental health treatment approaches in addition to Western therapies. While the Affordable Care Act (ACA) will expand health care coverage for AI/ANs by increasing both Medicaid coverage and insurance coverage, uncertainty remains regarding how the ACA implementation will impact healthcare costs and availability for AI/ANs and all Americans.[93]

Agencies may want to refer to the eight themes identified here as implications for care when considering changes or expansions to their mental health care services. In addition, the sources cited may prove useful for grant or proposal development requiring evidence or support for program objectives aligned with these themes. The programs reviewed provide examples of these themes applied in practice. For example, agencies without in-house behavioral health provider(s) may want to consider partnership opportunities like South Central Depression Collaborative's[90] to leverage resources and partner with a local behavioral health agency.

Improving the mental well-being of AI/ANs and eliminating racial disparities in mental health outcomes requires a multifaceted effort. These efforts necessitate improved coordination and integration of activities, including social and economic supports, along with increased funding and evaluation efforts. Several examples of how this can be achieved programmatically were illuminated in this report. The striking disparities in the prevalence of depression and common mental health conditions among AI/ANs require these more comprehensive, systematic approaches in order to reduce disparities in mental health. Only by achieving these systematic improvements, will health equity become a reality.

Page intentionally left blank.

REFERENCES

1. Nebelkopf E, King J. (2003). A holistic system of care for Native Americans in an urban environment. *Journal of Psychoactive Drugs*, *35*(1), 43-52.
2. McSwain RG. (2009). *Statement of Robert G. McSwain, Director Indian Health Service Before the Senate Committee on Indian Affairs on Youth Suicide in Indian Country*. Retrieved August 10, 2012 from http://www.hhs.gov/asl/testify/2009/02/t20090226c.html.
3. National Alliance on Mental Illness (NAMI). (2009). *American Indian and Alaska Native Women and Depression Fact Sheet.* Arlington, VA. National Alliance on Mental Illness. Retrieved August 10, 2012 from http://www.nami.org/Template.cfm?Section=Women_and_Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88885.
4. Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE. (Eds.). (2002). *Reducing Suicide: A National Imperative*. Washington, D.C. The National Academies Press.
5. Substance Abuse and Mental Health Services Administration. (2007). *Results from the 2006 National Survey on Drug Use and Health: National Findings.* Rockville, MD. Retrieved August 10, 2012 from http://www.samhsa.gov.
6. Dinges NG, Duong-Tran Q. (1992). Stressful life events and co-occurring depression, substance abuse and suicidality among American Indian and Alaska Native adolescents. *Culture, Medicine and Psychiatry*, *16*(4), 487-502.
7. Duran B, Sanders M, Skipper B, Waitzkin H, Malcoe LH, Paine S, Yager J. (2004). Prevalence and correlates of mental disorders among Native American women in primary care. *American Journal of Public Health*, *94*(1), 71-77.
8. United States Census Bureau. (2000). Census 2000 Summary File 2 (SF 2) 100-Percent Data; Table: PCT002; Urban and rural [6]; Universe Total Population; Population group name: American Indian and Alaska Native alone or in combination with one or more other races. Retrieved August 2, 2012 from http://factfinder2.census.gov/
9. United States Department of Health and Human Services. (2010). Fiscal Year 2010 Budget in Brief: Indian Health Service. Retrieved July 27, 2012 from http://dhhs.gov/asfr/ob/docbudget/2010budgetinbrieff.html.
10. United States Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD. Retrieved April 24, 2012 from http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec3.html
11. Mental Health America. (2012). Mood Disorders. Retrieved July 19, 2012 from http://www.mentalhealthamerica.net/index.cfm?objectid=C7DF96B5-1372-4D20-C868380DE081DCAB.
12. Beals J, Manson SM, Whitesell NR, Spicer P, Novins DK, Mitchell CM, AI-SUPERPFP Team. (2005). Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. *Archives of General Psychiatry*, *62*(1), 99-108.
13. Hodge DR, Limb GE, Cross TL. (2009). Moving from colonization toward balance and harmony: A Native American perspective on wellness. *Social Work*, *54*(3), 211-219.
14. Dalal PK, Sivakumar T. (2009). Moving towards ICD-11 and DSM-V: Concept and evolution of psychiatric classification. *Indian Journal of Psychiatry*, *51*(4), 310-319.
15. Widiger TA, Sankis LM. (2000). Adult psychopathology: issues and controversies. *Annual Review of Psychology*, *51*, 377-404.
16. Vedantam S. (2005, June 26). Patients' Diversity Is Often Discounted, *The Washington Post*. Retrieved August 10, 2012 from http://www.washingtonpost.com/wp-dyn/content/article/2005/06/25/AR2005062500982.html.
17. Beals J, Novins DK, Whitesell NR, Spicer P, Mitchell CM, Manson SM. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: mental health disparities in a national context. *American Journal of Psychiatry*, *162*(9), 1723-1732.
18. Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta GUSDoHaHS, Centers for Disease Control and Prevention, 2005-2010 as reported in Urban Indian Health Institute. (2011). *Community*

REFERENCES

Health Profile: National Aggregate of Urban Indian Health Organization Service Areas. Seattle, WA. Retrieved August 13, 2012 from http://www.uihi.org/wp-content/uploads/2011/12/Combined-UIHO-CHP_Final.pdf.

19. Suicide Prevention Resource Center. (2011). *Suicide among racial/ethnic populations in the U.S. American Indians/Alaska Natives.* Newton, MA. Education Development Center, Inc. Retrieved August 10, 2012 from http://www.sprc.org/sites/sprc.org/files/library/AI_ANFactSheet.pdf.

20. Goldston DB, Molock SD, Whitbeck LB, Murakami JL, Zayas LH, Hall GCN. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. *American Psychologist*, *63*(1), 14-31.

21. Brave Heart MYH, DeBruyn LM. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center*, *8*(2), 60-82.

22. Duran B, Duran E, Brave Heart MYH. (1998). Native Americans and the trauma of history. In Thornton R. (Ed.), *Studying Native America: Problems and prospects* (pp. 60-76). Madison, WI. University of Wisconsin Press. Retrieved April 23, 2012 from http://books.google.com/books?id=_EA-UwvN_HUC&pg=PA60&lpg=PA60&dq=native+americans+and+the+trauma+of+history&source=bl&ots=v8fOUuB07B&sig=m6KQk9HjHsgKQ2KpM8EVg3cU8Y4&hl=en&sa=X&ei=mAhMT4neFaqciAL-vZm6Dw&ved=0CDQQ6AEwAg#v=onepage&q=native%20americans%20and%20the%20trauma%20of%20history&f=false.

23. United States Department of Health and Human Services - Office of Inspector General. (2011). *Access To Mental Health Services At Indian Health Service and Tribal Facilities*. (OEI-09-08-00580). United States Department of Health and Human Services. Retrieved August 13, 2012 from http://oig.hhs.gov/oei/reports/oei-09-08-00580.pdf.

24. Whitbeck LB, Adams GW, Hoyt DR, Chen X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, *33*(3-4), 119-130.

25. Whitbeck LB, Walls ML, Johnson KD, Morrisseau AD, McDougall CM. (2009). Depressed affect and historical loss among North American Indigenous adolescents. *American Indian and Alaska Native Mental Health Research*, *16*(3), 16-41.

26. Tann SS, Yabiku ST, Okamoto SK, Yanow J. (2007). triADD: the risk for alcohol abuse, depression, and diabetes multimorbidity in the American Indian and Alaska Native populations. *American Indian and Alaska Native Mental Health Research*, *14*(1), 1-23.

27. Duran B, Malcoe LH, Sanders M, Waitzkin H, Skipper B, Yager J. (2004). Child maltreatment prevalence and mental disorders outcomes among American Indian women in primary care. *Child Abuse and Neglect*, *28*(2), 131-145.

28. American Psychological Association. (2010). *Fact sheets on disparities among specific population groups - Mental Health Disparities: American Indians and Alaska Natives*. Office of Minority and National Affairs. Retrieved August 13, 2012 from http://www.psychiatry.org/practice/professional-interests/diversityomna/diversity-resources.

29. Indian Health Service. (2011). Quality of IHS Health Care - Performance Measures: Behavioral Health - Depression Screening. Retrieved July 27, 2012 from http://www.ihs.gov/qualityofcare/index.cfm?module=chart&rpt_type=gpra&measure=21.

30. Stuart P. (2009). *Behavioral Health Screening: Depression, Suicide and Alcohol*. Presented at the Medical Providers Best Practices and GPRA Measures Conference, Sacramento, CA. Retrieved August 13, 2012 from http://www.ihs.gov/california/UpLoadedFiles/GPRA/BP2009_BehavioralHealthScreenings.pdf.

31. Pfizer. (n.d.). Patient Health Questionnaire (PHQ) Screeners. Retrieved August 9, 2012 from http://www.phqscreeners.com.

REFERENCES

32. Woodis W, Frazier F, Cullen T, Patterson A. (2007). Depression Screening Information for Providers: Documenting Depression Screening in RPMS. Retrieved August 13, 2012 from http://www.ihs.gov/medicalprograms/Behavioral/documents/Depression_Screening_Information_for_Providers_01-17-07.pdf.

33. Harris KM, Edlund MJ, Larson S. (2005). Racial and Ethnic Differences in the Mental Health Problems and Use of Mental Health Care. *Medical Care*, *43*(8), 775-784.

34. Indian Health Service National Tribal Advisory Committee on Behavioral Health, IHS Behavioral Health Work Group, IHS. (2011). *American Indian/Alaska Native National Behavioral Health Strategic Plan 2011-2015.* Rockville, Maryland. Indian Health Service Retrieved July 27, 2012 from http://www.ihs.gov/medicalprograms/Behavioral/documents/AIANNationalBHStrategicPlan.pdf.

35. Walls ML, Johnson KD, Whitbeck LB, Hoyt DR. (2006). Mental health and substance abuse services preferences among American Indian people of the northern Midwest. *Community Mental Health Journal*, *42*(6), 521-535.

36. Freedenthal S, Stiffman AR. (2007). "They might think I was crazy": Young American Indians' reasons for not seeking help when suicidal. *Journal of Adolescent Research*, *22*(1), 58-77.

37. Kahn MW, Lejero L, Antone M, Francisco D, Manuel J. (1988). An indigenous community mental health service on the Tohono O'odham (Papago) Indian reservation: Seventeen years later. *American Journal of Community Psychology*, *16*(3), 369-379.

38. United States Department of Health and Human Services. (2010). *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved August 13, 2012 from http://www.sprc.org/sites/sprc.org/files/library/Suicide_Prevention_Guide.pdf.

39. Oetzel J, Duran B, Lucero J, Jiang Y. (2006). Rural American Indians' Perspectives of Obstacles in the Mental Health Treatment Process in Three Treatment Sectors. *Psychological Services*, *3*(2), 117-128.

40. Walters KL, Simoni JM. (2002). Reconceptualizing native women's health: an "indigenist" stress-coping model. *American Journal of Public Health*, *92*(4), 520-524.

41. Gone JP, Alcantara C. (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: a review of the literature. *Cultural Diversity & Ethnic Minority Psychology*, *13*(4), 356-363.

42. Harper FG. (2010). Advocating for whole health: the role of the mental health professional in promoting diet, nutrition, and management of physical disease with American Indian clients. *Journal of Creativity in Mental Health*, *5*(3), 275-289.

43. Goodkind JR, Lanoue MD, Milford J. (2010). Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth. *Journal of Clinincal Child & Adolescent Psychology*, *39*(6), 858-872.

44. Ngo V, Langley A, Kataoka SH, Nadeem E, Escudero P, Stein BD. (2008). Providing evidence-based practice to ethnically diverse youths: Examples from the cognitive behavioral intervention for trauma in schools (CBITS) program. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(8), 858-862.

45. Morsette A, Swaney G, Stolle D, Schuldberg D, van den Pol R, Young M. (2009). Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. *Journal of Behavior Therapy and Experimental Psychiatry*, *40*(1), 169-178.

46. Renfrey GS. (1992). Cognitive-Behavior Therapy and the Native-American Client. *Behavior Therapy*, *23*(3), 321-340.

REFERENCES

47. Strickland CJ, Walsh E, Cooper M. (2006). Healing fractured families: parents' and elders' perspectives on the impact of colonization and youth suicide prevention in a pacific northwest American Indian tribe. *Journal of Transcultural Nursing*, *17*(1), 5-12.

48. Alcantara C, Gone JP. (2007). Reviewing suicide in native American communities: Situating risk and protective factors within a transactional-ecological framework. *Death Studies*, *31*(5), 457-477.

49. University of California Davis Center for Reducing Health Disparities. (2009). *Building Partnerships: Conversations with Native Americans about Mental Health Needs and Community Strengths*: UC Davis Health System. Retrieved July 24, 2012 from http://www.dmh.ca.gov/peistatewideprojects/docs/Reducing_Disparities/BP_Native_American.pdf.

50. Mental Health America of San Diego County. (2009). *Addressing Barriers to Mental Health Services for Native American/Alaska Native populations in San Diego County*. Retrieved August 13, 2012 from http://www.mhasd.org/Reports/Addressing%20Barriers%20to%20Mental%20Health%20Services%20for%20Native%20American%20Populations.pdf.

51. Grandbois D. (2005). Stigma of Mental Illness Among American Indians and Alaska Native Nations: Historical and Contemporary Perspectives. *Issues in Mental Health Nursing*, *26*, 1001-1024.

52. Substance Abuse and Mental Health Services Administration. (2010). Circles of Care: Creating Models of Care for American Indian and Alaska Native Youth. *SAMHSA News.* 2010;*18*(6):4-7.Accessed August 13, 2012 from http://store.samhsa.gov/shin/content//SAM10-186/SAM10-186.pdf.

53. De Coteau T, Anderson J, Hope D. (2006). Adapting manualized treatments: Treating anxiety disorders among native Americans. *Cognitive and Behavioral Practice*, *13*(4), 304-309.

54. Brucker PS, Perry BJ. (1998). American Indians: Presenting concerns and considerations for family therapists. *American Journal of Family Therapy*, *26*(4), 307-319.

55. Wright S, Nebelkopf E, King J, Maas M, Patel C, Samuel S. (2011). Holistic system of care: evidence of effectiveness. *Substance Use & Misuse*, *46*(11), 1420-1430.

56. Washington Institute for Mental Illness Research and Training. (2003). *A Summary of Best and Promising Mental Health Practices for Select Consumer Populations* Washington State Univeristy, Spokane Retrieved August 13, 2012 from http://www.dshs.wa.gov/pdf/dbhr/mh/resourceguide/Bestpracexecsum.pdf.

57. Tolman A, Reedy R. (1998). Implementation of a culture-specific intervention for a Native American community. *Journal of Clinical Psychology in Medical Settings*, *5*(3), 381-392.

58. Middlebrook DL, LeMaster PL, Beals J, Novins DK, Manson SM. (2001). Suicide prevention in American Indian and Alaska Native communities: a critical review of programs. *Suicide and Life-Threatening Behavior*, *31 Suppl*, 132-149.

59. Niven JA. (2010). Client-centered, culture-friendly behavioral health care techniques for work with Alaska Natives in the Bering Strait region. *Social Work in Mental Health*, *8*(4), 398-420.

60. Allen J, LeMaster PL, Deters PB. (2004). Mapping pathways to services: description of local service systems for American Indian and Alaska Native children by Circles of Care. *American Indian and Alaska Native Mental Health Research*, *11*(2), 65-87.

61. Stiffman AR, Freedenthal S, Dore P, Ostmann E, Osborne V, Silmere H. (2006). The role of providers in mental health services offered to American-Indian youths. *Psychiatric Services*, *57*(8), 1185-1191.

62. Storck M, Beal T, Bacon JG, Olsen P. (2009). Behavioral and Mental Health Challenges for Indigenous Youth: Research and Clinical Perspectives for Primary Care. *Pediatric Clinics of North America*, *56*(6), 1461-1479.

REFERENCES

63. Gary FA, Baker M, Grandbois DM. (2005). Perspectives on suicide prevention among American Indian and Alaska native children and adolescents: a call for help. *Online Journal of Issues in Nursing*, *10*(2), 6.

64. Rodenhauser P. (1994). Cultural barriers to mental health care delivery in Alaska. *Journal of Mental Health Administration*, *21*(1), 60-70.

65. Cutler M. (2010). *Counseling Stategies with American Indian Clients: Approaches and Techniques*. Presented at the Idaho Counseling Association Conference, Boise State University Retrieved August 10, 2012 from https://docs.google.com/viewer?a=v&q=cache:U0zV7bmTSpQJ:education.boisestate.edu/instituteforthestudyofaddiction/pp/Approaches_and_Techniques.pptx+&hl=en&gl=us&pid=bl&srcid=ADGEESgx710ChqVdqfePz96GAjPg1r-MFuJs8kNbVtJWNhhMeWu0muZC4xbtqYCC6ZzaZIBxBGGB6ox6Yehu94EoTnHUHtrMjOg-P26QRgi8pDTUVa2zOeB7FPcZ9C8VgNCwt6EVtZSr&sig=AHIEtbRDlWxhoAyA8YSN10fg_gDaNjK2tw&pli=1.

66. Garroutte EM, Goldberg J, Beals J, Herrell R, Manson SM, AI-SUPERPFP Team. (2003). Spirituality and attempted suicide among American Indians. *Social Science & Medicine*, *56*(7), 1571-1579.

67. Howard-Pitney B, LaFromboise TD, Basil M, September B, Johnson M. (1992). Psychological and social indicators of suicide ideation and suicide attempts in Zuni adolescents. *Journal of Consulting and Clinical Psychology*, *60*(3), 473-476.

68. May PA, Serna P, Hurt L, DeBruyn LM. (2005). Outcome evaluation of a public health approach to suicide prevention in an American Indian Tribal Nation. *American Journal of Public Health*, *95*(7), 1238-1244.

69. Newport C, Jimenez J. (2011). TeenScreen: Implementing Mental Health Screening for Youth in Native Communities. Retrieved August 13, 2012 from http://www.ihs.gov/suicidepreventionsummit/documents/TeenScreenPPT_Carro_508.pdf

70. Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, Hegerl U, Lonnqvist J, Malone K, Marusic A, Mehlum L, Patton G, Phillips M, Rutz W, Rihmer Z, Schmidtke A, Shaffer D, Silverman M, Takahashi Y, Varnik A, Wasserman D, Yip P, Hendin H. (2005). Suicide Preventoion Strategies: A Systematic Review. *Journal of the American Medical Association*, *294*(16), 2064-2074.

71. Goodkind JR, Ross-Toledo K, John S, Hall JL, Ross L, Freeland L, Coletta E, Becenti-Fundark T, Poola C, Begay-Roanhorse R, Lee C. (2010). Promoting Healing and Restoring Trust: Policy Recommendations for Improving Behavioral Health Care for American Indian/Alaska Native Adolescents. *American Journal of Community Psychology*, *46*(3), 386-394.

72. Manson SM. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives*: National Association of State Mental Health Program Directors and National Technical Assistance Center for State Mental Health Planning. Retrieved August 14, 2012 from http://www.icctc.org/Meeting%20the%20Mental%20Health%20Needs%20of%20AI-AN%202004.pdf.

73. World Health Organization (WHO) and World Organization of Family Doctors (Wonca). (2008). *Integrating Mental Health Into Primary Care: A Global Perspective.* Geneva, Switzerland. Retrieved July 31, 2012 from http://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf.

74. Jackson LC, Schmutzer PA, Wenzel A, Tyler JD. (2006). Applicability of cognitive-behavior therapy with American Indian individuals. *Psychotherapy*, *43*(4), 506-517.

75. Cognitive Behavioral Intervention for Trauma in Schools. (n.d.). CBITS At-a-Glance. Retrieved August 14, 2012 from http://cbitsprogram.org/.

REFERENCES

76. Niven JA. (2007). Screening for depression andthoughts of suicide: A tool for use in Alaska's village clinics. *American Indian and Alaska Native Mental Health Research*, *14*(2), 16-28.

77. Indian Health Service. (2009). Implementing suicide intervention training in rural Alaska. *The IHS Primary Care Provider.* 2009;*35*(7):206-210.Accessed May 15, 2012 from http://www.ihs.gov/MedicalPrograms/InjuryPrevention/Documents/PROV0709.pdf.

78. Suicide Prevention Resource Center. (2011). Best Practices Registry Section III - Adherence to Standards: Applied Suicide Intervention Skills Training (ASIST). 2011.Accessed August 14, 2012 from http://www.sprc.org/sites/sprc.org/files/bpr/ASIST.pdf.

79. Living Works. (2012). Applied Suicide Intervention Skills Training (ASIST). Retrieved July 17, 2012 from http://www.livingworks.net/page/Applied%20Suicide%20Intervention%20Skills%20Training%20%28ASIST%29.

80. Freeman B, Dogs E, Novins DK, LeMaster PL. (2004). Contextual issues for strategic planning and evaluation of systems of care for American Indian and Alaska Native communities: An introduction to Circles of Care. *American Indian and Alaska Native Mental Health Research*, *11*(2), 1-29.

81. Deters PB, Novins DK, Manson SM. (2004). Editorial. *American Indian and Alaska Native Mental Health Research*, *11*(2), ix- xi.

82. Novins D, LeMaster P, Thurman PJ, Plested B. (2004). Describing community needs: Examples from the Circles of Care initiative. *American Indian and Alaska Native Mental Health Research*, *11*(2), 42-58.

83. Coll KM, Gerald M, LeMaster PL. (2004). Feasibility Assessment of the Service Delivery Model. *American Indian and Alaska Native Mental Health Research*, *11*(2), 99-108.

84. Nebelkopf E, Penagos M. (2005). Holistic Native Network: Integrated HIV/AIDS, substance abuse, and mental health services for native Americans in San Francisco. *Journal of Psychoactive Drugs*, *37*(3), 257-264.

85. Muehlenkamp JJ, Marrone S, Gray JS, Brown DL. (2009). A College Suicide Prevention Model for American Indian Students. *Professional Psychology-Research and Practice*, *40*(2), 134-140.

86. Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based Programs and Practices. (2011). Sources of Strength. Retrieved August 14, 2012 from http://nrepp.samhsa.gov/ViewIntervention.aspx?id=248.

87. QPR Institute. (2011). QPR Gatekeeper Training for Suicide Prevention. Retrieved July 19, 2012 from http://www.qprinstitute.com/gatekeeper.html.

88. Indian Health Service. (2007). The prevention of suicide in Alaska's tribal health care setting. *The IHS Primary Care Provider.* 2007;*32*(7):198-201.Accessed May 15, 2012 from http://www.ihs.gov/MedicalPrograms/InjuryPrevention/Documents/PROV0707.pdf.

89. Maniilaq Association. (n.d.). Project Life. Retrieved May 15, 2012 from http://www.projectlifealaska.org/.

90. Dillard DA, Christopher D. (2007). The Southcentral Foundation depression collaborative. *International Journal of Circumpolar Health*, *66 Suppl 1*, 45-53.

91. Parker T, May PA, Maviglia MA, Petrakis S, Sunde S, Gloyd SV. (1997). PRIME-MD: Its utility in detecting mental disorders in American Indians. *International Journal of Psychiatry in Medicine*, *27*(2), 107-128.

92. Kahn MW, Williams C, Galvez E, Lejero L, Conrad R, Goldstein G. (1975). The Papago psychology service: a community mental health program on an American Indian reservation. *American Journal of Community Psychology*, *3*(2), 81-97.

93. Indian Health Service. (2011). *American Indian/Alaska Native Behavioral Health Briefing Book.* Rockville, MD. U.S. Department of Health and Human Services. Retrieved August 14, 2014 from http://www.ihs.gov/medicalprograms/Behavioral/documents/AIANBHBriefingBook.pdf.

REFERENCES

94. Indian Health Service. (2011). Tohono O'odham Nation Division of Behavioral Health. *Indian Health Service Division of Behavioral Health Newsletter.* 2011;*April Edition*:4-5.Accessed August 14, 2012 from http://www.ihs.gov/MedicalPrograms/Behavioral/documents/April2011Newsletter.pdf.

95. Mills PA. (2003). Incorporating Yup'ik and Cup'ik Eskimo traditions into behavioral health treatment. *Journal of Psychoactive Drugs*, *35*(1), 85-88.

96. Lafromboise TD, Lewis HA. (2008). The Zuni Life Skills Development Program: a school/community-based suicide prevention intervention. *Suicide and Life-Threatening Behavior*, *38*(3), 343-353.

97. Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based Programs and Practices. (2007). American Indian Life Skills Development/Zuni Life Skills Development. Retrieved August 14, 2012 from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=81.

98. Roubideaux Y. (2009). *Statement of Yvette Robideaux, MD, MPH, Director Indian Health Service Before the Senate Committee on Indian Affairs on S. 1635, 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009*. Retrieved July 27, 2012 from http://www.indian.senate.gov/public/_files/YvetteRoubideauxtestimony0.pdf.

99. Indian Health Service. (2010). Friendship House Association for American Indians, Inc. *Indian Health Service Division of Behavioral Health Newsletter.* 2010;*December Edition*:4-5.Accessed August 14, 2012 from http://www.ihs.gov/MedicalPrograms/Behavioral/documents/December2010Newsletter.pdf.

100. Indian Health Service. (2011). Multiple articles. *Indian Health Service Division of Behavioral Health Newsletter.* 2011;*February Edition*:6, 10, 17.Accessed August 14, 2012 from http://www.ihs.gov/MedicalPrograms/Behavioral/documents/February2011Newsletter.pdf

101. Indian Health Service. Online Search, Consultation, and Reporting (OSCAR) System. Retrieved May 15 2012, from http://www.ihs.gov/oscar/index.cfm?module=search.

102. Indian Health Service. (n.d.). Phoenix Area Integrated Behavioral Health Programs. Retrieved May 20, 2012 from http://www.ihs.gov/phoenix/index.cfm?module=dsp_phx_services_ibh.

103. Indian Health Service. (2011). Youth Regional Treatment Centers. *Indian Health Service Division of Behavioral Health Newsletter.* 2011;*Special Edition - Youth*:13-17.Accessed July 30, 2012 from http://www.ihs.gov/MedicalPrograms/Behavioral/documents/October2011Newsletter.pdf.

104. Walker RD, Loudon L, Walker PS, Frizzell L. (2006). *A Guide to Suicide Prevention for American Indian and Alaska Native Communities*: One Sky Center, The American Indian/Alaska Native National Resource Center for Substance Abuse and Mental Health Services, Oregon Health & Science University. Retrieved August 14, 2012 from http://www.oneskycenter.org/pp/documents/AGuidetoSuicidePreventionFINAL.pdf.

105. Indian Health Service. (n.d.). IHS American Indian and Alaska Native Suicide Prevention Website. Retrieved May 14, 2012 from http://www.ihs.gov/NonMedicalPrograms/nspn/index.cfm?page=LinksAndDocs.cfm&type=Resources&sub_cat_id=06080902.

106. National Alliance on Mental Illness (NAMI). (2011). Education, training and peer support programs. Retrieved June 25, 2012 from http://www.nami.org/template.cfm?section=Education_Training_and_Peer_Support_Center.

107. National Alliance on Mental Illness (NAMI). (2003). *American Indian and Alaska Native Resource Manual*. National Alliance on Mental Illness. Retrieved August 15, 2012 from http://www.nami.org/Content/ContentGroups/MIO/CDResourceManual.pdf.

108. Columbia University. (2003). TeenScreen Resources. Retrieved August 15, 2012 from http://www.teenscreen.org/resources/.

REFERENCES

109. Bossarte R, Grenier D, Wisdom W. (2011, August 1-4). *Depression and Suicide Data Collection in the IHS and VA*. Presented at the 2011 IHS/BIA/BIE/SAMHSA Action Summit for Suicide Prevention. Retrieved August 15, 2012 from http://www.ihs.gov/suicidepreventionsummit/documents/DepressionSuicideDataCollectionIHSVA_Grenier.pdf.

110. Crofoot TL, Harris N, Plumb MA, Smith KS, Gault J, Brooks G, Hungry L, Geary A, Holland I. (2008). Mental health, health, and substance abuse service needs for the Native American Rehabilitation Association Northwest (NARA NW) in the Portland, Oregon metropolitan area. *American Indian and Alaska Native Mental Health Research*, *14*(3), 1-23.

111. Manson SM. (2000). Mental health services for American Indians and Alaska Natives: Need, use, and barriers to effective care. *Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie*, *45*(7), 617-626.

112. Hill R, Perkins R, Wexler L. (2007). An analysis of hospital visits during the 12 months preceding suicide death in Northern Alaska. *Alaska Medicine*, *49*(1), 16-21.