Adm Policy Ment Health
DOI 10.1007/s10488-016-0777-7

POINT OF VIEW

Identifying and Reducing Disparities in Mental Health Outcomes Among American Indians and Alaskan Natives Using Public Health, Mental Healthcare and Legal Perspectives

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Abstract The purpose of this paper was to investigate disparities in mental healthcare delivery in American Indian/Alaska Native populations from three perspectives: public health, legal policy and mental healthcare and provide evidence-based recommendations toward reducing those disparities. Data on mental health funding to tribes were obtained from the Substance Abuse and Mental Health Services Administration. As a result of analysis of these data, vital statistics and current literature, we propose three recommendations to reduce mental health disparities. First, where possible, increase mental health funding opportunities for federally-recognized tribes. Second, model funding practices on principles of tribal self-determination. Finally, support diverse interventions that are culturally-based and culturally-appropriate.

Keywords Disparities · Depression · Suicide · SAMHSA · Federal grants

American Indians/Alaskan Natives (AI/AN) experience some of the highest poverty rates and poorest mental health outcomes in the United States (Sarche and Spicer 2008). This disparity in mental health outcomes between AI/AN and the general population has been heavily influenced by US policies such as forced relocation, separation of families, and assimilation programs designed to terminate tribal cultural identity and inhibit traditional cultural-religious practices (Whitbeck et al. 2004; Bolt 2009). While AI/AN are often thought of as marginalized, a more adequate term is "colonized;" being physically and culturally dispossessed (Dunbar-Ortiz 2015). From the 1940s to the 1960s, the termination policy, designed to promote legislative termination of tribal affiliation, communal land base, and the federal-tribal trust relationship, was based upon the concept that AI/AN groups should be compelled to assimilate to partake of the prevailing concept of the American dream of individual mobility and prosperity. The philosophies underlying these policies were rooted in competing desires to be rid of "the Indian problem" and to address the abject poverty that followed the removal of tribes to reservations (United States 1949). Federal programs that prohibited the practice of AI/AN religions and cultures were not made illegal until 1978 with the American Indian Religious Freedom Act (American Indian Religious Freedom Act of 1978). However, such policies have fostered distrust between many tribes and government agencies.

AI/AN populations also experience the impact of historical trauma, defined as "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (Brave

Electronic supplementary material The online version of this article (doi:10.1007/s10488-016-0777-7) contains supplementary material, which is available to authorized users.

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Published online: 31 January 2017

Heart 2003), including higher than average rates of post-traumatic stress disorder (PTSD) and depressive disorders (Beals et al. 2005). A complex interplay between historical trauma, cultural context, poverty, substance abuse, and modern cultural discontinuity experienced by AI/AN individuals and communities makes it difficult to provide effective mental health prevention and intervention programs. Furthermore, AI/AN tribal groups are frequently unable to access federal funds and implement mental health interventions that meet their needs, while difficulties in assessing culturally-based initiatives make it difficult for external agencies to improve access (Cross et al. 2011; Gowen et al. 2012).

The Indian Health Service (IHS) and Substance Abuse and Mental Health Services Administration (SAMHSA), both agencies of the Department of Health and Human Services (HHS), are the primary agencies with responsibilities for healthcare services and mental health and substance abuse prevention funding, respectively, to federally recognized tribes (Indian Health Service 2016). SAMHSA administers substance abuse prevention and mental health services grants to eligible applicants, including eligible AI/AN entities (Substance Abuse and Mental Health Administration 2016). The IHS provides direct clinical and educational services to AI/AN tribes and tribal members or administers self-determination and self-governance contracts and compacts for AI/AN entities to manage and provide these services. We will discuss self-determination in greater detail later in the paper, but briefly, it is a framework that allows for the flexible use of funds as deemed appropriate by the AI/AN group receiving those funds. The IHS has been widely criticized as perpetually under resourced and mismanaged (US Government Accountability Office 2016). This is particularly true of the limited behavioral health services offered by the IHS. Many tribes have successfully assumed management of IHS programs and services pursuant to the Self-Determination Act. Estimates indicate 57% of all AI/AN rely on the IHS for healthcare (Sarche and Spicer 2008). In many service areas, only 7% of IHS federal funds were allocated to mental health needs, despite the fact that mental health problems are estimated to comprise one-third of the demand for services in AI/AN populations.

In this paper, we analyzed and reviewed current policies in mental healthcare access for AI/AN groups through the lens of public health outcomes, funding initiatives and legal policies, and culturally-appropriate mental healthcare delivery structures. Three questions guided the review of information: First, what are the needs for increased funding to reduce AI/AN mental health disparities? Second, what types of mental health services would be most effective toward reducing disparities? Finally, what are the legal policies that could be implemented to improve current funding practices? Based on the review of information we provide the following recommendations:

1. Where possible, increase funding opportunities designed to assess and reduce mental health disparities among AI/AN populations.
2. Provide support for interventions that incorporate methods that are culturally-based and culturally-appropriate, taking into account diversity within AI/AN populations.
3. Model funding practices, oversight and program evaluation on principles of tribal self-determination to better fulfill the federal trust responsibility to AI/AN populations.

The remainder of the paper proceeds through each of three sections derived from one of the fields represented (public health, mental healthcare and law). Section 1 presents certain data on AI/AN mortality, poverty and funding for mental healthcare initiatives. The second is a brief discussion of how these moneys may be best employed toward reducing disparities by employing appropriate mental healthcare methods. Section 3 is a discussion of current legal and funding policy surrounding access to grant funding for AI/AN. The final section combines these perspectives into a description of the aforementioned policy recommendations.

Identifying Disparities in AI/AN Mental Health Outcomes

Data Sources and Analysis

In order to identify if there is a need for further funding opportunities for AI/AN mental health interventions to reduce disparities, we investigated three data sources: mortality statistics obtained from the Centers for Disease Prevention and Control (CDC), funding data provided by the SAMHSA, and federal data on Health Professional Shortage Areas (HPSA). Vital statistics allowed for comparisons in deaths due to mental illness between AI/AN populations and other minority and majority groups. SAMHSA and HPSA data were respectively used to evaluate funding opportunities provided in recent years and locations and groups for whom mental health services have been federally identified as under-resourced. Descriptions of the data sources as well as the literature search that formed the basis for our recommendations are included in the online supplement.

Results

Rates of Mental and Behavioral Disorders and Suicide

As shown in Fig. 1, rate ratios calculated as the number of deaths divided by the number of persons in subgroup populations indicated consistently higher rates of death from suicide among AI/AN than Whites or Blacks/African Americans for all ages less than 35 years old, and remained high until persons were 50 years old. The disparities are striking, with rates among AI/AN more than three times higher than African Americans between the ages of 15 and 19 years old, and still over two times higher from 30 to 34 years old. While suicide among adolescent and young adult Whites also is high, they do not become higher than those for AI/AN until reaching 35–39 years old. (As later described, suicide among African Americans and other minorities tends to be underreported, and therefore these numbers should be considered estimates.)

Rates of death due to mental and behavioral disorders were also elevated among Native American populations. Among all ages and both sexes, AI/AN had a rate of death due to mental and behavioral disorders between 1.10 and 1.53 times higher than the White reference groups. There was very little variation in any rate ratios from year to year. AI/AN men between the ages of 15 and 24 had markedly higher (between 2.38 and 2.69 times) rates than the African American reference group, again with little annual variation. AI/AN men and women ages 25–34 had generally lower rates of death from mental or behavioral disorders than the African American reference group, with rate ratios among women experiencing an upward trend and becoming larger than one in 2012. The rate ratios remained consistently slightly elevated for AI/AN women between 15 and 24 years old (rate ratio between 1.01 and 1.20) when compared with African Americans.

Health Professional Shortage Areas

It is important to determine whether AI/AN populations are likely to have resources available to alleviate mental health disparities without further aid. While vast differences in resources exist between tribal groups, AI/AN mental health disparities occur in areas that also often experience high

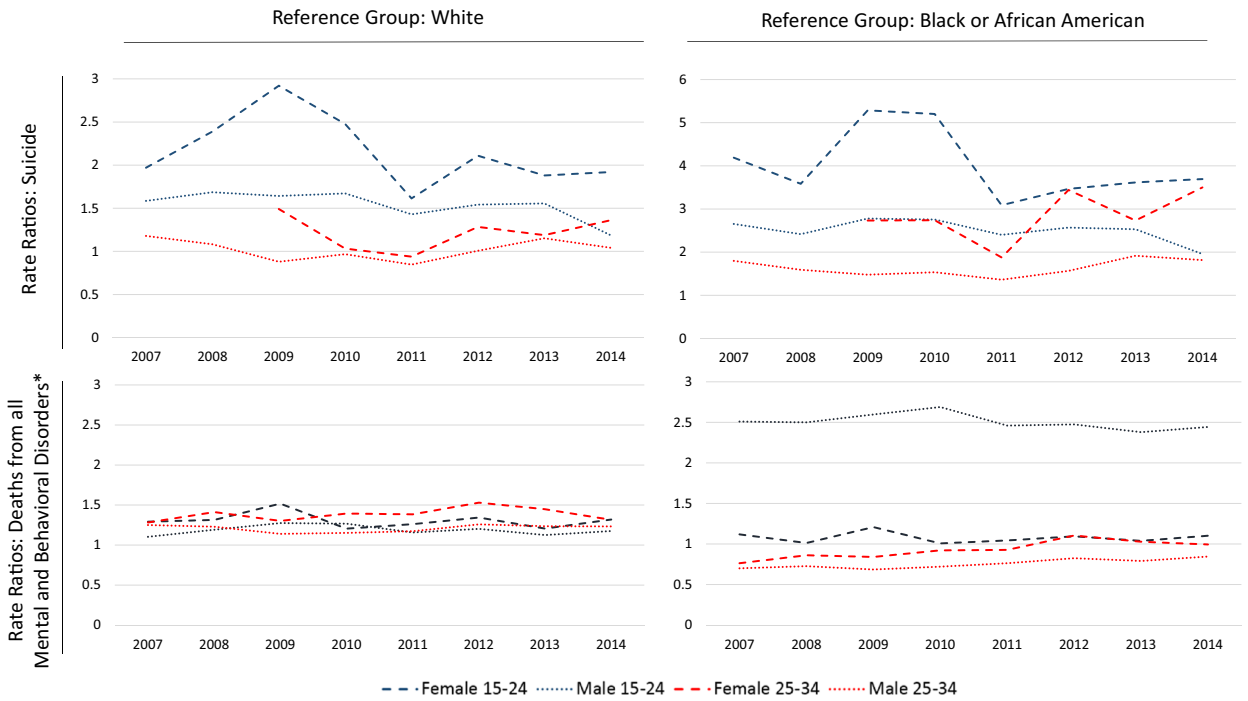

Fig. 1 Rate ratios of suicide and death from behavioral or mental disorders per 100,000 persons among those identifying as Native Americans or Alaskan Natives. A ratio of one would indicate no difference in rates between groups. Ratios greater than one indicate higher rates among Native Americans or Alaskan Natives. In the first column, the reference group is White. In the second column the reference group is Black or African American. Note the difference in the y-axis for the graph of suicide rates with the Black or African American reference group. Data for Native American female suicide between 25 and 34 years old was not deemed reliable by CDC for the years 2007 and 2008, and theus are not shown here. *Mental and behavioral disorders data does not include ICD-10 codes associated with mental retardation

rates of poverty and low access to healthcare. At the time of writing, there were 4215 population groups or geographic areas in the United States designated as HPSAs for mental health services (United States Department of Health and Human Services, n.d.). Of these, 313 (7.4%) are designated as Native American Tribal Populations, 82 (1.9%) are designated as IHS facilities, and 11 (0.3%) are listed as Alaskan Native Tribal populations. While all HPSA sites or areas demonstrate high need, Native American Tribal populations have the highest poverty among patients living in HPSAs except for those at state mental hospitals.

Improvements Needed in Data Collection

While our approach ties together knowledge from multiple sources and datasets, assessment and surveillance among AI/AN is inadequate. Health-related statistics often underrepresent the prevalence of mental health disorders among Native groups, as they may fail to distinguish between AI/AN, inquire about tribal affiliation, appropriately classify the cause of death to suicide when applicable, identify if participants live on or near reservations, or account for the level of bicultural identity or level of acculturation of those with AI/AN ancestry (CDC 2015; Hack et al. 2014; Stewart et al. 2013). As an example, a report by the CDC indicated that while race reporting for Whites and African Americans is considered "excellent" and "reasonably good" for Asians and Hispanics, up to 30% of AI/AN are misclassified as some other race at the time of death (Centers for Disease Control and Prevention 2003). Therefore, data on suicide should be interpreted as low estimates. While specific data for AI/AN remain unclear, it has been noted that suicide is often under-reported by coroners for other minorities (Hispanics and African Americans) (Rockett et al. 2010). Data on mental health diagnosis is likely underrepresented also because many AI/AN tribes do not have the words 'depressed' or 'anxious' in their languages, but instead use a rich variety of terms often referring in some way to personal harmonic imbalance (Kleinman and Good 2004; National Alliance on Mental Illness n.d.).

Supporting More Culturally-Appropriate Mental Healthcare Practice

SAMHSA Funding Initiatives

Given the notable disparity in mental health outcomes among AI/AN and the associated poverty, many tribes and tribal consortia seek outside funding. As the primary provider of grant funding for mental health services, SAMHSA has made reducing the disparity a priority (see Table 1). From 2007 to 2014, SAMHSA awarded $96,117,959 (0.55% of budget total) directly to tribal organizations in the form of 182 separate awards to 83 tribal groups (these numbers do not include those groups that may serve AI/AN populations but are not themselves federally-recognized tribes, or tribal consortia).

Table 1 General categorizations of SAMHSA funding announcements for those awards granted to Native American tribal groups

Type of program announcement	Total spent	Percent of total
Youth mental health	$28,860,936	30.03
General mental health	$18,237,409	18.97
Substance abuse	$13,026,487	13.55
Suicide prevention	$13,036,616	13.56
Targeted capacity expansion	$10,284,694	10.70
Infrastructure	$4,673,863	4.86
Tribal mental health communities	$2,893,690	3.01
Suicide and substance abuse (combined initiative)	$2,880,264	3.00
Homelessness	$1,200,000	1.25
Women's health	$1,024,000	1.07

The percentage of the total budget awarded to federally recognized tribes ranged from 0.26% in 2009 (at the lowest) and 1.14% of their total funding in 2007 (the highest) (Fig. 2; SAMHSA). As illustrated, SAMHSA levels of funding to AI/AN entities have remained largely flat over the last 8 years (SAMHSA). While the percentage of funding to AI/AN entities remained small, the overall SAMHSA grant award budget remained relatively flat as well. The total number of funds awarded in 2007 was $2,153,696,142. In 2014 it was $2,273,990,292. There was a 5.2% drop in overall SAMHSA funding in 2013 to $2,101,139,871, but then an 8.2% rebound in 2014 to the previously mentioned levels (SAMHSA). As shown in Fig. 2, funding awarded to AI/AN entities more closely coincided with overall SAMHSA funding levels in 2011–2013, whereas in 2007–2010 they did not.

Programs such as *Circles of Care* and *Native Connections* seek to respond to the unique needs of the AI/AN population and to adapt to the structure of tribal governments and organizations. *Circles of Care* has provided $2,893,690 in funding to at least eight tribal groups since 2009 to promote culturally-relevant approaches to mental health services, although grant funds cannot be used to provide direct services (Substance Abuse and Mental Health Services, n.d.). *Native Connections* is a recently launched 5-year grant program specifically targeted to assist AI/AN groups to address youth suicide and substance abuse. As an initial matter, *Native Connections* will serve 20 tribal grantees and will provide additional training and technical assistance (Substance Abuse and Mental Health Services, n.d.).

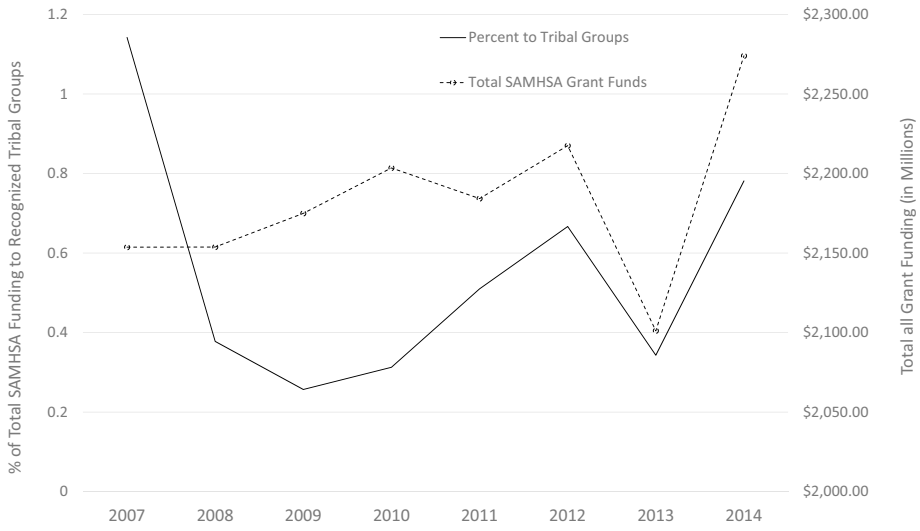

Fig. 2 SAMHSA funding specifically given to Native American recognized tribal groups from 2007 to 2014, presented as a percent of their total allocated funding (SAMHSA) and total grant awards allocated in each year

Since the data were acquired, the 2016 SAMHSA budget was announced, including an initiative to "Promote Mental Health and Prevent Suicide and Substance Abuse." This initiative includes increased funds for certain grant programs from $5 million to $30 million and is specifically designated to be used in collaboration with IHS and tribal leaders (US Department of Health and Human Services 2016). The authors applaud this effort as a major step forward, however the increase of $25 million remains just 1% of the overall budget likely to be awarded as grants (data described in supplement). While our data do not allow for more in-depth comparisons with other groups that may have specialized mental health needs (e.g. homeless populations, other minorities, veterans), this is an area that warrants future study.

Approaches to Culturally-Based Practice

In light of the current disparities, increased development and support of sustainable, culturally-sensitive mental health programs and interventions are needed. It is important to note that while the authors have been discussing AI/AN populations as an aggregate and will identify general themes to consider in developing culturally-appropriate interventions, the vast number of tribal heritages, varying levels of biculturality, and individual preferences of AI/AN people necessitate flexibility in applying specific recommendations.

In general, the traditional religious, spiritual and communal practices that often comprise appropriate interventions may be seen as outside the purview of funding agencies (Pember 2015). For example, qualitative studies indicate spirituality is a major component of mental well-being for many AI/AN (Yurkovich et al. 2011) and that many view mental health challenges as a spiritual imbalance, and indicate them as an area of concern (Hodge and Limb 2010; Giordano et al. 2009; Gone 2007). AI/AN are far more likely to seek help from spiritual leaders or healers in their communities than they are to seek Western-style counseling or therapy (Beals et al. 2005; Walls et al. 2006). Spiritual leaders, or shamans, have a lifetime of cultural wisdom and background helping them understand individuals' sacred experiences and direct them on how to restore harmony and balance through religious expression (Trujillo 2000).

Effective interventions and programs take into account the level of biculturality and the role of historical trauma in the community and the individual's life, especially when treating AI/AN youth. Young AI/AN live with historical trauma daily through poverty, living on non-native lands, and loss of language and cultural identity as well as family-connectedness (Whitbeck et al. 2004). However, some current interventions intended to address historical trauma often do not significantly improve depressive symptoms (Prussing 2014). For example, many AI/AN clients in one focus group reported that their experiences of historical trauma were seen as "delusional" or were otherwise misunderstood by clinicians (Hack et al. 2014). It should be noted that clinicians can and frequently do provide services that result in a great deal of improvement in mental health among AI/AN using Western methods. The clinicians must, however, be highly culturally competent and capable of creating a trust relationship by not purposely or inadvertently attacking or minimizing AI/AN cultural or religious values and worldviews (Nebelkopf and Penagos 2005; Trujillo 2000). Fortunately, culturally-based mental health assessments are improving capabilities for AI/AN leaders, clinicians, and public health researchers to measure

culturally-appropriate mental health indicators and outcomes, and health professionals have designed successful workshops to teach practitioners how to better address AI/AN mental health needs (Giordano et al. 2009; Mays et al. 2009; Cross et al. 2011.; Gowen et al. 2012).

In addition to taking into consideration biculturality, spiritual values, the impact of historical trauma, and more collectivistic attitudes, mental health interventions and programs should incorporate reservation resources, share infrastructure with ongoing community initiatives, and be directed by local tribal leaders whenever possible (Gone 2007). This could include consulting with local healers by inviting tribal leaders to speak at prevention events or with therapy groups (Bassett et al. 2014), providing referral services (including case management services), assisting with transportation, and working to reduce stigma through family and community education (Gone 2007). Again, programs must also recognize that not everyone with AI/AN heritage would prefer highly culturally-focused care, as this heterogenous population reflects varying degrees of traditional cultural identification (Hack et al. 2014). It is therefore recommended that legal policy allow for funding agencies to collaborate with tribal bodies in such a way as to increase the AI/AN community's autonomy and customization of interventions as well as program development and administration. There are currently a few SAMHSA initiatives that are working to incorporate this autonomy.

Advocating Legal and Funding Policy to Reduce Access to Resources

Principles of Self-Determination

Beginning in the 1970s, the United States adopted a policy of tribal self-determination, meaning that it is the goal of the United States to promote laws and policies designed to empower tribes to chart their own futures, manage their own resources, and govern their own people (Indian Self-Determination and Education Assistance Act of 1975). The Indian Self-Determination and Educational Assistance Act (Self-Determination Act, sometimes called Public Law 93-638) was passed in 1975. Under the Self-Determination Act, resources dedicated by the federal government pursuant to the federal-tribal trust responsibility to offer services to tribes, may be "contracted" by tribes. These are called "638" contracts or compacts. Tribes may enter into so-called 638 self-determination compacts or contracts with the federal government to manage the transfers of funds and the responsibilities for management of the programs, resources, and services to the tribe. Tribes retain the responsibility to perform the service or fulfill the function, and must comply with relevant regulations per the contract terms. However they have enhanced flexibility to carry out the projects and services in ways that build institutional capacity, incorporate and reflect tribal priorities and values, and may be more economically efficient (Indian Self-Determination and Education Assistance Act of 1975). Lomay and Hinkebein acknowledged that AI/AN are currently in a "self-determination era", as the federal government is increasingly fostering autonomy in the management of programs and services for AI/AN tribes (Lomay and Hinkebein 2006).

The federally recognized AI/AN tribes in the United States retain significant aspects of inherent, aboriginal sovereignty (US Department of the Interior Indian Affairs 2016). Tribes exercise broad governing authority over people and territory. Tribal self-determination and the federal statutes enacted in furtherance of this policy, like the Indian Self Determination and Educational Assistance Act of 1975 (ISDEAA), seek to fulfill the unique legal and historical trust responsibility and government-to-government relationship with AI/AN tribes. The trust responsibility of the federal government to the tribes arises from treaties, statutes, and Supreme Court precedent. The trust responsibility includes the obligation to provide health services to federally recognized AI/AN tribes (Indian Health Service 2015). At the time of writing, 567 tribal entities were recognized by the Department of Interior's Bureau of Indian Affairs as having this government-to-government relationship with the Federal Government, entitling these tribal entities to the privileges, responsibilities, and services associated with federal recognition (Indian Affairs Bureau 2016).

Barriers to Funding

Despite the high need for efficacious mental health interventions in AI/AN populations and persistent efforts by IHS to provide mental health services and by SAMHSA and other funding organizations to meet those needs, funds remain difficult to access (McLeigh 2010). This is due to a variety of factors including misunderstandings of AI/AN culture and sociopolitical context, AI/AN mistrust of governmental services, and a lack of administrative resources to apply for and oversee individual projects (Lomay and Hinkebein 2006; Yurkovich et al. 2011). For example, interviews with tribal leaders from the Northern Plains Indian reservation indicate that many communities feel tribal relationships with the federal government are strained and tainted by mutual mistrust (Gone 2007). Additionally, the delivery of health services to AI/AN communities is complex. The Federal government is highly involved in the delivery of these services through the IHS, even though the federally recognized tribes are governments in their own right with inherent sovereign powers. These overlapping governing authorities and jurisdictions can result in a

fragmented system and reported difficulty in accessing care (Yurkovich et al. 2011). The previously-described mental healthcare delivery methods also do not fit well with current funding structures that reward evidence-based practices and require extensive administrative oversight (Green and Mercer 2001).

Much of the funding available to tribes, including funds received from the federal government or granting agencies, comes with what tribal leaders have characterized as culturally-inappropriate, inflexible stipulations on the administration, allocation, and designation of those resources (Pember 2015). This may be especially true where the granting agencies primarily tailor the grants for the use of states. As a result, traditional funding models may be underutilized by tribes and perpetuate unmet needs (Levinson 2011).

One major concern with importing the self-determination contracting model wholesale into the mental health, and in particular, a SAMHSA grant context, is that under the self-determination contracting regime, tribes are only entitled to funding the federal government would have spent to carry out the program or activity (Strommer and Osborne 2014). Agencies sometimes resist therefore entering into these contracts or seek to limit their scope because the agency essentially transfers an element of its own mission over to the tribes (Strommer and Osborne 2014). This can result in the federal agencies tasked with serving tribes pursuant to the trust relationship morphing into de facto supervisors of the tribes in carrying out programs and services. The tribes find government promotion of self-determination can sometimes dis-incentivize the government from allocating adequate resources to the activity once tribes have the primary responsibility for carrying out the objective (Strommer and Osborne 2014). Many tribes believe that programs and services offered pursuant to the trust responsibility must be provided directly by the federal government, and are skeptical that self-determination contracting is an attempt by the federal government to shirk its trust responsibilities (Bakken 2000). Still, there are ample examples of tribes very successfully implementing and improving programs, utilizing the management flexibility, and maximizing resources in culturally-appropriate ways under self-determination contracts and compacts, even as the model of self-determination contracting evolves.

Finally, as a model to further increase flexibility, funding could be consolidated under an umbrella structure similar to the "477" program (Indian Employment, Training and Related Services Demonstration Act of 1992, Public Law 102-477). The 477 program was developed to provide a gathering place for the scattered funding opportunities available through multiple, sometimes overlapping programs for tribal economic development. Under Public Law 102-477, the funds stem from multiple federal resources designed to offer federal support for education and job training offered by the Department of Interior, the Department of Labor, the Department of Education, and the Department of Health and Human Services, and tribes are permitted to consolidate management under a plan approved by the Secretary of Interior. Tribes gain considerable flexibility in prioritizing the consolidated funds while serving the aims of the programs funding the initiatives.

SAMHSA's recently launched *Native Connections* program appears to draw upon the principles of tribal self-determination, as does *Circles of Care*. These programs should be monitored for effectiveness, and expanded if they are shown to improve mental health outcomes in AI/AN communities (Substance Abuse and Mental Health Services Association, n.d.; Substance Abuse and Mental Health Services, n.d.).

Future Directions and Recommendations

Recent increases in mental health disparities, particularly in youth suicide, assert the need for a new framework in providing funding for mental health services among AI/AN (Bosman 2015). While promising efforts to improve the general status of AI/AN have been initiated by governmental bodies and policymakers in recent years, we present three specific policy recommendations to more effectively reduce mental health disparities among AI/AN populations:

1. Where possible, increase funding opportunities designed to assess and reduce mental health disparities among AI/AN populations.
2. Provide support for interventions that incorporate methods that are culturally-based and culturally-appropriate, taking into account diversity within AI/AN populations.
3. Model funding practices, oversight and program evaluation on principles of tribal self-determination to better fulfill the federal trust responsibility to AI/AN populations.

Increased funding for the assessment of mental health disparities, reduction of disparities, and treatment of mental health conditions are badly needed, both in the amount of funds made available and in the number of funding programs. While we focused on SAMHSA's framework in this analysis, certainly funding initiatives should not be limited to SAMHSA alone, but treated as a priority area for other private and federal agencies. While SAMHSA's efforts suggest that improved mental health outcomes for tribal groups is a high priority for them, what they currently allocate specifically to these initiatives remains a small portion of their total budget, and would appear to leave significant unmet needs. Increased

collaboration between IHS, SAMHSA, and AI/AN governing bodies to advocate for additional funding from sources inside and outside of the HHS may assist in this effort. For example, these groups could partner with other funding bodies to increase collaborations with AI/AN groups to create scholarship and educational opportunities to train AI/AN students as professionals in mental healthcare, assessment, policy and administration.

Certainly, best practices for mental healthcare and treatment would not take a "one size fits all approach," but instead improve mental health outcomes by working within the local context and unique belief systems of different groups (Kim et al. 2013). Many of the issues that would arise under self-determination for healthcare funding among AI/AN tribes have been faced by global public health workers for decades, with repeated findings that programs that incorporate local community leaders and health workers are much more successful than those run outside the cultural context. It is therefore recommended that current and future policy model funding practices and program oversight and evaluation on principles of self-determination through compacts and contracts to better fulfill the federal trust responsibility to AI/AN populations. This should also allow for decreased administrative burdens and increased transparency between grantors and grantees, thus decreasing the skepticism and mistrust that may be preventing AI/AN groups from accessing federal funding.

Conclusion

We chose to pursue a multidisciplinary approach to considering the disparities in mental health outcomes among AI/AN, because of their complex and historical sources. Elevated suicide rates, especially among AI/AN youth, warrant urgent priority research and action from clinicians, the public health community and policy makers. Solutions must be forward-thinking and flexible. The influence of past US policy in conjunction with strong cultural differences and disparities in outcomes make it difficult and even counter-productive to pursue mental health improvement among AI/AN solely through a Western clinical approach. The principles of self-determination, in combination with increased funding and renewed interest in appropriate clinical practices can serve as a framework for mitigating this critical situation in AI/AN communities.

Acknowledgements The authors kindly acknowledge Sheila Cooper and SAMHSA for providing access to data on funding to federally-recognized American Indian/Alaska Native tribes.

Funding This study was funded by Ira and Mary Lou Fulton Gift Fund at Brigham Young University.

Compliance with Ethical Standards

Conflict of interest All author declares that they have no conflict of interest.

Ethical Approval This article does not contain any studies with human participants performed by any of the authors.

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