

The First Americans Have Much to Teach Us

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In this month's issue of the *Journal*, Whitbeck et al.¹ report that indigenous adolescents living on the northwest border of the United States experienced a striking increase in mental disorders between 10 and 12 and 13 and 15 years of age. The rates in this population were accounted for by increases in conduct disorder and substance use disorders. According to the authors, the study participants' rates for these disorders were two to four times the rates of adolescents in general population studies and similar to lifetime prevalence rates for adults.¹

The article by Whitbeck et al. sounds the alarm on a mental health crisis for indigenous youths in rural reservation communities. However, two caveats must be noted. First, the Indian Health Service consistently reports large regional differences in all health trends across tribes, so caution must be exercised before generalizing these findings to all Native American youths. Second, as Whitbeck et al. have acknowledged, mental health measures have not been well tested with Native American youngsters, and cultural differences may produce measurement biases.²⁻⁴

Nonetheless, it is essential to counter those caveats with other evidence that supports the reality of a mental health crisis for Native American youths. First, the environmental and developmental risks that Whitbeck et al. describe for childhood behavior problems and substance use disorders are common in rural indigenous populations across the United States and the world. Second, although mental health measures used in the study may lack some degree of cultural sensitivity, measurement biases would likely result in underreporting in general, especially substance use disorders and internalizing disorders. Disruptive behavior, which is more overt, may be less subject to reporting bias,¹ but may still be underreported in indigenous communities. Third, the

findings of Whitbeck and colleagues are harbingers of the painful truth that Native American youths as they move through adolescence and into young adulthood (ages 15–24) shoulder an eightfold greater rate of alcohol-related deaths and twofold or higher rates for suicide, motor vehicle accidents, and all injury-related deaths.⁵ Coming to grips with the pivotal association of early disruptive behavior and substance use disorders with these tragic statistics is critical to finding the solution to high rates of mental health morbidity and mortality in Native American youths.

Thus, the article by Whitbeck et al. begs the question: how do we prioritize scarce research dollars and clinical resources for Indian country to address the mental health crisis and resulting mortality of this generation of adolescents and young adults? Is more research needed to rediscover⁶ the causal pathways from cultural oppression and economic and psychosocial adversity to poor mental and behavioral outcomes for indigenous children? We would argue no.

Rather, we propose that the field accept that a constellation of historical, demographic, and sociological factors have precipitated a mental health crisis for Native American youths and move on to seek approaches to deploy cost-effective, evidence-based solutions that reflect indigenous cultural strengths and community will.

To begin to address these problems, we would ask what the existing research tells us about the antecedents of early disruptive behavior and substance use. What are critical time points for intervention and targets for prevention? A large body of research points to early childhood as the critical stage for intervention⁷ and family-based approaches, specifically early parenting training, as a key strategy for the prevention of children's future disruptive behavior problems and substance use disorders.⁸

Parent training and family-based approaches have a natural cultural fit within pan-Native American world views.⁹ There are numerous examples of how Native Americans traditions favor "family" above any other domain as the nexus of strength for individuals.¹⁰ Native Americans often introduce themselves by name and clan, underscoring the link between personal identity and family lineage. Many healing traditions and puberty ceremonies involve extended family members who represent stabilizing and restorative forces. In addition,

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ceremonies emphasize spiritual kinship, expanding the concept of family to include “goddaughters,” “aunts,” “uncles,” and “grandparents,” regardless of bloodlines. Historically, extended family members lived communally and shared the spectrum of child-rearing responsibilities.¹⁰ Although these values continue to be well supported, the history of discrimination, poverty, and dominant society social forces has undermined these traditions. The result is fragile homes and communities that beg for evidence-based family strengthening interventions that are consistent with local cultural ideals and focused on renewing positive Native American parenting and child-rearing strategies.

In addition to considering culturally appropriate prevention intervention approaches, the mental health crisis that Whitbeck et al. describe is also linked to and heightened by the fact that on a per-capita basis, health and mental health services have been grossly underfunded for Native American communities for decades.¹¹ Furthermore, there are few trained Native American mental health professionals to staff mental health services in reservation communities, and the Indian Health Service struggles to recruit and retain non-Native American mental health practitioners in reservation settings.

To address the ongoing service gaps, national advocacy is needed to persuade academic medical institutions to recruit and train more Native American mental health providers and pressure Congress to increase mental health service dollars for the Indian Health Service and tribal communities. In the meantime, creativity and cost-efficiency must be exercised in crafting an immediate response. Our nearly 2 decades of experience with Southwestern tribes supports the feasibility, cultural acceptability, and utility of training Native American paraprofessionals in assessment, education, and case management for Native American youngsters at risk for mental health problems.¹⁰ Thus, it stands to reason that research and resource allocation should extend beyond outpatient medical or mental health practices to afford Native American communities the opportunity to develop and support community-based, paraprofessionally delivered prevention interventions that are consistent with the evidence base and align with indigenous concepts of mental health and local cultural strengths.

High rates of mental disorders for Native American youths may be sentinel for what seem to be increasing rates of mental health and substance use disorders among disadvantaged youths across the nation and the world. Meanwhile, the modern approach to this crisis—a professionally delivered, integrated continuum of psychiatric care (combining outpatient, partial care, inpatient services, residential, and crisis intervention programs)—remains financially and logistically infeasible for even resource-rich communities in America. The evidence base is available for the prevention of disruptive

behavior and substance use disorders, but the implementation of those methods by paraprofessionals has not been extensively evaluated.

Culturally competent, community-based participatory prevention research and innovative mental health services delivery by paraprofessionals show promise for Native Americans.¹² Native American communities have an abundance of intelligent and committed paraprofessionals who can be trained immediately and inexpensively as prevention interventionists to address the problems among the youths described by Whitbeck and colleagues. The first Americans have much yet to teach us about community-based approaches to rebuilding family and community.

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