



National American Indian and Alaska Native

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration



Mental Health Evidence-Based Practices for American Indian and Alaska Native (AI/AN) Schools and Communities

AN ENVIRONMENTAL SCAN REPOSITORY

November 2019



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PREFACE

In the fall of 2018, the National American Indian and Alaska Native Mental Health Technology Transfer Center (NAIAN MHTTC) received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the expansion of allowable activities for Native school-age children who experience adverse childhood experiences (ACEs) that contribute to mental health problems. This publication was created in an effort to provide a repository of programs and practices that could be used by communities who serve Native school-age children, as well as to avoid the duplication of efforts. We would like to acknowledge the invaluable work of those individuals who created the programs, and who teach the practices, which are referenced in the following pages. Additionally, we are so appreciative of the work of our contributors, especially JBS International, Inc. towards the creation of this repository.

To learn more about the NAIAN MHTTC or the MHTTC Network, please visit:

www.mhttcnetwork.org/native

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Disclaimer

The content of this publication does not necessarily reflect the views or policies of SAMHSA or the Department of Health and Human Services (DHHS).

SAMHSA

Substance Abuse and Mental Health
Services Administration



INTRODUCTION

The following is an environmental scan of evidence-based mental health programs and practices found to be effective with American Indian and Alaska Native (AI/AN) school-aged children and youth who experience adverse childhood experiences, including violence and trauma, that contribute to mental health problems.

The environmental scan involved a literature review of articles, guidance documents, and other resources to identify evidence-based mental health programs and practices that have been created by and used in tribal communities, including programs and practices created by non-Native developers that have been culturally adapted for Native youth. Using academic databases and government and institutional websites to identify scholarly resources of information, the literature review uncovered the mental health programs and practices included in this repository. Programs and practices that were specific to substance abuse were not included in the scan, although some of the identified mental health programs and practices include substance use as a risk factor in the program or practice.

Like beads in a variety of colors, materials, shapes, and sizes woven together by Native American artists to express their own tribal patterns, culture and traditions, these programs have been developed or adapted based on tribal culture and traditions and transformed to express other traditional Native practices and beliefs.

The repository is not meant to be static. As new and emerging practices are identified and found to be effective with AI/AN school-age children and youth, they can be added to the repository. For example, it was not possible to include the tribally owned and locally cultivated programs in Indian Country that are not currently represented in journal articles, government clearinghouses, or other readily accessible sources. As these programs and practices are identified through MHTTC field work, however, they can be included in this repository.

The pages that follow contain information about relevant mental health programs and practices for AI/AN youth and often their families. In addition, the document contains abstracts to research and literature of interest and a section that includes links for further reading.





RELEVANT MENTAL HEALTH PROGRAMS AND PRACTICES

Honoring Children, Mending the Circle^{1,2,3}

The Indian Country Child Trauma Center developed an American Indian and Alaska Native (AI/AN) adaptation of an evidence-based child trauma treatment, trauma-focused cognitive-behavioral therapy (TF-CBT), for children **ages 3–7**. Honoring Children, Mending the Circle (HC-MC) guides the therapeutic process through a blending of AI/AN traditional teachings with cognitive-behavioral methods. HC-MC is a cultural adaptation of TF-CBT that supports AI and AN cultural views of well-being. The Indian Country Child Trauma Center partnered with tribal programs to identify, design, test, and refine the program. Tribal partners included stakeholders (tribal leadership, consumers, and traditional and society helpers and healers), local programs (e.g., schools, tribal colleges, behavior health representatives, law enforcement), and other providers. AI/AN partners assisted in incorporating into the model beliefs, practices, and understandings consistent with their individual tribal culture.

Contact: Indian Country Child Trauma Center, Center on Child Abuse and Neglect, Native American Programs

Website: <http://www.icctc.org>
Address: 940 NE 13th Street,
Nicholson Tower, 4N, 4900
Oklahoma City, OK 73104
Phone: (405) 271-8858
Fax: (405) 271-2931

HC-MC has adopted core constructs based on AI/AN worldviews: (a) all things are interconnected, (b) all things have a spiritual nature, and (c) existence is dynamic. Central to wellness and healing is the core AI/AN belief that all things, human and earth, have a spiritual nature. AI/AN helpers and healers have been taught words, prayers, practices, rituals, and ceremonies that help connect the physical world with the spiritual to bring about wellness, balance, and harmony. Spirituality has played and continues to play an important role in the life of American Indiansⁱ and is the center of the circle. As reflected in the graphic on the next page, the HC-MC model is based on the construct that there is no separation of the physical from the spiritual; it is interwoven and intertwined.

ⁱ Bryde, J. F. (1971). *Modern Indian psychology*. Vermillion, SD: The Dakota Press.

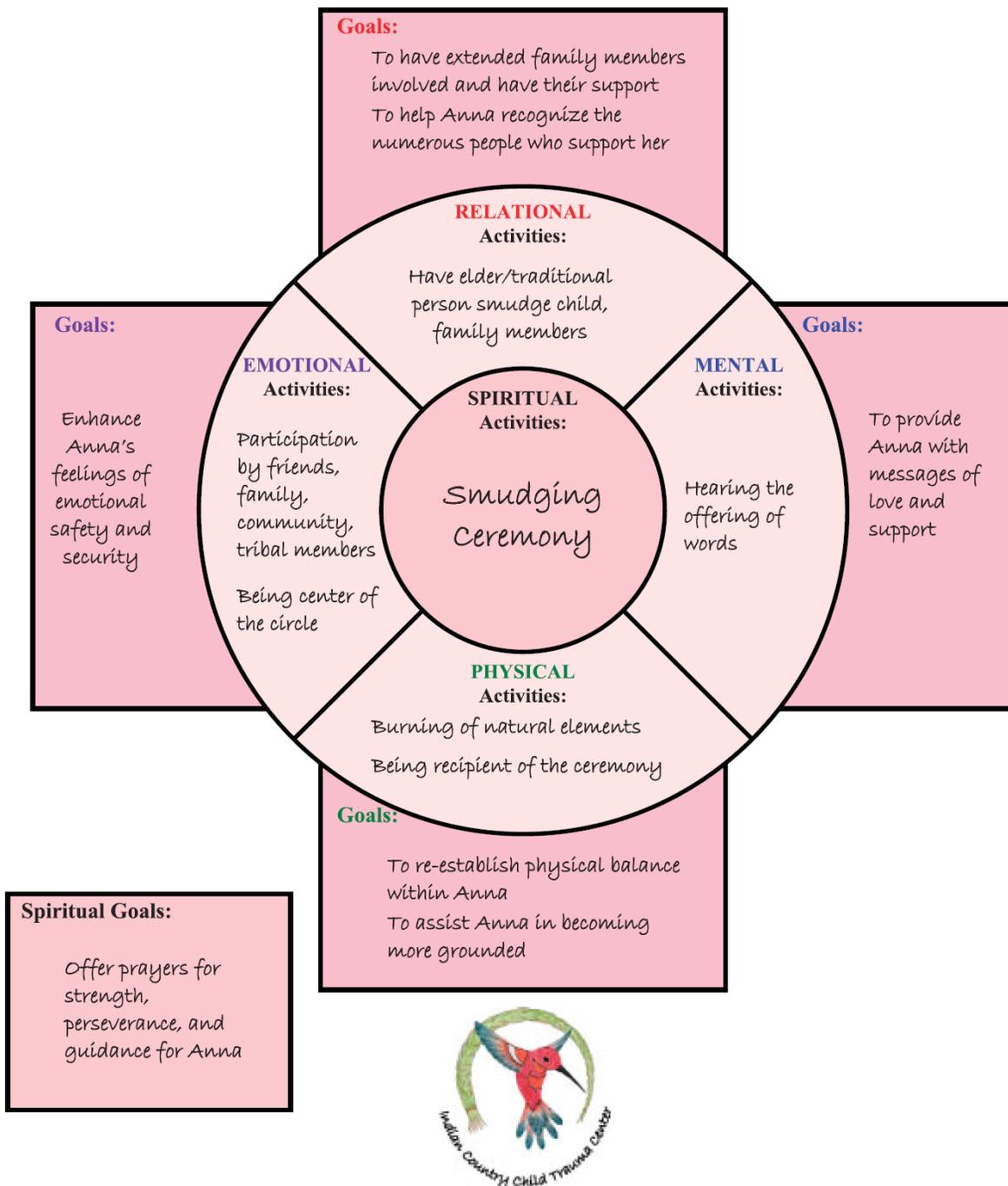


Figure 1. Honoring Children, Mending the Circle: Component worksheet is illustrated.

Journal of Clinical Psychology DOI: 10.1002/jclp



American Indian Life Skills Development Curriculum^{4,5,6}

American Indian Life Skills (AILS) is a universal, school-based, culturally grounded life-skills training program that aims to reduce high rates of AI/AN adolescent suicidal behaviors by reducing suicide risk and improving protective factors. The curriculum, for youth **ages 13–17**, includes between 13 and 56 lesson plans and is typically delivered over 30 weeks during the school year or as an afterschool program, with students participating in lessons three times per week. The curriculum emphasizes social–cognitive skills training and includes seven main themes:

1. Building self-esteem
2. Identifying emotions and stress
3. Increasing communication and problem-solving skills
4. Recognizing and eliminating self-destructive behavior
5. Information on suicide
6. Suicide intervention training
7. Setting personal and community goals

The curriculum also incorporates three domains of well-being that are specific to tribal groups: (1) helping one another, (2) group belonging, and (3) spiritual belief systems and practices. Lessons are interactive and incorporate situations and experiences relevant to AI/AN adolescent life, such as friendship issues, rejection, divorce, separation, unemployment, and problems with health and the law. Lessons may be delivered by teachers working with community resource leaders and representatives of local social service agencies.

AILS is the currently available version of the former Zuni Life Skills Development program. The latter was developed with cultural components relevant to the people of the Zuni Pueblo in New Mexico, including Zuni norms, values, beliefs, and attitudes; sense of self, space, and time; communication style; and rewards and forms of recognition. The Zuni curriculum served as the basis for the broader AILS curriculum that is now in use; AILS can be used with other AI/AN populations when implemented with appropriate and culturally specific modifications.

This curriculum is broad enough to address concerns across diverse American Indian tribal groups yet is respectful of distinctive and heterogeneous cultural beliefs and practices.

Contact: American Indian Life Skills

Website:

<https://www.sprc.org/resources-programs/american-indian-life-skills-developmentzuni-life-skills-development>

Or developer:

Teresa LaFromboise, Ph.D.
Professor, Developmental and Psychological Sciences, Stanford Graduate School of Education
Address: 485 Lasuen Mall
Stanford, CA 94305-3096
Phone: (650) 319-5016
Email: lafrom@stanford.edu



Project Venture^{7,8,9}

Project Venture is the evidence-based flagship program of the National Indian Youth Leadership Project. Geared toward **5th–8th grade** Native American youth, Project Venture addresses noncognitive skills, such as group cohesiveness, youth confidence, and motivation and also provides a drug abuse prevention program. The program is implemented both in and outside the school context.

This program uses a positive youth development approach, with a unique, culturally based group-development process that centers on strengths, positive behaviors, and healthy lifestyles as the core focus areas for Native youth. It incorporates actively engaging youth in developing life skills, while reinforcing traditional Indigenous values regarding family, community, service, and appreciation for the land and natural environment. Illustrative activities include culturally grounded group development, service learning, and outdoor adventure activities, all of which are offered through a strengths-based, experiential-learning process that is aligned with Indigenous cultures and traditions.

Contact: National Indian Youth Leadership Project—Project Venture

Website: <https://projectventure.org>

Sheri Pfeiffer-Tsinajinnie

Director of Operations

Address: 2501 San Pedro NE, Suite 116

Albuquerque, NM 87110

Phone: (505) 554-2289

Fax: (505) 554-2291

Email: info@niylp.org

To foster a positive climate, Project Venture’s foundation is built on six core values that guide youth in all that they do:

1. Be here and be present.
2. Be safe.
3. Speak your truth.
4. Care for self and others.
5. Set goals.
6. Let go and move on.

Project Venture is currently working with Indigenous youth in sites throughout the United States and Canada. The 2002 National High-Risk Youth Study (which evaluated 48 SAMHSA-funded prevention programs) identified it as “one of the top four programs for all young people.”ⁱⁱ Project Venture was also recognized by the National Registry of Effective Programs and Practices and SAMHSA’s Center for Substance Abuse Prevention.

Note: Project Venture has implemented several adaptations to meet the needs of various tribal implementers and may be able to create other flexible adaptations as needed.

ⁱⁱ The Atlantic Philanthropies. (2009, September). [National Native American substance-abuse prevention program named best practice by First Nations Behavioral Health.](#)



Mental Health First Aid^{10,11}

Mental Health First Aid (MHFA) is an 8-hour course that teaches individuals how to help someone who may be experiencing a mental health or substance use challenge. MHFA gives people the skills to help someone who is experiencing a mental health problem or a mental health crisis. Trainees are taught how to apply a five-step action plan in a variety of situations, such as helping someone through a panic attack, engaging with someone who may be experiencing a suicidal crisis, or assisting an individual who has overdosed. While MHFA was first created in Australia in 2001 by Betty Kitchener, a nurse specializing in health education, and Tony Jorm, a respected mental health literacy professor, it has been adapted by trainers for AI/AN communities (e.g., see graphic on next page). **MHFA training, both Adult and Youth versions, is available at no cost from the Indian Health Service (IHS) Community Health Representative Program** (<https://www.ihs.gov/chr>). Each training session

involves a concise presentation of the topic with opportunities for case discussion and consultation. Providers working in primary care, human services, and schools, as well as behavioral health agencies, are urged to connect and receive continuing education credit for their participation. Below are the MHFA training objectives:

1. Identify, understand, and respond to signs of mental illnesses and substance use disorders.
2. Identify risk factors and warning signs for mental health and addiction concerns.
3. Perform strategies for how to help someone in both crisis and non-crisis situations.
4. Identify where to turn for help to assist someone experiencing a mental health or substance use-related crisis.
5. Implement/discuss case examples of using The Mental Health First Aid Action Plan in a variety of situations, including when someone is experiencing: panic attacks, suicidal thoughts or behaviors, non-suicidal self-injury, acute psychosis (e.g., hallucinations, delusions), overdose or withdrawal from alcohol or drug use, or reaction to a traumatic event.
6. Define and identify the differences between recovery and resiliency.
7. Distinguish between facts and myths of mental health, illnesses, and disorders.

Contact: Mental Health First Aid

Website:

<https://www.mentalhealthfirstaid.org>

Mental Health First Aid USA is

managed, operated, and

disseminated by:

the National Council for Behavioral

Health and the Missouri Department

of Mental Health

and through:

the Indian Health Service

<https://www.ihs.gov/chr/education/mh>

[firstaid](https://www.ihs.gov/chr/education/mh)



In addition, MHFA is often delivered through a Project AWARE federal SAMHSA grant; many tribes have been recipients of these funds and have implemented relevant programming. Note: The flyer below is one example of adapting MHFA for Native communities.

The **National Indian Health Board (NIHB)** is partnering with the **National Council for Behavioral Health (NCBH)** to offer

MENTAL HEALTH FIRST AID TRAINING

The training is a full day course that will introduce participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments.

This is a live training course, which uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect persons to professional, peer and social supports as well as self-help resources.

The course will also provide information on how to adapt mental health first aid to AI/AN communities.

For more information or to RSVP contact Courtney Wheeler, cwheeler@nihb.org or 202-507-4081

This event is free of charge.

TUESDAY, JULY 24, 2018
8:00 AM - 5:00 PM
WASHINGTON MARRIOTT WARDMAN PARK
2660 WOODLEY ROAD, NW
WASHINGTON, DC 20008



Adolescent Coping with Depression¹²

Adolescent Coping with Depression (CWD-A), for youth in **middle childhood (ages 9–12)/adolescence (ages 13–18)**, combines cognitive and behavioral strategies aimed at addressing the types of problems commonly found in depressed adolescents. The CWD-A program includes the therapist leader’s manual and a student workbook. CWD-A is based on the social learning theory analysis which proposes that episodes of depression are associated with a decrease in pleasant, and an increase in unpleasant, person/environment interactions.

The CWD-A program is designed for use with groups of four to eight adolescents, or it can be modified for use on an individual basis. The treatment sessions are conducted as a class in which a group leader teaches adolescents a variety of skills for successfully controlling depression. Eight core CBT skills are taught to the participants:

1. Mood monitoring
2. Social skills
3. Pleasant or fun activities
4. Relaxation techniques
5. Constructive thinking
6. Communication
7. Negotiation and problem solving
8. Maintenance of gains

Each adolescent is provided with a student workbook, which is closely integrated with course discussion and group activities. The workbook contains brief readings, structured learning tasks, self-monitoring forms, homework assignments, and short quizzes.

An important feature is that the course is non-stigmatizing, with the intervention presented and conducted as a class in coping skills rather than as a “therapy.” It is a cost-effective, community-oriented approach that can successfully reach the great majority of depressed adolescents who typically do not make use of the services of school counselors, therapists, and other mental health professionals.

The CWD-A program was originally designed to be completed in sixteen 2-hour sessions scheduled over an 8-week span of time. However, an adaptation guide for providing the content in different formats (e.g., shorter sessions, a modular format, or on an individual basis) is available. While not specifically developed for Native youth, this program has been implemented successfully with populations that include Native students.

Contact: Adolescent Coping With Depression

Website:

<https://www.saavsus.com/adolescent-coping-with-depression-course>

Address: PO Box 11136

Eugene OR, 97440

Phone: (541) 283-6283

Fax: (866) 557-2244

Email: paulberger@saavsus.com

The Kaiser Permanente Center for Health Research provides free downloads of the CWD-A therapist manual, teen workbook, parent manual, and parent workbook at <http://www.kpchr.org/public/acwd/acwd.html>.



Cognitive Behavioral Intervention for Trauma in Schools¹³

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a school-based group intervention for **5th–12th grade** students that has been shown to reduce post-traumatic stress disorder (PTSD) symptoms, depression symptoms, and psychosocial dysfunction in children who have experienced trauma. CBITS is designed to reduce symptoms of PTSD, depression, and behavioral problems; it is also designed to improve functioning, grades and attendance, peer and parent support, and coping skills. CBITS has been used with students who have witnessed or experienced traumatic life events, such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters. CBITS uses cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, exposure).

Contact: Cognitive Behavioral Intervention for Trauma in Schools

Website: <https://cbitsprogram.org>

For more information about an in-person training:

Phone: (213) 821-4398

Email: info@cbitsprogram.org

CBITS is designed for delivery by mental health professionals in a school setting. The program consists of the following sessions:

- 10 group sessions
- 1–3 individual sessions
- 2 parent psychoeducational sessions
- 1 teacher educational session

Extensive research since 2000 has shown that students who participate in the program have significantly fewer symptoms of post-traumatic stress, depression, and psychosocial dysfunction. Since 2001, CBITS has been implemented widely across the United States and abroad and is also being actively disseminated through SAMHSA's National Child Traumatic Stress Network. CBITS offers both online and in-person training. While not specifically developed for Native youth, this program has been implemented successfully with populations that include Native students.



Lakota Circles of Hope¹⁴

Lakota Circles of Hope (LCH) is an innovative, culturally specific prevention curriculum that teaches **elementary and middle school** students how to use Lakota culture to deal more effectively with risky behaviors such as drug and alcohol use, tobacco use, bullying, and suicide. The curriculum is intended to foster a positive Lakota identity and enhance students' understanding and appreciation of Lakota culture. LCH traditional Lakota values comprise the core of the classroom-based prevention curriculum:

- Respect—Wahola
- Generosity—Wacantognaka
- Bravery—Woohitika
- Fortitude—Wowacintanka
- Wisdom—Woksape

Train the Trainer provides schools with an opportunity to be qualified by LCH program managers. Each school district will be taught to use and implement the LCH curriculum.

The training offers the following:

- Training from LCH-program managers
- Training toolkit for each school
- Web-based pre/post evaluation for students
- Fidelity observation site visit by LCH program managers
- Coaching and technical support
- Completed evaluation report
- Train the Trainer certificates

Contact: Lakota Circles of Hope

Website:

<https://lakotacirclesofhope.org>

Address: 529 Kansas City Street,
Suite 100

Rapid City, SD 57701

Phone: (605) 348-6086

Fax: (605) 348-1050

Email: css@cssrapidcity.com



Positive Youth Development Framework^{15,16}

Positive youth development (PYD) is a framework that guides communities in the way they organize services, opportunities, and supports so that young people can develop to their full potential. PYD is not just another framework. PYD differs from other approaches to youth in that it rejects an emphasis on trying to correct what is considered wrong with children’s behavior or development. PYD views young people as “resources” who have much to offer rather than as “problems” who need to be treated or fixed. Programs and practitioners seek to empathize with, educate, and engage children in productive activities. Though the field is still growing, PYD has been used across the world to address social divisions, such as gender and ethnic differences.

PYD enhances the sense of belonging, creating, and strengthening relationships with peers, friends, and identification of one’s culture within a community. Increased resiliency and risk reduction can be fostered by utilizing PYD principles and practices with youth and communities of different ethnicities, races, cultures, specific needs with respect to behavior and learning, and sexual orientation. Examples of PYD principles in research and programming for AI/AN youth include:

- Within cultures of the United States, Native American youth with a high sense of cultural identity and self-esteem displayed lower levels of alcohol and drug use.ⁱⁱⁱ
- The use of traditional American Indian/Alaska Native values through activities, such as storytelling, have shown success in decreasing substance abuse among these youth.^{iv,v}

As there are many examples of PYD frameworks, there is not one set of contact information. Below are two examples of such resources, and readers are encouraged to search for others:

<https://www.youthpower.org/positive-youth-development-pyd-framework>

<https://youth.gov/youth-topics/positive-youth-development>

ⁱⁱⁱ Zimmerman, M. A., & Arunkumar, R. (1994). Resiliency research: Implications for schools and policy. *Society for Research in Child Development*, 8(4), 1–20.

^{iv} Moran, J. R., & Reaman, J. A. (2002). Critical issues for substance abuse prevention targeting American Indian youth. *Journal of Primary Prevention*, 22(3), 210-233.

^v SAMHSA. (2007). National Registry of Evidence-Based Programs and Practices [Database].



Telehealth/Telemental Health^{17,18}

One way to address healthcare disparities among AI/AN communities and members is through increasing access to quality behavioral health services through telehealth/telemental health in ways that are holistic, cost-effective, and culturally respectful. Benefits of telehealth services include increased care, decreased patient travel, decreased organizational costs, and meeting a perceived patient preference.

Telehealth/telemental health offers rural AI/AN communities a means of accessing care without incurring high costs. With attention to reimbursement policies, educational services, technological infrastructure, and culturally competent care, using this technology has the potential to decrease costs, increase quality, and increase access to health care for rural Native American patients. While challenges facing the implementation of telemedicine programs exist, there is great potential for it to improve healthcare delivery in rural AI/AN communities. Promising ways forward include incorporating traditional practices and the Seven Teachings into telemental health services (see next section). Due to the many versions of telehealth there is no single recommended platform.

Telehealth Platform Considerations

- HIPAA compliant
- Device and browser agnostic (will work on/with various systems and programs)
- Affordable
- Flexible (not locked into lengthy contracts)



The Seven Teachings¹⁹

The traditional concepts of respect and sharing that form the foundation of the Native American way of life are built around the seven natural laws, or sacred teachings. Each teaching honors one of the basic virtues intrinsic to a full and healthy life. Each law is embodied by an animal to underscore the point that all actions and decisions made by man are manifest on a physical plane. The animal world taught man how to live close to the earth; the connection that has been established between the animal world and that of man has instilled a respect for all life in those who follow the traditional way.

One resource, of many available, is located at

https://prevention.nd.gov/sites/default/files/Seven_Sacred_Teachings.pdf.



Adolescent Suicide Prevention Program²⁰



Adolescent Suicide Prevention
Program Manual: A Public Health Model
For Native American Communities
Patricia Serna, LISW

The Model Adolescent Suicide Prevention Program (MASPP) is a public health-oriented suicide prevention and intervention program originally developed for a small American Indian tribe in rural New Mexico to target high rates of suicide among its adolescents and young adults. The goals of the program are to reduce the incidence of adolescent suicides and suicide attempts through community education about suicide and related behavioral issues, such as child abuse and neglect, family violence, trauma, and alcohol and substance abuse. As a community-wide initiative, MASPP incorporates universal, selective, and indicated interventions and emphasizes community involvement, ownership, and culturally framed public health approaches appropriate for an American Indian population **ages 6–25**.

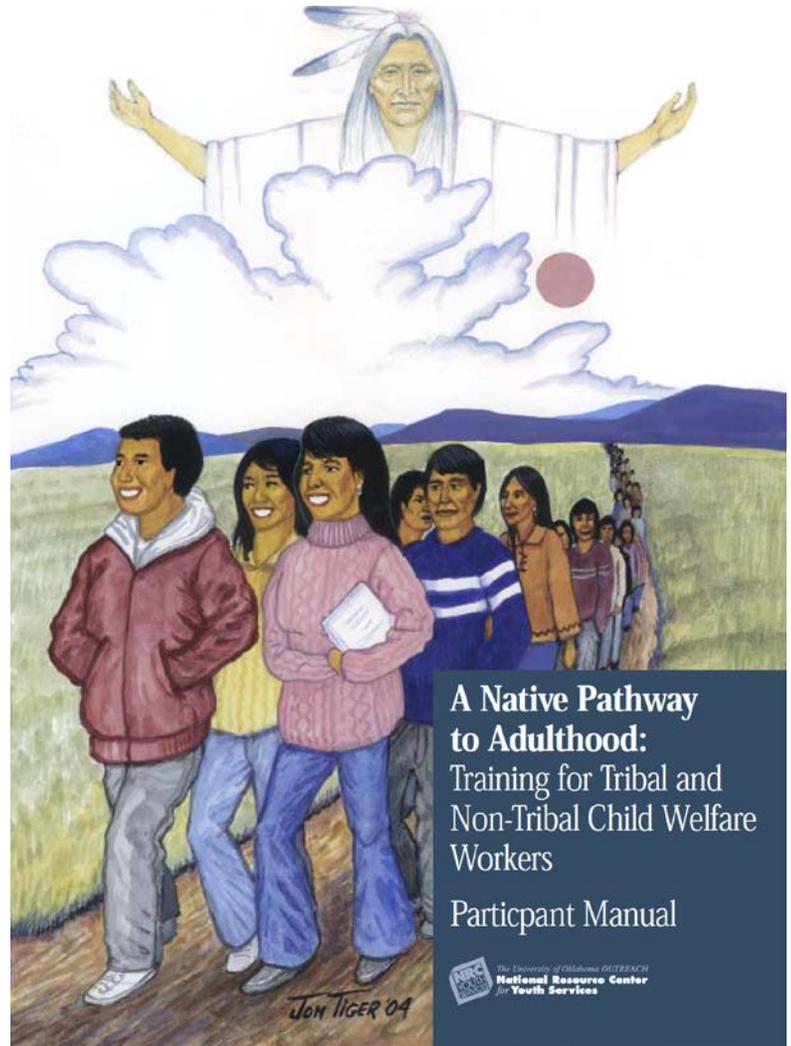
Central features of the program include formalized surveillance of suicide-related behaviors; a school-based suicide prevention curriculum; community education; enhanced screening and clinical services; and extensive outreach provided through health clinics, social services programs, schools, and community gatherings and events. In addition, neighborhood volunteers of various ages are recruited to serve as “natural helpers.” These individuals engage in personal and program advocacy, provide referrals to community mental health services, and offer peer counseling (with guidance from professional mental health staff) to youth who may prefer to seek assistance from trusted laypersons in a less formal setting.

More information on MASPP, including a link to the program manual, can be found at https://www.sprc.org/sites/default/files/migrate/library/AdolescentSP_ProgramManuaPH_ModelNA_Communities.pdf.



A Native Pathway to Adulthood: Training for Tribal and Non-Tribal Child Welfare Workers²¹

The Native Pathways to Adulthood independent living program is designed to provide support and assistance to Native American youth **ages 14–21** who are currently in or who have been in state or tribal foster care systems. This competency-based curriculum enhances the skills of tribal and state workers in facilitating the transition of older Native American youth from out-of-home care to adulthood. The curriculum also encourages collaboration between tribes and public agencies to ensure that culturally relevant transition services are provided. The University of Oklahoma National Resource Center for Youth Services developed this curriculum with assistance from the National Indian Child Welfare Association, the New Mexico Indian Child Welfare Association, and many tribes. The manual introduces the unique life path of tribal youth, provides information to enhance current intervention skills, and adds to the knowledge base of accessible local and national resources. To access a copy of the manual, visit



https://secure.goozmo.com/user_files/7756.pdf.

Note: This model was *not* identified through the literature review but rather through secondary online searches. The following website includes some implementation information:

<http://nayapdx.org/services/foster-care-support/pathways-to-adulthood/>.



RESEARCH CITATIONS FROM FEATURED PROGRAMS

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OTHER RELEVANT LITERATURE

Adelsheim, S., Bonham, C., Fore, C., Glass, J., Simmons, D., & Thomas, L. (2015). Creating a national Native telebehavioral health network: The IHS Telebehavioral Health Center of Excellence. In L. W. Roberts, D. Reicherter, S. Adelsheim, & S. V. Joshi (Eds.), *Partnerships for mental health: Narratives of community and academic collaboration* (pp. 77-88). Cham, Switzerland: Springer International Publishing. doi:10.1007/978-3-319-18884-3_6

This chapter discusses the creation of a national Native telebehavioral health network. The Indian Health Service (IHS) Telebehavioral Health Center of Excellence was created through a partnership between the Albuquerque Area IHS (AAIHS) and the University of New Mexico (UNM) Department of Psychiatry and Behavioral Sciences Center for Rural and Community Behavioral Health (CRCBH). The AAIHS is one of 12 area IHS offices. The AAIHS is responsible for the provision of health services in New Mexico to 19 Pueblos; the Jicarilla and Mescalero Apaches; and the Alamo, To'hajiilee, and Ramah Chapters of the Navajo Nation. In addition, the AAIHS also serves the Southern Ute and the Ute Mountain Ute reservations in southern Colorado; the Ysleta Del Sur Pueblo in El Paso, Texas; and two Urban Indian Centers, located in Albuquerque, New Mexico, and Denver, Colorado. The CRCBH was developed through the Department of Psychiatry and Behavioral Sciences at the UNM School of Medicine, with a mission to address "health care disparities through: education and workforce development; health services research and evaluation; capacity building; and through increasing access to quality behavioral health services that are holistic, cost-effective and provided with respect to the unique cultures within the communities of New Mexico."

Antonio, M. C. K., & Chung-Do, J. J. (2015). Systematic review of interventions focusing on Indigenous adolescent mental health and substance use. *American Indian and Alaska Native Mental Health Research*, 22(3), 36-56. doi:10.5820/aian.2203.2015.36

Mental health and substance use are pressing public health concerns among Indigenous adolescent populations. This systematic review analyzed interventions focusing on mental health and substance use that utilize the Positive Youth Development (PYD) framework, incorporate culturally tailored programs, and are geared toward Indigenous adolescents. In total, 474 articles were retrieved from PSYCInfo and PubMed databases. Eight articles were eligible for analysis, with six focusing on AI/AN populations in the U.S. Most programs reported positive or expected outcomes. All the programs incorporated PYD variables, while all but one were culturally grounded or included deep structure adaptations. Implications are further discussed.

Auger, M., Crooks, C. V., Lapp, A., Tsuruda, S., Caron, C., Rogers, B. J., & van der Woerd, K. (2019). The essential role of cultural safety in developing culturally-relevant prevention programming in First Nations communities: Lessons learned from a national evaluation



of Mental Health First Aid First Nations. *Evaluation and Program Planning*, 72, 188-196. doi:10.1016/j.evalprogplan.2018.10.016

Mental Health First Aid is a population health approach that educates people to recognize and respond to mental health challenges. Since 2012, the Mental Health Commission of Canada has worked with six First Nations communities to develop a culturally relevant version of the program called Mental Health First Aid First Nations (MHFAFN). This paper presents mixed methods, multi-informant data from a national evaluation to assess the extent to which the course was experienced as culturally safe by Indigenous participants, factors that contributed to these experiences, and ways in which cultural relevancy of MHFAFN can be improved. Our evaluation team conducted participant interviews and surveys, as well as facilitator interviews. Nearly all Indigenous participants (94.6%) experienced the course as safe. Participants and facilitators identified a range of factors that promoted cultural safety, including the knowledge and skills of the facilitators and the cultural components of the course. Participants that did not experience safety identified trauma-related factors and facilitation style. The findings suggest that MHFAFN may be situated in a way where shared cultural backgrounds are imperative to the success of the course. Further evaluation of the MHFAFN curriculum, with the goal of continual improvement, may help to further enhance participants' experiences in taking the course. Copyright © 2018 Elsevier Ltd. All rights reserved.

Avey, J. P., & Hobbs, R. L. (2013). Dial in: Fostering the use of telebehavioral health services in frontier Alaska. *Psychological Services*, 10(3), 289-297. doi:10.1037/a0028231

Telehealth programs continue to develop rapidly in the United States, with video teleconferencing leading the way in rural areas. Unfortunately, organizational factors can limit the use of these innovative services. Researchers explored key factors that foster initial or renewed interest, continued extensive use, and adaptations to barriers in implementing Telebehavioral Health Services in rural Alaska. A total of 18 key informant interviews were conducted with direct care staff, administrative staff, and information technology professionals. Summative interview narratives were thematically coded by hand. Results indicate that direct care and administrative staff were found to be interested in the following benefits of telehealth services: increased care, decreased patient travel, decreased organizational costs, and meeting a perceived patient preference. The fulfillment of these interests, coordination, adequate staffing, accessibility of equipment, and clinician competency all contributed to the use of telehealth services. Numerous adaptations to barriers were found involving coordination, personal oversight, acceptance of limitations, education, staffing, billing for services, consultation, modifying referrals patterns, and creating treatment alternatives. Information technology professionals identified communication and assistance, testing connections, resolving initial issues, maintenance, and vision and control as vital factors. Findings may aid programs in dealing with pragmatic issues to maintain organizational readiness. PsycINFO Database Record (c) 2013 APA, all rights reserved.



BigFoot, D. S., & Schmidt, S. R. (2009). Science-to-practice: Adapting an evidence-based child trauma treatment for American Indian and Alaska Native populations. *International Journal of Child Health and Human Development*, 2(1), 33-44.

According [to] the National Child Traumatic Stress Network, the effects of childhood trauma can have devastating consequences for relationships, academic performance, emotional adjustment, and the future capacity to endure adversity. The impact of traumatic events in childhood and adolescence can continue to resonate in adult life, affecting physical and mental health, citizenship and community involvement, relationships, parenting, and family stability. American Indians and Alaska Natives (AI/AN) are a vulnerable population with high levels of trauma exposure. To enhance trauma-sensitive mental health care for AI/AN children, Indian Country Child Trauma Center (part of the National Child Traumatic Stress Network) designed an AI/AN adaptation of the evidence-based child trauma treatment, Trauma-Focused Cognitive-Behavioral Therapy. The adapted model, Honoring Children—Mending the Circle, guides the healing process in a framework that supports AI/AN traditional beliefs and practices regarding wellness, spirituality and healing. This article provides an introduction to the HC-MC model, reviews cultural considerations incorporated into ICCTC's model adaptation process, and discusses lessons learned through the initial steps of the HC-MC model dissemination process.

BigFoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology*, 66(8), 847-856.

American Indians and Alaska Natives are vulnerable populations with significant levels of trauma exposure. The Indian Country Child Trauma Center developed an American Indian and Alaska Native (AI/AN) adaptation of the evidence-based child trauma treatment, trauma-focused cognitive-behavioral therapy. Honoring Children, Mending the Circle (HC-MC) guides the therapeutic process through a blending of AI/AN traditional teachings with cognitive-behavioral methods. The authors introduced the HC-MC treatment and illustrated its therapeutic tools by way of a case illustration.

Brooks, E., Manson, S. M., Bair, B., Dailey, N., & Shore, J. H. (2012). The diffusion of telehealth in rural American Indian communities: A retrospective survey of key stakeholders. *Telemedicine and e-Health*, 18(1), 60-66. doi:10.1089/tmj.2011.0076

Objective: Mental health issues are a serious concern for many American Indian Veterans, especially for post-traumatic stress disorder and related psychiatric conditions. Yet, acquiring mental health treatment can be a challenge in Native communities where specialized services are largely unavailable. Consequently, telehealth is increasingly being suggested as a way to expand healthcare access on or near reservation lands. In this study, we wanted to understand the factors affecting the diffusion of telehealth clinics that provided mental health care to rural, American Indian Veterans. **Materials and Methods:** We surveyed 39 key personnel and stakeholders who were involved in the decision-making process, technological infrastructure, and implementation of three clinics. Using Roger Everett's Diffusion Theory as a framework, we gathered information



about specific tasks, factors hindering progress, and personal reactions to telehealth both before and after implementation. **Results:** Many participants expressed initial concerns about using telehealth; however, most became positive over time. Factors that influenced participants' viewpoint largely included patient and staff feedback and witnessing the fulfillment of a community health need. The use of outside information to support the implementation of the clinics and personal champions also showed considerable influence in the clinics' success. **Conclusion:** The findings presented here address critical gaps in our understanding of telehealth diffusion and inform research strategies regarding the cultural issues and outcomes related to telemental health services. Information contained in this report serves as a long overdue guide for developing telemental health programs and policies among American Indians, specifically, and rural populations in general.

Brooks, E., Spargo, G., Yellowlees, P., O'Neill, P., & Shore, J. H. (2013). Integrating culturally appropriate care into telemental health practice. In K. Myers & C. L. Turvey (Eds.), *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice* (pp. 63-82). Amsterdam, Netherlands: Elsevier. doi:10.1016/B978-0-12-416048-4.00005-1

This chapter introduces culturally sensitive care in telemental health practice. Individual culture often defines how patients express and interpret their personal health symptoms and, ultimately, the health care choices they make. For example, some traditional Chinese American and American Indian cultures rely on the healing powers of traditional medicines, herbs, and rituals instead of, or as an adjunct to, the use of modern Westernized medicine. Because of this, there has been a growing awareness of the interplay of culture and healing among many service providers who wish to practice culturally appropriate care. While there is not a universal definition for what constitutes such treatment, telemental health experts have identified culturally appropriate care as “the delivery of mental health services that are guided by the cultural concerns of all racial or ethnic groups, including psychosocial background, typical styles of symptom presentation, immigration histories, and other cultural traditions, beliefs, and values.”

Carroll, M., & Horton, M. B. (2013). Telehealth and Indian healthcare: Moving to scale and sustainability. *Telemedicine and e-Health*, 19(5), 377-379. doi:10.1089/tmj.2012.0296

Telehealth innovation has brought important improvements in access to quality healthcare for American Indian and Alaska Native communities. Despite these improvements, substantive work remains before telehealth capability can be more available and sustainable across Indian healthcare. Some of this work will rely on system change guided by new care model development. Such care model development depends on expansion of telehealth reimbursement. The U.S. Indian healthcare system is an ideal framework for implementing and evaluating large-scale change in U.S. telehealth reimbursement policy.



Crooks, C. V., Lapp, A., Auger, M., van der Woerd, K., Snowshoe, A., Rogers B. J., . . . Caron, C. (2018). A feasibility trial of Mental Health First Aid First Nations: Acceptability, cultural adaptation, and preliminary outcomes. *American Journal of Community Psychology*, 61(3-4), 459-471. doi:10.1002/ajcp.12241

The Mental Health First Aid First Nations course was adapted from Mental Health First Aid Basic to create a community-based, culturally safe and relevant approach to promoting mental health literacy in First Nations contexts. Over 2.5 days, the course aims to build community capacity by teaching individuals to recognize and respond to mental health crises. This feasibility trial utilized mixed methods to evaluate the acceptability, cultural adaptation, and preliminary effectiveness of MHFAFN. Our approach was grounded in community-based participatory research principles, emphasizing relationship-driven procedures to collecting data and choice for how participants shared their voices. Data included participant interviews (n = 89), and surveys (n = 91) from 10 groups in four provinces. Surveys contained open-ended questions, retrospective pre-post ratings, and a scenario. We utilized data from nine facilitator interviews and 24 facilitator implementation surveys. The different lines of evidence converged to highlight strong acceptability, mixed reactions to the cultural adaptation, and gains in participants' knowledge, mental health first aid skill application, awareness, and self-efficacy, and reductions in stigma beliefs. Beyond promoting individual gains, the course served as a community-wide prevention approach by situating mental health in a colonial context and highlighting local resources and cultural strengths for promoting mental well-being.

DeJong, J. A., & Holder, S. R. (2006). Indian boarding schools and the therapeutic residential model project. *American Indian and Alaska Native Mental Health Research*, 13(2), 1-16. doi:10.5820/aian.1302.2006.1

The BIA (Bureau of Indian Affairs) has historically been charged with the responsibility of providing educational opportunities to American Indian children. BIA boarding schools are often the last resort for American Indian children who have experienced psychological trauma, grief, abuse, neglect, or school failure. This need was addressed by Public Law 103-382 which authorized the creation of the Therapeutic Residential Model (TRM) program. The Office of Indian Education Programs was charged with implementing this legislation. The legislation mandated evaluation. An independent external evaluator was contracted to conduct a cross-site evaluation. Methodology used in the evaluation was patterned after a multifaceted approach used in assessments of prevention demonstration projects. The cross-site evaluation included gathering of quantitative data using spring and fall collection of paper-and-pencil student surveys providing yearly baseline and outcome data; analysis of information contained in school and academy records such as academic performance measures, retention-related information, and student conduct violations; staff questionnaires collected at the beginning and end of each school year; and records of services received by students. The collected data indicate the majority of students coming into these TRM programs have had experiences which place them at risk and are in need of therapeutic services to address academic and mental health needs.



Doarn, C. R., Shore, J., Ferguson, S., Jordan, P. J., Saiki, S., & Poropatich, R. K. (2012). Challenges, solutions, and best practices in telemental health service delivery across the Pacific Rim—A summary. *Telemedicine and e-Health, 18*(8), 654-660.

doi:10.1089/tmj.2012.0123

The Telemedicine and Advanced Technology Research Center, U.S. Army Medical Research and Materiel Command, in conjunction with the American Telemedicine Association's Annual Mid-Year Meeting, conducted a 1-day workshop on how maturing and emerging processes and applications in the field of telemental health (TMH) can be expanded to enhance access to behavioral health services in the Pacific Rim. The purpose of the workshop was to bring together experts in the field of TMH from the military, federal agencies, academia, and regional healthcare organizations serving populations in the Pacific Rim. The workshop reviewed current technologies and systems to better understand their current and potential applications to regional challenges, including the Department of Defense and other federal organizations. The meeting was attended by approximately 100 participants, representing military, government, academia, healthcare centers, and tribal organizations. It was organized into four sessions focusing on the following topic areas: (1) Remote Screening and Assessment; (2) Post-Deployment Adjustment Mental Health Treatment; (3) Suicide Prevention and Management; and (4) Delivery of Training, Education, and Mental Health Work Force Development. The meeting's goal was to discuss challenges, gaps, and collaborative opportunities in this area to enhance existing or create new opportunities for collaborations in the delivery of TMH services to the populations of the Pacific Rim. A set of recommendations for collaboration are presented.

Gibson, K., O'Donnell, S., Coulson, H., & Kakepetum-Schultz, T. (2011). Mental health professionals' perspectives of telemental health with remote and rural First Nations communities. *Journal of Telemedicine and Telecare, 17*(5), 263-267.

doi:10.1258/jtt.2011.101011

We conducted an online survey and interviews amongst mental health workers in Canada who reported experience in working with rural and remote First Nations (although not necessarily telemental health). Sixty-three respondents (of the 164) to the online survey reported experience in working with clients in remote and rural First Nations. Only 16 of the online survey respondents with remote and rural First Nations experience reported having received training in videoconferencing use. When asked how frequently they used videoconferencing with clients, 51% reported never using it, 19% used it once every few months and 10% reported using it a few times a month. Approximately 50% of participants reported finding it useful. Approximately 38% found the technology easy or very easy to use, and 15% found it very difficult. Individual in-depth interviews were also conducted with professionals who had First Nations telemental health experience specifically (n = 5). A quantitative data analysis was used to explore their perceptions of usefulness and ease of use of telemental health, as well as the relationships among these constructs. Advantages, disadvantages and challenges in using the technology were identified from the qualitative data. Promising



ways forward include incorporating traditional practices and the Seven Teachings into telemental health services.

Gibson, K. L., Coulson, H., Miles, R., Kakekakekung, C., Daniels, E., & O'Donnell, S. (2011). Conversations on telemental health: Listening to remote and rural First Nations communities. *Rural and Remote Health, 11(2)*, 1656.

Introduction: Telemental health involves technologies such as videoconferencing to deliver mental health services and education, and to connect individuals and communities for healing and health. In remote and rural First Nations communities there are often challenges to obtaining mental healthcare in the community and to working with external mental health workers. Telemental health is a service approach and tool that can address some of these challenges and potentially support First Nations communities in their goal of improving mental health and wellbeing. Community members' perspectives on the usefulness and appropriateness of telemental health can greatly influence the level of engagement with the service. It appears that no research or literature exists on First Nations community members' perspectives on telemental health, or even on community perspectives on the broader area of technologies for mental health services. Therefore, this article explores the perspectives on telemental health of community members living in two rural and remote First Nations communities in Ontario, Canada. **Methods:** This study was part of the VideoCom project, a collaborative research project exploring how remote and rural First Nations communities are using ICTs. This current exploration was conducted with the support of Keewaytinook Okimakanak (KO), our partner in Northwestern Ontario. With the full collaboration of the communities' leadership, a team involving KO staff and VideoCom researchers visited the two communities in the spring of 2010. Using a participatory research design, we interviewed 59 community members, asking about their experiences with and thoughts on using technologies and their attitudes toward telemental health, specifically. A thematic analysis of this qualitative data and a descriptive quantitative analysis of the information revealed the diversity of attitudes among community members. Finally, based on a discussion with the community telehealth staff, a 'ways forward' section was proposed as a way to begin addressing certain issues that were raised by community members. **Results:** This article explores the continuum of community members' perspectives that range from interest and enthusiasm to hesitancy and concern. One participant reported personal experience with using telemental health and found the approach helpful in increasing her comfort in the therapeutic situation. In addition, concerns relating to appropriateness and safety were voiced. A variety of advantages (e.g., facilitation of disclosure, increased access to services, usefulness) and disadvantages or concerns (e.g., interference with capacity building, concerns about privacy) are reported and discussed. Following a coding procedure, a descriptive quantitative analysis demonstrated that 47% of the participants were categorized as having a positive response toward telemental health, 32% as having a negative response, and 21% as being neutral or undecided. **Conclusions:** Valuing Indigenous knowledge can help us understand community members' experiences of and concerns with telemental health and inform more successful and appropriate initiatives. With the



invaluable support of the KO Telemedicine co-authors, we offer ways forward to address concerns identified by the community members. Most importantly, any ways forward for community telemental health initiatives need to be community driven and community led.

Goodkind, J. R., Lanoue, M. D., & Milford, J. (2010). Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth. *Journal of Clinical Child and Adolescent Psychology*, 39(6), 858-872. doi:10.1080/15374416.2010.517166

American Indian adolescents experience higher rates of suicide and psychological distress than the overall U.S. adolescent population, and research suggests that these disparities are related to higher rates of violence and trauma exposure. Despite elevated risk, there is limited empirical information to guide culturally appropriate treatment of trauma and related symptoms. We report a pilot study of an adaptation to the Cognitive Behavioral Intervention for Trauma in Schools in a sample of 24 American Indian adolescents. Participants experienced significant decreases in anxiety and posttraumatic stress disorder symptoms, and avoidant coping strategies, as well as a marginally significant decrease in depression symptoms. Improvements in anxiety and depression were maintained 6 months postintervention; improvements in posttraumatic stress disorder and avoidant coping strategies were not.

Hamilton, S. M., & Rolf, K. A. (2010). Suicide in adolescent American Indians: Preventative social work programs. *Child and Adolescent Social Work Journal*, 27(4), 283-290. doi:10.1007/s10560-010-0204-y

Suicide is a leading social problem among the adolescent American Indian community. This literature review examines the demographics of American Indian adolescents who attempt suicide, along with the effects it has on the entire family/community. This paper describes various programs used to address individuals, while correlating them to specific use within the American Indian population. The authors look at the effectiveness of the Adolescent Suicide Prevention Project, American Indian Life Skills Development Curriculum, and Zuni Life Skills Development, along with the drawbacks associated with the implementation of each program. The importance of incorporating culturally specific programs and addressing the issue at a community level in an attempt to enhance the well-being of at-risk American Indian Adolescents is emphasized.

Harris, E., McFarland, J., Siebold, W., Aguilar, R., & Sarmiento, A. (2007). Universal prevention program outcomes: Safe Schools Healthy Students in a rural, multicultural setting. *Journal of School Violence*, 6(2), 75-91. doi:10.1300/J202v06n02_05

The Idaho Consortium for Safe Schools Healthy Students consists of three school districts in rural North Central Idaho and the Nez Perce Tribe's Students for Success Program. Universal prevention programs implemented in the elementary schools include Second Step and the middle schools implemented the Life Skills program. Each of the three districts serves a multicultural population, including Native American and Caucasian youth. Outcomes documented through school-wide surveys during the second year of implementation include reduced fighting at school for all grade levels and decreased absenteeism. Additional outcomes include a decrease in the percentage of



youth who report destruction of others' property at all elementary schools and two out of the three district middle and high schools. The discussion focuses on the challenges of implementing ethnic-specific programming in a multicultural setting, and the need for further investigation into potential outcomes related to indicated prevention programming provided through Idaho Consortium schools.

Hilty, D. M., Feliberti, J., Evangelatos, G., Lu, F. G., & Lim, R. F. (2019). Competent cultural telebehavioral healthcare to rural diverse populations: Administration, evaluation, and financing. *Journal of Technology in Behavioral Science*, 4(3), 186-200. doi:10.1007/s41347-018-0076-0

Medical healthcare settings have begun to use telepsychiatry and telebehavioral health to improve access to evidence-based care for culturally diverse patients. This paper is a companion paper to another, which focused on components of culturally competent clinical care, fundamental approaches, and linkage of outcomes to competencies. An administrative foundation is needed to address workforce, program evaluation, and short- and long-term financing and reimbursement issues. This paper focuses on three questions, particularly related to medical settings: (1) What administrative approaches facilitate culturally competent care via telebehavioral health? (2) What outcomes should be prioritized for program evaluation? (3) What financing and reimbursement approaches help to overcome/prevent obstacles/barriers and promote sustainability? Administrators need an approach to evaluation, interprofessional/disciplinary teams, stepped/comparable models of care, and telebehavioral health to leverage expertise. Clinicians and team members need integrated cultural and telebehavioral health skills and all members of a clinic/system need to support diversity by reducing stigmatization, facilitating language access and flexibly adapting practices. On one hand, telehealth and culturally competent care are just part of regular services, but on the other hand, few accommodations are made for these in short- and long-term financing and reimbursement streams. Building a viable system and sustaining requires prevention/management of many barriers/obstacles. Populations need culturally competent care and telebehavioral access. More quantitative/qualitative research/evaluation is suggested to improve the approach and outcomes.

Husted, J., Johnson, T., & Redwing, L. (1995). Multi-dimensional adolescent treatment with American Indians. *American Indian and Alaska Native Mental Health Research*, 6(3), 23-30. doi:10.5820/aian.0603.1995.23

Conducted a 2-yr follow-up study of a treatment program for American Indian adolescents, using data from 290 Ss (aged 11–18 yrs; 171 completers). The program was designed to provide consistency in behavioral and attitudinal expectations and consequences, as well as nurturing counseling experiences. The program had 4 levels representing increasing degrees of freedom and responsibility. Chi-square analysis showed no difference between Ss who completed the program and those who dropped out in terms of age, time in treatment program, gender, and type of family unit. Ss who completed the program were significantly more likely to remain in school and to progress academically. There was no difference between groups in number of Ss with legal



problems. When the groups were combined, the total number of adolescents experiencing legal problems declined from 86 before to 56 after treatment.

Kruse, C. S., Bouffard, S., Dougherty, M., & Parro, J. S. (2016). Telemedicine use in rural Native American communities in the era of the ACA: A systematic literature review. *Journal of Medical Systems, 40*(6), 145-145. doi:10.1007/s10916-016-0503-8

Native American communities face serious health disparities and, living in rural areas, often lack regular access to healthcare services as compared to other Americans. Since the early 1970s, telecommunication technology has been explored as a means to address the cost and quality of, as well as access to, healthcare on rural reservations. This systematic review seeks to explore the use of telemedicine in rural Native American communities using the framework of cost, quality, and access as promulgated by the Affordable Care Act of 2010 and urge additional legislation to increase its use in this vulnerable population. As a systematic literature review, this study analyzes 15 peer-reviewed articles from four databases using the themes of cost, quality, and access. The theme of access was referenced most frequently in the reviewed literature, indicating that access to healthcare may be the biggest obstacle facing widespread adoption of telemedicine programs on rural Native American reservations. The use of telemedicine mitigates the costs of healthcare, which impede access to high-quality care delivery and, in some cases, deters prospective patients from accessing healthcare at all. Telemedicine offers rural Native American communities a means of accessing healthcare without incurring high costs. With attention to reimbursement policies, educational services, technological infrastructure, and culturally competent care, telemedicine has the potential to decrease costs, increase quality, and increase access to healthcare for rural Native American patients. While challenges facing the implementation of telemedicine programs exist, there is great potential for it to improve healthcare delivery in rural Native American communities. Public policy that increases funding for programs that help to expand access to healthcare for Native Americans will improve outcomes because of the increase in access.

Le, T. N., & Gobert, J. M. (2015). Translating and implementing a mindfulness-based youth suicide prevention intervention in a Native American community. *Journal of Child and Family Studies, 24*(1), 12-23. doi:10.1007/s10826-013-9809-z

The present study is a feasibility study, aimed at investigating whether a mindfulness-based prevention intervention can be translated and implemented in a Native American youth population. Guided by the adaptation process model, a mindfulness youth suicide prevention intervention was developed and implemented in a Native American school. One group of eight youth, ages 15-20, participated in a 9-week pilot of the intervention. Results of the mixed-methods process and outcome evaluation suggest that the intervention is acceptable to Native American youth, with positive indications in terms of better self-regulation, less mind wandering, and decreased suicidal thoughts. It became clearly evident that a collaborative and Indigenous research framework is both required and necessary to ensure feasibility and sustainability of mindfulness-based interventions.



Listug-Lunde, L., Vogeltanz-Holm, N., & Collins, J. (2013). A cognitive-behavioral treatment for depression in rural American Indian middle school students. *American Indian and Alaska Native Mental Health Research, 20*(1), 16-34. doi:10.5820/aian.2001.2013.16

Rural American Indian (AI) middle school students with depressive symptoms who participated in a culturally modified version of the Adolescent Coping with Depression (CWD-A) course (n = 8) reported significant improvement in depressive symptoms at post-intervention and at 3-month follow-up. There was also a nonsignificant but clinically relevant decrease in participants' anxiety symptoms. Students reported satisfaction with the intervention, and it was potentially more cost-effective and less stigmatizing than the individualized treatment-as-usual interventions to which it was compared. These results suggest the CWD-A is a promising approach for reducing depressive and anxiety symptoms in rural AI students and should be further evaluated with a larger sample of students.

McIntosh, K., Moniz, C., Craft, C. B., Golby, R., & Steinwand-Deschambeault, T. (2014). Implementing school-wide positive behavioural interventions and supports to better meet the needs of Indigenous students. *Canadian Journal of School Psychology, 29*(3), 236-257. doi:10.1177/0829573514542217

This article examines the need for and importance of culturally responsive behaviour support for Indigenous students. Many of the educational challenges currently faced by Indigenous students can be explained by cultural disconnect and a mismatch between school expectations and cultural values. Principles of Indigenous approaches to behaviour support are described and compared with school-wide positive behavioural interventions and supports (PBIS), a framework for building a positive school culture that shows promise in relation to culturally responsive practice. The authors provide a brief overview of PBIS and adaptations of this practice to meet the needs of Indigenous students. A descriptive case study of PBIS implementation in a high school in the Northwest Territories provides an example of culturally responsive implementation of PBIS.

McMahon, T. R., Kenyon, D. B., & Carter, J. S. (2013). “My culture, my family, my school, me”: Identifying strengths and challenges in the lives and communities of American Indian youth. *Journal of Child and Family Studies, 22*(5), 694-706. doi:10.1007/s10826-012-9623-z

Historically, the majority of research with American Indian (AI) youth and communities has focused on vulnerabilities, problems, and needs rather than resilience, strengths, and assets. Adding to the limited research which has examined AI youth and communities using the strengths perspective, we examined community assets, personal strengths, community challenges, and personal hardships as perceived by reservation-based, Northern Plains AI youth via open-ended survey questions. The present study was conducted during the spring and fall of 2009 at a tribal school in the Northern Plains (N = 95; n = 37 males; n = 58 females; aged 14.4-20.95 years; M = 17.3, SD = 1.47 years). The majority of youth self-identified their ethnic background as solely AI (85.3 %),



with small percentages reporting additional ethnic backgrounds. Analyses revealed that the people in their lives, especially their families, are significant sources of strength for AI youth. Findings also indicated that AI youth have a positive orientation toward themselves and their communities, which was evidenced by the fact that the youth identified more strengths than challenges in their lives. Somewhat unexpectedly, when asked what aspects of their lives and communities they would most like to change, a significant number of the youth identified they wanted to change “nothing” about their personal lives or their communities. Reasons for these responses are explored.

Monthuy-Blanc, J., Bouchard, S., Maïano, C., & Séguin, M. (2013). Factors influencing mental health providers’ intention to use telepsychotherapy in First Nations communities. *Transcultural Psychiatry*, 50(2), 323-343. doi:10.1177/1363461513487665

Telemental health is the use of information and communications technologies and broadband networks to deliver mental health services and support wellness. Although numerous studies have demonstrated the efficiency and utility of telemental health, certain barriers may impede its implementation, including the attitudes of mental health service providers. The current study draws on the technology acceptance model (TAM) to understand the role of mental health service providers’ attitudes and perceptions of telemental health (psychotherapy delivered via videoconferencing) on their intention to use this technology with their patients. A sample of 205 broadly defined mental health service providers working on 32 First Nations reserves in the province of Quebec completed the questionnaire adapted to assess TAM for telepsychotherapy. Confirmatory factor analysis and structural equation modeling provided evidence for the factor validity and reliability of the TAM in this sample. The key predictor of the intention to use telepsychotherapy was not mental health providers’ attitude toward telepsychotherapy, nor how much they expected this service to be complicated to use, but essentially how useful they expect it to be for their First Nations patients. If telemental health via videoconferencing is to be implemented in First Nations communities, it is essential to thoroughly demonstrate its utility to mental health providers. Perceived usefulness will have a positive impact on attitudes toward this technology, and perceived ease of use will positively influence perceived usefulness. Cultural issues specific to the populations receiving telemental health services may be more efficiently addressed from the angle of perceived usefulness.

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. doi:10.1016/j.jbtep.2008.07.006

This study examines a pilot school-based treatment program for American Indian adolescents residing on a reservation who presented with symptoms of Posttraumatic Stress Disorder (PTSD) and symptoms of depression. This is the first study directed at treating American Indian children with trauma; seven case studies demonstrate our findings that a manualized cognitive behavior therapy intervention delivered in group format for 10 weeks has potential for helping some children who experience PTSD



symptoms and depression. The findings generally replicate previous research conducted with groups of non-Indian adolescents in urban settings. PTSD and depressive symptoms decreased for three of the four students who completed treatment. Directions for future research include the need to understand and control attrition and to address cultural influences, including making adaptations in the cognitive behavioral formulations and techniques regarding feelings as operant behaviors. Results contribute to knowledge of feasibility and acceptability of cultural adaptations of CBT for trauma in an under-served population.

Morsette, A., van den Pol, R., Schuldberg, D., Swaney, G., & Stolle, D. (2012). Cognitive behavioral treatment for trauma symptoms in American Indian youth: Preliminary findings and issues in evidence-based practice and reservation culture. *Advances in School Mental Health Promotion, 5*(1), 51-62. doi:10.1080/1754730X.2012.664865

This study reports on the use of Cognitive Behavioral Intervention for Trauma in Schools (CBITS), an evidence-based practice, with 43 students in six schools on three American Indian reservation communities. CBITS was helpful in treating the majority of American Indian children and adolescents who were experiencing symptoms of post-traumatic stress disorder and depression. Using a limited quasi-experimental design, on a measure of traumatic stress, there was symptom reduction with the passage of time; however, symptoms reduced more substantially with treatment. Local cultural experts, that is, Tribal Elders, were invited to provide traditional cultural activities and teachings in the introductory lesson and at graduation. A 3-year follow-up involving school counselors reported on acceptability and additional impacts of the program. They expressed that treating trauma was a priority for their students, CBITS was perceived as an advantageous approach, and counselors said they would use it in the future. Further, counselors observed positive results outside of the treatment setting, and integrating traditional cultural activities was perceived favorably. We discuss some of the issues surrounding attempts to evaluate the nature and contribution of traditional American Indian cultural activities to evidence-based trauma treatment.

Nelson, D., Hewell, V., Roberts, L., Kersey, E., & Avey, J. (2012). Telebehavioral health delivery of clinical supervision trainings in rural Alaska: An emerging best practices model for rural practitioners. *Journal of Rural Mental Health, 36*(2), 10-15. doi:10.1037/h0095810

The purpose of this paper is to advance knowledge about emerging best practices in telebehavioral health to train professionals in the field given the geographical remoteness and/or place bound limitations many clinical supervisors find themselves practicing within. One of the most common telebehavioral health interactions occurs between providers in the realm of clinically relevant client casework. The Alaska Rural Behavioral Health Training Academy (ARBHTA) has addressed this area of patient care by providing education and training opportunities regarding clinical supervision to workers in remote locations via teleconferencing, web-based platform for document sharing, and life size video conferencing. These trainings serve to not only provide education about clinical supervision, but also to serve as a catalyst for linking isolated



providers with others in the state. Thus far we have been successful in attracting mental health professionals to participate in these trainings and have accumulated a list of emerging best practices for providing such trainings. We are also beginning to address the challenges associated with the distance learning format that transcends to the use of telebehavioral health in providing and receiving clinical supervision. This paper aims to provide a compilation of emerging best practices in training providers via telebehavioral health that are applicable to rural Alaska. This paper will also highlight the importance of “cultural attunement” when working with rural Alaskan villages and mental health workers.

Robinson-Zañartu, C., Butler-Byrd, N., Cook-Morales, V., Dauphinais, P., Charley, E., & Bonner, B. (2011). School psychologists working with Native American youth: Training, competence, and needs. *Contemporary School Psychology, 15*(1), 103-115. doi:10.1007/BF03340967

Despite growing emphases on multicultural competence, Native American youth remain tremendously underserved by schools: low achievement, high dropout rates, and over-identification for special education persist. The authors analyzed responses of 403 school psychologists to a national survey regarding their competence gained in training, in current practice, and that needed for effective work with Native Americans. Respondents reported significant under-preparation in training and inadequate preparation for competent practice. Both ethnicity and length of experience with the population yielded significant differences in perceived levels of competence.

Salvador, J., Goodkind, J., & Ewing, S. F. (2016). Perceptions and use of community- and school-based behavioral health services among urban American Indian/Alaska Native youth and families. *American Indian and Alaska Native Mental Health Research, 23*(3), 221-247. doi:10.5820/aian.2303.2016.221

Understanding youths’ awareness and use of behavioral health services is important for improving services and engagement. Interviews and focus groups were conducted with students, parents, and teachers/staff in an urban area to understand awareness and use of a school’s Native-tailored and -staffed school-based behavioral health center (NT-BHC) and community-based services. Results showed overwhelmingly positive responses regarding NT-BHC staff and services, with concerns focused on too few staff and services, and on privacy and confidentiality, as well as important differences in awareness and use of behavioral health services among youth, parents, and teachers/staff, valuable for improving engagement with and services for AI/AN youth.

Senate bill uses technology to help Indian youth. *Federal Assistance Monitor, 6*(10), 7-8.

The article reports on the approval of legislation by the U.S. Senate which allows demonstration grants to promote the use of technology in helping Indian youth with mental health problems in 2006. An overview of the Indian Youth Telemental Health Demonstration Project is presented. The article also offers information on eligibility requirements for the project.



Sidhu, S. S., Fore, C., Shore, J. H., & Tansey, E. (2017). Telemental health delivery for rural Native American populations in the United States. In H. Jefee-Bahloul, A. Barkil-Oteo, & E. F. Augusterfer (Eds.), *Telemental health in resource-limited global settings* (pp. 161-179). New York, NY: Oxford University Press. doi:10.1093/med/9780190622725.003.0011

Despite suffering huge health disparities, Native Americans are a resilient and pragmatic people. Telemental health is a viable treatment model for delivering quality mental health care to Native American communities where the burden of mental health conditions and difficulty accessing care continue. There is evidence to suggest that Native American groups find telemental health to be an acceptable form of treatment with good efficacy. While many barriers to the use of telemental health in Native communities exist, there are simultaneously many facilitators of this treatment model. Future directions include addressing these barriers, improving collaboration with Native communities, ensuring telemental health remains financially viable, and using technology to expand the reach of this treatment modality.

Spargo, G., Karr, A., & Turvey, C. L. (2013). Technology options for the provision of mental health care through videoteleconferencing. In K. Myers & C. L. Turvey (Eds.), *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice* (pp. 135-151). Amsterdam, Netherlands: Elsevier. doi:10.1016/B978-0-12-416048-4.00008-7

Videoteleconferencing (VTC) has long been recognized as a staple technology in the telehealth community. In the past, VTC was limited to specific networks, locations, and/or computers. Today, health care providers are increasingly comfortable with VTC and are moving toward anytime, anywhere VTC availability. Demands are being placed on organizations to offer VTC to their providers, patients, and partners with reliable, easy-to-use video capabilities. Manufacturers have responded by creating a variety of VTC software applications that support real-time audiovisual communications and that operate on personal computers. These new technologies are requiring organizations to assess needs, product capabilities, and risks posed by new venues for communication in health care. As the concepts and operations involving VTC are the same across all health care applications, this chapter utilizes the broad and inclusive term telehealth to designate uses of VTC in medical, mental health, and education applications. This chapter explains the concepts and terms behind VTC solutions with emphasis on desktop, or computer-based, solutions. It includes discussions on various types of desktop VTC products, bandwidth, cloud computing, audio technology, privacy concerns, and the costs and benefits of certain videoconferencing options. It also discusses the need for backup technologies and protocols in the event of VTC failure. In short, after reading this chapter, health care providers of modest technological knowledge and skills should be able to make an informed choice about which types of VTC equipment and programs will best serve them and their patients, how to use this equipment as efficiently and effectively as possible, how to protect the privacy of their patients, and how to ensure continuity of care if the technology fails.



Tingey, L., Larzelere-Hinton, F., Goklish, N., Ingalls, A., Craft, T., Sprengeler, F., . . . Barlow, A. (2016). Entrepreneurship education: A strength-based approach to substance use and suicide prevention for American Indian adolescents. *American Indian and Alaska Native Mental Health Research, 23*(3), 248-270. doi:10.5820/aian.2303.2016.248

American Indian (AI) adolescents suffer the largest disparities in substance use and suicide. Predominating prevention models focus primarily on risk and utilize deficit-based approaches. The fields of substance use and suicide prevention research urge for positive youth development frameworks that are strength based and target change at individual and community levels. Entrepreneurship education is an innovative approach that reflects the gap in available programs. This paper describes the development and evaluation of a youth entrepreneurship education program in partnership with one AI community. We detail the curriculum, process evaluation results, and the randomized controlled trial evaluating its efficacy for increasing protective factors. Lessons learned may be applicable to other AI communities.

Turvey, C., Coleman, M., Dennison, O., Drude, K., Goldenson, M., Hirsch, P., . . . Bernard, J. (2013). ATA practice guidelines for video-based online mental health services. *Telemedicine and e-Health, 19*(9), 722-730. doi:10.1089/tmj.2013.9989

The article discusses the American Telemedicine Association's practice guidelines for video-based online mental health services. It mentions that the guidelines cover the provision of mental health services provided by a licensed healthcare professional using internet-based videoconferencing software programs. The practice guidelines include clinical, technological, and administrative guidelines.

Usera, J. J. (2017). The efficacy of an American Indian culturally-based risk prevention program for upper elementary school youth residing on the Northern Plains reservations. *Journal of Primary Prevention, 38*(1-2), 175-194. doi:10.1007/s10935-016-0462-3

Culturally-based risk behavior prevention programs for American Indian elementary school children are sparse. Thus, a group of American Indian educators collaborated in the creation of a program that helps children make healthy decisions based on their cultural and traditional value system. In this paper the effectiveness of Lakota Circles of Hope (LCH), an elementary school culturally based prevention program was studied and evaluated. Three cohorts of fourth and fifth graders participated in a mixed methods quasi-experimental evaluative research design that included focus groups and surveys prior to and following the intervention. Five research questions regarding the program's impact on students' self-esteem and self-efficacy, Lakota identity, communication, conflict resolution and risk behaviors were addressed in this study. Participants were compared to non-participants in three American Indian reservation school sites. Educators completed a survey to record their observations and feedback regarding the implementation of the program within their respective school sites. The study provides preliminary evidence that, when delivered with fidelity, LCH contributes to statistically significant changes in risk behaviors, Lakota identity, respect for others, and adult and parent communication. A two-way multivariate analysis of variance with post hoc analysis of data collected from the LCH participants (N = 1392) were used to



substantiate a significant increase in respect for others and a decrease in risk behaviors which included alcohol, tobacco, and substance use at the 0.10 alpha level. Significant positive improvements in parent and adult communication and an increased Lakota identity at the 0.01 alpha level were obtained. There were no significant differences in self-esteem and conflict resolution from pre to post intervention and in comparison with non-LCH participating students.

Yilmaz, S. K., Horn, B. P., Fore, C., & Bonham, C. A. (2019). An economic cost analysis of an expanding, multi-state behavioural telehealth intervention. *Journal of Telemedicine and Telecare*, 25(6), 353-364. doi:10.1177/1357633X18774181

Introduction: In this paper the economic costs associated with a growing, multi-state telepsychiatry intervention serving rural American Indian/Alaska Native populations were compared to costs of travelling to provide/receive in-person treatment. **Methods:** Telepsychiatry costs were calculated using administrative, information-technology, equipment and technology components, and were compared to travel cost models. Both a patient travel and a psychiatrist travel model were estimated utilising ArcGIS software and unit costs gathered from literature and government sources. Cost structure and sensitivity analysis was also calculated by varying modeling parameters and assumptions. **Results and Discussion:** It is estimated that per-session costs were \$93.90, \$183.34, and \$268.23 for telemedicine, provider-travel, and patient-travel, respectively. Restricting the analysis to satellite locations with a larger number of visits reduced telemedicine per-patient encounter costs (50 or more visits: \$83.52; 100 or more visits: \$80.41; and 150 or more visits: \$76.25). The estimated cost efficiencies of telemedicine were more evident for highly rural communities. Finally, we found that a multi-state centre was cheaper than each state operating independently. **Conclusions:** Consistent with previous research, this study provides additional evidence of the economic efficiency associated with telemedicine interventions for rural American Indian/Alaska Native populations. Our results suggest that there are economies of scale in providing behavioural telemedicine and that bigger, multi-state telemedicine centres have lower overall costs compared to smaller, state-level centres. Additionally, results suggest that telemedicine structures with a higher number of per-satellite patient encounters have lower costs, and telemedicine centres delivering care to highly rural populations produce greater economic benefits.



ADDITIONAL LINKS OF INTEREST

- [*To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults \(SAMHSA\)*](#)
- [Mental Health First Aid Training \(Boys & Girls Clubs of America Native Services, in partnership with IHS\)](#)
- [Mental Health First Aid Training \(IHS\)](#)
- [Mental Health First Aid Training \(Southern Plains Tribal Health Board\)](#)
- [Tribal Behavioral Health Hosts ‘Mental Health First Aid’ Training \(*Tribal Tribune*\)](#)
- [Indian Health Service Mental Health First Aid Training—Minneapolis](#)
- [Cherokee Nation Provides Mental Health First Aid Training \(*Native News Online*\)](#)
- [Mental Health First Aid First Nations \(Mental Health First Aid in Canada\)](#)
- [Project AWARE \(SAMHSA grant announcements/descriptions\)](#)
- [Project AWARE recipients \(press release\): Saginaw Chippewa Indian Tribe, Tribal Education Department, Mt. Pleasant Public Schools, and Shepherd Public Schools](#)
- [Utah Project Aware](#)
- [Project Venture](#)
- [*Supporting the Development of Young Children in American Indian and Alaska Native Communities Who Are Affected by Alcohol and Substance Exposure \(HHS Policy Statement\)*](#)
- [Implementation Considerations for Tribal Telehealth Programs \(Rural Health Information Hub\)](#)
- [IHS Telebehavioral Health Center of Excellence](#)
- [*Step-By-Step Guide for Setting Up Telebehavioral Health Services \(IHS\)*](#)
- [Indian Health Service Launches Telehealth Program To Expand Health Care Access for Native Veterans \(IHS blog\)](#)