PERCEPTIONS AND USE OF COMMUNITY- AND SCHOOL-BASED BEHAVIORAL HEALTH SERVICES AMONG URBAN AMERICAN INDIAN/ALASKA NATIVE YOUTH AND FAMILIES

Julie Salvador, PhD, Jessica Goodkind, PhD, and Sarah Feldstein Ewing, PhD

Abstract: 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.

There are significant health disparities between American Indian and Alaska Native (AI/AN) populations and the general U.S. population, including, but not limited to, cardiovascular disease, tuberculosis, infectious diseases, diabetes, substance use disorders (SUD), homicide, and suicide (Grim, 2003; Holman et al., 2011; O'Connell, Rong, Wilson, Manson, & Acton, 2010). While much has been done to elucidate the existence of these disparities in health for AI/AN communities, more research is needed to understand the contributing factors and how to address them (Manson, 2000). Culturally appropriate and accessible services for AI/AN populations, including adolescents, still lag behind Western practices (Gone & Trimble, 2012). This disparity matters because AI/AN communities have stressed the need for behavioral health services that are culturally congruent (Gone & Trimble, 2012).

Regarding mental health, rates of suicide are higher for AI/AN youth versus all other youth (Centers for Disease Control and Prevention, 2013), and AI/AN youth are more likely to experience SUD and psychiatric disorders (Beals et al., 2002; Beals, Novins, Mitchell, Shore &

Manson, 2002). In addition, according to the Urban Indian Health Commission (UIHC, 2007), urban AI/AN populations face challenges, including high rates of poverty and depression, limited culturally appropriate health services, and ineligibility for or inability to utilize health services offered through the Indian Health Service or tribes.

Specifically, many AI/ANs, like those families and youth that are the focus of this study, live in urban areas, while many of the federally funded health care services are provided on reservations. Time constraints, transportation issues, cost of traveling, and distrust of government programs are some of the issues that AI/AN youth and families face in accessing behavioral health services (Kaiser Family Foundation, 2004). Furthermore, for AI/AN persons accessing services in urban clinics, Medicaid pays only part of the cost of service, which, with the high rates of poverty among many AI/ANs, creates additional barriers to receiving care (UIHC, 2007).

One place where urban AI/AN youth can access treatment without many of the above barriers is school. Schools are the major providers of mental health services for children (Burns et al., 1995; Costello et al., 1996; Leaf et al., 1996). In fact, 75% of children who receive mental health services receive this care through the education sector, with schools as the most common point of entry (Farmer, Burns, Phillips, Angold, & Costello, 2003). Providing mental health services within schools can also support improved school outcomes, as children whose emotional, behavioral, or social difficulties are not addressed have a reduced capacity to learn (Rones & Hoagwood, 2000) and are more likely to drop out of school (Kerns et al., 2011). Thus, making services accessible at schools may be key to successfully serving otherwise hard-to-reach urban AI/AN youth. The fact that school-based services increase access to and use of behavioral health services is a critical foundation from which additional and rigorous effectiveness and implementation research can lead to positive outcomes for youth.

Research has emphasized that, while basing health services in schools is an important step to ensure access for youth, it is not sufficient. For AI/AN youth, of equal importance is collaboration with AI/AN communities to support services that are culturally sensitive and meet the needs defined by the consumers and communities themselves (Ball & Pence, 1999; Sarche & Spicer, 2008). Researchers have examined many school-based interventions and programs developed for AI/AN youth (Brown & Summerbell, 2009; Caballero et al., 2003; May, Serna, Hurt, & DeBruyn, 2005; Sharma, 2006), including attitudes toward school-based health centers and reviews of existing programs (Guo, Wade, Pan, & Keller, 2010; Rones & Hoagwood, 2000). However, among these studies, there are almost no data on school-based centers that have been

tailored specifically for Native adolescents and operated by Native counselors/staff. Native tailoring and staffing may be an important combination for enhancing engagement, use, and successful outcomes for AI/AN youth.

Partnership approaches to research, such as the community-based participatory research (CBPR) approach (Wallerstein & Duran, 2008) used in this study, help place community perspectives and needs at the forefront of the research endeavor. This study also used a qualitative approach to help ensure that the views, opinions, and experiences of AI/AN youth and parents informed our understanding of how people perceive and use services, as well as how to tailor existing behavioral health services to fit the needs of this important and underserved population. Because qualitative methods focus on describing how people understand and give meaning to their experiences, they are different in key ways from quantitative methods. For instance, while quantitative researchers often apply random sampling techniques in order to conduct statistical analyses that will allow generalizations to be made about a population, qualitative research methods use non-random "purposeful" sampling where the aim is to select information-rich cases for in-depth study (Rice & Ezzy, 1999). Qualitative research, therefore, does not aim to generalize; rather it specifies and provides a view of meanings and interpretations of a small group of persons with shared experiences.

The current study follows in the footsteps of previous research with Indigenous communities that used a partnership model (Daley et al., 2010; Jernigan, 2010; Wallerstein & Duran, 2010) or qualitative research methods to better understand and improve current health services (Baldwin, Johnson, & Benally, 2009; Dickerson & Johnson, 2011; Leston, Jessen, & Simons, 2012). The existing research base indicates that comprehensive efforts are needed to improve the effectiveness of school-based services (Atkins, Hoagwood, Kutash, & Seidman, 2010), and more studies on effectiveness are needed (Kutash, Duchnowski, & Lynn, 2006). This study focused on awareness, utilization, and perceptions of a Native-tailored behavioral health center (NT-BHC) by urban AI/AN youth, a population for whom there has been limited clinical research and particularly high treatment need (West, Willians, Suzukovich, Strangeman, & Novins, 2012). This study used a qualitative CBPR approach to 1) learn about perceptions of the NT-BHC and 2) understand awareness and use of school- and community-based behavioral health services/supports, including the NT-BHC.

METHODS

The Community-based Participatory Research Partnership

This research project was developed in partnership with an NT-BHC implemented by mostly AI/AN staff in a Southwestern city and with the local university's Department of Psychiatry. The NT-BHC is located on a charter school campus that serves mainly AI/AN youth (referred to here as the Native American Charter School, or NACS). NACS had approximately 350 students in 6th through 12th grades from more than 37 tribal nations during the course of this study.

The NT-BHC focuses on providing behavioral health support to students, including case management, education, crisis intervention, individual and family counseling, group therapy, and referrals for medication management, as well as other, more general support services, such as providing bus passes to students to get to after-school jobs. However, the foundation and approach to services is what makes the center tailored for AI/AN youth and families. The NT-BHC is grounded in their traditions and in elements of traditional healing, and seeks to improve well-being by building upon each youth's personal strengths. Key elements of the center include Indigenous wellness promotion that is provided by and for the AI/AN community. Most staff members are AI/ANs who have trained under AI/AN mentors and clinical supervisors in AI/AN service agencies or with traditional cultural and spiritual leaders. Both the NACS and the NT-BHC use a wellness wheel that approaches students' health from a holistic perspective and is grounded in respect for Indigenous knowledge. The wheel is interactive and includes wellness goals in the following areas: 1) intellectual, 2) physical, 3) social/emotional, and 4) community/relationships. The NT-BHC also has a private space called the Bison room that is a culturally based area for all students, families, and even school staff to use for meditation and prayer honoring AI/AN traditions. It is a private room with pillows and items associated with AI/AN traditions and healing, including flute music, posters, sage, and eagle feathers, and also is used as a space for youth to sit alone quietly when they want to do so.

The CBPR partnership upon which this study is based started when clinical staff at the NT-BHC contacted the local university partner, wanting to learn about the aspects of the NT-BHC and other behavioral health services/supports noted earlier. The university had an existing relationship with the NT-BHC, having provided ongoing behavioral health-related consultation as the NT-BHC was developed; therefore, the partnership was a logical and important next step to help ensure the program was meeting the needs of youth and families. The university and

NACS partners held collaborative research team meetings and determined that interviews and focus groups would be the best methods for understanding these questions. All procedures were approved by the university Institutional Review Board. To provide confidentiality, the lead author, who was unknown to the youth and was not a member of the school or the NT-BHC staff, conducted interviews with youth who had used NT-BHC services. AI/AN students from the university were hired to conduct focus groups with youth to determine what services/supports they were aware of and might use in their school and in the larger community. Parents and teachers/staff participated in separate focus groups about these topics. Because the two qualitative methods followed distinct procedures, participant selection, data collection, analysis, and results, they are each described below in detail. Interviews are discussed first, followed by the focus groups. This description is followed by the overall discussion of findings from both the interviews and focus groups.

Interviews

Participants and Procedure

Between September 1, 2010 and January 31, 2011, 17 youth (9 female, 8 male; age range, 11-19 years) participated in one-on-one interviews (n = 17). This number is 10% of the 170 students who used NT-BHC services at the school that year. Youth received a $15 gift card for their participation.

Process, Measures and Data Collection

All middle and high school youth who used the NT-BHC during the September 2010-January 2011 timeframe (170 out of the total school population of 350) were asked by staff after their appointment if they would be interested in participating in a confidential interview to provide feedback about NT-BHC services. This qualitative sampling process is called criterion sampling (Rice & Ezzy, 1999). Youth were asked the following questions: “What did you like best about the services you received at the NT-BHC?” “What didn’t you like about the services you received?” and “What would you like to see changed or done differently to provide better services?” Youth were told that the interviews would be conducted by a researcher from outside the NT-BHC to encourage open feedback. Interested youth were asked to let NT-BHC staff know a good time to complete the interview to avoid conflict with classes (e.g., at lunch, after school, or during school hours with permission from a teacher). NT-BHC staff scheduled the interview times.

Youth ages 14 years and older provided informed, written consent. In the setting for this study, youth 14 and older are allowed to consent for behavioral health services without parental/legal guardian consent; therefore, the NT-BHC research team believed that asking for adult consent for these students to participate in research about their services might violate their privacy and possibly put them at risk. Self-consent for these youth was approved by the university IRB and is a common practice with studies presenting minimal risk to youth. Youth under the age of 14 years needed parental/legal guardian consent to participate.

The university researcher (and lead author) met the students at the NT-BHC in a private room to conduct the interviews. Interviews addressed the three questions of interest to the NT-BHC (see Table 1). The lead author, who is an intensively trained qualitative researcher with over 20 years of experience documenting interview and focus group responses, recorded interview responses in detailed notes on paper and reflected them back to participants to confirm accuracy and meaning.

Table 1
Interview Questions, Themes, and Examples (*N*=17)

1. What did you like best about the services you received at the NT-BHC?
2. What didn't you like about the services you received?[a]
3. What would you like to see changed or done differently to provide better services?

Supportive staff to listen:

- Liked that staff were supportive, had time for them, would listen to them when feeling down
- Staff described as cool, flexible, nice, open
- Hard when staff were not there (not enough staff), hard when you need to talk

A place to be alone:

- Liked the NT-BHC Bison Room, a place to be alone, to reflect

Confidentiality and privacy:

- Being checked up on at school:
  - Liked that staff gave notes in class, pulling youth out of class to talk
  - Did not like being pulled out of favorite class to go to NT-BHC[b]
  - Embarrassing to be checked up on
- Talking to parents
  - Liked that staff only told parents about serious issues
  - Sometimes told them things they did not need to know (e.g., cutting)

Initiation of services:

- Did not like being told by parent or school to go to the NT-BHC to talk to staff
- Did not like being pulled out of favorite class to go to NT-BHC[b]
- Embarrassing to be followed in the lunch line

Bigger space and more services:

- More counselors
- More programs (anger management, art, music, food/ drink, bus passes)

[a] Negative comments underlined. [b] Cross coded under two themes

Data Analysis

Responses for each of the three questions were coded to identify the main categories and themes. Given the brief interview responses, this process was done by hand by the lead author.

Interview Results

The interviews did not have a predetermined time limit, but youth tended to be brief and completed the interview in approximately 10-15 minutes. Interview themes and examples are presented in Table 1. The vast majority of the youth interviewed (n = 16) had positive things to say about the NT-BHC (one youth said that she had not used the NT-BHC enough to make a comment). These positive comments cut across three of the four themes listed in Table 1 (and listed here in italics). One interview theme was that the NT-BHC had *Supportive Staff to Listen* to the youth. Youth described the staff as flexible and "cool." The only negative issue around talking with staff was that sometimes a counselor was not available when youth wanted to talk. Wanting more staff and greater availability of staff was one of the main concerns of the youth. A second and related theme was that youth liked having *A Place to be Alone*. This opportunity was provided by the Bison room of the NT-BHC. Youth said that they liked this space because it gave them a place to be by themselves and think.

A third interview theme, *Confidentiality and Privacy*, had two sub-themes. One sub-theme related to <u>being checked up on at school</u> by NT-BHC staff. Some youth said they liked when staff checked on them. Examples included having a personal note delivered to them in class from the NT-BHC staff asking about how they were doing, or a note delivered to the teacher that called them out of class to come to the NT-BHC to talk. However, other youth said they did not like this practice or were embarrassed by it. These youth said they did not like to be pulled out of a favorite class or "followed" in the lunch line (this theme is also coded under a second theme regarding initiation of services). A second sub-theme under *Confidentiality and Privacy* was NT-BHC staff <u>talking to parents</u> about concerns with the youths' behavioral health. While some youth said that staff were very careful about keeping issues private and would only talk to parents if an issue was "serious," other youth said that staff told parents things that were not serious and should not have been reported. Specifically, one youth mentioned cutting behavior, but said it was not serious and should not have been reported to the parent. The reporting led to the youth being removed from the home for a period of time, which the youth said was upsetting. A fourth theme, *Initiation of Services* at the NT-BHC, included comments from youth who did not like being told to go to the NT-BHC by someone else, such as a parent or school staff member.

The final interview question asked youth for suggestions for improving services. This theme focused on wanting more of what the NT-BHC had to offer. Youth wanted a bigger space that was less "cramped" and wanted more counselors and services. In particular, youth mentioned wanting programs on anger management, and a space to do art or play music. They also wanted the NT-BHC to have food/drinks, or to allow students to bring them in. One youth suggested NT-BHC give bus passes to help students get to after-school and weekend jobs. (The youth understood that passes currently were given only to low-income students).

Focus Groups

Participants and Procedure

Four focus groups were conducted between September 2010 and March 2011. A total of 26 people participated in the focus groups. Six youth participated in a middle school focus group (4 male, 2 female) and six in a high school focus group (2 male, 4 female). All youth in the middle and high school focus groups were under the age of 18 years. Five parents (all female) and 9 teachers/staff (5 male, 4 female) also participated.

Data Collection

While the lead author was able to both conduct the brief interviews in a one-on-one format with youth and take detailed notes, the research team agreed that a separate facilitator would be needed for the focus groups so that the lead author could concentrate on documenting the responses. Responses were documented using word processing software on a computer for rapid note taking, active listening, and clarifying responses, and were reviewed with the facilitator directly after the focus group. The research team recruited two college-age AI/AN youth to facilitate the groups. They had experience working with youth and were trained by the lead author in focus group facilitation.

NACS students were invited to participate via fliers posted around the school and read aloud in class by teachers and during school-wide announcements. The fliers asked any interested youth to call the NT-BHC or stop by to pick up a consent or consent/assent form. The lead author completed the consent process, reviewed completed consent forms, and answered questions prior to starting each focus group. Parents were recruited during a school open house event via an information table, where NT-BHC staff provided fliers about the focus groups, as well as by announcements at parent-teacher association meetings over the course of 2 months. Teachers/staff were invited through fliers placed in their mailboxes at school and were asked to contact the NT-BHC to sign up. All participants received a $15 gift card for their time.

Focus group questions are listed in Table 2. All youth were asked the same questions. Some parent and teacher/staff questions were slightly modified to ask about behaviors of the youth (rather than their own behaviors) and relevant information about one's child (for parents) and for students generally (for teachers/staff).

Table 2
Focus Group Questions

High School and Middle School	1. Where do people in your community go for help when they are having emotional problems, like feeling sad or angry, and stuff like that? 2. Where do people in your community go for help if they have a problem with drugs and alcohol? 3. What services are available at your school for kids who are having problems emotionally, like feeling sad or angry? What about substance abuse problems? 4. Do you know about the NT-BHC? Have you ever thought about using these services? 5. What culturally based services do you use to remain healthy? 6. What kinds of services or things could be provided at NACS to help students?
Parents	1. What mental health and substance abuse services are available for your family/child in the community? 2. What mental health and substance abuse services are available for your family/child at school (NACS)? 3. What services have your family/child used at the NT-BHC at NACS? 4. What do you like about the NT-BHC? What does your child like about the NT-BHC? What could be improved? 5. What culturally based services do you need to keep your family healthy?
Teachers/Staff	1. What mental health and substance abuse services are currently available in this community? 2. What mental health/substance abuse services are currently available at this school? 3. Do you think NACS students use the NT-BHC? (if yes, for what?) 4. What do you like about the NT-BHC? What could be improved? 5. What culturally based services are needed at the school/at the NT-BHC?

Data Analysis

Typed responses for each focus group were entered into the NVivo qualitative software program. Responses initially were open coded by the lead author to establish a general range and to list themes and examples from each focus group. Responses were then coded using a thematic analysis approach, with the initial coded responses grouped into broader overarching themes (Liamputtong, 2013). Both initial codes and larger theme areas were reviewed and finalized by the research team to ensure coding accuracy and agreement of final themes and appropriate

examples. The coded responses under each question, and themes developed from the responses, were reviewed by the research team for differences and similarities across the four focus groups (middle school, high school, parents, and teachers/staff).

Focus Group Results

Overall Focus Group Themes: Overall themes and examples from each focus group (middle school youth, high school youth, parents, and teachers/staff) are presented in Table 3 and cover focus group questions 1-5. The table then describes the themes from each focus group for these five questions and progressively displays similarities and differences across them. This table is designed to help readers quickly visualize the similarities and differences among the focus group responses from different focus group participants.

Table 3
Focus Group Themes

Middle School ***N* = 6**	**Friends and Family** (No specifics mentioned)	**NT-BHC** Bison Room, NT-BHC **Go to place alone** Bedroom Garage (to play drums) Park/lie in grass	**Professional Services** Rehab	**Traditional Activities** Healing ceremonies Medicine men Sweat lodges
High School ***N* = 6**	**Friends and Family** Grandparents Parents Elders Teachers they liked/ trusted Sometimes better not to share problems with community members	**NT-BHC** Talking groups Counseling (substance abuse, anger) Bison Room (has sage—used to cleanse oneself; music; feathers)	**Professional Services** Rehab Jail Police Therapy	**Traditional Activities** Ceremonies Traditional activities (No specifics mentioned)
Parents ***N* = 5**	**Family and People they Trust** Other parents Community members Healers School staff	**NT-BHC** Caring Responsive Convenient **NACS** Families share similar backgrounds Supportive	**Professional Services** Counseling Therapy (Covered by Medicaid; not always culturally sensitive) Would not use services offered in city	**Traditional Activities** Traditional healers Ceremonies Services in their home or tribal community Feel whole, rejuvenated
Teachers ***N* = 9**	**Trusted Adults** Teachers Parents **NACS** Student alliance Student council	**NT-BHC** Counseling Talking circles Talk box Always someone available	**Professional Services** Counseling Therapy Substance abuse services	**Culturally Based Education** Professional development to learn more about other AI/AN cultures

Middle School Youth: Middle school youth said they would talk with family and friends when they needed help, as well as teachers they trusted and liked. Middle school youth mentioned almost no professional services/supports. Only "rehab" was mentioned, with no further discussion. One youth said he did not know where to get help. Middle school youth responses were unique in that the youth talked about various *places* they would go when they felt sad or needed help. For example, things like going to the park to sit in the grass were mentioned, as well as going to their room, or going to their garage to play music (drums mentioned specifically). Spending time outdoors has been demonstrated as an important coping strategy for AI/AN youth that provides a sense of connection to the land (Goodkind, Gorman, Hess, Parker, & Hough, 2014), and appears to be valuable to youth even when the land is in an urban area rather than their home or tribal community. When asked about services at their school, middle school youth said they knew of the NT-BHC and knew that it helped students, but did not elaborate further. When asked about traditional activities in which they participated to stay healthy, middle school youth mentioned ceremonies, songs and dances, powwows, feast days, making/eating traditional foods, painting, weaving, hunting, and making pottery.

High School Youth: High school youth primarily talked about going to family and friends when they needed help, as well as talking with teachers that they liked and trusted. One youth mentioned talking with grandparents because they were wiser "and know what they are talking about." However, some youth said that they would *avoid* talking with someone in their community about personal issues because they did not want community members to know about their problems. The high school youth were the only focus group participants to mention this concern. (However, interview respondents also raised the issue of confidentiality and privacy, suggesting such concerns were more widespread, particularly if youth had received services.) High school youth said they were aware of the NT-BHC and the therapy and counseling services it provided, including "talking groups" where youth met with an adult staff member to discuss issues together after school. However, none of these youth were certain of the exact days when the groups met. High school youth who mentioned using the NT-BHC services said that the services helped students with substance abuse and anger issues. Youth were not asked directly about personal use of services, for privacy reasons, but could discuss this if they chose. High school youth also mentioned a few services that they were aware of in the larger community, such as "rehab" and "jail," but did not elaborate further. When asked specifically about

traditional practices related to their cultural background that they used to stay healthy, high school youth said that they participated in ceremonies and traditional activities, but did not go into further detail or provide examples when prompted.

Parents: Parents mentioned talking with family when they needed help or support, but did not specifically mention talking with friends in these situations. Rather, they identified talking to a person that they trusted, which could be a friend, family member, or other person. Parents said that when they (and their youth) needed help, they could talk with some of the teachers at the school as well as other parents and staff at the NT-BHC. When asked about services at the school, most parents knew about the NT-BHC and that it offered counseling and mediation. Parents said that they found services helpful and convenient; they also reported that staff were caring, established one-on-one relationships with youth, and were responsive to parents. One unique theme in the parent focus group included comments that the NACS itself was supportive. Parents explained that the NACS helped them and their youth because it was made up of other families similar to their own, where people knew each other and youth shared similar backgrounds.

When asked about behavioral health services available in the larger community, parents mentioned professional services/supports, such as counseling and therapy, and mentioned by name specific clinics that were aimed at serving AI/AN people. They mentioned the Indian Health Service and said that they were aware that the cost of their services could be covered in part by Medicaid. However, despite this awareness, parents expressed a preference for services provided in their home or tribal community, or offered at the NT-BHC, which they contrasted with culturally insensitive services that they or their children received in the local urban area. It is important to note that many parents preferred to get wellness services/supports in their home or tribal community, even though it required travel ranging from 20 minutes to several hours each way. Parents' discussion about dissatisfaction with services in the local urban area included an example from a health center in a nearby public school available to NACS students. Some parents said that this health center was not culturally sensitive like the NT-BHC and, therefore, their youth did not use it much. One parent said that her son, who had used this health center, felt judged by staff members' questions regarding drinking in the home. The parent said that these questions seemed to define problems in advance, make assumptions about the family and its problems, and endorse only one view of how families should be.

Parents also provided examples of traditional practices they and their families used to stay healthy or when they needed help. They reported that ceremonies, sweat lodges, and medicine men in their home or tribal community helped them to feel "whole" and "rejuvenated." One parent said she trusted her medicine people because they could see things that others could not.

Teachers/Staff: Themes in the teacher/staff focus group centered largely on professional services and supports, such as treatment and counseling available at the NT-BHC and in the larger community. These responses contrasted with those from the other focus groups that first mentioned family and friends, use of spaces (e.g., parks, garage), music, and traditional services. Teachers/staff mentioned a wide range of school services/supports, including the NT-BHC, talking circles, the talk box (where youth could ask questions anonymously), the student alliance, and the Student Council. They also knew of many clinics in the area that primarily served AI/AN people, the Indian Health Service, local hospitals, substance abuse treatment centers, and in-school behavioral health services provided by external personnel. Teachers/staff also mentioned that youth would talk with teachers, school staff, and parents to get help they needed, which was common across all the focus groups.

Teacher/staff responses about what students did when they needed help or support focused on talking to adults at the school (like teachers and other staff), talking with parents, and using professional (paid) services like counseling and therapy. While teachers/staff were not asked specifically to talk about students' use of traditional services, this theme did not emerge during the discussion about available services/supports for youth. Teachers/staff expressed interest in learning more about different AI/AN cultures and having further professional development in this area.

What could be provided to help students? Youth Responses: Youth only (middle and high school) were asked one additional question about what services and other things could be provided at NACS to help students (Question 6). Results are presented in Table 4 on the next page.

Table 4
What Could be Provided at NACS to Help Students

Middle School	**More activities:** • Activities; clubs; play instruments • When I play drums, it helps me feel better **Help with schoolwork:** • Helping us with our homework, having an older person or teacher tutor us **Other:** • Game Stop cards, new shoes; Need more sleep.
High School	**More activities:** • Activities, field trips, dances, fun stuff **Student apathy or disengagement:** • Activities, being open (to new things), doing things, like going to the park. That keeps people on their feet and taking everything in. Less sitting around. [Some kids] don't care. • Keep the kids that care in school, and let the others stay home **More health services:** • Classes on being healthy (examples: sex education, self-defense) **More behavioral health services:** • Counselors for drugs • Counselors/programs for emotional wellness/dealing with abuse, suicide, grief For example: o To learn what is bothering you and how to help yourself feel better o When someone passes away, how to deal with it **School safety:** • A lot of kids that have drugs, alcohol, and weapons they bring to school. It is scary. **School campus:** [Note: classes held in metal trailers instead of permanent buildings] • School is not ready yet. Completing the school first would have provided more student support services. • If our school was done the teachers would be more prepared. • We don't need a big school [completed buildings] to learn.

Themes from the middle school youth responses included *More Activities*, such as clubs or playing drums, *Help with School*, including tutoring, and basic items such as gift cards to a game shop, shoes, and sleep. Themes from the high school youth responses covered a wider range of topics. As with the middle school youth, high school youth also wanted *More Activities*, and expressed frustration with *Student Apathy or Disengagement* in participating in school and related activities. One youth said that students who are not interested in participating in things should just "stay home." Another theme was wanting more *Health Services*, which included sex education and self-defense classes. But the majority of the discussion focused on *Behavioral Health Services*, including counselors for drugs, but in particular focused on emotional pain and grief, often in response to losing a relative or close friend: "Losing someone …drastically

changes your life 'til you can't deal with it." Students discussed wanting to improve the school environment, including the themes *School Safety* and the *School Campus*. Regarding safety, students wanted police to protect youth from those who bring weapons to school. Discussion about the *School Campus* focused on the belief that the school was not fully ready in terms of buildings and space to provide for the students adequately: "They should have made the school first and then they would have more student support services." One youth, however, disagreed, explaining that the portables which made up the majority of classrooms at the school were not a negative aspect, as least in terms of supporting learning: "We can learn behind a trash can."

Loss/Lack of Cultural Knowledge and Ways to Strengthen: The high school focus group alone had an important, impromptu discussion in relation to the question "What culturally based services do you use to remain healthy?" While direct responses to this question are included in Table 3, the additional conversation this question inspired warrants a separate table, presented below (Table 5). The conversation revolved around two main themes: *Loss/Lack of Cultural Knowledge* students experienced and *How School can Support Strengthening Cultural Knowledge*.

Table 5
Loss/Lack of Cultural Knowledge and Suggestions for Strengthening

High School	**Expressing loss of/lack of cultural knowledge:** • [Used to] go to my aunt's house and dance fancy shawl. Used to do a lot of traditional things, and then went to public school. • Don't know our traditions, we are raised in [City], and we would like…like me and my sister, we don't really know our background and traditions. We were born and raised in [City]. We don't have family to teach us. • [Don't know] culturally sensitive information, cultural protocols. • Don't know my background. • As a child, used to be traditional and dance back home on the reservation. But then went to elementary school and forgot…like dissecting a frog. Didn't know I wasn't supposed to do that and had to have a ceremony. • Lady brought an anaconda into the school and that was wrong but I didn't know it. • One time in history [class] my sister she was asked to bless and feed a tree. She didn't know what to do. **How school can support strengthening cultural knowledge** • Activities: Indian dances; pottery making; cutting trees for firewood; planting trees; harvesting • Learn language [3 Southwestern languages mentioned specifically] • Bad thinking about my family… know more Spanish than Navajo… kind of weird. • If students don't know their own culture, then maybe they could meet someone from where they are from to help them learn. Rights and wrongs of what to do. • A younger person coming in, like a parent to help teach. • Bringing in people to teach us about our culture.

In the first theme area, *Loss/Lack of Cultural Knowledge*, students gave examples, often based in school settings, where they became aware of their lack of cultural knowledge in relation to their AI/AN heritage. Examples from the high school youth include dissecting a frog in class and viewing a snake at school. In both cases the youth did not realize until later that these practices were against traditional beliefs and cultural norms. Another student mentioned being asked to bless and feed a tree at school and not knowing how to do it. Many students noted that they had been more involved with cultural practices when they were younger, and felt that being in the urban area made them more disconnected from their cultural practices and beliefs. This unique discussion among the high school youth, and the range of examples, suggest that these moments when they became aware of their limited cultural knowledge and skills were emotionally powerful and created lasting memories. It is also important to note that some examples (e.g., frog dissection, viewing a snake) likely occurred at other public middle or high schools before the youth transferred to NACS.

The second theme was *How School can Help Support Strengthening Cultural Knowledge*. Examples included having cultural activities at school, such as traditional dances and AI languages, cutting firewood, and making pottery. With regard to language loss, one youth described feeling it was a "bad thing" and that it was "kinda weird" to know more Spanish than one's own AI/AN language. Youth suggested having someone come to the school to help teach them about cultural practices and beliefs, with one youth suggesting that someone "young…like a parent" would be a good fit.

DISCUSSION

Effect of Cultural Tailoring on Service Utilization

The study findings above demonstrate the importance of culturally appropriate services for AI/AN youth and families. The interviews with both middle and high school youth who had used the services demonstrated showed positive views of the NT-BHC staff, with negative comments focused on wanting more services. In the parent focus group, cultural tailoring of services was an important theme. Some parents talked about a nearby school health center that was lacking in culturally appropriate services and that, therefore, their youth did not like to use. Such experiences were likely a driving force in parents' stated preference for getting services/supports in their home or tribal community, even though it entailed traveling, sometimes great distances. This finding is supported by studies that show AI/AN underutilization of

biomedical services offered by mainstream providers (Beals et al., 2005; Novins, Beals, Moore, Spicer, & Manson, 2004), and a preference among some AI/ANs for traditional healing practices to meet behavioral health needs (Gone, 2008; Gurley, et al, 2001). For further rich discussion concerning the use of and preference for traditional healing among urban AI/ANs and related cultural considerations, see Hartmann and Gone, 2012. Despite the availability of health services in urban areas, this study and related literature suggests that cultural tailoring and service provision by AI/AN staff may be important factors in encouraging the use of behavioral health services for AI/ANs. The only urban services the parents reported liking were the services at the NT-BHC that their youth sometimes used. This finding is important because it suggests that culturally tailored services for AI/AN youth, such as those offered at the NT-BHC, may be more important than convenience and location for improving service utilization.

Another valuable finding was the fact that teachers/staff focused on the availability of services/supports in the urban area, and did not discuss use of traditional services (or informal supports from family and friends). This finding suggests an opportunity to raise awareness about preferences and actual use of services that can help teachers/staff better understand and support students and families.

Native-tailored and Native-staffed: Improving Utilization Rates

In this study, we found that 170 out of a total of 350 students had used the NT-BHC (49%) during the 2010-2011 school year. While this percentage is comparable to utilization rates for other mainstream school-based health centers (Anglin, Naylor & Kaplan, 1996), it is important to remember that utilization rates of AI/ANs and other ethnic minority groups are often *lower* than those of White youth (Farmer et al., 2003; Shim, Compton, Rust, Druss, & Kaslow, 2009). Thus, the nearly 50% utilization rate in this study provides support for the practice of providing culturally appropriate services to encourage behavioral health service utilization among AI/AN youth. For example, studies of urban AIs have shown low rates of service utilization (Evaneshko, 1999) with numerous challenges in accessing quality health care services (Brown, Ojeda, Wyn, & Levan, 2000; UIHC, 2007). One study of foster care-placed youth found that AIs were significantly less likely to receive school services than were White children of the same gender with similar social service experiences and mental health problems (Farmer et al., 2001). Other studies have found that, while attitudes about services may be positive initially among ethnic minority groups, use often declines after services are begun,

possibly because services are not culturally sensitive (Diala et al., 2000). Therefore, offering culturally appropriate and tailored services may be an important factor in raising AI/AN utilization rates.

Variations in Awareness of School and Community-based Services/Supports

While there was overall general awareness of the NT-BHC, an important study finding was the variation in awareness of behavioral health services among the participating groups. Understanding this variation can be important in the design and marketing of services in both schools and the larger community. The middle school youth demonstrated very limited awareness of any services, school or community based. Largely, their responses including things like going to the park or their room, playing music, and talking to friends and family. These findings are particularly interesting when contrasted with teacher/staff responses about services available to youth, which reflected mainly services that were professional in nature (e.g., agencies, clinics). Understanding this apparent disconnect can help to develop appropriate services and strategies to engage youth. Such strategies might include holding a clinic or support center "open house" which younger youth can attend with friends or family, increasing their comfort and familiarity. Other efforts might include focused, age-appropriate marketing and education to encourage younger youth to become more aware of and to use professional services (e.g., therapy).

Privacy and Confidentiality

Another important study finding was that youth were concerned about privacy and confidentiality. Being pulled out of class or checked on by NT-BHC staff at school was embarrassing. Some youth also were upset that their parents were told about problems they had discussed in confidence with NT-BHC therapists. Many youth are very concerned in general with being embarrassed in front of friends, especially in school. However, because some youth in this study liked being checked on by staff, the recommendation for school-based health centers in general is to ask youth if they would like to be contacted during school regarding their well-being. If so, the youth and staff should agree on a format that feels safe and private for the youth (e.g., youth who do not want to be contacted at school could set up a time to call or come by the health center). Also, staff should work with youth to clarify the limits of confidentiality and the kinds of things that need to be shared with parents.

Initiation of Services

Youth expressed concern that they were not always in charge of initiating services on their own. Some were told they had to go by a parent, and, in some cases, NT-BHC staff members pulled youth from class when they did not want to go (as noted above, youth also believed that this practice limited their privacy). We recommend that student health center staff discuss with youth and parents the best way to involve youth in services that are initiated by a parent, so students can establish a role in the process. Increased student involvement may help build a trusting relationship and encourage future use. A youth-guided approach as to when, how, and what services are provided is a cornerstone of national Systems of Care principles and has been associated with positive youth outcomes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010).

Importance of Informal Supports: Family and Friends

This study also reflects another important finding in behavioral health research: that a main source of support for all youth is family and friends. Research with AI/AN youth has shown the value of talking with family and friends for helping them cope with stress (Goodkind et al., 2014). Therefore, providing education and training can help strengthen the capacity of family and friends to give support and offer referrals for services. Programs such as the Model Adolescent Suicide Prevention Program (MASPP) utilize the concept of "natural helpers," which is based on the premise that, when young people have problems, they most often turn to friends for help, and that schools have an informal helping network that can be enhanced to support youth. MASPP is listed on SAMHSA's National Registry of Evidence-Based Programs and Practices (SAMHSA, 2015). Another example is the Strengthening Families Program, which works to enhance families' capacity to support adolescents (Kumpfer, 1998). Programs that work to build up the natural support capacity of friends and families can be an effective approach for meeting the behavioral health needs of youth.

What Could be Provided at NACS to Help Students

Having the school provide support for some of the students' basic needs was another theme that emerged. Middle school youth mentioned shoes, sleep, tutoring, and more activities; for high school youth, the conversation touched on activities, but went more in depth regarding frustration about other youth who are not engaged at school. It would be important to explore

some of these concerns, such as sleep, more in depth (perhaps in a short wellness survey or discussion with teachers about their perception of the concern in class) to understand how widespread these issues are, and then work to develop strategies to address them.

Importantly, there was significant focus among high school youth on the loss of family members and friends, especially their desire to have the school help them cope with their feelings of grief. This discussion highlights the trauma faced by many AI/AN youth and the need for behavioral health services related drugs, abuse, and suicide. The focus on this issue directly relates to the relatively high exposure of AI/AN peoples to a range of violent and traumatic events involving serious injury or threat of injury to oneself, or witnessing this threat or injury to others (Manson, Beals, Klein, Croy, & the AI-SUPERFP Team, 2005). Of all races, they have the highest per capita rate of violent victimization; children between the ages of 12 and 19 years, in particular, are more likely than their non-Native peers to be the victims of both serious violent crime and simple assault (Rennison, 2001). The positive impressions of the NT-BHC among youth who had used services provide support for the important role that this culturally appropriate school-based health center plays in the lives of these urban youth.

Loss/Lack of Cultural Knowledge and Suggestions for Strengthening

High school youth were unique in having additional discussion about loss/lack of cultural practices and making suggestions for the school to help address this issue. Interestingly, when asked about cultural practices they used to stay healthy, middle school youth mentioned a number of activities, whereas high school youth mentioned a smaller range. This finding reflects their memories of being more culturally active and spending more time in their home or tribal community when they were younger: “When I was 3 or so I used to be traditional and dance back home on the reservation. But then when I went to elementary school I forgot…” High school youth provided very specific and memorable examples of violating cultural norms or forgetting cultural practices in a public context, revealing a shared experience that they wanted the school to help them address.

Limitations

This study expands what is known about AI/AN student and parent awareness and use of school- and community-based services, and this information can be used to improve services and utilization and to inform future research. Participants demonstrated awareness of, positive

attitudes toward, and relatively high use of an NT-BHC; these findings may support the development of similar centers in other urban schools that serve AI/AN students. This study used mixed methods, including the collection of NT-BHC use rates, but was predominately qualitative. The qualitative approach provides important strengths as well as limitations. Qualitative research (e.g., interviews and focus groups) is not intended to be representative of an entire population, and, therefore, the results are not generalizable (Vogt, King, & King, 2004). However, these methods provide much-needed information—in this case, about how AI/AN youth and parents perceive and utilize available services, both in school and in the larger community. While not generalizable, this type of research can provide critical data to make practical improvements in existing services and approaches, as well as inform future mixed methods or quantitative studies. A second limitation was reliance on notes rather than recordings of the focus groups, which would have provided more quotations and is preferred with qualitative research, when appropriate. However, because this study was foremost a CBPR study, respecting the school's desire *not* to record respondents was paramount in the research team's methodological decisions.

CONCLUSION

Significant health disparities among AI/AN youth may be alleviated through use of behavioral health services. Ensuring that such services, like those provided at the NT-BHC, are culturally appropriate may be an important factor in increasing both first-time and repeated use of services/supports among urban Native youth and families. This study suggests that tailoring behavioral health services for AI/AN youth can lead to high satisfaction with services and high levels of use. It also highlights differential awareness and use of behavioral health services/supports among youth, parents, and teachers/staff. If utilized to improve behavioral health services for urban AI/AN youth, the findings from this study can contribute to improved health outcomes and reduced health disparities.

REFERENCES

Anglin, T. M., Naylor, K. E., & Kaplan, D. W. (1996). Comprehensive school-based health care: High school students' use of medical, mental health, and substance abuse services. *Pediatrics, 97*(3), 318-330. Retrieved from http://pediatrics.aappublications.org/

Atkins, M. S., Hoagwood, K. E., Kutash, K., & Seidman, E. (2010). Toward the integration of education and mental health in schools. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1-2), 40-47. http://dx.doi.org/10.1007/s10488-010-0299-7

Baldwin, J. A., Johnson, J. L., & Benally, C.C. (2009). Building partnerships between Indigenous communities and universities: Lessons learned in HIV/AIDS and substance abuse prevention research. *American Journal of Public Health*, 99(Suppl 1), S77-82. http://dx.doi.org/10.2105/AJPH.2008.134585

Ball, J., & Pence, A. R. (1999). Beyond developmentally appropriate practice: Developing community and culturally appropriate practice. *Young Children, 54*(2), 46-50. Retrieved from http://www.jstor.org/stable/42728505

Beals, J., Manson, S. M., Shore, J. H., Friedman. M., Ashcraft, M., Fairbank, J. A., & Schlenger, W. E. (2002). The prevalence of posttraumatic stress disorder among American Indian Vietnam veterans: Disparities and context. *Journal of Traumatic Stress, 15*(2), 89-97. http://dx.doi.org/10.1023/A:1014894506325

Beals, J., Novins, D. K., Mitchell, C., Shore, J. H., & Manson, S. M. (2002). Comorbidity between alcohol abuse/dependence and psychiatric disorders: Prevalence, treatment implications, and new directions for research among American Indian populations. *NIAAA Research Monograph Series, 37*, 371-410. Retrieved from http://www.niaaa.nih.gov/

Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental health disparities in a national context. *American Journal of Psychiatry, 162*(9), 1723-1732. http://dx.doi.org/10.1176/appi.ajp.162.9.1723

Brown, R. E., Ojeda, V. D., Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care*. Los Angeles: University of California, UCLA Center for Health Policy Research.

Brown, T., & Summerbell, C. (2009). Systematic review of school-based interventions that focus on changing dietary intake and physical activity levels to prevent childhood obesity: An update to the obesity guidance produced by the National Institute for Health and Clinical Excellence. *Obesity Reviews, 10*(1), 110-141. http://dx.doi.org/10.1111/j.1467-789X.2008.00515.x

Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D, Farmer, E. M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*(3), 147-159. http://dx.doi.org/10.1377/hlthaff.14.3.147

Caballero, B., Clay, T., Davis, S. M., Ethelbah, B., Holy Rock, B., Lohman, T., . . .The Pathways Study Group. (2003). Pathways: A school-based, randomized controlled trial for the prevention of obesity in American Indian schoolchildren. *American Journal of Clinical Nutrition, 78*(5), 1030-1038. Retrieved from http://ajcn.nutrition.org/

Centers for Disease Control and Prevention. (2013). *Web-based Injury Statistics Query and Reporting System (WISQARS).* Atlanta: National Center for Injury Prevention and Control. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

Costello, E. J., Angold, A., Burns, B. J., Stangl, D. K., Tweed, D. L., Erkanli, A., & Worthman, C. M. (1996). The Great Smoky Mountains Study of Youth: Goals, design, methods and the prevalence of DSM-III-R disorders. *Archives of General Psychiatry, 53*, 1129-1136. http://dx.doi.org/10.1001/archpsyc.1996.01830120067012

Daley, C. M., Greiner, K. A., Nazir, N., Daley, S. M., Solomon, C. L., Braiuca, S. L., … Choi, W. S. (2010). All Nations Breath of Life: Using community-based participatory research to address health disparities in cigarette smoking among American Indians. *Ethnicity & Disease, 20*(4), 334-338. Retrieved from http://www.ishib.org

Diala, C., Muntaner, C., Walrath, C., Nickerson, K. J., Laveist, T. A., & Leaf, P. J. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry, 70*(4), 455-464. http://dx.doi.org/10.1037/h0087736

Dickerson, D. L., & Johnson, C. L. (2011). Design of a behavioral health program for urban American Indian/Alaska Native youths: A community informed approach. *Journal of Psychoactive Drugs, 43*(4), 337-42. http://dx.doi.org/10.1080/02791072.2011.629152

Evaneshko, V. (1999). Mental health needs assessment of Tucson's urban Native American population. *American Indian and Alaska Native Mental Health Research, 8*(3), 41-61. http://dx.doi/org/10.5820/aian.0803.1999.41

Farmer, E. M., Burns, B. J., Chapman, M. V., Phillips, S. D., Angold, A., & Costello, E. J. (2001). Use of mental health services by youth in contact with social services. *Social Service Review, 75*(4), 605-624. http://dx.doi.org/10.1086/323165

Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services, 54*(1), 60-66. http://dx.doi.org/10.1176/appi.ps.54.1.60

Gone, J. P. (2008). "So I can be like a Whiteman": The cultural psychology of space and place in American Indian mental health. *Culture & Psychology, 14*(3), 369-399. http://dx/doi.org/10.1177/1354067X08092639

Gone, J. P, & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology, (8),* 131-160. http://dx.doi.org/10.1146/annurev-clinpsy-032511-143127

Goodkind, J. R., Gorman, B., Hess, J. M., Parker, D. P., & Hough, R. L. (2014). Reconsidering culturally competent approaches to American Indian healing and wellbeing. *Qualitative Health Research, 25*(4), 486-499. http://dx.doi.org/10.1177/1049732314551056

Grim, C. W. (2003). Health of American Indians and Alaska Natives: Health influence factors in common with other Indigenous populations. *BMJ, 3,* 242-243. http://dx.doi.org/10.1136/bmjusa.03050002

Guo, J. J., Wade, T. J., Pan, W., & Keller, K. N. (2010). School-based health centers: Cost-benefit analysis and impact on health care disparities. *American Journal of Public Health, 100*(9), 1617-1623. http://dx.doi.org/10.2105/AJPH.2009.185181

Gurley, D., Novins, D. K., Jones, M. C., Beals, J., Shore, J. H., & Manson, S. M. (2001). Comparative use of biomedical services and traditional healing options by American Indian veterans. *Psychiatric Services, 52*(1), 68-74. http://dx.doi.org/10.1176/appi.ps.52.1.68

Hartmann, W. E., & Gone, J. P. (2012). Incorporating traditional healing into an urban American Indian health organization: A case study of community member perspectives. *Journal of Counseling Psychology, 59*(4), 542-554. http://dx.doi.org.1037.a0029067

Holman, R. C., Folkema, A. M., Singleton, R. J., Redd, J. T., Christensen, K. Y., Steiner, C. A., . . . Cheek, J. E. (2011). Disparities in infectious disease hospitalizations for American Indian/Alaska Native people. *Public Health Reports, 126*(4), 508-521. Retrieved from http://www.publichealthreports.org/

Jernigan, V. B. (2010). Community-based participatory research with Native American communities: The Chronic Disease Self-Management Program. *Health Promotion Practice, 11*(6), 888-99. http://dx.doi.org/10.1177/1524839909333374

Kaiser Family Foundation. (2004). *American Indians and Alaska Natives: Health coverage and access to care*. Menlo Park, CA: Author. Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/american-indians-and-alaska-natives-health-coverage-access-to-care.pdf

Kerns, S. E., Pullmann, M. D., Walker, S. C., Lyon, A. R., Cosgrove, T. J., & Bruns, E. J. (2011). Adolescent use of school-based health centers and high school dropout. *Archives of Pediatrics & Adolescent Medicine, 165*(7), 617-23. http://dx.doi.org/10.1001/archpediatrics.2011.10

Kumpfer, K. L. (1998). Selective prevention interventions: The Strengthening Families Program. In R. S. Ashery, E. B. Robertson, & K. L. Kumpfer (Eds.), *Drug abuse prevention through family interventions* (pp. 160-207). U.S. National Institute on Drug Abuse Research Monograph Series, 177. Rockville, MD: Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse.

Kutash, K., Duchnowski, A., & Lynn, N. (2006). *School-based mental health: An empirical guide for decision makers.* Tampa, FL: University of South Florida, The Louis De La Parte Florida Mental Health Institute, Department of Child and Family Studies, Research and Training Center for Children's Mental Health.

Leaf, P. J., Alegria, M., Cohen, P., Goodman, S. H., Horowitz, S. M., Hoven, C. W., . . . Regier, D. A. (1996). Mental health service use in the community and schools: Results from the four-community MECA Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(7), 889-897. http://dx.doi.org/10.1097/00004583-199607000-00014

Leston, J. D., Jessen, C. M., & Simons, B. C. (2012). Alaska Native and rural youth views of sexual health: A focus group project on sexually transmitted diseases, HIV/AIDS, and unplanned pregnancy. *American Indian and Alaska Native Mental Health Research, 19*(1), 1-14. http://dx.doi.org/10.5820/aian.1901.2012.1

Liamputtong, P. (2013). *Qualitative research methods* (4th ed.). Oxford, England: Oxford University Press.

Manson, S. (2000). Mental health services for American Indians and Alaska Natives: Need, use and barriers to effective care. *Canadian Journal of Psychiatry*, *45*(7), 617-26. Retrieved from http://publications.cpa-apc.org/

Manson, S.M., Beals, J., Klein, S.A., Croy, C.D., & the AI-SUPERPFP Team. (2005). Social epidemiology of trauma among 2 American Indian reservation populations. *American Journal of Public Health*, *95*(5), 851-859. http://dx.doi.org/10.2105/AJPH.2004.054171

May, P. A., Serna, P., Hurt, L., & DeBruyn, L. M. (2005). Outcome evaluation of a public health approach to suicide prevention in an American Indian tribal nation. *American Journal of Public Health*, *95*(7), 1238-1244. http://dx.doi.org/10.2105/AJPH.2004.040410

Novins, D. K., Beals, J., Moore, L. A., Spicer, P., Manson, S. M., & the AI-SUPERPFP Team. (2004). Use of biomedical services and traditional healing options among American Indians: Sociodemographic correlates, spirituality, and ethnic identity. *Medical Care*, *42*(7), 670-679. http://journals.lww.com/lww-medicalcare/pages/default.aspx

O'Connell, J., Rong, Y., Wilson, C., Manson, S. M., & Acton, K. J. (2010). Racial disparities in health status: A comparison of the morbidity among American Indian and U.S. adults with diabetes. *Diabetes Care*, *33*(7), 1463-1470. http://dx.doi.org/10.2337/dc09-1652

Rennison, C. (2001). *Violent victimization and race, 1993-1998*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Retrieved from http://www.bjs.gov/content/pub/pdf/vvr98.pdf

Rice, P. L. & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Oxford, England: Oxford University Press.

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*(4), 223-241. http://dx.doi/org/10.1023/A:1026425104386

Sarche, M., & Spicer, P. (2008). Poverty and health disparities for American Indian and Alaska Native children: Current knowledge and future prospects. *The Annals of the New York Academy of Sciences, 1136*, 126-136. http://dx.doi.org/10.1196/annals.1425.017

Sharma, M. (2006). School-based interventions for childhood and adolescent obesity. *Obesity Review, 7*(3), 261-269. http://dx.doi.org/10.1111/j.1467-789X.2006.00227.x

Shim, R. S., Compton, M. T., Rust, G., Druss, B. G., & Kaslow, N. J. (2009). Race-ethnicity as a predictor of attitudes toward mental health treatment seeking. *Psychiatric Services, 60*(10), 1336-1341. http://dx.doi.org/10.1176/appi.ps.60.10.1336

Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). *Comprehensive community mental health services for children and their families program. Evaluation findings: Annual report to Congress*. Rockville, MD: Author. Retrieved from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

SAMHSA (2015). *National Registry of Evidence-based Programs and Practices*. Rockville, MD: Author. Retrieved from www.nrepp.samhsa.gov

Urban Indian Health Commission. (2007). *Invisible tribes: Urban Indians and their health in a changing world*. Seattle, WA. Retrieved from http://www.uihi.org/wp-content/uploads/2009/09/UIHC_Report_FINAL.pdf

Vogt, D. S., King, D. W., & King, L. A. (2004). Focus groups in psychological assessment: Enhancing content validity by consulting members of the target population. *Psychological Assessment, 16*(3), 231-243. http://dx.doi.org/10.1037/1040-3590.16.3.231

Wallerstein, N., & Duran, B. (2008). The theoretical, historical and practice roots of CBPR. In M. Minkler & N. Wallerstein (Eds.), *Community based participatory research for health: From process to outcomes*. (2nd ed., pp. 25-46). San Francisco, CA: Jossey-Bass.

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health, 100*,(S1), S40-S46. http://dx.doi.org/10.2105/AJPH.2009.184036

West, A. E., Williams, E., Suzukovich, E., Strangeman, K., & Novins, D. (2012). A mental health needs assessment of urban American Indian youth and families. *American Journal of Community Psychology*, *49*(3-4), 441-53. http://dx.doi.org/10.1007/s10464-011-9474-6

ACKNOWLEDGEMENTS

We wish to acknowledge the generosity and openness of the students, teachers and parents who participated in this study, as well as the school leadership who provided guidance and permission to conduct this study. We are grateful to the Center for Participatory Research that provided funding for this study.

AUTHOR INFORMATION

Dr. Salvador is with the Department of Psychiatry and Behavioral Sciences, Division of Community Behavioral Health, University of New Mexico. She is the corresponding author and can be reached at jgsalvador@salud.unm.edu or (505) 934-0485.

Dr. Goodkind is with the Department of Sociology at the University of New Mexico.

Dr. Feldstein Ewing is with the Department of Child and Adolescent Psychiatry at Oregon Health Sciences University.