American Indian Youth: Current and Historical Trauma

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Introduction

This cultural and trauma brief was develop at the request of the NCTSN to provide information about American Indian and Alaskan Native youth exposure to trauma. The Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center is dedicated to improving clinical services for American Indian and Alaskan Native children and youth affected by different kinds of trauma. To accomplish the mission of the Indian Country Child Trauma Center (ICCTC) of developing and implementing culturally appropriate interventions, we have adapted evidence based treatment modalities to better serve this vulnerable population.

Background Information on Current and Historical Trauma in Indian Country:

The impact of current and historical trauma on American Indian and Alaska Native(AI/AN) youth can not be fully understood without a careful retrospective study of the multiple layers that undermined the social and emotional fabric that once supported intact American Indian and Alaskan Native families. A brief review on federal policy is necessary to build an understanding of the complexity of what contributes to the traumatic events that surround AI/AN youth who reside in what is called Indian Country.

Indian Country is a legal definition used by the federal government designating the land base for tribal groups and this affects which jurisdiction has authority for governing both lawful and unlawful activities involving Indians, non-Indians, and illegal aliens. There are over 650 federally recognized tribes in the US, with the majority of American Indians and Alaska Natives (AI/AN) living in the western states and in non-reservation areas. Over the past 200 years, the social and psychological aspects American Indian and Alaskan Native people have suffered from a lack of education, unemployment and economic disadvantage, family disorganization, and personal despair with alcoholism and suicide emerging as significant causes of death (Manson, 2004). The Federal Indian Boarding School Movement and the Dawes Act forever changed the economic, physical, and social lives of AI/AN people. Once self reliant and self-sufficient, the policies of the federal government forced tribes toward removal, relocations, isolation and in some cases, termination, resulting in social, economic and spiritual depravations. Despite these overwhelming obstacles, AI/AN people have survived. Survival has been a struggle; AI/AN populations continue to experience high rates of suicide and violent deaths.

American Indian and Alaskan Native youth share a unique association with the federal government of the United States of America; however not all AI/AN youth may share in the benefits of this association. It is based on the unique trust relationship that as an enrolled member of a federally recognized tribe, the federal government recognized the tribe as being a sovereign nation within the nation of the US. This has been determined based on historical rulings of legal precedent and congressional laws. This special trust relationship has been reaffirmed by the US Supreme Court. More information about tribal sovereign can be found at www.indianz.com.

However, as not all AI/AN youth are enrollment members of federally recognized tribes nor are they allowed the privileges of tribal enrollment, thereby limiting their access to

health care, education, housing, or other benefits. Some youth may be members of state recognized tribes or affiliated groups seeking recognition as a tribe and may even view themselves as treaty Indians, American Indian, or Alaskan Native people. However, their ability to determine who they are as indigenous people is undermined by what the federal government decrees as eligibility for a sovereign tribal nation.

How this impacts AI/AN youth is two fold; first by the historical efforts of the federal government aligning with states, churches, schools, and other dominate entities to structure the environment toward forced assimilation. Secondly, the identity as American Indian or Alaskan Native people was not valued, creating additional conflict with youth today who may feel very confused about their tribal identity.

The outcome is that historical trauma affected each indigenous person when their cultural base is assaulted resulting with each subsequent generation carrying this trauma to the next generation. According to the NCTSN (2004), trauma is a unique individual experience associated with a traumatic event or enduring conditions. This definition is of limited application within the AI/AN communities, since it does not take into account the cultural trauma, historical trauma, and intergenerational trauma that has accumulated through centuries of exposure to racism, warfare, violence, and catastrophic disease. Cultural trauma is an attack on the fabric of a society, affecting the essence of the community and its members. Attacks on AI/AN communities have included prohibiting the use of traditional languages, banning spiritual/healing practices, removing or relocating individuals or whole communities, and restricting access to public or sacred spaces. Historical trauma is the cumulative exposure of traumatic events that affect an individual and continues to affect subsequent generations.

Intergenerational trauma occurs when the trauma of an event is not resolved and is subsequently internalized and passed from one generation to the next through impaired parenting and lack of support or effective interventions. These types of traumas increase individuals' risks of experiencing traumatic stressors while also decreasing their opportunities to draw on the strengths of their culture, family, or community for social and emotional support. Youth cannot draw on the collective strength of tribal identity when much as been taken and there is little cohesiveness within the tribe, community, or family about who they are as tribal people and what is valued.

Service Delivery System in Indian Country

The Indian Country service delivery system is a complicated mixture of multiple service entities guided and impacted by jurisdictional overlays that create significant problems in the delivery of trauma services. According to Manson (2004), the system of services for treating mental health problems in Indian Country is a complex and inconsistent set of tribal, federal, state, local, and community-based policies and services. The agencies directly responsible are Indian Health Service, Bureau of Indian Affairs, and the Department of Veterans Affairs; other programs providing services are the DOJ – Office for Victims of Crime and the Office of Juvenile Justice and Delinquency, tribal health programs, urban Indian health programs, and state and local service agencies and schools, including non-profit, and/or religious, and traditional healing resources. Manson's 2004 report on "Meeting the Mental Health Needs of American Indians and Alaska Natives" states that while the need for mental health care is significant, the services are lacking, and access can be difficult and costly. The report lists problems in service utilization patterns that include AI/AN children as being more likely to: 1) receive

treatment through the juvenile justice system and in-patient facilities than non-Indian children, 2) encounter a system understaffed by specialized children's mental health professionals, and 3) encounter systems with a consistent lack of attention to established standards of care for the population. In summary, AI/AN youth experience high levels of unmet needs.

Within this kind of system the effective treatments will vary widely from having well-established mental health agencies to others having no trained service providers within a 200 to 500 mile range. Overall, AI/AN people are less likely to have access to mental health services than the general population; receive poorer quality care, and are under-represented in mental health research (NFCMH, 2003). The barriers to treatment include a fragmented service system, limited funding, unavailable services, and racism coupled with mistrust and fear of mental health treatment. The service provision for all AI/AN people are problematic as there are a limited number of professionals trained to work with youth, particularly traumatized youth. The need for appropriate and accessible mental health services in Indian Country is high.

Current Status of American Indian and Alaskan American Indian and Alaskan Native Youth

Today's youth are faced with overwhelming need for basic safety; otherwise they are subject to increased risk of trauma. Unintentional injury is the leading cause of death among U.S. children aged 1 - 19 years.* Homicide is the second leading cause, and suicide is the fourth. Mortality rates from injury, whether unintentional or intentional, are particularly high among certain racial/ethnic populations (*1*). Previous studies have examined differences in injury death rates according to race/ethnicity and have consistently documented that black and American Indian/Alaska Native (AI/AN) children are disproportionately affected (*2*). During the 1990s, injury death rates for black and AI/AN children were two to three times those for white children. In contrast, injury rates for Hispanic and Asian/Pacific Islander (A/PI) children were equal to or less than rates for whites (http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5605a1.htm)

The factors contributing to the current conditions of injustices toward the AI/NA population has evolved from various activities. Being the most vulnerable of populations did not evolve in isolation. Invariably AI/AN families vulnerability to injury, harm, and criminal acts are increased by the political, economic, and social inequalities. Policies dictated by federal, state, or other regulatory agencies continue to present barriers to services. This led to the complete disregard for service delivery or produced biased services that proved ineffective and inappropriate to AI/AN populations especially youth. Youth became the recipients of poor coping behavior on the part of parents ill equipped to deal with life or their offsprings. According to Child Trends Date Bank, AI/NA children make up less then 1% of the total child populations, but represent 2% of the children in foster care (www.acf.hhs.gov). DOJ report also indicates that approximately one substantiated report of child abuse or neglect occurs for every 30 American Indian and Alaskan Native children. Native American families had the highest re-referral rates for sexual abuse, physical abuse, and neglect relative to other ethnic categories (Stevens, et al., 2005). An equally alarming statistic is those youth who are not in foster care have a highly likelihood of being incarcerated within states with high AI/AN populations.

The number of AI/AN children and youth reporting depression and suicidal ideation is a significant cause for concern (Olson & Wahab, 2006). Despite the concern and media attention given to suicide prevention among AI/AN populations, progress has been slow in understanding suicide from a cultural perspective (Angell, Kurz, & Gottfried, 1997) and in measuring the efficacy of interventions to prevent suicide among AI/AN (Olson & Wahab, 2006).

Multiple traumas in Indian Country are cumulative and can increase feelings of hopelessness and helplessness that can lead to suicide. From 1979 to 1992, the suicide rates for AI/AN youth were 1.5 times higher than the national rate. In 1999, violent deaths (homicide, suicide, and injuries) accounted for 75% of all deaths for AI/AN in their 20s (US DHHS, 1999). Despite these alarming statistics, the New Freedom Commission on Mental Health (NFCMH) reported that the US mental health system has not met the needs of racial and ethnic minorities, including AI/AN (NFCMH, 2003).

Given the multiple risks present in AI/AN communities, it is not surprising that the prevalence of post-traumatic stress disorder (PTSD) is substantially higher among AI/AN persons that in the general community (22% vs. 8%; Kessler, et al, 1995). It is likely that higher rates of exposure to traumatic events coupled with the over-arching cultural, historical, and intergenerational traumas make this population more vulnerable to PTSD. In addition, people who have traumatic experiences and develop PTSD are also at risk for several other negative mental health outcomes. Rates of substance abuse disorders and other mental health disorders, particularly depression, are also elevated (e.g., Beals, et al., 2001). In short, the AI/AN population is especially susceptible to mental health difficulties.

Crimes Against Youth, Juvenile Delinquency and Criminal Activity

Crimes against American Indian and Alaskan Native people are higher than for other populations. According to the recent publication by the Department of Justice (Perry, 2004) the average annual violent crime rate among American Indians 12 years and older is approximately 2.5 times the national rate. The rates of violent victimization for both males and females are higher among American Indians and Alaskan Natives than for all races. American Indians and Alaskan Natives experience approximately one violent crime for every eight residents age 12 or older compared to one violent victimization for every 16 black residents, one for every 20 white residents, or one for every 34 Asian residents.

The states of North Dakota, South Dakota, Iowa, Wyoming, and Minnesota have significant rates of incarceration of AI/AN youth. Iowa has a ratio of 1,025 per 100,000 drawing from bordering states with a high number of Indian reservations (ND=1,240; WY=1,285; SD=1,575; MN=1,712; NB=1,682) with Minnesota and Nebraska having the highest rate of incarceration of AI/AN than for any other group. A combination of delinquent behavior coupled with substance abuse and poor impulse control create greater opportunity for AI/AN youth to come under juvenile justice supervision. Many youth enter the juvenile justice system after multiple out of home placements and poor academic performance. The number of out of home placements for AI/AN children and youth continue to rise while the age of onsite for use of alcohol and other drugs decreased leading toward more conflict with the law and more delinquent behaviors. This is making it more important to recognize the relationship among substance abuse, violence, and child trauma.

Violence is a critical public health issue in the United States, particularly due to its devastating impact on the health and well being of women and children. Recent research on specific types of violence against women have been increasingly persuasive in underlining the association among childhood abuse and neglect, subsequent adult victimization and abuse, trauma experiences, and substance abuse and mental health disorders, especially depression and post-traumatic stress disorder (Kendler, et al., 2000; Campbell, 2002). One study revealed that 38% of people who had been sexually abused and 33% who had been physically abused as children experienced PTSD during their lifetime (Widom, 1999). In examining the effects of historic and cumulative lifetime violence on women's health, research has shown that 32 to 68% of women in non-psychiatric samples report some lifetime experiences of physical or sexual assault, with one in five to one in two women reporting multiple abuse experiences (Bohn, 2002).

According to Major et al article (2004), in the past few years, a growing concern about crime, delinquency, and gang activity in Indian Country has emerged. Previous research shows that much of the gang activity seems to be an expression of youthful experimentation with gang identity and that a strained social environment, the appeal of popular culture surrounding gang activity, and a lack of positive activities for youth contribute to the AI youth gang phenomenon (Armstrong, et al., 2002). Findings in this Bulletin reveal that 23 percent of responding Indian Country communities to a survey indicates that they have experienced a youth gang problems. The survey findings indicate that larger communities have a greater number of gangs and gang members, experience more violent crime by gang members (including homicides), and report gang activity as a more serious social problem.

Developmental Disabilities and Academic Achievement

Fetal alcohol spectrum disorders among American Indian and Alaska Native population indicate that they have some of the highest rates in the Nation. Among some tribes, the rates are as high as 1.5 to 2.5 per 1,000 live births. Among others, the rates are comparable to that of the general population and range between 0.2 to 1.0. The prevalence of FAS in Alaska is 5.6 per 1,000 live births for American Indians/Alaska Natives, compared with 1.5 per 1,000 in the State overall which leads to increase vulnerability for maltreatment and trauma.

According to Müeller and Markowitz (2005) more than 90,000 AI/AN students were served under the Individuals with Disabilities Education Act during the 2002-2003 academic year. Although this represents only 1.36 percent of the total number of students served under this act, it is still a significant number of students. Unfortunately there are no national data comparing the educational outcomes for AI/AN students with the outcomes for other racial/ethnic groups, however a study conducted by the Government Accounting Office (GAO) found that the academic achievement of many Bureau of Indian Affairs (BIA) students (10% of 500,000 AI/AN), is significantly below that of students in public schools. For example, in 1999-2000, mean scores for BIA students served in North Dakota, South Dakota and Arizona – all states where large numbers of students are served by the BIA – were in the 25th to 33rd percentiles on state assessments. Furthermore, 10 percent of students enrolled in BIA/Tribal schools dropped out or withdrawn from school at some time in their careers, as opposed to five percent of students in public schools (NCES, 1997).

American Indian students have the highest dropout rate of any racial or ethnic group (36%) as well as the lowest high school completion and college attendance rates of any minority group (Clark & Witko, 2006). These authors continue that it is often difficult for Indian youth in urban schools to develop a sense of pride in their heritage. Indian youth may learn about certain aspects of their heritage in school, they much still content with stereotypes of their people and what those stereotypes reflect of themselves. Coping with biculturalism poses a particular problem for AI/AN youth who are growing up as members of an extraordinarily disadvantaged minority (Bechtold, 1994). According to Clark & Witko (2006) social forces makes it extremely challenging for youth to maintain an authentic sense of tribal identity when there is pressure to assimilate to either deviant groups such as gangs or toward mainstream dominate society.

Effects of trauma

According to the Surgeon General Report (1999), there are no published estimates of the rates of mental disorders among American Indian and Alaskan Native youth. One study of Eskimo children seen in a community mental health center in Nome, Alaska, indicated that substance abuse, including alcohol and inhalant use, and previous suicide attempts are the most common types of problems for which these children receive mental health care (Aoun & Gregory, 1998). An earlier study found a high need for mental health care among Yup'ik and Cup'ik adolescents who were in boarding schools (Kleinfeld & Bloom, 1977), but current DSM diagnostic categories were not used

As a result of lower socioeconomic status, AI/ANs are also more likely to be exposed to trauma than members of more economically advantages groups. Exposure to trauma is related to the development of subsequent mental disorders in general and of post traumatic stress disorder in particular (Kessler, et al., 1995).

Prevalence of PTSD must be considered with the number of exposures to trauma. Because American Indian and Alaskan Natives probably are similar to non-Indians in their likelihood of developing PTSD after a traumatic exposure (Kessler, et al., 1995), the substantially higher prevalence of the disorder (22% for AI/AN vs 8% in the general community) does not signal greater vulnerability to PTSD, but rather higher rates of traumatic exposure.

The suicide rate is particularly high among young AI males ages 15-24. Accounting for 64% of all suicides by AI/AN, the suicide rate of this group is 2 to 3 times higher than the general US rate (May, 1990; Kettle & Bixler, 1991; Mock, et al., 1996). In another survey of AI adolescents (N=13,000), 22% of females and 12% of males reported having attempted suicide at some time; 67% who had made an attempt had done so within the past year (Blum, et al., 1992). Violent deaths (unintentional injuries, homicide, and suicide) account for 75% of all mortality in the second decade of life for AI/ANs (Resnick, et al., 1997). According to the Morbidity and Mortality Weekly Report publication, "AI/AN children and youth are a greater risk for preventable injury-related death then other children in the US" (CDC, 2007). Although AI/AN death rates from motor-vehicle crashes, pedestrian events, drowning, and fire decreased during 1989-1999, the overall injury disparity compared with rates for whites persists. AI/AN children and youth have not benefited to the same degree as white children and youth from interventions in areas such as traffic safety (i.e., increased child-restraint use, safety-

belt use, and reductions in alcohol-impaired driving). AI/ANs have the highest alcohol-related motor-vehicle-death rates of all racial/ethnic groups which place youth at risk when riding with impaired drivers or even as pedestrians. In states with reservations, an estimated 75% of suicides, 80% of homicides, and 65% of motor-vehicle-related deaths among AI/ANs involved alcohol. Young drivers are at risk particularly for dying in a car crash as a result of driver inexperience, nighttime driving, and alcohol use.

Assessment

A brief caution will be given regarding standardized assessment instruments with AI/AN populations. A major concern regarding use of standardized instruments, with AI/AN, is the lack of norms for this culturally diverse population. Content bias must be considered when using any items based on dominate society understanding of the world. Improper use of assessment instruments can also be due to the lack of understanding or inexperience working with AI/AN population leading to inaccurate assumptions about intent or reasons for behavior. With this caution, clinicians should make proper and meaningful assessments based on their professional training utilizing tools that are less bias and more appropriate.

Treatment and Prevention

Many AI/AN will seek help from family members or traditional healers before considering professional mental health services. One supported project sponsored by SAMHSA specifically for tribal communities is Circles of Care. The purpose of the **Circles of Care** program is to provide tribal and urban Indian communities with tools and resources to design systems of care to support mental health for their children, youth, and families in American Indian and Alaska Native (AI/AN) communities. The intent for Circles of Care is to allow the building of infrastructure to increase the capacity and effectiveness of behavioral health systems serving AI/AN communities.

Prevention of Suicide in Indian Country

Recent efforts to address suicide prevention in Indian Country has taken many forms. SAMHSA is supporting the implementation of Garrett Lee Smith Memorial Act and Native Aspirations with tribal communities by conducting community training and providing crisis intervention. Within the NCSTN, the ICCTC is providing Honoring Children, Honoring the Future a school/community based curriculum for middle and high school students. Indian Health Service has established a Suicide Prevention Committee with the purpose to develop, advocate for and coordinate a comprehensive cultural- and community-based approach to reduce suicidal behaviors and suicides in AI/AN communities.

Many considerations should be given for any intervention; according to Stevens, et al. (2005). There are implications for providing appropriate and culturally meaningful prevention and intervention programs for AI/AN youth. First, the importance of secondary prevention programs aimed at victimized youth since there is a high percentage of victimized youth experiencing multiple episodes of sexual or physical assault throughout their lifetime. Second, secondary prevention programs should be designed for implementation with young children, as their findings suggested that younger age of onset may be a key factor associated with risk for subsequent victimization. Third, programs that focus on secondary prevention of re-victimization should consider broadening educational efforts beyond those related to a single type of violence and be multiple facets. For example, child sexual abuse victims in a re-

victimization prevention program not only might receive education on future risk of sexual re-victimization but also might benefit from education designed to reduce risk of physical assault, witnessed violence, and other forms of victimization. Fourth, their study, consistent with previous research, identified parental alcohol problems as a strong correlate with multiple victimizations in childhood. Fifth, different patterns of findings emerged across genders, which highlights the need of future research that examines the relative efficacy and effectiveness of secondary prevention programs for girls as compared to boys. Thus, secondary prevention components that effectively reduce risk for subsequent victimization among girls may not translate precisely to male victims. Sixth, clinicians can better inform their practices by incorporating detailed questions about multiple forms of victimization into their assessment procedure. The authors also stress that research indicates that physical and sexual assault victims are at high risk for exposure to additional forms or episodes of violent or traumatic events making the recommendation that practitioners should attend to the range of abusive or traumatic experiences that may be contributing to the clinical problems of a victimized child or adolescent (Stevens, T.N., et al., 2005).

ICCTC Treatment Activities

The treatment approaches adapted by ICCTC used a learning collaborative model similar to one recommended by the National Initiatives for Children's Healthcare Quality (NICHQ) for implementing evidence-based treatment (EBT) in pediatric primary care. The model utilized for dissemination and community uptake was reciprocal and transactional in nature as opposed to a fidelity or adherence training approach typically used in clinical trial projects.

ICCTC project personnel have been innovators in the adaptation of evidence-based treatments and implementation in the science-to-practice and practice-to-science movement for Indian Country. The *Honoring Children Series* (*1-Honoring Children; Making Relatives; 2-Honoring Children; Respectful Ways; 3-Honoring Children, Mending the Circle; and 4-Honoring Children, Honoring the Future)*, is culturally sensitive and culturally congruent within the world view of wellness and recovery by AI/AN communities. The initial offering of the *Honoring Children Series* was well received in Indian Country and ICCTC proposes that these adaptive evidence based treatments become the core trauma treatment environment selected by tribal behavioral health and community based programs for implementations. It must be recognized that tribal communities are hesitant to use EBT, given the lack of AI/AN participation in the establishment of their effectiveness (Manson, 2004). However, the Honoring Children Series has been viewed very positively and complimentary by tribal communities.

Honoring Children, Mending the Circle (HC-MC) is the adapted version of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), an evidence-based model of psychotherapy which combines trauma-sensitive interventions with elements of cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2006). The treatment approach is designed to address the unique needs of children with Post Traumatic Stress Disorder (PTSD) and other problems related to traumatic life experiences. It is appropriate for most types of trauma and for children up to the age of 18. TF-CBT is designed to reduce children's negative emotional and behavioral responses and correct maladaptive beliefs and attributions related to the traumatic experiences. It also aims to provide support and skills to help parents cope effectively with their own emotional distress and optimally respond to their children.

Honoring Children, Mending the Circle offers a clinical application of the healing process in a traditional framework that supports the AI/AN cultural model of well-being. The HC-MC model is founded on the AI/AN beliefs of the interconnectedness between spirituality and the healing and recovery process. Elements incorporated into the HC-MC model have long been a part of AI/AN beliefs, practices, and traditions. The HC-MC model is now creating an organizational structure for incorporating these elements into the healing process for traumatized children and their families. AI/AN ceremonies are centered on the cultural healing practices, activities, and relationship between the body, mind and spirit. Well-being is viewed as a healthy balance both within and between the spiritual, physical, relational, mental and emotional aspects of an individual's life. All aspects are interconnected, meaning that what impacts one aspect of an individual's life will affect all areas of that person's life. As trauma creates imbalance both within and between each of these life components, healing must work to restore balance and harmony to the components. This relationship is also a core concept of the TF-CBT "Cognitive Triangle," which teaches the interconnectedness between one's thoughts, emotions, and physical reactions.

The fourth in the series, *Honoring Children, Honoring the Future*, focuses on suicide intervention/prevention work which targets middle and high school students. The American Indian Life Skills Development Curriculum (AILSDC) (LaFromboise, 1995) was selected for implementation based on its original development for AI/AN youth and empirical evidence for its effectiveness. In a review of suicide prevention programs in AI/AN communities, AILSDC stood out as the only program with evidence of its effectiveness. The AILSDC uses risk and protective factors specific to AI/AN youth to inform the development of prevention strategies, provides details of how culture-specific factors are related to an increased risk of suicidal behavior, and contains material for working with students at risk for suicidal behaviors as well as students in general (Middlebrook et al., 2001). The AILSDC has been recognized by the Department of Health and Human Services in 2005 as a SAMHSA program of excellence and by the National Registry of Effective Programs in 2004.

The AILSDC was found to reduce suicidal thoughts and behaviors and feelings of hopelessness among AI/AN youth. It was also found to increase problem solving skills and suicide intervention skills with AI/AN youth through activities based on cultural knowledge gained through community resources (LaFromboise & Howard-Pitney, 1995). ICCTC supported implementation of AILSDC in a tribal school by 2 trained interventionists during the 2006-2007 school year with 160 high school students participating, ending with 120 completions as of May 2007.

Preliminary work with this intervention has been done by building community coalitions, buy-in by consensus, training, followed with implementation beginning with the fall school year (2007-2008). The intervention model to be implemented is also part of a school-based suicide prevention model within Honoring Children, Honoring the Future: *American Indian Life Skills Development Curriculum*. This model will be disseminated and implemented through: (1) direct contact with reservation schools or tribal programs that are identified as part of the suicide prevention initiative or others who may be invited, (2) formation of a required community coalition with consumer (youth and parent) involvement, (3) signed Memorandum of Agreement with local partners including participation in program evaluation, (4) training of personnel, (5) regular

consultation, and (6) evaluation of the effectiveness using focus groups, consumer feedback, behavior measures, academic measures, and evaluation on content and implementation. The participating schools, coalition members, and agencies will have access to email trauma alert messages, ICCTC and NCTSN website information.

Conclusion

The American Indian and Alaskan Native youth have a proud and rightful heritage; it is hoped that by supporting the cultural beliefs and practices of Tribes, communities and families within the orientation of tribal wellness and well being that it will help in decreasing the occurrence of trauma. Trauma, based in historical events or the result of current destructive activities, is impacting youth and putting at risk the future of Tribes. American Indian and Alaskan Native youth should have the reassurance that tribal communities with the support of programs such as the Indian Country Child Trauma Center, National Child Traumatic Stress Network, and the Substance Abuse and Mental Health Services Administration, are providing a foundation for healing and recovery.

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