

Chapter 5

American Indian and Alaska Native Mental Health Perspectives

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In order to present an overview of American Indians and Alaska Natives mental health issues, the authors have purposefully avoided specific examples or generalizable guidelines that would mislead the readers due to the extreme cultural and historical differences that comprise the many American Indians and Alaska Natives nations. It is also important to note that in the context of diversity, American Indian and Alaska Native identity is defined politically due to their collective history of being citizens of sovereign nations, not solely by racial, ethnic, or cultural terms.

The general terms, American Indian and Alaska Native, are used to describe the Indigenous people of the continental United States; other terms use in the literature include Indians, Treaty Indians, Tribal, Native Villages, Alaska Native Villages, Native Corporations, Native American, Native, First Americans, Tribal Nations, First Nations, Indigenous Nations, American Indian Tribes, Tribal people, Indian tribes, organized bands, pueblos, Alaska Native villages, tribal communities, Federally

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Recognized Tribes, non-federally recognized tribes, state recognized tribes, Rancherias, urban Indians, reservation tribes, reservation Indians, or specific tribes. There are more than 560 distinct federally recognized tribes listed with the federal government. Many other non-federally recognized groups exist and may be seeking federal recognition of their status including those tribes that are state recognized but not federally recognized.

To effectively and competently provide mental services for American Indians and Alaska Natives one must understand the extraordinarily diverse demographic and individual identity characteristics of the groups that make up North America's indigenous populations. These populations are no doubt more diverse than those that make up the rich tapestry of national and ethnic groups in European countries. American Indians and Alaska Natives reside in all of the US states. Slightly more than 50 % reside in urban areas, with the remainder living in rural villages and small rural communities and on reservations. An unknown number follow traditional lifestyles, and countless others embrace the values and lifestyles of the common North American culture. The extraordinary variation in lifestyle orientations and physical appearance among American Indians and Alaska Natives presents a daunting challenge for anyone who tends to view American Indians and Alaska Natives as a homogeneous group.

Indeed, the tendency of non-Natives to view American Indians and Alaska Natives in a collective manner has been a source of considerable concern among scholars. It may well be the major reason so many non-Natives experience difficulty in understanding the complexity of the varied lifeways and thoughtways of American Indians and Alaska Natives. Later, we present some definitions as well as information concerning demographic patterns among American Indians and Alaska Natives to show how diverse the population is and to demonstrate why it is nearly impossible to create a monocultural silhouette that portrays "Indianness" in a compendious manner. Mental health professionals must be aware of the variations and distinctions if they want to work effectively with American Indian and Alaska Native clients.

Historically, psychopathology, mental health, and personality among American Indians and Alaska Natives (Following a 1978 resolution by the National Congress of American Indians, people indigenous to North America are referred to as "American Indians" and "Alaska Natives," except when specific tribal designations are appropriate.) held an enduring fascination as objects of study for social scientists. Native scholars note the seemingly unceasing stream of biased research findings, case studies, and critical commentaries that flowed from researchers and practitioners [1, 2]. For example, in a review of the American Indian and Alaska Native mental health literature Attneave and Kelso [3] remark on the overwhelming but severely imbalanced amount of available information; their review of almost 500 articles represents a small portion of that literature.

Furthermore, most programmatic efforts to provide services in American Indian and Alaska Native mental health were guided by Euro-American psychiatric and professional traditions (see [3, 4]). It has been demonstrated that the Euro-American practices conflicts with the basic worldview of many American Indian and Alaska Native communities [5]. Continuation of these practices will in all likelihood create more problems than are solved. Miranda et al. [6] reported that American Indian and Alaska Native populations are largely missing from the literature on the effectiveness

of mental health care and that the limited literature focuses on prevention strategies with American Indian and Alaska Native youth. Bernal and Scharron-Del-Rio [7] suggest that, “it is essential that researchers construct theories of psychotherapy and evaluate treatments grounded in the realities and experiences of ethnic minority populations” (p. 337). In addition, Bernal and Saez-Santiago [8] reported that too few studies have: (1) incorporated culture and ethnicity as part of the intervention; (2) tested the effectiveness of such interventions; (3) articulated and documented how ethnicity and culture play a role in the treatment process; and (4) described how interventions may need to be adapted or tailored to meet the needs of diverse families.

Over the last 3 decades, mental health services delivered to American Indians and Alaska Natives have grown dramatically in terms of general availability as well as in the range of care offered. This growth can be attributed to a number of factors, notably changes in federal public health policies, increasing tribal resources and expertise, and community demands for more comprehensive and “culturally relevant care.” The rapid expansion of mental health services to American Indians and Alaska Natives has, however, frequently preceded careful consideration of a variety of questions about several critical components of such care, specifically, the delivery structure itself, treatment processes, program evaluation, epidemiological data, and preventive strategies. However, as a more informed perspective toward American Indian and Alaska Native mental health is emerging, federal and state agencies are now initiating and implementing new and more culturally sensitive mental health programs. Simultaneously, more accurate research and reporting are emerging. For example, recently many federal agencies have developed initiatives under the directive of health disparities research to promote preventive intervention efforts in American Indian and Alaska Native communities [4, 9, 10]. These interests and the initiatives are positive steps and have potential for improvement of mental health conditions.

While improvements have been made, a recent report by the Department of Health and Human Services Office of Inspector General [11] found that:

- Eighty-two percent of IHS and tribal facilities reported that they provide some type of mental health service; however, the range of available services is limited at some facilities.
- Staffing issues and shortages of highly skilled providers limit American Indian and Alaska Native access to mental health services at IHS and tribal facilities.
- Physical, personal/social, and economic challenges may affect access to mental health services at IHS and tribal facilities.

The report concluded that the high rates of suicide, substance abuse, depression, unemployment, and poverty in American Indian and Alaska Native communities demonstrate the need for access to mental health services. Although over 80 % of IHS and tribal facilities reported that they provide mental health services, these services are limited by shortages of highly skilled providers and by other staffing issues. Furthermore, the majority of American Indians and Alaska Natives seeking these services live in rural areas and face physical, personal/social, and economic barriers that limit access. The report recommended that IHS:

- Provide guidance and technical assistance to help tribes explore potential partnerships with non-Indian and Native providers of community mental and behavioral health services.

- Continue to expand its telemedicine capabilities and provide guidance and technical assistance to tribal health care providers to expand and implement telemedicine.
- Develop a plan to create a single database of all IHS and tribal health care facilities.

The Center for Disease Control and Prevention report that from 1999 to 2004 the suicide rate for American Indians and Alaska Natives was higher than the overall US rate; the highest rate of suicide was with adults aged 25–29; suicide was the eighth leading cause of death for American Indians and Alaska Natives of all ages, and that suicide ranked second in leading cause of death for those aged 10–34. They also reported that in this same period, American Indian and Alaska Native males in the 15–24 age range had the highest suicide rate compared to same-age males of all other ethnic groups. Their report linked suicide to behavioral health problems such as, anxiety, substance abuse, and depression. They linked suicides to the underutilization of mental health services; high poverty, poor educational outcomes, substandard housing, and disease. Finally, they noted the major disruptive impact of forced assimilation across generations on tribal unity, family strength, and typical coping strategies [12].

Given the long history of limitations and meager attempts at delivering formal services, it is not surprising that the recognition of the stark and immediate needs in these communities led to explosive growth, which outstripped the knowledge for designing and implementing appropriate programs. The time has come to take stock of the current situation.

Toward this end, we selectively review the literature pertinent to each of the areas listed above. A series of questions are posed as points of departure for future inquiry, the answers to which will, in our opinion, form the basis for significant advances in the delivery of mental health services to American Indian and Alaska Native people.

Before turning to a discussion of specific aspects of the delivery of mental health services to this special population, some mention of the broader context is in order, particularly for readers who may be unfamiliar with these communities.

In 2010, there were 5.2 million people in the United States who identified as American Indian and Alaska Native, either alone or in identification with one or more other ethnicities. Out of this total, 2.9 million people identified as solely American Indian and Alaska Native. Almost half of the American Indian and Alaska Native population, or 2.3 million people, reported being American Indian and Alaska Native in combination with one or more other ethnicities. The American Indian and Alaska Native population has experienced rapid growth, increasing by 39 % since 2000 [13]. In 2010, the majority of the American Indian and Alaska Native population (7 out of 10) lived outside of American Indian and Alaska Native areas (i.e., federal reservation and/or off-reservation trust land, Oklahoma tribal statistical area, state reservation, or federal- or state-designated American Indian statistical area). Twenty percent of the American Indian and Alaska Native population lived inside an American Indian and Alaska Native area.

American Indian and Alaska Native communities are culturally heterogeneous, having been classified into distinct regions in terms of differences in language, social organization, religious practice, and ecological relationships. Of the over 200 major Native/Indigenous American languages that existed immediately prior to European

contact, approximately 150 are still spoken, excluding hundreds of dialectal variations. At present, there are over 560 federally recognized tribal entities, an additional 100 or so that have been afforded tribal status by the states in which they reside, and several dozen that are not formally recognized in any fashion. Here, too, many more distinctions are possible and are made by American Indian and Alaska Native people.

Treatment varies widely across Indian Country from having well-established mental health agencies to others having no trained service providers within a 200 mile range. Overall, American Indians and Alaska Natives are less likely to have access to mental health services than the general population; receive poorer quality care, and are underrepresented in mental health research [14]. 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 American Indians and Alaska Natives are problematic as there are a limited number of professionals trained to work with American Indians and Alaska Natives. The need for appropriate and accessible mental health services in Indian Country is enormous [15]. Mental health services to American Indians and Alaska Natives are delivered by a diverse array of providers, many acting through federal agencies, some through locally controlled organizations, and others as part of private as well as state-managed systems. Eligibility criteria are even more confusing and vary with the provider agency in question. Indeed, this confusion prompted a study sponsored by the U.S. Department of Education, Office of Indian Education [16], to determine workable definitions of “Indian.” Despite the “definition” of Indian study, bureaucratic ambiguity remains, employing tribally defined membership criteria (which differ across tribes), blood quantum (frequently one-fourth, genealogically derived), personal identification/community consensus, and various permutations thereof [17]. It is within this setting, then, that the following issues and concerns arise.

Delivery of Services

Mental health services to American Indians and Alaska Natives are provided through private agencies and practitioners, county- and state agencies, community mental health centers, the Bureau of Indian Affairs, the Indian Health Service, urban Indian health and family support programs, and tribal health departments [18]. The nature and extent of services delivered vary with each agency or community organization, as does our knowledge concerning their respective client populations, problems treated, and outcomes.

State and Local Services

Very little information exists on client profiles and diagnostic distribution for American Indians and Alaska Native seeking services from private agencies. Given the availability of services provided by other institutions, it is likely that relatively

few individuals seek private care. Numerous American Indians and Alaska Natives from both urban areas and reservations are served by county and state mental health facilities. However, the diverse points of entry into this system—such as state hospitals, day treatment centers, the Social Security Administration, CETA, Department of Justice, hospital emergency rooms, and vocational, rehabilitation sectors—yield a confusing and often unmanageable set of service use data. American Indians and Alaska Natives appear to use mental health services far less frequently than their need for services would suggest [19]. The American Indian Service Utilization and Psychiatric Epidemiology Risk and Protective Factors Project (AI-SUPERPPF) reported that between 21 and 24% (depending upon the tribe) of an American Indian sample were diagnosed with any alcohol, drug and mental disorder compared to 22 % reported by non-American Indians in the National Comorbidity Study [20]. Reasons for low incidence of seeking mental health services included use of primary care for mental health rather than specialized care—most likely due to stigma associated with emotional or mental health treatment, privacy issues associated with confidentiality (e.g., having to receive care at facilities where friends and relative work), and negative social support or criticism for seeking help from people in their social network. Furthermore, clients with anxiety disorder who had concerns interacting with others were also reluctant to seek mental health services [19].

Bureau of Indian Affairs

The Bureau of Indian Affairs (BIA) serves tribal governments in the administration of employment and job training assistance; law enforcement and justice; agricultural and economic development; tribal governance; and natural resources management programs to enhance the quality of life in federally recognized tribal communities located in 34 states.

Historically, the BIA's responsibilities included providing health care services to American Indians and Alaska Natives. However, in 1955 the responsibility was legislatively transferred as the Indian Health Service to the U.S. Public Health Service within the Department of Health, Education and Welfare, now known as the U.S. Department of Health and Human Services (DHHS). The BIA is also responsible for the administration and management of 55 million surface acres and 57 million acres of subsurface minerals estates held in trust by the United States for American Indian, Indian tribes, and Alaska Natives. The Bureau of Indian Education (BIE) is a branch of the BIA and provides education services to approximately 42,000 American Indian and Alaska Native students. This responsibility is met through tribal and state contracts, federal boarding schools, and educational and vocational guidance programs. This branch encompasses child welfare, including care, supervision, and other services for delinquent, dependent, or neglected children, and family services involving counselor interventions related to family breakdown and emotional instability [21]. Mental health professionals and paraprofessionals are employed in both branches. However, their diagnostic

observations are seldom a matter of formal record; at best they are expected to refer clients to mental health care providers, such as the Indian Health Service or the tribal-based behavioral health services. Typically, there is little or no post-referral monitoring. One primary concern of many BIE boarding schools is the placement of youth directly from residential care without formal follow up or referral [21].

The Indian Health Service

The Indian Health Service (IHS) annually provides inpatient and outpatient care to more than two million American Indians and Alaska Natives, through direct or contract services in 12 regional areas each harboring approximately 772 facilities of hospitals, clinics, and satellite centers [11]. A relatively new but growing component administers social service and mental health programs. Because of varying and limited resources, service provision can range from exemplary to extremely lacking. Many facilities are not able to provide mental health services due to staff shortages of psychiatrists and other licensed providers [11, 22].

Urban Indian Health Care Programs

Beginning in the early 1970s, American Indian and Alaska Native communities started to assume direct control of the management and provision of health services to their members. At present there are approximately 37 urban American Indian and Alaska Native health programs. These programs—authorized under Public Law 93–437, the Indian Health Care Improvement Act, and implemented on a contractual basis with the Indian Health Service—have only recently expanded to include mental health care, and then on a limited basis. Urban Indians are much more likely to seek health care from urban Indian health organizations (UIHOs) than from non-Indian clinics [23]. However, these Indian-operated clinics must struggle to obtain and maintain their funding, resources and infrastructure needed to serve this growing population. The vast majority of American Indians and Alaska Natives living in cities are ineligible for or unable to utilize health services offered through the Indian Health Service or tribes (i.e., because of access to a facility or tribal enrollment difficulties), so the UIHOs are a key lifeline for this group. The Indian Health Service contracts with private Indian-controlled nonprofit corporations to run UIHOs. Today, there are 34 UIHOs. In fiscal year 2006, Congress spent \$32.7 million on the program, or about 1 % of IHS's \$3 billion annual budget. The 34 organizations served roughly 100,000 Indian people in 2005. However, there is no formal public health surveillance system for urban Indians. Federal, state, and local public health institutions might collect such data, but they are rarely disaggregated or separately analyzed [24]. Many standard federal health surveys cannot report accurately on urban Indians, in part because they lack adequate racial designations. In one effort

to address some of these gaps, the Urban Indian Health Institute was created as a division of the Seattle Indian Health Board in order to unify data from the UIHOs, identify urban American Indian and Alaska Native health needs, and to clarify health disparities [24]. The majority of current urban American Indian and Alaska Native health data available is the work of the Urban Indian Health Institute.

A summary of urban mental health problem areas in 2007 indicate that: (a) American Indian and Alaska Native children, adults, and families have significant and multiple mental health needs, and (b) these needs lie especially in the areas of chemical dependency, vocational/employment/financial, family, learning, emotional and interpersonal, and cultural difficulties. Among the total population, the most frequent problem areas were: chemical dependency, family strife, learning disability or difficulty, physical complaints, and employment. While these issues present themselves at these facilities, this pattern is thought to be representative of just a fraction of the broader American Indian and Alaska Native community [25].

Tribal-Based Health Care Programs

A similar set of circumstances characterizes tribal health programs. Reservation communities are empowered to assume either partial or total responsibility for the delivery of a wide range of services, including mental health care, as part of Public Law 93–638, the Indian Self-Determination Act. To date, 108 different tribal programs have been established under contract to the Indian Health Service. Less than half of these programs have a formal mental health component due to similar reasons mentioned with urban and Federal services: lack of adequate funding, lack of qualified providers, isolated location, stigma, and lack of priority by tribal government.

Service Delivery Considerations

The American Indian and Alaska Native 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 [15], 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 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 Department of Justice—Office for Victims of Crime and the Office of Juvenile Justice and Delinquency, tribal health programs, urban Indian health programs, state and local service agencies, schools—including nonprofit and/or religious, and traditional healing resources. Manson’s 2001 report on “Mental Health Care for 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 [26]. The report lists problems in service utilization

patterns that include American Indian and Alaska Native children as being more likely to: (1) receive treatment through the juvenile justice system and inpatient 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. The proliferation of services within the delivery structure outlined above raises a large number of critical questions, the answers to which can guide future growth and create greater efficacy in care: Is there a relationship between the form of delivery structure and the degree of service utilization (frequency of return~ as well as initial contact)? What are the channels by which information about service availability is communicated to and among American Indians and Alaska Natives? What service programs have successfully engendered participation in planning and operation? How have they accomplished this? Does participation relate to differential program effectiveness? How so? What impact will federal policy changes in service delivery control and eligibility requirements have on delivery structure and subsequent organizational development? To what extent can service duplication be avoided? How can service delivery be restructured to render existing health resources more cost-effective? What is the rate of referral compliance by American Indian and Alaska Native patients? To what extent is it affected by different eligibility requirements across services? How can one increase such compliance?

Though this article focuses on the formal mental health delivery structures, one should be aware of the important and extensive role that traditional healers play in the mental health care among American Indians and Alaska Natives. The function of traditional healers and their relationship to western health care professionals is an essential but not a necessarily utilized collaboration. It is our opinion that any effort to plan and deliver mental health services to Native communities must take the potential impact upon traditional healing practices into account. Central to wellness and healing is the American Indian and Alaska Native belief held by many traditional people that all things in life have a spiritual nature. Spirituality as part of healing understanding has played—and continues to play—an important role in the individual and collective well-being of American Indians and Alaska Natives; helpers and healers have been taught words, prayers, practices, rituals, and ceremonies that help connect the physical world with the spiritual to bring about wellness, balance, and harmony. The spiritual dimension is interwoven and intertwined with the physical, mental, emotional, and relational well-being dimensions [27]. Johnson and Cameron in their [28] review of mental health services with American Indians note the frequent use of traditional healing on a regular basis by both urban and reservation dwelling members of this population. King [23] found that more than half of urban American Indians and Alaska Natives had wanted traditional healing in the past year. Robert Bergman writes about medicine men that were able to provide types of healing that Western medicine could not provide, including the healing of schizophrenia [29]. He mentions one case in particular:

...a woman who had been hospitalized several times as a schizophrenic. A social worker and I set out to track her down to see how she was. We found her father first. He agreed to take us to see her but said that maybe we wouldn't be interested anymore because now she was perfectly well. We said that if she was perfectly well, we were even more interested in

seeing her. She was at home taking care of several very active, healthy-looking children and weaving a rug at the same time. After a visit of several hours, we agreed that she was indeed well again. (p. 8).

We would do well to collectively and more seriously consider what traditional healers are able to offer the field of mental health as well as develop integrated, holistic services.

Treatment Approaches

Counseling and psychotherapy outcome research has emphasized the importance of client or patient variables, expectation, and degree of disturbance, therapist characteristics, and the like. The development of a facilitative relationship or working alliance is also of considerable importance. This interpersonal climate is thought to result from the ability of the therapist to understand the client and to communicate this understanding adequately [30].

Therapy in cross-cultural settings—which characterizes the vast majority of American Indian and Alaska Native mental health experiences—has its most serious problems in those very areas of interaction that have been demonstrated to effect psychotherapy outcome. Cross-cultural therapy implies a situation in which the participants are most likely to evidence discrepancies in their shared assumptions, experiences, beliefs, values, expectations, and goals. Several recent literature reviews indicate that in the absence of this openness, this situation, at its extreme, establishes conditions that are clearly unfavorable for successful therapy, whereas effective cross-cultural therapy allows for the safe and open exploration of these discrepancies. This view is supported by the subjective reports of many clinicians involved in cross-cultural psychotherapy, as well as the limited cross-cultural research conducted in this domain [30, 31].

Complexities in Counseling and Psychotherapy

Among the most notable difficulties is the client's inaccurate or inappropriate perception of the therapist's role and client responsibilities. Thus, there is often a discrepancy between what the client expects and what the therapist interprets as the most beneficial role. This same theme has been emphasized [32, 33] in discussions of the difficulties often inherent in attempts by non-Natives to work with American Indian and Alaska Native clients. They suggest that, in general, traditional therapeutic forms of social or interactional control and influence are viewed by American Indians and Alaska Natives as out of the realm of proper behavior of action and that American Indian and Alaska Native clients frequently react with disquiet, fear, or bewilderment. Clear differences exist and do affect subsequent outcomes.

In addition to expectation for role performance, the clients of cross-cultural therapy do not always find themselves motivated to change in ways that are congruent with the therapist's goals and value system [34]. Although they may be motivated to seek treatment, they probably do not share as many valued directions of change as participants from the therapist's cultural background and training. Trimble [35] makes exactly this point, citing major differences between White and Sioux [36], Pueblo [5, 32], Hopi [37], and Arapaho [38] cultural values. Moreover, American Indian and Alaska Native clients may hold quite different beliefs about the etiology of their problems and the manner in which change can be accomplished [39–41].

Characteristics of Service Providers

Certain therapist characteristics, qualities, and activities have been identified as contributing to positive and negative outcomes in psychotherapy in general. In fact, many clinicians believe these qualities to be the most important determinants of patient improvement. Therapist variables such as warmth, honesty, self-disclosure, empathic communication, specific personality characteristics, and personal adjustment are among those that have received the greatest attention in empirical studies. This research was initially summarized by Strupp [42], among others, and has been updated on several occasions [30, 43]. The evidence indicates that the quality of the relationship correlates with positive outcomes.

Cross-cultural research suggests that many of the same therapist characteristics are also related to positive outcome between participants from different cultures. Perceived expertness, positive regard and empathy, comfort, and previous cross-cultural experience have been shown to be related to different-culture patient improvement [44–47]. Considerably more work needs to be done in this regard, especially with respect to the manner in which such variables are defined and operationalized. Little or no data are available on the therapist variables most closely linked to positive outcomes in psychotherapy among American Indian and Alaska Native patients. Speculation and anecdotal impressions abound, yet remain to be evaluated systematically.

Treatment-Related Considerations

To this end, the following questions must be examined within American Indian and Alaska Native communities: (1) What treatment modalities (indigenous and nontraditional) are available for various forms of psychopathology? (2) What expectancy variables define the therapeutic relationships? From the American Indian and Alaska Native patient's viewpoint? From the therapist's viewpoint? (3) What process variables occur between therapists and American Indian and Alaska Native patients? (4) How does one appropriately measure outcome? (5) What constitutes

effective treatment? (6) To what extent and under what conditions are treatment modalities differentially effective? (7) Under what conditions and for what reasons are practices and techniques of traditional healers appropriate? The importance of these questions cannot be understated.

Program Evaluation

Program evaluation proceeds at a different level of analysis than does the measurement of treatment outcomes. It examines specified organizational and service delivery goals in the context of community needs and the subsequent impact of an intervention scheme. Planners and administrators of American Indian and Alaska Native programs advocate evaluation of this nature, but seldom practice it. In those few instances in which such efforts are carried out, program response (in the form of modification or redirection) rarely follows. This seems to be true of the delivery of mental health services in general as well as in the American Indian and Alaska Native case [48].

Utilization of Services

With one major exception, which is discussed at the end of this section, the evaluation of services delivered to American Indians and Alaska Natives has taken the form of studies of reasons for underutilization, or, more specifically, barriers to service. Murdock and Schwartz [49] surveyed 160 elderly Sioux residents of a South Dakota reservation and found the overall awareness of available services to be remarkably low. More than 40 % of the respondents were unaware of 15 of the 21 service agencies on the reservation. Awareness of service availability closely paralleled previous differences in perceived need by household type. Elderly persons living alone were less aware of medical, home maintenance; and personal maintenance services than their counterparts residing as couples or with children. Moreover, the former were *more* aware of social and mental health services, for which they expressed considerable need, but that were sorely lacking. King [23] found that approximately half of an urban Indian sample were not aware of and did not know how to access basic health services.

Additionally, beliefs about the effectiveness of mental health care staff can affect use patterns. Reporting on their work among the Navajo, Schoenfeld et al. [50] indicate that patient referrals are directly related to the attitudes that program staff holds toward the provider agencies. For example, few, if any, clients were referred to the BIA program since attitudes toward its staff were largely negative. Furthermore, whereas the mental health personnel were viewed positively, a great deal of mistrust existed between them and other agencies, hampering effective coordination of the delivery of services in this community. Similar results were reported by Saylor and Daliparthi [51].

Urban American Indian and Alaska Native leaders and community members share a mutual concern for mental health conditions and availability of services [52]. According to Clark [53], urban Indians believe that their mental health needs are not being met adequately and that the federal government shares in the responsibility for providing care. Available services are viewed with suspicion and hence are underutilized—a recurrent finding among American Indian and Alaska Native populations and other ethnic minority populations [54].

Nonurban and off-reservation American Indian and Alaska Native apparently experience problems similar to those of their urban counterparts. Many off-reservation American Indians and Alaska Natives and those have been “dis-enrolled” have ambiguous status; state and federal governments typically consider them to be outside the realm of their responsibility. Nonetheless, their need for services is as great as those of American Indians and Alaska Natives from other settings—perhaps greater, considering the few services available to them.

Evaluation-Related Considerations

The rather limited focus of past evaluation efforts suggests that we must begin to ask a series of broader, more comprehensive questions: (1) What services currently maintain an active program evaluation component? What is this component’s function? How are data collected and used to inform development? (2) What evaluation models are available in general, especially those culturally appropriate for use in certain American Indian and Alaska Native areas? Are there program examples? (3) Are certain types of evaluation more appropriate for one delivery structure than for another? (4) What are the major barriers to program evaluation? How can these be overcome? (5) How does one meaningfully apply evaluation data to program development? (6) What efforts are being made to evaluate the effectiveness of traditional healers in providing services, or the effectiveness of collaborative efforts between professionals and healers? (7) What are the competencies required for delivering effective mental health services in American Indian and Alaska Native areas? Must all programs fit the cultural needs of communities? Or must the orientation of the clientele be adjusted to accommodate the limitations of the programs? To what extent are these issues being researched and assessed?

Epidemiology

Epidemiological data are requisite to the cost-effective deployment of mental health resources and are especially important when said resources are limited, as is the present case. Several studies report diagnostic distributions and prevalence rates, and explore the relationship between psychiatric morbidity and contemporary social pressures [55]. Though open to various methodological criticisms, these kinds of data provide a broader and more divergent picture of the nature and pattern of disorder in American

Indian and Alaska Native communities than those that derive from service utilization studies, by far the more common approach to estimating such trends [48, 56].

Epidemiological Considerations

Future epidemiological work among American Indian and Alaska Native communities must address the following questions: (1) To what extent are current diagnostic tools valid and reliable indicators of psychopathology as perceived and experienced by American Indians and Alaska Natives? (2) What is the relationship between “treated” prevalence and incidence rates (derived from service records) and patterns of disorder as manifested in the community at large? (3) Are the data that serve as the basis for “treated” prevalence and incidence rates collected in a reliable, systematic fashion? (4) Can these data be organized, collated, and reported in a regular, relatively current and accessible form? (5) Can a mechanism be developed to translate such data into meaningful recommendations for the development of mental health services to American Indians and Alaska Natives?

Collecting and Measuring Mental Health Data

In response to the first question, recent studies indicate the methodological and conceptual shortcomings of several diagnostic instruments when administered to members of American Indian and Alaska Native populations. Regardless of the scale of interest, the scores of nonpsychotic depressed American Indian and Alaska Native patients can be indistinguishable from the scores of schizophrenic American Indian and Alaska Native patients [47]. On the basis of these findings, researchers conclude that the similarity of subgroup profiles demonstrates significant cultural influence on the response patterns, rendering the MMPI useless among American Indians and Alaska Natives [47, 57, 58]. Clearly, answers to questions about reliability and validity of diagnostic tools among American Indian and Alaska Native communities await careful studies such as these.

There is little or no indication in the literature as to the relationship between “treated” prevalence and incidence rates and patterns of disorder at the community level in the American Indian and Alaska Native population. No service utilization records were available for comparison among the communities in which epidemiological studies have been conducted previously.

The Indian Health Service collects mental health data systematically across its 12 service unit areas. A computerized patient care information system has been implemented in some of the service areas and, depending upon availability of funds, will be put into effect service-wide in the near future. The protocols for collecting data of this nature have not been examined in terms of inter-rater reliability, which is further complicated by the disparate educational backgrounds and varied training of service providers. Until common valid diagnostic procedures are adopted and the

reliability of the collection of patient information is established, this question will also plague future planning and delivery efforts [11].

Health care planning and policy are monitored by a diverse array of agencies and community organizations: the Indian Health Service and its advisory committees, tribal health departments, the National Indian Health Board and its constituent area offices, the Urban Indian Health Care Association, Bureau of Indian Education and the Bureau of Indian Affairs. Some attention needs to be given to how the kinds of data described above can be introduced into such a network to ensure appropriate consideration in the design and modification of mental health services, both those currently delivered and those planned. Successful efforts in this regard will probably prove to have had multiple points of contact with unequivocal relevance and strong community support [26, 59].

Prevention

Prevention approaches, especially those that involve mental health promotion and enhancement, have long held the interest of tribal planners and service providers, the Indian Health Service, local as well as national advisory boards, and American Indian and Alaska Native people. This interest stems from a community-derived sense of self and of others that lends itself to the public health model that underpins the western health care system introduced into Indian country through past treaty arrangements [60]. Moreover, indigenous approaches to health and welfare at the levels of the individual and of the tribe provide fertile ground for the growth of such concepts. Traditional healers, their patients, significant others, social context, and common ethos are intimately linked in an attempt to realize many of the same goals as those expressed in the National Institutes of Health (NIH) prevention policy, specifically: family cohesion and positive family relationships; positive well-being, a basic belief in one's self-worth and relative value to the world, however personally defined; respect for others; interpersonal and social skills necessary for effective functioning in society; positive coping capacities and generalized stress resistance, and availability of networks and positive community support systems [48, 59].

Prevention-Related Considerations

In light of the present state of the art, future research on and the delivery of prevention services to American Indian and Alaska Native communities must consider the following questions: (1) What forms of psychopathology are thought to be preventable? By indigenous means? By nontraditional means? (2) What are the available techniques? (3) How does one appropriately measure outcome? (4) What constitutes effective prevention? (5) To what extent and under what conditions are these techniques differentially effective? (6) How can "mental health" be sustained and promoted?

Primary Prevention Efforts

Primary prevention seeks to lower the prevalence of disease by reducing its incidence, which can be accomplished in three ways: health promotion and enhancement, disease/disorder prevention, and health protection.

Health promotion and enhancement involve building or augmenting adaptive strengths, coping resources, survival skills, and general health. In addition to focusing upon the capacity to resist stress, health promotion, and enhancement require an understanding of the conditions that generate stress and that may affect psychosocial functioning negatively. There are very few evidence-based efforts of this nature in the American Indian and Alaska Native mental health literature [6]. Disease/disorder prevention encompasses a much narrower spectrum of concerns. It targets a specific disorder and, based on an analysis of risk factors, attempts to manipulate one or more conditions to forestall the occurrence of the disease in question.

The majority of primary prevention projects in American Indian and Alaska Native mental health are of this type, but they seldom move beyond the identification of risk factors to study the differential success of interventions according to the conditions manipulated. Hence the literature is replete with profiles of the “typical” American Indian and Alaska Native alcoholic, delinquent, addict, and suicide, and lacks data on the effectiveness of potential responses.

Secondary Prevention Efforts

Secondary prevention seeks to reduce the prevalence of disease or disorder through early case finding and treatment. A reduction in the duration of a case consequently decreases the total number of active cases at any given point in time. Efforts of this nature are extremely sparse in the American Indian and Alaska Native mental health literature. Manson et al. [61] identified the relationships among psychophysiological symptoms, indigenous categories of illness, and research diagnostic criteria for depression within a southwestern American Indian tribe, permitting earlier intervention and more appropriate treatment [62].

Tertiary Prevention Efforts

Tertiary prevention addresses the degree of disability that an individual suffers as the consequence of a disease/disorder. The most common approach is rehabilitation, complemented by community support programs to reduce the need for institutionalization. Despite a number of tertiary prevention programs in the area of American Indian and Alaska Native mental health, largely for chronic alcoholics and drug abusers, *little or no research* has been conducted on the relative effectiveness of rehabilitation strategies, on the kind and nature of community support that best facilitates deinstitutionalization, or on *how* to engender and to maintain such support [48].

Summary and Conclusion

There have been several national task forces that have specifically addressed the mental health of American Indians and Alaska Natives. Among them are: the President's Commission on Mental Health (PCMH) in 1978; Manson's ([56] supplemental report of the US Surgeon General; and the 2011 report by the Office of the Inspector General. Many of the questions posed in this article echo the recommendations of those reports. Those recommendations note that "at present services and service delivery systems to (American Indian and Alaska Native) people ... are disjointed, disorganized, wasteful, fragmented, and counterproductive" (PCMH [63], p. 982) and call for an examination of ways in which to coordinate the delivery of mental health care more effectively. Concern is expressed over the lack of knowledge about the relative efficacy of nonindigenous forms of counseling and psychotherapy with American Indians and Alaska Natives and about mechanisms to enhance and support traditional practices. Thorough and ongoing program evaluation is set forth as the cornerstone for eliminating duplication of services, for achieving greater institutional accountability, and for increasing awareness of successful, appropriate methods of care. The lack of a solid epidemiological database is recognized, as is the cultural bias of diagnostic instrumentation. Mental illness prevention is frequently cited in the context of the chronic physical ailments that plague American Indians and Alaska Natives; mental health promotion is held out as a possible and desired function of schools serving American Indian and Alaska Native youth. Basic and applied research on the full range of phenomena associated with these aspects of service is a common theme across all the recommendations.

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