



*Cultural Diversity Series:*

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**Meeting the Mental Health Needs of  
American Indians and Alaska Natives**

**2004**

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## Introduction to the *Cultural Diversity Series*

*The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the mental health system's success in addressing cultural differences.*

As the 21<sup>st</sup> century unfolds, state mental health agencies face the growing challenge of accommodating an increasingly diverse and evolving constituency. The call to provide appropriate and accessible mental health services to all consumers—regardless of color, ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation, or socioeconomic standing—challenges state mental health agencies to develop effective, culturally competent services and treatment methods. As the U.S. population changes dramatically, so does the public mental health system consumer base. Immigration is now the nation's major source of population growth. More than 1 in 4 Americans (27%) are non-White and/or Latino. The U.S. Census Bureau (May 1996) projects that by the year 2050, nearly 1 in 2 Americans (47%) will be non-White and/or Latino. Mental health staff may be unprepared for differences in language and worldview. They may be even less prepared to support a gay inpatient consumer facing prejudice from other staff or residents, or to provide crisis intervention to a consumer who is deaf or has another disability. However, local and/or federal statutes may require appropriate service provision to these consumers.

The National Technical Assistance Center's *Cultural Diversity Series* attempts to provide basic information and guidelines regarding the needs of a variety of ethnic and non-ethnic minorities. Each of these technical assistance reports provides a synopsis of the particular population's mental health needs, relevant cultural characteristics and traditions, perceptions about mental illness, and preferences for services and supports. Each report also describes several mental health programs that have successfully tailored their services to meet the needs of diverse consumers and contains a comprehensive resource section with recommended readings and organizational resources.

The goal of the *Cultural Diversity Series* is to assist state mental health agencies in moving toward mental health service delivery systems that are appropriate and accessible to all consumers. This report in particular explores ways to develop culturally competent public mental health systems and services for American Indians and Alaska Natives. The following reports in this series are available from the National Technical Assistance Center (NTAC): *Meeting the Mental Health Needs of Asian and Pacific Islander Americans*; *Creating Culturally Competent Mental Health Systems for Latinos: Perspectives from an Expert Panel*; *Meeting the Mental Health Needs of African Americans*; *Meeting the Mental Health Needs of Persons Who Are Deaf*; and *Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons*.

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## **Disturbing Service Utilization Trends**

Despite their growing numbers, members of ethnic and racial groups are often underserved or inappropriately served by the public mental health system. Research suggests that various ethnic groups underutilize mental health services, either by dropping out of services or by entering services at much later stages in their illness, thereby creating a need for more costly services (Lefley, 1990; Munoz & Endo, 1982). For example, studies have found that although African Americans, Native Americans, and Latinos/Hispanics in most states underutilize community-based services, they are significantly overrepresented in state inpatient facilities (Aponte, 1994).

In anticipation of increased future service demands by growing ethnic minority populations, state mental health agencies are increasingly examining their accessibility to both ethnic and non-ethnic minorities. State mental health agencies may be able to reduce the use of costly inpatient services by engaging ethnic minorities during earlier stages of their mental illnesses. More important, by providing culturally competent community-based care to all minorities, mental health services will be more effective and efficient.

## **Cross-Cultural Mental Health Services and Barriers to Service Delivery**

Cross, Bazron, Dennis, and Isaacs (1989) view culture as encompassing “the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group.” Cross-cultural mental health service delivery occurs whenever two or more of the participants are culturally different. Thus, Atkinson, Morten, and Sue (1998) point out that cross-cultural service delivery occurs, for example, in “a counseling dyad consisting of a low-aculturated Mexican American client and a high-aculturated Mexican American counselor.” Similarly, a married heterosexual service provider brings a vastly different world view and set of experiences to the counseling relationship than a single client who is lesbian. Policymakers and service providers are coming to understand that cultural diversity must be broadly defined to accommodate wide variations among consumers.

Cultural differences exist on many levels, including help-seeking behaviors, language and communication styles, symptom patterns and expressions, nontraditional healing practices, and the role and desirability of medical intervention (Comas-Diaz & Griffith, 1988; Gaw, 1993). Members of ethnic and non-ethnic minorities may be underserved by the public mental health system for varied and complex reasons. Some commonly cited factors include the following:

- ◆ the stigma of mental illness and the varying ways that members of different ethnic minority groups may define mental health and mental illness;
- ◆ lack of culturally appropriate services to accommodate the needs and beliefs of diverse consumers;
- ◆ consumer fears of experiencing discrimination in the treatment setting;

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- ◆ mental health providers' lack of awareness or knowledge regarding culturally appropriate policies and practices;
  - ◆ language barriers increased by the growing numbers of both consumers and providers whose native language is not English;
  - ◆ communication barriers based on differences in verbal and nonverbal styles that may lead some minority consumers to feel they have given very clear messages to providers who have not understood the communication;
  - ◆ lack of familiarity with Western or mainstream mental health services;
  - ◆ fear of exposure or discomfort about disclosing sexual orientation or gender identity concerns to service providers; and
  - ◆ systemic barriers, such as funding sources that place strict limits on reimbursable services.

### **Cultural Competence**

Developing cultural competence within a mental health system is a dynamic and evolutionary process. The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the mental health system's success in addressing cultural differences. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health services, including assessment, treatment, and evaluation (Miller, Peck, Shuman, & Yrn-Calenti, 1995). The authors identify six stages of developing cultural competence.

Stage 1: Sees other cultures as inferior: seeks to destroy other cultures.

Stage 2: Cultural incapacity: adopts paternalistic posture toward so-called inferior people.

Stage 3: Cultural incapacity: seeks to assimilate differences, ignore strengths.

Stage 4: Cultural precompetence: realizes weaknesses and makes commitment to improve.

Stage 5: Culturally competent: respectful, accepting, self-monitoring.

Stage 6: Takes advocacy and educational role.

Developing respect for differences and cultivating successful approaches to diversity requires increased awareness—of one's self; of unstated institutional cultural norms; and of the history, culture, and needs of diverse consumers. To increase cultural competence, mental health service providers need to develop an awareness of their own racial and cultural

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heritage; to understand how that heritage influences their understanding and biases about normality/abnormality and the process of mental health service delivery; and to understand the significant impact of differences both in language and in verbal and nonverbal styles on the process of communication (Atkinson et al., 1998). Mental health systems typically operate on unstated Western principles—for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body, and devaluing of altered states of consciousness—which may be at odds with the underlying values and beliefs of some ethnic and racial populations. Without awareness of this dynamic, mental health providers may impose this Western framework on minority consumers.

The populations that are the subjects of these reports have all experienced and/or are experiencing some form of social inequity that is directly relevant to their status as underserved groups. Exploring and sometimes challenging the assumptions and biases held by stakeholders and the wider community is a crucial step toward achieving a culturally competent system. These attitudes have a direct impact on the functioning of minorities, their mental health needs, and their willingness to seek services. Similarly, cultural assumptions affect the mental health system, its practitioners, and its ability to engage minorities.

Some mental health systems and providers seeking to increase cultural awareness may inadvertently rely on overgeneralizations that ignore subgroup and individual variation, thus belying the basic value of cultural competence. To be truly culturally competent, mental health systems must be aware of significant differences in lifestyle and worldview among diverse populations, while valuing and responding to the distinct needs of each client. Rather than relying on stereotypes about groups, administrators and practitioners need to be aware of their own cultural assumptions and should ask consumers how *they* understand their problems and what *they* need.

These *Cultural Diversity Series* reports are designed to help key decision makers wrestle with the challenges facing public mental health systems, while effectively addressing the need for individualized, culturally competent services for ethnic and non-ethnic minorities.

### ***A closer look at: Refugees***

People seeking refuge in the United States come from all ethnic and racial backgrounds, and they often have great difficulty obtaining traditional mental health services. These individuals have often experienced severe stress, resulting from continuous threat to life or freedom, traumatic flight, death of family members or friends, torture and imprisonment, living in concentration or refugee camps, uncertainty and lack of control over relocation, and inability to return to their homeland (Garcia-Peltoniemi, 1991). Their mental health may be jeopardized by multiple losses (of country, family, status) and other major disruptions (e.g., unemployment) that often accompany resettlement in a new country. A proportional number can be expected to be sexual minorities, or deaf or disabled, and the meaning and impact of these attributes will vary widely by culture.

Unfortunately, definitive prevalence rates of mental illness among refugees are elusive. The few studies available reveal that depression, anxiety, and Posttraumatic Stress Disorder are reported at disproportionately higher rates in refugee populations. In addition, a small

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percentage of refugees experience schizophrenia or brief reactive psychoses marked by delusional content strongly related to culture that may require prolonged, intensive intervention (Garcia-Peltoniemi, 1991). Typically, state mental health agencies have contact with refugees during times of crises through crisis counseling services or inpatient treatment. Successful strategies to engage refugees prior to the eruption of crises include the following:

- ◆ networking with and through the refugee community;
- ◆ conducting home visits;
- ◆ linking with physical health services;
- ◆ using bicultural professional and paraprofessional staff; and
- ◆ making outreach efforts that focus on helping refugees meet basic needs, such as housing and income.

Such services are accepted more easily when linked with resettlement agencies (e.g., religious-based organizations, private organizations, state agencies or ethnic organizations that assist individual refugees upon arrival), and mutual assistance associations in which former refugees and immigrants help their own people. The Center for Mental Health Services' Office of Refugee Mental Health serves as a bridge between the mental health and refugee communities, providing consultation and training to states and refugee organizations.

### ***A closer look at: Non-English-Speaking Consumers***

The challenge of developing culturally competent mental health services is complicated by the vast number of languages that are spoken in the United States. Mental health providers may have difficulty reaching, communicating with, and treating non-English-speaking and/or deaf consumers who exist within all communities.

Ideally, bilingual mental health professionals will be available to engage and provide treatment to people whose primary language is other than English. However, the need for academically trained, multilingual and multicultural mental health professionals far exceeds the number now available. While increasing the numbers of these professionals is essential, other models of services are also in use, including the following examples.

**Bilingual Paraprofessionals.** While they may not have formal clinical training, bilingual workers serve many valuable functions, including translator, paraprofessional counselor, culture broker, outreach worker, community educator, community advocate, and trainer of service providers about the refugee's culture (Egli, 1987). Ultimately, the goal may be to encourage bilingual workers to obtain further academic training in mental health to increase the supply of bilingual and bicultural psychiatrists, psychologists, social workers, and other mental health professionals. It should be noted that persons who can communicate in both American Sign Language and a spoken language are considered bilingual.

**Interpreters.** Using interpreters for assessments and treatment is a less desirable route, but one that many systems rely upon given the shortage of bilingual mental health professionals. As Adkins (1990) noted, "A facility with language does not make a person an effective interpreter unless there has been adequate training, agreement on interpretation system, and

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building of rapport between the mental health professional and interpreter.” Thus, relying on family members to serve as interpreters is considered inadequate and inappropriate.

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## Executive Summary

American Indians and Alaska Natives have withstood tremendous adversity during the short history of this nation, a history marked by such turmoil that their presence in today's world is indisputable evidence of the resilience, strength, and enduring spirit of their people. It is a remarkable story of the influence of cultural and political forces in shaping health and well-being. To that end, this report highlights the mental health needs of American Indians and Alaska Natives, describes the service ecologies that have emerged to address these needs, and discusses Native peoples' access to and use of mental health services. The report concludes with a discussion of innovative practices for the care of American Indians and Alaska Natives as well as an itemization of "lessons learned" so that states can properly address the mental health needs of this population.

### Demographic and Epidemiologic Transitions

Major demographic and epidemiological transitions have impacted the health and well-being of American Indians and Alaska Natives. First, there was exposure to European colonialists and their diseases, followed by the unsanitary conditions found on reservations. With the increasing urbanization of the Native American population, chronic diseases ("diseases of modernization") such as cancer, cardiovascular diseases, obesity, and diabetes have increased as causes of morbidity and mortality. Furthermore, with Native American social and psychological environments plagued by economic disadvantage, family disorganization, and personal despair, social pathologies such as suicide and alcoholism have emerged as causes of death.

There are over 500 federally recognized tribes and over 150 different languages spoken among them. The majority of American Indians and Alaska Natives live in western states and in non-reservation areas. Their attainment of higher education is below that of the general population, and many American Indians and Alaska Natives are unemployed or hold low-paying jobs. Employment opportunities are especially scarce in most reservation communities. According to the 2000 Census, about 26% of American Indians and Alaska Natives lived in poverty, compared with 13% of the general population, with the median income for the former being \$30,800 compared with \$41,600 for the latter (U.S. Census Bureau, 2000). American Indian and Alaska Native children live in single parent families at the highest rates in the country, compounding the scarcity of available resources. Finally, their rates of adoption and foster care placement are unparalleled in any other segment of the population.

Yet, despite these and other obstacles, Native American peoples have rebounded "politically, culturally, linguistically, and spiritually," (Hamley, 1994; U.S. DHHS, 2001) thanks in part to a "shared social consciousness across previously disparate tribes" (U.S. DHHS, 2001). American Indians and Alaska Natives are ready for significant change in current health care practice, and will welcome a revitalized mental health system of care with the condition that societal Native beliefs that affect health must be understood and addressed by the providing entities.

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## *Critical Historical Events*

Understanding the mental health needs of American Indians and Alaska Natives requires a firm grasp of critical historical events that have dramatically altered their lives. Virtually all of these events involve federal policies that forever changed the physical, social, and economic climate for Native Americans. These policies include the Federal Indian Boarding School Movement beginning in 1899, the Dawes Act of 1887, the Indian Self-Determination and Education Assistance Act (P.L. 93-638) of 1975, and the Indian and Child Welfare Act (ICWA) of 1978. Historically, federal policy concerning Native Americans has been characterized by geographic isolation, discrimination, and disenfranchisement, as well as attempts at redress for the negative effects of these same policies.

## **Mental Health Needs**

This report highlights suicide and other violent deaths as a paramount concern for the Native American population. From 1979 to 1992, the suicide rate for American Indians and Alaska Natives was 1.5 times the national rate. Violent deaths including unintentional injury, homicide, and suicide account for 75% of all mortality in the second decade of life for American Indians and Alaska Natives (U.S. DHHS, 1999). Oppression, discrimination, and removal from traditional lands have contributed to Native peoples' current lack of educational and economic opportunities and their significant representation among populations with high need for mental health care. American Indians and Alaska Natives are frequently among the most highly vulnerable populations including those who are homeless, incarcerated, and victims of trauma.

## **The Local Service Ecology**

The system of services for treating mental health problems among American Indians and Alaska Natives is a complex and often fractured web of tribal, federal, state, local, and community-based services. The agency most directly responsible for providing mental health services to American Indians and Alaska Natives is the Indian Health Service (IHS), specifically its Mental Health and Social Services Programs Branch (MHSSPB), IHS primary health care services, and Alcoholism/Substance Abuse Programs Branch. However, other programs and agencies also play important parts in this effort, including the Bureau of Indian Affairs, the Department of Veterans Affairs medical and counseling programs, tribal health programs, urban Indian health programs, state and local service agencies, and traditional healing resources. Despite the wide range of services described here, the availability and adequacy of these programs varies considerably across communities.

## **Access to and Use of Mental Health Care**

The available research indicates that while the need for mental health care is great, services are lacking, and access can be difficult and costly. For example, although the federal government provides varying degrees of health care to the members of more than 500 federally recognized tribes through the Indian Health Services, only 1 in 5 American Indians reports access to IHS services (Dixon, 2001). Furthermore, it is reported that IHS Mental

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Health Programs are operating at one-third the budget necessary for minimal provision of mental health care (personal communication, S. Nelson, June, 1998, IHS). Other research indicates that only about half of American Indians and Alaska Natives have employer-based insurance, as compared to 72% of Whites (Dixon, 2001). Where Native Americans are covered by health insurance, the move to managed care has made it difficult for tribally operated programs to receive Medicaid reimbursement. For example, many individuals who otherwise qualify for Medicaid have dual diagnoses that include alcoholism, complicating billing, and compensation.

With regard to service utilization patterns, the existing research suggests that American Indian children may be more likely to receive treatment through the juvenile justice system and in-patient facilities than non-Indian children; encounter a system understaffed by children's mental health professionals; encounter systems with consistent lack of attention to established standards of care for their population; and experience high levels of unmet need. In the adult population, it appears that American Indians use community mental health facilities less frequently than other segments of the American population, and experience higher non-return rates than those of other populations.

### **Native Views of Mental Health and Illness**

Barriers to mental health care are not limited to issues of availability, access, or cost. Stigma is a prominent factor in reducing help-seeking by American Indian and Alaska Native populations. Cultural differences between patient and provider in regard to conceptions of health and illness may also impede both help-seeking and treatment effectiveness. For example, spirituality is a core system of belief—focusing on intangible elements imparting vitality and meaning to life's events—that is so essential to Indians and other Natives and is pointedly absent from the perspectives that guide the bulk of available mental health care. Public mental health providers must understand that among most Native people, to live in health is to live in accordance with moral or behavioral codes that strive to maintain harmony between one's self and his/her family, community, environment, and spiritual world (Avery, 1991). Illness can result from negative mental, physical, or spiritual activity or from disruptions in the world around one. In Indian communities, ceremony and ritual are the mechanisms by which the ensuing imbalance or loss of connection is restored.

Fortunately, numerous models of cultural competence, recognizing the importance of patients' cultures and the skills, knowledge, and policies to deliver effective treatments, have been proposed.

### **Promising Directions**

This report describes the following innovative approaches to mental health care in American Indian and Alaska Native communities.

- ◆ The Rural Human Service (RHS) Certificate Program, a human services delivery model designed to address the special needs of Alaska's rural, largely Native communities. A unique aspect of the RHS program is that the curriculum and instructional methods are strongly influenced by traditional values of Alaska Native communities.

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- ◆ Several SAMHSA-funded experiments are underway to provide for the planning and implementation of coordinated services for Indian/Native children suffering from serious emotional disturbance.
  - ◆ The Circles of Care Initiative, supporting 15 Indian and Native grantee communities in their efforts to redesign local systems of care in a manner more consonant with rapidly changing circumstances and with local priorities, as rooted in their cultural values.
  - ◆ The Comprehensive Community Mental Health Services for Children and Their Families Program, a large SAMHSA grant program providing funds for over 67 comprehensive systems of care designed to better meet the needs of the nearly 4 million children with emotional disturbance in this country (SAMHSA, 2001).
  - ◆ The Kmiqhitahasultipon Program of the Passamaquoddy Tribe of the Indian Township of Maine, targeting very young children and their families (Simpson, Jivanjee, Koroloff, Doertfler, & Garcia, 2001). This program intentionally built links with a wide array of other child-serving agencies in the community, employing tribal consumer and family advocates as the principal liaisons.
  - ◆ The Sacred Child Project, an inter-tribal effort that serves distinct tribal groups on the Standing Rock, Spirit Lake, Turtle Mountain, and Fort Berthold reservations. Similar to the Alaska and Passamaquoddy examples, this project also employed the wraparound concept (efforts must be community based, individualized, culturally competent, flexible, unconditional, include parental involvement, implemented on an inter-agency basis, and must result in measurable outcomes [VanDenBerg & Grealish, 1996]), but more consciously sought to integrate this orientation with local tribal philosophies.

### **Lessons Learned and a Roadmap for Action**

The lessons learned from promising initial efforts suggest a roadmap for states to become better partners in addressing the mental health needs of American Indians and Alaska Natives.

**Cultural Competence and Managed Care.** Managed care plans providing behavioral health care should consider how current practices, including auto-enrollment, preauthorization procedures, definitions of medical necessity, and the medicalization of behavioral problems, may affect the appropriateness of care for Native people.

**Behavioral Carve-Outs.** While most states often separate the financing and management of behavioral health care from physical benefits, this approach poses problems for American Indians and Alaska Natives. First, the same financing approach may not be appropriate when applied to both rural and urban areas. Second, given the widespread stigma associated with mental illness, coupled with Native Americans' more holistic views on illness, there may be

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a strong basis for not carving out behavioral health care from general health care.

**Need for High Quality Data.** Although there is a need for accurate data on clients, tribes and Indian health programs usually lack the infrastructure or experience to collect and analyze such data. More opportunities should be created for states to collaborate with Indian and Native communities for enhanced data collection.

**Availability and Accessibility of Services.** Managed care organizations control costs by limiting the availability and duration of behavioral health services. This practice, however, often excludes the services most relevant to the mental health problems of American Indians and Alaska Natives including intensive case management, family support and education, and culturally sensitive interventions. Health plans can become more responsive by including American Indians and Alaska Native perspectives in standing mental health councils or advisory committees, as well as targeting an aggressive educational campaign toward consumers and tribal leaders.

**Credentialing and Licensing.** Current credentialing procedures emphasize the more established behavioral health disciplines and do not consider licensing provisions for other providers such as primary care physicians, mental health paraprofessionals, or laypersons. Even though these latter providers typically lack licensure or certification, they usually represent the first, if not ongoing, point of contact for Native Americans in need of behavioral health care. States should explore how to address issues of credentialing for these vitally important providers.

**Urban Indian Health Programs.** While Medicaid programs are required to cover services provided by Urban Indian health programs, many of them lack the financial resources or expertise to become Medicaid Managed Care organizations. Consequently, they must either subcontract with managed care organizations in their service area or remain unaffiliated, which often results in unmet need for consumers. States, by providing technical assistance, could enhance the organizational capacities of many urban Indian health programs and assist them in becoming more effective vehicles for funding these services.

**Integrating Mental Health and Substance Abuse Services.** There is extensive comorbidity of mental health and substance abuse problems among Native people. Public health plans should strive toward integrating mental health and substance abuse services, including potential solutions such as:

- ◆ more comprehensive evaluation;
- ◆ integration of treatment and rehabilitation models from both arenas;
- ◆ more aggressive follow-up as clients migrate between urban and rural areas;
- ◆ improved interagency cooperation and pooling of funds; and
- ◆ provision in the benefits package for service planning and transition to new providers for those leaving the plan.

**Care for Children, Adolescents, and Elders.** Technical assistance regarding developmental implications for care and joint planning by states and tribes as well as urban Indian health

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programs can maximize available resources, yield better program efficiencies, and improve treatment outcomes. For the provision of services to youth, special attention should be given to preventive services focusing on families as well as leveraging resources by integrating coverage with funding from special education, juvenile justice, and social service agencies. In the case of Native elders, special attention should be given to the role of families in their care. “Carved-in” approaches that integrate primary and behavioral health care within a single setting deserve careful consideration because physical and health problems often increase with aging.

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## Introduction

Consistent with other publications in the *Cultural Diversity Series* produced by the National Technical Assistance Center for State Mental Health Planning, this report seeks to summarize and illustrate our field's knowledge regarding a specific, underserved population—in this case, American Indians and Alaska Natives. The mental health needs of this population are considerable and pervasive. But understanding their mental health needs, and the directions that promise relief, requires a firm grasp of the forces—historical, social, cultural, individual—that gave rise to and perpetuate those needs. In this vein, the adage “a problem well-stated is a problem half-solved” is particularly true, for few providers, administrators, payers, or policy-makers understand the dynamics that underpin this set of circumstances.

This discussion opens by examining the demographic and epidemiologic transitions that American Indians and Alaska Natives have endured, and the ensuing implications for their health and welfare. The report subsequently considers the critical historical events that have influenced not only individual lives, but also the very shape of Indian communities today, including their challenges and opportunities. The discussion then briefly highlights the mental health needs of this special population, foregoing a detailed exposition of the current state of our knowledge, because that information has been chronicled in *Mental Health: Culture, Race, and Ethnicity* (U.S. DHHS, 2001), *A Supplement to Mental Health: A Report of the Surgeon General* (U.S. DHHS, 1999). With the stage set by the Surgeon General's report, this American Indian and Alaska Native report moves to the complicated, often fractured service ecologies that have emerged in an attempt to address these needs. Rapid change and dramatic shifts in organizational responsibilities for delivering relevant care are the most prominent features of today's programs.

This report will then focus on an overview of access to the care offered through this array of providers, summarizing what we know about the help-seeking behavior of Native people, their use of these services, and the barriers encountered. But it becomes readily apparent that availability and accessibility constitute only part of the explanation for the observed utilization patterns. Hence, we subsequently reflect on the limits of our conceptual frameworks for understanding and addressing Native views of mental health and mental illness. The experience and manifestation of psychopathology can be different and the same across cultures, hinging upon the extent to which assumptions such as the relationship of mind to body—and spirit in the case of Native people—or the primacy of the individual or social collective are shared.

The report closes with a brief overview of how and where American Indian and Alaska Native communities are charting new paths across their current landscapes, looking carefully to key social and cultural values as guides in developing innovative solutions to local problems of care. The emerging solutions are as exciting in their form as well as promise for future directions. A series of lessons learned are evident, and they are discussed with special emphasis on the contribution that states can make to building new, productive partnerships in this endeavor.

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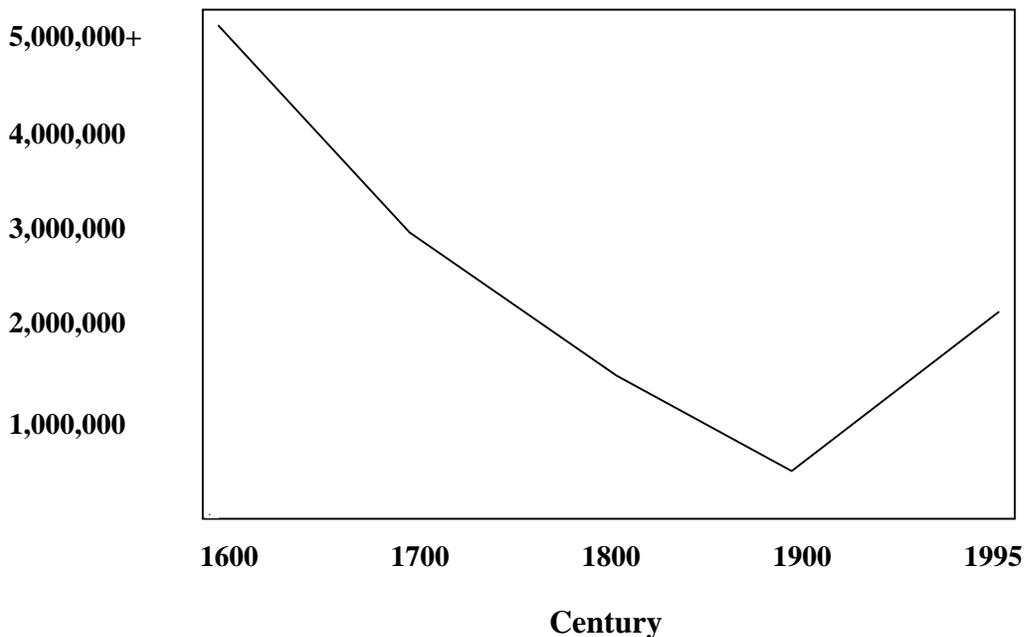
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## Fundamental Transformations in the Landscape of Native Communities: The New Morbidities

### Demographic and Epidemiologic Transitions

The demographic history of American Indians and Alaska Natives can be broadly divided into several periods (Dobyns, 1983; Johansson, 1982; Thornton, 1987). During pre-contact, when an estimated 5 million or more American Indians lived in what is now the United States, the birth rate was slightly higher than the death rate, and the population remained more or less stable. After what has been referred to as “contact shock,” when European “discovery” of North America occurred and immigration as well as colonization began in earnest, the rate of birth declined while mortality increased, resulting in a dramatic depopulation to only 250,000 Indians and Natives in the middle 1800s. By the end of the 19<sup>th</sup> century, most Native populations began to recover and the birth rate eventually overtook the death rate. In the latter half of the 20<sup>th</sup> century, “modernization” occurred, with both mortality and birth rates turning downward in the fashion of the classic “demographic transition” (Johansson, 1982; Kunitz, 1976).

**Figure 1: Population Demographics**



Demographic trends of this nature often occur in tandem with “epidemiologic transitions” (Omran, 1971). Exposure to the infectious diseases of Europeans in the 17<sup>th</sup> century ravaged Native peoples, as their natural immunization was ineffective. But other cultural transformations—domestication of animals, an increasingly sedentary lifestyle imposed by restriction to reservations—also contributed to such vulnerability. Indeed, once American

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Indians were resettled on reservations, most were plagued by loss of traditional subsistence, economic impoverishment, and unsanitary living conditions that exacted a terrible price for many generations to come. The Meriam Report (Brookings Institution, 1971) documented much of this, citing the devastating consequences in terms of influenza, dysentery, and tuberculosis epidemics.

In 1940, the life expectancy of American Indians was approximately 52 years, far lower than their Black or White counterparts of the time. Likewise, at about the same time, the infant mortality rate, due to these same circumstances, was 53 per 1,000 live births, more than twice that of the general U.S. population. However, during this period, public health measures introduced by the then newly founded Indian Health Service (IHS) began to successfully control the conditions that fanned the flames of such epidemics so that by a decade or two later the prevalence of many infectious diseases was significantly reduced (Sorkin, 1988). Infant mortality rates are now equivalent to or lower than those of the U.S. general population; the gap in life expectancy, although still evident, is much less than it once was, with American Indians now reaching 72.9 years.

As infectious, communicable diseases declined among American Indians and Alaska Natives, chronic diseases, accidents, and acts of violence—“diseases of modernization” or “Western diseases” (Trowell & Burkitt, 1981)—have increased in importance as causes of morbidity and mortality. Cancer, cardiovascular diseases (including ischemic heart disease, hypertension and dyslipidemia), obesity, diabetes, and gall bladder disease are much more prevalent than they were 40 years ago. For example, diabetes has been observed to increase among populations undergoing urbanization and lifestyle changes, factors that clearly characterize Indian and Native people (Young, 1994). Though rates of diabetes vary widely across Native communities, deaths due to this disease are more than 230% more common for Indians than the U.S. as a whole (U.S. DHHS, 1997).

Most relevant to the present topic is the emergence of social pathologies as causes of death. Despite improvements in the physical surroundings of many Indian and Native communities, their social and psychological environments remain plagued by economic disadvantage, family disorganization, and personal despair (Bachman, 1992). It is not surprising, then, that in the last decade the suicide rate for American Indians was 16.5 deaths per 100,000 population, 85% higher than the 11.5 deaths per 100,000 for the rest of the nation (U.S. DHHS, 1997). Likewise, the alcoholism mortality rate for Native people was 51.8 deaths per 100,000 population, 630% higher than the U.S. total rate (7.1 per 100,000). Clearly, “modernization” has carried a high cost for this special population.

### **Indian Country Today**

Presently, most American Indians live in western states, including Alaska, Arizona, Oklahoma, California, New Mexico, Montana, and South Dakota with 42% residing in rural areas, as compared with 23% of Whites (Rural Policy Research Institute, 1999). Fewer American Indians live on reservations and trust lands (areas with boundaries established by treaty, statute, and/or executive or court order) today than in past decades. For example, in 1980, most American Indians lived on reservations or trust lands; today, only 1 in 5

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American Indians live in these areas, and more than half live in urban, suburban, or rural non-reservation areas.

The following information, which is paraphrased from *Mental Health: Culture, Race, and Ethnicity* (U.S. DHHS, 2001), *A Supplement to Mental Health: A Report of the Surgeon General* (U.S. DHHS, 1999), further details some of the major sociological data of Indian Country Today.

*As of 1990, 66% of American Indians and Alaska Natives age 25 years and older had graduated from high school or achieved a higher level of education; in contrast, only 56% had done so in 1980. Despite this advance, the 1990 figure was still below that for the U.S. population in general (75%). American Indians and Alaska Natives were not as likely as others in the United States to have completed a bachelor's degree or higher (U.S. Census Bureau, 1993).*

*The social environments of Native people remain plagued by economic disadvantage. Many American Indians and Alaska Natives are unemployed or hold low-paying jobs. Employment opportunities are especially scarce in most reservation communities. Of the 10 counties in the nation with the highest unemployment rates in 1990, three included Northern Plains Indian reservations. Nationally, the unemployment rates for American Indians is significantly higher than their counterparts, with American Indian males being two times as likely as White males to be unemployed in 1998, and a similar pattern among females (Pollard & O'Hare, 1999). From 1997 to 1999, about 26% of American Indians and Alaska Natives lived in poverty, compared to 13% of the United States as a whole, and 10% of White Americans (U.S. Census Bureau, 2000). The median household income for the former is \$19,865, compared with \$30,056 for White Americans; 31.7% of American Indian families live below the poverty level, compared with a national rate of 13.1%.*

*In 1990, 60% of Indian and Native families were headed by married couples, in contrast to about 80% of the rest of the nation (U.S. Census Bureau, 1993). In 1993, American Indian families were slightly larger than the average size of all U.S. families (3.6 versus 3.2 persons per family) (U.S. Census Bureau, 1993). Even more telling is the dependency index, which compares the proportion of household members between the ages of 16 and 64 with those younger than 16 years of age combined with those 65 years of age and older. The former (between age 16 and 64) are more likely to contribute economically to a household, and the latter (under age 16 and over age 65) are not, thus the dependency of one on the other. In this regard, households in many American Indian communities exhibit much higher dependency indices than other segments of the U.S. population and are more comparable to impoverished Third World countries (Manson & Callaway, 1988). Thirty-seven percent and 28% of American Indian and Alaska Native children, respectively, live in single parent families—rates among the highest in the country—a fact that further compounds the scarcity of resources available to them.*



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## Critical Historical Events

*Critical Historic Events—American Indian and Alaska Natives* (Figure 2) depicts a number of prominent historical events and experiences that have affected the lives of this special population. A detailed analysis of their impact is beyond the present discussion. Nonetheless, these events either heralded or demarcated important periods that noticeably affected the lives of Native Americans. Virtually all the events entail the introduction of federal policies that dramatically altered the physical, social, and economic climates of the times. For example, the Federal Indian Boarding School Movement began in earnest in 1875. By 1899, there were 26 off-reservation schools scattered across 15 states. The emphasis within the Indian educational system later shifted to reservation schools and public schools, but boarding schools continued to have a major impact into the next century because they were perceived as “civilizing” influences on American Indians. More specifically, the goal for these schools was to remove all aspects of the children’s cultural existence and instill in them the beliefs, values, customs, and behaviors of white culture—to turn the children into white people. During the 1930s and 1940s, nearly half of all Indian people who received formal education attended such schools.

In 1887, the Dawes Act provided for the allotment of property rights to individual Indians. This event, which ran counter to indigenous concepts of collective rights and obligations regarding land, led to the sale of trust lands and subsequent disenfranchisement of landless Native people. At about the same time, moved by the devastating consequences of largely unchecked infectious diseases, the Bureau of Indian Affairs (BIA) launched a major health initiative that laid the groundwork for the present-day Indian Health Service.

Several decades later, in 1934 Native Americans were formally granted U.S. citizenship and the right to vote. This was accompanied by a major reorganization of local government, which swept away traditional forms of leadership and instituted tribal councils and formal elections (Act of June 18, 1934). This same act introduced a wholesale change in diet and subsistence practices, making available free refined wheat, sugar, lard, bacon, and cheese. Also during this era the federal government's educational policies—which revolved around boarding schools as mechanisms of assimilation—reached their zenith, resulting in massive upheavals in Indian family structure.

World War II brought a brief respite from these pressures. Indian and Native men entered military service in large numbers. After the war, they returned to their homes as a new political force, bringing an unprecedented level of knowledge and sophistication to local governance. However, federal assimilation policies were revived with even greater vigor. Economically successful reservations were encouraged to divest themselves of federal guardianship. BIA programs relocated thousands of families to cities such as Chicago, Denver, and Los Angeles to provide vocational training and employment opportunities. Many reservations saw jurisdiction over their legal matters transferred from the federal to state governments.

**Figure 2: Critical Historic Events—American Indian and Alaska Natives**

<b>1880-1920</b>	<b>1920-1940</b>	<b>1940-1960</b>	<b>1960-1980</b>	<b>1980-Present</b>
Dawes Act	Citizenship Granted to all Indians	WWII Involvement in Services	War on Poverty Program	American Indian Religious Freedom Act
Federal Indian Boarding School Movement	Indian Reorganization Act	Hoover Commission and Termination	Economic Opportunity Act	Indian Gaming Regulatory Act
Medical Division Established in Indian Services		Indian Relocation Program	P.L. 638 Indian Self-Determination & Education Assistance Act	Tribal Restorations
Prohibition of Liquor Sales on Reservations		P.L. 280 Transfer Jurisdiction	P.L. 437 Indian Health Care Improvement Act	Omnibus Drug Act
			Alaska Native Lands Claim Settlement	Comprehensive Mental Health Programming
			Vietnam War	Indian Child Protection and Family Violence Prevention Act
			Indian Child Welfare Act	

The Kennedy and Johnson Administrations, through the New Frontier and War on Poverty programs, signaled a radical turnabout. Economic development began in Indian communities, focusing on local employment opportunities and necessary infrastructure. In July 1970, President Nixon issued his now-famous *Message to Congress on Indian Affairs*, which laid the foundation for modern Indian law and policy by reaffirming the special legal and political relationship between Indian tribes and the United States, and emphasizing the principle of Indian self-determination and economic self-reliance. Building on this message, Congress enacted the Indian Self-Determination and Education Assistance Act of 1975 authorizing tribal governments maximum flexibility in administering federal programs and services for their members. Unparalleled increases in health care funding soon followed, including urban Indian programs (for the first time). Longstanding disputes over Alaska Native lands were settled, establishing regional corporate self-governments. In 1978 Congress enacted the Indian Child Welfare Act (ICWA) to curtail the massive removal by state agencies and courts of Indian

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children from their homes and to ensure that children who must be removed are placed in homes that reflect their unique cultures and traditions. Similarly, in 1978 Congress approved the American Indian Religious Freedom Act, designed to guarantee Indian tribes the inherent right to practice their religions, later amended in 1994 to protect the traditional religious use of the peyote sacrament in the Native American Church.

In 1971, upon the discovery of huge oil deposits on Alaska's North Slope and the wish to clear the area for construction of the Alaska Pipeline, Congress enacted the Alaska Native Claims Settlement Act (ANCSA). This Act organized Alaska Natives into regional and village corporations and gave them control over more than 44 million acres of land and almost \$1 billion. In exchange, Alaska Natives waived all claims to many of their original lands. Alaska Natives subsequently petitioned for the right to self-government, and traditional institutions such as tribal courts and councils re-emerged. The U.S. Census Bureau now recognizes 200 Native communities in Alaska; more than half have state-chartered municipal governments, and 69 have elected Native Councils.

Congress also recognized that, among American Indians and Alaska Natives, behavioral health problems stem in large part from a variety of historical and socioeconomic conditions including poverty, high unemployment, lower educational attainment, geographical isolation, discrimination, and disenfranchisement. This recognition led to enactment of P.L. 99-570, the Omnibus Drug Act of 1986, which provided new resources for alcohol and substance abuse programming, and P.L. 101-630, the Indian Child Protection and Family Violence Prevention Act in 1990, which authorized a comprehensive mental health program. The Indian Gaming Regulatory Act of 1988 acknowledged the cultural practice of gaming in Indian communities and affirmed that tribes have the power to conduct gaming on Indian lands. However, it also gave states the ability to negotiate gaming regulation and games played through the signing of tribal/state compacts. In some communities, local gaming ventures have provided significant revenues for reinvestment in local tribal infrastructure.

All of these events, and the experiences that they spawned, have touched the lives of all Native people, albeit at various points in their personal histories that lend different meanings to each person. Thus, there are cohort and intergenerational differences in cultural values, social organization, and health behavior within this special population that arise as a function, at least in part, of such conditions.



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## Mental Health Needs

*Mental Health: Culture, Race, and Ethnicity* (U.S. DHHS, 2001), *A Supplement to Mental Health: A Report of the Surgeon General* (U.S. DHHS, 1999), provides a timely, comprehensive summary of the mental health needs of American Indians and Alaska Natives, and the availability, accessibility, and actual use of relevant services. Rather than repeat this well-documented litany of emotional and psychological problems that trouble Indian and Native people, here we highlight those problems of greatest concern and/or those that warrant immediate attention.

### Suicide

Suicide is a major concern among Indians and Natives, for it is seen as a threat to the very fabric of their communities. The basis for this concern is readily borne out by the available data.

- ◆ From 1979 to 1992, the suicide rate for American Indians and Alaska Natives was 1.5 times the national rate (Novins, Duclos, Martin, Jewett, & Manson, 1999; U.S. DHHS, 1999).
- ◆ In a survey of more than 13,000 American Indian adolescents, 22% of females and 12% of males reported having attempted suicide at some time (Blum, Harmon, Harris, Bergeisen, & Resnick, 1996).
- ◆ Suicide is particularly common among young Native males ages 15 to 24, accounting for 64% of all suicides by American Indians and Alaska Natives. This rate is 2 to 3 times higher than the general U.S. rate (Kettle & Bixler, 1991; May, 1990; Mock, Grossman, Mulder, Stewart, & Koepsell, 1996).
- ◆ Violent deaths (unintentional injury, homicide, and suicide) account for 75% of all mortality in the second decade of life for American Indians and Alaska Natives (Resnick, Bearman, Blum, Bauman, Harris, Jones, Tabor, Beuhring, Sieving, Shew, Ireland, Bearinger, & Udry, 1997; U.S. DHHS, 2001).

A number of preventive interventions, ranging from school-based to community-wide efforts, have been mounted over the past decade with varying results (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). New, creative approaches are required, drawing upon multiple agencies and working sectors of care to address this devastating problem. Some existing promising practices are included in this publication.

### Vulnerable Segments of This Population

Oppression, discrimination, and removal from traditional lands have contributed to Native peoples' current lack of educational and economic opportunities and their significant representation among populations with high need for mental health care (U.S. DHHS, 2001).

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- ◆ Although they comprise less than 1% of the general population, American Indians and Alaska Natives constitute 8% of the U.S. homeless population (U.S. Census Bureau, 1999). The homeless, in general, are at significant risk of mental disorder, thus calling special attention to this segment of the Native population.
  - ◆ In 1997, 4% of American Indian and Alaska Native adults were under the care, custody, or control of the criminal justice system. Also, 16,000 adults in this group were held in local jails (U.S. Bureau of Justice Statistics, 1999). Mental disorder is more prevalent among detainees than their counterparts in the community at large. This is especially true of Indian youth (Duclos, Beals, Novins, Martin, Jewett, & Manson, 1998).
  - ◆ Alcohol problems and mental disorders often co-occur among American Indians and Alaska Natives (Beals, Novins, Mitchell, Shore, & Manson, 2001; Kinzie, Leung, Boehlein, Matsunaga, Johnston, Manson, Shore, Heinz, & Williams, 1992). Fifty percent of Indian youth in treatment for substance abuse have significant untreated psychiatric comorbidity (Novins, Beals, Shore, & Manson, 1996).
  - ◆ Exposure to trauma is related to the development of subsequent mental disorders in general, and Posttraumatic Stress Disorder (PTSD) in particular (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Recent evidence suggests that a significant percentage of American Indians are at high risk for exposure to trauma and its mental health sequelae (Beals, Holmes, Ashcraft, Fairbank, Friedman, Jones, Schlenger, Shore, & Manson, in press; Gurley, Novins, Jones, Beals, Shore, & Manson, 2001; Jones, Dauphinais, Sack, & Somervell, 1997).
  - ◆ Children who are removed from their homes are at increased risk for mental health problems (e.g., Courtney & Barth, 1996), as well as serious subsequent adult problems such as homelessness (Koegel, Burnam, & Farr, 1995). Estimates suggest that as many as 25% to 30% of American Indian children have been removed from their families (Cross, Earle, & Simmons, 2000), a practice that continues even today.

American Indians and Alaska Natives are frequently among the most highly vulnerable populations, including those who are homeless, incarcerated, and victims of trauma. The economic vulnerability of these segments of the Indian and Native population also leads to vulnerability to mental disorders. Native people who suffer from substance abuse problems are at increased risk for mental disorders. Indian youth are at increased risk for incarceration and trauma. Furthermore, some subsets (e.g., 18-21-year-olds) of the youth population appear more vulnerable to suicide, which is an extreme indication of the need for mental health care.

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## **The Local Service Ecology: Private, Tribal, State and Federal Sectors**

The federal agency most directly responsible for providing mental health services to American Indians and Alaska Natives is the Indian Health Service (IHS), specifically its Mental Health and Social Services Programs Branch (MHSSPB), IHS primary health care services, and Alcoholism/Substance Abuse Programs Branch. However, other programs and agencies also play important parts in this effort, including the Bureau of Indian Affairs, the Department of Veterans Affairs medical and counseling programs, tribal health programs, urban Indian health programs, state and local service agencies, and traditional healing resources. Together, these fragmented services comprise the unique ecology within which American Indian individuals and families seek help for emotional and psychopathological distress. After briefly reviewing the key elements in this service array, we will turn to Native people's actual access to such care.

### **Indian Health Service**

#### *Mental Health Programs Branch*

The mission of the IHS Mental Health and Social Services Programs Branch is to provide access for all Indian persons to high-quality and culturally appropriate mental health services that are also appropriate to the nature and severity of their mental illness (U.S. DHHS, 1989). As of April 1995, IHS reported that 251 staff were supported by mental health categorical funds, 198 of whom provide direct care (personal communication, S. Nelson, April, 1995, MHSSPB, IHS). On average, then, between one and two mental health direct treatment personnel are available in each of IHS's 127 service units. In actual practice, 80% of the service areas have a mental health presence, and 20% do not.

The distribution of mental health resources and staff varies considerably from area to area, as does the availability of mental health professionals trained to work with children or adolescents. In fiscal year 1993, the per capita budget for mental health services for persons of all ages in IHS areas ranged from \$6.75 per person in California to \$22 per person in the Billings, MT, and Portland, OR, areas. Only 28 (14%) of the 198 direct care professionals were trained to work with children or adolescents, while children age 19 and younger account for approximately 43% of the Indian population. This amounts to an average of 0.44 providers per 10,000 children and adolescents. In 4 of the 12 IHS areas, there are no child- and adolescent-trained mental health professionals.

#### *Primary Health Care Services*

Most of the Indian Health Services budget is devoted to the provision of primary acute health care services. Because of the paucity of mental health professionals, primary care practitioners may be the principal source of detection and treatment of mental health and substance abuse problems. The extent of such screening and treatment is not known and there are problems in availability of service. In every IHS service area, the ratio of providers to population is well below accepted standards, due to the extensive physical health care needs

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among Indians, the fact that IHS' financial resources have not increased relative to inflation since 1978, and difficulties in recruiting clinical personnel to IHS service areas (U.S. Congress, 1990). Moreover, even if there were a sufficient number of primary care physicians to treat those with mental health problems, the delivery of such services by non-psychiatric physicians is a problem (U.S. Congress, 1990).

#### *Alcoholism/Substance Abuse Program Branch*

The Alcoholism/Substance Abuse Program Branch (A/SAPB) of the Indian Health Services, originally known as the Office of Alcohol Programs, was established in March of 1978. Presently, the IHS funds 309 Indian alcoholism service contracts in Indian reservations and urban communities. The most extensive summary of IHS alcoholism programming efforts can be found in Peake-Raymond and Raymond's (1984) report that identifies and assesses a series of model projects. Peake-Raymond and Raymond and other reports (Alaska Native Health Board, 1973, 1976; Charleston, Meyers, & Charleston, 1984) found little coordination or continuity of care among alcoholism, social service, and mental health programs.

The A/SAPB has responded to these deficiencies (U.S. DHHS, 1988). Recent initiatives, made possible through 1986 Omnibus Drug Act funding, led to the development of youth services. The A/SAPB youth services component has three elements: prevention, outpatient treatment, and residential treatment. In fiscal year 1993, 3,249 Indian youths were treated as outpatients, and 522 were treated in residential facilities. All 12 residential treatment facilities for substance abuse now have been opened, with one in each of eight areas. In 1994, IHS reaffirmed its previous commitment by allocating funds to the administration and evaluation of five demonstration projects for innovative Indian alcohol and drug abuse prevention programs.

#### **Bureau of Indian Affairs**

The Bureau of Indian Affairs was established in 1824 as part of the War Department. It became a part of the U.S. Department of the Interior (DOI) in 1849, when the DOI was created. BIA education programs furnish BIA-funded schools (182 in 1992-93) with curriculum materials and technical assistance to develop and implement alcohol and substance abuse programs, with special emphasis on identification, assessment, prevention, and crisis intervention through the use of referrals and additional counselors at the schools. Boarding schools also depend on a number of BIA personnel—typically social workers, educational psychologists, and special educators—to screen for, intervene with, and monitor students who experience social and mental health problems. Much of this effort takes place within the context of the local Intensive Residential Guidance program. In 1994, the BIA reported that 19.2% of all Indian children were in BIA-funded schools (personal communication, C. Gabow, Office of Indian Education, 1994).

The BIA funds Indian Child Welfare Act programs that provide a wide range of human services. Managed by tribes, these services often address the social and mental health problems of both Indian adults seeking to retain or reassume parental responsibility for their children, and Indian children subject to the stresses inherent in foster care and adoption.

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Indian Child Welfare workers also play a role in identifying abused adolescents in need of mental health services, and in attempting to see that these needs are met.

The BIA also plays a major role in the law enforcement and criminal justice systems in many reservation communities. These systems frequently encounter mental health-related issues, such as the detention and diversion of Indian adolescents involved with alcohol and substance abuse, and those who experience serious emotional disturbance. This involvement is likely to increase, as outlined in the joint BIA-IHS Organizational Management Action Plan (U.S. Department of the Interior, 1988).

### **Department of Veterans Affairs**

The Department of Veterans Affairs (DVA) plays a major role in providing mental health services to many American Indian veterans. Two separate health care programs provide services to American Indian veterans. The Patient Care Services program provides primary, acute, long-term, and rehabilitative care for American Indian veterans with physical and mental health problems. These services are offered through urban medical centers (e.g., Albuquerque, Denver, and Phoenix) and more distant, outpatient satellite programs (e.g., Ft. Mead, SD, Gallup, NM, Prescott, AZ). The Department of Veterans Affairs has specifically identified Posttraumatic Stress Disorder, substance abuse, and serious mental illness as health problems of special programmatic concern. In addition, Readjustment Counseling Services (RCS) are offered through more than 200 field-based Veteran's Centers. This branch of the DVA provides a range of services, including initial assessment, supportive counseling and self-help groups, referral for more intensive out- and in-patient care, and relapse prevention. Six RCS/Veterans Centers recently were established on or immediately adjacent to reservation communities to increase their outreach to this special population.

### **Tribal Health Programs**

As a consequence of the Indian Self-Determination and Education Assistance Act (1975), many tribes have assumed administrative control of local health programs, either partially or in their entirety. This transfer occurs through either of two mechanisms: contracting or compacting. A compact is akin to a block grant and allows the tribe significantly greater management, administrative, and fiscal authority (Dixon & Roubideaux, 2001). Scopes of work and monitoring are negotiated on a tribal basis, leading to considerable variation in program activities and services. Approximately 42% of the tribal health programs report providing mental health services; yet only 3% of tribal health staff work in mental health services, indicating limited provision of such services. Ten percent of the tribal health programs report that mental health services were not available at all.

### **Urban Indian Health Programs**

In 1976, the Indian Health Services began to fund urban health programs, which differ from IHS reservation-based clinics in their emphasis on increasing access to existing services rather than providing or paying for services directly. There are currently 36 urban Indian health programs, encompassing 40 urban areas in 20 states (Forquera, 2001). Authorized

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under Title V of the Indian Health Care Improvement Act (1976), in fiscal year 2001 they received \$29.9 million from the IHS, only 1% of its entire budget. The paucity of funding stands in sharp contrast to the mental health needs of urban Indians, as documented in a special issue of *American Indian and Alaska Native Mental Health Research* (Novins, 1999). Among the five urban Indian health programs in that document reporting local needs assessments, from 45%-68% of their clients reported significant mental health problems.

Until recently, urban Indian health programs were not eligible for mental health funding through Indian Health Services, creating service accessibility problems for the estimated 50% of American Indians who live in cities. Within this context, many smaller urban Indian health programs offer mental health services as part of primary medical care; mental health problems that cannot be managed by the primary care provider are referred to outside resources. Other urban programs receive categorical funding for substance abuse or child welfare problems, and they address mental health problems within the context of these services. Still, other larger, urban programs are able to provide a range of on-site mental health services with funds received through such sources as mental health block grants, substance abuse treatment/prevention block grants, and community mental health center funds. On average, expenditures for mental health services represent about 3.8% (\$600,000 per year) of all ambulatory health services provided by urban Indian health programs. Between 1985 and 1987, the total number of on-site mental health providers ranged from 15 to 20 for all urban programs, representing less than 4% of the entire staff. During this period, the average number of service users per full-time provider more than doubled, and the number of visits per provider also increased (American Indian Health Care Association, 1988). Several of the respondents in the American Indian Health Care Association study reported that available services are of poor quality and that waiting periods for services are excessively long. A replication of this survey was recently completed; initial results suggest little change (personal communication, F. Miller, American Indian Health Care Association, 1994).

### **State and Private Service Agencies**

Very little information exists about the extent to which local agencies, such as community mental health centers and state psychiatric facilities, serve Indian communities. It seems fair to assume, though, that numerous Indian people obtain care from these settings, especially in urban communities. However, the diverse points of entry into this system—e.g., state hospitals, day treatment centers, the Social Security Administration, the criminal justice system, detoxification facilities, and vocational rehabilitation centers—yield a confusing and often unmanageable set of service utilization data. For example, in Oregon alone, more than 30 service agencies potentially may see emotionally disturbed Indians. A survey by Denver Indian Health and Family Services, Inc. (an urban Indian health program) revealed that 71 municipal, county, state, and private agencies offered mental health services within the immediate metropolitan area (Denver Indian Health and Family Services, 1989). Less than 40% of these agencies' patient information systems track ethnicity, although virtually all of them (91%) answered affirmatively when asked if they could recall having had an Indian patient in care during the month prior to the survey (Denver Indian Health and Family

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Services, 1989). This is not, of course, an indication of the extent of care available to Indians from non-IHS agencies.

### **Traditional Healing Resources**

The use of traditional healers is common in many American Indian communities. Several studies in both rural reservation and urban communities have found generally frequent use of traditional healing among American Indians receiving biomedical health services, with estimates ranging from 38% to 70% (Buchwald, Beals, & Manson, 2000; Csordas, & Garrity, 1994; Fuchs, & Bashshur, 1975; Grossman, Krieger, Sugarman, Forquera, 1994; Guilmet, 1984; Kim & Kwok, 1998; King, 1999; Marbella, Harris, Diehr, & Ignace, 1998; Taylor, 1988; Waldram, 1990). However, little has been published about the role of traditional healers in treating diagnosable mental health problems. Mental health and substance abuse practitioners at some IHS clinics encourage the use of traditional healers, particularly when individuals offer culturally specific explanations for their distress. Similarly, regional adolescent substance abuse treatment centers all report active involvement of traditional healers in their programs, which is entirely consistent with IHS policy that supports respect for and appropriate participation of traditional healers in patient care. These findings about the parallel use of biomedical and traditional services are consistent with other, recent work (Gurley et al., 2001; Westermeyer, Canive, Thuras, Chesness, & Thompson, 2002).

The system of services for treating mental health problems among American Indians and Alaska Natives is a complex and often fractured web of federal, state, local, tribal, and community-based services. Despite the wide range of services described here, the availability of these programs varies considerably across communities. Moreover, the system is inadequate for the overall needs of American Indians. Questions about service use and outcomes assume critical importance within this complicated service ecology.



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## Access to and Use of Mental Health Care

The following information, paraphrased from *Mental Health: Culture, Race, and Ethnicity* (U.S. DHHS, 2001), *A Supplement to Mental Health: A Report of the Surgeon General* (U.S. DHHS, 1999), serves as an excellent introduction to access and usage issues for Native Americans.

*Although the federal government provides varying degrees of health care to the members of more than 500 federally recognized tribes through the Indian Health Services, only 1 in 5 American Indians reports access to IHS services (Brown et al., 2000). IHS services are provided largely on reservations; consequently, Native people living elsewhere have quite limited access to this care. Furthermore, American Indian tribes that are recognized by their state, but not by the federal government, are ineligible for IHS funding (Brown et al., 2000).*

*According to a recent report based on national data, only about half of American Indians and Alaska Natives have employer-based insurance coverage; this is in contrast to 72% of Whites. Medicaid is the primary source of coverage for 25% of Native people, particularly for those who are poor and near poor. Twenty-four percent of American Indians and Alaska Natives do not have health insurance (Brown, Ojeda, Wyn, & Levan, 2000). The lack of parity for mental health coverage further reduces the resources available to acquire needed services beyond those offered by the IHS.*

*These circumstances are compounded by the dramatic change that the IHS is undergoing as a consequence of tribal options to self-administer federal functions under the contracting or compacting provisions of P.L. 93-638. The attendant downsizing of federal participation in Indian health care has diminished local ability to recover Medicaid, Medicare, and private reimbursement, leading to fewer resources to support health care delivery to Native people (Dixon & Roubideaux, 2001).*

There are only a few published studies that speak directly to the question of mental health service use among American Indian youths. A Denver Indian mental health survey found that only one out of ten urban Indian youth (10.9%) sought out counseling for their problems (King, 1999). Strikingly, this same survey found that one out of four youths (28%) reported asking no one for help. The Great Smoky Mountains Study found that 1 in 7 Eastern Band Cherokee children with a diagnosable DSM-III-R psychiatric disorder received professional mental health treatment, a rate similar to that for their non-Indian counterparts (Costello, Farmer, Angold, Burns, & Erkanli, 1999). However, Cherokee children were more likely to receive this treatment through the juvenile justice system and in-patient facilities than were the non-Indian children, despite the fact that free mental health services were available to the Cherokee children through the IHS.

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This study reveals that the behavioral health utilization patterns for Indian youth are different from those of non-Indian youth. It also suggests that the assertion that the behavioral health needs of Indian children are met by the Public Health Service—thus freeing local authorities from their responsibility for contributing to such care—is simply wrong. Though IHS services may be free, few are oriented toward child behavioral health. As an Office of Technology Assessment report (U.S. Congress, 1990) indicated, at that time there were only 17 child-prepared mental health professionals within the entire IHS system. As mentioned earlier, this yielded an average of only 0.44 providers per 10,000 children, less than 10% of the number recommended by the Office of Technology Assessment for the general population. More than a decade later, the circumstances are little different.

Novins, Beals, Sack, and Manson (2000) investigated the relationship between psychiatric diagnosis and the use of alcohol, drug, and/or mental health (ADM) treatment services among a school-based sample of Northern Plains. Sixty-one percent of those youth who met criteria for a psychiatric disorder never used ADM services during their lifetime (unmet need). The majority who received services were seen through school (68%); just one adolescent received service from a mental health professional. Among those youth with a psychiatric disorder who did not receive services, 57.1% were recognized as having a problem by a parent, teacher, or employer (recognized unmet need).

Anticipating the Great Smoky Mountain Study's finding that Indian youth in detention are especially at risk of psychopathology, Novins, Duclos, Martin, Jewett, and Manson (1999) examined the relationship between diagnostic status and use of ADM treatment services among a sample of 150 Indian youth admitted to a juvenile detention center in a Northern Plains reservation. Thirty-four percent of those diagnosed with an anxiety, mood, or disruptive behavior disorder reported having received alcohol, drug, and/or mental health treatment at some point in their lives. Services for emotional problems were commonly provided through outpatient settings. Traditional healers and pastoral counselors provided more than a quarter of these services.

Halfon and colleagues at UCLA recently completed a nationwide study of state and county compliance with standards of health care for children in foster care (Halfon, Inkeles, Flint, Spicer, & Manson, 2002). They explored the extent to which relevant agencies collaborate regarding health care to children in out-of-home placements, and the factors that affect the adequacy of such care. To augment their survey findings, these investigators made site visits to states and localities that had developed innovative approaches, as well as to those that experienced significant problems meeting the needs of children in out-of-home care. Special attention was accorded Native American children.

In this study, child welfare agencies in 36 states and 45 counties completed a mailed self-administered questionnaire covering the collection of data on American Indian/Alaska Native children, knowledge and implementation of the Indian Child Welfare Act (ICWA), agency interaction with Indian Child Welfare programs, policies and procedures regarding the provision of health services to American Indian and Alaska Native children in out-of-home care, delivery of mental health services, and knowledge of Indian Health Service protocols or policies for American Indian and Alaska Native children. The results documented a consistent

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lack of attention to the unique requirements of ICWA and the mental health needs of American Indian and Alaska Native children in out-of-home placements. While this neglect was by no means universal, there was a persistent pattern revealing superficial familiarity with the requirements of ICWA and a lack of established policies and procedures for American Indian and Alaska Native children and families in many jurisdictions. This pattern was even more dramatically evident in site visits with American Indian and Alaska Native service providers and advocates. Most absent were planning mechanisms and resources to develop policies and procedures for ensuring that these needs would be addressed at tribal, state, and county levels.

Little is known about service utilization for psychopathology, specifically among Indian adults. To date, almost all of the literature has focused on substance-related disorders. In terms of non-substance related disorder, we know that American Indians appear to use community mental health facilities far less frequently than other segments of the American population (Sue, 1977). This likely is due to issues of distance and perceived relevance of the available care (Provan & Carle, 2000). However, King (1999) reported that close to half (44%) of the Indian adults surveyed in his study who had experienced a mental health problem did not seek out any kind of help, and of those that sought help (55%), only 28% contacted a mental health agency. In a 3-year survey of 17 community mental health centers in Seattle, Sue (1977) reported that 55% of the Indian patients seen were unlikely to return after the initial contact, a significantly higher non-return rate than was observed for Black, Asian, Hispanic, or White patients.

The American Indian Vietnam Veterans Project carefully examined the nature and extent of the services used by this segment of the Native population to address their physical as well as mental health problems (Beals et al., in press; Gurley et al, 2001). The *extent* of overall service use (combining biomedical and traditional healing options) was similar across the two participating communities, located in the Northern Plains and Southwest, respectively. This was true whether for physical, alcohol, drug, or mental health problems, all of which manifested similar levels of need. However, the *kinds* of services used varied by availability. For example, VA services were significantly more available to Northern Plains than Southwestern veterans, and, thus, were used more by the former. IHS and private sources of biomedical care, equally available to both, were used to a similar degree. Traditional healing options, more readily available to Southwestern veterans, were used to a greater extent by Southwestern veterans than by the Northern Plains veterans. Especially noteworthy is the fact that veterans were more likely to use the VA than IHS for the care of ADM problems, despite the latter's proximity. This pattern clearly is attributable to the stigma attached to seeking mental health care within the local community as well as to the belief that fellow veterans are more empathic and understanding of combat-related trauma.

The move to managed care has made it difficult for tribally operated programs to receive Medicaid reimbursement. Many individuals who otherwise qualify for Medicaid have dual diagnoses that include alcoholism, complicating billing, and compensation. The treatment programs in which they reside often are unable to meet the credentialing standards of managed care plans. There also appears to be a mismatch between the services covered by behavioral health managed care organizations—which frequently exclude intensive case management, family support and education, supported employment, and culturally sensitive interventions—and the needs of American Indian clientele. Driven by the economics of

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health care, the shift to brief therapeutic interventions and termination of non-compliant patients disproportionately affects Native people (Provan & Carle, 2000).

This small but growing knowledge base represents a promising start for understanding the mental health service needs, patterns of use, and barriers to care among American Indian children and adults. There seems to be little doubt that their needs are great, that services generally are lacking, and/or that access is difficult and can be costly.

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## **Native Views on Mental Health and Illness: Beyond Mind-Body Dualism and the Individual**

Barriers to mental health care are not limited to issues of availability, access, or cost. Indeed, we now know that the acceptability of services has a significant affect on the help-seeking behavior of those in need. Some minority groups, American Indians and Alaska Natives included, are more likely than Whites to delay seeking treatment until their symptoms are more severe (U.S. DHHS, 2001). Moreover, racial and ethnic minorities are less inclined than Whites to seek treatment from mental health specialists. In this regard, there are a number of patient-, provider-, and program-level factors worthy of consideration.

Stigma has been singled out as the “most formidable obstacle to future progress in the arena of mental illness and health” (U.S. DHHS, 1999). Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn, 1999). Clearly such stigma abounds in Indian Country, as evident in the personal testimonies of many Native military veterans who suffer from PTSD, such as the following: “I would rather be drunk than crazy” (U.S. Department of Veterans Affairs, 2000). Yet very little appears in the literature about stigma related to mental health among American Indians and Alaska Natives in general. The information that is available indicates that contact with individuals with mental illness will likely help to reduce stigma in this special population (Whaley, 1997), lending hope to public education and information campaigns.

Most mental health care offered in this country, especially that which springs from psychiatry and clinical psychology, typically distinguishes between psyche and soma in its conceptualization of mental illness, reflecting a long Western intellectual history of mind-body dualism. Current approaches to assessment and treatment revolve around this distinction. Yet, as we will see in a moment, the worldview of Native people stands in sharp contrast to this orientation. Spirituality—a system of belief that focuses on intangible elements that impart vitality and meaning to life’s events (Maugans, 1996) and that is so important to Indians and other Natives—is pointedly absent from the perspectives that guide the bulk of the care available. There is growing evidence that various aspects of spiritual practice, affiliation, and belief are beneficial for mental health. The findings are strongest for a link to subjective well-being, life satisfaction, and reduced risk of suicide (e.g., Ellison & Smith, 1991; Garrouette, Goldberg, Beals, Herrell, & Manson, in press; Jarvis & Northcott, 1987; Koenig, George, & Peterson, 1988; Levin, 1994).

Definitions of the self vary along a continuum between "egocentric" and "sociocentric" (Shweder & Bourne, 1984). The former, best exemplified in Western, industrialized populations, characterizes the person as unique, separate, and autonomous. The latter, found in many non-Western cultural traditions, depicts the person in relational terms, as part of an interdependent collective defined by kinship and myth. In the United States, such differences often distinguish American Indians and Alaska Natives from White, middle-class Americans (Cross, 1998; Trimble, Manson, Dinges, & Medicine, 1984). It should not be surprising, then, that the location and experience of emotions vary along similar lines. In other words, they are not necessarily *just* intrapsychic phenomena. Rather, they are very much a function of and

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reflect a Native person's relationship to other elements of his/her social universe. Hence, clinicians who seek to elicit individualistically oriented, context-less self-statements of affect—e.g., “*I feel blue*,” “These things no longer mean anything to *me*” —or worry—e.g., “*I am bothered by things that usually do not bother me*,” “*I fear things that I do not normally fear*”—are constrained, intrinsically, from discovering other ways of feeling and expressing key emotions among American Indians. “The hurt of one is the hurt of all,” an often heard phrase in Indian communities, captures their deeply collective, intersubjective experience of dysphoria, for example, which represents a radical departure from the assumptions that underpin mainstream clinical practice.

Locust (1988) identified a number of key concepts regarding the relationship of self and spirituality to health that are widely shared among American Indians and Alaska Natives. These concepts include:

- ◆ belief in a Supreme Creator;
- ◆ each person is composed of mind, body, and spirit;
- ◆ all physical things, animate and inanimate, are part of the spirit world;
- ◆ the spirit existed prior to its embodiment and will exist after death;
- ◆ health is harmony of mind, body, and spirit;
- ◆ illness is disharmony of mind, body, and spirit; and
- ◆ an individual is responsible for his/her own health.

Among most Native people, to live in health is to live in accordance with moral or behavioral codes that strive to maintain harmony between one's self and his/her family, community, environment, and spiritual world (Avery, 1991). Illness results from negative mental, physical, or spiritual activity or from disruptions in the world around one. In Indian communities, ceremony and ritual are the mechanisms by which the ensuing imbalance or loss of connection is restored.

*The DSM-IV, both within the main text and in its “Outline for Cultural Formulation,” provides much clearer guidelines than previous versions for addressing such cultural matters, including those specific to this population, in the assessment and treatment of mental health problems (Manson & Kleinman, 1998; Mezzich, Kirmayer, Kleinman, Fabrega, Parron, Good, Lin, & Manson, 1999). A growing body of case material demonstrates the utility of applying these guidelines to American Indian children (Novins, Bechtold, Sack, Thompson, Carter, & Manson, 1997) as well as to adults (Fleming, 1996; Manson, 1996; O’Neill, 1998). (U.S. DHHS, 2001).*

This advance is part of a much larger emphasis on cultural competence, which recognizes the importance of patients' cultures and the skills, knowledge, and policies needed to deliver effective treatments (Sue & Sue, 1999). Numerous models of cultural competence have been proposed, from those such as the DSM which focuses narrowly on the patient/provider interaction to those that encompass organizations and entire systems of care (U.S. DHHS, 2001). Both are relevant to the mental health needs of American Indians and Alaska Natives.

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Tribes and their constituent programs typically are organized around four core values (Harris & Wasilewski, 1992).

- ◆ Being a Good Relative: Tribal communities govern and function through inclusive relational webs of mutual reciprocal exchange obligations based on kinship principles.
- ◆ Inclusive Sharing: Goods, resources, opportunities are redistributed throughout the community by sharing.
- ◆ Contributing: The social system and its various components are designed so that each person can participate in as well as contribute to the community.
- ◆ Non-Coercive Leadership: Leadership—and consequently influence as well as authority—springs from an assumption of responsibility for others rather than the ability to coerce or control.

Dixon, Bush, and Iron's interviews of leaders drawn from a representative cross-section of tribes illustrate how these key core values guide tribal decisions about health care (1997). Examples ranged from service priorities, types of programming, and preferred delivery mechanisms to expectations of behavioral health contractors and management oversight. Local commitment to these values and their expression in the health care system, they concluded, are often unrecognized or misread by states as they negotiate Medicaid managed care contracts with Indian communities (Dixon, 2001). Provan and Carle's *A Guide to Behavioral Health Managed Care for Native Americans* (2000) provides valuable insight into this interplay, suggesting new strategies for conceptualizing as well as operationalizing collaboration.

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## Promising Directions, Lessons Learned

### Innovative Approaches to Mental Health Care in Indian Communities

American Indian and Alaska Native communities are charting new paths across their current landscapes, looking carefully to key social and cultural values as guidance for developing innovative solutions to local problems. The emerging solutions are exciting in their form and promise for future directions.

The Rural Human Service (RHS) Certificate Program is a human services delivery model designed to address the special needs of Alaska's rural, largely Native communities. The program was the product of a collaborative effort among the University of Alaska, the Division of Mental Health of the state of Alaska, regional Native health corporations, a coordinating council, Native elders, and rural communities. It emerged from a 1987-88 study conducted by the National Center for American Indian and Alaska Native Mental Health Research and the Division of Mental Health among Inuit residents of Norvik and Kiana, AK (Minton, 1990). The study employed ethnographic and survey research methods to identify local forms of emotional and psychological distress, to place such experiences within an Inuit cultural context, and to determine how formal mental health services could accommodate indigenous help-seeking behavior. The emergent RHS program was designed to provide training for village-based delivery of human services by community paraprofessionals and natural helpers who are actual residents of the communities served.

RHS participants receive entry-level training and basic skills development with respect to mental health and substance abuse problems. Training addresses crisis intervention, suicide prevention, healing, and community development. Specific counseling skills focus on substance abuse, interpersonal violence, and grief. A unique aspect of the RHS program is that the curriculum and instructional methods are strongly influenced by traditional values and principles of Alaska Native communities. RHS emphasizes traditional Native approaches that focus on cooperative learning and are grounded in oral tradition. Traditional techniques for learning, such as visual observation, oral communication, and hands-on experience are central to the curriculum. Appropriate Native and Western cultural values and principles that serve to facilitate individual, family, and communal healing have been integrated into the program.

Several exciting, SAMHSA-funded experiments are underway that include strategic planning and implementation of coordinated services for Indian/Native children who suffer from serious emotional disturbance. One, the Circles of Care Initiative, has supported 15 Indian and Native grantee communities in their efforts to redesign local systems of care in a manner more consonant with rapidly changing circumstances and with local priorities, as rooted in their cultural values (Circles of Care Evaluation Technical Assistance Center). Grantee efforts on this initiative developed or strengthened partnerships with other agencies and service providers in their communities as well as with tribal leadership. Networking and contacts made within the service delivery areas opened up these opportunities. Many collaborative agreements as well as formal Memoranda of Understanding and Memoranda of Agreement with other agencies were secured by the grantees. A number of grantees

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participated in local and state councils and task forces on children's mental health and other policy issues as well as in committees of other agencies. These partnerships with providers and community members were essential to the planning and eventual implementation of new service systems.

Another related initiative is the Comprehensive Community Mental Health Services for Children and Their Families Program, a large SAMHSA grant program that has provided funds for over 67 comprehensive systems of care designed to better meet the needs of the nearly 4 million children with emotional disturbance in this country (SAMHSA, 2001). Nine of the sponsored programs have been located in American Indian and Alaska Native communities. The Alaska Youth Initiative (VanDenBerg, 1993; VanDenBerg & Grealish, 1996) focused on returning Alaska youth who were in out-of-home placements. The program was managed by a cross-system team representing child welfare, juvenile justice, child mental health, and developmental disabilities. It was built upon significant representation of consumers and their families, and pointedly included Alaska Natives in planning, allocation of monies, oversight, and evaluation. Organized in terms of a wraparound model, local and state agencies were aggressively linked and funding became more flexible, supporting individualized care plans that went beyond the formal intervention to include informal community talent and resources.

A second example, the Kmiqhitahasultipon Program of the Passamaquoddy Tribe of the Indian Township of Maine, targets very young children and their families (Simpson et al., 2001). It intentionally built links with a wide array of other child-serving agencies in the community, employing tribal consumer and family advocates as the principal liaisons. The program systematically linked parents, teachers, law enforcement personnel, and health providers to discuss the children's circumstances and needs. Special attention was given to the cultural context surrounding these children's challenges and opportunities. As a result, the parents acquired a much better sense of the respective roles and responsibilities of teachers, police, and health workers, and these professionals obtained a much better understanding of the children's mental health issues. This process and the information it generated were incorporated into regular, extensive cross-agency training of all service providers that emphasized improving the coordination of care, as well as the potential for community members to augment existing services.

A third example is the Sacred Child Project, an inter-tribal effort that serves seven distinct tribal groups on the Standing Rock, Spirit Lake, Turtle Mountain, and Fort Berthold reservations (Kendziora, Burns, Osher, Pacchiano, & Mejia, 2001). Like the Alaska and Passamaquoddy examples, this project also employed the wraparound concept, but more consciously sought to integrate this orientation with local tribal philosophies. As a consequence, intense cultural support was combined with equally intense mentoring and counseling, job support and tutoring, recreational opportunities, family advocacy, and treatment planning. Consistent with tribal values, consumer and family choice was strongly emphasized, weaving together the available resources in a way that acknowledged the consumers' needs; that respected their preferences; and that underscored a community-based, individualized, coordinated, and culturally competent approach to care.

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## **A Roadmap for Action**

Set against this backdrop of historical events, current problems, the local service ecology, access to care, and cultural values, the lessons learned from these important initial efforts suggest a roadmap for more properly addressing the mental health needs of American Indians and Alaska Natives. Drawing from Provan and Carle's (2000) guide, the lessons can be grouped into eight broad categories: 1) cultural competence and managed care; 2) behavioral health carve-outs; 3) need for high-quality data; 4) service availability and accessibility; 5) credentialing and licensing; 6) urban Indian health programs; 7) integrating mental health and substance abuse services; and 8) care for children, adolescent, and elders.

### *Cultural Competence and Managed Care*

Auto-enrollment procedures in managed care (assigning Indian and Native people to plans without their input) fail to appreciate prior provider-client relationships as well as the special needs of populations such as these. Disrupting an existing therapeutic alliance—especially among American Indians and Alaska Natives for whom trust is a paramount issue and is slowly established—is particularly problematic in behavioral health care. Program planners and administrators should anticipate this issue and provide focused education through tribes and community-based organizations to prepare consumers for these changes and to maximize their choices.

Managed behavioral health plans often have unrealistic expectations of Native clients, many of whom are unaware of, or are unable to implement pre-authorization procedures in a new system when services are needed. The denial of claims frequently is a logical consequence, further contributing to individual and tribal views that these systems are not responsive to their needs. Family advocates and program “navigators” promise to increase client and program adherence to these requirements.

Behavioral health care plans define “medical necessity,” thereby dictating what services can be reimbursed or funded. Yet, an immediate barrier to access emerges when these plans and the individual members as well as communities subscribe to different views of the cause of mental illness, its course, and appropriate treatment. Ensuring Indian and Native representation in the process of defining medical necessity will suggest a more appropriate mix of service options at the local level and will enhance individual as well as community choice.

Choice, as noted earlier, can be a key issue for most American Indians and Alaska Natives. This is especially true when managed behavioral health plans make it difficult to obtain care from past providers. Lacking access, clients are likely to turn to emergency rooms as an alternative, with its attendant increase in costs and decreased continuity of care. Providing for appropriate transitions, even recognizing past providers in current plans, can alleviate such problems.

Effective communication is essential to high quality, successful behavioral health care. Unfortunately, although it is widely acknowledged, this tenet usually becomes confused with

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English-language competency. Communication encompasses much more: differences in education, geography (rural vs. urban), as well as culturally defined gender and family roles can be just as important to the clinical encounter and to adhering to administrative requirements. Careful, respectful attention to these differences can contribute substantially to treatment adherence and improved quality of care. King's (1999) study of urban Indian adults reported they felt the greatest need in the community was for Native American care providers.

Stigma related to mental illness, as underscored earlier, is an even greater issue for most Indian people than the country at large. Behavioral health care plans need to anticipate this in how their services are characterized, where they are located in the community, and the manner in which the relevant care is delivered. Outreach into local settings, coupled with educational campaigns that draw upon experienced, respected tribal members will ease this burden and increase the acceptability of mental health care.

Most behavioral health care organizations focus on individuals, tending to medicalize their behavioral problems in ways that dismiss the social and cultural contexts of everyday life in Indian and Native communities. Family and community roles in health and healing typically fall beyond the scope of most plans as presently conceived, but need not, as evidenced by exciting programs in Alaska, North Dakota, and Maine.

#### *Behavioral Carve-Outs*

Most states enroll some if not all of their Medicaid population in managed care, and in doing so often separate the financing and management of behavioral health care from physical health benefits. This approach poses two problems for American Indians and Alaska Natives. First, there are enormous differences between rural and urban settings in the structure and delivery of behavioral health care. Thus, approaches that yield fiscal savings in urban-based programs are not necessarily appropriate to rural populations, and can threaten access to care and treatment effectiveness. Second, given the widespread stigma associated with mental illness, coupled with Natives' more holistic views on the nature of illness, there may be a strong basis for not carving behavioral health care from general health care, which could enhance the integration of such services and lead to economic efficiencies.

#### *Need for High Quality Data*

Everyone recognizes, in principle, the need for accurate data on clients. Managed care organizations depend upon such data for billing, tracking costs, and quality assessment. Tribes and urban Indian health programs stand to benefit from these and other types of data to improve their own health care services as well as to monitor managed care plans. But, tribes and urban Indian health programs usually lack the infrastructure or experience to collect and analyze such data. The relatively new tribal epidemiology centers and the Urban Indian Health Institute at the Seattle Indian Health Board (Forquera, 2001), all IHS-sponsored, offer concrete opportunities for states to collaborate with Indian and Native communities along these lines.

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### *Availability and Accessibility of Services*

Managed care organizations control their costs by limiting the kind and duration of behavioral health services made available. However, the services most often relevant to the mental health problems of American Indians and Alaska Natives are not covered: intensive case management, family support and education, culturally sensitive interventions, supported employment, and other rehabilitation services. A related cost-saving strategy is to reduce the intensity of services, shifting to brief therapies and group interventions which are less well-suited to the deeply entrenched, psychiatric comorbidities that often affect this population. The issue of medical necessity arises here again.

Of equal concern is the frequent termination of a benefit plan (“disenrollment”) due to individual non-compliance such as missing appointments or failure to take medications. Then, too, choice—or its absence in this case—is a significant concern for Native clients residing in urban settings. Network providers who are eligible for reimbursement seldom include urban American Indian clinicians or service organizations. And transportation, for rural as well as urban Indian communities, becomes especially problematic when managed behavioral health care plans require treatment at approved facilities that are located at considerable distance from Native people. Although state Medicaid agencies must ensure necessary transportation, the realities are that the related costs prove to be disincentives for managed care organizations to reach out to rural, isolated Indian communities. The latter’s lack of awareness of service options translates into a very real barrier to care.

Incorporating American Indian and Alaska Native perspectives in standing mental health councils or advisory committees, as accomplished through the Circles of Care Initiative, is a first step toward correcting many of these deficiencies and oversights. Combining an aggressive educational campaign targeted to consumers as well as tribal or urban Indian health leadership holds considerable promise for rendering these health plans more appropriate and responsive.

### *Credentialing and Licensing*

Current credentialing procedures, controlled by national organizations such as the National Committee for Quality Assurance, emphasize the behavioral health disciplines of psychiatry, psychology, social work, and clinical psychiatric nursing. They do not consider licensing provisions for primary care physicians, mental health paraprofessionals, or laypersons. As evident in each of the exemplary programs described above, lay health advisors, advocates, and outreach workers usually represent the first, if not ongoing point of contact for American Indians and Alaska Natives in need of behavioral health care. Though local “experts” in their own right, they typically lack licensure or certification. Hence, their status becomes highly equivocal when managed behavioral health care plans are introduced into these communities. Alaska’s Rural Human Service Program is a cutting edge example of how state, university, and community collaboration can address issues of credentialing for such vitally important providers. Another example that could be easily extended to this situation is embodied in Oregon and Utah’s practice of “deemed status” in their community mental health centers and other mental health service organizations. This status enables credentialed organizations to

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cover their staff, including paraprofessionals and non-mental health specialists, under their broader reimbursement umbrella.

### *Urban Indian Health Programs*

Many managed care organizations assume that tribal or IHS services are intended for or should serve the needs of urban Indians. However, most urban Indians are only eligible for direct, on-site IHS care offered at federally recognized reservations. By virtue of their residence off-reservation, they are not eligible for the contract health services that usually fund specialty care such as behavioral health.

Urban Indian health programs supported under Title V of the Indian Health Care Improvement Act (P.L. 94-437) hold a favored status in the Medicaid Program, recognized as federally qualified health centers (FQHCs). As a result, state Medicaid programs are required to cover in their benefits package the services provided by FQHCs, and to pay for these services at a statutorily specified rate (Forquera, 2001). However, many urban Indian health programs lack the financial resources or expertise to become Medicaid managed care organizations themselves. As a consequence, they must either subcontract with managed care organizations operating in their service areas or remain unaffiliated. Both pose major problems for these programs, resulting in many urban American Indians and Alaska Natives in need falling through the cracks. States, through focused technical assistance, could enhance the organizational capacities of many urban Indian health programs, and assist them in becoming more effective vehicles for funding these services.

### *Integrating Mental Health and Substance Abuse Services*

Many private behavioral health carve-out managed care plans encompass both mental health and substance abuse benefits, but most public plans do not. Given the extensive comorbidity of these problems among Native people, this is particularly problematic for clients and programs alike. Solutions include early, more comprehensive evaluation, integration of treatment and rehabilitation models from both arenas, more aggressive follow-up as clients migrate between urban and rural areas, improved interagency cooperation and pooling of funds, and provisions in the benefits package for service planning and transition to new providers for those leaving the plan.

### *Care for Children, Adolescents and Elders*

The elements of behavioral health care, their mix, and coordination require different approaches depending upon where a client resides in the developmental life span. Among youth, preventive services assume special importance, as do families, both as potential support and ongoing risk. Particular attention needs to be given to integrating the coverage provided through a managed care plan with funding by special education, juvenile justice, and social service agencies, thereby leveraging the available resources.

In the case of Native elders, for whom physical health problems such as diabetes and musculoskeletal diseases significantly increase as one ages, “carved-in” approaches that

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integrate primary and behavioral health care within a single setting deserve careful consideration. Then, Medicaid and Medicare funds can be blended for those who are elderly as well as poor, and thus are dually eligible. No other segment of the Indian and Native population is in as desperate need of outreach, for they are among the most isolated and in need of services. Families play a critical role in their care, but suffer enormous burden. Hence, respite services for family members assume special importance.

Technical assistance regarding developmental implications for care and joint planning by states and tribes as well as urban Indian health programs can maximize the available resources, can yield better program efficiencies, and can improve treatment outcomes. Tribal and urban Indian programs, as a function of past federal funding strategies, tend to organize health care in categorical terms, constrained by client characteristics (e.g., age, disease) and institutionally separate fiscal streams. With appropriate consultation from states, and well-illustrated alternatives, more developmentally appropriate models are possible, to the likely benefit of all parties.



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## Conclusion

A promising enterprise known as the W.K. Kellogg Foundation's Community Voices Initiative seeks to strengthen local health safety nets and to give voice to the underserved in the national dialogue on health reform (Silow-Carroll, Anthony, Seltman, & Meyer, 2001). Here, "the underserved" refers to people who do not have access to appropriate, affordable, timely health care, including American Indians and Alaska Natives, as this briefing document demonstrates. Thirteen communities across the country serve as learning laboratories on health care for this segment of the nation's population. They represent dense urban neighborhoods as well as remote rural towns, covering a broad racial and cultural spectrum. Their experience indicates that:

- ◆ there is broad-based support for significant changes in health care;
- ◆ relationships are essential components of health and health care;
- ◆ societal bases that affect health must be understood and addressed; and
- ◆ no one entity can create meaningful change on its own.

These voices echo those of Indian and Native people. They ring a consonant chord in the private and public conversations taking place in families, programs, and the halls of leadership in tribal and urban Indian communities. American Indians and Alaska Natives stand ready to risk old relationships in hopes of building new ones that will better serve the needs of their children, youth, adults, and elders who suffer from mental health problems. They seek to do this consistent with the social and cultural values that underpin their particular history and daily lives. States have an unprecedented opportunity to join them as partners in this endeavor, with mutual benefit for all involved.

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