

6**American Indians
and Alaska Natives****Jay H. Shore and Spero M. Manson****INTRODUCTION**

As the original inhabitants of the lands that became the United States, mental health disparities for American Indian and Alaska Native populations are deeply rooted in the history of the country's development. This history has created dynamic and complex social, political, economic, and cultural contexts that affect the mental health of this population. This chapter begins with an overview of mental health disparities in American Indian and Alaska Natives with concentration on sociopolitical contexts, diversity of this population, and the current state of their mental health status and treatment. Attention is then focused on patient-provider interactions and the impact of the larger ecology in which these interactions are nested. A discussion of future challenges and directions for the mental health services for American Indians and Alaska Natives concludes the chapter, with an emphasis on the role of traditional treatments, the promise of technology, and issues raised by evidence-based practices.

**MENTAL HEALTH OF AMERICAN INDIAN AND
ALASKA NATIVES: HISTORY AND CONTEXT**

Health disparities for minority populations are defined strongly by sociopolitical contexts. American Indians and Alaska Natives are unique among American minorities in their historical and current relationship with the U.S. government. From first contact, European settlers' interactions with the native groups were characterized by conquest, seizure of resources, compulsory relocation, and systemic campaigns of genocide. The new government of the United States continued these practices, developing policies of resettlement, attempted assimilation, and forced reservation relocation. By the 20th century, most American Indian tribes had been exterminated, dispersed, or driven onto federally created reservations. On the reservations, tribes continued to face threats to their identity from explicit governmental policies, for example, with federal laws banning traditional religious practices. The latter half of the 20th century for many American Indian and Alaska Native communities brought self-determination, self-governance, community and cultural rights, and greater awareness of the challenges facing American Indian communities.

Disparities in mental health for American Indians and Alaska Natives are inherently tied to the history and current sociopolitical landscapes experienced by this population. Present-day American Indians and Alaska Natives are characterized by incredible diversity in terms of their culture, environments, and socioeconomic circumstances. A detailed examination of this diversity is beyond the scope of this chapter, but there are currently 562 federally recognized tribes (1) representing a diverse array of distinct cultural groups and a wide range of acculturation. There are more than 200 different languages with more than a quarter million of the 4 million Americans (1.5% of the U.S. population) identifying themselves as having American Indian or Alaska Native heritage who speak a native language at home. Through the 1980s, most American Indians or Alaska Natives lived on reservations or trust land, but today only 20% live there, with greater than 50% of this population residing in urban and suburban areas. Because of the geographic isolation of many reservations, a substantial portion of this population continues to live in rural areas, with more American Indians living in rural areas compared with whites (42% vs. 23%) (2).

American Indian and Alaska Native communities have a unique relationship with the U.S. government as sovereign entities who retain all aspects of self-government not subsumed by the government, which continues to exercise significant control over these communities (3). Through its treaty obligations the U.S. government is required to provide healthcare services, including mental health, to federally recognized tribes, which the Indian Health Service (IHS) oversees. Only 20% of this population has direct access to IHS clinics, which are largely reservation based (2). The healthcare received by this population is delivered by a wide array of systems including the IHS, other federal organizations (e.g., SAMSHA, HRSA), state agencies, private providers, and tribally run healthcare services.

American Indian and Alaska Native mental health disparities cannot be understood without understanding the healthcare resource gap that exists for this population. The IHS is the largest provider of care for this population. It has an estimated 59% of the resources required to provide the needed care and spends 50% of the national average per enrollee on health expenditures. Estimates for 2003 for the IHS were roughly \$1900 per person annually versus \$6000 for Medicaid recipients and \$5200 for veterans (4). Only half of American Indians and Alaska Natives have employer-based healthcare coverage (72% for whites). Roughly one-quarter have Medicaid as a primary insurer, with another quarter having no healthcare coverage compared with 16% of the general population without coverage (2). This shortfall in healthcare resources for these communities plays a significant role in the ability to adequately address mental health problems.

The definitive work to date on American Indian and Alaska Native mental health disparities appears in the Surgeon General's Report on Mental Health's supplement on Culture, Race, and Ethnicity published in 2001 (5). It provides a detailed overview of historical contexts, current status, mental healthcare needs, service utilization, services outcomes, prevention, and mental health promotion for this population. The report also contains salient case studies, which add a clinical context to the material. This work arrives at several important conclusions:

- Compared with other populations, there is insufficient data on mental health problems and treatment for American Indians and Alaska Natives, but the existing data show that this population suffers significant mental health disparities compared with the general population. More data are required across the lifespan for this population.
- Native peoples are overrepresented in vulnerable populations (homeless, incarcerated, trauma victims) that are often in need of mental healthcare.

- Significant comorbidity exists in this population between mental health and substance use disorders. These are unlikely to be dealt with in conventional treatment settings.
- The availability of culturally appropriate treatment, accessible services (both financially and geographically), and accompanying medical care is critical in the provision of effective services for this population.
- A better understanding of the financing and organization of mental health service for American Indians and Alaska Natives is needed to characterize the rapidly changing service delivery environment.
- Mental health treatment guidelines have been developed on the basis of the majority population, with little specificity for minority groups despite evidence of the importance of ethnic and cultural differences. Research must focus on the applicability, outcomes, and modifications for treatment guidelines for American Indians and Alaska Natives.
- Improved methods are needed to better integrate traditional healing and spiritual practices that can complement mental healthcare for this population.
- A greater focus on prevention strategies and an exploration of individual and collective strengths and resiliencies of American Indians and Alaska Natives is warranted.

Over the ensuing 8 years, sustainable progress has been achieved regarding many of the recommended lines of inquiry. Worth briefly reviewing here is the American Indian Service Utilization, Psychiatric Epidemiology, Risk, and Protective Factors Project (AI-SUPERPFP) (6,7).

AI-SUPERPFP and its associated findings were not available at the time and therefore not addressed in the Surgeon General's Report. AI-SUPERPFP represents the largest psychiatric epidemiology project ever conducted on two well-defined samples of American Indians. Drawing on more than 3000 tribal Southwest and Northern Plains tribal members living on or near their home reservations, the lifetime and 12-month prevalence of nine psychiatric disorders were estimated together with patterns of service utilization. Its design allowed direct comparison with the National Comorbidity Survey, highlighting the contrast to the general U.S. population. Overall, AI-SUPERPFP demonstrated that this sample of American Indians had at least comparable or greater mental healthcare needs when compared with the general population. Substance- and trauma-related disorders were among the more prevalent problems (7). Additionally, as in other studies with this population, use of traditional healing services was common (6).

THE PROVIDER-PATIENT RELATIONSHIP AND CLINICAL DISPARITIES

Having briefly reviewed the general context of American Indian and Alaska Native mental health disparities, we now turn to clinical perspectives on these disparities. The relevant literature is scarce and generally descriptive in nature. As underscored in the Surgeon General's Report, the integration of general mental health treatment guidelines with best practices for American Indian and Alaska Native populations has not been systematic. The published literature is silent in respect to randomized controlled outcome trials with this population on either specific pharmacological or behavioral health interventions. Finally, although the majority of American Indians and Alaska Natives reside in urban areas, much of the work to date has focused on

reservation or community residents, contributing to an important gap in knowledge about mental health disparities for urban Native populations. The clinical encounter between mental health providers and American Indian and Alaska Native patients underscores the most obvious disparities in mental healthcare. Using the lens of the Cultural Formulation for the *Diagnostic and Statistical Manual*, 4th edition (DSM-IV) (8), we draw on our experience of the University of Colorado Denver's American Indian and Alaska Native Programs (AIANP) to discuss challenges, pitfalls, and assets in clinical work with this special population.

The Cultural Formulation for DSM-IV, hereafter referenced as the Cultural Formulation, is the most widely known transcultural approach used in psychiatry. It encourages one to consider the cultural identity of the patient, the patient's cultural explanation of distress, cultural factors related to the psychosocial environment, and cultural factors in the treatment relationship, synthesizing these elements together in an overall cultural assessment for diagnosis and care. Of particular relevance are the backgrounds of both the patient and provider and the impact of culture on the patient-provider relationship (8). The background, past experiences, and cultural identities of both the patient and the provider set the stage for the clinical interactions, determining idioms of distress and cultural context that influence the treatment process.

American Indians and Alaska Natives represent an enormous array of cultural beliefs about healing, health, and illness. These beliefs affect a patient's expression, manifestation of, and communication about their distress. In addition to the diversity of cultural idioms of illness, one's degree of "acculturation" needs to be considered with respect to each patient and the extent to which each patient adheres to traditional tribal concepts of mental health and illness. This becomes more complicated in light of the multiple cultural systems that patients may identify with, which includes traditional beliefs, Western culture, and regional cultural and urban versus rural cultural perspectives. The interplay of these belief systems with each unique cultural background determines the patient's expression and communication of distress. For example, previous work on satisfaction of care among American Indian elders revealed that those with a higher self-report of Indian ethnic identify report lower levels of satisfaction with medical care and higher levels of frustration in communicating with providers (9).

Communication can be further complicated when working with patients whose primary language is their tribal language. In the AIANP clinical programs, it is rare to encounter an elder who does not speak English at least as a second language. Although clinical interactions may be carried out in English, our experience has demonstrated that often the meaning differs between patients and providers. For example, in the Northern Plains the term "lonely" is often used by bilingual patients to describe states similar to depression. The meaning of "lonely" for Native speakers goes beyond the feeling of being without company, often referring to a feeling or state of social disconnectedness from one's family and community. The concept of "lonely" often correlates clinically and approximates feelings of depression. Providers need to remain alert to patient's use of specific words and enquire further about context and meaning.

Despite diverse beliefs, there are common and shared aspects of American Indian and Alaska Native cultures. In partnership with the National Center for Posttraumatic Stress Disorder, we developed a program (*Wounded Spirit, Ailing Hearts*) to educate providers working with Native veterans (10). This program discusses general values of Native culture that may clash with dominant society values. Among these are (i) placing tribe and extended family before self; (ii) focusing on today rather than preparing for tomorrow; (iii) valuing age over youth; (iv) cooperative rather than a competitive stance in working with others, emphasizing patience and humility over aggression; (v) orientation

toward the land and living in harmony with the environment versus conquering and controlling the environment; (vi) honoring the intuitive and mysterious rather than skepticism; (vii) having flexible rules rather than a rule for every contingency; (viii) judging for oneself rather than depending on external aides to perform the function of judging; and (ix) Different ways of conceptualizing time. Dominant Western culture is time-driven, whereas many traditional tribal cultures believe things should happen at the “right time,” unfolding as opposed to rigidly dictated by a schedule. Providers working with American Indian and Alaska Native patients must have a general knowledge about the diversity of this population, specific communication issues that may arise, and common shared values in Native cultures.

The providers’ background also has a significant impact on the clinical process. The type of provider working with Native populations is directly influenced by the larger social and economic environments. There is a significant deficit of behavioral health providers who are American Indian and Alaska Native (11). Even if a provider is Native, unless practicing in his/her home community, he/she interacts with patients of different cultural backgrounds. Being Native may help to bridge cultural gaps, but it does not guarantee culturally appropriate care. Providers who are trained in cross-cultural settings with Native populations are critical to culturally appropriate care. Because of lower salaries, remote locations, complex cases, and limited resources, it is often difficult for the IHS and other health systems serving American Indians and Alaska Natives to recruit and retain mental health specialists (11).

Tension exists for providers between general versus explicit knowledge about the specific tribal group with whom they are working. General knowledge of American Indian and Alaska Native values and specific knowledge of a tribe’s history, environment, and customs must be integrated by the provider during individual clinical encounters. Level of acculturation and individual group identity must be taken into account to facilitate this fit. This can be especially challenging for providers serving a patient population from multiple different tribal backgrounds (e.g., an urban clinic), where tribal origin may differ from one clinical encounter to the next.

Providers should familiarize themselves with the histories, environments, and cultures of the specific tribal groups from which their patients originate. This can be accomplished through an array of recourses including published materials, colleagues, meetings, trainings, patients, and community events. We recommend taking a detailed cultural history during the initial assessment that includes tribal background, first language spoken (tribal vs. English), current languages spoken and identity of patient’s primary language, traditional practices in the home and developmental environments, current engagement in traditional practices, spiritual history, and past and current use of traditional healing. This part of the assessment also offers the provider an opportunity to learn more about the patient’s culture of origin. This approach also facilitates rapport with the patient by allowing the provider to express interest and begin the dialogue around cultural issues at an early stage in the patient-provider relationship.

In addition to properly assessing their patients’ background, mental health providers working with American Indian and Alaska Native patients must be adept at monitoring the clinical process. For example, our clinical experience has shown that for many American Indian and Alaska Native patients from more traditional backgrounds, direct confrontation, particularly with an authority figure such as a physician, is considered impolite. Such patients will verbally agree with their providers’ recommendations and/or report to the provider what they think a provider wants to hear. Providers who have an overly paternalistic/confrontational style are at risk of misread-

ing politeness for compliance. This type of interaction may lead to poor adherence with treatment, decreasing communication, and worsening clinical outcome.

Many American Indian and Alaska Native cultures have strong narrative traditions. American Indian and Alaska Native elderly patients with a traditional identity often have a narrative style of expressing themselves. This can lead to frustration from patient as well as the provider when the latter attempts to use a symptom checklist or follows a highly structured interview. Abruptly cutting off or redirecting patients during an initial interview not only inhibits the history gathering but can interfere with further communication and establishing the patient-provider relationship. Ideally, providers must respect the narrative structure and should be prepared to be flexible with their clinical time to do so, especially for initial assessments. If time is an issue, explaining this can prevent damaged rapport and communication. In our clinical experience, it is possible with careful attention to conduct highly structured interviews and at the same time honor the narrative flow of the patient, although this requires more time for the assessment process.

Family and community can be very important to American Indian and Alaska Native patients. Involving family early in the treatment process, when clinically feasible, can improve the process of care. It is important to educate family and community members about a patient's mental health problems and destigmatize mental illness for the patient.

Finally, in any negotiated treatment with the patient, providers should enquire about the role of traditional treatments. For those patients expressing interest or currently engaged in traditional treatments, providers may want to consider formal or informal collaboration with traditional healers (12). At the very least, providers should attempt to understand traditional treatments, the beliefs surrounding this treatment, and how such traditional treatment can affect the care offered by the provider.

So far, we have reviewed issues to improve clinical disparities with American Indians and Alaska Natives by addressing patient and provider factors that contribute to disparities, which are summarized in Table 6.1. However, major gains for patients can be accomplished through improvements in the systems of mental health treatment and delivery. An important priority should focus on knowledge, training, and availability of providers. Providers need information on cultural background, pertinent mental health problems (e.g., trauma, substance disorders), the clinical process, and knowledge of best practices. This area is clearly underdeveloped, and more research is required. We must look to training as an ongoing process throughout a provider's career. Methods to disseminate this knowledge especially must be developed to assist those working in rural areas. Increasing the availability of culturally competent mental health providers for American Indian and Alaska Native populations is critical to effectively address clinical disparities.

The next section examines several recent developments that have potential to address many aspects of clinical disparities. These include evidence regarding traditional treatments, technologies that have fostered new models of care delivery, information dissemination, and the growing movement of evidence-based and personalized medicine.

PROMISING PRACTICES, CHALLENGES, AND FUTURE DIRECTIONS

Undoubtedly, addressing funding and treatment challenges is a necessary but not sufficient step for addressing clinical disparities with American Indians and Alaska Natives.

- Become familiar with shared cultural elements of American Indian and Alaska Native populations.
 - Develop knowledge about the culture, history, and customs of the specific the tribal groups you are working with.
 - Gather a detailed cultural history during the initial assessment that includes tribal background, first language spoken (tribal vs. English), current languages spoken and identity of patient's primary language, traditional practices in the home and developmental environments, current engagement in traditional practices, spiritual history, and past and current use of traditional healing.
 - Consider acculturation level of patient and how this affects patient's cultural identities and expression and communication of distress.
 - Listen carefully to patients whose primary language is a tribal language when conversing in English for words that may represent differing concepts.
 - Be respectful of a narrative style of communication and adapt clinical interviews for this style when warranted.
 - Become attuned to patients' processes of communication with authority and be careful not to assume politeness is correlated with treatment compliance.
 - Involve family when possible as appropriate in treatment.
 - Assess patient's current use of traditional healing practices and desire to have traditional treatment incorporated into current treatment. For interested patients, consider collaborations with traditional healers in the community.
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Solving these challenges requires not only gathering relevant data to develop new models but promoting these solutions through advocacy. Addressing the fundamental economic and systems disparities inherent in the mental health treatment of American Indians and Alaska Natives is a complex, intricate, and lengthy process. Solutions targeted initially at the patient-provider level, as opposed to the systems levels of clinical disparities, are easier to implement, can be funded on a small scale, require less political advocacy, and have the potential to diffuse upward to a system-wide level.

Among the more exciting recent developments is the use of live interactive videoconferencing, telepsychiatry, to provide mental healthcare to remote and rural populations. Telepsychiatry holds particular promise for American Indians and Alaska Natives because of the rural, remote, and dispersed nature of many of these communities. Over the past decade, the AIANP developed telepsychiatry clinics to provide services and to test the effectiveness of this technology. An accumulating body of evidence at the AIANP demonstrates the capacity of telepsychiatry to provide reliable psychiatric assessments and treatments with equivalent levels of satisfaction, comfort, and cultural sensitivity in direct care for American Indians and Alaska Natives (13). A growing series of AIANP telepsychiatry clinics in partnership with the Department of Veterans Affairs provides ongoing care for American Indian veterans struggling with posttraumatic stress disorder on rural reservations in the Northern Plains. As these clinics currently grow from 1 to 13 tribes in the region, they serve as a demonstration of how clinically implemented solutions can diffuse throughout treatment systems (14).

Another example of leveraging technology to address disparities is the AIANP's Native Telehealth Outreach and Technical Assistance Program (NTOTAP). The

“digital divide” throughout much of rural America disproportionately affects American Indian and Alaska Native communities (Native Digital divide) (15). Even when sufficient technological infrastructure is present, community members often lack the technical skills or experience to use these resources. This often forces community members to use programs designed for and implemented by those who are not familiar with their communities. Furthermore, the dissemination of relevant healthcare information takes a “top-down” approach in which government agencies dictate the focus of these efforts. NTOTAP trains Native community members at the lay and professional levels (including providers) in the use of technology to address local healthcare needs. The program imparts technical knowledge and skills that enable participants to develop healthcare training for community-wide and regional dissemination. NTOTAP has completed eight multimedia-based projects (e.g., Web sites, interactive CD-ROMs, and video focusing on a variety of health concerns) that have been disseminated throughout rural communities (15). NTOTAP demonstrates how technology can be used to address provider training, enhance community involvement in healthcare, and involve communities in creating and distributing best practices discussed below.

Collaboration between traditional healers and behavioral health providers represent another important area for clinical disparities. Significant percentages of American Indian and Alaska Native use traditional healers. In the previously discussed AI-SUPERPPF study, the use of traditional healers by participants with DSM-IV behavioral disorders was high: 34% to 49% in the past year (6). Indeed, 16% to 32% of users of biomedical services for emotional problems had also seen a traditional healer (7). In a different study of American Indian veterans, service utilization rates for the two groups of veterans (Northern Plains vs. Southwestern) were compared across biomedical and traditional healing. The VA facilities were closer and more available in the Northern Plains than in the Southwest, causing significantly lower use of VA facilities for Southwest veterans. Southwest veterans had higher use of traditional services, erasing the overall health service difference with the Northern Plains, indicating that type of service use (biomedical vs. traditional) varied on the basis of availability (16).

These findings support the importance of making both behavioral health services and traditional services available to American Indian and Alaska Native patients. We strongly encourage providers to seek active collaboration with traditional healers when treating patients who use or are interested in such services. We recently created a set of guidelines that outlines recommendations for mental health providers seeking active collaboration with traditional healers (12). Several programs and systems around the country are already engaging in this work, which can be used to further enhance models and frameworks (12).

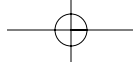
There is an increasing trend in the U.S. general population to adopt evidence-based medicine, best practices, and individualized medicine. Several important issues affect the implementation of evidence-based practices with American Indian and Alaska Native populations. The data underpinning evidence-based mental health practices rarely includes minority populations or considers cultural factors that affect treatment and outcomes. We simply do not know how applicable evidence-based practices are for American Indian and Alaska Native populations, what adaptations may be needed to render these practices acceptable and relevant for this population, and the impact these adaptations could have on treatments, processes, and outcomes (17). Furthermore, the generally accepted ranking of evidence, with the highest level being the randomized controlled trial, does not adequately account for cultural variation, the rich narrative and experiential traditions of Native culture, and the contribution of

qualitative data. Although evidence-based medicine could prove to be a powerful tool for reducing clinical disparities among American Indians and Alaska Natives, its application in this population begs for further investigation. We need realistic models and methods of community collaboration, together with cultural adaptation and assessment of evidence-based practices.

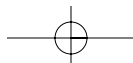
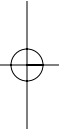
The U.S. Government has a special obligation, based on both the historical record and negotiated treaties, to address mental health disparities specific to American Indians and Alaska Natives. This work should proceed with both a “top-down” and a “bottom-up” approach. The resource deficit must be addressed. Provider training and increased availability, the integration of cultural practices, and improving treatment practices can help to reduce clinical disparities. Tailoring technologies, traditional healing, and evidence-based medicine to Native communities builds on current advances in medicine and the growing belief that these practices can improve outcomes for this unique population.

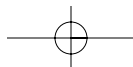
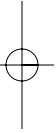
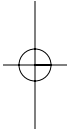
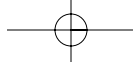
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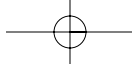
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