MENTAL HEALTH DISORDERS

Mental health disorders are widely understudied among the AI/AN population according to the Surgeon General's Report on Mental Health.[31] This assertion is echoed by the National Alliance on Mental Illness (NAMI), which explains in a mental health fact sheet that the two major studies conducted on depression did not report data on AI/ANs.[32] Despite gaps in data, several sources reveal that AI/ANs are at higher risk for certain mental health disorders than other racial/ethnic groups.[33] For example, the Office of Minority Health reports that AI/ANs experience higher rates than all races in the following areas:

- serious psychological distress;
- feelings of sadness, hopelessness, and worthlessness;
- feelings of nervousness or restlessness; and
- suicide.[34]

AI/ANs are also overrepresented among high-need populations requiring mental health services (e.g., people who are homeless, incarcerated, drug and alcohol abusers, and exposed to trauma as well as children who are in foster care).[35]

Treating Mental Health Disorders in Indian Country

Despite widespread risk factors for and symptoms of mental health disorders in Indian Country, significant access barriers to treatment exist. In his testimony before the Senate Committee on Indian Affairs, Coloradas Mangas, a 15-year-old Tribal member and survivor of teen suicide on the Mescalero Apache Reservation, explained that cultural stigmas against talking about death and seeking psychological help often prevent AI/ANs from accessing the mental health services they need.[36]

Even when AI/AN individuals do decide to see a psychologist, reservation hospitals simply lack the mental health resources needed to serve them. Indeed, the Surgeon General's Report on Mental Health reveals the availability of approximately 101 AI/AN mental healthcare professionals per 100,000 AI/ANs in contrast to the 173 available per 100,000 white persons.[37] This workforce shortage may explain the low rates among AI/ANs for accessing mental health counseling and treatments, including prescription medicine for mental health disorders.[38]

Another issue is ensuring the provision of culturally competent services that recognize the needs and challenges of the AI/AN community. It is critical that mental healthcare professionals understand the stress and anxiety associated with AI/AN identity, the AI/AN acculturation and deculturation that trigger mental health disorders, and the need for traditional and cultural practices as a part of the treatment and prevention process.[39] [40] [41]

The Effects of Mental Illness on the AI/AN Community

Multiple studies have found a correlation between AI/AN rates of depression or other mental health disorders and AI/ANs' overrepresentation among people who are incarcerated, die by suicide, or who suffer from alcohol and drug use disorders.[42] Concerning suicide, Dr. Paula Clayton, in her testimony before the Senate Committee on Indian Affairs, indicated that 90% of suicide victims suffered from mental health disorders at their time of death.[43] Likewise, *The Surgeon General's Report* suggests that some behavioral risk factors, such as alcoholism and violence, are in actuality expressions of depression or other mental health disorders.[44] Regardless of the causal link between these risk factors and mental illness, the overall health and well-being of AI/AN communities are undoubtedly affected by mental health disorders.

90% of AI/AN suicide victims suffered from mental health disorders at their time of death.

SUICIDE

Suicide in Indian Country is a significant behavioral health issue affecting AI/ANs. The suicide rates for AI/ANs are even more alarming than the rates for the general population, at 1.7 times higher than the U.S. rate for all races and ages.[45] It is the second leading cause of death for Indian youth between the ages of 15 to 24 (3.5 times higher than the national average).[46] Alaska Natives die by suicide at rates four times the national average. For Alaska Native males, the suicide rate is six times higher than the national average, with teen suicide rates almost as high—nearly six times the rate of non-Native teens.[47]

The suicide rate among AI/AN young men is alarmingly high. Special attention to the situation of AI/AN teenagers and young adult men is needed in order to heal and address the risk factors for suicide, as well as to determine supports that would allow young men at risk to successfully receive help. While recognizing the serious risk factors for AI/AN young men, suicide and suicidal behavior are also concerns that affect AI/AN people of both genders and across the life cycle. For example, while AI/AN males ages 15 to 24 are at highest risk for suicide completion, the group at the highest risk for suicide attempts is females of the same ages,[48] indicating the prevalence of the same troubling risk factors in the lives of young women—drug and alcohol use, violence, trauma, abuse, and depression and other mental illness. In addition, young people between ages 15 and 24 make up 40% of all suicide deaths in Indian Country. In the discussion of suicide as a behavioral health problem, it is important to recognize risk factors at all ages and the need for comprehensive and integrated solutions across communities and generations, even as strategies for suicide prevention and appropriate treatment may also be specially adapted for relevance to certain groups, such as AI/AN teenagers and young adult men.

Suicide Contagion and Suicide Clusters in Indian Country

In some communities, the suicide rate may be pushed higher by a phenomenon called suicide contagion. In her September 2009 Statement before the Senate Committee on Indian Affairs, IHS Director Dr. Yvette Roubideaux explained, "Indian Country has communities each year where suicide takes on a particularly ominous and seemingly contagious form, often referred to as suicide clusters."[49] Specifically, *suicide contagion* is when exposure to suicide, suicidal behaviors, or other unexpected deaths influence others to attempt or complete suicide, while *suicide clusters* are the occurrence of more suicide attempts or deaths by suicide in a given time period than would be expected for a community.[50] It is important to note that suicide clusters can be sparked by unintentional deaths that are not the result of suicide and may instead be caused by accidents or violence. Teenagers and young adults are at highest risk for suicide contagion, and experimentation with drugs or alcohol can increase their vulnerability. These connections reveal additional implications of the issues discussed in this section and show the overlap and interconnectedness of many behavioral health concerns.

> **"Our young people live in great despair—witnessing the extreme emotional and social impact of high rates of infant deaths, living with poverty and often within abusive households, and watching other young people taking their own lives."**
> ***—Robert Moore, Councilman, Rosebud Sioux Tribe***

The devastating trend of suicide contagion continues to be the experience of many Tribal communities. In recent years, Tribes that have been severely affected by suicide deaths have faced dozens of deaths by suicide in short spans of time. Often, these tragic deaths can be followed by hundreds of suicide attempts that are documented by local healthcare facilities.[51] The Tribal chairman of the Rosebud Sioux Tribe testified before Congress in February 2009, saying that ―our young people live in great despair—witnessing the extreme emotional and social impact of high rates of infant deaths, living with poverty and often within abusive households, and watching other young people taking their own lives. The result is that we tend to see clusters of youth suicides in many of our communities.‖[52]

Addressing Suicide in Indian Country

Dealing with—and healing—the effects of suicide can be daunting. When a person dies by suicide, it adversely affects the lives of many other individuals and can lead to permanent consequences on the productivity, self-esteem, or physical and mental health of affected individuals. Tribal leaders and members alike describe the hopelessness they feel when their people turn to suicide and the contagious nature of this hopelessness.[53] [54] [55]

In her September 2009 testimony before the Senate Committee on Indian Affairs, IHS Director Dr. Roubideaux said, ―Siucide and suicidal behavior and their consequences send shockwaves through many communities in Indian Country, including urban communities. The pain only deepens when those seeking help for their loved ones in crisis, or those left behind as emotional survivors of such acts, are unable to access adequate care.‖[56] Services and resources necessary to address suicide for at-risk individuals and survivors of suicide are not always available in AI/AN communities. Navigating complex or fragmented combinations of Tribal, Federal, State, local, and community-based services can be confusing and discouraging, making it difficult to access care even if it is available. In addition, severe provider shortages are common.[57] Especially regarding services for children and young adults, research reports that AI/AN youth ―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.‖[58]

In addition to clinical care, the importance of public health and community-based interventions is becoming more widely recognized.[59] This perspective is transforming suicide prevention strategies and has increasingly brought innovative and culture-based programs, such as Native Aspirations, to the forefront. One factor that makes community- and culture-based interventions especially important is the role of historical trauma in the increased risk of suicide among AI/AN people. *Historical trauma* describes the cumulative effects of the massive group trauma experienced by AI/AN peoples and nations since the arrival of European settlers on the American continent.[60] This trauma has taken various forms, from outright violence of wars and forced relocation to damaging prohibitions on

Native languages and cultural and religious practices. Historical trauma has many dimensions, but one important aspect is that, as with any trauma situation, parents and caregivers who have been traumatized often pass on trauma response patterns to their children. This means that the effects of historical trauma in AI/AN communities include not just past or present acts of oppression and racism that AI/AN people have been victimized by, but also the ways that trauma response behaviors are internalized, repeated, and passed on within AI/AN families and communities. Historical trauma is linked to increased suicide risk not only through depression, despair, and helplessness felt because of cultural oppression, but also because anger, aggression, and violence felt in response to experiences of victimization can be turned against oneself.[61]

Stigma and Other Obstacles to Delivering Behavioral Healthcare

It is important to consider obstacles that may stand in the way of AI/ANs seeking and receiving behavioral healthcare. The goal in doing this is to investigate the complex factors that affect both problems and opportunities in this area and to ensure that solutions are wisely crafted and do not replicate problems with past mental and behavioral health approaches.

Cultural stigma against talking about death, the shortage of mental and behavioral health providers across Indian Country, and unmet needs for culturally relevant care all add to the difficulty of delivering appropriate behavioral healthcare, including suicide prevention, to AI/AN populations. Another important factor that can pose an obstacle is that stigma against accessing behavioral healthcare services is very high. As with most AI/AN health issues, the topic is under-researched, but a review of available data suggests that AI/ANs access community mental health facilities far less frequently than other races. A 1999 study indicated that 44% of AI/AN adults surveyed who had experienced any type of mental health problem did not seek any help, and those who did seek help did not choose to contact mental health agencies. A second study reported that 55% of AI/AN patients did not return after initial contact with mental health facilities, a significantly higher rate than other races.[62] The impact of this stigma can be life-threatening, as described in a presentation at the IHS/BIA 2010 National Behavioral Health Conference, where Michael Gomez reported IHS data indicating that 96% of individuals who had attempted suicide stated they would not seek professional help.[63]

While provider shortages and access factors, such as distance to health facilities, do affect these figures, stigma plays a defining role. Stigma related to behavioral healthcare for AI/AN people has multiple dimensions. First, it has been reported that AI/ANs have felt that mental and behavioral healthcare services have not been relevant to their needs and situation.[64] The perception and reality of this situation are certainly changing as outreach and awareness efforts targeted toward AI/AN populations increase and as the behavioral health field becomes more aware of the key role of culture in providing appropriate care. However, the perception that mental and behavioral healthcare lack relevance to AI/AN needs remains, and efforts to develop mental health services within AI/AN communities can be negatively associated with historic attempts to transform Native culture.[65] Second, prejudice and misinformation on the part of the behavioral health field—that is, its disregard or even hostility toward AI/AN traditional healing practices—also discourage AI/ANs from seeking behavioral healthcare services. As many as 2/3 of AI/ANs choose to use traditional healers, occasionally in conjunction with mental healthcare

providers.[66] Due to a lack of understanding, Western perspectives portray traditional and cultural practices as incompatible with behavioral healthcare, as a result some AI/AN people choose not to access behavioral health services.

A final barrier in delivering appropriate behavioral healthcare in AI/AN communities is a focus on individualized analysis and treatment in the mental health field that obscures the role of community and historical factors. To fully understand suicide, mental health disorders, alcohol and substance abuse, and even domestic violence and sexual assault, we must view these issues within the context of the AI/AN experience. A history of forced relocation, the removal of children from their homes and into harsh boarding schools, the prohibition of the practice of language and cultural traditions, and the outlawing of traditional religious practices has resulted in intergenerational impacts, known as historical trauma. The effects of historical trauma, as well as racism and victimization that continue in the present day, must be acknowledged. Historical trauma is experienced by and rooted in communities. Because of this, community-based interventions can recognize and address historical trauma in a way that treatments focused on the individual may not. Many culturally based suicide prevention programs that include traditional practices and engage entire communities are currently underway, as described in Chapter 4, IHS Area Profiles and Behavioral Health Program Spotlights.

Available data and analysis describe the role of stigma and cultural factors in complicating access to mental healthcare, including suicide prevention services. Behavioral healthcare offered for alcohol and substance abuse, domestic violence, and behavior-related chronic diseases may face similar obstacles. While addressing access and resource shortages throughout the AI/AN behavioral health system is critical, it is necessary to go beyond addressing care availability and delivery systems and to critically examine the type and paradigm of care that is provided. For successful behavioral healthcare efforts, we must ensure that care offered in AI/AN communities is culturally relevant and takes its cues from successful Tribally managed behavioral health efforts, including evidence-based, cultural, and traditional practices. Successful behavioral healthcare must also allow the lingering Western model of individualized disease and treatment to be challenged and transformed by alternate understandings.

VIOLENCE

Violence is another serious problem in Indian Country. Violent deaths—deaths from unintentional injuries, homicide, and suicide—account for 75% of all mortality among AI/ANs in their 20s.[67] Age-adjusted death rates among AI/ANs in 2002-2004 for unintentional injuries were 2.5 times higher, and the homicide rate was two times higher, than the U.S. all-races rate in 2003.[68] Even when violence is non-fatal, its effects are damaging to individuals and communities, and its scope in Indian Country is widespread.

Bullying and Its Effects

An important but sometimes unrecognized aspect of violence is bullying that occurs among AI/AN youth. Bullying describes overt acts of violence between peers, but it can also include a variety of other negative or threatening behaviors such as name-calling, teasing, spreading lies or rumors, ignoring or social exclusion, stealing, or threats of physical harm.[69] Studies indicate that AI/AN youth experience bullying at rates higher than youth of other races. There are 27.5% of AI/AN students in grades 6 through 12 who reported being a victim of bullying, compared to 20.1% of students nationally. In addition, 30.9% of AI/AN students in grades 6 through 12 reported being a bully (i.e., participating in bullying behaviors), compared to 18.8% of students nationally.[70]

Bullying can be—and until recently, often has been—dismissed as situational behavior that youth outgrow over time. But changing perspectives and new research present a different story. Research reports that victims of bullying are at risk for depression, low self-esteem, health problems, and poor

grades.[71] Students who bully their peers are more likely to participate in a wide variety of anti-social behaviors: they more frequently get into fights, vandalize or steal property, drink alcohol, smoke, skip school, drop out, and carry weapons.[72] Suicidal ideation and suicide attempts are higher among targets of bullying, *as well as among bullies*.[73] Especially among AI/AN youth, where suicide risk factors are higher than average, high rates of bullying should be viewed with special concern.

The effects of bullying extend beyond youth who are victims and bullies. Bullying creates an environment where violence and aggression are accepted, and bystanders learn to align with dominant individuals for protection and status.[74] Concretely, bullying behavior in schools is linked to an increase in violent behavior, weapons carrying, and gang membership.[75] Over time, in adolescence and adulthood, behavior patterns learned from bullying translate into other serious problems such as sexual harassment, dating violence and sexual assault, child abuse, and elder abuse.[76] Bullying can also be understood as an expression of lateral violence related to historical and intergenerational trauma.[77] Violence, anger, or aggression that cannot be expressed toward an oppressor is turned against the self or others, as is seen with suicide. These violent acts then serve to repeat and reinforce trauma, victimization, and trauma responses.

As in other areas of behavioral health, more research that is specific to AI/AN youth and communities is needed. However, available research suggests connections between the occurrence and impacts of bullying and other behavioral health concerns, including mental health disorders, suicide, alcohol and substance abuse, and domestic violence and sexual assault.

The Rise of Domestic and Sexual Violence in Indian Country

The statistics on domestic violence and sexual assault against AI/AN women are also bleak. According to the CDC, 39% of Native women have experienced intimate partner violence—the highest percentage in the U.S.[78] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,[79] and AI/AN women are more than five times as likely to die from domestic violence-related injuries than women of any other race.[80]

One out of every three AI/AN women will be sexually assaulted in her lifetime

As with suicide and bullying, it is important to acknowledge the role that historical and intergenerational trauma has played in the high levels of domestic violence and sexual assault against AI/AN women. Colonization brought significant changes for AI/AN people—changes that have been attributed to the high levels of violent crime in Indian Country and particularly the violence against women.[81] [82] [83] [84] In colonizing Native people, the U.S. government sanctioned horrific acts of violence against them, now acknowledged by the Department of the Interior as ~~"~~the cowardly killing of women and children.~~"~~ [85] There are countless stories of soldiers raping Indian women in a violent display of power.[86] This oppression and domination continued even after relocation, most notably during the boarding school era, when children as young as five were forcibly removed from their homes and sent to live in military-like dormitories for cultural assimilation purposes.

As was discussed briefly in the issue profiles on alcohol and substance abuse, substance abuse has also played a significant role in the rise of

violent crime and violence against women and children in Indian Country. Alcohol abuse is indisputably linked to violence. For example, the Bureau of Justice Statistics reports that in violent crimes against AI/ANs, 62% of victims reported the offender was under the influence of alcohol.[87] The rise of methamphetamine abuse has been cited by Tribal law enforcement as responsible for increases in domestic violence, assault and battery, and child abuse and neglect.[88] In addition, the Deputy Director of the Office of Justice Services for the Bureau of Indian Affairs stated in an interview that rape ―was a problem long before methamphetamine, but methamphetamine is making it worse.‖[89]

The Effects of Domestic Violence and Sexual Assault on Public Health and Safety

Violence such as intimate partner violence and sexual assault has been correlated with adverse health conditions and health risk behaviors.[90] The effects of violence and assault go beyond the short-term injuries such as cuts, bruises, and broken bones received by victims. For example, intimate partner violence has been linked to increases in heart disease, asthma, and stroke as well as migraines and fibromyalgia.[91] Victims also experience negative emotional and mental health problems such as stress, depression, anger, self-hatred, and post-traumatic stress disorder. [92]

Domestic violence and sexual assault have also been correlated with an increase in high-risk health behaviors. People who have been victimized are more likely to smoke cigarettes, drink alcohol, and use drugs.[93] They are also more likely to engage in risky sexual behaviors, which can lead to in increased risk of contracting sexually transmitted infections. Increased risk for drug use and increased likelihood of engaging in risky sexual behaviors have been documented among AI/AN physical and sexual assault victims, as well as among victims of domestic violence.[94] [95]

The Violence Against Women Act of 1994 (reauthorized in 2000 and 2005) has provided some discretionary grants to Tribes to address domestic violence and sexual assault. However, domestic violence and sexual assault have remained serious public safety concerns, partially because responding to and prosecuting these cases is problematic. In his testimony before the Senate Committee on Indian Affairs in June 2007, the President of the National Congress of American Indians explained that the combination of jurisdictional complexity, lack of commitment from Federal and State authorities, and insufficient resources dedicated to law enforcement in Indian Country is leading to increased criminal activity and creating fear in victims to come forward.[96] He went on to say that ―criminal activity is encouraged when ‗routine' crimes such as domestic violence and drug and alcohol offenses are unaddressed.‖[97] Indeed, Federal Indian law precludes Tribal governments from prosecuting non-Indians. This law creates a serious problem given the high rate of sexual assault against AI/AN women by non-Indian men (nearly 90%) and the resulting high rate of assault cases that go unprosecuted.[98]

The Tribal Law and Order Act (TLOA) of 2010 addresses these significant legal and jurisdictional loopholes. Along with strengthening Tribal law enforcement and increasing Tribal court prosecution and sentencing authority, two sections of the TLOA specifically address domestic violence and sexual assault procedures within IHS. Section 263 addresses the process of obtaining testimony from IHS healthcare providers for legal proceedings and Section 265 requires the development of IHS standardized sexual assault response procedures, in order to ensure that patient care is culturally sensitive, patient-centered, and the community response is coordinated. Taken together, these measures promise to increase the rate of domestic violence and sexual assault conviction,

which may increase the reporting of domestic violence and sexual assault incidents and ultimately change the climate surrounding violence against women in AI/AN communities. There is, however, clearly also a need for prevention, intervention, treatment, and services at the level of behavioral health treatment for both victims and offenders.

BEHAVIOR-RELATED CHRONIC DISEASES

With regard to chronic diseases and behavior-related chronic conditions, numerous health disparities exist in AI/AN populations. According to the CDC's Office of Minority Health and Health Disparities, the top 10 causes of death among AI/AN individuals are listed below. [99]

1. Heart disease
2. Cancer
3. Unintentional injuries
4. Diabetes
5. Chronic liver disease and cirrhosis
6. Stroke
7. Chronic lower respiratory disease
8. Suicide
9. Nephritis, Nephrotic syndrome, and Nephrosis
10. Influenza and Pneumonia

When comparing death rates for all races with those for AI/AN populations, significant disparities exist. The IHS reports that AI/AN individuals have a 750% greater incidence of tuberculosis, 524% greater incidence of alcoholism, 193% greater incidence of diabetes, and 47% greater incidence of pneumonia and influenza.[100] The CDC also reports that AI/AN individuals are 2.3 times more likely to be diagnosed with diabetes and 1.6 times more likely to be obese when compared with rates among white adults.[101] Closely echoing CDC reports on health disparities, Cynthia Manuel, National Indian Health Board Member, noted in her testimony at the Fourth Annual CDC Tribal Consultation, that Tribes "consistently identify the following as National Tribal Health Priorities." [102]

1. Diabetes
2. Cancer
3. Behavioral Health*
4. Cardiovascular Disease**
5. Health Promotion/Disease Prevention
6. Injury Prevention
7. Maternal and Child Health
8. Dental Health
9. Water and Sanitation
10. Respiratory/Pulmonary Health

*Including alcohol/substance abuse and mental health
**Including heart disease and stroke

In its overview on Chronic Diseases and Health Promotion, the CDC indicates that four "modifiable lifestyle factors" contribute to most of these causes of death, including: "lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption." [103] Indeed, fully 7 of the top 10 causes of death in Indian Country could be favorably impacted by health promotion activities focusing on these four modifiable risk factors.

National Indian Health Board Member Cynthia Manuel's testimony supports this assertion stating, "Tribal communities experience health disparities in multiple forms, and many of the chronic diseases that affect AI/ANs are preventable."[104]

As such, because so many of the leading causes of death in Indian Country and the top National Tribal Health Priorities are preventable, efforts that integrate behavioral health and health behavior modification strategies (e.g., health promotion/disease prevention) into primary care and community settings may have particular benefit for AI/AN populations.

SUMMARY

Each issue profiled in this chapter demonstrates the seriousness of the problems facing our Tribal communities. When read in aggregate, the combined gravity of these issues can become overwhelming, but the efforts to address these problems nationally, regionally, and locally offers hope. The next two chapters of this Briefing Book will explore the work being done to address existing disparities, beginning with a chapter on financing and resources dedicated to behavioral health prevention and treatment, and followed by a chapter profiling behavioral health programs in the 12 IHS Areas.