June 2003

AMERICAN INDIAN & ALASKA NATIVE

RESOURCE MANUAL

NAMI

The Nation's Voice on Mental Illness

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A Word from NAMI

If mental health is the foundation of a vibrant, productive society, then access to treatment must be its cornerstone. Yet, even here in the U.S., where resources for treatment far outstrip those of our counterparts across the globe, less than a third of those with mental illness seek treatment. And those Americans whose race, ethnicity, primary language, and/or economic status have pushed them to the margins of U.S. society face daunting barriers to the most basic health care. Nowhere are these inequities more evident than among American Indians and Alaska Natives (AI/AN) with mental illness, whose morbidity rates for various mental illnesses are astronomically higher (alcoholism, 770% higher; suicide, 190% higher) than those of their white peers.

NAMI's commitment to reach out to AI/AN communities and other underserved populations was made an official priority on November 9, 2001. On this day NAMI's Board of Directors approved its new Strategic Plan.

Goal # 3 of this Strategic Plan states:

NAMI must actively reach out to diverse and priority populations.
To improve access to services, NAMI must continue to build its grassroots advocacy movement by involving increasingly diverse groups. To accomplish this, NAMI must enlist leaders from diverse cultural communities in order to establish a dialogue with the communities they represent and to assure that NAMI adopts practices, messages, and methods that are "culturally competent". NAMI must develop targeted marketing and outreach strategies to successfully involve these groups. In addition, NAMI must continue to develop a culture of respect for increased diversity in its governance and membership.

To achieve this goal NAMI created a Multicultural and International Outreach Center (NAMI MIO). NAMI MIO's goals are to:

- More centrally involve members of diverse communities in education/advocacy efforts.

- Develop and disseminate culturally competent direct service/support models in the field.

- Decrease stigma through public education models that address specific racial and cultural barriers.

- Improve mental health policy development at the local, state and national level by increasing grassroots participation.

It is a serious decision to start an AI/AN outreach initiative. It requires a thoughtful planning process and real commitment. The purpose of this manual is to aid in this process by providing key information regarding the AI/AN communities, mental illnesses, outreach strategies, and available resources. This manual is designed as a tool to help NAMI state offices and affiliates to better understand what is involved in an AI/AN outreach campaign and aid in the creation of an outreach plan.

This manual covers the following area: the need for AI/AN outreach, the importance of cultural competence and how to develop it, how to create AI/AN outreach plan (NAMI examples), how to evaluate your efforts, and how to share your experience with other NAMIs.

Jim McNulty
President
NAMI Board of Directors

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Chapter One

Issues At A Glance: Assessments from the Indian Health Services

Health Disparities Trends

Facts on Indian Health Disparities

Mental Health

Excerpts from the Surgeon General's Report, Mental Health: Culture, Race and Ethnicity

ISSUE

Specific intervention strategies are required to address the significant disparities that exist between the health of the American Indian and Alaska Native population and the general U.S. population.

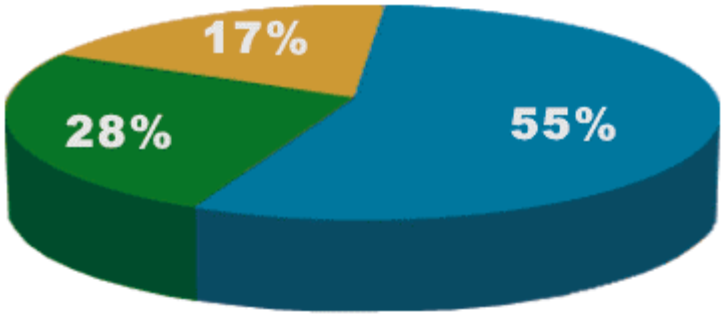
BACKGROUND

The Indian population is diverse, geographically dispersed, and economically disadvantaged. Disease patterns among Indians are strongly associated with adverse consequences from poverty, limited access to health services, and cultural dislocation. Inadequate education, high rates of unemployment, discrimination, and cultural differences all contribute to unhealthy lifestyles and disparities in access to health care for many Indian people.

- **32% fall below poverty standard**
- **Unemployment is 2.5 times higher**
- **Many live in remote places**
- **55% rely on IHS as the only source of health care**

Indians experience disproportionately high mortality compared to other Americans from:

- **Alcoholism 740% higher**
- **Tuberculosis 500% higher**
- **Diabetes 390% higher**
- **Injuries 340% higher**
- **Suicide 190%higher**
- **Homicide 180% higher**



PRIVATE INSURANCE | IHS ONLY | OTHER PUBLIC COVERAGE

Source: Survey of American Indians and Alaska Natives: July 1991

IHS is the only source of health care coverage for 55% of Indians. Only 28% had employment related insurance.

SITUATION

Tribal leaders cite *diabetes*, *unintentional injuries*, *and alcoholism and substance abuse* as rising to crisis proportions in Indian communities. They are concerned that Indian health resources may not be adequate to deal with the enormous needs—a concern consistent with a recent actuarial study that found IHS funding for personal health services at 60% compared to mainstream employer-provided plans such as the Federal Employees Health Benefit Plan. Efforts to address these health problems cannot be expected to yield quick results. The most serious health problems are long-term, intractable issues that will be greatly affected by social-economic conditions in Indian communities and the resources available to respond to them.

OPTIONS/PLANS

The IHS employs a formal consultation process with tribal and urban Indian leaders to identify leading health priorities. The IHS will continue to assist tribes and urban Indian health programs in developing local and community level approaches to their health issues.

ADDITIONAL INFORMATION

For referral to the appropriate spokesperson, contact the IHS Public Affairs Staff at 301-443-3593.

This issue summary should be used in conjunction with the IHS "Heritage and Health" and "IHS Profile" documents, available at http://info.ihs.gov

February 2001

Indian Health Service

Facts on Indian Health Disparities

"The elimination of health disparities is an important step in accomplishing the mission of the Indian Health Service – to raise the health status of American Indian and Alaska Native people."

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director, Indian Health Service

Members of more than 560 federally recognized American Indian and Alaska Native tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS is an agency within the Department of Health and Human Services that provides a comprehensive health service delivery system for approximately 1.6 million of the nation's estimated 2.6 million American Indians and Alaska Natives. Its annual appropriation is approximately $2.8 billion. The IHS strives for maximum tribal involvement in meeting the health needs of its service population, who live mainly on or near reservations and in rural communities in 35 states, mostly in the western United States and Alaska.

- Approximately 60% of American Indians and Alaska Natives living in the United States rely on the IHS to provide access to health care services in 49 hospitals and over 500 other facilities operated by the IHS, by tribes, by Alaska Native corporations, or purchased from private providers.

- The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

- American Indians and Alaska Natives born today have a life expectancy that is almost 6 years less than the U.S. all races population (70.6 years to 76.5 years, respectively; 1996-98 rates). American Indian and Alaska Native infants die at a rate of 8.9 per every 1,000 live births, as compared to 7.2 per 1,000 for the U.S. all races population (1996-98 rates).

- American Indians and Alaska Natives die at higher rates than other Americans from alcoholism (770%), tuberculosis (750%), diabetes (420%), accidents (280%), suicide (190%), and homicide (210%). (Rates adjusted for miscoding of Indian race on state death certificates; 1997-99 rates.)

- Safe and adequate water supply and waste disposal facilities are lacking in approximately 7.5% of American Indian and Alaska Native homes, compared to 1% of the homes for the U.S. general population.

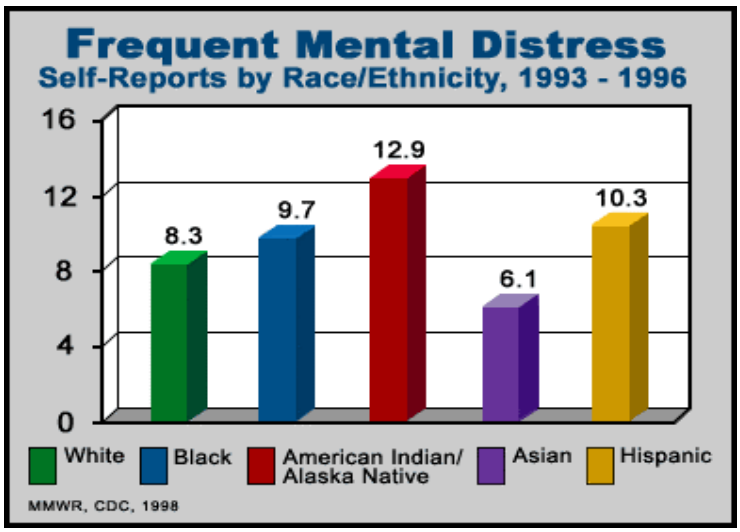
- Given the higher health status enjoyed by most Americans, the lingering health disparities of American Indians and Alaska Natives are troubling. In trying to account for the disparities, health care experts, policymakers, and tribal leaders are looking at many factors that impact upon the health of Indian people, including the adequacy of funding for the Indian health care delivery system.

- The American Indian and Alaska Native population has several characteristics different from the U.S. all races population that would impact upon assessing the cost for providing similar health services enjoyed by most Americans. The Indian population is younger, because of higher mortality, than the U.S. all races. The IHS service population is predominately rural, which should suggest lower costs; however, the disproportionate incidence of disease and medical conditions experienced by the Indian population raises the costs, which almost obliterates the lower cost offsets.

- A stakeholder workgroup has developed a model to estimate the costs of providing a package of personal health care services for Indian people based on mainstream health plan benefits enjoyed by many Americans. According to the workgroup's cost model, the IHS appropriated funding provides only 59% of the necessary federal funding for providing mainstream personal health care services to American Indians and Alaska Natives using the system and only 54% for those living in the IHS service area of 35 States.

ISSUE

Greater than one-third of the demands made on health facilities in Indian country involve mental health and social service related concerns.

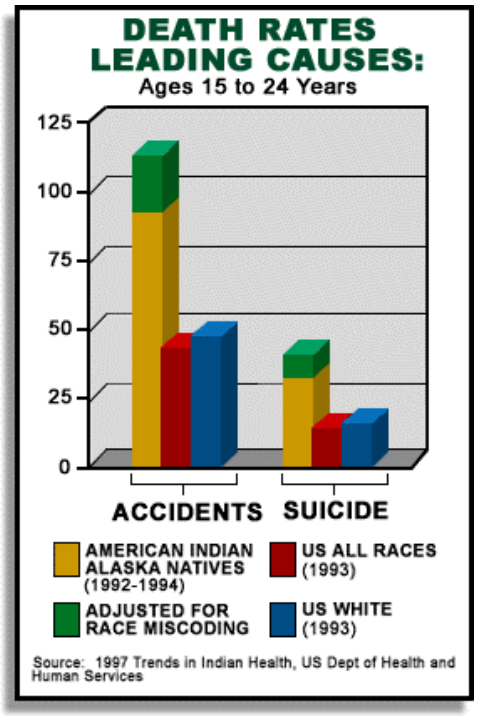


BACKGROUND

The Mental Health and Social Services program is a community oriented clinical and preventive service program whose activities are part of a broader, multidisciplinary behavioral health approach. Behavioral health teams are composed of psychologists, mental health counselors, psychiatrists, social workers, substance abuse counselors, and traditional healers. The composition of each team is tailored to the specific issue to be addressed. Substance abuse, trauma, and poverty often complicate the healing process for American Indians and Alaska Natives. Currently, Mental Health and Social Services programs promote the mental health of individuals, families, and communities by providing appropriate and culturally responsive intervention, treatment, and prevention services.

SITUATION

Considerable disparities exist in the psychological well being of American Indians and Alaska Natives. American Indians, compared to the general population, tend to underutilize services, experience higher therapy drop-out rates, are less likely to respond to treatment, and have negative opinions about non-Indian providers. The suicide rate for American Indians is 72% higher than the general population. The highest suicide rate is found in American Indians ages 15-34 compared to ages 74 and older for the general population. There is a significantly higher rate of poverty in American Indian and Alaska Native communities. Poverty often leads to a lack of housing and overcrowding in homes, as well as other socioeconomic, education, and health problems. Economic concerns are often related to domestic violence and childhood sexual abuse. The potential for mental health problems is evident.



OPTIONS/PLANS

Additional intervention and prevention strategies that meet specific needs of individuals, families, and communities are needed. Investing in inpatient, outpatient, home, and community services will have a dramatic effect on decreasing the need for direct health services to respond to the consequences of behavioral and mental health related issues.

ADDITIONAL INFORMATION

For referral to the appropriate spokesperson, contact the IHS Public Affairs Staff at 301-443-3593.

This issue summary should be used in conjunction with the IHS "Heritage and Health" and "IHS Profile" documents, available at http://info.ihs.gov.

February 2001

Need for American Indians and Alaska Native Outreach

The Surgeon General's 1999 Report on Mental Health offered a singular recommendation: People should seek help if they have a mental health problem or if they think they have symptoms of a mental disorder.

This simple statement belies the complex reality underlying it: access to mental health services is fraught with barriers, especially for consumers and families whose race, culture and class push them to the margins of U.S. health care systems.

Understanding how issues of race and class create barriers to care is essential to addressing those barriers. Accordingly, this section of the American Indian and Alaska Native Resource Manual presents demographic information on the concentration and distribution of the American Indian and Alaska Native populations in the United States, as well as current research by the Surgeon General's Office on the state of mental health care for American Indians and Alaska Natives and a vision for the future.

Surgeon General's Report
Chapter 4- Mental Health Care for American Indians and Alaska Natives
Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. *U.S. Department of Health and Human Services:*

Introduction

American Indian and Alaska Natives were self-governing people who thrived in North America long before Western Europeans came to the continent and Russians to the land that is now Alaska. American Indians and Alaska Natives occupy a special place in the history of our Nation: their very existence stands as a testament to the resilience of their collective and individual spirit.

The U.S. Census Bureau estimates that 4.1 million American Indians and Alaska Natives lived in the United States in 2000. This represented less than 1.5 percent of the total U.S. population. (U.S. Census Bureau, 2001) The recorded population of this minority group increased by over 250 percent, largely due to better data collection by the Census Bureau, an increasing number of individuals who identify themselves as American Indians and Alaska Natives.

Historical Context

As members of federally recognized sovereign nations that exist within another country, American Indians are unique among minority groups in the United States. Ever since the European "discovery" and colonization of North America, the history of American Indians has been tied intimately to the influence of European settlers and to the policies of the U.S. Government.

Early European contact in the 17th century exposed Native people to infectious diseases from which their natural immunity could not protect them, and the population of American Indians plummeted. In 1820, as European settlers pushed westward, Congress passed the Indian Removal Act to force Native Americans west the Mississippi River. Brutal marches of Native people, sometimes in the dead of winter, ensued. Later, as colonists moved farther westward to the Great Plains and beyond, the U.S. Government sent many tribes to live on reservations of marginal land where they had little chance of prospering. Treaties between the tribes and the U.S. Government were signed, then broken, and struggles for territory followed. The Plains Indian Wars raged until the end of the 19th century, punctuated by wholesale slaughter of American Indian men, women, and children. As the settlers migrated toward the Pacific Ocean, the U.S. Congress passed legislation that effectively made Native Americans wards of the state.

Even as American Indians were being killed or forced onto reservations, some Americans protested the destruction of entire Indian "nation" (tribes and tribal confederacies). In 1887, after the bloodiest of the Indian Wars ended, Congress passed the Dawes Severalty Act, which allotted portions of reservation land to Indian families and individuals. The government then sold the leftover reservation land at bargain prices. This Act, which intended to integrate American Indians into the rest of U.S. society, had disastrous consequences. In addition to losing surplus tribal lands, many Natives lost their allotted lands as well and had little left for survival. But the early 1900s, the population of American Indians reached its lowest point, an incredible 5 percent of the original population estimated at first European contact (Thornton, 1987)

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. During the 1930s and 1940s, nearly half of all Indian people who received formal education attended such schools.

American Indians experienced both setbacks and progress during the 20th century. In June 1924, Congress granted American Indians U.S. citizenship. The Indians Citizenship Act later was amended to include Alaska Natives (Deloria, 1985; Thornton, 1987). The subsequent passage of the Indian Reorganization Act (1934) placed great emphasis on civilizing Native people and teaching them Christianity. To this end, many more Native American children were sent to learn "American ways" at government- or church-run boarding schools that were often thousands of miles from the " detrimental influences" of their home reservations.

The era of American Indian educational reform began in the 1920s. Public criticism of Indian Bureau policies and practices culminated in an in-depth investigation of Indian affairs by the Brookings Institution in 1926. Its report, *The Problem of Indian Administration concluded:*

The first and foremost need in Indian education is a change in point of view. Whatever may have been the official government attitude, education for the Indian in the past has proceeded on the theory that it is necessary to remove the Indian child as far as possible from his home environment; whereas the modern point of view in education and social work lays stress on upbringing in the natural setting of home and family life. Although some children did well in these settings, others did not. Reports of harsh discipline were widespread (Brookings, 1971)

Even worse, the National Resource Center on Child Sexual Abuse (1990) cites evidence that many Native American children were sexually abused while attending boarding schools (Horejsi et al., 1992).

One positive result of the collective experience of boarding school students is that it gave rise to a shared social consciousness across previously disparate tribes, thereby fueling political change. One lesson from the boarding school era is that tribal peoples have encountered tremendous adversity yet survived- politically, culturally, linguistically, and spiritually (Hamley, 1994). Near the end of the World War II, Congress began to withdraw Federal support and to abdicate responsibility for American Indian affairs. Whereas earlier assimiltionists had envisioned a time when tribes and reservations would vanish as Native Americans became integrated into U.S. society, the proponents of "termination" decided to legislate such entities out of existence. As a consequence, over the following two decades, many Federal services were withdrawn, and Federal trust protection was removed from tribal lands.

One policy from this era was an attempt by the U.S. Government to extinguish Native spiritual practices. A government prohibition on participation in traditional spiritual ceremonies continued until the American Indian Religious Freedom Act of (1978). Despite the prohibitions and the Christianizing efforts by various churches, indigenous culture and spirituality have survived and are widely practiced (Bryde, 1971). Even in areas where many Native people practice Christianity, traditional cultural views still heavily influence the way in which Native people understand life, health, illness, and healing (Todd-Bazemore, 1999).

In the 1970s, American Indians and Alaska Natives began to demand greater authority over their own lives and communities, encouraged by the 1969 publication of the report of the Congressional Committee on Labor and Public Welfare: *Indian Education: A National Tradedy- A National Challenge*. Current Federal policy encourages tribal administration of the government's health, education, welfare, law enforcement, and housing programs for Native Americans. Local communities have responded to this in a variety of ways that reflect the continuing diversity of their experiences and perspectives.

Current Status

Geographic Distribution

Most American Indians live in Western States, including California, Arizona, New Mexico, South Dakota, Alaska, and Montana, with 42 percent residing in rural areas compared to 23 percent of whites (Rural Policy Research Institute, 1999). The number of American Indians who live on reservations and trust lands (area with boundaries established by treaty, statute, and executive or court order) has decreased substantially in the past few decades. For example, in 1980, most American Indians lived on reservations or trust lands; today, only 1 in 5 American Indians live in these areas, and more than half live in urban, suburban, or rural nonreservation areas.

Family Structure

Consistent with a national trend, the proportion of American Indian families maintained by a single female increased between 1980 and 1990. However, the Native American increase of 27 percent was considerably larger than the national figure of 17 percent. In 1990, 6 in 10 American Indian and Alaska Native families were headed by married couples; in contrast, about 8 in 10 of the Nation's other families were headed by married couples (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). An even more telling insight into the family structure of American Indians follows from consideration of the dependency index, which compares the proportion of household members between the ages of 16 and 64 to those younger than 16 years of age combined with those 65 years of age and older. Here the assumption is that the former are more likely to con-tribute economically to a household, and the latter 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).

Education

In 1990, 66 percent of American Indians and Alaska Natives 25 years old and over had graduated from high school or achieved a higher level of education; in contrast, only 56 percent had done so in 1980. Despite this advance, the 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). Data suggest that Indian students achieve on a par with or beyond the performance of non-Indian students in elementary school and show a crossover or decline in performance between fourth and seventh grades (Barlow & Walkup, 1998). Explanations for this crossover vary. Indian children may have a culturally rooted way of learning at odds with teaching methods currently used in public education. Several researchers cite differences between Indian cognitive styles and

Western teaching styles. For example, Indian children are primarily visual learners, rather than auditory or verbal learners. Indian youngsters tend to excel at nonverbal performance scales of development and fall below national averages on verbal scales (Yates, 1987). Verbal learners are favored by modes of mainstream public education and testing (Yates, 1987). Linguistic experts have observed that Native languages stress keen descriptive observation and form rather than the verbal or conceptual abstractions that are common in English, which may make learning in English-language schools difficult (Basso, 1996).

Regardless of the reasons for lower academic achievement, negative consequences often ensue. The academic crossover is paralleled by a similar trend in mental health status, as extrapolated from rates of child and adolescent outpatient treatment. Specifically, one study noted that Indian youth enter mental health treatment at a sharply increased rate during the same period, fourth to seventh grades, and that the rate dramatically exceeds their non-Indian counterparts, with a continuously widening gap into late adolescence (Beiser & Attneave, 1982). Subsequent work by Beiser and colleagues clearly underscores the contribution of cultural dynamics in the classroom to these outcomes (Beiser et al., 1998).

Income

Following the devastation of these once-thriving Indian nations, the social environments of Native people have remained plagued by economic disadvantage. Many American Indians and Alaska Natives are unemployed or hold low-paying jobs. Both men and women in this population were roughly twice as likely as whites to be unemployed in 1998 (Population Reference Bureau, 2000). From 1997 to 1999, about 26 percent of American Indians and Alaska Natives lived in poverty; this percentage compares with 13 percent for the United States as a whole and 8 percent for white Americans (U.S. Census Bureau, 1999b).

Physical Health Status

With some exceptions, the health of this ethnic minority group has begun to improve, and the gap in life expectancy rates between Native Americans and others has begun to close. For instance, the infant mortality rate of American Indians decreased from 22 per 1,000 live births in 1972–1974 to 13 in 1990 and 9 in 1997 (Indian Health Service, 1997). Still, American Indians and Alaska Natives have the second highest infant mortality rate in the Nation (National Center for Health Statistics, 1999) and the highest rate of sudden infant death syndrome (DHHS, 1998). The death rates among American Indians ages 15 to 24 are also higher than those for white persons in the same age group (Grant Makers in Health, 1998). American Indians and Alaska Natives are five times more likely to die of alcohol-related causes than are whites, but they are less likely to die from cancer and heart disease (Indian Health Service, 1997). The rate of diabetes for this population group is more than twice that for whites. In particular, the Pima tribe of Arizona has one of the highest rates of diabetes in the world. The incidence of end-stage renal disease, a known complication of diabetes, is higher among American Indians and Alaska Natives than for both whites and African Americans.

Nationally, one-third of American Indians and Alaska Natives do not have a usual source of health care, that is, a doctor or clinic that can provide regular preventive and medical care (Brown et al., 2000). In 1955, the U.S. Government established the Indian Health Service (IHS) within the Department of Health and Human Services (DHHS). The IHS mission is to provide a comprehensive health service delivery system for American Indians and Alaska Natives "… with opportunity for maximum Tribal involvement in developing and managing programs to meet their health needs" (IHS, 1996). The IHS is responsible for working to provide health delivery programs run by people who are cognizant of entitlements of Native people to all Federal, State, and local health programs, in addition to IHS and tribal services. The IHS also acts "as the principal Federal health advocate for the American Indian and Alaska Native people in the building of health coalitions, networks, and partnerships with Tribal nations and other government agencies as well as with non-Federal organizations [such as] academic medical centers and private foundations" (IHS, 1996).

Although the goal of the IHS is to provide health care for Native Americans, IHS clinics and hospitals are located mainly on reservations, giving only 20 percent of American Indians access to this care (Brown et al., 2000). Furthermore, IHS-eligible American Indians are less likely than others with private health insurance coverage to have obtained the minimum number of physician visits3 for their age and health status.

More than half of American Indians and Alaska Natives live in urban areas (U.S. Census Bureau, 1990). Title V of Public Law 94–437 of the Indian Health Care Improvement Act authorizes the appropriation of funds for urban Indian health programs. Presently, there are 34 such programs across 41 sites, independently operated through grants and contracts offered by the IHS. Though there is little data available regarding the health needs and access to care among urban Native Americans, the constellation of problems is similar to that of rural communities and includes serious mental illness, alcohol and substance abuse, alcohol and substance dependence, and suicidal ideation (Novins, 1999). An Urban Indian Epidemiology Center was recently funded by the IHS to address this important knowledge gap (Indian Health Service, 2001).

Even where the IHS is active, health service systems in general fail to meet the wide-ranging needs of indigenous populations, especially in remote and isolated regions of the United States. This includes rural, "bush" Alaska, which is divided into 12 Native regions that encompass several villages whose languages, dialects, and cultural connections are only somewhat similar (Reimer, 1999). For example, ethnographic studies in two Pacific Northwest Indian tribal communities document the lack of trust between American Indians and the IHS. Many community members felt they were not receiving appropriate care. Furthermore, holistic education programs to address health needs across the lifespan were considered lacking. Overall, many community members reported that they felt unheard and trapped in a system of care over which they have no control (Strickland, 1999).

Today, the IHS remains the primary entity responsible for the mental health care of American Indians and Alaska Natives. Until 1965, the delivery of mental health services was sporadic. That year, the first Office of Mental Health was opened on the Navajo Reservation. It remained severely understaffed and underfunded until its dissolution in 1977. Legislation to authorize comprehensive mental health services for tribes has been enacted and amended several times, but Congress consistently failed to appropriate funds for such initiatives (Nelson & Manson, 2000). Financial inadequacies have resulted in four IHS service areas without child or adolescent mental health professionals. Fragmented Federal, State, tribal, private foundation, and national nonprofit attempts to meet such obvious needs have led to isolation, difficult work conditions, cultural differences, and high turnover rates that dilute efforts to provide mental health services (Barlow & Walkup 1998; Novins, Fleming, et al., 2000).

The Need for Mental Health Care

Historical and Sociocultural Factors That Relate to Mental Health

The history of American Indians and Alaska Natives sets the stage for understanding their mental health needs. Past governmental policies regarding this population have led to mistrust of many government services or care provided by white practitioners. Attempts to eradicate Native culture, including the forced separation of Indian and Native children from parents in order to send them to boarding schools, have been associated with negative mental health consequences (Kleinfeld, 1973; Kleinfeld & Bloom, 1977). Some argue that, as a consequence of past separation from their families, when these children become parents themselves, they are not able to draw on experiences of growing up in a family to guide their own parenting (Special Subcommittee on Indian Education, 1969). The effect of boarding school education on American Indian students remains controversial (Kunitz et al., 1999; Irwin & Roll, 1995).

The socioeconomic consequences of these historical policies are also telling. The removal of American Indians from their lands, as well as other policies summarized above, has resulted in the high rates of poverty that characterize this ethnic minority group. One of the most robust scientific findings has been the association of lower socioeconomic status with poor general health and mental health. Widespread recognition that many Native people live in stressful environments with potentially negative mental health consequences has led to increasing study and empirical documentation of this link (Manson, 1996b, 1997; Beals et al, under review; Jones et al., 1997).

Key Issues for Understanding the Research

Because American Indians and Alaska Natives comprise such a small percentage of U.S. citizens in general, nationally representative studies do not generate sufficiently large samples of this special population to draw accurate conclusions regarding their need for mental health care. Even when large samples are acquired, findings are constrained by the marked heterogeneity that characterizes the social and cultural ecologies of Native people. There are 561 federally recognized tribes, with over 200 indigenous languages

spoken (Fleming, 1992). Differences between some of these languages are as distinct as those between English and Chinese (Chafe, 1962). Similar differences abound among Native customs, family structures, religions, and social relation-ships. The magnitude of this diversity among Indian people has important implications for research observations. Novins and colleagues provide an excellent illustration of this point in a paper that shows that the dynamics underlying suicidal ideation among Indian youth vary significantly with the cultural contexts of the tribes of which they are members (Novins, et al., 1999). A tension arises, then, between the frequently conflicting objectives of comparability and cultural specificity—a tension not easily resolved in research pursued among this special population.

As widely noted, language is important when assessing the mental health needs of individuals and the communities in which they reside. Approximately 280,000 American Indians and Alaska Natives speak a language other than English at home; more than half of Alaska Natives who are Eskimos speak either Inuit or Yup'ik. Consequently, evaluations of need for mental health care often have to be conducted in a language other than English. Yet the challenge can be more subtle than that implied by stark differences in language. Cultural differences in the expression and reporting of distress are well established among American Indians and Alaska Natives. These often compromise the ability of assessment tools to capture the key signs and symptoms of mental illness (Kinzie & Manson, 1987; Manson, 1994, 1996a). Words such as "depressed" and "anxious" are absent from some American Indian and Alaska Native languages (Manson et al., 1985). Other research has demonstrated that certain DSM diagnoses, such as major depressive disorder, do not correspond directly to the categories of illness recognized by some American Indians. Thus, evaluating the need for mental health care among American Indians and Alaska Natives requires careful clinical inquiry that attends closely to culture.

Census 2000 reports a significant increase in the number of individuals who identify, at least in part, as American Indian or Alaska Native. This finding resurrects longstanding debates about definition and identification (Passel, 1996). The relationship of those who have recently asserted their Indian ancestry to other, tribally defined individuals is unknown and poses a difficult challenge. It suggests a newly emergent need to consider the mental health status and requirements of individuals who live primarily within mainstream society, while continuing to build the body of knowledge on groups already defined.

Mental Disorders

Although not all mental disorders are disabling, these disorders always manifest some level of psychological discomfort and associated impairment. Such symptoms often improve with treatment. Therefore, the presence of a mental disorder is one reasonable indicator of need for mental health care. As noted in previous chapters, in the United States such disorders are identified according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic categories established by the American Psychiatric Association (1994).

Adults

Unfortunately, no large-scale studies of the rates of mental disorders among American Indian and Alaska Native adults have yet been published. The discussion at this point must rely on smaller, suggestive studies that await future confirmation.

The most recently published information regarding the mental health needs of adult American Indians living in the community comes from a study conducted in 1988 (Kinzie et al., 1992). The 131 respondents were inhabitants of a small Northwest Coast village who had participated in a previous community-based epidemiological study (Shore et al., 1973). They were followed up 20 years later using a well accepted method for diagnosing mental disorders, the Schedule for Affective Disorders and Schizophrenia-Lifetime Version. Nearly 70 percent of the sample had experienced a mental disorder in their lifetimes. About 30 percent were experiencing a disorder at the time of the follow-up.

The American Indian Vietnam Veterans Project (AIVVP) is the most recent community-based, diagnostically oriented psychiatric epidemiological study among American Indian adults to be reported within the last 25 years (Beals et al., under review; Gurley et al., 2001; National Center for Post-Traumatic Stress Disorder and the National Center for American Indian and Alaska Native Mental Health Research [NCPTSD/NCAIANMHR], 1996). It was part of a congressionally mandated effort to replicate the National Vietnam Veterans Readjustment Study that had been conducted in other ethnic groups (Kulka et al., 1990).

The AIVVP found that rates of PTSD among the Northern Plains and Southwestern Vietnam veterans, respectively, were 31 percent and 27 percent, current; 57 percent and 45 percent, lifetime. These figures were significantly higher than the rates for their white, black, and Japanese American counterparts. Likewise, current and lifetime prevalence of alcohol abuse and/or dependence among the Indian veterans (more than 70% current; more than 80% lifetime) was far greater than that observed for the others, which ranged from 11 to 32 percent current and 33 to 50 percent lifetime (NCPTSD/NCAIANMHR, 1997).

There are no recent, scientifically rigorous studies that could shed light on the need for mental health care among Alaska Natives. The only systematic studies of Alaska Natives are outdated (Murphy & Hughes, 1965; Foulks & Katz, 1973; Sampath, 1974) and not based on the current DSM system of disorders. One study of Alaska Natives seen in a community mental health center indicated that substance abuse is a common reason for men (85% of those seen) and women (65% of those seen) to seek mental health care (Aoun & Gregory, 1998).

Children and Youth

Two recent studies examined the need for mental health care among American Indian youth. The Great Smoky Mountain Study assessed psychiatric disorders among 431 youth ages 9 to 13 (Costello et al., 1997). Children were defined as American Indian if they were enrolled in a recognized tribe or were first- or second-generation descendants of an enrolled member. Overall, American Indian children were found to have fairly similar rates of disorder (17%) in comparison to white children from surrounding counties (19%). Lower rates of tics (2 vs. 4%) and higher rates of substance abuse or dependence (1 vs. 0.1%) were found in American Indian children as compared with white children. The difference in substance abuse is almost totally accounted for by alcohol use among 13-year-old Indian children (Costello et al., 1997). Rates of anxiety disorders, depressive disorders, conduct disorders, and attention-deficit/hyperactivity disorder (AD/HD) were not significantly different for American Indian and white children. Yet, for white children, poverty doubled the risk of mental disorders, whereas poverty was not associated with increased risk of mental disorders among the American Indian children. Overall, these American Indian children appeared to experience rates of mental disorders similar to those for white children.

The second study reported a follow up of a school-based psychiatric epidemiological study involving Northern Plains youth, 13 to 17 years of age (Beals et al., 1997). Of 109 adolescents, 29 percent received a diagnosis of at least one psychiatric disorder. Altogether, more than 15 percent of the students qualified for a single diagnosis; 13 percent met criteria for multiple diagnoses. In terms of the broad diagnostic categories, 6 percent of the sample met criteria for an anxiety disorder, 5 percent for a mood disorder (either major depressive disorder or dysthymia), 14 for one or more of the disruptive behavior disorders, and 18 percent for substance abuse disorders. Only 1 percent was diagnosed with an eating disorder. The five most common specific disorders were alcohol dependence or abuse (11%), attention- deficit/hyper-activity disorder (11%), marijuana dependence or abuse (9%), major depressive disorder (5%), and other sub-stance dependence or abuse (4%). Considerable comorbidity among disorders was observed. More than half of those with a disruptive behavior disorder also qualified for a substance use disorder. Similarly, 60 percent of those youth diagnosed with any depressive disorder had a substance use disorder as well.

Beals and colleagues compared their findings with those reported for nonminority children drawn from the population at large (Lewinsohn et al., 1993; Shaffer et al., 1996). The American Indian youth were diagnosed with fewer anxiety disorders than the nonminority children in the Shaffer sample. However, American Indian adolescents were much more likely to be diagnosed with AD/HD and substance abuse or substance dependence disorders. The rates of conduct disorder and oppositional defiant disorder were also elevated in the American Indian sample. Rates of depressive disorders were essentially equivalent. This latter finding was consistent with a study published in 1994 (Sack et al., 1994) that reported clinical depression among youth from several reservations below 1 percent, “a prevalence rate compatible with other studies in white populations, which typically varies from 1 to 3 percent” (Fleming & Offord, 1990).

When compared with the Lewinsohn sample, American Indian adolescents in the study by Beals and colleagues demonstrated statistically significant higher 6-month prevalence rates than did the nonminority children for lifetime prevalence of ADHD and alcohol abuse/dependence. In addition, the American Indian youth had higher 6-month rates of simple phobias, social phobias, overanxious disorder, and oppositional defiant and conduct disorders than the nonminority children's lifetime rates for those disorders.

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

Box 4–1: Charlie (age 9); Mike (father, age 29)

Charlie frequently argued with teachers and started fights with other children. Charlie's schoolteacher recommended him for counseling because of his acting out in school.

Charlie had lived all his life with his mother and two younger siblings on their Southwestern reservation. Charlie's father, Mike, lived in the home until Charlie was 3 years old, when he was sent to prison for attempted murder of Charlie's mother. Mike was a chronic alcoholic who frequently battered his wife when their arguments became heated. Charlie often witnessed violence between his mother and father and was aware of the circumstances leading to his father's imprisonment. During Mike's incarceration, Charlie visited him in prison and maintained regular contact by mail and phone. At the time of Charlie's referral, Mike had been out of prison for one year and had just returned home from a 30-day alcohol rehabilitation program.

Mike had been the youngest of eight children; his mother, the primary caretaker, sent Mike away to boarding school because she was unable to care for him. Mike never had contact with his father, whom he described as "an alcoholic and a womanizer." Although Mike recognized the economic hardship his mother faced after his father left, he nonetheless felt abandoned by her and frequently wondered why she had had him in the first place.

Mike described boarding school as a constant struggle. On the weekends and holidays, Mike rarely went home; his family did not visit him. Over the years, Mike felt great sadness over his childhood loss and great anger toward his mother for her complete abandonment of him.

In addition to being physically abusive toward his wife, Mike frequently fought other men. He often felt great rage and was easily provoked

Mike was a talented artist who created pottery and woodwork designs that were derived from traditional practices within his tribe. He was a full-blooded member of his tribe. Though raised on the reservation, he spent most of his life shuttling between it and various institutions, such as boarding school, prison, and alcohol rehabilitation facilities.

In talking about his childhood, Mike was confused and incoherent, especially about his parents. He sometimes needed to leave the therapeutic setting because he had become so agitated by these feelings. Mike was preoccupied with the sense that he had been dealt a bad lot in life. This contributed to his quickness to see that others were betraying him and thus needed to be dealt with swiftly and harshly without forgiveness.

At the time of Charlie's referral, Mike was newly committed to being a parent. Mike wanted to teach his children about his art and culture, to play sports with them, and to guide them in ways that he had not been guided. Mike acknowledged that the problems Charlie was having were not unlike the problems he had as a child. He had not appreciated the impact that the rage rooted in his own childhood experience of abandonment had on Charlie's development. In witnessing the violence that his father let explode on his mother, Charlie had learned to fear his father and to feel powerless to protect his mother. Charlie appears to be making up for this powerlessness at home by dominating his peers through his own acts of violence. (Adapted from Christensen & Manson, 2001)

Older Adults

Although large-scale studies of mental disorders among older American Indians are lacking, Manson (1992) found that over 30 percent of older American Indian adults visiting one urban IHS outpatient medical facility reported significant depressive symptoms; this rate is higher than most published estimates of the prevalence of depression among older whites with chronic illnesses (9 to 31%) (Berkman et al., 1986). In another clinic-based investigation, nearly 20 percent of American Indian elders who received primary care reported significant psychiatric symptoms (Goldwasser & Badger, 1989), with rates increasing as a function of age. These findings are consistent with a survey of older, community-dwelling, urban Natives in Los Angeles, among whom more than 10 percent reported depression, and an additional 20 percent reported sadness and grieving (Kramer, 1991).

A recent study of 309 Great Lakes American Indian elders revealed that 18 percent of the sample scored above a traditional cutoff for depression on the Center for Epidemiology Studies Depression Scale (CES–D) (Curyto et al., 1998, 1999). However, upon further examination of that data, the factor structure of the CES–D was found to be different in this population as compared to available norms (Chapleski, Lamphere, et al., 1997). Therefore, the concern remains that the CES–D may not accurately measure depressive symptoms in this population. Nonetheless, depressive symptoms were strongly associated with impaired functioning (Chapleski, Lichtenberg, et al., 1997), which is in keeping with past findings (Baron et al., 1990) and underscores the burden posed by such distress, as well as the need for intervention (Manson & Brenneman, 1995).

Mental Health Problems

Symptoms

Although little is known about rates of psychiatric disorders among American Indians and Alaska Natives in the United States, one recent, nationally representative study looked at mental distress among a large sample of adults (Centers for Disease Control and Prevention, 1998). Overall, American Indians and Alaska Natives reported much higher rates of frequent distress—nearly 13 percent compared to nearly 9 percent in the general population. The findings of this study suggest that American Indians and Alaska Natives experience greater psychological distress than the overall population.

Somatization

The distinction between mind and body common among individuals in industrialized Western nations is not shared throughout the world (Manson & Kleinman, 1998; Manson, 2000). Many ethnic minorities do not discriminate bodily from psychic distress and may express emotional distress in somatic terms or bodily symptoms. Relatively little empirical research is available concerning this tendency among American Indians and Alaska Natives. However, a sample of 120 adult American Indians belonging to a single Northwest Coast tribe was screened using the Center for Epidemiologic Studies

Depression Scale, which includes both psychological and somatic symptoms. Analyses showed that somatic complaints and emotional distress were not well differentiated from each other in this population (Somervell et al., 1993). Other inquiries into the psychometric properties of the CES–D and other measures of depressive symptoms among American Indians have yielded similar findings, providing some evidence of the lack of such distinctions within this population (Ackerson et al., 1990; Manson et al., 1990).

Culture-Bound Syndromes

A large body of ethnographic work reveals that some American Indians and Alaska Natives, who may express emotional distress in ways that are inconsistent with the diagnostic categories of the DSM, may conceptualize mental health differently. Many unique expressions of distress shown by American Indians and Alaska Natives have been described (Trimble et al., 1984; Manson et al., 1985; Manson 1994; Nelson & Manson, 2000). Prominent examples include ghost sickness and heart-break syndrome (Manson et al., 1985). The question becomes how to elicit, understand, and incorporate such expressions of distress and suffering within the assessment and treatment process of the DSM–IV.

Suicide

Given the lack of information about rates of mental disorders among American Indian and Alaska Native populations, the prevalence of suicide often serves as an important indicator of need. The Surgeon General's 1999 Call to Action to Prevent Suicide indicates that from 1979 to 1992, the suicide rate for this ethnic minority group was 1.5 times the national rate. The suicide rate is particularly high among young Native American males ages 15 to 24. Accounting for 64 percent of all suicides by American Indians and Alaska Natives, the suicide rate of this group is 2 to 3 times higher than the general U.S. rate (May, 1990; Kettle & Bixler, 1991; Mock et al., 1996). In another survey of American Indian adolescents (n = 13,000), 22 percent of females and 12 percent of males reported having attempted suicide at some time; 67 per-cent who had made an attempt had done so within the past year (Blum et al., 1992). Furthermore, an analysis of Bureau of Vital Statistics death certificate data from 1979 to 1993 found that "Alaska Native males had one of the highest documented suicide rates in the world" (1997). Alaska Natives, in general, were more likely to commit suicide than non-Natives living in Alaska (Gessner, 1997). It is important to note that violent deaths (unintentional injuries, homicide, and suicide) account for 75 percent of all mortality in the second decade of life for American Indians and Alaska Natives (Resnick et al., 1997).

High-Need Populations

American Indians and Alaska Natives are the most impoverished ethnic minority group in the United States. Although no causal links have yet been demonstrated, there is good reason to suspect that the history of oppression, discrimination, and removal from traditional lands experienced by Native people has contributed to their current lack of educational and economic opportunities and their significant representation among populations with high need for mental health care.

Individuals Who Are Homeless

American Indians and Alaska Natives are overrepresented among people who are homeless. Although they comprise less than 1 percent of the general population, American Indians and Alaska Natives constitute 8 per-cent of the U.S. homeless population (U.S. Census Bureau, 1999a). It is not clear that homeless American Indians and Alaska Natives are at greater risk of mental disorder than their non-Native counterparts. In one study, American Indian veterans who were homeless had fewer psychiatric diagnoses than did white veterans who were homeless (Kasprow & Rosenheck, 1998), although these differences were relatively small. Nevertheless, because there are more individuals with mental disorders among the homeless population than among the general population (Koegel et al., 1988), this finding likely points to a substantial number of Native people with a high need for mental health care.

Individuals Who Are Incarcerated

In 1997, an estimated 4 percent of racially identified 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 (Bureau of Justice Statistics, 1999). Although research specific to rates of mental disorders among American Indian and Alaska Native adults in jails is not available, a recent study has evaluated disorders among incarcerated adolescents. Rates of mental disorders among those held in a Northern Plains reservation juvenile detention facility were examined (Duclos et al., 1998). Among the 150 youth evaluated, nearly half (49%) had at least one alcohol, drug, or mental health disorder. The most common problems detected were substance abuse, conduct disorder, and depression.

These rates were higher than those found in Indian adolescents in the community, indicating that incarcerated American Indians are likely to be at high need for mental health and substance abuse interventions.

Individuals with Alcohol and Drug Problems

Actual rates of alcohol abuse among American Indian adults are difficult to estimate, yet indirect evidence suggests that a substantial proportion of this population suffers from this problem. For example, the estimated rate of alcohol-related deaths for Indian men is 27 percent and for Indian women 13 percent (May & Moran, 1995). Rates appear to vary widely among different tribes. Although the topic of substance abuse is beyond the scope of this Supplement, alcohol problems and mental disorders often occur together in American Indian and Alaska Native populations (Westermeyer, 1982; Whittaker, 1982; Westermeyer & Peake, 1983; Kinzie et al., 1992; Beals et al., 2001). A recent study, which sought to understand the link between alcohol problems and psychiatric disorders in American Indians, included over 600 members of three large families (Robin et al., 1997a). More than 70 percent qualified for a lifetime diagnosis of alcohol disorders. Among both men and women, those who were alcohol-dependent were also more likely to have psychiatric disorders, as were those who engaged in binge-drinking behavior. This finding underscores the likelihood that American Indians with alcohol disorders are at high risk for concomitant mental health problems.

Given the high rates of alcohol abuse among some American Indians and Alaska Natives, fetal alcohol syndrome is an important influence on mental health needs (May et al., 1983). The Centers for Disease Control and Prevention (1998) monitored the rate of fetal alcohol syndrome (FAS), identifying cases based on hospital discharge diagnoses collected from more than 1,500 hospitals across the United States between 1980 and 1986. The overall rate of FAS was 2.97 per 1,000 for Native Americans, 0.6 per 1,000 for African Americans, 0.09 for Caucasians, 0.08 for Hispanics, and 0.03 for Asians (Chavez et al., 1988). As might be expected given the fact that physicians often do not identify this disease, these rates are much lower than those found in clinic-based investigations (Stratton et al., 1996). Fetal alcohol syndrome now is recognized as the leading known cause of mental retardation in the United States (Streissguth et al., 1991), surpassing Down's syndrome and spina bifida. Fetal alcohol syndrome is not just a childhood disorder; predictable long-term progression of the disorder into adulthood includes maladaptive behaviors such as poor judgment, distractibility, and difficulty perceiving social cues. Consequently, American Indians and Alaska Natives with fetal alcohol syndrome are likely to have high need for intervention to facilitate the management of their disabilities.

Drinking by American Indian youth has been more thoroughly studied than drinking by American Indian adults. Ongoing school-based surveys have shown that, although about the same proportion of Indian and non-Indian youth in grades 7 to 12 have tried alcohol, Indian youth who drink appear to drink more heavily than do youth of other ethnicities (Plunkett & Mitchell, 2000; Novins et al., under review). They also experience more negative social consequences from their drinking than do their non-Indian counterparts (Oetting et al., 1989; Mitchell et al., 1995). Although drinking and mental disorders may be less linked for youth than for adults, those adolescents with serious drinking problems are likely to be at risk for mental health problems as well (Beals et al., 2001).

Individuals Exposed to Trauma

Lower socioeconomic status is associated with an increased likelihood of experiencing undesirable life events (McLeod & Kessler, 1990). As a result of lower socioeconomic status, American Indians and Alaska Natives are also more likely to be exposed to trauma than members of more economically advantaged groups. Exposure to trauma is related to the development of sub-sequent mental disorders in general and of post-traumatic stress disorder (PTSD) in particular (Kessler et al., 1995). Recent evidence suggests that American Indians may be at high risk for exposure to trauma.

An investigation of Northern Plains youth ages 8 to 11 found that 61 percent of them had been exposed to some kind of traumatic event. These children were reported to have more trauma-related symptoms, but not substantially higher rates of diagnosable PTSD (3%) (Jones et. al., 1997). According to the Bureau of Justice Statistics (1999), the rate of violent victimization of American Indians is more than twice as high as the national average. Indeed, the data regarding reported child abuse in Native communities indicate that this phenomenon has increased 18 percent in the last 10 years (Bureau of Justice Statistics, 1999). Another study noted a high prevalence of trauma exposure (e.g., car accidents, deaths, shootings, beatings) and PTSD within those in the family study mentioned above (Robin et al., 1997c). Of those studied, 82 percent had been exposed to one traumatic event, and the prevalence of PTSD was 22 percent. Because American Indians probably are similar to non-Indians in their likelihood of developing PTSD after a traumatic exposure (Kessler et al., 1995), the substantially higher prevalence of the disorder (22% for AI/AN vs. 8% in the general community) does not signal greater vulnerability to PTSD, but rather higher rates of traumatic exposure.

Maltreatment and neglect have been shown to be relatively common among older urban American Indian and Alaska Native patients in primary care. A chart review of 550 Native adults 50 years of age or older seen at one of the country's largest, most comprehensive, urban Indian health programs during one calendar year revealed that 10 percent met criteria for definite and probable physical abuse or neglect (Buchwald et al., 2000). After control-ling for other factors in a logistic regression model, patient age, female gender, alcohol abuse, domestic violence, and current depression remained significant correlates of physical abuse or neglect of these Native elders.

The previously mentioned American Indian Vietnam Veterans Project (AIVVP) replicated the National Vietnam Veterans Readjustment Study that examined psychiatric disorders among African American, Latino, and white veterans (Kulka et al., 1990). Between 1992 and 1995, researchers evaluated random samples of Vietnam combat veterans drawn from three Northern Plains reservations (n = 305) and one Southwest reservation (n = 316). Approximately one-third of the Northern Plains (31%) and Southwestern (27%) American Indian participants had PTSD at the time of the study. Approximately half had experienced the disorder in their lifetimes (57% and 45%, respectively). This rate is far in excess of rates of current PTSD for white veterans (14%) and for black veterans (21%) (Kulka et al., 1990). The excess rates, however, were largely attributable to the fact that American Indian veterans had been exposed to more

combat-related traumas than their non-Indian peers (National Center for Post-Traumatic Stress Disorder and the National Center for American Indian and Alaska Native Mental Health Research, 1996; Beals et al., under review).

Box 4–2: John : Vietnam Combat Veteran (age 45)

John is a 45-year-old, full-blood Indian, who is married and has 7 children. The family lives in a small, rural community on a large reservation in Arizona. John served as a Marine Corps infantry squad leader in Vietnam during 1968–1969. He most recently was treated through a VA medical program, where he participates in a post-traumatic stress disorder (PTSD) support group. John suffers from alcoholism, which began soon after his initial patrols in Vietnam. These involved heavy combat and, ultimately, physical injury. He exhibits the hallmark symptoms of PTSD, including flashbacks, nightmares, intrusive thoughts on an almost daily basis, marked hypervigilance, irritability, and avoidant behavior.

Some 10 years after his return from Vietnam, John began cycling through several periods of treatment for his alcoholism in tribal residential programs. It wasn't until one month after he began treatment for his alcoholism at a local VA facility that a provisional diagnosis of PTSD was made. Upon completing that treatment, he transferred to an inpatient unit specializing in combat-related trauma. John left the unit against medical advice, sober but still experiencing significant symptoms.

John speaks and understands English well; he also is fluent in his native language, which is spoken in his home. John is the descendant of a family of traditional healers. Consequently, the community expected him to assume a leadership role in its cultural and spiritual life. However, boarding school interrupted his early participation in important aspects of local ceremonial life. His participation was further delayed by military service and then fore-stalled by his alcoholism. During boarding school, John was frequently harassed by non-Indian staff for speaking his native language, for wearing his hair long, and for running away. Afraid of similar ridicule while in the service, he seldom shared his personal background with fellow infantrymen. Yet John was the target of racism, from being selected to act as point on patrol because he was an Indian to being called "Chief" and "blanket ass."

Until recently, tribal members had never heard of PTSD, but now frequently refer to it as the "wounded spirit." His community has long recognized the consequences of being a warrior, and indeed, a ceremony has evolved over many generations to prevent as well as treat the underlying causes of these symptoms. Within this tribal worldview, combat-related trauma upsets the balance that underpins someone's personal, physical, mental, emotional, and spiritual health. The events in John's life (the Vietnam war, his father's death, and his impairment due to PTSD and alcoholism) conspired to prevent his participation in this and other tribal ceremonies.

John attends a VA-sponsored support group, comprised of all Indian Vietnam veterans, which serves as an important substitute for the circle of "Indian drinking buddies" from whom he eventually separated as part of his successful alcohol treatment. John reports having left the VA's larger PTSD inpatient program because of his discomfort with its non-Native styles of disclosure and expectations regarding personal reflection. Through the VA's Indian support group, he joined a local gourd society that honors warriors and dances prominently at pow-wows. His sobriety has been aided by involvement in the Native American Church, with its reinforcement of his decision to remain sober and its support for positive life changes.

Though John has a great deal of work ahead of him, he feels that he is now ready to participate in the tribe's major ceremonial intended to bless and purify its warriors. His family, once alienated but now reunited, is busily preparing for that event. (Adapted from Manson, 1996).

Children in Foster Care

Studies have consistently indicated that children who are removed from their homes are at increased risk for mental health problems (e.g., Courtney & Barth, 1996), as well as for serious subsequent adult problems such as homelessness (Koegel et al., 1995). By the mid-1970s, many American Indian children were experiencing out-of-home placements. In Oklahoma, four times as many Indian children were either adopted or in foster care as investigation that led to the passage of the act concluded non-Indian children. In New Mexico, twice as many that "a pattern of discrimination against American Indian children were in foster care than any other minor-Indians is evident in the area of child welfare, and it is ity group. Estimates suggest that as many as 25 to 30 the responsibility of Congress to take whatever action is percent of American Indian children have been removed within its power to see that Indian communities and their from their families (Cross, et al., 2000). As a result, families are not destroyed" (Fischler, 1985). Congress passed the Indian Child Welfare Act in 1978 to Accordingly, in 1999, the number of American Indian protect American Indian children. The Congressional and Alaska Native children in foster care had decreased to 1 percent of all children in foster care in the United States (DHHS, 1999). Yet the mental health consequences for the children, now adults, who were placed out of their homes, especially those placed in non-Indian homes, during this lengthy period of mass cultural dislocation is not known (Nelson et al., 1996; Roll, 1998).

Appropriateness and Outcomes of Mental Health Services

During the past decade, many guidelines for treating mental disorders have been offered to ensure the provision of evidence-based care. Even though few American Indians or Alaska Natives were included in the studies that led to their development, such professional practice guidelines offer the clearest, most carefully considered recommendations available regarding appropriate treatment for this population. They therefore warrant special attention.

The DSM–IV, both within the main text and in its "Outline for Cultural Formulation," does provide clear guidelines for addressing cultural matters, including those specific to this population, in the assessment and treatment of mental health problems (Manson & Kleinman, 1998; Mezzich et al., 1999). A growing body of case material demonstrates the utility of applying these guidelines to American Indian children (Novins et al., 1997), as well as to adults (Fleming, 1996; Manson, 1996; O'Nell, 1998).

Novins and colleagues (1997) critically analyzed the extension of the "Outline for Cultural Formulation" to American Indian children. Drawing upon rich clinical material, they demonstrated the merits and utility of this approach for understanding the emotional, psychological, and social forces that often buffet Native children. However, Novins and his colleagues underscored the importance of obtaining the perspectives of adult family members and teachers, as well as the children themselves, which is not explicitly considered in the formulation.

No studies have been published regarding the out-comes associated with standard psychiatric care for American Indians and Alaska Natives. Hence, it is not known if practitioners accurately diagnose the mental health needs of American Indians and Alaska Natives, nor whether they receive the same benefits from guideline-based psychiatric care as do whites. For this we must await related studies of treatment outcome, studies that venture beyond the limitations of current thinking with respect to intervention technology and best practices.

Up to this point, the chapter has focused on the prevalence, risk, assessment, and treatment of mental illness among American Indian and Alaska Native youth and adults. The public health model that guides this Supplement stresses the importance of preventive and promotive interventions as well. Indeed, virtually any serious dialogue at both local and national levels about mental health and well-being among American Indians and Alaska Natives underscores the central place of preventive and promotive efforts in the programmatic landscape (Manson, 1982).

Preventing Mental Illness

Among Indian and Native people, efforts to prevent mental illness have been overshadowed by a much more aggressive agenda in regard to preventing alcohol and drug abuse (May & Moran, 1995). The research literature mirrors a similar emphasis on interventions intended to prevent or ameliorate developmental situations of risk, with special emphasis on family, school, and community (Manson, 1982; Beiser & Manson, 1987; U.S. Congress, 1990).

As discussed earlier, poverty and demoralization combine with rapid cultural change to threaten effective parenting in many Native families. This can lead to increased neglect and abuse and ultimately to the removal of children into foster care and adoption (Piasecki et al., 1989). Poverty, demoralization, and rapid culture change also increase the risk for domestic violence, spousal abuse, and family instability, with their attendant negative mental health effects (Norton & Manson, 1995; Christensen & Manson, 2001). The preventive interventions that have emerged in response to such deleterious circumstances in American Indian communities are particularly creative, in form as well as in reliance upon cultural tradition. One example is the introduction of the indigenous concept of the Whipper Man, a nonparental disciplinarian, into a Northwest tribe's group home for youth in foster care (Shore & Nicholls, 1975). This unique mechanism of social control, coupled with placement counseling and intensive family outreach, significantly enhanced self-esteem, decreased delinquent behavior, and reduced off-reservation referrals (Shore & Keepers, 1982). Another example is a developmental intervention that targeted Navajo family mental health (Dinges et al., 1974). This effort sought to improve stress resistance in Navajo families whose social survival was threatened and to prepare their children to cope with a rapidly changing world. It focused on culturally relevant developmental tasks and the caregiver-child interactions thought to support or increase mastery of these tasks. Delivered through home visits by Navajo staff, the intervention promoted cultural identification, strengthened family ties, and enhanced child and caregiver self-images (Dinges, 1982).

Fueled by longstanding concern regarding the disruptive nature of boarding schools for the emotional development of Indian youth, early prevention programs focused largely on social and cultural enrichment. The most widely known of these early efforts is the Toyei Model Dormitory Project, which improved the ratio of adult dormitory aides to students, replaced non-Navajo houseparents with tribal members, and trained them to be both caretakers and surrogate parents (Goldstein, 1974). As a result, youth in the Toyei model dormitory showed accelerated intellectual development, better emotional adjustment, and superior performance on psychomotor tests. The promise of this approach was slow to be realized, however, in part because of a change in Federal policy away from boarding school education for American Indians and Alaska Natives, and in part because local control over educational settings in Indian communities was rare until recently (Kleinfeld, 1982). Schoolwide interventions only now are emerging in Native communities, as successful litigation and legislative change in funding mechanisms transfer to tribes the authority to manage health and human services, including education (Dorpat, 1994).

Targeted prevention efforts have flourished in tribal and public schools. Most have centered on alcohol and drug use, but a growing number of programs are being designed and implemented with a specific mental health focus, typically suicide prevention (Manson et al., 1989; Duclos & Manson, 1994; Middlebrook et al., 2001). These preventive interventions take into account culture-specific risk factors: lack of cultural and spiritual development, loss of ethnic identity, cultural confusion, and acculturation. Careful evaluation of their effects, though still the exception, illustrates, as in the case of the Zuni Life Skills Development Curriculum, the significant gains that can accompany such investments (LaFromboise & Howard-Pitney, 1994).

With increasing frequency, entire Indian and Native communities have become both the setting and the agent of change in attempts to ameliorate situations of risk and to prevent mental illness. Among the earliest examples is the Tiospaye Project on the Rosebud Sioux Reservation in South Dakota, which entailed organizing a series of community development activities that were cast as the revitalization of the tiospaye, an expression of traditional Lakota lifestyle based on extended family, shared responsibility, and reciprocity (Mohatt & Blue, 1982). More recent ones include the Blue Bay Healing Project among the Salish-Kootenai of the Flathead Reservation (Fleming, 1994) and the Western Athabaskan “Natural Helpers” Program (Serna et al., 1998). Both of these community-based interventions marshaled local cultural resources consistent with long-held tribal traditions, albeit in quite different ways that reflected their distinct orientations. Other nationwide initiatives, such as those mentioned earlier in this chapter, are likewise deeply steeped in the emphasis on community solutions to community problems.

Promoting Mental Health

Indian and Native people are quick to observe that the prevention of mental illness—with its goals of decreasing risk and increasing protection—is defined by a disease-oriented model of care. Although this approach is valued, professionals are encouraged by Indian and Native people to move beyond the exclusive concern with disease models and the separation of mind, body, and spirit, to consider individual as well as collective strengths and means in the promotion of mental health.

There is less clarity about and little common nomenclature for such strengths, their relationship to mental health, and technologies for promoting them than there is for risk, mental illness, and prevention. Even less data exist upon which to base empirical discussions about tar-gets for promotion and outcomes, but there are relevant intellectual histories that suggest this is no quixotic quest. For example, the contemporary literature on psychological well-being has its roots in past work on dimensions of positive mental health and the related concept of happiness (Jahoda, 1958; Bradburn, 1969), which have evolved into the closely related constructs of competence, self-efficacy, mastery, empowerment, and communal coping (David, 1979; Swift & Levin, 1987; Sternberg & Kolligian, 1990; Bandura, 1991). Clear parallels exist between these ideas and central themes for organizing life in Native communities. Consider, for example, the concept of hozhq in the Navajo worldview:

Kluckhohn identified hozhq as the central idea in Navajo religious thinking. But it is not something that occurs only in ritual song and prayer; it is referred to frequently in everyday speech. A Navajo uses this concept to express his happiness, health, the beauty of his land, and the harmony of his relations with others. It is used in reminding people to be careful and deliberate, and when he says good-bye to someone leaving, he will say hozhqqgo naninaa doo "may you walk or go about according to hozhq." (Witherspoon, 1977)

Hozhq encompasses the notions of connectedness, reciprocity, balance, and completeness that underpin con-textually oriented views of health and well-being (Stokols, 1991). Although the terms of reference vary, this orientation is commonly held across Indian and Native communities. The American Indian and Alaska Native experience may lead to the rediscovery of the fundamental aspects of psychological and social well-being and the mechanisms for their maintenance.

In this regard, as noted in Chapter 1, recent years have seen the development of sophisticated theoretical formulations of the relationships among spirituality, religion, and health. Most work in this area has focused on populations raised in Judeo-Christian traditions and, consequently, measurement approaches generally remain contained within this cultural horizon (The Fetzer Institute & National Institute on Aging, 1999). American Indian and Alaska Native populations, on the other hand, often participate in very different spiritual and religious traditions, which require expanded notions of spirituality and religious practice (Reichard, 1950; Gill, 1982; Hultkrantz, 1990; Vecsey, 1991 Beauvais, 1992; Harrod, 1995; Tafoya & Roeder, 1995; Csordas, 1999). Especially

notable here are the importance in many Native traditions of private religious and spiritual practice, an emphasis on individual vision and revelation, ritual action in a world inhabited by multiple spiritual entities, and complex ceremonies that are explicitly oriented to healing. Moreover, many American Indian and Alaska Native people participate in multiple traditions. Traditional tribal and pan-Indian beliefs and practices continue to be influential, especially in help-seeking (Kim & Kwok, 1998; Csordas, 1999; Buchwald et al., 2000; Gurley et al., 2001). Christian religions are also quite important in many Indian communities (Spangler et al., 1997). There is mounting evidence that many Indian people do not see Christianity and traditional practices as incompatible (Csordas, 1999). This dynamic is probably most evident in the Native American Church (NAC), where Christian and Native beliefs coexist (Aberle, 1966; Pascarosa et al., 1976; Vecsey, 1991).

More explicit attention to the connections between spirituality and mental health in Native communities is especially warranted given the nature and type of problems described previously.

Conclusions

As evidenced through history and current socioeconomic realities, American Indian and Alaska Native nations have withstood the consequences of colonialism and of subsequent subjugation by the U.S. Government. Many members of this minority population are regaining control of their lives and rebuilding the health of their communities.

1. Although relatively little evidence is available, the existing data suggest that American Indian and Alaska Native youth and adults suffer a disproportionate burden of mental health problems compared with other Americans. Because of the unique and painful history of this minority group, many of its members are quite vulnerable. Given the high rates of suicide documented among some segments of this population, they are likely to experience increased need for mental health care as compared with white Americans. Yet, in sharp contrast to other minority groups and the general population, there is a lack of epidemiology and surveillance. This information is needed to understand the nature, extent, and sources of burden to mental health, as well as concomitant disparities. This is true across the developmental lifespan.

2. Those who are homeless, incarcerated, and victims of trauma are particularly likely to need mental health care. Indian and Native people are overrepresented in these vulnerable groups. It is not known whether they receive mental health care within the institutions intended to serve them, but there appears to be considerable unmet need. Research is needed to understand the paths by which American Indians and Alaska Natives reach these points. Just as important, methods for detecting and managing their mental health are needed in related institutional settings through culturally appropriate ways that both ameliorate their present burden and protect them from the future consequences of adversity.

3. There is significant comorbidity in regard to mental and substance abuse disorders, notably alcoholism, among both Native youth and adults. There is some indication that disorders occurring together are unlikely to be addressed by most mental health or substance abuse treatment settings. This underscores an important unmet need. Neither philosophies of treatment nor funding streams should preclude the timely and culturally appropriate treatment of such comorbidities, which otherwise threaten successful, lasting intervention.

4. Little is known about either the use of mental health services by American Indians and Alaska Natives, or whether those who need treatment actually obtain it. However, the available research has important implications. First, practical considerations, such as availability of culturally sensitive providers and accessibility of services through insurance or geographic location, are extremely important for this ethnic group. Second, services for those in greatest need of care may best be provided within targeted settings, such as those serving the homeless, incarcerated, or alcohol dependent. Medical services that provide care for victims of trauma or older primary care patients also hold promise for meeting the needs of a significant portion of this population.

5. Major changes in the financing and organization of mental health care are underway in American Indian and Alaska Native communities as a con-sequence of relatively recent policies regarding self-determination. There is limited understanding of these changes, their implications for resources, the resulting continuum of care, or the quality of services. Thus, it is imperative that organizational and financing changes be closely examined with an eye toward the best interests of Native people. It would be a sad legacy to conclude 20 years from now that the assimilationist pressures that proved so devastating in the past have been unwittingly repeated.

6. The knowledge base underpinning treatment guidelines for mental health care have been built with little specific analysis of their benefit to ethnic minority groups. The evidence behind them is an extrapolation from largely majority clinical populations. This is in spite of the fact that cultural forces are known to be at work in virtually every aspect of psychopathology, from risk to onset, presentation, assessment, treatment response, and relative burden. Moreover, the efficacy of treatment alternatives that may be especially relevant to this population has not yet been examined. Accordingly, clinical research needs to be undertaken to shed light on the applicability and outcomes of treatment recommendations for American Indians and Alaska Natives.

7. Though long-suppressed by social and political forces, traditional healing practices and spirituality are strongly evident in the lives of American Indians and Alaska Natives. They usually complement, rather than compete with, medical care. The challenge is to find ways to support and strengthen their respective contributions to the health and well-being of those in need. How well this is accomplished depends on advances in the science by which healing practices and spirituality are conceptualized and examined.

8. Despite the mental health problems that plague Indian and Native people, the majority, though at risk, are free of mental illness. Thus, prevention should remain a high priority. Native voices are clear and unequivocal in this regard; preventive and promotive approaches strike a resonant chord in the hearts of these individuals and their communities. Abundant evidence attests to the creativity of intervention strategies mounted in an attempt to ameliorate situations of develop-mental risk for mental health problems among American Indians and Alaska Natives. Unfortunately, the current limits of science, notably the conceptualization and measurement of both the culturally defined and relevant points of intervention as well as outcomes, impede the evaluation of these strategies. Here the challenge is to understand how preventive interventions developed in other populations work for the American Indian and Alaska Native population in order to determine what adaptations must be made to improve their cultural fit and effectiveness. Conversely, the country as a whole has a great deal to gain by attending to advances in prevention among American Indians and Alaska Natives, for the lessons learned in these instances may have broader application to all Americans.

9. Lastly, the individual and collective strengths of Native communities warrant closer, systematic attention. Interventions are needed to promote the strengths, resiliencies, and other psychosocial resources that characterize full, productive, meaningful lives and contribute to their maintenance. New perspectives need to be explored, bending our scientific tools to the task.

American Indian and Alaska Native people speak about a journey as beginning with its initial steps. With respect to mental health, this journey already has begun. Some paths have been well traveled and feel familiar; some paths are new and intriguing; some paths have yet to be marked. It is clear that the Nation can serve as a guide for hastening this journey along certain paths. It is equally clear that the Nation would also do well to watch carefully and follow Native people along the paths that they have emblazoned.

Surgeon General's Report
Chapter 7- A Vision for the Future
Mental Health: Cultural, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. *U.S. Department of Health and Human Services*

Introduction

The extensive evidence reviewed in this supplemental report to Mental Health: A Report of the Surgeon General (1999) supports the conclusion that mental illnesses are serious and disabling disorders affecting all populations, regardless of race or ethnicity. This Supplement also concludes that culture and social context influence mental health, mental illness, and mental health services in America. Despite the existence of effective treatments, disparities lie in the availability, accessibility, and quality of mental health services for racial and ethnic minorities. As a result, these populations bear a disproportionately high disability burden from mental disorders. This Supplement underscores the recommendation of the original Surgeon General's Report on Mental Health: People should seek help if they have a mental health problem or if they think they have symptoms of a mental disorder. In addition, the literature reviewed herein suggests that mental health researchers, policymakers, and service providers must be more responsive to the social contexts, cultural values, and historical experiences of all Americans, including racial and ethnic minorities.

Lack of information regarding the mental health needs of many racial and ethnic minorities is also a critical disparity. Too often, the best available research on racial and ethnic minorities consists of small studies that cannot be generalized to today's increasingly diverse communities. While the research reported in this Supplement is the best science available, it represents a science base that is incomplete.

To better address the dynamic impact of culture, race, and ethnicity on mental health and mental illness, more research is needed on how to prevent and treat mental illness and to enhance the mental health of all racial and ethnic groups. Following an extensive consultation process with public health experts, service providers, and consumers, the Surgeon General released Healthy People 2010 in early 2000 as a challenge to the Nation to address disparities in health care access and outcomes. For the first time, among the 10 "leading indicators" of the Nation's health on which progress will be regularly monitored is one mental health goal: increasing treatment of depression for underserved minority groups. This national agenda encourages the field to strive toward the highest possible quality of health care and health outcomes, with equally high standards of care across groups.

A public health approach to reducing mental health disparities will require a national commitment, bringing together the best of the public and private sectors, individuals and communities, Federal, State, and local governments, universities, foundations, mental health researchers, advocates, health service providers, consumers, and their families. Through active partnership, these stakeholders can generate the knowledge and resources

necessary to improve mental health services for racial and ethnic minorities in this country. This chapter highlights promising courses of action that can be used to reach the ambitious goals of reducing barriers and promoting equal access to effective mental health services for all persons who need them.

Continue to Expand the Science Base

Base

The mental health knowledge base regarding racial and ethnic minorities is limited but growing. Because good science is an essential underpinning of the public health approach to mental health and mental illness, systematic work in the areas of epidemiology, evidence-based treatment, psychopharmacology, ethnic- and culture-specific interventions, diagnosis and assessment, and prevention and promotion needs to be developed and expanded.

Epidemiology

In March 1994, the policies of the National Institutes of Health (NIH) regarding inclusion of racial and ethnic minorities in study populations were significantly strengthened (NIH Guidelines, 1994, p. 14509). This change requires inclusion of ethnic minorities in all NIH-funded research. The results of this policy will be apparent in the coming years as studies funded during this era begin to be published.

Several large epidemiological studies that include significant samples of racial and ethnic minorities have recently been initiated or completed. These surveys, when combined with smaller, ethnic-specific epidemiological surveys, may help resolve some of the uncertainties about the extent of mental illness among specific racial and ethnic groups.

The National Institute of Mental Health (NIMH) recently funded a collaborative series of projects that will make great strides in psychiatric epidemiology nationwide. The National Survey of Health and Stress (NSHS) will interview a nationally representative sample of adolescents and adults to estimate the prevalence of mental disorders in the United States. Although the NSHS will interview nearly 20,000 adolescents and adults, its samples of specific racial and ethnic minority groups will be proportionate to their size in the Nation's population, and, thus, not very large. To complement the NSHS, NIMH has funded the National Survey of American Lives (NSAL) and the National Latino and Asian American Study (NLAAS), which will include large samples of different racial and ethnic minorities. In the NSAL, approximately 9,000 African American adolescents and adults will be interviewed; about a quarter of them will be immigrants to the United States. In the NLAAS, a total of about 8,000 Latino and Asian American adults from a few specific ethnic groups will be interviewed about their mental health and service use patterns. Project investigators have made a substantial portion of the NSHS, NSAL, and NLAAS surveys similar to facilitate cross-study comparisons. Taken together, these studies will permit the most comprehensive assessments to date of symptom patterns,

prevalence rates of disorders, access to services, and functioning for different racial and ethnic minority groups.

In addition, a major effort to examine the psychiatric epidemiology and the use of mental health services by American Indians has recently been completed. The American Indian Services Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI–SUPERPFP), sponsored by NIMH and conducted by the National Center for American Indian and Alaska Native Mental Health Research, is a large-scale, multi-stage study of prevalence and utilization rates among over 3,000 individuals in two large American Indian communities, a Southwestern tribe and a Northern Plains tribe. In this study, mental disorders are diagnosed in a manner that is culturally relevant, using methods similar to those employed by the National Comorbidity Survey. The results of this study will be available in 2002 and will add greatly to our understanding of the need for mental health care among American Indians.

The National Household Survey on Drug Abuse (NHSDA) is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) and interviews approximately 70,000 respondents each year. The NHSDA conducts interviews in both Spanish and English and has generated samples of white Americans, African Americans, and Hispanic Americans large enough to allow separate data analyses by racial or ethnic group. Through this annual survey it will be possible to track changes in the prevalence of substance abuse and dependence, as well as certain mental health problems for several racial and ethnic groups.

It is important that findings from these studies serve as a basis for improving mental health services for all groups.

Evidence-Based Treatment

Research reviewed in the previous chapters provides evidence that ethnic minorities can benefit from mental health treatment. While the Surgeon General's Report on Mental Health contained strong and consistent documentation of a comprehensive range of effective interventions for treating many mental disorders (DHHS, 1999), most of the studies reporting findings for racial and ethnic minorities had small samples and were not randomized controlled trials. As discussed in Chapter 2, the research used to generate professional treatment guidelines for most health and mental health interventions does not include or report large enough samples of racial and ethnic minorities to allow group-specific determinations of efficacy (see Appendix A). In the future, evidence from randomized controlled trials that include and identify sizable racial and ethnic minority samples may lead to treatment improvements, which will help clinicians to maximize real-world effectiveness of already-proven psychiatric medications and psychotherapies.

At the same time, research is essential to examine the efficacy of ethnic- or culture-specific interventions for minority populations and their effectiveness in clinical practice settings. A good example of a well-designed study addressing these issues is the WE Care Study (Women Entering Care), a major effort to examine treatment for depression

in low-income and minority women. Funded by NIMH, this study examines the impact of evidence-based care for depression on a large sample (N = 350) of white, African American, and Latina women who are poor. This randomized controlled trial is not only examining the impact of treatment for depression on this group of women, but it will also determine whether providing treatment to women who are mothers results in improvements in the mental health and functioning of their children.

Psychopharmacology

Some of the variability in people's responses to medications is accounted for by factors related to race, ethnicity, and lifestyle. Information about race and ethnicity, as well as factors such as age, gender, and family history, may provide a starting point for medical research aimed at developing and testing drug therapies tailored to individual patients. Identifying the various mechanisms responsible for differential pharmacological response will aid in predicting an individual's likely response to a medication before it is prescribed.

A few studies have examined racial and ethnic differences in the metabolism of clinically important drugs used to treat mental illnesses. As the evidence base grows, improved treatment guidelines will help clinicians be aware that differences in metabolic response, as well as differences in age, gender, family history, lifestyle, and co-occurring illnesses, can alter a drug's safety and efficacy. For example, clinicians are becoming sensitized to the possibility that a significant proportion of racial and ethnic minority patients will respond to some common medications at lower-than-usual dosages. Care must be taken to avoid overmedicating patients, because over-medication can lead to adverse effects or toxicity. However, because each racial and ethnic population contains the full range of drug metabolic activity across its membership, a clinician should not come to firm conclusions about higher or lower metabolic rates based on an individual's race or ethnicity alone.

Currently, there is little empirical evidence around improving systems of care for racial and ethnic minorities. To reduce disparities in quality of care, research is needed on strategies to improve the availability and delivery of evidence-based treatments, including state-of-the-art medications and psychotherapies. Consumers, communities, mental health services researchers, and Federal agencies have an opportunity to work together toward the development and dissemination of evidence-based treatment information to improve quality of care for racial and ethnic minorities. In particular, studies are needed that identify effective interventions for minority subpopulations, such as children, older adults, persons with co-occurring mental and physical health conditions, and persons who are living in rural areas.

Ethnic- or Culture-Specific Interventions

Clinicians' awareness of their own cultural orientation, their knowledge of the client's background, and their skills with different cultural groups may be essential to improving access, utilization, and quality of mental health services for minority populations. While no rigorous, systematic studies have been conducted to test these hypotheses, evidence suggests that culturally oriented interventions are more effective than usual care at reducing dropout rates for ethnic minority mental health clients. While the efficacy of most ethnic-specific or culturally responsive services is yet to be determined, models already shown to be useful through research could be targeted for further efficacy research and, ultimately, dissemination to mental health providers.

Because stigma and help-seeking behaviors are two culturally determined factors in service use, research is needed on how to change attitudes and improve utilization of mental health services. Some promising areas of study in racial and ethnic minority communities are reducing stigma associated with mental illness, encouraging early intervention, and increasing awareness of effective treatments and the possibility of recovery. These messages should be tailored to the languages and cultures of multiple racial and ethnic communities. Communities that can incorporate evidence-based knowledge about disease and treatments will have a health advantage.

Diagnosis and Assessment

Though the major mental illnesses are found worldwide, manifestations of these and other health conditions may vary with age, gender, race, ethnicity, and culture. Research reported in this Supplement documents that minorities tend to receive less appropriate diagnoses than whites. Further study is needed on how to address issues of clinician bias and diagnostic accuracy, particularly among those providers working with racial and ethnic minority consumers.

As noted in Chapter 1, the DSM–IV marked a new level of acknowledgment of the role of culture in shaping the symptoms and expression of mental disorders. The inclusion of a "Glossary of Culture-Bound Syndromes" and the "Outline for Cultural Formulation" for clinicians was a significant step forward in recognizing the impact of culture, race, and ethnicity on mental health. Further study is needed, however, to examine the relationship between culture-bound syndromes and existing disorders and the connection of culture-bound syndromes with underlying biological, social, and cultural processes. Examining the extent to which culture-bound syndromes are unique idioms of distress for some groups or variants of existing syndromes or disorders is particularly important.

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, now under development, will extend and elaborate concepts introduced in DSM–IV regarding the role and importance of culture and ethnicity in the diagnostic process. While striving to understand the processes that underlie disorders and syndromes, it is also critical to examine how clinicians apply cultural knowledge in their clinical evaluations. Further research is needed on the impact of culture in interview-based diagnosis and assessment

techniques, as well as in the use and interpretation of formal psychological tests. Quality mental health assessment and treatment rely on understanding local representations of illness and distress for all populations.

Prevention and Promotion

Preventive interventions have the potential to decrease the incidence, severity, and duration of certain mental disorders or behavioral problems, e.g., depression, con-duct disorder, or substance abuse. In addition, promotive interventions, such as increasing healthy thinking pat-terns or improving coping skills, may be integral to fostering the mental health of the nation. Unfortunately, only a handful of interventions to promote mental health, reduce risk, or enhance resiliency have been empirically validated for racial and ethnic minorities. As part of a public health approach to mental health and mental illness for all Americans, the growing knowledge base for preventive interventions must include racial and ethnic minorities.

Important opportunities exist for researchers to study cultural differences in stress, coping, and resilience as part of the complex of factors that influence mental health. Such work will lay the groundwork for developing new prevention and treatment strategies — building upon community strengths to foster mental health and to ameliorate negative health outcomes.

Study the Roles of Culture, Race, and Ethnicity in Mental Health

How do racial and ethnic groups differ in their manifestations and perceptions of mental illness and their attitudes toward and use of mental health services? What is it about race and ethnicity that helps explain these differences? The mental health community will benefit from a better understanding of how factors such as acculturation, help-seeking behaviors, stigma, ethnic identity, racism, and spirituality provide protection from or risk for mental illness in racial and ethnic minority populations. While no single study can shed light on all these issues simultaneously, scientific research will advance knowledge, increase our ability to prevent or treat mental illness, and promote mental health.

New studies will advance our knowledge about the social and cultural characteristics of racial and ethnic minority groups that correlate with risk and protective factors for mental health. As described earlier, researchers involved in the NSHS, NSAL, NLAAS, and AI–SUPERPFP large-scale epidemiological studies have collaborated on a set of core questions that will facilitate comparisons across populations. For example, across all four studies, it will be possible to assess how socioeconomic status, wealth, education, neighborhood context, social support, religiosity, and spirituality relate to mental illness among African Americans, Latinos, Asian Americans, American Indians, and whites. Similarly, it will be possible to assess how acculturation, ethnic identity, and perceived discrimination affect mental health outcomes for the four underserved racial and ethnic groups. These types of analyses go beyond straightforward epidemiological comparisons; with these ground-breaking studies, the mental health field will gain crucial insight into how social and cultural factors operate across race and ethnicity to affect mental illness in diverse communities.

Improve Access to Treatment

Race, ethnicity, culture, language, geographic region, and other social factors affect the perception, availability, utilization, and, potentially, the outcomes of mental health services. Therfore the provision of high-quality, culturally responsive, and language-appropriate mental health services in locations accessible to racial and ethnic minorities is essential to creating a more equitable system.

Improve Geographic Access

Racial and ethnic minorities have less access than white Americans to mental health services. Minorities are more likely to be poor and uninsured. Many live in areas where general health care and specialty mental health services are in short supply. An increasingly distressed safety net of community health centers, rural and migrant health centers, and community mental health agencies provides physical and mental health care services to racial and ethnic minorities in medically underserved areas (IOM, 2000). Innovative strategies for training providers, delivering services, creating incentives for providers to work in underserved areas, and strengthening the public health safety net promise to provide greater geographic access to mental health services for those in need.

Integrate Mental Health and Primary Care

Many racial and ethnic minority consumers and families prefer to receive mental health services through their primary care physicians. Explanations of this preference may be that members of minority groups fear, feel ill at ease with, or are unfamiliar with the specialty mental health system. Community health centers as well as other public and private primary health settings provide a vital frontline for the detection and treatment of mental illnesses and the co-occurrence of mental illnesses with physical illnesses.

The Federal Government, in collaboration with the private sector, is working to bring mental health care to the primary health care system. A variety of demonstration and research programs have been or will be created to strengthen the capacity of these providers to meet the demand for mental health services and to encourage the delivery of integrated primary health and mental health services that match the needs of the diverse communities they serve. Developing strong links between primary care providers and community mental health centers will also assure continuity of care when more complex or intensive mental health services are warranted.

For example, the Chinatown Health Center in New York City, a Health Resource Services Administration (HRSA)-funded community health center, participates in two important Federal projects. The first is a study of whether it is more effective to treat older Chinese American health center patients with mental illnesses in an integrated primary and behavioral health program or to have the primary care physician refer them to specialty mental health services. The second project is part of a “Break-through Collabrative” series co-sponsored by the Institute for Healthcare Improvement, the Robert Wood Johnson Foundation, and several Federal agencies. This intensive quality

improvement program is aimed at trans-forming the way the health center treats patients with depression. These Breakthrough Collaboratives are changing the way safety net health providers engage and treat their patients who may have chronic physical health conditions as well as mental health problems.

Ensure Language Access

A major barrier to effective mental health treatment arises when provider and patient do not speak the same language. The DHHS Office of Civil Rights has published guidance on this subject for health and social services providers (DHHS, 2000). All organizations or individuals receiving Federal financial assistance from DHHS, including hospitals, nursing homes, home health agencies, managed health care organizations, health and mental health service providers, and human services organizations have an obligation under the 1964 Civil Rights Act to ensure that persons with limited English proficiency (LEP) have meaningful and equal access to benefits and services. As outlined in the guidance, satisfactory service to LEP clients includes identifying and documenting the language needs of the individual provider and the client population, providing a range of translation options, monitoring the quality of language services, and providing written materials in languages other than English wherever a significant percentage of the target population has LEP. Efforts such as these will help ensure that limited English skills do not restrict access to the fullest use of services for a significant proportion of racial and ethnic minority Americans.

Coordinate and Integrate Mental Health Services for High-Need Populations

The Nation is struggling to meet the needs of its most vulnerable individuals, such as those in foster care, jails, prisons, homeless shelters, and refugee resettlement pro-grams. Accordingly, the attention being given to the development and provision of effective, culturally responsive mental health services for these populations is increasing. Because racial and ethnic minorities are over-represented among these vulnerable, high-need populations, the introduction, expansion, and improvement of mental health services in settings where these groups are is critical to reducing mental health disparities. Another promising line of research is the role of mental health treatment in preventing individuals from falling into these vulnerable populations.

One innovative Center for Mental Health Services (CMHS) demonstration program to reduce homelessness integrates housing supports with medical and mental health services. This program has successfully brought adults with serious mental illness off the streets and helped them stay in housing, reduced their illicit drug use, decreased minor crime, and increased their use of outpatient mental health services. It has also shown that it is possible for organizations with very different missions and funding streams to work together to deliver effective, integrated services when they are focused on a common goal: to meet the real and complex needs of vulnerable people. These grants have helped several thousand homeless adults with severe mental illness (over 50 percent of whom were racial or ethnic minorities) to move off the streets and into stable housing (CMHS, Rosenheck et al., 1998). Because of the over-representation of ethnic minorities among

persons who are homeless, such programs may play an important role in reducing racial and ethnic disparities in access to the mental health system.

Reduce Barriers to Treatment

Organization and financing of services have impeded access and availability for racial and ethnic minorities. Therefore, reducing financial barriers and making services more accessible to minority communities should be aims within any effort to reduce mental health disparities. Shame, stigma, discrimination, and mistrust also keep racial and ethnic minorities from seeking treatment when it is needed. Therefore, effective efforts to increase utilization will target social factors as well as quality of services.

Racial and ethnic minorities do not use mental health services at rates comparable to those of whites or in pro-portion to the prevalence of mental illness in either minority populations or the general population. The reasons for lower rates of utilization are complex. Research suggests that cost and lack of health insurance, fragmentation of services, culturally mediated stigma or patterns of help-seeking, mistrust of specialty mental health services, and the insensitivity of many mental health care systems, all discourage racial and ethnic minorities' use of mental health care. Opportunities exist to remove barriers and to promote consumers' access to needed services.

Ensure Parity and Expand Public Health Insurance

Minorities are less likely than whites to have health insurance and to have the ability to pay for mental health services. Across racial and ethnic groups, lack of health insurance is a significant financial barrier to getting needed mental health care. Even for people with health insurance, whether public or private insurance, there are greater restrictions on coverage for mental disorders than for other illnesses. This inequity, known as lack of parity in mental health coverage, needs to be corrected. The original Surgeon General's Report on Mental Health made clear that parity in mental health coverage is an affordable and effective objective for the Nation.

Another important step toward removing the financial barriers that contribute to unequal access to needed mental health care is the extension of publicly supported health care coverage to children who are poor and near poor. Federal legislation has created prospects for significantly expanding mental health coverage for the nation's 10 million uninsured children. The State Children's Health Insurance Program is a federally funded program enacted in 1997 that provides $24 billion over five years to ensure health care coverage for children in low-income families who are not eligible for Medicaid. If this program were modified to ensure adequate coverage for mental health and substance abuse disorders, it might substantially reduce the financial barriers to treatment and enhance access to health care for millions of children from all racial and ethnic back-grounds.

Extend Health Insurance for the Uninsured

Approximately 43 million Americans have no health insurance. Federal and State parity laws and steps to equalize health and mental health benefits in public insurance programs will do little to reduce barriers for the millions of working poor who do not qualify for public benefits, yet do not have private insurance. Today, the Nation's patchwork of health insurance programs leaves more than one person in seven with no means to pay for health care other than by out-of-pocket and charity payments. The consequences of the patchwork are many holes in the health care system through which a disproportionately greater number of poor, sick, rural, and distressed minority families frequently fall.

Efforts are currently underway to create more systematic approaches for States and local communities to extend health and mental health care to their uninsured residents. In 2000 and 2001, HRSA awarded planning grants to communities in 20 States to develop strategies to extend health coverage to their uninsured. Recipients of the grants will receive technical assistance to ensure that mental health needs of their uninsured residents are met in equal measure with other health needs. The pro-gram is modeled on a Robert Wood Johnson Foundation program, Communities in Charge, which is assisting 20 cities to stretch a safety net of health care insurance for people who have no health coverage. This and other efforts will have a significant impact on many racial and ethnic minority individuals who are uninsured.

Examine the Costs and Benefits of Culturally Appropriate Services

The burden of untreated mental illness is costly for all Americans. As the Nation looks into ways to remove financial barriers to mental health and addictions treatment, it is also important to look at the long-term cost-effectiveness of offering culturally appropriate services. Engaging and treating racial and ethnic minority children, adults, or older adults by reaching out to family members and other social supports may require a greater initial investment of resources, but it may also result in substantial decreases in disability burden. In addition, undertaking other case management services that do not involve direct client contact, such as discussing a coordinated treatment plan with a traditional healer, may not be payable through insurance. Nevertheless, such "ancillary" services may be essential to ensuring that those in need of services will enter and stay in treatment long enough to get help that is effective.

Similarly, bilingual or bicultural community health workers may be needed to bridge the gap between the formal health care system and racial and ethnic minority communities. Funds to support these community workers are scarce, and in the bottom-line environment of man-aged care, often nonexistent. Yet studies across many areas of health have shown that community health workers— neighborhood workers, indigenous health workers, lay health advisers, consejera, promotora—can improve minorities' access to and utilization of health care and preventive services (Krieger et al., 1999; Witmer et al., 1995). These community health workers can also bridge language differences that create communication barriers for a substantial proportion of racial and ethnic minority

Americans receiving health care (Commonwealth Fund, 1995; President's Advisory Commission on Asian Americans and Pacific Islanders, 2001).

Many Americans, including members of racial and ethnic minorities, use alternative or complementary health care. The findings from a study of American Indian veteran's use of discrimination biomedical and alternative mental health care suggest that medical need drives service use, but the physical, financial, and cultural availability of services may influence the form that such service use assumes (Gurley et al., 2001). Research is needed to fully understand the effects of complementary care and their interactions with standard mental health interventions. In the meantime, it is important that mental health systems create avenues for working with complementary care providers to foster greater awareness, mutual understanding, and respect. Consumers and families may be more likely to take advantage of effective mental health treatments if both the formal mental health and complementary care systems work together to ensure that individuals with mental illness receive coordinated, and truly complementary, treatments.

Although providing services to meet the cultural and linguistic needs of more diverse populations may demand more of an initial investment than continuing services as usual, cost-effectiveness studies will help to examine the benefits of providing (or the costs of failing to provide) culturally appropriate services.

Reduce Barriers in Managed Care

Evidence cited in this Supplement suggests that managed mental health care is perceived by some racial and ethnic minorities as creating even greater barriers to treatment than fee-for-service plans. However, more systematic assessment of the treatment experiences, quality, and out-come of racial and ethnic minorities in managed care may help to identify opportunities for using this mechanism to improve access and quality of services. Because managed care organizations contract to provide all necessary services to beneficiaries at a fixed cost, managed care offers a potential means for increasing providers' flexibility to reach out and engage minority populations. For example, a health maintenance organization (HMO) might be able to support more outreach and engagement to people of color living in rural communities by removing inflexible billing methods based on individual office visits.

Overcome Shame, Stigma, and Discrimination

Shame, stigma, and discrimination are major reasons why people with mental health problems avoid seeking treatment, regardless of their race or ethnicity. The effects of negative public attitudes and behaviors toward people with mental illness may be even more powerful for racial and ethnic minorities than for whites (Chapter 2). For example, in some Asian American communities, the shame and stigma associated with the mental illness of one family member can affect the marriage and employment potential of other relatives. More research is needed to develop effective methods of overcoming this powerful barrier to getting people with mental health problems the help they need. Public

education efforts targeting shame, stigma, and are likely to be more effective if they are tailored to the languages, needs, and cultures of racial and ethnic minorities.

Build Trust in Mental Health Services

Mistrust of mental health services deters many individuals from seeking treatment for mental illness. Although there are undoubtedly myriad complex reasons for this lack of trust, one of its major sources for racial and ethnic minorities may be their past negative experiences with the mental health treatment system. Mistrust is understandable in light of research findings that minorities receive a higher proportion of misdiagnoses, experience greater clinician bias, and have lower access to effective treatments that are evidence-based, as compared with whites. As detailed in the next section, one of the most essential steps to building trust in mental health services is reducing racial and ethnic disparities in the quality of available services. Minority communities also need more information about the effectiveness of treatment and the possibility of recovery from mental illness.

Improve Quality of Care

This Supplement identified racial and ethnic disparities in the quality of mental health services people receive. Therefore, the provision of high-quality services in settings where there is an appreciation for diversity and its impact on mental health is a priority for meeting current and future needs of diverse racial and ethnic populations.

Ensure Evidence-Based Treatment

As noted earlier, the recommended treatments available for all patients are those based on a strong and consistent evidence base and tailored to the age, race, gender, and culture of the individual. It is clear that the Nation's mental health service system needs to ensure that all Americans receive the highest standard of care. This Supplement finds that racial and ethnic minorities are less likely than whites to receive effective, state-of-the-art treatments. Therefore, frontline providers need incentives and opportunities to participate in quality improvement activities that will help them better manage medications and provide effective psychosocial treatments to racial and ethnic minority consumers, children, and families in ways that are both culturally and linguistically appropriate and consistent with practice standards.

Develop and Evaluate Culturally Responsive Services

Culture and language affect the perception, utilization, and, potentially, the outcomes of mental health services. Therefore, the provision of culturally and linguistically appropriate mental health services is a key ingredient for any programming designed to meet the needs of diverse racial and ethnic populations. This programming should include:

(1) language access for persons with limited English proficiency;

(2) services provided in a manner that is congruent, rather than conflicting, with cultural norms; and

(3) the capacity of the provider to convey under-standing and respect for the client's worldview and experiences.

The refinement and study of cultural competence may reveal a mechanism for helping mental health organizations and providers deliver culturally appropriate services. This approach underscores the recognition of cultural differences in consumers and families and then develops a set of skills, knowledge, and policies in an effort to deliver services more effectively. There have been, however, few direct empirical studies of cultural competence. Research is needed to determine its key ingredients and what influence, if any, they have on improving service delivery, utilization, treatment response, adherence, outcomes, or quality for racial and ethnic minorities.

Engage Consumers, Families, and Communities in Developing Services

One way to ensure that mental health services meet the needs of racial and ethnic minority populations is to involve representatives from the community being served in the design, planning, and implementation of services. Modeled on primary health care programs that successfully target recent immigrants and refugees, some minority-oriented mental health programs appear to succeed by maintaining active relationships with community institutions and leaders. These programs do aggressive outreach, furnish a familiar and welcoming atmosphere, and identify and encourage styles of practice tailored to racial and ethnic minority groups.

State, county, and local communities carry the primary responsibility for developing, organizing, and operating their own mental health services. Their leaders are frequently in the position to determine the investment of Federal, State, and local mental health resources. It is incumbent upon those who control the organizational structure of local programs to engage consumers, families, and other community members in the process of reducing mental health service disparities.

One organization that is successfully reaching out is the Feather River Tribe of California. With Federal seed-grant funds, this tribe has developed a plan for serving tribal children with serious emotional problems that is based on community members' assessment of needs and expectations from mental health treatment.

Their effort has engaged tribal members so successfully that, through their own fundraising efforts, they have netted sufficient tribal, State, foundation, and Federal resources to implement a comprehensive, community-based children's services program. As a result, this community feels ownership and commitment to its mental health service delivery system, and Feather River children are receiving more and better quality services.

Support Capacity Development

Minorities are underrepresented among mental health providers, researchers, administrators, policymakers, and consumer and family organizations. Furthermore, many providers and researchers of all backgrounds are not fully aware of the impact of culture on mental health, mental illness, and mental health services. All mental health professionals are encouraged to develop their understanding of the roles of age, gender, race, ethnicity, and culture in research and treatment. Therefore, mental health training programs and funding sources that work toward equitable representation and a culturally informed training curriculum will contribute to reducing disparities.

Train Mental Health Professionals

Racial and ethnic minorities continue to be badly under-represented, relative to their proportion of the U.S. population, within the core mental health professions — psychiatry, psychology, social work, counseling, and psychiatric nursing. Although it is certainly not the case that only minorities can understand or treat persons of like race or cultural background, minority providers treat a higher proportion of minority patients than do white providers. There is also evidence that ethnic match between provider and client encourages consumers to enter and stay in treatment.

The ability to reduce health disparities through the research proposed in the NIH 2001 Health Disparities Plan requires a strong commitment to training and sup-porting investigators in this area. Not only are there disparities in the number of studies that analyze their findings by race or ethnicity, but there are also disparities in the number of racial and ethnic minority investigators applying for and receiving grants to pursue mental health research.

Without concerted efforts by policymakers, educational institutions, and senior researchers, the shortage of providers and researchers equipped to address the needs of minority populations will contribute to the disproportionate burden of mental illness on racial and ethnic minorities. Programs that encourage students who are committed to serving racial and ethnic minority communities to enter the field of mental health will help to reduce the mismatch between needs and capacity. Furthermore, it is important that professional training programs include curricula that address the impact of culture, race, and ethnicity on mental health, mental illness, and mental health services. Hence, there is a need to encourage targeted Federal training or grant programs, educational programs for high school, college, and graduate students, outreach by graduate and professional schools, and continuing education by accrediting professional organizations.

Encourage Consumer and Family Leadership

Whereas the movement to give voice and leadership to the recipients of mental health services — consumers and family members — has been growing rapidly over the past 20 years, racial and ethnic minorities continue to be underrepresented in this arena. Although there have been recent Federal, State and local efforts to develop net-works and

leadership among minority consumers and families, concerted efforts are needed to give voices to these relatively unheard stakeholders of the mental health system.

Promote Mental Health

Mental health promotion and mental illness prevention can improve the mental health of a community. Therefore, dedicated efforts should investigate avenues for reducing the effects of historical social inequities and for promoting community and family strengths.

Address Social Adversities

Mental health is adversely affected by chronic social conditions that disproportionately affect America's poor and its racial and ethnic minority groups. These conditions include poverty, community violence, racism, and discrimination. The reduction of social adversities, while a formidable task, may be vital to improving the mental health of racial and ethnic minorities. Although there is substantial literature on the damaging effects of poverty on mental health, there is less empirical evidence for the effects of exposure to racism, discrimination, and community violence. As these relationships are examined, it is in the Nation's interest to reduce the impact of such social problems, as well as to promote respect and under-standing among Americans of all backgrounds.

Build on Natural Supports

Efforts to prevent mental illness and promote mental health should build on intrinsic community strengths such as spirituality, positive ethnic identity, traditional values, educational attainment, and local leadership. Programs founded on individual, family, and community strengths have the potential for both ameliorating risk and fostering resilience. Furthermore, culturally appropriate efforts are needed to educate families and communities about mental health, mental illness, treatment effectiveness, the possibility of recovery, and the avail-ability of services in their area.

Strengthen Families

Families are the primary source of care and support for the majority of adults and children with mental health disorders or problems. Given the important role of family in the mental health system, it is essential that efforts to reduce racial and ethnic disparities include strategies to strengthen families to function at their fullest potential and to mitigate the stressful effects of caring for a relative with mental illness or serious emotional disturbance. Furthermore, strong families are better equipped to cope with adversity and to provide mentally healthy environments for their children. As with mental health interventions, family support and family strengthening efforts need to be tailored to the linguistic and cultural needs of racial and ethnic minorities.

Conclusions

Mental Health: Culture, Race, and Ethnicity presents compelling evidence that racial and ethnic minorities collectively experience a disproportionately high disability burden from unmet mental health needs. Despite the progress in understanding the causes of mental illness and the tremendous advances in finding effective mental health treatments, far less is known about the mental health of African Americans, American Indians and Alaska Natives, Asian American and Pacific Islanders, and Hispanic Americans.

The Nation has far to go to eliminate racial and ethnic disparities in mental health. While working toward this goal, the public health system must support the strength and resilience of America's families. The demo-graphic changes anticipated over the next decades magnify the importance of eliminating differences in mental health burden and access to services. Ethnic minority groups are expected to grow as a proportion of the total U.S. population. Therefore, the future mental health of America as a whole will be enhanced substantially by improving the health of racial and ethnic minorities.

It is necessary to expand and improve programs to deliver culturally, linguistically, and geographically accessible mental health services. Financial barriers, including discriminatory health insurance coverage of treatment for mental illness, need to be surmounted. Programs to increase public awareness of mental illness and effective treatments must be developed for racial and ethnic minority communities, as must efforts to overcome shame, stigma, discrimination, and distrust. The time is right for a commitment to expand or redirect resources to support evidence-based, affordable, and culturally appropriate mental health services for racial and ethnic minorities, particularly in settings where those with the highest need are not being adequately served, such as jails, prisons, homeless shelters, and foster care.

Clinical practice guidelines and program standards for culturally competent mental health services should be subject to rigorous empirical study. If they are found to be effective for racial and ethnic minorities, such standards should be disseminated and implemented with fidelity. For state-of-the-art, evidence-based interventions, it is critical that quality improvement processes be inaugurated, so that clinicians and programs actually use them and use them appropriately.

Building capacity for research, training, and community leadership is essential to meet the needs of racial and ethnic minorities in the 21st century. Where gaps exist in the evidence base about the prevalence, perception, course, detection, and treatment of mental illness in racial and ethnic minority populations, individuals must be trained and supported to carry out systematic pro-grams of research. Where shortages of accessible services are evident, both mainstream and bilingual-bicultural providers and administrators must learn to create culturally appropriate and evidence-based systems of care. Where leadership is lacking in consumer and family groups, encouraging grassroots efforts will help to strengthen the voices of racial and ethnic minorities.

Accountability for making progress and providing state-of-the-art services will help to reduce disparities in the mental health and health care systems. This Supplement sets a foundation for national efforts to pro-vide racial and ethnic minorities affected by mental disorders with effective and affordable treatments tailored to their specific needs. Public reports throughout the decade will provide excellent opportunities to gauge successes, evaluate directions, and chart necessary changes. Addressing disparities in mental health is the right thing to do for all Americans.

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Chapter Two

Cultural Competency

Working with American Indian and Alaska Native Communities

Cultural Competency: Notes for NAMI Chapters

Self Assessments Checklist

Example: Healing Our Spirit Worldwide
A Culturally Congruent Mental Health Framework

Working In Indian Communities

Excerpted from the US Department of Health and Human Services Substance Abuse and Mental Health Services Administration's Cultural Competence Series, Volume 9:

Heath Promotion and Substance Abuse Prevention in American Indian and Alaska Native Communities: Issues in Cultural Competence. *Chapter 2: "Prevention Principles for American Indian Communities," by James R. Moran, Ph.D, pp 40-42.*

Overcoming Distrust

One of the first issues to consider in understanding the dynamics of carrying out…programs in American Indian Communities is that like many other ethnic minority communities, American Indian communities often have a historical distrust of the dominant society (Lockhart, 1981). This distrust is based in the historical nature of the relationship between the dominant culture and American Indians that includes a 500-year history of oppression and domination – at times approaching genocide. **When programs are seen as imposed from outside the community, this distrust is likely to escalate and to form a significant barrier. In such situations…programs are not likely to produce useful results**. *(emphasis, NAMI)*

…A key part of making programs relevant is to have them emerge out of a process of community involvement. Beauvais and LaBoueff (1985) present a model of community action that progresses from a few interested people to a core group to a community task force. Each step involves more community members committed to the idea…

There are several ways that noncommunity members can demonstrate their commitment to American Indian communities. Simply responding to the stated needs that are defined by a process of community involvement instead of having a set program that is defined by academic interests or by government or foundation announcements is a strong statement to the community. Providing technical assistance that is needed in the community even though it may not be funded directly by grants also demonstrates commitment. Perhaps most important…being willing to stick around and deal with a problem as long as it takes, even if that means moving beyond the original funding period. This might mean locating and securing additional funding in order to continue a program. In summary, working in American Indian communities requires us to directly address issues of distrust by listening to and then responding in a committed manner to community-defined interest.

Developing Cultural Sensitivity

To accomplish the above, one must be culturally sensitive. But what does this mean?

Cultural competency occurs in stages with simple awareness of cultural differences being a necessary first stage. The second stage is self-assessment, that is, the awareness of ones own cultural values. This approach to cultural competence holds that people must understand their own culture (i.e. recognize that they have a cultural lens) before they can be sensitive to other cultures. The third stage is an understanding of the dynamics such as conflict and racism that may occur when members of different cultures interact. Working through these three stages enables individuals to adapt to diversity and to adjust professional skills to fit within the cultural context of ethnic community.

…To be culturally competent means to conduct one's professional work in a way that is congruent with the behaviors and expectations that members of a cultural group recognize as appropriate among themselves. …That does not mean that nonmembers of a community will be able to conduct themselves as though they are a member of the group. Rather, they must be able to engage the community on something other than their own terms and demonstrate acceptance of cultural difference in an open, genuine manner, without condescension.

Cultural Competency: Notes for NAMI Chapters

Changing the Way We Work

The mental health field in the U.S. continues to be dominated by white, middle-class professionals who are primarily English speakers.

What implications does this have for people of color with mental illnesses and their families? This section of the American Indian and Alaska Native Resource Manual recognizes that tremendous racial and cultural barriers persist for American Indian and Alaska Native families seeking resources and support.

If NAMI is to live up to its mission - to serve and advocate for all persons with mental illness and their families - then achieving cultural competency within NAMI groups is paramount.

The following section offers concrete strategies toward reaching out to and serving American Indian and Alaska Native families dealing with mental illness. Creating culturally competent NAMI groups is a critical step toward creating a society in which all persons with mental illness have the dignity, resources and support essential to their well-being.

What is Cultural Competency?

Cultural Competency can be defined as:

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. Cultural competency is the assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations (Cross et al., 1989).

Davis (1997) operationally defines cultural competency as the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes.

Cultural competency does not refer to the establishment or maintenance of diversity per se. The concept of competency is not related to numbers of representation, either in clients or in service providers. Competency refers more explicitly to folkways, mores, traditions, customs, formal and informal helping networks, rituals, dialects, and so forth. In these areas, knowledge about various cultures and the development of specific skills and attitudes in providing services in a manner consistent with the consumers' needs are essential.

Why is Cultural Competency Important?

The cultural appropriateness of mental health and support services may be the most important factor in the accessibility of services by people of color. Developing culturally sensitive practices can help reduce barriers to treatment. Knowing whom the consumer perceives as a "natural helper" and whom he/she views as traditional helpers (such as elders, the church) can facilitate the development of trust and enhance the individual's investment and access to treatment.

America's population is not only growing, it is changing dramatically. NAMI groups and chapters must reflect this reality. Shifts in ethnic diversity are not just about numbers, but also the impact of cultural differences. New approaches to organizing, support, and advocacy are needed to address cultural differences among consumers.

Essential Knowledge, Skills, and Attitudes to Developing Cultural Competence
Ensuring the provision of culturally competent services to potential members places a great deal of responsibility upon the organization. In particular, there are a number of generally expected levels of knowledge, skills and attitudes that are essential to providing culturally competent support services.

Knowledge

Make efforts to understand self and (if applicable) one's dominant culture position in terms of dynamics of race, ethnicity and power.

Understand the historical factors which impact the health of American Indian/Alaska Native (AI/AN) population, such as racism, dislocation, and immigration patterns.

Understand the particular psycho-social stressors relevant to AI/AN patients. These include poverty, war trauma (historic and present), migration, acculturation stress, disproportionate incarceration, and racism.

Understand historic dismemberment of families, centrality of tribal traditions, and intergenerational conceptual framework among AI/AN families.

Understand indigenous healing practices and the role of spirituality in the treatment of AI/AN people with mental illness.

Understand the cultural beliefs of health and help seeking patterns of AI/AN people with mental illness.

Understand the health service resources for AI/AN population, including the Indian Health Service.

Understand historic and present-day public health policies and their impact on AI/AN patients and communities.

Skills

Ability to discuss mental health issues of AI/AN people based on a psychological/social/biological/cultural/political/spiritual model.

Ability to communicate effectively - possibly with cross cultural use of interpreters.

Ability to discuss mental health issues with an understanding of cultural differences in pathology. Awareness of particular risks facing AI/AN communities (substance abuse, suicide).

Ability to appreciate the need for culturally sensitive treatment that fits the family's concept of health and illness.

Ability to utilize community resource (church, CBOs, self-help groups_

Ability to network and draw on other community resources to support the family.

Attitudes

Respect the tremendous survival merits of AI/AN families and tribes.

Respect the importance of cultural forces.

Respect the holistic view of health and illness

Respect the importance of spiritual beliefs

Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.

Own a lack of awareness or defensiveness in situations that may require additional education, resources or support.

Promoting Cultural Diversity and Cultural Competency

Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and their Families

Tawara D. Goode, -Georgetown University Center for Child and Human Development-University Center for Excellence in Developmental Disabilities Education, Research & Service.

Adapted from - Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings-June 1989. Revised 1993, 1996, 1999, 2000 and 2002.

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment.

A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials & Resources

_____1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____4. When using food during a program, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program and agency.

_____5. I insure that toys and other play accessories in reception areas and those which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____6. For families that speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them.

_____7. I use visual aids, gestures, and physical prompts in my interactions with families that have limited English proficiency.

_____8. I use bilingual staff or trained/certified interpreters for educational and support programs.

_____9. When interacting with families that have limited English proficiency I always keep in mind this:

_____* limitations in English proficiency is in no way a reflection of their level of intellectual functioning.

_____* they may or may not be literate in their language of origin or English.

_____10. When possible, I insure that all notices and communiqu_s to families are written in their language or origin.

_____11. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values & Attitudes

_____12. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____13. In group situations, I discourage participants from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____14. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with families served by my program or agency.

_____15. I intervene in an appropriate manner when I observe other parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.

_____16. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____17. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____18. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____19. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families.

_____20. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____21. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____22. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____23. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

_____24. I accept that spirituality and other beliefs may influence how families respond to illnesses, disease, disability and death.

_____25. I recognize and accept that folk and religious beliefs may influence a family's reactions and approach to a child with mental illness or special health care needs.

_____26. I understand that traditional approaches to disciplining children are influenced by culture.

_____27. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

_____28. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____29. Before visiting family members in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____30. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program agency.

_____31. I advocate for the review of my program's or agency's mission treatment, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for people with mental illness and their families.

HOSW: Culturally Congruent Framework for Addressing Mental Health Issues

HOSW Conference Brings Together Indigenous People from Around the World

Indigenous people from around the world recently met to address alcohol and substance abuse issues, health care, traditional healing and leadership at the fourth Healing Our Spirit Worldwide Conference. The conference was seen as a landmark event that included the participation of over 3,400 people from around the world. The opening ceremonies spanned over four hours and included the participation of over twenty-five different countries bringing keynote speakers, musical and cultural performances by people representing Australia, Canada, Ecuador, New Zealand and the United States.

The conference hosted by the National Indian Health Board (NIHB) included 130 different workshops that focused on the many struggles associated with alcohol and substance abuse including prevention and treatment, mental health, governance and leadership, public health, trauma and violence, among others. Common in many of the themes of the plenary sessions and workshops were the issues associated with cultural and political oppression of Indigenous people and how this has manifested itself as substance abuse, violence and alienation in tribal communities. The Healing Our Spirit Worldwide movement brings together Indigenous people to discuss and share approaches to addressing these issues in tribal communities.

Presenters focused on the cultural and spiritual significance of healing and how these are important in the treatment, healing and recovery process. The Healing Our Spirit Worldwide movement stresses the importance of healing from within in order to rebuild individuals, families, communities and nations.

Three Concurrent Events

In addition to the overall event, two other conferences were held concurrently so that other groups could benefit from the message of Healing Our Spirit Worldwide. The National Indian Council on Aging (NICOA) and United National Indian Tribal Youth (UNITY) also held conferences in Albuquerque during the same week. Many attendees participated in events held by all three groups. UNITY even scheduled specific times for youth and elders to communicate informally so that the youth could learn from the experiences of the elder community.

In addition to the events hosted by UNITY and NICOA, a Tribal Leader Summit on Alcohol and Substance abuse was conducted by the NIHB and National Congress of American Indians.

The purpose of the summit was to take a holistic look at alcohol and substance abuse issues in tribal communities and provide tribal leaders with an opportunity to dialogue with key federal agency representatives. The summit resulted in the development of a Tribal Leader Proclamation on alcohol and substance abuse and serves as a commitment by Tribal Leaders to work diligently to eliminate the devastating effects of alcohol and substance abuse in tribal communities. It further recognizes the importance of Tribal Leadership to be sober and drug free in order to improve the quality of life for American Indian and Alaska Native families and communities.

HR

The Covenant

Preamble

We, Indigenous peoples of the world, have gathered in a combined voice in the last two decades to address the healing of each and every one of us, and our communities concerning health issues, including environment, disease and alcohol and substance abuse.

Declaration

Continue to live lives in the traditional ways; Maintain and keep our integrity and right to self-determination; We urge national governments to adopt measures that ensure the full enjoyment of Indigenous people's rights.

Action

Maintain fundamental rights of:
The right to our lands and territories;
Self-determination and self-governance and recognition of traditional authorities;
Respect and protection of our sacred cultural and ceremonial sites;
Protection fo our heritage;
Respect for our oral histories and laws;

A full copy of the covenant is available at www.healingourspiritworldwide.com

Chapter Three

Culturally Competent Outreach

Part 1: *100 Questions for 500 Nations*

Research: Exploring Issues Facing American Indians and Alaska Native Communities

Part 2: *Formulating an Outreach Plam*

Making the Final Decision to conduct outreach
Materials adapted from Outreach to African American and Hispanic Families: A Manual for NAMI ffiliates. Prepared by Judith A. Cook and Jesse Knox, 1993.

Identifying the Target Group

Formulating Your Basic Outreach Plan
Funding for Your Outreach Efforts

Planning to Disseminate and Publicize Your Outreach Efforts

Case Examples

Summary

The American Indian and the Media

Edited by Mark Anthony Rolo
The National Conference for Community and Justice. (NCCJ)

Indian Country Resource Guide

100 Questions for 500 Nations

Contributed to the American Indian and the Media by Knight-Ridder

Who is an American Indian?

1. Who is an American Indian?
There are millions of people with Indian ancestry, but that does not make them American Indians in the eyes of tribes or the federal government. The federal government considers someone American Indian if he or she belongs to a federally recognized tribe. Individual tribes have the exclusive right to determine their own membership. Tribal governments formally list their members, who must meet specific criteria for enrollment. Some require a person to trace half of his or her lineage to the tribe, while others require only proof of descent.

2. Where did American Indians come from originally?
Many anthropologists believe that Indians traveled about 35,000 years ago across a land bridge spanning the Bering Strait from Asia to North America. Most tribes have their own creation story: Many believe that Native peoples originated from this continent.

3. Why are Native peoples referred to as Indians?
Indigenous people in the United States were first referred to as Indians because Columbus believed he had reached the East Indies when he touched the shores of North America. Today, many Native people prefer to call themselves American Indian to avoid stereotypes associated with Indian.

4. Which is correct: American Indian or Native American?
Either term is generally acceptable, although individuals may have a preference. Native American was first used in the 1960s for American Indians and Alaska Natives. Over times, Native American has been expanded to include all native peoples of the United States and its territories, including Hawaiian natives, Chamorros and American Samoans. (Native American and American Indian are used interchangeably in this document.)

5. How many American Indians and Alaska Natives are there?
There are 2.3 million, according to U.S. Census estimates for 1997. They represent roughly 1 percent of the overall population. Before Europeans arrived in North America, Native Americans may have numbered as many as 10 million. By the time colonists began keeping records, the population was substantially less, ravaged by war, famine, forced labor and disease from Europeans.

6. Who are Native American families?
Nearly two-thirds are married couples, and 27 percent are families headed by single women. Birth rates are higher among American Indian families than the rest of the United States, and there are more American Indian families living in poverty than other Americans. American Indian families' median income was $22,000 in 1990, compared to $35,000 for all U.S. families.

7. Are the numbers of American Indians declining today?
The population is young and growing steadily. Since July 1990, the American Indian and Alaska Native population increased 12 percent, while the white population grew 3 percent. The U.S. Census projects that the American Indian and Alaska Native population will reach 4.4 million by 2050.

8. What are the reasons for the rise?
American Indians and Alaska Natives get better health care and live longer than they did in the recent past. Also, more people are likely to identify themselves as American Indians and Alaska Natives than in earlier Census counts.

9. Why does the government refer to indigenous people in Alaska as Alaska Natives instead of as American Indians?
Alaska Natives are Eskimo (Inupait and Yupik), Alaskan Indians (Athabascan, Haida, Tlingit and Tsimshian) and Aleut. They are culturally distinct and prefer to be called Alaska Native instead of being grouped as American Indian.

10. Are Native Hawaiians considered American Indians?
No, Native Hawaiians, known as Kanaka Maoli in Hawaiian, trace their lineage and language to Polynesians, including Tahitians, Maoris and Samoans. Starting in 2000, the federal government will recognize Native Hawaiians ans Pacific Islanders as a distinct group, including in Census counts. Native Hawaiians often unite with other Native Americans over issues of self-governance and self-determination.

What is a Tribe?

11. What is a tribe?
Originally, tribes were a society of people bound by blood ties, family relations and a common language. They also had their own religion and political system. When members of different tribes were forced to live together on reservations, some new tribal grouping formed.

12. How many tribes are there?
In 1998, there are 554 federally recognized tribes in the United States, according to the federal Bureau of Indian Affairs. This includes 226 native villages in Alaska. Federal recognition acknowledges the government-to-government status a tribe has with the United States, and also provides for certain federal services.

13. OK, there are a lot of different tribes. But aren't American Indians pretty much the same as a group?
Indian tribes are as different, for example, as the Irish and Italian. Individual tribes have their own culture, language and tradition. Many groups may be strangers to one another. Some were once enemies.

14. Which is the larges tribe?
With a 1990 population of 308,132, Cherokees are the largest U.S. tribe. Most live in Oklahoma, though more than 5,000 Cherokees live on a reservation in North Carolina.

15. Are Indian tribes and Indian nations the same?
Yes. The federally recognized tribes are considered self-governing – or sovereign nations – by Congress. Thus, the federal government deals with tribes as political entities, not as persons of a particular race. The political status of tribes is written in he Constitution: "The Congress shall have power…to regulate commerce with foreign nations…and with the Indian tribes."

16. Can any tribe be federally recognized?
A rigorous application process determines federal recognition. Many nations were recognized by treaty-making in the 18th and 19th centuries, though several groups are petitioning for recognition today. The Bureau of Indian Affairs in the U.S. Department of the Interior maintains a directory of federally recognized tribes.

17. How recently have tribes won federal recognition?
In 1996, the Huron Potawatoni of Michigan received status as a federally recognized Indian nation. In 1998, there were 14 tribes under active consideration by the Bureau of Indian Affairs, which has final approval.

18. What powers do the tribes, as nations, hold?
They have a nationhood status, enjoying the powers of government, except for those expressly taken away by Congress or overruled by the Supreme Court. The United States recognizes the tribes 'rights to form their own government, determine membership, administer justice, raise taxes, establish businesses and exclude people from reservations. Tribal nations regulate Indian land, resources and the conduct of tribal members on Indian land.

19. What kind of governments do the tribes run?
Most tribal governments are organized democratically with elected leaders in highly developed political systems that often predate the arrival of European settlers. While similar in structure to American governments, the tribal governments are smaller, with far fewer resources.

20. What is the tribal council?

The tribe's governing body is usually referred to as the tribal council, and is elected by adult members of the tribe. Heading the council is one elected chairperson, president, chief or governor who is the recognized leader. The council performs the legislative aspects of tribal government.

21. Are reservations and tribal governments the same?
No. Tribal governments existed long before reservations were established. However, the governing authority on reservations is the tribal council. In cases where different tribes share a reservation, they often run separate government, as the Shoshone and Araphao do in Wyoming.

What is a reservation?

22. What is a reservation?
Indian reservations are areas of land reserved by the federal government as permanent tribal homelands. The United States established its reservation policy for American Indians in 1787. Today there are 314 reservations, among the last large tracts of private lands.

23. Why is it called a reservation?
The term originates from the federal government's act of reserving land for federal purposes. In the United States, there are two kinds of reserved land that are well known: military and Indian.

24. Do all American Indians live on reservations?
No. More than 60 percent live away from reservations, the U.S. Census reports. However, many return to visit family and attend ceremonies.

25. How much land do Native Americans hold?
About 56 million acres in reservations and trust land. The Navajo Reservation is the largest, numbering 16 million acres and occupying parts of Arizona, Utah and New Mexico. Many smaller reservations are less than 1,000 acres.

27. Who owns reservations?
The United States holds title to the land for the tribes, with the Department of Interior acting as trustee. The tribe or individual whose land is held in trust is the owner. Non-Indians also own significant portions of reservation land, though tribes may exercise jurisdiction over it.

28. Has the government tried to take away tribal land?
Form the 1880s to the 1930s, Congress opened tribal lands for sale, with reservations losing two-thirds of their land base. In the 1950s, the Eisenhower administration adopted a "termination" policy, closing many reservations while trying to assimilate Indians into white society.

29. What kind of mineral reserves are on tribal land?

Reservations contain a wealth of minerals: 5 percent of U.S. oil and gas reserves, 50 percent of the uranium and 30 percent of the low-sulfur coal. Other minerals include phosphate, quartz crystal, sand, gravel, potash and sodium. Even if tribes do not mine the minerals, they may lease the rights to others.

30. What is Indian country?
Indian country is a legal term used in Title 18 of the U.S. Code. It broadly defines federal and tribal jurisdiction in crimes affecting Indians on reservations. But it also has popular usage, describing reservations and areas with American Indian populations.

31. What are the living conditions in Indian country?
While health, education and economic conditions have improved in the last several years, native communities still lag behind the rest of the country in most every category. Income levels are substantially lower in Indian country than the rest of the nation. Indians on reservations also are much more likely to die from accidents, alcoholism, diabetes, pneumonia, suicide, homicide and tuberculosis.

What is tribal sovereignty?

32. What is tribal sovereignty?
Just like states, tribes have attributes of sovereignty – to govern their own territory and internal affairs. The status of tribes as self-governing nations is affirmed and upheld by treaties, case law and the Constitution. Legal scholars explain that tribes are inherently sovereign, meaning they do not trace their existence to the United States.

33. How does sovereignty work?
The doctrine of tribal sovereignty was affirmed in three Supreme Court ruling in the 1800s. It recognizes the right of American Indian tribes to self-govern and run their internal affairs as so-called “domestic, dependent nations.” It keeps states from interfering with that right, while allowing Congress to override an Indian nation’s authority.

34. Is sovereignty largely symbolic today?
There is nothing more important to Indian governments and people than sovereignty, tribal leaders say. It is a fundamental principle of the U.S. Constitution with increasing legal significance. Recently, tribes have worked to regain control of their economies and resources by asserting their rights as sovereign powers, sometimes in conflict with neighboring states.

35. What is the government-to-government relationship?
It is federal policy expressing how the United States interacts with tribes. It requires the United States to assess federal actions affecting tribes and to consult with the tribes about those actions.

36. How are tribes exercising their status as sovereign nations?

In New Mexico, for example, the Isleta Pueblo tribe is requiring the city of Albuquerque to abide by its clean-water standards, which are stricter and costlier than state requirements. In the Pacific Northwest, tribes partner with state and federal governments to co-manage fisheries and protect salmon stock.

37. What is sovereign immunity?
It is the ability of a government to define the terms upon which it can be sued. Tribes have invoked sovereign immunity in suits that challenge their authority to regulate land use. There have been recent efforts in Congress to limit a tribe's sovereign immunity, but they have not been adopted.

38. Do states have jurisdiction over American Indians or their land?
States do not have any civil or criminal jurisdiction in Indian country unless Congress delegates it or the federal courts determine it exists. Most recently, the 1988 Indian Gaming Regulatory Act, adopted by Congress, requires tribes and states to enter into compacts, or agreements, before gambling operations can open on Indian land.

39. Do American Indians have to obey the same laws as non-Indians?
When tribal members are off reservations, they are generally subject to local, state and federal laws. On reservations, they are subject only to federal and tribal laws. Under federal law, known as the Assimilative Crimes Act, any violation of state criminal law on a reservation is a federal crime.

40. Are Indians American citizens?
Yes. Indians have dual citizenship as tribal members and as American citizens. Congress extended citizenship to American Indians in 1924.

41. Can American Indians vote?
American Indians and Alaska Natives have the same right to vote as other American citizens. They vote in local, state, federal and tribal elections. Each tribe has the right to determine its criteria for eligible voters in tribal elections.

42. Do Native Americans pay state or federal taxes?
They pay the same taxes as everyone else with the following exceptions: Native Americans employed on reservations do not pay state income taxes. American Indians living on trust land are free from local and state property taxes. Generally, state sales taxes are not levied on Indian transactions made on reservations. Indians do not pay federal income taxes on money earned from trust lands, such as fees received for grazing rights and oil drilling.

What are treaties?

43. What are treaties?
From 1777 to 1871, U.S. relations with Indian nations were negotiated through legally binding agreements called treaties. These treaties, or agreements,

between tribal governments and the United States transferred and created property rights as well as service obligations. There were 371 treaties signed with American Indian tribes, usually to gain rights to their land.

44. What agreements did the treaties contain?
The treaties often promised Indians protection, goods, services, self-governing rights and a tribal homeland in exchange for their cooperation and vast acres of land.

45. Why did European settlers enter into treaties with the tribes?
Tribes had power because of their military strength and knowledge of the land. They could have forced Europeans off the continent, if they had banded together. European law also taught colonists that land transactions required legal documentation.

46. Why did the tribes agree to the treaties?
Faced with giving up their lands or losing their people to war, disease and a rising tide of settlers, the Indians entered into the agreements. The tribes view treaties as solemn moral obligations.

47. Were the treaties broken?
Over the years, conflicting federal policy and court rulings resulted in Native peoples losing some of their civil rights and lands. An early example was the Trail of Tears, the forced march of 14,000 Cherokees from Georgia, Alabama and Tennessee to Oklahoma, despite a 1791 treaty granting them a permanent homeland. About 4,000 Cherokees – mostly babies, children and old people – died from starvation, exposure and disease.

48. What is trust responsibility?
The federal Indian trust responsibility is considered one of the more important principles in federal Indian law. It is a legally enforceable fiduciary obligation by the United States to protect tribal lands, assets, resources and treaty rights. Supreme Court rulings suggest that trust responsibility entails legal as well as moral duties.

49. Are treaties still valid?
Although the government stopped entering into treaties with Indian tribes in 1871, the Constitution holds treaties as “the supreme law of the land.” Once a treaty is signed, it stays in effect unless superseded by acts of Congress or other treaties.

50. Do treaties grant Native Americans special rights today?
In the Pacific Northwest, tribes are able to hunt, fish and gather food as their ancestors did. On all reservations, tribes have access to free education and medical care provided by the federal government. These are examples of Indian rights based on treaties signed years ago.

51. Are treaties being challenged?

There are many efforts in modern times to dilute and challenge treaty rights. Most recently, bills have been introduced in Congress that seek to limit the ability of tribes to govern themselves and give authority to states over the tribes. No major changes have been enacted, however.

52. What is the American Indian Movement?
The activist organization, known as AIM, was founded in 1968 to promote civil rights for Native Americans. Over the years, it has sought recognition of treaty rights through sit-ins and highly visible protests. In 1972, AIM organized the "Trail of Broken Treaties," converging on Washington, D.C., before the presidential election. AIM is still active today, with branches across the United States.

What does the Bureau of Indian Affairs do?

53. What does the Bureau of Indian Affairs do?
The bureau is the principal federal agency working with tribes. Its job is to provide services and/or funds for services to benefit tribal members. Unlike the 1800s, when the bureau was in the War Department, the bureau's stated goal is to help tribes with self-determination. Almost 100 percent of its employees are tribal members.

54. How does someone qualify for BIA services?
Persons must belong to a federally recognized tribe.

55. What services does the BIA provide?
The bureau's $1.7 billion budget in fiscal 1998 funded law enforcement, social services, land, management, forestry services, education and other areas.

56. What other federal offices work with tribes?
Just about all federal agencies work with Indian tribes. The Health and Human Services Department, for example, runs the Indian Health Services, which provides medical care on or near reservations. The Justice Department has the Office of Tribal Justice, which coordinates law enforcement in Indian country.

57. Do American Indians have the right to hold elective office?
Indians have the same rights as all citizens, and have held most levels of elective office. Charles Curtis, a member of the Kaw tribe, was vice president under Herbert Hoover. U.S. Sen. Ben Nighthorse Campbell, a Republican from Colorado, is a member of the Northern Cheyenne tribe. Campbell also served three terms in the U.S. House of Representatives as a Democrat.

58. Do Native Americans serve in the U.S. armed forces?
Native Americans have fought in all American wars since the Revolution, and one out of four Indian men is a U.S. military veteran. Their patriotism in World War I led Congress to pass the Indian Citizenship Act of 1924, In World War II,

Navajo Marines used their language as a code to transmit messages; it was the only code the enemy failed to break.

Who regulates Indian casinos?

59. Who regulates Indian casinos?
The National Indian Gaming Commission, established by Congress, oversees bingo operations, casinos and certain other types of gambling on tribal land. It sets rules for licensing, reviews yearly audits, and approves ordinances that tribes develop to run gaming operations. The U.S. Departments of Treasury, Justice and Interior have authority over aspects of Indian gaming. Indian nations, as well, have their own gaming commissions, tribal police forces and court systems.

60. What is the Indian Gaming Regulatory Act?
The federal law requires states to enter into compacts with tribal governments that plan to engage in casino gambling, including slot machines and blackjack. Gaming must be conducted on tribal land, and the states control is limited to the terms in the compacts. Compacts are approved by the U.S. Secretary of the Interior.

61. How much money do Indian gaming operators make each year?
In 1997, they reported a total of $6.4 billion in revenues. Not all tribes get rich, though. The General Accounting Office reports that nearly half of all revenue is earned by the six largest gaming tribes: the more successful operations are usually located in or near large metropolitan areas.

62. Is Indian gaming a major player in the gambling industry?
Indian gaming is growing at a rapid pace, but represents only 8 percent of the revenue market share, according to the National Indian Gaming Association.

63. Do all tribes have casino gambling?
No. Roughly a third of the 554 tribes have gaming operations, and many are limited to bingo.

64. Do the tribes pay taxes on their revenues?
No. As sovereign governments they do not pay taxes on their revenues to the state or federal governments, though casino workers are generally subject to the same payroll and income taxes other Americans pay. States can assess fees to the tribes for costs of gambling regulation and administration. Some states, including Michigan, Connecticut and Washington, have formal arrangements with tribes to receive additional revenue.

65. Are individual tribes getting rich from casinos?

While gaming has helped tribes such as the Grand Traverse Band of Ottawa and Chippewa in Michigan stem poverty, Indians are the nation's poorest population. They rank at the bottom of most social and economic measures.

66. Are individual Indians getting rich from casinos?
The Indian Gaming Regulatory Act requires tribal governments to spend revenues on operations, welfare, economic development and charity. Once tribes meet those obligations they can seek permission from the U.S. Secretary of the Interior to set up a per-capita distribution plan to benefit individual members. Approximately 50 tribes have approval to do so.

67. Why are Indian casinos a popular enterprise among the tribes?
Gambling is an accepted tradition that figured in celebrations and ceremonies long before European settlement. With many reservations in distant and remote areas, gaming seems to be one of the few viable sources of employment and revenue.

68. Do all American Indians favor gaming?
No. Some argue that the gambling operations hurt their culture, and that tribes with casinos show less interest in traditional ways and religious functions.

What is a tribal school?

69. What is a tribal school?
Since the early 1800's, the Bureau of Indian Affairs assumed responsibility for the education of children on reservations through Indian schools. In 1978, the federal government began turning over school control to the tribes, while still providing oversight and funding. Today the bureau funds or operates 187 schools with 50,000 students.

70. How many American Indian students attend public schools off the reservations?
About 480,000 American Indian children attend public schools off reservations. Some states with large populations of Indian schoolchildren provide fund for Indian language and cultural education.

71. How many American Indians are high school graduates?
In 1990, 66 percent of American Indians who were at least 25 years old were high school graduates, according to the U.S. Census. The national figure is 75 percent.

72. What is a tribal college?
Thirty tribal colleges were developed over the past 25 years to meet the unusual educational needs of students on reservations, often located in remote areas unserved by other post-secondary schools. Most of the colleges are two-year schools that focus on local economic development and work-force training.

73. How do graduation rates for American Indians compare with the general population?
College graduation rates are lower for American Indians than any other minority group, according to the American Indian Higher Education Consortium. Only 30 percent of American Indian students completed a bachelor's degree within six years of enrolling, compared with 54 percent of all students.

74. What percentage of the American Indian population holds degrees?
Nine percent of American Indian adults had completed four years of college, according to the 1990 U.S. Census. The national average for all adults is 20 percent. Graduation rates vary greatly among tribes.

75. Do Native Americans get a free college education?
No. While some tribes offer stipends or scholarships to members, Native Americans as a group do not receive a free college education. But many students qualify for federal help and other needs-based aid, because they meet poverty guidelines for all students. Eighty-five percent of students at tribal colleges live in poverty.

76. How are tribal colleges funded?
The 1981 Tribally Controlled Community College Assistance Act provides operational funds for 25 tribal colleges. All of the colleges receive support from the U.S. Department of Agriculture as land-grant institutions, and from the U.S. Department of Education. In addition, they may receive competitive grants, foundation money and private support. But the colleges receive little or no state funds, and are not supported through property taxes as are many mainstream community colleges.

Do American Indians speak their own language?

77. Do American Indians speak their own language?
The vast majority of Indians speak English as their main language, though some know their native language as well. When Europeans first arrived here, about 350 Indian languages were spoken.

78. How many American Indian languages are still spoken?
The precise number is unknown. It is estimated that about 200 languages are spoken. Native American languages are classified geographically, since they do not belong to a single linguistic family, as the Indo-European languages do.

79. Which are the most common languages?
There is no standard American Indian language, but a number are spoken regularly by the larger tribes, such as Navajo (spoken by 80,000) and Ojibwe (spoken by 40,000).

80. Were there written Indian languages?
Before European settlement in North America, Indian writing was in pictographs, such as the birchbark scrolls inscribed by the Ojibwe. Exposure to written European languages, including their direct study, resulted in several groups developing their own forms of writing.

81. Are American Indian languages continuing to die out?
Yes. More than a third are spoken only by elders and may not survive to the next generation, according to “the Handbook of North American Indians: Language.” Some languages are known to just two or three speakers.

82. What is being done to preserve American Indian languages?
Tribes have written language books and have created teaching tools for Indian schools. Some languages are taught in universities. In cases where the number of speakers has dwindled, a language may ultimately die out.

Is there an American Indian religion?

83. Is there an American Indian religion?
Many Native Americans believe in a Great Spirit that reveals itself through nature and influences all life. Indigenous religions also are filled with lesser spirits that inhabit the everyday world. In the 19th century, Native Americans lost many of their religious customs as colonists forced them to convert to Christianity, sent their children to mission schools and banned some of their ceremonies.

84. How many American Indians identify themselves as Christians?
In the 1990s, more than two-thirds of Native Americans characterize themselves at least nominally as Christians. Others combine Christian beliefs with their native religions or practice two separate faiths.

85. Are Native Americans free to practice their native religion?
Until the 1930s, the United States tried to ban Naïve American religious rituals, including the Ghost Gance, sun Dance and peyote cult. In 1978, Congress passed the American Indian Religious Freedom Act, and official expression of goodwill toward Native American spirituality. Many religious practices once considered on the verge of disappearing were revived. These include pipe ceremonials, sweat lodges, vision quests and Sun Dances.

86. Where do Native Americans go to worship?
In many types of Native American spirituality, followers do not consider their practices a religion, nor do they rely on an institution to worship. Instead their beliefs are an integral part of daily life. Prayers have taken a variety of forms, including songs and dances and acts such as sprinkling tobacco or corn meal.

87. What is sweat lodge?

Much like a sauna, sweat lodges are heated by fire or by pouring water over hot stones. Sweat lodges are used by some Native Americans to induce sweating for medicinal and spiritual purposes.

88. What is a vision quest?
In some traditional native religions, Indian boys performed certain rituals, including meditation and fasting, in order to receive a vision to guide them into manhood and for the rest of their lives. Sometimes they separated from the tribe and entered the wilderness to seek a guardian spirit.

89. How does tobacco figure in American Indian religion?
Tobacco has been regarded as the most sacred plant, used in Indian religion, medicine and diplomacy. Smoking at gatherings was a symbol of hospitality. Sharing a pipe sealed treaties, and sprinkling leaves ensured a good harvest. Ritualistic use of tobacco continues today.

90. Did Native Americans learn about tobacco from white settlers?
On the contrary, Native peoples introduced tobacco and the pipe to white explorers. Native Americans had been smoking tobacco for a thousand years or more by the time Columbus returned to Spain with some leaves, and its use spread across Europe.

What is peace pipe?

91. What is a peace pipe?
When various tribes dominated North America, carrying a pipe was evidence of peaceful intent, a passport universally honored, according to “A Guide to America’s Indians.” White explorers carried “peace pipes” for chance meetings with Indians.

92. Why is an eagle feather significant to American Indians?
Certain symbols, including the eagle feather, seem to be universal in their importance to the various tribes. The eagle is revered for its strength, size and intelligence. Its feathers are used in religious ceremonies.

93. How do American Indians obtain the feathers of a protected bird like the eagle?
The U.S. fish and Wildlife Service administers a program that makes the feathers available to Indian religious practitioners. The feathers are from eagles that die naturally or by accident.

94. What is a medicine bundle?
It is a collection of objects believed to heal disease and ward off enemies. Traditionally, individuals, households and villages kept medicine bundles for self-protection. The bundles might contain herbs, stone, pollen, horns, bone teeth and feathers.

95. Why do Native Americans object to the use of Indian symbols, like feathers and face paint, in U.S. sports?
Many Native Americans believe the use of Indian symbols by sports teams and fans trivializes their way of life. For example, some Native Americans take offense when fans paint their faces at football games. In traditional native cultures, face-painting is reserved for sacred ceremonies that include weddings and funerals.

96. What is a pow wow?
Pow wow comes from the Narragansett word for shaman. It is a celebration and social gathering, honoring sacred Indian traditions through dancing, drumming, singing and the gathering of people. Pow wows may be held to honor an individual or for a special occasion. Most commonly, the pow wow is a social event.

97. Are non-Natives welcome at pow wows?
There are ceremonial pow wows that are closed to non-tribal members, but everyone is welcome at a publicized pow wow.

98. What are teepees?
The teepee, or tipi, was a dwelling used by nomadic Plains tribes. Made from buffalo hides, it was stretched over a cone formed by poles, which made it strong and easy to move. Similar to the teepee, the wickiup was used by tribes in the south. It was made from brush secured over arched poles. The wigwam of the eastern woodlands was a domed or conical frame covered with bark or mats. The traditional dwellings are no longer used as shelters.

99. Why do American Indians object to the commercial use of the Crazy Horse name?
Many Indians believe that using Crazy Horse to sell malt liquor exploits Indians and distorts the image of a revered leader. Crazy Horse was the Sioux leader who militarily resisted the encroachment of whites in the Black Hills of South Dakota and joined Sitting Bull in the defeat of Gen. George A. Custer at Little Bighorn in 1876. Crazy Horse was unarmed when he was stabbed to death, while being held at a federal prison camp.

100. How can a person trace his or her Indian ancestry?
The first step is basic genealogical research to obtain specific information on ancestors' names, birth dates, marriages and deaths, and places where they lived. The next step is to find out if ancestors are on official tribal rolls. For information, write to the National Archives and Records Administration, Natural Resources Branch, Civil Archives division, 8th and Pennsylvania Ave. NW, Washington, DC 20408. After determining tribal heritage, individuals should contact individual tribes to learn about membership. Tribes have the final determination on who qualifies.

Research: Exploring Issues Facing American Indians and Alaska Native Communities

The dearth of research in American Indian and Alaska Native Communities leads to misinformation, stereotyping, misdiagnosis and mistreatment of AI/AN people with mental illness. Organizations like the National Center for American Indian and Alaska Native Mental Health Research are trying rectify this situation with community-based research that illuminates the tremendous barriers to care. The following articles provide a glimpse of the many issues that need to be addressed if AI/AN people are to achieve equity in mental health treatment and care. In reaching out to American Indians and Alaska Native, NAMI chapters will benefit from understanding the specific challenges facing these communities.

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DENVER AMERICAN INDIAN MENTAL HEALTH NEEDS SURVEY

Jeff King, Ph.D.

Abstract: American Indians are at higher risk for mental health problems than other ethnic groups in the United States (Nelson, McCoy, Stetter, & Vanderwagen, 1992). Little attention has been directed towards assessing mental health problems among urban American Indians. In response to an Indian Health Service (IHS) call for proposals, this survey addressed the mental health needs of Denver urban American Indians. The purpose of the survey was to gather data from Denver American Indian adults and adolescents as well as service providers in the Denver area who work, to one degree or the other, with members of the American Indian community. These data were to provide a general idea of the breadth of mental health and other associated problems among the Denver American Indian population.

Demographic Profile For Denver American Indians

The estimated population for American Indians living in the Denver metropolitan area is 20,000 (Source: Catchment Area Population Estimates, extracted from Colorado Division Local Government [DLG], 1991). Most of the American Indian population live in or near the downtown area, although there is not an "American Indian community" by locale. The survey totals for youth and adults (442) was approximately 2% of this population. Denver American Indians comprise about 0.9% of the Denver metro population.

The term American Indian will be used for description of the Native population. A second term, Native people will also be used.

Survey Design

Three mental health questionnaires were developed for: American Indian adults, American Indian adolescents, and service providers. The survey items were derived from a number of mental health and health surveys (American Indian and non-American Indian) from various areas in the United States. The early drafts were critiqued for their readability and content

appropriateness for Denver American Indians by American Indian professionals in Denver. Items were deleted, added, and modified accordingly.

Survey administration began in March, 1992 and ended in August, 1992. Professionals and agencies in the Denver American Indian community were very willing to help out in the administration of the surveys. Survey administrations took place at: Title V (American Indian Education), the Denver Indian Center, Denver Indian Health and Family Services, the Spirit of the Rainbow project, and at a Health Fair at the Denver Indian Health and Family Services. Flyers regarding the survey were posted at all three places, and a write-up of the study and information about obtaining and completing a questionnaire appeared in the Title V newsletter. Service provider questionnaires were given out to American Indian Child Welfare, Win'Yan'Was'Aka (Domestic Violence program), American Indian Health Education program, Vision Quest, and the American Indian Alcohol and Substance Abuse Prevention program.

There were many difficulties in accessing the Denver American Indian population. The American Indian population is spread out throughout the city. Therefore, the use of Title V, DIHFS, and the Denver Indian Center only reached a small portion of the 20,000 or so American Indian residents. Furthermore, American Indian adolescents were extremely hard to locate. Title V coordinators were contacted throughout the Denver metropolitan area and consistently reported that there were no schools which contained a large number of American Indian students. There was no easy access to these adolescents. The small number of actual completed surveys reflects this difficulty. This paper will focus specifically on the sample of American Indian adults.

Methodology

The survey design focused on three primary sampling domains. Phase One focused on the urban American Indian adults, Phase Two focused on urban American Indian adolescents, and Phase Three addressed the service providers. The survey sample is not a representative sample. Rather it is a sample of convenience. However, it is thought that the sample obtained is composed of those most likely in need of mental health services. The demographic information described later will clarify this notion. From the beginning, this survey was considered to be a community effort. Many of the questions were obtained from community members. Early drafts were submitted to American Indian professionals and non-American Indian professionals who work in the American Indian community for their input and criticism. The various American Indian agencies in Denver participated in the survey distribution and administration.

The survey design focused on three main domains of mental health: (a) personal problems past and present, (b) problems experienced by household members, and (c) perceptions of problems existing in the

community. Within these domains, questions were asked regarding psychological problems, personal trauma, and substance abuse. Questions pertaining to service utilization were also asked. These asked if services were sought and if so, which services; and if not, reasons for not seeking services. Other survey questions asked respondents questions about ethnic identification and to list what they viewed as the critical mental health needs for the Denver American Indian community.

Participants were provided with a cover sheet to the survey which served as an informed consent. This cover sheet briefly explained the purpose of the study and the confidentiality of the respondent's answers. They were told that the consent sheet they signed would be placed in a separate pile from the questionnaire so that there would be no way to link their name with their survey. Adults were reimbursed $5 and adolescents $3 for their participation.

Statistical Procedures

Since the overall goal of the survey was to gain a breadth of perspective, statistical procedures were descriptive in nature. There are considerable data in which more in-depth analyses could be made, and hopefully this will occur in the near future. However, the focus of this survey is to provide frequencies of the various mental health and related problems in the Denver American Indian community. In this paper, descriptive data is provided for the adult American Indian sample.

Results

The following results are those thought most useful to readers. Full descriptive data from the survey are available upon request to the author.

Sample

Survey participants included 374 adults from the Denver urban areas. There were 205 females, 165 males, and 4 did not indicate their gender. Ages ranged from 17 years to 71 years old. The average age of the adult respondent was 34 years old. One-hundred-fifty-eight adults reported being single, 74 married, 57 divorced, 43 living with someone, 27 separated, 12 widowed, and 3 did not indicate their marital status.

Family Size

Although 78 persons reported having no children, almost 80% of the sample reported having at least one child. The average number of children was almost two and a half. Number of children here did not necessarily mean number of children still with the parent. Sixty-five percent of the households have children in them. The average number of children per household is approximately one and a half.

Tribal Enrollment

Most participants were tribally enrolled (91%). Almost half (47%) were from South Dakota, 11% from Oklahoma, and there were smaller numbers from eighteen other states.

Degree of American Indian Blood

Eighty-five percent of those sampled reported being at least 1/2 degree of American Indian blood. A high percentage of the respondents (51.9%) reported being full-bloods.

Education

Over half of the survey participants have completed at least a high school education. However, approximately one out of four of the respondents (26.6%) did not finish high school.

Years in Denver

The average amount of time lived in Denver was ten years. However, the range was quite broad, with the highest number of respondents having lived in Denver less than one year (14.4%), and the second and third highest reporting one and two years residency respectively. More than one-third of the respondents have lived in Denver two years or less.

Employment

Only 18% of the sample reported having a full-time job. Twenty percent reported having part-time jobs and 58%, a majority of this sample, were unemployed.

Income

Almost 70% of those sampled reported annual incomes of less than $10,000. The second highest frequency (12%) were those reporting incomes of $10-15,000. Combined, 80% of the American Indian adults surveyed had incomes of less than $15,000 per year (Table 1). This result may reflect some of the sampling bias, as it seems that more affluent American Indians living in Denver did not participate in the survey.

General Health Care

Almost half of the sample did not know how to find the medical information they needed.

Table1
Total Yearly Household Income

Annual Income	Frequency	Percent
10,000 or less	255	68.2
10,001-15,000	45	12.0
15,001-20,000	24	6.4
20,001-30,000	24	6.4
30,001-40,000	11	2.9
40,001 or more	7	1.9
MISSING	8	2.1
TOTAL	374	100.0

Personal Problems

Substance Abuse

Almost two-thirds (61.2%) of those surveyed reported having at one time or other an alcohol or drug problem. Of those that had an alcohol or drug problem, 66% sought help and 34% did not. Those that sought services reported contacting agencies specializing in substance abuse treatment. The agency most sought out was an American Indian alcohol treatment program (19%).

Foremost reasons for not seeking help were either wanting to work the difficulty out without asking for help, disbelief in helping systems, financial barriers, and lack of knowledge about available services. A number of the higher frequency items appear to relate to a distrust of service systems (e.g., didn't want services, didn't think it would help, wouldn't understand American Indian ways).

Psychological Problems Ever

Fifty percent of those surveyed reported having experienced depression at one time in their lives. Second highest frequency was marital problems, followed by anxiety, and almost one out of five individuals reported experiencing suicidal thoughts or making a suicidal attempt. Of those who reported experiencing psychological problems, 56% sought out help and 44% did not. The church and traditional methods were the help most often sought. This demonstrates the importance that many American Indians place upon spirituality as part of their healing process.

Reasons for not seeking help included: not wanting services, did not think services could help, did not know of services, and could not afford

services. These responses suggest a possible distrust of service systems as well as an inability to pay for treatment.

Personal Trauma Issues Ever

There was a high prevalence of personal trauma among this sample of the American Indian population in Denver. Almost two-fifths (37.2%) have been victims of spouse abuse, 12% reported being victims of child abuse or neglect, and 10% reported having been raped or sexually abused. Of those reporting some sort of trauma, almost half (48%) did not seek treatment. Service providers most sought were the church (8%), police (8%), and social services (7%).

Reasons for not seeking help included: believed I should work it out myself (10%), didn't know of services (8%), didn't think it would help (8%), and could not afford services (7%).

Psychological Symptom Scale

This set of items addressed current psychological and financial problems (Table 2). Listed are those problems which occur weekly or more often. Overwhelmingly, the foremost problem reported was financial difficulties (65%). Second to financial problems were family problems (35%). Feeling overwhelmed (29%) was the third most reported symptom. Of concern also were the next five items in which almost one in four reported experiencing at least once per week: anxiety (28%), overeating (28%), angry or bitter feelings (26%), and loneliness (25%).

Household Problems

Psychological Problems

These questions asked whether or not anyone living in the respondent's home had experienced any kind of psychological problem. Respondents reported only 32% of household members experienced depression. This is lower than the 50% reported by individuals about themselves. Responses for others in household tended to be lower or about even to the individual problem categories: anxiety reported at 14%, and suicidal thought/attempts also 14%.

Again, about 50% sought help for their problem(s) and about 50% did not. Household members tended to use the hospital more frequently than the individual, but also exhibited a strong trend toward traditional healing methods and agencies which served the American Indian population.

Personal Trauma

These are traumatic events for persons living in the household of the person filling out the questionnaire. Reports here are lower than those

Table 2
Problems Which Occur Weekly or More Often[1]

	Frequency	Percent
Financial Problems	244	65.2
Family Problems	131	35.0
Overwhelmed	118	28.9
Anxiety	105	28.1
I Eat Too Much	104	27.8
Angry or Bitter	98	26.2
Lonely	92	24.6
Depressed	88	23.5
Physical Problem	87	23.2
Drink Too Much	83	22.2
Guilty	76	20.3
My Thoughts Race In My Mind	76	20.3

[1]Psychological symptom scale—occurring weekly or more often—among 20% or more of Adult Sample.

of the individuals themselves, but this may be due to victims not telling others about what happened. Twenty-five percent indicated household members had been victims of spouse abuse, and 10% reported household members having been abused or neglected as children. Help-seeking falls in the 50-50 ratio, with half of the sample reporting seeking help for their problems and half not seeking help.

Services most sought were social services (9%), police (7.5%), and church (6%). Reasons for not seeking help were similar to previous answers: did not think it would help, could not afford services, didn't know of services. Also included as reasons were fear of repercussions: afraid of what might happen, and afraid that others would find out.

Mental Health Problems For American Indian Community

This question is directed to the individual's knowledge about people in the broader American Indian community. Community problems reported were: alcohol abuse (69%), unemployment (56%), financial problems (52%), youth runaway problems (48%), drug abuse (45%), spouse abuse (40%), school problems (38%), depression (35%), and child abuse/neglect (28%). Although unemployment and financial problems are not mental health problems directly, they were included because of their significant link to problems in mental health.

Counselor Preference

Client Comfort Level

Regarding mental health treatment, questions asked about client comfort level and counselor preference. Given that 50% of the American Indian people sampled said they did not seek help for their problems, one of the possible reasons is distrust for the dominant culture's type of care provision. If American Indian people are not comfortable talking about personal issues with White people, it makes sense that they do not access services provided by predominantly White-staffed agencies. Almost two-thirds (61.2%) of those sampled reported that they felt uncomfortable talking with Whites about personal issues, while 36% reported no discomfort.

Counselor Preference

In terms of actual preference for counselor ethnicity, the percentage is similar to the previous question: two-thirds indicated they would prefer an American Indian counselor, 27% indicated that it did not matter, and only 4% said no to preferring an American Indian counselor.

Traditional Healers

The use of traditional methods of healing is still very important to the American Indian community. On this item, over half reported that they wanted to see a traditional healer over the past year.

School Testing

Another realm for cultural issues in mental health is with the testing of our children at school. Very little attention has been directed at this area, and perhaps none directed at asking the parents how they feel about testing for their children at school. Most adults (83%) indicated no real problems with school testing. Approximately 20% had at least some reservations about testing for American Indian children.

When it came to fairness in school testing a greater number of adults felt testing was unfair (46%), while (51%) felt tests were fair for American Indian children, (3%) responded "don't know."

Eighty-three percent of the respondents indicated they would prefer examiners who were sensitive to American Indian cultural issues. Only 10% of the sample indicated they would not like testing to be carried out by someone familiar with American Indian culture.

Community Input on Mental Health Prevention
-Perceived Availability of Services

Approximately one-quarter to one-third of those sampled felt that most of the services listed below were not available to them or other American Indians. The five services most endorsed are listed in order: marriage and family counseling (38%), a mental health center (34%), educational testing (33%), self-help groups (33%), family therapy (31%), and emergency home visits (31%).

Ninety percent of respondents said they would use these services if they were available. This finding must be contrasted with the other finding that only 50% have sought help in the past.

In terms of which services respondents would use, the primary characteristic appeared to be culturally sensitive and traditional methods (58%). However, they also indicated a willingness to use: individual counseling (52%), financial counseling (51%), stress management (41%), substance abuse education (37%), help with self-esteem (37%), and family counseling (36%).

Current Problem Areas For Denver American Indian Community

This question addressed broader issues than just mental health that the individual feels are current problems in their life. Again, finances were by far the most frequent problem. Second and third were housing and jobs—both related to financial problems. Fourth was alcohol, and interestingly racial prejudice was reported by 26% of those sampled as a current problem.

Activities Needed In American Indian Adult Community

A significant proportion of those surveyed reported the need for American Indian social workers (66%). The other responses focused on social networking of one sort or the other: organized recreation (47%), community meetings (46%), transportation (45%), a newsletter (37%).

Activities Needed In American Indian Youth Community

Activities for youth were also much in need. Adults most often reported the need for instruction in cultural heritage for the youth (66%). Second was the need for tutoring (46%). This is not too surprising, given that nation-wide American Indian students have the highest drop-out rates for any ethnic minority group. All of the following were endorsed by a large portion of the adults surveyed: someone to listen (43%), summer jobs (40%), substance abuse counseling (36%), recreational activities (34%), a youth center (34%), general counseling services (23%).

Family Services

Sixty-six percent of adults surveyed felt the need for protection of children from violence and 55% indicated the need to protect children from neglect. This indicated a note of serious concern by the community for the welfare and well-being of American Indian children. Other responses included: parenting classes (43%), American Indian foster homes (38%), domestic violence prevention (38%), and child protection (36%).

Cultural Identity

This part of the survey addressed level of cultural affiliation for this sample (Table 3). Eighty-four percent of the sample reported identifying with American Indian culture "sometimes" or "often," as compared to responses of "a little" or "not at all." This suggests that most of the Denver American Indian community has strong ties with their culture. Mental health services must recognize this fact and tailor their services to the cultural aspects of this population.

Summary

It is difficult to summarize such a broad range of areas related to mental health. Acknowledging this difficulty, a general profile for the Denver American Indian community will be described. This profile suggests the target areas and concerns for mental health efforts in the city of Denver.

Table 3
Cultural Identity[1]

	Frequency	Percent
How much do you identify with Indian culture?		
A lot	194	51.9
Some	106	28.3
A little	47	12.6
Not at all	8	2.1
How much do you identify with White culture?		
A lot	48	12.8
Some	140	37.4
A little	103	27.5
Not at all	67	17.9

[1]Note: Percentages do not equal 100% because of missing responses.

DENVER MENTAL HEALTH NEEDS SURVEY

The American Indian population in Denver is poor. Most of the community lives below, or close to the poverty line for annual income ($14,000 per household of four). Many of these residents are new to Denver (moved here within the last two years). The major problems besetting this group are financial and job related. Unemployment is extremely high, therefore finances are slim and housing situations leave much to be desired. Research has demonstrated that these sort of socioeconomic conditions contribute significantly to increased mental health problems.

Over half of the Denver American Indians surveyed have experienced some kind of mental health problem in their lives, with approximately 30% currently experiencing at least weekly symptoms of psychological problems. There is reported widespread problems for domestic violence, child neglect and abuse, spouse abuse, and marital and family problems. Basically, most areas of mental health difficulties included in the survey show high rates of occurrence within the Denver American Indian community.

Even though there are high occurrences of mental health problems in the Denver American Indian Community, more than half of those people experiencing these problems do not seek help. Those that do seek help tend to first consult with someone from church or traditional healing methods/ persons. Lack of affordable mental health care also prevents getting help.

All this suggests that many in the American Indian community are distrustful of the broader mental health provider agencies and want American Indian providers or at least providers who are sensitive to American Indian culture. This finding has been noted elsewhere (Neligh, 1990). It is striking that over 90% of the American Indian adults surveyed indicated they would use mental health services if they were available.

The need clearly is for American Indian mental health providers with a broad range of expertise to serve the Denver American Indian community. There are dire needs at all levels of mental health care. Some of these levels are: family, marital, adult, adolescent, and child therapies; school-related, court-related, Social Services-related, and American Indian Child Welfare-related interventions; psychological, developmental, and learning disability testing; child-custody evaluations; interventions for domestic violence, spousal abuse, child physical and sexual abuse; alcohol and drug related case management; psychiatric care for medication evaluations and monitoring; and community level interventions such as prevention, and information dissemination.

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NORTH AMERICAN INDIAN ALLIANCE MENTAL HEALTH NEEDS ASSESSMENT REPORT

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Abstract: The North American Indian Alliance (NAIA), located in Butte, Montana, conducted a mental health needs assessment from December, 1991 to June, 1992. The goals of this assessment were to identify unmet health needs, obtain input regarding the need for additional services, and identify barriers to providing and accessing services. Surveys of mental health service providers (n=30) and consumers of NAIA services (n=74) were conducted. The results of these surveys and their implications for service provision are explored.

The North American Indian Alliance (NAIA), an urban American Indian Health Program, is located in Butte, Montana. The NAIA is a non-profit organization that provides a limited realm of services to the approximate 1,000 American Indians within the Butte-Silver Bow counties. It began operation in 1969 through the initiative of community members identifying a need for American Indian services. Program operations and policy decisions are made by a seven member Board of Directors. The primary purpose of the NAIA is to promote health, educational, economic, social, and cultural development of American Indians in the Butte-Silver Bow urban community. The current staff consists of the director, a health coordinator, a data coordinator, two chemical dependency counselors, an education and prevention facilitator and a number of volunteers. The alliance also serves as an advocate for American Indians within the Butte-Silver Bow community, to facilitate and promote a better awareness of the American Indian culture.

The location of the NAIA places it further away from any American Indian reservation than any other IHS program in the state of Montana. The closest reservation is the Flathead Reservation, located about 180 miles northwest of Butte. Thus, while other urban American Indian health programs have easy access to referral services on reservations for eligible consumers, the NAIA continues to attempt to operate without that benefit. There is limited information available concerning the need for mental health services among American Indians residing in the Butte-Silver Bow communities. Therefore, a mental health needs assessment was conducted to identify

health needs that continue to be unmet, obtain input related to what kinds of programs and services are needed, and identify barriers to providing and accessing services.

Methods

The NAIA Mental Health Needs Assessment was conducted from December, 1991 through June, 1992. Two separate surveys were conducted of: (a) Mental Health Service providers within the community, and (b) consumers of NAIA services.

An estimated 515 males and females, 15 years of age and older, used NAIA services within the past year. This is almost 100% of the 519 American Indians found to be residing in the Butte community by the 1990 U.S. Census. These consumers were determined to be the most appropriate sample to identify American Indian community mental health needs. However, to capture data from individuals who may have other unique needs, the questionnaire also was completed by American Indian individuals in the Butte Pre-release Program. The Butte Pre-Release is a transitional living facility for state prisoners who are in the process of becoming paroled by the State of Montana's correctional institution. At best three males and three females were interviewed.

A stratified (by sex) systematic sample with a random start was selected from the list. An estimated sample size of 81 was expected to yield resulting data within the 95% confidence level, + or - 10%. However, in consideration of the response rates in past face-to-face, community based studies in the urban American Indian population of between 62% to 73%, a slightly larger sample was drawn (50 males and 50 females). This sample size represents approximately 20% of the Butte American Indian population, according to the 1990 U.S. Census. This information was taken from the Department of Vital Statistics records in Helena, Montana.

Separate questionnaires were developed for use in interviewing providers and consumers. Questionnaires were completed through the use of face-to-face household interviewing. A contract male interviewer arranged and completed the interviews.

Results

Survey of Providers

Of the 55 Mental Health Care Providers in the Butte Community, 35 were offered the opportunity to participate. As a result of difficulties in scheduling interviews with the providers and the six month time frame for the survey, 30 actually completed questionnaires.

Provider Characteristics

Seventeen percent of the respondents reported being in the Medical Professional group, indicating that they were physicians, psychiatrists, or psychologists. Fifty percent reported being in the Mental Health group, indicating that they were social workers, chemical dependency counselors, or mental health workers. Twenty-three percent reported being in the Human Services group, indicating that they may be social workers or referral sources such as in-take counselors, etc. Ten percent reported being in the "other" group, which included physicians and other professional/paraprofessional health providers who were not directly involved in the treatment of mental illness. Seventeen percent of the respondents reported being American Indian.

Children's Services Offered

Sixty-three percent of the respondents offered crisis services; 47% offered outpatient services, 50% offered inpatient services, 10% offered residential services, and 33% offered other types of children's services not specifically listed in the questionnaire. These included prevention and early intervention, aftercare, evaluation, education, parenting classes, adolescent support groups, cultural education, child abuse and neglect investigative services, and referral services.

Adult Services Offered

Forty-seven percent of the respondents offered crisis services, 16% offered outpatient services, 4% offered inpatient services, 3% offered group home/transitional services, and 11% offered "other" kinds of services not specifically listed in the questionnaire. These included prevention and intensive outpatient early intervention, family therapy, ACT (drivers education related to convictions for driving under the influence of alcohol), parenting classes, cultural education, chemical dependency education, health education, adult abuse and neglect investigative services, and referral services.

American Indian Client Population

Eighty percent of the respondents reported that 25% or less of their client population was American Indian; 13% reported that between 25% and 50% of their client population was American Indian, and 7% reported that between 75% and 100% of their client population was American Indian. Thus, most of the providers surveyed do not specialize in the treatment of American Indians.

Contacts with American Indian clients are made by: (a) self referral 47%, (b) referral from agencies such as Social Services or Department of Family Services 15%, (c) referrals from hospitals or reservations 8%, (d) during inpatient treatment 7%, (e) during project work 5%, (f) at the

Community Health Center 5%, (g) during community outreach visits 3%, (h) in client work environments 3%, (i) when visiting American Indian homes 2%, (j) during agency meetings 2%, (k) in the schools 2%, and (l) during visits to the emergency room 1%.

Referral Practices

Seventy-seven percent of the provider respondents reported that in their client encounters they refer American Indian clients to other agencies; 23% reported that they do not. The agencies clients are referred to: (a) NAIA 67%, (b) Human Services 13%, (c) Probation Services 5%, (d) family planning services 4%, (e) safe houses 4%, (f) Mental Health Services 3%, (g) foster care 1%, (h) American Indian Health Service 1%, (i) specific tribal services 1%, and (j) Alcoholics Anonymous 1%.

The reasons given by respondent providers for referral of clients included: (a) the agency they referred clients to had access to reliable supportive resources in a variety of areas, (b) placement, (c) investigation, (d) obtaining benefit from other programs for which they are eligible, (e) obtaining additional specialty services/treatment, and (f) at the request of patients and/or their families.

Knowledge of and Referral to NAIA

Ninety percent of the provider respondents indicated that they knew about the North American Indian Alliance. When asked about their awareness of specific services offered by NAIA, 77% of providers were aware of the Chemical Dependency (CD) Counseling program, 63% of the Health Education/ Prevention program, 50% of the Job Training Partnership Assistance program, 73% of the Youth Chemical Awareness program, and 57% were aware of the Youth Cultural Awareness program. Slightly more than half (54%) of the provider respondents reported that they made referrals to the NAIA.

Provider Perceptions of How the Mental Health of American Indians Differs From the General Population

Seventy-two percent of the provider respondents reported that they felt the mental health of American Indians is different than those of the general population. The following are examples of the differences they described:

1. While classic mental illnesses will have similar symptoms in both subpopulations, the American Indian community may be negatively affected to a larger degree because of the lack of economic resources available to treat the individual. This may be further complicated by the fact that American Indians are more likely to have to rely on treatment from public facilities, which may not be necessarily the best source of treatment for their specific illnesses. In addition, we may be attempting to treat social problems and

political problems as mental health problems; in which case, it is not the individual who needs appropriate treatment, but the situation.

2. American Indians often have cultural, religious, and often social, values and beliefs that are much different from, poorly understood, and ultimately accepted, by the general population. Not only do these differences create problems between subgroups, but often the expectations of families and communities create a conflict within individuals to meet personal and social needs. Thus, not only are the mental health needs different, or greater, but require an approach that is different than the general population, includes a genuine sensitivity, and considers the more traditional holistic approach.

3. The transitional period involved in moving from the reservation to the urban community has a tremendous impact on the mental health of American Indians. The stressors of leaving an area that they were raised in and support groups they have grown accustomed to and trying to fit into the general population and be productive, without the familiar coping skills and support systems, would adversely impact most individuals, but is magnified in the American Indian for a variety of reasons. Those reasons are not only related to cultural, religious, or social differences, but the result of human responses to changes in socialization, poor assimilation into unfamiliar and different settings, etc. It often leads to loss of identity, and resulting loss of self-esteem, etc.

Suggested Improvements to the Mental Health Care System

Providers were asked to suggest ways to improve the delivery of mental health services to American Indians. Suggestions included: (a) use of American Indian mental health workers, (b) improved interaction and communications with tribal agencies, (c) improve non-Indian provider knowledge of services offered and how to access them, and (d) more outreach and targeted case management.

Provider respondents were also asked to suggest the types of education and information that would enhance their knowledge, awareness, and sensitivity to the American Indian community. Suggestions included: (a) demographic information about the population, (b) information on experience of American Indian women and their relationship to American Indian men, (c) training on cultural networking, (d) cultural training workshops, (e) listings of resources available to American Indians, (f) information about what the NAIA does and the services offered, and (g) interagency meetings that included cultural education and presentations by spiritual leaders.

Survey of Consumers

Of the 50 males and 50 females randomly selected as the sample, 44 males and 30 females agreed to participate. This resulted in an overall response rate of 74% (88% for males and 60% for females).

Population Characteristics

Age: The age of the respondents ranged from 17 to 79 years of age, with an average age of 37 years. Females were slightly older than males, with average ages of 39 and 36, respectively.

Marital Status: One-quarter of both the females and males were currently married or living with someone. Twenty-five percent of the males and 10% of the females had never been married or lived with anyone. Males and females reported that they have been married or lived with someone an average of 3 and 2 times respectively.

Size of Household: Males reported having a range of between 1 and 6, with an average of 2.2, people living in their household. Females were similar with a range between 1 and 5 and an average of 2.3 people in the household.

Education: Over a third of the males and females (39% and 33%, respectively) reported to have completed their high school or equivalent education (G.E.D. or Vo-tech). And, slightly more males (19%) than females (13%) reported having some college education.

5. *Income:* A quarter (25.8%) of all the respondents reported that they had received less than $2,000 as total family income during the past year. Males were more prevalent in this low income category than females (34% and 13%), respectively. Ninety percent of the males and 86.4% of the female respondents reported receiving less than $10,000 in total family income during the last year.

Employment Status: Part of the reason for the low levels of total family income reported may be the employment status of the respondents during the last 12 months. Only 14.6% of the males and 13.3% of the females reported being employed at least part-time during the past year.

Other Assistance: When asked if they received benefits from other subsistence assistance during the past year, 52% of the respondents reported receiving some kind of alternate subsistence assistance. Eighty percent of these respondents received Aid to Families with Dependent Children, 20% received food stamps, 18% received Medicaid, 15% received General Assistance (State Welfare), 14% received some other assistance, 8% received Social Security, and 4% received Human Resources or Commodities.

Of the 14% reporting that they received other assistance, 21% received disability compensation, 14% received Energy Assistance, 14% received VA pensions, 7% received American Indian Per Capita, 7% received Medicare, 7% received Railroad Retirement, 7% received Unemployment Compensation, and 7% received assistance from the North American Indian Alliance.

Mobility: When asked how long they have lived in Butte, the respondents indicated a residence of between 1 and 79 years; with an average residency of 21.4 years. When asked how long they have been living off a reservation, the respondents reported a range of between 3 and 50 years;

with an average of 18.9 years. Nineteen percent of the respondents reported that they have never lived on a reservation.

Mental Health Needs

Talking About Problems: When asked who they usually talked to when they had problems, 23% of the females and 16% of the males reported that they didn't discuss their problems with anyone. Twenty-three percent of the females and 54% of the males indicated that they talked to friends about problems. In addition the males reported that they talked to family (26%), doctors (9%), NAIA counselors (7%), and AA sponsors (2%). When they discussed problems with anyone, females reported talking to family (37%), a minister or priest (10%), NAIA counselor (7%), doctors (3%), and other counselors (3%).

Thus, while the males and females differ slightly in who they discuss problems with, there appears to be a large percentage (23% and 16%, respectively of females and males) who do not discuss their problems with anyone. This could be the result of a variety of factors such as not being aware of who they go to, how to access counseling services, distrust, etc.

Problems Experienced are reported in Table 1. Males identified different problems than females. Sexual abuse, conflict with children, and depression were more commonly reported as problems by the female respondents. Adult alcoholism, teenage drinking, legal problems, and marital problems were more commonly reported as problems by the male respondents.

Frequently Experienced Problems: Problems respondents identified as experiencing at least on a weekly basis are reported in Table 2. Financial problems were the most commonly reported problems by both men and women. The next most commonly reported problems for males were social withdrawal, difficulty sleeping, feeling angry/bitter, and family problems. The next most commonly reported problems for females were difficulty sleeping, spouse/family member abuses, alcohol/drugs, feeling angry/bitter, and family problems.

Perceived Problems for the American Indian Community are reported in Table 3. Almost all the respondents identified employment and over two-thirds identified domestic violence as problems for the community. As was the case when asked to identify personal problem areas, males endorsed different problems than females. Drug abuse, racial discrimination, alcoholism, and teenage pregnancy were perceived as problems for the community by females. Access to medical care, marital conflict/divorce, law enforcement, school, and sexual abuse were perceived as problems for the community by males.

Desired Programs/Services are reported on Table 4. A majority of respondents of both genders reported an interest in using all the services listed except for group and family counseling. The "other" services seen as useful by the female respondents were pastoral services and schooling.

Table 1
Problems Experienced

Problem Area	Males		Females	
	n	%	*n*	%
finances/money	46	93	45	90
adult alcoholism	40	82	37	67
jobs	12	75	37	67
teen-age drinking	33	66	17	33
depression	29	59	36	73
health problems	26	52	21	43
conflict within family	25	50	31	63
drug abuse	24	48	24	47
social services system	23	46	24	47
school dropout	23	46	18	37
legal problems	20	39	3	7
racial prejudice	20	39	21	43
marital problems	18	36	6	13
housing	17	34	20	40
adjustment to city living	11	23	8	17
suicide	7	14	15	30
conflict with children	7	14	13	27
child abuse	7	14	1	3
sexual abuse	3	7	10	20
elder abuse	1	2	0	0

Respondents interest in workshop opportunities is summarized in Table 5. A majority of the respondents expressed an interest in all of the workshops listed.

Other educational/workshop opportunities desired by the respondents included: (a) life coping skills, (b) career planning, (c) community health service clinic and mental health services, (d) dealing with social discrimination, (e) continuing educational counseling, (f) home economic skills, (g) working with senior citizens, (h) family counseling services, and (i) Native American holistic approach to problems and concerns.

Discussion

The major problems being experienced by the consumer respondents appear to focus on economics, social, and mental health areas. It becomes a vicious cycle for the 90% of the American Indian consumer respondents, who receive less than $10,000 annual income. While some of their basic subsistence needs may be supplemented through food stamps, commodities,

Table 2
Identified Problems and Affect

Problem	At least weekly			
	Males		Females	
	n	%	*n*	%
financial problems	31	62	35	72
social withdrawal[1]	26	54	15	31
difficulty sleeping	23	46	22	44
feeling angry/bitter	20	40	21	43
family problems	20	40	18	37
feeling depressed[1]	15	30	11	23
spouse/family member abuses alcohol/drugs	15	30	22	45
feeling lonely	15	29	15	31
frequent back pain[1]	14	28	15	30
legal problems	12	25	10	20
frequent severe headaches[1]	10	21	15	30
feeling guilty	10	21	12	24
feeling that I'm not good/decent person	10	21	8	17
lack of appetite	10	19	13	27
feeling lack of control	8	17	14	28
too much drinking	7	14	13	27
frequent stomach aches[1]	7	14	10	20
use of drugs	1	2	3	6

[1]*Diagnostic and Statistical Manual of Mental Disorders*: Clients experiencing at least 5 of these criteria for 2 weeks, representing a change in previous function, may be clinically depressed.

etc., the need to seek out and apply for benefits from these special programs often adversely impacts an individual's self esteem. Thus, those who feel they have little control over their lives may seek alternate coping mechanisms, such as alcohol or drug abuse, to get away from their problems, if only momentarily. The prevalence of self-reported chemical abuse in the consumer population (82% of males and 67% of females self-reported adult alcoholism in their lives while 48% of the males and 67% of the females self-reported drug abuse as a problem in their lives) may be partially responsible for the domestic and personal violence, abuse, and problems reportedly experienced by 20% to 50% of the client population.

While there are mental health services available within the community, 80% of the provider respondents reported that less than 25% of their client population was American Indian. Only 17% of the providers surveyed identified

Table 3
Perceived Problems for the American Indian Community

Problem Area	Males		Females	
	n	%	*n*	%
employment	49	98	48	97
domestic violence	40	80	35	70
access to medical care	40	80	28	47
drug abuse	36	73	46	93
racial discrimination	36	73	46	93
marital conflict/divorce	35	71	28	57
law enforcement	35	71	13	27
alcoholism	33	66	41	83
child abuse/neglect	28	57	31	63
communication	28	57	28	57
school	25	50	0	0
finances	21	43	26	53
sexual abuse	21	43	10	20
social service system	20	41	27	53
teenage pregnancy	12	25	21	43
housing	11	23	18	37
suicide	9	18	6	13

Table 4
Desired Programs/Services

Service	Males		Females	
	n	%	*n*	%
Professional Mental Health Provider	26	52	36	73
Information/referral counseling	30	61	36	73
Individual counseling	40	80	45	90
Family counseling	23	47	40	80
Group counseling	19	39	21	43
Self-help groups	38	77	36	73
Outreach/transportation	45	89	46	93
Native American Spiritual Leader/Holy man	34	68	33	67
Other	0	0	2	7

Table 5
Workshop

Workshop	Males		Females	
	n	%	*n*	%
Stress management	30	61	41	83
Anger control	29	58	30	60
Alcohol/drug education	39	79	41	83
Parenting	32	65	35	70
Grieving/loss	27	55	36	73
Traditional/cultural activities	39	79	41	83
Financial management	37	74	40	80
Building self-esteem	39	79	46	93
AIDS/HIV education	36	72	35	70

themselves as American Indian. While needed services are available, they are inaccessible for a variety of reasons. If these consumers cannot afford to meet basic existence needs for themselves or their families, they certainly are not going to seek out services for which they are required to pay. The provider community also recognizes the barriers to access for American Indian clients, i.e., more than three fourths (76%) of the provider respondents felt that there are barriers to both providing and accessing services that would meet the mental health needs of the Butte American Indian community. These barriers include lack of American Indian providers (who may possess the cultural knowledge and sensitivity necessary to meet American Indian needs), lack of financial resources, and, the complexities of the welfare system which makes it difficult to obtain and provide necessary financial support to those American Indians in need. An additional barrier to treatment is the lack of trust American Indian clients may have for the many non-Indian providers practicing in the Butte-Silver Bow community.

Recommendations

The NAIA's Job Partnership Training Program needs to make more of a concerted effort to get American Indian clients in to provide information, guidance, and counseling in seeking out employment opportunities within the community. This program may be able to function as a referral source for those individuals who have disabilities but are able to work if given appropriate accommodation.

There is clearly a need for American Indian Mental Health Care Providers in our community. However, considering the prevalence of mental health problems reported here, it is doubtful that there will be enough American Indian providers to meet the service needs of the community. An American Indian Provider may be better used as both a conduit for referral of clients to appropriate treatment resources as well as a source of training and information to non-Indian providers about the cultural expectations, customs, and beliefs of their American Indian clientele.

The NAIA has operated in the Butte-Silver Bow community for over twenty-five years and almost the entire American Indian population of this community utilize its resources. Thus, the NAIA is in a unique position in being able to: (a) identify the mental health needs of this American Indian community, (b) provide culturally sensitive treatment, and (c) develop a referral network of knowledgeable outside providers.

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Formulating an Outreach Plan

Making the Final Decision to Conduct Outreach

In order to begin planning in earnest for your outreach activities, it is necessary to develop a consensus within your organization to embark on an outreach effort. This phase is crucial to the future development of your project. This is because outreach activities often appear attractive "in theory" to affiliate members when, in actuality, such efforts can be quite time consuming and demanding. For these reasons, it is imperative that unanimous or near-unanimous agreement exists among the membership that an outreach effort is needed and desired.

You should hold a meeting or several meetings at which the idea of an outreach plan is presented and the pros and cons of developing such an effort is honestly discussed. Be aware that some of your affiliate's members may hesitate to openly express their reluctance or disagreement with the decision to conduct outreach activities. It is important that people be given a chance to express negative feelings about the potential of doing outreach without. fear of being accused of insensitivity to the needs of AI/NA families. It is much better to allow all opinions to be heard before making the final decision to develop an outreach program. Even if the group is unable to reach a consensus about embarking on the effort, you will be aware of which affiliate members are enthusiastic and which have some reservations. Allowing everyone's opinions to be heard will help to ensure that as many members as possible "buy-into" the plan.

Identifying the Target Groups

It is important to be realistic when choosing the target community. Although your group may be quite enthusiastic, selecting more than one ethnic population to work with may drain your resources. Remember, targeting two groups involves doing twice the work. This may not be a good idea if your membership is small, if financial resources are severely limited, or if some members have lower enthusiasm than others do. Ultimately, however, the decision is up to you because you will have to live with the consequences.

In making your decision, it may be helpful to consider something we learned when conducting a national telephone survey of NAMI-affiliated minority outreach programs (Cook Knox, 1993). In that survey, representatives of outreach efforts targeting more than one group expressed reservations about their decision. First of all, only a third of the 50 programs contacted were even attempting to work with more than one ethnic group. Those that did report many problems, including their belief that targeting more than one group meant that neither group was served well.

Formulating Your Basic Outreach Plan

Your next meeting should involve members of your affiliate along with a key informant or community gatekeeper and any other members of your target community who are willing to provide you with feedback and suggestions. Identifying these key community agents is a critical part of your early planning process.

It is important to involve community members at *this* stage, in order to ensure that plans are relevant, responsive to the community's needs, and as culturally meaningful as possible. We have not suggested that community members attend the initial planning meetings, because their presence may inhibit people who are opposed to the effort from making their feelings known to the group. However, at this point, affiliate members will have been given ample opportunity to air their opinions and concerns, so that the attendance of community members can enrich the planning process without stifling opposition.

One of the most important parts of developing your outreach plan involves deciding on the major focus of your activities. Our national survey identified four basic components of outreach. The first component is education of AI/AN families about the nature of mental illness, its causes and treatment, available services and resources, and current research. The second component is formation of ethnic-specific family support groups, which are led by and focus on the experiences and problems specific to that community. The third component is recruitment of community members into the local and national NAMI organizations. Finally, the fourth component is advocacy on behalf of mentally ill people and their families through lobbying for better services and a more responsive mental health system.

Your particular outreach program can include one, several, or all of these components. In a NAMI national survey, we found a diverse mix of components in the different outreach programs studied. Interestingly, every one (100%) of the programs we surveyed reported that their outreach efforts included an educational component. Over half of all affiliates (56 %) surveyed reported that their activities involved efforts to recruit people of color as members of the local and/or national NAMI organization Over half (55 %) of the programs surveyed included the formation of ethnic specific support groups. The least frequent component of outreach programs was advocacy, reported by 40% of all respondents.

The decision about which components to include in your plans is totally up to you. It is important to solicit the opinions of your community members to help you make this decision. For example, they may feel that establishing support groups is more important than recruitment. A sole focus on recruitment may convey the impression that you are only interested in increasing the size of your dues-paying membership and not in meeting the needs of your target community. Also, members of your target group may not have the financial resources to pay affiliate dues. If recruitment is a major goal of your project, consider offering free membership for a year to demonstrate your sincerity and give people an opportunity to see what you can offer before they are asked to contribute

financially. As another example, your AI/AN community advisors may feel that their community needs education more than it needs advocacy. Listen to their opinions carefully because they are in the best position to accurately assess needs.

After considering their opinions, your members' preferences, available monetary resources, and the natural talents of your affiliate's members, you will be in a good position to map out the components that you want to include in your planning. More specific strategies for accomplishing each of the components are presented in a later section of this manual.

After making decisions about which components will be part of your plan, it is time to identify the specific goals that your activities will address. You should try to identify one or two goals for every component. Keep in mind that goals are statements that say exactly what you expect to accomplish through each component. Listed below are some examples from our national survey of outreach program goals and the component to which they are related.

COMPONENT	POTENTIAL GOALS
Education-	-Creation of culturally and linguistically appropriate Pamphlets about the causes and treatment of mental illness. -Creation of a videotape explaining different types of psychotropic medications and their side-effects -Compilation of a resource book containing the names, addresses and telephone numbers of all AI/AN mental health treatment professionals and agencies in the community
Ethnic-Specific	-Establishment of a Native-speaking family support group
Support Groups	-Encouragement of attendance at a support group without requiring membership in NAMI
Recruitment	-Sponsoring the first year of NAMI membership for low-income community participants -Setting a target of increasing AI/AN membership by some proportion -Making a commitment to increase the representation of minorities on an affiliate's board of directors
Advocacy	-Lobbying state government officials to increase funding for mental health services in the target community -Meeting with the directors of all mental health agencies serving the American Indian and Alaska Native community to ensure those Native language services is available

-Making surprise visits to state inpatient psychiatric facilities serving American Indian and Alaska Natives to assess conditions

The foregoing are just samples of the many types of goals that your group may identify in your planning process. The exact nature of your goals is not as important as the requirement that they be specific and realistic outcomes of your activities. Start with a potential set of goals, but do not be afraid to add or subtract goals as you proceed in your efforts.

Funding for Your Outreach Effort

The next issue to consider as you proceed with your planning is how you will fund your activities. This is no easy question given that funding for such programs is quite limited. In our national survey we learned of a variety of funding mechanisms. Some affiliates used special fundraising efforts (such as street fairs, concerts or silent auctions) or committed a proportion of their operating budget (typically derived from dues paid by members) to pay for outreach activities. Others were able to obtain funds from their state NAMI organizations or from state or local (i.e., city or county government) mental health, child protection, or health agencies. Still other programs had been successful in applying for funds from the federal government, specifically the National Institute of Mental Health Community Support Program (Brown & Ruiz, 1988). Some affiliates were successful in obtaining funds from local philanthropic foundations such as Community Trusts or United Way.

Given the limited funding available, it is a good idea to be aware of funding issues at the outset of your planning. However, you may wish to begin developing your plan in the absence of identified funding. This way you can establish an "ideal" set of activities and fund those you find you can afford as you go along. Having plans in place puts you in a position to apply for money once you learn it is available rather than starting from scratch after you learn of potential funding mechanisms.

Planning to Disseminate and Publicize Your Outreach Efforts

A final aspect of your planning should cover the ways in which you are going to inform others about your activities. The most important group you want to reach is the community you are outreaching. You should pay close attention to how you are going to let community members know that your program is operating and what it has to offer. Another target for dissemination consists of AI/AN mental health professionals and mental health treatment programs serving predominantly AI/AN and other minority populations. These individuals and organizations are crucial to your success because they, in turn, can help you reach members of your target community. Still another target groups for dissemination are local community organizations such as churches, ethnic clubs, sports facilities, and public educational institutions. Many people can be reached

through groups such as these, and you should have identified them in the early stages of your planning process.

Finally, you should make plans for a public relations campaign that accesses the media familiar to your community. You should plan to create press releases, public service announcements, short newspaper articles detailing your efforts, and consider appearing on local television programs that cover local activities and events. Identify media outlets that are frequently used by members of your target community; advertising your program in culturally appropriate media will ensure that information reaches the people you want to inform.

Case Examples to Use in Outreach

At some point during the planning process, you should read and complete the following case examples. These vignettes illustrate "typical" problems faced by affiliates who attempt to outreach minority communities. Reading and discussing them will help you clarify which components you want to include in your project, as well as potential barriers you may need to overcome. Read each case and record your answers to the questions below.

Case #1: Your organization is a rural self-help group for family members of persons with mental illness. You hold one "multicultural day" at your office, for which you advertise in the newspaper, but attendance is poor. Despite this, your group is determined to try again. What barriers are you facing? What plans will you make for your new efforts? Be very specific.

Case #2: Your urban affiliate advocates for persons with mental illness and is trying to get started on a AI/AN outreach program. Although some of your Board members are not enthusiastic about the effort, others support it. However, most are white, with very limited knowledge about cultures other than there own. Board members want to reach all of the AI/AN groups in your area. How would you get started? What barriers are you facing? What plans will you make for your new efforts? Be very specific.

Case #3: You are a small town affiliate wanting to increase your AI/AN membership. However, your members know very few non-white families. They have difficulty knowing where to find others to invite to a support group meeting. On top of that, you have a very small operating budget and *cannot* afford to spend a lot of money.
How would you get started? What barriers are you facing? What would you plan and how would you locate your target group?

Case #4: Your small city affiliate has been trying to start a AI/AN outreach program for about four months. You have started a monthly lecture series on AI/AN mental health issues. Affiliate members have posted signs announcing each month's speaker and topic at various mental health agencies around the city in the hope that a wide range of people would attend. This is not working out as planned because no AI/AN families have attended *the* first four lectures. What is your next step? What barriers are you facing? What are you going to do next?

Summary

By the end of your planning process, your group will have *accomplished several* major objectives. You will have dealt with the question of whether or not to embark on an outreach program; identified a target group; find a key informant, formulated your basic outreach plan; identified potential funding for your activities; and planned for publicizing your efforts to target community members, professionals, and others. The next steps involve "filling in the blanks" by planning and actually implementing *some of the specific* outreach strategies that you have learned. What follows are brief descriptions of successful NAMI AI/AN Outreach strategies and exercises that will aid you in this process.

Outreach Planning Pages

Identifying Where We Are Now and Where We Want to Go…..

Complete the following questions to the best of your ability. There is no "wrong" answer, only a way for you and others to determine your group's level of activity.

At the American Indian Mental Healthcare Symposium you will be learning from others and acquiring many new strategies to move your group into fast forward.

You will have an opportunity to develop an outreach plan containing ideas and tasks ready for you to implement when you return home to your affiliate group.

Where Are We Now?

What does your group offer to a American Indian and Alaska Native person or family?

Does your group offer support to American Indian and Alaska Native family members and consumers? If your answer is positive, what type of services? Yes No

_____

_____

_____

_____

Do you have special committees that address the specific concerns/issues of the American Indian and Alaska Native population in your area?
Yes No

If yes, which committees?

_____

_____

_____

Is your local newsletter culturally sensitive and appealing to the American Indian and Alaska Native population?
Yes No

Do you have materials (fact sheets, membership application forms, etc) in Native American languages?
Yes No

Do you have education programs or support groups for American Indian and Alaska Natives?
Yes No

Do you have American Indian and Alaska Native members?
Yes No

Approximately how many? _____

Some things to consider…
Pay particular attention to your "no" responses. These areas can serve as good starting points for your group to consider implementing programs.

What are the demographics in your area?

Is there a strong American Indian and Alaska Native population?
Yes No

What is the geographic distribution of this population?

_____

_____

_____

_____

_____

_____

_____

Is there easily accessible public transportation?
Yes No

Where does the American Indian and Alaska Native population in your area look to get reliable information?
(Please circle all that apply.)

radio	newspaper
television	cinema
place of worship	internet
peers/family	libraries
clinics	professionals (i.e. doctors, lawyers)

Some things to consider…
If you are interested in engaging the American Indian and Alaska Native population of members, you must provide attractive services and benefits for this population. Review your answers to the above questions. Your answers will help you form the basis for your outreach strategies.

Find out what prompted your current American Indian and Alaska Native members to join your NAMI and what encouraged them to remain.

What attracted them to join your affiliate?

_____

_____

_____

_____

_____

How did your affiliate reach these individuals?

_____

_____

_____

_____

_____

Why did they remain active?

_____

_____

_____

_____

Are they happy with their membership? Why? Why not?

_____

_____

_____

_____

_____

Some things to consider…
Think about ways to make your American Indian and Alaska Native members feel welcome, supported, and needed. Structure support groups and program meetings so that all those who attend feel part of the group. Find out what your American Indian and Alaska Native members need and try to supply that. Also find out what skills and resources they have so you can get them involved in helping others.

Do you have the necessary resources?

Do you have resources to reach the American Indian and Alaska Native population?
Yes No

If yes, please list all the resources that you have. Please be specific.

_____

_____

_____

_____

_____

If not, what resources will be needed?

_____

_____

_____

_____

_____

Some things to consider…
Once you have considered the best vehicle for communicating with them, it is time to look for tools to help market your affiliate. Refer to the American Indian and Alaska Native Outreach Web Site for some ideas and contact information.

Where Do We Want to Go?

DEVELOPING A STRATEGIC OUTREACH PLAN TO INCREASE YOUR AMERICAN INDIAN AND ALASKA NATIVE MEMBERSHIP

This assignment is designed to help you develop an outreach plan to enhance your American Indian and Alaska Native outreach campaign. Here you are going to develop a strategy to reach the American Indian and Alaska Native population in your area. The goal of the exercise is to have at least a 10% increase in your American Indian and Alaska Native membership by the end of 12 months.

This is your opportunity to incorporate into your plan the wealth of ideas from speakers and other NAMI leaders that participated at the American Indian Mental Healthcare Symposium. Remember you are working on a plan that will fit your particular affiliate group, so make certain you choose the best recommendations.

Use the 12-month Strategic Outreach Plan Form.

Twelve Months Strategic Plan

Current number of American Indian and Alaska Natives in your group
_____

Your goal is to increase this group by _____%

MONTH	Identify what tools and strategies you will use to reach the American Indian and Alaska Native population in your area. Try to approximate costs involved. Include the materials that you will need and the assistance that you will need.
July 2003	
August 2003	
September 2003	
November 2003	

December 2003	
January 2004	
March 2004	
April 2004	
June 2004	
July 2004	

Looking Ahead

Question: Looking ahead to next year and beyond, what new and innovative ways can you identify to enhance your American Indian and Alaska Native outreach activities? Think of the different approaches that you could use to include potential members in your affiliate activities.

Identify three different American Indian and Alaska Native outreach approaches:

_____

_____

_____

_____

_____

_____

Identify three different American Indian and Alaska Native membership-retention approaches:

_____

_____

_____

_____

_____

_____

_____

_____

_____

When a AI/AN contacts you, how could you respond to his/her emotional support needs and provide information about mental illnesses and NAMI in a culturally sensitive manner?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What kind of resources can you provide to AI/AN consumers and their families?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Enlisting American Indian and Alaska Native Community Leaders

To reach the American Indian and Alaska Native community in your area, you need to identify what their needs. To perform a needs assessment, you should partner with community leaders that will help you understand the American Indian and Alaska Native culture and guide you through cultural differences so that you become culturally sensitive and competent. American Indian and Alaska Native community leaders can help you establish bridges of communication and trust between you and the rest of the community.

Identify the American Indian and Alaska Native community leaders in your area. Make sure you have all their contact information.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How can you establish a working relationship with them?

_____

_____

_____

_____

_____

_____

_____

_____

Chapter Four

Evaluating your Outreach Efforts

Materials adapted from Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates. Prepared by Judith A. Cook and Jesse Knox, 1993.

Program Evaluation
Satisfaction Surveys
Outcome Assessment
Conclusion

Evaluating Your Outreach Efforts

Materials adapted *from Outreach to African American and Hispanic Families: A Manual for NAMI Affiliates*. Prepared by Judith A. Cook and Jesse Knox, 1993.

Introduction

Whatever activities you decide to include in your outreach project, you should plan to evaluate them. Although the idea of evaluation is threatening or intimidating to some people, it need not be. The basic idea of evaluation is to gain an understanding of how well your activities worked and how participants perceived them. This kind of feedback can then be used to redesign program components that were unsuccessful and to improve activities that were successful. Another reason to evaluate your activities is to show potential funding agencies that your project is successful in accomplishing its goals. This chapter offers some suggestions regarding how you can plan and conduct both global and strategy-specific evaluations. The intent here is to set up a rudimentary evaluation component that provides you with feedback about participant satisfaction and with evidence of your project's effectiveness.

Type of Program Evaluation

There are many types of program evaluation strategies and levels of analysis. We suggest that your evaluation plans include at least the following two: client (or participant) satisfaction, and outcome assessment. Participant satisfaction assessments directly question your target population about whether or not they found your services or activities helpful, what could be done to improve them, and what positive parts of your program should be retained and/or expanded. Client satisfaction information is usually gathered through a brief questionnaire, completed by individuals who have participated in one of your program's activities. This method of evaluation is appropriate for support groups, conferences, trainings, presentations, newsletters, celebrations, and companion programs.

Satisfaction Surveys

A major requirement of using a satisfaction questionnaire is that people should be easily able to receive, complete, and return it to you for analysis. Although you can send questionnaires directly to individuals via the postal system, this decreases the chances that they will be returned to you. Sending questionnaires through the mail also requires that you obtain names and addresses, which may be difficult or may raise issues of confidentiality for some respondents. One relatively foolproof way to administer questionnaires is by handing them out at the end of an event while people are still gathered together, asking the group to complete them, and then collecting them as people leave.

The questions or statements to which people respond on a satisfaction questionnaire are called "items.' Some items force the respondent to choose between a number of pre-specified answers; these are referred to as forced-choice items. Some examples of this type of item include: true/false questions; statements with which the reader "strongly agrees," "agrees, " "disagrees," or "strongly disagrees;" or items which ask the reader to pick one of a series of alternative answers. Another kind of item asks for a written opinion or statement from the respondent; these are referred to as open-ended items. Some examples of open-ended items include: those which ask individuals to say what they liked or disliked about something; those which ask for suggestions for improvement of a program or service; and those which ask individuals to speculate about how they will use something they gained from an activity. It is a good idea to include both types of items in any satisfaction questionnaire you design.

If you are using open-ended items it is important that you allow enough space below the item for people to write their answers; encouraging people to write on the back of the page is another way to ensure that there is enough room for feedback. When using forced-choice items it is important to make sure that the choices you provide are relevant to all of the items. For example, some items are aimed at eliciting the intensity of respondents' reactions to a statement; in these cases, it is important to be sure that the potential responses that people have to choose from make sense in terms of the wording of the statements. The example below illustrates this principle. Note that the first two items are answerable according to the available response categories while the third and fourth items are not.

Possible Format:

Strongly Agree Agree Not Sure Disagree Strongly Disagree

The training held my interest throughout the afternoon.
I learned things in this training that will help my family.
How satisfied were you with this training?
How relevant was the information to your own family's needs?

Appropriate response categories to the third and fourth items might be the following:

Very Somewhat Not Sure Minimally Not at All

3. How satisfied were you with this training?

4. How relevant was the information to your own family's needs?
Here is another possible format:

strongly agree (a)	agree (b)	somewhat agree (C)	somewhat disagree (d)	strongly disagree (e)

(Please circle the best response.)

This group will have a positive effect on my family's experience with mental illness.	a	b	c	d	e
The meeting location is accessible and comfortable.	a	b	c	d	e
3. I feel comfortable talking in this group.	a	b	c	d	e

Please provide brief responses to the following questions.

What topics or issues are most important to your family?

What changes would make this group more helpful to your family?

What sections did you find the least beneficial?

Please feel free to make any additional comments. Thank you for your input and participation.

Once you have received the completed questionnaires, you can make assessments of your current efforts.
One consideration in using forced choice items is to word some of them negatively and some positively. This is because some respondents have a tendency to agree with most statements (these people are called "yea-sayers" by researchers) while other respondents tend to disagree with most statements (termed "nay-sayers). Given this, you may want to include items such as the second and fourth statements shown below:

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

The group held my interest throughout the afternoon.
Many of the topics covered were not relevant to my own needs.

I learned things in this group that will help my family.
The translation services were not adequate; I didn't understand much of the discussion.

By assigning numbers to the response categories, you can create averages that capture the reactions of all respondents in a single figure. Simply add up the ratings of a single item across all respondents and then divide by the number of respondents to arrive at your average. The following example uses the items listed above:

Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
(1)	(2)	(3)	(4)	(5)

The group held my interest throughout the afternoon.
Many of the topics covered were not relevant to my own needs.
I learned things in this group that will help my family.
The translation services were not adequate; I didn't understand much of the discussion.

For item number one, above, a score of 4.5 would indicate that the average respondent fell in the range between agreement (a "4") and strong agreement (a "5") that the group held their interest. For item number two, a score of 2.1 would indicate that the average respondent disagreed with the notion that the group's topics were not relevant to his or her needs. Using averages in this way can help you summarize the views of the multiple persons reached by your outreach activities.

Outcome Assessment

Another type of evaluation you may want to consider is to measure the degree of change that occurs as a result of your project's activities. This is a way to measure the outcomes of your efforts. In order to assess change, however, it is important to measure a desired outcome before you begin your project and again at some point in time after your activities have occurred. Researchers refer to this as a pretest/posttest design because you measure ("test") something before ("pre") and then after ("post") your activities. For example, suppose one of your project's goals is to increase the number of calls for information received from your target population. Here, you will want to measure the volume of calls from Latinos before you begin your outreach efforts and then after your efforts are underway. One way to do this is to use a telephone log. The person taking every call would record the date, racial or ethnic identity, and nature of the request for a month or two before you begin your efforts and then perhaps six months after activities commence. Better yet, you might track calls throughout the entire period that your project is operating, so that you can monitor changes in calling volume from month to month. The minority outreach project of AMI-GC used this method and found that the proportion of minority callers rose from 5 % before their project began to 10 % after one year of operation, 15 % after two years of operation, and 25 % at the end of their third year of operation. A sample log sheet used in this project is included on the following page.

Another type of pre- and post- project evaluation would concern outcomes such as the proportion of people of color serving on your affiliate's board of directors before and after your project begins or the proportion of affiliate members who are people of color before and after your project begins.

The simplest type of outcome evaluation is to count the number of people reached by your efforts, and the numbers of different types of activities that occurred as a result of your project For example, you might wish to keep a simple count of the number of times you responded to requests for information or the number of training sessions you conducted in a given year. That way you can tell interested parties that you responded to over 250 requests for written materials, say, or that you held 25 training sessions at local mental health organizations over a twelve month period. Such figures- go a long way toward convincing funding agencies that your project is organized enough to track its outcomes and that you have evidence of the concrete outcomes of your efforts.

Conclusion

Whatever type of evaluation you conduct, remember that the most important considerations are that you do so accurately and fairly. You will want to collect information that provides you with an honest idea of how well you are accomplishing your goals and ways in which your activities could be improved. You also will want to share the results of your evaluation with your target population, which helps to enhance your project's legitimacy. When you are as willing to entertain both negative feedback and praise, you increase your chances of developing activities that are truly responsive to the needs of your target group.

Resources

Annotated Bibliography:

Handbooks
Popular Books
Clinical Research

NAMI Resources:

Multicultural and International Outreach Center (MIO)
MIO Partner Coalition
MIO Technical Assistance
MIO State/Affiliates & AI/AN Outreach
Policy
Development
Family-to-Family
In Our Own Voices
Communications

Annotated Bibliography
Handbooks, Popular Books, Clinical Research

Ford CW. We Can All Get Along; 50 steps You Can Take to Help End Racism at Home, At Work and in Your Community. New York, NY: Dell. 1994.

Health of Indigenous Peoples of America. Washington, DC: Pan American Health Association. 1997. [Discusses need to respect traditional beliefs and migration patterns to overcome language barriers and consider the effects of poverty and lack of education.]

Kivel P. Uprooting Racism: How White People Can Work for Racial Justice, Philadelphia, PA: New Scoiety Publishers. 1996. [Explores dynamics of racism, history, being an ally, institutional racism and democratic, anti-racist multiculturalism.]

Kutz JH. White Awareness: Handbook for Anti-Racism Training. Norman, OK: University of Oklahoma Press. 1978. [Explores definitions and inconsistencies, dealing with feelings, cultural racism, the meaning of whiteness, and developing strategies for action.]

Manson SM, The wounded spirit; A cultural formulation of PTSD. Culture, Medicine and Psychiatry. 1996;20(4):489-498. [Explores relationships among traumatic stress, combat, alcohol, and American Indian culture.]

Morse JM, Young, DE, Swartz L. Cree Indian healing practices and Western health care: A comparative analysis. Social Science and Medicine. 1991;32(12):1261-1267.

Novins DK, Bechtold DW, Sack WH, et al The DSM-IV outline for cultural formulation; A critical demonstration with American Indian children. Journal of the American Academy of Child and Adolescent Psychology. 1997;36(9):1244-51. [Discusses strengths and limitations of the outline, including gaps concerning cultural identity and cultural elements of the therapeutic relationship.]

Walker PL. Chumash Healing: Changing Health and Medical Practices in a American Indian Society. Banning, CA: Malki Museum Press. 1993.

Weatherford J. Indian Givers: How the Indians of the Americas Transformed the World, Crown Books. 1998.

West C. Race Matters. New York, NY: Vintage Books, A Division of Random House, Inc. 1993. [Confronts prejudices of readers and insists that we share a common destiny. A best-selling book described as "challenging and deeply healing."]

NAMI's MULTICULTURAL PROJECT

The National Alliance for the Mentally Ill (NAMI) is dedicated to improving access to treatment and the quality of care for all Americans with mental illness and their families. Accordingly, NAMI has created a Multicultural Outreach Center to:

- More centrally involve members of disadvantaged communities in these efforts,
- Develop and disseminate culturally competent direct service/support models in the field,
- Decrease stigma through public education models that address specific racial and cultural barriers, and
- Improve mental health policy development at the local, state and national level by increasing grassroots participation.

Increasing Involvement of Racial and Ethnic Minorities.
Mental health service providers and advocates in the U.S. are largely of European descent. By forming coalitions with grassroots groups that serve diverse communities, and developing cross-cultural alliances that address mental illness, the Multicultural Outreach Project will build a multicultural grassroots network that improves understanding of mental illness among members of diverse communities and increasingly represents all people who are affected by mental illness.

Cultural Competency.
Given the prevalence of workers of European descent in the mental health field, education on the specific barriers facing distinct minority communities is essential in improving access to treatment and care. NAMI's Multicultural Outreach Center will be equipped to provide the latest research and thinking on such issues as: over-diagnosis of disorders based on race, the overlay of poverty on different racial and ethnic communities, history of state repression and its impact on accessing care, cultural prohibitions against seeking help, etc.

Public Education.
Misinformation and overwhelming stigma continue to surround mental illness. To address this, public education messages are often developed to reach a broad audience, bypassing specific cultural and material realities that racial and ethnic minorities may face. Through partnerships with organizations that directly serve racial and ethnic minorities, NAMI's Multicultural Outreach Center will draw on community-based expertise to create public education messages that address varied and complex barriers to treatment and care.

Policy Development.
If there is a paucity of workers from racial and ethnic minority communities in the mental health field, there are fewer still involved in policy-making, from the local to the national level. NAMI's Multicultural Outreach Center will draw on the alliances it creates at the local level to create opportunities for grassroots policy initiatives.

Working strategically on four key fronts, NAMI's Multicultural Outreach Center will work to transform practices in the field while strengthening our advocacy efforts across the nation.

NAMI's Multicultural & International Outreach Partners Coalition

NAMI's Multicultural & International Outreach Center will bring together a cadre of national and international partners to join NAMI and its members in meeting the mental health needs of individuals from diverse communities. The primary role of the NAMI MIO Partner Coalition is to support community organizations and NAMI organizations in grassroots activities aimed at addressing mental health needs of racial, ethnic and cultural minority groups. The NAMI MIO Center works to improve education and understanding of mental illness and to ensure access to quality treatment and services for racial and ethnic minorities and other under-served groups.

By developing and maintaining relationships with organizations that already meet many of the needs of these individuals, NAMI MIO Partners will provide immediate access to community members and opportunities for improved understanding and policies addressing the research, treatment, services and support needs of these individuals. We will look to organizations, like NAMI, with a particular interest in engaging their affiliates/members locally to meet community needs. Most important, we will work with organizations that are interested in facilitating involvement with NAMI national, state and local affiliates to address community mental health needs.

NAMI MIO Partner Coalition members will also act as advisors to the Center on strategic initiatives and opportunities. The goal is to ensure that people from all races, cultures and ethnic groups with mental illness receive the best and most appropriate treatment and services that are available. We hope to eliminate stigma and discrimination, shape governmental policies to better meet the needs of people with mental illness and their family members and ensure that these individuals live with dignity and respect regardless of their ethnic, racial or cultural identities.

Partner Benefits:

- Networking with multicultural and multinational coalition members
- Assistance with addressing mental health needs of organization constituents
- Collaboration on community projects with NAMI's state organizations and local affiliates
- Use of NAMI's educational materials for coalition organization's constituents
- Collaboration on special projects
- Potential for joint funding opportunities
- Access to leading information on mental illness
- NAMI support of advocacy issues relevant to diverse cultures, races and ethnic groups
- Co-sponsoring of special events

For more information or to become a NAMI Coalition Partner contact Teresa Brown (teresa@nami.org) or María-José Carrasco (majose@nami.org) at 703-524-7600.

Multicultural and International Outreach Partner Coalition

Alianza Nacional de Salud Mental
American Psychiatric Association, Committee on Surgeon General's Report on Culture, Race and Ethnicity
Apoiar, Brazil Family and Consumer Support Organization
American Society of Hispanic Psychiatry
Asian Community Mental Health Services
Asoiciacion Argentina de Ayuda a laPersona que Padece de Esquizofrenia
Asociaci_n Maníaco Depresivos
Asociación Salvadoreña de Familiares y Amigos de Pacientes Esquizofrénicos
Black Psychiatrists of America
Center for Psychiatric Rehabilitation Boston University
Fundacion Contener
Fundacion Luz y Vida
Health Watch Information and Promotion Service, Inc.
Ingenium, Mexico Family and Consumer Support Organization
Ingenium, Morelos
Latino Behavioral Health Institute
Massachusetts Mental Health Services Program
National Council of La Raza
National Latino Behavioral Health Association
National Medical Association, Psychiatry Section
National Organization of People of Color Against Suicide
New Jersey Mental Health Institute
Self Reliance Foundation
Student National Medical Association
The Alliance for the Mentally Ill of R.O.C., Taiwan
The Depression and Anxiety Support Group of South Africa
Zenkaren, Japan Family Organization
National Asian American Pacific Islander Mental Health Association

For more information about the Center, Contact:
Darlene Nipper, Chief Operating Officer, & National Director of MIO, at 703-516-7969 or email: darlene@nami.org
Teresa Brown, Program Manager, at 703-600-1105 or email: teresa@nami.org
Maria-Jose Carrasco, Program Manager, at 703-312-7894 or email: majose@nami.org

NAMI Resources
Policy

Keys to Effective Lobbying

Anyone can Lobby! If you can write a letter or make a phone call you can lobby. This is not something that is left to the experts; people in the grassroots do some of the most effective lobbying where a member of Congress has a reason to pay attention. You vote and you count!

1. Be prepared and Know Your Subject

What is the substance of the legislation you support? Why is it so important? What will happen if it passes or if it does not pass? How much will it cost? NAMI keeps its members up to date on key pieces of federal legislation through the NAMI E-News. Often times there is an "Action Alert" to our members where you can make a real impact. Are you signed up to receive the electronic newsletter in your email account? If you aren't, please contact Marie Wyffels, marie@nami.org, and you're well on your way.

2. Set Up An Appointment in Advance

Not everyone can easily make a trip to Washington, DC. Each member of Congress has at least one office back in his or her state or local district. You can find contact information for all members of Congress by calling the Capitol Switchboard at 202-224-3121 or by going to the policy page of the NAMI website at www.nami.org/policy.htm and click on "Write to Congress."

3. During the Meeting

In a meeting or telephone conversation it is important to try to remember to be brief, be clear, be accurate, be persuasive, be timely, be persistent, and be grateful. Members often prefer to discuss issues of personal interest. Always return to your specific subject instead of jumping from one issue to another. Even if you have an appointment in advance you maybe referred to an aide. Do not be offended if you do not get to meet with a member of Congress, their staff members are very influential.

4. After The Meeting

Remember to send a thank you note. The most mail a legislator gets is either asking for personal favors, complaining about something the government has or has not done, or attacking the legislator on is or her policies. A thank you letter will leave behind a lasting impression, and it will remind the legislator of your meeting and the issue.

The NAMI Family -to-Family Education Program Design: Multicultural Aspects

The Family-to-Family Education Program was designed to be transcultural. It is based on the premise that there elemental, shared responses to the human experience of coping with mental illness that are common among family members of all racial and ethnic groups. The course is founded on these universal aspects of coming through, and living with, serious and persistent brain disorder, as follows:

The experience of pain, anxiety, and grief is a universal response among family members to the trauma of mental illness in a loved one.

Misunderstanding and confusion among family members are universal reactions to the unfamiliar symptomatic behaviors which occur in serious mental illness.

The willingness to learn, to master a new knowledge base in order to help a stricken relative is a sign of the strength and perseverance that exists universally among families in the face of serious mental illness.

No matter how ones race or culture may view mental illness, family members new to the experience are universally in the dark about how to navigate the mental health system, and need to be empowered to do so effectively.

Whatever differences do exist in the way families deal with mental illness can be universally acknowledged with respect and compassion.

The evaluations and feedback we have from Latino and African American classes affirm the premises upon which the Family-to-Family curriculum was designed. Participants tell us the course is "life-changing", empowering, emotionally enlightening, and that it helps them understand and assist their relative more realistically.

Frequently Asked Questions

NAMI Family-to-Family Department Personnel

Q: How can I contact Family-to-Family (FTF) personnel at NAMI?
A: Your FTF staff consists of:

- Joyce Burland, Deputy Executive Director of Education and Training: (703) 524-7600 or joyce@nami.org
- Lynne Saunders, Director of Technical Assistance, Department of Education and Training: (703) 524-7600 or lynne@nami.org
- Rayna Gunther, Program Coordinator, Family-to-Family Education Program: (703) 312-7898 or rayna@nami.org
- Marshall Epstein, Fulfillment Assistant, Department of Education and Training: (703) 516-7975 or marshall@nami.org

Please contact us with any questions or concerns.

Donations to the Family-to-Family Education Program

Q: How can I donate money to NAMI specifically for the Family-to-Family Program?
A: Just write in the memo section of your check, "Family-to-Family." Donations can be sent to: NAMI, Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 222201-3042. If you have any questions at all about donations, contact Joyce, Lynne, or Monique and we'll get back to you promptly!

Q: I want to donate stock to the Family-to-Family Program. How can I do this?
A: Just contact Winsome Clarke in the NAMI Department of Charitable Giving at (703) 524-7600 or winsome@nami.org. Winsome will tell you everything you need to know.

Q: I know someone who I think would donate to the Family-to-Family Education Program. Who do I tell?
A: Just contact Joyce, Lynne, or Monique, and thanks!

Family-to-Family Program Materials

Q: How do I order Family-to-Family materials?
A: You can order FTF materials in two ways:

- Go on-line on the Family-to-Family Section of NAMINet, click on "Family-to-Family Materials Ordering," click on "On-Line Catalogs" and follow instructions from there to order all of your materials on-line.
- Mail or fax in a Family-to-Family Materials Order Form, along with a credit card number or check, to the NAMI office. You can obtain order forms on-line in the same "Family-to-Family Materials Ordering" section by clicking on "Printable Catalogs." Or, you can call Marshall and request that he fax or mail you an order form.

Q: Does NAMI sell sets of all the charts used in the Family-to-Family course?
A: Not at this time. Your best bet is to have the charts from your teacher's manual blown up at a local print shop. The only chart that NAMI sells for Family-to-Family is the Emotional Stages chart.

Q: Does NAMI copy the class handouts for Family-to-Family classes?
A: No. Your State Program Director is responsible for having this done from a master copy set that we send to her/him. If you do not know your State Program Director's name, contact your NAMI state office.

Q: What is a Teacher Resource Kit, and how do I get one?
A: A Teacher Resource Kit is a packet of information available for free from NAMI, for you to put out your resource table in your Family-to-Family class. Publications included are back issues of the *Advocate*, back issues of *Because Kids Grow Up*, Family-to-Family *Advocate* special flyers, a listing of resources for children and adolescents, PACT Advocacy guides, and a NAMI Resource Catalog. To obtain a Teacher Resource Kit, just go the FTF section of NAMINet and click on "Upcoming FTF Classes." Here you will see an option to post your class information on the NAMI Web site. Click this option, fill in your information, and on the bottom of the form, check the box that says, "Check here if you need to order teacher resource kits for this class" and submit your class information. Alternatively, you can call or email Marshall to request a teacher resource kit, or print off an order form from the "Printable Catalogs" section of the "Family-to-Family Materials Ordering" section of NAMINet.

Q: My order is incomplete! Who do I talk to, to get this corrected?
A: Just call or email our friendly fulfillment assistant, Marshall. He will quickly take care of your problem.

Q: I need to place an order for items I needed *yesterday*. Help!
A: Call Marshall and see if he can send your order out via UPS Overnight or 2nd Day Air. We require payment for the FTF materials and overnight shipment costs *up-front* to do this. This means you must supply us with a credit card number. No exceptions! And, please, try to avoid ordering items at the last hour.

Family-to-Family Curriculum

Q: I want to use Family-to-Family handouts in a meeting/presentation/training. Can I?
A: You must get permission to use handouts from Family-to-Family, as the material is copyrighted. Contact Joyce or Lynne with the specific page numbers of the pages you want to use, and she'll let you know whether it is permissible to use them.

Q: I am about to teach the course, and I fear that some pages in the curriculum have been updated, but I didn't get them. What should I do?

A: Contact your State Program Director and ask him/her if you were sent the most recent page updates, which were done in February 2001. Your Program Director can contact Rayna to verify what the updated pages were, and s/he can then send them to you.

Q: What's the difference between a date at the bottom right corner of the page, 5/98 or 5/98(e)?

A: The dates at the bottom right corner of the curriculum page tell you when the page was first written or updated. The (e) indicates some editing (correcting typos, spelling, formatting, etc.) occurred. There is no change in content.

Family-to-Family Class Locations

Q: I need to know how my relatives in another state can get in touch with a Family-to-Family Teacher in their area, to take the class. How can I get this information?

A: Go to our Public Web site at www.nami.org, click on "Education," then click on "Family-to-Family Education Program" to reach the Family-to-Family Home Page. From this page you should click on "Course Locations." Here you will see a list of states. Click on the desired state to find the State Family-to-Family Program Director, who can refer you to teachers in any area in their state. Alternatively, if you have access to the Family-to-Family section on NAMInet, go to the "Coordinator's Corner" and click on "Family-to-Family State Program Director Listing" to see a list of all State Family-to-Family Program Directors.

As well, please check your state or local NAMI Web site for FTF class listings. Just go to the NAMI Web site at www.nami.org, click on "Support," then click on "Local Affiliates and Support Groups" to find a listing of State NAMI Web sites. Follow the prompts to find your local affiliate and/or state Web site. Family-to-Family classes are often listed on state and local NAMI Web sites.

Q: How do I get my classes posted on the NAMI Web site?

A: Just go the FTF section of NAMINet and click on "Upcoming FTF Classes." Here you will see an option to post your class information on the NAMI Web site. Click this option, fill in your information, and press the button to submit. Alternatively, you can email, call, or fax Rayna or Marshall with the following info for your class: city, meeting day/time, class start date, and contact information to register for the class (name, phone number, and email address).

Teaching Family-to-Family

Q: I want to be a Family-to-Family teacher in my state. How do I become one?
A: To become a Family-to-Family teacher, first you must take the Family-to-Family class. Let your FTF teacher know that you would also like to become a teacher. S/he can refer you to the State FTF Program Director, who can enlist you in a state FTF Teacher Training session to become a teacher.

Q: What if my state organization doesn't offer the Family-to-Family Education Program?
A: NAMI policy does not allow anyone to teach Family-to-Family in a state that does not offer the program. Your best bet is to lobby your state NAMI office to offer the Family-to-Family Program.

Q: I don't have a teaching partner. What do I do?
A: It is not permissible to teach the class solo. When there is one teacher in the class, people are far more likely to view the teacher as a "therapist." This is not good. Contact your state Program Director to see if arrangements can be made to find you a teaching partner.

Q: Our 12-week course has started, and one of our teachers is unable to continue teaching with her team member due to a circumstance beyond her control. Can our resource person who has covered three previous classes finish the class with the lead teacher?
A: This is considered a "special circumstance," and a resource person who has been in one or more FTF classes can step in to co-teach. However, the resource person is required to participate in the next upcoming state teacher training in order to continue serving as an FTF teacher in future classes.

Q: I'm a mental health professional and I want to teach Family-to-Family. Can I? And, do I need to even take the training, since the manual is so clear, and I am a Ph.D. and can figure it out on my own?
A: If you have already taken the Family-to-Family class and are a family member, you are eligible to teach the course, given that you agree to take off your "professional hat" and only wear your "family hat." We don't grant any exceptions to the requirement to take the formal teacher training: <u>all</u> FTF teachers must go through the formal training process.

Family-to-Family Class Members

Q: Can consumers take the Family-to-Family course?
A: If a consumer's present condition is stable and s/he has a first degree relative who is ill, s/he is eligible to take the course. This is a course where the highest priority is placed on protected disclosure of family emotions. These classes are offered as respite sessions for family caregivers, so they can recount their traumatic experiences and feel no constraint about expressing their pain, frustration, and grief. The course is therefore not appropriate for primary consumers suffering from severe and persistent mental illness. The new NAMI Peer-to-Peer Recovery Course is appropriate for such consumers. Call your state NAMI office to find out if it is available in your area.

Q: I have a deaf person in my class. What can I do to get a signer?
A: Most states have funds available through their Department of Mental Health to provide a sign language interpreter for people with disabilities. Contact your State Program Director for help in contacting your state's DMH. You might also want to contact the following organizations for contact information on sign language interpreters:

National Association of the Deaf
814 Thayer Ave.
Silver Spring, MD 20190-4500
(301) 587-1788 or (301) 587-1789 (TTY)
http://www.nad.policy.net

Gallaudet Interpreting Service
Gallaudet University
800 Florida Ave. NE
Fay House
Washington, DC 20002
(202) 651-5199
http://gis.gallaudet.edu

Q: I have a blind person in my class. How can I get him/her the handouts?
A: If the person is visually impaired, however has a limited ability to see, consider enlarging the handouts for them to 11" x 17" paper. If the person is completely blind, see if you can get volunteers to read the handouts onto tape for this person. Or, consider contacting your state's Department of Mental Health to inquire about available funding to prepare materials in braille. Unfortunately, NAMI does not have the funding to offer the handouts in braille. You might also want to contact the following organizations for contact information on getting braille materials:

American Council of the Blind
1155 15th St. NW, Suite 1004
Washington, DC 20005
(202) 467-5081 or 1-800-424-8666
http://acb.org

National Federation of the Blind
1800 Johnson St.
Baltimore, MD 21230
(410) 659-9314
http://www.nfb.org

Funding for Family-to-Family

Q: How are other states funding their Family-to-Family Education Programs?
A: For tips, look at the "Fundraising Corner" on the Family-to-Family section of NAMINet. Also, contact Lynne or Raina and ask them to let you know which State Family-to-Family Program Directors would be good sources to contact for information about their state's funding.

NAMI Support Group Model

Q: After finishing the twelve-week Family-to-Family Education Course, do the Family-to-Family graduates stay in a support group?
A: Hopefully! Family-to-Family graduates are invited to join their local affiliate support groups. NAMI has designed a support group model that addresses the following issues:

· How to ensure that a support group starts and stops on time
· What to do if someone is monopolizing all of the group's time
· How to handle disrespectful group members
· How to handle "hot potato" subjects such as involuntary commitment or suicide
· How to handle problems that just don't seem solveable
· How to ensure that quiet members in the group get a chance to participate

Currently, 45 states offer training in the NAMI Support Group model to affiliate support group leaders. However, all state organizations offer some type of support group for families.

Q: do only Family-to-Family graduates use the NAMI Support Group model?
A: No. We encourage all NAMI affiliates to use the NAMI Support Group model.

Q: How can I get trained in the NAMI Support Group model?
A: Call your state NAMI office and find out whether your state has any NAMI Support Group Facilitator Trainers. If it does, ask when the next Support Group Facilitator Training Session is, and ask to register. If it does not, consider coming to the next National NAMI Support Group Training session yourself and becoming a State Facilitator Trainer for your state. Talk to your state office about whether this is a possibility. You can find out more about the next National Training Session by contacting Rayna.

Q: Can I obtain the NAMI Support Group Manual for use in my affiliate's support group prior to our group having any facilitators who are trained in the NAMI Support Group model?
A: Yes. See next question for ordering information.

Q: How do I get a NAMI Support Group manual and/or other NAMI Support Group materials?
A: You can order NAMI Support Group materials in two ways:

- Go on-line on the Family-to-Family Section of NAMINet, click on "Family-to-Family Materials Ordering," click on "On-Line Catalogs" and follow instructions from there to order all of your materials on-line.
- Mail or fax in a NAMI Support Group Materials Order Form, along with a credit card number or check, to the NAMI office. You can obtain order forms on-line in the same "Family-to-Family Materials Ordering" section by clicking on "Printable Catalogs." Or, you can call Marshall and request that he fax or mail you an order form.

OTHER NAMI PROGRAMS MODELED AFTER FAMILY-TO-FAMILY

Program for Families of Young Children

Q: Is there a Family-to-Family Program for families of young children?
A: No, but there is a program called *Visions for Tomorrow*, which is expressly for families of young children. If you're interested in finding out whether this program is available in your area, contact Linda Zweifel of NAMI-Texas at (281) 367-2314 or email lzweifel@worldnet.att.net. As well, there is a program for young families called *Hand-to-Hand*. For additional information, contact Marcy Dvorak, Executive Director, NAMI of Greater Toledo, One Stranahan Square, #560, Toledo, OH 43604; (419) 243-1119.

Program for Consumers

Q: Where can I get information on the new Peer-to-Peer Program for consumers?
A: Contact Kathryn Cohan-Haerry of NAMI, at (703) 524-7600 or kathryn@nami.org, or check out the info on our Web site at www.nami.org and click on "Education" then "Consumer Outreach."

Q: Does NAMI have other consumer programs?
A: Yes. *In our Own Voices, Living with Mental Illnesses* is another of our consumer programs. Contact Lainie DeMelle at (703) 524-7600 or lainie@nami.org, or check out our Web site as listed in the question above.

Q: Does NAMI have a consumer support group program?
A: Yes. It's called NAMI CARE. Contact Kathryn Cohan-Haerry of NAMI, at (703) 524-7600 or kathryn@nami.org, or check out our Web site as listed above.

Program for Professionals

Q: Is there a program similar to Family-to-Family for mental health professionals?
A: Yes; it's called the NAMI Provider Education Program. For more information, call Rayna and request that she sends you a copy of the Provider Education Program Overview.

NAMI Resources Development

FUNDRAISING TIPS FOR NAMI AFFILIATES

Foundation Grants and Grantwriting

Today, there are well over 65,000grantmakers registered with the Foundation Center. Nationally, foundations and corporations represent about 11 to 12 percent of support for nonprofit organizations such as NAMI. Yet, many people see the grantsmanship process as shrouded in mystery and approach it with the same zeal they would a college term paper that is due first thing tomorrow morning. If you take the time to learn about the business of grantsmanship and approach foundation fundraising as a key element of your organization's development effort, it will pay off!

Making a Match with Foundations

There is a significant amount of detective work involved in identifying and "qualifying" potential foundations to support the work of your NAMI organization. A number of excellent web-based resources are available including:

The Foundation Center
www.fdncenter.org

Guidestar
www.guidestar.com

The Chronicle of Philanthropy
www.philanthropy.com

Charity Channel
www.charitychannel.com

The Gannett Foundation
www.gannettfoundation.org

Proposal Writing is Program Planning

Proposal writing can be likened to the forward-thinking process involved in planning the programs that are the heart and soul of your NAMI organization. In most foundation proposals, you need to document the following:

- Need: The need based on the situation in your community. Use real life examples and local statistics. This section should generally be no more than one page.
- Goals, Objectives and Methods: This is the heart of your proposal. The goal is the overarching and broad purpose of your project; whereas objectives are concrete, specific and measurable. Methods are how you accomplish the goals and objectives. This section is generally about two to three pages.
- Evaluation Plan: Many programs incorporate process evaluations that document activities that have taken place as part of the program and outcome evaluations that specify what impact the project had on the community. This section is generally about half a page.
- Organizational capacity: Here you BRIEFLY describe why your organization is the most appropriate one to accomplish this project. Include information about your mission, history, membership and any programming that shows evidence of your ability to conduct a project such as the one you are proposing. This section is generally about half a page.
- Budget: Be sure to cover your costs. Typical budgets may include personnel expenses, supplies, travel, meetings, phone, copying, equipment and overhead. Don't forget to include overhead costs such as rent and utilities! This section is generally about one page.

A Smorgasbord of Random, but Noteworthy Grantwriting Tips

- If in doubt, call the foundation and ask.
- If there are guidelines, read them and follow them to the letter.
- Leave lots of white space and try to break up the text with bullets.
- Use a font no smaller than 12 point.
- No fancy binding. Someone at the foundation has to make copies of your proposal…if you bind it…it makes their job harder.
- Number the pages.
- No colored paper…use black ink on white paper.
- Type everything and do use spell-check.
- Don't miss the deadline.
- Ask your neighbor to read the proposal…if they don't understand it, neither will the funder.
- Once you have heard from the funder, be sure to send a thank you. If you are funded, it will be a joyous thank you. If not, ask for feedback so that you can improve your chances in the future. Ask when you can apply again. Remember,

even if you don't get the funding, you are building a relationship that could pay off in the future.
- When you get the grant, take time to celebrate…you will have done a bunch of hard work and you deserve it!!!

For Additional Information, Contact:
Joleen Bagwell
National Development Director
Ph: 703-516-7228
Joleen@nami.org

Member/Donor Cultivation

Ultimately, much of your ability to attract members and donors is dependent on providing relevant services and information to the audience you are attempting to target. If your audience feels served by you, there will be a natural inclination to become a closer part of your organization. The other sections of this manual will certainly guide you in such program development.

But in addition to having services available, it is equally important that your community is aware of them. This means marketing your services, and appropriately targeting your messages to specific populations. If you are able to accomplish this, your membership will certainly grow.

Database Development

Keeping accurate and complete records of your constituency is critical to building the foundation of good fundraising practices. Make sure all names, addresses, phone numbers and email addresses are as up to date as possible. And never underestimate the power of spell-check!

When targeting unique populations with unique interests, it is especially important to keep records on key demographic information such as:

- age
- ethnic background
- status (consumer, family member, professional)
- primary interests (depression, youth, advocacy, etc.)

When you have gathered this information about your constituency, it will enable you to better address their needs as a whole group as well as in segments and as individuals.

Direct Mail

The first rule of fundraising is that you must ask! But there are several keys to developing an appropriate "ask" that will compel individuals to respond.
Whether you are inviting an individual to become a member, renew their membership or to donate, your direct mail piece should utilize personal stories to emotionally captivate them and illustrate the importance of supporting your organization. Be sure to tell your audience specifically how their donation will help people from their community. Utilize the specific information you've gathered about your constituency to develop and target your ask.

You can use your direct mail piece to accomplish multiple goals. Allow your recipients to sign up for your newsletter, receive specific information on a topic of their choice, or contact their Congressperson about issues that affect your community specifically. Giving several options to participate in the mission will appeal to some unwilling to donate until they learn more about you. However – be careful! Too many asks for too many different actions can potentially frustrate and confuse the recipients to the point where they will do nothing at all. And always remember that the main purpose of your direct mail piece is to gain members and raise additional donations.

E-Newsletters

Both print newsletters and email communications allow you to target program information to your audience, therefore further engaging them in your mission. However, when you use email, the speed of this medium enables instantaneous feedback from your audience, therefore allowing you to constantly update and perfect your messaging to your audience. Therefore, e-newsletters can become powerful fundraising and membership marketing tools.

When developing a fundraising strategy, it is important to remember that donors are simply individuals who feel a strong connection to your mission and want to participate in it. It is your responsibility to help create that connection – and targeted marketing and communication strategies, such as direct mail and E-Newsletters, make that connection even stronger.

For more information on how to enhance your membership and donor services program, please contact:

Jennifer R. Jones
Director, Donor Acquisition & Direct Mail
(703) 600-1116
jenniferj@nami.org

Planned Giving

"Planned giving" refers to charitable gifts that require some planning before they are made. They are often made in connection with estate planning. Planned gifts can be an integral part of achieving personal and financial goals while creating a legacy to support organizations such as NAMI. Planned gifts are popular because they can provide valuable tax benefits and/or income for life. Whether a donor uses cash or other assets, such as real estate, there are potential benefits, for example planned gifts can:

- Provide current income for the donor or others he/she wishes to provide for
- Help the donor save on income tax, capital gains tax, and gift and estate taxes
- Help the donor make major gifts to charity

NAMI National through its joint fundraising activities can assist any state or local affiliate office to work with a donor to complete a planned gift whether through their will, a revocable trust, a charitable trust or a gift annuity. Gifts can involve life insurance, real estate, IRA's or other retirement plans.

Do not be intimidated by the technical nature of planned gifts. Every organization can use a simple method of encouraging planned gifts. On all correspondence to your members, e.g. newsletters, solicitations, include the following questions:

- ❒ Have you named NAMI _____ (your state of local name) in your estate plans?
- ❒ Would you consider naming NAMI _____ (your state or local name) in your estate plans?

When your members respond in the affirmative to the above questions, contact them and thank them for their commitment to future support of your organization. Be sure they have the correct legal name of your organization, your federal tax identification number, and the current address for including your organization in their will or trust. Then continue to treat them as the special donors they are. Remember major gifts and planned gifts are based on donor cultivation.

For information about joint planned giving fundraising or for assistance, contact:

Winsome Elizabeth Clarke
Director, Major Gifts and Estate Planning
(703) 516-7992
winsome@nami.org

Special Event Fundraising

Special events are one of the most widely used techniques to raise money, attract publicity and educate the public about a cause. All kinds of non-profit organizations use special events. With minor modifications, they fit large and small, urban and rural.

When properly conducted special events can be a valuable source of additional contributions that compliment a nonprofit organization's traditional fund-raising campaigns. They also can be a way to increase volunteer involvement with an organization, resulting in a larger pool of more committed volunteers to draw upon for future fund-raising and membership campaigns. These are very important goals of any non-profit, but they should be considered secondary to the goal of raising money.

A number of excellent resources are available on the web, including:

http://www.fdncenter.org/learn/useraids/events.html

http://www.raise-funds.com/112601forum.html

http://www.fundraisingsamples.com/company.htm

http://www.pch.gc.ca/progs/pc-cp/pubs/e/Specev1.htm

http://www.markrandallcompany.com/pdf/spec%20event.pdf

NAMIWalks for The Mind of America

NAMI initiated a new nationwide walkathon program in 2003 that is designed to raise both dollars and awareness in our Campaign for the Mind of America. All proceeds from the Walk program will be used by NAMI to fund our family, child and consumer educational programs, continue our advocacy at local state and national levels, promote research into mental illness and to continue to support the mentally ill and their families and friends.

To learn more about NAMIWalks access our web site through:

http://www.nami.org/walk2003/

or Contact:
Mari B. Pierce
Director, National Events and NAMIWalks
(703)600-1101
mari@nami.org

NAMI Resources
Office of Consumer Affairs

NAMI's Recovery-based Program Opportunities for Consumers

People with mental illness comprise a significant minority in NAMI's membership, and they participate in state and local NAMI organizations in a wide variety of ways. NAMI coordinates many types of support, education and advocacy work at the national level, including these four major opportunities for local NAMI consumer members.

The NAMI Consumer Council

NAMI bylaws afford for a National Consumer Council to act in an advisory capacity to the NAMI Board of Directors. Among many others things, the National Consumer Council - which was established in 1985 -- elects a representative to the NAMI Board of Directors. It is the function of this Consumer Council Board Director to communicate the options and viewpoints expressed by the Consumer Council to the full Board, and to advise the Board with regard to consumer perspectives on the various matters with which the Board is occupied.

The National Consumer Council is comprised of a Representative and an Alternate from each state, Puerto Rico and the District of Columbia and an Executive Committee of five members. How someone becomes a Representative or an Alternate- and this is the recommended practice. Some state elects their Representative and Alternate. In some states, consumers attending the state's Consumer Council is, a tremendous service opportunity exists for persons to organize, develop, maintain, cultivate and participate in this sort of advocacy and advisory activity in NAMI at the local, state and national level.

In Our Own Voices: Living With Mental Illness Project

In 1996, NAMI launched its first consumer-to-consumer education program called Living With Schizophrenia and Other Mental Illnesses. The program involves a combination of live presentation and videotaped narrative of the first-hand experience of living with mental illness. Renamed In Our Own Voice: Living With Mental Illness in 2002 , a newer videotape contains people who have a variety of diagnoses. The program has maintained its consumer presentation format and the authentic presentation of the reality of living with mental illness,

and has evolved into a major public education initiative that changes attitudes and perspectives of the general public. NAMI believes that there is nothing as powerful as personal testimony to combat discrimination an prejudice. In Our Own Voice is a wonderful public education service opportunity that helps consumers develop self-confidence, self-respect, and skills that can be applied towards successful daily living.

NAMI-C.A.R.E Mutual Support Program

NAMI's consumer mutual support initiative offers an opportunity for growth and service to consumers as well. NAMI has a long history of providing and promoting mutual support for its members, and since about 1995, NAMI has been working diligently at helping consumers develop local mutual support groups. Many local NAMI affiliates started around kitchen tables all over the country as concerned relatives of people with mental illness ourselves, in order that we have safe, private places to share our hope and encouragement, and our experience at living with mental illness.

At present, some NAMI consumer mutual support groups call themselves NAMI-C.A.R.E. groups: an acronym that stands for "Consumers Advocating Recovery through Empowerment." As time has gone on , and as NAMI has developed successful model for Family Support Groups, the emphasis in consumer support is shifting from informal, do-it-yourself support groups to groups that are run by trained co-facilitators according to that same effective model. Materials and training are available to those who would like to start a NAMI C.A.R.E. mutual support group.

The Peer-to-Peer Education Course

The NAMI Peer-to-Peer Education Course is a nine-week, two hour per week, experiential education course about recovery for any person with serious mental illness who is interested in establishing and maintaining wellness. After a year and a half's preparation beginning in 1999, NAMI piloted The Peer-to-Peer Education Course in four states before rolling it out on a nationwide basis. The Course uses a combination of lecture, interactive exercise, and structured group processes. The diversity of experience among course participation affords for a lively dynamic that moves the course along and enriches each participants learning. Each course is taught by a team of three trained "mentors," or peer-teachers, who are themselves experienced at living well with mental illness. Mentor trainings are provided over long weekends in locations around the country. Being trained as a Peer-to-Peer mentor is a rewarding and important

opportunity to "give back" to others who are facing the challenges of living with mental illness.

NAMI's Peer-to-Peer Education Course is offered free of charge to people who experience mental illness, via NAMI state and affiliate organizations. You do not need to be a member of NAMI to take Peer-to-Peer, and we hope you'll join us through our "Open Door," or reduced price option.

American Indian and Alaska Native
Media Contact Results

Outlet Name	Contact Name	Contact Title	Phone	Fax	Email	City	State
American Indian Quarterly	Mihesuah, Devon	Managing Editor	402-472-5946	402-472-6214		Flagstaff	AZ
American Indian Report	Carroll, Marguerite	Editor	703-352-2250	703-352-2323	Marquerite.carroll@falmouthinstitute.com	Fairfax	VA
Bear Country	Mallon, John	Publisher	807-623-8545	807-623-7110		Thunder Bay	ON
Big Horn County News	Cenis, Bill	Publisher	406-665-1009	406-665-1012	News@bighorncountynews.com	Hardin	MT
Big Horn County News	Crockford, Dick	Editor	406-665-1009	406-665-1012	News@bighorncountynews.com	Hardin	MT
Carolina Indian Voice	Barton, Rick	General Manager	910-521-2826	910-521-1975	Carolinaindianvoice@nativewave.net	Pembroke	NC
Carolina Indian Voice	Bell, Joey	Business Columnist	910-521-2826	910-521-1975	Carolinaindianvoice@nativewave.net	Pembroke	NC
Carolina Indian Voice	Ledwell-Cummings, Wendy	Lifestyle Reporter	910-521-2826	910-521-1975	Carolinaindianvoice@nativewave.net	Pembroke	NC
Carolina Indian Voice	Locklear, Barbara B.	Features Reporter	910-521-2826	910-521-1975	Carolinaindianvoice@nativewave.net	Pembroke	NC
Char-Koosta News	Greene, Jennifer	Editor	406-675-3000 ext. 1350	406-675-6001	News4@charkoosta.com	Pablo	MT
Char-Koosta News	Sessions, Patti	Assistant Editor	406-675-3000	406-675-6001	News4@charkoosta.com	Pablo	MT
Cherokee Observer	McClain, Franklin	Language Editor	580-363-3363	580-363-3533	Ecwy@rectec.net	Blackwell	OK
Cherokee Observer	McLain, Franklin	Book Review Editor	580-363-3363	580-363-3533	Cfmclain@cherokeewoods.com	Blackwell	OK
Cherokee Phoenix and Indian Advocate	Agent, Dan	Editor	918-456-0671 ext. 2765	918-458-6136	Phoenix@cherokee.org	Tahlequah	OK
Chieftain	Johnston, Sandra	Editor	613-652-4395	613-652-2508	Comnew@magnacom.com	Iroquois	ON
Confederated Tribes of Grand Ronde	Merrill, Brent	Director/Editor	503-879-2321	503-879-2173		Grand Ronde	OR
Country Living	Gage, Marjorie	Deputy Editor	212-649-3519	212-956-3857	Mgage@hearst.com	New York	NY
Country Living	Konstantin, Lynn	Features Editor	212-649-3520	212-247-0864	Ikonstatin@hearst.com	New York	NY

American Indian and Alaska Native
Media Contact Results

Delaware Indian News	Roulston, Gary	Editor	918-336-5272	918-336-5513	Delawareindian@hotmail.com	Bartlesville	OK
Fort Apache Scout	Nez, Sky	Editor	928-338-4813	928-338-1894		Whiteriver	AZ
Gallup Independent	Brown, Alvarez, Gaye	Staff Writer	505-863-6811 ext. 224	505-722-5750	Gallpind@cia-g.com	Gallup	NM
Gallup Independent	Peter, Zsombor	Staff Writer	505-863-6811 ext. 224	505-722-5750	Gallpind@cia-g.com	Gallup	NM
Gallup Independent	Zollinger, Robert	Publisher	505-863-6811 ext. 301	505-722-5750	Gallpind@cia-g.com	Gallup	NM
The Hartford Courant	Green, Rick	Affairs Reporter	860-241-6483	860-241-3865	Green@courant.com	Hartford	CT
Indian Affairs	Flute, Jerry	Executive Editor	605-698-3998	605-698-3316		Sisseton	SD
Indian Journal	Morris, Connie	Publisher	918-689-2191	918-689-2377	Mcp1@mcalesternews.com	Eufaula	OK
KABC-TV	Hernandez, Miriam	Reporter	818-557-7777	818-863-7080	Abc7@abc.com	Glendale	CA
KCEC-TV	Pinzón, Juan	Reporter	303-832-0050	303-318-6252		Denver	CO
KILI-FM	Two Lance, Wilson	Program Director	605-867-5002	605-867-5634	Lakotaco@gwtc.net	Porcupine	SD
KUVN_TV	Brito, Alexis	News Anchor (Weekend) & Reporter	214-758-2300	214-758-2351	Abrito@univision.net	Dallas	TX
KZOL-FM	Brindis, Raul	Morning Show Host	559-456-4000	559-251-9555	Raulbrindis@netmio.com	Fresno	CA
Medial Herald	Wyatt, Hugh	Editor	212-983-3525	212-922-9211	Themedicalhearld@aol.com	New York	NY
Menomiee Nation News	Kaquatosh, Yvonne	Editor	715-799-5167	715-799-5250		Keshena	WI
Minority Nurse Magazine	Anderson, Valerie	Associate Editor	847-448-1005	847-475-8839	Valerie.anderson@casscom.com	Evanston	IL
NAPT (Native American Public Telecommunications)	Blythe, Frank	Executive Director	402-472-3522	402-472-8675	Native@unl.edu	Lincoln	NE
NAPT (Native American Public Telecommunications)	Koehler, Mary	Business & Project Manager	402-472-3522	402-472-8675	Native@unl.edu	Lincoln	NE
NAPT (Native	Patton Cornsilk,	Director of	402-472-3522	402-472-8675	Ccornsilk1@unl.edu	Lincoln	NE

American Indian and Alaska Native
Media Contact Results

American Public Telecommunications)	Carol	Programming & Production					
Narragansett Indian News- Kent County Daily Times	Young, Lauren	Editor	401-821-7400	401-828-0810	Kceditor@ricentral.com	West Warwick	RI
National Native News	Braine, Susan	General Manager of Cultural Program Development	907-258-8880		Sbraine@nativeamericacalling.com	Anchorage	AK
Native America Calling	Ghahate, Jon	Associate Producer	505-277-7999	505-277-4286	Native@unm.edu	Alburquerque	NM
Native American Press/Ojibwe News	Shortridge, Julie	Managing Editor	651-224-6656	651-224-6304	Presson@isd.net	St. Paul	MN
Native Peoples Magazine	Avey, Gary	Publisher	602-265-4855 ext. 14	602-365-3113	Gavey@natiepeoples.com	Phoeni	AZ
Native Peoples Magazine	Gibson, Daniel	Managing Editor	602-265-4855	602-265-3113	Dgibson@nativepeoples.com	Phoeni	AZ
Native Peoples Magazine	Phillips, Stephen	Associate Editor	Ext. 128	602-265-3113	Sphillips@nativepeoples.com	Phoeni	AZ
Native Voices-KHSU-FM	Ludlow, Candace	Coordinator	707-826-6085	707-826-6082	Khsu@humbolt.edu	Arcata	CA
Navajo Times	Arviso Jr., Tom	Editor	928-871-6641	928-871-6409		Window Rock	AZ
Navajo Times	Beyal, Duane	Managing Editor	928-871-6641	928-871-6409	Duanebayal@thenavajotimes.com	Window Rock	AZ
Navajo Times	Shebala, Marley	Reporter	928-871-6422	928-871-6409	Marleyshebala@thenavajotimes.com	Window Rock	AZ
Navajo-Hopi Observer	Marion, Don	Editor	928-226-9696	928-226-1115	Observer@infomagic.net	Flagstaff	AZ
NCAI Sentinel	Purdy, Laura	Development Assistant	202-466-7767	202-466-7797	Mary-velarde@ncai.org	Washington	DC
News Tribune	Carson, Rob	Reporter	253-597-8693	253-597-8274	Rob.carson@mail.tribnet.com	Tacoma	WA
Pequot Tomes	DeMeyer, Trace	Editor	860-396-6572	860-396-6570	Pequottimes@mptn.org	Mashantucket	CT
Sault Tribe News	Hatch, John	Editor	906-632-6398	906-635-7016	Saultribenews@saulttribe.net	Sault Sainte	MI

American Indian and Alaska Native
Media Contact Results

						Marie	
Seminole Tribune	Bowers, L. Rod	Editor	954-966-6300	954-967-3482	Tribune@seminoletribe.com	Hollywood	FL
Shiwi Messenger	Mahkee, Wells	Managing Editor	505-782-2336	505-782-4503	Wmahke@zuni.k12.nm.us	Zuni	NM
Sho-Pai News	Jones, Sandy	Editor	775-757-3211	775-757-2219	Shopaitr10@aol.com	Owyhee	NV
Stockbridge-Munsee Community	Gardner, Anne	Director of Communications	715-793-4388	715-793-4388	Mnation@frontiernet.net	Bowler	WI
Tahlequah Press	Poindexter, Kim	Editor	918-456-8833 ext. 19	918-456-2019	Press@intellex.com	Tahlequah	OK
Tulalip Tribes	Sheldon, Lita	Communications Manager	360-651-4330	360-651-4334	Seeyah@sub@aol.com	Marysville	WA
Turtle Mountain Times	Davis, Logan	Editor	701-477-6670	701-477-6875	Thetimes@utma.com	Belcourt	ND
Utne	Utne, Eric	Founder	612-338-5040	612-336-6043	Editor@utne.com	Minneapolis	MN
Wana Chinook Tymoo	Hudson, Charles	Public Information Manager	503-731-1257		Hudc@critifc.org	Portland	OR
The Washington Post	Cohn, D'Vera	Metro Reporter	202-334-7233	202-334-5672	Cohnd@washpost.com	Washington	DC
The Washington Post	Harriston, Keith	Deputy Metro Editor	202-334-6249	202-334-5672	Harristonk@washpost.com	Washington	DC
WEXS-AM	Garcia, Enrique	General Manager	787-839-0610	787-839-0960		Patillas	PR
WGTD-FM	McGrath, Dave	News Director	232-656-6973	262-564-3801	Mcgrathd@gtc.edu	Kenosha	WI
Wikwemikong Newspaper	Murray, Ellen	Editor	705-859-2933	705-859-2000	Wikynew@wiky.net	Wikwemikong	ON
Winds of change	Weidlein, Jim	Managing Editor	303-444-6607	303-444-6607	Jrw@indra.com	Boulder	CO
Witness	Ralph, Thomas	Editor		563-558-0557	Dbqcwo@arch.pvt.k12.ia.us	Dubuque	IA
WMCH-AM	Seaver, Randall	News Director	423-357-5601	423-357-5601	Randall@weye.org	Church Hill	TN
WOFX-FM	Tolliver, Tony	News Director	513-421-9724	513-749-4923	Ttolliver@wofx.com	Cincinnati	OH
WOJB-FM	Schurbring, Erick	News Director	715-634-2100	715-634-3906	Wojbfm@aol.com	Hayward	WI
Wotanin Wowapi	Red Elk, Bonnie	Editor	406-768-5387	406-768-5743	Wotanin@netmontel.net	Poplar	MT
WZUP-FM	Aycock, Keith	Editor	877-747-8887	877-747-8888		Snow Hill	NC

FOR MORE INFORMATION
CONTACT NAMI'S
MULTICULTURAL & INTERNATIONAL
OUTREACH CENTER (NAMI MIO)
703-524-7600
1-800-950-NAMI (6264)

The Nation's Voice on Mental Illness

COLONIAL PLACE THREE
2107 WILSON BLVD. SUITE 300
ARLINGTON, VA 22201-3034
800-950-NAMI (6264)