1991

A roundtable conference on dysfunctional behavior and its impact on Indian health.

JA Kauffman

J. Smith

Follow this and additional works at: http://digitalrepository.unm.edu/nhd

Recommended Citation

A ROUND TABLE CONFERENCE ON DYSFUNCTIONAL BEHAVIOR AND ITS IMPACT ON INDIAN HEALTH

FINAL REPORT

INDIAN HEALTH SERVICE
December 11-12, 1991
Albuquerque, New Mexico
INTRODUCTION

The Indian Health Service (IHS) sponsored a “Roundtable Conference on Dysfunctional Behavior and its Impact on Indian Health” in Albuquerque, New Mexico, on December 11-12, 1991. The IHS convened the group of experts to develop consensus statements regarding important, topical, and controversial issues related to “dysfunctional behavior and its impact on health in American Indians and Alaska Natives (AI/AN) communities.” The panel included experts in the areas of AI/AN family health, mental health, employment, counseling, and substance abuse from the community, clinical, academic, and health policy settings.

The IHS used a consensus statement model similar to the National Institutes of Health (NIH). The NIH has used this method of consensus building among health science professionals to develop standards of care and generate general guidance in the health field. The issues that were examined in this Roundtable were of a health policy nature rather than a clinical nature. The meeting was held to provide a means of bringing together a variety of perspectives and forming a consensus statement on issues related to dysfunctional behavior. The Roundtable process did not require unanimous agreement on issues, but basic agreement on statements which accurately reflected the position of its panel members, including positions of dissent.

Dysfunctional behavior has been defined as “The inability of an individual and those people affected by that individual at times to love, be fulfilled, and contribute in the context of their family, culture, and community” (Nelson). To grasp the significance of dysfunctional behavior in the context of health status, the Roundtable participants were provided data and a review of the literature describing the human and financial costs to families affected by dysfunctional behavior of its members. The range of behaviors can include alcoholism, chronic unemployment, mental illness, drug or inhalant abuse, promiscuity, child abuse, gambling and other addictions, self-destructive acts, violence in all forms (e.g., sexual abuse, domestic violence, homicide, suicide, etc.) and other criminal offenses.

In July 1991, the IHS published an article in The Provider entitled, “A Research Agenda for Indian Health: Research in Family Function and Dysfunction.” In this article, particular attention was given to the myriad of AI/AN health problems which seem to be associated with “dysfunctional families.” A dysfunctional family is generally defined as one in which the focus of the family’s attention is on something other than the nurturing of its members. For example, primary attention may be focused on the alcoholism and violence of one of its caretakers, rather than the well-being of its members. “Denial” of the behavior by family members is key to sustained family dysfunction. The IHS has recognized that to accomplish its mission of elevating AI/AN health status to its optimal level, it must understand and address the impact of dysfunctional behavior.
The long-term impact of dysfunctional behavior has multi-generational effects. The IHS is confronted by AI/AN mortality and morbidity trends which seem to be tied to dysfunctional behaviors, which are enmeshed in a systemic collage of historic, cultural, psychosocial, and multi-generational factors. Vital health statistics on deaths due to alcoholism, homicide, and suicide are identifiable indicators of dysfunctional behavior in the community. For the period between 1982 to 1987, alcoholism mortality in the AI/AN population hovered between 25 and 30 per 100,000 population; this is between 4 to 5 times the U.S. All Races rate. Age-adjusted alcoholism mortality for the AI/AN has declined since the 1970's, but this downward trend has now reversed. The IHS 1991 Trends Data Book shows AI/AN alcoholism mortality rising at its highest rate since 1980. Alcoholism mortality rates are highest in both men and women in age groups 45-54 and 55-64. Men die of alcoholism at a higher rate than do women, except in the 15-24 age group, where women's deaths are slightly higher than men's.

Correlation between dysfunctional behavior and other less obvious health problems such as infant mortality, chronic disease, unintentional injuries and deaths due to accidents, is cause for serious attention to be paid to dysfunctional behavior as a risk factor for prevention activity. The Roundtable found that simply identifying families as “dysfunctional” and intervening to prevent the onset of other health problems, without understanding and addressing the dysfunctional behavior of the individual, family, community, and tribe, and without seeking the opportunity for long term “optimal functioning” in a cultural holistic context, would be shortsighted.
CONSENSUS STATEMENTS

The Roundtable participants developed statements reflecting consensus on issues related to dysfunctional behavior and its impact on AI/AN health. First and foremost, the consensus was that the IHS and those working in AI/AN communities must understand and value the resilience of healthy traditions and cultural strengths. Attention should be given to “functional” aspects of AI/AN life. “Dysfunctional behavior” should be defined within those aspects; they should be taken into account in any effort to overcome dysfunctional behavior. In that context, the participants reached consensus on the following statements:

STATEMENT #1: CREATE A VISION FOR HEALTH

The Roundtable envisioned AI/AN Nations and communities being attentive to the interconnectedness of all things and beings, as well as the ability to grow and develop as human beings. They also envisioned that interconnectedness implies accountability and responsibility, not only for the individual, but for the family, tribe, and community, including those systems that serve them. This interconnectedness is called “optimal functioning.” Optimal functioning of self and others is a continuum that includes the ability to love, nurture, contribute, and be fulfilled within the relationship of family, culture, and community. The elements of optimal functioning include balance and nurturing of the physical, mental, emotional, and spiritual areas of the human being (love, work, play, bicultural and multi-cultural living, coping mechanisms, sobriety, etc.)

STATEMENT #2: FAMILY

There is a need to recognize the resiliency of AI/AN families. The Roundtable participants recognized the enormous capacity of the family unit to survive and wished to enhance and support their healthy functioning. By focusing on the family unit, the Roundtable participants hoped to promote the preservation of AI/AN tribes and culture. The concept of family, as significant persons available for nurturing support, needs to be seen within the context of a changing society. Thus, “families of choice,” that is, various forms of surrogate relationships, have been added to the traditional definition of nuclear and extended family.

STATEMENT #3: CULTURAL WELLNESS

The Roundtable participants were unanimous in their position to preserve and enhance the integrity of the AI/AN, to reverse the effects of cultural oppression which, in the opinion of the Roundtable, contributes to dysfunctional behavior. The IHS, tribes, and AI/AN organizations must build on the healing, vitality, and resilience inherent within the individual, family, tribes, and community. The Roundtable participants agreed that intergenerational effects of cultural oppression, grief and loss have divided families, tribal organizations,
communities, and tribes, and that a comprehensive and sustained healing within the family unit, must occur to foster the feeling of connectedness. The Roundtable participants made the following recommendations:

A. An effort must be made by AI/AN and non-Indian health care providers to incorporate and respect the values, beliefs, and traditions of the AI/AN in the planning and delivery of quality community-based services. Specialized training must be provided to the IHS professional staff for this purpose; and,

B. Intertribal efforts and coordination must occur to reduce the turmoil created by dissension so the cycle of pain, loss, and isolation can be broken. There is a need to promote tribal identity. The value of sharing traditional and contemporary resources and beliefs, to facilitate a sense of belonging, should be encouraged.

STATEMENT #4: CREATE A HEALING ENVIRONMENT

The Roundtable participants took the position that AI/AN communities must break the silence around dysfunctional behaviors. Community awareness of the issues that affect individual and family wellness is the first step in a healing process. This includes identifying existing strengths, resources, and needs or disparities that impact individuals, families, communities, and service delivery systems. This must include a challenge to leaders at all levels (the IHS, the Bureau of Indian Affairs (BIA), tribes, schools, etc.) to look at their own issues, begin their own healing, and as healthy role models, make the commitment to promote wellness and community rebuilding. The participants made the following specific recommendation:

Leadership must develop a community wellness plan involving a variety of community organizations, programs, and individuals to carry out this healing process. This collaboration should focus on healthy role models, improved human services delivery, and coordination of resources to achieve the goal of community wellness.

STATEMENT #5: HOLISTIC APPROACH VS. MEDICAL MODEL

The current model of medical service delivery advocates a polar view of functional vs. dysfunctional behavior and enables a rigid, hierarchical, and exclusionary relationship among service providers. This model also encourages a narrowly defined and fragmented health care delivery system as exemplified by the IHS. There is a need to go beyond the medical models goal of diagnosing and classifying illness to a more comprehensive assessment of the scope of individual and family strengths, resources, and needs. This could be accomplished through a community-based holistic approach. A multi-disciplinary collaboration of Native healing and resources is the key to
addressing complex individual and family health care issues. Adhering to the holistic approach would not only force better coordination among fragmented services, but also foster an attitude towards building healthy lifestyles, rather than mere symptom removal.

RECOMMENDATIONS:

A. There must be training in Case Management and Case Collaboration to the IHS, tribal, and other providers of health care services to AI/AN communities;

B. As a top priority, at least 10 percent of the IHS resources must be dedicated to case management to improve holistic care to AI/AN;

C. Representation(s) of AI/AN views must be incorporated into the next revision of the Diagnostic Standards Manual for Mental Health (DSM) IV. The IHS should convene a special panel to develop a diagnostic manual specific to AI/AN experiences, culture, and recognition of strengths; and,

D. The IHS needs to assess the delivery system, explore health seeking behaviors, and identify the barriers to adequately service the needs of individuals and families in a holistic context. The IHS must broaden the definition of service delivery beyond one-to-one clinic visits to include outreach in homes and group activities.

STATEMENT #6: EPIDEMIOLOGY

Professionals and paraprofessionals working in AI/AN communities need to be oriented on the culture, history, and structure of the tribe or AI/AN communities served. The law (Section 113 of Public Law (P.L.) 100-713) requires that such training and orientation be provided; on-going training and education needs to be provided.

The Roundtable participants found that there is a paucity of reliable baseline data about the functioning of AI/AN individuals, families, and communities. Without baseline data, which consistently and uniformly describes individual and social functioning in all dimensions (physical, emotional, mental, and spiritual), AI/AN cannot demonstrate progress in achieving greater levels of wholeness and wellness. In this regard, it was recommended that:

A. An interdisciplinary task force should be formed by the IHS to address the need for baseline data addressing the functions and dysfunctions of AI/AN, families, communities, and tribes; and,

B. The Roundtable urges the creation of more centers focusing on AI/AN issues which do research, research training, information dissemination,
and technical assistance. The Roundtable supports AI/AN self-determination. The AI/AN communities need to become involved with the establishment and implementation of their own research agenda.

STATEMENT #7: FUNDING ISSUES

Federal agencies (IHS, NIH, Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), Maternal and Child Health Bureau (MCH), Centers for Disease Control (CDC), BIA) funding needs to be reprogrammed to implement mental health, social services, substance abuse, and child welfare services to address prevention, intervention, and treatment of dysfunctional behavior as directed in P.L. 94-437, P.L. 100-713, P.L. 101-630, P.L. 99-570, and P.L. 100-690. As an example, the IHS Mental Health (IHS MH) programs were authorized to provide for improved mental health and child abuse and neglect services in the amount of $19.2 million for fiscal year (FY) 1992. The IHS MH budget increased by only $2 million during a time when the IHS budget was increased by $450 million (FY 1991 and FY 1992).

Agencies need to ensure that funds are available to provide the complete continuum of care (primary, secondary, and tertiary care) with tribes taking an active role in pursuing additional funding and developing programs. The Roundtable participants are encouraged about the demonstration project approach. When programs have been evaluated as effective, mechanisms need to be included to ensure continuation and replication in other tribal communities and programs.

STATEMENT #8: PROMOTE SHARING AND ACCESS

A means to facilitate sharing and access to information about programs, resources, literature, studies, experts, etc., is needed for tribes and local AI/AN communities. It was recommended that the IHS initiate an inter-agency collaboration process with the BIA, Administration for Native Americans (ANA), Office for Substance Abuse Prevention (OSAP), and other related organizations to disseminate models of successful tribal or community programs or initiatives via conferences, publications, videos, telecommunications, clearinghouses, and newsletters, etc.
BACKGROUND INFORMATION ON DYSFUNCTIONAL BEHAVIOR AND INDIAN HEALTH STATUS

The Roundtable participants represented a broad spectrum of backgrounds and experience in AI/AN communities. The consensus statements reflect the perspective that “dysfunctional behavior” is more prevalent than anticipated and that addressing the roots and multi-generational nature of dysfunctional behavior may offer significant insight and opportunity for wellness and balance in AI/AN communities. Their analysis of dysfunction centered on AI/AN individuals, families, communities, or entire tribes which find themselves “out of balance” and not able to function in a manner which is nurturing, fulfilling, accountable, and responsible.

The theme of “being out of balance” was consistent throughout the discussions of the Roundtable. The genesis of “dysfunctional behavior” in AI/AN communities could not be identified with absolute certainty, but the panel identified perturbations or assaults to a normal healthy system of coping as key. The Roundtable agreed that trauma is a part of life, as death is a part of life; however, the inability of an individual, family, or community to identify, understand, and process the trauma, are indications of the beginnings of dysfunction or non-function. A coping system must be found for traditional AI/AN societies where understanding one’s life through rituals and teachings of balance and harmony becomes disrupted at times. The Roundtable identified the effects of cultural oppression, racism, loss of traditions, boarding schools, and its impact on family and parenting, alcoholism and substance abuse, and internal violence as major contributors to sustained, multi-generational dysfunctional behavior.

Cultural Oppression:

In an unpublished essay, Anna Latimer, a Native Mental Health Therapist, compiled the observations of authors on the subject of cultural oppression and the impact of institutionalized racism on AI/AN in today’s society. Her research finds that the dominant culture has institutionalized both its position of economic/racial power and its cultural values in such a way as to create a sense of powerlessness and hopelessness in minority cultures (such as those of the AI/AN). The “racism” which exists in the majority culture institutions is not readily visible or easily attacked. The anger and frustration with this powerless position may be expressed by members of minority cultures in the form of “horizontal violence” where individuals within the culture turn on each other or themselves in acts of violence or self-destructive behavior.

Middleton-Moz (as cited in Latimer) builds a case for institutionalized “self-hate” by observing that often, native people devalue other natives. A couple of examples of “self-hate” in action are: 1) choosing not to hire qualified fellow
tribal members for jobs; and, 2) meeting efforts by tribal members to solve community problems with sabotaging tactics. This is also an example of how dysfunctional behaviors can influence community behaviors and become community dysfunction. Middleton-Moz suggests that prolonged feelings of helplessness can stop communities from looking for solutions and ways to work through past problems. She indicates that communities may be impaired, and begin to deny information suggesting control over the situation, is possible to achieve. Cultural oppression and self-hate can produce significant undercurrents of dysfunctional behavior in entire AI/AN communities. Community-wide dysfunction creates real barriers to effectively addressing improved health and wellness initiatives.

Poverty—the Impact of Social Disadvantage on Health:

Child homicide has been linked with a number of family characteristics. However, in sociological cross-national studies, the level of government spending on social programs has had a mitigating effect on the child homicide rate especially in societies where women make up a large part of the labor force (Gartner 1991). There is also a great deal of research in literature that ties social disadvantage to higher rates of severe mental illness (Hamburg, Parron, 1982). Not all researchers support the idea that social disadvantage is a cause of mental illness, but the high correlation between the two conditions cannot be ignored as relevant to the issue of dysfunctional behavior in the community.

If one considers the social etiology of the increased risk of mental illness among those in the lower socioeconomic rungs of society; then, being socially disadvantaged could very well be considered a contributing factor to dysfunctional behavior in the community. Hamburg and Parron put forth four explanations of increased prevalence of mental illness among the socially disadvantaged: 1) increased chances of receiving a more severe diagnosis; 2) greater frequency and duration of stress among the socially disadvantaged; 3) more restricted options for dealing with stresses; and, 4) fewer and less equal treatment resources available to the socially disadvantaged.

Some of the increased exposure to stress and reduced access to options in dealing with stress could be a function of racism interacting with social disadvantage. Some studies, discussed by Hamburg and Parron, demonstrated greater environmental exposure to pathogens on the job was more frequently the case for Blacks than Whites, even under conditions of equal employment. Also, it has been shown that Blacks receive poorer quality and less comprehensive health care services than Whites of equal socioeconomic status. The racial differences in exposure to pathogenic environments and access to quality health care for Blacks and Whites is likely to also apply to differences between AI/AN and Whites.
Alcoholism and Substance Abuse:

The tremendous and overwhelming effects of alcoholism and substance abuse on AI/AN health cannot be overstated. Alcoholism and alcohol abuse are the cause of a large percentage of social and health problems experienced in AI/AN populations where the end results are domestic violence, homicides, suicides, depression, deaths, and injuries. There is also a disproportionate amount of suffering and death from illnesses such as pneumonia, diabetes, and cancer. The link between alcoholism and “dysfunctional behavior” is much more resounding when examined in a multi-generational concept. While there is little argument that alcoholism or alcohol abuse leads to dysfunctional behavior by the alcoholic, such as criminal behavior, violence, or chronic unemployment, more is being understood about the effects of alcoholism on the behavior of the alcoholic’s family members.

The psychosocial hazards of growing up in an alcoholic home have been researched and documented by therapists and researchers in the field, such as Claudia Black, Jane Middleton-Moz, and Robert Ackerman. The basis for alcoholism as a “family disease” stems from the pervasive element of denial regarding the disease itself. Ackerman has found that children of alcoholics are more likely than other children to be physically, emotionally, and sexually abused by their caretakers. Yet, children of alcoholics are also less likely to report these abuses, due to their own denial, and their efforts to protect the family from outside intervention by authorities. The survival patterns developed by children in alcoholic homes have been identified by Black as “Don’t Trust; Don’t Talk; and Don’t Feel.” Children of alcoholics are more likely to develop their own alcoholism or substance abuse, seek out, and marry an addicted or dependent spouse, experience self-destructive behavior, depression, suicide, promiscuity, violence, and difficulty in parenting in a healthy family environment. Middleton-Moz suggests that these difficulties are compounded by a double stigma or triple stigma as added traumas occur, such as sexual abuse, racism, and poverty. She adds that the resilience of children in this environment can also be aided by nurturing and supportive adults, such as grandparents or school counselors.

Domestic Violence:

Though little data is available on the magnitude of the problem of domestic violence in AI/AN communities, Ms. Phyllis Old Dog Cross, an IHS mental health worker indicated in 1982 that rape, sexual assault, and incest were occurring at a much higher rate in AI/AN communities than generally believed. This appears to be the growing consensus among mental health professionals working with AI/AN families and communities.

Ms. Old Dog Cross goes on to state that where the typical battered woman syndrome is observed, sexual assault is the norm. She reports that in a survey
conducted at a five-state regional psychiatric center, at least 80 percent of AI/AN women receiving care had experienced child sexual assault. She goes on to state that, boys who witness the physical abuse of their mothers are more likely to batter their female partners as adults than boys raised in non-violent homes; therefore, 95 percent of the victims of domestic violence are women. The rise of domestic violence and sexual assault against women in AI/AN communities probably mirrors the rise of these problems in the majority culture. Identifying the cause(s) of this rise in violence against women is a source of much controversy; however, the National Woman Abuse Prevention Project in Washington, D.C., indicates that more than half of the children whose mothers are battered, are likely to be physically abused themselves.

Unaddressed and generally unrecognized as a health problem is the growing national trend in violent acts of abuse, both sexual and physical, in which women are the victimizers of children. Since all violent acts against family members are a source of shame in the AI/AN and majority cultures, effective action to address these problems is hampered by individual and community denial of the problem.

**Child Abuse and Neglect:**

Several studies have examined the issue of child abuse and neglect in AI/AN communities; prevalence rates of child abuse and neglect in AI/AN communities have not been reported to be higher than the general population (Piasecki). However, Lujan, et.al., indicated that considerable underreporting of cases occurs; this is especially true of cases of sexual abuse.

The American Indian Adolescent Health Survey conducted by the IHS and the University of Minnesota (U of M) found that the prevalence of American Indian child abuse and neglect does not appear to exceed rates in the White population (U.S. Congress). Unfortunately, as a self-reporting study, the results are likely an underrepresentation of child abuse, particularly sexual abuse, where denial and memory loss occurs. The results were reported as follows:

<table>
<thead>
<tr>
<th>Percentage of Indian and Minnesota Adolescents who Indicated ever being Physically or Sexually Abused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian Males (n=1,297)</td>
</tr>
<tr>
<td>6.0%</td>
</tr>
<tr>
<td>Indian Females (n=1,360)</td>
</tr>
<tr>
<td>Minnesota Urban Males (n=6,300)</td>
</tr>
<tr>
<td>Minnesota Urban Females (n=11,538)</td>
</tr>
</tbody>
</table>

The socioeconomic and psychosocial risk factors for abuse and neglect are more prevalent in the AI/AN population. Research conducted by Dr. DeeAnn DeRoin, an Indian family practitioner, studied child abuse reporting in AI/AN
communities; she presented her findings at a national meeting of the Association of American Indian Physicians in 1988. She found that while the overall rate of reports for AI/AN does not exceed that of the general public, the rate of convictions of AI/AN child abusers far exceeded the number of convictions of child abusers in the general public. She suggests these findings substantiate a problem of underreporting, where only the most blatant and most severe cases, are reported in AI/AN communities. For individuals who have grown up in dysfunctional homes, the concept of “normal behavior” could be skewed or distorted. At a community level, this distortion of “normal” or “acceptable” behavior could also be a factor for underreporting of child abuse.

Two surveys conducted in the IHS Albuquerque and Phoenix service areas provide descriptive information on some of the major family characteristics common to households where child abuse and neglect exists. Alcoholism among family members, particularly parents and grandparents, was a common feature of households where child abuse and neglect took place. Family disruption, as a result of divorce or death in the family, due to accidents or alcoholism, was more common among the children who were more severely abused and neglected (Lujan, Piasecki). Adults in the household where abuse and neglect occurred were frequently victims of child abuse themselves (Lujan). In both studies, a combination of abuse and neglect was the most common diagnosis for children in the study (Lujan, Piasecki). Children experiencing both abuse and neglect were more likely to abuse non-alcohol related drugs and to be poly drug users than children who only suffered from neglect (Piasecki).

Behavioral, social, developmental, and cognitive deficits occur in children experiencing abuse and neglect. When compared to children who are emotionally disturbed, but have no history of abuse, abused/neglected children appear to exhibit similar diagnostic characteristics, yet are observed to be more violent. Symptomatically, female victims of child abuse were more self-destructive than non-abused females, while abused males were more aggressive than non-abused males.

Depression:

Shore, et al., described depression in a pilot study of AI/AN from different tribal groups. They found the two largest groups to be those with primary depression and those with depression secondary to alcohol abuse. There was a smaller, yet significant group of substance abusers who had underlying primary depression; this condition was more often observed in male patients. Each one of these groups required different treatment approaches; and therefore, careful distinguishing diagnoses. Shore concludes that there is a core of depressive conditions common among patients across different tribal groups. The varying nature of the types of depression observed in the AI/AN illustrates the importance of screening patients appropriately so that intervention more effectively addresses the problem in the individual AI/AN client.
**Excessive Loss and Delayed Grief:**

The AI/AN have an extremely high mortality rate when compared to other Americans. Death rates for AI/AN exceed the U.S. All Races rate up through the age of 64 years. The highest death rate is seen in the 25-34 age group where AI/AN die at almost two times the rate as others in the U.S. (Trends). In the Minnesota Adolescent Health Survey, AI/AN adolescents reported more often than White adolescents that one or both parents were dead (12 percent vs. 3 percent). When asked about family problems, over 50 percent of the AI/AN adolescents feared the immediate death of a parent.

The significance of AI/AN mortality on dysfunctional behavior, according to the Roundtable, was not that death occurs, but that the excessive number of deaths in AI/AN communities, combined with the lack of available grieving processes for members of these families, adds to the depression, delayed grief, and dysfunctional behavior of surviving family members. Rather than proceeding through a grief process, family members become stuck in anger or denial surrounding the deaths.

**Suicide:**

May, in a 1987 article, reported that the large majority of all AI/AN who attempt suicide are under age 25. Those who attempt suicide are considerably different, both in a qualitative and a quantitative sense, than those who complete suicides. The "attempted to completed suicide rate" is approximately 13 to 1; the AI/AN males are more likely to complete a suicide than AI/AN females. This sex difference in completion rate is in part due to the choice of suicide method. Males tend to choose more lethal methods such as guns or hanging. In general, though, the AI/AN tend to use more lethal methods than other groups in the U.S. population. Tribes that are undergoing rapid change and have a loose pattern of social integration, where a high degree of individuality is emphasized, have higher rates of suicide.

May considers suicide completers, suicide attempters, and sufferers of single vehicle crashes somewhat independent populations that overlap to a certain degree in their self-destructive intent. May also estimates that 20 to 40 percent of AI/AN suicide attempters are similar in intent and motive to those who actually succeed in killing themselves, while 2 to 20 percent of drivers in single vehicle crashes, may be highly suicidal.

A recently reported analysis (Grossman, Milligan, Deyo, 1991) of the Navajo component of the AI/AN Adolescent Health Survey examined risk factors for adolescents who reported attempting suicide. Factors that indicated high risk for attempted suicide among the Navajo adolescents surveyed were as follows: a history of mental health problems; alienation from family and community; having a friend who attempted suicide; weekly consumption of hard liquor; a
family history of suicide completions or attempts; poor perception of one's own health status; history of physical abuse; female gender; and, sexual abuse.

The age-adjusted suicide mortality rate for AI/AN is 1.3 times higher than the U.S. All Races rates; suicide age trends follow the homicide trends. However, the mortality rates in the 25-34 age group for AI/AN men, far exceed rates in other age groups for the same population. Suicide completion rates are far lower for AI/AN women compared to AI/AN men. However, suicide attempts are higher among AI/AN women compared to AI/AN men. Homicide rates are slightly higher than suicide rates for AI/AN women. Whereas, for AI/AN men, suicide rates are higher than homicide rates in the high risk age groups of 15-24 and 25-34.

Criminal Behavior:

Based on a review of the literature by LaFromboise, delinquency, and arrest rates of AI/AN are among the highest of any ethnic minority group. For violations committed under the influence of alcohol, AI/AN living in urban areas are taken into custody four times more often than Blacks and ten times more often than Whites. AI/AN youth are also more likely to be arrested for violations of the law committed under the influence of alcohol (LaFromboise).

Homicide:

The age-adjusted homicide rate among AI/AN is greater than the U.S. All Races population, although certain other minorities in the U.S. population experience homicide deaths at a higher rate than AI/AN. In 1987, the AI/AN homicide death rate was 1.6 times higher than the U.S. All Races rate. Peak rates in AI/AN of both sexes are observed in the 25-34 age group with high rates also observed in the age groups just above and below this category. This same age related trend is apparent in the U.S. All Races population.

Though the majority of homicides are not interracially motivated, racism is an important sociocultural factor in the risk of violence between individuals. Other sociocultural factors of importance are poverty, availability of weapons, media influences, and gender expectations. Spivak presented the following data before the House Select Committee on Children, Youth, and Families, for all U.S. races:

--80 percent of homicides occur between members of the same race;
--60 percent of homicides occur between two people who know each other; and,
--20 percent of victims and assailants in a homicide are from the same family.
Spivak relates that evidence is mounting to demonstrate that violence is a learned response to stress and conflict. Not only is exposure to violence in the home associated with violence in children and youth, but there is a growing body of work to indicate violence in the media is perpetuating violence in the community. Because of the way violence is portrayed on television, the use of it in conflict resolution is not seen by young people as having negative consequences and is viewed as a successful method.

In Spivak's opinion, the criminal justice system intervenes only after the fact. The law enforcement system is generally ineffective in preventing death or injury. The role of the public health sector should be, in Spivak's view, to prevent the use of violence in conflict resolution, to alter the environment, to reduce risk, and to advocate for secondary prevention through more extensive mental health and social support services for those at risk for violent behavior.

The IHS 1991 Trends Data Book reports that homicide rates for AI/AN men and women from 1986 to 1988 exceeded that for U.S. All races; although, AI/AN male homicide rates exceeded AI/AN female homicides for those between the ages of 1 to 4. Both sexes suffer a homicide rate twice the U.S. All Races for most age categories.

A Model for Comparing Dysfunction and Socioeconomic Status by the IHS Area:

In preparation for this final report, data was examined which compares the IHS Area socioeconomic data to violent mortality, as a means of predicting areas at risk for dysfunction. This is an experimental model developed by Ms. Juneal Smith, Research Assistant, Kauffman and Associates, Incorporated (KAI), for use by the Roundtable. It suggests a correlation between socioeconomic status and dysfunctional behavior.

Methods:

“Median household income, household size, percentage of males employed, and average years of school of adults over 25 years of age,” were combined into an index of socioeconomic status. The IHS Areas were designated as the units of analysis. Then, three sets of death rates were used to create an index of dysfunctional behavior. These rates were as follows: deaths due to alcoholism, homicide, and suicide. All these rates were taken from the “IHS 1990 Regional Differences in Indian Health Data Book.” They were all indexed to the U.S. All Races rates as ratios. Then, regression models were generated for socioeconomic status and dysfunctional behavior. Rates of short-stay hospital admissions were also indexed to national rates and compared to the two regression models and some individuals.
Results:

Socioeconomic status was negatively correlated with the dysfunction index by the IHS Area. The Phoenix and Navajo IHS Areas could prove to be high leverage points, either reducing significance of the correlation (Navajo) or increasing significance (Phoenix), if removed from the data set:

\[ r = -0.54 \]
95 percent C.I. for the B coefficient: -0.090143 to -0.002065
F stat = 4.2104, df= 1, 11

Dysfunction also appears to be positively correlated with the rate of hospital admissions. Thus, as the rates of death due to alcoholism, suicide, and homicide go up in an IHS Area, so does the rate of hospital utilization. So, if the death rates from these causes could be lowered, a reduction in hospitalization and hospital costs, could be effected:

\[ r = 0.59 \]
95 percent C.I. for the B coefficient: 0.008208 to 0.098036
F stat = 5.3740, df= 1, 11

The socioeconomic status of an area seems to be negatively correlated with the rate of hospital admission. Thus, as socioeconomic status declines in an area, the rate of hospital admissions increases. Raising the socioeconomic status could result in a decline in the demand and need for expensive hospital care in Al/AN communities:

\[ r = -0.57 \]
95 percent C.I. for the B coefficient: -1.017936 to -0.058630
F stat = 4.8382, df=1, 11

Some other trends in the data indicate that a high homicide rate in a given Area may be tied to low educational attainment and low rates of male employment in the Al/AN population served by that area. High suicide rates seem to be, to some degree, also tied to low rates of male employment, but not to educational attainment. Variables like median family income and household size do not appear to play much of a role by themselves in the various aspects of dysfunctional behavior examined in this analysis.

Finally, though deaths due to alcoholism appear to be correlated with deaths due to suicide, the link between alcoholism deaths and homicides by area is not strong.
A Comparison:

If one uses the “dysfunction index” model (alcohol, homicides, suicides) to rank order the IHS areas from the most dysfunctional to the least, the following would be the rank order list:

<table>
<thead>
<tr>
<th>Area</th>
<th>INDEX SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TUCSON</td>
<td>14.80</td>
</tr>
<tr>
<td>PHOENIX</td>
<td>14.72</td>
</tr>
<tr>
<td>ABERDEEN</td>
<td>14.61</td>
</tr>
<tr>
<td>BILLINGS</td>
<td>12.48</td>
</tr>
<tr>
<td>ALBUQUERQUE</td>
<td>12.23</td>
</tr>
<tr>
<td>ALASKA</td>
<td>10.88</td>
</tr>
<tr>
<td>NAVAJO</td>
<td>9.78</td>
</tr>
<tr>
<td>BEMIDJI</td>
<td>7.504</td>
</tr>
<tr>
<td>PORTLAND</td>
<td>7.476</td>
</tr>
<tr>
<td>NASHVILLE</td>
<td>5.758</td>
</tr>
<tr>
<td>CALIFORNIA</td>
<td>4.825</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>3.5011</td>
</tr>
</tbody>
</table>

Performing the same rank ordering of the IHS Areas by the “socioeconomic status Index” model would result in the following list going from the highest status to the lowest:

<table>
<thead>
<tr>
<th>Area</th>
<th>INDEX SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALIFORNIA</td>
<td>2.501</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>2.488</td>
</tr>
<tr>
<td>PORTLAND</td>
<td>2.443</td>
</tr>
<tr>
<td>NASHVILLE</td>
<td>2.301</td>
</tr>
<tr>
<td>PHOENIX</td>
<td>2.290</td>
</tr>
<tr>
<td>ALBUQUERQUE</td>
<td>2.213</td>
</tr>
<tr>
<td>BEMIDJI</td>
<td>2.029</td>
</tr>
<tr>
<td>ALASKA</td>
<td>1.950</td>
</tr>
<tr>
<td>BILLINGS</td>
<td>1.937</td>
</tr>
<tr>
<td>TUCSON</td>
<td>1.874</td>
</tr>
<tr>
<td>ABERDEEN</td>
<td>1.739</td>
</tr>
<tr>
<td>NAVAJO</td>
<td>1.372</td>
</tr>
</tbody>
</table>

By examining the two lists above, one can see the opposite trends in direction. The IHS areas with high indexes of dysfunction tend to be toward the bottom of socioeconomic status index list, suggesting a correlation between factors of poverty and its impact on normal functioning.
AMERICAN INDIANS AND ALASKA NATIVES PROGRAM(S)  
TARGETING DYSFUNCTIONAL BEHAVIORS

Mental health prevention and treatment services are a major component of the Indian Health Care Improvement Act (amended P.L. 100-713 and approved on November 23, 1988). The Act is up for re-authorization in this year as is the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (P.L. 99-570). In addition, the Indian Child Protection and Family Violence Prevention Act is intended to have Federal agencies (the IHS and the BIA) address the issues around child abuse and family violence in AI/AN communities. Unfortunately, neither the IHS MH nor the Indian Child Protection and Family Violence Prevention Act have been given an adequate share of the IHS appropriations for implementation.

The IHS receives a modest line-item for alcoholism and mental health treatment in congressional appropriations each year. This funding is inadequate to meet the need, and does not represent the number of other providers dealing with issues related to dysfunctional behavior. Hospital social workers provide some services related to substance abuse, domestic violence, child abuse, and other health problems stemming from dysfunctional behavior. According to the IHS workload data, Public Health Nurses (PHN) and Community Health Representatives (CHR) also provide services in this area. Annual increases for mental health services at the IHS increased by only $2 million in FY 1991, a year when the IHS received a significant overall increase in appropriations.

In the 1986 Congressional Office of Technology Assessment (OTA) report on Indian Health Care, the authors indicated that utilization of mental health and alcoholism services by the AI/AN population, is dissonant with the estimated need for those services. LaFromboise, in her article on Indian Mental Health Policy, suggested this underutilization of existing services may be due to two factors: 1) the patient's perception that the services offered are unresponsive to his/her needs; and, 2) fear and mistrust of non-Indian psychologists (and other mental health care providers) due to their insensitivity toward the cultural complexities of AI/AN problems.

The IHS inpatient data from the IHS 1990 Trends Data Set showed only two categories of health conditions that could be associated with dysfunctional behavior; these were injuries & poisonings and mental disorders. Typically, the "injuries & poisonings" category incorporates all injuries, whether they are accidental, self-inflicted, or inflicted by another party. Injuries and poisonings were the leading reasons for hospitalizations of AI/AN males (17.6 percent of total hospitalizations of males) seen in the IHS direct service and contract hospitals in 1988.

Conditions in the "Mental Disorders" category constituted the fourth leading reason for hospitalizations of AI/AN males representing 6.8 percent of the total male admissions. Hospitalizations for AI/AN females in these two categories,
when combined together, constituted less than 10 percent of total female admissions for 1988. In absolute numbers, male admissions exceeded female admissions in these two categories.

Mental health services were provided by CHR and PHN. Though mental health technicians, psychologists, psychiatrists, and social workers do provide services to AI/AN communities via the IHS direct service or contract health care, their workload statistics are not readily available for review by this Roundtable panel. For PHN, mental health services were given in 6.2 percent of their client visits. Whereas, CHR identified mental health problems as the leading reason for client contact in only 1.2 percent of contacts made.

Despite the apparent needs for mental health services, rates for hospitalizations related to mental disorders, have declined in the IHS system faster than observed in private sector and public-county short-stay hospital systems. Though AI/AN patients may receive mental health services on an outpatient basis, this is not apparent from the ambulatory care data collected by the IHS. The OTA Report stated that the IHS MH services are generally regarded as relatively unavailable, and alcoholism treatment and prevention programs do not meet the need for them in the areas that they serve.

Mental health services provided by tribal entities are incorporated into less than one-half of the 61 tribal health programs created through enactment of the 1975 Indian Self-Determination and Education Assistance Act. Yet, informal sources of support for AI/AN community mental health can and do exist. The extended family, and even political organizations, provide informal community and tribal support for the improvement of mental health (LaFromboise 1990).

Successful programs for the treatment of substance abuse problems in the AI/AN population have yet to be systematically evaluated. Many treatment programs lack any guiding philosophy of treatment. Many researchers in the field believe that a single treatment modality for substance abuse for AI/AN would be unsuccessful because of the diversity of use patterns and psychosocial situations that surround abuse in this population (Institute of Medicine (IOM) 1990).

In the treatment of alcoholism, there has been a need for a new multi-modality strategy for treatment. However, the relative absence of treatment outcome evaluation in AI/AN alcoholism programs, makes strengths and weaknesses of each modality difficult to assess. A number of long-standing questions continue to go unanswered about effective treatment of alcoholism in AI/AN. Some of the important questions identified by IOM as needing answers are: 1) What specific programs produce successful treatment outcomes; 2) What individual modalities or blends of treatment modalities work best for particular sub-populations of AI/AN clients; and, 3) What is the significance of the interplay between sociocultural factors and successful treatment outcome?
DISCUSSION OF THERAPY TECHNIQUES
AMERICAN INDIANS AND ALASKA NATIVES

Many Al/AN seek professional assistance only after informal community-based networks have failed or are unavailable. The incompatibility of conventional counseling approaches and indigenous perspectives are frequently a source of much discussion in the counseling literature. LaFromboise, Trimble, and Mohatt analyze four counseling theories in order to help improve decisions about appropriate treatment approaches with Al/AN.

Person-centered or Rogerian therapy emphasizes internal values and autonomy, and is broadly consistent with traditional Al/AN values. However, there are several process-oriented aspects of this form of intervention that creates barriers for effective counseling. Primarily, the problem with this type of therapy is the focus on the one-on-one interaction of the client and the therapist outside the context of the family system and community.

Social learning theory appears to deal with diverse cultural norms better than person-centered therapy because of its skills-training paradigm. Social skill training focuses on teaching appropriate every-day skills and behavior to clients through the use of modeling and rehearsing activities in the therapy session. Behavioral therapy, like social skills training, is action-oriented and focuses on the present, rather than the past. This present-time focus of therapy is consistent with Al/AN cultural world views, according to these authors. Behavioral therapy techniques also can be more easily adapted to para-professional implementation than some of the other forms of therapy. However, social skills and behavioral therapy methods have a potential for misuse through a too narrow or inappropriate foci. This potential increases when the behavior change processes are controlled by the professional's goals and does not respect the client's goals.

The fourth form of therapy and the one most strongly advocated by the referenced researchers, is the network approach. The client and his or her problem is addressed in the context of a family and community social system. This type of therapy is less formal in nature, often conducted in the home or community, where a large number of family members can participate. Because of the traditional Al/AN value of family and community, this form of therapy sounds appropriate in the ideal circumstance. Yet, in a large extended family household where considerable dysfunction exists, it may be difficult to achieve.

LaFromboise, et.al., as well as others writing in the field of mental health for Al/AN, mentions "reconstituted families" and "re-traditionalization" as social movements appearing in Al/AN communities. The potential impact these movements might have in altering dysfunctional behavior within communities, merits some consideration in the Roundtable discussion.
COMMUNITY RECOVERY MOVEMENTS

There are many Al/AN communities that are actively involved in their own “community recovery.” Triggered in large part by the popular documentary, “The Honour of All,” about a Canadian Indian village which struggled to overcome rampant alcoholism, many U.S. Al/AN communities are building upon sobriety to include a more comprehensive recovery process. For example, the Salish-Kootenai Confederated Tribes on the Flathead Indian Reservation, in western Montana, has used Federal funding from the Omnibus Anti-Drug Act of 1986, to develop the Blue Bay Healing Center. The tribe's approach is to treat the whole community, beginning with tribal leaders, educators, law enforcement people and others, prior to approaching the treatment and prevention needs of their youth. This philosophy requires that healthy and sober adults will make better role models for health and support persons for sober youth.

The Pine Ridge Indian Reservation and the Cheyenne River Sioux have incorporated their efforts (to eliminate alcoholism) into tribal ordinances on the licensing of alcohol vendors, domestic violence, and prenatal substance abuse. A consistent feature to most successful Al/AN community recovery efforts is the emphasis on restoring tribal traditions and a strong value on native spirituality. Communities which have made a commitment toward recovery from alcohol, violence, suicide epidemics, etc., seem to proceed with or without Federal intervention. The National Association for Native American Children of Alcoholics (NANACOA) was formed in 1988 without any Federal support, and has held three national training conferences for Al/AN in the past 3 years. These training sessions have drawn between 500 to over 1,000 Al/AN participants annually, focusing on issues of children of alcoholics, child sexual abuse, boarding school recovery, cultural oppression/depression, and other issues central to Al/AN community recovery from dysfunctional behavior.

ADOLESCENT HEALTH PROGRAM, *Results of the Indian Health Service Adolescent Health Survey for the National Native American Sample*, Minneapolis, Minnesota, University of Minnesota (unpublished report), April 1990.


INDIAN HEALTH SERVICE, *Indian Health Service Regional Differences in Indian Health 1990*, U.S. Public Health Service, Department of Health and Human Services.


NELSON, SCOTT, M.D., Chief, Mental Health Programs Branch, IHS Headquarters West, Personal Interview with Juneal Smith, 1991.


PARTICIPANT LIST

Nancy Abel, Yerington Paiute tribe
Child Abuse Prevention Educator
P.O. Box 21
Wadsworth, Nevada 89442
(702) 575-2890
(702) 463-2416 FAX

Phyllis Old Dog Cross
9609 Walden Lane
Black Hawk, South Dakota 57718
(605) 787-4017

Candace Flemming
UCHSC, Department of Psychiatry
4200 East 9th Avenue, Room C249
Denver, Colorado 80262
(303) 270-4600

Yvette Joseph
Senate Select Committee on Indian Affairs
838 Hart Building
Washington, D.C. 20510-1102
(202) 244-2251

JoAnn Kauffman
Kauffman and Associates, Inc.
206 G Street, Suite 200
Washington, D.C. 20002
(202) 543-3944

Wanda Kittrell
Choctaw of Mississippi
P.O. Box 6010
Philadelphia, Mississippi 39350
(601) 656-5251

Dr. Teresa LaFrombolse
University of Wisconsin
Department of Psychology and Consulting Education
1000 Bascom Hall, Box 56
Education Building, 3rd Floor
Madison, Wisconsin 53706
(608) 263-1397

Anna Latimer
Middleton-Moz, Moz and Latimer, Assoc.
515 116th Ave NE, Suite 165
Bellevue, Washington 98004
(206) 842-6732

Leo J. Nolan, Director
IHS/OPEL, Room 6-40
5600 Fishers Lane, Parklawn Building
Rockville, Maryland 20857
(301) 443-4700

Marianne O'Neal, Chief, Social Work
Mental Health Initiative Program
IHS Headquarters West, Room 210S
300 San Mateo NE, Suite 500
Albuquerque, New Mexico 87108
(505) 262-2873

Donna Powaukee
TERO Program
Nez Perce Tribe
Box 365
Lapwai, Idaho 83540
(208) 843-2253

Louise Zokan-Delos Reyes
BIA Branch of Social Services
316 N. 26th Street
Billings, Montana 59101
(406) 657-6651

Dr. Eva Smith
Alcoholism/Substance Abuse Program
IHS-HQ West, Room 4S
300 San Mateo NE, Suite 500
Albuquerque, New Mexico 87108
(505) 766-2115

Juneal Smith
UCLA
11120 National Blvd #7
Los Angeles, California  90064
(213) 477-6415

Anna Sorrell
Blue Bay Healing Center
Salish-Kootenai Confederated Tribes
Tribal Human Services
26 Round Butte Road W.
Ronan, Montana 59864
(406) 676-2500

Beverly Wilkins
Albuquerque Indian Health Service
Mental Health Initiative
2401 12th Street NW
Albuquerque, New Mexico 87102
Wednesday, December 11, 1991

9:00 Welcome and Introductions
Leo J. Nolan, IHS/OPEL

9:30 Overview of Agenda and Consensus Building Process
JoAnn Kauffman, Consultant to the IHS

9:45 Defining our Mission
JoAnn Kauffman

10:00 Discussion

10:15 Break

10:30 Cultural Oppression and its Multi-Generational Impact on Indian Health
Anna Latimer

11:15 Discussion

12:00 Lunch

1:00 Violence and its Effects on Indian Families and Communities
Phyllis Old Dog Cross

1:45 Discussion

2:15 Alcoholism, Substance Abuse, and its Effects on Indian Health

3:00 Discussion

3:30 Break

3:45 Mental Health Issues
Candace Flemming, Ph.D

4:15 Discussion

5:00 Adjourn

Thursday, December 12, 1991

9:00 Announcements/Review Agenda

9:30 Family Dysfunction and Community Dysfunction
Nancy Able

10:00 Discussion

10:30 Identifying Areas for the Development of Consensus Statements
JoAnn Kauffman

10:45 Develop Consensus Statements

1:00 Adjourn