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# "Mental Health Service Delivery to American Indians in the State of Minnesota" Conference:

## FINAL RECOMMENDATIONS

March 20, 1979

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INTRODUCTION

On February 28 and March 1, 1979 a conference was held which was titled "Mental Health Service Delivery to American Indians in the State of Minnesota " at the Minneapolis Regional Native American Center. Over 120 people attended the one-and-a-half day program and represented nearly every American Indian population area in Minnesota, a significant number of the mental health center directors from across the state, and many other state, county and local administrative/legislative and service providing agencies in Minnesota. In addition, representatives from agencies outside of Minnesota included those from Indian Health Service Mental Health-Albuquerque and the H.E.W. Regional Office-Chicago, among others. The conference was funded in part through a grant from the Center for Minority Research on Mental Health-NIMH, channelled through the Division of Alcohol and Drug Abuse and Mental Health Regional Office in Chicago to the Division of Mental Health-Minnesota Department of Public Welfare, and was put on, coordinated, and hosted by the Indian Health Board of Minneapolis/Mental Health Unit. The following pages are a summary of the recommendations reached by consensus between this state-wide body of American Indian consumer representation and non-Indian mental health service provider representation.

# SUMMARY OF RECOMMENDATIONS

I. A state-wide board/committee/group should be formed which meets on a periodic basis and is made up of American Indian and non-Indian representatives of both mental health professional and mental health consumer experience. This group should be representative of reservation, urban, and rural areas as well as mental health, social service, and medical perspectives. (Organizational and agency representation should include at least the following: Division of Mental Health-Minnesota Department of Public Welfare, Community and Comprehensive Mental Health Center Directors, Minnesota Chippewa Tribe Social Services and Mental Health, Urban Indian Mental Health Programs, Upper and Lower Sioux Social Services, Chemical Dependency (and other mental health-related programs), Indian consumer representatives from reservation and urban areas, Indian Health Service-Mental Health Programs, and Red Lake Programs.)

Because the board is representative, it could determine whether its responsibilities would be gathering information, planning, advisory, or coordinating and facilitating in nature, in regards to improving the delivery of mental health services to American Indians in the State of Minnesota.

II. There should be the creation of a mechanism whereby the availability of mental health funding, technical, and human resources could be communicated to all those providing (or interested in providing) mental health services to American Indians in Minnesota; and through which the securing of these resources for service efforts could be facilitated. Basically this mechanism should process information: letting providers (and researchers) know where the money is; connecting up providers with others who are interested in similar efforts; disseminating information regarding

successful efforts and models; connecting providers to those having training capabilities; facilitating providers securing federal, state, county, and local funds; and in general coordinating and facilitating a comprehensive flow of information to all service providers concerning funding opportunities, technical and human resource availability, and innovative program efforts.

III. There should be an effort to facilitate the training of American Indian mental health service providers <u>within the State of Minnesota</u> and thereby increasing the number of trained Indian personnel in operating mental health programs. There are at least three methods to accomplish this: through increased efforts to provide adequate educational and academic opportunities at pre-college, undergraduate and graduate levels for American Indian students; through increased efforts to provide settings in which field training can occur where Indian students are working with Indian clients; and through giving the highest priorities to combining training components to all aspects and levels of actual service delivery to American Indian clients so that American Indian mental health staff can learn from and contribute to the efforts of non-Indian mental health professionals.

IV. There should be a knowledge base developed that could help non-Indian mental health providers learn effective ways of interacting with Indian people; in effect, resources should be developed to train non-Indian mental health professionals serving Indian clients.

V. The overlap and interrelationships between mental health and chemical dependency needs, programs, and funding should be explored as they relate to serving American Indian clients.

VI. The perceptions of mental health and mental illness, as well as related values and esteemed role models (i.e. spirituality, elders), that are held as important by American Indian communities should be explored and articulated. They should then be incorporated into the goals and objectives and processes of mental health programs serving those American Indian populations.

In attempting to summarize the content, process, and products of the conference, "Mental Health Service Delivery to Amrican Indians in the State of Minnesota" taped recordings, written notes, and staff recollections were utilized. This information tended to structure itself into five areas: 1) questions generated, 2) definitions of mental health (in relation to American Indians) offered, 3) problems in service delivery specified, 4) suggestions and tentative recommendations put forth, and 5) definite recommendations made.

## Questions Generated

Perhaps one of the major foci of the conference participants was the felt need for more information, for more knowledge, and for more skills. This need for greater knowledge was evident in the questions that were frequently asked by both Indian consumer representatives and non-Indian mental health service providers. Listed below is a summary of some of these questions:

a) What are the specific differences in culture that result in a lack of understanding by non-Indian providers, lack of trust and rapport between Indians and non-Indians, lack of contact and relationships with the Indian community by professionals, and other problems? Can these differences be specified in behavorial, emotional, interpersonal, and psychological terms?

b) What are the specific characteristics of differences in terms of socio-economic status which result in the inability of Indian consumers to cover the cost of mental health services, insufficient funds for adequate mental health programs, not enough finances to deal with problems like child care, and in general reduce the accessibility of mental health service for Indian persons? Can these differences and their consequences be specified in demographic, sociological, political, and vulnerability terms? Can the federal, state, county, local, and community inputs into mental health service delivery to American Indians in Minnesota be specified and evaluated as to extent and adequacy of coverage?

c) In what ways can differences in geography (residence, location) which result in problems of transportation and distance, lessened familiarity with available resources (less felt input and ownership) by Indian people, fewer and less available trained staff on the reservation, scheduling difficulties, child care difficulties, and other problems which again tend to decrease accessibility and effectivneess, be specified and their consequences determined and impacted?

d) What are the specific characteristics of differences in language which impede communication? To what extent and in what specific ways does the lack of understanding mental health terminology, jargon, and the language of therapy prevent successful helping efforts?

e) In what specific ways do differences in educational level and experience which result in a lack of knowledge about the concept of mental health by Indian consumers, lack of information (awareness) about specific functions of existing resources and processes, lack of trained Indian personnel, and a distancing effect coming out of the high educational levels of providers detrimentally effect successful helping efforts?

f) How do we cope with the fact that Indian consumers may be realistically afraid of losing rights as free individuals and as guardians of their children because of the history of past relaitonships with non-Indian social services and legal systems?

g) In terms of the state of the art of professional technical resources: To what extent is there a lack of adequate understanding of the development and prevalence (etiology, epidemiology) of Indian mental health problems? What can be done to remediate the situation? How can the lack of adequate

identification-assessment-intervention skills and powers in relation to unique aspects of Indian mental health problems be specified and dealt with? How can the lack of trained Indian personnel be reversed? How can the rigidity of fixed responsibilities of existing provider roles, which flows partially from limited resources, be changed? How can preventative efforts be initiated and maintained?

## Definitions of Mental Health, Service Delivery Problems and Recommendations

In terms of the generation of definitions of mental health, service delivery problems, and more specific recommendations in relation to mental health service delivery to American Indians in Minnesota, there was great diversity to the discussions. There was a very real sense that the dialogue in these areas was barely begun, definitely not resolved, and needed to be continued. Therefore, rather than attempt to summarize the whole dialogue, the following pages are presented which represent brief small group reports and notes turned in at the end of the conference. Although diverse they generally are in harmony with the findings of the pre-survey report.

Yesterday we had approximately 107 participants. Participants represented Indian population groups, mental health centers, State Department of Public Welfare, legislative/political organizations, and other social service agencies from across the State of Minnesota.

The morning was spent sharing information...video tape, verbal and written communication, and some minimal dialogue occurred. The focus of this information centered around funding and resource allocation issues and the requirements, responsibilities, and mandates that exist in relation to mental health service delivery to American Indians (especially for comprehensive mental health centers).

From the perspective of the Indian Health Service Mental Health component, the comprehensive mental health center representation, and the tribal and urban Indian groups, present funds are extremely inadequate to meet the mental health needs of American Indians in the State of Minnesota and elsewhere. Training and other support-type resources exist but are minimal and not sufficient to meet the need and demand.

From the perspective of mental health centers, inability to meet legal, legislative, and professional mandates and responsibilities flow partially from the situation of inadequate funds and from the lack of having proven, adequate and effective mechanisms and strategies for working with American Indians.

From the American Indian perspective the lack of funds, also related to a lack of trained Indian staff (or trained non-Indian staff able to maintain contact over an extended period), are factors significant in not being able to supply adequate mental health services to their own people.

Over lunch, a panel discussed a wide range of issues and directions.

In the afternoon, small group dialogues occurred. These small groups reported back to the whole group at the end of the day as to the nature of the discussions that took place, with a definite sense of progress. The major theme passing through nearly every group was one of dealing with culture...with cultural experience and knowledge, difference and similarity...with cultural characteristics that may describe a group versus individual variations with and between cultural groups.

Some of the specific issues brought up included:

1.) the high importance American Indians attach to personal identity, both for themselves and those they may seek help for;
2.) the importance of securing effective intermediaries, links, or what could be called "in-between people,"
3.) an extremely high incidence of depression may be a form of generalized grief process that not only comes with a personal loss of family or friends but loss of identity, culture, meaningful roles, and so on.
4.) the importance of cultural processes that relate to such things as natural support systems, body language, elders and healers, time, silence, the work ethic, and spirituality;
5.) the problem of group culture versus individual differences
6.) the vocabulary of spirituality as mental health is only beginning to develop.

The small group discussions were often characterized by statements such as "it was hard to find common ground" or "there was a lot of effort to get points effectively across." Differences between non-Indian providers and Indian consumer representatives became clearer and more adequately defined as dialogue greatly increased (as the groups proceeded). Although a feeling of large distances was still there, the gap was clarified and slightly narrowed.

Group A What is mental health?

Medical model vs. social service model role conflicts with mental health providers. What can be classified as mental health activities? (Ex. Being a supportive advocate in systems management.)
Federal definition restricts funding to programs which represent the medical model. How can basic needs of clients be classified as mental illness?
The community provides limited services; there should be better planning and coordination between agencies (ex. CUHCC, Family Health and Indian Health Board) to control duplication and to monitor service delivery systems. New programs are being implemented that use natural support systems, provide training and/or co-therapy, use professionals, para-professionals and clients to provide care and case management.
What are the responsibilities of State, County and Local mental health administrative components? An Indian coordinator should be hired to address the issues relating to service delivery to Indian clients.
Service delivery is not responsive to Indians and to non-Indians, mental health centers can be the pits, both private and public.

Group B What is mental health?

The group came up with a variety of answers.

1) a functioning mind, functioning well.
2) positive insight
3) spiritual functioning, which relates to what elders talk of concerning "Indian Mental Health".
4) positive functioning mind in most social settings.
5) a composite of cultural values and cultural definitions.

6) one person notes (with much agreement) that the concept of mental health is there for Indian people, but not the vocabulary. Also, that Indians are starting to make a declarative statement on what is acceptable behavior and what is not acceptable behavior.

All peoples have their own concepts of values, what is right or wrong, and Indian people may not accept but will tolerate the values imposed on them.

A couple people clarified question #4 "A positive functioning mind in most social settings in terms of role models. Indian people put into age categories would constitute the role models as follows: elders - traditional group (spirituality) 20 to 60 years - survival group (denied traditional), those under 25 - looking more to traditional ways.

The group agreed that everyone is susceptible to mental health illnesses regardless of race. In relation to Indian mental health the major problems were alcoholism and depression as a symptom of a grief process. (The grief process as a result of loss of a way of life; land, language, religion, and/or family members.)

In regards to the alcoholism the relationship is between coping with one's own situation and on the now six theories of chemical dependency and alcoholism. ex.) psychological, using a self-medicator, etc. Someone notes that the alcoholism could stem from one or a combination of these theories.

Other problems concerning mental health:

1) internal bitterness.
2) need elders' response to tying Indian spirituality with mental health.
3) undefined role-models for Indians and non-Indians.
4) the mislabeling of problem areas has led to improper diagnosis and thus leads to wrong treatments.
5) limitations of mental health workers like time, education and cultural knowledge.

6) the number of systems available and the lack of communication between agencies adds to the fragmentatation of services to meet the needs of clients.
7) there is a definite need for more clear definitions.
8) another major area of concern is Indian people need to have a base for self identification, possibly through the need for affiliation in the extended family.

In reference to the resources of mental health someone stated that in theory there are mental health resources but the flexibility of these resources are dependent on the accessibility and distance of major resource centers.

Others comments were: no follow up; that brief encounters with the professionals amounted to primary service are the existing resources viable? Do people get what they want from resources here in the city?

It was noted that the Indian Health Board was a viable resource.

As an existing resource, traditional healing could be utilized more through an awareness of traditional healing from the extended family.

It was noted that community outreach is very important. This existing resource works very well but there is a need for more outreach workers who live where they work.

Groups C & D SUMMARY

One group member suggested that mental health was related to freedom to act and be. Another person added that this occurs within a social context. That is, a person depends on peer reinforcement or feedback for boundaries of acceptable behavior. He described how these boundaries change for Indian people depending on whether they're acting in the white business world, with "educated Indians," with family and friends on the reservation, etc.

The Indian members of the group described some of their awareness of cultural differences (e.g., having to "think twice" about what a non-Indian person means, sense of time, humor, sprituality, money and material goods). These differences lead to practical problems in employment, housing, social relations, and contacts with social service agencies.

It's good to witness people taking an active interest in wanting to learn the best way to help Indian people with mental health problems. It's a long, hard struggle on the red road and the support is getting steadily stronger. The outcome of this conference will be to the benefit of everyone involved and they can carry their new knowledge to others.

Group E Summary of "Problems" Workshop

1. Depression was identified as the most common mental health problem seen on and near reservations and urban area.
2. After prolonged discussion of mental health problems the consensus was that all poor people share the same problems.
3. The differences between other poor and Indian people was the arrogance that the dominant society (largely made up of Europeans and their value system) exhibited and still exhibits toward Indian people, depricating them as human beings, denying them not only rights but demeaning them in most interactions. The result of this racism is low self esteem in our young which is reinforced by society throughout the life of many Indian people.
4. Failure by Indian people to attend appointments was another issue discussed. It was felt that lack of transportation or distance was not a factor. There was no resolution of this problem.
5. Indian people seem to fear the stigma imposed by association with the mental health facility.

6. Fear by some of breach of confidentiality by indigenous counselors who may live in the community was expressed as an argument for utilizing non-Indian people in the mental health facility so that people would have freedom of choice of counselor.
7. Lack of coordination among providers prevents provision of either comprehensive or continuous care. Further discussion revealed that because of the lack of follow up for alcohol programs, termination of clients at halfway houses sent the unfortunate back to the original environment which started the cycle of drinking-detox, etc., over again.
8. Some discussion centered on the absence of male role models in the family setting. It was felt that there is a need for surrogate fathers to function in some way in the community, to fill this gap.
9. In conclusion it was felt that there is a need for public education to increase awareness of emotional problems and behavior and the use of available mental health resources.

Group F Summary

Question I:

Points of view:

The American way of life might be better considered salad bowl with side dishes. You have to be comfortable in the bowl. Other minority groups have compromised to become American. Indian people do not want to make compromises.

Acculturation or assimilation is not a "problem"; "sovereign nation" status -- tribal government.

Parallel or separate.

Recommendations

1) Increase dialogue - education
2) Whites get out of way (not "What can we do to get you what you want?")
3) Whites take some initiative for own education about Indians.

Question II: Chemical Dependency relation to mental health

Generic approach - specialists working together.

Dual approach - deal simaltaneously

Chemical dependency referrals (A.I.S.)

Issues for chemically dependent Indians - family dysfunction; undereducation, under-employed; identity, sprituality.

Treatment first; sobriety demanded for work on other programs.

Family is chemical dependency. Some call family treatment, chemical dependency treatment.

Recommendation:

1) Treat chemical dependency first, but as a total life treatment.

2) "Empathetic" approach - Indian people running own treatment facilities.

Economics and political reality have made an artificial distiniction between chemical dependency and mental health. Although chemical dependency is a primary disease, we recommended it be viewed as part of a mental health problem.

Recommendation for future:

Question IV Planning on-going dissemination

1. Distribution of findings of this conference to agencies/programs that weren't represented.
2. Continue mail contact with people who met at conference.
3. Newsletter for participants-information on service available and planned.
4. Annual conference similar to the current one.
5. Resource directory: services, training, workshops, etc. Funding sources for American Indian mental health programs.
6. Committee made up of participants in this conference to meet periodically.

7. Mental health facilities with no Indian members on mental health and chemical dependency advisory board. Investigate getting members to assure more appropriate services.
8. In areas sparsely populated by minorities-hire minority person to do a needs assessment. Need statewide support via power structure.
9. In keeping with the Presidents Commission on Mental Health Report it was suggested that American Indians be represented on Minnesota Association of Community Mental Health Programs support from Carter's mandate in committee on mental health report.

Case management - Indians needed to be case managers for Indian clients.

Need for minority perspective in social services, more Indian advocates in white agencies.

Is there a financial resource (e.g., IHS) to help add minority personnel to social services?

BIA money via Welfare Department - trust monies - find out about allocations.

Group G

## RECOMMENDATIONS

1. Continuity of psychiatric counseling from detoxification and mental health.
2. Trust factor - recognition of Indian para-professionals as service providers.
3. Have Indian staff available in CMHC to provide choice of vendor to Indian consumers.
4. Indian people are not given white mental health programs.
5. More dollars into a study on what is needed for Indian mental health research with Indian participants.
6. Recognize that no one group or approach can service the Indian population.
7. A textbook be developed on Indian mental health services based on research.
8. A workshop given to non-Indian counselors that are going to be working with Indian people or that already are to be put on by the Indian community.
9. A planning committee or advisory board be set up from participants of this conference comprised of urban, reservation and CMHC.

Small group reports:

A: It is desirable to have continuity of psychological counseling from substance abuses, to detox through mental health support. A trust relationship needs to be developed by the Anglo community, especially in terms of recognizing American Indian para-professionals as being general service providers even though they might not be carrying a lot of credentials around. There should be a choice of counselors available at service delivering institutions and above all if they're to serve Indian people, there must be some Indian persons on the staff. A program of mental health delivery should not be a white program, it must be an Indian program. It must take into account the needs of the people. It must be recognized that no one group or approach can serve all Indian people. More money should be channelled into the study of what is needed for Indian Mental Health. And by this, we mean practical research not academic stuff, per se, but something with real teeth in it to be used, and it must have Indian participation. That a text book on Indian Mental Health and metnal health service delivery be developed. Orientation courses for non-Indians who enter into work with Indian people should be developed. From this situation a planning committee should be developed to follow up this conference.

B: The issue about the acculturation, it was the Native American people do not want to make compromises in other words. Acculturation or assimilation is not a problem to them and it's important to get this fact across to the white population. We talked about the government as being the preferred way, to increase the dialogue and that there be education of White Americans about the Native American's way of life and their culture. Whites should get out of the way and it shouldn't be "What we can do for you," but "What do you want?" Whites take some initiative to their own education about Indians. Chemical Dependency

related to mental health, it was mentioned that several of the mental health centers represented that they use an generic approach, use someone from the chemical dependency counselor and a mental health person in dealing with the people that have chemical dependency problems, so this is a dual approach. A gentleman from the American Indian Service gave us some information about his work. The issues from the chemically dependent Native American were found to be family dysfunction, under-education, under-employment, identity, problems related to sprituality. Treatment for chemical dependency should come first. Sobriety should be demanded for work or other programs. Specific recommendations were that you treat chemical dependency first, but as a total approach to a person's social problems. That there be anempathic approach with Indian people running their own treatment programs. Indian people do a better job handling their own programs and someone in our group was familiar with the treatment centers that were totally Native American developed. Theirsuccess indicated that was the best way to go. We should plan for on going disemination of information. There should be a distribution of findings of this conference to agencies and programs that were not represented. Continue mail contact with people who met at this conference, on going mail contact like a newsletter for participants as to information, as to services available and plan funding sources as it relates to Native Americans. There should be an annual conference similiar to this one. There should be a resource directory or services, training workshops, funding resources for Native American mental health programs. A committee made up of participants from this conference to meet periodically. Mental health facilities with no Indian members, mental health or chemically dependent advisory boards should investigate getting members to assure more appropriate services for areas sparsley populated by minorities. A minority person could be hired just to help the minority pooulation, but would also help the staff to understand the needs of the minorities. In keeping with the presidential commission on mental health, it was suggested that there be a Native

American representative on the Minnesota Association of community mental health programs.

C: The melting pot is entirely false. A very drastic sudden change for the Indian as opposed to the white immigrant who came from Europe, the change was not so great in their culture. It is unfortunate about the policy the United States used, in say, conquering the pacific islands during World War II; it was not the same policy used with Indians. The policy at the time, was to adjust to the native way of life and not to put down their religion, and daily activities in part of their life, just to accept and adjust to that yourself while you're there. Linking Indians living in the urban areas which basically is bigotry racism, poor job market (which put the Indian out of balance) - and it would help to have some kind of community spirit for the urban Indians to keep them in touch with tribal presidents and people. Fitting into the mental health system prevention and crisis intervention efforts should happen. There was some discussion about utilizing the resources of the elderly people in the tribe to work with the preschools and children so the older people would fill an important part of their life. They can tell stories and relate their traditions and culture to the young children. This would alleviate some of the depression. Mental health services should consider the extended family as your client and not the individual who's coming in for treatment. There is also a need for an Indian mental health service located on the reservation. There was not consensus on this point, but it was felt that there is a need for some part that is Indian in the mental health system. We should ensure Indian representation on the state mental health advisory board. There's a real need for committment from funding bodies and service providers. The input that is collected from the Indians in regards to their needs and programs should be received and acted on. They should receive equal priorities in terms of requests to federal sources. A committment from conference participants is needed so when you return home and

tell someone what happened and make sure they know that there is some effort at the state level to provide Indian mental health services and people. Conference participants should form some kind of committee to continue this effort. That input from Indian consumer services should be requested at a future conference. There is a need to set a date for the next meeting. Information that's useful in setting up mental health services should be collected. There should be a close look at Indians and their use of services across the state. Putting together a needs assessment as to what their needs are should occur. Reviewing the available services and looking at the hassels that are involved with their utilization and funding for all these different services is necessary. How can this information be collected?

D. Each of us look at our health care setting as a human services laboratory. That we collect the information that would prove this way or that way that would improve some of the others. A language that was understandable to us and the patients, clients needs to be developed. To collect that information would require some tools that don't exist. We have to find the tools, no one will give them to us. It would have to involve clients, patients, in their family setting. It would also require the back up of researchers who know all about variation, and just as importantly it should involve the clients. We would come out with maybe three best ways to approach a population. More than that this would be for your particular population, or you're particular setting and that's real important because then you would be giving good care. Whatever you came up with would be patient-valuable, it would be not my idea or your idea but something that had worked and demonstrated to work and there were outcomes that could prove it. How to get funding? If we've really got that kind of data from the point where patients and providers really meet, it's going to be easier when you make the request, it's

going to be clearer in coming, it's going to be easier to grant the budget request, and the really good news is that if there's really no funding at all, you would still have still done right.

E. Assure that this conference continues in the future and we recommend that a planning board or advisory board be set up made up of representatives from different areas, reservations, urban, health board, other professionals. Also discussed sprituality and the importance of including it in any mental health program. Spirituality, whether it be Christianity or Indian traditional religion, including medicine men or individuals who are knowledgeable about traditional religion. Also training Indian people to provide health services to the community. Where would that training come from? There are individuals in the state who are equipped. There are Indian professionals and non-Indian professionals who are working in the Indian community for some time. There was much discussion about chemical dependency and mental health and their relationship to each other. One suggestion was that we use the chemical dependency treatment programs as a starting point for mental health programs. A lot of people on the reservations go to treatment centers for mental health problems. The people get some kind of counseling from treatment programs. If there should be a planning or advisory board made up from this conference, it should get sanction from different groups in the state who represent Indians.

F. I would like to respond to the idea of this conference being continued and at this point, I would like to give public recognition to the fact that this conference was sponsored, in part from a grant from the Division of Alcohol and Drug Abuse and Mental Health dministration in Chicago to the Department of Public Welfare in Minnesota. The money we got came from the Center for Minority Research on Mental Health. We are supposed to get the same amount of money this year - which we intend to give to Minnesota disseminate and continue the findings of this conference. So it'll take care of it, in some way, for another year.

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