Traditional Healing and Indigenous Sovereignty: Assessment and evaluation of current potential, development and deficits of Indigenous mental health care provision in Washington State, USA

I n a u g u r a l - D i s s e r t a t i o n

zur

Erlangung des Doktorgrades
der Mathematisch-Naturwissenschaftlichen Fakulät
der Universität zu Köln
vorgelegt von

Mirjam Hirch
aus Darmstadt

Berichterstatter: Prof. Dr. Frauke Kraas

Prof. Dr. Josef Nipper

Tag der mündlichen Prüfung: 13.10.2011

Zusammenfassung

Die vorliegende Doktorarbeit erforscht aus kulturgeographischer Perspektive Bedarf und Potential selbstbestimmter Gesundheitsversorgung im Bereich psychischer Gesundheit für indigene Gemeinschaften im Bundesstaat Washington, USA.
Weltweit bestehen große gesundheitliche Disparitäten in indigenen Gemeinschaften, die zu den Gruppen mit dem schlechtesten Gesundheitsstatus zählen. Im Bereich psychischer Gesundheit haben Substanzmissbrauch und Suizid teils ein epidemisches Ausmaß erreicht.
Seit den 1960er Jahren findet das Konzept indigener Selbstbestimmung vermehrt Anwendung im Bereich indigener Gesundheitsversorgung. Eine wachsende Zahl von indigen verwalteten Gesundheitseinrichtungen bietet kultursensible Dienste an, die der effizienteren Versorgungsleistung dienen sollen. Gleichzeitig ist im nicht-institutionellen Kontext das Phänomen einer wachsenden kulturellen Bewegung für bessere Lebensqualität und Gesundheit indigener Nationen zu beobachten. Diese basiert auf der Anwendung traditionellen Wissens von ganzheitlichen Heilkonzepten.
Diese rezenten Bestrebungen werden in der Arbeit im Untersuchungsraum aus geographischer Sicht analysiert.

Das Fach Geographie wird zunehmend als zentral für ein umfassendes Gesundheitsverständnis anerkannt. Es werden vermehrt soziale Phänomene betrachtet und alternative, die Umwelt einbeziehende, Perspektiven auf Gesundheit entwickelt. Kulturelle Herangehensweisen geographischer Gesundheitsforschung an mentale Gesundheit im indigenen Kontext fehlen jedoch bislang weitestgehend. Wenige Geographen haben erforscht wie kulturelle Werte und Kosmovisionen indigene Gesundheit und Versorgungsstrukturen beeinflussen, geschweige denn die Verbindung von Identität, Ort und Gesundheit bzw. die Bedeutung "therapeutischer Landschaften" im indigenen Kontext analysiert. Hierzu möchte die Arbeit einen Beitrag leisten.

Die vorliegende qualitative Forschung kommt zu dem Ergebnis dass im Untersuchungsraum existierende selbstbestimmte, integrative Modelle, für den nachgewiesenen Bedarf, eine adäquate Versorgungsform auf institutioneller Ebene darstellen. Es wird weiterhin festgestellt dass die, auf Konzepten traditionellen Wissens basierende, kulturelle Bewegung auf Gemeinschaftsebene zur Besserung der psychischen Befindlichkeitslage indigener Nationen der pazifischen Nordwestküste in Washington State, USA beiträgt.

Abstract

This dissertation from a geographical perspective analyzes the need and potential of self-determined Indigenous health care structures amongst Indigenous nations of Washington State, USA for the improvement of Indigenous mental health status.
Dramatic inequalities dominate Indigenous health. Mental health problems, chronic stress, substance use as well as suicide are over proportionately high within Indigenous communities who have a significantly lower life expectancy the world over. At the same time Indigenous nations are exposed to lack of health care, culturally appropriate services and oftentimes discrimination and institutional racism. Through endeavors of self-determination since the 1960s Indigenous nations have started to establish Indigenous health care systems to improve health care provision and lay the basis for an upward trend in their (mental) health status. At the institutional level self-governed clinics offer culturally sensitive services based on Indigenous models of integrative care. At the community level public health movements have been initiated that are based on traditional knowledge and on revitalization of Indigenous cultural practices to improve health status.

There has been little research done in any discipline pertaining to the specific regional needs and types of as well as distribution of Indigenous healing services. Very few geographers have explored how cultural values and cosmovisions shape Indigenous health – not to mention the connection between place, identity and health and the importance of cultural and therapeutic landscapes in Indigenous peoples' everyday lives. In this regard geographers possess valuable knowledge and interdisciplinary skills that can be harnessed for the analysis of comprehensive systems of health and care as a means of ensuring wider coverage of service provision particularly to minority groups such as Indigenous peoples. Incorporating local Indigenous peoples' perspectives of (mental) health and place the dissertation wants to contribute to the emerging field of Indigenous mental health geographies. Using mainly qualitative methods the thesis tries to 'map' an Indigenous cultural approach to understanding the underlying factors behind Indigenous consistent poor health and methods to eliminate health disparities.

The study comes to the conclusion that self-governed health care institutions can improve service provision at the institutional level. The analysis of community based health interventions attest use of traditional medicinal knowledge to be an adequate instrument to improve psychological well-being among Indigenous nations in the research area.

Acknowledgements

I would like to warmly thank all the people, whose interest, presence and help allowed the realization of this thesis. The preparation of this thesis has built on several years of experience in the field of Indigenous health. I am very grateful to the many, Indigenous and non-Indigenous individuals and organizations that have assisted and inspired me in this work for about 10 years and which culminated in this thesis. I regret that they are too numerous to all be mentioned individually, but special thanks are extended to the Center for World Indigenous Studies and Center for Traditional Medicine which first enabled me to work in the area of Indigenous health and traditional healing closely working with numerous nations in the Pacific Northwest of the United States, Canada and Mexico. Dr. Rÿser and Dr. Korn were a source of great encouragement and support throughout my research on the topic. Their supporting encouragement from the very beginning to attend various international conferences and workshops in order to present and discuss my work with researchers from all over the world gave me a invaluable insight into topics related to Indigenous peoples. Particularly revealing was accompanying my academic advisor Dr. Rÿser to attend the fifth session UNPFII United Nations Permanent Forum on Indigenous Issues in May 2006 at the UN Headquarters in New York. I wholeheartedly acknowledge Dr. Rÿser's help and support during the fieldwork and writing, his valuable feedback, constant encouragement and firm support throughout.

Of the many people and agencies that have assisted in the preparation of this thesis, I extend particular thanks to the following:

Special thanks to the supervisor of this thesis Prof. Dr. Frauke Kraas who through a lecture on Indigenous peoples in 2002 at the University of Cologne ignited my strong wish to dedicate my time and energy to the Indigenous cause and then gave me the freedom to write this work in as self-determined a way as possible and hand it in as my dissertation. Thus enabling me to make it accessible to a broader audience. Her trust encouraged me and strengthened my will to complete the project successfully.

I would like to thank Prof. Dr. Josef Nipper very much for his willingness to review the thesis as co-examiner.

I am deeply grateful to my mentor Dr. Ted Mala for his transformative teachings.

I would also like to thank Gregory Twiddy for his help and support during my fieldwork.

Grateful thanks go to my sister Ellen and Dr. Ana Cangahuala.

I greatly appreciate that the German Research Foundation and DAAD - German Academic Exchange Service provided me with a travel grant to support the work.

Finally I deeply thank my family, and especially my father and sister, for always encouraging me to go my own way, and for the sympathy and appreciation they constantly showed me.

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Abbreviations

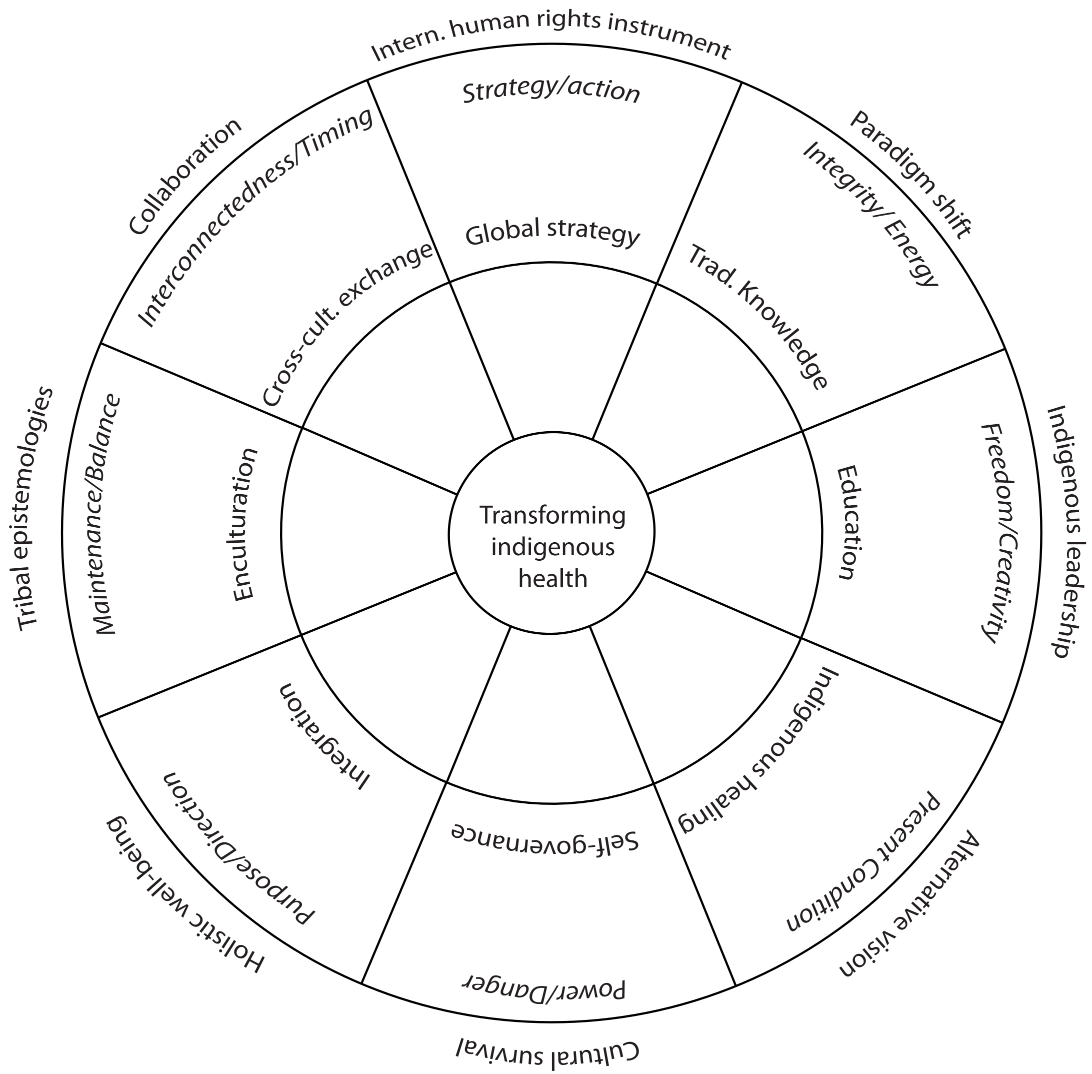
AA	Alcoholics Anonymous
AAAHP	Association of Allied Health Professionals
AAMC	Association of American Medical Colleges
ABS	Australian Bureau of Statistics
ADHD	Attention Deficit Hyperactivity Disorder
AI/AN	American Indian/ Alaska Native
AIHC	American Indian Health Commission
AIVVP	American Indian Vietnam Veterans Project
APA	American Psychological Association
APTA	American Public Transportation Association
AOA	Administration of Aging
BIA	Bureau of Indian Affairs
BHR	Behavioral Health Resources
CAM	Complementary and Alternative Medicine
CARF	Commission on Accreditation of Rehabilitation Facilities
CDC	Center for Disease Control and Prevention
CFR	Code of Federal Regulations
CHS	Contract Health Services
CHSDA	Contract Health Service Delivery Area
CMS	Centers for Medicare and Medicaid Services
CTM	Center for Traditional Medicine
CWIS	Center for World Indigenous Studies
DHHS	Department of Health and Human Services
DMHP	Designated Mental Health Professional
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
EHMA	European Health Management Organization
FTE	Full-Time Equivalent
FY	Fiscal Year
GA	United Nations General Assembly
GOIA	Governors Office of Indian Affairs
HHS	Health and Human Services
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
HOSW	Healing Our Spirit Worldwide

ICCPR	International Covenant on Civil and Political Rights
IHS	Indian Health Service
IHCIA	Indian Health Care Improvement Act
IRA	Indian Reorganization Act
ISDEAA	Indian Self-Determination and Education Assistance Act
I/T/U	IHS Tribal Urban
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MAA	Medical Assistance Administration
MAM	Medicaid Administrative Match
MHD	Mental Health Division
MHSSPB	Mental Health and Social Services Programs Branch
MOA	Memorandum of Agreement
MPO	Metropolitan Planning Organization
NIH	National Institutes of Health
NCAIANMHR	The National Center for American Indian and Alaska Native Mental Health Research
NPAIHB	Northwest Portland Area Indian Health Board
NSDUH	National Survey on Drug Use and Health
ODFW	Oregon Department of Fish and Wildlife
OIP	Office of Indian Policy
PAHO	Pan American Health Organization
PHC	Primary Health Care
PHS	Public Health Service
PTHA	Puyallup Tribal Health Authority
PTSD	Posttraumatic Stress Disorder
RSN	Regional Support Network
SAMHSA	Substance Abuse and Mental Health Service Administration
SED	Severe Emotional Disorder
SIHB	Seattle Indian Health Board
SMI	Serious Mental Illness
SPIPA	South Puget Sound Intertribal Planning Agency
TCAM	Traditional Complementary and Alternative Medicine
TRPC	Thurston Regional Planning Council
UNDRIP	United Nations Declaration on the Rights of the Indigenous Peoples
UNECOSOC	United Nations Economic and Social Council
UNPFII	United Nations Permanent Forum on Indigenous Issues

U.S.	United States
USDA	U.S. Department of Agriculture
WDFW	Washington Department of Fish and Wildlife
WHO	World Health Organization
WIPCE	World Indigenous Peoples Conference on Education

Outer wheel:
What is needed

Inner wheel:
What is the response



Source: Own illustration according to Cris de Groot in Higgins (2005)

Preface

Over the last three decades there has been an increasing awareness of the loss of traditional medicinal knowledge. At the same time the potential of traditional healing knowledge to improve significantly the availability, access and quality of mental health and care services has been acknowledged (WHO 2001a: 4). In this regard traditional health care practitioners are seen to possess valuable and unique knowledge and skills that can be harnessed for the development of a holistic health system as a means of ensuring wider coverage of healthcare particularly to minority groups such as Indigenous people. Hence the current attempts internationally to rediscover and reinstate Indigenous traditional health systems in the most acceptable, affordable and accessible way to Indigenous peoples. Governments and international organizations such as the World Health Organization (WHO) have been promoting regulations and health policies that comprise the contributions made by traditional healing practices for decades. A series of questions asked in this context are: What are examples of best practices in Indigenous healing that could serve as role models for bettering the health situation of Indigenous groups? How can possible benefits and potentially negative outcomes of these practices best be analyzed, evaluation and standardization be achieved? What are options and efficiency of integrating or combining Indigenous healing practices and biomedical systems of care to achieve best health? So far, however, in the area of Indigenous health - let alone Indigenous mental health, serious action in response to the recommendations and questions of the WHO has not been undertaken. Few studies have been conducted that enquire into these questions and investigate into local traditional practices and how these might be integrated into Indigenous health care provision (WHO 2002). Traditional healing therefore does not enjoy the status that would correspond to its significance.

The world over the health status of Indigenous peoples is deplorable. Experts working in the field of traditional healing, as expressed throughout the WHO Traditional Medicine Strategy 2002-2005, emphasize the need to make visible and promote the resource potential of traditional medicine in offering solutions to the contemporary problems in mental and Indigenous health. In the backdrop of this urgent need for action Indigenous nations themselves have been taking proactive steps to find solutions to improve their health situation. There has been significant movement in Indigenous communities to coordinate and legitimize Indigenous concepts of health, illness and care with the mainstream health care system. First self-governed clinics offer integration of services. One such Indigenous health care system, the relationship-based Nuka System of Care has recently been proposed as a model for national reform in the U.S. (TRAHANT 2010). Accordingly the emerging efforts of Indigenous self-

determination in health and Indigenous medicine claims on government sponsored systems to provide effective, culturally sensitive health care need to be discussed.

This paper considering historical, social cultural and legal contexts, from a geographical perspective, will give an analysis of the need and potential of Indigenous self-determination in mental health and care. The focus area is the Pacific Northwest Coast, particularly Washington State, USA a region which is home to some of the most political and litigious of United States' Indigenous nations.

Choosing the topic of this thesis goes back to personal interest concerning debates on the holocaust and intergenerational trauma after WWII in my home country Germany. Key meetings with Indigenous representatives and developing friendships with members of Indigenous groups while studying at the University College of the Cariboo in Kamloops, Canada and doing research on my Masters thesis inspired my interest in the broader topic discussed in this paper. A lecture on the UN Decade of Indigenous Peoples at the University of Cologne by the advisor of this doctoral thesis, Prof. Kraas, inspired me to do a two-year internship at the Center for World Indigenous Studies, Olympia, WA, USA in 2003/04. During the internship in Olympia I attended gatherings, conferences, traditional medicine seminars and meetings with the local tribes in Washington State. Through direct learning experiences and the narrated insights of my local supervisor, Dr. Rÿser, scholar of the Cowlitz nation, I could witness how the general community knowledge base and the protected knowledge (knowledge specifically owned by a family, individual or society within a tribal community) are endangered by outside forces, and by rapid changes in the interests and preferences for ideas and experiences within local cultural communities. Outside interventions have caused and forced substitution of introduced knowledge for the ancient knowledge of Indigenous societies in the Pacific Northwest. The result is that large pieces of ancient knowledge have been lost or become hidden to members of each society - undermining social wellbeing and in particular undermining public and individual physical and spiritual health. It is this knowledge, in particular the health and healing knowledge, long evolved in these cultures held to be essential by Indigenous leaders for the restoration of social, physical and spiritual health as well as security of the community and thus long-term future survival of these societies. Because of the cultural nature of this knowledge base, virtually all application of the knowledge is dependent on the successful transmission of knowledge from one generation to the next. Knowledge is transmitted through the complex of relationships, languages and social organizations of life experiences that bind diverse individuals and groups together in an area. Irrespective of any regulations if the knowledge is not successfully transmitted, then it is effectively lost to the ages. Confronted with this insight, the approach used in this thesis was apart from analyzing

the legal and institutional levels to focus on the activities and attitudes found within the local communities. This increased awareness of the need for community based research modalities and local community control of knowledge and local decision taking to keep or let go of that knowledge. Concerning knowledge preservation a variety of approaches was encountered. While some nations in the U.S. might use modern technology in the form of smartphone apps for language learning technical tools to transmit knowledge used by Indigenous nations in Washington State were digital story telling besides written documentation, primarily collected and digitized in the library of the local NGO, Center for World Indigenous Studies.

The internship in Olympia and subsequent travels furthermore yielded the opportunity to learn first hand about some of the hundreds of different forms of healing found worldwide, many of them flourishing beyond the boundaries of Western medicine. I could compare and contrast various systems of health care, to see medicine's many strengths and also its weaknesses. I could observe a more holistic view of health and illness. A view that sees how illness can cause (or result from) an imbalance in the patients' personal cosmos, particularly their connections to those around them, and how, through talk or ritual, social interventions or other treatments, this balance could be restored, psychological well-being achieved. This led me to an interest in traditional healing especially in the treatment of mental health issues. Throughout the time of writing I had the chance to meet with institutions working on issues of Indigenous mental health and on the integration of traditional and Western medicine within a different paradigm of medical and cultural understanding. I had direct contact with Indigenous representatives and the opportunity to talk to some of the most respected Indigenous leaders knowledgeable in the topic with a broad range of backgrounds and fields of activism. This yielded the opportunity to find out first hand what their perspectives are about the future of local Indigenous healings and the possible combination with Western medicine. This thesis relies significantly on the qualitative input of these individual experts and healers and their professional and personal experience of the status of Indigenous mental health, local healing concepts and traditions.
Moreover attending Indigenous conferences allowed me to talk about issues seldom discussed in most international forums. Exposed to Indigenous issues debated in the international arena I got to understand that Indigenous peoples as practitioners of traditional medicine oftentimes are not able to fully voice their concerns and interests concerning traditional healing and defining of their own, cultural healing methods.

The paper calls for a new reflection on self-determined approaches of Indigenous mental health and mental health treatments taking into account the specific local cultural and geographical realities of the individual peoples concerned.

The research was supported through travel grants by DAAD - Deutscher Akademischer Austauschdienst (German Academic Exchange Service) and Deutsche Forschungsgemeinschaft (German Research Foundation).

Part 1 Introduction

Dramatic inequalities dominate global health. The situation for the world's Indigenous peoples is particularly severe. Adequate health care provision for Indigenous groups remains a major challenge the world over. Enormous disparities exist. The devastating health situation of many Indigenous groups threatens their very survival. Even within affluent countries the living and health conditions of Indigenous peoples or so-called fourth world nations are appalling - equaling those of third world countries in some areas in the U.S. Not only does the extreme poverty many Indigenous groups live in lead to highly problematic (mental) health conditions (NCHS 2007:10). Confronted with a legacy of colonization and rapid lifestyles changes severe strain on Indigenous individuals' and nations' mental health is caused by these and related stress factors (GUILMET and WHITED 1989:73). Mental health problems such as inter-personal violence, substance abuse, and related accidental deaths and suicides are rampant in Indigenous communities and lie significantly above the national average (IWGIA 2007: 4).

Conducting a wide range of health disparities research in Indigenous communities, that is research undertaken to understand, discover and conduct studies to eliminate unjust differences in health and health care is urgently needed to close the gaps in health status. This research has to be scientifically meritorious as well as grounded in community engagement research approaches. Due to its place based and interdisciplinary nature geography seems to lend itself ideally as a tool to Indigenous health disparities research. The discipline can offer a strength, human rights–based instead of a deficit approach to Indigenous health which corresponds to Indigenous models of health. Geographic analysis thus could play an essential role in reversing the health disparities Indigenous communities are facing as will be further explained below.

It is more than thirty years after the landmark agreement was reached at the International Conference on Primary Health Care (PHC) in Alma Ata in 1978 by 134 Member States of the World Health Organization (WHO) gathering to adopt primary health care as the key strategy for achieving "health for all" by the year 2000 (MAHLER 2008:747). The public policy approach of the landmark agreement reached at Alma Ata implied a consensus on equity of distribution of important health-producing goods as well as services which has shaped the dynamics of public health from that time on (RAFTERY 2006: 30). Yet even though indisputable advances have been made, the situation today remains "health for some." Therefore Indigenous communities have started to act themselves and find responses to their health crisis in all sectors involved. The right of self-determination which they consider the

"most fundamental basis for the improvement of living and health conditions" (UNECOSOC 1996) allows Indigenous nations to re-establish control over their own affairs. Indigenous self-determination in health aims at making universally accessible to Indigenous peoples essential and affordable health care services at high quality. The concept of self-determination, since the 1960s a working concept for Indigenous nations throughout the world, is not limited to health but can be found in various areas including politics, society and culture as well as science and research.

Figure 1 Areas of Indigenous Self-Determination

	Self-Determination in	
Politics	**Society/Culture**	**Science/Research**
Indigenous territories/ land claims	Relationships to people and place	Community Based Participatory Research
Self-government	Lifestyle/Worldview	Tribal epistemologies

Source: Own illustration

The world over Indigenous groups through endeavors of self-empowerment are exploring ways to actively recover land and cultural autonomy, and are consciously participating in the search for alternatives for Indigenous health (BLAISDELL 1997). Throughout the United States tribes are seeking to increasingly gain local control over health. Health care reform has recently been realized in the US. The current period is a critical time to address fundamental concerns and achieve important goals in Indigenous health. Today mainstream health care for Indigenous peoples in the U.S. can be regarded as still essentially "neocolonial," a system that is dependent on the international relation to the U.S. - for health care and health care workers. Mainstream mental health programs and services are designed in keeping with Western views of mental health and illness embedded in a health care system with minimal focus on health promotion and disease prevention. Among those working in the U.S. mainstream health care system there is not much incentive to offer services that take into consideration the unique cultural identities, histories and sociopolitical contexts of Indigenous peoples or other minority groups. Indigenous individuals tend to avoid using mental health services provided and the medication offered by that system (MCCORMICK 1996). A high drop out rate has been reported if services are accessed and, for many Indigenous individuals, treatments are not effectual (TRIMBLE and FLEMING 1990). This puts Indigenous people "at risk of not having their mental health care needs recognized and met" (SMYE and MUSSELL 2001). Indigenous self-government in institutional health care settings therefore aims at increasing cultural sensitivity to improve uptake of services. In the non-institutionalized community setting self-determination is closely linked to re-generating of identity. What can be observed

in communities all along the Pacific Northwest Coast of Washington State, USA is a phenomenon that can well be described as a 'cultural public health movement.' There is a resurgence of interest in traditional practices such as canoe journeys or food ceremonies among the tribes. Underlying this movement is an alternative health model with a focus on prevention and promotion of health and has Indigenous culture and peoples at its center. Engaging in these community-based activities reflects a self-help approach that legitimizes traditional knowledge long kept underground.

With the arrival of European settlers on the North West Coast of the United States European health services were superimposed on the traditional health care system. Earlier missionaries sought to discredit traditional health practitioners, since their traditions ran counter to the belief that Western civilization was the acme of human achievement. The active participation of local communities in the healing process and prevention of illness was a possible political threat to colonial autonomy and the social control that Western medicine provided. Besides forbidding traditional medicine practices early settlers prohibited the exercise of local culture and consumption of traditional foods. Kenyan author Ngugi wa Thiong'o explains this as being part of achieving mental control through "the destruction or deliberate undervaluing of a people's culture, their arts, dances, religions, history, geography, education, orature [oral traditions] and literature, and the conscious elevation of the language of the colonizer" (1986:16).

Accordingly for a long time Indigenous groups of the Northwest Coast were ashamed of their 'backwardness.' They thought that their traditional ideas were old-fashioned, and tried to ignore them. The contemporary Native sovereignty, cultural and health movement in places like the Pacific Northwest can be seen as an endeavor of liberation from this legacy of colonialism and institutional racism if not ethnocide. This makes the Indigenous cause distinct from those of other ethnic minorities. Native Hawaiian activist Huanani Trask states that the Indigenous health movement reflects Indigenous peoples "actively engaged in their collective liberation" (1986:177). Trask remarks that as a decolonization movement the Indigenous health movement is "political to the core" because it functions to "unscrew the power of the colonizing force by creating a new consciousness very critical of foreign terms, foreign definitions and foreign solutions" (1999: 90). Hence Indigenous peoples' redefining and re-thinking of components of their health and care systems includes finding a place for their own traditional beliefs about health and healing within the institutionalized as well as non- institutionalized systems of care.

Within the contemporary health system two areas of work can be distinguished. One strand, the other so-called 'contemporary' strand, considers illness to occur naturally and culture-

free. The underlying concept is based on the belief in technical solutions to problems quantified by accurate measurements. Within this strand over the course of the last few decades, mental disease has increasingly been treated by drug-based therapies to influence the 'chemical imbalance.' In contrast to this view a stance is adopted which argues, in various ways, that the key determinants of health and variations in health are intimately linked to power relations in society. Underlying causes of disease are seen as being embedded in the social, political and economic systems (KRIEGER 2001: 668). According to this strand explanations are not to be sought at the individual level alone - for example, the kinds of "unhealthy" behaviors an Indigenous person adopts. Instead it is the broader social context that matters. Therefore adherents to this view maintain that the politics of health in the context of dominant ideological understructures of social and political forms have to be analyzed more closely. Because of the stress on these macro-scale social, political, and economic structures, this style of approach is often also referred to as structuralist, or alternatively as a political economy perspective (Ibid: 670). The current global resurgence of interest in traditional and alternative medicine practices on the international scene as a means of avoiding overuse of pure chemicals and achieving wider or total coverage of healthcare for all people especially the poor, vulnerable and marginalized groups of people is in line with the structuralist perspective. The political economy perspective best corresponds to Indigenous concepts. Indigenous peoples often consider mental health issues as synonymous with social, political and economic issues of environmental degradation, loss of land and political disenfranchisement (COHEN 1999: 26). To improve Indigenous mental health status Indigenous peoples argue not only the immediate causes of disease ought to be treated. As emphasized by the WHO Commission on Social Determinants of Health the root causes, i.e. the 'causes of the causes' of ill health have to be attacked (WOODMAN, GRIG et al. 2007: 13). In the Indigenous context some of the root causes are the long-term effects of colonization on Indigenous communities (compare figure 6 below) and the fundamental structures of social interaction. By revitalizing their traditional culture and lifestyle local Indigenous communities are testing the hypothesis that societal and cultural factors are amongst the root causes for their consistent poor health. In line with the structuralist approach psychological distress with Indigenous groups is seen to occur more as a result of geography than genes. A place-based approach to health therefore seems particularly relevant for Indigenous groups considering their close connection to the land. This 'Indigenous medical geography' bears promising potential to analyze health disparities. Yet, there is little evidence in the discipline of geography that demonstrates understanding and awareness of Indigenous health issues from this perspective. A sense of place and sacred

geography has been directly linked to mental and spiritual well-being. While more abundant for cultures in Europe and Mesoamerica research on Indigenous conceptions of sacred geography in North America is sparse (TAYLOR, KAPLAN et al. 2005: 1448).[1] Very few geographers have explored how cultural belief systems, values and cosmovision (worldview that integrates the structure of space and rhythms of time) shape Indigenous health - let alone the connection between place (the land) and mental health and the importance of cultural and therapeutic landscapes in Indigenous peoples' everyday lives (WALKER 1991; Martin 2008). The special role for 'place' has been recognized to represent interconnected physical, spiritual, symbolic and social aspects and involves physical and cultural space as well as sense of place and place in the world. The medical geographer Gatell explains that places may also be thought of as 'social settings' or 'social environments' and that we are "literally surrounded, or 'environed' by other people and features of the landscape" (2009: 12). Interconnections between place, identity and health and how exactly Indigenous mental health is related to if not inseparable from issues of place has yet to be better understood. Geographic research could aid in the process. Geography's central role in understanding comprehensive health issues is increasingly being acknowledged (MCGIBBON 2009). Starting in the 1970s and gathering full momentum in the 1990s, medical geography has been focusing on the influence of culture on health and the importance of place as expressed e.g. through the movement of the 'cultural turn' (BONNELL, HUNT et al. 1999). In line with the endeavor of the structural approach to 'go outside the body,' as described previously, geography increasingly puts into focus a range of social phenomena such as mental illness, suicide and medical care (PHILO 2005: 585). An expanding but still relatively small field of inquiry is the discipline of mental health geography or geography of mental health. One impetus for the field of study emerged in the 1970s linked to so-called radical geography which confronted human challenges such as social inequalities. Questions were raised about oppressive relations within social structures and societies, misery and suffering, as expressed spatially. A distinct body of research has emerged since then.[2] Nevertheless there is no single

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[1] For examples of the benefit of combining spirituality and medical practice see: Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice: Using the HOPE Questions as a practical tool for spiritual assessment. American Family Physician, 63(1), 81-88, http://www.aafp.org/afp/20010101/81.html. Barnes, P. M., Powell-Griner, E., McFann, K, & Nahin, R. L. (2004). Complementary and alternative medicine use among adults: United States, 2002. Advance Data from Vital and Health Statistics, 343. Hyattsville, Maryland: National Center for Health Statistics. Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious involvement, spirituality, and medicine: Implications for clinical practice. Mayo Clinic Proceedings, 76(12):1225-35. Prayer and spirituality in health: Ancient practices, modern science. (2005). Complementary and Alternative Medicine at the NIH Newsletter, 12(1): 1-4, highered.mcgraw-hill.com/sites/dl/free/0072972351/230020/H03_6.pdf.

[2] For examples, see: Smith, C. Geography and Mental Health. Resource Paper No. 76-4, The Association of American Geographers, Washington DC, 1977. Dear MJ, Wolch JR. Landscapes of despair: From deinstitutionalization to homelessness. Princeton University Press; Princeton, NJ: 1987. Wolch J, Philo C. From distributions of deviance to definitions of difference: Past and future mental health geographies. Health and Place. 2000;6:137–157. Beal G, Veldhorst G, McGrath JL, Gurunge S, Grewal P, DiNunzio R, Trimnell J. Constituting community: Creating a place for

conceptual and methodological approach to mental health geography research. In his essay "Geography of mental health: An established field?" Chris Philo remarks on mental health researchers' standpoints that some of the researchers are:

> "Happy to deploy the models and terms of mental illness, and borrowing in the process from conventional medical-psychiatric thinking whereas others have preferred to remain agnostic about the deeper causes behind the alternative 'states of being' experienced by people with mental health problems" (2005: 585).

The latter group being highly critical of common categorizations in medical psychiatric practice.

Geographer Doug Richardson aware of geography's potential role in medical research quotes a scientist at the U.S. National Institute of Health (NIH) encouraging geographers to help address the complex but pressing mental health research and human needs:

> "To date, most mental health research has focused largely on biomedical pathways. Increasingly, however, researchers are considering how people's environments—the physical and cultural contexts in which they live—influence the prevalence and consequence of mental health disorders" (2009: 42).

As of yet the spatio-environmental preconditions for sustained mental health though has been less discussed with only a few researchers concerned with geographical variations in human welfare or quality of life (SMITH 1984). Spatial epidemiology studies were conducted by scholars such as Giggs (1973) or in the United States by Daiches (1983). Their and other researchers' findings suggest that mental ill-health and stressful local socio-economic environments usually are associated. They therefore emphasize that explanations for mental illness should take into account more contextual factors characterizing the individual's immediate environment of living and working and focus on the everyday lives and geographies of people.

Much of the research conducted in the field has been interdisciplinary involving a range of social sciences, medical sciences, and arts and humanities collaborating with researchers in mental health geographies. An integrative collaborative approach to health could be seen developing which offers an alternative social, cultural and environmental perspective. Interdisciplinary in nature various factors could be analyzed on multiple planes - such as global forces of loss of cultural and biological diversity as well as regional phenomena of lifestyle changes or particular socio-cultural conditions. Along with other sciences in the fields of public health, biomedicine and education, to name but a few, geography and cultural

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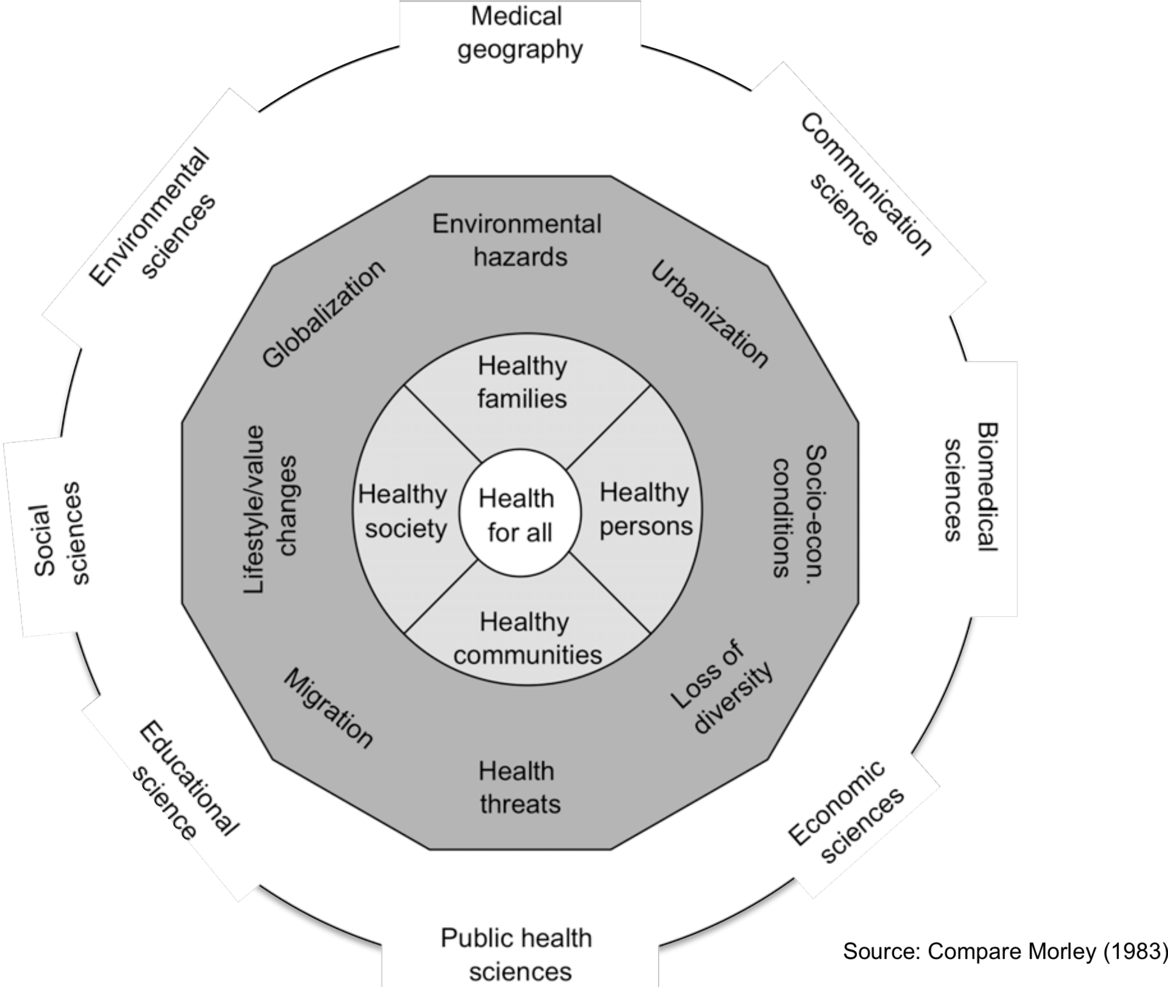
oneself. Psychiatry. 2005;68:199–211. For examples, see: Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: A multilevel study of collective efficacy. Science. 1997;277:918–924. Parr H, Philo C. Social geographies of rural mental health: experiencing inclusion and exclusion. Trans Inst Br Geographers. 2004;29:401–419.

approaches to "medical geography" can play an important part in this holistic health research model.

Figure 2: Integrative Collaborative Approach to Health



A holistic approach to health and health system research was already discussed in 1848 by 19th century German pathologist, Rudolf Virchow, in a report he published on the typhus epidemic in Upper Silesia, Germany. Virchow remarked the poor population of the region to be "starving before the epidemic occurred [...]. There can no longer be any doubt that such an epidemic dissemination of typhus could only have been possible under the wretched conditions of life that poverty and lack of culture had created in Upper Silesia" (2006: 2104). Virchow regarded the improvement of the economic situation and eradication of poverty in the region fundamental to better the health of the inhabitants. The promotion of education, transportation, agriculture, and manufacturing he commented to be essential in order to avoid like disaster in the future. As Virchow observed, "medicine is a social science, and politics is nothing more than medicine in larger scale" (Ibid). Virchow's early historic example

describes how a combination of social, cultural, economic, environmental and political factors, functioning at the community level, influence health status. In line with this school of thought social epidemiologists Kawachi and Kennedy in a contemporary article which probes the links between income inequality and social cohesion explain that "Reducing inequities between various communities and improving health depends on the actions and policies of multiple sectors such as education, food, housing economic opportunities all of which lead to greater social cohesion" (1997: 1037).

Sociological, philosophical, psychological and neuro-scientific models during the last century have largely contributed to a more holistic understanding of mental health and psychological illness. These models take into account biological, psychological and social factors and thus distance themselves from the Cartesian dualism of mind and body (LENGEN 2010: 34). This approach focuses less on disease-causing factors but on those that support human health and well-being. Antonovsky's "salutogenic model" (1980) similarly focuses on 'the origins of health' (Latin: salus = health, Greek: genesis = origins). In this model, primarily used in the fields of health psychology, psychiatry, alternative and preventive medicine, health supporting factors, the relationship between health, stress and coping are considered rather than the disease causing factors of the pathogenic paradigm.

There has been a shift in mental health care ideology from institutional to deinstitutionalized solutions (small-scale facilities - day care centers, drop-ins, group homes, sheltered homes, etc.) with numerous spatial implications (Gleeson, Hay et al. 1998: 1). This makes it a profoundly geographical phenomenon. Previously spatially removed, these facilities have become part of the local reality affecting the daily life of people who live and work in the neighborhoods, health care sector workers and service users. Communities have proven to be caring places. People in such areas do not expect mental patients to necessarily be kept at a distance a concept which also corresponds to Indigenous practices and value systems (KORN, RYSER et al. 2008: 14). Research has found self-help and advocacy networks establishing among people with mental health problems (ESTROFF 1981). Work has uncovered the value of friendships and acquaintances fostered in formal and informal spaces such as cafés, clubs, food counters, and other largely invisible layers of caring practices (PARR and PHILO 1995). The understandings conveyed in these mental health and geography studies in many respects correspond to Indigenous experiences as expressed in concepts of traditional healing. This dissertation therefore puts mental health geography in the Indigenous context and looks at traditional healing from a geographical perspective.

The central question asked in this dissertation is the one of the need, efficiency and potential of self-determined Indigenous mental health care structures for the improvement of Indigenous peoples' mental health status, identifying areas for the development of integrating traditional healing strategies for better health care in tribal communities. Based on participatory fieldwork conducted in Indigenous communities in Washington State this thesis tries to 'map' an Indigenous cultural approach to understanding mental health issues and the role of place for maintaining mental, emotional, spiritual and physical health in the context of the everyday lives of local Indigenous nations. Regarding individuals in their respective web of relations formed by family and community as well as relations to places presents a sociocentric view which corresponds to the group rather than individual consciousness of Indigenous peoples. Descriptions concerning Indigenous peoples practices of hunting, fishing and canoeing reflect an ecocentric perspective.
By analyzing data through the lens of geographical area, culture, indigeneity and other variables relevant to Indigenous peoples' mental health, multiple factors contributing to the poor health of local Indigenous groups are being addressed. Needs, potential and disparities are discussed.
The ethno-geographical analysis gives priority to single Indigenous groups of Washington State, USA. The situation revealed in this paper, however, can be duplicated in many other Indigenous communities around the world and thus has implications extending beyond Washington State and its Indigenous inhabitants. For behind the tables, figures, and bullet points presented in this thesis stands the pan-Indigenous endeavor to use traditional healing knowledge as a survival method.
The thesis is informed by Indigenous ways of knowing and aims to contribute to a better understanding of these nations' health issues and to reveal the potential of other conceptualizations of mental health and geography.

Throughout the research process information was gathered to: a) identify the government and non-government and community resources available; b) characterize the structure of the mainstream and traditional mental health systems; c) obtain data on researchers, therapists and organizations involved in the development and promotion of traditional healing and integrative services; d) understand the regulatory structures of traditional healing; and e) identify needs for future research.
Accordingly an analysis of institutional structures of mainstream and traditional medicine provision and distribution in the field of mental health among local Indigenous communities

is presented. Informal community practices are discussed. Spatial patterning of service provision and facilities and patterns of utilization are considered.
The primary research questions addressed in the local study are amongst others:
What are the mental health service needs of American Indians in Washington State? What barriers exist in the publicly funded mental health care system to meet these service needs? Is there sufficient programmatic capability, legislative and administrative clarity, and intergovernmental cooperation to effectively serve and support American Indians with mental health issues? What are tribal efforts to meet Indigenous mental health needs? Are there self-directed tribal efforts based on Indigenous concepts of mental health care programs which could translate into reform at the local, national and state levels? These questions are significant because, outside of as well as within Washington State, little is known about the current need and practice of local Native Americans' medicinal knowledge.

The review of mental health care programs and an extensive consultative process across the State of Washington are underlying this study. I have attempted to confine the study to the central questions as noted. Individuals directly involved in the delivery of support and services, policy makers and those who guide and direct practices at the county, state, federal and tribal level were interviewed mainly in Western Washington State. Meetings and conferences of state and tribal organizations were also observed. Concrete findings and recommendations drawn from tribal, state and federal informants are offered. I have also carefully reviewed the extant literature as well as the legislation, existing law and the roots and original intent of legislation supporting the delivery of support and services to American Indians. Where legal issues are mentioned this study directly aims at a comparison of legal standards with the lived realities of Indigenous nations on the ground, which thus presents very much a bottom-up perspective. The thesis also looks at a superordinated scale – the global dimension of the principle of self-determination and Indigenous peoples (mental) health. One of the long-term goals of this thesis is to analyze and develop innovative strategies to create mutual understanding and increased dialogue and collaboration between diverse stakeholders, public and traditional health care providers in Washington State as well as other places. This is envisioned in order to improve the quality and increase the uptake of mental health care services.

The thesis is divided into nine chapters. First Indigenous peoples' contemporary issues are discussed. Then views on mental health and well-being are presented, as defined by Indigenous cosmovision. Concepts of traditional healing, research and policy are illustrated.

Chapter three discusses ethical and methodological questions when doing research and writing about Indigenous issues. In this section the research methodology employed in this thesis is described.
Chapter four explores and outlines federal American Indian policy in its historical dimension and the current legal status of the Indigenous nations in the United States. An assessment of the American Indian population and ethnographic overview is provided.
Chapter five depicts the mental health care system provided for American Indians and the relations between tribes, state and local governments in Washington State. The necessity of and differences in cultural competency in mental health service delivery is discussed. Additionally financial issues concerning mental health care services are outlined.
Chapter six first discusses the state of mental health of American Indians in Washington State in its historical, social and cultural contexts. The American Indian mental health needs are examined. Then the question is asked in how far the mental health care system can meet those needs. An assessment of Indigenous mental health care in Washington State is done.
Chapter seven reviews the Indigenous medical system. The chapter documents the existing mental health programs and services provided on Indigenous lands to tribal members. The relationship of place-based culture to mental health of Indigenous communities is discussed. Potential and possible deficits are examined carefully. Questions asked are what are some of the cultural, political, economic and regional factors influencing utilization of healing services?
Chapter eight analyses the strength, weakness, as well as potential and threats of the traditional healing system.
In chapter nine the conclusion of the study is presented. Recommendations for policy change and future research are offered.

Part 2 Indigenous peoples today

Indigenous peoples comprise about 5% of the world's population It is estimated that there are over 370 million people belonging to 5000-6000[3] distinct Indigenous groups living in over 70 countries (UNITED NATIONS 2006).

The term Indigenous peoples is essential for this paper.[4] Therefore first a short definition of the term Indigenous is given. An internationally recognized standard definition of Indigenous peoples does not exist. In this paper the working definition of Indigenous peoples developed by former UN Special Rapporteur José Martínez Cobo in 1986/87 known as 'the Cobo definition' is used which also was adopted by the United Nations Working Group on Indigenous Populations. In his Study on the Problem of Discrimination against Indigenous Populations Martínez Cobo defines:

> "Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing in those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal systems."

In addition, Article 1 of International Labor Organization (ILO) Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries recognizes in the contained statement of coverage:

> "[...] peoples in independent countries who are regarded as Indigenous on account of their descent from the populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonization or the establishment of

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[3] It is hard to come up with precise estimates on the exact number of Indigenous peoples world-wide. UN organizations and states that conduct the estimates do not agree on who is Indigenous.

[4] A note on terminology

In the choice of terminology I strive to respect the wishes of the population groups concerned. The term Indigenous is most frequently used by Indigenous peoples' organizations and non- governmental organizations specialized in the field. It is also the term most frequently used in international human rights standards. The paper accepts R. Stavenhagen's definition of the term "peoples,", which indicates that: "The concept of a "people" refers to the features characterizing a human group in territorial historical cultural and ethnic terms that give it a sense of identity STAVENHAGEN, R. (1992). "Los derechos indígenas: algunos problemas conceptuales." Revista del Instituto Interamericano de Derechos Humanos **15**: 123-143.

Terminology used to refer to the indigenous peoples of the United States is based on the recommendation in the 1977 joint resolution by NTCA (National Tribal Chairmen's Association) and the NCAI (National Congress of American Indians) which due to the absence of specific tribal designations indicated the preferred reference to be American Indian and/or Alaska Native (AI/AN). Other references widely used within the U.S, include First Americans, Native American and Natives, as well as the terms tribe, tribal, tribal nation. In keeping with the 1977 resolution, this paper uses American Indian as a general term to describe the descendants of those people who occupied North America prior to Columbus' "discovery" of North America in 1492. Moreover "Indigenous people" and "Native people" as well as "Fourth World Nations," (a term coined by George Arthur Manuel in his book An Indian Reality) are terms which are interchangeably used. Throughout the United States, the term "Indian" is often used for the same purpose. To avoid confusion the term "Indian" may cause in the international context it is not used in this paper.

present State boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions."[5]

As to what regards Indigenous peoples political situation all over the world these groups can be seen as "part" of political systems which have been created and defined by settler governments with rules that are not their own indigenous, but imposed systems with unknown social structures. A common experience for Indigenous groups is that they face forms of oppression, marginalization and exclusion in all possible political settings. Over the last centuries, however, Indigenous peoples have gained diverse experiences in dealing with and various strategies to react to these 'alien' systems of politics. Even though able to influence the political situation of their respective countries in some cases such as the Greenlanders, the political context for Indigenous nations still is, in most cases, largely dependent upon the will of the nation-state. Increasingly Indigenous communities, though, are seeking freedom from colonial powers trying to attain rights for their nations within the State, or attain new political territories out of existing states as they maintain they need autonomy for cultural, economic, and political survival (SMITH 1999: 13). Seeking fundamental change within the political system Indigenous groups promote the emergence of a norm of self-determination via local and global political movements. With the help of these movements Indigenous nations internationalize domestic disputes by making appeals to organizations such as the United Nations and the Unrepresented Peoples and Nations Organization (SMITH 1999: 8). Several international bodies such as the UN Permanent Forum on Indigenous Issues (UNPFII), an advisory body to the Economic and Social Council (ECOSOC) have been installed to discuss these Indigenous matters.

2.1 Indigenous health

Health is recognized to be a priority for Indigenous people. Many Indigenous communities lack basic health care services and facilities, and most government programs do not consider Indigenous peoples in their health programs (UNITED NATIONS 2003).
Today an increasing number of global instruments can be found that state health as a human right and provide for Indigenous peoples' right to their traditional medicines. To state but a few, the International Covenant on Economic, Social and Cultural Rights recognizes the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' [...] (Article 12.1). Article 25 of the Universal Declaration of Human Rights by General

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[5] International Labour Organization (ILO) 169 is the first document that recognized indigenous collective rights and the only international instrument for indigenous peoples that is legally binding. To date only twenty-two countries have ratified ILO 169.

Assembly resolution 217A (III) of 10 December 1948 indirectly provided for the right to health:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

The Universal Declaration on the Rights of Indigenous Peoples (UNDRIP) adopted on September 13, 2007 by the United Nations General Assembly (GA) guarantees Indigenous peoples right to health and traditional healing systems in the following articles:

> Article 7: "the rights to life, physical and mental integrity, liberty and security of person [...]"
>
> Article 23: "the right to determine and develop priorities and strategies [...] for health programs affecting them"; and
>
> Article 24:
>
> 1. "Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services."
>
> 2. "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right."
>
> Article 31:
>
> "[...] the right to maintain, control, protect and develop their [...] medicines, knowledge of the properties of fauna and flora [...]"[6]

Despite these and other legal instruments adequate provision of health care is not guaranteed for Indigenous groups. Federal and state public policies addressing health and well-being are yet to be made compliant and consistent with international law and accepted covenants relating to human rights, and to Indigenous peoples' rights relating to health and well-being. There is increasing international as well as national attention to Indigenous peoples' health status. Scientifically accurate data, however, is, if available at all, oftentimes incomplete and fragmented. The category ethnicity in national health surveys and analyses is not systematically included in national reporting systems of countries with Indigenous

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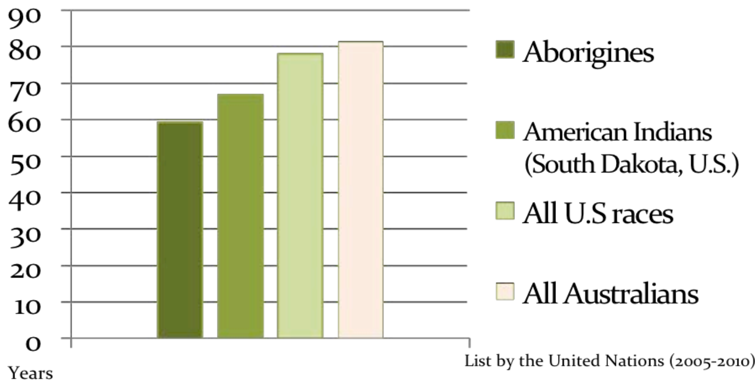
[6] UNDRIP is not legally binding and thus remains 'aspirational'. Indigenous leaders demand that both the governments and private corporations incorporate the declaration into national economic, political, cultural and environmental policies. President Obama announced that his government support for the Declaration at the December 2010 White House Tribal Conference. Federal and state public policies addressing health and well-being are to be made compliant and consistent with international law and accepted covenants relating to human rights, and to Indigenous peoples' rights relating to health and well-being. Discussions are being pursued on the objectives of public health, the appropriate balancing of trade and more effectively controlling the private sector as well as enhancing the community-based sectors.

populations. Relevant information oftentimes at best found through informal sources. Furthermore wide variation in types of ethnic categories used exists. This prevents comparison across regions and countries and impedes the identification of common health risks and problems on the different scales. Due to the information gap on ethnicity, and scarcity of comprehensive research on health risk and disparities among Indigenous peoples in many countries, the necessary evidence-base and infrastructural foundation for creating meaningful policy and work plans relating to Indigenous peoples' health is not given.
The data gaps and lack of information was noted by WHO and acknowledged to impede a "broad national and global understanding of the range and extent of health issues affecting Indigenous peoples everywhere" (UN COMMISSION ON HUMAN RIGHTS 2001). Despite the dearth of reliable health data some consistent patterns show. The sum of available data indicates higher morbidity and mortality rates, lower life expectancy and a generally lower health status compared to the respective national average (Ibid). Life expectancy at Pine Ridge Indian Reservation in South Dakota is amongst the shortest of any nation in the Western Hemisphere with a median age of death of 58 for Native Americans. The life expectancy of Indigenous people in Australia is an estimated 17 years lower than that for the total population (ABS 2004; table 3A.1.1).

Figure 3: Indigenous Life Expectancy



The health situation confronting many Indigenous nations world-wide was reported to be alarming. The rates of Indigenous death due to diabetes, alcoholism, tuberculosis, suicide, unintentional injuries, and other health conditions have been noted as "shocking" (OFFICE OF THE GENERAL U.S. COMMISSION ON CIVIL RIGHTS 2004: 2). Immediate action was recommended at the first Pan American Health Organization (PAHO) Workshop[7] on Indigenous Peoples and Health in the Americas held in Winnipeg in April 1993. Resolution V adopted by PAHO acknowledges that:

[7] The recommendations of the Winnipeg workshop and resolution V are contained in "Health of Indigenous people", Pan American Health Organization, 1993.

> "The living and health conditions of the estimated 43 million Indigenous persons in the Region of the Americas are deficient, as reflected in excess mortality due to avoidable causes and in reduced life expectancy at birth, which demonstrates the persistence and even the aggravation of inequalities among Indigenous populations in comparison with other homologous social groups."[8]

Apart from recommending the promotion of Indigenous peoples' access to mainstream health care provision the Winnipeg workshop also discussed the need to strengthen local health care systems which are socially and culturally sensitive (Ibid).

The foundation for an international Indigenous health movement with a focus on the specific health needs of Indigenous groups was laid as early as 1990. The International Congress on Alcohol and Addictions at its Berlin Conference included a special forum on Indigenous health issues. Many Indigenous peoples attended the conference. This new movement entitled "Healing Our Spirit Worldwide" (HOSW) attracted more than three thousand participants from around the globe when held for the second time in Edmonton, Canada in 1992. This international Indigenous conference led by the International Indigenous Council, a group of Indigenous leaders, focuses on strengthening and healing Indigenous families and communities and discusses best practices, successes and common issues in health and healing within Indigenous nations. The latest, Sixth Gathering took place in 2010 in Honolulu, hosted by Papa Ola Lokahi under the stated mission of the conferences "to gather in a cultural celebration inviting the world to share holistic healing experiences of Indigenous peoples in the movement toward healthy lifestyles."[9]

Underlying this international Indigenous movement and emerging health models are Indigenous views on well-being. There is not one standard definition of conceptions of health. Every culture's intrinsic perception and understanding of health and disease is influenced by their particular belief systems living contexts. Common to Indigenous definitions of health is a comprehensive concept of health that moves beyond the mere physical and includes social, cultural and historical elements. The comprehensive definition of health by the World Health Organization in the primary health care approach runs as follows: "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO 1948: 100). Aboriginal peoples have defined health as:

> "Not just the physical well being of the individual, but the social, emotional and cultural well being of the whole community […] [and] a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem and of justice. […] [health is] shaped by the intricate relationship with the land. The land simultaneously contributes to physical, mental, spiritual and emotional health in

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[8] Working Group on Indigenous Populations-Health And Indigenous Peoples: Note by the Secretariat, http://www.austlii.edu.au/au/journals/AILR/1997/23.html#fnB1 (last accessed 06.Jan.2011).
[9] For further information see: http://www.hosw.com.

> a variety of ways […]" (NATIONAL ABORIGINAL HEALTH STRATEGY WORKING PARTY 1989).

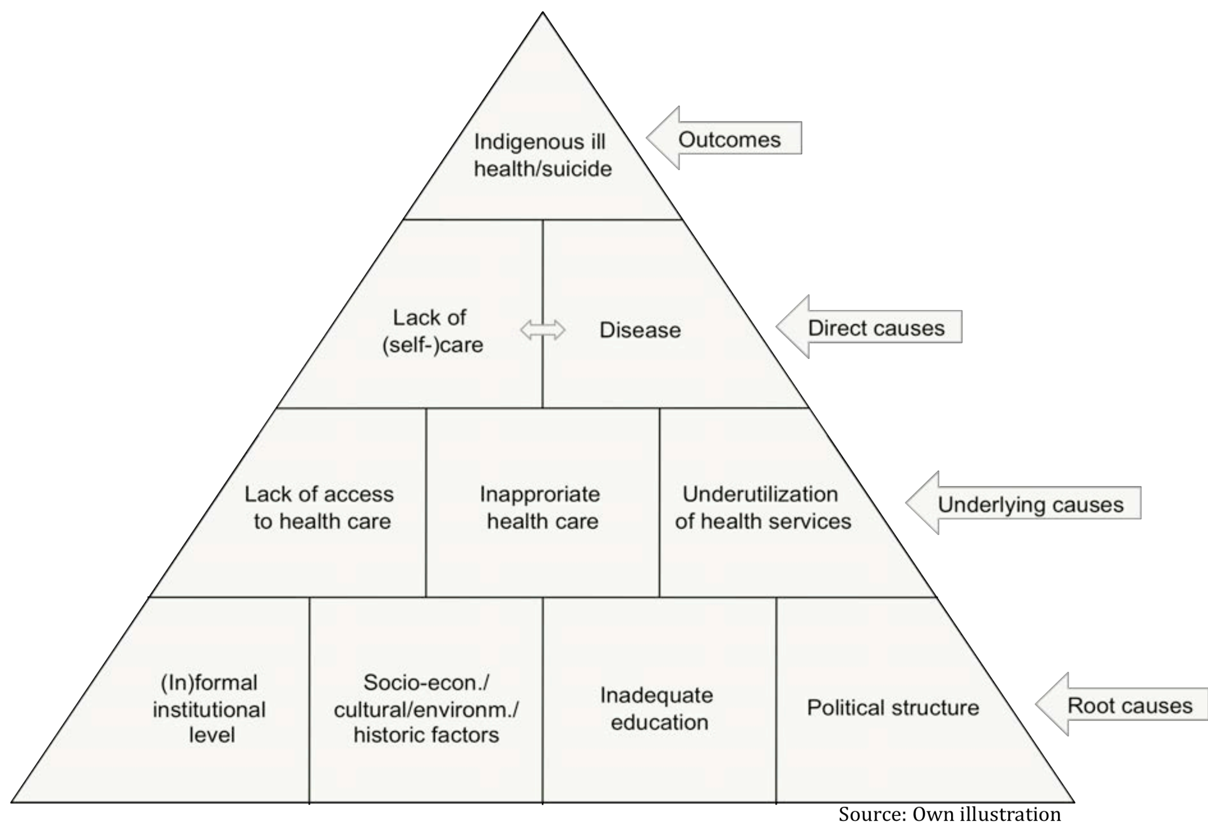
In the last decades social and emotional well-being has been acknowledged by decision makers and become part of health reform in Australia. Aborigines further describe their wellbeing:

> 'Enjoying a high level of social and emotional wellbeing can be described as living in a community where everyone feels good about the way they live and the way they feel. Key factors in achieving this include connectedness to family and community, control over one's environment and exercising power of choice (SAAHP 2005; SOUTH AUSTRALIAN ABORIGINAL HEALTH PARTNERSHIP (SAAHP) 2005: 6).

Kanaka Maolis' (Native Hawaiians) conception of maintaining health is 'the continuum of a people.' Connective social elements such as traditions and history upheld between the generations are held to be fundamental for good health. In their absence health it is believed cannot be maintained. Therefore Kanaka Maoli want to see these connective social elements addressed in the provision of health services. Pōkā Laenui from the Wai'anae community of Hawai'i, summarizes this view: "Health services should support the continuity of the consciousness of a people"(LAENUI 1997).

Colonialism starting in North America in the 16th century severely disrupted connective social elements. The place of communal interaction was taken away. Radical change brought about disruption of Indigenous social, cultural and economic systems. Participation in the introduced system was limited in economic as well as socio-cultural terms. Problems resulted from genocide, displacement from their land, policies of assimilation and denigration of culture, environmental contamination, and economic disempowerment (BURGER 1990). Furthermore diseases were introduced in the communities. Smallpox, diphtheria, influenza and measles resulted in what has been called the "great dying" (1999: 11). The legacy of colonization has been explained to contribute to the poor health status of many Indigenous peoples exposing them to specific health risk factors (such as obesity, physical inactivity and high blood pressure as well as mental diseases). In the developed model illustrated below factors are shown which work in concert to affect Indigenous health status. The root causes leading to Indigenous consistent ill health lie outside the realm of the health sector. They are the consequences of colonization which reflect in the overall circumstances of Indigenous people - such as the political structure, educational, economic and employment opportunities, adequate housing. Besides factors more specific to the health sector underlying causes of ill health include the lack of access to good quality care, absence of social and cultural sensitivity of care and underutilization of services.

Figure 4: Conceptual Framework for Causes of Indigenous Ill Health/Suicide



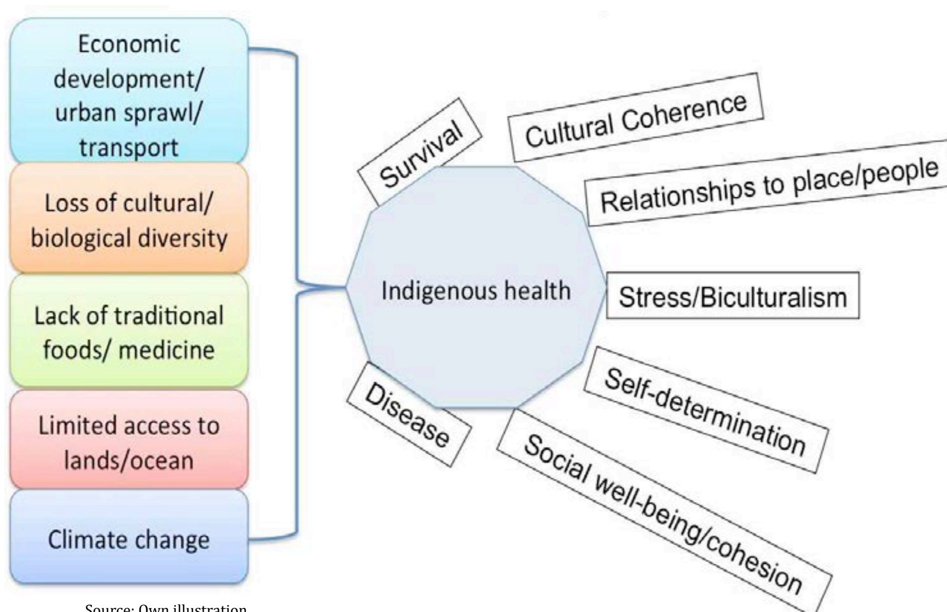
Source: Own illustration

As this illustration suggests improvements in Indigenous health status are only likely to be achieved with substantial improvements in the general circumstances of Indigenous nations. A better understanding of the phenomenology of ill health, Alexander Cohen explains, must not only encompass symptoms but consider interrelationships between history, culture and ill health and analyze "the social contexts and cultural forces that shape one's everyday world, that give meaning to interpersonal relationships and life events" (COHEN 1999: 11). The long term effects of dislocation, epidemics, depopulation, and subjugation along with the break-up of traditional culture, way of life and belief systems show in Indigenous communities around the world today in the high incidence of mental health disorders, substance abuse, physical and sexual violence depression and anxiety (WILLIAMS, LABONTE et al. 2003). Smith states that as a result of the colonial experience, people now "live in the shadow of what they once were", deprived of "nearly all that gave interest to their lives" (1999: 39). Psychotherapist Alex Cohen in his WHO report on the mental health of Indigenous peoples explains that it is "the loss of interest in life which allows Indigenous peoples to work such ravages upon life and health" (1999: 11). Cohen explains that "a central task of any culture is to provide its members with a sense of meaning and purpose in the world [...][and] when a people's way of life is destroyed through disease, genocide, loss of territory and repression of language and culture, when pathways to meaning are no longer available, the result is psychopathology and mortality" (Ibid:12). An Aboriginal woman has summarized her experience:

> "It never goes away. Just 'cause we're not walking around on crutches or with bandages or plasters on our legs and arms, doesn't mean we're not hurting. Just 'cause you can't see it doesn't mean [...] I suspect I'll carry these sorts of wounds 'til the day I die. I'd just like it to be not quite as intense, that's all" (WILSON 1997: 178).

Aboriginal elder Dr. Alf Bamblett in his keynote address at the World Indigenous Peoples Conference on Education, 2008 in Melbourne, Australia explained that the effects of colonization and the trauma it caused are "palpable in Indigenous communities today." Families and communities are yet coping with the pervasive changes that disrupted Indigenous social and cultural systems. The following observation about Kanaka Maoli is suggestive of all Indigenous peoples. "Hawaiians have not exhibited ineptitude in the face of change but have been caught in that tragic bind that occurs when a people confront change [...] try to control its quality and pace, and find they cannot do so" (KING 1987). Internalizing their grief they expose themselves, families and communities to further trauma by misusing substances, domestic violence, suicide and similar sources of risk. Various factors that form the basis for resiliency of Indigenous communities are held to bear potential to break the vicious cycle of traumatic life circumstances. The persistence of traditional practices and extended family systems have been found to have a positive impacts on health (CARLTON, GOEBERT et al. 2006), as has the strengthening of community cohesion (STEENHOUT and ST. CHARLES 2002:27), and self-determination (SMITH 1999:153). Contemporary global issues of climate change, access to land and ocean resources, loss of cultural and biodiversity and economic development furthermore form a variety of factors influencing Indigenous health.

Figure 5: Indigenous Health Vulnerabilites



Source: Own illustration

There is increasing awareness of the need for examining all these essentially interrelated factors (BODLEY 1988).

2.2 Traditional healing

The terms 'traditional' and 'Western' medicines are frequently used throughout this paper. It is problematic to describe the principles, philosophy and practices of and to assign accurate definitions to these rather awkward and politically loaded terms. The term traditional healing (TM) will be preferred in this paper as defined below. The terms complementary/alternative/non-conventional medicine are used interchangeably. Western medicine is defined by the American Psychological Association (APA) as "a system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery."[10] Western medicine is furthermore called conventional, allopathic, orthodox, mainstream medicine as well as biomedicine.

The World Health Organization estimates that the majority, about 80 percent, of the population of most developing countries still relies on traditional forms of medicine for their everyday health care needs (WHO 2002).

The WHO gives an essential working definition observing that traditional medicines:

> "[Include] diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness" (WHO 2002).

The WHO regards traditional medicine as

> "The sum total of all knowledge and practices, based on the theories, beliefs and experiences Indigenous to different cultures, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing" (WHO 2000a: 1).

Amongst Indigenous peoples there is not one adequate description of traditional medicine. Medicine is viewed as a "cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal arrangements" (KLEINMAN 1980: 24). Traditional medical systems are at the heart of Indigenous cultural identity. They form century old systems of knowledge intended for maintaining Indigenous communities' well-being. Healing systems vary greatly within countries and regions. They are unique products of Indigenous peoples' history, cosmovision, beliefs about life, health and healing and interaction with the natural environment of the place they inhabit (HOLLOW 1999). Therefore, when analyzing traditional medical systems and practices the cultural

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[10] Western medicine. (n.d.). *Dictionary of Cancer Terms*. Retrieved August 25, 2011, from website: http://www.expertglossary.com/cancer/definition/western-medicine

background of the people involved and the particular concepts of the TM practice must be considered.

Traditional healing is based on a holistic approach towards the intervention and person to be treated (ONG, BODEKER et al. 2005: ix). Traditional healing considers the whole person and is to simultaneously act on the physical, mental, spiritual and emotional level. Prevention and health promotion are a main focus. Use of plants and herbs, food as medicine and counseling on lifestyle choices and habits are commonly observed with traditional healing practitioners. Vitalizing the life force has been described as a concept of many Indigenous healing systems (WHO 2001a).

Traditional healing has a long history. Until the beginning of the 19th century all medical practice was what is now referred to as traditional. Traces of a traditional healing concepts can be found in older Indoeuropean cultures within which healing (the act and the word) is connected to wholeness, holiness and integrity, as suggested by the origin of the word "health"[11]. Very much like the Indigenous people of the present world the Indoeuropean healers of ancient times focused on the understanding of the full structure of the cosmos (KREMER 1995: 13). This worldview changed when the Cartesian scientific materialism was introduced into medicine and other disciplines during the time of the great philosophical upheaval of the renaissance. The focus developed then was on scientific experiment and statistical validation, research and organization. Emotions and intuition were belittled (BANNERMAN 1983: 11). Despite outside pressures of colonialism and cultural imperialism traditional healing survived in many Indigenous communities. (OLSON-GAREWAL 2000). During efforts of forced assimilation of Indigenous nations in the U.S. in the past traditional healers were dismissed and outlawed. However, to the present day, traditional healing is widely accepted and used among American Indians (BUCHWALD, BEALS et al. 2000). Most forms of traditional healing therapies in order to be efficient depend heavily upon the skills and experience, i.e. the proficiency of the practitioners. Their client-centered, personalized care is relationship oriented which encourages communication about the illness and social issues related to the disease. In many communities they frequently play a key role as first point of consultation.

Traditional healers use Indigenous knowledge in their treatments and protocols. They are oftentimes regarded as experienced local leaders, folk psychologists and comprise psychic

[11] health. (n.d.). Online Etymology Dictionary. Retrieved January 07, 2011, from Dictionary.com website: http://dictionary.reference.com/browse/health

healers, herbalists, traditional birth attendants, bonesetters, faith healers, diviners, and spiritualists. Traditional healers' holistic view on health is one of harmony, a state of balance and equilibrium within a person's body, psyche and relationship with other people around them. Ill health is sign of an imbalance in any of these relationships and the healer is to restore that balance seeing the disease in a wider personal, social and cosmic context (HELMAN 2006: 201).

'Western' medicine or biomedicine and its dominant contemporary medical practices have become a cornerstone of health worldwide today. The medical model is based on evidence from scientific research and technology developed mainly in Western Europe and North America. Accurate diagnosis and classification of diesease is the basis for prognosis, course of illness and treatment. From the Western medical perspective Indigenous medical systems are oftentimes viewed as backward cultural beliefs. In an appeal for the abandonment of the prevailing bias against folk science, the anthropologist Weston La Barre has called attention to the extraordinary contributions of American Indians, and stated:

> "As scientists we cannot afford the luxury of an ethnocentric snobbery, which assumes a priori that primitive cultures have nothing whatsoever to contribute to civilization. Our civilization is in fact a compendium of such borrowings, and it is a demonstrable error to believe that contacts of "higher" and "lower" cultures show benefits flowing exclusively in one direction. Indeed, a good case could probably be made that in the long run it is the "higher" culture, which benefits the more through being enriched, while the "lower" culture not uncommonly disappears entirely as a result of the contact" (1942:200).

Biomedicine from an Indigenous perspective has been characterized as being reductionist as the focus is mainly on the physical body. Despite these contrastive concepts of health care provision an integrative approach have been promoted. Back in 1978 the World Health Organization formally recognized the importance of collaborations between mainstream and traditional health practitioners. Traditional medicine practitioners were seen as possible allies of the medical system despite the remaining caution as to superstitious beliefs and practices with all their potential dangers (HELMAN 2006: 200). Guidelines on traditional medicines, traditional healers and collaboration between biomedicines and traditional medicines were issued, expert consultations and conferences organized. The issue of traditional medicines was linked to biodiversity conservation and Indigenous peoples' rights over their intellectual knowledge and resources (TIMMERMANS 2003: 745). In subsequent years there has been an increasing use of complementary and alternative medicine (CAM)[12] in

[12] CAM "complementary and alternative medicines" relates to health care practices that do not form part of a country's own tradition, or not integrated into its dominant health care systems, such as acupuncture, homeopathy and chiropractic systems. See Traditional Medicine Strategy 2002-2005, World Health Organization, WHO/EDM/TRM/2002.1, Geneva, p.7.

many developed and developing countries (ONG, BODEKER et al. 2005: xiii). Consistent with WHO's definition of health (as stated above) there is an emphasis on a more holistic approach to health including the physical, mental, social and spiritual well-being.
Supported by national governments efforts to develop adequate policies and strategies to protect traditional healing knowledge have increased internationally in recent years. Despite its continued use for centuries the majority of countries does not have official policies (as of the year 2000, only 25 of WHO's 191 Member States reported having a national traditional medicine policy (WHO 2002: 20). WHO has defined three types of health system structures to describe the degree to which traditional medicine is an officially recognized component of care. In a tolerant health system health care is entirely based on allopathic medicine. Traditional medicine practices are not officially recognized. In an inclusive health system, even though not incorporated in all areas of care, traditional medicine is recognized - be this in the delivery of health care or the educational and training context or regulations. The third category is an integrative health system which officially recognizes and incorporates traditional medicine in all the different areas of health care provision (WHO 2002: pp. 8-9).
In countries where traditional health practitioners are regulated by laws they can be classified as part of the formal health system. In countries like the United States where no legal frameworks exist which recognize Indigenous healing as valid healers are part of the informal health workers. They either have to adjust to the existing administrative and labor standards like any private entity (WHO 2003) or work under the regulations of tribal clinics which have started defining their own rules for qualification and certification, supervision and quality control of traditional healers. Safety, efficacy and quality standards of their healing methods are being designed. Simultaneously documentation and recording of the medicine knowledge has been endeavored in some areas.

Part 3 Methodological framework

3.1 Indigenous mental health research - limitations of current research paradigms.

Considering the small number of the inhabitants, Indigenous communities are among the most heavily researched populations of the world. Many of the existing surveys and studies done are based on standard Western approaches, research methods and models that pose difficulties to measure Indigenous culture and achievement. There is a lack of developed research and evaluation guidelines that are culturally responsible and responsive to Indigenous ways of knowing. In most modern research the traditional positivist paradigm is embodied. The researcher is an expert distant and value-free who discovers a static, single reality (MATSUNANGA, ENOS et al. 1996). Kleinman summarized the effect of the perceived lack of sensitivity of this approach to medical research:

> "The ingrained ethnocentrism and scientism that dominates the modern medical and psychiatric professions follows the paradigm of biomedical science to emphasize in research only those variables compatible with biological reductionism and technological solutions, even if the problems are social ones" (KLEINMAN 1980: 32).

This concept is foreign to Indigenous communities whose research is not based on the Western Cartesian outline but Indigenous epistemologies and ways of knowing. Indigenous researchers have identified that the positivist concept of research is deeply problematic for Indigenous peoples as it elaborates histories of encounters between Indigenous peoples and researchers embedded in the story of imperialism and colonialism and thus conveys deep cynicism and suspicion. This has been described as persisting intellectual colonization (DURAN, DURAN et al. 1998: 68). Tuhiwai Smith states that Indigenous peoples until recently have always been 'the researched' and treated as the 'object', the 'subject' of research (1999: 39). As a result, there is a growing and strong resistance in tribal communities to research generally, but outside motivated research specifically.

Indigenous leaders have criticized the magnitude and orientation of those research projects, which have not been perceived by the Indigenous group to address the concerns of the group, have had little or no input as to research ideas, study design, dissemination, interpretation, or integration of research findings and are not conducted in culturally appropriate ways. Dr. Leslie Korn, principal researcher of an NIH Indian Elder Caregiver Study explains: "So much research has no relevance to Indian country [...] Native communities themselves need to be the ones who ask the questions" (personal communication). Or as has been remarked: "We're getting studied the heck out of, and we don't know what the study is about [...]. Maybe not all studies are beneficial" (WAX 1991: 431). In fact, Natives are wary of research as findings may be considered harmful through a failure to share financial or professional profit with the community and abuses they have encountered (NORTON and MANSON 1996: 856). A project

manager in Washington State observed in an interview about a colleague from Shoalwater Bay, Washington State:

> “She was really sensitive to ‘studies’ and very put off by the term study as ‘people in her community have been really hurt by other studies’. She said she had experienced many ‘studies’ in her time working at Shoalwater Bay and mentioned one study on infant mortality where University of Washington micro-biologists and scientists came in the community and were entirely insensitive to the women and their grief, then left and the community received nothing. The truth was never told that it was the pollution in the bay and the cranberry bog […]” (personal communication).

The interviewee stated that often participants “never received anything for their time” but felt they were “used as guinea pigs” instead or exploited to “advance the researcher’s career.” Generally Indigenous communities have developed a distrust of research and researchers. High levels of suspicion and a severe reluctance to participate in research exist. Native Hawaiian Dr. Marjorie Mau stated in her speech at the Pacific Region Indigenous Doctors’ Congress (PRIDOC), 28 August 2010 at Whistler, Canada: “When you say research a lot of doors close. Research is the dirty ‘r’ word.” Or as has been stated by another scholar: “The word 'research,' is probably one of the dirtiest words in the Indigenous world's vocabulary.” (Debra Harris personal communication). A Salish researcher explained on a study conducted in his home communities:

> “We said we have a ‘program’, we would not say we are doing a ‘study’ but say we have that money right now to do alternative therapy and people responded to that. They understood the program, maybe you have the game you have the net, you have the money so you try it while the program still exists” (personal communication).

Overall though Indigenous peoples are becoming increasingly receptive to the importance and significance of research. Dr. Ted Mala, first Native male Alaska doctor explained at his 2010 PRIDOC talk on the relationship of science to emerging Indigenous partnerships about research and empowering tribes:

> “There are areas we are just starting and research is one of them. Research done on Natives has been really awful. We have let people in they have used research against us. The joke being that the typical Eskimo family is mother father two kids and the anthropologist […]. Now is the time to train us to fish and not just to give us a fish every day.”

Research is perceived to be a valid way to apply contemporary understanding to ancient knowledge, when the research is designed, implemented, evaluated and fed back to Indigenous communities so that “something is left for the people on the ground” (Dr. Rÿser, personal communication). Alternative research modalities exist that unlike contemporary progressive research techniques are not invasive or directed to the benefit of institutions and individuals outside of tribal communities but are for the benefit of tribal communities from

which knowledge is acquired. Recently using a community-based participatory research (CBPR) model to conduct studies has been preferred to involve the community at all levels and address the health of the Indigenous community within the broader cultural, social, economic, and political context. Instead of adhering to a positivist paradigm, researchers engage in a transactional and interactive relationship with study participants and their respective communities based on and mediated by values (GOODCARE and LOCKWOOD 1999). These modalities should be employed so that the needs of tribal communities become a primary goal of research and that research practitioners respond to the questions raised within tribal communities about their own needs.

The notion of self-determination in research is explored and becomes a political and social justice goal, which is expressed through and across a wide range of psychological, social, cultural and economic terrains. Thus Indigenous peoples take an active step toward retelling their own stories, reconstructing and re-presenting knowledge about themselves which involves, as Linda Smith explains, the processes of transformation, decolonization, healing as well as mobilization as peoples (1999: 116).

Also Western researchers want to emphasize what is less readily measured and quantified; the subjective experience of health and illness. Since these approaches address implicitly human beliefs, values, meanings and intentions geographers have for many years referred to them as 'humanistic,' or as social interactionist. In a health context, such approaches continually engaged people in the construction of knowledge. A corollary of this is that the views of ordinary people (referred to as "lay" or commonsense views) have as much status as those of the health professional. The emphasis is on the meaning of the illness or disease to the individual. The task for the researcher is to see things from the individuals' point of view, i.e. to uncover or interpret these understandings and meanings that make it "rational" to act in a particular way. For example, not going to have a child with aggressive acting out behavior sent to treatment may be irrational to the health professional yet perfectly logical to the parent.

The social interactionist approach is a move away from the "dominance of bio-medical based large-scale research" and will typically rather study small numbers of communities and people. It seeks a greater understanding of the social processes that are involved in shaping health-related behaviors and outcomes and holds the experience of place to be important. In the social interactionist accounts, therefore, people are not simply seen as collections of possibly diseased body parts or merely passive recipients of knowledge about health and

health care. The methods used are essentially qualitative, and the ultimate goal is empathetic understanding and explanation rooted in the social, rather than the natural world.
Such approaches are subject to criticism from positivists who emphasize on objective matters more than on the subjective. They doubt verifiability of results and credibility of conclusions due to small numbers. However these approaches are best responded to by Indigenous communities as they are more in line with their epistemologies.

Research infrastructure for conventional medicine is significantly more developed than that for traditional medicine. Research in the field of traditional medicine has great difficulty finding academic attention and support, and adequate funding despite being a vast area with a high need to be explored as it is urgent. Biodiversity and culture in the Indigenous world are extremely rich and could be the source of traditional healing practices which could herald a new age of efficient medicinal treatments, cheap or altogether new drugs as well as crops. Especially when analyzing the contributions of traditional medicines to mental health, however, there are a series of resistances conventional medicine comes up against. These difficulties include for example the use of techniques to induce modified states of consciousness, frequent use of psychoactive plants or substances, and the missing scientific objectivity in the therapeutic relationship, both by the patient and the therapist, as well as the supremacy of experience over technique in traditional medicine therapeutic practices. Neither quantity nor quality safety and efficacy data is sufficient to allow for the worldwide use of traditional medicines. Lack of adequate or accepted research methodology for evaluating traditional medicine and health care policies are the main reasons for the lack of research data.
Moreover traditional medicine in many regions took refuge in the lower social classes which oftentimes is researched by laypeople. What has also been observed as a normal stress reaction is a general tendency towards alternative methods and esoteric escapism. Currently many westerners are searching for solutions to their mental, moral, existential or spiritual suffering. This produced a dubious form of neo-shamanism and shamanic tourism and threatens to degenerate and destroy traditional medicines. Furthermore this New Age movement contains the danger of laying the groundwork for charlatanry. A traditional healer explained on this: "Traditional healing is medicine, not shamanism."

The need for data in Indian Country

An attempt to assess the mental health care services and needs of a population presents several challenges to the investigator. Data must be available for a representative population

that provides reliable valid information. Data is an essential component for decision-making, advocacy, and education. Especially where data drives policy and funding. Everything that is done requires documentation of need, impact, or cost effectiveness. If data does not exist or does not represent the true situation in communities, these communities continue to be silenced, leaving individual's needs invisible, while health disparities grow which can be described as a form of statistical genocide.

Finding information on Indigenous peoples in general and Native American health in particular is a difficult task in the United States. Especially Indigenous traditional health practices that are part of the informal sector are not easy to study and acquire reliable data on. There are a number of national efforts to monitor the health of the U.S. population. Considerable health research has taken place. While data gathered by these efforts may be used to inform programs and services for larger populations such as Whites, African Americans, Hispanics, and Asians, very little information can be gleaned to support services for smaller populations such as American Indians. A consistent national assessment of Indigenous peoples' health status is hard to obtain and wide discrepancies in estimates and statistics are common. Comprehensive national Indigenous health statistics, however, are essential to adequately assess the Indigenous mental health status and monitor developments in Indigenous mental health. Social policy measures rely on dependable statistics in Indigenous health to set priority areas of concern, observe changes in Indigenous health and report on policy effectiveness and efficiency (ALTMAN 1992).

Surveys and administrative datasets often do not apply adequate Indigenous identifiers, which results in inaccurate and incomplete levels of identification. Indigenous peoples do not appear in many statistics. The main sources of Indigenous statistics are the ten–yearly nationalU.S.Census count which since1860 includes American Indians as a separate population category. Since 1960, in particular, the Census Bureau has made many changes in its methods of enumeration in an effort to get a more accurate and complete count for American Indians and Alaska Natives (1999: 3).

The Office of Management and Budget (OMB) intending to promote comparability among the country's systems of data issued Race and Ethnic Standards for Federal Statistics and Administrative Reporting (U.S. OFFICE OF MANAGEMENT AND BUDGET) in 1977. These Race and Ethnic Standards found a categorization for the data systems of the federal government to classify individuals into five racial groups which constitute the minimum set for data on ethnicity in federal. The categories are as follows: AI/AN, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. With the 1997 Race and Ethnic

Standards respondents are not restricted to select one category only which leads to several possible multiple-race categories (NCHS 2007: 542).
To create an ethnic category such as Native American is problematic as differences abound. There are many different groups and large numbers of individuals of mixed heritage that developed their own social relationships, traditions and family structures. Several alternative approaches are possible which contrast in whether ethnic group membership rests on a biological/genetic, cultural, social network, or psychological identification criterion. Since that is the nature of the classification in the available data, that orientation will be reflected in the ethnic categories used in the data analysis presented in theses chapters. While a more sophisticated approach might be more desirable, this classification is consistent with most existing published studies on American Indians (JOHNSON 1989: 57).
Furthermore research findings are constrained by the fact that American Indians comprise only a relatively small percentage of the total U.S. population. Thus oftentimes nationally representative studies cannot come to precise conclusions as to what regards need for mental health care because generally the samples of the Indigenous groups are not large enough. Also the magnitude of the diversity and heterogeneity that characterizes American Indians has important implications for research observations due to lack of cultural comparability.

Availability of Native American mental health data in Washington State
Currently an accurate set of data describing the American Indian health status in Washington State does not exist. Data on Native American mental health issues, especially, is very scarce. There is no clear methodology for providers to classify mental illness in American Indians and generate statistical data. Another reason for the lack of data is that for a traditionally oral culture maintaining written records is not culturally congruent. To describe or quantify mental illnesses in American Indian populations that are not formally recognized by Western science or viewed by American Indians as being interrelated with spirituality and environment poses another problem for data collection (STEENHOUT 1996: 61).
Furthermore American Indians in Washington State receive mental health services from several different locations, Regional Support Networks (RSN) contracted providers, IHS run facilities, urban-based programs, and tribal-based mental health care programs, as will be described in more detail further down. These four mental health services providers, keep limited data on their clients. RSN and other non-tribal institutions do not list ethnic categories as part of their brief screening which serves to find out what the mental health issue or chemical dependency issue is and what is the coverage. There is not any statistics available on

this. It is not known how many American Indians there are in the programs. Neither are there lists of therapists specifically working with ethnic minorities such as Native Americans. Most American Indian mental health programs do not keep statistical data at all and very few tribal run programs are maintaining datasets of their clientele or programs let alone traditional practices - also due to costs and lack of technical skills required. Moreover the different programs have no formally established link with one another. As a result, what limited data is available is fragmented. These issues impede the creation of a reliable set, or source of data from which one can confidently measure the general state of mental health of American Indians in Washington State.

3.2 Methodology

A lone geographer cannot develop a new theory on the potential of self-determined Indigenous mental health care and comprehensive medicinal approaches in the treatment of mental disease and then test it by fieldwork in nearly 6000 Indigenous communities the world over. A study of this magnitude necessitates attention to broad socio-cultural and political processes at various scales and relies upon the work of innumerable other scholars. In this paper three different geographic scales of analysis are used to the hypothesis: global (general theory), national (USA) and regional (Northwest Coast of Washington State). Fieldwork was conducted in Washington State where a two-year internship at the Center for World Indigenous Studies and Center for Traditional Medicine in Olympia, WA, USA, was done from 2003 to 2005 and subsequent fieldwork in the summers of 2006 and 2009 as well as two last visits in August 2010 and April 2011. Inspiration to conduct this research came from my ongoing work as a senior fellow in traditional healing arts policy with the Center for World Indigenous Studies. In the course of this work, I closely interacted with traditional medical practitioners during local cultural events conferences and Northwest Coast Salish foods and medicines seminars. During my two-year stay in Olympia I travelled extensively along the ancient tribal travel routes, so-called oolichan grease trails of the Northwest Coast all through British Columbia, Canada up to the Alaskan border. On the southbound route I drove all the way down into Arizona and down into Mexico taking video footage and interviewing tribal members and experts on health, traditional foods, and cultural and psychological well-being. A short documentary production has been the result of these investigations.[13]

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[13] Available at: http://gallery.me.com/mhirch/100087

Based on previous research for a Masters thesis concerning humor in Indigenous nations in Canada I analyzed the historical as well as current context of the colonization of Indigenous peoples and its impact on health and medicine today.
Gathering the required data and getting a deep insight into the topic on as global a scale as possible involved:
(1) Several years of correspondence and discussion with Fourth World nation organizations and leaders.
(2) Study trips that brought me to Indigenous territories in thirteen states of the U.S. and 4 provinces in Canada where I witnessed folk knowledge, knowledge about foods and medicines.
I received three times a travel grant sponsored by German Academic Exchange Service for travels to the Indigenous world in Russia and Central Asia to explore Indigenous health issues as well as Avicenna Ibn Sina - the roots of modern medicine. For one month I stayed with a medical doctor in Uzbekistan as well as with a student of medicine in Tajikistan. I attended and conducted several weeks long classes at traditional medicine seminars in the Pacific Northwest of the U.S.and in the Comunidad Indigena de Chacala in Yelapa, Jalisco, Mexico. I visited the Tarahumara, Baranca del Cobre, Chihuahua, Mexico whose main access to health care provision is traditional medical practices.
(3) Participation and presentation of papers since 2003 in numerous international forums and conferences associated with Fourth World issues, education and medicine.[14]
At these venues I participated in round table discussions with key stakeholders and Indigenous medical doctors and traditional healers to discuss issues involved in integrating traditional healing with Western medicine, community health centers, and the native Indigenous health care systems. Moreover I met representatives from the federal agencies that share responsibility with tribal authorities for addressing or responding to Indigenous health needs. Visits to the UN in New York and Geneva and a meeting at WHO headquarters with Indigenous representatives could be arranged.
(4) A careful monitoring of news accounts, journals, and a growing list of publications on Indigenous health and medicine. Existing government and non-governmental reports, including studies conducted by the U.S. Department of Health and Human Services (DHHS), medical studies articles and media reports of traditional healing were reviewed as well as federal and state law and legislation. I have also taken various onsite and online courses that have provided me with experience and knowledge to aid me in my research project.

[14] See list in the appendix.

Data sources

This thesis relies on data from several major sources. The data presented is partly drawn from both published academic work and government publications. Literature and data from international, national, state and local sources was reviewed.

On the international level the World Health Organization Statistical Information System (WHOSIS) provides health and health-related statistical information from the World Health Organization. Nationally the U.S. Census Bureau, Department of Health information was used as well as The Medical Expenditure Panel Survey (MEPS), which collects nationally representative data on use of health care, costs, payment sources, and insurance coverage for the U.S. civilian non-institutionalized population. Although data from these sources are highly useful in a general sense, often the datasets do not permit specific analysis by race and ethnicity.

Searching databases for books and journal articles, most of which in electronic format provided some easily accessible information even though no comprehensive coverage. A lack of indexing renders identification of relevant material difficult. There are considerable amounts of useful information on the subject though contained in the fugitive literature (SHARON, GRAY et al. 1993).

To amplify data a systematic bibliographic search and Internet search strategy was used. The Internet was used to search for contacts, organizations and education centers involved with Indigenous health. Keywords such as 'mental health', 'Indigenous healing', 'Indigenous healers', 'traditional medicine', 'alternative therapies' and the names of individual therapies, were submitted to a number of broad-based search engines which included MEDLINE, www.google.com. In the internet search all major official health websites relating to American Indian mental health and well-being were identified and scanned for information on traditional medicine (with the aid of internal search engines in the sites where available). A search of PubMed was done with search terms such as 'Indigenous', 'Native American', 'Alternative Therapies', with 'Health Outcomes', and/or 'Traditional Medicine/Healing'. Many online sources are available to get more information on American Indian health issues. The One Sky Center's Web site offers the Native American community up-to-date information regarding mental health and substance abuse issues. The NCAIANMHR (National Center for American Indian and Alaska Native Mental Health Research) at the University of Colorado is another source of relevant information as is the Substance Abuse and Mental Health Services Administration (SAMSHA).

This information was supplemented by Indigenous health and social data published by governments and statistical agencies in the different jurisdictions. "Grey" or unpublished

literature was also sought. The grey literature databases were searched for dissertations, and local and regional projects/reports.
Moreover some audiovisuals exist on topics concerning Indigenous health. However, audiovisuals are less accessible. Most are not produced and marketed by commercial operations but by local organizations and agencies for specific purposes, mainly educational. As a results there are no references to be found in the usual databases which limits access. Additional contributions were also gained through personal contacts and extant collaborations in TCAM work in several places in the world. Major traditional medicine organizations in various countries and regions were also contacted and asked to provide local scientific papers, reports or journals about Indigenous mental health. Through means of modern technology I could from a distance accompany my mentor Dr. Mala to local tribal events, health conferences and Indigenous health meetings be they in the White House in Washington DC, at NIH or various other locations throughout the country. This allowed further insights into the current endeavors undertaken concerning the elimination of health disparities in Indigenous communities.

Conduct of the regional study

Local data in Washington State was collected primarily in in-depth, interactive interviews, participant observation and the examination of institutional documents. In total more than 30 telephone and personal interviews were conducted in the Pacific Northwest some of which were recorded and transcribed. Participation in several meetings, conferences, tribal cultural events was possible. Traditional medicine seminars and traditional food feasts were attended with elders and youth, extended family groups, Native health and community workers, Native mental health workers and local mainstream mental health workers.
The research process involved tribal, county and federal officials and service providers, tribal members and employees from Washington State Indigenous organizations. Mental health providers and administrators at the DSHS, Regional Support Network (RSN), the Mental Health Division (MHD), Indian Health Services (HIS), Seattle Indian Health Board (SIHB), National Indian Health Board (NIHB), the N.A.T.I.V.E. Project policymakers and other key stakeholders were interviewed.
Interviews were conducted in settings in participants' communities, usually in tribal clinics, offices, their homes, coffee shops or restaurants, as well as during three tribal Canoe Journeys. Because of distance and time constraints, interviews were also conducted by telephone. Personal interviews were 1 to 2 hours in length and either tape-recorded or the interviewer noted comments in field notes and incorporated them into the analysis; telephone interviews

varied in length and were usually about a half-hour and partly tape-recorded. Some interviewees were interviewed various times.
The local NGO Center for World Indigenous Studies was able to provide expert advice and establish appropriate initial contacts with Indigenous community representatives. Contacts were mainly established through the chair of the board, a Salish scholar who has worked in Indigenous affairs for the last three decades and is very well known and respected all along the Northwest Coast. Contacts at the Indigenous run NGO helped me to understand tribal culture and guided me through cultural differences so that I became more culturally sensitive and competent. Contact was made using the modern communication devices of the Center for World Indigenous Studies while in Olympia, including an e-mail address that made clear my affiliation to the organization which further contributed to establish trust between me and the communities.

Interviews were conducted in English. Since quantitative procedures involved complex and numerous problems, mainly cultural and trust issues as well as permission by the authorities, only qualitative interviewing methods were used.
Research interviews were guided by open-ended questions that inquired about participants' definitions of mental health, concerned their assessment of mental health services, local traditional knowledge and practices, cultural activities and self-determination.
Rather than refer to interviews as structured and unstructured I agree with Hammersley and Atkinson who write, "All interviews, like any other kind of social interaction, are structured by both researcher and informant" (2007: 151-152). They argue that the distinction lies in whether an interview is "standard," that is, the questions are planned in advance, or "reflexive," that is, questions flow from a conversational style. I experienced both styles of interviews, but as the depth of relationships increased I experienced more reflective conversations. At times question-and-answer sessions could not be differentiated from ordinary conversations. This was due, in part, to a shift in power relations; the Indigenous people with whom I worked demanded control of what knowledge I needed to know. Traditionally, interviews have been noted as one person (the interviewer) asking another (the interviewee) questions (MISHLER 1986). In essence, one person seeks answers and another person has them to give. Asking questions is a key part of qualitative research. How, after all, are we to know why individuals are behaving in particular ways if we do not ask them? Interviews have traditionally been a rich source for data collection for obvious reasons. Standard interviews, however, are not necessarily useful tools for collecting data within Indigenous communities. Instead of using a "traditional" interview format, I would have

conversations with individuals to recount particular experiences while a digital voice recorder was running in case interviewees agreed to have their voice recorded. I tried to keep quiet and deeply listen as taught by Aboriginals in Australia. This style of interviewing was chosen because both the linguistic and medical literatures suggests there is a need for ethno-specific communication methods, such as indirect questioning, when conducting research with Indigenous peoples (BRIGGS 1986). Humorous stories and laughter were used to relieve the inevitable tension brought about by the subject matter.

I also was confronted with cultural issues during my interview phases. At certain times e.g. as during the canoe journey or local powwow it was impossible to get hold of some people in offices. At other instances interview partners would not show up like e.g. a tribal leader did not join a scheduled lunch giving spontaneous support to her community due to a sudden death in the community. As a whole the reaction to the research was twofold. A number of people were unfavorably surprised since they made prior experience with researchers coming in to exploit their knowledge for egoistic reasons. The topic therefore met with considerable resistance with some mainly non-institutionalized contacts. Nobody refused directly to be interviewed. However, some found excuses which prevented further contact or said they would call back which they never did. Overall, people were favorably surprised that their knowledge was recognized and appreciated. They were generally willing to speak freely about their work and experiences and share information and knowledge. This resulted in the accumulation of a high amount of primary data. Most people contacted took considerable time to talk without any monetary compensation.

Talking with people allowed me insight into the strength of communities. I saw their continuing self-confidence and pride in themselves, their culture, encountered hope and optimism that life would get better. I listened to the questions they were asking and perspectives of well-being.

> “Our health will not improve unless we have full self-determination and take on responsibility, we are sick and tired of hearing what we should do, what is wrong with us“ (personal communication).

The large amount of open-ended questions and documented conversations required extensive work with analysis. The replies varied considerably, and therefore it required time to structure, categorize and analyze the material. The computer program NVivo was used to facilitate data management and analysis. Transcripts of the coded NIH caregiver study data were reviewed line by line.

Data analysis occurred partly concurrently with data collection using the constant comparative method (GLASER 1978). When no new information or insight was forthcoming

data collection and analysis ceased. By then the theory seemed to be elaborated in complexity and clear in articulation.

While interviews were the main mode of data collection during field work, participant observation of cultural healing practices was undertaken in certain relevant situations. First hand information could be obtained by observing and interacting mainly in the activities of the local Salish tribes. This contributed to, as far as possible, experiencing the phenomena from within. I was able to attend the therapeutic practices of the tribal canoe healing journey and other experiences. This methodological tool enabled me to see as far as possible the Coast Salish and related tribes medico-cultural beliefs and practices from the perspective of the Indigenous groups. This was accomplished through attaining frequent interaction, observations and recording some activities by technical devices while gaining an empathetic insight into underlying dynamics of the phenomena studied. By utilizing the phenomenological method this thesis hopes to contribute to further the knowledge already acquired on the impact of traditional medicine in Indigenous mental health.

Additional data deepened understanding of the geographical, socio-cultural, and historical contexts in which Indigenous nations of the Pacific North West live. Observational data collected during travel to interviews included information about geographical terrain, distance, public transportation infrastructure, road conditions, towns, and homes. Written documents such as maps, tourist guides, and locally produced histories and newspapers provided rich information about communities.

During the mapping exercise, lists of reserves, tribal clinics, government and private mental health units were made. A list of traditional healers situated in the surroundings of each health facility could not be developed due to time and financial constraints as well as access to information tribal communities are keeping secret from outsiders and even members from other local tribes to this day. Information with outsiders generally is not shared without being a member or employee of the tribe, having substantial experience with community affairs and guaranteeing maximum involvement of tribal people in the research effort. Mental health issues are particularly personal to tribal communities. In order to obtain information an awareness of the values, the traditions, customs and way of life of the people is crucial. When tribal members felt my interest in their culture they were more appreciative and sharing. Moreover being a young, female doctoral student from Germany there was much less of an issue as it would have been the case for a Euro American researcher. Germans it was

explained are generally perceived to show true appreciation and a high interest in Native culture.

Every effort was made to obtain information from the Indigenous groups themselves on their mental health problems and priorities; only if direct access was problematic third parties were approached in this respect.
Critical questions concerning research and representation were also raised as with presenting the results from this research and interpreting the link between Indigenous mental health, culture and the relationship to the land, I risk to speak for others, "continuing the imperialist project" (SPIVAK and MORRIS 2010). However as it is not the aim of this thesis to present an authoritative account of Indigenous perspectives on the significance of the relationship between traditional medicine practice, place, culture and mental health or uncover universal truth, Indigenous representatives were very appreciative and supportive of my research interest. I tried to be as flexible and open as I could be to learn about Indigenous epistemologies and begin to understand the limitations of my own ways of seeing and knowing. Through asking questions: What does the community need? Can traditional healing play a role in this respect? Interviewees understood the goal of this dissertation is rather to reveal the potential of self-determined Indigenous mental health practices and that recognizing the Indigenous cultural conceptualization of land as places that are more than just physical locations but also represent the daily interconnected social, symbolical and spiritual aspects may improve geographic research on Indigenous health. Indigenous leaders said they believed the paper could create a counter-narrative that may demonstrate that the current conceptualization of mental health and place within academic disciplines and the geography of health are rather limited and another' or more nuanced perspective is required that represents the complex intersection of culture, identity and health as manifested in Indigenous daily lives and geographies. Acknowledging that Indigenous ways of knowing exist that are valid 'Western' perceptions may be challenged if not contradicted.

Part 4 Peoples health and place in Washington State

4.1 Assessment of American Indian population

Measures of specific health needs and health determinants have to be linked to the relevant population numbers, socioeconomic and geographic realities in order to be meaningful. The assessment of Indigenous health therefore requires specific information about the composition of that population - broken down by sex and age at national, state/ territory/ regional, and local levels. In the following the composition, size, age and geographic distribution will be analyzed as well as the current status that is family structure, income, housing, education and the general physical health status of American Indians in the U.S. and where sufficient data is available in Washington State.
In terms of family situations, poverty, education, living conditions, and other socioeconomic indicators according to the results of the U.S. Census in 2000 (the results of the latest Census 2010 are not yet fully available) count American Indians and Alaska Natives trail behind all other racial groups in the U.S. Tribes vary in population size, culture and geographic location which results in some variance of lifestyles (US CENSUS BUREAU 2007: 16). Health delivery faces many challenges. Generally Native communities are small and many are geographically distant from major cities. In the North West Indian reservations are dispersed across vast distances, usually in isolated sparsely populated areas. This results in fewer material resources for medical and social services (PUUKKA, STEHR-GREEN et al. 2005: 838).

Composition of the American Indian and Alaska Native populations

The American Indian and Alaska Native (AI/AN) population like Blacks, Asians, Hispanics and Pacific Islanders, have represented increasing shares of the U.S. total population and of each State's and region's population (HOBBS and STOOPS 2002: 73). In the years from 1960 and 2000 there has been an increase recorded of more than 250 percent. In Washington State the AI population grew 27.4% between 1990 and 2000 (7.5% faster than the state population as a whole (AIHC 2003: 1). The reason for this lies in the improved data collection system by the Census Bureau.[15] However also speaks of an increase in the birth rate of American Indians and the fact that an increasing number of the population states their American Indian or Alaska Native identity. On July 1, 2050 the projected population of AI/AN, including those of more than one racial category, is at 8.6 million. They would comprise two percent of the total population (POPULATION PROJECTION:2010).

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[15] Census 2000/2010 asked respondents to report one or more races using the category two or more races for the first time. This paper focuses on people identified as AI/AN alone or in combination with another race group.

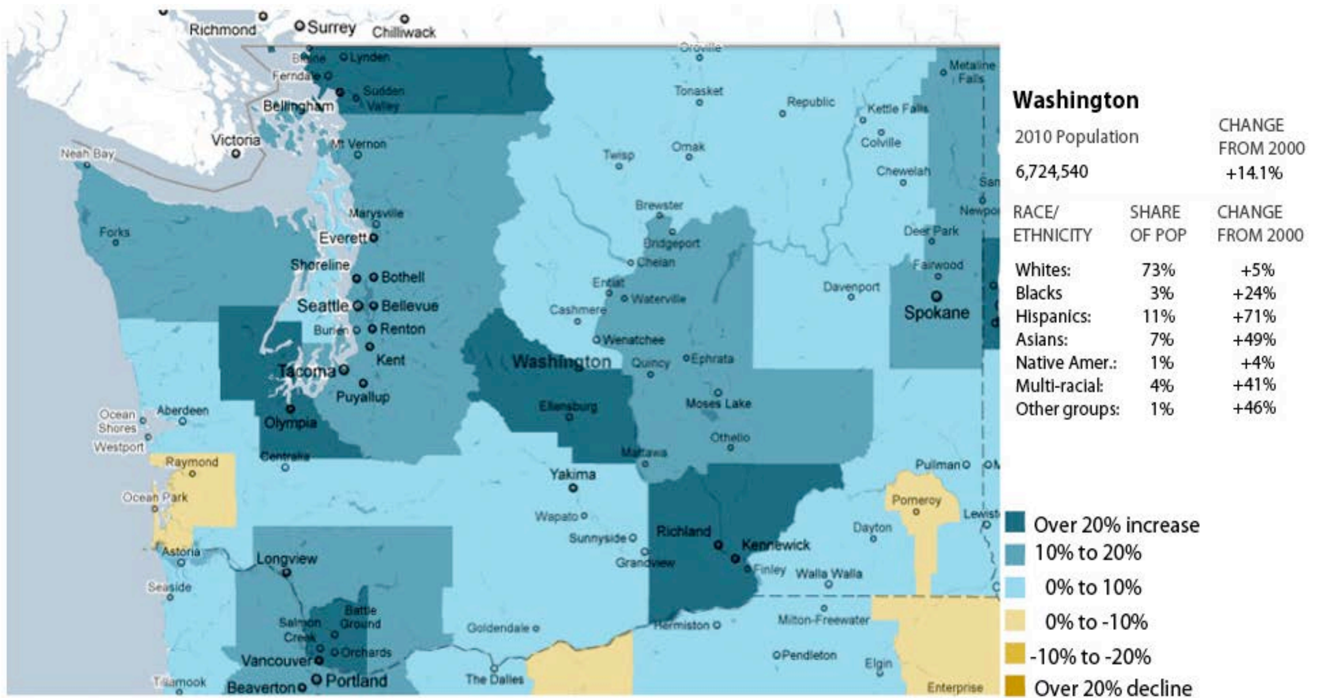
Table 1: U.S.Census Data 2010

	Washington State	United States
Total population	6,724,540	308,745,538
Total AI/AN population (alone or in combination)	198,998	5,220,579
Percentage AI/AN of total population	3%	1.7%
AI/AN population alone	103,869	2,932,248
Percentage AI/AN population alone	1.5%	0,9%
Number of AI/AN on reservation	30,096	ca. 1,100,000
Number of AI/AN off reservation	134,385	ca. 3,150,000

Source: U.S.Census Bureau http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

According to the latest 2010 U.S. Census, those who claim solely American Indian or Alaska Native heritage comprise 0.9 percent of the United State's population, or approximately 2.93 million individuals - an increase of 18,4 percent compared to the 2.48 million people in 2000 U.S. Census (HUMES, JONES et al. 2011:4). The population of American Indians and Alaska Natives, including people identifying themselves as AI/AN and/or multiracial members of this group was 5.2 (compared to 4.1 million in 2000) American Indians and Alaska Natives. They make up 1.7 percent of the total population of more than 3 billion (Ibid: 7). Washington State is one of the eleven states with more than 100,000 AI/AN residents on July 1, 2007 (POPULATION ESTIMATES).

Figure 6: Mapping the 2010 U.S. Census



Source: http://projects.nytimes.com/census/2010/map

The U.S. Census Bureau states in 2010 an increase in AI/AN population of 4% with a total AI/AN population in Washington of 178.794 (1 % of the estimated state's population of 6,724,540[16]) making it one of the smallest racial groups in the state.
The U.S. Census report indicates that the Native American population is much younger than the rest of the population, expected to grow at a high proportion of the total U.S. population. About 33 percent of American Indians and Alaska Natives are under the age of 18, as compared to 26 percent of the total population. The median age of the single-race American Indian and Alaska Native lies at 30.3 as compared to the median of 36.6 for the overall population (US CENSUS BUREAU 2007: 7).
Insight into the family structure of American Indian families reveals that the average size of families living on reservations (6 persons per family) is larger than of all U.S. families (3.2 persons) and more likely to be maintained by a single female (U.S. Census Bureau, 1993). The consideration of the dependency index is also telling. Dependency indices are much higher in American Indian groups as compared to other segments of the U.S. population which means that there are proportionately more household members younger than 16 years or more than 65 years old compared to those between 16 and 64 years old. The assumption is that the latter are not so likely to contribute economically to a household as the former, thus the dependency of one group on the other.

American Indians and Alaska Natives social environments have been plagued by economic disadvantage after the devastation of their cultures. This reflects in their job situation with high numbers of unemployment and low-paying jobs. The poverty level thus is almost twice as high as for the rest of the population. Poverty affected 25.7 percent of American Indian and Alaska Native households (U.S. PUBLIC HEALTH SERVICE, CENTER FOR MENTAL HEALTH SERVICES (U.S.). et al. 2001: 88). Even though an equal amount of Native women (57 percent) as non-Native women (58 percent) were employed, fewer Native men (66 percent) were in the workforce compared to non-Native men (71 percent) (US CENSUS BUREAU 2007: 7). While poverty and unemployment are higher the median and per capita income of AI/ANs are lower than average for Native men ($28,900) and Native women ($22,800), the national average is $37,100 for men and $27,200 for women (AIHC 2003: 1). Contributing to this is the fact that those Native Americans in the labor force are less likely than the total population to be employed in management, professional, and related occupations.

[16] U.S. Census Bureau http://2010.census.gov/2010census/data/?sms_ss=mailto&at_xt=4de212ebe54ebeb2,0.

Many American Indian reserve communities lack adequate housing. Special housing initiatives such as safe housing for women and children, elders and youth and supported housing for those with mental health concerns are largely unavailable. Housing for AI/ANs living in Washington is more crowded, and there is a higher percentage of AI/AN homes without phone and/or internet service (AIHC 2003: 1).
American Indians and Alaska Natives are leading the statistics in homelessness constituting 8% while representing not even 2% of the U.S. population (U.S. CENSUS BUREAU 1999).

The formal education attainment of AI/ANs is lower than the nationwide population. According to the data in Washington, about 71 percent of AI/AN age 25 and over finished high school, compared to 90 percent of the general population. 14 percent of AI/AN age 25 and over graduate from college compared to 27,2 percent of the general population. 4.5 percent of AI/AN age 25 and over have attained graduate degrees - i.e., master's, Ph.D., medical, or law (AIHC 2003: 1).
Most Native households speak English as their only language at home, with English being the exclusive language. More than 200 tribal languages are still spoken in the U.S., however, Native language and culture are undervalued by mainstream institutions. The data for tribal and non-tribal populations showed an interesting development. American Indians who live on tribal lands do better in school and are more likely to live in family, rather than single-parent, households than those who live off tribal lands (HYON 2003: 3). Other studies suggest that while in elementary school Native students achieve on a par with non-Native students there is a significant decline in performance by Native students between grade four and seven (BARLOW and WALKUP 1998). Work by Beiser and colleagues (1998) clearly confirmed findings from previous studies which found sharply increased rates for Indian youth to enter mental health treatment fourth to seventh grades dramatically exceeding the rate of non-Indian youth which he explained to be related to cultural dynamics in teaching situations. Teaching methods used in Western public education have been cited to be conflicting with Native cognitive styles and culturally rooted ways of learning. Many Native children are visual or physical, kinesthetic learners (known as somatic learning) who excel at nonverbal performance scales, artistic endeavors, skilled trades and specialized physical activities. Conventional teaching methods are rather linked to logical-mathematical and linguistic output. This difference between cognitive modes also reflects in the languages. Contrary to the verbal or conceptual abstractions common in the analytic English language, oftentimes polysynthetic, Native languages usually emphasize keen descriptive observation even though

it is hard to generalize due to the high diversity of the Indigenous languages spoken in North America north of Mexico (YATES 1987).

As for health status, Native Americans consistently appear to have the first or second worst health status among racial groups. Native Americans generally have a higher burden of serious disease and premature death (U.S. DHHS 2010). According to the DHHS report titled Healthy People 2000 the six major causes of early death for American Indians and Alaska Natives are unintentional injuries, cirrhosis, homicide, suicide, pneumonia, and complications of diabetes. Native Americans in Washington experience a disproportionately high mortality and morbidity burden compared to the general population. The total age-adjusted mortality rate is not closing. Between 1999 and 2001, the average life expectancy of Native Americans in Washington was 74.4 years, 3.9 years less than the statewide population.
American Indians have higher rates of several infectious diseases. They fare worse with respect to the prevalence of modifiable risk factors with respect to European Americans in Washington State (AIHC 2003: 1). Obesity is a major risk factor for adults and youth linked to coronary heart disease, high blood pressure and stroke. The obesity rate especially for Native youth is constantly increasing, resulting partly from the adoption of a Western diet. This has paralleled the increase in diabetes, which is 230% higher than the general population. One of the highest rates of diabetes world-wide has been reported with the Pima tribe of Arizona (KNOWLER WC 1978). Obesity is also.
Tribal leaders have stated the rates of diabetes, substance abuse and unintentional injuries, to be reaching epidemic levels in American Indian communities. Tobacco use and alcohol and substance abuse is a significant problem among Native American men, women, and youth, with death rates due to causes related to alcoholism substantially higher (five to seven times higher) than for the general population. Alcohol is related to high rates of domestic abuse, fetal alcohol syndrome, motor vehicle crashes, suicide and homicide. Death due to injury and poisonings is three times higher compared to the number for all races in the U.S., 91 percent higher from suicide, and 20 percent higher from heart disease (IHS 2006).
The disproportionately poorer health status is reported to stem from a combination of contemporary issues including living conditions receiving less care, access to psychiatric and substance abuse treatment and poorer quality of care, diminished funding at all levels and personal lifestyle choices - but the prevalence of many of these factors could be diminished or even eliminated (U.S PUBLIC HEALTH SERVICE 2001: 21).

Geographic Distribution

American Indian and Alaska Native population heavily concentrates in Western states (4 out of 10) with a concentration that remained relatively stable throughout the century (HOBBS and STOOPS 2002).

Figure 7: Distribution of American Indian or Alaska Native (AI/AN) Population

Before the 1960s, American Indians American Indians resided primarily on reservations and were geographically isolated. The 2000 Census showed that today 57% of the AI/AN population lives in urban and urbanized areas (FORQUERA 2001:2). 23 percent of whites compared to 43 percent of AI/AN reside in rural areas (U.S. DHHS 2001:81).

Only 1 in 5 American Indians live on reservations (specific parcels of land) many of which in Washington are small and trust lands. This number has gone down significantly over the last decades according to the Census Bureau (2007). Individuals leave their home environment and go to the city with the idea to find employment and gain economic independence.

Almost 60 percent of Washington's residents live in the center of business, industry and transportation, the Seattle metropolitan area.

Most AI/ANs live in Western Washington (72.4%), with 1/3 of the entire AI/AN population in King and Pierce counties (AIHC 2003: 1). The largest of the tribes are the Yakama and the

Colville tribes in the east.[17] The Salish form two cultural groupings: the Interior Salish (river basins of the Columbia and Fraser rivers), with a seminomadic lifestyle; and the Coast Salish who had a sedentary culture with Northwest Coast Indian influence. Their home territory covers most of the Strait of Georgia where the modern-day cities of Vancouver, British Columbia and Seattle, Washington are located. The largest group of Salish tribes living in the Puget Sound Basin of Washington, number some 11,000 people (2000). They comprise the Nisqually, Suquamish, Tulalip, Swinomish, Stillaguamish, Skagit, Snoqualmie, Samish, Skokomish, Muckleshoot, Squaxin, Duwamish, and Steilacoom. Only eight of these have been granted reservations. Their economy is based on fishing, logging, and tourism, including gaming.

[17] For more information on these tribes, see http://www.dshs.wa.gov/IPSS/tribalmap.htm.

4.2 Ethnographic basis

Geography of Washington State

Washington is the northwestern-most state of the contiguous United States in the Pacific Northwest region (see appendix D, figure A-2. Its northern border lies mostly along the 49th parallel bordering British Columbia, Canada. To the south Washington borders Oregon mostly along the Columbia River. To the east Washington borders Idaho. To the West lies the Pacific Ocean. The State was named after George Washington, the first President of the United States. In the west of Washington deep rainforests exist, in the center there are mountain ranges and eastern areas consist of semi-deserts. Climate ranges from oceanic which prevails in Western Washington with an average annual temperature at 51 F (11C) to a much drier semi-arid climate that predominates east of the central Cascade mountains with an average temperature of 40 F (4C) in the northeast.

In Fall 2009 the Washington State Board on Geographic Names declared that the three bodies of water that merge where Canada meets Washington State — Puget Sound, the Strait of Juan de Fuca and the Strait of Georgia— are now collectively called the 'Salish Sea'. The Coast Salish as described above are a grouping of Indigenous peoples who live north and south of the 49th parallel nowadays referred to as British Columbia, Canada and the northwest corner of the United States of America. They share a common linguistic and cultural origin. State lines that were drawn do not correspond to the ethnic reality of the Indigenous groups living in Washington. To local Indigenous groups the boarder is an 'artificial construct' which separates Indigenous families with strong cultural connections. Since Sept. 11, 2001, the border between Canada and the U.S. has become more rigid than ever. An Indigenous spokesperson said, "The place is a whole, but it got chopped up."

Current scientific data and archaeological evidence of established settlement indicate that Native Americans have been present in Washington for 12,000 to 15,000 years arriving via the Bering Sea from Siberia during the last Ice Age (KIRK and DAUGHERTY 1978). In contrast to most contemporary, non-Native archaeologists many native people do not believe that their ancestors entered North America on the "Bering Land Bridge" but that they have always been in their homeland. Salish origin stories relate that their world was created far in the past during an ancient "Myth Time" when the earth was made ready for human beings by Snoqualm, the Changer, a powerful supernatural entity. However, every tribe and their stories are different as Northwest Coast cultures differ considerably. Most cultures e.g. are matrilineal. Salish culture is amongst of the few patrilineal culture along the coast.

Collectively though local native nations such as the Muckleshoot, Suquamish, Nisqually share many attributes in their beliefs, values, way of life and circumstances. After the "Myth Time" they built complex social, cultural, and economic structures. The mild climate and abundant natural resources provided abundant and rich foods. Indigenous groups subsisted primarily through hunting (elk, seals, other animals Indigenous to the region), gathering, and fishing - with fishing on the coast being of particular importance also for culture and identity (DELORIA 1977). Berries and strips of cedar bark were gathered and harvested. Harvesting of natural resources often involved ritual or prayer, to thank the plant or animal for giving of itself for the humans' needs and to ensure next year's plentiful harvest.
In their daily lives there was sufficient time to be able to develop fine arts and crafts and devote energy to religious and social ceremonies. Far from just subsisting therefore these Indigenous groups had developed highly structured cultures and complex and extensive pre-contact trading networks in which foodstuffs, handicrafts, raw materials, slaves, and items of wealth and prestige were commonly exchanged and that often extended from east of the Cascades to the Pacific coast (STEENHOUT 1996: 73).
Northwest Coast cultures were peaceful peoples to who social ties were the "real indicator of a person's worth" (GUNTHER 1927: 213). The main units of social organization were small independent villages (often comprised of a single extended family) that maintained ties to other villages through intermarriage, trade, and cultural similarities (STEENHOUT 1996: 73). Traditional villages in which people over-wintered were made up of one or more, rectangular houses with roofs and walls of split cedar boards called piGidaltx (pee-gwee-dalt-wh), a "smokehouse" or "longhouse" home to an extended family which served as the spiritual, social, economic and political center of Northwest Coast life.
Throughout the people engaged in storytelling in these big cedar houses. During these gatherings dances and songs were shared with friends and relatives from other nations. Also marriages were conducted or name giving ceremonies. Being recognized at ceremonial occasions - funerals and namings, for instance, "affirmed an individual's place in an estimable group" (BOYD 1999: 225). Inclusion in an Indian family or community and recognition as individuals was very important. Kinship ties were stressed during speeches at the large ceremonials and a shared dedication to maintaining Indigenous traditions expressed (KEW 1970: 145). Legends and stories were utilized often by an elder skilled at oral tradition as a method to teach and to convey traditions, ethics, spiritual beliefs and worldview. The purpose of such teaching and learning was to achieve balance, restore balance or renew.
With the arrival of British explorer George Vancouver who was looking for a water passage to cross the continent the world of Washington State's nations started to change dramatically

after 1792. For several decades after that visit the region was left alone as the fur trade industry had its focus area further north. In the 1840s Catholic missionaries arrived. Beginning in the 1850s, more Euro-American settlers poured into Washington State. They brought with them a completely new way of life for the Northwest Coast peoples and put new pressures on Native communities.

In 1846 through the Treaty of Washington the U.S. took over control in the region. The demands of the settlers were to sign treaties to extinguish Native title to the land. In the winter of 1854-55 the new Washington territorial governor Isaac Stevens, Superintendent of Indian Affairs, and head of the North Pacific Railroad, met in council with most Western Washington tribes (BOYD 1999: 170). This marked the time when local tribes first formalized relations with the government of the United States. Nearly 400 treaties were negotiated with different content often involving ceding tribal lands and creating reservations. With the treaties of 1854 and 1855 the story of Native American history in Washington is referred to as one of trauma and transformation. The Upper Skagits e.g. were left without land in the Point Elliot Treaty. By treaty at Medicine Creek, Wash., Dec. 26, 1854, the Puyallup and other tribes at the head of Puget Sound ceded their lands to the United States and agreed to go upon a reservation set apart for them. The Puyallup Treaty of Medicine Creek was one of only about two dozen of the treaties that mentioned any kind of medical services. Article 10 in the Treaty of Medicine Creek provides that the U.S. will ensure a physician to look after the health care of the Puyallup.[18] Due to the Treaty of Medicine Creek and like treaties the tribes consider medical care to be a treaty right besides being an obligation that exists because of the federal government's trust responsibility towards American Indians. As a treaty right, health care local Indigenous nations maintain should accordingly be provided "without charge" as it is a "pre-paid" service to be provided in exchange for ceding tribal lands.

As more settlers came to the region, Native American access to resources was made difficult if not impossible. Ceremonies were outlawed by missionaries and government agents who forced children to go to boarding schools where Native languages and tradition were not encouraged. Poverty and disease, as well as loss of land to the settlers led to an often miserable life on the reservations.

Military conflicts between the tribes and the United States arose stemming from a mixture of land hunger, greed, the belief in a divine mission and racism that was reinforced by popular 19th century scientific theories of the inferiority of non-Caucasian peoples (STEENHOUT 1996: 37).

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[18] http://www.historylink.org/index.cfm?DisplayPage=output.cfm&File_Id=5253.

Discrimination led to a loss of self-respect. Techniques that Indigenous people had long used to earn respect and admiration such as intercommunity giveaways winning a gambling game, or wielding a shaman's power started to confuse or fail to impress a growing number of natives' descendants as these practices lowered a person in the eyes of most settlers. Potlatches and spirit dances could not ease the tension that many Natives felt when they compared the achievements of Natives and whites. For this reason, the "old rituals no longer united an Indigenous community as surely as in the past" (EELLS and CASTILE 1985: 136-137).

The rate of emotional disease among the tribes during the end of the 19th century is unknown. No cases of "mental illness" were reported. Considering the rapid social and cultural changes tribes were experiencing, however, emotional illnesses probably existed in the high percentage of cases involving somatic complaints.

The 1800s also marked a time of great conflict between the United States and Northwest Coast tribes with the U.S. Army taking steps to curb infectious diseases among tribes to protect soldiers and neighboring non-Indians. This is described by American Indians to have been "the first provision of health services" to them by the federal government or "the most profound trauma resulting from the external interventions."[19] Smallpox, measles, diphtheria, malaria, and other infectious diseases to which the tribes had not built resistances were brought in by Non-Indian settlers and grew to epidemic proportions. (COHEN and STRICKLAND 1982).

Smallpox began to emerge in the first decade of the 1800s. The occurrence of smallpox reduced the total population of the Pacific Northwest by a considerable amount. Mortality estimated at 20 to 80 percent had also disrupted kinship networks and subsistence activities on which individuals' well-being and self-confidence depended (GUILMET, BOYD et al. 1991). The smallpox epidemic also, undoubtedly, caused a change in the geographic distribution of the surviving populations. Some local groups were wiped out, others escaped with few fatalities deserting certain regions (BOYD 1999: 48).

Referring to the effect of disease transfer on the peoples of the New World, geographer William Denevan stated in 1976," The discovery of America was followed by possibly the greatest demographic disaster in the history of the world" (BOYD 1999: 262). The historic Salish population was collectively of more than 200,000 before the mid 1700s and comprising hundreds of longhouses with populations ranging from perhaps 50 to as many as 450. Contemporary population estimates during the smallpox periods are imprecise. For the Puget

[19] Rudolph Ryser, Report GWAIN

Salish, near complete Hudson's Bay estimates in the 1900s from the late thirties give 5,479 people; the total for the same population taken at temporary Puget Sound reservations in 1855-56 was 4,872 - 607 fewer (BOYD 1999: 170).
In addition bellicose outsiders had robbed many local communities of their sense of security. Armed Natives of Vancouver and regions farther north such as the Cowichan and Kwakwaka'wakw enriched by the maritime fur trade descended with increasing frequency on the more pacific peoples south of the Strait of Juan de Fuca. All but two communities had lost close relations and property to the northerners (CURTIS and HODGE 1970: 20).
Beyond specifically demographic and social effects, the new diseases interacted with and caused changes in Indigenous cultural systems, i.e. health care and religious systems. Many tribal communities' natural cultural evolution was repeatedly interrupted or seriously stunted as a result of the traumatic intervention that came as a result of introduced diseases. Indigenous treatments, health care practitioners, and explanations for disease were strongly affected by the introduction of new diseases. The dramatic reduction of tribal population in a relatively short period of time resulted in much of the knowledge of generations and centuries held by individuals and families disappeared when whole families and key individuals died within days and weeks of contracting an alien disease. Traditionalist elders, who "had a strong hold over the thoughts of the others" were removed. Oral traditional healing knowledge, which was held by a number of experts only, likewise was lost (STORM 1991). Thus oftentimes introduced diseases were a turning point in the religious history of the peoples. Thousands of people discovered that their powers were insufficient to defend new agents of illness and death loose in the land. So many natives had sickened and died from imported pathogens that some could not make sense of their afflictions and loss in unusual ways (HARMON 2000: 38). Epidemics "shattered Native peoples' faith in the shamans who, despite their guardian spirits, died together with those who sought their help." Or members of longhouse communities under siege often killed medicine doctors when they were unable to cure the various new diseases and were held responsible for the deaths of family members. Northwest health care practitioners generally occupied the ambiguous position of being able to both cure and "cause" illness. Thus also sorcery and witchcraft accusations resulted in these temporal "doctor - killings" reported during some epidemic periods (BOYD 1999: 277). Dr. Spinning, a local practitioner for the Indian Health Service (IHS) maintained that local tribes would readily abandon traditional healing:

As they associate with the white and witness the superiority of their medication over that of their own, they soon desire to be treated by the physician in charge. They are gradually

losing confidence in their own incantations and will, ere long, abandon them entirely (SPINNING 1864).
Finally vaccination, once proved to be effective, showed “that the European settlers had a greater and more perfect knowledge.” Treatments that no longer worked were dropped from the cultural inventory, traditional methods were modified; new treatments and medicines from outside sources were added. After epidemics Natives were more willing to convert to Christianity (BOYD 1999: 122). This explains Agent Starling’s remark when Washington Territory’s first governor arrived in Olympia at the end of 1853, that Indians of the area did not know of their own strength. Instead, Starling told Isaac Stevens (Starling to Stevens, December, 10, 1853, WTSIA Roll 9), Indians look up to the whites “as superior beings” [...]. “They are becoming more and more convinced [...],” the agent continued, “that their destiny is fixed; and that they must succumb to the whites [...]. They, therefore, feel every day, more inclined to look to them […] for order, as to what they must do”(HARMON 2000: 68).

Northwest Coast religion was primarily shamanistic and animistic. It involved healing rituals and the belief in guardian spirits, which were acquired by vision quests. The guardian spirit dance held in winter was the most important ritual. The “spirit dance” was/is undertaken in the event of “spirit illness” which comprise conditions that affect the physical, emotional or spiritual health of a human being and include possessions by “bad powers.” It may be accompanied by a loss of consciousness or promoting hyper-consciousness. An Indigenous doctor experienced in spirit dance accompanies the person who is ill and engaged in the spirit dance to help them through the process of regaining a balance and help to bring back the spirit of the sick individual through singing as well as gift giving (potlatch). (PRIZKER 2000: 190). Vision quest journeys and beliefs in shape shifting abilities were common and a close relationship to the sprit world described (STURTEVANT, SUTTLES et al. 1990: 486-487).
In the mid to late 1800s with the arrival of the missionaries many of the tribes became Roman Catholic or converted to Shakerism, a unique Indian Christian religion which combined Native and Christian elements and first appeared among Washington tribes in 1881 or 1882 (BARNETT 1957). It augmented winter dancing and other spirit ceremonies. Spirit dances and Shaker meetings boosted people’s morale and validate positive aspects of their ethnicity. To participate in spirit dancing, individuals had to belong to an Indian community, and their participation confirmed that community members accepted them. The hosts of a successful dance expressed and contributed to the pride of a group that identified itself as Indian (BOYD 1999: 224). However, the Shakers were said they had tried, with considerable success, to “retake the initiative in the process of drawing boundaries between Indians and non-Indians

and defining the character of society on the Indian side of the boundary" (BOYD 1999: 130). Practicing these syncretic religions allowed local tribes to continue practicing healing without being involved in illegal activities. In 1871 a ban on "Indian doctoring" was issued by the Superintendent of Indian Affairs of Washington Territory (GUILMET and WHITED 1989: 20). Psychospiritual practices, like oracle methods, working with dreams, and rituals using hallucinogenic substances, became more and more a "medicine of the underground". With the Religious Freedom Act for American Indians enacted in 1978 the government discontinued the prohibition to participate in traditional spiritual ceremonies.

Today, Shakers, Native American Church and the more traditional Smokehouse, Longhouse, Dreamer and Winter Spirit Dance are some of the syncretic religions prominent amongst the local tribes. Their Indigenous culture and spirituality have survived being widely practiced underground. Todd-Bazemore explains that even in places where American Indians practice Christianity traditional cultural views still have a strong influence on how Indigenous groups understand health, illness and healing (1999).

Northwest Coast people believe illness to be a result from a lack of harmony and balance between the ill person and the individual's surroundings. Strong connections to the environment and subsistence lifestyle are key pieces to health and wellness. There is an understanding that health, culture and the environment are linked (Circle of life). Out of this approach to life there comes an intense and absorbing love for nature; a respect for life; enriching faith in a Supreme Power, and principles of truth, honesty, generosity, equity and brotherhood as a guide to mundane relations with an understanding of well-being as a an achieved quality that is developed through relationships of mutual care (OREIRA 1995). For among most Native people, to live in health is to live in accordance with moral or behavioral codes that strive to maintain harmony between one's self and his/her family, community, environment, and spiritual world (AVERY 1991: 2231). Illness can result from negative mental, physical, or spiritual activity or from disruptions in the world around one. Offenses against spirit powers and violation of the communal laws would cause sickness. Disease causation in the Native Northwest also is uniformly described to supernatural influences: contamination, soul or spirit loss. The tribes' Indigenous view of health and disease is influenced by their spiritualistic cosmovision. The power of the spirit world as the source of all things ensures the possibility of restored health and healthy births as well as deaths in the physical world. The place where everything begins is the Spirit World. In the Spirit World there are things that give rise to pleasure, happiness and satisfaction. Also the Spirit world is the place of negative or unhappy or unsatisfying things. In the local Indigenous reality, it is necessary to achieve the balance between all these things. Underlying healing is this spiritual

approach to the world according to which most natural things, like animals, people, trees possess spiritual power. It is believed that an individual's health, both mental and physical, is directly related to the well-being of the individual's spirit. Thus, very much in line with modern psychosocial approaches the patient's family and support system is involved into the healing process. Therefore the healer deals with the patient's surroundings, the relationship to family and community and incorporates social relationships in ritual and ceremony. Thus providing balance, restoration and renewal for individuals, families and extended families (GUILMET and WHITED 1989: 25).

In Native communities, ceremony and ritual are the mechanisms by which the ensuing imbalance or loss of connection is restored. Other means aimed at restoring the balance include fasting and meditation as well as sleep deprivation for several days or stimulation with loud sounds including songs, prayers, rhythmic drumming or chants for long periods of time. Various forms of isolation combined with hyperactivity and external stimulation are used. These include "Psychic Shock." During this practice the initiate is surprised by "grabbing" or "switching" or "clubbing" and sometimes thrown into icy water. Seclusion and restricted mobility is also employed. An alternative is to put the person being assisted into a full "run" through the bush until totally exhausted. Physical stimulation by "grabbing" or lifting and tossing one into the air is also employed to restore the balance.

An important source of power for local Indigenous nations is Tumonous, a power that resides in the Spirit World and requires careful and studied approaches by way of fasting, dreaming, spirit quests, meditation, isolation, waiting and or song and dance. Tumonous may be used for good or ill, but in any case comes as a very specific power to the individual retrieving it (R.Atleo personal communication).

The worldview of many Native nations was modified as they adapted to changes in their surrounding, adopting new ways of life. Still however, Native American nations more often regard the world as a unit and humans as part of a complex, interrelated, sentient universe, not as a set of individuals. Each human being is both physical and spiritual, material and immaterial. The over arching reality is Qui-tee or "the one who owns everything" as the Nuu-chah-nulth would say. Qui-tee is total consciousness while each human is but a humble aspect of the one who owns everything. Thus consciousness is characterized by the comprehension of a totality, a unity of all things. All things are interdependent yet singularly identifiable. The relationship between all the dimensions, the physical/ spiritual, material/ immaterial, ordinary/ fantastic, and between the obvious and the mysterious is as one. Human beings are seen as the "little brothers," the most recent arrivals in the world having responsibility to respect all other elements of creation.

Inanimate objects and places were believed to be living beings that contained spirits. Beings like Raven, or Bear, or Mowich (Deer) or the Mountain, River or the Cedar tree have a spirit that is fully formed and a consciousness that is fully realized (RYSER 2005).

Modern Northwest Coast peoples are no longer identified with specific longhouses but as tribes or as families within tribes or more appropriately described with the word "nation." In the face of all the upheaval and change Native Americans, however, "maintained fraternal relations across the political, legal, and geographic lines that officials tried to run around them" (HARMON 2000: 249). As a result a renaissance of Native culture started in the 1960s with civil rights actions for being granted treaty rights of logging and fishing. In the mid 70s the Boldt Decision of the U.S. Supreme Court recognized the rights of the Treaty of Point Elliot of 1855. Economic autonomy was achieved through casino gambling (the 1988 Indian Gaming Regulatory Act gave tribes the permission to operate casinos in certain states), fisheries, tax-free tobacco sales, and cultural development.

The economies of Northwest Coast peoples were and to an important extent still are redistributive economies. Prestige was maintained through the redistribution of wealth either in public ceremonial context such as give-always or community settings (GUILMET and WHITED 1989: 76). Sharing is at the basis of the cultural system and informs social structure and relations in tribal communities in Washington. The interviews indicate and observations confirm that sharing is omnipresent at every level, including but not limited to regional foods such as seals, oolichan, salmon, berries. Elders, family members friends and the community partake in the sharing and bartering of foods. Sharing was said to reveal the anatomy of Indigenous resilience in the face of social change such as disease and the emphasize on individual accumulation through market economy as well as technological change.

The potlatch is a millennia-old event that is central to the Northwest Coast Native Peoples' way of life. The word ''potlatch'' is a Chinook Jargon word meaning ''to give.'' For centuries, the potlatch has been a central system of social contact, sharing and distribution of resources. Inherited names or privileges were bestowed and formalized through the witness of those in attendance, marriages were solemnized and relatives that had passed were honored, accompanied by feasting, competitions and sharing songs and dances. During the forced assimilation era in the United States, until 1934, in Canada, until 1951 potlatches were illegal. Today, most potlatches include traditional religious practices and are not open to attend for the general public. The ''Return of the Potlatch'' at Lummi during the tribal canoe healing journey 2006 native tribes took as an affirmation that "their way of life survived and continues to survive" (WALKER 2007).

Part 5 Mainstream and Indigenous health care systems

5.1 The U.S. health care system

Health care, insurance and facilities in the United States are provided and operated by many separate legal entities, many of which are private. In the U.S. mainstream health and mental health care follows the Western scientific and medical paradigm with a focus scientific research modalities and objective evidence (U.S. DHHS 2001: 25). America's health today shows a landscape in which people in a "golden age of science" enjoy longer lives with an average American anticipated life span that rose inexorably from 61 years in 1933, the year comprehensive data first became available, to 78 years in 2005 (ARIAS 2010: 31).
Despite advancements in technology which helped to improve the overall quality of psychological and physical health for Americans and President Clinton's Initiative on Race which calls for eliminating racial and ethnic disparities in selected health problems by the year 2010 substantial differences in health and life expectancy based on the interwoven variables of income, race, sex, education and geography remain between racial and ethnic groups who are lagging behind the overall U.S. population in good health (NELSON, MCCOY et al. 1992; KAAS, WEINICK et al. 1999). The relationship between the Federal Government and American Indians has been marked by empty promises to address, reduce or even eliminating existing health disparities. This results in ethnic minorities affected by disproportionately high rates of mental disability. The Surgeon General has determined as disparities in mental health and services exist for racial and ethnic minorities mental illnesses exact a greater toll on their overall health and productivity with a disproportionate number who are not able to completely participate and benefit from the opportunities of U.S. society (U.S. DHHS 2001). These disparities have been researched in a growing body of health services studies and received public policy attention. The new research supports the political construct popularized by former Senator John Edwards of North Carolina, that "there are at least two Americas, measured by both wealth and health," and that the "poles are growing further apart" (SACK 2008). Without any concrete steps being taken to realize the expressed commitment to health equality. The system furthermore lack in a show of respect or understanding of the specific histories, value systems and traditions of culturally diverse groups (SHALALA 1998).
Among 191 member nations included in a study by the WHO in 2000 the U.S. health care system was ranked 37th in overall performance and 72nd by overall level of health, but first in both responsiveness and expenditure (WHO 2000b). Today health care in America is at a pivotal point where reform (including mental health) is being planned to correct the health

care system. The current debate about U.S. health care concerns questions of access, efficiency, finding better treatments in order to reduce high costs, and quality purchased by the high sums spent. The costs of health care are considered one of the greatest challenges in U.S. public policy (CATLIN, COWAN et al. 2008). In 2007, the U.S. spent $2.26 trillion on health care, i.e. more than 15% of the nation's gross domestic product estimated at 14.264 trillion (U.S. IMF 2009).

Up to the recent U.S. health care reform in 2010 at least 15% of the U.S. population was completely uninsured (DENAVAS-WALT, PROCTOR et al. 2008). According to the Institute of Medicine a subunit of the National Academy of Sciences, the U.S. did not provide universal coverage while all other industrialized nation did (2004). A lack of mental health coverage for Americans has been acknowledged to bear significant ramifications to the U.S. economy and social system. A landmark study conducted by the WHO (2001b) found that mental illnesses is on second position among illnesses that cause disability in the U.S., Canada, and Western Europe. Studies revealed that mental illness accounts for 25% of all disability in major industrialized countries (NCHS 2007: 15). In 2000 the total economic burden depression causes in the U.S. has been estimated at $83 billion (comprising mortality, direct care, lowered productivity and absenteeism in the workplace (GREENBERG, KESSLER et al. 2003). Therefore the conclusions of the WHO Commission call for prevention measures and enhancement of mental health.

National studies attest an amount of 5% to 7% of adults to be affected by a serious mental illness in any given year (U.S. DHHS 2001) with only one-third of them receiving treatment (NCHS 2007: 9). This serious public health challenge is under-recognized as a public health burden though as besides the tragedy the disease has on lives mental illnesses effect significantly high financial cost. Especially due to indirect costs of mental illnesses to society, incurred through reduced labor supply, lost employment or decreased productivity, accidents, mortality costs (loss of productivity due to premature death) public income support payments and costs associated with other consequences such as incarceration or homelessness or productivity losses for the time for care of the individuals who provide family care, (RICE and MILLER 1996). In the U.S., the yearly indirect economic cost has been estimated at $273 billion a year. About $70 billion of that $273 billion is the estimated cost of untreated mental illness. These are major additional costs shifted on to other sectors of society such as the added cost of emergency room care, law enforcement, and education making them the front lines of mental health treatment.

The direct costs (e.g., medication, clinic visits, or hospitalization) to treat mental disorders is estimated to be at 6.2% of the amount the U.S. spends on health care. As noted by the

American Psychological Association (APA), the direct cost of treating and supporting mental illness is approximately $55 billion a year. The majority, 57% of mental health expenditures are publicly funded, while public funds for overall health care expenditures are at 46% (MARK, LEVIT et al. 2007). For the elderly, poor or children government programs exist such as Medicare, Medicaid and the Children's Health Insurance Programs as well as the Veterans Health Administration. Medicaid is currently the largest payer of mental health services in the U.S. Medicaid eligibility is determined by factors related to age, disability, family, employment and medical status, and the financial income and assets (CROUCH 2009: 13).

Besides these services the informal sector is a significant, albeit not well documented, source of health care, particularly among rural and poor populations (O'HANLON 2009). It is very popular among Native Americans living on reservations. An active informal health sector exists which consists of alternative medicine practitioners and traditional healers.
Nation-wide so-called CAM - complementary and alternative medicine is becoming more and more mainstream among the general population. A federal study sponsored by the National Institutes of Health's subdivision National Center for Complementary and Alternative Medicine (NCCAM) found in 2007 that amongst adults more than one in three used some form of CAM (FUHRMANN). Traditional practitioners mostly operate outside the official health care system but in some areas in collaboration with it. In the U.S. alternative providers such as chiropractors and acupuncturists receive licenses by most states. Concurrently, Western trained medical doctors upon recognizing patients' demand for alternative therapies are increasingly choosing to get training in these therapies. Others added alternative professionals to their staffs.
In response to the recent economic slow-down consumers have been reducing their health care spending. In September 2008 the Wall Street Journal reported that both the number of prescriptions filled and the number of office visits dropped between 2007 and 2008. In one survey, 22% of consumers reported going to the doctor less often, and 11% reported buying fewer prescription drugs. Most people pursuing alternative therapies have to pay some, if not all, costs out of pocket even though more insurance companies are now offering full or limited coverage, or arranging discounts, on alternative treatments. People in the U.S. spend more than one-tenth of their out-of-pocket health care dollars on alternative medicines. A session at the acupuncturist can cost around $100. Vitamins, herbal supplements and homeopathic remedies like pharmaceuticals can range in price considerably from a $12 bottle of vitamins to supplements costing hundreds of dollars. Altogether Americans spent nearly $40 billion out of pocket on alternative remedies in 2007 to pay for practitioners as well as vitamins and

supplements (MARCHIONE and STOBBE). As the spending on alternative therapies is "substantial" more research into which therapies work is critically needed.

5.2 Pre-paid Native American health care

Traditional Native health care practices and the Western-model (Indian) health care system exist within a complex legal and historical framework. Influenced by shifts in U.S. policy between assimilation and self-determination and an ongoingly changing political landscape. Prior to contact which started in the 16th century Indigenous nations in the U.S. were sovereign nations, governing themselves. This included the provision of health care to members of their nations. They had highly developed systems for health care and maintenance in pre-Columbian times (DURAN, DURAN et al. 1998: 67). American Indian nations are said to have lived a healthy active existence feeding on natural foods obtained from their environment and displayed an elaborate set of traditional medical beliefs and practices by the time of contact with Western culture (GUILMET and WHITED 1989: 51). It is generally agreed that psychic disturbances were rare among Native Americans. Physical ills, however, were sometimes treated by methods which might today be called psychotherapeutic. With traditional cures having been thought to be aids in easing the patient's mind and creating the emotional basis for recovery involving the use of the "power of suggestion" (VOGEL 1990: 188-189).

Contact indelibly impacted the historical sovereignty of tribes and health care for Indigenous people in the U.S. Upon the introduction of Christianity and Western education in combination with restrictive government policy Native traditional medical system rapidly changed. Indigenous nations got isolated from their own traditions as well as many aspects of their societies' health care systems.

Under the doctrine of discovery Indigenous land was taken by the settlers relegating the local Indians' land rights to one of mere occupancy. Through signing of treaties with the resident tribes later on the colonizing nations could make full use of the land. As partial consideration for tribal land cessions to the United States some treaties provided for medical supplies and physicians' services. The tribes understandably unwilling to leave lands desired for colonial expansion were removed under the doctrine of conquest (SHELTON 2004: 3).

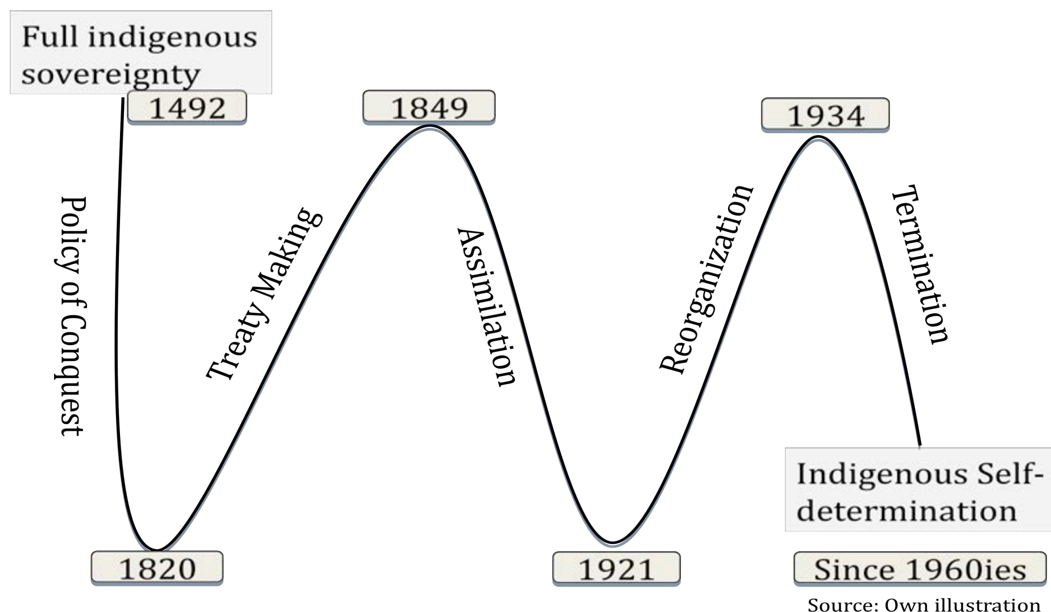
Arising from the doctrines of discovery and conquest Indian health care initially was under the military control of the War Department until in the Act of March 3, 1849, ch. 108, § 5, 9 Stat. 395 it was transferred to the newly formed Department of the Interior (Ibid:6).

Funding for medical services to Indians always meager with only 77 physicians serving the entire American Indian population in the United States and its territories in 1880 got worse in

the last part of the 19th century when a period of "Indian wars" arose. Killing Indigenous peoples in battle, not providing health care was the incentive of the day (COHEN and STRICKLAND 1982).
In ensuing years when the policy of removal and eradication turned out to be too expensive and embarrassing, to deal with the "Indian problem" the policy of assimilation got popular. The premise the assimilation policy was based on was that Indigenous nations would adopt the economic goals and cultural values abandoning their own cultural heritage attaining instead the same manner of living as other groups living in the same state of the dominant society thus. As Richard Henry Pratt, founder of the Carlisle Indian Industrial School (an Indian boarding school) put it, the goal of assimilation was to "kill the Indian and save the man"(WOODHEAD 1995). During the assimilation era many traditional health care activities were banned, traditional ceremonies prohibited and practitioners aggressively sanctioned which left the Indigenous nations with pressing mental health concerns (SHELTON 2004: 6). Shelton quotes the U.S. Department of the Interior, *Rules Governing the Court of Indian Offenses,* 4th ed. (March 30,1883): Federal courts, the Courts of Indian Offenses, were set up on reservations and empowered to detain "medicine men" indefinitely if they practiced their traditional ceremonies (Ibid:15). The United States continued to prohibit the practice of traditional ceremonies and medicine until the last half of the 1970's.
Primary tools of assimilation policy were allotment of reservation land under the General Allotment Act of 1887 and introducing the boarding school system. Relocation and termination policies later can be seen as variations repeating the theme. During these times the population reached its lowest point, in certain areas according to estimates about 5 percent of the original population at the times the settlers first arrived (THORNTON 1987).
To improve deplorable health and sanitary conditions on reservations Congress passed the Snyder Act 25 U.S.C. § 13 in 1921 mandating the expenditure of funds for "the relief of distress and conservation of health … [and] for the employment of … physicians … for Indian tribes." The Snyder Act of 1921 provides permanent authority for the Congress to appropriate funds (amounting to a total of $4.03 billion in FY 2010) every year to the Indian Health Service to provide health care services to AI/AN people fulfilling the federal government's trust responsibility.
In order to identify what factors would help Indians meet a minimum standard of health in 1928 the "Merriam Report" reflected a subtle shift in policy. As Cohen quoting the Institute for Government Research (1928) explains that in marked contrast to assimilation it defined the goal of Indian policy to be "the development of all that is good in Indian culture "rather than to crush out all that is Indian" (1982:144-5). Thus setting the stage for a new era: Indian

Reorganization (SHELTON 2004: 8). The report compared Indian health services with health services for the general population describing the devastation caused by allotment, the failures of Indian education, and the dreadful health status of American Indians.
The Indian Reorganization Act of 1934 ("IRA")[20] helped tribes to exercise more self-determination even though trying to "civilize" them through sending Indigenous children to far away boarding schools to learn "American ways" and separate them from "detrimental influences" of their Indigenous homelands (U.S. DHHS 2001: 80). As soon as the 1950s however assimilation policy re-emerged in the form of terminating tribes' legal existence by removing their federal recognition as tribes, eliminating their reservations, and relocating Indians away from their homelands (SHELTON 2004:9). This had devastating effects on tribal economies, society, and (mental) health.[21]
In the 1960s and 1970s policy shifted again from termination toward tribal sovereignty and better health care as in the Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975[22] and the Indian Health Care Improvement Act (IHCIA) of 1976.[23] These Acts allowed Indigenous groups the freedom to decide the pace and nature of their future development, as will be further described below.

Figure 8: Policy Background - Health Care for American Indians



Source: Own illustration

[20] Ch. 576, 48 Stat. 984 (codified as amended at 25 U.S.C. §§ 461, 462, 463, 464, 465, 466-70, 471-473, 474, 475, 476-478. 479) (1934).
[21] See, e.g., Chairman Allen Foreman et al., "Termination: An Account of the Termination of the Klamath Reservation from the Tribe's Point of View," Herald and News, Klamath Falls, Ore. Oct. 13, 1999.
[22] P.L. 93-638, codified as amended at 25 U.S.C. §§ 450a-450n (1975).
[23] P.L. 94-437, codified at 25 U.S.C. §§ 1601 et seq., and 42 U.S.C. §§ 1395qq and 1396j (1976).

Today health care for members of American Indian tribes and Alaska Natives often comes from a separate health care delivery system, provided by the federal government, as an outgrowth of the unique and complex history of interactions between the various tribes and the United States government (SHELTON 2004:1). American Indians are in a unique situation compared to other minority groups in the U.S. due to afore mentioned historic conflict and subsequent treaties in which they specifically retained their sovereignty. American Indian and Alaska Native tribal governments have sovereign nation status with the Federal government. As "nations within a nation" they are recognized as distinct political entities operating within the American government system and thus have a unique government-to-government relationship with the federal government.

Based on a the United States Constitution, treaties between the federal government and the tribes, policy, court decisions and executive orders there is a federal trust responsibility to the tribes that have been federally recognized. The United States plays a role as "guardian," which obliges the government provision of services to American Indian nations in a variety of areas, including health care and education.

The amount of American Indian sovereignty retained depends on the varying degrees of assimilation that each particular nation has undergone and the outcome of past and present disputes about tribal governance. The amount of sovereignty can have an impact on the health care available to the members, because sovereignty affects the choices available to the tribe providing health care services (Ibid:3). As the tribes are recognized sovereign nations, State law does not affect the tribes. Federal law is ahead of tribal law. Tribal law is above State law. The federal government, not the state is in charge of Indian affairs.

Important to note is that the federal authority and responsibility for matters relating to members of Indigenous tribes only applies to those tribes that are in some way recognized by the federal government. Federal recognition may be by treaty or other methods. According to the National Congress of American Indians (NCAI), "there are roughly 563 federally recognized tribes in the United States, with a total membership of about 1.7 million. Several hundred more groups are seeking recognition (Ibid:4). There are an estimated 115,000 individuals who are members of non-recognized tribes, including tribes that are state - but not federally recognized with over 200 Indigenous languages spoken (CHAMPAGNE 1994). In Washington State currently, only twenty-nine of the thirty-six tribes are federally recognized.[24] Tribes that are not federally recognized are not eligible for most federal-Indian

[24] The federally recognized tribes in Washington State include the Chehalis, Cowlitz, Hoh, Nooksack, Jamestown S'Klallam, Kalispel, Lower Elwha S'Klallam, , Samish, Makah, Snoqualmie, Nisqually, Port Gamble S'Klallam, Puyallup, Quileute, Sauk-Suiattle, , Swinomish, Shoalwater Bay, Muckleshoot, Skokomish, Lummi Nation, Squaxin Island, Stillaguamish, Suquamishand Upper Skagit Tribes, as well as Spokane, the Yakama Indian Nation, the the Quinault

programs nor are they able to maintain governments that exist beyond state jurisdiction. Unrecognized tribes that have not yet been able to successfully prove their cultural continuity as a people, such as the Chinook in Washington, accordingly cannot get federal funds for health care and are not eligible for IHS services. Members of these tribes have either been uninsured or privately insured.

The responsibility and basic principles of federal Indian law were established early in U.S. history when the United States gained its independence and the federal government declared that it would be the gatekeeper for relationships with local Indigenous peoples in the Commerce and Treaty Clauses of the Constitution. The Commerce Clause (Article I, § 8, clause 3) authorizes Congress to regulate commerce "with foreign Nations, and among the several States, and with Indian Tribes." The Treaty Clause (Article II, § 2, clause 2) grants to the federal government the exclusive authority to make treaties on behalf of the United States.
In 2000 president Clinton issued Executive Order #13175 entitled "Consultation and Coordination with Indian Tribal Governments." President George W. Bush reiterated his administration's adherence to a government-to-government relationship and support for tribal sovereignty and self-determination. In the White House Memorandum of September 23, 2004, "Government-to-Government Relations with Native American Tribal Governments" as well as Executive Order #13336 of the same year which is consistent with the AI/AN policy statement of March 30, 1995 adopted by the Department of Commerce (DOC) (MURDOCK 2008:1).

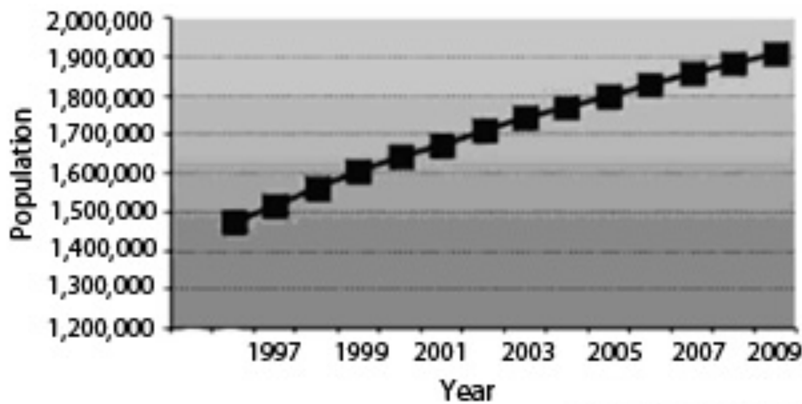
Tribes living in Washington State have one of the largest amounts of self-determination nationwide. This means that instead of federals deciding e.g. how funds are distributed, the tribes decide.
Indian policies recognizing sovereignty and trust responsibility relevant in the area of health are on the federal level the HHS (Health and Human Services) policy and Medicaid - Memorandum of Agreement (MOA). On the State level there is the Centennial Accord from 1989 which requires state agencies to consult with tribes and the Gregoire Proclamation. Within the Washington State DSHS 7.01 Policy exists requiring administration staff to consult with tribes on any major policy affecting the tribes.

Nation, the Colville Confederated Tribes, and the Tulalip Tribes. The tribes in Washington State that lack federal recognition are the Chinook, Duwamish, Kikiallus, Snohomish, Snoqualmoo, Steilacoom, and Marietta Band of Nooksack Indians.

The Snyder Act of 1921 and the Indian Health Care Improvement Act (IHCIA) are the statutes that form the basis for federally-funded care delivery and direct delivery of health care to (AI/ANs). The legal framework for carrying out the trust responsibility of the government to provide health care to AI/ANs is the Indian Health Care Improvement Act ("IHCIA" or P.L. 93-437) which passed in 1976. The Act was originally enacted to address the devastating Indigenous health status. The national goal set forth in the declaration of health objectives (25 U.S.C. § 1602) was to provide "the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy." Quantity and quality of Indian health services were to increase, the participation of Indians in planning and providing those services was to improve (SHELTON 2004:11).
Congress' last comprehensive review of IHCIA took place in 1992. Since then the U.S. health care delivery system has undergone fundamental changes. Improvements have been realized in area such as preventive medicine especially in the treatment of mental illness, domestic violence and substance abuse issues. In contrast to this the federal Indian health care system has not changed much.
Despite its still crucial role providing for the provision of funds to implement health care programs, the IHCIA expired in 2001. President Obama signed health reform legislation into law only in 2010. This legislation permanently authorizes the IHCIA. Still some people maintain the "system is broken" others say the system is chronically underfunded and thus "starved" operating with only 54% level of needed funding (FRANKLIN 2009).

To "uphold the federal government's obligation to promote healthy AI/AN people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes" the federal government created IHS, an agency working under the DHHS. The sole mission of the IHS is to deliver health care to AI/ANs and "to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level" and to "assure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people (AIHCWS 2007:6)." The IHS provides health care services - using a public health model - to 1.9 million AI/ANs residing in Indigenous communities which are located in 35 States. The Indian health system of federal, tribal, and urban Indian operated programs is the primary source of health care services for many AI/ANs. More than a half-million direct ambulatory visits are provided by IHS and tribal clinics each year. Currently, the IHS services approximately 60% of the AI/AN population increasing at a rate of about 2.0% per year (JOHNSON, ANDERSON et al. 1995).

Figure 9: IHS Service Popluation



Indian leaders describe their care as “universal, but rationed.” Those AI/ANs who can get to Indian health programs, get services provided with no cost. This is true only to the extent that funding allows so that when funding runs low, patients with lesser problems may find their medical care postponed or never provided.

Indian Tribes can choose the governmental source of health care for their enrolled members through (1) direct services from the Indian Health Service, (2) “Self-Determination Contracts,” i.e. contracts which the tribes establish with the IHS in the interest of administrative and funding control of the services and programs that would otherwise be provided by the IHS, or (3) “Self-Governance Compacts,” i.e. compacts between the tribes and the IHS to gain control over programs and health care services otherwise provided by the IHS in order to design health care programs which meet the specific needs of tribal communities.

Typically, treaty obligations were carried out through the Bureau of Indian Affairs (BIA) of the Department of the Interior. The Indian Health Service on July 1, 1955 assumed primary responsibility for providing health care (including mental health services) to Native Americans, a year after the transfer of Native American health services from the BIA to the Public Health Service (PHS).

The hope was, that once this was fully developed and comparable to the nation's health care systems, Congress could relinquish its responsibilities to American Indians. This goal was part of the termination policy formulated by Congress during the Truman and Eisenhower administrations (SAMSHA 2001). Under the self-determination policy developed during the Nixon administration, tribes were encouraged to take over governing their health care programs (FLACK, AMARO et al. 1995). In 1975, President Ford signed into law the Indian Self-Determination and Education Assistance Act (ISDEAA) - Public Law 93-638. This landmark legislation strengthened the federal policy of Tribal Self-Determination with Indian Tribes exercising decision-making authority over their own affairs. After an amendment to

the ISDEAA by Congress in 1992 to authorize a Tribal Self-Governance Demonstration Project, in 2000, Congress passed P.L. 106-260, the Tribal Self-Governance Amendments of 2000. This enabled the tribes to attain increased autonomy in health care programs management and service delivery, authorizing a permanent Tribal-Self-Governance program in the IHS under Title V of the ISDEAA. On May 17, 2002, the DHHS declared its final statute to implement Title V (IHS 2011).

Under ISDEAA (Public Law 93-638), 300 tribes across the nation now compact or contract with the Federal government to provide part or all of the health care for their tribal members. As of December 2010, the IHS has negotiated a total of 78 Self-Governance Compacts and 100 funding agreements with 332, 59% of the 562 federally-recognized Indian Tribes in the United States. Self-Governance Tribes currently control nearly $1.4 billion of the IHS budget of approximately $4.03 billion, or about 35% of the total IHS FY 2010 budget appropriation. Tribal Self-Governance programs served 37% of users (550,646 out of a total of 1,483,423) of Indian health care programs in 2008 (IHS 2011). The tribes under the authority of ISDEAA Title V assume additional IHS programs every year.

IHS services include clinical care as well as environmental health, facility maintenance, and critical public health functions. The AI/AN health care system now consists of three major types of programs often called the I/T/U system (ROUBIDEAUX 2002). The "I" refers to IHS health centers and hospitals operated by the federal government. In the whole country, the IHS directly manages 52 health centers, 31 hospitals, and 31 health stations. Tribally managed services, the "T" of the system, in addition, are services operated by the tribes authorized by contracts and compacts under the Indian Self-Determination and Education Assistance Act. Tribally managed services manage nearly 50% of the IHS system. Health care is provided by tribal services in 256 health centers, 15 hospitals, 282 health stations (which include 166 Alaska Native village clinics) and 9 school health centers. Furthermore 11 regional youth substance abuse treatment centers are operated by the IHS or tribal systems. In addition, Urban Indian health programs, the "U" of the system, under Title V of Public Law 94-437 of the Health Care Improvement Act, presently, authorizes 41 independently operated sites to manage 34 urban Indian health programs. Urban programs represent about 1% of the IHS budget attempting to serve the most disadvantaged Natives and those from distant tribes who may not be eligible for IHS contract services. Comparable to rural settings urban Indians are confronted with mental health problems, alcohol and substance misuse, and suicidal ideation. In urban settings small amounts of data are available about Indigenous health needs and access to care. To improve the lack of data the IHS funded an Urban Indian Epidemiology Center (IHS 2001). This gets more important with an increasing amount of individuals leaving

their home environment for the city with the idea to find employment and gain economic independence as well as to have access to the stimuli of urban living. However, oftentimes they do not get a job. Isolated from their communities they lack emotional and spiritual support systems necessary to keep themselves in balance and good health (GUILMET, BOYD et al. 1991:75). They are emotionally disturbed because they do not know what to do as they feel disconnected from land and family and cannot go hunting or fishing or pursue any of the traditional outdoor activities. Also in urban settings, an interview partner at the Chief Seattle Indian Club in Seattle expressed, "They find less ceremonialism to provide basic cultural support in the urban environment which puts them at higher risk for mental disorders" (personal communication)

On the West Coast the Portland Area IHS is responsible which provides access to care for approximately 150,000 American Indian/ Alaska Native residents of 42 tribes in Washington, Idaho and Oregon.

Figure 10: Indian Health Services Portland Area

In Washington there are 31 IHS clinics, 27 of which are tribally-operated, and two urban Indian clinics. There is no IHS hospital in Portland Area. Therefore specialty care must be referred out and paid for using Contract Health funds. The Portland IHS Area has Contract Health Service Delivery Area (CHSDA)[25] counties in 4 states. 64 (43%) of the 148 counties in

[25] (CHSDA) – Counties that are in or near tribal lands served by IHS Service Units in which AI/AN must live to be eligible for Contract Health Services.

these 4 states, are Portland CHSDA counties. Three of the states in this area have counties that belong to more than one IHS Area, and one state has CHSDA counties that are shared with other IHS Areas.

Furthermore several institutions and organizations work in Native health. The Northwest Portland Area Indian Health Board (NPAIHB) established in 1972 is a non-profit tribal advisory organization representing the 43 federally recognized tribes throughout the Pacific Northwest (Washington, Oregon, Idaho). Each member tribe appoints a delegate to represent them on the Board of Directors. NPAIHB delegates discuss and develop positions on current legislative and budget issues related to Indian health care. A strategic plan is created and updated containing five main functional areas: surveillance and research, disease prevention, health promotion, legislative and policy analysis and training and technical assistance.

The American Indian Health Commission for Washington State (AIHC) created in 1994 consists of individuals delegated by resolution from federally recognized tribes. Unrecognized tribes and urban Indian clinics are represented through At-Large delegate seats. AIHC provides a forum for Tribal-State health issues. The mission is to achieve high-quality, comprehensive health care to AI/AN.

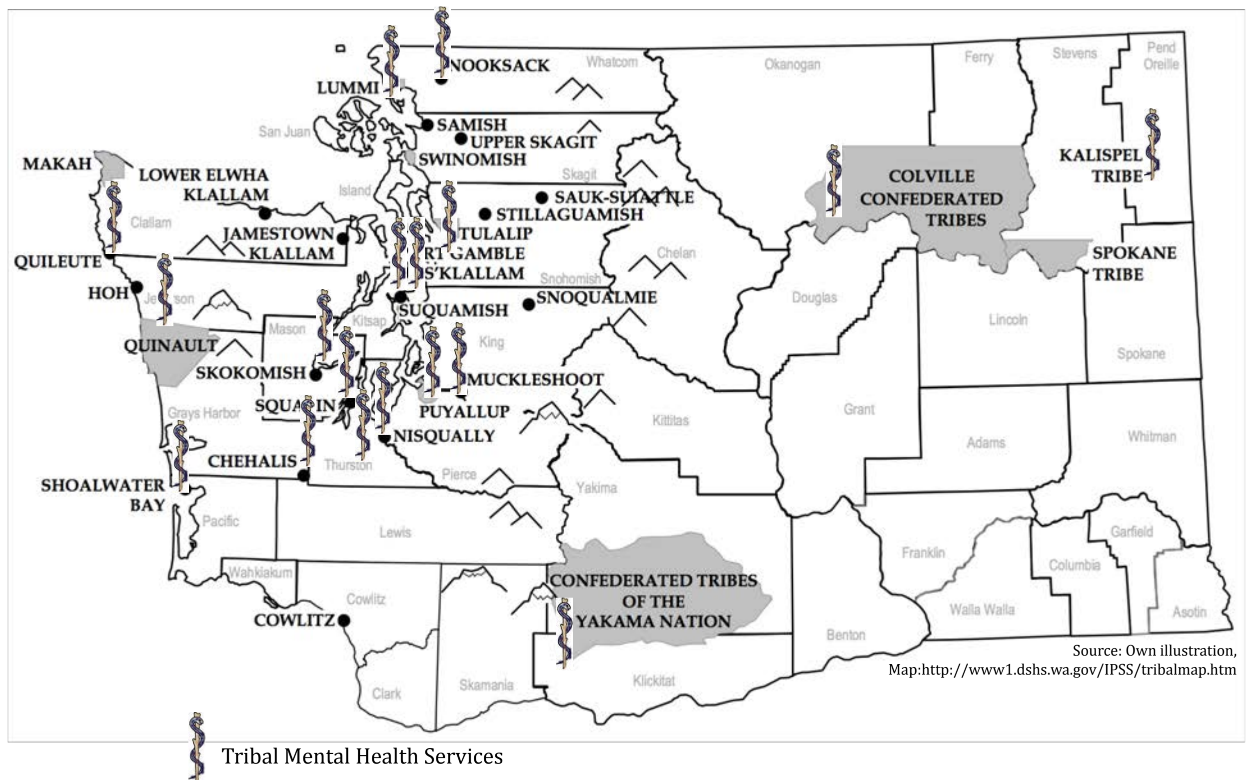
Additionally non profit organizations exist such as the Center for Traditional Medicine (CTM) which convenes practitioners and individuals interested in traditional medical healing services to participate in conventions and workshops promoting the integration of traditional healing with Western medicine, community health centers, and the native Indigenous health care systems.

Part 6 Mental health services for Native Americans

The mental health system is made up of both private and public services – which are amongst others, the Department of Social & Health Services (DSHS) and the Office of the Superintendent of Public Instruction (OSPI). This includes publicly funded services delivered by such and like agencies. The system of services providing help for American Indian individuals and families who seek help for emotional and psychopathological distress is a complex web of federal, AI/AN, state, and community-based services. Presently, there are numerous agencies/departments involved to varying degrees in providing mental health services to Native Americans. However, there is a lack of clarity regarding the roles of the IHS, the BIA, states, counties, cities, and tribes in mental health care. Spatial planning is unlikely to be considered at all. With the fragmentation of services among multiple providers, the task of fitting them together in time and space in a form suitable for each individual is complex. Although multiple providers may mean more flexibility in the form of services, they also mean that it is up to the individual - defined under this philosophy of health care as a "consumer" - to negotiate the complexities of the system. There are relatively few working agreements among service delivery systems (WICHE 1993). American Indians in Washington can access mental health services from two parallel systems, the IHS system and the State System.
The IHS remains the most directly responsible entity for the provision of mental health services to AIAN, specifically its Mental Health and Social Services Programs Branch (MHSSPB), IHS primary health care services, and Alcoholism/Substance Abuse Programs Branch. Other programs and agencies which also play important parts in mental health provision, include tribal health programs, urban Indian health programs, state and local service agencies, the Bureau of Indian Affairs, the Department of Veterans Affairs medical and counseling programs, and traditional healing resources. Other programs housed within Health and Human Services (HHS) and support Americans Indians. The Center for Disease Control and Prevention's (CDC) Office of Minority Health provides programmatic capacity for initiatives in public health. Another main source for supporting research in health disparities in AI/AN populations is NIH National Center on Minority Health and Health Disparities.
The U.S. government initiated mental health programs for American Indians and Alaskan Natives in 1966 opening the Office of Mental Health on the Navajo Reservation run until 1977. By then 40 reservation based mental health programs were supported by the IHS of the U.S. Public Health Service. In that same year there were 60,000 visits by Native American patients to these outpatient mental health services (SHORE and MANSON 1983:163).
Even though legislation was enacted to authorize comprehensive mental health services for American Indians Congress has not appropriated funds for comprehensive services (Nelson &

Manson, 2000). In four IHS service areas there are no child or adolescent mental health professionals due to financial inadequacies. Fragmented attempts by various stakeholders from government to tribal or foundations and nonprofit organizations to provide mental health services have met with obstacles (NOVINS, FLEMING et al. 2000).
The 29 federally-recognized tribes in Washington have 31 clinics in Washington, all but four of which are tribally-operated. There also are two urban Indian health clinics in Washington. Twenty-two of the twenty-nine federally recognized tribes in Washington State have mental health programs. The availability of these programs and the range of mental health services provided varies considerably across communities; in most cases however, these programs deliver only a limited range of services.

Figure 11: Tribal Mental Health Services in Washington State



In addition to these tribal-based programs, Washington State has two urban-based American Indian mental health programs, the Seattle Indian Health Board (SIHB), and the N.A.T.I.V.E. Health Project[26]. The SIHB serves a large clientele of American Indian people in Seattle, while the N.A.T.I.V.E. projects serves clients in the Spokane area; like tribal-based programs, these

[26] An urban-based program means a program currently operating under Title V of PL 94-437. It should be noted that some American Indian mental health care programs located in tribal communities consider themselves to be urban-based programs, although they contract under PL 93-638.

programs struggle to maintain adequate funding mechanisms and meet the extensive mental health needs of the populations that the programs serve.

In addition to tribal - and urban-based programs on an equal basis with all other U.S. citizens, American Indians in the State of Washington are entitled to access all publicly funded State and local mental health services. Tribes do not have hospital or inpatient services. There is not one tribe in the state that has services for a member who is suicidal and needs inpatient care. The Indigenous coordinator of the States Mental health services for American Indians explained:

> "If a tribe needs crisis services or somebody needs inpatient treatment, then the tribes are relying on these other systems and have to go through the RSN with the community mental health. […] One of the biggest flaws in our system is that the tribes get frustrated with the crisis response" (personal communication).

In the State system, since 1989 when Washington State Legislature passed SSB5400 a revision of the Community Mental Health Act mental health services have been decentralized and provided through local entities called Regional Support Networks (RSNs) which provide mental health services to eligible residents (for most services, eligibility equates to Medicaid eligibility). As the designated mental health authority for Washington State, the Mental Health Division (MHD) has primary responsibility for the oversight of delivery of these mental health services to eligible residents. The oversight authority for providing outpatient mental health services was thus taken away from the State DSHS which enabled counties (or collections of counties) to have formal control and responsibility in the planning, development, and managing the local publicly funded community mental health services within their jurisdictions. The creation of the RSN system forced tribes to work with the RSNs in acquiring these services. Prior to the RSN system, tribes were required, in most instances, to access health services in outpatient settings for their communities offered by the individual counties. There are13 Regional Support Networks in Washington State 10 of which have American Indian tribes in their regions. The responsibilities of RSNs include 24-hour crisis services, involuntary inpatient treatment, outpatient services, state hospitals admissions and stays, community residential and other community support services. Mostly the tribes are not tapping into those services though.

Relations between Indian and non-Indian governments and institution also within the context of mental health are often rather poor. This is not only due to inherent difficulties accommodating a minority population. Jurisdictional disputes are a major source of controversy. The state-Indian conflict stems from the historical relationship between tribes and other governments in the State of Washington which has been one of colonial oppression and is worst at the local level. There are differing understandings concerning the Natives

exemption from state taxation and regulation which particularly strains the relations between tribes and local Washington State governments. Because of a general lack of information, different interpretations or misunderstanding of sovereignty and responsibility there is distrust and misunderstanding between tribes and local governments also in the field of health. However in some areas of Washington, tribes have developed good relations with regional agencies or local administrators who fully support working with Indian health programs. From interviews with the MHD, several RSNs with tribal communities in their regions and experts working with the RSN system, differences showed concerning the current state of intergovernmental relations. The quality of services very much relies on the local RSN and the individual relationship between the RSN and the tribe. Relations described range from "pretty good" to "neutral" while others seem totally insufficient. RNS Pierce County commented about a visit to Kwawachee at the Puyallup tribe in Tacoma: "My work partner and I when we visited Kwawachee they were so welcoming and explained their process and like they believe in that when you have guests they gave us a little gift you know that they made." The quality of the relations concerns accessibility of services for Natives when facing crisis. Also the level of knowledge about the tribes' diverse cultures and understanding of the tribes' legal status as sovereign nations being different from other ethnic minorities and the understanding of the framework for interacting with tribes on a government-to-government basis, the Centennial Accord agreement[27], varies considerably between the RSN. Communication issues or breakdowns between some RSNs and tribes also involve the provision of adequate access to culturally competent mental health services for American Indians, considering the cultural, geographic and systemic barriers involved. These services some tribes do not consider to be adequate while the RSNs do not see adequate acknowledgements of their efforts to meet the tribes needs for services.

As to what regards the general and mental health referral system, generally, referral is made inside the tribal system. Primary care physicians in a tribal clinic refer patients to counseling. Besides that, there are several ways to enter specialized mental health services for Native customers. Referral can be organized directly by the individual him/herself or family or from the tribal community. The tribal school can also refer students. Referral from outside institutions can be made such as private or State hospitals, the tribal court, as well as the Washington State DSHS and various outside court and jail systems.
Specialized mental health care in private and public treatment facilities outside the tribal system is less common. There is a lack of funds to pay for these referrals, remarkable

[27] Local governments are not bound by the Centennial Accord (since it is an executive order, not a law).

bureaucratic obstacles and lack of cultural sensitivity. Referral is made to the closest office where people live.

Primary health care providers can refer patients to counseling when the patient has psychiatric complaints or the primary health care provider identifies a need. However, direct psychiatric complaints generally are absent because of the stigma that is generally attached to mental disorder. The ensuing disorder of identity confusion and frustration in acculturative conflicts is basically of reactive depression and anxiety. In many cases though it is disguised either as physically destructive somatizing symptom formation or as aggressive behavior, highly deviant according to traditional native norms.

American Indians do not discriminate bodily from psychic distress. Somatic symptoms can be discerned as an expression of stress or emotional distress. Even though in depth empirical research is lacking concerning this tendency among American Indians, a study among 120 members of one Northwest Coast tribe found the tight interrelatedness of somatic complaints and emotional distress in the American Indian population (SOMERVELL, BEALS et al. 1993). Often Native patients go to primary health care providers and seek help from Indian community clinics for bodily complaints such as headaches, digestive or stomach problems, colds and back pain which are masking mental disorder such as depression, a precursor to suicide. Health care providers thus could play an important role in the early identification and treatment e.g. of people who are suicidal. This seems so much more important seen the fact that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses. However, providers generally lack specialized training to identify the cultural nature of emotional dysfunction so that they do not recognize the underlying emotional distress that causes somatic complaints. Health care providers do not refer patients to counseling when the problem is still easier to work through and are unaware of other community resources for treating depression and other mental illness. The Surgeon General recommended in a 1999 Call to Action to Prevent Suicide that early intervention as part of a multi-faceted, comprehensive approach to prevention thus is missed.

Furthermore there is a lack of addiction screening in primary health care settings like doctors' offices and emergency rooms. Even though just as e.g. with hypertension or diabetes, there is a concrete way to measure whether someone has an alcohol problem. Thus treatment is not available in the medical system itself, but segregated in rehabilitation and detox programs, with few substance abusers receiving treatment and high failure rates of the programs.

6.1 Mental health care needs analysis

The following aims to examine the nature of mental health service delivery to the Native American population of Washington State. It attempts to note the role which various modes of service have in preventing, controlling and treating mental health problems, and how health programs might be more effectively targeted for the Native American population. First a general definition of mental health is given. Then the presence of mental disorder among Native Americans is described which indicates the need for mental health care. In the following section the adequacy of mental health care resources for Native Americans is assessed.

6.1.1 Psychology a fast growing infant

Mental health disorders such as major depression rank among the top 10 causes of disability worldwide. The tragic and devastating effects of mental illnesses which are highly disabling conditions has been recognized. It has been acknowledged they have to be addressed with the same urgency as other medical problems as mental health is fundamental to overall health and paramount to personal well-being, family relationships, and successful contributions to society (MURRAY, LOPEZ et al. 1996). A clear definition that is uniformly acceptable seems not possible "Because values differ across cultures as well as among some groups (and indeed individuals) within a culture, the ideal of the uniformly acceptable definition of [mental health] is illusory" (COWEN 1994). The whole discipline of psychology as it is defined within the world of the professional psychologists, to Indigenous nations is a new science, or as they put it, "a fast growing infant" (ATKINSON 2008:103). A Native researcher of the American Indian Caregiver Study explains concerning terminology: "Mental health is not a word that one likes to use on the reserves. People prefer psychological well-being. Mental health is equalized with substance abuse. Alcohol comes from the outside. Now we have to find cultural methods to heal it."

Mental illness is defined as "any of various disorders in which a person's thoughts, emotions, or behavior are so abnormal as to cause suffering to himself, herself, or other people."[28] The exact factors that cause and influence most mental dysfunction are not yet fully understood. Single or a combination of multiple factors (genetic predisposition social, psychological and cultural) could be underlying forces (U.S. DHHS 2001:6). As in many chronic illnesses, risk factors for mental illness are thought of as leading to or being associated with the disease while protective factors are traits, situations or events that reduce the odds for mental illness

[28] mental illness. (n.d.). *Collins English Dictionary - Complete & Unabridged 10th Edition*. Retrieved August 31, 2011, from Dictionary.com website: http://dictionary.reference.com/browse/mental illness

such as discussion of problems with family or friends, connectedness to family, and emotional health (BOROWSKY, RESNICK et al. 1999). Generally, when risk factors outweigh protective factors, individuals are at higher risk for mental imbalances such as suicide or suicidal behavior. Thus, mental illness prevention interventions are aimed at reducing risk and/or enhancing protective factors.

Mental health treatment is defined as "counseling, inpatient care, outpatient care, or prescription medications for problems with emotions or anxiety and does not include alcohol or drug treatment" (US DHHS 2008:72). Treatment outcome is ordinarily measured by the effectiveness (treatment turn out in settings of clinical practice) and efficacy (treatment turn out in research settings) (CARROLL 1997:352). Outcomes are measured in improvement of mortality rates or morbidity, e.g. reduced number of suicides.

American Indians are significantly under-represented in mental health research. Large-scale epidemiological studies have not been conducted. Data on rates of psychiatric disorders, epidemiology and surveillance would be needed to understand of American Indians' specific mental health issues (SNIPP 1997). Although relatively little information and evidence about the prevalence of mental disorders among the American Indian population is available, the existing data suggest that mental illnesses vary significantly among tribes as well as between tribal and urban based American Indians (STEENHOUT 1996:26) and that a clear overall pattern exists, which relies on smaller suggestive studies that need to be further confirmed in the future. The data for Washington State is consistent with national information. One recent, nationally representative study by the Centers for Disease Control and Prevention showed that there is greater psychological distress (nearly 13 percent) among AI/AN compared to the overall population (nine percent) (GRANT and BROWN 2003:26). One small study with a 20-year follow-up in Northwest Coast villages found the lifetime prevalence of mental disorders to be 70%. (U.S. DHHS 2001).

Another community - based epidemiological study among American Indians is the AIVVP (American Indian Vietnam Veterans Project) which found significantly higher rates of PTSD (National Center for PTSD 1996).

Some of the various mental health and substance issues acknowledged by researchers and professionals to adversely impact Native American communities are depression, methamphetamine, alcohol and drug abuse, (childhood) psychiatric disorders, major anxiety, including panic disorders, running away from home, dropping out of school (INOUYE 1993:7). Learned helplessness, developmental disabilities, poor self-esteem and alienation, dependence and the breakdown of values that correlate with healthy living, as well as

destructive acting-out behavior (such as youth suicide, rape, fighting, and domestic violence) have furthermore been reported by researchers and professionals (DURAN, DURAN et al. 1998:61). Other common mental health problems among American Indians are psychosomatic symptoms and emotional problems resulting from disturbed interpersonal and family relationships (AIHC 2007:45).

6.1.2 Social adversities and racial schizophrenia

While significant progress has been achieved in the control of biomedically oriented pathologies, as stated earlier the rate of death due to violence, suicides and substance abuse still is high. This is explained by cognitive dissonance that Natives are coping with attributed to rapid cultural change and the stress of biculturalism they experienced. A phenomenon described as "epidemiological transition or schizophrenic bicultural existence" (GUILMET and WHITED 1989:73). Indigenous leaders explain Native people are suffering from massive racial schizophrenia as traditional norms have become discredited while the values of Western civilization appear contradictory and the goods unattainable. They have two different cultural identities and must walk in two different worlds with conflicting values. One is a foreign world in which they have a Western identity. The necessity for survival in the dominant Western world fosters individual competitive assertion for personal power, materialism, degradation and commercialization of Native culture, language and religion, with waste and destruction of natural resources. The other world is an Indigenous world with an identity within the community which is collective with traditional values calling for group affiliation, sharing with others, working together within the family system for common goals, and respect for the inherent value of everything in the Indigenous cosmos. The development of both identities depends on each different tribe and individual. The group at a tribal substance abuse healing center on the Olympic peninsular in Washington State said: "We do not want our Indigenous culture taken away from us. But take part in this program feeling like we want to come". Indigenous activist Hayden Burgess comments on this "dilemma of having to choose placing one's spirit in a foreigner's or an Indigenous world", this fundamental problem of the division of spirit: "Schizophrenia is what some would call our condition a disassociation from our environment and a deterioration of our personality" (POKA LAENUI 2005). Others describe the situation that most Indians live in a cultural 'no man's' land suffering from loss of positive cultural identity, loss of family and traditional support systems, loss of traditional experiences and leadership. They have not adapted to mainstream cultures and have been far removed from their own traditional belief and practices (BLAIR 1990:285).

That schizophrenia or loss of positive cultural identity has been explained by Native experts to lead to feelings of defeat, discouragement, lowered self-esteem, apathy, and moral disorientation poor education, high unemployment rate and crime rate and leading in acute and chronic health conditions and in substance abuse.

President Obama in his 2010 White House Tribal Conference address acknowledges Indigenous bicultural existence:

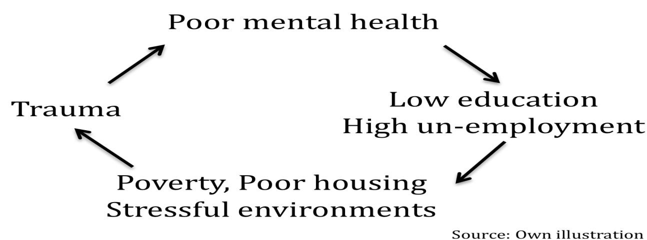
> "So we're making progress. We're moving forward. And what I hope is that we are seeing a turning point in the relationship between our nations. The truth is, for a long time, Native Americans were implicitly told that they had a choice to make. By virtue of the longstanding failure to tackle wrenching problems in Indian Country, it seemed as though you had to either abandon your heritage or accept a lesser lot in life; that there was no way to be a successful part of America and a proud Native American. But we know this is a false choice. To accept it is to believe that we can't and won't do better. And I don't accept that. I know there is not a single person in this room who accepts that either. We know that, ultimately, this is not just a matter of legislation, not just a matter of policy. It's a matter of whether we're going to live up to our basic values. It's a matter of upholding an ideal that has always defined who we are as Americans" (THE WHITE HOUSE 2010).

Chronic social conditions which disproportionately affect AIs adversely affected mental health. Already in the 80ies research has demonstrated that the American Indians' mental health problems are inseparable from the peculiar socioeconomic conditions and sociocultural situation they are confronted with (JILEK and JILEK-AALL 1972). Even though unemployment and financial problems are not mental health problems directly, they have a significant impact on the mental health status especially of vulnerable groups in which Native people are overrepresented like those who are homeless, or victims of trauma. (KOEGEL, BURNAM et al. 1988). It is agreed that especially housing is one of the most important considerations in mental health planning. Those persons with serious mental health concerns who are unable to access appropriate, safe, affordable and secure housing will have a significantly reduced quality of life and an increased need for and reliance on emergency, support and treatment services. Thus it can be presumed that there is considerable unmet need (U.S. DHHS 2001:96).

In 2005, adults living below the poverty level were five times more likely to have serious psychological distress as compared to adults over twice the poverty level. Likeliness for mental health disorder is about two to three times higher for people in the lower stratum of education and income compared to those in the highest stratum (NCHS 2007:10). Exposure to violence, unemployment or other stressful social environments is more likely amongst poor people who are less likely to have social and material resources (DOHRENWEND 1973:230). Therefore poverty, along with demoralization, and rapid culture change, is a risk factor for

mental illness, held to increase disruptive behavior in communities (MCLEOD and KESSLER 1990). The negative influence of mental disorder on individual productivity in turn can lead to poverty which furthermore explains the link between poverty and mental disease. In this respect, poverty is a consequence of mental diesase. (US DHHS 2008:59).

Figure 12: Vicious Cycle of Poor Mental Health and Socio-Economic-Cultural Conditions



There is substantial literature on the damaging effects of poverty on mental health, empirical evidence for the effects of social problems such as exposure to community violence and discrimination, even though currently examined, still is rather limited (U.S. DHHS 2001:167). The causal factors of discrimination and the historical legacy of racism in the case of American Indians have been acknowledged.

In order to understand the factors which leave many Native Americans vulnerable and the mental health issues currently faced as well as the difficulties tribal communities confront in fully responding to those issues, it is crucial to also understand the historical context of Native and non-Native relations as described above. Similarly, the difficulties many Native communities face in dealing with mental health problems are a product of this history. Many of the methods and networks traditionally employed by American Indian communities to deal with their mental health needs have been disrupted, and to a certain degree even destroyed, as a result of the perennial attack on traditional American Indian ways of life (STEENHOUT and ST. CHARLES 2002:26).

Moreover racism defined as "the systemic application of racial and ethnic bias through social mechanisms of power which oppress and subvert the culture and the political systems of Indigenous peoples to the benefit of the race which is the dominant society" (TRASK 2000) exists in health care services.

The Committee on the elimination of racial discrimination states in it shadow report:

> "The United States perpetuates a constitutional and legal system that legitimizes discriminatory practices towards Indigenous Peoples by failing to protect their rights to property, religious freedom and practice, despoiling spiritually significant areas, denying Indigenous Peoples' control and management of resources and self-determination even on their own lands" (SALDAMANDO 2008:84).

An inability to exercise power means that poor and vulnerable people cannot change the condition of their vulnerability and must remain dependent on others to do so.
Acts of discrimination intend to remind the individual of his/her "place" in the societal hierarchy. In the case of the American Indian this "place" is assimilation, acculturation and ethnic cleansing (WHITBECK, CHEN et al. 2004:416).
The effects of discrimination-induced stress effects on physical and mental health among minority groups have been reported by experts Kessler and others. They find discrimination to be a primary contributor to psychological distress and rank it with major stressful life events such as loss of close relations, divorce and job loss (1999:227). Perceived discrimination is associated with internalizing symptoms (e.g. depression, hypertension anxiety (U.S. DHHS 2001:42), externalizing symptoms (e.g. attention problems, aggression and delinquency) and substance use among American Indians (WHITBECK, CHEN et al. 2004:410).
The reduction of conditions such as racism, and discrimination is regarded to be crucial to improving the mental health of American Indians as well as other racial and ethnic minorities.

6.1.3 Native holocaust and postcolonial stress syndrome

Indigenous experts have gone as far as to argue that the higher burden of disability is not about psychological and individualized failure but about colonization or lack of collective self-determination (SMITH 1999:153). European contact and the decimation of the Indigenous population had a severe impact upon the psyche of the local Indigenous population. In line with this, professionals in the field argue that cultural disruption experienced in history resulted in what they call a "survivor syndrome" accompanied by self-loathing, guilt, chronic depression and other long term personality changes common in all survivors. It gets acted out against self or within one's group and clinically shows in high rates of alcoholism, homicides, suicides, social and educational failures etc. Furthermore the subjugation and humiliation of Native Americans by the United States government resulted in Native Americans' loss of control over their own communities. This erosion of social cohesion has had profoundly aggravating effects on American Indian mental health (STEENHOUT and ST. CHARLES 2002:27).
Indigenous societies have had their medicine chests filled with well-developed means to deal with trauma, alleviating and comforting, building resilience through rituals, ceremonies, humorous and optimistic, narratives that re-established hope and confidence reinforcing a sense of worth, future and possibility. When experiencing trauma an individual would return to a supportive environment, able to reach into his family and community. Utilizing the

sociocultural and spiritual resources available the individuals would be able and willing to overcome the trauma. Instead of blaming they could give themselves a perspective and move on with life without staying stuck in debilitating personal narratives and behaviors, numbed and dissociated from individual feelings. However, when whole communities and families are frozen in trauma these social and cultural resources that help people to heal and to make positive meaning out of the traumatic events that happen to them can be damaged. They remain without remedies for trauma which results in collective post-traumatic narratives, loss of trust and a sense of alienation, isolation, and disillusionment: "Nobody outside cares about us [...] ." (ABADIAN 2006:20)

Mental illness, alcoholism, and suicide therefore are explained to arise from the colonization experience - referred to as "Post Colonial Stress Syndrome" stemming from what is called "historical traumas" and "intergenerational grief" (KORN, LOGSDON et al. 2009:8). Native Americans understood the effects of colonization as a spiritual injury, since their cultures remain based on spirituality as a cornerstone of their worldviews (DURAN, DURAN et al. 1998:64). The impact of colonization has been called "colonization of the life world." Colonizers interfered with Indigenous mechanisms needed to reproduce their life world domains - culture, social integration, and socialization, which informed Indigenous identity and mechanisms of sociocultural reproduction and control. This led to disintegration explained to be at the root of many present-day social and health problems (DURAN, DURAN et al. 1998:62).

The trauma of colonialism was visible in the forms of the loss of Indigenous homelands, introduction of diseases as well as military actions. Acts of warfare and disease destabilized harmony. Discord turned into the communities' unconscious perception and evolving narratives that the world was an unfriendly and hostile place to live in. These perceptions were the symptoms of a deeper wound, called the "soul wound." There is not a DSM-IV diagnosis for these symptoms. How to call it, deal with it and treat it currently are ongoing issues. Synonymous terms are "intergenerational post traumatic stress disorder," "historical trauma," and "Native American holocaust" (DURAN, DURAN et al. 1998:64). These "historical traumas" result in a complex array of ongoing "intergenerational trauma" and continue to affect Native communities in significant ways. The construction of intergenerational trauma as an integral part of Indigenous lay knowledge has been long known to healers and elders in American Indian communities and empirical evidence that intergenerational trauma exists was provided in clinical studies of Jewish holocaust survivors (DURAN, DURAN et al. 1998:60).

For American Indians, the U.S. government is the perpetrator of their holocaust. They still live in a colonized country, since unlike other oppressed groups in other places they did not have the opportunity to escape physical and psychic genocide as no other country welcomed them. Their holocaust has not been fully validated by the world community. The patterns how Native Americans have dealt with their grief has been described to be comparable to Jews in Europe who were in complete denial and repressed their emotions resulting in psychic numbing.

Memory and awareness of historical trauma that encompasses the after effects of racism, oppression and genocide that contributed to deep feelings of distrust are obvious in the daily consciousness of many Native Americans. Exposure to interpersonal violence and accidental trauma is held to be "the sequelae of historical trauma and intergenerational grief characterized as incomplete mourning" (EVANS-CAMPBELL 2008).

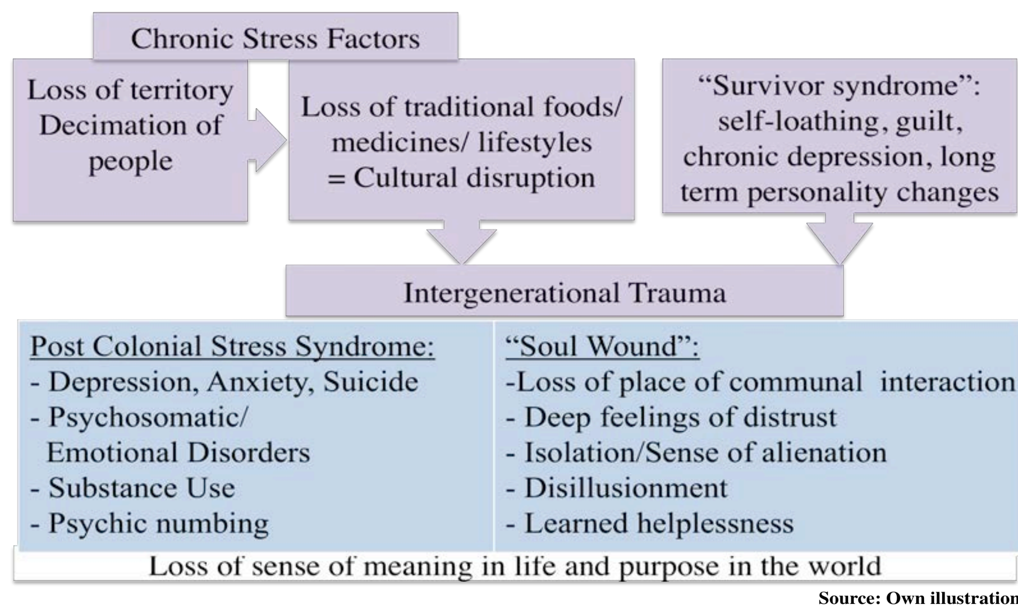
Trauma represents an "emotional state of discomfort and stress resulting from memories of an extraordinary and catastrophic experience which shattered the survivor's sense of invulnerability to harm" (FIGLEY 1985:xviii). Trauma leads to disconnection from oneself, physically, emotionally and mentally. It can cause feelings of betrayal and a deeply damaged sense of trust that fragments peoples' relationship with their surroundings, family, community, culture as well as nature. If the shock in trauma is too intense, overwhelming or repeated proper personal functioning can be completely disrupted, cause re-enactment and lead to learned helplessness and no way to escape the chronic stress unaided. A cycle of damage begins. With no other treatment available, alcohol or other psycho-active substances become the treatment of choice for the experienced psychic pain (ATKINSON 2008:115). And might prevent more direct forms of suicide.

The rate of violent victimization of AI/ANs is more than twice the national average. The higher rate of traumatic exposure is related to the increase of various mental disorders, particularly Posttraumatic Stress Disorder (PTSD) –defined by the American Psychiatrist Association as a "mental disorder caused by exposure to severe trauma, such as genocide, war combat, torture, or the extreme threat of death or serious injury" (APA 1994). Causative factors of post-traumatic stress disorder are socio-cultural.

Work with victims of chronic trauma and loss indicates that the risk of developing psychiatric morbidity is especially high where there is little or no opportunity for the victims to remove themselves from the traumatic situation or to work through their grief. Evidence suggests that a significant percentage of American Indians are over-represented among people exposed to trauma and its mental health sequelae as most cannot escape the impact of chronic trauma because of the parallel process of acculturation and marginalization

(MANSON 1996). Unresolved trauma due to a shortage of resources and time has been regarded as the underlying cause for many problems Native communities face today. Trauma has to be resolved and an adequate period of grieving and bereavement when experiencing traumatic events has to be possible for a person to live a psychologically healthy existence. Otherwise unresolved trauma is "intergenerationally cumulative, thus compounding the mental health problems of succeeding generations with people suffering from symptoms such as, anxiety, psychosomatic disorders and depression" (DURAN, DURAN et al. 1998:62).

Figure 13: Root Causes of Physical and Mental Distress



Source: Own illustration

Depression

Large-scale studies of depression among American Indians are lacking, but smaller studies have found that depression seems to be the most common mental disorder among both young and adult American Indians with rates of depression in the range of 10 to 30% with considerable social and economic consequences. Similar to national trends, the rate of depression among American Indians in Washington State seems to be very high (AIHC 2007:32). Experts commented that the rate of depression among Washington State American Indian tribes is extremely great (Verbal testimony).

There are many different physical and psychological symptoms characterizing major depression. Symptoms include profound sadness, loss of a sense of pleasure or interest in commonly enjoyed activities and other symptoms which affect the normal functioning of a person. As it is common for depression to recur it can take an enormous toll on life quality, productivity, as well as physical health as depression has been associated with elevated risk of heart disease and many "acting-out" type problems, such as suicide, assault, homicide,

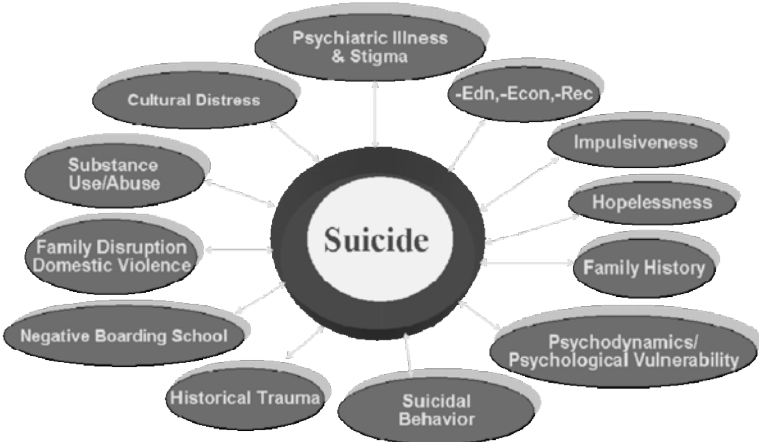
sexual abuse and domestic violence (NIH 2011). Substance abuse, anxiety, low self-esteem and poor performance in school, have been linked to depression as well. The high rate of depression amongst American Indians is rooted in low socioeconomic status (MCLEOD and KESSLER 1990:162). Psychologists explain that insecurity that is particularly high among minority groups in the U.S. leads to pessimism. This pessimism can turn into fear and both can be seen as potentially causative factors for the chronic depression from which Natives suffer disproportionately and even lead to suicide (WALKER, LONDON et al. 2006:62). Also threatening situations such as unemployment which the person seems unable to avoid or escape and that the individual cannot change cause helplessness and depression (WINTERHOFF-SPURK 2008:148).
There likewise is a well-established link between decreased physical and mental health and higher levels of stress (HERTZMAN and DANIELS 1997). Stress can result from acute, major events, such as job loss (WHEATON 1983). More commonly, stress results from ongoing, daily struggles, such as chronic shortage of money, or exposure to noise, pollution and crime in the daily environment. There are two stresses held to be most damaging to health: the first is a pervasive feeling of social inferiority. The second is exposure to situations in work and personal life over which one has little control (SELCKY, SITAKER et al. 2006:18). Constant source of stress and feelings of inferiority were explained to be or stem from "accumulated insults arising from everyday experiences" that can be violent at times, or "being treated as a second class citizen." In this context lack of control over their situation and the difficulties experienced by Native Americans to move up in U.S. society and thus from societal goods and status were mentioned. Because of constant societal pressures there sometimes is denial of ethnic origin or the need to act like non-Natives. This results in feelings of guilt of betrayal to the ways of Native ancestors, subjective feelings of rejection or low self-esteem. Similarly Native Americans experience multiple losses, many having completely or partially lost traditional mourning rituals.

Suicide

Suicide defined as the intentional ending of one's own life or attempts, is one of the most distressing and preventable as well as predictable consequences of undiagnosed, untreated, or under-treated mental illnesses. Research and anecdotal evidence over the past three decades reveal that suicides are an emerging epidemic the world over. The WHO reported that more deaths are caused worldwide by suicide every year than homicide or war (2002). Suicide is a particularly severe problem amongst Native Americans and Alaska Natives which has been misunderstood, surrounded by silence and stigma. Risk factors may include

depression, alcohol/substance abuse, social support loss, rational thinking loss, chronic illness or hopelessness. The interactions of race, ethnicity, poverty, and education for suicide have not been widely researched. Dale Walker and her colleagues show specifically for Native Americans that suicide is due to a complex interaction of social, environmental, biological and cultural factors operating in an individual's life. These factors, as shown in the diagram below, cross over personal, family, interpersonal, community, and societal environments (2006:3).

Figure 14: Factors Influencing Native Suicide



Source: (WALKER, LONDON et al. 2006:5)

The prevalence rate of suicide as well as serious psychological distress for AI/ANs is 1.5 times the national rate (NCHS 2007:Table 61). AI/AN males ages 15 to 24 account for two-thirds of all AI/AN suicides. In the same age group 75% of all mortality is accounted for by violent deaths (RESNICK, BEARMAN et al. 1997). In Washington State for 2003 – 2005 combined, age-adjusted suicide rates were highest for American Indians and Alaska Natives with 14 per 1000 (NPAIHB 2008:19). Mental health professionals working in American Indian mental health programs state this rate to be higher for American Indians. They caution that social stigma and attitudes toward mental illness held by some Indigenous groups do not only prevent acknowledgment of the condition and may prevent seeking help for suicidal ideation, depression and related conditions (ROCKETT and THOMAS 1999), professionals believe that many single-vehicle accidental deaths are actually suicides (NELSON, MCCOY et al. 1992). As a result, suicides are often underreported. Therefore, suicide rates are only a relative measure of disparities in access to good quality care for various groups, especially for racial and ethnic groups and accordingly should be used with due caution (WARSHAUER and MONK 1978). A diagnosable mental illness at the time of death has been found with 90% of all teenagers who committed suicide. However, only half of the teenagers who died by suicide had ever consulted a mental health care professional. Given the high rates of suicide clearly

documented among some segments of the American Indian population, one thus can conclude that there likely is a higher need for mental health care.

Substance abuse

In the U.S. popular media misrepresentations and stereotypes to this day create the image of "the drunken Indian." There are no official rates of substance abuse among Indigenous adults. Indirect evidence suggests that substance abuse is a serious problem among many Indigenous communities, particularly among adolescents and young adults (WHITBECK, CHEN et al. 2004:410). Results from a national survey on drug use from 2005 show that AI/AN and Native Hawaiians have the highest prevalence of alcohol dependence and need for treatment of illicit drug abuse compared to any other racial/ethnic group in the United States (Office of Applied Studies 2006). Illicit drugs refer to inhalants, heroin, cocaine, marijuana, hallucinogens, or prescription-type drugs used non-medically, such as pain relievers, stimulants, tranquilizers, and sedatives. The National Survey on Drug Use and Health (NSDUH) gives definitions for alcohol dependence or abuse or illicit drug based on criteria described in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (APA 1994). Use of illicit drugs can be associated with serious and potentially life-threatening consequences. These include injury, sickness, disability, and death as well as crime, domestic violence, and lost productivity at school or at the workplace as well as long-term consequences, such as chronic depression, psychiatric disorder and sexual dysfunction (SAMSHA 2007). Furthermore research indicates that especially drinking is associated with risk-taking and sensation-seeking behavior. The disinhibiting effects of alcohol heighten the likeliness of engaging in unsafe activities (NCHS 2007:36).
In 2002-2005, likeliness for a past year alcohol use disorder was 10.7 vs. 7.6 percent of AI/AN compared to other racial groups. Similarly rates for past year illicit drug use disorder was 5.0 vs. 2.9 percent among AI/AN as compared with other racial groups (SAMSHA 2007:4). Substance dependence or abuse is continued substance use despite significant social, mental and physical dysfunction. It includes such symptoms as withdrawal, tolerance (consuming large amounts of the substance), use in dangerous situations, problems including legal, work and social/family during the past year. There are two theories that explain the individuals' underlying reason for substance abuse. It could be a means to better the negative effects of acculturation of American Indians and discrimination via self-medication or it could be a reaction to internalized anger stemmingxf from negative socio economic or factors such as discrimination (WHITBECK, HOYT et al. 2001). Other risk factors may include family history/ dysfunction, depression, anxiety, poverty and genetic disposition.

Also health-related disparities in association with substance abuse are significantly higher among American Indians such as e.g. rates of many psychosocial problems including increased domestic violent crimes, burglary, assault and battery, and child neglect/abuse. Native Americans accounted for 2.4% of all admissions to publicly funded substance abuse treatment facilities. However in total, only 20% of Native American adults ages 18-44 and 11,2% of children ages 12-17 who were in need to be treated for illicit drug use in 2006, received it (U.S. DHHS 2008:75).
The likeliness to die of alcohol-related causes are five times higher for AI/AN than for whites. Even though differing widely among the tribes alcohol-related deaths among Native Americans ages 15-24 are 17 times higher compared with the national average (GRANT and BROWN 2003:25).
Ongoing drug related problems do not just involve chemical but Natives are more and more susceptible to prescription drugs. Health workers reported in interviews that especially oxycodone addiction, a strong opioid analgeic (pain killer) drug with a high potential for physical and psychological dependence is getting more and more problematic on reserves in Washington State.
Moreover a clear connection between psychological and physical health as well as alcohol and drug abuse has been internationally recognized (Council Resolution 1999). This situation that the patient is experiencing both mental health issues as well as drug dependencies is often described as co-morbid disorders, co-occurring disorders, concurrent disorders or dual diagnosis. Five million adults in the U.S., a study found in 2002, had a serious mental illness, and had substance abuse problems. Co-occurring disorders of alcohol problems and mental disorders have been found in American Indian populations (BEALS, NOVINS et al. 2001). Research conducted that proofed the existence of co-occurring disorders among AI comprised three large families and in total more than over 600 members (ROBIN, CHESTER et al. 1997). Amongst American Indian youth in treatment for substance abuse fifty percent have significant untreated psychiatric co-morbidity (NOVINS, BEALS et al. 1996). Due to high rates of alcohol abuse among American Indians the rate of fetal alcohol syndrome is also high which has an important influence on mental health needs as there is an increased need for treatment with people suffering from fetal alcohol syndrome.
Given the high rates of substance abuse and the evidence of co-occurring psychiatric disorders as well as fetal alcohol syndrome among American Indians this population has a clear need for mental health care.

5

Child abuse

Due to socio-cultural vulnerability parenting in American Indian families can be dysfunctional with a reality of neglect and abuse which leads to adoption or child removal into foster care (PIASECKI, M. et al. 1989:59). Child abuse, i.e. behavior outside the norms of conduct that entails a substantial risk of causing child physical or emotional harm, comprising physical and sexual abuse, neglect, and emotional maltreatment. Child maltreatment affects short as well as long-term physical and emotional well-being. It increases the risks of delinquency, substance abuse, adolescent pregnancy, suicide attempts, and HIV-risk behaviors as the affected children grow up. Child abuse is particularly difficult to measure accurately in Indigenous communities. Challenges include underreporting (as many as half of the children with substantiated physical abuse are reported and do not receive mental health services), varying definitions, changes in community perceptions over time, and changes in capacity to accept referrals (AIHC 2007:32).

In 2006, Washington State's Child Protective Services accepted for investigation 36,882 referrals for child abuse and neglect. These involved 41,455 different children ages 0 – 17. In Washington in 2003 – 2005 (the years for which population estimates by race and age are available), the highest rates of child maltreatment were among American Indian and Alaska Natives (75 per 1,000 children) (Ibid:33). Mental health services for abused children found in the study area to address potential adverse consequences of child maltreatment are trauma-focused cognitive-behavioral therapy, therapeutic day care programs and psychotherapy. None of which interventions to reduce child maltreatment having been adequately evaluated. Until 1978 when Congress passed the Indian Child Welfare Act to end "a pattern of discrimination against American Indians," state child custody proceedings in a period of mass cultural dislocation had taken an estimated 25-30 percent of all American Indian children from their homes and families (DELORIA 1985). The adoption rate in Washington State was 19 times higher than that of non-Indian children. By 1999, 1% of children in foster care were American Indian children (U.S. DHHS 2001:90). According to 2003 data, there were 1,690 Indian children in state foster care in Washington, the fifth largest population among all fifty states (US GAO 2001:19). The percentage of children in foster care in the state of Washington of were Native Americans that year (Ibid:13). The state provides $6.5 million to the tribes for services under contracts. Funding and the services provided through tribes are both lower than that provided to children in the state's foster care system.

The removal of Indigenous children from their families and communities had extremely negative effects on American Indians' mental health (SWINOMISH INDIAN TRIBAL COMMUNITY 1991:28). The exact mental health consequences for the children, who were put

in foster care, especially those placed in non-Indian homes, are not known. Studies show though that there is a higher risk in children separated from their families and homes to be vulnerable to later problems such as homelessness (KOEGEL, MELAMID et al. 1995). Irving Berlin states a higher risk for suicide - rates twice as high compared to that of the American youth living on reservations - (1978:218) and other pathologies emerging during adolescents and young adulthood. He observes the children feel rootless without a clear sense of identity as they remain without ties to both their own and the majority culture. The loss of ties with their Indigenous as well as mainstream customs and culture Irving Berlin explains can result in an estrangement from both worlds (Ibid:214).

Also the long - term effects of the BIA boarding school system that attempted to eradicate Native culture by the forced separation of Native children from their parents have been linked to adverse mental health impacts (KLEINFELD and BLOOM 1977). Personal interviews revealed the information that some children were successfully hid by family members and thus did not attend boarding schools. Many who went to boarding schools related traumatic experienced which disconnected them from their families, culture and native territories. Cultural coping methods were no longer accessible, parental influence weakened. This lack of experience of family life in turn had influences on the children's own parenting in later life. What was generally described, as one of the most negative impacts of boarding school besides the prohibition of cultural practices, as well as traditional medicine and philosophies is the emotional and sexual abuse of children. The devastating experiences at boarding schools were identified to be contributing factors for the now high rates of alcoholism, depression, suicide and domestic violence among Native Americans due to underlying historic trauma.

Native youth's mental health

Alarming statistics were revealed in federal reports and other studies concerning American Indian youth AI/AN youth were found to have more serious issues with mental health disorders compared to other racial and ethnic groups especially reporting issues of substance abuse, related violence and delinquency as well as depression, and suicide. (OLSON and WAHAB 2006).

In 1986, a study entitled Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children, estimated that between 11 to 20 percent of Indian children in HIS Portland area are seriously emotionally disturbed (Cross, 1986). Another study entitled the Washington State Children's Mental Health System Analysis regarded Washington State in particular. This so-called Trupin Study found that 17.6 percent of American Indian youth in the public school system suffered from a severe emotional disorder

(SED). The rate of SED among American Indian children was substantially higher than SED rates among African-American (7.3 percent), Hispanic (4.1 percent), and Asian-American (1.6 percent) children.[29] Another significant finding of the Trupin Study was that 94.1 percent of all SED children were not receiving State-funded mental health services (TRUPIN, LOW et al. 1988). To this day this seems to not have changed to the better. The rate of violence for Indian youth aged 12-17 e.g. is 65% greater than the national average (NPAIHB 2009:22).
The assessment of the Great Smoky Mountain Study involved 431 youth in age groups 9 to 13 suffering from psychiatric disorders. It was found that Native American children had similar rates of disorder (17%) compared to white children (19%). There is a higher rate of substance abuse or other dependency issues among Native American children (1 vs. 0.1%) most of which in the 13 year old age group. (U.S. DHHS 2001:85).
Similarly another school-based psychiatric epidemiological study involving 109 Northern Plains adolescents, aged 13 to 17 years identified attention - deficit/hyper-activity disorder (11%), alcohol and drug abuse (20%), major depressive disorder (5%), and other substance issues (4%) to be the four most common disorders. Comorbidity was found to be high (29%). While anxiety disorders were fewer among American Indian youth diagnosis of ADHD and substance abuse/dependence disorders was higher (PIASECKI, M. et al. 1989:1257).

American Indians in the prison system

Mental health problems are also clearly connected to the law. About two-thirds of the nation's juvenile inmates in the U.S. (92,854 in 2006) have at least one mental illness and are reliant on multiple psychotropic drugs. Due to the lack of research and available data mental health issues among American Indians in the prison system is lacking. A study in 1998 in a juvenile detention facility on a Northern Plains reservation found that there are higher rates of mental health issues and multiple disorders among inmates compared to American Indians adolescents living in the community. One out of every two had a mental health disorder or misused substances. This indicates a significant need for substance abuse interventions and mental health treatments among American Indians in the prison system which appears to be unmet. As many Indigenous crimes committed are petty offences associated with alcohol abuse, or involve forms of minor assault that are connected to interpersonal problems inmates seem more in need of therapy than punishment. However are facing a shortage of therapists. Therefore mental health experts report the jail system in the U.S. to be in crisis. As states cut their mental health programs in communities and schools, jails and juvenile prisons

[29] Trupin noted that because of small sample sizes, prevalence estimates were not overly stable.

have been described as “the caretaker of last resort”, and “the new asylums” to handle a generation of “young offenders with psychiatric disorders” (MOORE 2009).
For the national average, an estimated 1 in 25 American Indian/Alaska Native adults, as opposed to 1 in 106 whites is in the criminal justice system. American Indian youth accounted for close to 16% of inmates in custody in facilities nationwide in 2000. As of June 2009 the Native American inmate population was stated to be 4.6% by the State of Washington Department of Corrections (STATE OF WASHINGTON DEPARTMENT OF CORRECTIONS 2009). These high rates of incarcerated Native Americans indicate they are likely to be in high need for mental health care and substance abuse interventions.

Today there are dire needs at all levels of mental health care such as: 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 (BARRON, OGE et al. 1999:20).

6.2 Mental health care assessment

Adequacy of mental health care resources for Native Americans
Three criteria are defined for assessing the adequacy of the delivery of service and for analyzing the nature of mental health care: the availability, accessibility and appropriateness of health services. Analyzing these criteria is useful in identifying the types of problems, which must be addressed in tailoring more effective responses to the mental health needs of Native Americans.

6.2.1 The availability of mental health services

Availability of health services is determined by availability of staff and facilities or settings in which care is provided and include hospitals, community health clinics, long-term care facilities, care homes, physicians' as well as alternative health providers’ offices, pharmacies and home care agencies. Availability is measured by the providers to population ratio in a specified area and the providers ability to offer services that meet the expressed needs of the service population. (U.S. Center for Mental Health Services 2000).
In Washington State’s public mental health system county government agencies and currently 145 licensed private and non-profit organizations within the state provide services and

treatment for most of the estimated 188,100 adults as well as 74,000 children in Washington with mental illnesses (not including persons who are homeless or are institutionalized). Estimated numbers differ considerably.

Table 2: Estimated 12-Month Number of Persons with Serious Mental Illness (SMI), age 18 and Older, by State, 2002

State	Resident Population 2002	Resident Population with SMI (5.4%)	Lower Limit of Estimate (3.7%)	Upper Limit of Estimate (7.1%)
Washington	4,555,636	246,004	168,559	323,450

Source: http://mentalhealth.samhsa.gov/databases/stats.aspx?D1=WA

According to a study done by the Mental Health Transformation project, when applied to Washington State, the prevalence of moderate impairment due to mental illness was found to be 15.5% (MORRISSEY, THOMAS et al. 2007:2). Data on how many of these customers in Washington are Native Americans is not recorded. Likewise data on costs is scarce.

Table 3: State Mental Health Agency, Mental Health Actual Dollar & Per Capita Expenditures, 2001

State	SMHA Expenditures Total	Total Rank	FY'01 PerCapita	PerCapita Rank
Washington	$525,564,708	13	$88.13	19

Source: http://mentalhealth.samhsa.gov/databases/stats.aspx?D1=WA

In Washington State there is a highly unmet need for services in mental health. The workforce shortage i.e. the difference between the number of full-time equivalent (FTE) providers needed and the number of providers available is so high that one can speak of a mental health professional workforce crisis. The professional mental health workforce as defined by the Health Resources and Services Administration (HRSA) includes six different types of providers: psychologists, psychiatrists, psychiatric nurses, social workers, licensed professional counselors and family therapists. Prescribers are psychiatrists and advanced practice psychiatric nurses with prescriptive authority. Prescriber shortages are most concentrated in rural counties of the state with low per capita income. Other advanced practice psychiatric nurses, psychologists, social workers, licensed counselors, and marriage and family therapists are grouped as non-prescribers. Non-prescriber shortage across the state is not as high as prescriber shortage (MORRISSEY, THOMAS et al. 2007:3).
U.S. medical schools are not creating a physician workforce that meets the needs of all communities. There is a lower proportion of medical school graduates entering primary and mental care. The Association of American Medical Colleges (AAMC) projects an upcoming

shortage of physicians. This will put even more pressure on providers who serve Native communities and likely exacerbates the shortage of physicians, leading to a reduction in physician retention.

According to a recent study on geographic disparities in Washington State's mental health workforce four of the state's Regional Support Networks (RSNs) have at least 40% of their mental health workforce need unmet: North Central, Grays Harbor, Chelan-Douglas and Timberlands (Ibid). To account for county-level differences in mental health workforce shortages across Washington State county per capita income was found to be the single most important indicator. Various economic, social, and psychological factors are much less relevant predictor of mental health workforce shortages to be considered. Counties with high per capita income such as in San Juan and King counties show extremely low provider shortages; In contrast Adams and Grant counties, two low income counties, face high shortages. The other counties are clustered between these two extremes (Ibid:3).

Changes in state/county agencies are similarly affected by personnel changes. In order to improve their coordination with tribal programs these agencies have employed members of an Indian tribe so-called "tribal liaisons". These positions tend to be unstable as even though many individuals serving as liaison have improved communications not all can necessarily deal with or work with the programs in various tribes in the agency's service areas.

Even more extreme than in the RSN system is the labor shortage in IHS, tribal, and urban AI health programs. Indian mental health care programs are often understaffed and have difficulties in recruiting and retaining professional staff. Native American health professionals in the IHS system have increased by 272 percent, the proportion of Native American professional staff by 138 percent. Still the average physician vacancy rate in IHS programs is nearly 20 percent with vacancies being particularly hard on reservation and rural clinics where only a few physicians are on staff (HILL 2009). Health provider vacancies makes necessary referrals for services that could otherwise be provided from within the IHS system. Specific issues at IHS clinics are that few practitioners of any background are willing to work within tribal settings on a consistent and ongoing basis. The pay rate for physicians in the IHS system is considerably lower compared to that of the nonfederal health care system. Due to the low payment turnover rates of practitioners at tribal clinics are extremely high. This has significant effects on the care provided as practitioners most of who were stated to "learn as they go" lack opportunity to fully understand the cultural, socioeconomic and ethno-historic context of mental disorders among Native patients. With the practitioners changing constantly, moving to higher paying positions Native patients who take their time to build trust in a counselor or therapist cannot share their emotional troubles. Personnel stability

was reported an essential element in program effectiveness. Neither tribal nor state/county agencies are able to ensure such stability.

Especially the tribes living in Washington's rural areas in often economically challenged communities such as the Lummi e.g. have limited ability to compete for physicians and do not find qualified people to take the health positions. The reason stated being that "people are looking for employment in the cities". The doctors who go to work in reservation clinics oftentimes are "only the castaways." Even though at tribal clinics the tribes can decide whom to hire oftentimes they do not get "very good ones" (personal communication DSHS).

Therapists often are employed part - or full time by the tribes. A number of factors other than profit motivate for-profit providers to become involved in less lucrative areas of mental health in tribal settings. For some private health care experts motivation is the same as for NGOs and public-sector providers, the desire to improve people's health and well-being, advancing public health goals. As one private therapist said, "We are providers in tribal settings because we want to help and do what is best for tribal people (personal communication)." Moreover motivational factors for some mental health care providers and managers can also be personal reasons such as respect or good standing and status in tribal communities and building alliances between the tribes as well as the state and tribal sectors.

What became clear through the interviews is that a number of the therapists desiring to work within tribes have not a fact based image about the tribes but a romanticized notion of the American Indian. An MHD professional said that often the therapists "take more from the communities than they have to offer to them." (personal communication) A Skokomish therapist described:

> "Sometimes they get folks coming in looking for the wrong ways, looking for themselves more so than for the tribal community. They come in kind of with the mentality that they come in and save everybody. Therapists come in with the best of intentions but they get this mentality we are all screwed up and we are going to heal all of this and fix all of it. Because they can identify with the Native lifestyle so they come in and the difficult thing is they stay for years. They were given this position and stay for years. So folks start to know them and feel comfortable with them so I think they end up being accepted as doing a good thing. I think the tribes are still vulnerable to these types - called exploitation. So these guys they stay forever and they stay for 10-15 years and they give therapy and are accepted doing a good job because they are there and have knowledge in therapy. Probably the most benefit though is for themselves and then they walk away being Native American experts and the community is no richer for them being there. And that happens a lot and they have the same personality types come in. This used to amaze me sometimes. For one thing I think people are starved for culture too. And that's part of it. So just work at a tribe and get some of that culture. And that's what happens too. They get pulled into their culture and get pulled in their community and they stay" (personal communication).

On the other hand it was reported "there are some very good non-tribal therapists" who work for the tribes who "respect the culture and the differences" and were stated to be successful

because “they are wanting us to learn to remind us to giving more than they are getting.” Relationships like these were reported to be “the key to healing.” People can openly talk without fearing power issues or the hierarchical structure between patient and therapist. A therapist summarized this:

> “I am not that guy following up that power thing too much. And I think that worked for a lot of folks when you get in there and just realize hey this guy is okay. Find something with them in common a little bit. There is sometimes that understanding of power that makes it difficult for a relation to form” (personal communication).

Providers play a critical role in delivering services to Native Americans, as they are often the first point of contact for individuals seeking care and treatment. As noted, ensuring that health professionals are available, properly trained, culturally competent and knowledgeable about the Native communities they serve can have an important impact on health care delivery and quality. Therefore staffing and adequately trained workforce is crucial for mental health facilities. The tribes’ staffing strategies for their mental health programs are diverse. Usually tribes require their professional staff, such as psychiatrists, therapists or nurse practitioners to be certified or licensed by the State of Washington. Most mental health providers at American Indian mental health programs are non-Natives who were formally trained in universities. The availability of AI/AN mental health workers such as psychotherapists, psychiatrists, nurses, and counselors is approximately 101 per 100,000 members of Indigenous groups versus 173 mental health providers that are available per 100,000 for whites (MANDERSCHEID and HENDERSON 1998). There is not enough data available to indicate whether ethnical similarity of providers plays a role in American Indians’ care seeking behavior (see below cross-cultural issues affecting mental health services). Considering the historically tense relationships between American Indians and mainstream institutions a preference of the Indigenous population for ethnically matched providers can be expected. However, only few Native experts have been trained to meet tribal needs. American Indians are seriously under-represented in the core mental health professions (PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH 2003:50). Only .0003 % of physicians in the U.S. are members of an Indigenous group which comprises 1% of the population (U.S. DHHS 2001:91). As of yet few Native Americans have had the opportunity to pursue professional training in mental health. Particularly striking is the scarcity of Native American psychiatrists. In 1996, only an estimated 29 Native psychiatrists practiced in the United States. This number has increased over the last few years. According to American Medical Association data, as of May 2009, Native Americans make up 0.1 percent of U.S. psychiatrists (YAN 2009:16). An Indigenous medical student interviewed at PRIDOC stated about the reluctance to study at mainstream universities:

> "The system is racist, we get through it, but do not like it […] It hurts to get through the process, because of the deficit model and non-compliance […] I do not want to be a doctor who happens to be Indigenous but an Indigenous doctor"(personal communication).

6.2.2 Access to mental health care and insurance

Today it is recognized that the (timely) access of disadvantaged groups to health services is very important for the satisfactory performance of the health systems, in terms of their efficiency in the allocation of resources and of the health outcomes of the population. Without (timely) access enormous costs in mortality and disability are generated - cost which have to be borne by the State and society as a whole.

Barriers that deter mentally ill people from accessing mental health services are economic barriers (poverty level, employment related, etc.), fragmented services, high costs, and societal stigma, cultural and historic factors as well as geographic location and inadequate transportation.

Due to demographic factors across Indigenous groups such as age, education, family structure, work status, and family income Native Americans are particularly disadvantaged with respect to access to health care due to lower than average levels of education, high unemployment, and lower family incomes than other groups. Access to health care has been identified as a major barrier to eliminating disparities in health for racial and ethnic communities. Native Americans have had less access to health services than do non-Natives resulting, partly, from lack of health insurance. Health insurance coverage and the inability to pay for care are key indicators of access to medical care (AIHC 2003:1). Access to care looks at how probable the use of offered services is in respect to need. (BROWN, OJEDA et al. 2000). Having insurance provides people with greater access to services than those who are not covered. Through Washington State's mental health parity legislation of 2005 and 2007 public and private insurance programs have started to eliminate barriers so that mental health services can better be accessed when and as needed. The legislation requires health plans to cover mental health services in a manner that is comparable to other health services in its scope as well as limitations.

The nature i.e. details such as coverage limits is important to assess accessibility. However few studies of ethnic groups provide this level of specificity. Data on current patterns of health coverage among American Indians also is limited, in part, because of their small numbers and wide geographic dispersion in the U.S. There is an increased likelihood of being uninsured for Native Americans (prior to the implementation of major U.S. health care reform planned in 2010 by the president Obama legislation). AI/ANs had the lowest insured rate of any racial and ethnic group in Washington (AIHC 2003:2). Being uninsured has a large

negative impact on the quality of health care individuals receive (U.S. DHHS 2008:10). The U.S. Census Bureau reports in 2008 that nearly one-third, according to data, 809,000 Native Americans and Alaska Natives had no health care coverage. This corresponds to a 3-year-average (2005–2007) uninsured rate of 32.1 percent. That's more than twice the national average of 15.4 percent (DENAVAS-WALT, PROCTOR et al. 2008:21). Most especially poor AI/AN (25%) were reported to be relying on Medicaid services as the primary source of coverage (BROWN, OJEDA et al. 2000). Less than half of the uninsured Native Americans report IHS clinics to be their source of coverage. Most reservation-based members of a federally recognized tribe nationwide rely on the IHS to provide access to and receive their health care from the separate IHS system (U.S. DSHS 2004:24). Capacity, hours and staff are limited though. Many Native Americans who use the Indian health system have access only to limited outpatient primary care services. IHS providers are located predominantly on or near tribal reservations that are in rural areas of the U.S. Since over half, about 56%, (HEATON, CHADWICK et al. 2000) of the AI/AN population now live in urban areas, many IHS providers are not geographically accessible to urban Indians (FORQUERA 2001). Limited access to health care services and a frequency of poor health have been documented in studies on the urban American Indian and Alaska Native population.

IHS services are less accessible due to the changes related to Indigenous self-governance endeavors (P. L. 93–638) which involves a reduced possibilities to get back private expenses, Medicare and Medicaid which affects financing and availability of health care services (U.S. DHHS 2001:91).

Moreover, nationally, only one-third of Native Americans have a regular doctor or clinic as usual source of health care. Health promotion or preventative medical interventions thus are limited. A situation that particularly concerns IHS-eligible American Indians rather than the privately insured (BROWN, OJEDA et al. 2000).

Furthermore with a value orientation that emphasizes the spread of wealth instead of directing it towards personal gain there is no asset building. Money usually is shared or spent at once. In case of an emergency the individual usually does not have anything to fall back upon which makes an episode of mental illness even more stressful when the community network is not fully able to support the individual. Getting the best of care thus mainly remains unachievable for Indigenous nations in which the concept of sharing is deeply ingrained but who live within and vastly depend upon an overall structure that "esteems an ethics of saving accentuating the personal acquisition of wealth" (personal communication). Additionally, persons with mental illness are vulnerable to exclusion because of the specific nature of their mental health issues, which isolate them socially and lead them to self-exclude

in order to avoid discrimination. Even though all populations with mental health issues are affected by these barriers fears of experiencing cultural discrimination by individuals and institutions in the treatment setting as well as attitudes against treatment and mistrust are barriers preventing especially American Indians from seeking and accessing services and receiving proper treatment. People are hesitant to talk about mental health issues. Anonymity issues also compromise access to the mental health services that are available. A participant in the NIH study commented on seeking help for stress related issues, "You can't go to a local support group where everyone knows you. I'd rather go out of town [for services] to keep my anonymity." In bigger communities, nobody knows if and where people are going for help. It's easier for people to find out in a small community. One NIH study participant expressed her anxiety on arriving to one CAM treatment session that she saw somebody's car parked at a health center in Olympia, WA assuming that the person has gone there to get help. A Native health expert expressed in a personal conversation a similar issue that "even though they [Natives] have no relationship with the therapist and that person does not know them, still feel uncomfortable with their file being there".

As a result of the size and scale of Indigenous communities there is not the sort of anonymity that protects the practitioners' professional role in large cities. This anonymity provides privacy and safety for clients who wish to talk about embarrassing matters. It also allows the counselor to have some respite from being constantly available. In some communities counselors are often seen in social functions and can even relate to the people they are helping and have no way to step back from their role; which can rapidly lead to burn-out. One therapist commented: "When I worked in my own tribe sometimes it seemed I just knew too much. These folks were my relatives. So I did a lot of work in other tribes where I was not so emotionally involved either. So that worked well."

Likewise it was stated that it is not easy to go out to seek help for people who have a mentally ill in their family or close friends they do not know how to react to or correspond with in an adequate manner. This can be due to several reasons, lack of knowledge about resources available, lack of financial means, lack of time or stigma. A need to learn more about this was expressed.

There did not seem to be so much stigma attached to mental health and seeking out help on the reservation. A Native therapist described about his work on the Skokomish reservation: "People did not mind coming in and seeing the therapist. People would more freely access the services, kids would come in sometimes after school and sit down and say how is it going and would feel comfortable coming in. Sometimes Native consumers would just come in on a visit having a bad day and ask if there were someone to talk to."

Furthermore tribal institutions are highly aware of Natives' aversion of waiting and standing in lines. Tribal clinics have a house of the open door policy. That in their opinion is what makes a good quality delivery and reduces potential stigma for people seeking care and makes access much easier for people in need, especially when in a crisis situation. Stigma is also reduced through the high visibility and presence of therapists in Native communities which leads to therapists and tribal members knowing each other. One tribal health expert described:

> "It is really not much of a deal to go in and see a therapist, there is my therapist, it is not that big of a deal. At Chehalis we have the health clinic and the mental health, social services, the dentist, all is in one building so if you are there you could almost see anybody…. In the tribal communities the programs are smaller folks are more likely to access services as in the mainstream" (personal communication).

Tribal institutions are also aware of a great aversion of Natives to paperwork. This was explained by the fact that tribal culture is basically still more of an oral culture and lower educational level as well as negative experiences in history with treaties sales, etc (GUILMET and WHITED 1989:84). Because of this background culturally appropriate case management in some tribal clinics provide more personal, direct assistance completing necessary paperwork to increase access to mental health services.

Not any tribe could be identified who has its own RSN Designated Mental Health Professional DMHP (a psychiatrist, psychologist, psychiatric nurse, or social worker and such other mental health professionals as defined by WAC 388-865-0150 "Mental Health Professional"). DMHPs come out to tribal lands and do an assessment for a person who is suicidal. This was found to poses ongoing problems. Psychiatrist services oftentimes are contracted with a psychiatrist visiting the tribes once a week or once a month for a day or a few hours or to see special cases, primarily for prescribing of psychotropic medication. As a result health care resources lack consistency. A Skokomish health professional explained, "A psychiatrist comes in once every four weeks and treats lots of people." Even though the psychiatrist does not remain in the community long enough to build relationships with the locals and whose earnings provide no economic stimulus, access to services is increased as tribal members do not have to go out to other agencies for medication. Seeing a contracted psychiatrist who has a tribal consumer on medication oftentimes just takes half an hour of waiting. Generally there is not such a long waiting list which increases efficiency.

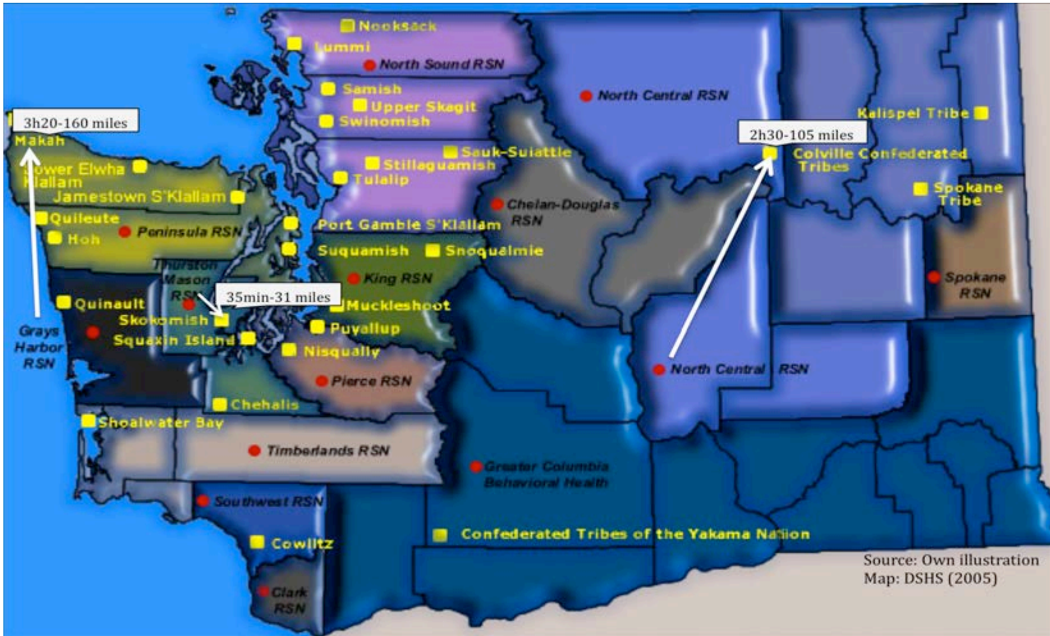
The tribal mental health care system reported a higher practitioner/patient ratio. The Skokomish e.g. have two therapists on staff for a community of 700 community members. Similar numbers apply at Squaxin as well as Chehalis, who have two therapists for 700-800 members. Despite the good ratio the drawback is the low number of practitioners, described

by a Skokomish father: “When I take my kids there I kind of have to like one or the other therapist because obviously there is only two to chose from. So in my case I took my son and went to a private therapist and paid out of my own pocket for the private services, so people do that. A lot of the tribal folks might not know about private services and just go with what is available. I would just go to the best services that are available. There are not so many folks who would seek services outside of the tribal area. It is also a matter of cost. It might get pretty expensive, it is cost issues. Well, here it is anywhere around $100-$150an hour. It depends on the levels of training. When you go to a tribal program it is free.”

When going to the federal system, Behavioral Health Resources (BHR), the consumer, if eligible, goes through a process that might take days before able to see a therapist unless it was urgent. The biggest differences between a tribal program and state, community mental health programs an MHD expert stated is that, “In that respect accessibilities of tribes is much greater and much better which is absolutely crucial and that influences the use of services too.”

As to what regards timely access, accessibility of services in case of emergency within the RSN system varies considerably.

Figure 15: Regional Support Network (RSN) - Suicide Intervention



Geographical distances and logistics are an important issue. The Chehalis tribe is only 40 miles away from Grays Harbor RSN of which a very good relationship was reported. A client at Chehalis who needs an assessment or is suicidal waits probably not more than an hour to do an assessment. The Quinault tribe, located out at the coast also needs to get someone from Grays Harbor RSN to come out. However, the Quinault reservation is 160 miles Northwest from the Grays Harbor RSN and thus less accessible. There is the Olympia based Mason RSN

for the Skokomish tribe which is very conveniently located 31 miles north of the RSN. The tribe, however, does not have a good relationship with the RSN. Therefore they are not using the services. The Yakima are relying on the Columbia mental health which is very far away from the reservation so it goes into the hours time it takes the service to get over to the tribe. This has negative effects on the relationship.

The most extreme waiting time for the emergency service to arrive to give professional support when facing acute crisis was experienced by a tribal member from Colville. It was reported it took the RSN provider who is to provide to the community mental health agencies the assessment for somebody who is suicidal six hours to come out to the reservation. This poses several challenges as by the time the RSN gets there the situation can be much different and the Native person might no longer be in need or available. A Snohomish therapist explained a case in which by the time the RSNs arrived the patient had settled down:

> "One day they came out and concluded he is okay right now and not endangering himself or others at that time. We could monitor him to see whether he is doing okay instead of around the clock in an inpatient center" (personal communication).

A survey or data does not exist yet of how many Native people are accessing RSN services and how accessible they are by Natives in general. The RSN does not necessarily document that they provided service to a tribal person even though the RSN should document it.

Apart from variables such as distance and acceptability, mobility of patients is important when analyzing access to services. Transportation to mental health providers has to be considered. AI/ANs like thousands of individuals in Washington State have special transportation needs as a result of disability, poverty or age. Public transportation is lacking in many regions though. A tribal program manager at South Puget Sound Intertribal Planning Agency (SPIPA) explained that "only few can afford a car or are able to drive." Especially elders need to have someone to drive them to obtain any services. To attend community meetings or cultural events at other tribes some tribes provide financial support for gas. Transportation facilities in Washington are owned and operated by the state, cities, counties, private business, and tribal governments (Washington State DOT 2007:1). There are 28 public transit agencies across the state providing regular fixed route services (Ibid:28). Most reservations, however, on which the tribes must manage and provide transportation services to their communities do not have public transportation and transit systems. Also the geography of some reservations makes transportation difficult. The Indian Reservation Roads system consists of all roads that directly serve tribal communities and Indian reservations. There are 5,021 miles in the Indian Reservation Roads system, which comprises 16.13 percent of the 80,986 miles of roads in Washington State, according to the 2005 Tribal

Transportation Database Project conducted by the Washington State Department of Transportation in coordination with the Tribal Transportation Planning Organization (Ibid:30).

In Thurston County the two Indian tribes, Nisqually Indian Tribe and the Confederated Tribes of the Chehalis Reservation, and a metropolitan planning organization (MPO) Thurston Regional Planning Council (TRPC) have shown willingness to work together to improve transportation service in the rural county where reservations are located. Coordination between the tribes and TRPC also relates to mapping so that data is provided to guarantee that the tribal areas are consistently shown on maps designed by TRPC. However maps with main public transportation services only exist with some county providers, not for the region as a whole which contributes to the difficulty to cover broader distances using public transportation.

Figure 16: Map of Thurston County

Courtesy of TRCP

Thurston County transportation services are amongst the best in the whole country, honored as number one in midsize class by American Public Transportation Association (APTA), the national umbrella organization over all the public transit agencies. Accessing the tribal clinic at the Nisqually and leaving that reservation on public transport is the easiest out of all the reservations in the region. City bus no. 94 from and to Olympia (11,6 miles one way) leaves about every hour. Rural transportation system also runs through the Nisqually reservation to destinations in a two mile radius within the Nisqually reservation area. It is an on demand service which has no schedule but picks passengers up at home or as close as possible at a time prearranged with a 24 hours in advance booking service. The bus travels on no set route and the traveler is dropped off where he needs to go within the covered area. Tickets are at $1

for every ride. Services are offered from 6am-6pm on weekdays. A map of the service area is under construction.

Visiting the Chehalis tribe located about 29 miles south of Olympia by car takes only about one hour one way. The return journey using public transportation and returning to Olympia in one day is a challenge. Depending on the day of the week transfer can be impossible altogether. When trying to leave the reservation and visit clinics or providers in urban areas the same holds true.

Similarly challenging is the situtaion to visit the Olympic Peninsular by public transportation. Using Grays Harbor Transit to switch to Jefferson transit from Forks to Olympia (94 miles) can involve up to 8 hours of travelling and transfer time when leaving Forks at 9:30 am to arrive in Olympia at 5:30 pm.

To sum up, in line with the President's New Freedom Commission on Mental Health's recommendations in its Interim Report to the President, the way in which mental health care is delivered in the U.S to has to be fundamentally transformed for improving accessibility to good quality care and services (2003:4). Improving access to quality care is particularly important and urgent for Native Americans.

6.2.3 (Under)utilization of services

Utilization of services is defined as "the extent to which a given group uses a particular service in a specified period."[30] Utilization is understood as a combination of the previously discussed themes - need, accessibility, availability and appropriateness. Representative community studies on utilization of services of American Indians have not been published. Therefore the data regarding the use of services by American Indians and Alaska Natives who suffer from mental disorders in Washington State is limited. To analyze mental health service efficiency to meet the needs, national data generated may yield some information even though comparisons due to differing rates of mental disease may not be accurate.

The current use of inpatient facilities is not fully documented. Inpatient needs of tribes in the State of Washington are not clearly defined. It is acknowledged though that improving access to the inpatient system is an important issue to tribal-based mental health care programs. Due to the fact that the Pacific Northwest does not have an IHS hospital, Tribes must purchase all inpatient care and the vast majority of specialty care from private health care providers

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[30] utilization. (n.d.) *McGraw-Hill Concise Dictionary of Modern Medicine*. (2002). Retrieved September 2 2011 from http://medical-dictionary.thefreedictionary.com/utilization

using IHS-funded Contract Health Service (CHS)[31] dollars (AIHC 2007:2). Inpatient treatment is provided by the state through community hospitals statewide. Eastern Hospital in Medical Lake and Western State Hospital in Lakewood are two such adult state-run hospitals which are established to serve the most severely ill or those individual to be evaluated or treated who were sent by state courts. Due to a shortage of funds, there is only a limited number of beds available. Trying to get somebody into inpatient psychiatric treatment was described as frustrating. The Puyallup Tribal Health Authority offers a 30-day primary residential program which is the first certified intensive inpatient chemical dependency program for Native Americans in Washington State. Inpatient care and referral specialty care are authorized for eligible individuals by the Managed Care Service operated under P.L. 93-638 authority. Under the current structure of the State of Washington's Inpatient Mental Health Care System, a designated non-Indian outpatient facility must assess all customers to gain admission to an inpatient bed.[32] For American Indians that may require admission to an inpatient facility after receiving outpatient treatment at tribal-based mental health care programs. This structure creates significant barriers. As stated earlier, American Indians have access to both tribal-based outpatient programs as well as the RSN system. Due to cultural competency issues they tend to choose the services of American Indian mental health programs. When a customer in a tribal-based program is in need of inpatient care, the American Indian mental health program must negotiate with the designated RSN provider to access a bed. The DMHP comes out to the reservation to assess the Native person in need to decide whether he can voluntarily be taken to a facility. Two issues with this structure were found. One is the fact that the RSN provider may not have any prior experience serving American Indians nor has he witnessed the earlier behavior of the Native customer who might behave differently and deny earlier comments when taken offsite out of his comfort zone away from the tribal community. The other is that RSN providers routinely disagree with American Indian mental health program assessments attributed to poor communication and relations and a lack of cultural competence. Hence it happens that a needy tribal customer is denied access to limited RSN inpatient beds. These and bureaucratic obstacles in dealing with the service providers, tribal health experts stated, leads to "a lot of people who practice self-care."

Smaller studies found that, of AI adults with a mental disorder, 32% received mental health or substance abuse services - about the same as the overall U.S. population. The likeliness for

[31] CHS are services not available directly from IHS or Tribes that are purchased under contract from community providers, including hospitals and clinical practitioners.
[32] There is one partial exception to this current situation. The North Sound RSN has worked with tribes to develop a model where tribal-based mental health programs can initiate voluntary admission to inpatient services. Two tribes are currently utilizing this model, which will be discussed in greater detail in a later part of this section.

racial and ethnic minorities in the U.S. to seek mental health treatment has been documented for years to be lower compared to whites. This largely accounts for under-representation of AI in most mental health services (VEGA and RUMBAUT 1991). Furthermore those American Indians seeking care were found to have a significantly higher non-return rate after the initial contact than was observed for other ethnic minorities and white customers (U.S. DHHS 2001:85).

There are several historical, current socioeconomic factors and mistrust of institutional sources of care as well as traditional conservatism and resistance to ideas from outside that may influence utilization of services by Washington State's tribes. A main reason why Indigenous groups tend to underuse existing health care services interviews showed is, apart from the afore mentioned difficulties associated with transportation and communications, furthermore due to these services failing to recognize cultural differences being fundamentally based on concepts of Western medicine and lacking traditional Native American concepts of healing.

6.2.4 Acceptability of mental health services

This section asks about and relates racial and ethnic differences in usual care services and barriers to obtaining needed health care. Barriers to mental health care are not limited to issues of availability, access, or cost. As noted cultural differences between patient and provider in regard to conceptions of health and illness may also impede both help-seeking and treatment effectiveness. For example, spirituality is a core system of belief—focusing on intangible elements imparting vitality and meaning to life's events—that is so essential to Indigenous groups and is pointedly absent from the perspectives that guide the bulk of available mental health care. Moreover Indigenous people have a different idea of e.g. addiction. They regard substance use as a chronic illness and not a moral or solely genetic issue as supported by providers of mainstream health care.

Appropriateness is defined as receiving an accurate diagnosis or guideline-based treatment (HYNMAN 1975:270). For a treatment to be appropriate it needs to be in line with evidence based publications on outcomes which are approved by a governmental agency or conform to a set of guidelines that have been compiled by mental health associations regarded professional in the field. Even though there has been an increasing number of guidelines to guarantee evidence based care for treating mental health disorders these guidelines are based on evidence from mainstream clinical populations in which few American Indians are represented. These professional practice guidelines do not specifically take into account the

specific realities of ethnic minorities and the cultural aspects that influence psychopathology, however they the most comprehensive recommendations existing for American Indians concerning appropriateness of treatment.

It is arguably more challenging for a mental health professional to diagnose a mental disease compared to other fields of health. Diagnoses depends on three components which have to met: subjective complaints of the patient describing the symptoms, signs that can be observed by others as well as behavior relating to distress (APA 1994). Diagnostic criteria used in the evaluation of a patient's symptoms have to correspond to criteria used in a classification system, the DSM-IV, compiled by the American Psychiatric Association. The DSM-IV is most widely used nationally as well as internationally (MASER, KAELBER et al. 1991). The DSM–IV provides clear guidelines for addressing cultural matters in mental health care specific to the American Indian population. The applicability of the DSM has been questioned though, considering the diagnosis of mental illness among American Indians (NELIGH 1990:25). Some Native American languages do not include words such as "depressed" and "anxious" (Manson et al., 1985). There are different understandings of mental disorders in Native culture so that diagnoses in the DSM, such as depressive disorder or other culture bound syndromes (sets of symptoms which are more prevalent in some ethnic groups than in others) are not congruent with American Indians categories of illness. There are different conceptualization of mental health which e.g. include ghost sickness and heart-break syndrome that are expressed in culture specific ways (NELSON and MANSON 2000). Likewise one Indigenous therapist expressed his concern about the failure of the RSN system to understand patients afflicted by spirit illness, which is a concept not known to institutional psychiatry. Customers are retained in the mental hospital. Symptoms of spirit possession treated for major psychiatric disorder. Research is needed to understand culture specific expressions of suffering which can be assessed and treated when incorporated into the DSM–IV as well as accurate diagnosis and outcomes of guideline-based psychiatric care of AI groups which has not yet been studied. Cultural appropriateness means that all policies and procedures used in the delivery of health care should be acceptable to all concerned, i.e. herein satisfy the essential health needs of Indigenous people, by using methods acceptable to them. Thus foremost cultural acceptability is concerned with whether the health care recipients perceive the service provided to be acceptable and culturally appropriate. In order to understand the need of culturally appropriate healing services the complex medical belief system as described earlier has to be fully understood.

In the delivery of mental health services the importance of culturally competent care is probably greater than in any other health sector. Cultural issues and communication between

customers and providers in mental health are a critical part of the services themselves. Culture can lead to variations in reporting of symptoms by consumers. More often, culture even bears upon peoples' help seeking behavior, coping styles available social support and amount of stigma attached to mental disease as well as what their strengths are, such as resilience. The cultural diversity existing among consumers of mental health services are brought into the treatment setting.

Many in the mental health field therefore perceive cultural competence as an essential component for good quality of care among ethnic and racial minorities. In order to establish an environment of cultural safety developing trust is paramount within the relationship between a therapist/psychiatrist and the person he or she seeks to help. Cultural competence therefore is considered the cornerstone of American Indian mental health programs (GUILMET & WHITED, 1989; NELIGH, 1990; SWINOMISH, 1991).

Culturally competent programs offer services that are aware of significant differences in lifestyle and worldview of racial and ethnic minority groups. They are responsive to cultural concerns, including traditions and diversity of beliefs and practices that abound in Indigenous communities as well as their languages and histories (U.S. DHHS 2001:146). These programs take a holistic, or whole body, approach in service delivery, and address many mental illnesses that are common to American Indian populations, including those illnesses not yet formally recognized by Western medicine. Psychotherapeutic methods are designed to be culture specific for a particular ethnic clientele, or congruent for problems believed to be especially prominent in certain ethnic groups (MANSON 2004:x).

Within the RSN system several problems exist rendering it difficult to effectively treat mental disorders. Program delivery models reflect predominately Western European concepts of [mental] health and illness. Even if Indigenous people have constructed a coherent and complex medical system out of disparate biomedical and Indigenous medical systems delivery models have been reported to be not efficient in responding to the needs of Indigenous people (WARRY 1998). Unstated Western principles on which mental health systems typically operate and which are at odds with the underlying values and beliefs of American Indians are for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body, and devaluing of altered states of consciousness. Without awareness of the dynamic of different values and beliefs, mental health providers thus are stated to "impose this Western framework" on Native consumers (MANSON 2004:x).

Furthermore non - Indian prevention and intervention programs are housed in intimidating non - Indian surroundings removed from the central support system. Many Natives are not accustomed to and even afraid of seeking services outside of existing Native social services providers. Practitioners in these programs are extremely overloaded with patients which results in long waiting times for customers. This might put customers off seeking the treatment. Overloaded practitioners' schedules means they have a precisely defined time within which they can see the patient. Natives though have a different understanding of time. They frequently do not show up or might show up late for appointments which makes treatment coordination much more problematic. Rigid time schedules can be an alien concept to a Native person who feels rushed and not treated with due respect. This was stated keeps the Native customer from expressing problems which affect him/her.
Also time issues make it hard for practitioners to find the time and energy necessary to understand and treat the psychological and social causes of individual dysfunction instead of treating the symptoms only. Thus they are emphasizing biomedical interventions rather than alternative forms of nondrug healing. Most non-Indian therapists in the programs do not recognize and utilize nor do they have access to traditional healing practices.
Due to the absence of cultural and spiritual sensitivity the RSN system fails to provide culturally competent mental health services to Washington's Indigenous populations. Thus these mainstream services lack acceptability.

In the following cultural competence with tribal mental health programs is analyzed. As stated before, mental health disorders in tribal communities differ from the mainstream. The extremely high death rate e.g. amongst the tribes due to accidents, illness etc. constantly expose tribal members to extreme stress due to the oftentimes unexpected death of friends and family. Therefore a lot of griefwork needs to be done on the reservations. Death may traditionally be viewed as "part of the natural way of things" (GUILMET and WHITED 1989:75) due to acculturation, however, many of the grieving patterns, such as open and overt grieving, have changed. With people becoming stoic and not crying as this along with the beliefs in mainstream society is seen as a sign of weakness makes the tragedies even harder to cope with.
When attending a funeral at the Nisqually Indian tribe the community support was clear from the high number of people present, singing, drumming and being close to each other. The clinic's personnel shut down formal office operations all day and were attending the funeral to join in the ceremonies and be there for family and friends providing support and counseling on a personal and informal basis. Mental health practitioners provided their

mental health support without people attending the funeral even being aware of it. This embeddedness in culturally meaningful events in the community leads to high acceptedness of this community/family-based mental health care system. Seeking mental health care from professional practitioners becomes more acceptable. Thus stigma is reduced. Respect for tribal culture and cultural sensitivity of the personnel, actively participating in tribal events and demonstrating membership in the community furthermore gives them greater access to ongoing traditional healing ceremonies among the tribes of the Pacific Northwest which are not easy to gain access to by clinical personnel. This further enhances their competence as culture is best understood through direct interaction. Qualities of open-mindedness, communicativeness, flexibility and adaptability thus are developed.
Like mainstream mental health programs, American Indian programs employ the diagnostic manual, the DSM-IV, in daily practices. Providers in American Indian mental health programs routinely use a mixture of Western and traditional approaches to serve customers. "Western treatments are often used concurrently with native interventions--one to cure a problem and the other to restore harmony" (KELTNER 1993:20). How traditional and Western approaches are applicable often depends on the client's degree of acculturation into mainstream society. Assessment tools therefore cannot be rigid in the way they apply the tick-the-box approach but ensure to be culturally relevant/ safe. As a result, mental health providers who serve Native American customers must have a familiarity with Native people or the specific community the customer is from to perform the necessary assessment of the level of a customer's acculturation. A task which a mainstream provider, is hardly able to. Then the practitioner can refer the client to the best resources, be it traditional, Western, or a mixture of both (STEENHOUT 1996: 61).

6.2.5 Cross-cultural issues affecting mental health services

Confidence amongst AI to get care when needed as well as satisfaction with care provided to them and their families is lower. Communication problems are reported to exist with their health care professionals. Apart from historic conflicts difficulties in cross-cultural communication often are at the root of Natives not trusting non-Native agencies or professionals when seeking mental health support which is mainly cross-cultural (GUILMET and WHITED 1989:90). [Cross-cultural mental health service delivery occurs whenever two or more of the participants are culturally different (MANSON 2004:xiii)]. Cultural issues affect both, those who seek help and those who provide services. The culture of the provider is as important a focus as that of the customer. Providers embrace a culture of values, norms and shared beliefs upon which communication is based. It is not possible to be culturally neutral

in any clinical encounter. Providers perception of mental illness, social support and interventions for disorders may differ from one another and from the culture of the sick individual. Comparable to therapeutic settings where a married heterosexual service provider brings a very different worldview and set of experiences to the counseling relationship than a single customer who is homosexual.

Many providers lack awareness or knowledge regarding culturally appropriate policies and practices and are not adequately trained provide services to culturally diverse groups. The Native consumers realize that the practitioners cannot relate to their problems and feel alone in their attitudes contrary to mainstream American society's believes. Providers who are not familiar with Native conversational styles and specific needs cannot openly discuss internal conflicts of value. Opportunities rarely are promoted that allow to note and discuss the similarities and differences of Native American consumers between colleagues. Providers asked about how they perceive the mental health of American Indians to be different from the general population reported though that American Indians show differences in religious beliefs and cultural and social value systems which are poorly understood or accepted by the general population. Another difference that was noted is that apart from the mental health needs that are different expectations of Native families and communities lead to individuals having to meet different personal and social needs.

Communication barriers are based on differences in verbal and nonverbal styles. Some Native American consumers feel they have given very clear messages to providers who have not understood the communication. The communicative structure of Natives can be characterized by using words sparingly. Small talk is not a common concept. Silence seems completely acceptable. However, silence also is the point of resistance. Nonverbal communication is very important which is crucial to properly speak and understand. While crossed arms in mainstream culture may mean the person is defiant, in Indian culture it means the person is thinking. Natives are very empathetic and haptic personalities. They like to touch each other which is unthinkable and ethically inappropriate in mainstream professional relationships. Upon greeting each other or at ceremonies people freely hug or touch each other as a sign of empathy or joy.

Moreover Native tribes have developed a remarkable sense of humor which can be labeled as a coping mechanism and definitely is a powerful survival tool which helps to make light in the face of adversity. This quality often is not properly understood by providers, however, when developed by a practitioner is highly appreciated by the tribes.

Verbal communication focuses on personal interaction. Direct questions often are avoided. Instead people engage in longer and more supportive conversations. The use of scientific,

professional vocabulary is stated to put customers off and distract them from the therapeutic relationship they seek to have with the practitioner. The clinical was described by a Seattle community leader to have "dehumanizing effects."

Indigenous people belong to person-oriented not information-oriented cultures. They prefer to interface with people not machines and do not appreciate providers sitting in front of their computers, looking at the computer screen instead of actively focusing on the consumer. Superficial therapeutic relationships described as they "call you by your first name without being interested in you" is not appreciated or understood.

Native Americans assess the person they interact with based on the ability the individual can relate to them personally, on that base either respecting, ignoring or avoiding the person and service offered. Thus they put the relationship they have with the therapist over and above how that person will perform in that area. Native patients may even temporarily give up their own health care practices and beliefs in order to satisfy the expectations of mental health care providers. In the end, however, many will discontinue treatment they understand to be contrary to internalized cultural values. This can lead to Native customers walking away from a service they desperately need. As a result, even though there are high occurrences of mental health problems in the American Indian community, more than half of those people experiencing these problems do not further seek help. Those that do seek help tend to first consult with someone from church or traditional healing methods/ persons.

It generally takes much longer for Indigenous consumers to feel safe and open up in their communication as they need to build relationship to the person before they share any oftentimes deeply personal or intimate experience or story. Some providers experience that initially it can be very difficult to establish a therapeutic contact with Native consumers unfamiliar with Western or mainstream mental health services. They might not be willing to talk much because they either appear frightened or defiant, suspicious, and hostile looking upon the therapist as "just another authority figure they had to defend themselves against." Even within an alternative therapeutic setting such as the NIH study people opened up only after the fifth session. One researcher describes her experiences during the Caregiver Study: "One man all the way out from the coast was not easy to work with. He did not want to do the questionnaire or talk on the phone about the study but I had to go there and read the questions out to him."

All this suggests that many in the American Indian community are distrustful of the broader mental health provider agencies. Ethnographic studies amongst two Pacific Northwest tribal groups identified trust issues between AIs and the IHS (Strickland, 1999). In which many community members stated they felt they were not receiving appropriate care. Native

Americans want American Indian providers or at least providers who are sensitive to American Indian culture. Interviewees' comments illustrate Natives wanted mental health care providers who take the time to respectfully listen to them and not dismiss or disparage their views and experiences as expressed by the following statement: "Therapists tell the Native customer that there is nothing physically wrong, his problems are 'all in the head,' at an early stage in the treatment process without properly knowing the person."

Another limiting factor in the establishment of a therapeutic relationship is the attitude to resolve individual problems on their own. Growing up in an Indigenous cultural context means learning through individual experience of trial and error not through being told not to do something. According to an Indigenous healer the only way for an Indigenous person to fully consent to any kind of treatment is "when his spirit is ready to accept good health" and the individual "accepts the suggestions of the provider as his own" as it is believed that "only the individual, not the mental health professional, has the answers for his problems." Oftentimes, people working with Native Americans do not appreciate this characteristic of many Native Americans that they like to decide for themselves, as it is not expected by or common within the Western medical system. Health care workers, teachers and social workers are trained for years in school to "help" others through telling them what is good for them, advice and counseling, have the answer for others. Psychiatrists were described to "in the process of learning to treat problems they forget that we are people" and they forget "the power of intangible aspects of people such as the human spirit." They turn to the prescription of psychiatric drugs when they fail "looking for a fast fix to complicated human problems." Amongst Natives who believe one has to learn how to deal with one's problems, Western trained health care approaches are oftentimes perceived as intrusive interventions or interference and thus are not appropriate or effective because of resistances. This often leads to much frustration by health service and other providers as well as patients. Providers believe that the patients are uncooperative. Patients rather think that often the providers of services are attempting to impose their will upon them. Accordingly patients might be listening to advise or accepting medication out of politeness, which the provider interprets as agreement. However when at home the patients won't do what they were told or do not use the medication as it was never the patients' decision. Overall, local American Indians reported that they felt their voices not to be listened to and dependent on a system of care which they felt not to have in their own hands.

Hence an approach is required that includes a genuine sensitivity, and considers the more traditional holistic approach. To avoid relying on stereotypes about Natives and increase cultural competence, mental health service providers, it was suggested by Native experts,

need to be aware of their own cultural assumptions and develop an awareness of their own racial and cultural heritage. This helps to understand how that heritage influences their understanding and biases about normality/abnormality and the process of mental health service delivery. Also it makes clear the significant impact of differences both in use of language and in verbal and nonverbal styles on the process of communication. Thus practitioners are more likely to ask consumers how they understand their problems and what they need. learning more about the Natives which diminishes the consumers' feelings of distrust (MANSON 2004:x).

Despite widespread acknowledgement of the need and use of the concept of cultural competence, there is not enough data to identify points of disparity. No set standards exist for culturally competent care. Empirical research on best implementation strategies and effectiveness measures are lacking as is research on consumer satisfaction of culturally competent services. Collaborative relationships with culturally driven, community-based providers should be established.
Even when well-prepared and trained mental health professionals express to still not be able to work effectively unless the political situation is discussed as disparities will become more severe if they are not properly addressed. The political substantially determines if the disproportionate burden of mental disorders on Native Americans will subside depending on how the workforce shortage of (Native) providers and researchers is addressed and how adequate training and support can be best provided.

6.3 Health program funding

One of the most severe problems facing the entire mental health system in the U.S. is the shortage of funds to support needed services. Mental health system already is fragmented with half the people suffering from serious mental illnesses in the U.S. unable to find the basic services they need. Significant budget cuts made to mental health threaten to further erode this. (MARK, COFFEY et al. 2005). A total of $1.525 billion ($821 million state) is provided for the operation of the public mental health system during the 2009-11 biennium. The estimated amount needed is stated to be $61 million (4percent) more to maintain the current level of mental health services and activities. Major reductions include amongst others 5 percent or 57.7 million for the community mental health services delivered through the RSNs. Of this total, the "state only" funding for people and services not eligible for the federal Medicaid program is reduced by a total of $23.2 million, or about 9 percent. Staffing in state psychiatric hospitals is reduced by approximately 40 FTEs (1,4 percent). The biennial budget 2009-2011

passed by the Legislature. The Governor proposed her supplemental budget changes in December 2009 expected to trim government spending to make up for a $2.6 billion shortfall in revenue. The money dedicated to mental health and developmental disabilities services is part of the non-protected budget and thus a possible area for more cuts. All federally Medicaid-funded mental health services are optional. In summer 2011 federal money for Medicaid assistance is expected to be cut by about $87 billion (personal exchange with DSHS).

Despite federal government's trust responsibility to Indian nations as provided for in the U.S. Constitution (Article 1 Section 8) AI/AN people continue to be underserved due to a lack of adequate federal funding. Tribes themselves have no tax base to support social services or infrastructure development. Indian health care programs are largely provided through annual funding appropriated by Congress through the Indian Health Service (IHS). The IHS is a discretionary program within the federal budget structure. The IHS historically has not been sufficiently funded to meet all AI/AN health care needs or to provide for the same level of services in all locations (SHELTON 2004:9). Over the past 30 years there has developed a chronic pattern of under funding. With the IHS system also resources to address ongoing operation and maintenance needs are not sufficient. The increasing maintenance backlog (IHS and tribal) is approximately $476 million. The IHS and tribal health programs have not been able to keep up to date systems and building equipment as well as medical and laboratory equipment which is generally used at least twice as long in Indian health service facilities as the average useful life indicates. Programs could not keep pace with the drastic changes in medical practices over the years.

In the IHS system, tribes under a 638 contract operate most tribal-based mental health programs, commonly referred to as "look-alike, stand-alone, IHS 638 programs." The programs receive limited funding from IHS, largely depending on Medicaid billing, third-party insurance, and/or tribal enterprise revenue to operate. IHS spends less than 2 percent of its annual budget on mental health. Health Programs thus are operating at one-third the budget necessary for minimal provision of mental health care. Urban-based American Indian people receive of the limited services that are provided a substantially smaller portion of services than tribal-based American Indians (personal communication).

The federal government spends less per capita on Indian health care than on any other federal health program. IHS clinical services currently receive about $2 billion less than $9,1 billion needed to provide clinic services to all eligible Native Americans. IHS is funded at only approximately 50% of the level of need compared to services available to the general

population. Annually the IHS system provides about $1000 per year per member only.[33] Federal prisoners and Medicaid patients each receive more than two times the amount spent on Indian health care. Varying levels of health services available from Indian health programs can be directly correlated to the availability of funding. Indian Health Service funding is distributed primarily based on population. In addition other factors such as cost of living, health status, and geographic isolation affect the allocation of funds (AIHC 2007:6).

In the following section funding mechanisms that support Washington State's mental health systems as a whole are discussed as well as the need for American Indian mental health programs to have increased access to this funding.
Washington State's mental health is supported by several state and federal funding sources. Research did not uncover extensive funds or readily available services that American Indian mental health programs can access. However some could be discovered. The Center for Mental Health Services e.g. provides grants for mental health services. Some of their discretionary grants have been awarded to Native American tribes in Western Washington. Nevertheless, most mental health (both Western and traditional native services) is funded by the Indian Health Service. Primary funding for all of the tribes in Western Washington to operate their own mental health and medical services is allocated by the IHS. Depending on the tribes, that funding can be supplemented with State funds or third party billing.

In 1976 Congress authorized Medicaid and Medicare payment for services delivered by IHS and programs provided in tribal facilities. A federal law Memorandum of Agreement (MOA) between the Indian Health Service and the Health Care Financing Administration, now Centers for Medicare and Medicaid Services (CMS) implemented tribal billing for Medicaid services. CMS became part of the federal trust responsibility financing health care to AI/AN in the Indian health system. Now tribes increasingly rely on Medicaid, Medicare or other third party revenue source. These payments provide 90 percent of third party revenues for I -IHS /T -Tribal /U -Urban providers (CROUCH 2009:3).
For services provided to AI/ANs in IHS and tribal facilities State Medicaid Programs are reimbursed at 100% federal medical assistance percentage. In cases where Native Americans are covered by health insurance, however, it is difficult for tribally operated programs to receive Medicaid reimbursement. For example, many individuals who otherwise qualify for Medicaid have dual diagnoses that include alcoholism, complicating billing, and

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[33] In 1999 the IHS and tribes developed a methodology to identify the resource shortfall for IHS-wide and each Indian health program and found that $2,980 per person is needed to assure annual benefits equivalent to those in a mainstream health plan.

compensation. The dated and limited written policy guidance about the relationship between tribes and Medicaid funding is a further current issue. Also a lack of alignment of Medicaid and IHS mission, goals and policies exists. Moreover regional staff misunderstand the political status of tribes and have limited experience and knowledge of working with tribes as nations, not providers.

Needed direct care that cannot be provided by the IHS or tribes, is purchased from private and public sector providers under a contract health services (CHS) program. Patients must seek care outside of the IHS system when e.g. problem drinking and substance abuse related injuries are so severe that IHS and tribal facilities cannot provide the needed services.
Using these services often leads to substantial additional medical costs. Private and public Medicare participating hospitals providing CHS services to AI/ANs are paid at reimbursement rates similar to Medicare payment rates. CHS funds are so limited that the CHS account is funding only 60 percent of the need. Therefore tribes must ration care and use a priority system to determine who will receive what care when. Oftentimes CHS funds can only be used to purchase health care that will "save life or limb," i.e. emergent or acutely urgent care. In an effort to stretch rationed CHS funding for tribes the IHS has adopted a policy placing itself as the "payer of last resort"; this means that if an AI/AN patient requires care outside of an IHS facility to buy the outside care, third-party (private) insurance is the primary source of payment, Medicaid has secondary responsibility, and if both of these are exhausted, IHS contract funds are to be used.

Tribes in the State of Washington are building their program capacity through billing under the MOA. The MOA has provided the opportunity for Medicaid eligible American Indians to more easily access culturally competent mental health care services.
Washington was the first state to implement contracts with federally recognized tribes to provide them with reimbursement through Medicaid Administrative Match (MAM). MAM is federal funding that supports the costs of assisting potential Medicaid beneficiaries to enroll and access Medicaid services (AIHC 2003:6). Since 1998 when the first tribal contract was signed tribes have been collaborating on a government-to-government basis with the Washington State Medicaid program, administered by the Health Recovery and Services Administration (HRSA), formerly called the Medical Assistance Administration (MAA) within the DSHS.
Currently, there are only limited opportunities for American Indian mental health programs to receive funding support for pilot programs, training, emergency relief services and

personal care directly from DSHS's Mental Health Division (MHD). RSNs have access to funding which they can grant to American Indian mental health programs. American Indian mental health programs though must take a proactive role in approaching both RSNs and MHD itself in order to gain access to what funding and services exist and actively negotiate for these funds and services. Also in the future, because of state law (RCW 71.24), American Indian mental health care programs must continue to negotiate with RSNs for access to the majority of state-only and 100 percent federal mental health block grant funds.

In some cases, RSNs give block grant funds to American Indian mental health programs because as state residents, Medicaid-eligible American Indian people have a legal right to receive culturally competent mental health services from Washington State's mental health system. As noted the RSNs' contracted providers are not capable of providing culturaly competent care, which the RSN system endeavors to deliver at least to some degree to the American Indian populations.

Contract terms between the RSN and the tribe generally designate the funds to be used for only non-clinical type training and educational services, or in support of tribal-specific, traditional healing services. Some tribes though also use the funds to contract with culturally competent providers. This funding along with funding for traditional healing services is of great importance to American Indian mental health programs. It helps to provide mental heath services to members of American Indian communities who prefer to use traditional methods of healing that are specific to their nation and will simply not access Western mental health services.

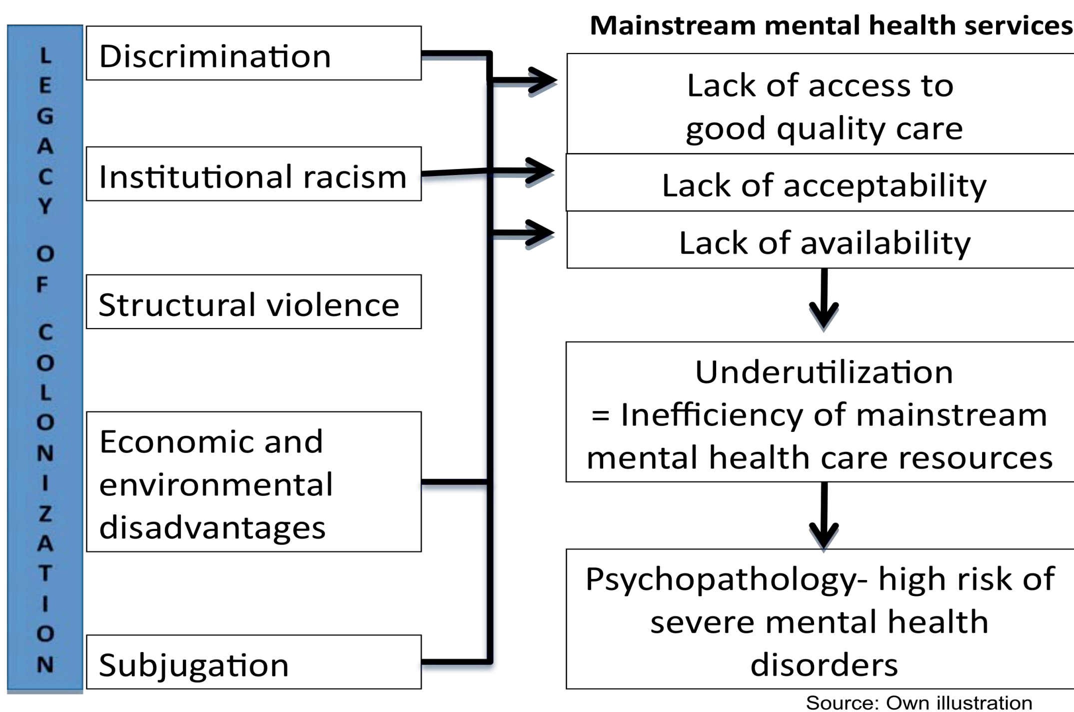
It is clear from the interviews and research that access to funding sources is scarce which does not allow programs to improve services to Native customers and is probably contributing to the disproportionately poorer health status of Native Americans. American Indian mental health programs in Washington State are greatly in need of funding to support not only pilot projects, training and education but also tribal-specific traditional healing services. Senator Baucus's in his call for action summarizes this: "IHS desperately needs additional funding. It is impossible to keep America's promise to provide care to Native Americans and Alaska Natives with the current level of IHS funding" (2009:28).

In recent years though, the Congress has failed to provide adequate funds even to address inflation and population growth which has further contributed to the disparity in health status for AI/AN communities. Annually the number of services that can be provided through the CHS is declining (NPAIHB 2009:22). When applying realistic medical inflation numbers and adjusting for a population growth of 1.2 percent a year, the IHS has estimated that to close the gap in health care between Native Americans and the rest of the citizens of the U.S. it

could conservatively use over $1 billion to meet 100 percent of the need for FY 2009 (Ibid:23).

To conclude, the mainstream mental health services offered are based on Western psychology and other forms of social service interventions which build upon the success models and achievement orientations typical to mainstream American society. The current mainstream and IHS mental health services are not adequate and thus not sufficient to provide for and to heal American Indians, due to: mental health professional shortages and high turnover, as well as culturally inappropriate services and lack of funding. For these reasons, Native Americans are likely to underutilize mental health services and discontinue therapy.

Figure 17: Colonization Legacy not Sufficiently Considered in Mainstream System



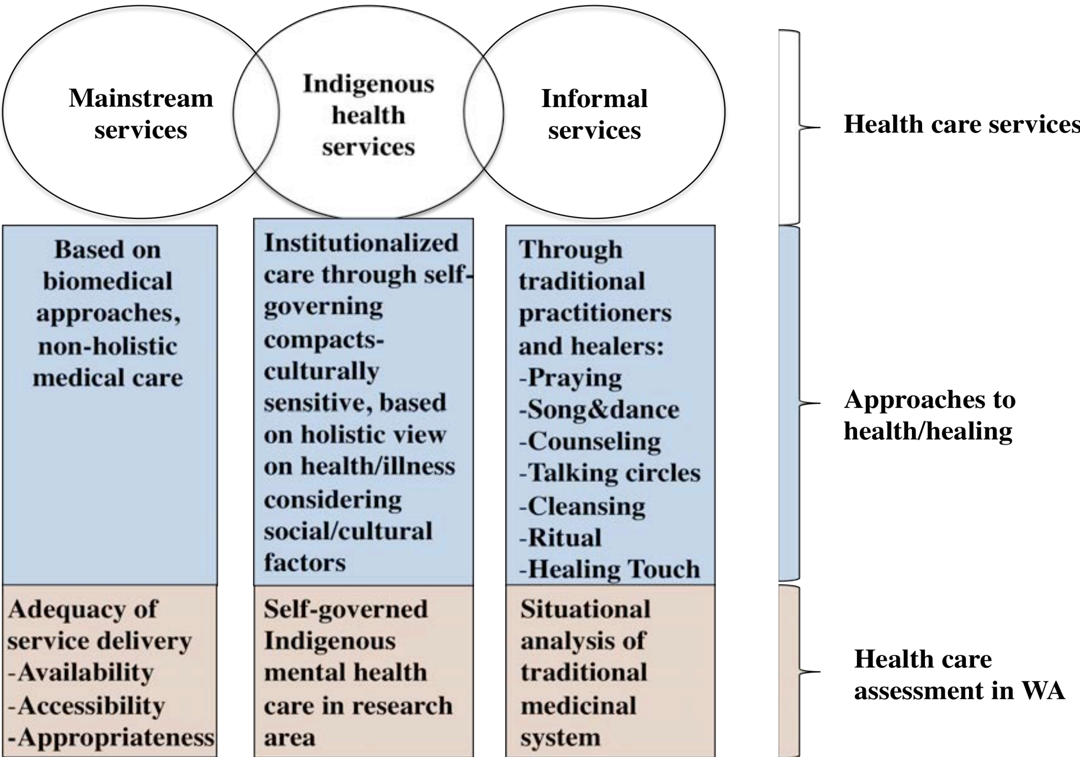
Overall, many Indigenous people stated they did not feel heard but rather “trapped in a heath care system” over which “they lack control.”

Part 7 "Recovery from discovery:" The need for alternative services

In 1972 Wolfgang Jilek already recognized the limitations of Western psychiatry which he identifies to be "insufficiently equipped to meet the specific needs of his Indian clientele" (:61). Realizing the potential benefit of Native patients from involvement in native therapeutic activities he called for a two-pronged approach in the treatment of Native Americans combining a modified psychiatric treatment with Indigenous procedures.
A cooperative relationship with Native therapists, Jilek found, "detaches the psychiatrist from the Indian-white conflict, reduces the cultural barrier between him and his patients, renders individual psychotherapy more effective, and forestalls the iatrogenic anxiety experienced by Indian patients when modern Western and traditional native approaches are in hostile competition" (Ibid: 62).
As analyzed in the above traditional healing still is only marginally integrated into treatment practices in the United States. During last two centuries Western health care gained enormously in reliability because of dramatic breakthroughs in biomedical treatment, antiseptic surgery, vaccines and bacteriology which increased popular confidence in science. Medicine in the minds became the legitimate domain of specialized experts excluding most other health care practitioners from practice. Introduced diseases ravaging among the tribes against which traditional healers were powerless initiated the disruption of traditional culture and gradually increased dependence of the tribes to Western pharmaceuticals and biomedical technologies (GUILMET and WHITED 1989:27).
Over the last decades though the failure of public mental health programs to improve the mental health of Indigenous communities significantly has motivated a drive by tribal governments towards more self-determined mental health care in the legal frame of Washington State's self-governing compacts, as well as a self-help approach by communities based on reactivating their knowledge base in line with Indigenous healing beliefs (SMITH 1999:155).
The medical community also has begun to realize the relationship between these traditional healing beliefs and practices and the maintenance of health among Native tribes. It is believed that for the restoration of the Indigenous people as healthy nations traditional ways of living have to be retained as much as possible. Denying Indigenous peoples' cultural values, knowledge and traditional medicine is acknowledged to act as a barrier to the attainment of Indigenous health. Deliberate integration of Native healing with Western treatment methods - especially in areas where Western treatment strategies have proven ineffective -might have particularly positive effects on Indigenous mental health issues that stem from the stress of biculturalism and cultural disorientation. (GUILMET and WHITED 1989:26). However, so far

no change has occurred within the mainstream system to implement these understandings. Therefore tribes have been starting to develop their own integrative mental health care system. This takes place in the context of tribal clinics and institutions. Services offered are based on a relationship-oriented model of care. Health care provision integrates biomedical approaches and traditional healing perspectives. Services offered are culturally sensitive and based on a holistic view of health and healing. Additionally informal services are offered through traditional practitioners who are oftentimes cultural leaders who are revitalizing their cultures within their communities, renewing interest in the areas of Native language, arts, spirituality and traditions.

Figure 18: Mental Health Care Provision For Indigenous Nations In WA



Source: Own illustration

This process of cultural vitalization and maintenance of a cultural identity has become an important movement in Indigenous nations (WHITBECK, CHEN et al. 2004:410). Its potential as a buffer for the effects of stressors such as discrimination on Indigenous mental health is being investigated as it is viewed to be a resiliency factor that compensates negative stress effects (Ibid:411). Resilience means "the personal and community qualities that enable to rebound from adversity, trauma, tragedy, threats, or other stresses — and to go on with life with a sense of mastery, competence, and hope" (PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH 2003:4). To develop resilience behavioral and psychological strategies are employed (LEIPERT 2005:56). The strategy based on the cultural renaissance of local

tribes to them means “selective revival of adjusted traditions” and cultural traits and “building new traditions to ensure the continuity of the communities” (personal communication). Dysfunctional coping mechanisms like drinking binges are to be replaced by new or revived life-affirming ceremonies -which does not mean living in the past. Cultural renaissance in part has been made possible by such new technologies as the internet, telephones and modern highways.

The question asked by experts concerning integration of the so-called Western and the Indigenous world in the area of Indigenous mental health care provision is what can be the intersection and relatedness between psychology -defined as the scientific study of the mind or of mental states and processes, of human behavior[34] and Indigenous healing practice which recognizes the interdependent nature of relational activities (ATKINSON 2008:109). The fundamental goal of Indigenous healing is to establish a better spiritual equilibrium between patients and their universe. This, in turn, translates into physical and mental health.
Elders commented that in order to better work together Western trained psychologists and Indigenous patients or healing practitioners have to “engage in relationships” rather than “interact upon principles of hierarchy and power.” Relatedness between psychology and Indigenous healing, elders maintain, will occur in day-to-day activities of teaching, theory and practice. It “evolves over time by sharing and building changing worldviews” -when “psychology begins to find its own story” (Ibid:103).

Even though particularly with mental illness a majority of American Indians utilize both westernized medical care and traditional healing techniques exchange between the two systems seems limited (U.S. DHHS 2001:93). Only few patients who see traditional practitioners tell their mainstream providers about their use. In a Tribal Elders Caregivers Study conducted in 2004/05 with elders from Washington State’s tribes continued practice and significant use of traditional medicine was reported among Indigenous groups of the Pacific Northwest on, near and distant from Indian reservations (KORN and RYSER 2006:6). A study conducted in 2000 in Seattle, Washington, found that two-thirds out of the total of 871 patients sampled used traditional healing practices regularly, primarily for mental health issues, associated with trauma, alcohol abuse, dysphoria, and cultural affiliation. Rather than as a substitute for westernized models of care, traditional healing was mainly used as complementary treatment (BUCHWALD, BEALS et al. 2000:1193). Many tribal members

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[34] psychology. (n.d.). Dictionary.com Unabridged (v 1.1). Retrieved September 05, 2009, from Dictionary.com website: http://dictionary.reference.com/browse/psychology

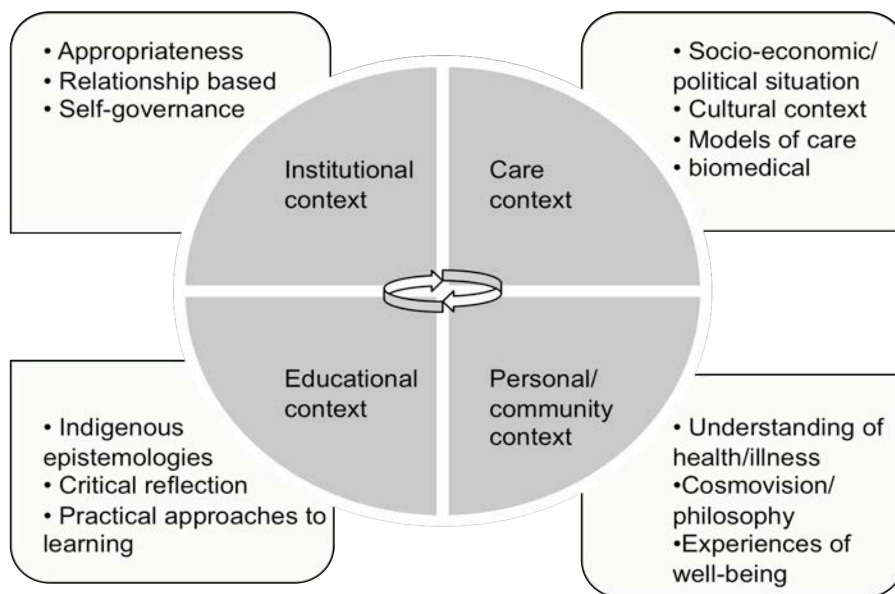
interviewed reported they would consider seeing a Native healer in the future if needs be. Those currently seeing a native healer reported to do so on a regular basis or to concurrently use a Native healer. Acculturated urban Indians around the Seattle area would more use mainstream services. This does not mean traditional medicine is not accessible the reason the Portland Indian Health Board explained is more that "they fall in with the mainstream."
Use and application of traditional healing practices generally vary, and, unless taking place in tribal clinical settings, are difficult to measure as a substantial proportion of traditional practices remains secret or is not easy to identify due to the fact that these practices derived from syncretic spiritual practices integrating Indigenous traditions with post-colonial religions (JILEK 1982:114).
A meaningful factor in the choice of traditional medicine was found to be dissatisfaction with or even fear of conventional medicine. Reasons for the appeal of alternative medicines for the nations of the North West Coast appear to be mainly socio-cultural and psychological as well as the Indigenous holistic orientation to health, their worldview and ethnic identification with the local tribes (even though in the past there was and in many areas in the present there still is a strong denial of one's ethnic origins, as common expressions such as "red on the outside and white on the inside" show). Besides use of alternative medicine is also mainly driven by monetary necessities. Services are at lower-cost. The cost-effectiveness of the utilization of traditional therapeutic resources for consumers compared to utilization of the official health services has been emphasized by the WHO (WHO 1993:179). Traditional medicine thus serves to improve health care coverage. However, safety and efficacy of these services is unknown.

7.1 Self-governed Indigenous mental health care in Washington State

The Indigenous mental health care system is in the process of changing towards a more integrative approach realizing the importance of culture and cultural competency. Cultural activities and traditional healing have become critical and integral components of most self-governed American Indian mental health care programs in the institutional context. Mental health care services currently operating among Native Americans increasingly use Indigenous epistemology for theoretical and clinical interventions. To be more efficient and effective in meeting Indigenous needs qualities in the programs include: services that exhibit cultural reflectivity of the Indigenous group, provide a spiritual belief of the individuals and services which enhance relationship building between the individuals and the respective communities and environment. In the area of suicide prevention cultural strategies are recommended e.g. to increase awareness of suicide and its risk factors among the public and health care

providers, to reduce the stigma associated with mental illness, improve intervention, and develop research aimed at reducing suicide. As these practices within the clinical setting are fairly new, researchers have not evaluated them for their effectiveness in reducing suicide yet. However, many of these practices are based on effective strategies that address risk or protective factors for suicide, such as substance abuse and depression.

Figure 19: Framework of Indigenous Health Contexts



Source: Own illustration

It is important to note that despite many cultural similarities between the different tribes in Washington State the American Indian population is very diverse. In different regions tribal communities and families possess unique values, customs and traditions and a history of their own (SWINOMISH INDIAN TRIBAL COMMUNITY 1991). Due to the ethnic and cultural heterogeneity of the Indigenous groups and the diversity of expressions of peoples' spiritual practices and beliefs healing services and philosophies also differ between and among the tribes. Thus it cannot be presumed that any one form of Indigenous spirituality, or healing is commonly or equally shared by all members of any given community. Apart from events like the canoe journey, that unites and is important for everybody, coming up with the "one size fits all" does not work well with the tribes. The tribal-based American Indian mental health programs existing in Washington State reflect this heterogeneity using a diversity of health care models and local health care strategies. Most tribal behavioral health programs in Washington have some sort of traditional activities such as the Lower Elwah in Port Angeles, the Puyallup and Yakama. The Makah, Quinault, Colville and Squaxin Island have a residential treatment program for male adults primarily for substance dependency. They have programs on plants, native cultural arts and crafts and traditional prayers. These programs are self-

determined. Tribes decide themselves what they offer, what practices they bring in their programs and participants have a choice what level of participation they want to have. There is a diverse sense of an appropriate program. Different methods of identifying what are culturally appropriate services and of delivering these services exist. Tribal clinics providing traditional healing services typically assess the individual needs of their patients and attempt to offer services which may be acceptable and desirable to the overall community.

As for institutional support to access services there is the service delivery area in Oregon which serves tribal members. Tribal members still receive services from their tribal program when they are from Oregon but are living in Western Washington. The program also helps people try to find a medical person in the area the person is living in or use services offered by other tribes. The Portland Area IHS stated: "There is a network established. It has increased over the last decades. People are looking more for traditional approaches too, for sure."

Apart from the programs at tribal clinics numerous institutions and organizations exist which support traditional medicinal approaches. The Seattle Indian Health Board (SIHB) in downtown Seattle stated a high interest in traditional services and did traditional approaches to mental healing, however, lost the individual that worked in that area. At the time of field research it was not known whether the position would again be advertized. As an urban center it was stated to be difficult to be specific to a set of traditions, cultural services or activities with any one culture. Specific services at SIHB serve people from over 200 different tribes. Staff commented to "design a treatment that is effective for everybody is not possible." It has to be "quite flexible, sometimes being more specific for one culture than to the other." A remarkable increase in pan-Indian healing practices was stated capable of unifying tribal members with different cultural backgrounds. A need for more information about traditions not originating in the West was expressed. Employees reported on the fact that there is a large population with a cultural background from the Plains traditions living in the Seattle area seeking support at local tribal clinics. This results in a heightened exposure and need for offering as well as participating in the healing traditions of other tribal entities. A basic integrative pattern of diverse Indian healing techniques can be discerned mainly among urban Indians. There are traditional practices such as talking circles, traditional sweat lodges or the Pipe Ceremony from the Plains tradition and Southwest healing practices being adopted by Indigenous communities in the Pacific Northwest which never had such traditions. To integrate traditional healing or other cultural activities tribal -based mental health services proactively ask for the assistance of other (local) tribes. Nurturing this multicultural perspective it was stated is becoming an important form of preventative mental

health care in the area encouraging help-seeking behavior. Still some programs were stated to not use integrative approaches because of the lack of availability of traditional healing service delivery models in the communities.

To try to meet peoples needs SIHB said to put Natives back with their original tribal network in order "to get people back in touch with their culture from which they have gone way from drinking, drugging or whatever the individual case may be." If Natives want SIHB can arrange for them to be sent back to their tribes of origin or alternatively do counseling also in collaboration with other organizations. The Seattle based NGO United Indians is one such organization which works with SIHB programs doing cradleboards as part of the psychological healing. In various tribes such as the Tulalip and Suquamish courses are offered for children that were sexually and physically abused. The children make baskets and drums. Work also is done with women in prisons. They do prayer, talking circles and openly talk about experiences.

Another NGO in Seattle is the Chief Seattle Club which works on a volunteer base serving 80-120 people a day mainly from outside Washington, as regional groups tend to use services within their local tribes and communities. Basic needs such as food and hygiene are provided. Socializing and community support is reported to probably be the "biggest service" as the Native frame of mind is "It takes a village to raise a child." An organizer explained:

> "There are people out there who think they are lost, away from their tribes, family, villages away from their religion. When you are out on the street you forget your connection. When they go down to Chief Seattle they know someone cares for them, clothes, food. It is a home space, the club is. There is much suffering at the Club but then some groups form to participate at the Tribal Canoe Journey and want to get sober for that."

He went on:

> "Our mission is basically to renew the spirit of native people in the urban environment… People shy away from 'pill popping.' They have chemical dependency issues, last thing they want to do is popping a pill to feel better. Becoming dependent like that, trading one dependency in for another. Rather go to talking circles instead of trading in one chemical dependency for another."

Homelessness and meth dependency are issues dealt with through community support. The Club has spirit walks and memorial walks for people who have died on the street. There is a parade through Pike Place market, during which instead of being invisible on the streets people participate in the parade. Traditional healing is a main part of what is done at the Club. This also reflects in the refurbished traditional-style building which contains a sacred circle room where healing circles, smudgings, blessings and sweat lodges are conducted.

Offer of specific healing modalities, access to and utilization of traditional mental health care unless institutionalized within tribal programs remains obscure though. A census of

traditional medicine practitioners has not been done, the location and specialty remains difficult to assess. A local Chinook woman stated that "traditional services are definitely growing especially getting back to traditional forms of healing." High interest in alternative therapies became evident during the Native Caregiver Study conducted at the Center for Traditional Medicine in Olympia. Today in Native communities to the eye of the researcher there is a perceived absence of traditional healers. This is understandable by the fact that native rituals and customs were discouraged for several decades as Western religion and culture infiltrated Indigenous communities. Their knowledge has been passed on by oral tradition and in secrecy. Many traditional Indigenous therapies still are covertly passed down from older to younger practitioners within the community. Some people in a tribal community are said to "possess special gifts of healing, or renewal." These gifts are sometimes "discovered very early in life and refined and perfected in many years of training." Many of the Indigenous healers have not had formal training. The three options seen for the future of healers is to remain underground, risking to lose the healing knowledge, submit control to the Western system and its inherent values or assert self-determined control in the tribal setting. Traditional approaches require more time to gain confidence and bonding. Indigenous medicine practitioners spend more time with the patients (longer visits, more frequent visits, follow-up phone calls, make home visits, "talk story" and share appropriate personal experiences about themselves). They might even spend hours or days with patients. "You are following their lead." Traditional medicine practitioners also try to incorporate respected family members, who may be elders, siblings, or even younger family members, to approve of the treatment plan and help.

Accessibility of services depends on where practitioners offer services which could also be off reservation. Often practitioners are based on their home reservations and work within their families so tribal members in contact with their tribal cultures can directly access traditional healing practitioners. When services are away from reservation or tribal offices even on the reservation that offer these services then it might be difficult for a consumer to go and see practitioners. It also depends on patients' family structure if they have anyone affiliated with or working in these services it would help to access these services. To get to know a traditional practitioner a local Native explained

> "It would be through social networking about feasts, events and cultural happenings at which traditional practitioners attend. More in terms of someone would say this is what is going on this weekend would you like to go down."

Like for mainstream services and practitioners information about good as well as counter productive traditional health care mainly is by word of mouth through a system of sharing information amongst extended family, friends or community network which impacts peer

referrals. Due to the fact that no registry or directory for easy reference exists the cultural vouching system within Indigenous communities is strong. It is expressed to be an efficient way of determining whether therapists or healers are culturally competent and as good as they claim to be. An Indigenous woman explained on choosing traditional healers: "You want to have someone who knows what they are doing. Follow certain rules and procedures, are trained." The community thus determines itself whether someone is culturally appropriate and culturally effective. Identified individuals, although not absolutely necessary, are usually from the community as they are better able to understand the culture, history, and needs of consumers. Despite varying consumer costs for utilizing services few healers have fixed fees, in economic terms. Traditional practitioners are paid by the service users by what they can afford, most likely in barter or by donations as many practitioners as well as caregivers would not accept monetary compensation for their services. A patient at Kwawachee Center said about the payment system: "You do not pay the person you give a gift. It might be a blanket you might bring in food so it is on an informal level." The center does not pay but the person. As there are usually no obligatory fees cost considerations do not impede utilization of traditional healing resources and therefore they are more accessible than mainstream services.

7.1.1 Traditional practices and CAM therapies

Concerning the use of alternative therapies two directions can be detected. One has a traditional focus. The other uses CAM. Guilmet stated in 1989 that traditional treatments provided are mainly of the local Indian smokehouse tradition (p.75). Dr. Korn, principal investigator of the NIH funded American Indian Elder Caregiver Health Study stated in a personal conversation in 2010 that, nowadays, there is a dominant pan -Christian religion which incorporates multiple traditions and elements from the smokehouse traditional and Evangelical, Christian elements which are not held to be opposing as is evident in the integrative Native American Church (NAC). During the last years, theoretical conceptualizations of the relationships among spirituality, beliefs, and health have been developed. The focus being primarily on Judeo-Christian traditions (HULTKRANTZ 1990). A study of American Indians living on reservations found that tribal spiritual orientation was a strong protective factor. Individuals with a strong tribal spiritual orientation were half as likely to report a suicide attempt in their lifetimes (GARROUTTE, GOLDBERG et al. 2003). More explicit attention to the connections between Native consciousness, spirituality and mental health in Indigenous communities is warranted considering the nature and kind of problems described previously.

Most traditional systems of medicine include methods of biofield/touch therapy healing. Touch therapies were evaluated and found to be effective in the reduction of stress, pain, as well as depression (KORN, LOGSDON et al. 2009:2). Having a history of using touch and massage therapies CAM interventions can be regarded as a hybrid approach and were identified as a potentially efficient culturally congruent CAM intervention for stress reduction in AI caregivers in the Pacific Northwest (KORN and RYSER 2006:6). Among AI of Washington State traditional healers, apart from hands-on healing, and a variety of massage techniques frequently employ herbs, singing and drumming as well as sweats. Jilek found one focus of traditional healing to be "on the restoration of energy or spirit balance" (1982:158). Rituals, ceremonies and feasts are central to the tribes. Tribal values and kinship ties are reinforced through these activities (GUILMET and WHITED 1989:78). Spiritual cleansing of individuals, offices, areas was observed to be practiced with cedar smoke or sweet grass. Naming ceremonies were stated to be essential for Native identity and a feeling of wholeness. A practice surrounded by complex rituals and giveaways.

Despite a societal wide phenomenon in most Western countries, especially the U.S. where alternative healing is flourishing in ethnic and mainstream sectors of the health care system fewer members of local tribes seem to be utilizing alternative practices such as homeopath, naturopath, chiropractors and acupuncturists. Tribal clinics or Health Maintenance Organizations (HMOs) on and off reservations are increasingly incorporating the use of and provide various forms of CAM services. Referrals to e.g. acupuncture meditation, yoga are not made on an institutionalized basis though but rather by health care providers who practice one or the other discipline in their personal lives themselves.

There is a growing acceptance and use of massage and complementary therapies primarily by those who can afford it and are "not hung up about religion" (Personal communication with CAM practitioner). In the American Indian Caregiver Stress and Health Study sample 78% of participants had used some CAM and/or Traditional healing methods (KORN, RYSER et al. 2008:25). Most patients who participated in the NIH American Indian caregiver study expressed their wish to continue with the CAM therapy treatments, however, were unable to afford it. Many of the participants did not have any health insurance and lived too distanced from where regular services were available. With guaranteed federal provision of and dependence upon the biomedical services provided without cost many tribal members have no access to alternative forms of treatment despite their interest in using these modalities. Interviewees on remote reservations noted limited or no access to alternative therapies and community health clinics. They felt that these resources would enhance their ability to access

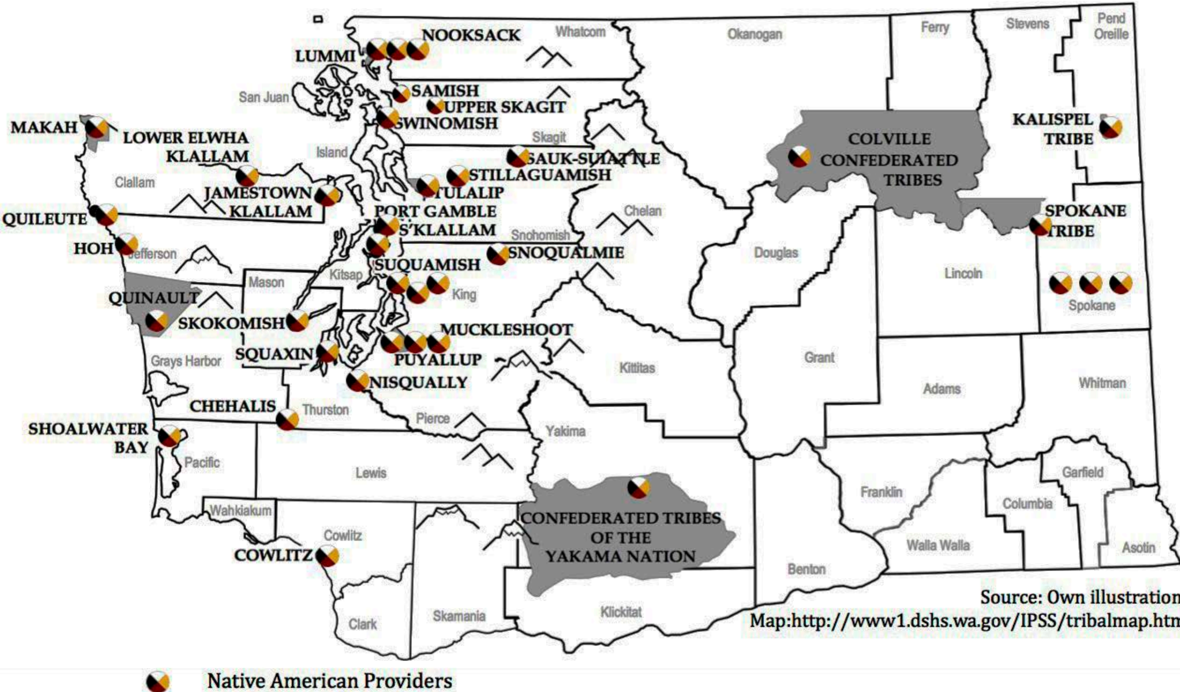
information and support, and help them to make decisions and engage in health promotion, illness prevention, and treatment behaviors.

7.1.2 Traditional medicine in the treatment of substance use

Indigenous nations reduce the prevalence of alcoholism on their territories significantly by reviving their ancestral practices. Such individuals, while vulnerable to 'burn-out', demonstrate strength and resilience in the face of overwhelming circumstances. The focus of these tribal programs is to identify pathways and methods whereby resilience can be built on and enhanced to measurably improve the wellbeing and social outcomes or life chances of individuals, families and groups.

While services for emotional problems typically are delivered through outpatient settings, substance-related problems are most commonly provided in residential settings. At the Skokomish inpatient treatment center in Elma, WA Natives who mainly are members of tribes from the Puget Sound area stay for 45 days. They get intensive treatment and classes including training on trauma, cultural issues, sweat lodge, traditional plants program, drumming, singing and sports. Upon graduation they go either straight back to their communities or are sent to halfway houses to get more stable first.

Figure 20: Locations of Certified Chemical Dependency Treatment Services



Traditional healers and Indigenous elders are responsible for one-quarter of care provided in these settings. Quality and availability of community-based substance abuse treatment

services for individuals and families of the Pacific North West of the United States of America varies. Treatment programs for people with dual diagnosis (substance abusers who also have at least one mental illness) exist and offer a blend of mental health and substance abuse treatment including detoxification and education as part of the treatment. Patients with dual diagnosis also can utilize services (such as support to find jobs, housing, education opportunities) which provide help to regain positive attitude and lifestyle. In addition group treatment sessions and social and recreational activities are offered. Family support is also provided for patients to have multiple support networks to rely on.

Community is a strong network that helps people functioning as was exlained: "They can get by in this community because they do have the community support." A Native father noted about a big tribal school graduation dinner where a drunk person attended:

> "We were sitting at the table and eventually he (the drunk person) went somewhere else. But it struck me that no one, we are so used to him being there. He just went on his way and kind of was grumbling around and no one said anything. In most areas outside of the Native culture the cops would have been there they would have dragged him off, he would have been in trouble. But the sense of community was such that he was able to just be there and as long as he was not disrupting anything no one cared. He is drunk most of the times, everybody knows him so he is kind of there and he is functioning among the families, the kids, not causing any harm. And he finally left and he was kind of grumbling and hollering about something when he left but again nobody was paying attention. And because nobody was paying attention there was not a scene he walked on his road and left. And I think that's sort of the community that keeps folks healthy and the mainstream would not have that. People are so isolated, there is a meaninglessness around them" (personal communication).

Alcohol and drugs are generally regarded as "powers" responsible for aberrant behavior while taking possession and influencing a person consuming these substances. For long-term abstinence and to gain control over these "powers" of drugs and alcohol it is believed the powers of traditional healers, the individuals' themselves or the power within anonymous group settings such as culturally transformed Amerindian Alcoholics Anonymous (AA) style groups must be stronger than the power of the substances. Western-type Alcoholics Anonymous has not been successful generally among North American Indians. Therefore the Coast Salish as the first Indigenous group to develop Amerindian AA-style groups in the 1960s modified the AA model according to their cultural understandings. With the Amerindian AA style movement cultural identity and self-respect are emphasized, including spiritual ceremonials, allowing for family participation and the acceptance of an Indigenous time concept. These self-help groups have shown positive rehabilitative effects among native populations (WHO 1993:177). Alcohol –related problems were found to have significantly decreased amongst some Coast Salish living on reservations where Native AA-style groups where introduced and where the revival of ceremonies was promoted by tribal leaders. The

youth actively participated in the ceremonial activities and got in contact with their tribal heritage (Ibid:167). Currently listed with the Native American Indian General Service Office of Alcoholics Anonymous there is an active AA talking circle "culture is healing" at the Squamish every week as well as weekly group meetings in Nespelam, Arlington, Shelton and Marrietta. Furthermore 13 loner meetings are held throughout the State (Arlington, Bothell, Buckley, Kingston, Nespelam, Coleville, Silverdale, Toppenish, Yakama and two in Auburn, Bellingham).

The revival of the Winter Spirit Dance was confirmed to have also been effective in motivating substance abusers to sobriety. An annual therapeutic program has been created which provides mutual support, acceptance and stimulation for the initiated dancers as well as relatives and friends who participate in a group enterprise that has a valuable psychohygienic and sociotherapeutic function (Ibid:179).

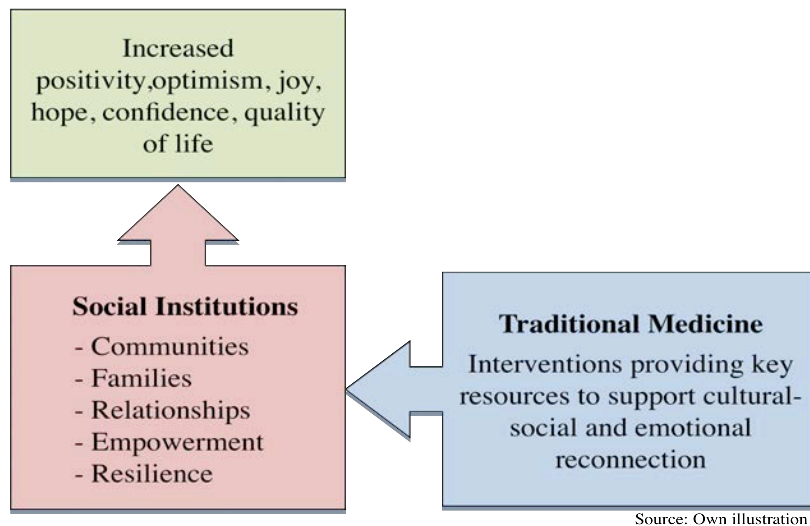
Reintegration to any sort of social spiritual and mental well-being or to reintegrate the person back to their family is part of the healing model of the sweat lodge. A local healer explained the underlying belief:

> "When you are an alcoholic you develop relationships with the border town because reservations are dry. Away from your clan, band, people who keep eyes on you, social control. They have a really bad relationship that separates them from their community."

7.1.3 Relationship to place and people

Meaningful relationships were reported to be "everything" to a Native person. As declared at the Healing Our Spirit Worldwide (HOSW) 2010 conference and written in the HOSW Covenant Indigenous nations believe that "the health and well-being of our people and nations is built on our ability to maintain compassionate, functioning relationships within ourselves, with the earth, each other, our families and communities" (SANTIAGO 2010). Relationships to people and places have been and are the center of Indigenous value systems and form much of Indigenous understanding of reality. Through the management of relationships to the land and people status as well as well-being were and still are socially determined. Potlatch ceremonies and give-aways are one visible element of this conception of reality and speak of the importance of Indigenous social life. Within the framework of feasts, family organization, belief and value systems social relationships have provided a context for psychological, social, and economic security (HODGSON 1997:13). Traditional healing interventions prevalent in the research area provide cultural- social and emotional connection to place and people to positively influence mental states.

Figure 21: Indigenous Pathways to Optimizing Psychological Well-Being



Not only people also places are conceptualized as social relations (See LAWS and RADFORD 1998). This makes explicit the link between place identity and health. The different healing places within which mental health care is delivered (whether clinics or natural surroundings) symbolize values, beliefs and social ideals. Indigenous individuals believe that the land is alive and contains spirits. It was stated they communicate with the spirit of places, rocks and trees oftentimes in times of conflict as a means of gaining focus and meditating. A Native woman commented on the importance of place for her emotional and positive mental well-being after a CAM session intended for stress reduction:

> "Just the different places you know how you go in and out during the session. I always go back to the water and the land where it takes me. It's always my favorite fishing ground, on the Quinault 'rez'. Just how peaceful it was, grandpa's property and land, healing waters" (personal communication).

Meaningful cultural cognitive maps were found to have formed in the region based on historic and social interactions of the different groups. Different from the ones of non-Indigenous groups these 'cultural cognitive maps' represent the individual reference and access points for local Indigenous groups, their intertribal connections and use of resources. According to a shared understanding of their cognitive map Native consumers seem to choose the mental health services they are to use or to avoid. The understanding of their cultural maps also influences the distribution of information and plays a higher role than geographic distance in decisions about travel to places in which mental health care is delivered.

The value of the relation to traditional homelands to provide sustenance for both physical and spiritual needs has been recognized (DURAN, DURAN et al. 1998:63). Native Americans' culture, their familial systems and kinship ties were closely connected to geography and the ability to move freely in their traditional territories before the arrival of the settler cultures. Subsequent introduction of the reservation system imposed boundaries which rendered free

movement from place to place impossible. This exacerbated what scholars have called psychic wounding or the "soul wound," mentioned previously as the relationship to a traditional environment was crucial for spiritual and psychological well-being.

A Native fisherman describes the importance of place for psychological well-being today:

> "There is really nothing to show that well-being of Native people improves through culture, lots of people have to realize that healing and everything just happens from the natural things we do on a daily basis, and part of that is family, part is community. And that really is part of a process of staying healthy."

A Native therapist states:

> "I think that for myself and many other Native Americans much healing occurs naturally which isn't considered mental health services. For myself and my tribe we spend a lot of time on the water commercial fishing. The water has always been a place of healing for Native Americans and for me personally I find amazing solace while on the water." He adds: "Another avenue of healing is the peace and serenity we find in the outdoors. Many of us still hunt and gather in our traditional grounds and the healing that comes from that can't be documented either" (personal communication).

Traditional hunting and fishing practices are not just a means of subsistence with the tribes. They are sociomoral and spiritual practices aimed at maintaining the health of person and community. One Lummi woman stated on the emotional healing benefits of these activities "hunting and harvesting medicines makes people feel good." The right to harvest fish has been recognized as fundamental for Northwest Coast tribal culture after years of courtroom battles over fishing rights. If the individual is member of a recognized tribe the individual can get as much fish as has been designated. Individuals from an unrecognized tribe would not be able to go out. For subsistence, they have to buy a license as every other Washington citizen. Unrecognized tribes are getting ceremonial rights to fish for feasts like the first salmon ceremony when they file a petition with the State stating the quantity they need for a particular ceremony. Meat e.g. is part of tribal ceremonies and gatherings and shared at funerals as in Indigenous culture, traditional foods are part of the process of grieving. Therefore throughout the year local Indigenous governments issue hunting permits for special ceremonial hunts. The data on these hunts is reported to the state of Washington in an annual report (KAPRALOS 2009). Gathering and hunting rights for deer, elk, bear and mountain goat were stated to be just as integral to Coast Salish life as fishing and that tribes ceded away part of their ancestral lands in order to retain these rights.

7.2 Mental health and place

7.2.1 The Tribal Canoe Journey

A healing ritual for the entire community, rooted in the geographic realities of the area, is the so-called Tribal Canoe Journey. The canoe journey which takes place during the summer

weeks is an Indigenous community cultural event in the Pacific North West. There were no known organized traditional-style intertribal ocean-going canoe journeys since the 1800's until their return emerged in 1989 with the historic event, the "Paddle to Seattle," the first of the modern-day Native Canoe Journeys. Nine traditional cedar dug-out canoes paddling from Tribal Communities of Northwest Washington, and one coming from the northern coastal village of Bella Bella, B.C., Canada made their journey to the Port of Seattle in July of 1989. Emmet Oliver (of Washington State), Frank Brown (Bella Bella, B.C.) and others conceptionalized the idea, timing it with Washington State Centennial Celebration. The Paddle To Seattle event reawakened old traditions sparked new interest in learning and living the Coastal Culture among the Washington Tribes, many of whom had not practiced Canoe Society traditions for many years. These journeys have brought renewed attention to the local tribes (STREITBERGER 1989:9).

More importantly keeping the canoe culture alive Northwest Coast peoples have brought back a traditional approach to individual, family and community wide healing of mental suffering and contributes to the safeguarding of Indigenous traditional knowledge through intergenerational transmission. At the landing of the Canoe Journey 2009 at Suquamish Chief Frank Nelson summarized the journey: "It is a way of life. Our culture is alive and vibrant." A paddler commented: "It touches our souls and stirs something inside of us that has been dormant for many years. Very few cultural events have had such an impact on Native Americans of the Northwest."

Canoe teams, or families are travelling the traditional highways of their ancestors seeking to honor the centuries-old custom of transport, harvest and trade by the coastal tribes. It is a journey of cultural revitalization and healing from historic and intergenerational trauma (SIEH 2007). During the journey participants are educated about historical trauma, experiences and effects are shared with others of similar background and within a Northwest Coast cultural context and traditions. This leads to an increased awareness of trauma, its impact and the grief-related effects. The intervention model includes many opportunities such as group sharing, abreaction, frameworks for expressing culture and language as well as ritual. The healing process results in an experience of more positive group identity, a reduction of grief effects, a sense of relief and an increased understanding and commitment to doing healing work on the individual as well as community level.

What is important to note is that the journey is a year round program of intense physical and psychological training and mandating a drug-free environment. It takes the paddlers oftentimes more than one year to prepare mentally, physically and spiritually for the journey. The reward for the long preparation gets clear from the following comments: "The energy and

camaraderie of these days in the boat is difficult to compare with anything today." Or: "The journey makes us strong in mind, body and spirit." As well as: "It is hard to express the feelings that make the canoe journey such a healthy and spiritual experience" and "I just get a feeling of peace." Fred Lane, Paddle to Lummi director was reported to say: "My spiritual cup is full, these are tears for the happiness we're sharing here." Billy Frank Jr., chairman of the Northwest Indian Fisheries Commission said at the Journey to Lummi 2003: ''It is one of the greatest days in our lifetime… people are happy. We should be happy all the time. Look at all the good people, all the good energy, people hugging each other and saying hello" (WALKER 2007).

Besides community empowerment the psychological value lies in the learning of cultural practices as well as traditional foods, underpinning the nutritional, cultural and social needs of the communities. Year round tribal members are learning how to do beadwork and make ceremonial regalia. They learn ancestral songs infused with knowledge that people describe makes them "feel at home in the world." Part of this reflects in the maps which list Indigenous place names and tribal designations that are being produced by the tribes themselves with the help of GIS technologies.

Figure 22: Map of Canoe Journey to Makah 2010

The days of the journey are a time of cultural festivities. The arrival of the canoes is a grand ritual, marked by drumming, dance and song. Tribal elders and leaders attend engaging in what could well be described as a modern networking process, building new or renew established alliances and strengthening family ties. Tribes proclaim their common history and their mutual

respect, need for and sharing with each other. The newly revitalized traditional Northwest potlatch ceremony during the journey serves a similar purpose of personal and cultural connection. Native youth make most of the handmade gifts to be handed out to thousands of attendees. An art teacher at Lummi Nation School explained: “We’re trying to keep our culture alive by teaching our kids our traditional art.” Tsawout First Nations Skipper John Etzel commented: “We took some kids this year who were really culturally deprived. And to see their faces light up when they’re involved in something like this, it’s really awesome.”

The long term effects of the journey sometimes only show months later. One paddler commented that he does not find “a logical explanation to what he felt deep in his heart. But this kind of learning is not the kind you get in the classroom. It’s a tremendous experience I’m grateful for—to learn something about who I am.”

The Canoe Journey thus can be seen as a story of resilience and hope which as science has shown plays a vital role in the recovery of an individual (PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH 2003:4). There are many definitions and perceptions of recovery. William Anthony, Director of the Boston Center for Psychiatric Rehabilitation identifies mental health recovery as "a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness" (ANTHONY 1993:17).

The activities have served as therapy for youth and adults in various drug and alcohol treatment programs. A series of ceremonies and counseling "circles" bring tribal elders, parents and youths together seeking to heal common ailments of drug and alcohol abuse. One participant stated: “the beauty of the journey is that it is a community, area wide sobriety. You do not see one intoxicated person at the journey. Out of the ordinary, as opposed to other events, you see people not at their best, at the journey it is a completely other story.”

One participant and former drug addict said he “sensed the journey would help him heal,” and “that the journey would change his life.” It did help to free him from addiction. Or: “Before the journey, I let my emotions get ahead of me. But now I can sit back and think about what I’m going to do before I do it” (WALKER 2007).

Because of the recognized success the canoe program thus also is eligible for funding as a drug elimination activity. Whether the Canoe Journey is billable is a point of discussion. Paddlers and accompanying ground personnel who leave their work for about one month in summer in order to be out on the water do not gain any money during this time. A Native organizer explained about the billing policy for the Journey that the Canoe Journey is billable

when “tribes say they go on a canoe and are taking a therapist with them. So they decide to turn it into a program rather than a cultural event and get into a state Medicaid billing.” This is

> “[…]where it gets complicated because the state wants to say they want to bill for this and this and this and it is not necessarily billable but they can make it fit.” However participants would argue that there can be a form of healing in the journey itself. On the other hand if participants do not have any therapeutic involvement when they went on the journey and they went on the journey and the group came and shared with their therapist things they learned on the journey that will be billable as well as the therapist is involved in the process. If there is no therapist involved and they just come back and say we gonna bill for these twenty individuals who were on the journey then it would not be possible to do the billing. So the therapist has to be a medically trained specialist. It has to be a state licensed therapist and they have to be involved in the process.”

Apart from discussions concerning billing hosting the journey involves considerable financial investment. The hosting nation has to raise sufficient funds to organize the journey and host the paddlers for one week of festivities upon their arrival. During the paddle to Suquamish 2009 at which nearly 100 canoes took part, 70.000 meals were served to participants (personal communication).

7.2.2 Dramatically changing diets

For local tribes, traditional food (food harvested from the local environment) has a central role in terms of nutritional, socioeconomic and cultural significance. Traditional food harvest involves increased physical activity likely to enhance physical health. The traditional food system in cultural and social support systems is furthermore likely to contribute to mental health. Indigenous identity and the collective sense of well-being is based on subsistence as an activity, a dietary staple and as a social system. The loss of belief in Indigenous food undermines belief in society and identity. Therefore traditional foods and medicines are part of the enculturation and healthy lifestyle movement among Northwest Coast tribes. Many health programs are trying to implement traditionally healthy diets. The movement is somewhat in line with the green lifestyle of health and sustainability promoted in the U.S. and other countries with a whole movement of local foods. People want the local connection and go to the farmers markets and farms in their areas. There are Native people introducing and supporting traditional foods that they know helped medicinally. One woman commented:

> “For Native peoples traditional foods had a reason scientifically e.g. because they have complementary proteins and philosophically…. We did that for thousand years. Understanding that we have some knowledge here. There is a lot we can learn from traditional practices.”

The shift away from traditional diets was created by the move to reservations in the 1800s. People were prevented from accessing their traditional foods such as fish and elk as it became

increasingly difficult or impossible to hunt and gather traditional foods and medicines in their territories. In addition on the North West Coast the peoples' for more than one hundred years until the Boldt decision in 1974 were forbidden to catch fish plunging the tribes into malnutrition and disease as well as loss of culture as the tribes' lifestyle depended on fishing, the economic mainstay of many tribes. Fishing was, and still is, the time when tribes exchanged information and stories were told and songs sung. It is an event where traditional food preparation and processing knowledge is transferred to younger generations through hands on experience.

Taking away their foods, and thus their culture local tribal members state "was an efficient way to colonize and ultimately break our minds and bodies."

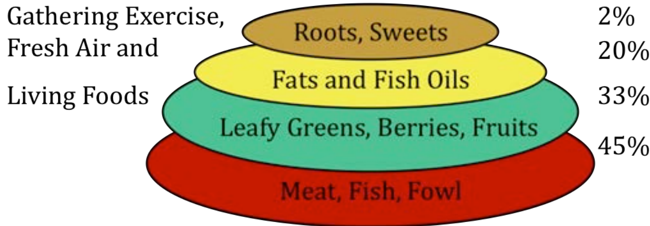
Forced to live on land unable to support them, the United States was obligated as "guardian" to help the increasing number of tribal members to subsist and provide food. The use of natural foods and culture consistent medicines declined as native peoples dependence on commercial so-called "introduced foods" and especially those foods delivered as surplus commodities increased. These food rations sent by the federal government mainly consisted of white flour, lard and canned meats. Fry bread made from flour, salt and lard thus would become part of Native culture (WAGNER 2005). Most of the introduced foods are heavily processed and contain high levels of refined sugar, wheat, hydrogenated fats and oils, milks, as well as heavily salted processed mixed meats and beans. This had harmful health effects. Many of the surplus commodities the metabolic characteristics of local Indigenous peoples cannot absorb. These foods likely in combination with the genetic predispositions of the Native led to the obesity epidemic ravaging Native communities today (ARCHIBOLD 2008). Indeed many of the health problems and the alarmingly epidemic chronic diseases in AI/AN populations, such as cancer, and heart disease, are considered to be related to shifts from traditional dietary patterns (SHELTON 2004:3). Today, the majority of Indigenous individuals tends to eat globally, including consumption of Western foods (e.g. hamburgers, pizza, soda). Especially commercially dependent populations turn to market driven processed foods and pharmaceuticals and low-fat or fatless diets combined with high levels of sugar. Even though still eaten by some Native Americans items unique to the traditional Native diet are no longer the primary source of nutrition and sustenance. (SMITH 1999:75). The traditional foods movement among the local tribes stems from the belief that good nutrition is necessary for growth and physical and mental health. The precise extent of the contribution of diet to disease, beside behavioral, biological, genetic and environmental factors, is not possible to determine by current research means. Seen in the context of the cultural revival movement

the awareness of the value of nutrition is a way of decolonizing diets. Thus it can be regarded as more than nutritional but as a social, political and cultural act.

7.2.3 Traditional foods and nutrition

The Salish peoples, including Siletz and Wasco in Oregon and Taidnapum Cowlitz, Quinault, S'Klallam, S'kagit of Washington and the Stl'atl'imx, Gitskan, Okanagan and Nuxalk in British Columbia, Canada as well as other tribes throughout the region all have unique diets defined by the cultural relationship between the people and the foods available in their specific territories. Some tribes will use plants like bear berries, and huckleberries and beaver in their diets while other tribes have different kinds of berries and animals that are more plentiful in their geographic areas. The traditional Native American diet on the North West Coast consists predominantly of fish, Wapato (sweet potato), squid, breadfruit and other seafood and fruits and berries.

Figure 23: Salish Food Mound



Traditional food is an important source of dietary energy, protein, iron and zinc and brings about improved diet quality as shown by the lower fat and saturated fat content of the diet when traditional food is consumed. Dietary lipids function as carriers of fat-soluble vitamins and are high sources of energy and essential fatty acids (mainly polyunsaturated which the human body cannot synthesize but which are essential to health). Raw fats or raw oils -a mainstay in human diets for thousands of years -are an essential nutritional source for health and healing in Indigenous peoples' culturally defined foods and medicines to the present day. Every society has developed parts of their culture around fatty acids for food and medicine, essential to survive. Whether it is garum, a fish sauce consumed in ancient Rome or the marmot oil used in Nepal, the underlying principles are alike. Even though the importance of fats and oils in the human diet has been subordinated to the dominance of refined carbohydrates and so-called healthy vegetable oil local traditional healers persist in their emphasis on unrefined fats and oils and complex carbohydrates as a normal and significant part of the daily diet (RYSER 2003:1). Many of the coastal and interior Salish peoples of northwest United States and southwest Canada use wild sources of fats and oil in their diet

including seal oil, whale oil, hazel nut fats and the fat from salmon, deer and elk brains. Something virtually all Coastal peoples have in common is the use of oolichan oil. For more than 4000 years these nations and their ancestor nations depended on this small fish, the oolichan, for their life, health, wealth and prosperity. Along with the salmon, seal, and the whale, the oolichan provide selenium, vitamin B12 as well as calcium and protein The fish is perhaps the most important source of oil and grease in the traditional Indigenous coastal diet. Skilled tribal members produce oolichan grease as a result of fairly exact processing techniques using one of the many runs of anadromous oolichan fish.[35] Oolichan grease is used as a fresh oil condiment in which to dip dried herring roe, smoked oolichan, smoked salmon, wild celery, wild onions, salmon berry sprouts, fresh berries, and potato-like roots called camas and bitter root (RYSER 2003:1).

After the Bold decision in 1974 affirmed the tribes' right to continue to harvest fish in the State of Washington the tribes increased their fish consumption. Oolichan oil and other essential oils are increasingly used again to prevent chronic disease and to restore health to those tribal members no longer reliant on traditional diets. Increased consumption put an end to dismally low docosahexaenoic acid intake by most local Indigenous communities. Fatty fish like salmon and oolichan are rich in essential fatty acids, especially the superunsaturated Omega 3 family containing alpha-linolenic acid (LNA), eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) and the highest n-3 polyunsaturated fatty acids hardly found in imported foods. Indigenous peoples of the Northwest Coast are especially dependant on EPA and DHA. Their metabolic system has adapted biochemically and bioculturally due to high levels of these fatty acids in their cultural foods. Therefore their bodies are unable to transform Omega 3 from plant material into DHA and EPA. Research has established that fish oils (EPA and DHA) play a crucial role in the prevention of atherosclerosis, heart disease, and cancer (PEPPING 1999). The human brain is one of the largest "consumers" of DHA. DHA is vital especially for fetuses and babies. The DHA content of their brains increases threefold in the first months of life (LEVINE 1997:248). Low DHA levels have been linked to age-related memory loss and cognitive function impairment. Several studies have established a clear association between low levels of omega-3 fatty acids with accordingly low brain serotonin levels and an increased likeliness for depression and suicide (HIBBELN 1998:1213). Patients given an omega-3-rich supplement experienced a significant improvement in their quality of life (LEVINE 1997:248). Researchers at Harvard Medical School have successfully used fish oil supplementation to treat bipolar disorder (CALABRESE, RAPPORT et al. 1999:413). British

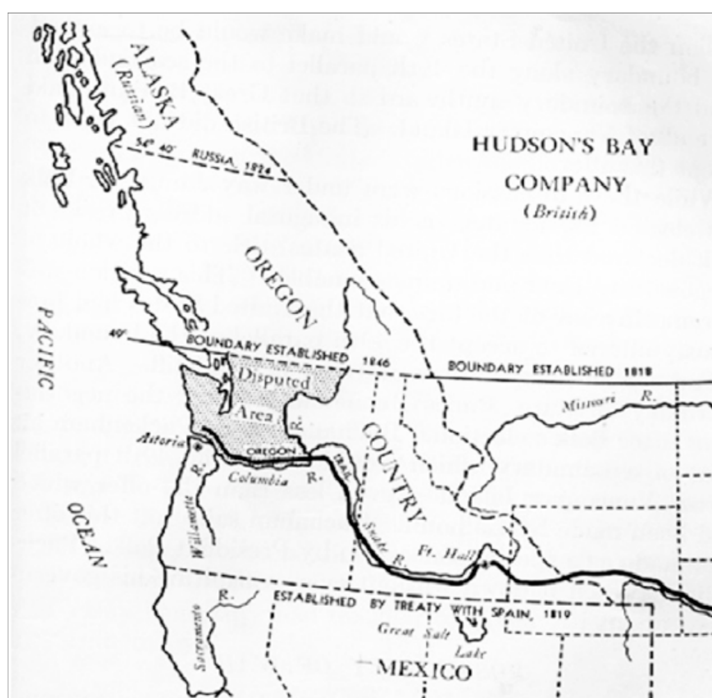
[35] The Oolichan, like salmon, is an anadromous species. The fish leaves the ocean to swim up rivers and streams in order to spawn from February to mid-May.

researchers found encouraging results in the treatment of schizophrenia (LAUGHARNE, MELLOR et al. 1996).
Moreover local Indigenous tribes were found to employ traditional fish consumption in the treatment of attention-deficit hyperactivity disorder (ADHD) ADHD is marked by emotional instability, impulsiveness, hyperactivity, short attention span, poor coordination and concentration and learning disorders. Recent studies linked ADHD to a deficiency in EPA and DHA. Researchers at Purdue University have been hypothesizing that subclinical deficiency in DHA is the reason for the specific behavior of children diagnosed with ADHD (BURGESS, STEVENS et al. 2000). ADHD was stated to be very common among local tribes and was explained to be linked with the "nutritional trauma" experienced through forced dietary changes that happened too rapidly for peoples whose very cultures were based on fishing (personal communication).

7.2.4 Healthy oolichan -a cultural hero

The oolichan, other common names are smelt, oilfish, and "candlefish" (given the fish because when dried, it retains enough oil to burn like a candle) is member of the 12 existing species of smelt. The fish was likely the namesake for Oregon country, a territory formerly stretching from the Columbia River in the south up to the 54th latitude in the north, reaching into regions today referred to as Alaska (BROOKS 2002:28).

Figure 24: Oregon Boundary Dispute and Settlement



Source: Hayes (1999), p.131

The Western Cree who use an R sound in place of an L would have said "ourigan" (Ibid:29). It might have been this Native word which, adopted from the Native traders, was misspelled by first explorers like Jonathan Carver[36] and accordingly turned into Oregon. This theory is also underlined by congruence of the historical boundaries of Oregon country and the natural habitat of the oolichan fish as shown on the map below. Historically, the range of the Oolichan has corresponded roughly to that of the coastal temperate rainforest, extending from northern California to Alaska.[37]

There is still limited understanding of the life history and biology of the Oolichan. Despite abundant Traditional Ecological Knowledge, compared to other fish species in BC, there have been relatively few genuine 'scientific' papers on Oolichan. Like salmon, Oolichan play an important role in the Pacific coast ecosystem. As part of the food chain Oolichan are prey or food for other animals, its predators: the sea lions, seals, porpoises, orca whales, eagles and flocks of gulls. Fishing techniques among American Indians show the influence of a sophisticated adaptive understanding of the fishes' lives and environment. The Oolichan was central to the culture of Northwest Coastal tribes for thousands of years. A Haisla elder explained:

> "The oolichan is food for the soul. It is part of Haisla culture. It has intrinsic values in helping us to define who we are. When we define ourselves, we closely link ourselves to our diet, and oolichan is a major part of our diet and our cultural identification" (personal communication).

The very life of the Native peoples depended upon the Oolichan. One of the Sm'algyax names for Oolichan is "hali'mootk" and means savior fish. Oolichan was the first resource available for harvest after the long winter months, even arriving before the salmon, often before the ice melts, giving life, saving people from starvation. Even a prolonged delay in the arrival of the fish caused untold suffering (HARRINGTON 1953:42). Charles Dickens in 1865 wrote about the appearance of Oolichan in spring:

> "It is by no mere chance that myriads of small fish in obedience to a wondrous instinct, annually visit the northern seas, containing within themselves all the elements necessary for supplying light and heat and life to the poor savage who, but for this supply, must perish in the bitter cold of the long dreary winter" (DICKENS 1865).

The importance of Oolichan therefore cannot be under stated, it is a cultural icon throughout its region and very present in the culture of the Northwest Coast and its development. Around

[36] Jonathan Carver was the first who mentioned the "River Oregon" in his best-selling Travels through the Interior Parts of North America, published in 1778, referring to the Fraser River in B.C.. He probably had contact with some Western Cree and allied Assiniboine traders at the Great Lakes who told of the "River Ourigan" that led to the Pacific and who had previously been to the far Northwest across the Rockies to trade and to raid, being well acquainted with the region and its river systems.

[37] In BC 33 different rivers or streams have been documented as Oolichan spawning sites, but only 13 appear to have a record of continuous, annual runs. The total number of sustained, regular runs is uncertain, but it may be as few as 30 or 40 in the world, and almost certainly fewer than 100.

the Oolichan fishing, traditions and rites developed. The catching, subsequent processing and distribution of Oolichan grease was an integral part and important unifying force of coastal Indian nations' culture and health, a season of mutual helpfulness and co-operation accompanied by feast and entertainment. The Native fishermen caught more than needed for their own requirements which they could barter for their foods. Because of it's timely arrival and high nutritional value oolichan has been one of the most valuable commodities and main article of a vigorous northeastern Pacific coast trade provided huge wealth and power to the people of the North Coast. Villages were built on strategic places for harvesting and trading the fish grease. In order to guard their wealth villages along the Skeena and Nass Rivers formed into organized chieftainships. Fortifications, like the Kitwanga Fort, were built along the oolichan trade routes in the early 1700s. One box of grease could be bartered for four blankets, two beaver skins, or two boxes of dried halibut. Two boxes of grease had the value of one canoe. The price paid for a woman slave might be two or three boxes of grease (LOPATIN 1945:90).

There being no butter, Oolichan oil was used instead. The Haisla Indians of Northern British Columbia considered it the tastiest product of the sea (Ibid:15). Native Americans throughout the region have traditionally used the Oolichan grease for almost everything. Lewis called Oolichan grease the "Swiss army knife" of trade goods. Once extracted, the valuable oil was used as salve, sauce, for seasoning, preserving food, source for vitamins A, E and C, as medicine to treat colds and the flu, laxative, lamp oil, leather-tanner, and for trading. It is also believed to clean the human body spiritually.

The trade in this oil was very extensive. So valued was this "golden grease" that it was shipped over trails on human backs or on travois attached to dogs running from the coast far into the interior to Indian nations to exchange pelts, baskets, pemmican, bitterroot, dried berries, dried meat or leather for clothing. The Northwest Coast got crisscrossed with elaborate trails, usually the easiest routes across plateaus, highlands and over mountains far into the Western interior, referred to as "grease trails" because these trails were commonly used by First Nations traders to transport Oolichan grease for thousands of years.

During the late 19th century era of railway euphoria many of those routes were overlaid by railway lines. Today the grease trails are at the basis of a modern highway system.

As Europeans began to settle in the area, they also dealt in the trade of Oolichan oil with some shipped to England and used as medicinal oil -as a substitute for cod liver oil (HART and MCHUGH 1944:12). Due to the wide use of Oolichan oil by local Indigenous groups supplies likely did not suffice for larger overseas trade.

The first explorers of BC didn't have topographical maps that are in existence today. For them it was natural to follow the ancient trading routes that did exist, used and shown to them by the First Nation's people.

Figure 25: Trade Routes Used by Early Settlers

Source: Harvey (1994), p. 22

With the first European explorers via the network of grease trails arrived devastating diseases. Due to the lack of resistance by the Northwest Coast tribes to foreign diseases such as smallpox, Spanish influenza, tuberculosis and veneral disease whole Native cultures were dramatically reduced or entirely destroyed (see appendix D, figure A-1).

A second devastating epidemic arrived later along the grease trails via the overland routes, spreading slowly out into the communities according to the time and route of travel from east to west wiping out whole villages, forcing tribes to amalgamate. All these traumatic experiences had tremendously negative long-term effects on the psychological well-being of these tribes.

Also today the cultural importance of Oolichan should not be understated. There is considerable local demand for the oil. The oil is mainly traded amongst families or tribes at cultural events or private meetings. Bottles of oolichan oil were observed to be given away at Potlatch feasts. Most is sold on the black market while some is available at tribal shops or restaurants.

Part 8 Situational analysis of the traditional mental health care system

8.1 Strength of the traditional mental health care system

The value of traditional service is multifaceted. The rural location of many tribes, which makes local health services a basic necessity, corresponds well to the structure of traditional medicine care delivery which is based in the communities. More important than geographic aspects is the fact that traditional medicine programs respond to a need for culturally competent services. This can contribute to rethinking appropriate forms of mental health services and prevention and promotion that take into consideration complex historical and social contexts and do not reinforce dependency on Western concepts. Moreover the use of traditional remedies can instill a sense of pride which people reported to have in using and having control over their own cultural remedies. This can contribute to increase self-esteem and awareness of the individuals. The incorporation of traditional practices has also been thought to have an influence on the overall improved sense of solidarity in a community (JOHNSON and JOHNSON 1993:229). Members of the larger community develop a higher degree of involvement, cooperation and collaboration, which is fundamental in tribal areas. The strength of these social bonds in many Native communities and the willingness to act for the benefit of the group can provide a supportive network. A reciprocal sense of caring for and valuing one another and belonging develops that comes from frequent interaction with a network of friends, family and others. The established trust, reciprocity and cohesion has important psychological benefits and positive health impact as with social support people recover from illnesses more quickly and are less likely to die from specific diseases (TAYLOR 1990).

8.1.1 Community and family support system

Part of Indigenous mental health care is the support system of the community. These existing traditional resources of family and community centered intervention programs based on participatory, postcolonial research are more and more held to offer strong alternatives in providing community mental health care. Revitalization of cultural and social group activities in the family or in the community help reduce stress that causes physical and mental distress in an individual which leads to arguments, low morale, low productivity and crime in the community. Group activities most of which require little or no equipment or money include music, dancing, singing, celebrating special individually or culturally meaningful days and sports. The WHO states about the positive psychological effects of such activities that “even with poor living conditions surrounded by sadness, no one is lost in sadness all the time (WHO 1996:18).”

Traditional community resources, are widely used to enhance mental well-being among tribes in Washington State. The Canoe Journey or like activities may constitute a community resource for mental well-being of people in cultures where these activities are recognized and valued. The short stay in a supportive milieu during the journey was reported could bring notable improvement. Apart from specific healing rituals, the observed benefits, indeed, appeared to result from a supportive non-threatening environment that functioned as a culturally valued place or refuge for people with mental imbalances or substance issues.

An existing scientific study among Native Hawaiians identified family support the most robust resiliency factor apart from physical fitness/health as well as achievement (CARLTON, GOEBERT et al. 2006). Tribal members in Washington State were generally found to be very connected to their immediate and extended families. Native understanding of family is summarized: "to be really poor in the Indian world is to be without relatives" (PRIMEAUX 1977:92). Relatives according to Native understanding, apart from immediate family, include extended kin. Support from family was stated in interviews to be "another avenue of healing." It is believed that the connection with the family is valuable for well being, "more so than any therapist or any program could ever do" and "that happens ongoing in tribal communities and it is not anything not therapy, it is a lifestyle." In tribal cultures the informal resource of an extended family support system was and is of paramount importance to provide emotional support, physical care, mediation etc. in times of emotional stress and need. Individuals with mental health issues are primarily taken care of by family. Family to depend upon instead of isolation Guilmet found makes it much easier to cope with acute episodes as well as chronic mental illness (1989:70). A Native psychotherapist and social worker in tribal clinical settings commented that "most healing takes place in the family" (personal communication). Due to the importance of family and strong family ties, it was observed, that tribal family will take care of the ill rather than sending them to inpatient facilities, or the elderly in nursing homes. Efforts to promote mental health in tribal groups therefore include strategies to strengthen families. Despite all the positive aspects to Native family the involvement of extended family can complicate delivery of inhouse services though when family members might disrupt therapeutic support. Because of severe intergenerational trauma as a consequence of rapid change that impacted families heavily Native specialists at tribal clinics emphasize the importance of "family counseling". Dysfunctional family structures make necessary a high level of involvement of outside agencies such as the welfare and legal systems, Children's Services and others. Coordination of these agencies and services for the patients and family is, in cases where possible, rather done through tribal outreach support services directly with

the patient, e.g. attending court with the patient, rather than from a desk within an office environment.

8.1.2 Therapeutic clinical landscapes

The mental health clinic environment amongst the tribes is a clear strength. What makes Native clinics unique is that the clinics' surroundings seem welcoming. They provide a safe place conducive to healing. Also local institutions providing community support in tribal settings, constitutes needed refuge to Indigenous people that facilitates healing.
When visiting psychiatric units and hospitals in the U.S. one finds a concrete courtyard that at best reinforces the cigarette-exchange culture. Tribes try to build facilities that could well be described as "Indigenous healthcare architecture" incorporating culturally meaningful shapes and designs. They offer surroundings that contain cultural elements such as artifacts, carvings, paintings or pictures. This makes patients as well as visitors feel welcome and more at ease given the clinical setting. In the more rural setting of reservation areas one can imagine a therapeutic "environment" built into Native treatment centers that is culturally meaningful. In most of these and like places alternative therapies are practiced by healers in an environment preferred by Native Americans to the cold and impersonal atmosphere of a doctor's office or hospital setting. In tribal rehabilitation facilities e.g. Lower Elwha courtyards are gardens that are tended by the patients. Local herbs are grown that are used and shown to the patients. During classes and medicinal plants walks they learn what plants to best use for cleansing or detoxification. There are adjacent sports fields where patients can work out regularly.
Another example is Kwawachee Counseling Center for mental health, operated by the Puyallup Tribal Health Authority (PTHA). The Kwawachee Center provides outpatient mental health counseling services that include medication management services for acute and chronic mental health conditions. The first floor of Kwawachee Center has a Spirit House, a large meeting area for cultural activities modeled after a Pacific Northwest longhouse seating about 180 people. In addition some alternative health clinics or practitioners have an ongoing policy of maintaining pets. These pets are partly cared for by customers and staff. Therapy dogs Native customers in Olympia stated offer a "great deal of affection" as well as "sense of responsibility" (personal communication).

Traditional medicine approaches in these clinics use culture as a resource and develop culturally relevant treatments and interventions to improve outcomes for Native consumers. This includes hiring Native American staff using approaches that are sensitive to the needs of

Native consumers and help them to regain control over their lives and use the natural resources within their communities during the healing journey.
Moreover what makes Native clinics special is a high practitioner/patient ratio and that teams are listening to professionals as well as consumers. This makes people identify with a mental health-care system that shows the responsibility to stimulate people to feel responsible and participate and respects their ideas.
The clinics are established places where traditional Coast Salish and other local Indigenous practitioners can meet, share their healing heritage, knowledge and visions. Thus collectively broadening the awareness of healing practices among Indigenous communities, focusing on issues that specifically affect the native Indigenous community -oftentimes issues central to the survival of healing practices in a changing world. Within these functional environments the demand for traditional native Indigenous healing practices are articulated, safe native Indigenous healing practices are discussed as well as what needs to take place (politically, legally, culturally) to make these services available.

Seen the success in Native acceptance of local Indigenous clinics it would be recommendable to establish a new facility in which to house an intertribal Traditional Healing Center. Included in the process for establishing a new facility would be obtaining the necessary licenses and insurance, purchasing appropriate equipment and supplies, and acquiring and training staff members. This would enhance the capacity of the study area to provide a concentration of traditional support services and activities which could help many Indigenous individuals at various stages in their lives and enhance psychological well-being.
The character of the place for the Traditional Healing Center in which services are provided must be considered by mental health care agencies and traditional medicine providers when creating caring environments for people as each geographic setting provides a unique set of strength, potential and challenges. Important criteria that would influence location options for a Healing Center and of which several potential locations exist in the area include appropriate size to handle organizational needs, central location for the geographically dispersed Native community, ample parking, and walking-distance proximity to public transportation or shuttle transfers.

8.1.3 Educational system

Apart from the family and extended family/community the educational system is stated to constitute the major institutions through which cultural knowledge is transferred from one generation to the next in Native communities (RYSER 2008:2).

After the treaties Natives were forced to attend boarding school. It was declared that, ”To educate the Indian is to prepare him for the abolishment of tribal relations” (Ibid:6). Indigenous nations sought and did not receive full community control over education, controlled by outside churches and the U.S. Bureau of Indian Affairs. Tribal leaders now say key elements that have been identified over the last decade as important to establishing community control over education to restore Indigenous cultural health are amongst others to negotiate new Self-Government Compacts, the development of new curriculum for each age group, as well as professional training for school administrators and faculty of North West Indian College in Bellingham, and an effective community communications capability. Indigenous nations believe that their cultural, social, material and spiritual existence depends on a well-educated population. Education and information is held to be vital for the creation of awareness leading to social change, enrich quality of life and enhance job and career opportunities. Dawn, a Tsimshian college student described the value of education as being “part of genuine capacity building,” with people being responsible for their own issues “it helps me to have the information to be responsible for myself,” and it “exposes me to new ideas.” Numerous surveys have found that higher levels of education have a positive correlation with better health and a longer life and even protect from depression. Better educated individuals are more aware of health risk factors, are better able to implement healthier lifestyle choices, feel a greater sense of empowerment and self-esteem, have greater problem-solving skills and more effective coping strategies (Ibid:6).
To this day there is a lack of educational opportunities in many Native communities which extends to postsecondary and vocational programs. This erodes and retards individual economic advancement. Special education programs for Native adults have not been funded for years. Vocational rehabilitation programs that assist individuals with physical and mental challenges are too underfunded to meet abundant need. Tribal colleges and universities receive 60 percent less federal funding per student than other public community colleges, resulting in increased financial burden for students who are already the most economically disadvantaged (U.S. Commission on Civil Rights 2003:xi). The designing and implementation of education and training that effectively confronts the implications of accumulative racism is still a major political challenge (MCDERMOTT 2008:35). To raise the low level of awareness of tribal sovereignty among the non-Native majority tribal sovereignty curriculum has been introduced at regular schools. The aim is to make schoolchildren understand the central role of treaty rights in the state of Washington teaching them about historical backgrounds of the local tribes.

Intensification of education on traditional health care systems is being pursued with the view to encouraging ethical practices and rational usage of traditional medicine at all levels of Indigenous as well as non-Indigenous society. Public education and community activities exist that promote the value of traditional knowledge and proper use of traditional medicine as both education and culture. This helps Native Americans define their identities, values and social and cultural systems which constitute their Indigenous ethnicity. Diverse ways of living and doing are encouraged to identify and promote those cultural practices, which help to improve people's health and stop those practices that are harmful to health. Education of Indigenous and non-Indigenous peoples about the potential and value of their own and Western healing systems in Native studies programs, workshops and seminars is recognized to play a major role in prevention and treatment.
Support for the educational system to develop programs to adequately deal with mental health issues should be increased. The emphasis on the role in and impact of the K-12 educational system in mental health, prevention curriculums and on-site health services are marginal. Addressing the mental health needs, through curriculum development, research projects, professional preparation and certification, and cultural competency training should be enhanced by Tribal Colleges to become more involved in these fields.
The University of Washington has tribal programs, Muckleshoot has a tribal college, most tribes have cultural programs, Squaxin and Skokomish, were found to have weekly classes, drumming, singing and nutritional programs. The Lummi envision to create an educational environment which provides all eligible Lummi enrolled students to participate in a Lummi culturally enriched educational program. Initiatives like the "Learning Lummi" Workshop offers Lummi Nation members the opportunity to initially set Lummi Education Standards that can evolve over time to contribute to establishing a first class Lummi educational system (RYSER 2008). Wahelut School at the Puyallup, Franks Landing does traditional activities and has a therapy program. Some of the Wahelut pupils went on a trip to Poland and said they were "shocked at the high interest there" which enhanced cultural pride. Integrated in such cultural educational activities the school does medical billing for mental health interventions.

Funding for programs comes from different sources such as the Washington Health foundation, or federally funded e.g. through the USDA food program. Tribal liaisons have funding. They work through Indian universities. Federal local agencies such as SPIPA get in contact with tribes about these grants. The tribes approve of the resolution and go through protocol process. When the tribes decide they have a need for the project the agency applies for funding. With some grants individuals can bring in their own proposal and ideas. Others are very regimented and applicants have to do a specific curriculum. A researcher explained,

“Some fund organizers you have to educate, others have been really great” (personal communication).
Tribes are generally very aware of the need for cultural education programs. How many and what type of programs are available depends on the tribes and on how much funds they have. There are considerable differences. Contacts and people who are supporting individuals and their programs are stated to be vital in the funding process.

No national, regional or district programs could be found to help educate people on the need to conserve medicinal plants and protect them from extinction. Community based programs within tribal settings are not regular. Through North West Indian College there are workshops on plants. Usually they have classes once a month. There is a garden at Skokomish integrated into the healing center. A program was set up which was trying to offer to all the regional tribes to teach them how to make their own healing garden and start their own projects.
Furthermore Salish Foods and Medicines Workshops are organized throughout the area by local NGOs. These workshops respect the difference in learner types in Native groups. They focus on hands-on direct body experiences. The workshops involve plants walk and cooking and bodywork besides theory on health and care. Basic knowledge in traditional medicine is taught to raise interest and reduce stigmatization of traditional medicine. These workshops and like events create a space for sharing experiences of using traditional medicines to resolve mental health problems, and to reflect upon these experiences. Participants stated the seminars greatly contribute to the interest, conservation, development and use of traditional medicine practices.
Similarly within SPIPA’s Comprehensive Cancer Project, a grass-roots project that gained national attention, the youth is taken to a camp for educating them about cancer issues recognizing the use of traditional medicine for prevention. One awareness activity on the schedule is to take the youth out to wooded areas to learn about medicinal plants. Apart from prevention traditional medicine in the face of the illness is taught as spiritual help to improve psychological condition of the sick as well as their caretakers. A daughter of a cancer patient commented, “because I feel I can actively do something against the cancer and the depression that comes along with it.” There are no yearly classes though due to lack of capacity more than lack of interest as was stated.
Furthermore Washington State University has awarded funds to The Evergreen State College in Olympia to develop educational programs on traditional foods and their use as medicine in order to support the cultivation of traditional foods for improved diets. The Evergreen State College through the development of the Northwest Indian Applied Research Institute, assists

local tribes in Cultural Revitalization Projects and the development of an Indigenous Nations Declaration of Cultural Property Rights.

There are Native Foods and basket weavers conferences and educational workshops within the Tribal communities, conducted for the creation of sustainable, community based food systems. IHS has tribal conferences during which teachers get in contact and tribes can share their programs and experiences by word of mouth.

To bring traditional practitioners and healers together it was suggested to hold annual Indigenous Healing Arts Conventions in line with the Canoe Journey's mission. Consensus among the healers of the important aspects, values, and healing methods that are unique to the Pacific Northwest of the U.S. has to be created. A body of Native Coast Salish and other Indigenous healers should be convened to share their thoughts, ideas, believes and opinions on the quality and provision of traditional healing services and catalyze action to improve Indigenous peoples' health and human rights. This could provide an international community forum to articulate issues pertaining to recognizing and preserving Indigenous healing practices and healers. The necessity to modify and adapt traditional medicine and practice to contemporary needs and demands that reflect the ongoing changes which happen in societies, their values, environments and living conditions could also be discussed at such venues. Joining the healers should be interested individuals and experts such as primary care providers working for Community Health Centers or similar institutions. These experts could discuss how native Indigenous Health Care Systems and their practices are blended with allopathic care in these settings to afford Indigenous consumers a comprehensive, culturally competent array of health care services. Knowledge of the unique issues faced by traditional healers, healthcare agencies and consumers in the provision of traditional Indigenous healing practices could be increased as well as the knowledge on standards of care in traditional healing and mutual respect among healers, and healthcare providers. This would help to sensitize and educate Western practitioners regarding the orientation and use of traditional medicine.

As Dr Ralph Bamblett noted in his keynote address at the World Indigenous Peoples Conference on Education in Melbourne, Australia in 2008 "Substantial improvements in Indigenous health will depend on long-term collaborative approaches. These have to involve all levels of government, Indigenous communities and leaders, the health and non-health sectors."

Not only in depth education of potential traditional medicine consumers therefore should be undertaken. Training of all mental health workforce are to be discussed. Vigorous training programs for mental healthcare professionals working with Natives and TM and CAM

practitioners are required. Attractive incentive packages could be developed to attract and encourage excellent resource persons and therapists to specialize in cultural awareness and traditional medicine practice. When compared to Western mental health practices cultural or traditional services should be viewed as legitimate and equal service, with equitable reimbursement from the state. The State should work with Tribes to increase the amount of culturally competent mental health service providers and researchers. Cultural Competency Training should be provided to local governments, State employees, administrators and other levels of personnel for non-Tribal providers, on Tribal legal status. Conducting educational workshops and trainings of public health professionals builds capacity to identify and act upon the specific mental health needs of Indigenous peoples.
Also traditional medicine practitioners are required to undertake ongoing training as the knowledge of healing is not static but open to other approaches. For the same reason internal arrangements within the tribes for maintaining excellence and avoid harm are being made. Likewise work with the elders is needed to define the specific role that the traditional practitioner has and will have within mental health care and determine the interest in the community to reintroduce traditional practices.

Another development is that local tribes increasingly enter the news and broadcasting business. The Tulalip Tribe in Snohomish County e.g. has its own TV station, called KANU TV. These modern tools help to break apart the combination of loss of traditional knowledge coupled with a lack of information and education. Local Indigenous news media develops culturally appropriate material focusing on stories. This is crucial for a successful mental health education as Indigenous groups usually do not respond well to statistics. A tribal member explained, "This is an opportunity for our people to tell our stories, our way. It's a huge leap“ (personal communication).
Encouragement and stimulation from cultural leaders and health professionals by disseminating relevant mental health information through traditional channels increases awareness of tribal members about health problems and can help to mobilize community resources and raise awareness of multilevel factors which affect Indigenous health (See MORLEY, ROHDE et al. 1983). Indigenous leadership in this was regarded to be essential. A Native health worker explained: “If you have good, inspired leadership people of passion that are really guiding the way they are like a magnet for us. Then people fall right in” (personal communication).

8.2 Weaknesses of the traditional mental health care system

8.2.1 Lack of well defined identifiable system of practice

The traditional medicinal knowledge base is fragmented and has been held in secrecy. The knowledge mainly is passed on by oral tradition based on experience, which makes it difficult to verify.

Through attempts at acculturation by the "mainstream society" much of the traditional methods and networks of healing long possessed and employed for treating physical, psychological and spiritual problems were nearly or altogether lost to the tribes. Many traditional healing systems and the traditional view of the interconnectedness of spiritual well being, with physical, psychological and social well being were destroyed by religious persecution and attacks on tribal doctors (SWINOMISH INDIAN TRIBAL COMMUNITY 1991). In week two of her treatment series a tribal participant in the NIH Caregiver Study commented on her knowledge about and use of traditional healing rituals that: "I don't know the healing, you make it up" (referring to traditional healing rituals). Through traditional ways of knowing some of the ancient practices are being rediscovered. Intertribal sharing of common practices helped that some of the almost lost cultural heritage could be retained. When the Puyallup tribe after 100 years of ignoring the once important rite of the "First Fish Ceremony" decided to first reinstate this ceremony, which serves to honor the salmon run, there was no living Puyallup tribal member who knew how to celebrate it. However an elder Lummi medicine man knew how the ceremony was done and taught it to the tribe (GUILMET and WHITED 1989:66).

Even though the tribes are interested in traditional medicine at tribal clinics this may not be a priority not at last due to very high workload. The focus is more on biomedicine. Sometimes tribes trust outsiders more than their own healers and traditional healers say they "run up against a whole system opposed to traditional medicine." Throughout history general practitioners with little or no experience in treating emotional disorders, discredited the local healers, the only practitioners who could provide appropriate and were responsible for mental health care with the tribes (GUILMET and WHITED 1989:20). Natives were trained to believe in Western medicine. With the Europeans epidemics arrived in 1830. Healers could not take care of the introduced diseases. Catholic priests in ritual gave Natives quinine, originally discovered by the Indigenous Quechua of Peru and Bolivia. The medicinal properties made local Natives believe that the Western medicine is more potent than their own. This underlying issue goes back far in history, and is not known actively. On the other hand there is mistrust of clinicians by Indigenous groups from historical persecution and the systematical suppression of traditional practices and many cultural and healing rituals.

Memories remain among Native Americans about what settler cultures did through deliberately providing them with infected blankets as "gifts" – described as "an early form of germ warfare" (personal communication). Due to the troubling history of relations between tribes and state as well as local governments building trust between Indigenous governments and individuals and non-Native government employees or health professionals may take considerable time. Despite distrust between partners, also due to existing political views, past conflicts should be solved to be able to interact more for mutual benefit.

Due in large part to present-day struggles with racism and discrimination as well as from personal experience in society or boarding schools there is a powerful reticence to speak openly of Indigenous practices least the fear that the knowledge is taken away from the holders of that knowledge (U.S. DHHS 2001:80). Some Natives lower their voices when talking about traditional medicinal knowledge as they do not feel safe about it. Locals expressed their fear to be used as "guinea pigs" in pharmaceutical trials. Some suspect scientists of having an interest to pirate their knowledge (as was reported has happened with Taxol, for breast and ovarian cancer "discovered" in *Taxus brevifolia,* the Pacific Yew tree in 1967). Suspicion has emanated from the fact that in the past researchers did not adhere to ethical research guidelines and suppression of Native practices. Lack of trust between traditional medicine practitioners and researchers and regulatory offices exists. However, in recent times, through the power of continuing education, some level of cooperation can be discerned.

The different actors can educate each other about health objectives and tribal realities. The diversity of health provision groups, with this understanding, can explore a variety of forms of engagement as necessary partners in an overall strategy to make better the availability and quality of health services for Native consumers.

8.2.2 Undefined management system for traditional health knowledge and programs.

Mismatch of times, terms and goals impede implementation and success of programs.

An example of a mismatch of times was reported: "Tribes will call up an agency and say 'we need this now.' The agency will say, 'we need to plan for this in advance, we can't do it now.'" Another example of mismatch was related:

> "Sometimes tribes are just looking for employment for their people. A program comes in and if someone is related to the person in charge, they get hired just because they are related. This has a large part in which families get income. This really is the employment tool. Thus tribal government produces a product that can't produce. The people who are hired either aren't trained properly or they are not committed. This not only produces a huge turnover of people, it produces a group of people who, first, aren't equipped to deal

> with the mismatches of terms and second aren't trained. These people want to do the job, but they have been given an external language to communicate external goals. In short you hire the Indian to find the Indians. But the problem is really the mismatch of terms and goals"(personal communication).

Competition for limited employment opportunities, lack of tribal specific professional development training, and uncertainties about the intent of the program episodic funding, management or personnel conflict leads to changes in personnel or other program interruptions. Frequent personnel turnover experienced in tribal social service and mental health programs destabilizes the program and complicates communications. Interruptions from the need for new personnel to learn about the program often slows a program and results in inconsistency.

Issues concerning regulations could also be found. A healer explained "now there is a room designated in the hospital for just traditional healing. But there are all sorts of regulations and restrictions in the hospital concerning sanitation. Smudging wasn't allowed and animal skins weren't allowed because they would contaminate the hospital. So the room goes unused." Institutionalized health services at Lummi IHS clinic that offer some traditional practices were reported to be so poor that Medicaid services at Bellingham were preferred by those who can travel there which opens up a broader field of care. Likewise private insurance plans were reported to increase choice of services.

In addition there is no standardized program for alternative medicine or traditional healing on the reserves. A tribal leader stated:

> "The success and adoption of a program really depends on the extent of the program or agency's integration into the tribal community. Often agencies will fail and will say, 'they (Indian nation) threw us out,' when really they just didn't know they existed." The director of the Center for Traditional Medicine explained that all relies not on the program but on personal contact. For traditional medicine and foods programs everything "relies on the individual person running the program to set aside some funds"

Similarly a therapist stated that programs "go back to bill for them." Tribes make programs "fit into a system around payment and not necessarily really therapy." An Indigenous activist and leader commented:

> "Tribal governments see their role as raising funds from the government. They do not see a proactive option, such as supporting the existing health programs. When we talk about the NIH study I've had people ask me, 'Will this make health care cheaper? I say to them, I hope so'. There have been huge cuts in the health programs and traditional healing can be used as an alternative system to the system offered by the IHS."

Concerning IHS funds it was stated that the

> "IHS gets funding according to who walks through the door suffering from what disease. Mentally ill or chronic patients tend not to go. Most are people with accident. That is

> where the budget goes. It does not mean that the highest amount of ill people have accidents, the others simply do not use the services" (personal communication)

Some funds for their own traditional services programs are provided by casino revenues. Remarkable differences exist due to better management as well as location in tourist or highly urban areas so that some thrive while others are not doing well.

Specific legislative provisions are needed to increase funding to break the cycle of mental illness and addiction Endeavors should be undertaken to ensure that federal and state guidelines and regulations authorize reimbursement of traditional treatment approaches. Reimbursement on a fee-for-service basis for the work of traditional healers and cultural practitioners in tribal -and urban-based mental health care programs should be made possible by Centers for Medicare and Medicaid Services (CMS). The State Medicaid Reimbursement Plan should include more services for prevention and community intervention to achieve long-term health benefits also for patients with mental illness and co-occurring disorders. For effective programs of treatment and preventative services to be developed, accepted and utilized by Indigenous groups and individuals, as stated in the above, local worlds, community beliefs and attitudes towards illness and the ways in which Indigenous peoples categorize disorders have to be understood (COHEN 1999:25).

8.2.3 Lack of data, literature, scientific reports and research

As described above there is an increased need for mental health care amongst Native American nations. To improve the mental health situation the creation of a knowledge base is essential. The U.S. health and demographic information systems need to be strengthened and regularly updated by new research data to analyze demographic patterns and provide accurate information on health trends, epidemiology and surveillance and disparities among and between Indigenous nations. This is crucial for optimizing the use of scarce resources, mutual understanding, capacity-building, evaluation of interventions and to make evidence-based decisions.

Comparable to the situation at the national level both the State of Washington and tribes recognize it to be a priority to improve the mental health status of the Indigenous population. However likewise there is not a consistent set of data that identifies and proves these issues. In order to develop effective service programs, to know treatment needs and the distribution and frequency of illnesses among Indigenous communities in Washington State reliable and valid data has to be acquired, an accurate state listing of all tribal needs and programs created. This might be challenging as Washington State's many self-governing tribes chose to manage their own health programs and are not always willing to dispose their statistics. A researcher on traditional/alternative medicine in Washington State commented:

> "People do not even know what the illnesses are at the tribes. They do not collect it, do not know what to do with it. Nothing. It is pathetic. There is nothing such as statistics on success rates for the Northwest Indian Treatment Center for example. They simply say how can you measure success…" (personal communication).

Although there has been a cultural renaissance and interest in traditional healing practices, there is still a considerable lack of information about their exact use. The American Indian Health Commission of Washington State acknowledged that there is a lot of promising practices in tribal communities addressing mental health in culturally appropriate ways but that they do not have a central place. Even though "the Commission is the entity that needs to develop this central place, of finding that kind of information they have not been able to address it yet" (personal communication). The important connection to the place and spiritual elements that accompany these healing methods are not known. On the one hand this provides the opportunity to evolve these practices within a changing world. On the other it contains the risk of the knowledge being lost. In this regard education is crucial and Indigenous concepts of protection of cultures and their healing systems.

Not having reliable data was reported to reduce the ability for mental health care programs to plan, monitor and improve service quality. For program planning and grant writing purposes data was stated to be important. Lack of data makes funding and competing for coveted grants extremely difficult. Tribal representatives expressed their interest in participating in an Indigenous controlled, statewide effort to collect data, compile basic mental health care statistics and standardize datasets about the prevalence of mental health issues among the tribes and programs offered or strategies employed by tribes throughout the State to improve services for grant writing, policy development, and lobbying purposes.

The agency considered the best data center for questions concerning Indigenous health in all of the Pacific Northwest is the Northwest Portland Area Indian Health Board. Contacting the agency revealed that there is only limited data available. Employees at the tribal organization expressed the need for collecting more data, however, due to a lack of staff, time and funding capacity is limited. Most of those interviewed emphasized that the process of improving data would need to be low-impact on staff time, the collection process designed by tribes, and the data controlled by tribes and/or an American Indian organization. An option to better provide comprehensive information, statistics and knowledge about healing, funding and the various determinants of Indigenous health could be to develop an online platform, similar to e.g. Naasautit: Inuit Health Statistics[38], to be used by decisionmakers, providers and community alike. This could lead to better policies and programs to improve Indigenous health conditions.

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[38] http://www.inuitknowledge.ca/graph?dsid[]=254.

Scientific literature on traditional medicinal knowledge is scanty. There is a lack of communication in that there is no publication of results in Indexed Journals as well as results obtained with the local Indigenous communities. Existing reports lack comparative study with no coordination in the activities among institutions. There is a general lack of communication between institutions and the information bank; there is little sharing of the information collected (e.g., how to access information that is not available in some communities).

There are likely to be found some papers on what services are provided in certain areas and how much they are utilized, but that information is not retained by any documentation center. Nor is there any documentation on the direct importance of cultural awareness and self-determination for mental health/suicides. The establishment of a traditional medicine program information center was stated to be imperative. The center should also act as a library for digital documentation of traditional medicinal knowledge in Washington State. However no concrete plans exist. In this context the issue of self-determination in information gathering and sharing was raised primarily concerning proprietary information, sacred sites, which the tribes might decide to not share with everyone.

Continuing education is expected to promote documentation of traditional medicine beliefs and practices by the practitioners themselves. It is believed that documentation of the traditional system is the first step towards ensuring the desired development and protection. This might encourage integration of the aspects of traditional medicine that are compatible with existing healthcare programs and support for public and private traditional health institutions. Official recognition of traditional medicine and its practice the role of traditional medicine in formal health care systems could be brought about by government documents. Moreover by completing e.g. publications on Indigenous Health and Human Rights awareness of the key health challenges faced by Indigenous peoples could be raised.

There is minimal research conducted. One of the original goals of the American Indian Caregiver Study research was to provide clinical evidence for the support of whole systems medicine and CAM methods in Indian Country and motivate similar research projects. The study suggests that there is both feasibility and efficacy of a CAM therapy derived from the American Indian dementia family caregiver one of the most stressed of cohorts. Publications of the results of the study are available. Ongoing research, however, does not exist.

As the scattered and fragmented patterns characteristic of Indigenous peoples' (mental) health research initiatives do not permit aggregation or comparison systematic information on the types of mental ill-health affecting Indigenous peoples is needed. The present small scale of most studies, the inconsistency of methodological approaches, and the

incomparability of results impede identification of the common and consistent root causes of Indigenous peoples' poor mental health.

The high need for a comparative study of integrated mental health programs was expressed to acquire necessary data to increase potential funding for traditional services. Funding and necessary expertise were reported to have been major issues to prevent this from being done so far.

Findings support that further research is needed for intervention programs designed to promote well-being, enhance resilience and improve mental health in culturally appropriate ways such as e.g. highlighting the importance of the family. In the long term cultural determinants especially associated with better emotional and social well-being ought to be more strongly considered.

Culturally competent research activities to improve the body of knowledge regarding Tribal best practices that could be transferred across different groups, and longitudinal data about what is effective should be increased in accordance with Tribal governmental approval. As contemporary progressive research techniques tend to be invasive and not directed for the benefit of tribal communities from which knowledge is acquired existing alternative research modalities which are deeply steeped in the emphasis on community needs and community solutions to community problems, may be employed, consistent with long-held tribal traditions.

Principles for participatory research management are needed to strengthen the evidence base on the health status of Indigenous Peoples in Washington State as the world over and should be widely adopted. The benefits that would result from this adoption are the greater involvement of those affected by the outcomes, facilitation of stronger partnerships between Indigenous and non-Indigenous organizations and networks, promotion of a more equitable approach to information acquisition and sharing, and to research benefits will encourage the research. A growing body of Indigenous health expertise at the local and academic level can thus be called upon to help ensure that health research with Indigenous Peoples is carried out with appropriate managerial and ethical guidelines.

Indigenous research capacity through scholarships, traineeships, professional development strategies likewise should increase.

The State should work with Tribes to develop a system to share medical record transactions and at the same time ensure that Indigenous consumers do not have to complete multiple eligibility forms or endure repetitive assessments.

The judicial system and law enforcement professionals should become a collaborator in the mental health service delivery system and be trained in cultural competency and (crisis)

interventions, dealing with people with mental illnesses in order to adequately protect communities. Furthermore Tribal court orders should be recognized by Washington State and local governments with full faith and credit, Tribal assessments should be accepted.

8.2.4 Infant stage of traditional medicine training institutions and credentialing

Many community members stated holistic education programs to be lacking which could address health needs. An undergraduate program in herbal medicine exists at Northwest Indian Community College but there is need to accredit the program to ascertain the placement of the graduates within the formal healthcare sector. A masters program exists through Lesley university as a distance learning opportunity.

IHS standards require that providers of mental health services are fully competent, certified, or licensed in the discipline in which they practice. Providers first contacted by Native Americans in need of behavioral health care usually are providers such as primary care physicians, mental health paraprofessionals, or laypersons. Licensing provisions for these providers are not considered by current credentialing procedures which emphasize the more established behavioral health disciplines (MANSON 2004:xvii). Despite being vitally important providers, primary care physicians, mental health paraprofessionals, or laypersons typically lack licensure or certification. In Washington State as in most U.S. states a recognized healing modality, such as massage therapy, is licensed by the state. Practitioners are required to pass tests, including certification in ethics. Thus the legitimate benefits of a trained massage therapist is recognized by medical professionals who often recommend a licensed massage therapist assist with the healing of a patient. There are no licensing boards or governed regulations for Indigenous healers. Anyone can call themselves a healer. As there is no such safety standards for Indigenous healers patients can become victim to any number of "healers" who do not possess expert credentials. As with the increase in popularity of unconventional healing techniques it might seem more lucrative for some to call themselves healers despite lack of proper training. In well functioning communities this is not seen as problematic as people check on each other and referral works on a word of mouth basis. Accountability of traditional healing providers, though, only is to the people they care for. States have not explored yet how to address issues of credentialing for these providers. Currently there are no professional associations created to help people choose a reputable Indigenous practitioner.

Traditional healers are not required to be certified when working within tribal programs. The tribes can decide themselves who to hire or ask to deliver services which can enhance in an

unbureaucratic way to improve culturally competent services. The tribes have to determine how to guarantee safe standards of these practices.

8.3 Present potential of traditional healing

Over the last years local groups have become more aware of traditional therapies, healthy foods and lifestyle. The NIH sponsored Indian Caregiver Study which used a CAM method showed that people enjoyed the alternative therapy used and wanted to follow up. A researcher commented on the strength of cultural treatments, "the importance about traditional medicine is the lifestyle changes that occur. People become aware and integrate it into their daily lives." Participants wanted to continue after the study, however, due to a lack of funds it was not possible. One year after the study the participants would get free massages and CAM treatments though when the research team was at conferences or other venues on the reserves. One participant said she was "Sad that it's ending [the study], but energized because it's a whole new path to take."

To reintegrate traditional healing back into tribal culture thus may have two effects. On the one hand recognizing and reevaluating traditional healing practices may lead to increased willingness to share and discuss cultural healing practices. On the other hand individuals may begin to learn and use medical practices lost to acculturation as well as explore more recently introduced forms of alternative healing.

How a program is respected, perceived, people are recruited, or get interested depends on the individuals. A practitioner explained, "When someone says it to be a good program people will participate." Recruiting participants for the NIH study researchers went directly to tribal centers. Trying to build anything from a distance in an area where everything is being local does not work. A local Chinook researcher commented,

> "When you go there [reservation] you are looked at like you look like you have an Indian face. If you ask a question and they know you are not from the area you meet with the same resistance. It depends from person to person. You could always go to a gathering there but when you are not from the tribe they are like what are you doing out here? They are pretty suspicious… Tribal communities are as all other small communities. Access works via health fairs. You have to be in the community. If your face is seen again and again they just talk. Just go there and just be there, chat with somebody randomly. Connect with them build a relationship. When we lost someone it was because we were not there often enough. It is all about relationship. Keep that relationship going. They wanted to have the relationship with the therapist. If it is just for me (as with the respite) then they might not do it. If there is somebody else waiting for me then they go… You really have to know someone there. You cannot just go to the tribes and pass out flyers and think that somebody is going to call you. If you are seeing someone who is respected in the community, they are curious, ask what you are doing. Health practitioners are the most helpful, nurses, doctors, oh, my cousin might have somebody."

For like reasons of networking an advisory council and personal connections is important for any type of studies.

At the tribal clinic level the bicultural model gains in popularity. The hybrid therapy or community clinic approach employs staff who are trained in both Western and Indigenous treatment as well as epistemological systems. Medical doctors and healers work alongside other psychotherapists. This model intends to offer more culturally appropriate services. It allows a historically and culturally inclusive approach and enables customers to openly talk about issues of internalized oppression or adoption of negative stereotypes. What customers report to be crucial is that practitioners are sincere and appreciative. They should genuinely believe in their medicine and healing powers and live a lifestyle that follows traditional forms or be genuinely respectful towards Indigenous cultural beliefs and practices. One Indigenous consumer described:

> "When you talk to a Native there is already shared knowledge but with a non-Native, I don't go into it. I just give small details. There should be a Native person asking questions, someone with empathy. I am not as open and honest as I could be if a non-Native is just asking the questions."

Furthermore national accreditation is becoming a more viable option for many tribal-based mental health programs which are increasing their revenues by billing under the Memorandum of Agreement. Meeting accreditation standards seems not to be a problem for these programs. Obtaining the accreditation would answer all questions concerning the level of professionalism by which these programs currently run. Furthermore, tribal-based programs, by gaining national accreditation, are in a much better position to negotiate for access to the State of Washington's inpatient system. Also competing for grant funding from state, federal, and private organizations gets easier when obtaining accreditation. Programs can receive national accreditation through several means. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) confers accreditation, however, can be quite costly. Alternatively, Association of Allied Health Professionals (AAAHP) and Commission on Accreditation of Rehabilitation Facilities (CARF) stated they have had great success in accrediting American Indian behavioral health programs in the past. They offer three-year accreditation at a cost of between $3,700 and $5,000 per three-year period (in 2010).

8.3.1 Political acceptability -stakeholders are willing to engage in dialogue

Historically longhouse societies in Western Washington defined the cultural and institutional mechanisms necessary for supporting mental health and care. It is now the modern tribal

governments that have the responsibility for creating new social health and economic institutions that support and serve those suffering from mental disease. Government sponsors the continuing development of self-determination strategies. The BIA is becoming less and less involved.

The Indian health service is very limited in their services as could be seen. Tribes are relying less and less on the IHS and doing more of their work, providing their own services because of financial and political issues. Model examples for good work are at Port Gamble and Nisqually. The Puyallup with their health center has a first class establishment and programs.

Unlike most states Washington has better laws and better policies than most other states securing state tribal relationships on a government level. The Centennial Accord 1989 sets the tone of this relationship, fully recognizing the tribes as sovereign governments and works together with them. Also 7.11 policy concerns the commitment of government and requires the state to build relationships with the tribes and maintain their government to government relationships with the tribes. Any policies that pertain to the tribes in any way the tribes have to get involved in the so-called consultation process. In accordance with the Centennial Accord, meaningful Tribal consultation should be established. This means that the State should work with Tribal representatives at the government-to-government level on a regular basis for the discussion of mental health issues, policy development, collaboration, as well as program assessment and evaluation. A process should be developed that ensures Tribal representation on all respective bodies of decision making that impact local tribes. Non-Indigenous government employees must respect tribal management and control and self-determined health care delivery systems - may this be through the IHS or Tribally-operated programs.

Necessary information to understand tribal sovereignty can be obtained directly from the tribal community or from Governors Office of Indian Affairs (GOIA) or DSHS Office of Indian Policy (OIP).

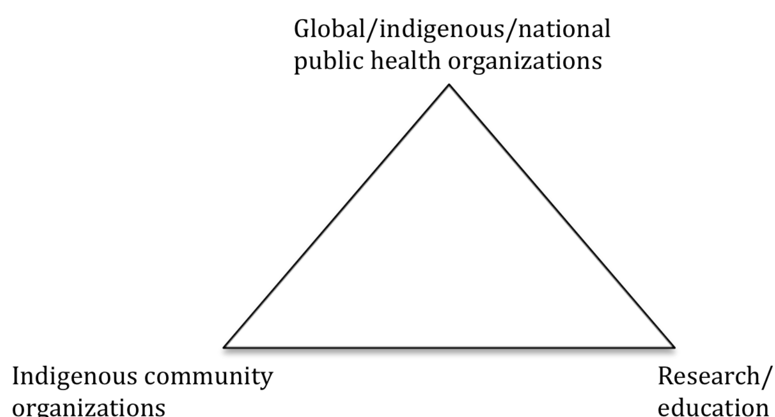
Due to the consultation process tribal governments are very connected to the states governments at the highest levels and the tribes will meet with the governors -on occasions with the highest executive branches of state government. A tribal leader explained: "It always amazed me how it puts you up there. It is practically a government to government relationship -it is very big."

Still the collaborative climate is very official. The headquarters of the DSHS where the MHD system is located, which is at the very top and oversees the mental health in all of Washington, is an anonymous work environment and not community based at all as a Native employee with the MHD explained: "It is this whole culture of I mind my business, you mind

your business…. And I think that is part of our culture that we are working in the environment at that level that oversees the mental health system which is the epitome of bureaucracy at its worst. And there is something that seems wrong to me with that. Humor is not allowed. Nobody is really joking, having fun. There are people who are actually products of the system. They went through the mental health system, some of them were hospitalized and had extreme difficulties and some of them went back to school and got educated. They had their issues, know the system and have risen above it, they are functioning."

Uncoordinated programs -Stakeholders within the traditional health sector are numerous and diverse. The DSHS, the IHS, Ministry of Food and Agriculture, Environmental Protection Agency, the tribes to name but a few. There is however no program for collaborating and coordinating their activities. A better understanding of the many actors involved and what motivates them as well as building relationships are fundamental for collaboration between the tribal and government and mainstream health systems. There is also need for regional state, federal and international collaboration in best practices research as well as consultation with National and Provincial mental health bodies and Indigenous people to develop program standards, outcome measures and evaluation criteria and methods. Collaboration through broad -based partnerships with Indigenous communities is needed for all program development that has important implications for mental health service delivery.

Figure 26: Collaboration Through Broad - Based Partnerships



Source: Own illustration

Collaboration is required to discuss the crisis in mental health workforce for Indigenous populations. To improve Indigenous health and eliminate disparities it is critical to increase the number of Native American physicians. This applies to the primary care setting as well as research and leadership in Indigenous health and medicine as well as medical training.

In workforce development it is important to train and engage minority consumers and families. Increased staffing and extra training, which allow for better understanding of the causes of mental problems in Indigenous communities, would enable practitioners to expand true involvement with their Native consumers. Training primary care providers to improve their ability to recognize depression, substance abuse and related mental illness would enhance early intervention.

At the moment people learn about existing programs through direct interaction and exchange mainly at statewide conferences. Exchange on programs takes place at these conferences or meetings in a by chance manner. There is no coordination or centralized information center. Communicated information obtained in conferences and other events is not broadly shared. The potential of building capacity through networks of research institutions and experts dealing with health and ethnicity issues in regional and country contexts was recognized. Furthermore it was identified that tribal agencies, state institutions and the persons they help frequently fail to communicate effectively between themselves and with the service population. Methods of communication with service populations commonly used to disseminate information in metropolitan areas (radio, television, newspapers, posters, flyers and pamphlets) are oftentimes ineffective in tribal communities. When written material is presented in the language of "bureaucratic jargon" either by the tribal program or the state/county agency, the degree of understanding and confidence in the information is frequently reduced or very low. Successful communications in many tribal communities are more labor intensive: visits in homes, conversations at gatherings, public presentations and supplemental written material outlining key elements of information. Mental health providers should seek both formal (i.e. programmatic) and informal relationships with local Indigenous groups in order to prevent the social stigmatization of mental health services and their users. Non -tribal representatives should realize more that Indigenous people tend to use different methods of interpersonal communication and social interaction and have many cultural and value differences. Understanding that interaction takes place in a cross-cultural environment and respecting differences could improve considerably the success of the communication process.

Improved cross-cultural communications is needed to maximize the benefits of inter-agency cooperation. On the one hand informants reported that some of the most effective staff and managers were able to navigate both worlds having spent time working in both state and tribal agencies and thus serving successfully as translators across the institutional and cultural barriers to cooperation between tribal and state players. On the other hand informants repeatedly mentioned cultural misunderstandings, perceived discrimination and

bigotry during communications between state and tribal personnel as well as programmatic miscommunications. The effect of "local politics" was seen in some cases as an obstacle to effective service delivery from the point of view of state/county personnel.
To work with appropriate provider groups dialogue between Western and traditional practitioners therefore needs to be promoted to encourage a greater understanding and acceptance of each other's philosophies and treatments, as well as to discuss the unsolved issues related to the practice of traditional healing. The wish to take the best from both healing systems was expressed despite disparate views as to the exact way how integrating Western and traditional approaches should be achieved. An Indigenous representative explained about the Indigenous concept of having one foot in both worlds:

> "Natives take whatever is useful from Western culture, e.g. horses and guns, or Sami people the snow scooter. The question being what is it we can take from Western culture and use it in our context - also in entrepreneurship [...]. How to use Western inventions to enhance your own?" (personal communication).

Tribally-chosen partnerships with outside institutions have provided access to outside expertise and high caliber information drawn from a variety of sources for the enhancement of existing programs/projects which can act as the foundation for further reform. Achievement or substantial improvements in Indigenous mental health will depend on long-term collaborative approaches involving Indigenous communities and leaders government representatives at all levels, the health and non health sectors. Addressing the housing issue discussing models of housing for supported/assisted living which fit with the family and community orientation of Indigenous groups e.g. demands integrated approaches which cross jurisdictional divides and address the politics of life on the reserve. Strong linkages need to be made with Band Councils.
In 2005 Washington State received a grant from one of the federal agencies in the U.S. and the center for mental health services, a subunit within the SAMHSA to make sweeping changes in its mental health system. This mental health transformation project is to build the infrastructure for an on-going process of planning, and innovation in mental health care trying to assess what the States' needs are and to support intervention in that regards. The SAMSHA program could be seen as a first step and small part of meaningful Tribal participation providing a chance for Tribes and State to work cooperatively to improve the delivery of mental health services to AI/ANs in Washington bringing together Tribal service providers, higher education, Tribal health organizations, SAMSHA, and other collaborators to discuss approaches (AIHC 2007:2).

Under the program community treatment team based mental health interventions are evaluated which are top of the list of evidence-based practices for severe mental issues. Many people believe they are alternatives to psychiatric hospitals because people with severe mental illness can be kept functioning in the community as opposed to needing full time hospitalization. The state has created 10 of those teams located in the communities in Washington. Experts are working with data of 722 individuals enrolled, including Native Americans. Ethnicity will be one of the categories looked at with one of the variables being the demographic status of individuals and whether that has any impact on their subsequent experiences.

Native American therapies need wider acceptance from mainstream sources to adapt in the contemporary context and gain appropriate funding.

Due to the many policy changes concerning self-determination there is a general need to increase understanding of the major organizational and financing changes of mental health care which are underway in American Indian communities and the implications of these changes for resources or the quality of services.

Because of the magnitude of the required overhaul and according reluctance to reform the health system a road map should be designed using a step by step approach, building incrementally on each legislative and political achievement. A definition of clear goals should be included as well as the identification of the existing elements of the system that could be enhanced.

As to what regards reform of the RSN system the State of Washington should not delegate the shared responsibility that it has with the federal government to provide mental health services to RSNs, municipalities, or other governmental institutions. In direct consultation with the Tribes the State, should develop a direct reimbursement system which responds to consumer needs and that provides reimbursement for all Tribal behavioral health services.

Besides cultural revival can spur controversy. Public acceptance of the Canoe Journey is high. People of all backgrounds like watching the canoes. Recently though attacks of the canoes by motor boats have been reported to increase (MANSON 2004).

There are also tensions because of non-Native people who do not understand the background of and begrudge Natives' special hunting and fishing rights. A Native fisherman of the Swinomish tribe complained about being verbally attacked all the time by non-Natives when fishing despite the fishing rights officially granted to local tribes. Some non-Natives opposed to fishing discriminate against Native fishermen when out on the water. In addition to overt institutional racism everyday discrimination in the form of derogatory remarks, outright

insults and humiliation pervade the life of American Indians. A Native leader commented on this that the local settler culture should take to heart Native knowledge that in the fight against discrimination and disadvantages in health, “tolerance of difference is likely to be more effective than tablets.”
In 1994 the Eastern Pacific gray whale was taken off the endangered-species list. Consequently the local Makah tribe, located at the northwesternmost tip of the Olympic peninsular resumed their traditional whaling practiced granted as a treaty right by the U.S. government in exchange for ceded lands. The special right to hunt whales was approved in the mid 1990s, by the International Whaling Commission. In 1999 several young Makah men harpooned a whale after a two-year training in which they had prepared for the whale hunt according to protocol. Tribal leaders would like to continue getting one whale a year as they believe it would get tribal members interested in their culture and help to reduce alcohol consumption through the stimulated interest in Makah culture and traditions especially with the youth. At the time of the 1999 whale hunt there were legal attempts from animal-rights organizations to stop the Makah from hunting the whale. To this day the hunt is discussed very controversially. Interview partners commented the hunters tortured the animal and then “did not even eat the meat” which is “still sitting in their fridges.”
Relations between Natives and non-Native individuals are oftentimes tense. Non-Natives begrudge the tribes the tax free status. There are also negative attitudes towards the tribes running casinos on the reservations generating considerable amounts of money in some favorable locations. Also stereotypes are rampant. While tribal members hold stereotypical views about non-Natives describing them as “mobile home people” without roots and proper culture. Concepts of the “drunken Indian and the non-working, lazy Native living off of tax money are common. These and perceptions of the “uneducated wild guy”, or romantic “living as one in nature”, or peoples who need help have to be challenged.

Furthermore the cultural revival efforts amongst the tribes on the Northwest Coast which directly show in their choice of mental health care alternatives and lifestyle initiatives, congruent with own values, traditional beliefs, and philosophical orientations toward health and life probably is somewhat in line with the ideologies underlying the alternative health orientations of the so-called LOHAS’ new lifestyle movement of health and sustainability mainly popular in the U.S., Europe and South East Asia. Some of which might have to do with a new age mysticism, an increase in antiscientific attitudes and in conspiracy theories towards profit oriented conventional medicine and pharmaceutical companies. This new interest in

Indigenous healing might lead to enhanced communication and exchange, however also yields the threat of further exploitation of Indigenous knowledge and practices.

8.3.2 More affordable type of care with a focus on prevention and promotion

Preventing Mental Illness and Promoting Mental Health

There are numerous mental health problems that plague Indigenous groups, the majority, however, though at risk, are free of mental disease. Therefore analyzing self-determined Indigenous approaches to health, including preventive and promotive interventions have to be considered as Indigenous groups themselves emphasize; preventive and promotive programs have a central place in Native mental health and well-being (See MANSON 1982). An interviewee at the Canoe Journey commented on the importance to practice preventive health care: "I believe that it really is necessary for us all to take care of our health, not to let it deteriorate. Sometimes there is no doctor around and oftentimes the doctors don't have all the answers."

Tribes maintain the mainstream health system, as of now, does not focus on preventative approaches and that the government needs to support prevention more. A state health expert commented:

> "Our health system is flawed it is not working as well as it should. Health care is what we are trying to fix. It is something we have not figured out quite yet.... There is still not really the concept around, not an understanding of thinking about on the front end or preventative or savings. People are more into saving money now, not thinking so much about thinking in the long run, saving money along the road and the impact it has on the whole family" (personal communication).

Prevention of mental illness has as its goal to decrease risk and increase protection. In the promotion of mental health Native nations move beyond this model. Due to their understanding of the unity of mind, body, and spirit Native people consider individual as well as collective strengths for psychological well being. The relationships of these strengths to mental health and methods for promoting them though are hardly clear yet due to a lack of data.

Increasingly in the past within tribal settings dedicated efforts to prevent mental disease and promote mental health have been undertaken. There has been an emerging focus on family and community empowerment programs, and strengths based approach to both ameliorate risk and foster resilience addressing those elements such as historical social inequities that have contributed to the cumulative stress experienced in many communities.

Interventions emphasize on finding community answers and solutions to their own problems although their ideas tend to be dismissed when suggested to various agencies and governments. Visits to tribal communities which run their self-developed projects show the

strength of commitment when the program is owned at the community level by the community.
Early prevention programs that are community oriented have a strong focus on social and cultural enrichment especially when addressing problems in development of youth related to boarding schools. Moreover mainly alcohol and drug prevention efforts have grown in tribal and public schools as well as programs that have a focus on mental health issues, e.g. suicide prevention.
A program that stands as an example for community involvement is the Senior Meals Program of the South Puget Intertribal Planning Agency at Squaxin funded through U.S. Department of Agriculture (USDA) and administered through the Administration of Aging (AOA)which serves meals to supplement Elders' diets. The program also functions as an opportunity for social gathering which participants reported is important for their psychological well-being. The Elders go to the Center to eat and meet but are limited to go elsewhere for social activities. Elders do not have transportational or financial means to go and visit friends in other tribes when they are invited. The federal grant does not allow enough funding to travel. Without tribal funds most would not be able to go to other tribes as far away as the Lummi, Suquamish or even Coeur d'Alene in Oregon. These relationships and visits are important for elders. "It helps against depression," an elder explained.
Community Services programs address a variety of needs within each tribe's community to improve the health and wellness of community members. Community organizations, such as senior centers, can also play a role in preventing suicide by providing either direct access or referrals to mental and physical health services. The State and Tribes should work together to develop Community Mental Health Centers to promote the seamless delivery of services.
Years ago already preventive interventions, which rely upon cultural tradition, have emerged addressing child neglect, domestic violence or spousal abuse in American Indian communities. The Whipper Man was successfully introduced in foster homes as an Indigenous concept of social control amongst Northwest tribes to enhance self-confidence and reduce crime (SHORE and NICHOLLS 1975).
Recently a program at the Shoalwater Bay Indian Tribe, located west of Tokeland, Pacific County, Washington, has been successful in prevention and improving outcomes by developing a community-based primary care program, which closely integrates behavioral health services. The model enhances, collaboration, communication and the sharing of patient information amongst all providers, which promotes understanding. Patients feel safer and better cared for. Bi-polar patients, who previously typically self-medicated with drugs and alcohol after going through treatment have become functioning productive citizens. The tribe

maintains that this integrative program run by a multidisciplinary team of professionals will reduce suicide through early identification and treatment of warning signs such as depression (AIHC 2007:36).

The perceived success of these and similar programs suggests that probably the most effective long-term need is the involvement of the Native community itself exploring alternative life style behaviors within their own culture which might promote resistance to mental health disorders. These preventive community-based interventions that differ according to the specific geographic realities of the tribes are consistent with the specific local tribal traditions. They take into account risk factors specific to Indigenous culture such as loss of tribal identity and acculturation.

Indigenous experts argue that Indigenous health services should use models and approaches to mental and behavioral health, which treat the whole person and could integrate areas such as substance abuse, suicide and violence prevention.

Just as other areas of medicine have promoted healthy lifestyles and thereby have reduced the incidence of conditions such as heart disease and some cancers, now also mental health providers, researchers, and policy makers should focus more on promoting mental health and preventing mental and behavioral disorders. Following this course might yield incalculable benefits, not only in terms of societal costs, but also in the significant decrease of human suffering. Progress in prevention and successful interventions among American Indians may have broader application to other populations. A better understanding of what some of the Indigenous people can give and have given mainstream society, their contributions to medicine and other aspects of culture, can constitute the basis for a healthier attitude (VOGEL 1990:266).

As could be seen various intervention strategies among American Indians use a place-based, cultural approach in the endeavor to improve mental health and decrease the developmental risk for mental health problems. There has not been an evaluation of their effects yet, however, personal accounts indicate significant gains that can accompany such interventions. One has to furthermore take into account that the evaluation of the preventive interventions that promote the strengths and resiliencies however is impeded by the current paradigms and limits of science. Culturally defined interventions and outcomes require appropriate conceptualization and measurement.

New perspectives and tools need to be explored that take into account cultural knowledge. One has to note that there has been work on psychological well-being based on concepts of the relation between happiness and positive mental health as well as ensuing work on self-empowerment, competence, and resiliency (STERNBERG 1990). These understandings

correspond to Indigenous consciousness and models one of which is the concept of tsawalk in the Nuu-chah-nult worldview as Native scholar Richard Atleo describes:
Tsawalk is the central idea in Nuu-chah-nult cosmovision upon which various fundamental aspects of Nuu-chah-nulth society are based. The literal translation of this Nuu-chah-nulth phrase tsawalk is “everything is one.” It is an ancient wisdom reflected in a Nuu-chah-nulth origin story that asserts the value of the individual, of the group and of the interdependence of all things. That view understands the nature of existence as an integrated and orderly whole, and thereby recognizes the intrinsic relationship between the physical and spiritual. It encompasses the notions of the value in life, connectedness, harmony of relations with others, reciprocity, balance, and completeness (ATLEO 2004:133). Recognition of the need for and possibility of transformative change is also part of this ancient Nuu-chah-nulth wisdom. Tsawalk provides a viable theoretical alternative that both complements and expands the view of reality presented by Western science and allows both Western and Indigenous views to be combined.

8.4 Threats to traditional medicine practice

The influence of foreign culture with the devaluation of traditional medicine and its inefficiency in the face of introduced diseases like smallpox against which traditional medicines were inefficient has led to it being rejected by people. Pursuing other foreign religious beliefs had the same effect. Even though the cultural base of the medical knowledge system still persists and enjoys some high levels of acceptance practitioners therefore may not have individuals within their lineage interested to receive their traditional medicinal knowledge for fear or acceptance. Still traditional healing constitutes an integral part of the socio-cultural foundations of local Native groups which places it in a strong position for its development.

Another threat is loss of diversity. Northwest Coast nations are confronted with many of the contemporary challenges facing humanity. The threat of loss of plant resources and over-exploitation of forest and plant medicinal as well as food resources has endangered many species. Problems of overfishing, pollution of waters, the risks of contaminated foods from herbicides, pesticides and heavy metals in e.g. Oolichan grease and the destruction of biodiversity are some of the issues. Moreover industry and traffic on the ever-expanding roads cause pollution. Although data currently available on the depletion of traditional foods and medicines is scanty, evidence exists that traditional medicine practitioners in the local communities face more challenges to find natural resources. Traditional resources like fish,

cedar and bitter root have been diminished by overharvesting and habitat destruction. The voracious hunger for exotic wood in foreign countries has decimated already more than 98% of Washington State's natural old growth forests consisting of the tall cedar trees the region is well known for. Indigenous carvers report they have difficulties to find enough material for their big dugout canoes.

Many plants have disappeared under concrete because of extensive building activities. As of 2009 Washington State has an estimated population growth of 13.1%. Due to ongoing development activities land property issues currently impede access to traditional hunting grounds. The widespread destruction of the environment motivated by commercial interests also renders hunting more and more difficult. Native fishing activities were impacted by salmon farms which affected the salmon markets and people making a living of fishing. Over the years farm fish has lost its appeal, fisheries faded out. Natives increasingly are in commercial diving and harvest local geoducks. Still, fish such as the oolichan which became a local hero – a symbol of plenty, recently, like a ghost, has vanished in many rivers. The great run of Columbia River smelt was once the largest run of oolichan in the world (Eulachon Research Council 1998:5). During 1940-1992, the average catch was a whopping 1,076 tons (WDFW&ODFW 1996:111/12, Table71). Since 1993, the returns to the Columbia River and its tributaries have been dismally low, yielding an average commercial harvest of just 90 tons. In the past decade puzzling variations in oolichan spawning runs have been noted, ranging from a complete disappearance in California, to dramatic seasonal drops in formally stable rivers such as the Fraser. The explanation for the decline is uncertain but could be a combination of broad-scale changes in ocean conditions or commercial fish bycatch and local effects such as overfishing or physical habitat degradation and human caused contamination of the ocean. Reduced numbers of oolichan due to pollution or other environmental changes dramatically affects the lives of other animals. As in addition to serving as a rich nutrient for Salish and neighboring Indigenous peoples oolichan are an essential food for whales, seals, salmon and other predatory fish. After three years living in the ocean spawning begins. If the environmental conditions aren't exactly right though, oolichan will not spawn and will simply return to the ocean where they attempt for two more years to spawn. If they fail to return to their river after five years, they die in the ocean.

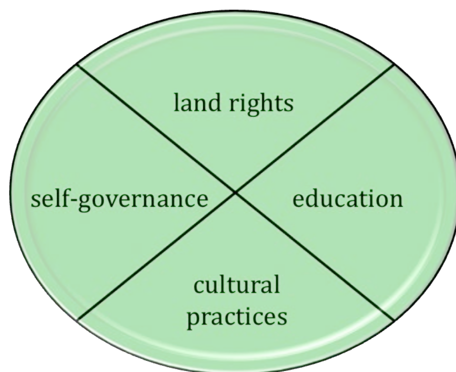
As a consequence, when the oolichan oil is available 500 milliliters will fetch as much as $25 in the United States or about $200 per gallon -a price some Native individuals are unable to afford. Smaller quantities of luxurious oil are delivered to specialty Salish restaurants and families unable to produce their own oil.

The depletion of plants and fish can be attributable to the ignorance of people about the dangers of over-exploitation of natural resources, environmental degradation and land use issues. Traditional healing practice therefore cannot develop sustainable industries without an aggressive program of biodiversity conservation and re-forestation. Educational campaigns on the conservation of medicinal plants and natural resources should be launched. National, regional and community based programs should be initiated to educate all people on the need to conserve biological and cultural diversity. Effective education, information, and communication strategies have to be developed by the tribes in collaboration with other sectors including Ministries of Environment, Land and Forestry, Food and Agriculture, Education etc. Use of local or tribal broadcasting network (TV stations, radio stations) should be employed in this regard. A program of culture and biodiversity conservation should be developed.

In addition to loss of foods and traditional medicines Indigenous exposure to environmental pollutants through cultural practice has consequences on physical and psychological well-being (SALDAMANDO 2008: 50). Cancer rates significantly above the national average and ensuing death were reported by Indigenous representatives in the Columbia River basin close to Hanford nuclear reservation in Washington State. Heavily exposed to high levels of persistent organic pollutants from their diet local Indigenous fishing communities remained deeply traumatized through the experience of loss.

Moreover urban sprawl, environmental pollution and overfishing endanger Indigenous lifestyles. For Indigenous individuals and communities the significance this has is equivalent to the loss of status and social role in non-Indigenous urban society. The threat of loss of forest areas and clean water and over-exploitation that has endangered species and polluted resources is a severe threat to the well-being and very survival of Indigenous cultures. Furthermore climate change endangers natural habitat with warmer water temperatures, glaciers melting, and shifting plant and animal species. Storms and floods are increasing which along with potential sea-level rise can negatively impacts coastal tribes (Grossman and Parker 2011). While Indigenous peoples are hard hit by contemporary issues such as climate change they have adapted to change. Indigenous knowledge especially in climate change discussions and concerning know how in harvest of natural resources has been acknowledged to contribute to meet change and was recognized as an important supplement. In this field harmony between knowledge based on experience and knowledge based on research is being reached in certain aspects. The extend to which traditional knowledge exists in a community varies. Several factors can serve as indicators for the existence of traditional knowledge.

Figure 27: Critical Indicators for Existence of Traditional Healing Knowledge



Source: Own illustration

To sum up effective mental health interventions for the Indigenous peoples in Washington State must consider all the facts listed above and ensure self-determination of policies and programs. Communities must be able to define the critical problems they face in a holistic way as well as to designate appropriate solutions to maintain or improve mental health. A community-based and culturally appropriate approach to mental health care in which traditional healing and Indigenous perspectives and understanding of their local geographic realities play a major role is essential to preserve Indigenous cultures and eliminate health disparities. The tribes are increasingly using GIS systems for cultural use maps or land use planning asking questions such as where does development interfere with traditional lifestyles? The use of newest information technology (apps, social networks, GPS) to exchange traditional knowledge is growing amongst the tribes as is telemedicine. This opens up a new field and opportunities of interspatial communication. "Indigenous cartography" as an innovative pragmatic discipline should be established and used as a new approach to land consciousness. Indigenous community groups and youth could be encouraged to engage in map making. The communities could get together in a collective attempt at trying to discover the individual components that form the intricate relationships between place people and health discussing the specific properties and place characters important to them in their specific regional area. Producing a comprehensive community atlas might lead to the development of a group-self of a caring collective. The common map making exercise might also enhance intertribal communication as different tribes could get together to discuss conflicting priorities and widely disparate points of view, share their experiences and stories and identify needs and potential in the whole region. Indigenous experts skilled in map making could use their acquired expertise in modern software and technology to create metaphorical pictures of the local reality on the community maps. Changes in environment and climate could be documented. Areas of high diversity, development and environmental destruction could be identified and potentially shown in how they relate to culturally

meaningful sites, such as hunting, canoeing or praying. Each map would contain unique elements of importance and knowledge distinctive to the region in which they get produced. The tribes then need to decide whether they want to share these maps or keep them to themselves as protected community knowledge. Communal learning and teaching about map making tools could furthermore take place in workshop settings.

8.5 Safety and efficacy

The field of Indigenous mental health is in its infancy. The new Indigenous cultural movement is inspiring for many. In the backdrop of a country where people are typically starved for culture many things will be tried out. This involves some danger. Questions arise how to best guarantee safety and avoid damage. When is the healing real?

Safety and efficacy standards are required for any type of healing practice. The majority of traditional healing practices, however, are not being assessed for safety and efficacy. There are no good measures of efficacy of overall health care services for the Indigenous population. Nor clear guidelines for people who work in Indigenous mental health. The same lack of regulations holds true regarding ethical guidelines for health care provision in Indigenous communities and research. Regulations on the use of traditional medicinal methods are if in existence at all at the most scattered and uncoordinated. Monitoring and evaluation are ineffective.

Evidence-based studies are lacking because it is a rather recent phenomenon. It poses numerous challenges to scientifically measure traditional healing approaches. Very few evidence-based programs that are adapted for Indigenous cultures exist (The Suicide Prevention Resource Center 2005).

There are two different evidence based models alleged to be effective with Native American communities. One model is based upon the culture of non-Indigenous developers with so-called "Indian window-dressing" so the model appears neither culturally grounded nor sufficiently tested with Indigenous population. However it is assumed to be effective with this population due to the fact it was utilized with other ethnic groups. Practices are adapted to specific cultures through e.g. substituting themes or Indigenous names.

The opposite model is the Native -developed and designed practice model which is based on culturally grounded and congruent practices emerging from traditional worldviews, behavioral norms, and relationships. The efficacy of these models has not been evaluated. Indigenous representatives, though, prefer this latter model to be fostered, promoted, and evaluated rather than simply applying practices developed with other ethnic groups. Federal agencies in close collaboration with tribes should promote and fund research and evaluation

of such practices conducted by Indigenous evaluators primarily using culturally appropriate measurement instruments and develop a practice database. Evidence based and promising practices which show the potential to be of use to the Indigenous population should be adapted.
Claims of success of this model are solely based upon observations which reflect participant experience and anecdotal information. As of now the model has not advanced to the level of being promising or evidence based.

Evidence based practice is talked about considerably in Washington State. However it has not happened at the tribes yet. There is very little information, and very few studies available. To get data on which methods are working and which ones are not working therefore is hardly possible. It has been difficult for tribes to establish good practice models in therapy or recognize what is culturally appropriate. There are internal mechanisms to identify appropriate interventions and it was reported that "if any tribe would say something is not working they will drop it" (personal communication). A therapist explained that Tribes are involved to "bring evidence based therapy in [… but] a lot of folks have not tried it in their communities [… and] what works in one tribe might not be applicable in another tribal setting" (personal communication).
The system is very autonomous. In Oregon there has been some acknowledgement for tribal methods of practices that can receive funding and are recognized without State regulation. The programs using traditional services are recognized and regulated as such by tribes and when billing for practices with Medicaid from the State. For billing with the State services have to be certified. Traditional healing ceremonies take place in addition to certified services in a blended approach offered in cultural centers and in the clinics. A typical treatment plan might be three alcohol and drug groups and one talking circle per week. Financially tribes support traditional services but are not necessarily allowed to bill for it even though some programs might be funded in state funding acknowledging that some traditional practices might be incorporated. According to the Portland Indian Health Board due to the many current cuts, it is not clear if "anything can be added but tribal programs will continue to incorporate traditional practices for sure" (personal communication).
There have been talks to increase research in that area as it was recognized to be important and helpful to find methods to improve services. It was reported to be priority a to see how patients react and see what the outcome, efficiency and value of integrated programs are. There is considerable support for traditional healing approaches, even without scientific evidence. An agency explicitly doing research in that field could not be identified. Some

qualitative data on the value of traditional services was reported to supposedly be managed by Portland Indian Health Board as the data management agency which, however, could not be verified by the contact person at that institution. A particular awareness of a study or body of knowledge about cost efficiency of traditional services does not exist. The agency to analyze program effectiveness is the IHS Portland.

In spite of inadequate scientific data on therapeutic evidence of success, credible anecdotal evidence exists. There are believable testimonies of therapeutic success in the use of some traditional healing interventions. Many present-day Indigenous practices which are still used in individual treatment by healers have been recommended by Native Americans for generations if not centuries.

To identify adequate interventions there needs to be research conducted in the area of evidence based practice. Professional data management is needed as well as efforts have to be undertaken in coordinating and legitimizing traditional health care with the biomedical system of care. More information about Indigenous healing beliefs and practices establishes the basis for policy development for culture based health care delivery to Indigenous group. Enquiries have to be done to analyze how traditional healing methods such as the canoe journey have an impact on lifestyle changes. A research fund should be created to support tribal investigations into traditional healing remedies. The capacity of tribal or non-tribal research would be strengthened to enable handling of the considerable volume of traditional healing practices. Effective models for assessing efficacy would be adopted. Findings will have to be translated into state-specific policies with a focus on practical policies for the individual population whose need might differ depending on their exact geographical locations.

Tribes should develop quality standards and create consensus among the healers of the important aspects, values, and healing methods that are unique to the individual local tribes.

8.6 Policy on traditional healing and the right of self-determination

Improving mental well-being was found to not merely be about individuals and groups changing their behavior through traditional knowledge interventions but about changing societal circumstances. Change must also be initiated at the political level, which is where significant attitude behavior gaps exist. Besides depending on changes in mainstream health care management, the future of health care for Indigenous Americans is intertwined with policy decisions at the federal as well as state level.

There are no official policies in the U.S. regarding traditional healing, whether Native American or imported systems, like Chinese medicine. In regard to U.S. medical policy, this lack of recognition of traditional healing practices has led to a situation where traditional healing resource remains underestimated and under researched.

As described in the above, Indigenous traditions could be kept alive in tribal communities in Washington State. These Indigenous groups have developed numerous (prevention) programs which focus on traditional approaches to physical and mental health and well-being. Although tribes know about and the IHS acknowledges the importance of traditional healing there is no formal policy to protect these methods within the IHS system. Nor is there any guidance to IHS staff to ensure that traditional healing practices are given the same respect that is given to conventional Western practices.

Washington State is fairly progressive compared to other States in the U.S. concerning regulations about the practice of alternative medicine. Massage therapy for example has to be covered by insurances. However nothing is moving on the policy level concerning integrative services. Indian health programs should be permitted to integrate traditional health care practices into their prevention/wellness programs with no adverse impact on the ability to receive federal support for prevention and wellness programs. There are initiatives to allow integration of traditional health practices and to assure that prevention and wellness programs are covered services in all public programs (Medicare, Medicaid and CHIP). There are no laws and regulations as yet. Research is just funded at the National Institutes of Health (NIH).

For Washington State the American Indian Health Commission (AIHC) is one of the entities which acknowledges that traditional healing issues need further examination and clarification within and among Washington tribes. In order to identify and address the barriers that prevent the integration of traditional healing with the rest of the Indian health care system AIHC states as an ongoing activity to promote continued discussion with tribal leaders, health care providers, traditional healers, and community members. AIHC also maintains as a next step it will continue to solicit input from tribes on how to best facilitate discussion and will

work with the Northwest Portland Area Indian Health Board and other interested organizations to seek funding to support such efforts (AIHC 2007:60).
Personal contact with AIHC in Sequim through the NGO Center for World Indigenous Studies in Olympia to establish collaboration, however, revealed passivity to even share published information, let alone an interest in an ongoing exchange and discussion with CWIS the local think tank that is known throughout the region to promote the health interests of regional tribes. More personal contact through the chair of the board might have provoked a different more collaborative reaction.
There are signs of a growing national movement in cross-cultural health care in the U.S. that take into consideration the cultural beliefs for medical treatment decisions. In a recent survey of 60 hospitals the largest hospital accrediting group in the U.S., the Joint Commission found cultural values and beliefs to be increasingly embraced, catering to immigrant, refugee and ethnic-minority populations (LEIGH BROWN 2009). In Washington State comparable services could not be identified in mainstream institutions. At White Memorial Medical Center in Los Angeles e.g. a "low-tech approach" is implemented geared toward prevention in which patients are referred to traditional healers by the physician on a case-by-case basis. At Mercy Medical Center in Merced, California with a high Hmong patient population from northern Laos healing includes shaman practices. The hospital enacted a "Hmong shaman policy" which is the first regulation in a mainstream hospital in the U.S. that formally acknowledges that traditional healers cultural role and approves ceremonies such as chanting (Ibid). Similar policies could be introduced to encourage traditional healing for Native Americans in mainstream institutions. In order to succeed in this representatives of public institutions and agencies have to be engaged to pay more attention to the resource potential of traditional healing. An American Regional Network should be created that will explore the field of traditional healing and its possible applications in health policies.
In order to integrate Indigenous peoples' health needs and perspectives into national as well as international health development frameworks, such as the Millennium Development Goals and national health sector plans guidelines for health policy makers need to be issued. In policy, service development and practice, access to and uptake of evidence should be improved. This would influence the development and implementation of strategies and policies to address health and wellbeing in Indigenous communities at local/regional, state and national levels. Policy makers thus are provided with a framework that allows them to shift focus, to developing and strengthening social approaches instead of 'caseness' problem and pathology.

In line with the policy requirements listed above a new legal framework is required to prevent the exploitation of traditional knowledge and resources internationally. Much of the world's remaining traditional knowledge rests in the hands and on the lands of Indigenous peoples. When identifying the biodiversity hot spots on our globe most of them can be found on the territories inhabited by the world's 6000 Indigenous nations. Not only are these pieces of land the most coveted because pristine and highly diverse bioregions (more and more so with the omnipresent threat of environmental pollution). The knowledge held by Indigenous peoples living on and with these lands are increasingly in the centre of interest. Internationally there is a move to protect local knowledge systems and traditional medicines. The UNESCO Declaration on Science and the Use of Scientific Knowledge, 1999 states that

> "Considering that traditional and local knowledge systems, as dynamic expressions of perceiving and understanding the world, can make, and historically have made, a valuable contribution to science and technology, and that there is a need to preserve, protect, research and promote this cultural heritage and empirical knowledge."

In general more support for the biological rather than cultural knowledge can be found. Integration of biodiversity protection and associated traditional knowledge into the WTO's TRIPS Agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights) has been demanded by countries.

In this context the Convention on Biological Diversity (CBD) is the only major international convention, signed or ratified by 190 countries, that asserts Indigenous peoples' right to protect their knowledge of biodiversity. Strengthening universal and comprehensive healthcare systems in all countries is an outcome included in the treaty as can be seen in the following statutes.
Article 8 (j): State Parties required to "respect, preserve and maintain knowledge, innovations and practices of Indigenous and local communities embodying traditional lifestyles relevant for the conservation and sustainable use of biological diversity and promote the wider application with the approval and involvement of the holders of such knowledge, innovations and practices and encourage the equitable sharing of the benefits arising from the utilization of such knowledge, innovations and practices."
Article 18.4: Contracting Parties should "encourage and develop models of co-operation for the development and use of technologies, including traditional & Indigenous technologies." Same as the Universal Declaration on the Rights of the Indigenous Peoples also the Convention is not legally binding. States governments including the United States, have not ratified the Convention.

The physical as well as psychological health and wellness of Indigenous people is particularly closely tied to the sound connection of the health of their surrounding environments. Not much attention has been given by public health experts and scientists to the close relation between the health of humans and that of other species (CHIVAN 2001: 66). The destruction of species continues at an alarming rate the world over. Those species value as unique and irreplaceable elements of Indigenous culture and lifestyle is disappearing, causing psychological distress. Accordingly Jacques Mabit commented at the Traditional Medicine, Interculturality and Mental Health Congress in Tarapoto, Peru in 2009 on the relative importance of traditional health policies: that "there is no point in continuing to develop health policies or eradication campaigns if society does not deal with the lack of meaning in life" which he believes is what can lead to mental problems and drug-addiction." The broader picture therefore should be considered. Efficient policies should be developed that are not limited to traditional healing and knowledge but guarantee justice, fair compensation, education and human rights protection amongst others.

The focus of the efforts described above is on integrating cultural revitalization and governance through implementing tribal self-determination. Indigenous Nations can seek self-determination or self-government in several forms calling for the implementation of either: new territorial boundaries, new political boundaries, or new ideological boundaries (SMITH 1999:14). Unlike other Native groups such as the Native Hawaiians the tribes in Washington State do not ask for total sovereignty in the form of new States nor limited sovereignty over a land base or legally incorporated land base units but adhere to the Nation within a Nation model (TRASK 1999).
When trying to understand the concept and significance of the Right of Self-Determination it is essential to analyze this right in its full historical dimension. Therefore a short overview, which starts with looking at the Pre World War II development, is given, starting at the end of the 18th century. The time in history when the American and French Revolutions and the revolutionary cry for equality made apparent the idea of the sovereignty of the people of a State as "a group right to resist external interference" (COLE and WEST 2000:13). In line with the intent of the American declaration of independence of 1776, the right of self-determination gave the people the means to "free themselves from a regime that no longer is supported by the consent of the governed" (On this THÜRER 1975:15).
U.S President Woodrow Wilson first introduced into international affairs the idea of political self-determination in the sense of "self-government" (CASSESE 1995:19). By the end of World War I, on Jan. 8, 1918, in a speech before Congress, Wilson announced his Fourteen Point

Peace Program as a part of which he proposed the establishment of a "general association of nations" (RYSER 1999:129), and introduced new principles for international cooperation and collective security. Wilson's concern was to find a peaceful model to reorganize the political landscape which would encourage negotiations between nations and state governments. Self-determination is, to Indigenous peoples, the most fundamental of the rights they ask the world and, above all, the State they have been made a part of, to recognize. The right of self-determination of peoples is a fundamental principle and right under international law, including human rights law. It is embodied in the Charter of the United Nations and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. Common Article 1, paragraph 1 of the "International Covenant on Civil and Political Rights" provides that:

> "All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development."

The right of self-determination has also been recognized in other international and regional human rights instruments such as Part VII of the Helsinki Final Act 1975 and Article 20 of the African Charter of Human and Peoples` Rights. Apart from being a right under international law the right of self-determination has been regarded as Jus cogens - a peremptory norm of general international law. [39]

The Baguio Declaration developed at the Conference on Indigenous Peoples' Self-Determination and the Nation State in Asia in April 1999 emphasizes further in Article 7 that

> "The implementation of the right of self-determination is fundamental for the survival and achievement of human security for Indigenous peoples, including, but not limited to, their cultures, values, languages, religions, economies, political and legal institutions, Indigenous knowledge systems, way of life, ancestral territories, lands and resources."

In its broadest formulation, the principle of self-determination encompasses the political, legal, economic, social and cultural subjects of the life of peoples. Article 3 of UNDRIP, endorsed on Sept 13 2007 speaks of the right of self-determination: "Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development."[40]

Since the 1970s, when Indigenous groups began to demand more self-governance Federal policy has encouraged less centralized Indigenous administration of government programs in

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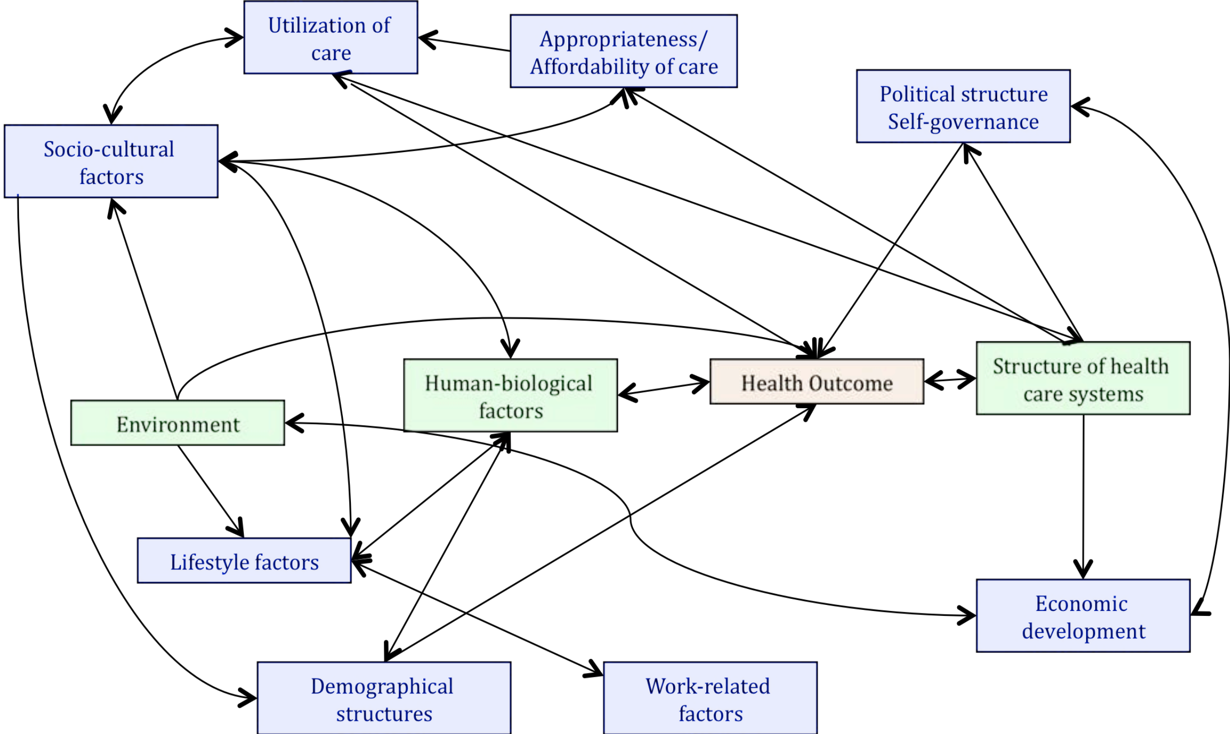
[39] For example see: Brownlie, Principles of Public International Law (4th ed. 1991) Oxford University Press, p. 513; Cassesse, International Law in a Divided World (1986) Oxford University Press, p. 136; Crawford (ed.), The Rights of Peoples (1988) Oxford University Press, p. 166; Hannum, Rethinking Self-Determination (1993) - Virginia Journal of International Law, Volume 34, Number 1, Fall 1993; and Sieghart, The International Law of Human Rights (1992) Clarendon Press, Oxford.

[40] See: http://www.un.org/esa/socdev/unpfii/en/drip.html

areas such as health and education. What has become evident throughout these last years and decades of self-governance and has only started to be discussed in depth fairly recently, is the fact that a lack of self-determination (the negation of the Indigenous way of life and world vision, the destruction of habitat, the decrease of biodiversity, the imposition of sub-standard living and working conditions, the dispossession of traditional lands and the relocation and transfer of populations) leads to decrease of health and well-being. Solutions to many of the problems faced by Indigenous peoples can only come from the nations themselves. They are closely connected to nation building - which must develop from inside out. Self-government initiatives, direct contact with and participation of Indigenous peoples when designing strategies to improve Indigenous health and defining comprehensive health services and policies are needed. Meaningful and valuable consultation and substantial Indigenous operation and control can produce more accepted and appropriate health outcomes. Discussion should not be limited to health but additionally concern areas like education, welfare, culture and community affairs. A new framework for health care systems analysis could be developed that considers a complexities of factors influencing health outcome.

Figure 28: Framework for Indigenous Health Care Systems Analysis



On the international scale only few international organizations are seeking to enable Indigenous nations to have greater visibility in national and international processes affecting them and to engage with Indigenous communities in mutually beneficial relationships. First and foremost therefore Indigenous peoples must be directly involved in all processes

affecting them and come up with strategies most suited to their needs so that they can relate to and trust those strategies. Cooperation between Indigenous peoples and policy makers (WHO, PAHO, EHMA) needs to be facilitated. Traditional health systems and the right to one's own culturally defined health system should be placed on the international agenda as a key element of self-determination of Indigenous peoples. Healing arts in international policy need to be discussed, the subject matter opened up as an agenda item at the UN Indigenous Peoples Forum. A national traditional medicine policy needs to be worked out, a global strategy on Indigenous people's health and mental health developed. As the effectiveness of a global strategy requires strong support and close involvement by respective state governments the feasibility of implementing such a strategy has to be questioned. How the states involved worldwide frame the issue of Indigenous health differs considerably as do Indigenous practices and beliefs. Adapting the strategy to the respective country-specific context would take time due to widely disparate needs and interests and because it must be a general, multi-stakeholder instrument (including Indigenous representatives, governments, members of the United Nations family, local leaders).

Part 9 Conclusion and next steps

As the findings in this paper suggest severe deficits in mainstream Indigenous mental health care provision exist. Self-governed health care institutions at the institutional level are better prepared to meet the specific needs of the Indigenous population of Washington State. Funding of these services needs to increase substantially not only to support Indigenous clinics but also to train an increasing Indigenous health workforce. Protection and preservation of Indigenous health cannot be achieved through specific health programs alone. Structural barriers within the mainstream health care services in Washington State prevent utilization of services by Indigenous groups. These problems have to be further addressed. Much of the mental health issues are stress related or require behavior changes by the Indigenous groups without which improvements in Indigenous health status through interventions within the health sector cannot be expected. Healing interventions based on traditional knowledge and rooted in the communities have demonstrated considerable potential to improve mental well-being of local Indigenous groups.

As has been shown in this paper the understanding of health amongst Washington State's cultures is a comprehensive one. A focus on improvements in health services alone accordingly is not sufficient. In order to improve mental health for Indigenous groups an interdisciplinary, holistic approach needs to include complex social and political, educational and economical as well as ecological factors. Due to the interdependencies between these various factors coordinated intervention of health care services, educational systems, and economic development programs are required. Collaborations and partnerships among Indigenous nations, urban Indian health organizations, medical centers, foundations, NGOs, and governmental agencies and programs need to be established. All these different stakeholders must come together to map out where to go.

As was demonstrated self-governed clinics provide a more culturally sensitive alternative to the mainstream mental health system. They offer a relationship oriented model of care that is more appropriate and integrates preventative interventions and health promotion - a model which considers geogene, epigene and pathogene within the Indigenous landscapes of care. The recently developed self-determined health approaches initiated by local communities which lie outside of the health sector and are rooted in traditional knowledge and practices demonstrate that local Indigenous groups have a central role in defining what is possible and practical to improve mental health. Indigenous communities in Washington State offer potential resources and instructive experiences which can serve as a catalyst or model for change at the regional, national if not global levels.

Tribes in the Pacific Northwest were found to exercise traditional healing interventions while working with the non-Indigenous culture. This integrative understanding amongst nations on the Pacific Northwest Coast of the U.S. and Canada might serve as a feasible model for Indigenous peoples who the world over are unifying their needs, exchanging experiences and discuss best practice models of self-determination to rebuild individual and communal health. Much more in depth research is needed in this field. Opposing societal structures, current paradigms and lack of funding were found to be limiting factors to self-determined approaches to Indigenous mental health within the research area. In order for the Indigenous health movement to be successful it needs the support of the whole society. Change can happen when the institutions as well as all the people are involved and wish to address the legacy of colonization and get beyond social inequalities. Thus a situation of respect and solidarity in which problems can be identified and solved in its holistic dimension can be reached and governmental institutions can be held accountable to address health inequalities. Models discussed here, such as the tribal canoe journey, which focus on forging intertribal but also interethnic ties along with attendance of cross-cultural events such as food feasts that are based on values of mutual respect and coexistence can help to achieve these goals.
A conclusion to be drawn from the analysis is that in essence Indigenous mental health is as much a question of political will and leadership as it is of consciousness and underlying cosmovision. The findings support the notion that the mental health position of Indigenous groups is the result of the differences between and difficulties to adjust Indigenous values and those of mainstream society. Interviews and observations revealed that many Indigenous members in the communities do not have or do not chose to have the key, which is a certain life-style, to be able to enjoy fully the highest standards U.S. society has to offer. To adopt the mainstream way of life would mean for many to internalize its basic values. However many Indigenous groups question the belief that if they follow the 'West's prescription' they will lead a better life and if they continue to live in a "disappearing Indigenous world" will not have a future. The common approach identified was the integrative endeavor to take the best of both worlds.

Through trying to incorporate local Indigenous peoples' perspectives of (mental) health and place it has been made evident that the current models within the field of medical geography are limited. In order to improve Indigenous health a paradigmatic shift towards a comprehensive approach is needed. As has become clear from the research undertaken, in order for geographers to gain clarity on causes of health disparities and barriers to reducing them, adequate theoretical frameworks are a necessity. Frameworks, such as the political

economy of health approach and the emerging eco-social theory are well suited for Indigenous health disparities research. Other multi-level theories that could be informed by Indigenous ways of knowing will need to be developed in order for geographers to be able to analyze the complex ways in which people understand and change the intermingled physical, biological as well as socio cultural worlds they live in. Theoretical frameworks will need to be elaborated, tested and modified by the data generated to expand and strengthen the required evidence-base on Indigenous mental health disparities. Systematical monitoring of mental health trends and their linkages to biological and socio-cultural and economic determinants of mental health (e.g. gender, ethnicity, age and income) has to be enhanced. Funding of interdisciplinary research has to be increased.

The research identified a need for mapping of specific categories of mental disease and services in the area as well as areas of traditional land use. What has become evident is the link between GIS, geographers and the Indigenous cause especially confronting contemporary issues of natural resources use, pollution and climate change. Action at both policy and technical levels will depend on the present health infrastructure and present ability within countries to collect data. Limitations of data availability in Washington State have been shown in this thesis. Parts of the Indigenous health infrastructure have been mapped as a first step. More work in the field is needed.

To sum up it has been shown that Indigenous traditional knowledge and healing practices exist in the research area and bear potential if appropriately supported and strengthened to improve mental health status. The assumptions raised by the kinds of phenomenon described in the above that are being pioneered in places like the Pacific Northwest of the United States and Canada where communities self-determinedly endeavor to work toward a healing of mind, body, and spirit might look much more like the Indigenous world to envision - despite the numerous challenges discussed. The voice of the Fourth World speaks to everyone concerned about health disparities calling for a holistic mental health system that offers a multidimensional approach – and in which the discipline of geography can have a major role to play.

"Working together, I know we can create a spectacular landscape for the entire world to see: the improved health of all Americans - no matter who they are or where they live" (SHALALA 1998).

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Appendix

Appendix A -Interview questions

MEDICAL SERVICES: DISTRIBUTION/ EFFICIENCY/COSTS

- What are the areas of services?
- Their regional distribution, institutions, patients, peoples served accessibility, affordability-disparities
- Which are the agencies/organizations offering components of mental services/education, training and support for mental health care patients/providers?
- What's the location of traditional medicine services
- What is the location of psychiatric hospitals/mental health clinics
- Are you aware of local in- patients, out-patient services
- What is the transport to health services
- What is the level of acceptability - cultural competence, sensitivity of mental health services?
- Conventional- CAM- Traditional: Existing Indigenous mental health programs, projects, institutions, services, schools educational/training programs?
- Integrative programs: Traditional healing or other cultural activities integrated directly into service delivery models?
- Who is incorporating traditional healing practices in the native Indigenous Health Care System environment? How?
- Awareness of traditional healing interventions amongst tribes?
- Is there stigma attached to traditional healing?
- Are patients open to try integrated services?
- What is the interest of patients to participate in traditional healing programs?
- Has traditional healing become more interesting in the context of the cultural revitalization movement?
- Is the use of traditional healing common among AI, particularly those with psychiatric problems?
- What are some of the traditional treatment methods?
- Are questions about traditional healing included in clinicians assessment and need for coordinating their services considered with their patients?
- Where (in what settings) is traditional healing being practiced (along with Western medicine)?
- What kinds of traditional services are being offered and practiced

- What is the relationship between traditional healers and medical physicians?
- Are the clinics/centers charging for these services and how?
- How are healers compensated? What form(s) of compensation exists?
- How do centers/clinics identify healers?
- Who is engaged in traditional medicine practice?
- Who is trained, how, where?
- What criteria must healers meet to work in this setting?
- Who should be designated and recognized as a traditional healer?
- How and by whom should healers be selected and trained?
- What about traditional healer license and supervision?
- Are there/should there be licensing boards or governed regulations to credential and/or oversee practice of Indigenous healers?
- How are safe and quality traditional healing services assured?
- Budget financing, funds?
- Governmental support for cultural health programs?
- Impact of financial crisis and health reform?
- Use of Services, insurance coverage?
- Underserved? Costs for full service?
- Is there an economic benefit in terms of cost savings offering traditional healing?
- Do studies exist of costs comparison btw. Conventional - alternative- cost reduction potential?
- What is the extent of collaboration and interest of NGOs, private care, insurance companies, HMOs, to have links with traditional medicine?
- Is there cooperation with community agencies and organizations to initiate social assistance and to encourage societal changes?
- What do the communities need? Can traditional medicine play a role in this respect?
- What psychosocial community programs exist?
- Canoe Journey support efficiency
- What is the relation of geography, place culture for mental health?
- Does the relationship to place play a role in healing?
- Traditional foods and medicines for mental health
- Where are the islands of biodiversity: Do you get plants and foods- access?

TRIBAL CLINICS/ MENTAL HEALTH CARE PROVIDERS

- What are the integrative/community treatment programs?

- How is the RSN tribal relation?
- Is there awareness of the underlying pattern and history of America's ethnic diversity?
- Is the ethnohistory of mental health considered?
- Is cultural competence an important component in providing effective mental health services?
- Potential of cultural mental health services- financial, spatial accessible use demand?
- Has there been a strengthening of culturally sensitive mental health care in last years?
- What are provider characteristics?
- What are the referral practices?
- What is the knowledge of traditional healing services?
- What types of education and information would enhance knowledge, awareness, and sensitivity to the American Indian community?
- What are identified Mental Health Needs?
- What are perceived problems for the American Indian Community?
- What about the access to care, information, school?
- Which would be desired programs/services?

DATA/INFORMATION
- Information material available?
- Data availability, resources, classification of tribes in the area?
- Is the information provided/names culturally appropriate?
- How is data management done (across agencies)?
- What are the information systems regarding available resources?
- Is the research conducted, available to Indigenous groups?
- What is the definition of (mental) health?

Appendix B- Conference activities

Paper/poster presentations

International Medical Geography Symposium, Durham, UK 10-15 July.2011: "Traditional health geographies."

Association of American Geographers Annual Meeting, Seattle, USA 10-15 Apr.2011: "Geography and Health in the Context of Colonization."

UArctic Thematic Network on Global Change in the Arctic, Kautokeino, Norway 22-26 March 2011: "People in a changing world."

Kastelli Symposium, Oulu, Finland 18/19 Nov.2010: "Geography's disruptive potential in Indigenous health and well-being."

Arbeitskreis Medizinische Geographie, Remagen, Germany. 9/10 Oct. 2010: "Indigenous Mental Health Geographies."

Healing Our Spirits Worldwide 03-10-September 2010 in Honolulu, Hawaii, "Integrating International Policy and Local Healing Knowledge."

The Pacific Region Indigenous Doctors Congress, Whistler, Canada, 26-29 Aug. 2010: "Indigenous Self-Determination in Mental Health."

20th IUHPE World Conference on Health Promotion, Geneva, Switzerland, 11-15 July 2010: "Traditional Knowledge and Self-Determination in Health."

International Conference "Traditional Medicine, Interculturality and Mental Health, Tarapoto, Peru, 07-10-06 2009: "Journeys of Healing. Indigenous Revitalization of Culture and Traditional Medicine as a Cure for Mental Illness in the Pacific Northwest."

Language, Silence and Voice in Native Studies, University of Geneva, Switzerland- July 16-17, 2007: "Healthy Humour: North American Natives` Powerful Survival Strategy."

UN Indigenous Peoples Forum 5th Session, New York May 15- 26, 2006

Global Summit on the Role of Traditional Medicine in Reproductive Health in Minneapolis, Minnesota, USA 25-28 July 2005"Traditional Medicine and International Policy: The Present State of Self Determination."

Conferences/seminars attended

The Seventh International Congress of Arctic Social Sciences, Akureyri, Icceland, 22-26 June 2011.

WHO meeting with Indigenous representatives at WHO headquarters, Geneva Switzerland, July 2010.

21st Native Health Research Conference “Science AS Storytelling and the Science OF Storytelling” August 3-6, 2009, Portland, Oregon

Travel Scholarship to Russia, German Academic Exchange Service (Deutscher Akademischer Austausch Dienst, DAAD), August/September 2006

Fifth session UNPFII United Nations Permanent Forum on Indigenous Issues, UN Headquarters in New York “The Millennium Development Goals and Indigenous peoples: Re-defining the Millennium Development Goals” in May 2006.

Travel Scholarship to Tajikistan, DAAD, September/October 2005

Trade&Development Symposium, 14-18.12 2005 Hong Kong.

Diets&Lifestyles Creating Healthy Lifestyles for the 21st Century, Conference on Food, Soil and Environmental Chemical Connections to Health: Using the Wisdom of the True Health Pioneers, Past and Present 5-8 August 2005.

Travel Scholarship to Uzbekistan, DAAD, September/October 2004

Second International Conference on the Right to Self-Determination (ICHR, IHRAAM) 6-8.08.04, and UN World Indigenous Peoples Day 09.04.2004, Geneva, Switzerland.

World Indigenous Peoples Conference on Education (WIPCE), 2003 in Morley, Canada; WIPCE 2005 in Hamilton New Zealand; WIPCE 2008 in Melbourne Australia and subsequent local area research for at least one month per trip.

Traditional Medicine Seminar, Chilies Chocolate and Coconut, Center for Traditional Healing, Yelapa, Jalisco, Mexico, 02.01.2004-22.01.2004.

Appendix C- Photos

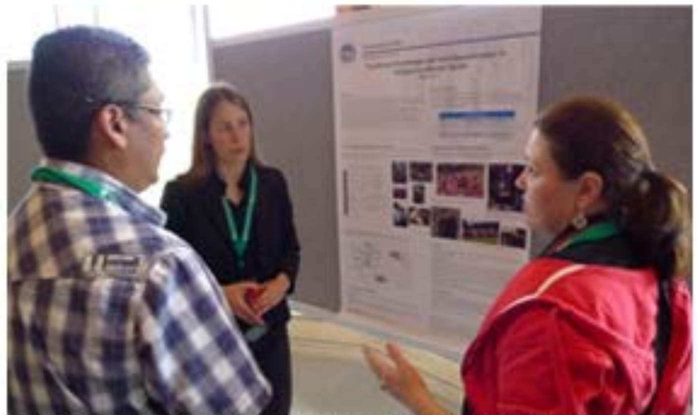
Traditional Healing Clinics

South Central Foundation, Anchorage, USA

Photos: Dr. Mala

Kawachi Health Center, Puyallup, USA

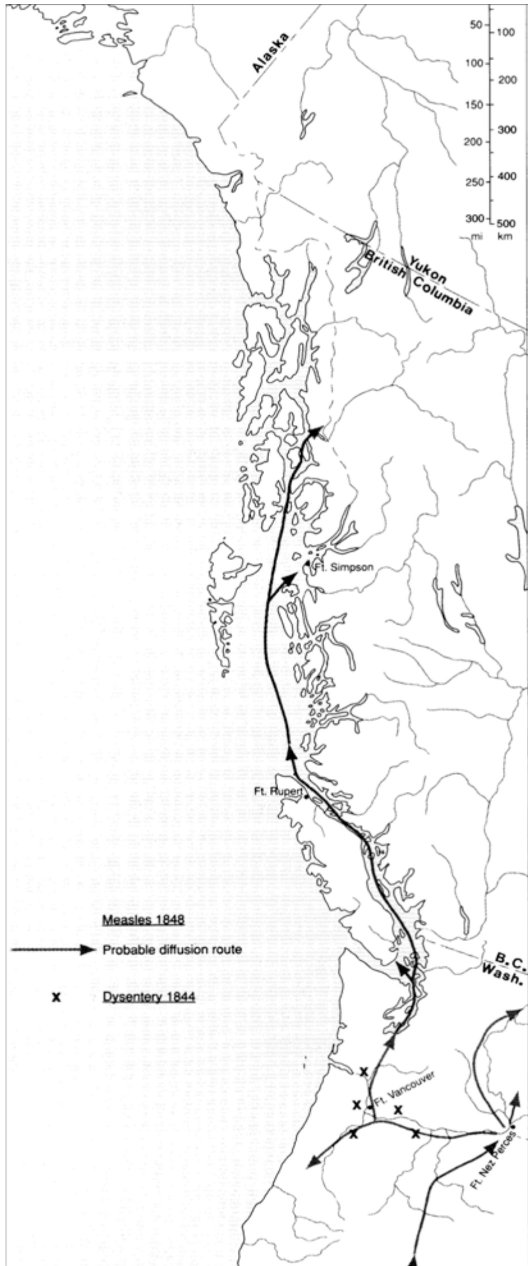
Canoe Healing Journey, Pacific Northwest, USA



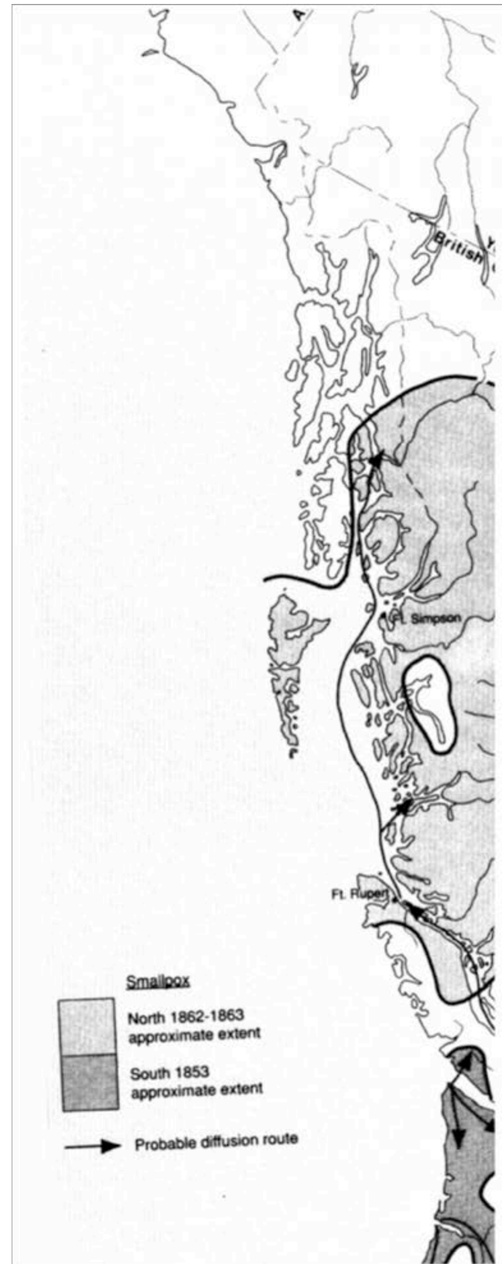
Pacific Regions Indigenous Doctors Congress, Whistler, Canada,

The Indigenous World

Appendix D: Figures



Source: Boyd (1990), p. 142



Source: Boyd (1990), p. 143

Figures D 1: Diffusion of Diseases

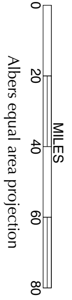


Figure A 2: Map of Washington State

Figure A 3: Tribal Reservations and Treaty Ceded Areas in Washington State

Erklärung

Ich versichere, dass ich die von mir vorgelegte Dissertation selbständig angefertigt, die benutzten Quellen und Hilfsmittel vollständig angegeben und die Stellen der Arbeit - einschließlich Tabellen, Karten, und Abbildungen -, die anderen Werken im Wortlaut oder dem Sinn nach entnommen sind, in jedem Einzelfall als Entlehnung kenntlich gemacht habe; dass diese Dissertation noch keiner anderen Fakultät oder Universität zur Prüfung vorgelegen hat; dass sie - abgesehen von unten angegebenen Teilpublikationen - noch nicht veröffentlicht worden ist sowie, dass ich eine solche Veröffentlichung vor Abschluss des Promotionsverfahrens nicht vornehmen werde. Die Bestimmungen der Promotionsordnung sind mir bekannt. Die von mir vorgelegte Dissertation ist von Frau Prof. Dr. Frauke Kraas betreut worden.

Mirjam Hirch
Köln, den 28.08.2011