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Mental Health and Substance Abuse Services Preferences among American Indian People of the Northern Midwest

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Abstract

This study examines factors that influence preferences between traditional cultural and western mental health and substance use associated care among American Indians from the northern Midwest. Personal interviews were conducted with 865 parents/caretakers of tribally enrolled youth concerning their preferences for traditional/cultural and formal healthcare for mental health or substance abuse problems. Adults strongly preferred traditional informal services to formal medical services. In addition, formal services on reservation were preferred to off reservation services. To better serve the mental health and substance abuse treatment needs of American Indians, traditional informal services should be incorporated into the current medical model.

Keywords: service utilization, American Indians, mental health, substance abuse.

Introduction

A 2001 supplemental report on mental health to the Surgeon General describes the current United States public health perspective as a ''population-based approach (that) is concerned with the health of the entire population, including its link to the physical, psychological, cultural, and social environments in which people live, work, and go to school (Dept of Health and Human Services (DHHS), 2001).'' This statement reflects a concept of holistic healing in a time of growing acceptance and utilization of alternative or complimentary health services beyond those available within professional medical systems. Rodenhauser (1994) notes that although psychiatry as a specific medical field shows increasing cultural awareness regarding clinical sensitivity within the academic literature, there has been little to no evidence of cultural factors found within mainstream journals for health administrators. In addition, very little research is available concerning the co-utilization of ''alternative'' and western medical approaches, let alone an examination of this overlap within specific cultures (Gurley *et al.*, 2001; Rhoades & Rhoades, 2000; but see Novins, Beals, Moore, Spicer, & Manson, 2004). An understanding of these services may be especially important within an American Indian cultural context where traditions often involve complex ceremonies and beliefs that require consideration far beyond that of mainstream religion (Rhoades & Rhoades, 2000).

The purpose of this study is to examine factors that influence the choice between traditional cultural and western mental health and substance use associated care among American Indians from reservations in the northern Midwest. Specifically, we examine preference in terms of perceived effectiveness and actual utilization of traditional vs. Western-based service outlets.

Barriers to Health Services

American Indians and Alaskan Natives have been found to report highest rates (12.9%) of frequent mental distress among all ethnic groups, including Hispanics (10.3%), African Americans (9.7%), Whites (8.3%), and Asian/Pacific Islanders (6.1%) (Centers for Disease Control (CDC), 1998). The 2000–2001 National Household Survey on Drug Abuse found American Indians/Alaskan Natives to be second only to multi-ethnic individuals to have received mental health treatment in the past year. At the same time, American Indian/Alaska Native respondents were second highest

among all ethnic groups who had not received mental health care to report perceived unmet service needs (Barker *et al.*, 2004). A similar pattern is found for substance abuse where again, American Indians/Alaskan Natives are second to multi- ethnic persons in terms of prevalence of illicit drug or alcohol dependence (Substance Abuse and Mental Health Services Administration (SAMHSA), 2002).

A majority of Indian people within the United States receive physical and mental healthcare from Indian Health Services (IHS) (Gone, 2004). IHS's Indian Health Care System served around 1.6 million American Indians/Alaska Natives residing on or near reservations in 2003 (IHS, 2003). Over one-third of service utilization within this system involves mental health and social service related concerns (IHS, 2002). Although Indian Health Services is meant ''to raise the physical, mental, social, and spiritual health of American Indiana and Alaska Natives to the highest level'' (IHS, 2002), a variety of barriers may impede American Indians' ability to receive adequate health care. Specific to mental health care delivery, and often overlapping with the characteristics of healthcare in general, Rodenhauser (1994) characterizes barriers into two major groups: (1) those within the current medical system, including under-funding and staffing issues, inconsistent services, insensitivities, fear of litigation and non-compliance with organizational requirements, and staff burnout; and (2) those inherent to American Indian/Alaska Native cultures, such as fear, high rates of accidents/violence, intrinsic conditions (i.e. denial, helplessness and hopelessness), and mistrust of government agencies.

Traditional Help Seeking

Research and anecdotal evidence suggests that many American Indians report health related help-seeking via culturally traditional outlets. For example, Marbella, Harris, Diehr, Ignace, and Ignace (1998) surveyed 150 American Indian adult patients at the Milwaukee Indian Health Center and found that 38% had sought help from a traditional healer in addition to physician-administered care. Furthermore, 86% of those interviewed said that they would consider seeking a traditional healer in the future. In instances where traditional healer's and physician's advice differed, patients said they would rely on their healer's advice 61.4% of the time. In a separate study including respondents from 2 different American Indian tribes, Novins, Beals, Moore, Spicer, and Manson (2004) found traditional healing options to be prevalent and important to both tribes, whether used alone or in combination with biomedical services.

Although traditional beliefs and practices can guide some American Indians through mental and physical illnesses and healing, there is disagreement concerning the degree of connection between traditional and professional medical services at an institutional level. A number of researchers discuss a gap wherein the processes of traditional and mainstream professional healing should be linked (Marbella *et al.*, 1998; Mohatt & Varvin, 1998; Novins, Beals, Sack, & Manson, 2000; Novins, Fleming, Beals, & Manson, 2000). Conversely, others feel that formal funding for traditional practices is difficult and perhaps inappropriate. Payment to a traditional healer by a patient may be compromised in a situation where billing must occur via a third party. Issues surrounding payment are complicated further considering the need to establish credentials for employees of government funded agencies like IHS (Rhoades & Rhoades, 2000). It is also important to consider the heterogeneity of the over 300 different tribal or language groups from which American Indian individuals belong (Beauvais, 1998). Tribal differences extend to various opinions regarding an integration of the two health care systems (Rhoades & Rhoades, 2000; see also Novins *et al.*, 2004).

Despite some documentation on the preference of traditional vs. western medical treatment among American Indians who receive both, we found little empirical evidence that directly tests the factors that affect this choice (but see Gurley *et al.*, 2001; Novins *et al.*, 2004; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). In addition, there is a lack of empirical research surrounding American Indian mental health/substance use related services utilization (Manson, 2000), and what work has been done typically focuses on Indian children (i.e. Novins, Harman, Mitchell, & Manson, 1996; Costello, Farmer, Angold, Burns, & Erkanli, 1997; Novins *et al.*, 2000). This research begins to address such gaps in the literature by examining predictors of service preferences among a sample of American Indian adults.

Hypotheses

In a review of the literature, Manson (2000) includes differences related to culture (i.e. acculturation vs. enculturation) as important predictors of formal mental health service utilization. Elsewhere, higher levels of social support (here measured as community support) have been shown to be related to receiving a treatment recommendation for substance use problems (Novins *et al.*, 1996); in turn, being recommended for treatment may increase actual service utilization. In addition, rates of mental health

treatment have been found to be higher for adults with a lower perceived health status (Barker *et al.*, 2004).

Based on these findings and coupled with the barriers to care discussed earlier, we hypothesize that higher levels of enculturation, experiencing discrimination, and living on a reservation will be positively related to perceived effectiveness or preferences for informal services and negatively related to formal services. In addition, self- reported physical health is hypothesized to be negatively related to preferences of both service types (Barker *et al.*, 2004). We also predict that higher levels of social support will be positively related to use of both informal and formal service outlets. Lastly, we control for the effects of age, gender, education, and employment on service utilization preferences.

Methods

Sample

These data were collected as part of the ''Healing Pathways Project,'' a 3-year lagged sequential study currently underway on four American Indian reservations in the Northern Midwest and five Canadian First Nation reserves. Because of national differences in health care systems, the data presented here includes only that from U.S. reservations. The data are from wave one of the study collected on two U.S. reservations from February through October 2002, and wave one on a second pair of U.S. reservations collected from February through October 2003. The reservations share a common cultural tradition and language with minor regional variations in dialects. The sample represents one the most populous Native cultures in the United States and Canada.

The project was designed in partnership with the participating reservations and reserves. Prior to the application funding, the research team was invited to work on these reservations, and tribal resolutions were obtained. As part of this agreement, the researchers promised that participating reservation names would be kept confidential in published reports. An advisory board was appointed by the tribal council at each participating reservation and is responsible for advising on difficult personnel problems, questionnaire development, reading reports for respectful writing, and assuring that published reports protected the identity of the respondents and the culture. Upon advisory board approval of the questionnaires, the study procedures and questionnaires were submitted for review and approved by an Institutional Review Board. All participating staff on the reservations were approved by the advisory board and were either tribal members themselves or non-members who are spouses of tribal members. To ensure quality of data collection, all interviewers underwent special training for conducting pencil-and-paper and computer-assisted personal interviewing for diagnostic measures, including feedback sessions. In addition, all of the interviewers completed a required human subject's protection training that emphasized the importance of confidentiality and taught procedures to maintain the confidentiality of data.

Each tribe provided lists of families of enrolled children aged 10–12 years who lived on or proximate to (within 50 miles) the reservation or reserve. We attempted to contact all families with a target child within the specified age range. Families were recruited via personal visits from Native interviewers during which they were given an explanation of the project, a gift of wild rice, and an invitation to participate. After agreement to participate and later completion of interviews, each participating family member received $40 for their time. This recruitment procedure resulted in an overall response rate of 79.4%.

Sample Characteristics

The sample for this analysis is made up individuals from the U.S. reservations only and consisted of 865 parents/caretakers (264 males and 601 females) of tribally enrolled children aged 10–12 years. Fathers/male caretakers ranged in age from 21 to 70 years with an average age of 42 years; mothers/female caretakers ranged in age from 17 to 78 years with an average of 39 years.

Measurement

To assess the perceived effectiveness of health service providers, respondents were given a series of questions asking them how effective various service outlets would be if ever there were to have (1) an emotional problem, or (2) a substance abuse problem. The response categories range from not at all effective to extremely effective. Traditional/ informal services include family, talking to an elder, sweat lodge, pipe ceremony, offering tobacco, traditional healer, traditional ceremony, and healing circle. Formal services include Indian Health Service (IHS), doctor, psychologist, social worker, counselor, psychiatrist, chemical dependency counselor, and nurse. Respondents were asked to evaluate the perceived effectiveness of formal services both on and off the reservation. For multivariate analysis a mean effectiveness score was computed for three categories of services: (1) traditional, (2) formal on reservation, and (3) formal off reservation, all within each realm of service need (emotional and substance abuse). Each mean score has a range from 1 to 5, with higher scores indicating greater perceived effectiveness.

Enculturation is a latent construct assessed by three basic elements: (1) participation in traditional activities, (2) identification with American Indian culture, and (3) traditional spirituality (see Costello *et al.*, 1997; Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002). The enculturation scale has high internal consistency (Cronbach's $\alpha = .79$), and the standardized version of the scale is used in these analyses.

Perceived discrimination is measured with an 11-item scale designed to tap a range of potential types and sources of discrimination. Respondents were asked to report how often they had experienced specific instances of discrimination. Those items included in the scale were; how often someone said something derogatory or insulting because of your race; how often a store owner, sales clerk or person working at a business has treated you in a disrespectful way because of your race; how often the police have hassled you because of your race; how often you have been ignored or exclude from an activity because of your race; how often someone has yelled a racial slur or racial insult at you; how often someone threatened physical harm because of your race; how of-

ten someone suspected you of doing something wrong because of your race; how often you have been treated unfairly because of your race; how often you have encountered whites who didn't expect you to do well because of your race; how often someone discouraged you from trying to achieve an important goal because of your race; and how often you have been treated unfairly in the courts because of your race. The four response categories range from never to always, with the mean of all 11 items used in these analyses. The scale has a high internal reliability with Cronbach's α of .90.

Social support is measured with a 17-item scale in which respondents were read statements regarding community and neighborly cohesiveness and conflict. Statements include: this is a close knit community; people around here are willing to help their neighbors; there are adults in this community that children can look up to; there are long standing family grudges in the community; the community is split by politics; the community is split by alcohol or drugs; and so on. Respondents were asked to answer true or false to each statement. Items indicative of community conflict were reverse coded, and then all items were summed so that higher values represent higher community support. Cronbach's α for this scale is .86.

Health status was assessed by response to the question ''In general, how well would you say your health is?'' Response categories ranged from excellent (5) to poor (1). Values are coded so that higher scores indicate better health.

Several control variables are included in the present analysis. Gender is a dummy variable coded as male = 0 and female = 1. Education is a five category item ranging from less than high school to an advanced degree. Employment is a dichotomous variable indicating if the respondents are employed full-time. Those with full-time employment are coded as 1. To assess the difference between those enrolled tribal members living on and off the reservation respondents were asked if they currently lived on the reservation at the time of their interview. Those who lived off of the reservation were given a value of 1.

Results

Descriptive Characteristics

The adults who comprised this sample had an average educational level falling between a high school diploma and at least some secondary school experience (mean = 2.4; SD = .87), and more than half (57%) were employed full-time. Very few of the adults lived off of the reservation (12%) at the time of our interviews. The self-reported health status of the adults in our sample averaged between 'good' and 'very good' (mean = 3.3; SD = 1.0), and the overall level of reported social support in the communities was 8.4 (SD = 4.1). Enculturation is a standardized variable in these analyses (mean = 0; SD = 1), while the mean level of perceived discrimination was 1.5 (SD = .69), indicating that the average response across all of the discrimination questions fell between 'never' and 'a few times.'

Among the dependent variables concerning service preferences among respondents, the highest mean scores were found for informal/traditional

services for both mental health (mean = 3.06; SD = 1.06) and substance use (mean = 3.09; SD = 1.15) related issues. Next highest were mean preference scores for on-reservation formal services (mental health = 2.51; SD = 1.01; substance use = 2.53; SD = 1.09), followed lastly by mean preference ratings for formal off-reservation care (mental health = 2.32; SD = 1.03; substance use = 2.34; SD = 1.09).

Perceived Effectiveness of Services

Figure 1 illustrates the perceived effectiveness of services that are commonly used for mental health or substance abuse problems. The reported percentage indicates those respondents who felt the services would be very or extremely effective. There is a clear distinction of the perceived effectiveness between informal or traditional services and more formal services. Seventy-one percent of respondents felt that talking to a family member would be very or extremely effective. Nearly 60% felt talking to a tribal elder would be highly effective for dealing with mental health or substance problems. More traditional practices/ services such as offering tobacco and praying, seeing a traditional healer, traditional ceremonies, healing circle, sweat lodge, and pipe ceremony all were rated between 30% and 50%. Speaking to a counselor on the reservation was the highest rated professional service with 32.9% of respondents indicating it would be very or extremely effective. Most of the on reservation professional services rated higher than services off the reservation but lower than more traditional services. Those services that were seen as least effective were those professional services located off of the reservation.

Use of Informal and Formal Services

Table 1 reports the coefficients from ordinary least squares regression analyses for predictors of respondent perceptions of the effectiveness (i.e. preferences) of informal traditional and formal services for substance abuse and mental health concerns. Because this sample contains some cases where two adult reporters were interviewed within a household, reported coefficients are based on standard errors that have been adjusted to account for the potential bias of nested designs (analyses performed using STATA 7.0). The same sets of variables significantly predict informal service preference for both mental health (MH, Model 1A) and substance use (SU, Model 1B) related problems. For both models, females were more

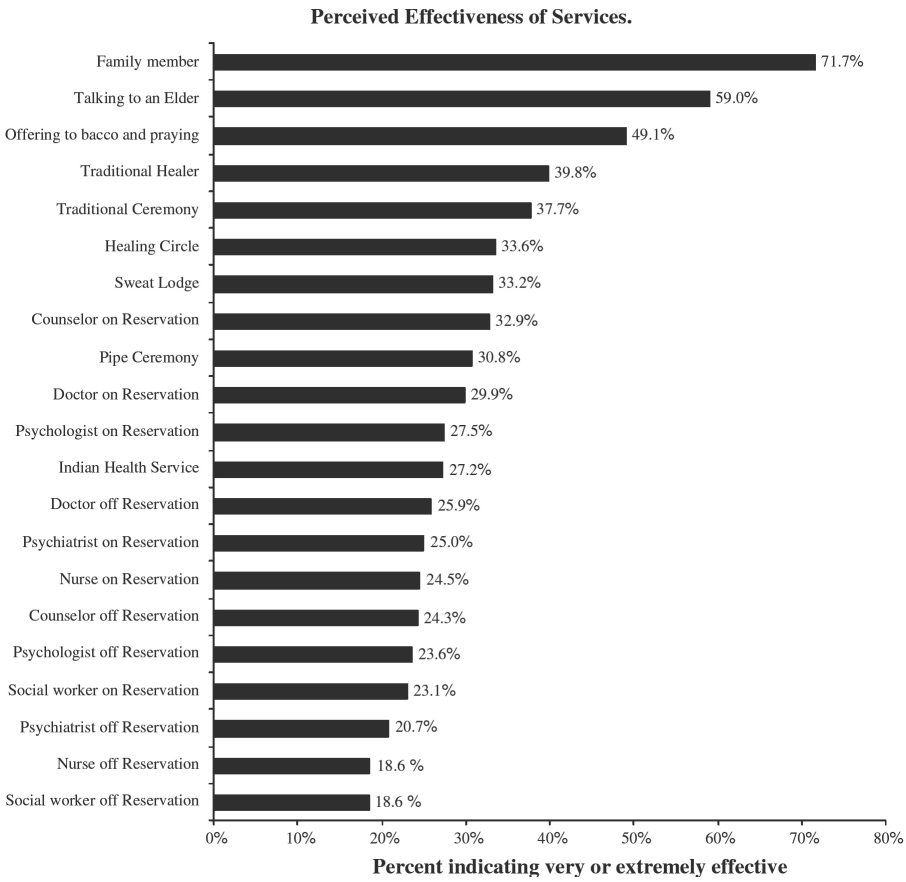

Figure 1. Perceived Effectiveness of Services

likely to prefer informal services (MH: $\beta = .06$, $p < .05$; SU: $\beta = .05$, $p < .10$), as were the employed (MH: $\beta = .07$, $p < .05$; SU: $\beta = .07$, $p < .05$). For both Model 1A and 1B, higher rates of social support (MH: $\beta = .13$, $p < .001$; SU: $\beta = .13$, $p < .001$), higher enculturation scores (MH: $\beta = .49$, $p < .001$; SU: $\beta = .44$, $p < .001$), and higher reports of perceived discrimination (MH: $\beta = .09$, $p < .01$; SU: $\beta = .11$, $p < .01$) were all positively associated with informal service preferences.

Moving to predictors of formal service preferences on reservations (Models 2A & 2B), higher levels of social support were a significant predictor in both the MH ($\beta = .13$, $p < .001$) and SU ($\beta = .17$, $p < .001$) models, as were higher rates of perceived discrimination (MH: $\beta = .07$, $p < .10$; SU:

Table 1. OLS Regression Models Predicting Perceived Effectiveness (Preferences) of Mental Health and Substance Use Related Services

	Mental Health						Substance Use					
	1A Informal		2A Formal (on res.)		3A Formal (off res.)		1B Informal		2B Formal (on res.)		3B Formal (off res.)	
	B	*β*	*B*	*β*	*B*	*β*	*B*	*β*	*B*	*β*	*B*	*β*
Age	−0.003	−0.03	0.01	0.05	−0.002	−0.02	0.001	0.01	0.01	**0.07**$^{+}$	0.00	0.003
Gender (female = 1)	0.15	**0.06***	0.13	$^{+}$	0.04	0.02	0.13	**0.05**$^{+}$	0.05	0.002	−0.03	−0.01
Education	0.04	0.03	0.14	**0.12****	0.21	**0.18*****	0.04	0.03	0.17	**0.13*****	0.19	**0.15*****
Employment	0.14	**0.07***	0.08	0.04	−0.01	−0.01	0.15	0.07*	0.02	0.01	−0.06	−0.03
Live off reservation	0.17	0.05	0.18	0.06	0.28	**0.09***	0.07	0.02	0.27	**0.08***	0.47	**0.14*****
Physical health status	0.01	0.01	0.03	0.03	0.02	0.02	−0.02	−.01	0.02	0.01	0.01	0.01
Social support	0.03	**0.13*****	0.03	**0.13*****	0.02	**0.08***	0.04	**0.13*****	0.05	**0.17*****	0.02	**0.09*****
Enculturation	0.52	**0.49*****	−0.05	−0.05	−0.05	−0.05	0.51	**0.44*****	−0.05	−0.05	−0.08	**-.07***
Discrimination	0.14	**0.09****	0.11	**0.07**$^{+}$	−0.07	−0.05	0.19	**0.11****	0.17	**0.1****	−0.09	−0.06
Constant	2.37		1.28		1.73				1.10		1.77	
R^2	0.29		0.05		0.06		0.25		0.06		0.07	
Adjusted R^2	0.28		0.04		0.05		0.24		0.05		0.06	

$^{+}p < .10$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$ (two-tail test).
Sample size across models ranges from $n = 803$ to $n = 822$ after listwise deletion.

β = .10, p < .01) and education (MH: β = .12, p < .01; SU: β = .13, p < .001). Age is significantly associated with formal on-reservation service preferences only for substance use problems (β = .06, p < .10), whereas females are more likely than males to prefer on-reservation formal care in the case of mental health problems (β = .06, p < .10).

Models 3A and 3B illustrate the coefficients for predictors of formal off-reservation service preferences. Both models contain similar findings: higher education (MH: β = .18, p < .001; SU: β = .15, p < .001), living off of reservation lands (MH: β = .09, p < .05; SU: β = .14, p < .001), and higher levels of social support (MH: β = .08, p < .05; SU: β = .09, p < .05) were all positively associated with higher preferences for formal off-reservation services. In addition, Model 3B shows that those who scored higher on levels of traditional enculturation were less likely to perceive formal off-reservation care as effective in terms of substance use related problems (β = –.07, p < .05).

Across all of the models in Table 1, the independent variables explain proportionately more of the variance for the informal service models than those with formal services as the dependent variable. Adjusted R2 values for these models indicate that the predictors explain 28% and 24% of the variance in informal service preferences for MH and SU problems, respectively. These values for formal reservation-based care are 4% for MH and 5% for SU problems. The models for formal off- reservation care explain 5% of the variance in preferences for MH problems and 6% of the variance for SU problems.

Discussion

The adults in our sample felt that more culturally traditional services (such as family or a traditional healer) would be more effective than either professional services on the reservation, or professional services off the reservation. Off reservation services were perceived to be least effective. These findings support literature that suggests American Indians generally place considerable trust in traditional practices (*i.e.* Marbella *et al.*, 1998). The finding that mainstream professional services are perceived as less effective than traditional informal services and some of the on-reservation professional services underlies the previous discussion surrounding issues of trust and appropriateness of Western care in relation to American Indian cultures. It is also possible that a crisis-oriented care system may not be suited to adequately deal with mental health and substance abuse needs (Oetting & Beauvais, 1990–1991).

The multivariate analyses supported several of our hypotheses. Among the control variables, females were slightly more likely than males to report higher preference for both (MH & SA) types of informal care, as well as for on-reservation MH care. Though not explicitly hypothesized, these results correspond with previous help-seeking research that has found women more likely than men to view care as an appropriate remedy for psychological issues (Horwitz, 1987). Higher educational levels and employment were generally related to higher effectiveness ratings for services in this study, also corroborating previous research (see, for example, Horwitz, 1999, p. 66).

As expected, those who are more enculturated were more likely to utilize informal traditional services than those who are less enculturated. In addition, in the case of services for substance use disorders, higher levels of enculturation were negatively associated with preferences for formal off-reservation care (Model 3B). Those who lived off the reservation were more likely to use formal services, especially in terms of off-reservation care. Consistent with past research (Novins *et al.*, 1996) and as hypothesized, perceived social support was positively associated with higher perceptions of effective care across all types of services. Our hypothesis that higher rates of perceived discrimination would be associated with preferences for informal or traditional care is supported here. We found similar effects for discrimination and formal on-reservation care. These findings are congruent with Rodenhauser's (1994) description of the barriers to dominant-culture care in terms of mistrust of government agencies, all stemming from a history of colonization and continued institutional racism experienced by many American Indian peoples (see, for example, Duran & Duran, 1995). Overall, the results of this study highlight a preference for informal or culturally based care, especially among the enculturated.

The differences in the proportions of variance explained across each of the models in Table 1 warrant discussion. These analyses include only one measure of cultural identity: enculturation. As discussed, this measure was significantly associated with ratings of informal service preference, but did little in terms of predicting formal service preferences. It may be that an important predictor of formal services is acculturation, or perhaps even biculturalism. Future work might include such measures to further our understanding of how cultural identity affects service preference and utilization (see Novins *et al.*, 2004).

Limitations

Although we interviewed a broad range of American Indian adults on multiple reservations that are dispersed geographically across two Midwestern states, these results pertain to a single culture and capture variations within this culture. We believe the findings represent the culture well, but they cannot be generalized to other Native cultures. A second caution regarding the sample is that it is made up of parents and caretakers of children aged 10–12 years. This could reflect a selection bias in that parents/caretakers may be more likely to utilize services and to be currently mentally healthy and alcohol and drug free than individuals with no children. Finally, all of our measures are based on self-reports. We did not have access to service utilization rates from local clinics or reports of services use from traditional healers.

Policy Implications

These findings have important policy implications for those who provide health services to American Indian people. Cultural traditions are very much alive on U.S. reservations and are preferred methods of healing for mental health or substance abuse problems. This should be taken into account when designing health services systems either by providing alternative services onsite or through creatively engaging informal traditional services. Simply acknowledging informal service providers by asking the patient if they have seen a traditional healer and then contacting him or her for an opinion would be an important step. Health providers could include key community spiritual leaders and healers on health advisory boards or create health partnerships that would encourage mutual referrals. Perhaps the place to begin would be to respectfully seek the advice of elders on decreasing barriers between the two.

Actual integration of services is already taking place on many reservations, but implementation is not always straight forward (Marabella *et al.*, 1998; Mohatt & Varvin, 1998; Rhoades, & Rhoades, 2000). Issues about selection of traditional healers, and how to reimburse them such as whether they should charge fees for services and coverage for third party payments must be worked out culture by culture. Some view such integration as a potential acculturation risk.

Changing the current shortcomings in mental health delivery first involves acknowledging that parallel systems exist in some cultures. The impetus for change may have to come from formal services providers

who should demonstrate respect for traditional healers, invite their advice, and consult with them if patient's give permission. Clinicians may need to be proactive in offering their patients this option rather than waiting for the patient to request it. Creating this sensitivity may require specialized training for services providers on American Indian reservations. Grant funding groups may want to consider supporting model programs that bring together the two healing modalities.

Future Research

There is much to be done to increase American Indians' confidence in health services systems. One avenue for this would be to work more closely with informal traditional services that are trusted. We need control group trials of innovative services models that cross over between formal medical services and traditional approaches to healing to assess the efficacy of combining the approaches. Continued failure to acknowledge the strong preferences for traditional ways is to ignore a valuable health resource.

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