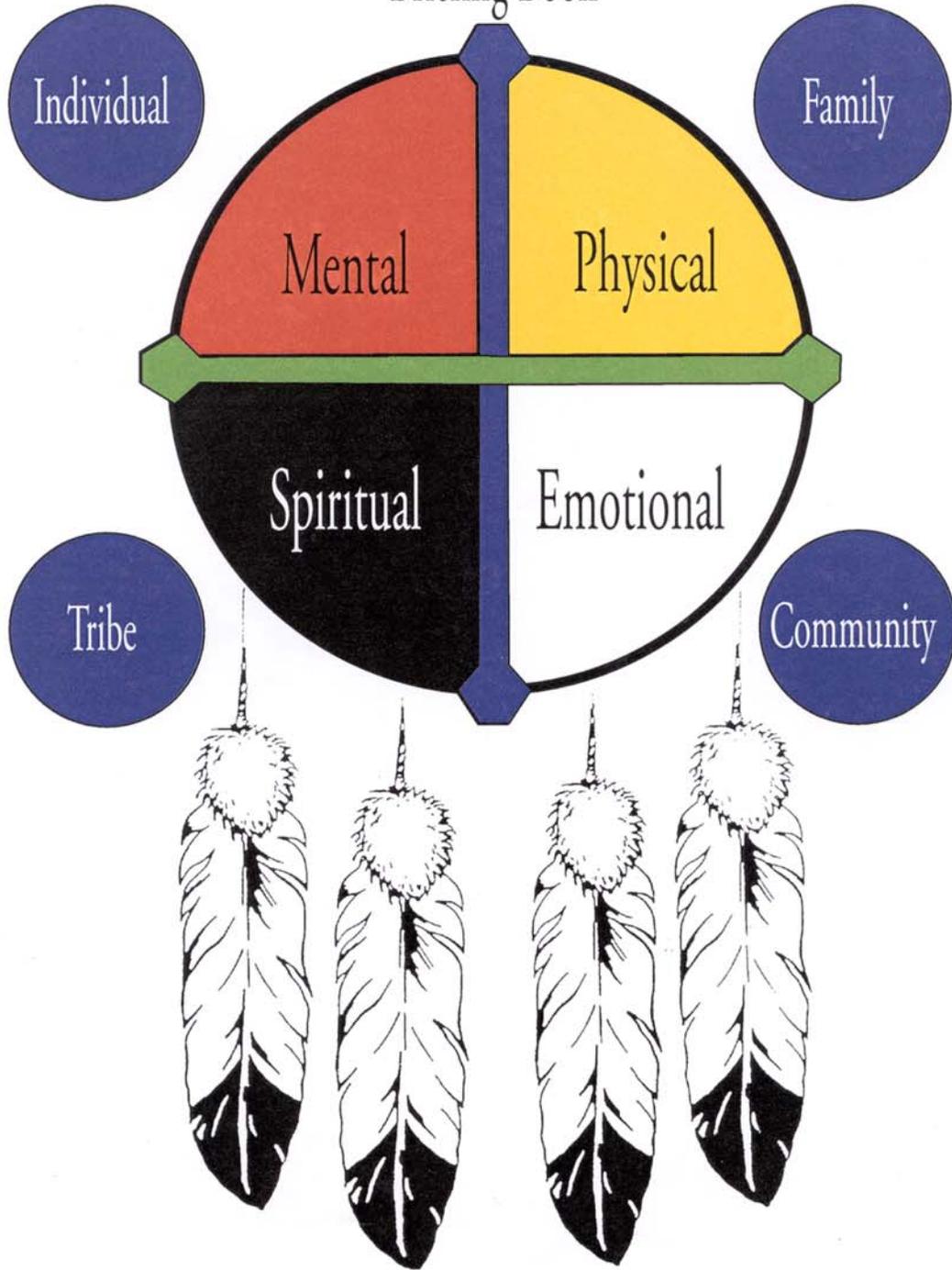


American Indian Symposium on
Mental Health & Chemical Dependency

Briefing Book



Acknowledgments

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INTRODUCTION

In working with tribal and urban Indian communities over the last 10 years or more, the Minnesota Department of Human Services (DHS) has held a number of focus groups and meetings at which representatives of these communities have identified issues that either impede or would improve the access and delivery of chemical dependency and mental health services to Indian people. DHS has learned that there is a great deal of capacity within communities to address these issues, both in terms of cultural supports and an evolving infrastructure that is becoming better equipped to address these issues. DHS has also learned from these focus groups that there are a number of resources that are lacking to effectively mobilize this local capacity and utilize the infrastructure.

For this reason, DHS, in partnership with the American Indian Advisory Council on Chemical Dependency and the American Indian Mental Health Advisory Council, has agreed to host a forum of tribal and urban Indian representatives from across the state to develop strategies that will allow DHS and the Indian community to address these problems.

The following pages contain a synopsis of the input from tribal chemical dependency and mental health professionals over the years. This is not meant to be a definitive statement of the issues. It is intended simply to be a starting point—a highlighting of some of the most often repeated statements made by tribal representatives. We have categorized the information that has been shared into three broad categories:

1. Community Capacity
2. Service System Infrastructure
3. Resource Needs

The synopsis is in the form of a narrative that attempts to pull together the common threads from the material. The objective is to provide a perspective of what has already been stated and to set it in a context that should be helpful for the symposium discussion. We have tried to retain the integrity of the material, which is attached as an addendum.

Before we get into these narratives, however, it is important to provide a brief overview of chemical dependency and mental health problems experienced by American Indians living within the state of Minnesota. In doing so, tribal and urban chemical dependency and mental health professionals believe that it is important to explain a phenomenon called Post-Traumatic Stress Disorder and its relation to this problem. Without this explanation, one cannot gain a proper understanding of chemical dependency and mental health problems within the American Indian community.

EFFECTS OF HISTORICAL TRAUMA

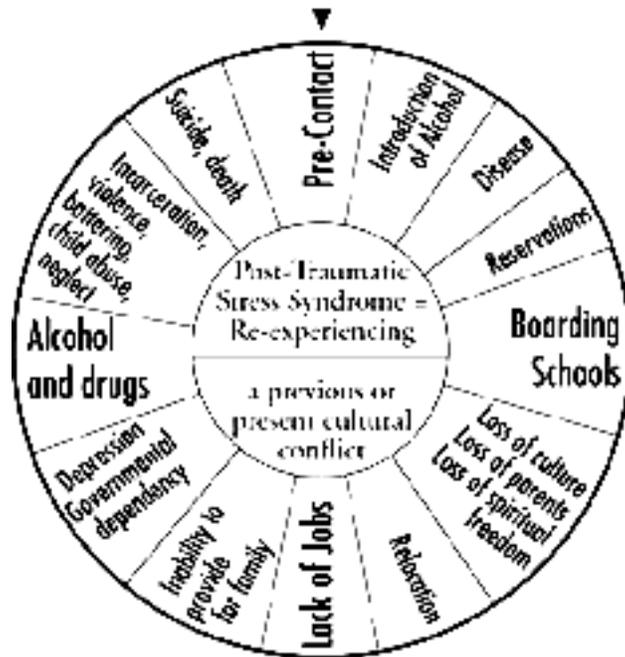
For any one Indian or group of Indians it is difficult to separate racial prejudice, family disintegration, or economic oppression from alcohol in the genesis of various problems. However, the danger exists that if alcoholism is focused on as the biggest problem, urgent political and economic issues may be ignored. This is especially true because much of what is done regarding alcoholism is done at the individual level, ignoring important social, cultural, and intercultural problems...In other words, simply attending to individual cases of alcoholism alone may neither help the alcoholic Indian himself, nor prevent new cases of alcoholism in the community, nor resolve the problems facing Indian communities. This is not to say that alcoholism treatment programs should not be undertaken, but rather that they should not be considered an across-the-board panacea for all the difficulties faced by Indian people. (author unknown)

The problems associated with chemical dependency and mental health issues have plagued the American Indian community for years. A variety of methods have been used to reduce the incidence of these problems, but to little avail, as five of the top ten causes of death of American Indians are alcohol and drug related. This lack of success has been attributed to the lack of resources, the lack of culturally sensitive approaches, and/or programs designed to “put out fires” rather than dealing with the real source of the problem. However, tribal leaders throughout this nation believe that little progress will be made until there is recognition and acceptance of the fact that many of the problems that American Indians are experiencing are related to **cultural genocide and are the effects of unresolved grief** experienced and handed down through generations. This unresolved grief is both a cause and effect of the perpetuation of current personal, family, community and cultural losses.

The life experiences of Indian people who are affected by chemical dependency and mental health issues has been interpreted by many American Indian leaders, at least in part, as the aftermath of the advance of the non-Indian into lands historically inhabited by American Indians. This advance led to disruption of the traditional lifestyle of American Indians, which had provided a comfortable life in balance with the environment. Cultural, political, social and economic structures had been based on a relationship to the land. This connection to the land was, and still remains, the basis of both individual and community health.

The following graph contains a few of the fire effects of the advance of non-Indian society into traditional Indian lands:

Post-Traumatic Stress:



The disconnection to the traditional land and lifestyles happened in a rapid period of time leaving the Indian people with little in the way of traditional supports. It has resulted in severe life stresses that place Indian people at high risk of chemical dependency and mental health problems. When disconnection is coupled with a series of federal policies aimed at assimilation the result was cognitive dissonance: a physical, intellectual, emotional, and spiritual disturbance of one's reality resulting from the difficulty of trying to live in two worlds. In the case of most Indians today, assimilation did not succeed. In fact, it did not have the effect of not moving them into the mainstream of society—but of creating a cultural void, in many cases an alienation even from their own culture.

The resulting confusion, depression and anger have often manifested themselves in the form of many chronic illnesses, including chemical dependency and/or mental health issues. Grief over the loss of loved ones; the wholesale separation of Indian children from their families; the loss of language, songs, ceremonies and other traditional cultural supports; and depression over the limited abilities to provide for one's family and community continues to contribute to the immobilization of the American Indian community.

While great progress has occurred, many tribal leaders recognize that to effectively mobilize the individual and community to address the problems of chemical dependency and mental health, as well as other related issues, the impact of this advance must be addressed. These leaders contend

that their ancestors experienced acts of atrocity at such levels that it caused a delayed reaction to the trauma, death, and unresolved grief which they experienced. Many leaders assert that they see evidence of this same phenomenon in the lives of their members today and they equate this with the phenomenon of **Post-Traumatic Stress Disorder**.

PTSD has been described as an event that is outside the range of usual human experience and would be distressing to anyone. Although the trauma often involves a physical factor, it always involves a psychological component that produces significant emotional trauma. Many victims attempt to rid themselves of their painful re-experiences, loneliness and panic attacks by using alcohol or other drugs as a self-medication that helps them blunt their emotions and forget the trauma. (Behavioral Health Services 1990)

In the process of observing and subsequently living through the traumatic event one had to adapt into what are called “survival roles.” In adapting to the traumatic event, one's identity was significantly changed, and indeed, may have been lost depending on the embarrassment or guilt one experienced in relation to this trauma. Many “survivors” in that “role” may very well block out all cognitive and, most important, physical and psychological meaning to those events in order to protect themselves from the potential psychic scarring of the event.

The end result of PTSD is cyclical—having a cause and an effect—impacting not only that individual's ability to effectively address common day life experiences, but also others whom he/she interacts with on a regular basis. In the words of Harold Napoleon, a Yupiq Indian who wrote the following from a prison cell where he was serving time for murdering his son while under the influence of alcohol:

"To such a person, escape from self becomes a necessity because even in sleep he finds no peace. He becomes a "runner", running from his memory, and from himself. He gets tired, begins to despair, and for him, in this day and age, alcohol and drugs become a readily available "escape" from the illness. These, for a time, are able to numb his mind and his soul. In time, without treatment, many veterans and others who suffer from PTSD become alcohol and drug abusers. Many become addicted, and, as a result, lose friends, wives, families and become isolated, exacerbating an already bad situation. Being unable to hold jobs, some become dependent upon others for support. Tragically, under the influence of alcohol and drugs, the pent-up anger, guilt, shame, sorrow, frustration and hopelessness is vented by outbursts of violence to self and others. Such acts, which are difficult for others and even for the sufferer to understand, drive him further into the deadly vortex of guilt and shame. Family and friends who knew him before he became ill, swear that he is not the same person, and that they do not know him anymore. Post-traumatic stress disorder is not a physical illness, but an infection of the soul --of the spirit.

This depression and anger is often first aimed at oneself—a belittling of oneself for an inability to cope with one's life experiences. This oppression is internalized, with the resulting loss of self-

esteem and shame producing a weak sense of personal identity and a feeling of alienation from the core values of the culture. As the shame adds up, the individual psychological problems become more and more unbearable. The result is often tragic, such as the case of Harold Napoleon.

Because of the tendency of persons experiencing PTSD to attempt to escape from their reality, there is a great deal of maladaptive behavior, which impacts many persons close to the individual. This, in turn, creates more individual trauma and remorse, which the individual has to confront again and again. As the person repeatedly experiences these realities it often times results in the desire to obliterate oneself from the world. Thus the incidence of suicide in the American Indian community is about 1.5 times higher than the overall United States rate.

Discussion among chemical dependency and mental health professionals and American Indians experiencing chemical dependency and mental health issues indicates that these problems often stem from a deep personal desire to escape from reality. For the Indian person, the realities of their life experience are often unbearable. The memories haunt and the present realities especially the inability to provide for one's family and/or community hurt. To escape this mental disturbance, one often begins using alcohol and or other drugs. As substance use progresses, so does an individual's tolerance level. Soon the effects of chemical dependency and mental health issues manifest themselves in the form of personal health problems, high drop-out rates, increase in juvenile and criminal behavior, and family domestic abuse problems that often result in loss of children to out-of-home placement and/or termination of parental rights. Each of these is cyclical, causing more and more personal, family, and community trauma.

To many, the explanation may seem too simple and even as an excuse, but the realities exist and hurt. Many estimate that 100% of American Indians experience in both a direct and indirect way the implication of this life experience. While the truth may never be known accurately, the impact of individual and community PTSD is undeniable.

So what is the answer? Again we quote Harold Napoleon:

My answer at least is this. That we, who are indeed the survivors of the Great Death must end it. That we must put all our energies and resources to end it...We must speak...because we don't know each other anymore, we have become strangers to each other....Only communication, honest communication, from the heart, and truthful, will break this down, because inability to share one's heart and feelings is the most deadly legacy of the Great Death. It was born out of the survivors' inability to face and speak about what they had seen and lived through. The memory was too painful--the reality too hard, the results too hard to hear. Without knowing it, the survivors began to deal with life and the difficulties of life this way, by trying to ignore them, by denying them, by not talking about them. And this is the way they raised their children, and their children raised us the same way. It has become a trait among our families, our people, holding things in. The results have been tragic...The only way it will end is if the built-up stresses, misunderstandings, and questions are released and satisfied by truthful

dialogue from the heart. It is only through this heart-to-heart dialogue, no matter how painful of embarrassing the subject, that the deadly stresses born of trauma on trauma, can be released. Then, slowly, we can all go home again, be alone and lonesome no more, be a family and a village again...Free to become what we were intended to be by he who created us."

Today, we are beginning to witness the personal heroics of many that understand these issues and have begun to passionately fight these historic and present realities. Still the battle is as intense as the vicious cycle has not been broken. To effectively win this war it will take an intense, coordinated attack. Not only will it take tribal governing officials, mental and chemical dependency staff, but health professionals, educators, law enforcement, elders and parents—and not only tribal but also non-Indian as well.

It is critical that Indian communities are provided the resources to end these problems. Policy makers must recognize the dynamic potential of those currently working with the communities and the multitude of untapped resources. It will be necessary to enlist one's knowledge and expertise—to enact laws and appropriate money and provide other resources. It will take a commitment not only to be thinking of seven generations into the future, but also a commitment to today's generation. To not do so is to perpetuate the agony—the trauma—perhaps unconsciously, but nevertheless, to perpetuate it. For those involved in combating this, we must believe that in at least a small way our contribution will prevail in the health of our communities. But at the same time, we must understand that the change will not occur "overnight" as the cataclysmic events of the past—it will take time and conscious choice.

MENTAL HEALTH

It is important to understand the impact of history on the mental health of Indian people, particularly the effects of colonization (Duran and Duran, 1995). The historical factors that have most affected Indian people include:

- federal policies, such as the U.S. Government's policy of extermination of American Indian people through use of military force;
- broken treaties;
- forced relocation, in which Indian people were removed from traditional homelands by force, leading to many Indian people acquiring a refugee syndrome as they were displaced from their loved ones and their lands;
- boarding school education, which created cultural and spiritual confusion and affected child-rearing practices;
- forced assimilation; and
- cultural neglect.

The importance of mental health services to Indian people must be understood in view of historical, geographical, educational, and tribal contexts. The predominant perception about mental health services in the Indian community is a historic distrust of the dominant society approach to dealing with mental health problems. This distrust is based on different cultural approaches and the belief that formal mental health services are an extension of society's attempt to assimilate the Indian. Past negative experiences reinforce this distrust. The perception exists that non-Indian service providers do not understand Indian culture, retain stereotypic images, and use approaches and techniques designed for and by the dominant society. The belief that formal mental health services tend to be judgmental, demanding, and inconsistent also contribute to the lack of service usage by Indian peoples (Cross, 1986)

Mental health and mental illness are clearly linked to social problems. When people are economically disadvantaged, lack control over their own lives, or endure the appropriation and destruction of their culture and way of life they usually experience high rates of mental health problems. On a national level, very high levels of poverty, unemployment, accidental death, domestic violence, alcoholism, child neglect and suicide affect Indian communities. Most authorities agree that there is a substantial level of unmet need for mental health services in tribal communities. Destructive forces such as alcohol and other drug abuse, sexual abuse, and family violence can interfere with a person's capacity to change, grow, and develop. Persons effected by these problems have a very limited capacity to learn, to grow emotionally, or to maintain physical and emotional health.

We lack data about the prevalence of mental illness in the Indian population. Definitions of mental health differ, according to fiscal limitations. Today, when mental health dollars are tight, definition is exclusive in its purpose. That is, by narrowly defining mental health, agencies can claim that they are meeting the mental health needs of their target population. For example,

mental health centers will say that fetal drug and alcohol exposure are organic and neurological and therefore not within their scope of services. People are also excluded from services by saying that the problem is behavioral, not mental health related. It is important that policy makers understand this trend to exclude services. The information that does exist makes clear that mental health services for Indians are inadequate.

Minnesota Data on Mental Health

- In Minnesota, American Indians receive more mental health services across all types of services than the rest of the population
- American Indians in Minnesota have a disproportionately high frequency of assessment and identification services, in comparison to treatment services.
- On average, Indian children in Minnesota receive more mental health services than do Indian adults.
- During the period 1996 – 1998, 30 American Indians in Minnesota committed suicide. This is an age-adjusted suicide rate of 19.5 per 100,000, which is the highest for any racial group in Minnesota, and over twice the statewide average. (Minnesota Department of Health data)
- The suicide rate for American Indian males, ages 13-24, was 56.6 per 100,000 in Minnesota, over three times the statewide average for males ages 13-24. (Minnesota Department of Health data)

National Data on Mental Health

- Indian adolescents have more serious mental health problems than other racial groups in the US with respect to:
 - developmental disabilities, such as mental retardation, learning disabilities, and Fetal Alcohol Syndrome/Alcohol Related Neurodevelopmental Disorders/Alcohol Related Birth Disorders;
 - depression;
 - suicide;
 - anxiety;
 - alcohol and substance abuse;
 - running away; and
 - school dropout. (Manness, 1998)
- Research shows that when an individual experiences trauma, there is a profound deregulation of the brain's biochemistry resulting in Post-Traumatic Stress Disorder (PTSD). Research does not talk about the prevalence of PTSD in children. We can estimate that it is of catastrophic proportions because: there continues to be a high rate of child abuse cases; the

high rate of substance abuse; and the prevalence of domestic abuse. We assert the Indian children suffer a higher rate of PTSD than non-Indians do. (Manness, 1998)

- 54% of American Indian children live below the poverty level (American Indian Research and Policy Institute)
- Prevalence rates of depressive disorders among American Indian populations may be six times the rate for the general United States population (Manson et al, 1985). National Institute on Mental Health research has shown that stress in the form of loss, especially the death of close family members or friends, can trigger depression in vulnerable individuals. Genetics research indicates that environmental stressors interact with genetic factors to increase the risk of developing depression. Stressful life events may contribute to recurring episodes of depression for some individuals.
- Depression is one of the most prevalent problems among hospitalized American Indians (Termansen and Ryan, 1970; Fritz, 1976).
- Mental health service utilization studies document depression as the most frequently diagnosed problem among American Indian clients presenting for assistance (Schoenfield and Miller, 1973; Rhoades et al, 1980; Shore and Manson, 1983; Kirmayer et al, 1993).
- According to the Centers for Disease Control report “*Homicide and suicide among American Indians and Alaskan Natives (1979-1992)*,” overall homicide rates for American Indians and Alaskan Natives who reside on or near reservations during this 14-year period were about twice as high as the overall United States rate. Suicide rates were about 1.5 times higher than the overall United States rate.
- 11.7% of all American Indian children are in out-of-home placement (American Indian Research and Policy Institute)
- Non-white children are less likely to receive all forms of treatment and are particularly likely to be served in correctional rather than medical facilities (Knitzer, 1982)

Mental Health Services

The United States Government has the responsibility, assumed through many treaties, to provide health care for members of federally recognized tribes. This obligation is carried out through the Indian Health Service, which is part of the Public Health Service. The Public Health Service assumed responsibility for the IHS in 1955, and today serves approximately 60% of the Indian population in the US.

There are numerous agencies/departments involved to various degrees in the provision of mental

health services to Indian people. At the broad systems level, there is a lack of clarity about the roles in mental health care of the Indian Health Service, the Bureau of Indian Affairs, states, counties, cities, and tribes. There are relatively few working agreements between these service delivery systems. Ambiguity and false assumptions that some other agency is responsible have contributed to Indian peoples remaining underserved. The reality is that a large number of systems overlap.

Many tribes and urban programs have difficulty attracting and retaining qualified mental health staff, due to a variety of factors, including isolation. Transportation is another barrier to providing good services. One result of these problems is that children have to be placed in off-reservation institutions, removing them from their community and support systems of extended families and placing them in a culturally unfamiliar environment, which can lead to undesirable treatment outcomes.

CHEMICAL DEPENDENCY

Minnesota Data on Substance Abuse

The following data is from Minnesota Department of Human Services' report "Substance use among American Indians in Minnesota: Treatment Issues and Prevention Opportunities."

Substance use

- More Indians use almost all the included substances (alcohol, tobacco, marijuana, and other illicit drugs) at almost all ages than others in the state do.
- Substance use in general peaks from late adolescence through young adulthood, but rates remain relatively high during midlife and late-life among Indians compared to others.
- Indians have more psychological distress, and their substance use is more strongly associated with this distress.

Substance abuse treatment

- Indians have a higher rate of need for treatment, and youths also have a higher need for preventive intervention.
- Fewer Indians perceive a need for treatment than the number who do need it, and the gap is larger among Indians than others; in addition, more Indians who enter treatment do so under legal compulsion.
- More Indians receive substance abuse treatment than others in the state, from adolescence through adulthood.
- Fewer Indians receive treatment than the number who need it, but this gap is smaller among Indians up to midlife and no different from others from midlife to late-life.
- Indians enter treatment with more problematic treatment histories, especially in adulthood.
- Fewer Indians complete treatment and more leave or are asked to leave before completion.

Preventive intervention targets

- Young Indians have more risks and fewer protectors in the family, community, and schools.
- More risks are related to higher substance use, more protectors to less use.

Minnesota Treatment Data

Data from Minnesota's Drug and Alcohol Abuse Normative Evaluation System (DAANES), which reports all admissions to and departures from substance abuse treatment in the state each year, show that Indian people use all forms of chemical dependency treatment at a higher rate than the rest of the state population. While the vast majority of individuals in treatment are white, the numbers of American Indians and African Americans in treatment are greatly disproportionate to their numbers in the general population. Specifically, American Indians constitute 9% of treatment admissions but only 1% of the state population aged 18 and older and 2% of the state population aged 17 and younger. Within the American Indian population, adult

males are the highest users of chemical dependency treatment, followed by adult females, male youth, and female youth.

There were 3,234 CCDTF placements for Indian people from July 1, 1999 to June 30, 2000. This number represents 2,191 different Indian individuals, as some received more than one placement, with an inpatient treatment followed by an outpatient treatment admission being the most common. The rate of unduplicated admissions was very similar for all race/ethnicity groups, ranging from 68% for American Indians and Hispanics to 70% for Whites and 71% for Blacks. As these rates are so close for all groups, in the rest of this report raw counts of CCDTF substance abuse placements are reported instead of unduplicated placements.

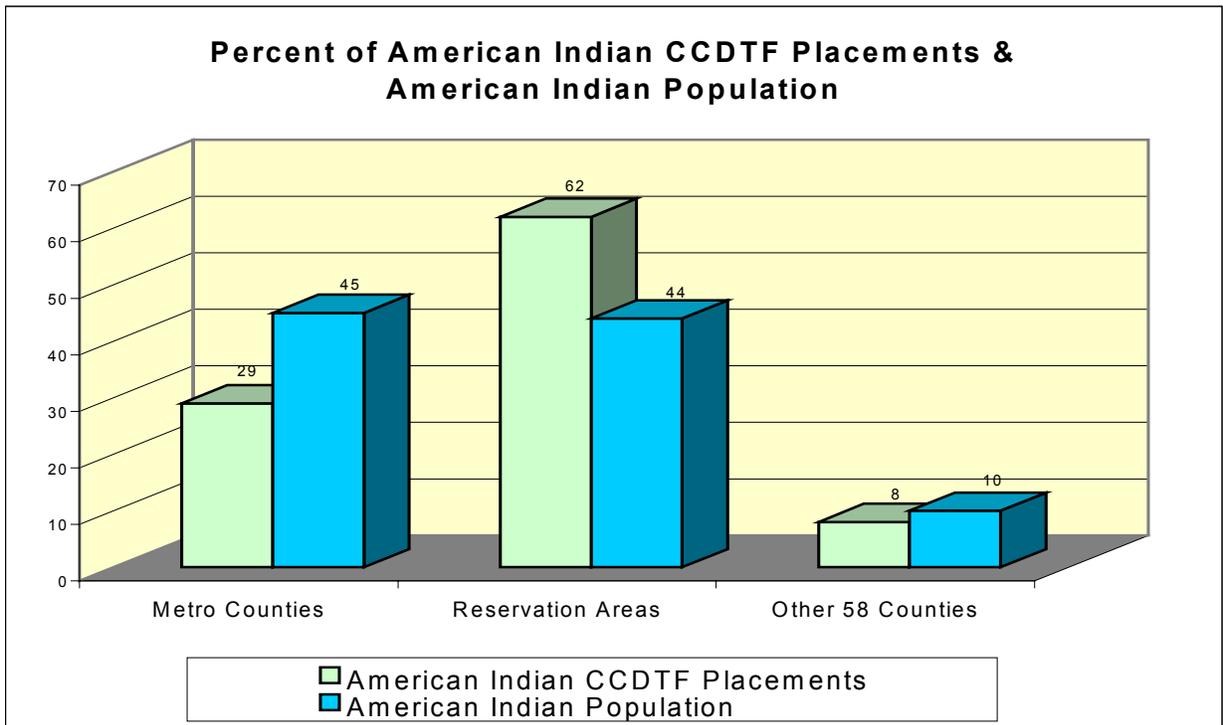
From July 1, 1999 to June 30, 2000:

1. There were 1,786 CCDTF treatment episodes for adult Indian men (65% of adult Indian placements)
 - Indian men were only slightly more likely to receive a substance abuse placement through reservations than through the county system.
 - Reservations made 930 of these placements, or 52%, and counties made 856 for 48%.
 - The seven counties in the metropolitan area made almost 62% (528) of the county placements; 38% (328) were made by the 80 Greater Minnesota counties.
2. There were 963 CCDTF treatment episodes for adult Indian women (35% of adult Indian placements)
 - Indian women were more likely to receive a substance abuse placement through the county system than through the reservations.
 - Reservations made 373 of these placements, or 61%, and counties made 590 for 39%.
 - The seven counties in the metropolitan area made 65% (382) of the county placements.
3. There were 291 CCDTF treatment episodes for Indian boys 17 years and younger (56% of Indian youth placements)
 - Reservations made 154, or 53%, of these placements and counties made 137 for 47%.
 - The seven counties in the metropolitan area made only 25% (34) of the county placements.
4. There were 232 CCDTF treatment episodes for Indian girls 17 and younger
 - Reservations made 120, or 52%, of these placements and counties made 112, or 48%.
 - The seven counties in the metropolitan area made only 27% (34) of the county placements.
5. While 45% of American Indians in Minnesota live in the six-county Twin City Metro Area¹,

¹Hennepin, Ramsey, Dakota, Anoka, Carver, & Washington. Scott County, which is usually included as

just 29% of the CCDTF substance abuse treatment placements for American Indians came from these 6 counties.

6. While 44% of American Indians in Minnesota live in the 23 counties² that include part of one of the 11 reservations or border one of the reservations, 62% (2,039 placements) of the CCDTF substance abuse treatment placements for American Indians came from either a reservation or one of these 23 counties.
 - Over 77% of these 2,039 placements came from the reservations, with less than 23% coming from the 23 counties.
 - The other 58 counties make up about 10% of the state’s American Indian population and accounted for almost 8% of the CCDTF substance abuse treatment placements.



the seventh Twin Cities Metro-Area county, was not included as it was included as one of the Reservation Area counties in this section of the report.

²Aitkin, Becker, Beltrami, Benton, Carlton, Cass, Chippewa, Clearwater, Cook, Crow Wing, Goodhue, Hubbard, Koochiching, Itasca, Mahnommen, Mille Lacs, Morrison, Pine, Redwood, Renville, St. Louis, Scott, & Yellow Medicine.

The number of substance abuse treatment placements was obtained from Consolidated Chemical Dependency Treatment Fund 904 reports, which gives the number of placements and the county or reservation the placement came from. This information shows where Indian people in Minnesota are accessing the substance abuse treatment system. Using CCDTF data misses information on those who access treatment services through private insurance or the Prepaid Medical Assistance Program (PMAP). This needs to be kept in mind when reading the data tables in this report on the number of American Indians vs. “All Others” who received treatment placements from different locations.

Only 7% of American Indians in Minnesota who receive treatment services do not use the CCDTF, while almost half (43%) of “All Others” do not use the CCDTF. Thus, the numbers in these tables for ‘All Others’ who received placements through the CCDTF is much lower than the number who actually received substance abuse treatment placements.

Care must be used in interpreting the meaning of larger vs. smaller treatment rates per 10,000. A larger number (larger rate) does not necessarily mean the substance abuse problem is worse in that location or that more of the population is affected. A particular area may be better at getting those who need services assessed and placed into treatment, or tribal members, who were not counted in the census as living on the Reservation or its surrounding area, may travel to the reservation for assessment and service, thus inflating the rate per 10,000 for that area.

Another factor is that a reservation area with a small number of American Indians listed by the census as living in that area will have a very large rate per 10,000 with just a few placements. This can be seen with both the Lower Sioux and Upper Sioux Reservations. For the Shakopee Reservation Area, the numbers are low due to the fact that all their members are covered by a private health insurance plan and placements do not show up on the CCDTF 904 reports. Those living and working in the substance abuse field in each community will know best how to interpret these rates for their community.

(Estimates of the Population of Counties by Race and Hispanic Origin: 1998 Source: U. S. Bureau of the Census Internet Release date: September 15, 1999)

Prevention efforts in American Indian Communities

The American Indian Prevention Programs seek to reduce the incidence of alcoholism and drug abuse within their communities. Prevention efforts of the 26 programs funded by the Chemical Health Division so far have focused on individuals and families but are beginning to expand to include communities. It is believed that responsibility for prevention belongs to many individuals and groups. The programs are focusing more and more on building community capacity to provide outreach, advocacy and education services.

The American Indian School-based programs provide age-specific, developmentally appropriate, and culturally sensitive curricula. Community programs have developed anti-alcohol and drug

abuse messages as prevention efforts. Other program prevention services include workshops for parents, training youth as peer leaders, court advocacy and diversion services, individual, group, and family counseling. Several of the prevention programs maintain a Drop-In-Center offering continued support and alternatives to chemicals/alcohol. All of the prevention and intervention programs incorporate the use of traditional Native American practices such as talking circles, sweat lodges, pipe ceremonies and cultural teachings for those who choose so. These practices strongly reinforce physical, social, mental, cultural and spiritual development.

Every year the prevention programs continue to learn from the past by applying new methods to bring families back into harmony with their communities.

National data on substance abuse

The following data is from *Prevalence of Substance Use among Racial and Ethnic Subgroups in the United States, 1991-1993*, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

- Native Americans have very high prevalence of past year substance use (including cigarettes, alcohol, and illicit drugs), alcohol dependence, and need for illicit drug abuse treatment.
- About 53% of Native Americans aged 12 and older used cigarettes in the past year, versus about 31% in the total U.S. population aged 12 and older.
- About 20% of Native Americans aged 12 and older used an illicit drug in the past year (versus 12% in the total U.S. population aged 12 and older)
- About 7.8% of Native Americans aged 12 and older were in need of illicit drug abuse treatment (versus 2.7% in the total U.S. population aged 12 and older).
- Native Americans (53%) had a relatively high prevalence of past-year cigarette smoking compared with other racial/ethnic subgroups of the U.S. household population aged 12 and over.
- The rankings of racial/ethnic subgroups with respect to past-year illicit drug use (including use of marijuana and cocaine) and need for illicit drug abuse treatment are similar, but not identical, to their rankings with respect to past-year cigarette use and past-month heavy cigarette use.
- 20% of Native Americans used an illicit drug in the past year.
- The prevalence of dependence on alcohol was relatively high among Native Americans (5.6%)

- Native Americans are the highest of the eleven subgroups on six of the nine measures: past-year cigarette use (53%), past-year use of any illicit drug use (20%), past-year marijuana use (15%), past-year cocaine use (5.2%), need for illicit drug abuse treatment (7.8%), and heavy past-month cigarette use (24%). However, given the small sample size of Native Americans (n = 411), the difference between Native Americans and the next highest subgroup is statistically significant for only one of these six measures: past-year cigarette use.

The next sections describe the pattern of usage of mental health and chemical dependency services by Indian people statewide and in selected Minnesota communities.

DEMOGRAPHICS

General

The State of Minnesota has the twelfth largest American Indian population in the country. According to the 1990 census, the Minnesota American Indian population totaled 49,909. This data shows a 36.6 percent increase since 1980. Approximately one-third of Minnesota's American Indian population live in the central cities of Minneapolis and St. Paul with 15 percent living in the Twin Cities suburbs. The reservations census count indicated that 12,402 American Indians are living on reservations. This represents a 25 percent increase from the 1980 census for American Indians residing on the reservations. (From *Indians, Indian Tribes and State Government*, Minnesota House of Representatives Research, Saint Paul, Minnesota, 1993)

American Indian Population on Reservations: 1980, 1990, 1993			
Reservations	1980*	1990*	1993**
Bois Forte (including Lake Vermillion)	495	433	1,926
Fond du Lac	514	1,106	2,922
Grand Portage	187	207	330
Leech Lake	2,759	3,390	5,771
Lower Sioux	65	225	266
Mille Lacs	293	428	1,151
Prairie Island	80	56	176
Red Lake	2,823	3,602	5,087
Shakopee-Mdewakanton	77	153	230
Upper Sioux	51	43	169
White Earth	2,554	2,759	4,395
Total	9,898	12,402	22,423

*Source: U.S. Census

**Source: BIA Labor Force Report

Counties with American Indian Population of 1,000 or more - 1990 Census / 1998 estimates		
County	1990	1998*
Hennepin	14,912	16,229
Beltrami	5,641	6,818
Ramsey	4,509	4,985
St. Louis	3,682	3,927
Cass	2,373	3,052
Anoka	1,865	2,450
Becker	1,864	2,117
Itasca	1,342	1,527
Carlton	1,297	1,490
Mahnomen	1,193	1,278
Dakota	905	1,229
Total	35,472	45,102

*Estimates of the Population of Counties by Race and Hispanic Origin: 1998

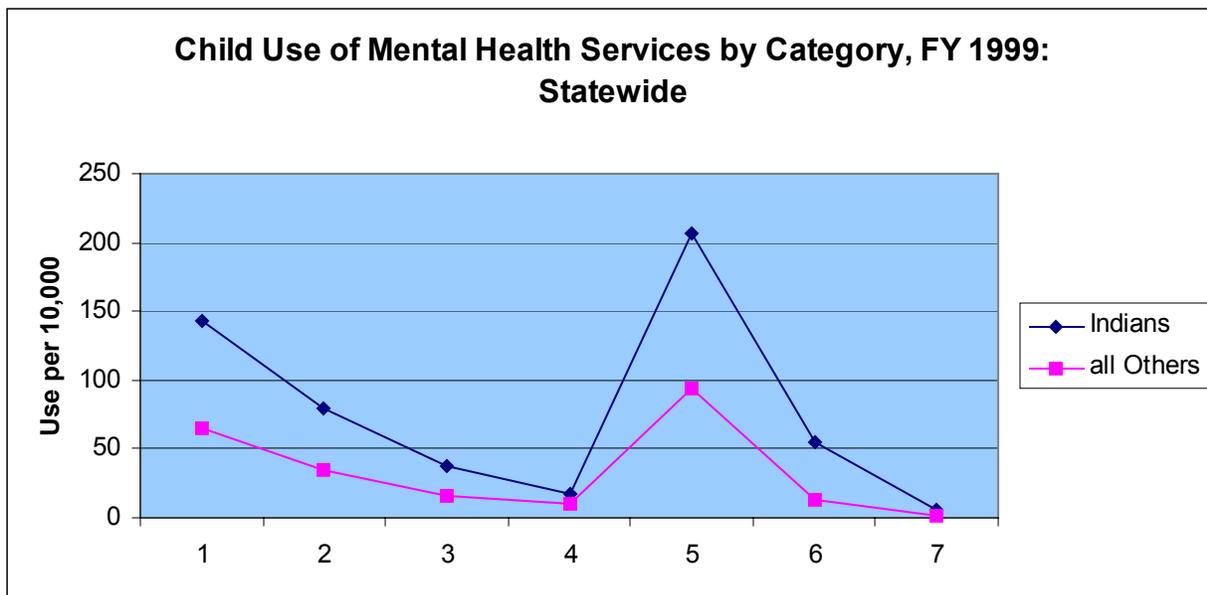
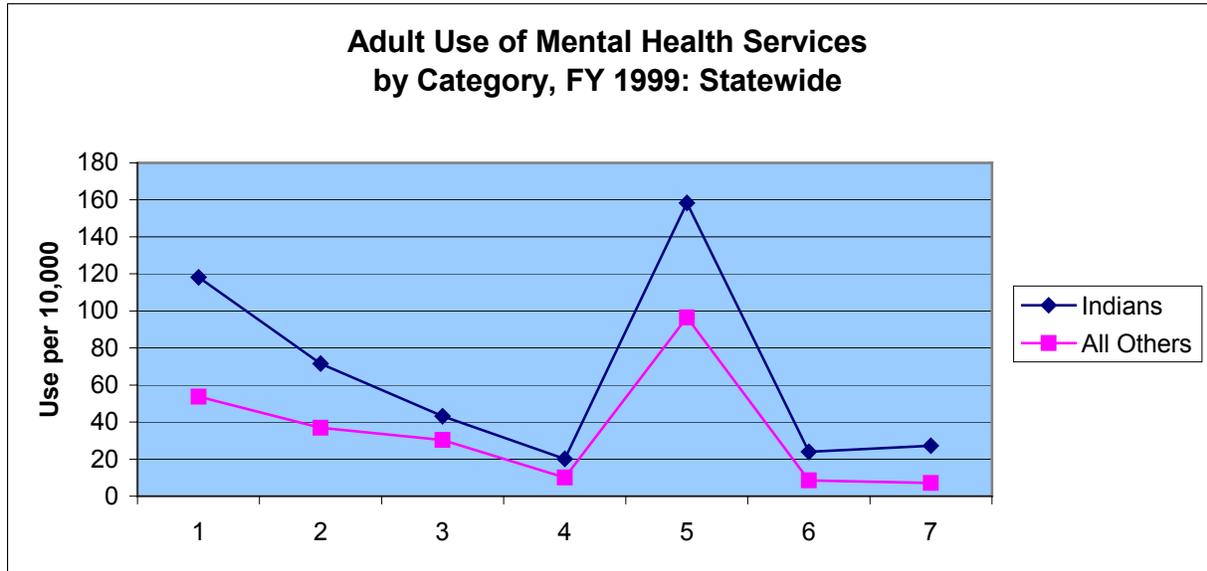
Source: U.S. Bureau of the Census, Internet Release date: September 15, 1999

	All Minn.	7 county metro	Greater Minn.	Mpls. (Hennepin Cty)	St. Paul (Ramsey Cty)	Bemidji (Beltrami Cty)	Duluth (St. Louis Cty)
% of adult population that is American Indian	1%	1%	1%	1%	0.4%	14%	2%
% of youth (0-17) population that is American Indian	2%	2%	2%	3%	1%	26%	4%

Proportion of the population that is American Indian varies by geographic area in the State. American Indian youth make up a larger percentage of the Minnesota youth population (2% of the total Minnesota youth population with up to 26% of Beltrami county youth) than the American Indian adult population is of the total Minnesota adult population (1% of the total State adult population, with up to 14% of the adult population of Beltrami county). These numbers are likely to change once the 2000 Census data is released.

Mental Health

The data on mental health in this and the following section is from the Minnesota Department of Human Services' Community Mental Health Reporting System, and is based on county-wide data for the counties listed on each graph. This does not include data from the American Indian projects that are funded through the Community MH federal block grant, nor does it include IHS data.



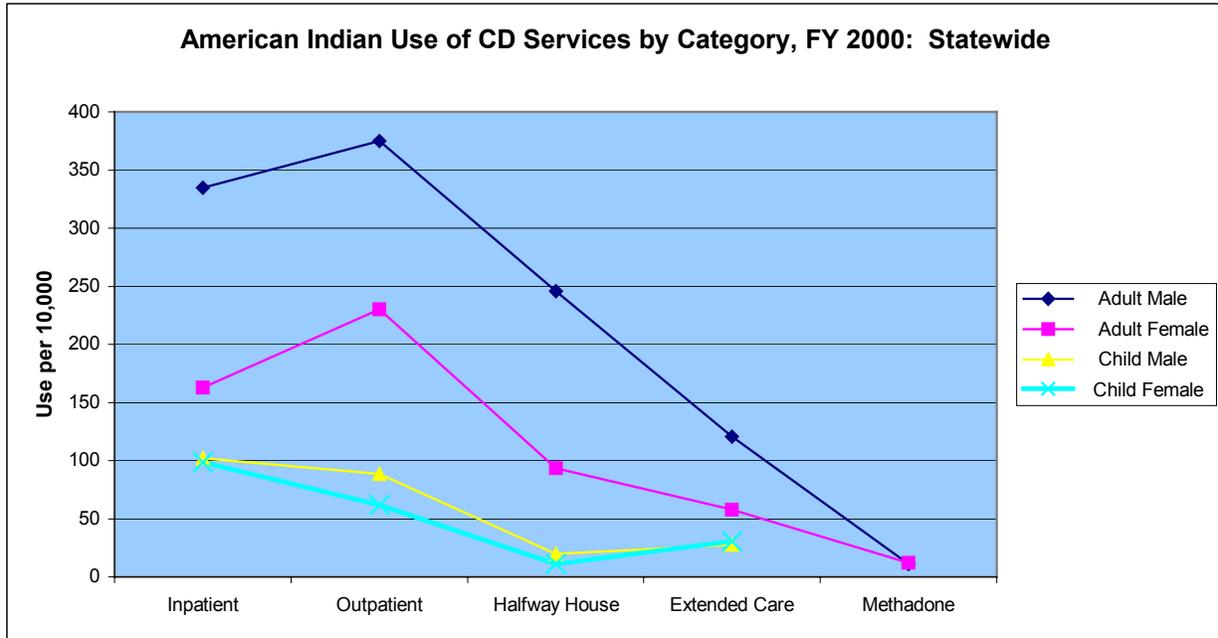
1: Assessment/Identification
2: Case Management
3: Community Support

4: Day Treatment
5: Outpatient Treatment
6: Residential Treatment

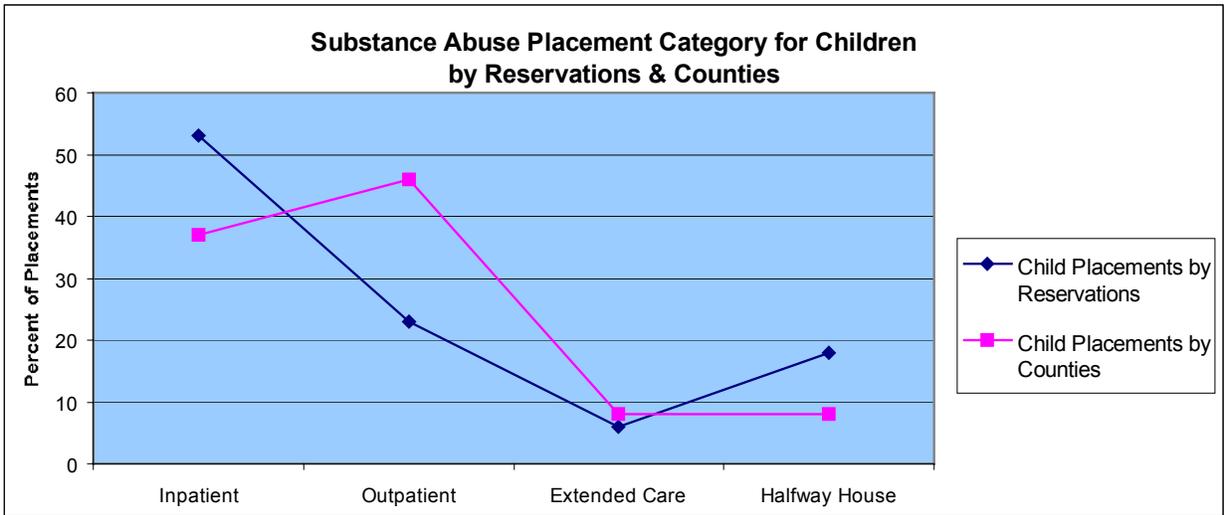
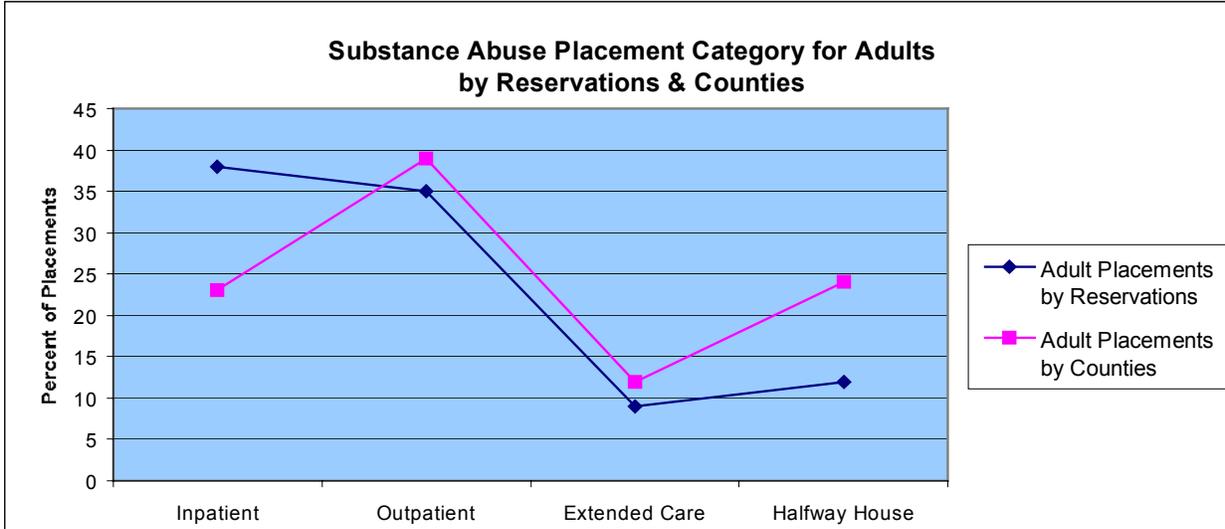
7: RTC

Chemical Dependency

The data on chemical dependency in this and the following section is from the Minnesota Department of Human Services' Consolidated Chemical Dependency Treatment Fund 904 reports.



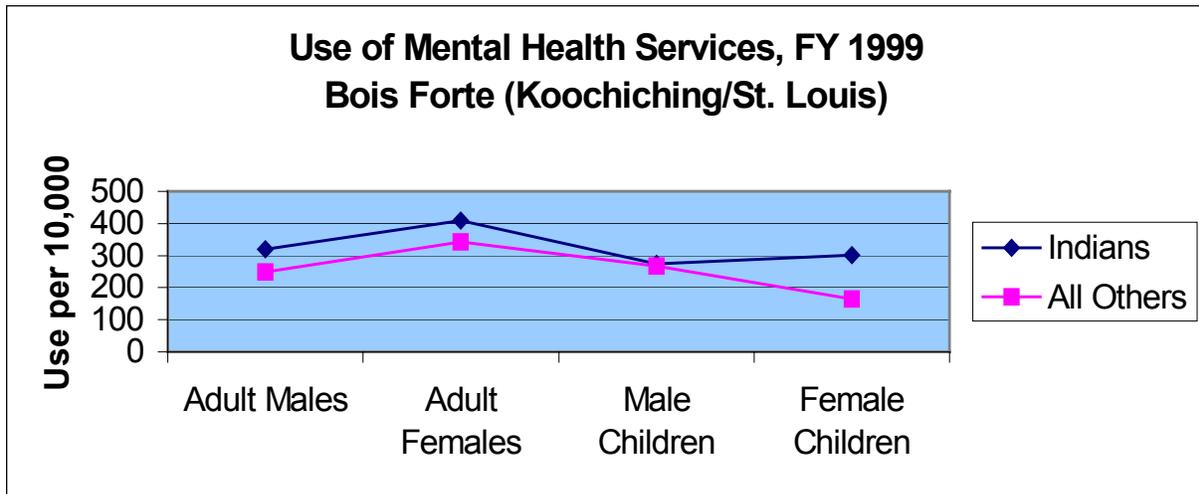
Placement rates for the different types of substance abuse treatment varied for reservations and counties. Counties had a lower rate of inpatient placements and a higher rate of outpatient placements for both children and adults than reservations.



COMMUNITY-SPECIFIC DATA

Bois Forte

Mental Health



Number Served	Indians	All others
Adult Males	40	1,875
Adult Females	54	2,764
Male Children	26	673
Female Children	26	399

Prevalence of mental health problems. Mental illness, as defined in the DSM-IV as diagnosable mental disorders, is present in every age group among our people. The estimated percentages are as follows: children, 28%; adolescents, 46%; adults, 34%; elders, 46%. This does not include grief, which occurs in 80-100% of the band members.

Infrastructure/Programs that address mental health problems. Our treatment approaches and programs utilize, when needed, medicine men, medical doctors, Protestant ministers, Catholic priests, psychologists, social workers, mental health counselors, and drug and alcohol counselors. Programs are tailored to meet the need for services and can include;

- PTSD group and individual therapy,
- pre-marriage counseling,
- couples/marriage/family counseling,
- parenting classes,
- screening for ADD/learning disabilities/Tourette's,

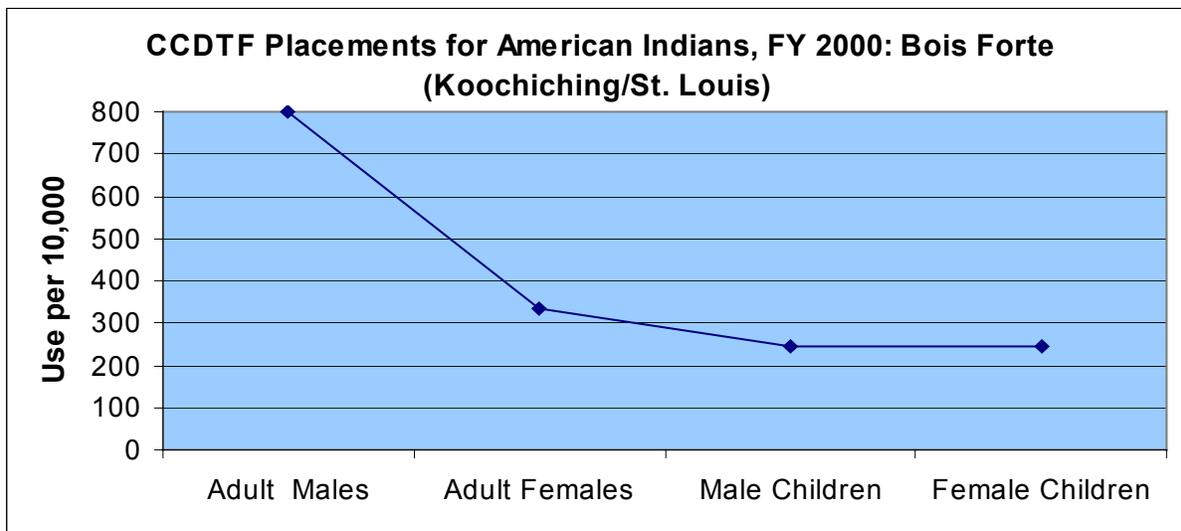
- assertiveness training,
- communication training,
- conflict resolution,
- anger management,
- group/individual treatment for perpetrators and victims of different forms of violence including physical and sexual abuse,
- group/individual grief work,
- drug and alcohol outpatient treatment,
- AA,
- NA,
- weight control training, and
- habit control training.

The Band also offers sports programs for our youth, including weight lifting and boxing, which can improve self-esteem, build self-confidence, and reduce symptoms of depression.

Community Priorities. Building or strengthening our families, encouraging permanent relationships, emphasizing spiritual growth and prayer, education and vocational skills training, decreasing chemical abuse, and treating those with mental/physical/spiritual illness.

Community Resource Needs. Inpatient treatment facility for juveniles with behavior/mental/spiritual illness problems, jobs that are close by and provide skills training and/or accredited educational opportunities for employees and opportunities to advance.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 4,377 American Indians residing in Koochiching and St. Louis Counties.

33% (62 of 188) of the CCDTF placements for American Indians were from the Bois Forte Reservation. 67% (126 of 188) of the placements were from Koochiching and St. Louis Counties.

Number of Placements	Indians	All Others
Adult Males	100	526
Adult Females	44	150
Male Children	23	33
Female Children	21	30

Prevalence of chemical dependency problems.

- Three-fourths of fathers and two-thirds of mothers have experimented with illegal drugs at some point in their lives.
- Initiation to using alcohol seems most likely between the fifth and eighth grades. The children’s drinking behaviors appear to be dangerous, The children say they consume a lot of alcohol at one time.
- Problems in the family and in the schools are emerging for young people who are using alcohol.
- Types of drugs the children report they have experimented with in the last six months were marijuana, methamphetamines, inhalants, speed, hallucinogens, barbiturates, crack cocaine, and tranquilizers.
- 62% of the American Indians referred were from Bois Forte. The infrastructure of programs available on Bois Forte is not enough to combat a problem of this magnitude.
- Chemical dependency evaluations indicate an earlier onset of usage for the younger population.

Infrastructure/Programs that address chemical dependency.

- Treatment Planning/Placement
- Outpatient Treatment Program
- Transportation (CD related)
- Individual/Family Counseling
- CD Assessment (Rule 25)
- DUI/DWI Program
- Ongoing Support
- P.I.E. (Prevention, Intervention and Education)
- Weekly AA (Alcoholics Anonymous) meetings
- Annual sobriety celebration
- Weekly aftercare program

- Annual women's wellness day

Community Priorities.

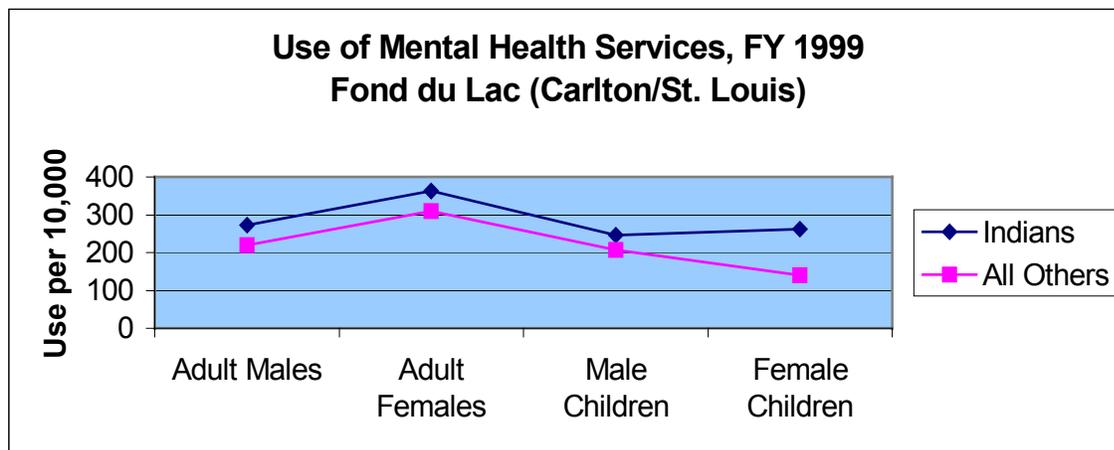
- CD Services for Youth
- Staff training in cultural family based systems for both reservation and urban settings
- More research and statistics
- Staff training in adolescent development
- Creation of new position(s) utilizing our elders working with youth in area of recreation/education

Community Resource Needs.

- Funding
- Chemical dependency program is short-staffed. We could be doing a lot more prevention activities. When we do chemical dependency activities, a limited number of people show up. Funding is needed to make these programs more attractive to our people.
- Grief/Loss work needed. Staff were trained in November 1999, but participation was minimal.
- Probation officer on Bois Forte enforces tribal court orders. Our use of the Consolidated Fund was way up in the last year as a result.

Fond du Lac

Mental Health



Number Served	Indians	All others
Adult Males	43	1,763
Adult Females	58	2,664
Male Children	29	563
Female Children	28	356

Prevalence of mental health problems. The prevalence of mental illness in our community is high. There are many individuals dealing with depression and anxiety, typically related to childhood trauma and neglect. We also have a high number of individuals who have learned to self-medicate and cope with their mental illness through addictive behaviors, including alcoholism and/or gambling. Therefore, many individuals in our community who are suffering from mental illness typically have dual diagnosis of depression and/or anxiety with chemical dependency. This results in a recurrence of depressive symptoms and relapses within the individual's sobriety.

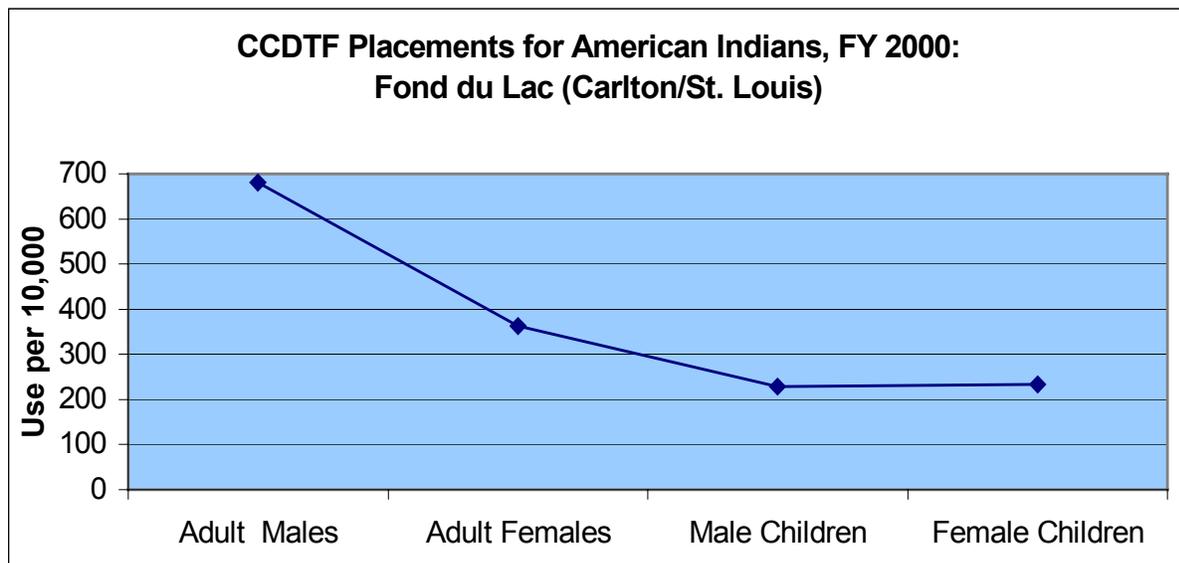
Infrastructure/Programs that address mental health problems. The programs used to address mental illness are our outpatient mental health services, which include full diagnostic assessments and psychotherapy. We offer hypnotherapy for those individuals who are experiencing anxiety or phobias and to address issues such as weight loss and smoking. We have a therapist who specializes in EMDR to assist individuals to process past traumas with the ultimate goal of reducing the anxiety and depression that accompany PTSD. We also have two consulting psychiatrists who assist the therapists and patients with medication management and treatment planning. Our Chemical Dependency program is capable of doing assessments and providing support and networking with individuals whose goal is to maintain sobriety. These

services are offered on an outreach basis and can assist with transportation and other barriers to the chemically dependent person. Mental health and chemical dependency program staff are responsible for providing prevention, awareness, and education to the community at all age levels. Our staff do presentations at public and reservation schools, with elders, and give in-service presentations to other human services staff. Our staff works closely with the other human services staff to provide a holistic case management service for our community members.

Community Priorities. The major priority is to provide more outreach services to persons with serious and persistent mental illness (SPMI). There is currently a gap in services for these individuals. Ideally, we would develop a program modeled after a community support program, which would include a mental health practitioner to offer in-home services for support, crisis prevention, and reducing the risk of hospitalization for the individual with SPMI. Other priorities include a day treatment program for our high risk and high needs youth, to address those needs on the reservation. We are also looking towards an outpatient program for individuals with both mental health and chemical dependency problems.

Community Resource Needs. The community resources needed to provide these priorities ultimately depend on funding. We would need to hire staff and provide all of the other expenses required for those programs. We could utilize some staff that are currently filling positions within our other programs. We are hoping to have space for these programs by May, 2001.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 5,417 American Indians residing in Carlton/St. Louis Counties.

37% (80 of 217) of CCDTF placements for American Indians were from the Fond du Lac Reservation. 63% (137 of 217) were from Carlton and St. Louis Counties.

Number Placed	Indians	All Others
Adult Males	107	509
Adult Females	58	157
Male Children	27	29
Female Children	25	32

Prevalence of chemical dependency problems. Because of the long term problem of alcohol and drug abuse, we need a halfway house for men and women trying to stay sober where they can stay in a safe environment for more than the commitment time than the law says they have to stay.

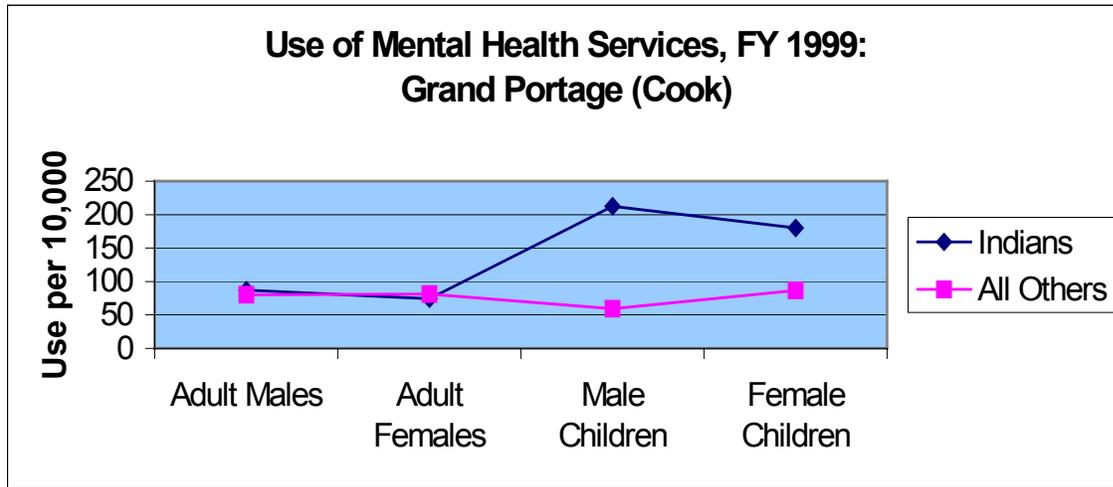
Infrastructure/Programs that address chemical dependency. We have a work program for the long term alcoholic and drug-addicted person. They work around on the reservation, painting houses, doing yard work, cleaning the lawns, and getting a fair paid job, like \$8 an hour for 20 hours a week. This gives the person self-esteem and they feel good about themselves because the community hasn't given up on them because of their disease of alcoholism and where other alcohol and drug treatment programs didn't help very much. We tried this in Wisconsin in 1977 and found that it worked really well. It is a good way, I think, to look at a growing problem with our native people.

Community Priorities. If we could have more community people involved with the decision of what to do with the alcoholics and drug persons, this might change our attitudes towards alcoholic use and abuse. They want to commit a person more often for alcohol and drug abuse than just taking their time in a good recovery program. Family members do not want to change their behavior of using drugs, only the person they're committing.

Community Resource Needs. I feel we need to address the problems together and not just a few people that are sober, and the ones that work in the field of alcohol and drug abuse. We need the help of everyone that cares and wants to change how people are and how they act. The family feels a person is going to change when they complete treatment of alcohol or drug abuse. But a lot of people don't want to change and continue using alcohol and drugs. It's hard for the family to accept that the person might die from alcohol and drug abuse.

Grand Portage

Mental Health



Number Served	Indians	All others
Adult Males	1	14
Adult Females	1	14
Male Children	1	3
Female Children	1	4

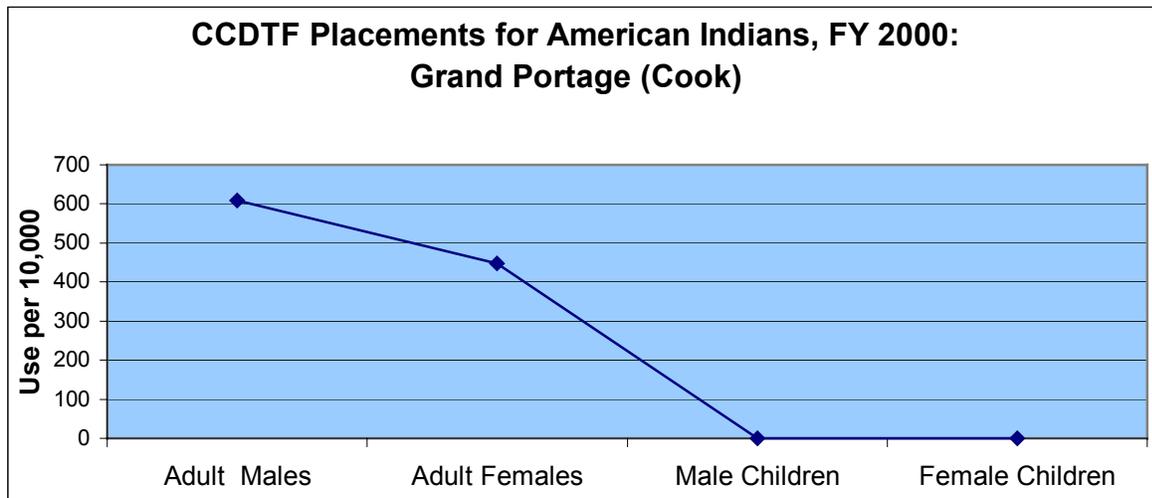
Prevalence of mental health problems. Grand Portage deals with long-term mental health problems, many of which are generational. Some stem from identity problems, addictions, low self-esteem, depression, anxiety, relationship problems, family problems, developmental disorders, domestic violence, academic problems, parenting problems, and fetal alcohol exposure. The majority of the population on our reservation is affected by these problems. Most of the community members are closely related, and this is a closely-knit community. When one community member is troubled, it is felt throughout the village.

Infrastructure/Programs that address mental health problems. Our Mental Health program is under the umbrella of the Human Services program. We now employ one therapist. We work closely with the Elders Program, Youth Program, Schools and Education Department, Domestic Violence Program, Chemical Dependency Program, Clinic, and our Tribal Council. Cultural Services and Traditions teachings such as pow-wows and sweat lodges are valued tools in this community.

Community Priorities. We strive to work with our community to reduce domestic violence, restore cultural pride, improve family structure, increase academic performance, offer more information and education that is useful to clients, and improve the physical and mental health of the community.

Community Resource Needs. Grand Portage is in desperate need of a Men’s Advocate or Male Therapist. Some of our male clients are not comfortable working with a woman. We have no domestic advocate who works with the men, which has been a complaint of some of the clients. There is a real need for a spiritual leader and elder advisors, for appropriate therapy, clinicians, physicians, and other health professionals, and for more communication devices, therapy tools, and transportation.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 352 American Indians residing in Cook County.

92% (12 of 13) of CCDTF placements for American Indians were from the Grand Portage Reservation. 1 was from Cook County.

Number of Placements	Indians	All Others
Adult Males	7	19
Adult Females	6	1
Male Children	0	1
Female Children	0	0

Prevalence of chemical dependency problems. Grand Portage deals with long-term

intergenerational chemical dependency problems. Some stem from identity problems, low self-esteem, addictions, depression, anxiety, relationship problems, family problems, developmental disorders, domestic violence, academic problems, parenting problems, and fetal alcohol disorders.

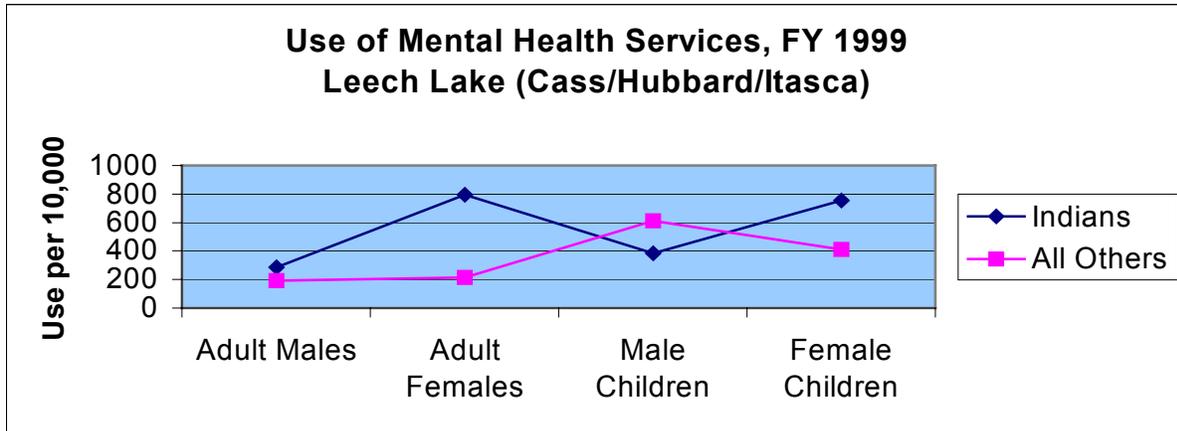
Infrastructure/Programs that address chemical dependency. Our Chemical Dependency Program is under the umbrella of the Grand Portage Human Services. At this time we have no Chemical Dependency Counselor but hope to soon employ someone. We work closely with the Elderly Program, Youth Programs, grade school, middle school and high school, Education department, domestic abuse program, mental health, social services, Cook County court system and probation, the Grand Portage Health Services, and our Tribal Council. The Waaban Center is where the Sweat Lodge, other traditional teaching, and adult support groups take place. There has also been numerous retreats for adult clients and adolescents held at Waaban.

Community Priorities. We strive to work with our community to reduce domestic violence, restore cultural pride, improve family structure, increase academic performance, offer more information and education that are useful to the clients, and improve physical and mental health of the community.

Community Resource Needs. see under Mental Health

Leech Lake

Mental Health



Number Served	Indians	All others
Adult Males	37	554
Adult Females	117	664
Male Children	41	658
Female Children	79	414

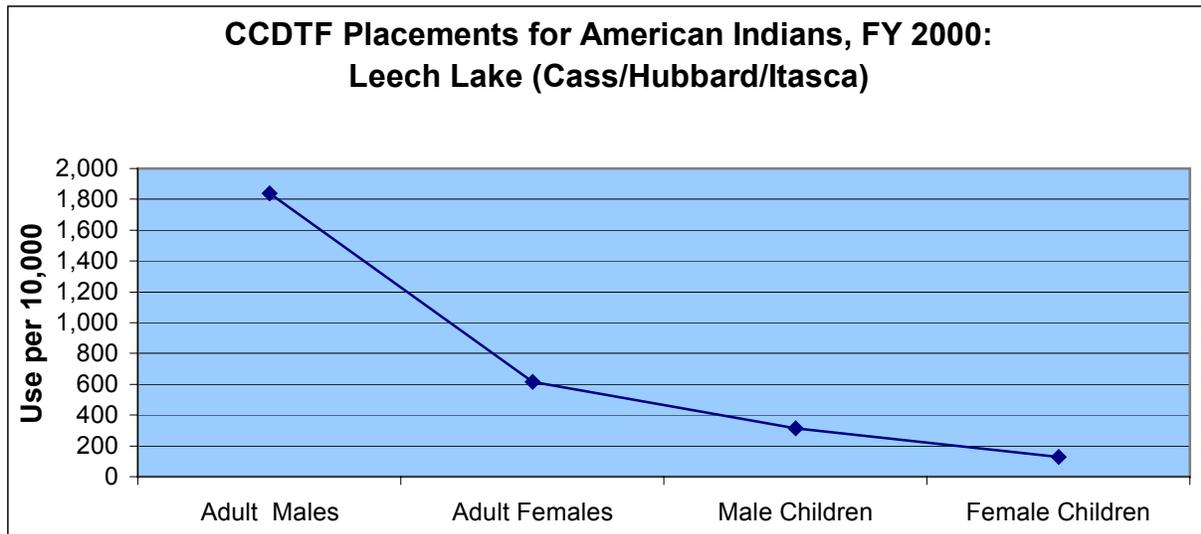
Prevalence of mental health problems. Depression, including major schizophrenia. Chemical dependency: people self medicate with alcohol and drugs instead of knowing they have a mental illness.

Infrastructure/Programs that address mental health problems. Indian Health Service/638 contract (counseling services). State Indian Mental Health Grant for outreach services.

Community Priorities. (1) Funding for another therapist, a person who will do group work at various communities (2) Hire a person to do cultural activities, such as sweats, teach culture on wellness

Community Resource Needs. (1) Adult foster homes for people with Traumatic Brain Injury. Right now these individuals are homeless and there are no activities for them, other than drinking. This is the top priority. (2) Staff to provide training for men who batter.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 5,120 American Indians residing in Cass/Hubbard/Itasca Counties.

95% (374 of 393) of the CCDTF placements for American Indians were from the Leech Lake Reservation. 5% (19 of 393) were from Cass, Hubbard, or Itasca Counties.

Number of Placements	Indians	All Others
Adult Males	249	156
Adult Females	95	60
Male Children	35	29
Female Children	14	6

Prevalence of chemical dependency problems. There is limited data available that will show an accurate account of the prevalence of chemical dependency on the Leech Lake Reservation. The data that is available will be program statistics regarding Chemical Dependency Assessments from the Rule 25 Records and other programs that address chemically dependent clients (i.e., Detox and Detox Case Management). Rule 25 Assessments have been increasing annually. From 1995 to 1997 the number of assessments increased almost 90%, from 287 to 538. The number of Detox Admissions, for a four-bed unit, on a quarterly basis is 235 clients. Detox Case Management has an active caseload of 65 clients.

Staff report an increasing amount of opiate users seeking assessments and treatment. This trend has yet to be analyzed for an accurate portrayal of prevalence. We have no data for other

resources that provide chemical dependency services, including employed clients who enter treatment through their own private insurance and those that have not presented themselves for treatment and are currently using alcohol or drugs.

Infrastructure/Programs that address chemical dependency. The following programs are in place to provide chemical dependency services:

1. Leech Lake Outpatient Programs Men,
2. Leech Lake Women's Services Out Patient Treatment Program,
3. Leech Lake After/Care Programs, Men's program and Women's program,
4. Half-Way House, and
5. Detox/Detox Case Management.

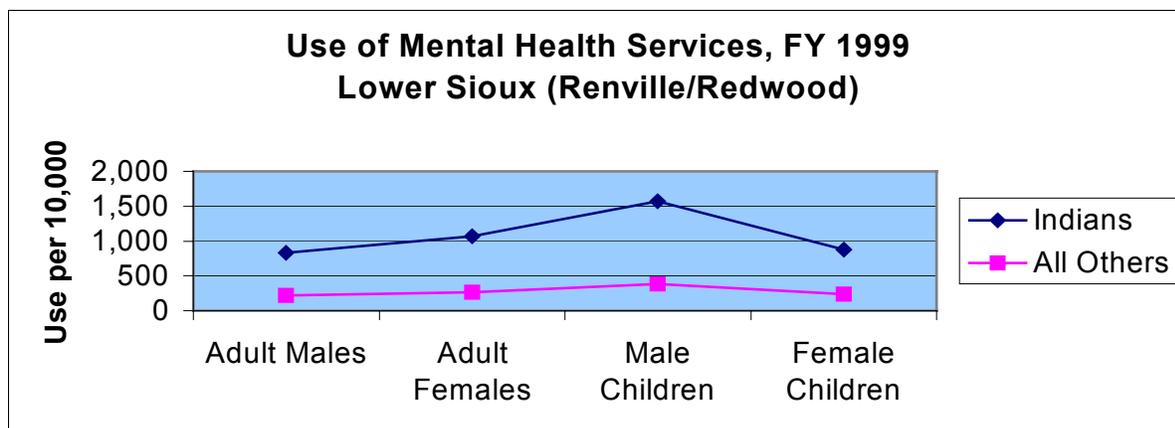
Community Priorities. The Leech Lake Tribal Council has stated, by resolution, that chemical dependency will be a priority. Leech Lake Reservation has established a working group through the substance abuse programs now serving the reservation, and other community participation is included in the group process. An assessment mechanism to determine accurate data on the current problems of chemical dependency is in development at this time through the working group.

Community Resource Needs. There has been a vast increase of that chemical dependency services needed and the funding for those services have not increased with the need.

- A comprehensive treatment family-oriented facility that will provide the broad spectrum of services for the family as a whole.
- A community-healing center.
- A community-based Treatment Center.
- Based on capped funding year after year there is no increase for adequate staffing ratios per increased clientele. To service the current clientele other services had to be developed which demands more staff. An example is commitment services, which by law has certain requirements that need to be followed. Leech Lake Outpatient Programs have added this service to their programs. Again, with no additional staff and there has been an increase in need for this service. The process is very in-depth and time consuming and involved numerous players to facilitate a commitment on a client.
- Other services are needed that will adequately address the continuum of care, from early intervention to maintaining the chronic chemical dependent client. This broad spectrum of services lacks the adequate staffing to address these issues.
- Lack of transportation has been a barrier for clients to obtain services. There are attempts made to provide the transportation but this service is limited. The Leech Lake Reservation is situated within three counties and covers more than 1,050 square miles.
- There are many issues and needs the Leech Lake Reservation has for addressing chemical dependency problems and the Leech Lake Tribal Council has a commitment to eradicating the chemical dependency problem.

Lower Sioux

Mental Health



Number Served	Indians	All others
Adult Males	7	264
Adult Females	11	329
Male Children	14	172
Female Children	7	101

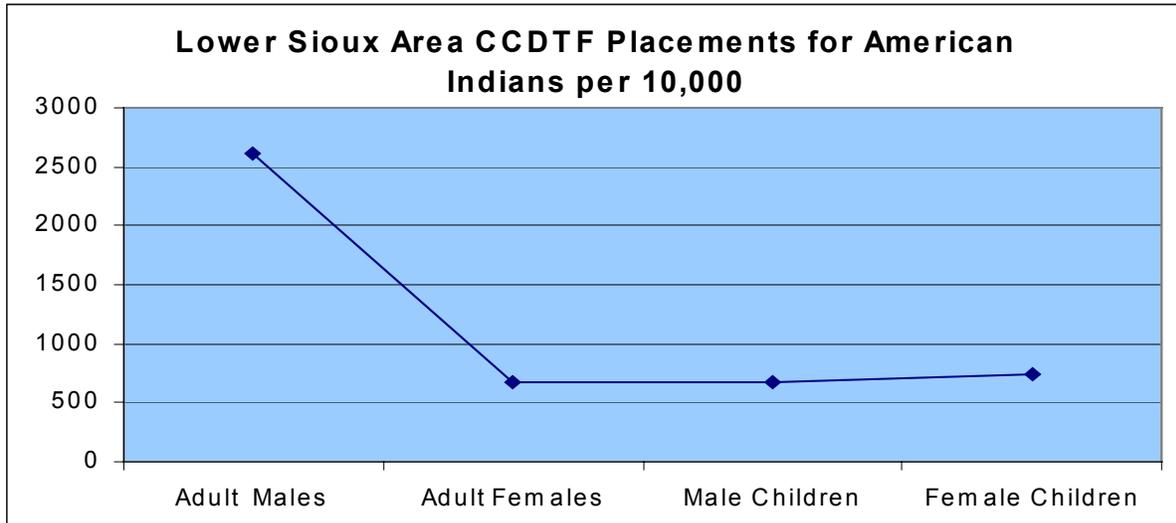
Prevalence of mental health problems. There are two major issues: generational grief and bringing it to the attention of community members, consequently (without intervention), it passes from generation to generation, causing a lot of self-medication through alcohol and drugs.

Infrastructure/Programs that address mental health problems. Collaboration and education and using existing agencies to start building physical and mental health (surveys, needs assessments, training, education, outreach)

Community Priorities. Education. Although the per cap payment is useful, it can interfere with children completing school because of inaccurate information and thinking that they don't need an education, as they will receive these payments when they turn 18.

Community Resource Needs. Need to work on strengthening mental health and chemical dependency programs through funding, resources - staff (outreach worker), more one-on-one to raise self-awareness, diversion programs for adolescents, and collaboration, which helps people to move out of isolation.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 356 American Indians residing in Redwood and Renville Counties.

76%, (31 of 41) of the CCDTF placements for American Indians were from the Lower Sioux Reservation. 24% (10 of 41) were from Redwood and Renville Counties.

Number of Placements	Indians	All Others
Adult Males	22	90
Adult Females	7	21
Male Children	6	11
Female Children	6	3

Prevalence of chemical dependency problems. The prevalence of chemical dependency on the Lower Sioux Indian Reservation is about 30%; the prevalence of chemical abuse is likely 20%; and the prevalence of chemical misuse is probably another 20%.

Infrastructure/Programs that address chemical dependency.

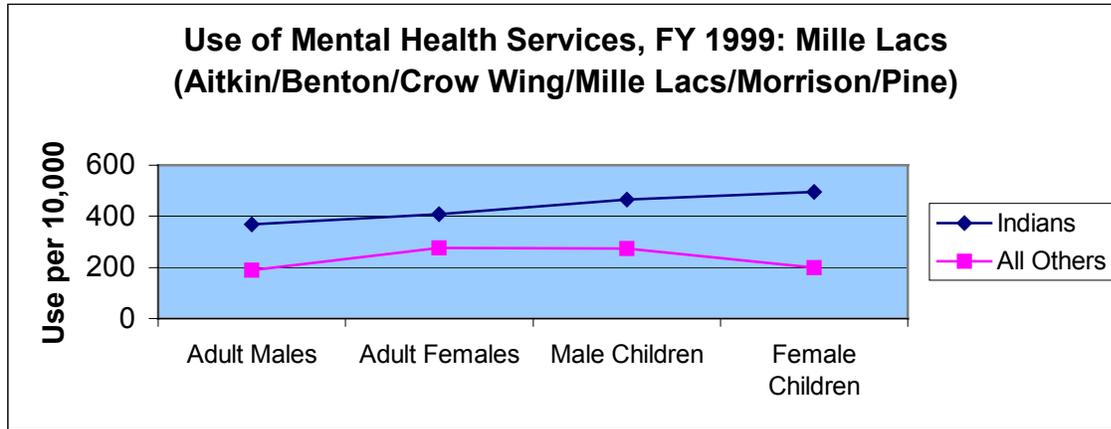
- Rule 25
- Primary Outpatient Treatment
- Early Intervention Treatment
- Relapse Prevention Treatment
- Aftercare Sessions
- Alcoholics Anonymous
- Sweat Lodge
- Individual Counseling Availability

Community Priorities. The main priority is adolescents. This area is in dire need of an Adolescent Outpatient Treatment Program which the Lower Sioux Indian Reservation supports and participates in the development and implementation. A halfway house for adolescents and/or adults is also a high priority. A halfway house near the reservation for Native Americans is a venture that would likely result in significantly improved “success” rates on the Lower Sioux Indian Reservation

Community Resource Needs. A halfway house is no small venture; therefore, more human and monetary resources would need to be added to find or build a suitable facility, develop programming, provide a Policy & Procedure Manual, offer 24 hour staffing, and meet state health and DHS licensing standards. The halfway house need is evidenced by the number of people who go off to Native or other treatment facilities, do exceptionally well in the programs, and return to the area for mere hours or days and begin the use of mood altering substances. These people need to live soberly in their environment. A controlled setting is little or no test whether long-term sobriety will be achieved

Mille Lacs

Mental Health



Number Served	Indians	All others
Adult Males	21	1,176
Adult Females	25	1,759
Male Children	21	674
Female Children	20	473

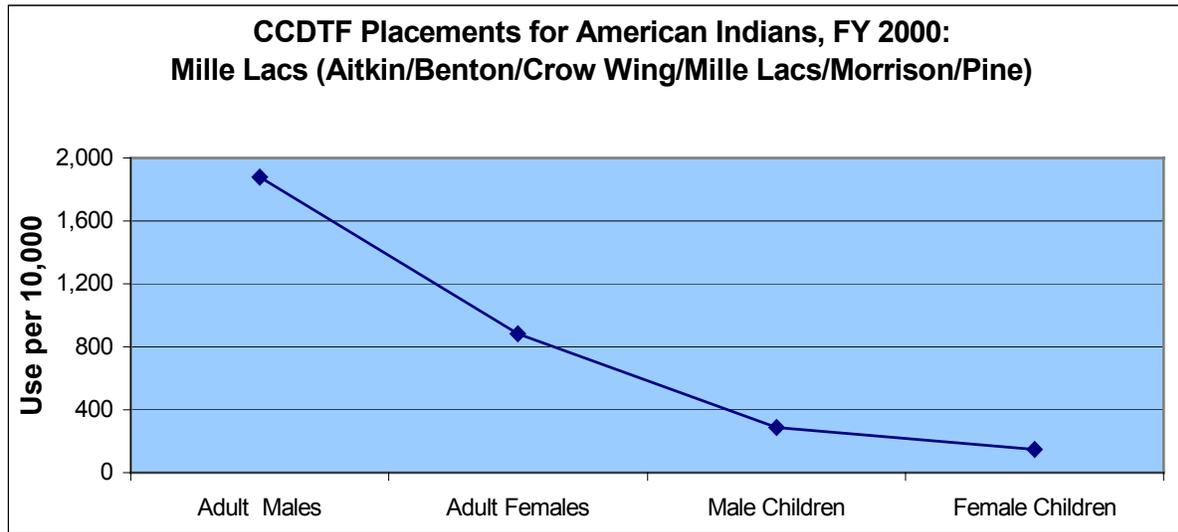
Prevalence of mental health problems. Mental illness is increasing, with a significant increase in dual diagnoses (mental illness and chemical dependency) which appears to be much higher than in the broader community. The major issues are substance abuse, post-traumatic stress disorder, and tremendous unresolved grief issues amongst all age groups.

Infrastructure/Programs that address mental health problems. The mental health staff works with tribal and county courts, schools, Sentencing Circle Program, Family Services, Chemical Dependency Program, Spiritual Healers, Foster Care, Group Home, and Women's Advocacy Program.

Community Priorities. Provide community education regarding chemical dependency issues, FAS/FAE issues, and child abuse and neglect issues. Work with existing school and human services programs to develop more community after-school programs.

Community Resource Needs. Lack of funding and staff. When funds run out we have to do budget modifications, which affects programming and services. We need more social workers, another Licensed Psychologist and/or Licensed Social Worker, and three or four case managers.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 2,036 American Indians residing in Aitkin, Benton, Crow Wing, Mille Lacs, Morrison, and Pine Counties.

77% (138 of 180) of the CCDTF placements for American Indians were from the Mille Lacs Reservation. 28% (42 of 180) were from Aitkin, Benton, Crow Wing, Mille Lacs, Morrison, and Pine Counties.

Number of Placements	Indians	All Others
Adult Males	107	523
Adult Females	54	253
Male Children	13	43
Female Children	6	26

Prevalence of chemical dependency problems. Chemical abuse continues to be a major problem on the Mille Lacs Reservation. Chemical abuse affects the entire family as well as community members. Chemical Dependency Rule 25 Assessors have noticed a pattern of abuse by some individuals who periodically seek treatment and recovery. The pattern consists of treatment, halfway house placement, return to the community, abusing of alcohol and/or chemicals and then seeking recovery again and the cycle continues. A primary question is “What can be done different?”

Infrastructure/Programs that address chemical dependency. The Chemical Dependency Division consists of prevention, intervention, treatment, aftercare, continued support and mental health services to families and individuals. A traditional healer is available at the Ne-Ia-Shing Clinic for those individuals who prefer to seek the services of a traditional healer.

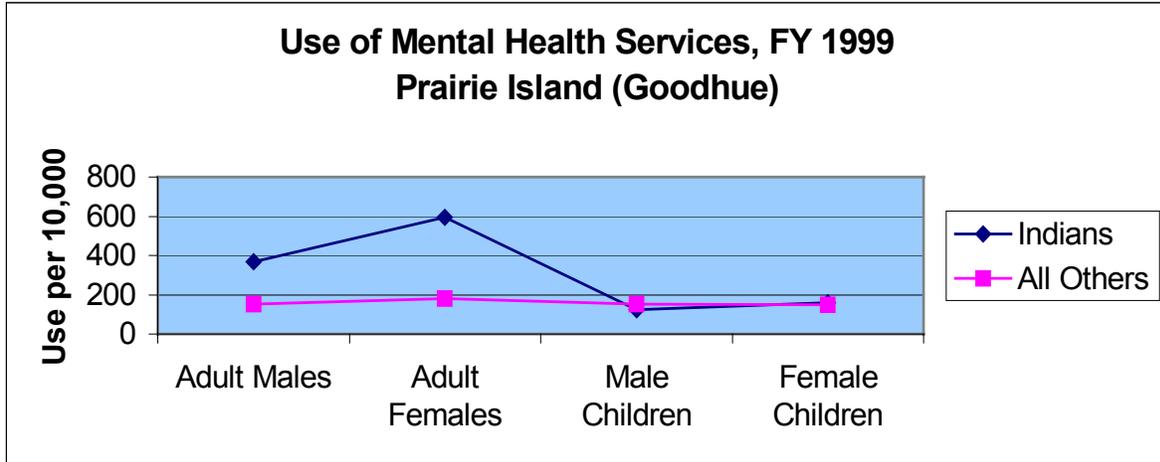
Community Priorities. A concern of the Mille Lacs Community is gang violence, the growing popularity of methamphetamine use, as well as prevention of FAS/FAE children. Programs that focus on chemical abuse as well as the effects of drugs and alcohol on the entire community stress community responsibility and accountability by its members.

Community Resource Needs.

- Training by the Alkalai Lake Canadian Indian Tribe on what works and doesn't work in Indian County.
- Recovery from the effects of historical trauma.
- Community organizing.

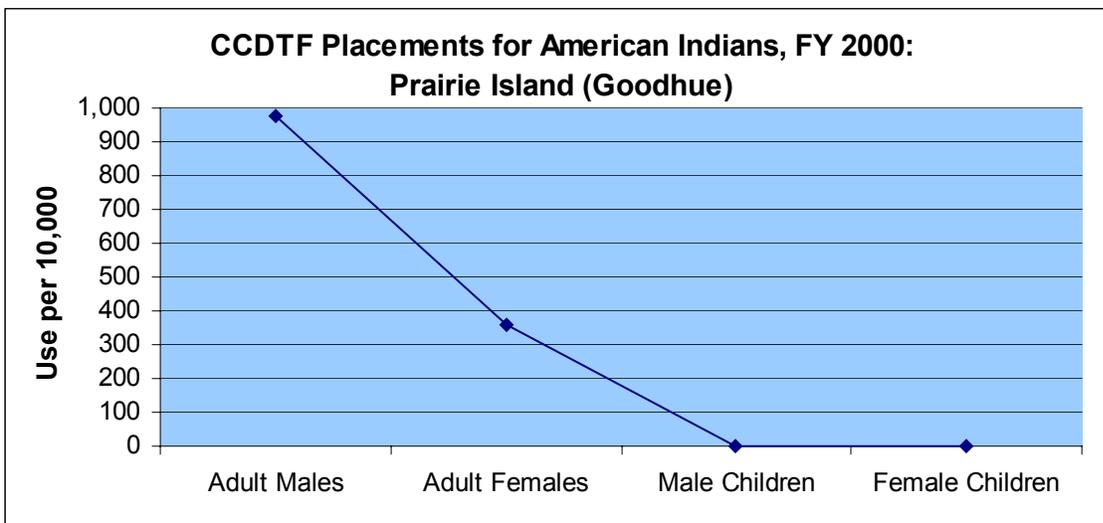
Prairie Island

Mental Health



Number Served	Indians	All others
Adult Males	3	231
Adult Females	5	288
Male Children	1	91
Female Children	1	83

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 309 American Indians residing in Goodhue County.

27% (3 of 11) of the CCDTF placements for American Indians were from the Prairie Island Reservation. 73% (8 of 11) were from Goodhue County.

Number of Placements	Indians	All Others
Adult Males	8	108
Adult Females	3	70
Male Children	0	9
Female Children	0	3

Prevalence of chemical dependency problems. We have FAS/FAE, depression, and violent crime increasing at a steady rate. Problems include multi-generational factors, i.e., abuse, addiction, grief, loss of parenting. Involuntary cooperation with our system is still the rule and not the exception. Chemical dependency affects our families beginning with the grandparents. Often, having a history of chemical use themselves, most presume just “stopping” the drinking is the answer. In this instance, missed is the needed information about changing beliefs, attitudes and behaviors. Subsequently, passed on to our parents are these dysfunctional living skills, which contribute, in turn, to continued use of alcohol and drugs. Chemical use prevails in the area of education – our children are suffering from FAE and FAS – they have learning disabilities, ADHD and other social disorders, i.e., gang activity. Culturally, our community is confused about spirituality, if not outright void of it. Lost is the connection to self through use of chemicals – the lack of direction from parents about spiritual matters, whether it be traditional or Christian, is apparent in the high numbers of adolescents in our legal system. Despite financial success of the tribe, chemical use problems remain a constant. The parent’s monthly income and available insurance benefits are radically reduced by continuous treatment episodes of their teens, and in some instances, zeroed out.

Infrastructure/Programs that address chemical dependency. There is a medical clinic, day care center, youth activities program, police officer, social services division and a tribal court. The legal department and grants and contracts play a vital role in the chemical dependency program. The chemical dependency program has resources to employ three Counselors and one Assessor. At present, there is a caseload of approximately 65 clients, one-fourth of whom are adolescents. The program staff conducts chemical dependency assessments and updates. In addition, staff makes referrals for treatment, in/out-patient, halfway house, group homes, and behavior modification programs for adolescents and adults. We also refer and network with mental health agencies. Staff also works closely with the court systems and the Department of Corrections. We conduct follow-up, home visits, random UA’s, testify in Tribal Court, and network with the Social Service Division in conjunction with client case plans. We transport clients, conduct outreach on prevention and intervention in the schools and other community activities on an ongoing basis. We have a weekly Men’s Group and a weekly Women’s Group. We also have a weekly A.A. meeting. Our office has computer access, reading, writing and

video information on chemical dependency covering a variety of topics related to sobriety.

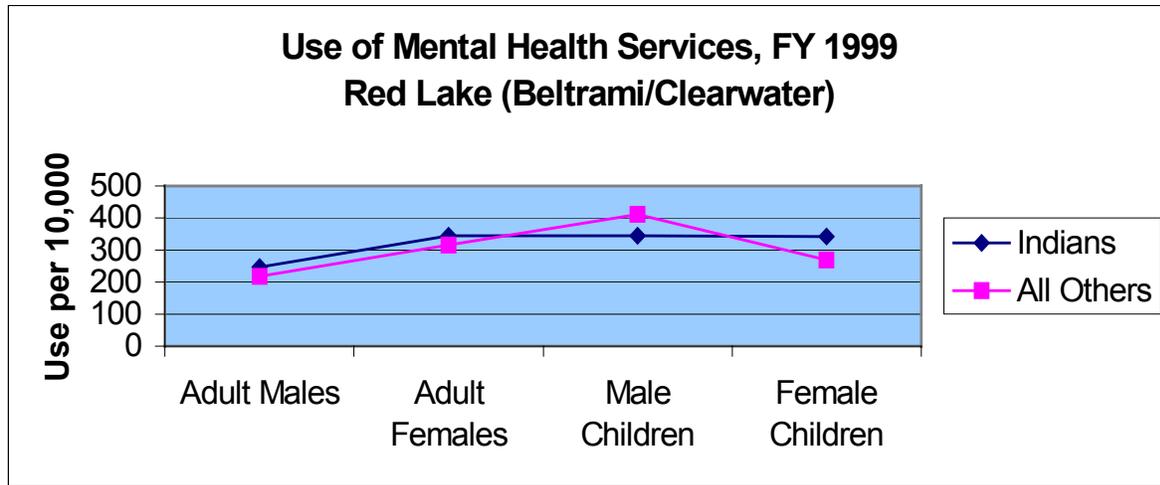
Community Priorities. Sobriety, family, culture, support networking with surrounding agencies.

Community Resource Needs.

- Elders are needed to share cultural activities/information.
- Healing center – where alternative healing methods are available to learn; i.e., massage, aromatherapy, healing touch, shiatsu, herbs, etc.
- Physical training personnel – i.e., assist community in healthy living, eating habits, exercise.
- Group Home for youth – structured living with emphasis on positive coping skills, volunteer adult community mentors.

Red Lake

Mental Health



Number Served	Indians	All others
Adult Males	50	307
Adult Females	72	460
Male Children	63	225
Female Children	53	143

Prevalence of mental health problems. Mental illness is significant and widespread among all age groups. Both consulting psychiatrists have full schedules at their bi-monthly visits. The Mental Health Department caseload is increasing.

Infrastructure/Programs that address mental health problems.

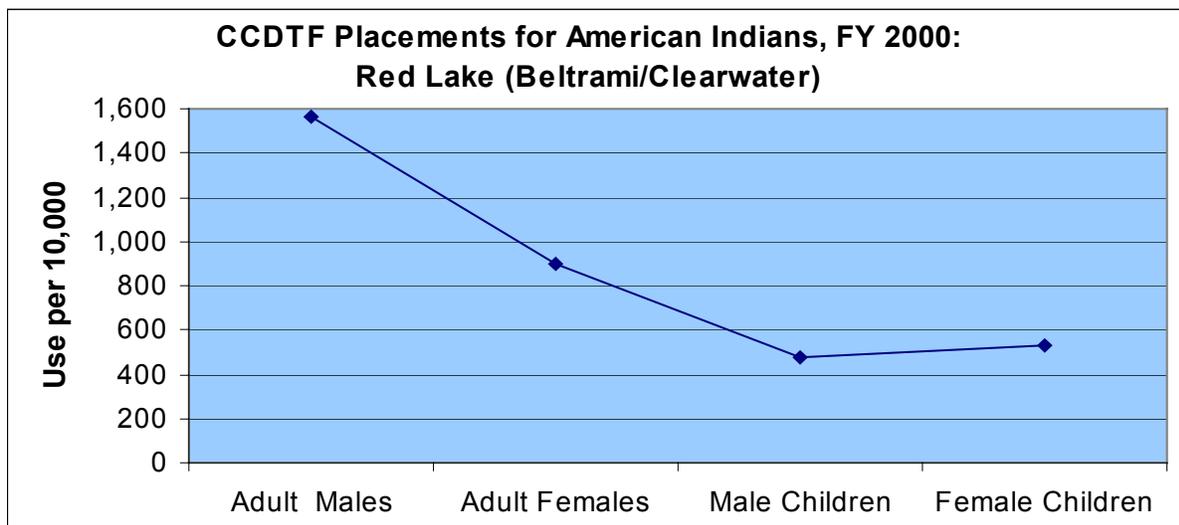
1. The Mental Health Department at the Red Lake Health Facility, which includes tribal and IHS services;
2. Three therapists at local schools (two elementary, one high school);
3. The Red Lake Mental Health Board provides involuntary commitment for treatment (mental illness, chemical dependency, and mental retardation);
4. The Red Lake Alcohol Rehabilitation Program includes outpatient, inpatient, and half-way house;
5. Two consulting psychiatrists (adult/child) meet bi-monthly with patients and consult with other staff;
6. Mental health staff provide workshops for community agencies and clients;
7. Mental health staff will be providing Parent Effectiveness Training to parents and their children who are court ordered for truancy

Community Priorities. Intervention for mentally ill and chemically dependent clients.

Community Resource Needs.

- More prevention programs and activities;
- Funding for MI/CD treatment off-reservation;
- In-house, long-term, intensive treatment capability for MI/CD youth. Currently, resources available are a long distance away;
- Housing and transportation to off-reservation support services such as day treatment;
- On-reservation support services, supervised living (i.e., adult foster/resident care), case management.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 7,506 American Indians residing in Beltrami and Clearwater Counties.

78% (526 of 675) of the CCDTF placements for American Indians were from the Red Lake Reservation. 149 of the placements were from Beltrami and Clearwater Counties.

Number of Placements	Indians	All Others
Adult Males	318	108
Adult Females	188	25
Male Children	87	13
Female Children	82	12

Prevalence of chemical dependency problems. The Red Lake Nation does not allow alcohol within the boundaries of the reservation. However, chemical dependency continues to be a problem. We are currently experiencing an influx of Red Lake members returning to the

reservation, which is creating problems with the unemployment rate, housing, and chemical dependency issues. With this influx, chemical dependency is becoming more prevalent. The Red Lake Substance Abuse Prevention/Treatment Programs are seeing more referrals from the court systems as well as the Social Services program. Retail sales of alcohol are within a two to five mile radius of the reservation. There are also bootleggers present on the reservation. Drugs such as cocaine and marijuana are also becoming more prevalent on the reservation.

Infrastructure/Programs that address chemical dependency problems. The Red Lake Substance Abuse Prevention/Treatment Programs address the problems of chemical dependency with the following programs:

1. Northern Winds Treatment Program is a 12 bed, 30-day inpatient treatment facility located in Redby, Minnesota.
2. Oshii-kii-mii-kah-nah Halfway House is a 14 bed, 90-day program located in Redby, Minnesota.
3. Red Lake Group Home is a 14 bed, extended care facility for youth, 11-17 years of age.
4. Red Lake Indian and Free Drug Abuse Prevention Program offers Youth Outpatient, Rule 25 Assessments, and cultural and prevention activities, educational seminars, and referrals.
5. Red Lake Outpatient Treatment/Ponemah Outpatient Treatment Programs offer Rule 25 assessments, eight-week outpatient treatment, referrals, group, one on one counseling, and aftercare programming.
6. Red Lake Alcohol Rehab Program offers Rule 25 assessments, referral, and prevention activities.
7. Pregnant Women and Women with Children Program is a comprehensive outpatient treatment program that is culturally sensitive to the unique needs of chemically dependent Indian women, their infants, and children, including pregnant and postpartum women.

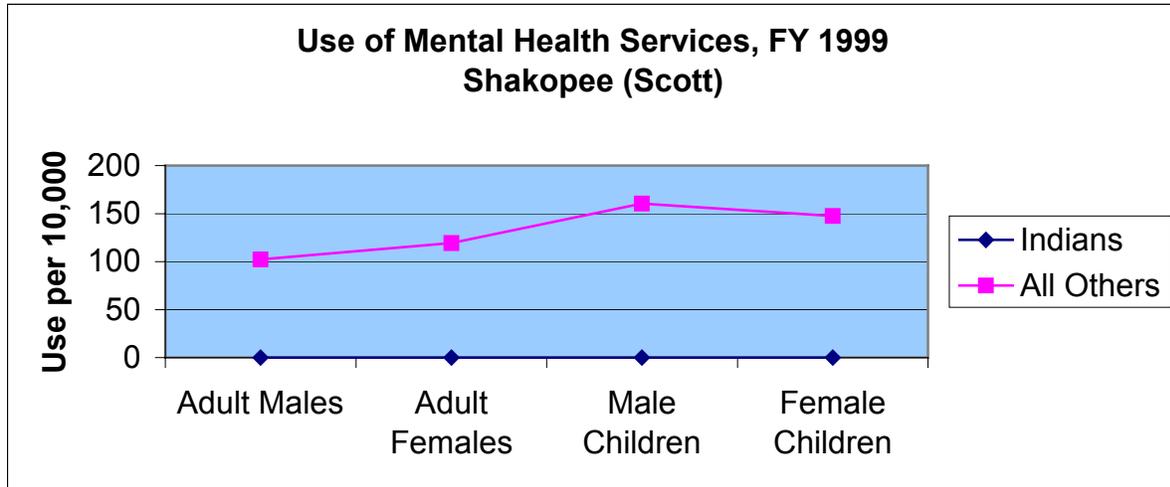
Community Priorities. Community priorities for the Red Lake Nation are to provide education, prevention, intervention, and treatment programming for our children. We must also provide these same services to our adults and elders. Our communities are committed to providing our people with a safe, alcohol and drug free environment.

Community Resource Needs. The Red Lake Substance Abuse Prevention/Treatment Programs collaborate with the following programs in the Red Lake Nation to provide services to the people:

1. Equay Wa Gamig – A shelter for battered women and their children. They also provide groups, counseling, and referrals.
 2. Tomorrow’s Leaders/Wahbung Ogichidag – A program with provides services for youth, which is funded through the public school.
 3. Red Lake Tribal Youth Program – this program is relatively new and involves the elders of the Red Lake Nation with the youth.
 4. Red Lake Tribal Courts, Red Lake Social Services, Red Lake Police Department. On going collaboration to assure the safe, alcohol/drug free environment of our communities.
- A family based healing/counseling program is a community need that none of the above address.

Shakopee Mdewakanton Sioux

Mental Health



Number Served	Indians	All others
Adult Males	0	283
Adult Females	0	323
Male Children	0	198
Female Children	0	170

Prevalence of mental health problems. It is difficult to estimate the exact number of the SMSC that suffer from mental health problems. We are in the process of completing a need assessment that will focus on the mental health needs of the community. Once this is complete, we will be in a better position to determine the Community's needs. However, over that past few years we are seeing a higher incidence of mental health and chemical dependency problems, and clients who have been treated in traditional chemical dependency programs are still dealing with underlying mental health problems. The most common mental health problems are depression, unresolved grief, anxiety, and childhood abuse issues. We are also seeing a higher prevalence of co-occurring mental illness and chemical dependency in all age groups. A conservative estimate of the recent increase in mental health and chemical dependency problems is 30%. The percentage of individuals with a severe mental illness, such as schizophrenia, manic depressive disorders, severe personality disorders, etc. is approximately 3%.

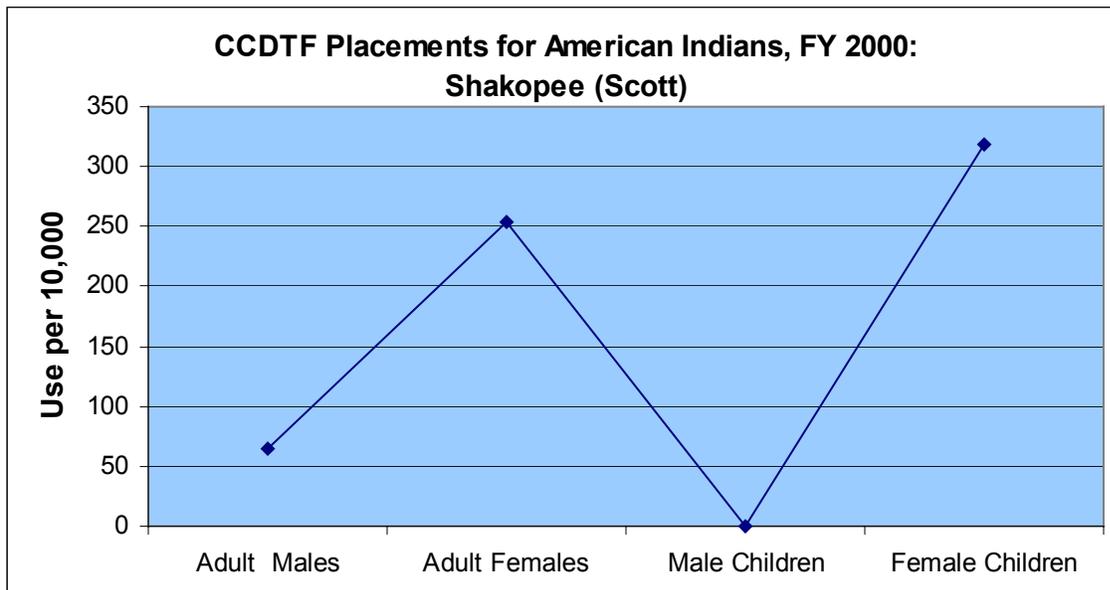
Infrastructure/Programs that address mental health problems. SMSC has one Mental Health Therapist (LICSW), who conducts individual and family therapy on-site. We have a nurse practitioner that can prescribe some types of medication. SMSC members can access off-site mental health services through Blue Cross/Blue Shield.

Community Priorities. SMSC is conducting a Community Needs Assessment that will focus on mental health and chemical dependency, to determine if there is a need to expand the SMSC Mental Health Program to include culturally-specific in-home family counseling and a structured outpatient MI/CD treatment program.

Community Resource Needs.

- Space to locate expanded programs,
- Additional training or Continuing Education money to empower staff to complete necessary degrees to become licensed by state,
- Technical assistance on licensing programs and contracting with HMOs.

Chemical Dependency



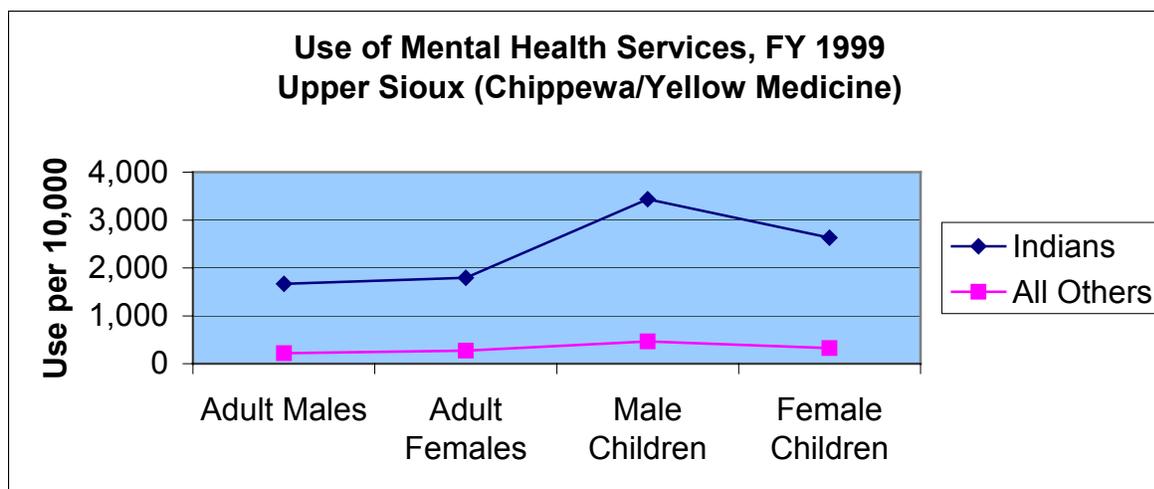
1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 540 American Indians residing in Scott County.

None of the 9 CCDTF placements for American Indians were from the Shakopee Reservation. All were from Scott County.

Number of Placements	Indians	All Others
Adult Males	1	92
Adult Females	5	29
Male Children	0	3
Female Children	3	1

Upper Sioux

Mental Health



Number Served	Indians	All others
Adult Males	6	191
Adult Females	10	251
Male Children	11	152
Female Children	9	101

Prevalence of mental health problems. The Upper Sioux Community has 180 children and about 25% have mental health issues, as measured by out-of-home placements in an adolescent group home or foster care. Only 6% of these children are diagnosed with severe mental health issues. About 40% of the 184 adult members of the Community have mental health issues, due to generational trauma, murders, suicides and other deaths, loss of homesteads from the 1997 flood, and substance abuse.

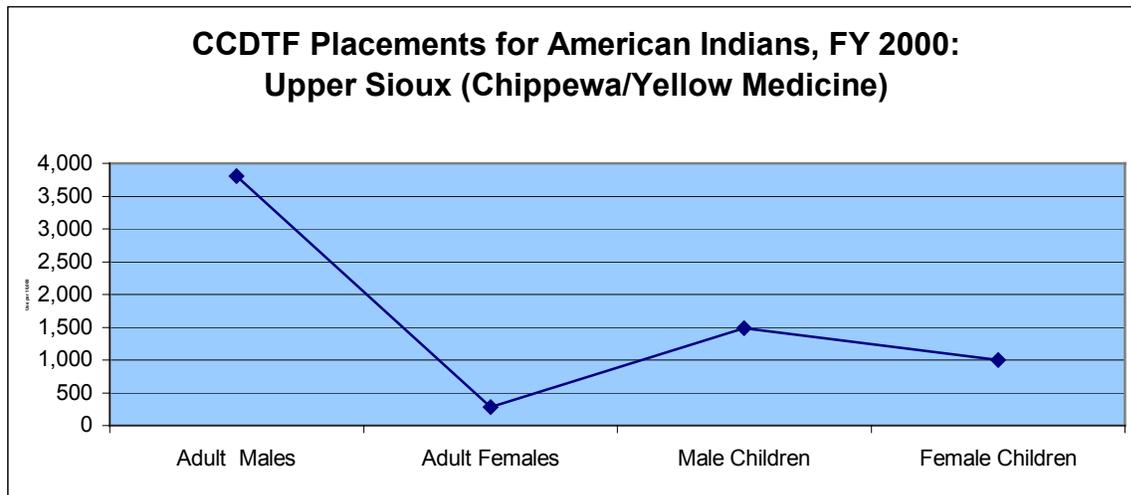
Infrastructure/Programs that address mental health problems. (1) Wrap-around, which is focused on all that persons need. Family, living environment, financial, education/vocation, social/recreation, health and medical, behavioral/emotional well being, culture, and safety are supported. (2) Alternative response is another form of child protection. A team will intervene with families to help them in crisis before out-of-home placement or court intervention is needed. (3) “Healing the Hurts” project is focused on the generational trauma, murder, suicide, death, and flood issues. As a community there was a need to confront these issues as these were, and still are affecting the community as a whole. We held four retreats, with about 20% of the community’s population in attendance.

Community Priorities. Upper Sioux Community needs commitment from families, school districts, and the department of family services. With the help of outside agencies, through intervention, the community can grow to be a healthy and safe environment to lower the percentage of mental health problems.

Community Resource Needs.

- More funding to enable Upper Sioux Community to hire additional help for mental health and chemical dependency issues. As of August 2000 we lost our Behavioral Specialist and are in need of a replacement for this position.
- Advocacy from other agencies with resources that would be available to us on an as-needed basis.
- Commitment from outside agencies and Upper Sioux Community members. Wraparound covers this but is a new program here.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 158 American Indians residing in Chippewa and Yellow Medicine Counties.

54% (13 of 24) of the CCDTF placements for American Indians were from the Upper Sioux Reservation. 46% (11 of 24) were from Chippewa and Yellow Medicine Counties.

Number of Placements	Indians	All Others
Adult Males	16	57
Adult Females	2	18
Male Children	4	17

Female Children	2	4
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Prevalence of chemical dependency problems. The problems we are having in the Upper Sioux community are alcohol and drug use, prescription drug misuse, gang activity, and drug dealers. The age ranges from 8 to elders. Approximately 80% are users in one way or another. Approximately 68% identify themselves as chemical users, which stretches to family problems, legal problems, and/or death or suicide.

Infrastructure/Programs that address mental health problems.

- Adolescent Group, which meets weekly,
- Dakota Wellness for children ages 4-12, which meets 4 times a week,
- School groups, one for high school and one for junior high, which meet three times a week ,
- Healing the Hurts retreat four times a year,
- Staff meetings,
- Women’s and men’s talking circle,
- Sweat lodges for men and women,
- Youth activities as performed by the Youth Coordinator and the Dakota Wellness person,
- Crisis and Court Advocacy,
- Assessment and Treatment,
- Individual and Family counseling,
- Aftercare Relapse, and
- Community Prevention with education, home visits, family night groups, and youth camp.

In addition we use personal resources or others from their areas to carry on cultural teachings.

Community priorities. We have five different programs that provide education, prevention, and individual needs:

1. Mental Health-works with needs and support groups, youth activities based on cultural, prevention, healthiness, and learning responsibilities.
2. Dakota Wellness-much needed attention skills, learning and having fun learning, and growth with culture.
3. Chemical Health-activities include broad range of activities supported with screen tools to assess individuals needs and finding the best way to provide for clients or families.
4. Dakota Language (Immersion Program).
5. Healing Retreat-family based, based on community issues and personal healing, which opens up areas of trauma, rape, domestic violence, sexual abuse, child abuse, which ranges back into elders childhood, which was found to be the main source of chemical and alcohol abuse and suicide. Since the murders and suicides, we have been working hard to heal families, individuals, and children and also to provide grief and death education in schools. Uses of cultural ways have been extremely positive in healing families.

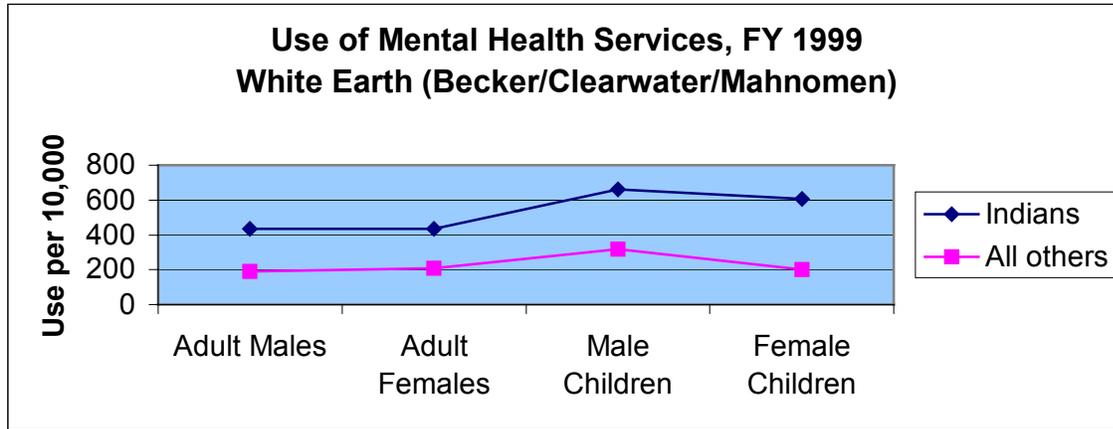
Community Resource Needs. Programs for children are in some of the above questions and we also have an elders program which includes an Elder dinner, home visits, home cleaning, medical attention, and special activities for elderly and at times are used as a grandparent and

grandchild program.

At times we are understaffed, overwhelmed and don't have enough funding in areas that need to be addressed and makes us very limited. Prevention monies are just not there at times. The main focus is the children at this time and we run into a lot of brick walls where the children are concerned. PC poses a lot of problems as far as negative influences coming into the community and the treatment package is always at the limit. Problems include staff turnovers, daily challenges, and unexpected crisis at many times. We utilize any and all assistants or volunteers and funding stretches as far as the dollar can go, but the percentage of healing that has been done in the year has been significantly rising. We are making a lot of accomplishments as time goes on. We are making successes in treatment centers, schools, restructuring in probation, alternative response, changes in regular court to tribal court, working collaboratively with the county, PACT 4, Pathways, and other programs that were untouchable before because of racial issues and working with an open door and an empty chair policy, but as the door opens more and the chair is eventually getting filled. We would like to start a program for men and women that have lost their driver's license to try to retrieve them again. I'm working on setting up a state evaluator to come the Upper Sioux just for community members, specifically.

White Earth

Mental Health



Number Served	Indians	All others
Adult Males	49	265
Adult Females	54	297
Male Children	61	170
Female Children	48	103

Prevalence of mental health problems.

Indian Health Service: Identified problems include agency misunderstanding or lack of understanding of the scope of treatment provided by the CD and MH programs, and lack of follow-up communication between agencies for treatment plans. Inadequate funding for tribal resources to provide services to SPMI and other adult mental health services. Tribal mental health focus is on children’s mental health. Prevalence of mental health problems is hard to track due to the outpatient service provision. There is no in-patient basis to track. IHS is not limited to the boundaries of the reservation.

Infrastructure/Programs that address mental health problems.

Indian Health Service: Clients with mental health problems are referred to IHS Mental Health for services. IHS services are open to anyone eligible for services; they can’t turn anyone away regardless of residence. We serve people from the Twin Cities, North Dakota, etc. We are forced to work on a priority basis; crisis first, then “as they can be fit into the schedule.” An example of a low priority is court-ordered anger management training. IHS contracts with psychiatrists to provide treatment for persons with SPMI and medication monitoring. IHS employs a clinical psychologist, a licensed psychologist, a LGSW, and a mental health technician.

Community Priorities.

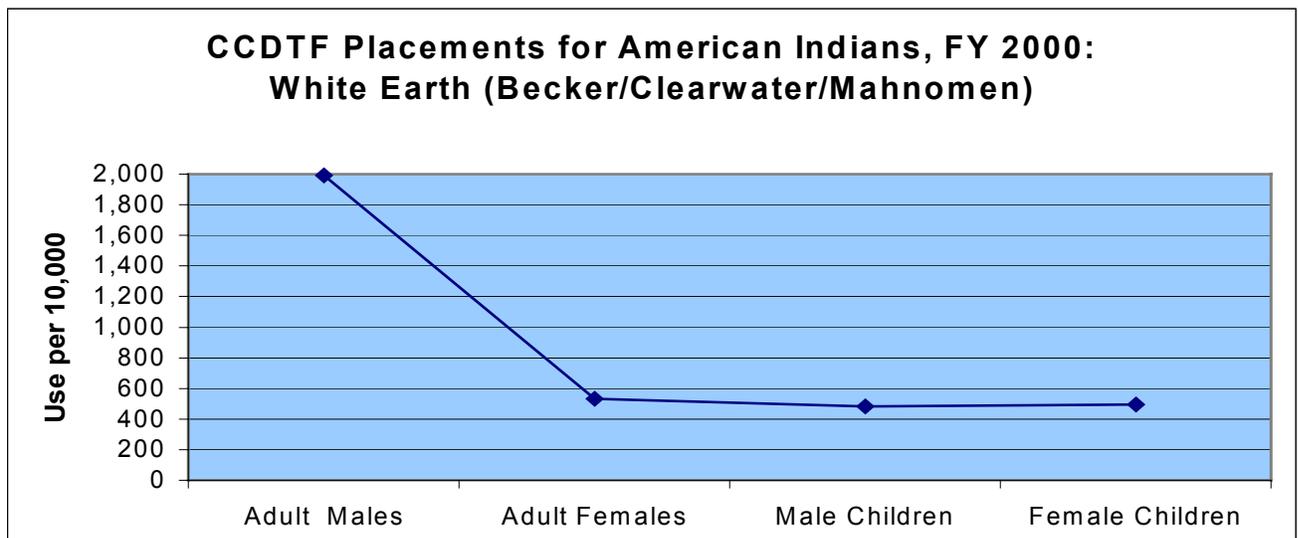
Indian Health Service: Crisis intervention, adolescent behavioral therapy, staff training, resources for individuals with SPMI, prevention and education, and services for court-ordered anger management training.

Community Resource Needs.

Indian Health Service:

1. Improve collaboration between agencies to improve service provision and follow-up,
2. In-patient facilities for referral,
3. Resources for court-ordered anger management training for adults,
4. Permanent funding sources to encourage recruitment of qualified applicants and improve job stability,
5. Increase funding sources to enable hiring of qualified staff at competitive pay scales to meet the demand for services and decrease the waiting period for services,
6. Recruitment and hiring of qualified, professional staff at the master’s level or above,
7. Culturally specific treatment models.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 4,083 American Indians residing in Becker, Clearwater, and Mahnomen Counties.

78% (338 of 431) of the CCDTF placements for American Indians were from the White Earth Reservation. 93 of the placements were from Becker, Clearwater, and Mahnomen Counties.

Number of Placements	Indians	All Others

Adult Males	257	144
Adult Females	76	41
Male Children	52	17
Female Children	46	13

Prevalence of chemical dependency problems. The White Earth Band of Chippewa is a federally recognized American Indian tribe located in the northwestern part of Minnesota. The Reservation surrounds the northern section of Becker County and southwestern Clearwater County as well as all of Mahnomen County. It's the largest reservation in the state of Minnesota with an enrolled population of 22,000. The nearest population centers are Fargo/Moorhead (roughly 90 miles) and Bemidji (65 miles).

According to the 1998 Bureau of Indian Affairs Labor Force Report, the Reservation has an on-reservation population of 6,491 enrolled members. The report indicated a 51% unemployment rate among the American Indians residing on the Reservation. More than half of all tribal members, including seven of every 10 children on the reservation, lives in poverty. Sixty-five percent of American Indian children live in poverty. More than 90% of female-headed households are impoverished. These figures are generally four times higher than the state average. The Minnesota Planning Agency depicts American Indians as poorer than the general population with a per capita income of \$5,625. Of the Reservations' tribal members over the age of 25, 39% do not have a high school diploma or a GED. Current levels of educational attainment average substantially behind the statewide average.

With that, 90% of all the tribal members are directly affected by chemical dependency, either as abusers or co-dependents. According to the 1999 *Minnesota Kids Count Databook*, more than twice as many children in Mahnomen County than in the entire state live below the poverty line and receive food stamps. The rate of children receiving free/reduced price lunches is about 2.5 times that of the state. In addition to these poverty statistics, White Earth Reservation residents have been experiencing a rising level of violence. From 1992 to 1997, violent crime rose 155%. From 1994 to 1997, the number of juveniles on probation per 1,000 people went from 48 to 112, while the statewide average went from 39 to 43. Similarly, in the same time period, the rate of adults on probation went from 48 to 55 per 1,000, while the statewide average went from 25 to 27.

Children and youth have been directly impacted by these conditions. According to the most recent Minnesota student survey (1995), 18% of ninth-grad girls report being a victim of sexual abuse, and 13% of ninth-graders report having witnessed family violence. For 12th graders, 25% of girls and 10% of boys report having been sexually abused, 8% of girls and 5% of boys report family abuse, and 21% of girls and 5% of boys have witnessed family violence.

Not surprisingly, the problems with poverty and violence co-exist with the alarming statistics regarding youth substance abuse. Twenty-four percent of ninth-grade boys and 36% of ninth-grade girls report using alcohol at least monthly. The figures for 12th graders are 21% and 44%, respectively. Twenty percent of ninth-grade girls and 8% of boys report a family alcohol problem; 5% of 12th grade boys and 17% of 12th grade girls report family alcohol problems. Mahnomen County/White Earth Reservation is first in youth cigarette use, youth marijuana use, and chemical dependency admissions. It is fourth in alcohol use, third in DWI arrests, and 11th in detox admissions.

Infrastructure/Programs to address chemical dependency. The White Earth Chemical Dependency Program is located near the village of White Earth and provides the following services:

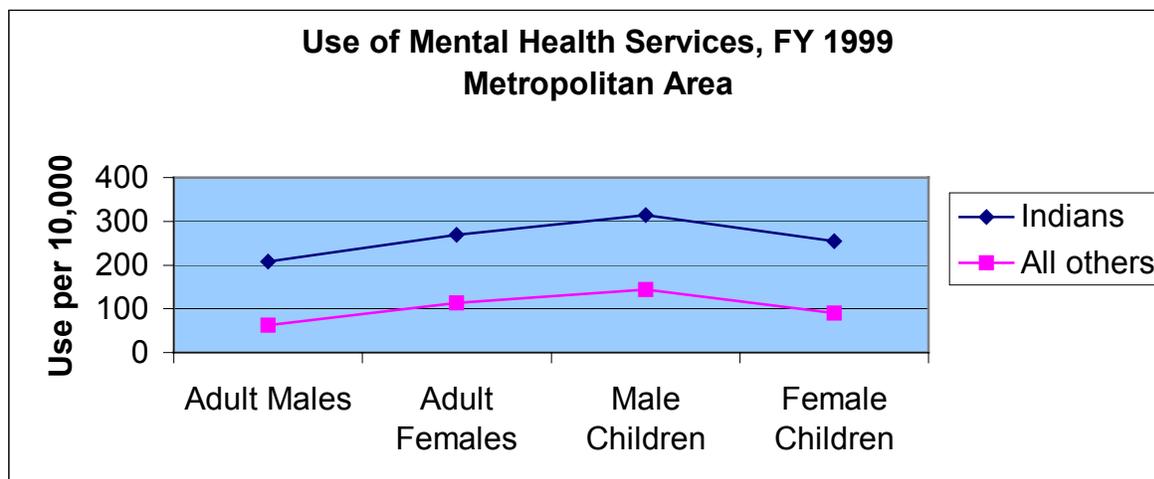
- Prevention/Education
- Assessment/Referral
- Adult Outpatient treatment
- Adolescent Outpatient treatment
- Aftercare and Follow-up

Community Priorities. Rising chemical dependency and violence issues are a high priority for the White Earth Chemical Dependency Program.

Community Resource Needs. Additional services are needed in Prevention and Aftercare. These two areas are the greatest need at this time. Also needed is additional space to accommodate increased referrals for outpatient treatment.

Twin Cities Metropolitan Area

Mental Health



Number Served	Indians	All others
Adult Males	160	5,610
Adult Females	222	10,933
Male Children	168	4,757
Female Children	135	2,902

American Indian Family Center

Prevalence of mental health problems. When we examine the mental health arena we find that American Indians are under-represented among mental health professions. Currently there are only 100 licensed American Indian psychologists practicing within the United States. As a result, there are many mental health professionals who lack the knowledge, cultural competence, and skills needed to work with American Indian clients. Equally disproportionate is the high number of American Indians in the St. Paul community who are struggling daily with issues of depression, substance abuse, physical/emotional/sexual abuse, homelessness, and poverty.

Infrastructure/Programs that address mental health problems. There is a lack of programs that address mental health specific to the American Indian community. The American Indian Family Center recently began a mental health program called the “Healing Generation.” This program works with American Indian families and children. Services include diagnostic, psychological, and parenting assessment; individual, couples, and family counseling; and ADHD assessments. Education and prevention services which address ADHD, FAS, suicide prevention, depression, and crisis plans are available to families and children.

Community Priorities.

- Mental health services to address depression, substance abuse, domestic violence, etc.
- Health insurance.
- Inpatient, culturally relevant treatment services to address chemical dependency and mental illness.
- Mental health services for children.

Community Resource Needs.

- Culturally competent services are essential for mental health treatment.
- Practicing mental health professionals who possess suitable knowledge and training to work in the Indian community.
- St. Paul should be designated a mental health professional shortage area for American Indians.
- Training non-Indian mental health professionals and agencies in culturally competency and sensitivity.

Indian Health Board of Minneapolis

Prevalence of mental health problems. The community has high rates of stress-related mental health problems: depression, anxiety, Post-Traumatic Stress Disorder, chemical dependency, etc.

Infrastructure/Programs that address mental health problems. At the Indian Health Board, the Counseling and Support Clinic has psychologists to address mental illness and conduct mental health assessment and therapy.

Community Priorities.

- Sustaining healthy families
- Reducing abuse, neglect, violence, and chemical dependency

Community Resource Needs. Many community agencies work collaboratively to meet the needs of our people.

Upper Midwest American Indian Center

Prevalence of mental health problems. The mental health issues of Upper Midwest American Indian Center clients include depression, suicidal tendencies, suicide, homicide, domestic abuse, sexual abuse, child abuse and neglect, post-traumatic stress, separation, loss and grief, homelessness, violence, chemical health issues, legal issues, disability issues, denial of mental health issues, ADHD, ADD, FAS and FAE, special education issues, truancy, under-education of basic skills, high school drop-outs, lack of job skills, multi-cultural issues, communication and relationship problems, single parent issues, low paying jobs, lack of child care resources,

insensitive providers, lack of technological resources such as telephones, families constantly moving, racism, elder and grandparent problems, welfare reform issues, and basic needs not being met with some families due to welfare reform.

Infrastructure/Programs that address mental health problems. The program funds two mental health staff members: a social worker who provides therapeutic services for the mental health needs of families and a therapist who serves adults and children who need therapy.

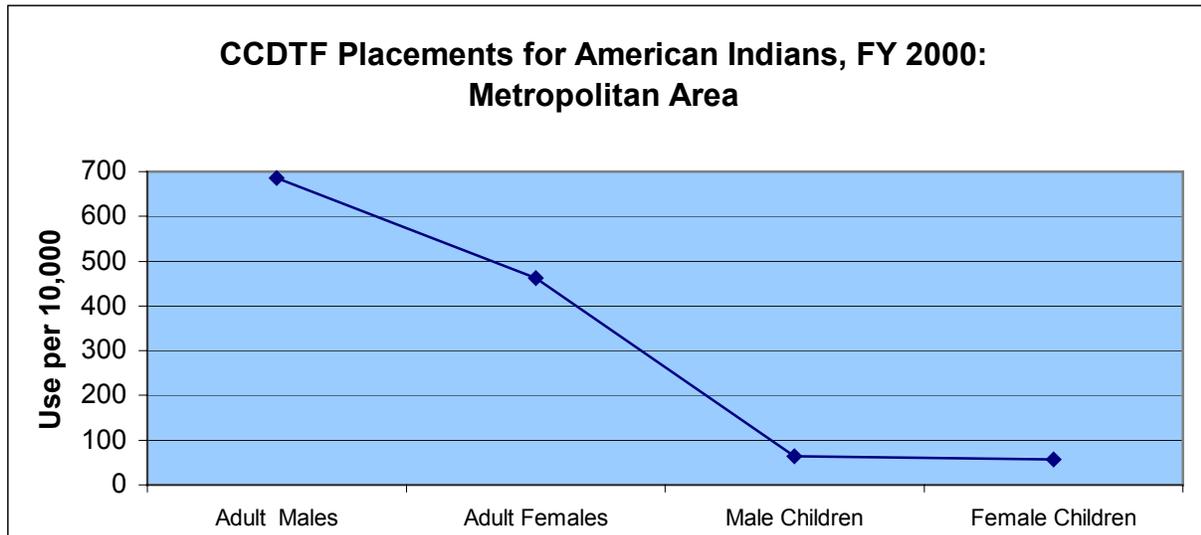
Staff conduct training on the special needs of families and utilize community resources. The mental health staff, foster care and adoption staff, and Early Head Start staff work with families and children who have mental health issues. UMAIC has a partnership with Four Directions Charter School and works on young adult issues. UMAIC and Four Directions have a partnership with Metropolitan State University to address the educational and training needs of young adults and adults.

Community Priorities.

- Becoming a provider in North Minneapolis and to expand the current program to meet the mental health needs of clients
- Maintaining current programs that provide mental health services to families and individuals
- Obtaining funding to train program staff, parents, and youth on mental health issues that are affecting the community
- Developing partnerships with other agencies to meet the needs of parents and children in the community

Community Resource Needs. Additional funding to employ a therapist and bookkeeper to work with the program on a full-time basis.

Chemical Dependency



1998 Estimates of the Population of Counties by Race and Hispanic Origin, 1998, U.S. Bureau of the Census reports 26,579 American Indians residing in Seven-County Twin Cities Metro Area.

These seven counties made 974 CCDTF placements for American Indians.

Number of Placements	Indians	All Others
Adult Males	528	8354
Adult Females	382	3242
Male Children	34	269
Female Children	30	106

13 "Chemical Juel Fairbanks Chemical Dependency Services

Prevalence of chemical dependency problems. Consistently American Indian students in the 9th through 12th grades report the highest weekly use of tobacco, alcohol, and marijuana when compared to other ethnic groups. In St. Paul, 72% of the family households consisted of a married couple family, in the American Indian community, it is 46%. Nearly 50% of the American Indian Children are in poverty. High school dropout rates and absenteeism are declining but are higher than other ethnic groups. (American Indians in St. Paul: A Preliminary Data Report, prepared by the American Indian Policy Center, June 7, 2000). Chemical dependency is prevalent as well as lack of education, poverty, and single parent families.

Infrastructure/Programs that address chemical dependency. The infrastructure to treat chemical dependency is in place but once it moves into the Aftercare Phase there is a major gap, in particular single female heads of household. This gap also includes single male heads of household.

Community Priorities. The issues facing many single heads of household in recovery are affordable housing, unlawful detainers, child protection, access to community cultural activities, transportation, childcare, education, and employment. A structured, in depth, culturally specific Aftercare Program needs to be put in place to deal effectively with the multitude of issues facing the head of household in recovery. This will significantly reduce the risk of relapse, improve the chances for families to stay intact, as well as providing positive opportunities for their children.

Community Resource Needs. A business plan needs to be developed that could include the development of a St. Paul American Indian Center to provide these Aftercare services as well as preventive culturally specific activities. The St. Paul American Indian Population is 4,000 to 5,000 residents including 879 American Indian students in St. Paul Public Schools in the 1998-99 school year. We are dealing with a quantifiable population where very positive outcomes can be generated in the near term. This plan needs to deal with the community as a whole, not just on the chemical dependency component to be successful.

Ain Dah Yung (Our Home) Center

Prevalence of chemical dependency problems. Three areas that have been detrimental for Indian families are boarding schools, foster care, and adoption. As a result of out-of-home placement, mental health and alcohol abuse issues have occurred, as well as suicide attempts and completion. The suicide rates of American Indian youth jumped up to five times the national average as compared to their American counterparts. American Indians had the highest rate of suicidal thoughts and attempts of suicide of all racial and ethnic groups involved in the Minnesota Student Survey (Minnesota Dept. of Children, Families and Learning, 1998). Poverty is a serious issue facing American Indian families. Living in poverty is a challenge that can create difficulties and hardships. In a report of the 1994 Urban Coalition, 55% of the state's American Indian children were living in poverty. Poverty can and does impact the mental health status of American Indian families.

Lack of culturally competent services is an issue for American Indian families. The families do not feel comfortable in accessing services where the providers do not understand their cultural backgrounds. There is a need for American Indian psychologists and social service providers. A report by T. LaFromboise states that there is one American Indian psychologist for every 8,333 American Indian persons in the United States.

Infrastructure/Programs that address chemical dependency.

- Emergency Shelter
- Family Services: Family Support Program
- Indinway Mug Enug (My Relatives)
- The Beverly A. Benjamin Youth Lodge
- Our Children Program (Ninijanisag)

Community Priorities.

- Ensure that American Indian people in St. Paul have access to affordable, culturally appropriate childcare.
- Increase agency ability to transmit American Indian culture, language and traditional practices.
- Expand mental health, chemical dependency programs to adolescents and their families.
- Expand services to homeless youth.
- Seek third part reimbursement for services.

Community Resource Needs.

- Staffing
- Funding
- Resources

MH/CD Symposium Recommendations

Vision: “American Indian communities and its members will continue to enhance and increase their strength by practicing traditional beliefs that validate their spiritual, cultural, physical and emotional well being.”

- DHS needs to make a commitment to work with tribes in implementing their vision of addressing Mental Illness and Chemical Dependency issues.
- Tribal leadership needs to make a commitment to implement the vision to address Mental Health and Chemical Dependency issues within tribal and urban communities.
- Historical Trauma needs to be addressed via integration of cultural strengths/approaches such as: talking circles, traditional practices/methods of healing and helping, and Elders, etc.
- Participation of the extended family in developing a service delivery system that is more holistic and culturally meaningful should be encouraged.
- Resources, such as funding, training, education, information (availability for access to service), and personnel (skilled, dependable work force), need to be tapped into for the entire continuum of care.
- Culturally meaningful resources, such as assessment/diagnostic tools and treatment methodologies, should be developed to most effectively address mental health and chemical dependency at various points of the continuum.
- Creativity and flexibility should be exercised in incorporating alternative treatment approaches to mental illness and chemical dependency.

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APPENDIX

Synopsis of Focus Group Discussions

Minutes of Focus Group Discussions

Testimony of National Indian Child Welfare Association

CAP Community Resource Assessment

Health Facts: Post-Traumatic Stress Disorder

Handouts on Chemical Dependency for Students/Families/Community Organizations

Children's Mental Health background information

SYNOPSIS OF FOCUS GROUP DISCUSSIONS

In reviewing the reports from various focus group discussions centered around the problems of chemical dependency and mental health problems in Indian communities, three central themes were recognized:

1. Community Capacity
2. Service System Infrastructure
3. Resources

The following pages provide a synopsis of these issues.

COMMUNITY CAPACITY

Access to information, the degree of collaboration within the community, and community ownership of a problem were the three most frequently cited factors that influence a community's capacity to address chemical dependency and mental health problems.

Information

The capacity of a community to address both mental health and chemical dependency issues is directly related to the resources that it has available to address these issues. One of the most critical resources is information. Individuals, families and community service providers need good information to effectively develop solutions.

Often individuals and families experiencing chemical dependency and/or mental health problems have inadequate information about the myriad of problems that result from these disorders. In addition, they lack information about the resources available to confront the problems. This is also true at the community level as service providers often find themselves with inadequate information to assist a client in addressing their mental health or chemical dependency problem. At times, it is information about specific types of drugs or mental illness. At other times, it is a lack of information about funding resources, training opportunities, or supportive services offered through other agencies.

Over and above this, the capacity within the community is greatly diminished when the community lacks professionals with proper education and training, and sometimes even culturally appropriate knowledge. This problem is further compounded when the information and education that is available has not incorporated the insight and solutions that evolve from families and the local community.

Collaboration

Another measure of the capacity of a community to address these problems is the degree of collaboration that takes place among the various policy makers and service providers. The needs of persons afflicted with mental health and chemical dependency problems cover a wide array. For this reason it will take a concerted commitment from every angle. Family members, tribal, county, and state elected officials, and Indian and non-Indian professionals from all major health and human service professions—including schools, law enforcement, business and non-profits, will not only have to be informed but must disseminate information about their own services that will increase the capacity to address these issues.

In addition to the needs of the individual, it is critical that communities also address these problems because of the cost to society that result from the actions of the individual. The morbidity associated with mental illness and chemical dependency includes domestic violence, property damage, incarceration, suicide and others. The costs of these problems have a growing impact on many agencies including schools, juvenile justice, child protection and social service, and health agencies.

Because of the cost to the individual, family, community and tribe, persons from all walks of life must put their heads together. While the answers must come from within the community, an investment from outside must follow. Tribal, county, state, and federal resources must be aligned in a manner that will most effectively address the issues. A multi-disciplinary approach must be created which means that policies that allow for greater flexibility and community-oriented approaches must be enacted. Turf issues must be set aside. Personal integrity must prevail.



Community Ownership

Those that work with persons afflicted by mental health and chemical dependency problems know that the first step in effectively addressing a problem is to admit that there is a problem in the first place. Problems in a family or in a community will persist unless the community first owns up to the realities of the problem. While there is agreement by members of these focus groups, there is also recognition that for one to truly own the problem and to do anything about this they have to have a means to address these problems.

Members of these focus groups assert that for many years the problems in tribal communities have not been on the radar screen of policy makers. In fact, they assert that this has happened for so long that the problems have reached such a crucial point that to say the problems in many communities have reached epidemic proportions is not a stretch.

From their perspective, this can be attributed to a number of issues, foremost among which is “cloudy jurisdiction.” For policy makers, this is an issue that must be looked at very closely. Because as it is explained it affects not only mental health and chemical dependency services but other health and human services as well. While the following statement is not part of the focus group discussion reports, it does offer a perspective that is shared throughout the reports. In testimony presented to the Senate Committee on Indian Affairs, Katherine Manness of the

National Indian Child Welfare Association stated, “just how the responsibility for mental health and social services for Indian people should be distributed among federal, state and tribal agencies has never been clear. Ambiguity and false assumptions that some other agency is responsible have contributed to Indian people being underserved.”

For many years, Indian tribes were stymied in their effort to provide services as resources were continually made available to other entities. In more recent years, largely the result of the Indian Self-Determination Education and Assistance Act of 1975, tribes have begun to take up the responsibility from federal and state governments. This has resulted in tribes taking community ownership. Most people that are involved in tribal administration or tribal relations recognize that tribal communities are no longer willing to watch quietly as various agencies and authorities exercise powers over the lives of Indian children and families and the tribal government itself.

Simultaneous to tribal communities assuming more and more in the way of self-determination is also a growing realization within various non-Indian agencies that there is value in this trend which demands validation. This is true not only because of the authority of a sovereign nation to govern within its own jurisdiction but also because of the belief that the most effective outcomes of any type of care must be delivered within the context of the values and beliefs of its recipients.

As this trend occurs, however, there is great concern that the transfer of authority could also lead to the abdication of responsibility on the part of the state or county. Tribal communities, more than any others in this country, have been disempowered (stripped of their right to speak their language, raise their children, practice their religion or spiritual ways, educate their own members, and even license their own facilities). As a result they have concerns that any time they are approached by non-Indian community they must be wary. For this reason, the efforts to empower tribal communities must be genuine.

SERVICE SYSTEM INFRASTRUCTURE

Experts that work with persons afflicted with chemical dependency and mental health problems recognize that while there are discipline-specific realities of these problems, there are also numerous correlated factors that either serve host to the problem or perpetuate it. These include employment, education, legal, health, housing and relationship issues. Most practitioners working with Indians experiencing chemical dependency and mental health problems recognize that effectively addressing these problems requires simultaneously addressing many of these other issues at the same time. It is like the chicken and the egg—which comes first?

A quote from a study conducted in 1972 (“A Survey of the Socioeconomic Status of Michigan’s Off-Reservation Indians”) is relevant to our efforts to address the chemical dependency and mental health issues of American Indians in Minnesota.

“In essence, conditions are so poor in so many areas that it is difficult to identify a

starting point for improvement. For example, unemployment is not likely to be significantly reduced until educational levels are improved. Educational achievement is not likely to improve before poverty becomes less prevalent. Poverty will not become less prevalent until the conditions of the Indians are improved, and health certainly cannot become a less significant problem until the Indian has an adequately equipped home. To have an adequately equipped home he must have employment.”

Persons working with Indians could easily add a sentence to the end of the above quote: “To have and maintain employment a person must be free of chemical dependency and mental health problems.”

To increase the likelihood that an individual will stay sober or learn how to effectively deal with his/her emotional disturbance, the individual must have access to providers of these type of services. However, communities vary in their ability to provide not only a wide continuum of chemical dependency and mental health services but also their ability to provide a continuum of other services such as food, shelter, clothing, jobs, educational opportunities, and cultural and social supports.

But these essentials must be available for the individual. If persons experiencing chemical dependency and mental health issues are trying to escape from realities of being unable to provide for themselves or their families, resources and opportunities to do so must be available within the community, and ultimately provided by community members, in order to reduce the sense of dependency which causes the stress that leads to many of the problems.

Availability of Services

Tribal and urban Indian communities often lack the infrastructure necessary to provide these services, and when they do it is usually limited. The reasons for this vary, but oftentimes even when there is recognition of a need for particular services there is no funding available to operate the program. When they are available, Indian programs do not enjoy the stable financial environment that is experienced by local counties or many private agencies. Tribal programs must compete on an annual basis for categorical funding and often are ineligible or not funded for a second year.

The instability creates another major problem that is felt in every tribal and urban community: recruiting and retaining qualified and experienced staff. As tribes and urban Indian communities attempt to build their infrastructure they need personnel. Because of the instability of funding, these communities are hard pressed to maintain any semblance of program continuity, which affects not only the amount of services they are able to offer but the quality as well.

Duplication of Services

Another problem is that while different providers exist they sometimes provide the same type of

services. At times, program rules and regulations lead to duplication. At other times tribal communities have found it necessary to offer same type of services as county, state, or federal agencies because tribal members refuse to go elsewhere for services. These tribal communities have often provided services without having access to the same resources that fund the outside agency duplicating the services. For these reasons, federal, state, county and tribal resources must not only be made available, but must be aligned in a manner that will bring optimum benefit.

Fragmentation of services

Another concern within tribal communities is that when service do exist, they are fragmented. Sometimes they are available through federal BIA or IHS offices, sometimes through county or state departments that are outside the community and still, at other times, through tribal providers. Each of these agencies have differing guidelines and eligibility requirements that are complex and make it difficult for the individual in need to navigate the various systems and obtain the necessary services.

To utilize the system effectively, a client and or advocate/case manager has to first understand the system and then has to be prepared to go to a number of different agencies, offering extensive personal and family information so that each agency can determine if they can assist him/her. This process often requires extensive travel and sometimes other costs such as childcare, and ultimately many clients find these providers to not be culturally competent.

RESOURCES

Undoubtedly the most commonly cited impediment to effective CD and MH service delivery was the lack of culturally appropriate services. Resources are needed to train personnel and to provide services. Literature, focus group discussions, and data demonstrate that services that are culturally sensitive are generally more accepted by consumers and their families and lead to better compliance with prescribed approaches and therapies. The general consensus among tribal representatives, however, is that most services available to tribal members are that they are not culturally sensitive. In fact, there is a strong belief that this is one of the major reasons that programs have had little success with Indian clients. The focus groups held within tribal communities definitively state indicate that there are a number of strengths within the culture that are being overlooked.

As a result we are witnessing a growth of chemical dependency and mental health programming in tribal communities with the goal of making these culturally sensitive. At the same time this is happening, however, both tribal representatives and DHS staff are learning that this is not always an easy task. Development of this programming is difficult because of:

- The lack of recognition of the value of cultural supports by mainstream providers and funding agencies;
- Pressures from health care purchasing plans that provide medical services to public assistance clients through managed care organizations who have not established a relationship with tribal providers;
- licensing requirements that differ from state requirements;
- the inability to get reimbursed for services provided by traditional healers; and
- the lack of qualified staff and funds to purchase their services.

While the above is offered as a synopsis of the primary themes embedded in the focus group reports, it is important to read each of them to get a sound perspective. The primary message, however, is that there is a wealth of expertise within tribal communities that is not being utilized in the development of CD and MH programs. They also remind us, however, that the primary resources needed to build effective programming are :

- time,
- funding with flexibility,
- training, and
- technical assistance to develop
 - culturally sensitive assessment tools;
 - prevention programs that incorporate traditional resiliency factors; and
 - treatment modalities that incorporate aspects of culture.