Mindful
Continuing Education

Issues Impacting American Indian and Alaska Native Populations Across the Lifespan

Introduction

Across the lifespan, American Indian and Alaska Native individuals have higher rates of disease, injury, and premature death than other racial and ethnic groups in the United States. Despite these obstacles, American Indians and Alaska Natives live longer than previous generations, and they must cope with illness and disability, and with experiencing significantly high rates of violence. Pervasive issues impacting their overall health throughout their lives include historical trauma, cultural barriers, geographic isolation, and poverty. As a result, they are at risk for numerous physical and mental health problems, including substance misuse. Furthermore, issues that impact American Indians and Alaska Natives children and adolescents may continue into adulthood if untreated.

American Indian and Alaska Native Demographics

American Indian and Alaska Native refers to the indigenous people of the continental United States and Alaska. It covers a large number of distinct tribes and communities and diverse ethnic groups. Other terms used include Native American and Native, Indigenous people, and when the term Indian is used here as a stand alone label, it is in historical context, ex. "The Indian Removal Act".

According to data from the 2020 U.S. Census Bureau, there are 9.7 million people in the United States who identify themselves as American Indian or Alaska Native, and this includes multiracial identification. Those who identified as only AI/AN and not of multiracial heritage accounted for 3.7 million people or 1.1% of the United States population. 22% of the AI/AN population is under 18 years old, 23% are aged 18- 34 years, 25% are aged 35-54, 13% are aged 55-64, and 16.5% are over the age of 65. In 2019 26.7% of AI/ANs spoke a language other than English at home. The median household income is $49,906 for AI/ANs compared to $71,664 for whites. AI/ANs have a lower life expectancy and higher rates of disease; one example is the tuberculosis rate in 2019 was seven times higher for AI/ANs, with an infection rate of 3.4% compared to 0.5% for the white population in the United States (HHS, 2022). Looking at basic demographics, the disparities between the AI/AN population and the general population in the United States can already begin to be seen.

It is important to recognize that although AI/AN people are considered one large population group, the cultures vary significantly amongst different tribes and areas of

the country. Sometimes differences can even be seen within one community due to federal policies, such as when multiple tribes have been placed on one reservation (youth.gov, 2022). Currently, there are 574 federally recognized tribes in the United States. These tribes are recognized by Congress, and have a government-to-government relationship that enables eligiblility for funding and services from the Bureau of Indian Affairs and IHS. These tribal lands and reservations are often referred to as a whole as “Indian Country” (Moss, 2021).

History

To fully understand the disparities American Indian and Alaska Natives face today, one needs to understand some of the historical events that continue to have an impact on today’s AI/AN communities.

1778 - 1820: The Treaty Era

As Europeans began to colonize North America, they set treaties with the Natives whose land they were attempting to settle. The British created treaties with tribes in New England to exclude other Europeans from interfering with their colonies. Once the United States established its independence, it continued by establishing treaties with Indian nations. The United States often negotiated agreements with tribes under false pretenses, securing land cessions and then going back on their word. At times the Senate would alter treaties before ratifying them and without consulting the tribe who entered into the treaty (Howard Law, 2022).

1820 - 1850: The Removal Era

The United States population was growing and needed more space; displacing Native Americans and moving them beyond the Mississippi River was the solution to expanding. In 1830 the Indian Removal Act was passed, moving thousands from their homelands, the most notable being the Cherokee. Over 4000 Cherokees died during their forced removal leading it to be called the Trail of Tears. Court cases during this time established laws that removed Indian land ownership and instead made them occupiers of the land where they lived, enabled the federal government to legislate over Indians, and allowed courts the authority to interpret treaties and laws and determine how they should pertain to Native Americans (Howard Law, 2022).

1850 - 1887: The Reservation Era

After their removal, the government then restricted Native Americans to reservations. Approximately 300 reservations were created; most were not located on the traditional homelands of the Tribes who were forced to live in these new confined boundaries. The goal was to clear traditional tribal lands for settler expansion and make it easier for assimilating tribes to American ways, and encouraging them to be farmers. Most of this was unsuccessful, and the dependency on food rations from the government began. Tribes had very little self-determination, they were policed by federal Indian Agents, and any crimes, including murder, rape, or kidnapping, could only be prosecuted by the federal government (Howard Law, 2022).

1887 - 1934: The Allotment and Assimilation Era

This Era focused on further attempts at controlling and eliminating cultural traditions. The Bureau of Indian Affairs' goal was to re-socialize Native Americans into the White European culture. Agents were key in kidnapping and enrolling Native American children into residential boarding schools. Not only did the children experience horrific traumas in these schools, but tribes suffered from loss of language, culture, and traditions. In 1887 the Dawes Act was passed, which removed the collective ownership of reservations and assigned parcels of land to individuals in another attempt to assimilate American Indians by pushing them toward agriculture on their individual private lands. Only those who accepted their division of tribal land were granted U.S. citizenship. Lands that were not accepted by individual American Indians were sold off to white settlers (Howard Law, 2022).

1934 - 1953: The Self-Government Era

Policies began to change during this time, giving Native Americans more power to self-govern. Land allotment policies were terminated, and if lands were not owned by other entities, they were returned to the tribe. Tribes were required to adopt and ratify their own tribal constitutions. This allowed for the creation of modern tribal councils and tribal courts. However, the constitutions were still subject to approval by the Department of the Interior, and there was inconsistency in how the approval process was implemented for each tribe (Howard Law, 2022).

1953 - 1968: The Termination Era

Several federal policies were reversed during the time period by terminating some of the federal supervision policies over AI/AN tribes, causing 109 Tribes to be stripped of their federal recognition. As a result, 1.4 million acres of land were removed from trust status and sold to non-Natives. AI/AN people were encouraged to leave the reservations for trade jobs in cities (although these employment opportunities turned out to be less plentiful than promised). While many returned to the reservations, many stayed, and now three-quarters of the AI/AN population live in urban areas.

History is important in understanding how AI/AN communities were forced to shift their relationship to land, the political policies used against Tribes that impacted economic stability, and the intergenerational passage of wealth. During this time, AI/AN people experienced a legacy of intergenerational trauma, disruption of traditional parenting practices, cultural loss, and genocide (Empey et al., 2021).

1968 - present: The Self-Determination Era

Civil rights activism took off during this timeframe and continues through today. Activists using political, legal, and civil tactics have forced the United States government and its people to address the history of abuses toward Native Americans.

Key areas of activism that have garnered significant attention are (Howard Law, 2022):

- **The Red Power Movement:** By occupying Alcatraz for 18 months, the group brought attention to poverty and other issues of concern and demanded acknowledgment and fulfillment of promises that had been made by the government. The Red Power Movement was able to turn frustrations and injustices into actionable causes that continue today.
- **Environmental Justice:** For Native Americans, the land is not just a natural resource but a cultural resource. Areas of concern include protection of ancestral remains and sacred lands, removal of hydroelectric dams that disrupt river flow and negatively impact aquatic life, halting construction of the border wall that cuts off members of tribes, and the construction of the pipeline as a violation of treaty rights and the risks of spills and the environmental harm that would cause.
- **Preserving Indian Country:** Government (both federal and states) and individuals have tried to invalidate land granted to tribes displaced during the United States

expansion. Native Americans still face threats of revocation of lands promised them and termination of their reservation status.

- **Murdered and Missing Indian Women:** Thousands of AI/AN women and girls have gone missing or have been murdered. Beginning in the 1990s, AI/AN women began marching, demanding justice for their "stolen sisters." Very little was done to address the problem, and reports were often minimized or ignored. In 2018 recognition from the Senate brought about the National Day of Awareness for Missing and Murdered Native Women and Girls.
- **Mascots:** Stereotypes of Native Americans have been manifested in sports teams' mascots. In 1968 the National Congress of American Indians advised against mascots for their harmful psychological and cultural impact on Native Americans. Over 50 years later, these debates are still happening, but there has been some progress, with some professional sports teams recognizing the detrimental effects their names and mascots have had on AI/AN people and agreeing to changes.

Genocide of AI/AN People

There is a debate among researchers, historians, activists and others as to whether the atrocities AI/AN people experienced should or should not be labeled as genocide. While examples can be found to support both sides of the argument, here the view will be taken that historical events that have happened in the United States can be viewed as genocidal acts.

The United Nations defines genocide as the deliberate targeting, with the intent to destroy, of a group based on their real or perceived membership of a national, ethnical, racial, or religious group. These acts committed can include:

1. Killing members of the group;
2. Causing serious bodily or mental harm to members of the group;
3. Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
4. Imposing measures intended to prevent births within the group;
5. Forcibly transferring children of the group to another group (UN.org, 2022).

Killing members of the group

The United States has a long history of targeting AI/AN people. Be it through military action against them, conflicts between tribes and settlers, or bounties that were placed on Native Americans and payments made upon proof of death. Below is just a small example of deliberate targeting of AI/AN people with the intent to destroy both the individual and their community.

1623 - English colonists in Virginia seek revenge for a previous attack by poisoning wine at a peace conference and killing 250 Powhatan

1644 - Pound Ridge Massacre, Lenape village is attacked and burned, killing 500

1675 - Great Swamp Massacre, Narragansett village attacked 300-1000 women, children and elders burned in the village

1730 - Massacre at Fox Fort, 500 Fox Indians were killed while trying to flee their besieged camp

1813 - Battle of Tallushatchee Creek town attacked, 180-300 warriors, women, and children were killed and burned

1851 - Old Shasta Town, miners kill 300 Wintu Indians and burn down their tribal council meeting house

1859 - Jarboe's War, at least 283 were killed over a six-month period, and white settlers were reimbursed by the U.S. government for their campaign

1890 - Wounded Knee Massacre, U.S. Cavalry attacked and killed 300 Lakota people (Wikipedia, 2022)

Bounties were offered for American Indian deaths (Wikipedia, 2022):

1641 - The Massachuesetts Bay Colony pays $60 per Indian scalp (they also offer a money for Indians sold into slavery and colonial men are allowed to rape and/or enslave Indian women and children)

1863 - military members were offered $25 per Dakota scalp and $75 per scalp was paid to non-military people, a few months later this was raised to $200 per scalp.

Serious bodily or mental harm

This area can be more difficult to argue and overlaps with other categories. There are numerous examples of death, mutilation, and rape throughout AI/AN history. Even under non-debated genocide examples (ex. Rwanda, Holocaust) there is not a clear definition from the U.N. as to where the line is for bodily harm or mental anguish to be considered genocide.

Some examples include causing starvation or controlling the food supply. This was seen with the near extinction of the buffalo, moving tribes to lands they were unfamiliar with and where they no longer had access to traditional foods, and tribes being forced to rely on government rations. During military conflicts with American Indians there are examples of burning fields and orchards to destroy food supplies and besieging villages forcing starvation.

It is well documented that AI/AN children were forcibly removed from their families and enrolled in residential schools. Many experienced neglect, starvation, physical and sexual abuse, and mental torture leading to an unknown number of deaths.

Inflicting on the group conditions of life to bring about its physical destruction

Over 300 reservations were created and tribes forced to move from their ancestral lands to these new restricted areas and monitored by Bureau of Indian Affairs agents. AI/AN movements were limited. By controlling all aspects of their life, the expectation was they would assimilate and become Americanized or be destroyed. In 1892 at the National Conference of Charities and Correction Captain Richard Henry Pratt shared his views on assimilation which was “Kill the Indian in him, and save the man.”

Children forced into residential schools were forbidden to speak their language or practice any of their traditional beliefs. Many were kept away from their families and communities for years at a time. The goal was to eliminate any cultural ties and become fully assimilated into American culture.

Imposing measures to prevent births in the group

Between 1973 and 1976, there were 3400 sterilizations performed at Indian Health Services facilities with zero consent from some to minimal understanding of consent for others. A third of the sterilizations were given to girls under 18 years old, with some as

young as nine years old. Some estimate the number to be higher than 25% of American Indian women who were sterilized. In 1976 the U.S. Government admitted to having unauthorized sterilizations performed. This is after a 1974 study by Dr. Connie Pinkerton-Uri (Choctaw/Cherokee) found that one in four American Indian women were sterilized without consent and that Indian Health Services targeted full-blooded Indian women for sterilization procedures (Donahue, 2021).

Forcibly transferring children of the group to another group

The attempts to destoy AI/AN communities through the forced removal of their children into residential boarding schools meets the genocide criteria for a number or the UN categories. Another area that has not garnered as much attention was after the closure of most residential schools there was then an uptick in the removal of AI/AN children into foster care and adoption with most being placed outside their communities. In 1978 The Indian Child Welfare Act was passed to stop this practice, but the burden to enforce it was left to the Tribal Government, and no financial resources were provided.

Historical & Racial Trauma

Historical trauma is characterized by mass cumulative trauma across generations. The trauma does not just target an individual but a whole collective community. It can be held personally and passed down over generations. Historical trauma was first studied by Dr. Maria Yellow Horse Brave Heart.

Trauma (like extreme stress or starvation, among many other things) can be passed from one generation to the next. Trauma can leave a chemical mark on a person's genes, which can then be passed down to future generations. This mark doesn't cause a genetic mutation, but it does alter the mechanism by which the gene is expressed. This alteration is not genetic but epigenetic. While genetics is the study of hereditary characteristics, epigenetics is the study of inheritable changes caused by the modification of gene expression, which seems to be the case with historical trauma.

From the first establishment of European colonies in North America, conflicts existed with the indigenous tribes as the settlers required more land and resources. Europeans' belief in Manifest Destiny allowed them to use their religious ideology to justify possession of land and its resources. Their white supremacist beliefs allowed them to justify eradicating people and cultures they viewed as inferior. Policies and treaties were

made and broken when the colonists wished to expand their reach. As the American government became established, policies were made to destroy the tribal ways of life, including cultural practices, spiritual beliefs, family systems, and traditional languages (Skewes & Blume, 2019).

The government and its people did not see that stripping the American Indians and Alaskan Natives of their land and moving them to reservations was sufficient to deteriorate their identities. The next step was forced assimilation through the removal of children and placing them in residential schools that were modeled after prisons. There they were forbidden to speak their native languages or practice any of their cultural beliefs, and disobedience was punished swiftly and harshly. While reports have been released of the horrific abuses some of these children experienced under the guise of assimilation training and/or religious conversion, recent media reports have found the number of deaths in many of these schools were underreported, and new investigations are finding unmarked mass graves on the sites of these schools. The first schools were opened in 1879 and grew to over 367 boarding schools. While most of them have now closed, there continue to be 64 still in operation (Skewes & Blume, 2019).

Family members experienced the trauma of forced removal of their children, sometimes hundreds of miles away, with no allowed communication, and sometimes not even receiving notification when their children died in care. This has caused generational trauma through the destruction of culture and disconnection within families and communities (Skewes & Blume, 2019, Empey et al., 2021).

Other examples of racist governmental policies include denying AI/AN the right to vote until 1948, attempts to re-negotiate land treaties, and denying religious protections until the American Indian Religious Freedom Act was passed in 1978. Additionally, in 1832 congress passed the ban of alcohol sales to AI/AN peoples, and it was upheld until 1953, and possibly worse of all, through the 1970s, AI/AN women were forced or had undisclosed sterilizations through government-sponsored programs (Skewes & Blume, 2019).

Racial trauma can continue to be seen in present-day statistics. For example, AI/ANs are twice as often victims of violent crimes compared to the general population of the United States. In 2015 they accounted for 3% of all hate crimes despite only making up 1% of the population, and they are overrepresented in the prison population. Both AI/AN youth and adults report experiencing microaggressions through outright discrimination on almost a daily basis (Skewes & Blume, 2019). All of these historical and

racial traumas have exacerbated the current distrust many tribes, and AI/AN individuals have of government programs and assistance.

American Indian and Alaska Native Youth

AI/AN youth make up the largest portion of the AI/AN population. AI/AN youth ages 15-24 are the most at risk group in the United States. They face a number of disparities in health, economics, education, and safety.

Obesity

Childhood obesity is an important marker to track in childhood as it can lead to additional health concerns later in life, including adult obesity, type 2 diabetes, hypertension, coronary heart disease, and some forms of cancer.

According to information from Indian Health Service National Data Warehouse on children ages 2-19, compiled by Bullock et al. (2017), 18.5% were overweight, and 29.7% were obese. Boys had a slightly higher rate of obesity than girls, 31.5% vs. 27.9%. These rates are higher than the general population of U.S. children in the same age ranges.

Zamora-Kapoor et al. (2019) found in their research that the reasons for obesity varied by age. In early childhood obesity, contributing factors included high maternal BMI, low birth weight, and early termination of breastfeeding. In older children and adolescents, factors that led to obesity included parental obesity, lack of access to fruits and vegetables, and a sedentary lifestyle. Bullock et al. (2017) found that stress and inadequate nutrition in utero and during early childhood led to increased obesity risk. Stress and inadequate nutrition during pregnancy can alter the child's metabolic programming, increasing the risk for obesity later in life. They stressed the need to address social issues such as health and poverty, stress, social injustice, trauma, forced cultural changes, and displacement that has led to cultural disintegration as all having an impact on obesity and other health issues experienced at a higher rate by AI/AN people. Experiencing numerous negative life events in childhood increases the risk of being overweight by the age of 15. Food insecurity, as demonstrated by the lack of access to dependable and sufficient quantities of high-quality food, is another contributing factor to childhood obesity.

An example of a program that is helping address obesity issues for AI/AN children is the Notah Begay III Foundation (NB3). It is a national Native-led nonprofit focused on ways

to improve Native American children's health. The foundation supports Native-driven and culturally centered programs focused on local, holistic prevention programs for children, families, and communities. Their four core focus areas are physical activity, healthy nutrition, youth development, and cultural connections.

Poverty

According to the 2020 statistics from the United States Census Bureau, 20% of American Indian families live in poverty; this is the highest rate among any ethnic group. For comparison for different racial family groups living in poverty for white 7%, African Americans 18.3%, Asians 7.6%, Hispanic 15.9%, and two or more races 12.2%. It is estimated that one in three AI/AN children live in poverty, and this number is even higher on some reservations.

Colonialism and systemic and Institutional racism uphold and perpetuate poverty. Poverty impacts physical health, mental health, social and emotional wellbeing, and the developmental trajectory of children and youth. AI/AN have some of the highest rates of chronic diseases, including obesity, cardiovascular disease, type 2 diabetes, dental cavities, depression and anxiety, and suicide. Living in impoverished conditions causes significant chronic toxic stress, and Adverse Childhood Experiences (ACEs) affect AI/AN children at a disproportionate rate compared to other races. As the number of ACEs a child experiences increases, the more emotional, behavioral, and developmental difficulties are seen. See Appendix A for Adverse Childhood Experiences List. Lack of access to health care and lack of health insurance can be linked to poverty and structural racism (Empey et al., 2021).

Examples of successful intervention to address poverty include:

The Family Spirit program is a home-visiting, evidence-based, culturally-centered program created in collaboration with tribal communities. Family Spirit uses paraprofessionals from the community to conduct home visits with young families focused on building upon their strengths and culture to promote family resilience. It was developed, implemented, and evaluated by the John Hopkins Center for American Indian Health in collaboration with the Navajo, White Mountain Apache, and San Carlos Tribes using community-based participatory research beginning in 1995. Since then, Family Spirit has spread to over 100 tribal communities. Through multiple randomized controlled trials, Family Spirit has been shown to increase parental knowledge and involvement and home safety and decrease maternal depression and behavioral problems in mothers and children.

The Indian Health Center of Santa Clara Valley, an urban Indian clinic, offers a program to AI/AN youth called Instilling Wellness through Workforce Development. Through a needs assessment, it was discovered that community members received very low wages, although they were living in an area with an extremely high cost of living. This program addresses this by helping youth build their employability through career exploration, resume building, interview skills, and financial literacy (Empey et al., 2021).

Interpersonal Violence and Victimization

It is estimated that 30% of AI/AN girls between the ages of 11 and 17 have been sexually abused, and 11% have been raped. Alaskan women and girls make up 8% of the state's population but makeup 33% of sex trafficking victims. These are more examples of Adverse Childhood Experiences AI/AN youth are more likely to experience than their non-AI/AN peers and have an impact on long-term health (increased heart disease, obesity, and diabetes are all linked to ACEs) See Appendix A for a full overview of the Adverse Childhood Experiences Questionnaire (Empey, 2021).

Types of victimization include dating violence, sexual assault, bullying (at school and electronically), sharing of nude photos, sexual harassment, homophobic teasing, and racism. Edwards et al. (2021) found that the most frequent forms of victimization induced bullying, racism, and sexual harassment. Older youth, girls, and sexual minorities experience more forms of violence than younger youth, boys, and heterosexual youth. Victimization was tied to depressive symptoms, suicidal ideations, alcohol use, and lack of feeling like school matters.

Experiences of interpersonal violence are, at least in part, the result of stress associated with intergenerational and historical trauma, racism, and prejudice, all of which increase risk factors for interpersonal violence (such as alcohol use and subsequent exposure to potential perpetrators). Historical and intergenerational traumas contribute to health inequities and higher rates of exposure to adverse childhood experiences (ACEs; a term given to describe abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18 years), leading to subsequent adverse health outcomes and increased risk for violence. While protective factors are present in many AI/AN communities, rates of violence among AI/AN youth are high. Urban AI/AN youth experienced sexual assault, suicide, and drug and alcohol use at rates higher than youth who identified as White. In another study researchers found that AI/AN youth reported

high rates of ACEs, and the prevalence of depression was higher among AI/AN youth with more ACEs compared to AI/AN youth with fewer ACEs (Edwards et al., 2021).

Research suggests that depressive symptoms, suicidal ideation, and alcohol use can be both risk factors as well as outcomes of interpersonal violence. For example, youth who are engaging in alcohol use are at risk for some forms of interpersonal violence (e.g., sexual assault) given the proximity to potential perpetrators. Youth also may use alcohol to cope with experiences of interpersonal violence (Edwards et al., 2021).

Substance Misuse

The impact of historical trauma and individual traumatic events on families and high levels of substance use among AI/AN adults impacts youth who consequently experience higher levels of psychological distress and increased susceptibility to substance abuse compared to non-AI/AN youth. AI/AN youth binge drinking rates are five times higher than all other ethnicities (binge drinking is considered having five or more drinks at one time). At a time when we see tobacco smoking rates lowering for youth in the United States, AI/AN youth are nine times more likely to smoke. Cannabis use is reported at a five times higher rate among AI/AN youth, and their rates are three times higher for injection drug use than their non-AI/AN counterparts. AI/AN youth typically start using drugs two to six years before non-AI/AN youth. Mental health problems, poorer educational outcomes, and long-term substance use disorders are all linked to the early onset and escalation of substance use among AI/AN youth (Snijder et al., 2020).

Woods et al. (2021) found that problem drinking starts early for AI/AN youth, and by the age of 18, they have an 18% rate of lifetime alcohol dependence. The AI/AN mortality rate from illegal drug use was double that of the general population at 22.7%. Among 12 to 17 year old AI/AN youth, 15% reported needing and receiving treatment for substance use (for comparison, the rate for non-AI/AN peers is 10%). Eighth graders living on or near a reservation report getting drunk (18.5%) or binge drinking (18.3%) compared to the national average of 4.9% and 7.1%, respectively. AI/AN youth have the highest rate among any racial or ethnic group of alcohol-involved vehicle related deaths.

Adolescents who report adverse childhood events have three times a higher rate of substance misuse compared to peers without a history of trauma. Many AI/AN youth must contend with both individual trauma and historical trauma (Wood et al., 2021).

Woods et al. (2021) identified risk and protective factors that impact AI/AN substance use through the lens of an ecological systems model that looks at individual, micro, and macro system themes. Their research suggests that by being aware of the risk and protective factors that contribute to substance use among AI/AN youth is key to developing successful prevention programs.

Individual Level Factors

Protective Factors

AI/AN youth's perception of the harmful effects of substances increased their resilience against substance misuse. Anti-drug attitudes and disapproval of antisocial behavior increase resilience against initiation. A reflective process on the Native way of life and having self-efficacy, optimism, and hope was important in this process. An additional protective factor was being a mentor to a young AI/AN youth.

Risk Factors

Older youth were more likely to initiate and misuse substances. Perceived drinking norms such as substances as a means of socialization and their peer's use of substances increased risk. AI/AN youth with behavioral problems had an increased rate of substance use. The younger the youth started their substance use, the greater the chances of future issues with substance use disorder. As far as gender differences in substance use, males were more likely to use marijuana than females, but if females initiated substance use, they were more likely to use multiple substances.

Microsystem Level Factors

Protective Factors

Family: Family connectedness that includes warmth and support, decreased AI/AN substance use, and parental (or grandparent) monitoring is a big component of prevention. A healthy relationship with family and community appears to be a bigger behavioral influence than peers. Living with both parents decreases the risk of marijuana use in middle school-aged youth. Family disapproval of substance use and communication and discussion about substance misuse increases resilience among AI/AN youth.

School: Connectedness to school, positive attitude toward school, and a school with resources all increased resilience for AI/AN youth against substance use. The more

connected to the school through in and after-school activities, involvement with teachers, and activities that were culturally sensitive, the more resilient the AI/AN youth were against substance misuse.

Peers: Peer social norms of what is approved or disapproved is significant. When the perception is that peers disapprove of substance initiation and use, individuals are less likely to initiate use for themselves. A supportive peer network with fewer deviant behaviors promotes resilience among AI/AN youth.

Risk Factors

Family: Exposure to interpersonal violence increased substance misuse and mental health concerns; youth who experienced three to six adverse childhood events were more likely to have multiple substance misuse. When parents were permissive toward alcohol use, the risk of all substance misuse increased.

School: Higher levels of substance misuse among AI/AN youth were linked to the perception of classmates' use of substances. If the AI/AN youth believed using substances was a normal part of adolescent development, they were 83% more likely to be currently using. Exclusionary discipline practices in school were more often employed with minority youth and linked to increased risk behaviors. These practices can make youth feel less connected to the school and increase feelings of stigmatization, which leads to decreased resilience against substance misuse.

Peers: Social norms that are positive for drinking decrease resilience against substance misuse, and social norms

Macrosystem Level Factors

Protective Factors

Communities with higher resilience against substance misuse had anti-drug social norms. Increased resilience was seen among AI/AN youth who had a sense of connectedness to their ethnic community. These protective factors continued into early adulthood among communities with a high kinship affiliation. Community monitoring and instilling future aspirations were also important factors against substance misuse. Communities focusing on increasing members' self-efficacy and ethnic pride showed an increase in resilience against substance misuse.

Risk Factors

Historical trauma and racial discrimination were highly connected to substance misuse and mental health concerns. Traumatic losses can also include the loss of a parent or a parent with a history of substance misuse. Historical traumas have led some AI/AN youth to no longer have a strong ethnic identity or cultural connection. Those with fragmented communities have increased misuse of substances.

Effective substance use prevention programs for AI/AN youth improve substance-related knowledge, attitudes, and resistance strategies, can reduce substance use frequency and intention to use, and delay substance use initiation. Effective programs are either culturally based or are mainstream programs where cultural adaptations were made. Effective substance use prevention programs include:

- Community Involvement: parents, youth, community leaders, and other community members are involved in the development of the program.
- Cultural Knowledge Enhancement: integration of cultural activities (ceremonies, storytelling, rituals, dancing), integration of culturally specific concepts, learning about traditional beliefs and practices, and use of culturally appropriate artwork and designs.
- Skill Development: problem-solving, substance resistance strategies, interpersonal skills, decision-making, and self-management skills.
- Substance Use Education; information on the effects of substances, short and long-term consequences, and information about addictions (Snijder et al. 2020).

Suicide

AI/AN individuals have the highest suicide rate of any racial or ethnic group in the United States. Suicide was the second leading cause of death for AI/AN youth ages 19-34 in 2019, with unintentional injury/accidents being the most frequent (Allen et al., 2022). Risk factors that impact suicide rates include previous suicidal behaviors, depression, substance misuse, exposure to peer suicides, and a family history of suicides. Contributing factors unique to AI/AN youth are historical traumas and loss and a history of inequalities. A limiting factor that has been found with risk factors is they have limited capability to predict suicidality. Allen et al. (2022) have found that targeting and strengthening protective factors for AI/AN youth is more effective than trying to reduce risk factors. Protective factors include a sense of belonging to one's culture, a strong tribal/spiritual bond, feeling connected to family, the opportunity to discuss problems

with family or friends, and positive emotional health. In addition, community factors such as social networks and support, economic environment, and access to traditional spiritual and cultural practices influence the social and physical environment and may impact individual behavior.

Current A/IAN suicide prevention science looks at protection, resilience, and cultural continuity as key areas to target to reduce the number of suicides. Allen et al. (2022) describe them as follows:

Protection

Protective factors are characteristics within the person or environment influencing suicide behavior or its absence. There are three protective factors that have been identified among AI/AN youth that reduce suicide attempts. An increase in these protective factors has shown a greater reduction in suicide attempts than attempting to decrease risk factors. Therefore, focusing interventions on protection factor growth versus risk reduction strategies have greater promise for suicide interventions with AI/AN youth. Such protective factors include:

- Discussing problems with friends or family
- Emotional health (identified as youth feeling in control, rested, satisfied, emotionally secure, cheerful, and relaxed
- Connectedness to family (defined as perceived caring, closeness, satisfaction with relationships, and feeling loved and wanted.

Resilience

Historically, resilience has been looked at as a person's capability of weathering an adverse situation and having better than expected outcomes. This view of resilience is restrictive to the individuals overcoming adverse experiences on their own and ignores the cultural, historical, and social context of the individual and community. Culture, family, and community all shape an individual's capacity for resilience. Looking at resilience in a broader context than just the individual has implications for AI/AN suicide prevention programs. Key considerations include:

- Community-level protective factors and the importance of local resources meeting the challenges within their communities.

- Utilizing resources depends not only on their availability and accessibility but, more importantly, if they have local community meaning, and they are culturally in tune with the communities beliefs and values.
- Historical and ongoing colonization must be acknowledged to have a clear understanding of how it has impacted suicide patterns and health inequalities.

Cultural Continuity

Cultural continuity takes the idea of self-continuity (one's perception of the interconnections of past, present, and future functioning) and expands it to a collective cultural continuity that includes a shared sense of the traditional past and what is presently experienced to build the future. This incorporates an understanding of significant past events and present circumstances, which leads to generating future action. Culturally grounded prevention programs seek to reach alienated youth by renewing cultural practices in the community.

Examples of programs that are helping address suicide issues for AI/AN youth include:

Promoting Community Conversations About Research to End Suicide (PC CARES). This program in Alaska brings together a diverse community group to learn about effective prevention strategies and discuss how members can adapt them to their own local and cultural needs. The intervention invites shared meaning-making to generate culturally- and locally- relevant knowledge mobilization to support prevention efforts within families and communities. The complex issue of youth suicide in self-determined, thus culturally-rooted ways is discussed.

The White Mountain Apache Tribe (WMAT) in the southwestern United States began a mandated tribal reporting system to track suicidal ideation, suicidal attempt, suicide deaths, nonsuicidal self-injury, and binge drinking. They implemented a prevention program involving the community, school, mental health agencies, family, and individuals which was led by the Community Advisory Board and the Elders' Council. The success of the program saw a reduction in youth suicides over a five-year period. The program has continued with the Elders' Resilience Curriculum, which is classroom-based with an intergenerational approach where the Elders visit the school to teach culture, language, and ways of life. The program promotes cultural continuity as a protective factor (Allen et al., 2022).

Education

The long-term effects of the Indian boarding schools continue to have an impact today. In 1975 the Indian Self Determination and Education Assistance Act was passed, which allowed Tribes to operate their own schools and to be able to include culturally relevant academics. However, most AI/AN children attend public schools (93%), where they are not exposed to experiences that are culturally sensitive or appropriate. They face significant disparities, including a lack of access to adequate educational opportunities, higher rates of suspension/expulsion, higher dropout rates, and lower graduation rates compared to other racial groups (Empey et al., 2021). Native American students perform two to three grade levels below their white peers in reading and math. They are two times more likely to drop out of school than their white peers. These statistics have remained relatively consistent since 2007 (NSBA, 2020).

AI/AN youth have fewer successful educational outcomes than their non-AI/AN peers by nearly all standards. Among AI/AN youth ages 25 and older, 22% have not finished high school, and only 13% have a bachelor's degree or higher, compared to 29% of the U.S. population who have a bachelor's degree. Only 19% of AI/AN youth ages 18-24 are enrolled in college compared to 41% of their non-AI/AN peers. In 2011, only 16% of AI/AN fourth and eighth-graders were proficient or advanced in reading and math compared to nearly 45% of white fourth and eighth-graders, according to the National Assessment of Educational Progress. While all other races/ethnicities saw an improvement in reading and math performance between 2005 and 2011, Native youth did not. Among students enrolled in four-year college or university, only 39% of Native students completed their programs of study and received their bachelor's degree compared to 62% of white students (youth.gov, 2022, powpows.com).

These significant educational gaps that not only impact academic achievement but employment and economic stability in the future. The following three areas have been identified as being helpful in improving educational outcomes for AI/AN students. Specific examples of how students were supported include:

Instructional Practices: Positive instructional practices included increasing local autonomy, ensuring harmony between home and community life and education, actively valuing elders' knowledge, and using culturally responsive educational practices.

Curriculum Content: Lesson plans that were found to be engaging for students included culturally relevant content that built on students' prior knowledge, experience, and

community values; and ensured that content was accurate and did not include bias and stereotypes.

School Climate: Important attributes of a healthy school climate include developing positive behavior support; communicating a belief in the abilities of learners; building relationships with students and families; learning about Indian heritage; and providing the necessary support to reach high levels of achievement (Youth.gov, 2022).

Juvenile Justice

AI/AN youth are disproportionately represented in both the state and federal juvenile justice system, with one study finding they make up 60% of the population in the juvenile justice system. They are 50% more likely than white youth to receive harsher punishments, from pepper spray, restraint, out-of-home placement, isolation, being charged in adult criminal court, and being detained in long-term placement facilities far from home. Risk factors that impact delinquency include exposure to brutality and domestic violence, child abuse and neglect, drug and alcohol use, and gang activity. This, in turn, increases youth's likelihood to utilize drugs and alcohol themselves, increases the likelihood of victimization, and increases the likelihood of participation in violence and running away. Lack of resources in tribal communities also exacerbated the problem, from insufficient training of law enforcement and other justice personnel to limited programs that target the prevention and intervention of juvenile delinquency (youth.gov, 2022).

Other areas of consideration to address juvenile justice needs include:

- Provide publicly funded legal representation to AI/AN youth who encounter the juvenile justice system. Doing so will mitigate instances of harm toward tribal youth and will better ensure their legal rights remain protected throughout their involvement with the system.
- Avoid punitive measures such as out-of-home placement and/or detention whenever possible (such measures may be necessary when the individuals pose a danger to themselves or society). Based on the abundance of evidence on non-AI/AN youth outcomes when provided with diversion/delinquency prevention programming and when given the opportunity to avoid exposure to the justice system, the same emphasis on restoration, habilitation, and rehabilitation must be taken with tribal youth.

- Provide individualized and culturally relevant reentry services post-detention.
- Provide trauma-informed, culturally appropriate screening, assessment, and care throughout the federal, state, and tribal justice systems so that AI/AN youth can effectively have their mental, emotional, and physical needs met in a manner that is not standardized for white and/or non-native youth (youth.gov).

There are a few evidence-based programs that have been specifically designed to address AI/AN youth needs and improve juvenile justice outcomes. A few examples are below:

Lower Brule Sioux Tribe's Talking Circles

In 2011 the Lower Brule Sioux Tribe in South Dakota began their Talking Circles program as an alternative to detention for girls involved with the juvenile probation system. The Talking Circles allow the girls to discuss whatever they are thinking about or experiencing, both negative or positive, resolve conflict, and choose how to manage their circle. The program also connects the youth with positive role models and mentors from their community. Participants in the Talking Circle program are reported to have improved school attendance, increased graduation rates, a decrease in suicide attempts, a reduction in gang activity, and overall improved compliance with probation conditions.

Village of Kake, Alaska's Adult and Youth Circle Peacemaking

The Kake Youth Circle Peacemaking group is an Alternative Dispute Resolution Group. Minors who are caught consuming alcohol and youth who commit first-time offenses are ordered by the Alaska State Court System into the Kake Youth Circle Peacemaking group as an alternative to more severe responses. Support from the community is essential, and while adults are often invited to participate, the youth participants act as the facilitators. The group's success has been measured through Tribal members' participation, the time taken to hear cases, and the restoration of relationships. Additional circles are held for follow-up cases and celebration circles for participants who have achieved milestones.

The Circle of Courage

The Circle of Courage is a model of positive youth development that integrates findings of modern youth development research, the cultural wisdom of tribal peoples, and the practice wisdom of professional pioneers with troubled youth. The four directions the Circle of Courage builds on are universal human needs that are the foundation for psychological resilience and positive youth development, including:

Belonging: In AI/AN cultures, the feelings of community belonging are critical. Treating others as kin forges powerful social bonds that draw into a relationship of respect.

Mastery: Competence in traditional cultures is ensured by a guaranteed opportunity for mastery. Participants were taught to carefully observe and listen to those with more experience and to see a person with a greater ability not as a rival but as a model for learning. Individuals strive for mastery not to be superior to someone else but for their own personal growth.

Independence: Power in tribal traditions means respecting the right to independence. In contrast to obedience models of discipline, Native teaching was designed to build respect and teach inner discipline. From early childhood, children are encouraged to make decisions, solve problems, and show personal responsibility. Adults nurture, model, teach values, and give feedback, but children are given abundant opportunities to make choices without coercion.

Generosity: The central goal in Native American child-rearing is to teach the importance of being generous and unselfish. Virtue is reflected in the preeminent value of generosity. In helping others, youth create their own proof of worthiness by making a positive contribution to another human life (Starr Commonwealth).

Native STAND (Native Students Together Against Negative Decisions)

Culturally adapted interventions are being shown as effective ways to impact AI/AN youth's unique health needs, behaviors, and worldviews. Native STAND is a 29-session peer education sexual health curriculum for positive decision-making for Native youth. It is based on the STAND intervention, which was designed and evaluated among rural youth in the southern United States and found to promote condom self-efficacy, STI risk behavior knowledge, and conversations with peers about other sexual health topics among participating students. Other positive results promoted are increased confidence, self-esteem, and youth involvement in their communities. The program's approach is comprehensive and skills-based and includes STI, HIV, and teen pregnancy prevention, dating violence, as well as drug and alcohol issues. Sessions focus on positive personal development, self-esteem, team building, diversity, decision making, negotiation, goals and values, refusal skills, effective communications, and peer educator skills. Native STAND was adapted by experts in Native health, Native elders, and Native youth, and the curriculum was adapted to meet the specific needs of Native youth. It honors tradition and culture at the same time that it meets today's Native youth where they are: walking between two different—but interconnected—worlds. While Native STAND acknowledges

that Native youth face many of the same challenges as mainstream youth, it embraces the power of traditional teachings and cultural strengths that Native youth have within themselves and their communities (nativestand.com, 2022).

American Indian and Alaska Native Adults

Health Care

American Indian and Alaska Native life expectancy is five and half years fewer years than all other races in the United States. AI/ANs die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes, accidents, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.

The Indian Health Service (IHS) is the agency responsible for administering the health portion of the trust obligation of the U.S. government to provide healthcare to AI/AN people. The IHS provides healthcare to 2.6 million people who belong to one of the 574 federally recognized Tribes. There are numerous shortcomings with the IHS, including an inadequate budget to meet the needs of those they serve (they are funded at 60% of their needed budget, which is another example of the federal government not upholding a trust agreement) and while 75% of AI/AN people live in urban areas less than 1% of the IHS budget is allocated for urban healthcare. This has led to the rationing of services, a high turnover in leadership positions, and a deteriorating infrastructure (nicoa.org, 2022).

Current federal policies and programs have fallen painfully short in fulfilling the Federal Indian Trust Responsibility, which calls for the protection of tribal sovereignty and the provision of basic rights, including social, medical, and education services for AI/AN. One clear and longstanding recommendation is for Congress to enact a just and appropriate level of funding for the IHS. IHS funding should be made an entitlement rather than an appropriation in order to reflect the very charge of its existence, to fulfill a federal trust responsibility. Enacting a Medicare for All policy would ensure coverage for AI/AN who are ineligible for IHS services (Empey et al., 2021).

While there are 574 federally recognized tribes, there are more tribes waiting for federal recognition, and therefore their tribal members are not eligible for IHS programs. In addition to these inadequacies, other contributing factors to health disparities include language and communication barriers, lack of diversity in the healthcare workforce, high

rates of poverty, lack of insurance coverage, discrimination against American Indians and Alaska Natives, and large distances from healthcare services (nicoa.org, 2022).

In 2020 COVID-19 was the leading cause of death for AI/ANs. The CDC reported that AI/ANs, along with other racial minorities, were at higher risk for severe COVID-19 outcomes. As discussed previously. historical trauma and persisting racial inequalities have contributed to disparities in socioeconomic factors and health compared to white populations. There have also been elevated incidents that may have been impacted by shared transportation, limited access to running water, and household size that all play into facilitating community transmission. In some areas, there is also a lack of emergency medical care and inadequate medical facilities that are understaffed and ill-equipped. Native American tribal elders have died at a high rate from COVID-19, leaving communities with a loss of knowledge, language, and connection (powwows.com, 2019).

Women Specific Health Care Issues

AI/AN women have the lowest rate of mammography of all ethnic groups. AI/AN women are almost twice as likely to develop cervical cancer than white women and are four times more likely to die from it; they are also more likely to be diagnosed at a later stage (Donahue, 2021).

AI/AN women have a high rate of maternal mortality and are three to four times more likely to die from complications from pregnancy or childbirth than their white counterparts. AI/AN women have a higher rate of maternal morbidity including preterm labor and obstetrical hemorrhaging. Some of the reasons behind these poor outcomes are:

Lack of access to insurance and medical care: This can include being geographically isolated from easy access to medical care or lack of transportation. 21% of reproductive age AI/AN women do not have health insurance and cite this as a reason for delaying or forgoing prenatal care.

Descrimination: AI/AN maternal health can also be impacted by discrimination which raises stress and cortisol levels, leading to lower maternal and infant health. Descrimination can also lead to delays in care.

Health Conditions: AI/AN women have higher rates of chronic diseases such as diabetes, cancer, and obesity. This can have adverse effects on maternal and infant health outcomes (NPWF, 2019).

Male Specific Health Care Issues

AI/AN males have a shorter lifespan by six years than AI/AN women (69.4 years vs. 75.8 years). In some tribal areas this number is even greater, with AI/AN men living eight years less than their female counterparts (63.0 years vs. 70.6 years). AI/AN males experience death rates two to five times higher than AI/AN females for suicide, HIV/AIDS, homicide, accidents, diabetes, firearm injury, and alcohol-related deaths. They also experience death rates 10-50 times higher than AI/AN females from cancer, heart disease, and liver disease (NIHB, 2022). The most common AI/AN men's health disease is prostate issues followed by diabetes, hypertension, and obesity. Prostate issues can be typical with aging, but screenings should be done regularly for early detection of cancer. As of 2019, one in six AI/AN adults had been diagnosed with diabetes which is more than double the general population. Men are more likely to have diabetes, and are also more likely than women to have high blood pressure and heart disease. AI/ANs are more likely to die from these diseases than other racial and ethnic groups. Obesity can have a negative impact on all the above chronic diseases. AI/AN men face greater health disparities, making it important to have regular healthcare visits to reduce their risks and provide access to early detection and treatment (Berrios-Payton, 2021). The Indian Health Services have been trying to grow awareness for preventable diseases and make services more accessible for men. One of their outreach programs is trying to bring awareness to men's health issues, acknowledging the difficulties men sometimes have asking for help, and trying to change thinking patterns so that they realize by addressing their health they are taking care of their families (IHS, 2022).

Barriers to Health Care

Cultural reluctance to access Western medicine for non-acute health problems, transportation difficulties (this includes not only lack of transportation but road conditions, distance, and weather), lack of childcare, negative perception of health providers, long waits for appointments, and poor patient-provider communications all create barriers for access to healthcare, including cancer screening (Donahue, 2021).

Needs for Health Care

Culture affects how people communicate with, understand, and respond to their providers about health care. This means it is crucial for professionals to be culturally competent —recognize the beliefs, languages, traditions, and health practices of the patients, and apply that knowledge to give the best care. Culturally competent providers should be aware that racial and ethnic disparities exist and be supportive of helping to eliminate these disparities while preserving the culture. (Donahue, 2021).

Best Practices

Culturally Competent Healthcare

A patient-centered focus ensures that patients are treated with care and consideration for both cultural differences and their own unique healthcare needs. It ensures that medical professionals help patients understand their conditions and the available care options, and that they respect the patient's health care choices.

AI/AN elders have historically been overlooked and underserved. Sometimes due to their lack of understanding of where to access the services they need, but also because they have not received culturally competent care in the past, some reluctance to return for care exists. Healthcare providers who learn elders' belief systems can offer more effective and respectful care for AI/AN elders. With so many AI/ANs living in urban areas, it is essential for healthcare providers to recognize that it may not be obvious that individuals are AI/AN, and they may not volunteer this information without being directly asked how they self-identify. Being able to recognize an elder as AI/AN opens up an understanding of the differing worldviews they may have or the adversities they have faced throughout history. It is also important to note that each person is an individual, and beliefs may vary from traditional to secular and that there are hundreds of different tribes in the United States, each with varying languages, beliefs, and practices (nicoa.org, 2022).

Culturally competent care requires the inclusion and participation of the patient. It is not possible to truly provide quality care to elders without understanding who they are and where they come from. Involving the entire community in the development and delivery of care is critical in ensuring participation from the elder, the family, and the community in delivering any type of service, whether institutional, home, or community-based. Facilities should have community involvement to help identify the needs of the specific Native population served. It is important for service providers to fully understand those

needs and not make assumptions. Each American Indian and Alaska Native community varies in terms of its specific beliefs and care preferences. Other considerations within the broad AI/AN communities are that American Indians and Alaska Natives understand that people and their communities are interconnected to nature and to the spiritual world. When confronting an illness, it may be seen as a lack of harmony between the physical body, the mind, the person's spirit, and emotions. Many Native people may choose to use western medicine to address the symptoms of an illness while also pursuing spiritual guidance from traditional healers in their communities with the treatment goal of recovering from an imbalance between the body, mind, and soul. Traditional healers often utilize medicinal plants and herbs as well as sacred ceremonial practices such as sweat lodges or sand painting to help correct imbalances in the patient who is seeking treatment. Unfortunately, western medicine and traditional practices have often been viewed as at odds with each other. Historical oppression and forced assimilation of American Indians and Alaska Natives into the broader melting pot of the U.S. have resulted in little consideration or deference for such traditions. It is important that healthcare providers be aware of traditional treatments that may be typical for the AI/AN communities they serve. They may be a positive complementary medicine the western medicine provider can collaborate on. There may also be contraindications with certain ceremonies or herbs, and the provider may need to discourage use at least temporarily and explain why. This is important for the safety of the patient but also for recognizing that in the past, discounting traditional practices was a way of controlling and suppressing the culture (nicoa.org, 2022).

Better healthcare outcomes for AI/AN is more than just providing the best medicine. Inclusivity can be demonstrated through featuring Native people in promotional and marketing materials, recognizing traditional holidays and feast days, and participating in Native community events. This can help to create understanding, as will learning the appropriate ways to show respect toward elders. Consistent efforts to learn and understand will help establish a relationship of trust over time.

Providers can benefit from understanding history and cultural values, listening to AI/AN needs (needs can vary if a patient is referred from an FQHC versus a tribal clinic), being adaptable, more culturally sensitive, and reflective (in approach, materials, etc.), and being open to bringing in experts (Donahue, 2021).

Obesity

In the United States, 41% of American Indians and Alaska Natives are obese, compared with 39% of non-Hispanic Blacks, 35% of Native Hawaiians/Pacific Islanders, 32% of Hispanics/Latinos, 26% of non-Hispanic Whites, and 8% of Asians. AI/ANs have a shorter life expectancy compared to other racial and ethnic groups. Cardiovascular disease, cancer, type 2 diabetes, stroke, and kidney disease are leading causes of death in AI/ANs, all of which have obesity as a risk factor.

Prior to colonization, AI/AN had a lifestyle that consisted of vigorous daily activity, and a diet of wild foods, lean meats, and healthy starches. American Indians were forced to leave their ancestral lands and moved to less hospitable areas in the United States. This restricted or completely prevented access to traditional hunting and agriculture. This led to tribes having to accept government food relief programs to avoid starvation. These foods were high in salt, sugar, and fat, which, coupled with the new sedentary lifestyle, contributed to the current high rate of obesity.

Contributing factors to adult obesity include high intakes of fats and carbohydrates, a sedentary lifestyle, high-stress levels, verbal abuse in childhood, and the belief of a lack of control over one's health (Zamora-Kapoor, 2019).

Mental Health

Several mental health issues have high rates of diagnoses for AI/ANs, including post-traumatic stress disorder, substance abuse, violence, and suicide. Recent statistics showed that approximately 37.5% of AI/AN women and 50% of AI/AN men had a DSM-IV disorder diagnosis. The most common for women was post-traumatic stress disorder and for men was alcohol abuse and dependence. There were high levels of comorbidity with depressive and/or anxiety and substance use disorders. The high levels of mental health disorders in the AI/AN communities can be attributed to historical trauma and ongoing contemporary discrimination. Additional social factors of academic failure, unemployment, high-risk occupations, and lack of healthcare accessibility all contribute to the behavioral health disparities experienced by AI/AN people (Baldwin et al., 2020).

Mental Health Prevalence

AI/ANs are at high risk for poor mental health outcomes. They are more likely to experience serious psychological distress in the past 30 days. They are 50% more likely to report hopelessness, worthlessness, and feelings of nervousness or restlessness all or

most of the time and 80% more likely to report frequent sadness in comparison to Caucasian or African American counterparts. 70% of AI/AN men and 63% of AI/AN women have experienced at least one mental health disorder in their lifetime.

People with a parent or caregiver who attended boarding school were significantly more likely to experience suicidal ideations, generalized anxiety disorders, or post-traumatic stress disorders than others, suggesting that boarding school attendance impacts intergenerational health. Even having a grandparent who attended boarding school was associated with an increased risk of suicide (20.4% compared to 13.1%) (Baldwin et al., 2020).

AI/AN Veteran Mental Health

AI/AN veterans experience poor mental health from combat experiences; diagnoses most often seen are depression, anxiety, other mood disorders, and PTSD. Almost half of AI/ANs who served in the military report some type of disability due to their service and identified their military service as contributing to their substance use. AI/AN veterans have a higher rate of PTSD (24.1%) compared to Blacks (11%) and Whites (6%); they are overrepresented among homeless veterans (AI/AN make up 1.6% of all veterans but account for 19% of the homeless veteran population); and they have higher rates of alcohol dependence hospitalization compared to any other veteran group (Baldwin et al., 2020).

Suicide

Severe mental distress can lead to suicide. The highest rates of suicide for AI/AN men is among 15-24 year olds (23.5/100,000) and 25-44 year olds (26.2/100,000). AI/AN women's suicide rates were slightly lower (5.5/100,000), and those between the ages of 15-24 were almost twice as likely to complete suicide as their same-age white peers. Two-spirit women who attended residential schools were six times more likely to have suicidal ideations and nine times more likely to have a suicide attempt than those who did not attend residential school.

Barriers to Mental Health Treatment

Several barriers for AI/AI individuals receiving adequate care exist, including the difficulty of diagnosing mental health conditions, lack of access to treatment services, funding limitations, and stigma toward mental health. Another barrier is that the western

definitions of mental health and treatment are not congruent with AI/AN understanding of wellness and healing, and attempts to treat AI/AN mental health patients can be seen as colonialistic. Despite the prevalence of traumatic experiences for AI/AN people, few seek treatment due to limited access to behavioral health services and fear of stigma and discrimination. For example, while 75% of AI/AN veterans reported mental health and/or substance abuse concerns, fewer than 20% sought mental health care.

Mental Health Intervention

Culturally adapted mental health interventions are four times more effective than standard health interventions. Culturally adapted interventions integrate cultural values, ideals, practices, and language. Making these adaptations improves access, increases engagement, and improves effectiveness. Culturally sensitive interventions promote both the individual and the community's well being. These programs often draw on the knowledge of the elders and community members in both designing and implementing the intervention (Baldwin et al., 2020).

To see a reduction in mental health disparities among AI/AN people, there needs to be a change in the system of care. System factors include reimbursements for traditional healers, supporting the mental health system to address historical trauma and modern stressors, and training providers in cultural competency. Finding a way to integrate traditional healing with western medicine may lead to better engagement and improved outcomes. Treatment programs that incorporate AI/AN worldviews, such as family-based interventions, talking circles, criminal sentences that incorporate traditional practices, and traditional ceremonies, have shown success (Baldwin et al., 2020).

Best Practices for Behavioral Health Providers

The following are core concepts to be aware of when working with AI/AN clients:

Importance of historical trauma: Providers should recognize, acknowledge, and address the effects of historical trauma.

Acceptance of a holistic view of behavioral health: The view of substance abuse and mental disorders is different among AI/AN people and western medicine beliefs.

Role of culture and cultural identity: Substance and mental disorders are often seen as a consequence of a loss of culture among AI/AN communities. Therefore healing can come from reconnection with traditional teachings.

Recognition of sovereignty: Tribal governments are sovereign nations and have their own tribal codes and governance systems.

Significance of community: Culturally responsive services require native community participation.

Value of cultural awareness: Providers who have an understanding of their own cultural backgrounds will be more effective and more able to respect clients' diverse belief systems.

Commitment to culturally responsive services: Organizations and their staff have an obligation to provide high-quality and culturally competent care.

Significance of the environment: Organizations should offer respectful, culturally reflective physical spaces and in their business practices.

Respect for many paths: While evidence-based practices are important, many are based on mainstream culture. Being open to traditional healing and practices will benefit clients significantly (SAMHSA, 2019).

Violence

Indigenous peoples are more likely to be victims of violent crime than any other racial or ethnic group in the United States. Official statistics suggest that, on average, American Indians experienced one violent crime for every ten residents age 12 or older. At the community level, the rate of violent crimes is staggering. In 2012, the Montana Indian Reservation, for example, had a homicide rate of 87.4 per 100,000 – more than double Detroit's rate and 50% higher than the rate in New Orleans. Similarly, one in five Southern Ute Indian Reservation residents are reported to be the victim of a violent crime; and nearly 25% of Zuni Pueblo Indian Reservation tribal members reported that they were victims of assault (Monchalin et al., 2019).

Homicide characteristics of AI/AN people do not follow those generally seen among other racial or ethnic groups, thus lending support to the need for a structural violence analysis of homicide rather than a solely individual one. For example, Indigenous peoples are more likely to be victims of inter-racial violence, whereas in most cases involving caucasian or African American victims, the offender is of the same race. Almost 70% of violent crimes committed against AI/AN people are perpetrated by non-Indigenous offenders. (Monchalin et al., 2019).

When looking at the extent Indigenous people are victimized, which largely goes unnoticed, it is apparent that structural violence accounts for a great deal of the incidents. This includes the theft of land, death by disease, attempted genocide, racism, inequality of income, disparities in wealth, dilapidated housing, mediocre education, rampant unemployment, homelessness, and poor health indicators. When these victimizations are brought forward, they are often seen as individual failings rather than the outcome of social structure. Structural violence includes social arrangements that put individuals and populations in harm's way, and they are generally embedded in the social, political, and economic organization of the country. They are destructive because they injure people who are typically not responsible for perpetuating the inequities (Monchalin et al., 2019).

Institutional violence includes violence perpetrated by police, discrimination in the criminal justice system, the legacy of residential schools, and harm caused by other colonial institutions. While the Black Lives Matter movement has garnered much attention and media coverage, what has been left unsaid or silenced is that Indigenous people are killed by police at a higher rate than any other racial group. Indigenous people are the racial group most likely to be killed by law enforcement at a rate of 1.9%. Between May 1 and October 31, 2015, there were 29 Indigenous peoples killed by police during that time frame. Reviewing the top ten newspapers in America, only one death received substantial news coverage. These erasures of Indigenous voices and experiences can be seen as another form of structural violence.

Violence and Victimization of Men

More than four in five American Indian and Alaska Native men (81.6 percent) have experienced violence in their lifetime. And overall, more than 1.4 million American Indian and Alaska Native men have experienced violence in their lifetime including (bia.gov):

- 27.5 percent who have experienced sexual violence
- 43.2 percent who have experienced physical violence by an intimate partner
- 18.6 percent who have experienced stalking, and
- 73 percent who have experienced psychological aggression by an intimate partner

These violent experiences have affected AI/AN men in the following ways:

- 26% had concerns about their safety
- 20.3% had physical injuries
- 9.7% had missed days of work or school
- 19.9% needed services and were unable to access them

Regardless of gender, victims of domestic violence often face significant barriers in speaking out. However, for Native men, there can be an added layer of silence and stigma in seeking help. In small, Tribal communities, a Native man may fear being judged or ridiculed as '*less of a man*' or '*weak*,' particularly if his abusive partner is a woman. In reality, when Native men are the victims of domestic violence, this in no way indicates weakness. Men who are being abused are often reluctant to seek help or tell friends or family out of embarrassment and/or fear of not being believed. They may worry that they — and not their partner — will be blamed for the abuse (ex. "But he started it…"). The fear of being mistaken for the abuser may also keep a victim-survivor from reporting the abuse to the police (Black & Hill, 2019).

Criminal Justice System

In 2019 there were 10,000 AI/AN people in local jails, which is up 85% since 2000. AI/AN people have a higher rate of incarceration in both jails and prisons. These numbers are disproportionate to the rate of population. In 2019 AI/ANs made up 2.1% of the federal prison population and 2.3% on federal community supervision programs. Incarceration numbers in 2016 reveal there were 19,790 AI/AN men and 2,954 AI/AN women in state and federal prisons. It is difficult to get accurate numbers on incarcerated AI/AN people due to misclassification (labeling people as “other” or “hispanic” on racial demographic paperwork (Prison Policy Initiative, 2021).

Violence and Victimization of Women

Violence against women, two-spirit people, and children are not traditional AI/AN ways. In traditional AI/AN cultures, women and children were honored and considered sacred. Many tribal societies were matriarchal, and two-spirit people were often revered in AI/AN communities.

National Violent Death Reporting System (NVDRS) found that 45% of homicides of AI/AN females was related to Intimate Partner Violence (IPV). 7.4% of the IPV-related homicides had multiple victims. 72.6% of AI/AN victims of IPV homicide were killed in a

house or apartment. In an intimate partner female homicide, the relationship with the suspect was most often either a current intimate partner (72%), former intimate partner (10%), or intimate partner, but the status of the relationship was unclear (5.2%). The IPV-related homicides most often were precipitated by an argument/conflict or jealousy of an actual or perceived relationship (this type of homicide often involved the suspect killing a non-intimate partner). 15.9% of AI/AN female victims had experienced interpersonal violence in the month preceding their death. Rape or sexual assault happened in almost one-third of IPV-related homicides. AI/AN women experience higher rates of sexual assault and rape, physical assault, and stalking than women of other racial backgrounds. IPV can also spill over and impact others who are not the intimate partner. These could be bystanders, children of the victim, family members or friends trying to help the victim, or a person who is involved in an actual or perceived relationship with the victim.

AI/AN women experiencing IPV face challenges when seeking assistance, they may experience inadequate or delayed responses by investigative authorities, and legal limitations on tribal sovereignty might constrain tribal authority to prosecute offenders. AI/AN women living on tribal lands may experience additional challenges of social isolation, inadequate access to resources, and cultural barriers when seeking assistance outside their community.

For violence prevention efforts to have the most impact, they should provide accessible behavioral health services, include trauma-informed strategies, and use strengths-based approaches to promote resilience and other protective factors that are inherent in AI/AN communities. AI/AN populations possess community and cultural assets that protect against violence, such as community-mindedness, participation in tribal ceremonies, connection to tribal leaders and elders, and spirituality. Native teachings and traditions help members develop a sense of identity, and generational sharing of knowledge through songs and storytelling contributes to a sense of connectedness and community resilience (Petrosky et al., 2021).

AI/AN communities have one of the highest rates of assault, abduction, and murder. Advocates say the crisis stems from the legacy of generations of government policies of land seizures, forced removal, and violence. 84.3% of AI/AN women (more than 1.5 million) have experienced violence in their lifetime, and 56.1% have experienced sexual violence. Of those who sustained injuries that needed medical attention, 38% were unable to access services. On some reservations, the murder rate of women is ten times higher than the national average (bia.gov).

Sexual violence against AI/AN women is especially deleterious. The lifetime prevalence of rape in AI/AN women is 27.5%, with another 55% reporting other forms of sexual violence (Baldwin et al., 2020).

AI/ANs females experience one of the highest rates of gender-based violence of all racial groups in the country. In addition to sexual violence, 84% of AI/AN women have experienced physical violence and 66% of AI/AN women have experienced psychological violence. Legislative policy attempts have thus far fallen short in addressing this epidemic.

According to the National Human Trafficking Hotline, there were 116 cases of human trafficking involving AI/ANs, of which 37% were minors, between January 1, 2011 and March 31, 2017. It is important to note that this data only reflects survivors who called the hotline; it does not account for all cases of human trafficking involving AI/AN individuals. Human trafficking predators target vulnerable individuals, such as those experiencing poverty, homelessness, and mental health and substance misuse; AI/AN women and youth are also disproportionately targeted (Stumblingbear-Riddle et al. 2019).

In some reservations, women are murdered at a rate ten times more than the national average. Homicide is the third leading cause of death among AI/AN women between the ages of 10 and 24, and the fifth leading cause of death for AI/AN women between the ages of 25 and 34. Due to her frustrations at the lack of tracking, activist Annita Lecchesi began building an online database of missing and murdered women and girls in the United States and Canada. In three years of research, she has gathered 3,000 names, and she estimates there are still 25,000 to 30,000 names that still need to be added. Amnesty International has stated there is "clear evidence" that AI/AN women are sought out as victims for attacks by men. Perpetrators are motivated both by racism and their realization of the lack of importance placed on the protection and wellbeing of AI/AN women, which allows them to evade justice more easily. Furthermore, from a structural violence perspective, it was apparent that the prominence of AI/AN women in their societies and settler colonialism had to be broken to be able to establish the current patriarchal society (Monchalin et al., 2019).

In 2016, according to the National Crime Information Center, there were 5,712 reports of missing American Indian and Alaska Native women and girls. But according to the U.S. Department of Justice's federal missing persons' database (called the National Missing and Unidentified Persons System), which is the national clearinghouse for information and resources for missing, unidentified, and unclaimed person cases in the United

States, they only had a record of 116 of those cases. There is no reliable count of how many AI/AN women go missing or are killed each year. Another complication is that women are often misclassified as Hispanic or Asian, or categorized under the "other racial" or "mixed-race" categories on missing-person forms and that thousands have been left off federal missing persons.

There are numerous reasons why this is still a problem and it continues to go unnoticed, including:

- Lack of media coverage; 95% of missing and murdered indigenous women cases are not covered by national or international news.
- Complicated jurisdictions with tribal, local, or state law enforcement lead to many cases being under-investigated or completely overlooked.
- Male-dominated industries near Native communities such as mining, logging, and fossil fuel extractions bring transient male workers into rural areas near reservations. The North Dakota oil boom resulted in a surge in numbers of violent crimes and aggravated assaults, including a rise in cases of missing indigenous women.
- Misclassification - Women are often misclassified as Hispanic or Asian or labeled under other racial categories on missing-persons forms. This also leads to an underrepresentation of the magnitude of the issue.
- Lack of funding for Native law enforcement which often forces families to turn into search parties and detectives.
- Lack of database or tracking system. In 2018 Urban Indian Health Institute compiled a list of 5,717 missing American Indian, and Alaskan Native women and girls, only 116 of those were listed on the Department of Justice Database. They have identified thousands of women who have gone unrecognized, ignored, and unprotected (sicangucdc.org).
- Data Gaps. In 2019 the BIA Deputy Bureau Director testified that his office had not compiled data on missing persons or domestic violence statistics. Tribal data was completely being left out of national databases.

Legislative reform to address the issues contributing to MMIW include:

- Savanna's Act (named after Savannah LaFontaine-Greywond, who was abducted and killed in North Dakota). This is a bill to address data collection gaps with the goal of coordinating DOJ and Tribal reporting. This was signed into law in October 2020.
- The Not Invisible Act is a bill to create a joint commission between the Department of the Interior and the Department of Justice to promote the coordination of a joint advisory body with the goal of reducing crimes against American Indians and Alaskan Natives. This was signed into law in October 2020.
- Operation Lady Justice is a two-year presidential task force to develop best practice guides and resources for Tribal communities, law enforcement, service providers, families, and victims. It also established a multi-disciplinary team to review cold cases and created a guide for steps family and friends can take should one of their AI/AN loved ones goes missing.
- The Violence Against Women Act was reauthorized in 2022. One of the key pieces that impact AI/AN communities is the expansion of Tribal courts' special criminal jurisdiction to be able to charge non-Native perpetrators of child abuse, stalking, sexual assault, sex trafficking, and assaults on tribal law enforcement officers on tribal lands. There is also financial support for the development of a pilot project to enhance access to safety for survivors in Alaska Native villages.
- The SURVIVE act (Securing Urgent Resources Vital to Indian Victim Empowerment). This is a pending legislative bill requiring funds for Native American tribes for programs and services for crime victims, such as domestic violence shelters, rape crisis centers, child abuse programs, child advocacy centers, elder abuse programs, medical care, legal services, relocation, and transitional housing.

Currently, grassroots Indigenous groups are the ones that have advocated for missing and murdered indigenous women, girls, and two-spirit persons. It is due to their work that the hashtag #MMIW took off and brought attention to the cause on social media. They have held vigils and marches, and their work has culminated with the establishment of the National Day of Awareness for Missing and Murdered Native Women and Girls, which takes place on May 5th (culturalsurvival.org).

This slow government action and the current crisis of missing and murdered Indigenous women and girls are tied to the structural conditions and lived material realities that upend the lives of Indigenous peoples. These circumstances render them as disposable,

unworthy, precarious, and even responsibilized for violent victimization and homicide experienced at the individual level.

Substance Misuse

American Indians/Alaska Natives have the highest rate of substance abuse of any racial/ethnic group in the U.S., and alcohol and illicit drug use are two to five times higher than the general population. AI/ANs had the second-highest overdose rates from all opioids in 2017 (15.7 deaths/100,000 population) among racial/ethnic groups in the U.S. Additionally, AI/AN women have one of the highest rates of drug-related mortality of any racial/ethnic group in the U.S. and 62% report they have used drugs at least once in their lifetime. Fetal alcohol syndrome is the highest among AI/AN children. High rates of alcohol and tobacco use among pregnant AI/AN women contributes to the high rate of AI/AN infant mortality. Also troubling is recent data that shows the percentage of adults who needed and did not receive substance use treatment at a specialty clinic in 2018 was the highest among AI/ANs (9.4%).

Addiction is a multi-dimensional disease that is impacted by a variety of biological, psychological, and social risk and protective factors, and it is necessary to understand the interplay of all of these to offer culturally appropriate substance use treatment.

Prior to contact with Europeans, recreational alcohol and other drug use did not exist among AI/AN. Some aspects that have increased substance use among AI/ANs include historical traumas, disruption of traditional and spiritual practices, and less access to community support systems for those who moved away from reservations to urban areas during the Relocation Act. AI/Ans have a higher rate of abstinence from alcohol than the general population, but those who do use alcohol do so at heavier or binge use.

According to the National Survey of Drug Use and Health (NSDUH), in 2018, the most reported substance use for AI/ANs was alcohol (39.2%), marijuana (15.1%), methamphetamine (0.9), and misuse of pain relievers (0.9). AI/ANs also have the highest tobacco use rate compared to all other racial/ethnic groups in the U.S. Smoking is more common among males and those living in poverty. In addition, several health issues that impact AI/ANs are directly tied to substance use. These include death due to cirrhosis of the liver, and those with lifetime use of alcohol use disorder also had higher rates of hypertension and obesity, and higher rates of cognitive impairment, particularly among male drinkers.

AI/ANs with post-traumatic stress disorder were more likely to also have alcohol use disorder compared to the general U.S. population. Alcohol use and intoxication prior to a completed suicide are highest among AI/ANs (Dickerson et al., 2021).

Drum-Assisted Recovery Therapy for Native Americans (DARTNA)

DARTNA is an example of a best practices treatment program for alcohol and other drug misuse that uses drumming as a key component of treatment. The program was developed specifically to work with AI/AN adults with alcohol and other drug use disorders. In addition to drumming, the program includes talking circles (a traditional AI/AN group discussion format) and the modified Northern Plains Medicine Wheel 12-step program of Alcoholics Anonymous/Narcotics Anonymous. The 12-step medicine wheel is divided into four directions for three weeks, each of spiritual, physical, emotional, and mental categories. While the program was originally created as a 24 session intervention, participants reported improvements in physical functioning, spirituality, and psychiatric symptoms after 12 sessions. It has now been modified to run as a 6,12, or 24 session program. Each session is divided over three hours, where 60 minutes is for working the 12 steps/medicine wheel, 90 minutes is for drumming, and the last 30 minutes is a talking circle. Participants can use one of the program's drums or make one of their own, giving them an opportunity to learn traditional drum making. This gives participants a chance to connect on a personal level to their AI/AN identity and commitment to recovery. Due to the sacred nature of drumming, no one is allowed to be under the influence of alcohol during sessions, and a breathalyzer is administered before each session. Promising results from DARTNA include improved cognitive functioning, fewer physical ailments, fewer drinks per day, and lower marijuana use (Dickerson et al., 2021).

Poverty and Employment

Approximately 33% of Native Americans live in poverty, according to the 2020 United States Census. The poverty rate does vary by state, for example, in South Dakota, it is 49%, while in Oklahoma, it is only 1%. 18% of AI/AN women live in poverty (compared to women of other racial categories: 18% Black, 15% Hispanic, 8% Asian, and 8% white). 43% of AI/AN families headed by unmarried mothers live in poverty, compared to the general population of unmarried mothers who are the head of the household at 31%. Older women are more likely to live in poverty than older men, with 21% of AI/AN women over the age of 65 living in poverty. Due to high poverty rates, many AI/ANs live

in overcrowded and poor housing conditions. There are over 90,000 AI/ANs who are under-housed or homeless. Lack of employment is a large contributor to poverty.

The AI/AN unemployment rate was 11.1% in January 2022, compared to the national average of 4.4%. The pandemic impacted Tribal communities more significantly than the overall population, with an unemployment rate of over 28% in February 2020. AI/AN workers are overrepresented in frontline service sector work (typically low-wage) which was the most disrupted during the pandemic. High levels of unemployment among AI/AN people may be attributed to the structural racism that impacts education access and employment opportunities (powwows.com, 2019; Maxim et al., 2022; Fins, 2020).

AI/AN people who are working are 42% more likely to be in a high-risk occupation compared to white workers. A high-risk occupation is one where the injury and illness rate is twice the national average. High-risk occupations can include the risk of death, and these on the job fatalities are typically male (92%) in the industries of construction, agriculture/forestry/fishing, and transportation and warehousing (CDC, 2020).

Difficulty with Maintaining an Appropriate Work-Family Balance

Women tend to have multiple social roles with conflicting responsibilities and demands. Women, in their role as caretakers and with their devotion to keeping the next generation healthy and safe, play a central part in the transmission of cultural knowledge and collective wellbeing. Women continue to carry most of the responsibilities as caregivers for children and extended family members, as well as performing household duties. Balancing these different demands can impact self-care, increase stress, and decrease overall health. AI/AN women may be particularly vulnerable to work-life imbalance because of the demands of multiple roles and an ethic of care that often places the needs of others before their own, especially in the context of poverty and large extended families. Women who are responsible for the caretaking of elderly family members are more likely to be employed under challenging conditions, and to have less schedule flexibility and limited access to paid leave. In addition, having caregiving responsibilities may interfere with participation in the labor force (Christiansen et al., 2017).

Christiansen et al. (2017) found the following three themes in their research on work-life conflict and its impact on health behaviors among AI/AN women:

Structural Characteristics: Rural Reservation Life

Poverty and the structure of employment: Women described how unemployment, seasonal employment, or low-wage work affected household life, particularly in having the resources for healthy food purchasing and access to facilities for physical activity. Participants that lived in rural areas discussed the distance of some worksites that could be hours away, and if a partner worked at a long-distance employer, it left female partners as the sole caregivers at home, leaving little time for themselves. Grocery shopping and access to social and medical services can also be a great distance away. This creates difficulties in accessing care and quality foods.

Loss of traditional eating, activity, and family life: The loss of traditional knowledge and ways of living following colonization affected wellbeing in the community in all its facets. There was less physical activity, and new foods were introduced with colonization that changed traditional diets and harmed health. In all communities that participated in their research, participants discussed trauma and grief over the loss of their cultural traditions, the loss of language, and the removal of children to attend boarding schools. Forced boarding school attendance disrupted family ties and the transmission of cultural knowledge.

Raising healthy families: Participants discussed the challenges and lack of resources available for raising healthy children in their communities. Alcohol and drug misuse, domestic violence, and involvement with the justice system that sometimes accompanied substance abuse were frequently cited as major problems for families in their communities. There is also a burden placed on some women to be both caregiver and breadwinner if their partner is involved with drug or alcohol misuse.

Role Stressors: Gender Roles and Responsibilities

An ethic of care: Women were most often the primary caregivers within the household, typically responsible for childcare, meal preparation, and housework. Many women reported caring for extended family members across multiple households and generations. Employed women faced high demands at home as caregivers and described the ways in which work responsibilities interfered with their performance in self and family care. A number of women even expressed guilt and shame when reporting that their husband was actually primarily responsible for domestic tasks typically done by women, such as cooking dinner or going grocery shopping. These women tended to work long hours or be employed far from home, making it difficult to perform some of the gendered roles of the household. Female participants reported particular household stress when they felt solely responsible for family care, either because they did not have a co-parent or because their partner didn't significantly contribute to domestic duties.

Social Support: Social and Institutional Support at Work and Home

The communal nature of care: Participants reported a communal nature of care, wherein 'families took care of families.' Many women described the people in their life they could turn to when they needed help with childcare. Those with strong social support spoke about how it enabled them to take care of themselves and their families, whether being able to exercise at the wellness center or go food shopping alone. They also explained how expectations for the communal nature of care could represent a high demand on women's time. Many participants reported that they were responsible for the care of others due to illness or problems with drug and alcohol misuse.

The workplace and employee health: The workplace can offer social support from coworkers and opportunities to engage in healthy activities through tribal wellness programs. Women discussed close relationships with coworkers and valued their opportunities to exercise or eat healthier together. Shift and seasonal work made it difficult for some women to participate in healthy workplace programs.

Natives Americans and the Climate Crisis

Continuing to this day, Native Americans have been exploited for the natural resources on their traditional tribal lands. These lands rich in natural resources have been overburdened for economic reasons and have been threatened with climate change. Many AI/AN groups are trying to safeguard natural resources and protect the environment (powwows.com, 2019).

Inability to Exercise Voting Rights

While AI/ANs have the right to vote, they are often unable to exercise this right due to the lack of available polling places. Some reservations do not have polling places in their communities, and to vote many miles away from home. Another barrier is that many reservations do not use traditional street addresses, and so AI/ANs voter registration applications are rejected. In 2021 the Native American Voting Rights Act was introduced; it is still pending review in the House of Representatives as of June 2022. Key Points of the piece of legislature include:

- It Improves access to voter registration, polling places, and drop boxes in Indian Country.

- It mandates the acceptance of tribally or federally issued identifications where IDs are required.
- It permits tribes to designate buildings to use as addresses for registration.
- It will establish a Native American voting task force.
- It requires pre-approval of any changes in election procedures.
- It mandates culturally appropriate language assistance(powwows.com, 2019).

Native Language is Becoming Extinct

According to the Indigenous Language Institute, only 175 out of more than 300 original native languages still exist today. By 2050 it is expected that only 20 languages will still be in use, unless there are some language restoration programs created. There are groups who are working to protect Native Languages, but many face a lack of resources and funding. The United Nations has designated the next ten years as the International Decade of the World's Indigenous People, which includes a Year of Indigenous Languages to draw attention to the loss of indigenous languages and the need to preserve them (powwows.com, 2019, UN.org, 2020).

AI/AN LGBTQ2S+

Sexual orientations and gender identities that are not heterosexual or cisgender are often labeled under the acronym LGBTQ2S+. This acronym stands for Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Two-Spirit.

The demographic representation of LGBTQ2S+ persons in Native nations is similar to other populations. Historically, many tribal languages have the vocabulary to refer to gender identity beyond male or female, and there were many differences amongst various tribes on how they responded to gender differences. In some AI/AN tribes, individuals who identify as LGBTQ2S+ have special standing in their community; their dreams, vision, and accomplishments set them apart as healers or ceremonial leaders. In other tribes, they have no special status, are ridiculed, or are accepted as members of society and live as equals. With European conquest and subsequent missionaries and boarding schools, cultural traditions were restricted, and new values were imposed, including the roles of LGBTQ2S+ Natives. In 1990, during the inter-tribal Native American/First Nations Gay and Lesbian American Conference, the term Two-Spirited

was adopted to refer to those who identify as lesbian, gay, bisexual, queer, transgender, transsexual, or gender-fluid. There are others who prefer to use their own tribal language words for gender variance, with the National Congress of American Indians has found dozens of examples in different languages for gender variations. They have also identified twenty-four tribes that recognize same-sex marriages. There is an increased traditional return to recognizing two-spirit roles and their serving in ceremonial events (Zotigh, 2020).

In the past, AI/AN two-spirit people were female, male, and intersexed individuals who combined traditional gender roles according to their own personal traits. In most tribes, they were not viewed as men or women but had a distinct alternative gender. The roles of two-spirit individuals varied across tribes, but they did share some common features.

Special work roles: Two-spirited people were usually described for their preference in what was considered work or roles of the opposite sex. They were experts in traditional arts (which were typically women's roles) and healers, hunters, and warriors (which were typically men's roles). They often combined gender roles which made them wealthier members of their tribe.

Gender variation: Two-spirit people did not meet typical gender standards for temperament, lifestyle, dress, or social roles.

Spiritual sanction: Supported by tribal mythology, two-spirited people were believed to be a result of supernatural intervention and reinforced by their visions and dreams. They often became healers, shamans, and ceremonial leaders, filling tribal religious roles.

Same-sex relations: Sexual and emotional relationships were typically formed with non-two-spirited members of their own sex. These may be both short and long-term relationships.

The LGBTQ2S population has unique healthcare needs, they are at greater risk for multiple health threats and frequently experience low-quality care due to a variety of factors, including discrimination. The LGBTQ2S community has a higher risk for suicide attributed to a lack of peer support and repeated harassment, mental health diagnoses, and substance use. Suicide is one of the leading causes of death for LGBTQ2S people aged 10 to 24 years, and those youth are three to four times more likely to experience suicidal thoughts, attempt suicide, or engage in self-harm than their non-LGBTQ2 peers. Between 38% and 65% of transgender individuals experience suicidal ideation (SAMHSA, 2019).

LGBTQ2S+ Native people are restoring the two-spirit duties and traditions and educating others on the historical roles they held in some tribes prior to colonization when so many traditions were lost. The number of groups and gatherings in-person and online continue to grow as the knowledge and understanding expand. There are now two-spirit-themed powwows, with the largest being hosted annually since 2012 by the Bay Area American Indian Two-Spirits. Across many issues, culture is seen over and over as a protective factor amongst AI/AN communities. We see this again in Two-Spirit healing work, including dance lessons, Two-Spirit gatherings and powwows, Two-Spirit drum groups, and restoring ceremonies such as the Naming Ceremony and Sun Dance (ihs.gov, baaits.org, SAMSHA, 2019).

American Indian and Alaska Native Aging Population

AI/AN life expectancy is five years less than all other racial groups in the United States (73.7 years versus 78.1 years). However, there are huge disparities in this number when comparisons are made to tribe-specific or region-specific data. For example, on the Pine Ridge Reservation in South Dakota, life expectancy there is 47 years for men and 52 years for women. This is comparable to the overall life expectancy from 120 years ago and is an abysmal number when the life expectancy for white women in the United States is 81 years old. Only 4.3% of the AI/AN population is over 65 years of age. (Moss, 2021).

Health inequities are differences in health that are unfair, unjust, and avoidable. They are affected by social, economic, and environmental conditions.

Health Disparities

As mentioned previously, AI/ANs have a higher mortality rate than the general U.S. population for chronic liver disease and cirrhosis (368% higher), diabetes (177% higher), unintentional injuries (138% higher), and chronic lower respiratory diseases (59% higher). Aging AI/ANs over the age of 65 have a higher need for long-term assistance for activities of daily living compared to their same-age non-AI/AN peers; Bathing (22% require assistance compared to 11% of the general population), Dressing (14% require assistance compared to 5% of the general population), Eating (10% compared to 3% of the general population), Getting in and out of bed (15% require assistance compared to 6% of the general population), Walking (32% require assistance compared to 10% of the general population). Not only is there a higher mortality rate, but there is also the

reduction in mobility and independence that older AI/ANs face, which leads to the need for a greater level of care (nicoa.org, 2019).

Income Disparities

- Older American Indians and Alaska Natives are twice as likely to live below poverty as compared to the general U.S. population.
- 54% of American Indian and Alaska Natives ages 50 to 64 are employed as compared to 66% of the general U.S. population. 40% of American Indian and Alaska Natives ages 50 to 64 are not in the labor force as compared to 30% of the general U.S. population.
- American Indian and Alaska Native elders aged 50 and above have a mean total personal annual income that is approximately $10,000 less than that of their same age peers of the general U.S. population, which equates to 25% lower income than the general population (nicoa.org, 2019).

Elder Abuse

In the past, American Indian and Alaska Native elders have held a place of honor in their communities for their experience, wisdom, and cultural knowledge. Sadly, this is no longer true among some tribal communities. American Indian and Alaska Native elders experience abuse and neglect at alarming rates in some tribal communities. In an attempt to address this community problem, tribal leaders have identified three major areas of need in addressing elder abuse and neglect issues on reservations, which are:

- Increase training about elder abuse and neglect
- Create codes to address elder abuse issues
- Develop specific policies and procedures for tribal agencies handling elder abuse and neglect issues.

Every year approximately 5 million older Americans are victims of elder abuse, neglect, or exploitation. This is about 1 in 10 aged persons, and some experts believe up to 6% of older persons have experienced some form of maltreatment in their homes. Researchers suspect that more than 79% of abuse or neglect incidents are not reported. For AI/AN elders, many tribes do not have their own specialized elder protective service programs. This means there may not be anyone to report abuse to or a lack of resources to

respond to even if a report is made. Furthermore, many elders have experienced the impacts of past federal government policies and may fear further institutional abuse by contacting government agencies and authorities.

Elder abuse is a serious social problem but is often considered taboo and kept as a private matter, which causes it to be underestimated and too frequently ignored by society. Unfortunately, as elder abuse awareness grows, it is becoming evident that it is at a level to be considered a public health problem. This is true for the general U.S. population and for tribal communities.

The definition of elder abuse is a single or repeated act or a lack of action to address a need, where there is a relationship with an expectation of trust that causes distress or harm to the older person. Elder abuse can include physical, emotional, sexual, psychological, or financial exploitation or abuse. Examples of elder abuse can be shoving, hitting, threats, intimidation, restraints, confinement, abandonment, sexual abuse, or inappropriate use of drugs and/or prescriptions. Elder abuse can also be intentional or unintentional neglect.

Neglect is the most frequent form of elder abuse. Many forms of abuse are interrelated and may be experienced simultaneously. Native American elders may also experience spiritual abuse, such as being denied access to ceremonies or traditional healing. Tribal social service providers estimate that close to 80% of those abusing American Indian and Alaska Native elders are immediate family members, and 10% are extended family members. Adult children are the most likely perpetrators, with spouses, other relatives, grandchildren, and caregivers as the next likely person to mistreat older persons.

Families where the income levels are extremely low for both the elder and the abuser/caregiver have the highest rates of abuse of American Indian and Alaska Native elders. Another risk factor for abuse in American Indian and Alaska Native communities is if the caregiver is unemployed, and higher abuse rates are seen when elders live in the same home as their primary caregiver. In 88% of cases where the gender of the abuser was known, the victim was female, and the perpetrator was male.

To address elder abuse on a community level, the connection between elder abuse and domestic violence, sexual assault, and stalking need to be explored. Tribal communities need comprehensive, victim-centered programs that can address abuse when it happens and build intervention programs to reduce interpersonal violence for future generations. When abuse is suspected, tribal law enforcement and Adult Protective Services should be notified immediately in cases where elder abuse is suspected (nicoa.org, 2022).

Those AI/AN from ages 65 through 90 and older have lived through the "Kill the Indian Save the Man/Child" Assimilation Era, those in their late 90s may not have been born as U.S. citizens, and others carry the marks of intergenerational trauma (Moss, 2021).

Conclusion

American Indians and Alaska Natives are diverse individuals who have experienced historical traumas that continue to impact their communities to this day. The legacy of the past can be seen in structural systems, institutional racism, and discrimination. All of this has led to poorer physical and mental health, higher substance use, lower educational achievements, higher exposure to violence, and greater unemployment and poverty when compared to the general population of the United States. Successful prevention and intervention programs for a number of AI/AN concerns have consistently involved aspects of culture and tradition. More studies are needed to ensure that culturally based treatment programs become evidence-based treatments. Thanks to cultural advocates and elders, issues and experiences of AI/AN people are gathering more attention, from sports mascots to missing and murdered women, and policy changes are slowly being implemented. It is important for behavioral health providers to know the historical events that AI/AN people have experienced over a 500 year period, the repercussions they continue to experience, and how that impacts treatment delivery.

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Appendix A : Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often …

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…

Touch or fondle you or have you touch their body in a sexual way?

or

Try to or actually have oral, anal, or vaginal sex with you?

Yes No If yes enter 1 _____

4. Did you often feel that …

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you often feel that …

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your “Yes” answers: _____ This is your ACE Score

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