Health and Its Complexity

Kim VanPelt
St. Luke’s Health Initiatives
Arizona Health Survey

- Respondents who reported having psychological distress, poor health and poor quality of life/sense of well-being were three to four times higher among respondents at or below 100 percent of the Federal Poverty level (FPL) than they were among respondents above 300 FPL.

- Not working was associated with negative health outcomes including psychological distress, poor health and poor quality of life.

- Not working due to disability was the factor associated with the highest rates of psychological distress, poor health and poor quality of life/sense of well-being, even more than race/ethnicity or economic status.
Arizona Health Survey

- Food insecure respondents reported worse health outcomes than those who were food secure.

- Individuals who were housing insecure experienced higher levels of psychological distress (39 percent compared to 14 percent), poor health (37 percent compared to 19 percent) and poor quality of life/sense of well-being (31 percent compared to 13 percent).
Reflections on the Social Determinants

• Health is complex

• Individual health is affected by a wide range of societal and environmental factors

• Partnerships, collaboration, systems change are key

• Advocacy is essential
National Prevention Strategy
Health Disparities Exist

- Racial and ethnic minorities tend to receive lower quality healthcare, even when access-related factors are considered

- Bias, language barriers, cultural barriers are among the causes

- Solutions: change how training and health delivery occur, monitor outcomes
Arizona Health Survey
Social Connectedness

People do not exist in isolation. They are part of complex social networks. And those networks matter.
Arizona Health Survey

• The Duke Social Satisfaction Score, Social Interaction Score and Neighborhood Cohesion Score have a positive correlation with perceived health and well-being. The more socially connected people are, the better they generally feel about themselves, even when their health is compromised.

• Psychological distress (Kessler score) is highly correlated with social satisfaction, social interaction and neighborhood cohesion. People with high levels of psychological distress report lower levels of social interaction and support.
Individuals Are Complex

- Often define people by their disability
- Interventions are often geared towards those “at risk”
- One-dimension application is flawed
- Need to think about how people – in all of their complexity – can best adapt to situations and bounce back
Resiliency

• The capacity to recover fully from acute stressors, to carry on in the face of chronic difficulties. To regain one’s balance quickly after losing it.
Health in a New Key

The Standard Key Health is the absence of illness and pathology:

*Stephen Hawking, the brilliant theoretical physicist who is crippled with an advanced neurological disease, is unhealthy.*

A New Key Health is the harmonious integration of mind and body within a responsive community:

*Stephen Hawking is healthy.*
Thoughts on Building Resiliency

• Start not with what’s missing, but with what’s already there

• Connections, relationships, community seem to make a difference

• Be a coach and an ally, not an expert

• Embrace complexity
Resources

St. Luke’s Health Initiatives  www.slhi.org
• Resilience: Health in a New Key (2003)
• Connect for What? Social Capital and Health (2011)
• Arizona Health Survey  www.azhealthsurvey.com

The Resilience Solutions Group (ASU)

National Prevention Strategy

Institute of Medicine
Improving Mental Health among Asian Americans and Pacific Islanders in Maricopa County

Doug Hirano, MPH
December 14, 2012
Presentation summary

- Who are AAPIs?
- What do we know about their mental health?
- How can this be applied to behavioral health care?
Defining Asian Americans and Pacific Islanders

- **Asian Americans** – Chinese, Koreans, Vietnamese, Japanese, Filipinos, Asian Indians, Burmese, Malaysians, Laotians, Cambodian

- **Pacific Islanders** – Native Hawaiians, Samoans, Guamanian, Tongans
AAPIs in the United States: Diversity and Growth

- Encompass 20 different countries, 66 ethnicities and more than 100 languages
- From 1990 – 2010, AAPIs increased from 7 million to 17 million (5.6% of US)
- By 2050, one in ten Americans will be an AAPI
## AAPIs in Maricopa County, US Census 2010

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>% of all AAPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Indian</td>
<td>30,625</td>
<td>21.9</td>
</tr>
<tr>
<td>Filipino</td>
<td>24,492</td>
<td>17.5</td>
</tr>
<tr>
<td>Chinese</td>
<td>23,721</td>
<td>16.9</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>18,934</td>
<td>13.5</td>
</tr>
<tr>
<td>Korean</td>
<td>10,616</td>
<td>7.6</td>
</tr>
<tr>
<td>Native Hawaiian/OPI</td>
<td>7,790</td>
<td>5.5</td>
</tr>
<tr>
<td>Japanese</td>
<td>5,663</td>
<td>4.0</td>
</tr>
<tr>
<td>Other Asian</td>
<td>18,184</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>140,015</strong></td>
<td></td>
</tr>
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</table>
## AAPIs: US born vs. foreign born
National Health Interview Surveys (2004 – 2006)

<table>
<thead>
<tr>
<th></th>
<th>Chinese</th>
<th>Filipino</th>
<th>Asian Indian</th>
<th>Japanese</th>
<th>Vietnamese</th>
<th>Korean</th>
<th>Other Asian and NHOPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>US born</td>
<td>18.8</td>
<td>31.5</td>
<td>6.9</td>
<td>58.0</td>
<td>8.2</td>
<td>10.6</td>
<td>29.7</td>
</tr>
<tr>
<td>Foreign born</td>
<td>81.2</td>
<td>68.5</td>
<td>93.1</td>
<td>42.0</td>
<td>91.8</td>
<td>89.4</td>
<td>70.3</td>
</tr>
</tbody>
</table>

By comparison, 96% of white adults are US born.
Asian Americans are the only group with a bimodal distribution of major socio-economic-status (SES) indicators:

- Education
- Income
- Occupation
Poverty rates for Asian subgroups, Maricopa County and US*

US Census 2006 - 2010
Linguistic isolation for Asian subgroups, Maricopa County and US*

US Census, 2006 - 2010
Prevalence of mental illness

“Overall prevalence of mental illness is similar or somewhat lower among Asian Americans than whites.”

Suicide rates are highest among racial/ethnic groups for females ages 15 – 24 years and more than 65 years of age.

PTSD disproportionately seen among Asian refugees

---

Utilization

“Asian Americans are less likely to use mental health services than other populations, and US-born Asians are more likely than foreign-born Asian Americans to seek help for mental health problems . . .”

Percent of adults age 18 and over who received mental health treatment within the past year, 2008

<table>
<thead>
<tr>
<th></th>
<th>Asian American</th>
<th>Non-Hispanic White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>-</td>
<td>10.8</td>
</tr>
<tr>
<td>Female</td>
<td>4.4</td>
<td>20.8</td>
</tr>
<tr>
<td>Total</td>
<td>4.5</td>
<td>16.0</td>
</tr>
</tbody>
</table>

2010 National Healthcare Disparities Report. Table 17_3_1.2a and 2b; http://www.ahrq.gov/qual/qrdr10/index.html
Percent of Adults age 18 and over who received prescription medications for mental health treatment or counseling, 2008

<table>
<thead>
<tr>
<th></th>
<th>Asian American</th>
<th>Non-Hispanic White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>-</td>
<td>9.1</td>
</tr>
<tr>
<td>Female</td>
<td>-</td>
<td>18.3</td>
</tr>
<tr>
<td>Total</td>
<td>3.4</td>
<td>13.9</td>
</tr>
</tbody>
</table>

Mental health service utilization

Service Use for Mental Health Problems
Asian Americans: Foreign-born and US-born

Any service use
Other complementary/alternative medicine
Prayer/spiritual practices
Non-MD clinicians/other human services
Any MD or medication
Medications
Other medical doctors
Psychiatrists and hospitalizations

Sribney, et al. (in Disparities in Psychiatric Care), 2010.
### Percent reporting mental health problems

<table>
<thead>
<tr>
<th>Report MH Problems to:</th>
<th>AAPIs</th>
<th>Caucasians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend or relative</td>
<td>12%</td>
<td>25%</td>
</tr>
<tr>
<td>Mental health professional</td>
<td>4%</td>
<td>26%</td>
</tr>
<tr>
<td>Physician</td>
<td>2%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Zhang, AY, et al., 1998
Why?

- Financial barriers/lack of health insurance
- Lack of awareness of mental health issues and services
- Stigma associated with mental illness
- Language and cultural barriers
- Perceptions of mental illness as a weakness and source of shame/burden to the family
50% believe mental illness is a result of a weak mind, 60% attribute it to superstitions, 30% to religious beliefs, 20% to bad thinking and 20% to genetics.

While participants voice that anyone could be impacted by mental illness, they consistently indicate they would not seek services.
Findings from listening sessions (APCA, 2010)

- Mental illness a result of energy imbalance (yin/yang), mistakes from past lives, "curse from God"
- Face saving is extremely important to many Asian peoples, and they don’t want others to know their family member is mentally ill
- Depression is viewed as a normal part of aging
Listening session findings

- Parental pressure and expectations can be very strong relating to academics.
- There is a lack of awareness of available resources for mental illness; traditional Asian Americans seek help from primary care physicians, community leaders or spiritual healers.
- Many Chinese Americans do not feel comfortable speaking to a mental health care professional who does not understand their language or culture.
Summary

- Asian Americans suffer disproportionately from preventable illness and death due to mental illness.

- They underutilize mental health services for various reasons but most likely due to language access and culture.
Recommendations

- Leverage protective factors such as familial connectedness, interdependence, and spirituality
- Reframe the value and effectiveness of prevention and treatment within AAPI cultural belief systems and practices
- Train primary care and behavioral health providers to better identify and treat mental illness among AAPIs
- Ensure linguistic access through trained interpreters and translators
Recommendations

- Increase the bilingual and bicultural behavioral health workforce

- Conduct more research among AAPIs to better understand prevalence, risk factors and health seeking behaviors related to behavioral health

- Begin conversations about mental health in AAPI communities
Doug Hirano, MPH
Executive Director
Asian Pacific Community in Action
6741 N. 7th Street
Phoenix, AZ 85014
(602) 265-4598
www.apcaaz.org
Creating and Maintaining Healthy People of Color Communities
SOCIAL AND CULTURAL DETERMINANTS OF HEALTH

OVERVIEW

Creating and Maintaining Healthy People of Color Communities
WHO WE ARE

People of Color Network (PCN) is a non-profit 501(C)(3) Adult and Children Provider Network Organization contracted with the Maricopa Regional Behavioral Health Authority.

Now part of a Growing Heathcare EcoSystem, PCN is evolving into an accountable care organization model including medical and specialty providers to delivery integrated community healthcare.
HISPANICS/LATINOS

- Spend $40 billion on goods and services in 2012 and an estimated $50 billion by 2015;
- Accounted for three of five people added to the state’s population from 2010 to 2011, and nine of 10 in Pima County over that period;
- Account for 65 percent of new homeowners over the next five years;
- Have more people per household on average than non-Hispanics;
- Have a fertility rate almost twice that of white non-Hispanics.

Source: DATOS – AZ Hispanic Chamber of Commerce
The Arizona Latino population is young and mostly of Mexican origin.

Latino students struggle to achieve academic success relative to their Anglo and Asian peers, regardless of grade, subject matter or income level.

Latinos attained only 13 percent of bachelor’s degrees awarded by the state universities in 2007.

Latinos are disproportionately exposed to health hazards and affected by conditions that include diabetes, obesity, heart disease, violence and workplace injury.

http://www.asu.edu/vppa/asuforaz/
BRIDGING THE GAP

- Bridging the gap between Latinos with mental illness and treatment is a pressing issue.
- Whites are far more likely to receive mental-health treatment than Latinos.
- In the Latino community, cultural and socioeconomic factors stigmatize people with mental illness.
- Hispanics life expectancy is cut short by 10 years than the general population.

TOP 3 PRIORITIES

- EDUCATION – health literacy
- ECONOMICS – employment
- ACCESS – resources to support whole health
A community development approach focuses on changing community conditions, building on assets/strengths and valuing people as resources. 

Serving people where they live, work, play and pray in the context of community, culture and language.
Geographic Coverage

- **11** zip codes were investigated:
  - 85004
  - 85006
  - 85007
  - 85009
  - 85012
  - 85013
  - 85034
  - 85040
  - 85041
  - 85210
  - 85283

- **5** zip codes are profiled:
  - 85006
  - 85009
  - 85013
  - 85040
  - 85283

Conducted Needs/Asset Mapping
My Healthy Neighborhood Profile

Conducted My Healthy Living Survey
The ruin of a nation begins in the homes of its people.

Ghanaian Proverb
A shared bio-genetic history is the most basic and fundamental facets of the link between one person and others. It provide a shared predisposition for external physical appearances as well as internal bio-medical assets and liabilities.
Cultural Identity: It Is Not About History

The past does not define who you are today. It simply provides a context for you to understand your current circumstances. What you chose to believe, who you chose to become and what you decide to do is a matter of personal choice.
SOCIETAL MACRO CULTURE
Unifying Vision

Social Context & Climate

SECONDARY CULTURAL DEFINING GROUPS

PRIMARY CULTURAL DEFINING GROUP
Defining Life Events

DEFINING BELIEF SYSTEMS
Making Sense of Injustice

- **NAÏVE IDEALISTIC VISION**: PEOPLE ARE THE SAME AND OPPORTUNITIES ARE THE SAME FOR EVERYONE.

- **FRAGMENTED VISION**: PEOPLE ARE DIFFERENT AND OPPORTUNITIES ARE NOT THE SAME FOR EVERYONE.

- **RECONSTRUCTED VISION**: OPPORTUNITIES/PEOPLE ARE DIFFERENT BECAUSE PEOPLE/OPPORTUNITIES ARE DIFFERENT

- **FULL VISION**: PEOPLE ARE THE SAME AND DIFFERENT. OPPORTUNITIES CAN BE FAIR AND UNFAIR
Prejudice: What’s the Big Deal?

- Prejudice is simply the natural tendency to draw a conclusion in the absence of sufficient information.

- Racism is easy to dismiss when it is define by only the most extreme actions of violence driven by overt bigotry. This not what defines racism. This is the unchecked natural consequence of racism when prejudice is entrenched.
Social Equality isn’t the belief in justice or that we are all the same. Social equality is the belief in injustice and the pursuit of justice because we are not the same but our opportunities and rights should be. It is not a destination...
A predisposition towards familiarity and comfort towards some and discomfort and suspicion towards others.

Racism has little to do with hatred and much more to do with what people do with their own insecurities and who they chose to blame...In fact, racism really has little to do with race. Race is simply a more convenient and obvious target.
Evidence of Racial and Ethnic Disparities in Healthcare

- Disparities consistently found across a wide range of disease areas and clinical services
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities in care are associated with higher mortality among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995)
USA Today, March 22 “Racial Bias in Health Care”

“In unassailable terms, the report found that even when their insurance and income are the same as those of whites, minorities often receive fewer tests and less sophisticated treatment for a panoply of ailments, including heart disease, cancer, diabetes and HIV/AIDS. By stripping away the pretense that the differences can be explained by minorities' lack of access to timely care, the report should spur doctors and patients to question why racial disparities are tolerated in medicine.”
Figure 1: Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care

- Clinical Appropriateness and Need
- Patient Preferences
- The Operation of Healthcare Systems and the Legal and Regulatory Climate
- Discrimination: Biases and Prejudice, Stereotyping, and Uncertainty
The Functional Consequences of Prejudice in Health Care

- Differential Patterns of Access
- Differential Consumer Attitudes
- Differential Provider Attitudes
Unequal Treatment: Confronting Racial and ethnic Disparities

**Differential Access**

- Differences in access due to uninsured populations
- The segregation effect of ‘low end’ versus “high end” health care plans
### Exhibit 1. Only 65 Percent of Adults Report Having an Accessible Personal Clinician

<table>
<thead>
<tr>
<th>Percent of adults ages 19–64 with an accessible primary care provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>U.S. Average</strong></td>
</tr>
<tr>
<td>2002</td>
</tr>
<tr>
<td>2005</td>
</tr>
<tr>
<td><strong>U.S. Variation 2005</strong></td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>400% + of poverty</td>
</tr>
<tr>
<td>200% –399% of poverty</td>
</tr>
<tr>
<td>&lt;200% of poverty</td>
</tr>
<tr>
<td>Insured all year</td>
</tr>
<tr>
<td>Uninsured part year</td>
</tr>
<tr>
<td>Uninsured all year</td>
</tr>
</tbody>
</table>

* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.

Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.
Community Mental Health Tradition

The De-Institutionalization of large state hospital and the emergence of federal and state funded community mental health program and facilities laid a foundation for the community mental health systems becoming a safety net for:

- Socially Disenfranchised
- Economically Distressed
- Uninsured
- Chronically Mentally Ill
**Children and Psychotropic Medication**

**Children and Antipsychotic Drugs**

A recent study indicates that antipsychotic drugs are more likely to be used to treat children covered by Medicaid than those who are privately insured. It is also more common for children with Medicaid to be treated with antipsychotics for less extreme conditions like attention deficit disorder, than for the more severe disorders for which the Food and Drug Administration has specifically approved the drugs’ use in children.

**Percentage of children aged 6 to 17 treated with an antipsychotic drug**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid Recipients</th>
<th>Privately Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>'01</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>'02</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>'03</td>
<td>3</td>
<td>5</td>
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<tr>
<td>'04</td>
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<td>6</td>
</tr>
<tr>
<td>'05</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>'06</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>'07</td>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

**Diagnoses of children aged 6 to 17 for whom antipsychotic drugs were prescribed**

- **F.D.A.-approved diagnoses (autism, schizophrenia or bipolar disorder)**
  - 2004
  - Medicaid Recipients: 26.9%
  - Privately Insured: 29.8%
  - A.D.H.D.: 18.9%
  - Other diagnoses: 44.1%

Note: Data for Medicaid recipients is from Medicaid Analytic Extracts for seven states: California, Florida, Georgia, Illinois, New York, Ohio and Texas. Data for privately insured is from an analysis by Stephen Crystal and Cecilia Huang of nationwide data from Thomson MarketScan. Data includes only those children who were in the insurance programs for the full calendar year. A.D.H.D. counts only those without a more severe diagnosis.

Source: Stephen Crystal, Rutgers University; Health Affairs Journal
Unequal Treatment:
Confronting Racial and Ethnic Disparities

Differential Consumer Attitudes

- Patient attitudes towards care takers and health care in general
- Patient experience and differences in understanding illness, reporting pain and beliefs in causes of illness.
Disparities in Health Care

• 45% of African Americans, 25% of Hispanics, and 16% of White Americans consider racism a “major problem” in health care. 64% overall view racism as a problem to various degrees.

• 30% of African Americans, 20% of Hispanics, and 19% of Asian Americans stated that prior discrimination was directly related to subsequent delays in pursuing health care in the future.

• Minority patients are more likely to refuse invasive procedures such as transplants, heart surgery, brain surgery etc/
Disparities in Health Care

Patients prefer racial/ethnic concordance in their physicians resulting in:
- Higher satisfaction rates
- Higher ratings of physician skill
- Perceptions of greater physician and patient involvement

Because patient satisfaction is related to greater involvement in preventative medicine and health care screening, patient compliance, and in some cases patient outcomes, racial/ethnic concordance is a relevant quality of care concern.
Unequal Treatment:
Confronting Racial and ethnic Disparities

Differential Attitudes of Providers

subjectivity in facing both clinical and ethnic/racial uncertainty

- Care taker biases in concepts, diagnostics, and in interpretation of information
- Intervention based on training, prior successes/failures, peer practice norms
Disparity in Health Care

Doctors rated black patients as:
- Less intelligent
- More likely to abuse prescription pain killers
- More likely to fail to comply with medical advice
- Less Educated

White physicians spent the least time with black patients, communication was most physician dominated, and pharmacies in low income areas are more likely to be poorly supplied (75%)
Disparities in Health Care

“Disparities in health care cannot be looked at outside of the context of discrimination, prejudice, and biases within a larger cultural context... Underutilization of advanced procedures and over-utilization of less desirable procedures are both a source of disparities in health care....”

Institute of Health
PROGRESSIVE DEVELOPMENT OF IDENTITY

INTERPERSONAL DYNAMIC CONTEXT OF IDENTITY

SELF-IMAGE:
BELIEFS ABOUT SELF

PROJECTED IMAGE:
BELIEFS ABOUT OTHER

INTROJECTED IMAGE:
BELIEF ABOUT WHAT OTHERS BELIEVE:
- ABOUT THEMSELVES
- ABOUT YOU
Views on Health and Health Behaviors in Native Americans

Yvonne Fortier LPC, LISAC
• There are an estimated 6.2 million people classified as American Indian (AI) and Alaska Native (AN) alone or AI/AN in combination with one or more other races
• 2 percent of the total U.S. population
• 22 percent of AI/AN live on reservations or other trust lands
• 60 percent of AI/AN live in metropolitan areas
• 31%, or 1.5 million are under age 18
• 566 federally recognized (AI/AN) tribes; more than 100 state recognized tribes. There are also tribes that are not state or federally recognized

• 2 million served by Indian Health Service (IHS) in 36 states

• 36 percent of the IHS service area population resides in non-Indian areas

• 600,000 are served in urban clinics

• Studies on the urban AI/AN population have documented a frequency of poor health and limited health care options.
There are an estimated 353,386 people classified as American Indian (AI) and Alaska Native (AN) alone or AI/AN in combination with one or more other races in Arizona, including 43,724 in Phoenix and 19,903 in Tucson.
<table>
<thead>
<tr>
<th>Place</th>
<th>Total Population</th>
<th>Rank</th>
<th>Alone or in combination Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York, NY.</td>
<td>8,175,133</td>
<td>1</td>
<td>111,749</td>
</tr>
<tr>
<td>Los Angeles, CA.</td>
<td>3,792,621</td>
<td>2</td>
<td>54,236</td>
</tr>
<tr>
<td><strong>Phoenix, AZ.</strong></td>
<td>1,445,632</td>
<td>3</td>
<td><strong>43,724</strong></td>
</tr>
<tr>
<td>Oklahoma City, OK.</td>
<td>579,999</td>
<td>4</td>
<td>36,572</td>
</tr>
<tr>
<td>Anchorage, AK.</td>
<td>291,826</td>
<td>5</td>
<td>36,062</td>
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<tr>
<td>Tulsa, OK.</td>
<td>391,906</td>
<td>6</td>
<td>35,990</td>
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<tr>
<td>Albuquerque, NM.</td>
<td>545,852</td>
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<td>32,571</td>
</tr>
<tr>
<td>Chicago, IL.</td>
<td>2,695,598</td>
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<td>26,933</td>
</tr>
<tr>
<td>Houston, TX.</td>
<td>2,099,451</td>
<td>9</td>
<td>25,521</td>
</tr>
<tr>
<td>San Antonio, TX.</td>
<td>1,327,407</td>
<td>10</td>
<td>20,137</td>
</tr>
<tr>
<td><strong>Tucson, AZ.</strong></td>
<td>520,116</td>
<td>11</td>
<td><strong>19,903</strong></td>
</tr>
<tr>
<td>Philadelphia, PA.</td>
<td>1,526,006</td>
<td>13</td>
<td>17,495</td>
</tr>
<tr>
<td>San Diego, CA.</td>
<td>1,307,402</td>
<td>12</td>
<td>17,865</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, 2010
• **Language Fluency:** Almost 28 percent of American Indians/Alaska Natives speak a language other than English at home
• **Educational Attainment:** 77 percent of AI/AN alone, age 25 and over have at least a high school diploma, as compared to 91 percent of non-Hispanic Whites. 13 percent of AI/AN age 25 and over have at least a bachelor's degree, in comparison to 31 percent of non-Hispanic Whites. 4.5 percent of AI/AN have at least an advanced graduate degree (i.e., master's, Ph.D., medical, or law)
• **Economics**: The median family income for AI/AN is $39,664, as compared to $67,892 for non-Hispanic Whites; 26 percent of AI/AN age 16 and over work in management and professional occupations, in comparison to 40 percent of Whites; 28% of AI/AN lives at the poverty level, as compared to 10.6 percent of non-Hispanic Whites
• **Insurance Coverage:** 41 percent of AI/AN had private health insurance coverage. 36.7 percent of AI/ANs relied on Medicaid coverage. 29.2 percent of AI/ANs had no health insurance coverage.
Health: leading diseases and causes of death among AI/AN are heart disease, cancer, unintentional injuries (accidents), diabetes, and stroke. AI/AN also have a high prevalence and risk factors for mental health and suicide, obesity, substance abuse, fetal alcohol spectrum disorder (FASD) sudden infant death syndrome (SIDS), teenage pregnancy, liver disease, and hepatitis.
Other Health Concerns: AI/Al have an infant death rate 60 percent higher than the rate for Caucasians. AI/ANs are twice as likely to have diabetes as Caucasians. An example is the Pima of Arizona, who have one of the highest diabetes rates in the world; AI/ANs also have disproportionately high death rates from unintentional injuries and suicide. In 2010, the tuberculosis rate for AI/NAs was 5.8, as compared to 2.0 for the White populations.

(2010 Census, HRSA, OMH)
Circular migration: Many American Indians and Alaska Natives migrate daily, weekly, or several times a year from reservations or rural areas to urban areas. This may either facilitate or impede access to needed preventive care or long-term treatment and/or contribute to spread of infectious diseases.
Violence

• Among American Indians age 25 to 34, the rate of violent crime victimizations was more than $2\frac{1}{2}$ times the rate for all persons the same age.

• For all AI/NA violent crime is more than 2x the national rate

• Rates of violent victimization for both males and females were higher for American Indians than for all races.
• Just under half the violent crimes committed against AI/NA occurred among those age 12-24

• Youth 17 and under had alcohol violation arrests 2x that of youth of all races

• Evidence of continued youth gang involvement

• Gila River has one of the largest juvenile detention in the country

U.S. Dept of Justice, Office of Justice Programs
The percentage of American Indian or Alaska Native adults who needed treatment for an alcohol or illicit drug use problem in the past year was higher than the national average for adults (18.0 vs. 9.6 percent)

NSDUH 6/2010
Alcohol and Mental Health

• Distress among AIANs is 1.5x higher than general population
• Most significant MH concerns: depression, substance use disorders, suicide, anxiety
• PTSD is experienced 2x as often as general population
• Stigma is identified as a barrier to treatment and progress for SUDs and MH care

APA, Office of Minority and National Affairs (OMNA) 2010
Discrimination and Health Outcomes

- Discrimination has been related to depressive symptoms; global measures of distress; anxiety symptoms; and poor general health.

- Everyday discrimination is much more stressful than time-limited discrimination, and, as a result, daily hassles have a greater impact on health outcomes (Unnatural Causes…).

- Among Natives, one study found that perceived discrimination was related to AOD use and depression (Whitbeck & Morris, 2001).

- Evidence suggests that oppressed statuses associated with multiple forms of discrimination may lead to more cumulative physical and mental health symptoms (Diaz & Ayala, 2001).
Trauma, Discrimination/Stigma, Loss and Separation are co-occurrences of Substance abuse.

Life domains are impacted: family roles, relationships, economic, housing, legal involvement, health and spiritual wellness.
Multigenerational/Historic Trauma

- **Cultural trauma:**
  - is an attack on the fabric of a society, affecting the essence of the community and its members

- **Historical trauma:**
  - cumulative exposure of traumatic events that affect an individual and continues to affect subsequent generations. “The collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of *genocide*.”

- **Multigenerational trauma:**
  - occurs when trauma is not resolved, subsequently internalized, and passed from one generation to the next.

Maria Yellow Horse Brave Heart
NAC Snapshot: Data reported at intake
(n=61 women)

- 81% physically assaulted
- 56% assaulted w/weapon and/or sexual assault
- 74% committed crimes
- 58% family member substance abusers
- 67% live w/relative/friend
- 36% severe depression symptoms
- 73% public assistance
- 35% 18-24 years old

ETOH 22, Meth 15, Marijuana 14, Cocaine 10
“Culture is not a vague or exotic label attached to faraway persons and places, but a personal orientation to each decision, behavior, and action in our lives”.

(Pedersen)
### Worldview Differences that Impact Healthcare

<table>
<thead>
<tr>
<th>American Indian/Alaska Native</th>
<th>Majority culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Relational, circular</td>
<td>• Linear, pt A to pt B</td>
</tr>
<tr>
<td>• Mind, body, spirit/One</td>
<td>• Psyche is the focus</td>
</tr>
<tr>
<td>• Mystical/acceptance</td>
<td>• Scientific, verification</td>
</tr>
<tr>
<td>• Ceremonials/rituals</td>
<td>• Psychotherapy</td>
</tr>
<tr>
<td>• Tribal connectedness</td>
<td>• Individualism</td>
</tr>
<tr>
<td>• Spirituality &amp; balance</td>
<td>• Organized religions</td>
</tr>
<tr>
<td>• Cooperation/sharing</td>
<td>• Competition/winning</td>
</tr>
<tr>
<td>• Patience/respectful</td>
<td>• Assertive/forceful</td>
</tr>
<tr>
<td>• Present oriented</td>
<td>• Future oriented</td>
</tr>
<tr>
<td>• Herbs, plants, nature</td>
<td>• Psychopharmacology</td>
</tr>
</tbody>
</table>

Grandbois 2005
Urban AI/AN Communities – “Urban Indians”

- Formation of a unique cultural base
- Dual citizenship
- Acculturation and integration through urbanization
- Adoption of intertribal communalism
- Distinctive identity and organic worldview
- Generational views about societal values and traditions
- Retention of ‘past to present’ features – decision-making includes elders and respected traditional leaders
**Shared beliefs:** fundamental beliefs related to health, illness, and prevention.

- All healing begins with the Great Spirit (or Supreme Creator). Illness is an opportunity to purify one’s soul.
- Humanity is made up of body, mind, and spirit, and health is maintained by preserving harmony. Illness affects the mind and spirit as well as the body. Spirituality and emotions are just as important as the body and the mind are.
- Plants and animals, as well as humans, are part of the spirit world that exists alongside, and is intermingled with, the physical world.
• Death is not an enemy but a natural phenomenon of life. The spirit existed before it came into a physical body and will exist after the body dies.

• One’s relationships with others and with the earth are essential components of health.

• Disease is felt not only by the individual but also by the family. (Diversity Resources, Inc., 2001).
Protective factors, enduring spirit

Strengths:
• Strong identification with culture
• Family
• Connection with past
• Traditional health practices (e.g. ceremony)
• Adaptability
• Wisdom of elders

Challenges to well-being:
• Enduring spirit (stubborn, hard to accept change)
• Clashes between Indian and non-Indian views of mental health
• Alcohol misuse
• Long memories
• Trauma is communal

APA, OMNA, 2010
‘Well Community’ Goals

- Equity from the start (care for the children)
- Healthy places, healthy people (housing)
- Fair and decent work
- Social and spiritual protection throughout life
- Equity in health care, disease prevention and health promotion
Supporting Concepts

• Racial metaphors and symbols perpetuate a visual shorthand for beliefs and ideas

• Accurate theoretical contributions from literature support culturally appropriate interventions

• Historical trauma in AI/AN must be addressed

• Disparities are pervasive; tied to historical & sociopolitical experiences

• Dispelling myths generates respect

• Educational systems to include and accurately portray AI/AN history and culture
‘Well Communities’ Models

• Whole person healthcare
• Infrastructures that support goals from ‘inside – out’
• Framing views of health and well-being as connectedness, reciprocity and balance
• Services grounded in social and spiritual well-being, and mechanisms for maintenance
• New programs designed from a Community, Environment and Culture perspective
“If you are dehydrated, a Western doctor would tell you that drinking water will alleviate your sickness. A traditional healer might bless you with a feather and water and tell you that you are not respecting the water. These are two very different ways of looking at health, but you get to the same place.”

Wilbur Woodis, Albuquerque area IHS
Native American Connections
4520 N. Central Avenue, Phoenix, AZ 85012
602.254.3247
nativeconnections.org
Is resilience an:

- Individual Trait
- Inner Capacity
- A Social Phenomenon
- Dynamic Process
- An Outcome
IS RESILIENCE DUE TO:

- Neurochemical Factors
- Neural Circuitry
- Genetic factors
- Psychosocial factors
- Intelligence
- Luck
THE MANY DEFINITIONS OF RESILIENCE:

Resilience refers to individual differences or life experiences that help people to cope positively with adversity make them better able to deal with stress in the future, and confer protection from the development of mental disorders under stress. (Richardson, 2002).
OR:

Resilience is best defined as an outcome of successful adaptation to adversity. Characteristics of the person and situation may identify resilient processes, but only if they lead to healthier outcomes following stressful circumstances.
Two fundamental questions need to be asked when inquiring about resilience:

- First is **recovery**, or how well people bounce back and recover fully from challenge (Masten, 2001; Rutter, 1987).

- Second, and equally important, is **sustainability**, or the capacity to continue forward in the face of adversity (Bonanno, 2004).
Resilience is powered by basic human adaptive systems shaped through processes of biological and cultural evolution (Masten, 2001). These protective systems include:

- Individual capabilities,
- Social supports and relationships, and
- Protections embedded in religions, community, or other cultural systems.
CAN IT BE LEARNED?

Researchers have found that nurturing the healthy development of these protective systems affords the most important preparation or “inoculation” for overcoming potential threats and adversities in human development.
WHAT FACTORS ARE PRESENT IN RESILIENT PEOPLE:

- Strong attachment relationships and social support;
- Intelligence or problem-solving skills;
- Self-regulation skills involved in directing or inhibiting attention, emotion, and action;
- Mastery motivation and self-efficacy;
- Meaning making (constructing meaning and a sense of coherence in life); and
- Cultural traditions, particularly as engaged through religion.
RISK AND VULNERABILITY

Most generally, risk can be defined as any factor or situation that increases the chance of developing negative health or behavioral outcomes (Grizenko & Fisher, 2002).

Vulnerability is defined by Rutter (1987) as “intensification ...of the reaction to a factor that in ordinary circumstances leads to a maladaptive outcome” (p.317).
DOES THE PRESENCE OF RISK FACTORS ALWAYS LEAD TO A BAD OUTCOME?

Research documents that one-fourth to one-half of children exposed to parental abuse and neglect show positive psychosocial functioning upon follow-up.
Adverse childhood experiences have been most consistently linked to the development of psychiatric disorders in adulthood, including major depression, suicidal behavior, anxiety disorders, substance use and abuse, and disorders involving aggression (Afifi et al., 2008; Anda et al., 2006; Kessler et al., 1997; MacMillan et al., 2001).
A series of articles emanating from the ACE study have linked childhood adversity to a wide range of behavioral and physical health-related outcomes as well, including sleep disturbances, severe obesity, alcoholism, smoking initiation and prevalence, sexual disorders, somatic symptoms, chronic obstructive pulmonary disease, chronic bronchitis and emphysema, ischemic heart disease, and use of prescription drugs (Anda et al., 2006).
DO ADVERSE EXPERIENCES WEAR OFF?

Longitudinal studies demonstrate that people typically do not return to their baseline levels of well-being after negative life events, such as a disability (Lucas, 2007), unemployment (Lucas, Clark, Georgellis, & Diener, 2004), divorce (Lucas, 2005), and widowhood (Lucas, Clark, Georgellis, & Diener, 2003). By contrast, people adapt relatively quickly and completely to positive experiences (Lyubomirsky, 2009).
A MODEL OF SUSTAINABLE HAPPINESS CHANGE

Specifically, they propose that a person’s chronic happiness level is determined by three factors:

- A genetically based happiness set point (accounting for approximately 50% of the individual differences in chronic happiness),
- Life circumstances that affect happiness (10%, and
- Activities and practices (the remaining 40%)
SUSTAINABLE HAPPINESS

Intentional activities appear to offer the best potential for lastingly increasing well-being. As described above, intentional activities and practices can account for as much as 40% of the individual differences in happiness.

Clinical population has shown that the use of several mood-boosting “exercises” helped to alleviate symptoms of depression (Seligman et al., 2005; Seligman, Rashid, & Parks, 2006), and the expression of gratitude and optimism among healthy students led to a reduction of depressive symptomatology for up to 6 months after the intervention ended (Lyubomirsky et al., 2008).