Mental Health Disorders Among an Invisible Minority: Depression and Dementia Among American Indian and Alaska Native Elders

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According to the 2010 Census, 5.2 million people identified themselves as American Indian or Alaska Native (AIAN) in the United States. This was an increase of 39% from the prior Census, making AIANs one of the nation’s fastest growing populations. The health and social programs reaching them, however, have experienced documented devastating shortfalls. Decades of inadequate resources have resulted in significant health and socioeconomic disparities. AIANs are often considered an “invisible minority.” In 2012, there were 266,000 AIAN elders 65 or older who claimed one race alone. That number is projected to almost triple by 2030—when the nation’s baby boomers move into the ranks of the older population. This article provides an overview of two primary mental health issues—depression and dementia—that will confront this emerging AIAN elder population. Although other health and social issues exist, this article addresses depression and dementia because they are hidden from the community and from health care agencies. This paper focuses both on the unique characteristics of the AIAN population and why it is important to address depression and dementia. The conclusion explores pragmatic policy recommendations for improving the health and long-term mental health care status of AIAN elders.

Key words: American Indian, Alaska Native, Indigenous, Mental health, Depression, Dementia, Alzheimer’s disease, Demography, Caregivers, Diabetes
Minority aging—the study of how ethnic populations differ in their experience of aging—reveals a common theme, that of inequity. Despite this commonality, most ethnic populations share very few common strategies to alleviate the disparities they experience. The long-ignored mental health of older AIAN adults is emerging as an epidemic that will catch social services and health care workers unaware. Demographically, the epidemic is occurring on two levels. One level is the generic aging of populations. The other is unique to Indian country—the out-migration of younger American Indian and Alaska Natives (AIANs) from Native communities. It has long been known that potential caregivers in some Indian communities have been disappearing (Garrett, Balbridge, Benson, & McGuire, 2008; Garrett & McGuire, 2008; Garrett et al., 2010). This demographic shift will intensify existing disparities within the health care delivery system for AIAN older adults. This article addresses the unique aspects of AIAN elders’ mental health—focusing on depression and dementia, because they will be the most prevalent mental health diseases—and identifies potential strategies that can be used to better serve this vulnerable population.

Health services for Indian communities are provided by a three-pronged health care delivery service structure. The Indian Health Service (IHS) is the federal arm, with the Tribes themselves providing their own health care and, in some cases, also the administration of services, whereas urban Indians have their own system of health care delivery system. Together these units make up the I (Indian Health Service), T (tribal), and U (urban), referred to as the I/T/U system.

Many shortfalls exist in the I/T/U health care system, especially regarding services to older AIANs. These shortfalls are most pronounced in mental health issues, including the identification and treatment of depression and dementia. They are compounded because AIAN older adult health has not been a priority in the I/T/U system. Depression and dementia have received very little focus across AIAN communities. Because of this lack of focus, both clinicians and the community remain unaware of the prevalence of depression and dementia within the community. As a result, depression and dementia together comprise a hidden malady among this minority population.

Demography

Vincent and Velkoff (2010) report that the number of AIAN individuals 65 years and older who solely report being AIAN and no other ethnic group is projected to grow from 235,000 in 2010, to 918,000 in 2050, increasing the proportion of older adults within the total AIAN population from 10% in 2010 to 16.8% by 2050. For those 85 years and older in 2050, the AIAN alone population is projected to reach 180,000, up from 20,000 in 2010. These projections indicate that by 2050, with just under a million older AIANs—nearly a fifth of these in their mid-80s—health services will have to have to address their growing health issues. Although AIANs comprise one of the smallest minority groups in the United States, such growth in the AIAN elderly population is new and dramatic.

Historical Overview

Delivery of federal health care services to AIAN communities has a long history (Warne & Frizzell, 2014). Unlike any other minority group, AIAN communities have a direct historical, codified relationship with the federal government of the United States, known as the Federal Trust Responsibility. Beginning in 1955, the IHS—an operating division within the U.S. Department of Health and Human Services—assumed responsibility for providing medical and public health services to members of federally recognized tribes and Alaska Natives. However, this responsibility has changed over the years. The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) and later the Indian Health Care Improvement Act of 1992 (P.L. 102-573) authorized the IHS to turn over full administrative responsibility, through contracts and compacts, to tribes upon request. The Indian Health Care Improvement Act of 1976 (P.L. 94-437), 1992 (P.L. 102-573), and recently the Patient Protection and Affordable Care Act/Indian Health Care Improvement Act of 2010 (P.L. 111-148) established urban Indian health programs and removed prohibition of Medicaid and Medicare reimbursements to IHS and tribally operated facilities.

Tribes and tribal organizations now operate almost half of the Indian health care system. The recent passage of the Patient Protection and Affordable Care Act, which authorizes the expansion of Federally Qualified Health Centers (FQHC), will further separate funding of Indian health clinics from the IHS. Whereas tribal programs and many of the nation’s urban Indian health centers are eligible for these grants; the IHS, as a federal agency, is not.

Because FQHC funding will be based on health outcomes at individual community health clinics, rather than on an annual federal budget allocation, the Federal Trust Responsibility may be weakened. This evolving new relationship between individual AIAN community health clinics and the federal government entails running clinics as a business rather than as a community service (Administration for Native Americans, 2014).

During the 1950s and 1960s, the IHS dramatically increased AIAN life expectancy by improving public...
health—in particular by reducing infant and child mortality (Watson, 2006). IHS is one of the few federal agencies that provide sanitation and sewage, community education, environmental health, facility construction, and clinical care—in addition to primary health care. Federal sanitation interventions, for example, account for almost 40% of the improvement in infant mortality rates on reservations since 1970 (Watson, 2006). Although this initiative helped address the most critical needs of a young population, it did so in part by emphasizing the notion of “years of potential life lost” (YPLL)—which enumerates mortality up to the age of 65. Through the use of YPLL, the IHS effectively eliminated older adult health from metrics used to measure success in health outcomes.

Today, in large part due to the agency’s ongoing financial shortfalls, older adults’ ill health is still not a significant metric used by IHS to measure health outcomes. YPLL doubtless contributed to the establishment of IHS priorities as “prenatal care, well-child care and developmental screening, hypertension screening and treatment, and education about diet, weight control, exercise, smoking, alcohol abuse, and vehicular and environmental safety.” (Rhoades, Hammond, Welty, Handler, & Amler, 1987, p. 368). It does not include either older adult, or mental health among IHS priorities. The residual effects of this YPLL metric are still present today (Pickering, 2013).

Older adults’ health—in particular mental health, and specifically depression and dementia—are still not priorities, despite an acknowledgement that chronic diseases are at an “epidemic” level (Sequist, Cullen, & Acton, 2011, p. 1968). This epidemic remains undefined, unaddressed and for the most part, untreated. A recent review of the literature by Espey and colleagues (2014) found that when examined by age, AIAN disparities in all-cause mortality were most evident in younger age groups—especially ages 25–44 years. In part because of YPLL, the IHS does not thoroughly record aspects of older adult ill health such as depression and dementia-related illness. Epidemiologic studies of chronic disease among AIANs have focused on diabetes, obesity, alcoholism, cancer, vascular disease, and gallbladder disease (McCabe, 1999; Polednak, 1989; Young, 1994). Funding is channeled to these chronic diseases, and as a result there is little funding for depression and there is no funding for dementia.

Roman, Jervis, and Manson (2012), in a review of the strengths and challenges in maintaining mental health among AIANs, acknowledge this lack of focus on mental health among older adults. The authors argue that these shortcomings can, however, be addressed by engaging community networks in the research process and incorporating cultural elements into mental health care. The problem with this approach is that dementia and depression are often not diagnosed or treated in Indian country. Because AIANs receive medical services from small clinics—even in cities—concerns of confidentiality may preclude individuals from disclosing mental health issues to health care workers who might know them personally. As a result, these diseases remain “private” (Yellowlees, Marks, Hilty, & Shore, 2008). If these diseases are hidden, then a community has a role in identifying and addressing them. These dynamics are promoted—albeit unintentionally—by a health care system that has essentially deprioritized older adult health. Among AIAN communities, mental health issues remain, for the most part, invisible. It comes as no surprise, therefore, that among older AIANs needing assistance, just under half (47.8%) reported an unmet need with one or more disability indicator—activities of daily living or instrumental activities of daily living (Schure, Conte, & Goins, 2014).

### Mental Health and AIAN Older Adults

Consistent with this lack of institutional focus, racial and ethnic minorities bear a greater burden from unmet mental health needs that contribute to disability (Manson, 1996; Murray & Lopez, 1996). Over 30% of older AIANs visiting one urban IHS outpatient medical facility reported significant depressive symptoms (Kramer, 1991). This rate is at the higher end of most published estimates of the prevalence of depression among older Whites with chronic illnesses—9–31% (Manson, 1992). Surprisingly, given this high prevalence rate, no national prevalence study has been conducted. One manifestation of untreated mental illness in AIANs—especially with depression and in particularly in rural areas—is the prevalence rate of suicide. Suicide among AIANs is 1.5 times the national rate (Herne, Bartholomew, & Weahkee, 2014). Rural areas—similar to reservations and most AIAN communities—have a shortage of mental health services providers and often provide inadequate treatment. Up to 70% of rural patients may have inadequate medication dosage for depression (Unutzer et al., 2002). Rural depressed patients have three times more hospitalizations and higher suicide rates than suburban patients (Rost, Fortney, Zhang, Smith, & Smith, 1999; Rost, Zhang, Fortney, Smith, & Smith, 1998).

Among AIANs, the consideration of depression as a serious disorder is complicated by its association with diabetes. Diabetes prevalence is endemic among ethnic minorities—it is higher among blacks (10.8%), followed by Mexican Americans (10.6%), and AIANs (9.0%), compared with 6.2% for whites (Mokdad et al., 2000). Because diabetes among AIANs has grabbed the attention of policy makers, diabetes might provide both a funding and a clinical base from which to transition to focusing on depression and
dementia. There is some evidence that among AIANs, diabetes is related to both depression and dementia. Such an association may provide a policy bridge to addressing these mental health issues by utilizing existing diabetes management tools to expand them to depression and dementia.

**Depression**

No national prevalence data on depression exists for AIANs. The World Health Organization reports that depression affects 350 million people worldwide and is predicted to be the second leading cause of disease burden by the year 2020 (World Health Organization, 2012). Depression is a major health care issue. Left untreated or undertreated, it diminishes quality of life, increases mortality, and leads to numerous complications (Akincigil et al., 2012). Although depressed people are more likely to die early when compared with nondepressed people, we are still unsure what are confounding variables (Wulsin, Vaillant, & Wells, 1999).

In a systematic review and meta-analysis, Luppa and colleagues (2012) reported that the prevalence of major depression ranged from 5 to 9%, and that of depressive disorders from 5 to 37%. They conclude that depression is common among older adults (Luppa et al., 2012). Although depression among older adults has long been studied (Feinson, 1987), we are unsure about the relationship between depression and age. Gurland, Cross, and Katz (1996) reported that the prevalence of major depression does, however, increase depending on the type of residence of older adults—from a prevalence of between 1 and 3% in community settings, to 6–9% in primary care settings, and 12–30% in an institutional settings such as nursing homes or assisted living facilities. Nevertheless, assigning a causal pathway is difficult. However, there is great variance among older adults.

Some large-scale epidemiologic studies have reported a reduced prevalence of depression in old age (Bland, Newman, & Orn, 1988; Weissman et al., 1988). While other studies report an increase in the prevalence of depression with age (Rashid & Rahmah, 2010). One reason for this inconsistency in the literature is that clinicians might not be measuring depression correctly among older adults. Although researchers normally associate depression with sadness, studies are now showing that older adults are generally less likely than young adults to report sadness—dysphoria—when they are depressed (Covinsky, Cenzer, Yaffe, O’Brien, & Blazer, 2014; Gallo, Rabins, & Anthony, 1999). Because of historical trauma response, AIANs may have “...difficulty recognizing and expressing emotions” (Brave Heart, 2003, p. 7). As a result, among AIAN older adults, depression remains essentially undetected.

Only three studies have researched the mental health status of older AIANs (Duran et al., 2004; Parker et al., 1997; Wilson, Civic, & Glass, 1995). Duran and colleagues (2004) focused exclusively on women, whereas Parker and colleagues (1997) focused on testing a diagnostic tool (PRIME-MD). Wilson and colleagues (1995) specifically examined depression and reported that 9% met the criteria for a major depressive syndrome. More importantly, the authors concluded by arguing that, “Also, as in other studies, depression appears to be either underreported or under-recognized by physicians at this IHS clinic.” (Wilson et al., 1995, p. 8).

Rates of depression are higher in men and women with diabetes when compared with those without diabetes (Calhoun et al., 2010). Among patients with diabetes, Li, Ford, Strine, and Mokdad (2008) reported that overall 8.2% of patients with diabetes in the United States also had depression but for AIAN the rate was the highest. AIANs with diabetes suffer higher rates of depression than any other ethnic group (Li et al., 2008).

Because diabetes is related to depression, incidence rates of depression will dramatically increase in the near future as a function of the increased prevalence rates of diabetes. Among those AIANs aged 75 or older, the prevalence of diabetes will increase five times (Trief, 2007). Despite this association, primary care providers infrequently assess depression in older adults. Trief (2007) found that depression assessments occurred in 14% of visits. Yet, treating depression—in addition to lessening depression—has broader positive outcomes.

Williams and colleagues (2004) reported that treating depression resulted in improvements not only in depressive symptoms, but also in the overall functioning and exercise compliance (Katon et al., 2005; Unutzer et al., 2002). Treating depression resulted in better diabetic control. These gains continued even after the intervention was discontinued (Hunkeler et al., 2006). Despite the efficacy of depression intervention, most AIANs do not seek treatment for depression. The IHS now mandates depression screening for all diabetes patients using PHQ-9 as an initial diagnosis tool. Through the treatment of diabetes, depression may move closer to the forefront of clinical care among older AIANs. But it has to be more than a matter of administering a diagnostic tool.

Diagnosing depression in the AIAN older adult population is further complicated because patients are likely to have multiple chronic conditions that cause, hide, or exacerbate depression. Even with these complications, using crude prevalence (rate of 8.9%; Wilson et al., 1995) and applying them to census data (Vincent & Velkoff, 2010), the projected number of depressed AIAN 65 years and older will quadruple to 81,702 by 2050, from 20,950 in 2010.
Dementia

If diabetes is a pathway to understanding depression among older AIANs, diabetes intervention could segue into dementia diagnosis and treatment. Mayeda and colleagues (2014) reported that among diabetes patients who were followed for 10 years—after adjusting for confounders—African Americans and Native Americans had a 40–60% greater risk of dementia compared with Asians, and to a lesser degree with whites and Latinos. Since diabetes among AIANs aged 75 and older is projected to increase fivefold (Trief, 2007), we would expect the incidence of dementia to reflect this growth. However, no national dementia prevalence data exists for AIANs.

Among indigenous populations, prevalence rates are usually higher than the general population—in some cases dramatically so. Smith and colleagues (2008) reported the prevalence of dementia by DSM-IV criteria to be 27% among Australian Aborigines aged 65 years and older. This estimate is five times higher than the overall Australian population after age standardization. Closer to the United States, Stryjer and colleagues (2011) conducted a prevalence study among an indigenous Mexican community with a total of 2,226 inhabitants. They reported that 9% were diagnosed with dementia according to DSM-IV criteria—although this rate dropped to 6% using the Brookdale test criteria. The authors argue that the higher prevalence supports the assumption that low education as well as age may contribute to a higher prevalence of dementia. Despite the small sample size it provides a crude gauge to the level of need within the community.

The lack of dementia statistics is not exclusive to AIAN populations. Minority issues in dementia research have only recently come to the forefront (Evans, 1992; Evans et al., 1989). Advocates have expressed concerns that dementia research—which is primarily conducted with white males—precludes generalization to AIANs. Although there is no clinical study of dementia among AIANs—and very few studies among Hispanics and Asians—when they are included, the results show different outcomes (Tang et al., 1998). In some cases, association between dementia and its precursors—such as mild cognitive impairment—are not as reliable among minority groups (Low et al., 2012). As with the case of apolipoprotein E—the gene that has closely been associated with predicting dementia—this correlation diminishes or disappears completely for ethnic groups (Tang et al., 1998). Minority populations comprise an important piece of the dementia puzzle, especially since dementia takes a heavier toll and at earlier ages on minority populations (Clark et al., 2005; Haan et al., 2003; Valle, Garrett, & Velasquez, 2013).

No epidemiological prevalence study has been conducted, and initial small sample studies have been inconsistent. Some studies indicate that dementia seems to be less prevalent among some AIAN groups (Hall et al., 1993; Henderson et al., 2002; Hendrie et al., 1993; Rosenberg et al., 1996). These studies were not established as epidemiological prevalence studies but rather as exploratory reports. In a review of the literature, Jervis and Manson (2002) and Jervis, Cullum, and Manson (2006) report extensive methodological and cultural disconnects in assessing dementia among the AIAN population. Henderson and Henderson (2002) specifically report how cultural and spiritual interpretation of dementia differs from established clinical definitions, using the concept of “supernormal” to explain one such discrepancy in interpreting dementing behaviors. Jervis, Beals, Fickenscher, and Arciniegas (2007) further caution against generalizations—identifying not only cultural issues but gender differences as well.

Despite this lack of accurate prevalence data, applicable algorithms have been developed for estimating dementia prevalence among minority populations (Valle et al., 2013). Eleven percent of those 65 years and older and 32% of those 85 years and older have dementia (Hebert, Weuve, Scherr, & Evans, 2013). Applying these estimates to census data (Vincent & Velkoff, 2010), we expect to find 23,850 AIANs 65 years and older with dementia in 2010, increasing to 100,980 by 2050.

Costs of Depression and Dementia

It is difficult to gauge the economic cost of depression and dementia among the community-dwelling individuals. Most patients have multiple comorbidities and each individual is unique in terms of their access and utilization of services. Technical challenges exits in separating the cost of one disease from another. Especially among older adults, who suffer from multiple comorbidities. There are also costs that are borne by caregivers, spouses, children, colleagues, and friends that remain undocumented. It is difficult to control for all of these factors especially as they apply to AIANs. But in order to support policy it is important to understand that depression and dementia—in addition to the personal, social, and familial devastation (Kessler, 2012)—has economic costs that society has to pay.

Greenberg and colleagues (1993) were the first to undertake an estimate of the economic burden of depression. The researchers later updated their estimates and found them to be relatively stable across time (Greenberg et al., 2003). They estimate that using a human capital approach, they developed cost estimates of three major cost categories: (a) direct costs which accounted for 31% of total costs, (b) mortality costs arising from depression-related suicides accounting for 7% of costs, and (c) costs associated with depression in the workplace, comprising 63% of the costs. Greenberg and colleagues (2003, p. 1471, Table 5) disaggregates the costs per capita with a total of $8,118 for each
individual, multiplying this figure by the 81,702 AIAN with depression for 2050, this cost translates to a total burden in 2050 of $663 million.

Dementia has higher costs associated with it. Wimo, Jonsson, Bond, Prince, and Winblad (2013) reports the worldwide economic impact of dementia as $604 billion. In the United States, the Alzheimer’s Association (2012) commissioned a report on national costs. Using the per capita figures for community-dwelling individuals with dementia the cost works out at $25,389 (for those living alone) and $25,943 (for those living with someone). Taking the average of $25,666 (for 100,980 AIAN with dementia by 2050 translates to a total cost of $2.6 billion by 2050 (Alzheimer’s Association, 2012, p. 159, Table 12). Such figures independently and together are staggering for small native communities to absorb and reiterate the need for conscious, preemptive policy change.

Consequences

In a systematic review, Mukadam, Cooper, and Livingston (2011) found significant barriers to seeking help for dementia in minority groups—often resulting in access to services at a late stage in their illness with increased stress on both patients and their caregivers. The authors identified several barriers among minority populations that might directly apply to AIANs: Not conceptualizing dementia as an illness; believing dementia was a normal consequence of aging; thinking dementia had spiritual, psychological, physical, or social causes; feeling that caring for the person with dementia was a personal or family responsibility; experiencing shame and stigma within the community; believing there was nothing that could be done to help; and having negative experiences with health care services. Among AIANs, the priority should be recognizing that dementia is an illness, understanding its prevalence, and having knowledge about dementia. These should facilitate accessing help earlier.

Without an awareness of the problem, there is no perceived need to provide specialized services, even though such care has been shown to be efficacious. A study evaluating participant and caregiver outcomes to such specialized care—Memory Care and Wellness Services within Specialized Dementia Care in Adult Day Services—resulted in significantly fewer depressive behaviors, while caregivers exhibited significantly less distress over behavior problems than comparison caregivers (Logsdon, Pike, Korte, & Goehring, 2014). Despite the effectiveness of these and other social therapies in mitigating some of the negative behaviors in dementia and depression, and therefore alleviating caregiver stress, few programs currently exist.

In a recent study that looked at AIANs in nursing homes (Garrett, Baldridge, & Williams, 2012) using the minimum data set, the authors reported that AIANs are entering nursing homes at earlier stages of need and are more likely to be more independent when compared with white patients. In addition, AIANs were more likely to have lived alone or in another nursing home or residential facility prior to their present nursing home. Such early admission to nursing homes indicates that the continuum of care for AIAN older adults is deficient. Mental health—fueled by depression and dementia—will increase the likelihood that more AIANs fall through the health care cracks and become admitted earlier to nursing homes or hospitals.

Because a well-developed continuum of care for older adults does not exist in Indian country, depression and dementia may remain unnoticed and therefore untreated. With fewer potential caregivers, and without clinical and social support services that reach out to older adults in AIAN communities, depression and dementia can result in early and preventable fatalities and at the very least, needlessly diminished quality of life. It is imperative to understand the prevalence of these illnesses through clinical studies.

Clearly, addressing depression and dementia among older AIANs has implications beyond mental health. But mental health among AIANs is indicative of an uneven health care delivery system that can create inequities across geography, ethnicities, and generations. Kane and Houston-Vega (2004) identify that among ethnic minorities—including AIANs—the primary issue is caregiving barriers, something that has been investigated in much detail by John (John, 2000; John, Hennessy, Dyeson, & Garrett, 2001; John, 2004). This is a much broader issue than supporting caregivers, since potential caregivers are migrating out of their Native communities. Given this demographic reality in Indian country, community empowerment alone may not provide a solution. Solutions may come in part through the use of new technologies, such as telehealth. In one study using videoconferencing, once cultural issues are addressed, diagnosis and treatment of adults with cognitive disorders was well accepted by Choctaw patients and families (Weiner, Rossetti, & Harrah, 2011). There are already models, tested in Indian country that should be taken off the research shelves and put in practice (Hilty et al., 2013).

Conclusion

Knowing the prevalence and incidence of depression and dementia among older AIANs is imperative to developing a strategy for dealing with this coming epidemic. The crude estimates developed here—AIANs with depression reaching 81,702 in 2050 and AIANs with dementia reaching 100,980 by 2050—are a wakeup call. A national review of prevalence and incidence rate of depression and dementia
in Indian country is needed. Without such basic information, health care services will not be able to address the level and quality of services required. Basic prevalence and incidence data will form the basis for a strategy dealing with and treating depression and dementia, given the demographic realities at the community level. Toward this aim, the use of Years of Productive Life Lost (YPLL) as a metric within the IHS and tribal communities has outlived its usefulness and is an inaccurate tool for quantifying older adults’ ill health. Different metrics should be instituted that are inclusive of older adults’ health.

A broader issue is how depression and dementia are assessed, documented, and managed at the point of contact with health care providers. It is possible that depression and dementia are not easily recorded on the intake form and there might be barriers to provider reimbursements. Community and health care providers need to understand the importance of early diagnosis and intervention. Community-based education programs will help ensure that early stages of depression and dementia can be identified. Health care and community workers need to be provided training in order to learn how to identify depression and dementia in the community and to have treatment options available. Such a comprehensive approach does not entail substantially more funding, but it requires the political will to bring about change. Community engagement is the key to making these changes happen. Information is a starting point.

**Recommendations**

1. The federal government should conduct or sponsor studies of the prevalence and incidence rate of depression and dementia among the AIAN population including those who reside within tribal lands and those who do not (the preponderance of AIAN). Ideally, support would come from the National Institutes of Health in collaboration with the IHS.
2. The federal government should support or otherwise undertake a comprehensive review of the state of elder health specifically including mental among the nation’s AIAN population.
3. IHS should eliminate Years of Productive Life Lost (YPLL) as a metric or create metrics to measure progress in health outcomes among the nation’s elderly AIAN population.
4. The IHS, the Administration for Community Living/Administration on Aging, and other agencies dedicated to serving the older AIAN population’s must ensure an adequate commitment to the health needs—including those related to depression, dementia, and other forms of mental health – of AIAN elders.
5. Policy makers should amend Title VI of the Older Americans Act to ensure Title VI providers have capacity to provide accurate and relevant education to elders about depression, dementia, and other mental health needs and that they are knowledgeable about tribal and nontribal resources available to respond to such needs including diagnosing and providing appropriate treatment or care for such conditions.
6. Policy makers should amend the AIAN part of the OAA’s National Family Caregiver Support Program to ensure that AIAN caregivers have training, educational, and other forms of support for dealing more effectively with depression, dementia, and other mental health needs of family members and others for whom they provide caregiving services.
7. Federal policy should catch up with the extraordinary demographic shift of AIANs from reservations and tribal lands to urban areas. Federal agencies not dedicated to serving tribal communities must recognize that their constituents include growing numbers of urban-dwelling AIANs, many of whom are severely disadvantaged or otherwise invisible to the health and service systems in U.S. cities. Agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the Administration for Community Living must ensure their programs respond to the mental health needs of nonreservation-dwelling AIANs.
8. The existing Indian health care delivery system (I/T/U), should develop and improve the capacity of clinical and social service staff to recognize, identify, and treat depression, dementia, and other mental health issues among elderly AIANs.
9. Providers working outside the I/T/U system should develop and improve the capacity of clinical and social services staff who serve AIAN elders to recognize, identify, and treat depression, dementia, and other mental health issues.

**References**


