CRB
SHORT SUBJECTS
HEALTHY AGING SERIES
July 2014 *S-14-017*

Psychosocial and Economic Health of Older American Indians and Alaska Natives in California

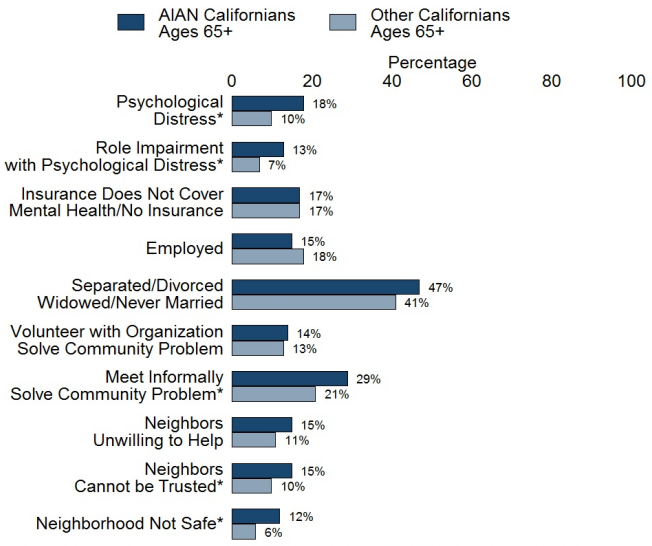
American Indian and Alaska Native (AIAN) life expectancy in California is difficult to estimate. Vital statistics about deaths often misclassify AIANs or misstate their age, causing AIAN deaths to be underreported.[1] Further, information on life expectancy for AIANs is collected by Indian Health Services (IHS), a federal program that serves only those AIANs who are enrolled in federally recognized tribes and live on or near a reservation.[2] Unlike IHS, California considers persons of both federally recognized tribes and non-federally recognized indigenous groups as members of California Native American tribes. This Short Subject employs California Health Interview Survey (CHIS)[3] indicators of mental health, social environment, and economic security to better understand California's older AIANs.

Mental Health and Social Environment

California has the largest number of older AIANs, followed by Oklahoma, Arizona, and Texas.[2] CHIS respondents are prompted to choose from nine tribal groups to identify themselves: Apache, Blackfeet, Cherokee, Choctaw, Navajo, Pomo, Pueblo, Sioux, and Yaqui, or identify as a member of a group not listed.[3]

Figure 1 reveals that older AIANs were 80 percent more likely to report having mild to severe psychological distress in the past 12 months than other older Californians (18 and 10 percent, respectively).[3] They were also 86 percent more likely than other older Californians to experience some kind of role impairment (i.e., social, family, work, and/or chore) with at least moderate psychological distress. Of those older AIANs who sought help or thought they should seek help, 17 percent said they did not have health insurance plans covering mental health care or did not have insurance. Access to health care services for older AIANs is complicated due to lack of transportation, nearby facilities, and available caregivers.[2]

Figure 1. Mental Health and Community Involvement [3]



Note: The indicator 'Insurance Does Not Cover Mental Health/No Insurance' only refers to those people who report needing help for mental health problems or who have sought help for mental health problems(10 percent of the sample).

Being connected to a community through such things as employment, volunteering, or problem solving can facilitate and reinforce mental health, while being less connected can contribute to and exacerbate poor mental health. Older AIANs were approximately 38 percent more likely than were other older Californians to seek to solve community problems by informally meeting with others. Older AIANs also reported volunteering with a formal organization to address community problems (14 percent), being employed (15 percent), and being separated/divorced/widowed/never married (47 percent).

Where older adults live and their perceptions of their neighbors and neighborhood might also be related to mental health. Older AIANs were 50 percent more likely to report not trusting their neighbors and 100 percent more likely to not feel safe at least some of the time in their neighborhoods. Fifteen percent of older AIANs reported that they view their neighbors as unwilling to help each other.

Economic Security

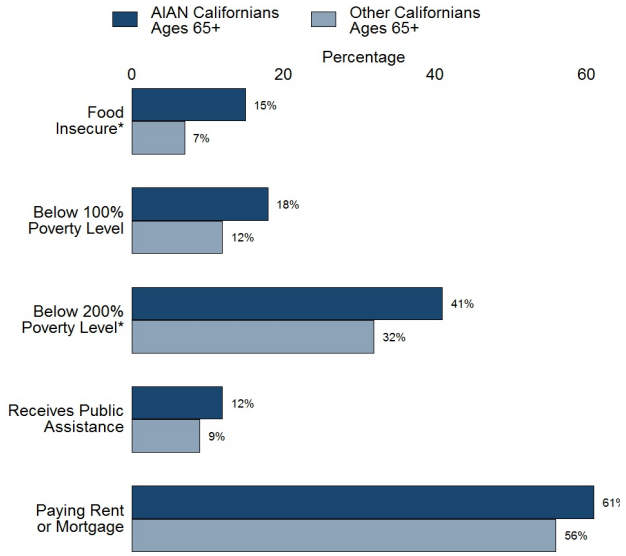
Figure 2 offers a comparison across economic indicators. Overall, older AIANs appear to have experienced less economic security than did other older Californians. They were 2.1 times as likely as other older Californians to experience some combination of not being able to afford food, skipping meals, going hungry, and not eating balanced meals and were also more likely than other older Californians to be below 200 percent of the poverty level (28 percent more likely). Some also reported being below 100 percent of the poverty level (18 percent), receiving public assistance (12 percent), and paying rent or mortgage (61 percent). Unlike older urban AIANs, older rural AIANs are more likely to live with someone else and experience poverty. Older AIANs may also face nutritional challenges as a result of commodities programs that offer less healthy non-traditional foods (flour, sugar, lard, peanut butter, and cheese) than traditional, culturally-appropriate foods (beans, corn, melons, squashes, vegetables, venison).[2]

Brief Discussion

Better understanding of the historical relationship of AIANs with the federal government is central to any discussion of older Californian AIANs. Experiences associated with colonization (disenfranchisement, extermination, unratified treaties, forced marches, missionization, allotment, and boarding schools), tribal sovereignty, and the unique trust relationship between AIANs and the federal government are additional layers of complexity that may affect this group.

Not all older Californian AIANs are automatically tribal "elders"—to be recognized as an "elder" means a person may hold a tribal leadership position (age is not a requirement of such a role). The diverse set of beliefs, ideas, attitudes, and behaviors within this group may impact how understandings of mental health and social environment are interpreted by researchers. Different definitions of health, healing, and community may also affect the direct relationship between older AIANs and health care providers. Sensitivity to cross-cultural expectations, levels of acculturation, gender roles, modesty and propriety, and an awareness of modes of interaction and respect (verbal and nonverbal communication styles like listening, pacing of conversation, indirect eye contact, control of emotions, physical distance) are important aspects of culturally-competent care for this group.[2]

Figure 2. Economic Security [3]



Endnotes

1. Elizabeth Arias, et al. (2014). "Period Life Tables for the Non-Hispanic American Indian and Alaska Native Population, 2007-2009." American Journal of Public Health, Vol. 104, No. S3.
2. Levanne Hendrix. (2010). Health and Health Care of American Indian Older Adults. Stanford School of Medicine.
3. California Health Interview Survey. CHIS 2011 Adult Public Use File, (Los Angeles, CA: UCLA Center for Health Policy Research, November 2013). Retrieved from http://healthpolicy.ucla.edu/chis/data/Pages/public-use-data.aspx. Comparative statements in this report in reference to CHIS data have undergone statistical testing. Comparisons are significant at the .10 level unless otherwise noted. Significant differences in figures are noted with an *. The 2011 CHS survey oversampled AIANS to increase their representation. Those included in analyses self-report California, non-California, and unknown tribal heritage (n=375). While the improved sample size means more robust analyses, one category (e.g. Insurance Does Not Cover Mental Health/No Insurance) has only 39 AIANS for the analysis. Smaller sample sizes are generally more prone to estimation error than larger sample sizes.

This Short Subject was requested by Assembly Member Mariko Yamada, Chair of the Committee on Aging and Long-Term Care.

The California Research Bureau is a division of the California State Library, providing in-depth research and nonpartisan public policy analysis to members of the State Legislature and the Governor. www.library.ca.gov/CRB/.

The authors of this short subject, Kellie Jean Hogue, Ph.D. and Tonya D. Lindsey, Ph.D., may be reached at kelliejean.hogue@library. ca.gov and tonya. lindsey@library.ca.gov, respectively.