ADA Live! Episode 94: A Look at the Mental Health Needs of Indigenous People in America

Broadcast Date: June 2, 2021

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Host: Olivia Gawehnidi Porter, an enrolled member of the Seneca Nation, student, and advocate for better mental health care in Indigenous nations

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Olivia Gawehnidi Porter: Hi, I'm Olivia Gawehnidi Porter, and you're listening to ADA Live .

4 Wheel City: (rapping) Yo. All right, let's roll. Let's go.

Beth Harrison: Hello, everyone. On behalf of the Southeast ADA Center, the Burton Blatt Institute at Syracuse University, and the ADA National Network, welcome to ADA live. I'm Beth Harrison, Director of Knowledge Translation at the Southeast ADA Center.

Listening audience, if you have questions about the Americans with Disabilities Act, you can use the online form any time at adalive.org.

In today's episode, our focus is on indigenous communities and disability. The term indigenous refers to those groups who lived in the United States prior to colonization by European settlers, and currently make up about 1.5% of the US population.

This population is a very complex society that lived and thrived here for centuries before Europeans. Unfortunately, indigenous peoples tend to have higher rates of mental health and substance abuse, and a suicide rate much higher, perhaps 70% higher, than the general population. And they may face particular barriers to receiving support for their disability due to rural location, lack of healthcare, and lack of culturally competent care providers.

In this episode of ADA Live, we welcome Dr. Hilary Weaver, Associate Dean for Diversity, Equity, and Inclusion, professor, University at Buffalo. Dr. Weaver is Lakota Sioux by birth. And Olivia Gawehnidi Porter, an enrolled member of the Seneca Nation, student, and advocate for better mental health care in indigenous nations.

They will discuss Dr. Weaver's work understanding indigenous teachings, how she is de-stigmatizing the Western idea of disabilities using traditional teachings of compassion and acceptance, and the importance of accepting people who are different. Olivia, I'll turn it over to you.

Olivia Gawehnidi Porter: Thank you. So, Dr. Weaver, what have some of your strategies been to implement practical policies that address diverse populations, such as refugees, and indigenous peoples?

Dr. Hilary Weaver: Well, I'm at University at Buffalo, so I'm in academia. It's not so much that I'm implementing policies, but in academia, I think I have an ideal platform to really get the word out. So I do a lot of presentations, a lot of writing, some teaching. This gives me an opportunity to really help people understand indigenous peoples, and understand refugees, and all sorts of diverse populations.

So I would say my primary strategy is getting information out there. Because I think often in this country, people don't know a lot about indigenous peoples, and don't know a lot about refugees. Both populations tend to be fairly invisible, or people have their own ideas and stereotypes about these populations that aren't necessarily true or grounded on anything. So I am able to educate, to get the word out, to help people understand these populations a bit better.

Olivia Gawehnidi Porter: Yeah, I think that is very important. As a social worker who deals with indigenous issues, have you found the resources in your field to be accessible? Or have they been scarce due to the little research and work that has been done on the subject of indigeneity in disabilities?

Dr. Hilary Weaver: There is very little information that has been published in scholarly journals, or presented at conferences, on indigenous peoples and disabilities. Very, very little information. I think that there probably are a number of tribal programs doing some very good, very creative work around issues related to disabilities. But this information isn't necessarily getting out there. It's more at the grassroots level, so it's not rising up to academics, to scholarly publications.

So I think there's some information, but it's just not getting out there. So you're right. What we know is very scarce, and that is a challenge for academia. If things aren't published, if things aren't presented, then that information is not being transferred to the next generation of social workers or other helping professionals. So there's really a gap in being able to educate people about what disabilities look like in indigenous contexts.

Olivia Gawehnidi Porter: That definitely seems to be a pattern in academia, and with indigenous people. You do a lot of work with indigenous peoples and refugees, and have said there are commonalities between the two groups based on their histories of displacement. What are other commonalities you have seen between the two groups, and how have your social work strategies differed between them?

Dr. Hilary Weaver: I would say other commonalities would be trauma and resilience. Going back to the displacement that you mentioned, that I think is the foundational commonality, where refugees by definition are people who have been displaced from their homelands. They have had to flee for safety.

Indigenous peoples, in most cases, are also displaced. There are a few that still are on their tribal territories, although their territories have shrunk quite a bit. Many more have been displaced, often relocated to different parts of the country. So, sometimes fleeing safety as well, like the people who are now at Six Nations in Ontario were people that

originated from what we now know as New York State, but they fled because it wasn't safe for them here after the American Revolution. So that displacement is a commonality.

Trauma is a commonality. I think the violence that both indigenous peoples and refugees have been exposed to is astounding. The violence that came with the displacement, the stereotypes, the racism. And I do want to be clear that trauma is not a thing of the past for either population, but particularly for indigenous peoples. There is still significant racism, there is still significant police brutality. These are modern-day phenomena that we all need to be aware of.

But the third commonality that I mentioned, resilience, is something that we must not lose sight of. After all of these challenges, we still exist as distinct peoples, and refugees have survived. They are still there as well. So, the resilience, the continuity I think is very important for all service providers to recognize.

Most of my work is around cultural issues in the helping process. And that's where we get to the distinction that you asked for, what's different with refugees and indigenous peoples? I think we need to be attentive to the culture of the people that we're working with. There is tremendous diversity, even among indigenous peoples. So you can't assume that an Inuit person from Alaska is going to have a similar culture to a Choctaw person from Mississippi. You need to understand the culture of the people that you're working with.

And for refugees, somebody who is Karen, who has come from Myanmar, is going to be very different than someone who comes from South Sudan. So there are distinctions that you must be aware of when you're working with people from different populations.

Another distinction that I would mention is legal status and policies. So as indigenous peoples, we are the original peoples of this land. We are not simply an ethnic minority group in the United States. And so there are specific laws and policies that only apply to indigenous peoples.

Likewise, there are specific policies that apply only to refugees. Refugees are a very small subset of the immigrant population. And there are specific laws that govern who is a

refugee, who qualifies for refugee status. And this has its root in the Geneva Convention of 1951 that came out after World War II to identify atrocities that happened to people. So, the policy and the legal context for refugees and for indigenous peoples is quite different, even though we share similarities of displacement, trauma, and resilience.

Olivia Gawehnidi Porter: That's very interesting. American Indians and Alaskan natives make up only 1.5% of the American population, but report experiencing mental health issues 2.5 times more than the overall population.

Despite these statistics, mental health and disability-related issues, in my experience, have always been very stigmatized in these communities. How has your incorporation of the medicine wheel and other indigenous traditions work towards the de-stigmatization of these issues?

Dr. Hilary Weaver: Boy, there are a lot of layers to that question. I'm going to try and address several different things. You share some statistics. And I think we need to recognize that we don't actually have good statistics on indigenous peoples, or the mental health of indigenous peoples.

How the data is collected, even census data on how many indigenous people there are, is questionable, because a number of indigenous nations like the Haudenosaunee often have traditional teachings that discourage people from answering the census. So we don't necessarily have good numbers. I would suspect that our census numbers are an undercount.

I don't think that we have good numbers about any social or health statistics on indigenous peoples. When researchers do their research, they often don't ask people about their indigenous or tribal status. They may look at us and assume what box we fit in, and decide, "Oh, this person, probably Hispanic." And so, we are miscounted, or we are listed as other.

So, I just needed to lay that foundation. I think the numbers are problematic, but the general principle that you stated rings true. I do believe that there are significant

disparities, and that we are disproportionately affected by mental health issues, as well as just about every other social and health disparity out there.

You mentioned stigma around mental health. I want to take it back a notch and say that I think part of the problem is stigma, and racism, and devaluing diverse people, including indigenous peoples. I think it is because there is such a climate of racism and colonization that leads to trauma that leads to mental health issues. So this is all related. And the context is ripe to create trauma and mental health issues.

And we are still creating trauma and mental health issues because of the tremendous amount of racism that we still have in this country against indigenous peoples, and against many other peoples, as well. So I think that we will continue to have trauma and problems as long as we continue to have this sort of colonial climate.

The statistics, although I still say that they're an undercount and they're not very good statistics, are so disturbing. There was a report that came out a few years ago saying that Native American children have rates of adverse childhood events and PTSD at the same rates as US veterans who have served in combat in Iraq and Afghanistan. Native children compared to combat veterans, and were exposed to the same amount of trauma? So we have a lot of things feeding these disparities.

Now, getting to the stigma that you asked me about. I think that throughout this country, it's often difficult for people to talk about mental health issues, because it is seen as stigmatizing, seen as a problem with the individual. As everything that I've said for these last few minutes suggests that it's not a problem rooted within the individual, it's a problem rooted within society that manifests within the individual.

And traditionally, our indigenous cultures valued balance, and recognized how we are all connected, rather than placing responsibility within just one individual, or one component. The medicine wheel I think is a really good reminder that we're all related, and that there are multiple dimensions to all of us and to everything.

For the listeners who may not be familiar with the medicine wheel, it's a circle divided into quadrants. Circles are inherently balanced. They're symmetrical. There's not even really an up or a down. It's interchangeable, and it suggests that we need diversity.

One interpretation of the medicine wheel talks about the balance between mind, body, spirit, and heart. And as a social worker, that's something that I refer to all the time. If any one of these elements is out of balance, your whole wellbeing will be out of balance.

So if you're doing an assessment, you can take inventory, "Okay, what's going on mentally with your mind? What's going on physically with your body? What's going on emotionally with your heart? What's going on with your relationships to others?" You look at these different components, you assess, and you rebalance. It's holistic. And I think it is de-stigmatizing because it does not place responsibility on an individual or on any one thing. It reminds us that there are multiple dimensions, and we need to be attentive to our balance.

So, those are multiple answers to your question. But yeah, I think there's trouble with the statistics, but I do believe that there are significant disparities. I believe that [inaudible 00:19:53] feeds into these disparities. And I think if we look at our traditional teachings, we will realize that it is not the fault of any one person, and therefore we should de-stigmatize the way we look at things.

Olivia Gawehnidi Porter:

It's really interesting to think about the problem with statistics, something I did not think about before. Thank you, Dr. Weaver.

ADA Live listening audience, if you have questions about this topic, or any other ADA Live topics, you can submit your questions online at www.adalive.org, or call the Southeast ADA Center at +1 404-541-9001. And now, a word from our sponsor, the School of Social Work at the University at Buffalo.

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The research center, the Buffalo Center for Social Research, highlights some of this work, as do faculty's publications. For more information about the important work of the School of Social Work at the University of Buffalo, please visit socialwork.buffalo.edu.

Olivia Gawehnidi Porter: Welcome back, listening audience. Before the break, we were talking about how you incorporate indigenous traditions in efforts towards de-stigmatization. The Haudenosaunee have a 400-year-old treaty with the Dutch called the Two Row Wampum. The treaty represents that the Haudenosaunee and the Dutch will coexist, but will not interfere with one another, nor disrupt each other's way of life.

You've talked about the de-stigmatization of Western ideas of disabilities as a means towards forging a better future in a shared world. What is your idea of a shared world in relation to the concept of coexisting without interference? How and when do you think a shared world will be achieved?

Dr. Hilary Weaver: Well, we do have a shared world. So I would say that it exists now. I wouldn't say that it's equitable at this point, but the fact is that we live in this world together. And the actions of one person or one entity affect others as well. Two Row Wampum reminds us of respect, and self-determination. That for instance, a tribe should be able to develop their own programming, their own education systems, their own social welfare systems, where they can implement services based on their own values, needs, norms. And a state shouldn't be telling them how to run a particular program.

So, it's a level of independence. It's a level of self-determination. But with this shared world, nobody lives in a vacuum. We do interact with each other. And with a shared world, we have opportunities to share ideas. Maybe somebody has a great example of a wonderful creative program that they have developed. They don't need to just keep that idea to themselves. Maybe it's something that another tribal nation would want to implement. Maybe it's something, a model that the state would want to use to inform their work with diverse populations, because not all indigenous people live in tribal territories. So maybe we need better programming in the cities, as well.

I've been doing a lot of work around looking at how indigenous peoples around the world have responded to COVID-19. And as I listen to different experts talk about what's going on in their different territories, I have heard an amazing amount of optimism. Something that I really didn't expect, because you hear about all the disparities, and we're hit very hard with COVID-19.

I have found that many of the leaders in social services, and tribal leaders as well, actually see this as a time of great opportunity. And crisis is, indeed, a time of opportunity. They see this as a time to reenvision health systems, reenvision how tribal governments coordinate with state governments. Because our systems really have not worked very well. Even though there are a lot of treaties about how the federal governments, both in the United States and in other nation-states around the world, will interact with tribal peoples, that's never worked very smoothly. We have not developed robust health systems with the help of our federal governments.

But now leaders are saying, with this crisis is opportunity. We know what doesn't work well. Let's rebuild the systems. So in this shared world, there is an opportunity for us to respect our individuality, and our individual programs that we have, but also share knowledge, and build better systems that serve the needs of all peoples.

Olivia Gawehnidi Porter: Thank you for that answer. There are over 570 federally recognized indigenous tribes and nations across America. So it is difficult to assume the same traditions when working with different indigenous peoples.

You are Lakota, but have also spent a lot of time living on Haudenosaunee territory. Would you say you have incorporated any Haudenosaunee traditions into your work, or has your traditional knowledge always been based on your Lakota upbringing?

Dr. Hilary Weaver: I think it is essential to integrate local knowledge. If I were to just come to Haudenosaunee territory as a Lakota person, and operate exclusively with my Lakota values base and traditions, and expect that to work here, that would be colonial of me. I think that all helping professionals need to recognize whose land they are on, and integrate the tribally-specific perspectives and values. Otherwise, it is not going to work.

So yes, I have learned so much being in Haudenosaunee territory. I moved here in 1993, and I made a commitment to this community, and the community made a commitment to me. And so, I would say that the majority of what I incorporate in my teaching really is much more Haudenosaunee-specific than Lakota-specific.

Because while there's maybe one or two Lakota in the community here, there are thousands of Haudenosaunee people. So, I must go with the traditions of this land. And I think that's a lesson to any of us who are mobile. We need to respect the traditions of the lands that we are on, and the traditional holders of those lands, the peoples that are there. We must adapt, and integrate that knowledge into our work. I think it's essential.

Olivia Gawehnidi Porter: You so much for your insight, Dr. Weaver. We are grateful to you for sharing your time and valuable insights on the important work you are doing on behalf of indigenous peoples. And thank you, ADA Live listeners, for joining us for this episode.

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ADA Live is a program of the Southeast ADA Center. Our producer is Celestia Ohrazda, with Beth Miller Harrison, Mary Morder, Emily Rueber, Marsha Schwanke, and Barry Whaley. Our music is from 4 Wheel City, the Movement 4 Improvement. See you next episode, and be safe, everybody.

4 Wheel City: (rapping)

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Disclaimer: The contents of this publication are developed under a grant from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant #90DP0090-01-00). NIDILRR is a Center within the Administration for Community Living (ACL), Department of Health and Human Services (HHS). The contents of this publication do not necessarily represent the policy of NIDILRR, ACL, HHS, and you should not assume endorsement by the Federal Government.

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