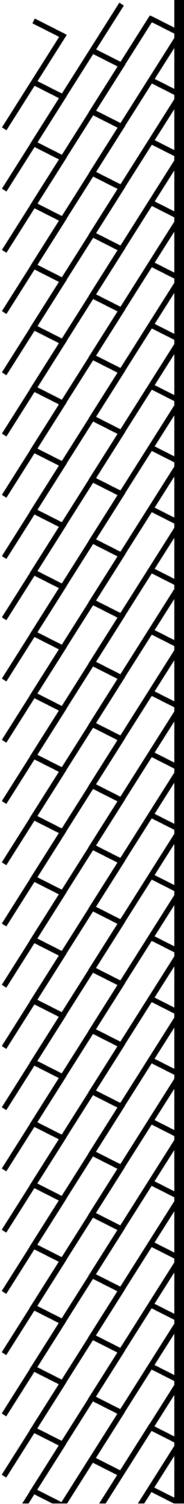

American Indian and Alaska Native Mental Health Research

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Volume 8, Number 3, 1999

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EDITORIAL

This Special Issue of *American Indian and Alaska Native Mental Health Research* presents a series of papers which describe the results of mental health needs assessments performed by four urban American Indian organizations. In 1991, the Indian Health Service funded this nationwide initiative with the goal of determining the need for culturally appropriate mental health services among American Indian people residing in urban areas. As the guest editor, I would like to take this opportunity to briefly explore the significance of these papers in the context of program evaluation and planning for alcohol, drug, and mental health (ADM) services for American Indian communities.

Why do evaluation, program, and strategic planning efforts for ADM services so often seem inadequate? Such efforts often involve the complex tasks of collecting information concerning markers, or "indicators," of the "quality of care" that a particular ADM service organization provides. Measures of the quality of care are most often divided into the following three domains (Donabedian, 1988): (a) the "structural" attributes of the organization itself [e.g., training, experience, and cultural competence of the clinical staff]; (b) the quality of the "process" of care provided by the organization [e.g., waiting time, whether the clinician queried and recorded her/his assessment of suicidal intent during the interview of a depressed individual]; and (c) the "outcome" of care of individuals and families who use services provided by the organization [e.g., symptom reduction, improvement in adaptive functioning, participant satisfaction]. Information of this nature is certainly critical for evaluation and program planning, yet we are often unconvinced that these indicators, as a whole, assure us of quality ADM services.

The critical community contexts of ADM services are strikingly missing from such efforts. Consider the following questions. What are the prevalence and patterns of ADM problems among community members? What are the prevailing community *attitudes* towards ADM disorders? Toward ADM services? Are needed services available? Do existing programs work together, particularly for individuals and families with complex needs? What gaps in services do community members identify? How do community members perceive existing ADM services? Are they *accessible* (e.g., convenient location and hours, affordable fees)? Are they *acceptable* (e.g., professional, knowledgeable, culturally competent, and appropriate staff)?

The answers to such inquiries can easily turn a program evaluation on its head. For example, consider an ADM service organization that demonstrates excellent outcomes, but is perceived by a substantial number of community members as difficult to access because of a long waiting list for scheduling initial appointments. Or a service organization that specializes

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in short-term, focused services for adjustment disorders in a community with a high prevalence of chronic ADM conditions. Or even a service organization that can document the cultural competence of its staff (a high percentage of American Indian staff), but is perceived by community members as unacceptable because of the culturally inappropriate behavior of one or two key clinicians.

Thus, internally focused ADM program evaluation is evaluation stripped of context, meaning, and value. How refreshing, then, are the 1991 Indian Health Service (IHS)-funded efforts for the mental health needs assessment of American Indians in a number of cities with substantial American Indian populations, four of which are presented in this volume.

The organizations funded by the IHS to perform these assessments faced the unenviable task of completing the work on a short time line with limited funding and lack of a consensus on how to proceed, either for American Indians or for urban populations in general. Indeed, these surveys have a number of significant limitations, including sampling strategies that do not ensure a representative sampling of each city's American Indian population and analytic approaches that are exclusively descriptive. Still, the papers presented here reflect a variety of responses to these challenges, resulting in a volume that gives voice to community members' concerns about the mental health problems that they and their families face, as well as how they feel these problems should be addressed.

First is a strong statement of need. The mental health problems identified include issues such as depression and substance use. However, these mental health needs are matched or even exceeded by needs for more supportive services such as employment and housing as well as strong concerns about maintaining connections with reservation communities and developing a center for American Indian culture within the city.

Second is a clear message around service delivery. Urban mental health providers often address such problems out of their social context. This is not acceptable to the participants in these assessments. Yes, the treatment of depression is important, but so is job counseling. Also, these mental health services should be delivered within a cultural context. The desire for cultural activities, American Indian mental health providers, as well as the need for traditional healers are strongly expressed. What emerges from these surveys is a vision of services which address mental health issues within these social and cultural contexts. The decontextualization of mental health needs is more than unacceptable to many of these respondents; it is frankly incomprehensible. This is most clearly seen in the apparent incompatibility of responses in the survey completed by Chester, Mahalish and Davis for the Native Americans for Community Action, Inc. (Flagstaff). Individuals were asked about the use of traditional healers in two contexts, first in the context of service use (which 1% responded affirmatively), and second in the context of culture (which resulted in an affirmative response of

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52%). These differences point out how the Western model of separating mental health needs from spiritual and cultural concerns is inappropriate for many urban American Indians. The need for organizations that serve the full circle of these domains is underscored by these studies.

This finding has major implications for the way the IHS and other providers of mental health services design services for urban American Indians. The IHS urban health projects often focus on increasing access to existing services funded from other sources. These existing services rarely provide programs specifically designed for American Indians, and certainly fail to meet the high standard of comprehensive services as outlined above. New groundbreaking collaborations need to be developed between the urban American Indian community, the IHS, and existing service organizations to ensure the development of such programs.

How exciting, eight years later, to consider these papers in the context of the Circles of Care Initiative. Circles of Care (CoC), sponsored by the Center for Mental Health Services (CMHS), the Indian Health Service, and the Office of Juvenile Justice and Delinquency Prevention, is funding nine American Indian organizations (including three in urban areas) to develop plans for comprehensive ADM services for American Indian children and adolescents with serious emotional disturbances. This strategic planning effort is aimed at preparing grantees to compete successfully for CHMS and other child services grants, which will enable them to make these plans a reality. Thus, CoC includes an extensive evaluation component that embraces a careful description of the existing system of services, assessment of community needs for mental health services, and sensitive explication of community members perspectives concerning ADM problems and services. Indeed, this extends even to developing community-specific definitions of serious emotional disturbance. The lessons of these 1991 papers is already providing critical guidance to the CoC grantees as they progress through their strategic planning efforts.[1]

What emerges from these papers is clear evidence for the need for ADM services and for the development of new comprehensive psycho-socio-cultural centers to meet this need. Also evident is the need to bring more rigorous scientific investigations into the scope, characteristics, developmental trajectory, and optimal treatment approaches of mental health problems among urban American Indians. Thus, this volume clarifies the challenges and tasks for practitioners, community leaders, and scientists.

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Notes

[1]You can learn more about Circles of Care by visiting the world wide web site of the Circles of Care Evaluation Technical Assistance Center (http://www.uchsc.edu/sm/coc).

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DENVER AMERICAN INDIAN MENTAL HEALTH NEEDS SURVEY

Jeff King, Ph.D.

Abstract: American Indians are at higher risk for mental health problems than other ethnic groups in the United States (Nelson, McCoy, Stetter, & Vanderwagen, 1992). Little attention has been directed towards assessing mental health problems among urban American Indians. In response to an Indian Health Service (IHS) call for proposals, this survey addressed the mental health needs of Denver urban American Indians. The purpose of the survey was to gather data from Denver American Indian adults and adolescents as well as service providers in the Denver area who work, to one degree or the other, with members of the American Indian community. These data were to provide a general idea of the breadth of mental health and other associated problems among the Denver American Indian population.

Demographic Profile For Denver American Indians

The estimated population for American Indians living in the Denver metropolitan area is 20,000 (Source: Catchment Area Population Estimates, extracted from Colorado Division Local Government [DLG], 1991). Most of the American Indian population live in or near the downtown area, although there is not an "American Indian community" by locale. The survey totals for youth and adults (442) was approximately 2% of this population. Denver American Indians comprise about 0.9% of the Denver metro population.

The term American Indian will be used for description of the Native population. A second term, Native people will also be used.

Survey Design

Three mental health questionnaires were developed for: American Indian adults, American Indian adolescents, and service providers. The survey items were derived from a number of mental health and health surveys (American Indian and non-American Indian) from various areas in the United States. The early drafts were critiqued for their readability and content

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appropriateness for Denver American Indians by American Indian professionals in Denver. Items were deleted, added, and modified accordingly.

Survey administration began in March, 1992 and ended in August, 1992. Professionals and agencies in the Denver American Indian community were very willing to help out in the administration of the surveys. Survey administrations took place at: Title V (American Indian Education), the Denver Indian Center, Denver Indian Health and Family Services, the Spirit of the Rainbow project, and at a Health Fair at the Denver Indian Health and Family Services. Flyers regarding the survey were posted at all three places, and a write-up of the study and information about obtaining and completing a questionnaire appeared in the Title V newsletter. Service provider questionnaires were given out to American Indian Child Welfare, Win'Yan'Was'Aka (Domestic Violence program), American Indian Health Education program, Vision Quest, and the American Indian Alcohol and Substance Abuse Prevention program.

There were many difficulties in accessing the Denver American Indian population. The American Indian population is spread out throughout the city. Therefore, the use of Title V, DIHFS, and the Denver Indian Center only reached a small portion of the 20,000 or so American Indian residents. Furthermore, American Indian adolescents were extremely hard to locate. Title V coordinators were contacted throughout the Denver metropolitan area and consistently reported that there were no schools which contained a large number of American Indian students. There was no easy access to these adolescents. The small number of actual completed surveys reflects this difficulty. This paper will focus specifically on the sample of American Indian adults.

Methodology

The survey design focused on three primary sampling domains. Phase One focused on the urban American Indian adults, Phase Two focused on urban American Indian adolescents, and Phase Three addressed the service providers. The survey sample is not a representative sample. Rather it is a sample of convenience. However, it is thought that the sample obtained is composed of those most likely in need of mental health services. The demographic information described later will clarify this notion. From the beginning, this survey was considered to be a community effort. Many of the questions were obtained from community members. Early drafts were submitted to American Indian professionals and non-American Indian professionals who work in the American Indian community for their input and criticism. The various American Indian agencies in Denver participated in the survey distribution and administration.

The survey design focused on three main domains of mental health: (a) personal problems past and present, (b) problems experienced by household members, and (c) perceptions of problems existing in the

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community. Within these domains, questions were asked regarding psychological problems, personal trauma, and substance abuse. Questions pertaining to service utilization were also asked. These asked if services were sought and if so, which services; and if not, reasons for not seeking services. Other survey questions asked respondents questions about ethnic identification and to list what they viewed as the critical mental health needs for the Denver American Indian community.

Participants were provided with a cover sheet to the survey which served as an informed consent. This cover sheet briefly explained the purpose of the study and the confidentiality of the respondent's answers. They were told that the consent sheet they signed would be placed in a separate pile from the questionnaire so that there would be no way to link their name with their survey. Adults were reimbursed $5 and adolescents $3 for their participation.

Statistical Procedures

Since the overall goal of the survey was to gain a breadth of perspective, statistical procedures were descriptive in nature. There are considerable data in which more in-depth analyses could be made, and hopefully this will occur in the near future. However, the focus of this survey is to provide frequencies of the various mental health and related problems in the Denver American Indian community. In this paper, descriptive data is provided for the adult American Indian sample.

Results

The following results are those thought most useful to readers. Full descriptive data from the survey are available upon request to the author.

Sample

Survey participants included 374 adults from the Denver urban areas. There were 205 females, 165 males, and 4 did not indicate their gender. Ages ranged from 17 years to 71 years old. The average age of the adult respondent was 34 years old. One-hundred-fifty-eight adults reported being single, 74 married, 57 divorced, 43 living with someone, 27 separated, 12 widowed, and 3 did not indicate their marital status.

Family Size

Although 78 persons reported having no children, almost 80% of the sample reported having at least one child. The average number of children was almost two and a half. Number of children here did not necessarily mean number of children still with the parent. Sixty-five percent of the households have children in them. The average number of children per household is approximately one and a half.

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Tribal Enrollment

Most participants were tribally enrolled (91%). Almost half (47%) were from South Dakota, 11% from Oklahoma, and there were smaller numbers from eighteen other states.

Degree of American Indian Blood

Eighty-five percent of those sampled reported being at least 1/2 degree of American Indian blood. A high percentage of the respondents (51.9%) reported being full-bloods.

Education

Over half of the survey participants have completed at least a high school education. However, approximately one out of four of the respondents (26.6%) did not finish high school.

Years in Denver

The average amount of time lived in Denver was ten years. However, the range was quite broad, with the highest number of respondents having lived in Denver less than one year (14.4%), and the second and third highest reporting one and two years residency respectively. More than one-third of the respondents have lived in Denver two years or less.

Employment

Only 18% of the sample reported having a full-time job. Twenty percent reported having part-time jobs and 58%, a majority of this sample, were unemployed.

Income

Almost 70% of those sampled reported annual incomes of less than $10,000. The second highest frequency (12%) were those reporting incomes of $10-15,000. Combined, 80% of the American Indian adults surveyed had incomes of less than $15,000 per year (Table 1). This result may reflect some of the sampling bias, as it seems that more affluent American Indians living in Denver did not participate in the survey.

General Health Care

Almost half of the sample did not know how to find the medical information they needed.

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Table1
Total Yearly Household Income

Annual Income	Frequency	Percent
10,000 or less	255	68.2
10,001-15,000	45	12.0
15,001-20,000	24	6.4
20,001-30,000	24	6.4
30,001-40,000	11	2.9
40,001 or more	7	1.9
MISSING	8	2.1
TOTAL	374	100.0

Personal Problems

Substance Abuse

Almost two-thirds (61.2%) of those surveyed reported having at one time or other an alcohol or drug problem. Of those that had an alcohol or drug problem, 66% sought help and 34% did not. Those that sought services reported contacting agencies specializing in substance abuse treatment. The agency most sought out was an American Indian alcohol treatment program (19%).

Foremost reasons for not seeking help were either wanting to work the difficulty out without asking for help, disbelief in helping systems, financial barriers, and lack of knowledge about available services. A number of the higher frequency items appear to relate to a distrust of service systems (e.g., didn't want services, didn't think it would help, wouldn't understand American Indian ways).

Psychological Problems Ever

Fifty percent of those surveyed reported having experienced depression at one time in their lives. Second highest frequency was marital problems, followed by anxiety, and almost one out of five individuals reported experiencing suicidal thoughts or making a suicidal attempt. Of those who reported experiencing psychological problems, 56% sought out help and 44% did not. The church and traditional methods were the help most often sought. This demonstrates the importance that many American Indians place upon spirituality as part of their healing process.

Reasons for not seeking help included: not wanting services, did not think services could help, did not know of services, and could not afford

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services. These responses suggest a possible distrust of service systems as well as an inability to pay for treatment.

Personal Trauma Issues Ever

There was a high prevalence of personal trauma among this sample of the American Indian population in Denver. Almost two-fifths (37.2%) have been victims of spouse abuse, 12% reported being victims of child abuse or neglect, and 10% reported having been raped or sexually abused. Of those reporting some sort of trauma, almost half (48%) did not seek treatment. Service providers most sought were the church (8%), police (8%), and social services (7%).

Reasons for not seeking help included: believed I should work it out myself (10%), didn't know of services (8%), didn't think it would help (8%), and could not afford services (7%).

Psychological Symptom Scale

This set of items addressed current psychological and financial problems (Table 2). Listed are those problems which occur weekly or more often. Overwhelmingly, the foremost problem reported was financial difficulties (65%). Second to financial problems were family problems (35%). Feeling overwhelmed (29%) was the third most reported symptom. Of concern also were the next five items in which almost one in four reported experiencing at least once per week: anxiety (28%), overeating (28%), angry or bitter feelings (26%), and loneliness (25%).

Household Problems

Psychological Problems

These questions asked whether or not anyone living in the respondent's home had experienced any kind of psychological problem. Respondents reported only 32% of household members experienced depression. This is lower than the 50% reported by individuals about themselves. Responses for others in household tended to be lower or about even to the individual problem categories: anxiety reported at 14%, and suicidal thought/attempts also 14%.

Again, about 50% sought help for their problem(s) and about 50% did not. Household members tended to use the hospital more frequently than the individual, but also exhibited a strong trend toward traditional healing methods and agencies which served the American Indian population.

Personal Trauma

These are traumatic events for persons living in the household of the person filling out the questionnaire. Reports here are lower than those

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Table 2
Problems Which Occur Weekly or More Often[1]

	Frequency	Percent
Financial Problems	244	65.2
Family Problems	131	35.0
Overwhelmed	118	28.9
Anxiety	105	28.1
I Eat Too Much	104	27.8
Angry or Bitter	98	26.2
Lonely	92	24.6
Depressed	88	23.5
Physical Problem	87	23.2
Drink Too Much	83	22.2
Guilty	76	20.3
My Thoughts Race In My Mind	76	20.3

[1]Psychological symptom scale—occurring weekly or more often—among 20% or more of Adult Sample.

of the individuals themselves, but this may be due to victims not telling others about what happened. Twenty-five percent indicated household members had been victims of spouse abuse, and 10% reported household members having been abused or neglected as children. Help-seeking falls in the 50-50 ratio, with half of the sample reporting seeking help for their problems and half not seeking help.

Services most sought were social services (9%), police (7.5%), and church (6%). Reasons for not seeking help were similar to previous answers: did not think it would help, could not afford services, didn't know of services. Also included as reasons were fear of repercussions: afraid of what might happen, and afraid that others would find out.

Mental Health Problems For American Indian Community

This question is directed to the individual's knowledge about people in the broader American Indian community. Community problems reported were: alcohol abuse (69%), unemployment (56%), financial problems (52%), youth runaway problems (48%), drug abuse (45%), spouse abuse (40%), school problems (38%), depression (35%), and child abuse/neglect (28%). Although unemployment and financial problems are not mental health problems directly, they were included because of their significant link to problems in mental health.

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Counselor Preference

Client Comfort Level

Regarding mental health treatment, questions asked about client comfort level and counselor preference. Given that 50% of the American Indian people sampled said they did not seek help for their problems, one of the possible reasons is distrust for the dominant culture's type of care provision. If American Indian people are not comfortable talking about personal issues with White people, it makes sense that they do not access services provided by predominantly White-staffed agencies. Almost two-thirds (61.2%) of those sampled reported that they felt uncomfortable talking with Whites about personal issues, while 36% reported no discomfort.

Counselor Preference

In terms of actual preference for counselor ethnicity, the percentage is similar to the previous question: two-thirds indicated they would prefer an American Indian counselor, 27% indicated that it did not matter, and only 4% said no to preferring an American Indian counselor.

Traditional Healers

The use of traditional methods of healing is still very important to the American Indian community. On this item, over half reported that they wanted to see a traditional healer over the past year.

School Testing

Another realm for cultural issues in mental health is with the testing of our children at school. Very little attention has been directed at this area, and perhaps none directed at asking the parents how they feel about testing for their children at school. Most adults (83%) indicated no real problems with school testing. Approximately 20% had at least some reservations about testing for American Indian children.

When it came to fairness in school testing a greater number of adults felt testing was unfair (46%), while (51%) felt tests were fair for American Indian children, (3%) responded "don't know."

Eighty-three percent of the respondents indicated they would prefer examiners who were sensitive to American Indian cultural issues. Only 10% of the sample indicated they would not like testing to be carried out by someone familiar with American Indian culture.

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Community Input on Mental Health Prevention -Perceived Availability of Services

Approximately one-quarter to one-third of those sampled felt that most of the services listed below were not available to them or other American Indians. The five services most endorsed are listed in order: marriage and family counseling (38%), a mental health center (34%), educational testing (33%), self-help groups (33%), family therapy (31%), and emergency home visits (31%).

Ninety percent of respondents said they would use these services if they were available. This finding must be contrasted with the other finding that only 50% have sought help in the past.

In terms of which services respondents would use, the primary characteristic appeared to be culturally sensitive and traditional methods (58%). However, they also indicated a willingness to use: individual counseling (52%), financial counseling (51%), stress management (41%), substance abuse education (37%), help with self-esteem (37%), and family counseling (36%).

Current Problem Areas For Denver American Indian Community

This question addressed broader issues than just mental health that the individual feels are current problems in their life. Again, finances were by far the most frequent problem. Second and third were housing and jobs—both related to financial problems. Fourth was alcohol, and interestingly racial prejudice was reported by 26% of those sampled as a current problem.

Activities Needed In American Indian Adult Community

A significant proportion of those surveyed reported the need for American Indian social workers (66%). The other responses focused on social networking of one sort or the other: organized recreation (47%), community meetings (46%), transportation (45%), a newsletter (37%).

Activities Needed In American Indian Youth Community

Activities for youth were also much in need. Adults most often reported the need for instruction in cultural heritage for the youth (66%). Second was the need for tutoring (46%). This is not too surprising, given that nation-wide American Indian students have the highest drop-out rates for any ethnic minority group. All of the following were endorsed by a large portion of the adults surveyed: someone to listen (43%), summer jobs (40%), substance abuse counseling (36%), recreational activities (34%), a youth center (34%), general counseling services (23%).

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Family Services

Sixty-six percent of adults surveyed felt the need for protection of children from violence and 55% indicated the need to protect children from neglect. This indicated a note of serious concern by the community for the welfare and well-being of American Indian children. Other responses included: parenting classes (43%), American Indian foster homes (38%), domestic violence prevention (38%), and child protection (36%).

Cultural Identity

This part of the survey addressed level of cultural affiliation for this sample (Table 3). Eighty-four percent of the sample reported identifying with American Indian culture "sometimes" or "often," as compared to responses of "a little" or "not at all." This suggests that most of the Denver American Indian community has strong ties with their culture. Mental health services must recognize this fact and tailor their services to the cultural aspects of this population.

Summary

It is difficult to summarize such a broad range of areas related to mental health. Acknowledging this difficulty, a general profile for the Denver American Indian community will be described. This profile suggests the target areas and concerns for mental health efforts in the city of Denver.

Table 3
Cultural Identity[1]

	Frequency	Percent
How much do you identify with Indian culture?		
A lot	194	51.9
Some	106	28.3
A little	47	12.6
Not at all	8	2.1
How much do you identify with White culture?		
A lot	48	12.8
Some	140	37.4
A little	103	27.5
Not at all	67	17.9

[1]Note: Percentages do not equal 100% because of missing responses.

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The American Indian population in Denver is poor. Most of the community lives below, or close to the poverty line for annual income ($14,000 per household of four). Many of these residents are new to Denver (moved here within the last two years). The major problems besetting this group are financial and job related. Unemployment is extremely high, therefore finances are slim and housing situations leave much to be desired. Research has demonstrated that these sort of socioeconomic conditions contribute significantly to increased mental health problems.

Over half of the Denver American Indians surveyed have experienced some kind of mental health problem in their lives, with approximately 30% currently experiencing at least weekly symptoms of psychological problems. There is reported widespread problems for domestic violence, child neglect and abuse, spouse abuse, and marital and family problems. Basically, most areas of mental health difficulties included in the survey show high rates of occurrence within the Denver American Indian community.

Even though there are high occurrences of mental health problems in the Denver American Indian Community, more than half of those people experiencing these problems do not seek help. Those that do seek help tend to first consult with someone from church or traditional healing methods/ persons. Lack of affordable mental health care also prevents getting help.

All this suggests that many in the American Indian community are distrustful of the broader mental health provider agencies and want American Indian providers or at least providers who are sensitive to American Indian culture. This finding has been noted elsewhere (Neligh, 1990). It is striking that over 90% of the American Indian adults surveyed indicated they would use mental health services if they were available.

The need clearly is for American Indian mental health providers with a broad range of expertise to serve the Denver American Indian community. There are dire needs at all levels of mental health care. Some of these levels are: family, marital, adult, adolescent, and child therapies; school-related, court-related, Social Services-related, and American Indian Child Welfare-related interventions; psychological, developmental, and learning disability testing; child-custody evaluations; interventions for domestic violence, spousal abuse, child physical and sexual abuse; alcohol and drug related case management; psychiatric care for medication evaluations and monitoring; and community level interventions such as prevention, and information dissemination.

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NORTH AMERICAN INDIAN ALLIANCE MENTAL HEALTH NEEDS ASSESSMENT REPORT

Lloyd Barron, Linda L. Oge, and Joseph Markovich

Abstract: The North American Indian Alliance (NAIA), located in Butte, Montana, conducted a mental health needs assessment from December, 1991 to June, 1992. The goals of this assessment were to identify unmet health needs, obtain input regarding the need for additional services, and identify barriers to providing and accessing services. Surveys of mental health service providers (n=30) and consumers of NAIA services (n=74) were conducted. The results of these surveys and their implications for service provision are explored.

The North American Indian Alliance (NAIA), an urban American Indian Health Program, is located in Butte, Montana. The NAIA is a non-profit organization that provides a limited realm of services to the approximate 1,000 American Indians within the Butte-Silver Bow counties. It began operation in 1969 through the initiative of community members identifying a need for American Indian services. Program operations and policy decisions are made by a seven member Board of Directors. The primary purpose of the NAIA is to promote health, educational, economic, social, and cultural development of American Indians in the Butte-Silver Bow urban community. The current staff consists of the director, a health coordinator, a data coordinator, two chemical dependency counselors, an education and prevention facilitator and a number of volunteers. The alliance also serves as an advocate for American Indians within the Butte-Silver Bow community, to facilitate and promote a better awareness of the American Indian culture.

The location of the NAIA places it further away from any American Indian reservation than any other IHS program in the state of Montana. The closest reservation is the Flathead Reservation, located about 180 miles northwest of Butte. Thus, while other urban American Indian health programs have easy access to referral services on reservations for eligible consumers, the NAIA continues to attempt to operate without that benefit. There is limited information available concerning the need for mental health services among American Indians residing in the Butte-Silver Bow communities. Therefore, a mental health needs assessment was conducted to identify

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health needs that continue to be unmet, obtain input related to what kinds of programs and services are needed, and identify barriers to providing and accessing services.

Methods

The NAIA Mental Health Needs Assessment was conducted from December, 1991 through June, 1992. Two separate surveys were conducted of: (a) Mental Health Service providers within the community, and (b) consumers of NAIA services.

An estimated 515 males and females, 15 years of age and older, used NAIA services within the past year. This is almost 100% of the 519 American Indians found to be residing in the Butte community by the 1990 U.S. Census. These consumers were determined to be the most appropriate sample to identify American Indian community mental health needs. However, to capture data from individuals who may have other unique needs, the questionnaire also was completed by American Indian individuals in the Butte Pre-release Program. The Butte Pre-Release is a transitional living facility for state prisoners who are in the process of becoming paroled by the State of Montana's correctional institution. At best three males and three females were interviewed.

A stratified (by sex) systematic sample with a random start was selected from the list. An estimated sample size of 81 was expected to yield resulting data within the 95% confidence level, + or - 10%. However, in consideration of the response rates in past face-to-face, community based studies in the urban American Indian population of between 62% to 73%, a slightly larger sample was drawn (50 males and 50 females). This sample size represents approximately 20% of the Butte American Indian population, according to the 1990 U.S. Census. This information was taken from the Department of Vital Statistics records in Helena, Montana.

Separate questionnaires were developed for use in interviewing providers and consumers. Questionnaires were completed through the use of face-to-face household interviewing. A contract male interviewer arranged and completed the interviews.

Results

Survey of Providers

Of the 55 Mental Health Care Providers in the Butte Community, 35 were offered the opportunity to participate. As a result of difficulties in scheduling interviews with the providers and the six month time frame for the survey, 30 actually completed questionnaires.

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Provider Characteristics

Seventeen percent of the respondents reported being in the Medical Professional group, indicating that they were physicians, psychiatrists, or psychologists. Fifty percent reported being in the Mental Health group, indicating that they were social workers, chemical dependency counselors, or mental health workers. Twenty-three percent reported being in the Human Services group, indicating that they may be social workers or referral sources such as in-take counselors, etc. Ten percent reported being in the "other" group, which included physicians and other professional/paraprofessional health providers who were not directly involved in the treatment of mental illness. Seventeen percent of the respondents reported being American Indian.

Children's Services Offered

Sixty-three percent of the respondents offered crisis services; 47% offered outpatient services, 50% offered inpatient services, 10% offered residential services, and 33% offered other types of children's services not specifically listed in the questionnaire. These included prevention and early intervention, aftercare, evaluation, education, parenting classes, adolescent support groups, cultural education, child abuse and neglect investigative services, and referral services.

Adult Services Offered

Forty-seven percent of the respondents offered crisis services, 16% offered outpatient services, 4% offered inpatient services, 3% offered group home/transitional services, and 11% offered "other" kinds of services not specifically listed in the questionnaire. These included prevention and intensive outpatient early intervention, family therapy, ACT (drivers education related to convictions for driving under the influence of alcohol), parenting classes, cultural education, chemical dependency education, health education, adult abuse and neglect investigative services, and referral services.

American Indian Client Population

Eighty percent of the respondents reported that 25% or less of their client population was American Indian; 13% reported that between 25% and 50% of their client population was American Indian, and 7% reported that between 75% and 100% of their client population was American Indian. Thus, most of the providers surveyed do not specialize in the treatment of American Indians.

Contacts with American Indian clients are made by: (a) self referral 47%, (b) referral from agencies such as Social Services or Department of Family Services 15%, (c) referrals from hospitals or reservations 8%, (d) during inpatient treatment 7%, (e) during project work 5%, (f) at the

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Community Health Center 5%, (g) during community outreach visits 3%, (h) in client work environments 3%, (i) when visiting American Indian homes 2%, (j) during agency meetings 2%, (k) in the schools 2%, and (l) during visits to the emergency room 1%.

Referral Practices

Seventy-seven percent of the provider respondents reported that in their client encounters they refer American Indian clients to other agencies; 23% reported that they do not. The agencies clients are referred to: (a) NAIA 67%, (b) Human Services 13%, (c) Probation Services 5%, (d) family planning services 4%, (e) safe houses 4%, (f) Mental Health Services 3%, (g) foster care 1%, (h) American Indian Health Service 1%, (i) specific tribal services 1%, and (j) Alcoholics Anonymous 1%.

The reasons given by respondent providers for referral of clients included: (a) the agency they referred clients to had access to reliable supportive resources in a variety of areas, (b) placement, (c) investigation, (d) obtaining benefit from other programs for which they are eligible, (e) obtaining additional specialty services/treatment, and (f) at the request of patients and/or their families.

Knowledge of and Referral to NAIA

Ninety percent of the provider respondents indicated that they knew about the North American Indian Alliance. When asked about their awareness of specific services offered by NAIA, 77% of providers were aware of the Chemical Dependency (CD) Counseling program, 63% of the Health Education/ Prevention program, 50% of the Job Training Partnership Assistance program, 73% of the Youth Chemical Awareness program, and 57% were aware of the Youth Cultural Awareness program. Slightly more than half (54%) of the provider respondents reported that they made referrals to the NAIA.

Provider Perceptions of How the Mental Health of American Indians Differs From the General Population

Seventy-two percent of the provider respondents reported that they felt the mental health of American Indians is different than those of the general population. The following are examples of the differences they described:

1. While classic mental illnesses will have similar symptoms in both subpopulations, the American Indian community may be negatively affected to a larger degree because of the lack of economic resources available to treat the individual. This may be further complicated by the fact that American Indians are more likely to have to rely on treatment from public facilities, which may not be necessarily the best source of treatment for their specific illnesses. In addition, we may be attempting to treat social problems and

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political problems as mental health problems; in which case, it is not the individual who needs appropriate treatment, but the situation.
2. American Indians often have cultural, religious, and often social, values and beliefs that are much different from, poorly understood, and ultimately accepted, by the general population. Not only do these differences create problems between subgroups, but often the expectations of families and communities create a conflict within individuals to meet personal and social needs. Thus, not only are the mental health needs different, or greater, but require an approach that is different than the general population, includes a genuine sensitivity, and considers the more traditional holistic approach.
3. The transitional period involved in moving from the reservation to the urban community has a tremendous impact on the mental health of American Indians. The stressors of leaving an area that they were raised in and support groups they have grown accustomed to and trying to fit into the general population and be productive, without the familiar coping skills and support systems, would adversely impact most individuals, but is magnified in the American Indian for a variety of reasons. Those reasons are not only related to cultural, religious, or social differences, but the result of human responses to changes in socialization, poor assimilation into unfamiliar and different settings, etc. It often leads to loss of identity, and resulting loss of self-esteem, etc.

Suggested Improvements to the Mental Health Care System

Providers were asked to suggest ways to improve the delivery of mental health services to American Indians. Suggestions included: (a) use of American Indian mental health workers, (b) improved interaction and communications with tribal agencies, (c) improve non-Indian provider knowledge of services offered and how to access them, and (d) more outreach and targeted case management.

Provider respondents were also asked to suggest the types of education and information that would enhance their knowledge, awareness, and sensitivity to the American Indian community. Suggestions included: (a) demographic information about the population, (b) information on experience of American Indian women and their relationship to American Indian men, (c) training on cultural networking, (d) cultural training workshops, (e) listings of resources available to American Indians, (f) information about what the NAIA does and the services offered, and (g) interagency meetings that included cultural education and presentations by spiritual leaders.

Survey of Consumers

Of the 50 males and 50 females randomly selected as the sample, 44 males and 30 females agreed to participate. This resulted in an overall response rate of 74% (88% for males and 60% for females).

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Population Characteristics

Age: The age of the respondents ranged from 17 to 79 years of age, with an average age of 37 years. Females were slightly older than males, with average ages of 39 and 36, respectively.

Marital Status: One-quarter of both the females and males were currently married or living with someone. Twenty-five percent of the males and 10% of the females had never been married or lived with anyone. Males and females reported that they have been married or lived with someone an average of 3 and 2 times respectively.

Size of Household: Males reported having a range of between 1 and 6, with an average of 2.2, people living in their household. Females were similar with a range between 1 and 5 and an average of 2.3 people in the household.

Education: Over a third of the males and females (39% and 33%, respectively) reported to have completed their high school or equivalent education (G.E.D. or Vo-tech). And, slightly more males (19%) than females (13%) reported having some college education.

5. *Income:* A quarter (25.8%) of all the respondents reported that they had received less than $2,000 as total family income during the past year. Males were more prevalent in this low income category than females (34% and 13%), respectively. Ninety percent of the males and 86.4% of the female respondents reported receiving less than $10,000 in total family income during the last year.

Employment Status: Part of the reason for the low levels of total family income reported may be the employment status of the respondents during the last 12 months. Only 14.6% of the males and 13.3% of the females reported being employed at least part-time during the past year.

Other Assistance: When asked if they received benefits from other subsistence assistance during the past year, 52% of the respondents reported receiving some kind of alternate subsistence assistance. Eighty percent of these respondents received Aid to Families with Dependent Children, 20% received food stamps, 18% received Medicaid, 15% received General Assistance (State Welfare), 14% received some other assistance, 8% received Social Security, and 4% received Human Resources or Commodities.

Of the 14% reporting that they received other assistance, 21% received disability compensation, 14% received Energy Assistance, 14% received VA pensions, 7% received American Indian Per Capita, 7% received Medicare, 7% received Railroad Retirement, 7% received Unemployment Compensation, and 7% received assistance from the North American Indian Alliance.

Mobility: When asked how long they have lived in Butte, the respondents indicated a residence of between 1 and 79 years; with an average residency of 21.4 years. When asked how long they have been living off a reservation, the respondents reported a range of between 3 and 50 years;

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with an average of 18.9 years. Nineteen percent of the respondents reported that they have never lived on a reservation.

Mental Health Needs

Talking About Problems: When asked who they usually talked to when they had problems, 23% of the females and 16% of the males reported that they didn't discuss their problems with anyone. Twenty-three percent of the females and 54% of the males indicated that they talked to friends about problems. In addition the males reported that they talked to family (26%), doctors (9%), NAIA counselors (7%), and AA sponsors (2%). When they discussed problems with anyone, females reported talking to family (37%), a minister or priest (10%), NAIA counselor (7%), doctors (3%), and other counselors (3%).

Thus, while the males and females differ slightly in who they discuss problems with, there appears to be a large percentage (23% and 16%, respectively of females and males) who do not discuss their problems with anyone. This could be the result of a variety of factors such as not being aware of who they go to, how to access counseling services, distrust, etc.

Problems Experienced are reported in Table 1. Males identified different problems than females. Sexual abuse, conflict with children, and depression were more commonly reported as problems by the female respondents. Adult alcoholism, teenage drinking, legal problems, and marital problems were more commonly reported as problems by the male respondents.

Frequently Experienced Problems: Problems respondents identified as experiencing at least on a weekly basis are reported in Table 2. Financial problems were the most commonly reported problems by both men and women. The next most commonly reported problems for males were social withdrawal, difficulty sleeping, feeling angry/bitter, and family problems. The next most commonly reported problems for females were difficulty sleeping, spouse/family member abuses, alcohol/drugs, feeling angry/bitter, and family problems.

Perceived Problems for the American Indian Community are reported in Table 3. Almost all the respondents identified employment and over two-thirds identified domestic violence as problems for the community. As was the case when asked to identify personal problem areas, males endorsed different problems than females. Drug abuse, racial discrimination, alcoholism, and teenage pregnancy were perceived as problems for the community by females. Access to medical care, marital conflict/divorce, law enforcement, school, and sexual abuse were perceived as problems for the community by males.

Desired Programs/Services are reported on Table 4. A majority of respondents of both genders reported an interest in using all the services listed except for group and family counseling. The "other" services seen as useful by the female respondents were pastoral services and schooling.

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Table 1
Problems Experienced

Problem Area	Males		Females	
	n	%	*n*	%
finances/money	46	93	45	90
adult alcoholism	40	82	37	67
jobs	12	75	37	67
teen-age drinking	33	66	17	33
depression	29	59	36	73
health problems	26	52	21	43
conflict within family	25	50	31	63
drug abuse	24	48	24	47
social services system	23	46	24	47
school dropout	23	46	18	37
legal problems	20	39	3	7
racial prejudice	20	39	21	43
marital problems	18	36	6	13
housing	17	34	20	40
adjustment to city living	11	23	8	17
suicide	7	14	15	30
conflict with children	7	14	13	27
child abuse	7	14	1	3
sexual abuse	3	7	10	20
elder abuse	1	2	0	0

Respondents interest in workshop opportunities is summarized in Table 5. A majority of the respondents expressed an interest in all of the workshops listed.

Other educational/workshop opportunities desired by the respondents included: (a) life coping skills, (b) career planning, (c) community health service clinic and mental health services, (d) dealing with social discrimination, (e) continuing educational counseling, (f) home economic skills, (g) working with senior citizens, (h) family counseling services, and (i) Native American holistic approach to problems and concerns.

Discussion

The major problems being experienced by the consumer respondents appear to focus on economics, social, and mental health areas. It becomes a vicious cycle for the 90% of the American Indian consumer respondents, who receive less than $10,000 annual income. While some of their basic subsistence needs may be supplemented through food stamps, commodities,

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Table 2
Identified Problems and Affect

Problem	At least weekly			
	Males		Females	
	n	%	*n*	%
financial problems	31	62	35	72
social withdrawal[1]	26	54	15	31
difficulty sleeping	23	46	22	44
feeling angry/bitter	20	40	21	43
family problems	20	40	18	37
feeling depressed[1]	15	30	11	23
spouse/family member abuses alcohol/drugs	15	30	22	45
feeling lonely	15	29	15	31
frequent back pain[1]	14	28	15	30
legal problems	12	25	10	20
frequent severe headaches[1]	10	21	15	30
feeling guilty	10	21	12	24
feeling that I'm not good/decent person	10	21	8	17
lack of appetite	10	19	13	27
feeling lack of control	8	17	14	28
too much drinking	7	14	13	27
frequent stomach aches[1]	7	14	10	20
use of drugs	1	2	3	6

[1]*Diagnostic and Statistical Manual of Mental Disorders*: Clients experiencing at least 5 of these criteria for 2 weeks, representing a change in previous function, may be clinically depressed.

etc., the need to seek out and apply for benefits from these special programs often adversely impacts an individual's self esteem. Thus, those who feel they have little control over their lives may seek alternate coping mechanisms, such as alcohol or drug abuse, to get away from their problems, if only momentarily. The prevalence of self-reported chemical abuse in the consumer population (82% of males and 67% of females self-reported adult alcoholism in their lives while 48% of the males and 67% of the females self-reported drug abuse as a problem in their lives) may be partially responsible for the domestic and personal violence, abuse, and problems reportedly experienced by 20% to 50% of the client population.

While there are mental health services available within the community, 80% of the provider respondents reported that less than 25% of their client population was American Indian. Only 17% of the providers surveyed identified

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Table 3
Perceived Problems for the American Indian Community

Problem Area	Males		Females	
	n	%	*n*	%
employment	49	98	48	97
domestic violence	40	80	35	70
access to medical care	40	80	28	47
drug abuse	36	73	46	93
racial discrimination	36	73	46	93
marital conflict/divorce	35	71	28	57
law enforcement	35	71	13	27
alcoholism	33	66	41	83
child abuse/neglect	28	57	31	63
communication	28	57	28	57
school	25	50	0	0
finances	21	43	26	53
sexual abuse	21	43	10	20
social service system	20	41	27	53
teenage pregnancy	12	25	21	43
housing	11	23	18	37
suicide	9	18	6	13

Table 4
Desired Programs/Services

Service	Males		Females	
	n	%	*n*	%
Professional Mental Health Provider	26	52	36	73
Information/referral counseling	30	61	36	73
Individual counseling	40	80	45	90
Family counseling	23	47	40	80
Group counseling	19	39	21	43
Self-help groups	38	77	36	73
Outreach/transportation	45	89	46	93
Native American Spiritual Leader/Holy man	34	68	33	67
Other	0	0	2	7

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Table 5
Workshop

Workshop	Males		Females	
	n	%	*n*	%
Stress management	30	61	41	83
Anger control	29	58	30	60
Alcohol/drug education	39	79	41	83
Parenting	32	65	35	70
Grieving/loss	27	55	36	73
Traditional/cultural activities	39	79	41	83
Financial management	37	74	40	80
Building self-esteem	39	79	46	93
AIDS/HIV education	36	72	35	70

themselves as American Indian. While needed services are available, they are inaccessible for a variety of reasons. If these consumers cannot afford to meet basic existence needs for themselves or their families, they certainly are not going to seek out services for which they are required to pay. The provider community also recognizes the barriers to access for American Indian clients, i.e., more than three fourths (76%) of the provider respondents felt that there are barriers to both providing and accessing services that would meet the mental health needs of the Butte American Indian community. These barriers include lack of American Indian providers (who may possess the cultural knowledge and sensitivity necessary to meet American Indian needs), lack of financial resources, and, the complexities of the welfare system which makes it difficult to obtain and provide necessary financial support to those American Indians in need. An additional barrier to treatment is the lack of trust American Indian clients may have for the many non-Indian providers practicing in the Butte-Silver Bow community.

Recommendations

The NAIA's Job Partnership Training Program needs to make more of a concerted effort to get American Indian clients in to provide information, guidance, and counseling in seeking out employment opportunities within the community. This program may be able to function as a referral source for those individuals who have disabilities but are able to work if given appropriate accommodation.

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There is clearly a need for American Indian Mental Health Care Providers in our community. However, considering the prevalence of mental health problems reported here, it is doubtful that there will be enough American Indian providers to meet the service needs of the community. An American Indian Provider may be better used as both a conduit for referral of clients to appropriate treatment resources as well as a source of training and information to non-Indian providers about the cultural expectations, customs, and beliefs of their American Indian clientele.

The NAIA has operated in the Butte-Silver Bow community for over twenty-five years and almost the entire American Indian population of this community utilize its resources. Thus, the NAIA is in a unique position in being able to: (a) identify the mental health needs of this American Indian community, (b) provide culturally sensitive treatment, and (c) develop a referral network of knowledgeable outside providers.

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MENTAL HEALTH NEEDS ASSESSMENT OF OFF-RESERVATION AMERICAN INDIAN PEOPLE IN NORTHERN ARIZONA

Barbara Chester Ph.D., Patricia Mahalish, and James Davis

Abstract: Native Americans For Community Action, Inc. (NACA) implemented a community-wide mental health needs assessment in Northern Arizona using bilingual interviewers recruited from the local community. A total of 235 people: 156 adults, 28 adolescents, and parents of 51 children were interviewed. File data from the NACA Family Health Center was also analyzed. Thirty-eight percent (38%) of adults reported problems with depression, 27% reported completed or attempted suicide among family members, 31% had problems with drugs or alcohol, and 25% reported problems with physical abuse. Sixty-five percent (65%) of those surveyed never sought professional help. A majority of respondents said that mental health services were needed in their community.

In September, 1991, Native Americans For Community Action, Inc. (NACA) received funding from the Department of Health and Human Services, Indian Health Service (IHS) to implement a broad-based, community-wide mental health survey. These funds were distributed as part of a national effort to encourage the provision of culturally-appropriate mental health services for American Indian people living in urban or off-reservation settings.

NACA is a non-profit American Indian organization providing a broad range of human services primarily to American Indians in Coconino County in Northern Arizona. NACA was founded in 1971 as a community-based agency to address the social and economic needs of American Indians residing off-reservation in Flagstaff, with outreach to other non-reservation areas such as Page and Grand Canyon Village.

NACA has grown from an outreach alcoholism program to a broad-based community service agency. NACA's programs include: (a) outpatient substance abuse counseling, (b) child and family counseling, (c) emergency services, (d) employment training and assistance, (e) adult education, (f) an intergenerational sharing program, (g) the Pathways program for high-risk youth, (h) an economic development project for artisans and other vendors,

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and (i) post-move services for individuals relocated from the Navajo-Hopi Joint Use Area. Within the two-year time period from February, 1989 - February, 1991, the substance abuse program alone provided treatment, screening, and prevention services to almost 1,800 people. In 1991, NACA added an outpatient, ambulatory health center offering family medicine, well child clinics, prenatal care, and AIDS and nutritional counseling. During its first year of operation, the health center accommodated approximately 6,000 patient visits from 3,000 unduplicated individuals.

NACA offices are located in Flagstaff, Arizona, and its service area includes all of off-reservation Coconino County. The county population is 91,900, which includes portions of the Havasupai, Hopi, Hualapai, Kaibab, and Navajo reservations (Arizona Department of Economic Security, 1989).

American Indians comprise almost 10% of Flagstaff's population, approximately 4,800 people. In the surrounding non-reservation areas of Coconino County, the American Indian population is 2,370 (for a total non-reservation Indian population of almost 7,200 people). This population is predominantly Navajo, which is reflected in NACA's current client population.

NACA estimates that 55% of all county American Indian adults are unemployed and 35% are under-employed. Seventy-five percent (75%) of adults have not completed high school or achieved a GED. School district figures show a 12.5% American Indian drop-out rate (this is undoubtedly an underestimate since the figure does not include children leaving elementary or middle school or the migrant youngsters who move from community to community without enrolling in school).

Flagstaff is the market center for the adjacent reservation areas. The reservation populations are increasingly moving from isolated rural home sites to reservation growth centers and bordertowns where schools, jobs, and services are concentrated. With this migration, the extended family and clan network that traditionally provided support for tribal members from birth through old age is breaking down.

In addition to this "immigration," Flagstaff also receives "refugees." These are former residents of the Navajo-Hopi Joint Use Area, now relocated as a result of the Navajo-Hopi Land Settlement Act (PL 93-531). The relocatees tend to be more traditional, lack cross-cultural skills, are less likely to speak English, and possess fewer employable skills than other off-reservation residents. The process of relocation and adjustment is extremely stressful, particularly for the elderly (Kammer, 1980).

Interviews with service providers in the Flagstaff area indicate that there are few culturally-appropriate services available on an in- or out-patient basis for American Indian people. While mental health services are provided by community agencies, none provide culturally-specific or bilingual services, and none employ American Indian staff.

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Methods

The primary purpose of this study was to gather information for NACA from the community that the organization serves. The survey was conducted in four phases:

Pre-Survey Interviews and Design of Protocol: This phase included interviews with NACA staff and consumers of service. NACA staff were interviewed to determine what questions they would like answered, what approaches were practical, and what problems they thought might be encountered in attempting to conduct these surveys. In addition, the staff were asked for their cooperation in referring people for interviews and were given a chance to review survey instruments prior to finalizing the procedures.

Time, monetary, and other constraints required using a protocol that could be completed in one hour, with instruments that could easily be translated into Navajo, Hopi, and other community languages. Telephone interviews with national experts were conducted to ascertain what instruments existed that would fulfill these requirements.

Selection and Training of Bilingual Surveyors: Four NACA staff and interns took part in the survey, and five additional individuals were interviewed and hired. All of these individuals received two days of training which covered such topics as project goals, concepts of mental health, mental health prevention models, psychological tests and survey instruments, interviewing skills, confidentiality, and mandatory reporting. Training also included discussion about how concepts and items could be interpreted into the Navajo language. Eight people completed the training of which seven were women, and all were bilingual Navajo speakers.

Interviews: Interviews were conducted from January 2 - June 1, 1992. The sample goal was between 200-300 individuals, based upon a semi-stratified sample of both selected and unselected people. By June 1st, 235 surveys were completed, and interviewing was discontinued.

Medical Record Review: In addition to the surveys, approximately 10% of adult intake files from the Family Health Center were reviewed for both corroborative and comparative purposes. According to the Health Center Director, 48% of the 3,000 unduplicated individuals seen at the clinic during the first year of operation were above age 18. The files of 144 adults were examined at random for demographic information, as well as for reviewing several items of the intake form. These items included (a) difficulty sleeping, (b) feeling tired, (c) feeling down/depressed, (d) feeling nervous/irritable, (e) alcohol/drug use, (f) frequent headaches, (g) shortness of breath, (h) night sweats, and (i) feeling dizzy/faint.

Sample

NACA's 15 programs include a range of services to the community. Several of these programs involve clients selected on the basis of health or

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mental health problems, while clients of other programs are not admitted to the agency on this basis.

The sample was semi-stratified in that both selected and unselected individuals were targeted from all age groups including (a) children, (b) adolescents, and (c) adults. Selected individuals were recruited from several NACA clinical programs while unselected individuals were recruited from NACA's non-clinical programs.

In addition to NACA programs, fliers announcing the project were distributed to area schools, churches, and service agencies. Also, letters were sent to all post-move clients (relocatees) living in or around Page, Arizona, one of NACA's off-reservation catchment sites. Meetings were also held with Title V counselors and the staff of the Flagstaff Bordertown Dormitory to enlist their aid with the project. All individuals interviewed were guaranteed confidentiality. Interviewers were instructed not to interview close friends or family members, but to pass these names to other, unrelated surveyors.

A total of 156 adults, 28 adolescents, and 51 parents of children in the community completed surveys. Of the adults surveyed, 12% were aged 60 or older. Seventy percent (70%) of the individuals came from unselected sources while 30% of the interviewees were clients selected from NACA health or counseling programs. Ninety-seven percent (97%) of the interviews were conducted in the Flagstaff area and 3% of respondents were interviewed in Page.

Measures

The final protocol included a demographic survey including a section on barriers to service utilization, acculturation scale (Albaugh, Robin, & Chester, 1991) and a standardized, age appropriate checklist. Both the demographic survey and acculturation scale were adapted from similar instruments presently being used by the National Institutes of Health (NIH) in three American Indian communities.

The *Child Behavioral Checklist* (CBCL) (Achenbach, 1991a) and *Youth Self Report* (YSR) (Achenbach, 1991b) were developed as part of a multiaxial empirically-based assessment procedure. For children, this procedure is based upon the assumption that parents and parent surrogates are typically among the most important sources of data about children's competencies and problems, particularly as these occur across both time and situations.

The YSR is interpreted through use of a profile analysis. The competence profile is based upon three scores: (a) activities, (b) social, and (c) school performance. Problem areas are scored on the basis of nine scales: (a) withdrawn, (b) somatic complaints, (c) anxious/depressed, (d) social problems, (e) thought problems, (f) attention problems, (g) delinquent behavior, and (h) aggressive behavior. The scores of scales a, b, and c are totaled to determine the "internalizing" problems scale score, while scales g and h are totaled to determine the "externalizing" problems scale score. The CBCL is scored in a similar fashion.

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Although used in a multitude of cross-cultural studies, great care must be taken when interpreting and applying the results of these surveys to the present population. This is due to the fact that only 3% of the combined normative sample of 2,368 were "other" (possibly including American Indians), as opposed to 7% Hispanic, 16% Black, and 73% White. Also, the normative sample came primarily from the northeast and north central regions, and was predominantly upper or middle class.

The *Personal Problems Checklist for Adults* (Schinka, 1984) is a gross survey of common problems, developed primarily for screening and intake purposes. The checklist covers 13 problem areas including (a) family/home, (b) crisis, (c) finances, (d) emotional problems, (e) health/habits, and (f) legal problems.

The *Acculturation Questionnaire* used in the present study was designed through a process of dialogue with acknowledged community leaders from several tribal groups in Arizona, New Mexico, and Oklahoma. This scale is a shortened version of an instrument presently being used by researchers from NIH. The scale examines such characteristics as values, beliefs, practice, and knowledge within the five dimensions of language, cultural heritage, ethnicity, spirituality, and perceived discrimination. Since the instrument has not yet been normed, interpretation for the purposes of this study involved a simple item analysis. This instrument was administered to individuals over the age of thirteen.

All but one of these instruments (the Acculturation Questionnaire) were originally designed to be completed by the interviewee. However, for purposes of this study, all items were presented orally by the trained, bilingual interviewers. This was done to increase rapport and interviewee willingness to respond, and to overcome possible lack of reading comprehension.

Analytic Plan

NACA staff were most interested in population specific results in order to design practical mental health services. Almost all information was tabulated by item with the exception of the YSR and CBCL. These checklists were scored using standard profiles in order to examine areas of competence, problem areas, and the percentage of children and youth whose problem scores placed them within the clinical range. Mean *T*-scores were calculated for the competencies scale, internalizing problems scale, externalizing problems scale, and overall problems scales. In addition the endorsement items from the YSR and CBCL were also examined.

Results

The entire survey packet was administered to a total of 235 people: 156 adults, 28 adolescents, and parents of 51 children. Interviews varied greatly in length, depending upon the age and interest of the interviewee

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and language of the interview. Eighteen percent (18%) of the surveys were conducted in the Navajo language and the remaining 82% in English. Demographic characteristics of the respondents are summarized in Table 1.

Factors Affecting Service Utilization

One important area of concern for NACA was the use of and barriers to use of services. The demographic survey explored several issues in this area, the results of which are summarized in Table 2.

Of those using professional help, 48% said that the experience was helpful and continue to use these services as needed. Others stopped using these services for a variety of reasons including (a) family criticism (20%), (b) feeling "judged" by the professional (16%), (c) referrals to costly professional services (8%), and (d) lack of skill on the part of the professional (8%). When traditional healers were included in the category of professional help, only 1% of respondents reported using this service.

Of those who never used professional services, 60% stated that they had no need of these services, 20% said that they had no information regarding these services, 17% felt that people should only talk about these things with close relatives, and 16% said that these services cost too much money.

Personal Problem Checklist for Adults

The endorsement of the 146 adult interviewees (46 male and 100 female) of specific problems from the personal problems checklist is summarized in Table 3. In terms of designing a mental health program, it is notable that 46% of these adults endorsed "family death," 39% anxiety, 37% depression, 16% drugs/alcohol, and 9% suicidal thoughts as personal problems. Twenty-seven percent (27%) of the adult interviewees reported that suicide attempts and suicide completion had occurred in their families.

Youth Self-Report

The mean competence *T*-scores and percentage of youth with below average competence scores from the YSR are summarized in Table 4. One quarter of youth who completed the YSR had below average competence scores. These low scores were due exclusively to low scores on the school performance scale.

The mean problems scores and percentage of youth scoring within the clinical range on the YSR is summarized in Table 5. *T*-scores on these scales ranged from 45 to 79. Almost one-fifth of youth scored within the clinical range on the Total Problems scale. Responses to several questions from the YSR were also examined. Fifty-eight percent (58%) of the 28 youths reported problematic nightmares, 51% associated with bad companions, 42% were truant, and 27% admitted to alcohol and/or drug use.

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Table 1
Demographic Survey Results

	n	%
SEX		
Male	97	41.3%
Female	138	58.7%
AGE		
0-6	19	8%
7-12	31	13%
13-18	21	9%
19-59	146	62%
60+	18	8%
TRIBAL AFFILIATION		
Navajo	176	75%
1/2 X 1/2 (different tribes)	28	12%
Hopi	14	6%
Apache	8	3%
Cherokee	2	1%
Havasupai		
Hualapai }	7	3%
Tewa		
Zuni		
MARITAL STATUS (Adults)		
Married	77	33%
Divorced	26	11%
Widowed	12	5%
Single	120	51%
RESIDENTIAL STATUS		
Live with parents or relatives	143	61%
Live with spouse or partner	49	21%
Live alone	26	11%
Dormitory or shared apartment	17	7%
COMBINED HOUSEHOLD INCOME		
$7,000 or less	61	26%
$7,001-12,000	44	19%
$12,001-30,000	78	33%
$30,001 or more	52	22%
SOURCE OF INCOME		
Blue/white collar job	75	32%
Professional job	30	13%
Spouse or parents	61	26%
Tribal/government assistance	35	15%
Pension	17	7%
Arts and crafts	17	7%

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Table 2
Factors Affecting Service Utilization[1]

	n	%
WHO PEOPLE BRING PROBLEMS TO		
Mother	40	17%
Spouse	31	13%
Both parents	21	9%
Sister	16	7%
Other	17	7%
Total family members	124	53%
Friend	52	22%
Professional	40	17%
Talk to no one	28	12%
Clergy	18	8%
WHY MENTAL HEALTH PROBLEMS EXIST?		
Early childhood environment	49	21%
Family problems	28	12%
Alcohol and drugs	26	11%
Stress	21	9%
Life is hard	14	6%
Other (sexual abuse, change, accidents, unemployment)	97	41%
DESIRED SERVICES		
Someone to talk to	170	72%
Parenting program	113	48%
Counseling for child		
Abuse/neglect	106	45%
Alcohol/drug counseling	98	42%
Suicide prevention	64	27%
FACTORS PROMOTING USE OF SERVICES		
More information about mental health	183	78%
American Indian staff	84	36%
Services on nights and weekends	57	24%
Transportation	52	22%
Telephone	19	8%

[1]Note: Numbers may not = 100% due to response overlap.

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Table 3
Personal Problem Checklist For Adults[1]

Items	n	%
Need exercise	73	46.8
Health problems	71	45.5
Family death	71	45.5
Family emotional problems	61	39.1
Anxious	61	39.1
Sleep disturbance	61	39.1
Depressed	58	37.2
Auto accident	40	25.6
Physical abuse	38	24.4
Emotional and verbal abuse	38	24.4
Family illness	35	22.4
Drugs/alcohol	25	16.0
Spouse alcoholic	21	13.5
Family suicide completed	20	12.8
Family suicide attempted	22	14.1
Suicidal thoughts	14	9.0

[1]Total adult sample: n = 156

Table 4
Youth Self-Report Competence Scores[1]

	Male (n=16)	Female (n=12)	Combined (n=28)
Mean Competence T-score	47	56	51
Percentage of Youth with Below Average Competence Scores	21%	33%	25%

[1]Note: Borderline range T = 41 or below. Below average scores are due exclusively to lower competence scores in the area of school performance.

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Table 5
Youth Self-Report Problems Scores[1]

	Male (n=16)	Female (n=12)	Combined (n=28)
MEAN *T*-SCORES			
Total Problems Scale	50	58	54
Internalizing Problems Scale	53	56	54.5
Externalizing Problems Scale	45	60	52.5
PERCENTAGE OF YOUTH SCORING WITHIN CLINICAL RANGE			
Total Problems Scale	21%	17%	18%
Internalizing Problems Scale	29%	17%	21%
Externalizing Problems Scale	14%	17%	15%

[1]Note: Borderline range T = 64 or above

Child Behavior Checklist

The mean competence *T*-scores and percentage of children with below average competence scores from the CBCL are summarized in Table 6. Almost one-fifth of children whose parents completed the CBCL had below average competence scores. As was the case with the youth who completed the YSR, these low scores were primarily due to low scores on the school performance scale.

The mean Problems scores and percentage of youth scoring within the clinical range on the YSR are summarized in Table 7. *T*-scores on these scales ranged from 36 to 81. About one-fifth of youth scored within the clinical range on the Total Problems scale. Responses to several questions from the CBCL were also examined. Forty percent (40%) of the parents of 51 children reported that their child suffers from nightmares. Fourteen percent (14%) stated that their boys set fires.

Acculturation Scale

Results from the Acculturation Questionnaire are summarized in Table 8. Although there has been a drastic decline in the use of traditional languages between generations, 97% of respondents believed that it is important to maintain their traditional language. Almost all respondents (95%) reported that knowledge of their tribal cultural histories is important to them.

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Table 6
Child Behavior Checklist Competence Scores[1]

	Male (n=35)	Female (n=16)	Combined (n=51)
Mean Competence T-score	45	51	48
Percentage of Youth with Below Average Competence Scores	28%	8%	18%

[1]Note: Borderline range T = 41 or below. Below average scores are due primarily to school performance.

Table 7
Child Behavior Checklist Clinical Scores[1]

	Male (n=35)	Female (n=15)	Combined (n=51)
MEAN T-SCORES			
Total Problems Scale	55	52	53.5
Internalizing Problems Scale	55	50	52.5
Externalizing Problems Scale	52	48	50
PERCENTAGE OF YOUTH SCORING WITHIN CLINICAL RANGE			
Total Problems Scale	31%	13%	22%
Internalizing Problems Scale	29%	19%	24%
Externalizing Problems Scale	20%	6%	13%

[1]Note: Borderline range T = 64 or above

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Table 8
Acculturation Scale[1]

	n	%
LANGUAGE		
Speaks traditional language fluently	118	64%
Verbal comprehension of language	138	75%
Speaks English fluently	162	88%
Children speak language fluently	27	15%
Traditional language spoken at home	13	7%
HERITAGE		
Reservation born	147	80%
Born in bordertown	30	16%
Never lived on reservation	7	4%
Told traditional stories as child	143	78%
Given Indian name	83	45%
SPIRITUALITY/RELIGION		
Participated in clan initiation ceremonies	101	55%
Use traditional healers or medicine person	96	52%
Belong to denominational church	112	61%
Belong to Native American Church	47	26%

[1]Total adult and adolescent sample: n = 184

In terms of ethnic identity, 58% of those responding to the survey identified primarily with their own tribal group (e.g., Navajo, Hopi, Hualapai), while 44% identified themselves more broadly as American Indian. Only 5% of those responding identified themselves primarily as "American." More than half (55%) of those responding to the survey reported that they have experienced discrimination because of their ethnicity. Thirty-nine percent (39%) also believed that they receive different treatment from other American Indian people who are not part of their tribe.

Most respondents (73%) felt that the best thing for American Indian people is to accommodate to modern life, and 74% said that modern technology has been good for peoples' lives.

Medical Record Review

Fourteen percent (14%) of adult clinic patients reported self or spousal problems with alcohol use. Ten percent (10%) reported feelings of depression. Reported physical symptoms that may be related to emotional distress are shown in Table 9.

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Table 9
Information From NACA Health Clinic Files[1]

	n	%
Frequent headaches	26	18%
Tired	26	18%
Alcohol/drug use	20	14%
Dizzy/faint	19	13%
Down/depressed	15	10%
Nervous/irritable	15	10%
Difficulty sleeping	12	8%
Shortness of breath	7	5%
Night sweats	4	3%

[1]Ten percent of adult intake files: n = 144

Discussion

Consistent with others studies of American Indian people, the current survey demonstrates a high rate of distress within this off-reservation population. After reviewing the survey results, it is clear that there are five primary factors that require serious consideration when planning a program for this community.

First, a mental health agency developed within this community needs to take an integrated approach to services, and to consider the impact of physical, social, and economic concerns on mental and emotional health. Consistent with other findings (i.e., Resnick & Blum, 1992), this community reports high rates of feeling depressed (38%), suicide in family members (27% completed or attempted), and drug and alcohol abuse (31%). In addition to these problems, people expressed concerns about their general health, the need for vacations, physical exercise, and job security. Almost half (45%) of the people surveyed live in households that are close to or below the poverty level for families of four or more.

Second, elements contributing to distress at differing ages should be the target of age-specific prevention programs. Children appear to demonstrate more competence than youth in school performance, a finding also noted by others (Lujan, Debruyn, May, & Bird, 1989). Internalizing problems appear to be more prevalent in the adolescents, and externalizing problems more prevalent in adolescent females when compared to the parental report concerning female children. Findings also demonstrate nightmares during sleep in 40% of children and 58% adolescents, suggesting

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the possibility of significant trauma in these groups. In general, this survey demonstrates a progression of both problems and coping mechanisms which, if handled well at critical developmental levels, might reduce crises and enhance coping in later life.

Third, the ability to adapt to another culture in the midst of rapid change, while maintaining one's own cultural integrity, is an inherent strength that can and should be utilized in program planning on both the individual and community level. It is clear from the responses to the Acculturation Questionnaire that culture is an important element in the lives of community individuals. To be effective, a mental health program must integrate cultural variables into the treatment milieu.

It is also important to note that there is a large contrast between the information obtained using the Acculturation Questionnaire (52%) and that obtained in the demographic survey (1%) regarding the use of traditional healers. This may be due to the fact that respondents view traditional healing from a cultural or spiritual context, as opposed to a professional one. This kind of contrast underscores the importance of using collateral forms of data and being aware of the context of questions, particularly when working with diverse cultures.

Fourth, an outreach component is necessary for a successful off-reservation mental health program. One compelling finding indicated that lack of information about mental health and available services is a strong barrier to service utilization. Similarly, almost one-fourth (22%) of the population is hampered by a lack of transportation. A bilingual, bicultural outreach to individuals is essential in order to address these needs.

Fifth, the screening for psychological distress in general health case settings should be reconsidered. The present survey supports the under-reporting of data from client files found in the literature (O'Nell, 1989). Much lower levels of self-reported psychological symptoms and behaviors were found on intake forms used by patients at the Health Clinic than when people were asked similar questions by local interviewers. For example, while 31% of the interviewed adult sample reported problems with alcohol or drug use by self or spouse, only 14% of adult clinic patients reported such use. While 38% of the interviewed adult sample reported problematic feelings of depression, only 10% of adult clinic patients self-reported such feelings.

As clinic patients are drawn from the same population as the interviewed sample, it is unlikely that their emotional distress or use of alcohol would be lower than the interviewed sample. It is more likely that, for various reasons, patients self-report significantly fewer emotional problems in medical clinics than they do in personal interviews with trained bilingual interviewers.

Conclusion

There are many elements that compose the value that is defined as mental health, and a number of factors that have a potential impact on well-

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being at all developmental stages. Although a community mental health program cannot reverse the deleterious effects of poverty, marginalization, and racism, such a program can name and recognize both the problem areas and competencies that have an impact on recovery.

> Happily I recover. Happily my interior becomes cool. Happily I go forth. My interior feeling cool, may I walk. No longer sore, may I walk. Impervious to pain, may I walk. With lively feelings, may I walk. As it used to be long ago, may I walk. Happily may I walk. (Navajo Night Chant)

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Authors' Note

Dr. Barbara Chester died in October of 1997. We lament the loss of an effective advocate for indigenous people and a champion of human rights.

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MENTAL HEALTH NEEDS ASSESSMENT OF TUCSON'S URBAN NATIVE AMERICAN POPULATION

Veronica Evaneshko, Ph.D., RN

Abstract: This report presents the design, implementation, and results of a 1992 mental health needs assessment of Tucson's urban American Indians. The study was conducted under the auspices of the Traditional Indian Alliance (TIA) of Greater Tucson, Inc.[1] TIA is a community-based, non-profit corporation committed to addressing the health and social welfare issues of Tucson's American Indians. As a result of having provided health and social services since 1974, TIA recognized that there were many unmet needs for culturally sensitive American Indian mental health programs. The organization established a goal of assessing the mental health needs of Tucson's urban American Indians in order to obtain the information needed to enhance program development and the provision of services. This survey was conducted in order for Traditional Indian Alliance to enhance its mental health program development and improve the provision of mental health services to Tucson's urban American Indians. The specific objectives of this study on Tucson's urban American Indian population included documentation of (a) the nature of socioeconomic problems that might have a psychological effect, (b) the existence of psychological distress, and (c) the types of available support systems and their utilization.

Urban American Indians have both the reservation population's burden of poor physical health and the urban area's burden of increased stress combined with fewer available health services (American Indian Health Care Association, 1989). A few studies have specifically documented the high levels of mental health problems among urban American Indians (Borunda & Shore, 1980; Joe & Miller, 1989; Rhoades, Marshall, Attneave, Echohawk, Bjork, & Beiser, 1980; U.S. Senate Select Committee on Indian Affairs, 1985).

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Methods

Study Design

Issues of study design that required resolution included (a) clarity of the concepts being measured, (b) adequacy of the instrument designed to measure the concepts, and (c) the most effective means of administering the instrument. While these are important issues in any study, they require particular attention when an assessment is done in a cross-cultural setting.

Data collection for screening purposes (as opposed to diagnostic uses) dictated a focus on social dysfunction rather than psychopathology per se (National Institute of Mental Health, 1985). Measurement of social dysfunction can involve behavior and/or attitudes and beliefs. For this study, emphasis was placed on obtaining data about how the individual felt since cognitive processes often have a greater impact than actual circumstances on how well an individual handles life's challenges.

Data collecting instruments used in American Indian cross-cultural settings have unique validation concerns (Liberman & Frank, 1980; O'Nell, 1989; Shore & Manson, 1981; Spaulding & Balch, 1985). The instrument used in this study was an amalgamation of several tools developed and used by other urban American Indian groups and was obtained from the Dallas Intertribal Center. Local American Indians assisted in adapting the questionnaire to Tucson's urban residents, focusing on relevancy and cultural meaningfulness.

A community-wide survey format utilizing American Indian interviewers was the collection design of choice. The Dallas Intertribal Center elected to employ their instrument, primarily (but not exclusively), in a self administered format to their clinic population. TIA was interested in obtaining knowledge and information from both clinic and nonclinic users in their needs assessment since there is extensive information identifying barriers to urban American Indian clinic use (Kahn, 1982; LaFromboise, 1988; Lake, 1982; Shannon & Bashshur, 1982). An interview design was preferred in order to provide an opportunity to clarify items if needed and to benefit from the American Indian interviewer's insights.

Data Collection Procedure

The data collection format involved home (or, rarely, office) interviews of American Indians living in the metropolitan area. Initially, five American Indian interviewers were recruited to administer the questionnaires. Two interviewers were female Tohono O'Odham Registered Nurses; two were male public school educators (one Navajo, one Apache); and one was a Tohono O'Odham female community resident. A male Yaqui public school board member and a female Yaqui community member were used to complete a small number of the questionnaires towards the end of the project.

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The five original interviewers participated in a six hour training session designed to acquaint them with the project's goals and procedures of data collection. During the training session the interviewers participated in adapting the questionnaire to ensure relevancy for the local American Indian population. The interviewers also recommended changes in wording and item sequencing which enhanced the quality of the final product as well as provided for easier administration of the instrument.

The interviewers were responsible for locating potential respondents. Each interviewer was assigned an area of the community with which he or she was familiar and was provided a suggested number of individuals to be interviewed from specific tribal groups for the area assigned. For example, one area might require interviews from 41 Yaqui, 38 Tohono O'Odham, 12 Navajo, etc. The number of respondents from each tribal group that was needed for city-wide proportional representation was extrapolated from 1990 U.S. Census tract maps for the greater Tucson area.

Respondent recruitment occurred in a number of ways, including the use of relatives, friends, neighbors, acquaintances, participant referrals, and serendipity. This recruitment format was used since addresses were not available and a reliance on clinic lists for potential respondents was not desired, nor was entry into unknown ghetto pockets where drugs and violence might exist. The interviewers understood and made a concerted effort to get proportional representation of the entire metropolitan area in terms of tribal affiliation, socioeconomic status, and area of residence.

Only one adult from each household was eligible to participate in the study for which s/he received a $10 compensation fee. Respondent qualifications included (a) tribal affiliation, (b) urban residency, and (c) age 18 or older. The interviewers received $20 per completed interview plus mileage. Although the data collection procedure emphasized an interview format at a place of residence or similar area, a few of the questionnaires were left at office settings for self administration. The interviewer was then responsible for going over any questionable parts with the respondent.

The questionnaire was extensive and took an average of 45-60 minutes to complete. Data on sociodemographics were collected to present a profile of the sample population; to discuss the sample population's representativeness; and to establish the existence of potential and actual social problems known to be associated with mental health disorders. Data on personal and community support systems were collected to identify knowledge of available support systems and their utilization. Mental health data were collected to document indications of psychological distress.

Results

A total of 199 questionnaires were obtained of which 174 were used in this analysis. Twenty-five questionnaires were not used because the respondents were at least one of the following: (a) nonurban, (b) homeless

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[with questionable commitment for responding fully to the questions], (c) more than one respondent from a household, and (d) age less than 18 years. Although direct interviewing was preferred, 26 questionnaires were self administered. Respondents were recruited through a variety of means including (a) the interviewers' friends, neighbors, and relatives (*n*=55), (b) Native American agency contacts (*n*=51), and (c) participant referrals (*n*=29) [See Table 1].

Table 1
Frequency Distribution of Respondent Recruitment Sources

Recruitment Sources	Number	Percent
Interviewer's friend, neighbor	41	23.6
American Indian agency	37	21.3
Participant referral	29	16.7
Other (school, phone, serendipity)	21	12.1
Interviewer's relative	18	10.3
Interviewer's relative's referral	14	8.0
American Indian agency employee	14	8.0
TOTAL	174	100.0

Sociodemographics

Of the 174 interviews 58 (33.3%) were males and 116 were females (66.7%). A total of 20 tribes were represented including Yaqui, Tohono O'Odham, and Navajo.

Twenty-six percent of respondents were single, 50.6% were married or lived with a companion, 14.9% were divorced or separated, and 8.0% were widowed. The average household size was 4.2 persons.

Almost three-quarters of respondents (73.0%) had lived in Tucson more than ten years with over one-third (36.8%) being life long residents. The most prevalent reason for choosing to live in Tucson was birthplace (36.8%), followed by education/economics (28.2%), family ties (23.0%), and area assets (12.1%). A majority of respondents (52.3%) had never lived on a reservation; only 10.3% had lived off a reservation less than ten years. Catholicism (58.6%) was the most prevalent religious preference (which included Catholic, and Native American Catholic). Traditional religion (17.8%) was the second most reported preference (which included Native American Church, Traditional, and Native American Church-Traditional). See Table 2.

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Table 2
Frequency Distribution for Tribal Affiliation, Marital Status, and Religious Affiliation

	Number	Percent
Tribal Affiliation		
Yaqui	55	31.6
Tohono O'Odham	50	28.7
Navajo	21	12.1
Apache	8	4.6
Cherokee	7	4.0
Other	33	19.0
Marital Status		
Married/Companion	87	50.0
Single	46	26.4
Separated/Divorced	26	14.9
Widowed	14	8.0
No Answer	1	0.6
Religious Affiliation		
Catholic	102	58.6
Traditional	31	17.8
Protestant	23	13.2
Other	18	10.3

In order to assess acculturation levels, respondents were asked whether they and their families held to traditional ways, to more modern ways, or to both modern and traditional ways. A large majority believed that they (73.0%) and their families (60.9%) "held to both modern and traditional ways." See Table 3.

A review of the available, albeit limited literature, indicated the study group was representative of Tucson's urban American Indian population in terms of age range, tribal affiliation, and acculturation (Miller & DeJong, 1990). However, the study's male-female ratio (1:3) deviated from parity to a larger extent than the usual sex ratio (1:1.2) for Tucson's urban American Indians (Evaneshko, 1984). The extra number of female respondents was not considered a severe impediment given the generally accepted knowledge that women respondents do better in participating and answering surveys of this nature.

A majority of respondents (57.5%) held jobs, 29.9% were unemployed, and 12.0% were retired, students, or individuals with incomes from self employment like bead and silver work. Among the employed the

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Table 3
Frequency Distributions of Acculturation Beliefs For Respondent and Respondent's Family

Acculturation Categories	Respondent		Respondent's Family	
	n	%	*n*	%
Traditional ways	18	10.3	26	14.9
More modern ways	29	16.7	41	23.6
Modern and traditional	127	73.0	106	60.9
No answer	1	0.6		

largest number (53%) held semiskilled jobs. The next largest group (33%) worked in skilled positions, while the remainder (14%) held unskilled positions. Also among the employed, 78% were full time and 22% were part time. More than half of the employed respondents (56%) had held their job three years or less.

Almost one-third (29.3%) of respondents had less than 12 years of education, 18.4% had earned a high school diploma, and 40.2% had some college or completed trade school. Almost half (47.1%) believed their education had *not* prepared them to provide for self and/or family.

More than half of all respondents (54.6%) had total yearly incomes of less than $10,000. Only one-third of respondents were satisfied with their incomes. Sixty-four percent of respondents rented with 8.6% receiving a rent subsidy or residing in public housing. Almost a quarter of the respondents (24.1%) were dissatisfied with their housing situation. Twenty-eight percent of respondents received welfare and 12.6% received tribal supplement assistance. Concomitantly, one third (33.9%) of the respondents identified Medicare or AHCCCS (Arizona's Medicaid) as their medical insurance, and slightly more than one third (36.2%) claimed only IHS (Indian Health Service) service eligibility or no insurance at all. The remaining respondents (29.9%) stated they had group, private, or VA medical insurance.

Cultural Support

Twenty percent of the respondents did *not* have a reservation or tribal area they called home. Of the 129 respondents who did identify a tribal home area, 40.8% had returned more than three times in 1991, while only 13.8% had not made any visits.

When asked what services were available at the tribal home area that could not be obtained in Tucson, the most prevalent response was full, free, or better health care (32.6%), followed by general assistance (28.7%).

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A few respondents (9.3%) mentioned cultural support (which included traditional medicine), but others (24.8%) said there were no services at the tribal home area that could not be obtained in Tucson. It is important to note that a quarter of the respondent group had no opinion on this question because they had no tribal home area experience. Close to 60% of the respondents said they would travel to the reservation or tribal area if the health care services they needed were there instead of using the services in Tucson.

Family Support

When respondents were asked whether they saw relatives as often as they wished 97 (55.7%) responded 'no'. Reasons given included: (a) distance (31.6%), (b) transportation (16.7%), (c) too busy (16.1%), and (d) money (5.7%). Seven percent of respondents mentioned some form of family estrangement as a reason for not wishing to see family.

The kinds of things with which relatives helped, that Tucson area agencies do not or cannot do, included: (a) financial aid (58.0%), (b) emotional support (29.9%), and (c) general assistance (16.7%).

Community Resources

A large majority of respondents (76.4%) indicated they knew of the places where community help was available. Respondents most often relied on local Indian Health Service facilities (50.6%) for their health care. The use of other community resources was determined by asking respondents to check off from a list of 19 community services. The most frequently checked community resources used in the past year were (a) food programs (40.2%), (b) Arizona's Medicaid (39.1%), (c) non urban Native American health care facilities (31.0%), (d) Traditional Indian Alliance (20.6%), (e) native medicine (20.1%), and (f) Native American church (16.7%). Eight percent of the respondents used an alcohol or drug program in the past year. See Table 4 for the top ten community resources reported used in the past year.

The most liked aspect of the community services used was their general helpfulness (42.5%). The miscellaneous category, which represented the second highest number of responses (13.8%) included such answers as compassionate, courteous, professionally efficient, minimal waiting, and transportation assistance. Almost a fifth (18.4%) of the respondents stated they had no opinion because they had not needed or had not used Tucson's community services.

Categories of responses for what the individual disliked about the community services that had been used included: (a) nothing (27.6%); and (b) management of time (24.1%) including the hours, excessive waits, faults with the appointment system, and lack of sufficient time spent with the patient or family; (c) insensitivity (15.5%); and (d) bureaucracy (16.1%).

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Table 4
Frequency Distribution of Top Ten Community Resources
Used in Past Year

Community Resource	Number of Responses	Percent of Respondents (n=174)[1]
1. Food programs	70	40.2
2. Arizona's Medicaid	68	39.1
3. Non urban IHS	54	31.0
4. Trad. Ind. Alliance	36	20.7
5. Native medicine	35	20.1
6. Nat. Am. church	29	16.7
7. Job service	25	14.4
8. Other Nat. Am. agency	24	13.8
9. School counselor	23	13.2
10. Religious leader	23	13.2

[1] >100% due to multiple answers.

The top category of suggestions for making visits to community services easier or better was transportation assistance (28.8%), followed by the category of time (20.1%) which included such reasons as (a) better hours, (b) efficient appointment system, and (c) reduced waiting. If community services could "come to you" 122 (70.1%) respondents would use them more, 11 (6.3%) would not, while 39 (22.4%) were not sure. (There were 2 no answers.)

Since TIA is contracted to provide health care services, under Title V, P.L. 94-437, Indian Health Care Improvement Act for Tucson's urban American Indians, respondents were asked about their knowledge of TIA. Half (51.1%) acknowledged they knew little, if anything about the agency. Only 11.5% respondents had correct knowledge regarding the services TIA currently offers.

A total of 137 suggestions were offered regarding services that respondents would like to see at Traditional Indian Alliance. These were grouped into eight categories with suggestions involving expanded health care the most often mentioned (33%). Suggestions concerning improved health care (27.8%) and social services (24.7%) were offered the next two most frequently (see Table 5).

In an attempt to identify personal resources, respondents were asked to check, from a list of four nonprofessional options, with whom they conferred when they had a problem. Approximately half (n=115, 50.7%) conferred

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Table 5
Frequency Distribution of Categories of Suggestions for Services Wanted at Traditional Indian Alliance

Services Wanted at TIA	Number of Responses	Percent of Respondents (*n*=97)[1]
1. Expand health care	32	33.0
2. Improve health care	27	27.8
3. Social services	24	24.7
4. Health education	18	18.6
5. Improve/add staff	12	12.4
6. Cultural sensitivity	8	8.2
7. Information on TIA	8	8.2
8. More transportation	8	8.2
TOTAL	137	

[1] Based on total number of study respondents minus those who offered *no* suggestions to this question (174-77=97) and >100% due to multiple answers.

with a family member. Between half and a third (*n*=94, 41.4%) relied on friends, with a few (*n*=13, 5.7%) relying on a neighbor.

Respondents were then asked to select, from a list of 14 community services, those they would most likely use if they had a psychosocial problem. Among a variety of counseling options, the most frequently chosen were (a) a private counselor (40.8%), (b) counseling for self only (37.9%), (c) educational groups (37.9%), and (d) religious leader (36.2%). Psychiatrists (9.2%) and psychologists (10.9%) were the least likely services to be used, see Table 6.

Psychosocial Concerns

A slight majority of respondents (*n*=101, 58.0%) described their health as good. Another third (*n*=62, 35.6%) believed their health was just okay, while the remaining few (*n*=11, 6.3%) felt they had poor health.

Respondents were asked to list the health problems they and their household members had had in the past year. The range of health problems listed was extensive but typical. Fifty-three respondents (30.5%) listed no health problems and the group as a whole averaged 1.1 reported health problems per person in the past year. Households averaged 1.4 reported health problems in the past year.

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Table 6
Frequency Distribution of Responses to List of Community Services Respondents Most Likely to Use[1]

Community Services Most Likely to Use	*n*	%
1. Emergency food program	72	41.4
2. Private counselor	71	40.8
3. Counseling for self only	66	37.9
4. Educational groups	66	37.9
5. Religious leader	63	36.2
6. Family counseling	56	32.2
7. Job counseling	46	26.4
8. Group counseling	44	25.3
9. Self help groups like AA	44	25.3
10. Sweat Lodge	39	22.4
11. Child care services	33	19.0
12. Emergency shelter	33	19.0
13. Psychologist	19	10.9
14. Psychiatrist	16	9.2
TOTAL	668	

[1]Based on total group (*n*=174); >100% due to multiple answers.

To access psychosocial concerns respondents were asked to identify, from a list of 23 psychosocial situations, those which had caused them or their family much concern during the past three years. Responses were grouped into 11 categories. The category of basic needs drew the largest number of responses and included concerns about (a) employment, (b) food, and (c) housing. Family issues was another major concern and included such problems as (a) marital stress, (b) divorce, (c) children, and (d) stepfamily (see Table 7).

Respondents were asked to identify problems the American Indians have, on which the American Indian community should be working. The most frequent category of response was alcohol (51.1%), followed by drugs (32.2%), and jobs (32.2%).

An adolescent category (20.1%) included such issues as gangs, teen pregnancy, delinquency, dropouts, and teen suicide. The category of health care (12.1%) covered concerns for elderly, home health, and support groups

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Table 7
Frequency Distribution of Categories of Psychosocial Concerns

	n	%[1]
1. Basic needs		
job	99	56.9
food	81	46.6
housing	67	38.5
2. Family issues		
marital stress	31	17.8
divorce	26	14.9
children	36	20.7
3. Money	140	80.5
4. Drug and/or alcohol	92	52.9
5. Transportation	88	50.6
6. Physical Health	76	43.7
7. Violence		
safety	37	21.3
suicide	17	9.8
abuse	11	6.3
8. Adolescent		
dropout	35	20.1
alcohol use	29	16.7
9. Depression	57	32.8
10. Law/legal problems	48	27.6
11. Prejudice	47	27.0

[1]>100% as multiple responses were allowed

such as parenting and money management. A cultural unity category (14.4%) concerned cultural support, self esteem, cultural networking and unity. A few of the items in the miscellaneous category (16.1%) included prejudice, general assistance, social activities, and the need for American Indians to volunteer their services to the community. See Table 8 for a full listing of the categories of American Indian community problems identified by study respondents.

To further assess potential psychosocial needs, respondents were asked to check how often (daily, weekly, seldom, or never) they had concerns about 22 examples of mental health stresses. When daily and weekly responses were combined, the most frequently mentioned stressor was money (55.7%), followed by family members who use alcohol (50.0%). Other high scoring stressors included (a) a feeling of being stressed out (46.0%), (b) feelings of anxiety (41.1%), (c) fear of neighborhood violence (30.5%), and

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Table 8
Frequency Distribution of Categories of American Indian Community Problems Identified by Respondents

Categories of American Indian Community Problems	Number of Responses	Percent of Respondents (n=174)[1]
1. Alcohol	89	51.1
2. Drugs	56	32.2
3. Jobs	56	32.2
4. Adolescent	36	20.1
5. Miscellaneous	28	16.1
6. Cultural unity	25	14.4
7. Health care	21	12.1
8. Housing	20	11.5
9. Health education	17	9.8
10. Dysfunctional family	12	6.9
11. None, DK	13	7.5
TOTAL	373	

[1]Based on total number of all respondents (n=174) and >100% due to multiple answers.

(d) a sense of wanting to get away from everyone (29.9%). See Table 9 for the top ten scoring psychosocial stressors.

Respondents were asked whether they would use Traditional Indian Alliance if the clinic offered extended services for the kinds of psychosocial problems listed above. A large majority (n=134, 77.0%) said yes, only 2 said an outright no, while 36 (20.7%) were not sure.

When respondents were asked what the worst part of their life was today, the most frequent responses were events grouped in the category of stress (19.5%), followed by finances (16.6%), and lack of employment (15.5%). On the other hand, one fifth of the respondents (n=33, 19.0%) noted there was nothing distressing currently in their lives. With regard to what was considered to be the worst thing to happen in the respondent's life, the greatest number of responses concerned death in the family (44.3%). Health problems (16.1%) were the second most frequent response, followed by issues dealing with the family (9.2%) (see Table 10).

Respondents were also asked what the best parts of their lives were today. Not surprisingly, responses referring to family (29.3%) led the list, with children (28.2%) mentioned separately a close second. Issues referring

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Table 9
Frequency Distribution of the Top Ten Psychosocial Stressors Worried About Daily and Weekly

Psychosocial Stressors	Responses				Respondents
	Daily	Weekly		(Daily/Weekly) Combined	Percent (n=174)
1. Worry about money	47	50	=	97	55.7
2. Family use of ETOH	36	51	=	87	50.0
3. Stressed out	36	44	=	80	46.0
4. Feel anxious	32	40	=	72	41.1
5. Neighborhood violence	28	35	=	53	30.5
6. Anti-social feelings	17	35	=	52	29.9
7. Family problems	15	31	=	46	26.4
8. Drugs: family members	22	22	=	44	25.3
9. Health problems	26	17	=	43	24.7
10. Feel lonely	19	18	=	37	21.3

Table 10
Frequency Distribution of Categories of Responses for Worse Part of Life Today and Ever

Worse Part of Life	Today		Ever	
	n	%	n	%[1]
Death in family	—	——	77	44.3
Stress	34	19.5	—	——
Nothing	33	19.0	14	8.0
Finances	29	16.6	9	5.2
Lack of job	27	15.5	—	——
Health/injury	16	9.2	28	16.1
Housing	7	4.0	—	——
Alcohol/drug	6	3.4	11	6.3
Family Issues	—	——	16	9.2
Miscellaneous	31	17.8	27	15.5
TOTAL	183		182	

[1]Based on total number of study respondents (n=174) and >100% due to multiple answers.

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to personal growth (21.3%) rounded out the top three categories of responses. Childhood (24.1%) was the happiest time in many respondent's lives, followed by meeting and/or marrying one's spouse (17.2%). Family (14.4%) and children (12.6%) rounded out the top four categories of responses to the question of happiest time ever.

Discussion

Socioeconomic Issues

The association between socioeconomics and mental health is well documented, with individuals living in poverty having the highest rates of severe emotional disorders (Dohrenwend & Dohrenwend, 1969; Hollingshead & Redlich, 1958; Srole, Langer, Michael, Kirkpatrick, Opler, & Rennie, 1962). Few people can stand up to the constant pressure inherent in deciding which among life's necessities will have to be foregone because money is not available.

Potentially significant socioeconomic stressors identified in this study included the high number of individuals (a) with less than 12 years of schooling, 29%; (b) with yearly incomes of less than $10,000, 55%; (c) with more than three people per household, 56%; (d) with semi or unskilled jobs, 39%; (e) with part time positions, 26%; (f) without transportation, 41%; (g) without employment, 30%; (h) without health insurance, 36%; (i) who lived in rented residences, 64%; and (j) who relied on income assistance, 36%.

The effect of these socioeconomic factors can be glimpsed from the number of respondents who felt the following had given them or their family much concern in the past three years: (a) money, 81%; (b) transportation, 51%; and (c) basic needs, including job, food, and housing, 47%. High percentages of one or two of the above noted economic indicators might be tolerable, but the combined weight of all of the indicators paints a grim picture of a group under severe pressure.

Psychosocial Concerns

Poverty, prolonged unemployment, substandard housing, poor nutrition, and inadequate health care in an environment that provides few satisfactory options for human action promotes the existence of psychological problems (DeLeon, 1977; LaFromboise, 1988). This situation is compounded for a minority group that in many ways has only weakly and partially accepted western values and has, in turn, been allowed only limited, conditional acceptance and access to the dominant culture (Kahn, 1982).

Evidence of potential psychological distress identified in this study included the high number of individuals: (a) who defined their health as poor or just okay, 42%; (b) whose family members abuse alcohol, 50%; (c) or drugs, 25%; (d) who frequently feel stressed out, 46%; (e) or anxious, 41%; or (f) who often feel the need to get away from everyone, 30%.

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Additional distress signs included reports of: (a) family violence, 18%; (b) other dysfunctional family behaviors, 26%; (c) personal depression, 33%; and (d) concern over personal health, 44%. The respondents further documented the stress that Tucson's American Indians were under with their identification of the following major problems confronting their community: (a) alcohol, 51%; (b) drugs, 32%; (c) employment, 32%; (d) adolescent troubles, 20%; and (e) cultural disruption, 14%.

Family, Cultural, and Community Resources

Use of the family as a resource was evident in this study. Many respondents (23%) chose to live in Tucson because their families were there. A very high 83% believed family members provided each other with strong support. Relatives helped with finances (58%), emotional support (30%), and general assistance (17%). A family member would be used as a nonprofessional resource by 51% of respondents if they had a problem. Another good indication of the strength of family ties was the fact that more than half (56%) of the respondents did not see relatives as often as they would like. Finally, the happiest event in the majority of respondents' lives concerned the family (68%), while the worse event also concerned family (55%).

Given the considerable pressures for assimilation which urban American Indians battle daily, it is surprising the extent to which traditional values and knowledge remain (Miller & De Jong, 1990). One study documented the high degree to which Tucson's American Indians retained their tribal customs and traditions (Joe, Miller, & Narum, 1988). The authors found that despite prolonged urbanization, many still speak their native language and continue to use various types of traditional healing ceremonies and medicines. Many Tucson American Indians see their residence in the city as a mere extension of their traditional homeland (Miller & De Jong, 1990). Evidence for cultural strength and resource was also found in this current study.

One of the most intriguing results of this study was the extent to which respondents maintained contact with their home reservations or tribal areas. This in spite of the fact that 52% had never lived on a reservation and another 26% had lived off reservation for 15 or more years. More than 40% had returned at least three times in 1991. Only 14% had not visited at all. The high degree of contact can be explained, in part, by the fact that the traditional home areas for 60% of the respondents are adjacent to the Tucson metropolitan area (e.g., San Xavier, Pascua Pueblo, Old Pascua, and the Sells Reservation). This proximity, however, was problematic for respondents with nearby traditional home areas who were part of the 56% not able to visit relatives as often as they wanted because of distance, lack of transportation, and finances.

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Another interesting area for consideration was the respondents' acculturation beliefs. Despite being long time urban residents a very large number (83%) retained some component of their traditional ways. Respondents also believed by a large majority (77%) that their families held to traditional ways. One interpretation of these results is the previously noted tendency for native peoples under bombardment to turn to their roots and seek sanctuary in their traditional value systems. It is not unreasonable to propose that, because of limited, conditional acceptance and access to the dominant culture, Tucson's American Indians are rediscovering and placing a higher value on their cultural traditions as a means of offsetting the dominant culture's dominance. This support of traditional values among urban American Indians has significance for the provision of their health and social services and is discussed further below. Additional evidence of the respondents' attachment to their traditional home areas was seen in their responses to other questions. Many would return for family and for tribal events (34%). Respondents would also return if they could meet their basic needs (61%), and would travel to the reservation if the health care services they needed were available (59%). The strength of cultural ties was also evident in: (a) preference for traditional religion, 18%; (b) family support of cultural values, 29%; (c) use of either native medicine, 20%; (d) and/or Native American church, 17%, in the past year; and (e) likely to use sweat lodge if needed, 22%.

Community Resources

Despite the value placed on, and support received from, family and cultural traditions, Tucson's American Indians are highly dependent on the dominant culture for social and health services. And while many, if not most, of the needed services are available in Tucson the issues of accessibility, acceptability, affordability, and accommodation determine their usage (American Indian Health Care Association, 1989). There has been some documentation regarding the failure of American Indians to utilize available services (Barter & Barter, 1974; Borunda & Shore, 1980; Dinges, Trimble, Manson, & Pasquale, 1981; Dukepoo, 1980; Red Horse, Lewis, Feit, & Decker, 1978; Sue, 1977; Trimble, Manson, Dinges, & Medicine, 1984). Frequently mentioned was (a) lack of knowledge of availability, (b) lack of understanding of the processes or resource agencies, (c) discouragement due to bureaucratic morass, and (d) perceptions of agency unresponsiveness. All these and more were reported by respondents in this study.

To begin with, 23% of respondents stated they did not know where they could get help in Tucson. And 36% stated that their lack of knowledge about the availability of community services kept them from using these resources. Other top reasons for not using community services included: (a) excessive waiting, 35%; (b) inconvenient hours, 29%; (c) distance too far, 29%; (d) lack of transportation, 24%; (e) could not afford available service, 22%; and (f) negative experience, 20%. In conjunction with some

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of these responses, it is appropriate to note that 70% of respondents said they would use community services more if the services could come to them. The above data do not say that Tucson's services were not appreciated. When asked what they had liked about community services which they had used, 52% state that the services were helpful, 11% like their cost (free), and 9% like their availability. Several respondents mentioned how much they appreciated the way they were treated at the "local" San Xavier IHS facility. Their comments specifically mentioned the staff's attempts to be culturally sensitive. The fairly substantial approval rating offered by the respondents may be due, in part, to the American Indians well known preference for acceding, especially *vis-a-vis* the dominant culture. The charming book "Yes Is Better Than No" by Byrd Baylor (1972) exemplifies the unwillingness of American Indians to become embroiled in dissension and negativity. Because all things are interrelated in the American Indian world view, everyone and everything is treated with respect; man's relationship to man is one of getting along, helping one another out. To respond in a negative fashion is to disrupt the harmony of the interrelated whole. "Rather than adjust things (including people) to him, the (Native American) is aware that he, as the one responsible for keeping the balance among all things, must adjust himself to them" (Bryde, 1971, pg. 13). Given this world view, the remarkable thing is the extent to which even some of the respondents voiced dislikes.

Additional data from the study points to problems with community services utilization. Whereas 68% of respondents had yearly incomes of less then $15,000, only 34% received assistance from Medicare or Arizona's Medicaid (AHCCCS). A similar discrepancy between need and assistance was noted in the American Indian Health Care Association study (1989) of Arizona's urban American Indians. In their study, of the 37% of Tucson's American Indians who applied for AHCCCS, only 22% received help.

Traditional Indian Alliance

The problem of the cultural vacuum - that is, lack of American Indian cultural sensitivity by mainstream society - must be bridged, especially when working in the crosscultural setting of American Indian mental health (Joe & Miller, 1989, p. 253). Enough information has been accumulated to identify that the direct application, of a mental health intervention model based on the dominant society's beliefs, to an American Indian group is almost guaranteed to fail (Attneave, 1969; Dinges et al., 1981; Kahn, 1982; Lake, 1982; Manson, Walker, & Kivlahan, 1987; Scott, et al., 1982). In this context, the importance of an urban clinic with a mission to provide health care for its American Indians, cannot be underestimated. Clearly TIA is in the position of being in the vanguard for providing the necessary mental health care for Tucson's American Indians. However, the data in this study pinpoint a few problems that will need to be addressed if TIA is to be successful.

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When respondents were asked what they knew about TIA, 51% stated they had no knowledge of the agency. Only 12% had correct information, while another 13% offered a vague comment that TIA provided American Indian services. The remainder of respondent answers mentioned just one of the several services provided by TIA. Respondents were also asked what services they would like to see at TIA. A large number (44%) had no opinion because of their unfamiliarity with the agency. Among those who did know something about TIA, (a) expanded health care, 33%; (b) improved health care, 28%; and (c) social services, 25% were the most frequent answers. Interspersed among the answers were a few rare comments on (a) the need for a better attitude among some of the staff, (b) the need to treat all American Indians who seek help, (c) a concern about nepotism, and (d) the desire to see more support for traditional medicine. Altogether, these negative comments came from less than 3% of all respondents.

Overall, just 21% of the respondents had used TIA's services in the past year. One explanation for this rather small usage figure was that 34% of the respondents said they had not needed services of a community agency in general. In addition, TIA offers only a limited number of services, including (a) home health care, (b) information and referral services, and (c) patient education programs. Due to the high cost of malpractice insurance and chronic underfunding by Congress, TIA was forced to terminate its medical clinic in 1989. Also, a significant number of TIA's potential client base was either unaware of its existence, or did not know of all the services the agency offers.

The summary statement to this study comes from The American Indian Health Care Association (1989, p. 6), in its study on the health care needs of Arizona's urban American Indians. "It is encouraging to note that the [urban American Indian] community reports a need for mental health services, indicating that the often significant barrier of denial of need for mental health care does not exist." However, providing for the mental health needs of Tucson's American Indian population remains a challenge for the TIA and other community services.

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