

NORTH AMERICAN INDIAN ALLIANCE MENTAL HEALTH NEEDS ASSESSMENT REPORT

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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

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.

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

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

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).

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;

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.

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,

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

Table 3
Perceived Problems for the American Indian Community

Problem Area	Males		Females	
	<i>n</i>	%	<i>n</i>	%
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	
	<i>n</i>	%	<i>n</i>	%
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

Table 5
Workshop

Workshop	Males		Females	
	<i>n</i>	%	<i>n</i>	%
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.

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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This project was made possible by the following individuals and organizations: Mr. Pete Conway, Assistant Area Director, Tribal Health Programs Staff, Billings Indian Health Service; Board of Directors, Native American Indian Alliance, Butte, Montana; Ms. Debra Ouellette, Office Manager/Data Coordinator, North American Indian Alliance, Butte, Montana