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

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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,

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.

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

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.

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

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.

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 } Tewa Zuni	7	3%
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%

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.

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.

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.

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

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.

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

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-

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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