Mental health needs assessment of Tucson's urban native American population
Veronica Evaneshko
American Indian and Alaska Native Mental Health Research; 1999; 8, 3; Research Library
pg. 41

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).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

[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.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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%).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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%).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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%.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

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.

Corrine Jymm
Executive Director
Inter-Tribal Health Care Center
307 E. University Blvd.
P.O. Box 27185
Tucson, AZ 85726

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

References

American Indian Health Care Association (1989). *Assessment of the health care needs of the urban Indian population in the state of Arizona.* (Senate Report 100-165 and Conference Report 100-498 of Fiscal Year 1988). Washington, DC: Superintendent of Documents, U.S. Government Printing Office.

Attneave, C. L. (1969). Therapy in tribal settings and urban network intervention. *Family Process, 8,* 192-210.

Barter, E. R., & Barter, J. T. (1974). Urban Indians and mental health problems. *Psychiatric Annals, 4,* 37-43.

Baylor, B. (1972). *Yes is better than no.* New York: Avon Books.

Borunda, P., & Shore, J. H. (1980). Neglected minority-urban Indians and mental health. *International Journal of Social Psychology, 24,* 220-224.

Bryde, J. F. (1971). Indian students and guidance. *Guidance Monograph Series, Series IV: Minority Groups and Guidance.* Boston: Houghton Mifflin Company.

DeLeon, P. H. (1977). Psychology and the Carter administration. *American Psychologist, 32,* 750-751.

Dinges, N., Trimble, J., Manson, S., & Pasquale, F. (1981). The social ecology of counseling and psychotherapy with American Indians and Alaska Natives. In A. Marsella & P. Pederson (Eds.), *Cross-cultural counseling and psychotherapy* (pp. 243-276). New York: Pergamon Press.

Dohrenwend, B. P., & Dohrenwend, B. S. (1969). *Social status and psychological disorders: A causal inquiry.* New York: Wiley.

Dukepoo, P. C. (1980). *The elder American Indian.* San Diego, CA: Campanile.

Evaneshko, V. (1984). *Demographics of Native Americans in the Traditional Indian Alliance catchment area.* Unpublished master's thesis, College of Nursing, University of Arizona, Tucson.

Hollingshead, A. B., & Redlich, F. C. (1958). *Social class and mental disorder.* New York: Wiley & Sons.

Joe, J., & Miller, D. L. (1989). Barriers and survival: A study of an urban Indian health center. *American Indian Culture and Research Journal, 13*(3&4), 233-256.

Joe, J., Miller, D., & Narum, T. (1988). *Traditional Indian Alliance: Delivery of health care services to American Indian in Tucson.* Tucson: Native American Research and Training Center, University of Arizona.

Kahn, M. W. (1982). Cultural clash and psychopathology in three aboriginal cultures. *Academic Psychology Bulletin, 4,* 553-561.

Lake, R. G. (1982). A discussion of Native American health problems, needs, and services, with a focus on northwestern California. *White Cloud Journal, 2*(4), 23-31.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LaFromboise, T. D. (1988). American Indian mental health policy. *American Psychologist, 43*(5), 388-397.

Liberman, D., & Frank, J. (1980). Individuals' perceptions of stressful life events: A comparison of Native American, rural, and urban samples using the social readjustment rating scale. *White Cloud Journal, 1*(4), 15-19.

Manson, S. M., Walker, R. D., & Kivlahan, D. R. (1987). Psychiatric assessment and treatment of American Indians and Alaska Natives. *Hospital and Community Psychiatry, 38*(2), 165-173.

Miller, D. L., & De Jong, D. H. (1990). *Native Americans in Tucson: Our home-your city.* Tucson: Metropolitan Tucson Commission on Urban Naive American Affairs.

National Institute of Mental Health. (1985). *Measuring social functioning in mental health studies: Concepts and instruments* (Series DN No. 5, by Kane, R. A., Kane, R. L., & Arnold, S., DHHS Pub. No. [ADM]85-1384). Washington, DC: Superintendent of Documents, U.S. Government Printing Office.

O'Nell, T. D. (1989). Psychiatric investigations among American Indians and Alaska Natives: A critical review. *Culture, Medicine, and Psychiatry, 13*, 51-87.

Red Horse, J. G., Lewis, R. L., Feit, M., & Decker, J. (1978). Family behavior of urban American Indians. *Social Casework, 59*, 67-72.

Rhoades, E. R., Marshall, M., Attneave, C., Echohawk, M., Bjork, J., & Beiser, M. (1980). Impact of mental disorders upon elderly American Indians as reflected in visits to ambulatory care facilities. *Journal of the American Geriatrics Society, 28(*1), 33-39.

Scott, N., Soule, S., Bill, D., Friendman, J., Collier, B., Walluk, S., Wiscinckas, E., & Graf, M. (1982). Community mental health in bush Alaska: A joint report. *Coping, Winter*, 20-27.

Shannon, G. W., & Bashshur, R. L. (1982). Accessibility to medical care among urban American Indians in a large metropolitan area. *Social Science Medicine, 16*, 571-575.

Shore, J. H., & Manson, S. M. (1981). Cross-cultural studies of depression among American Indians and Alaska Natives. *White Cloud Journal, 2*(2), 5-12.

Spaulding, J. M., & Balch, P. (1985). Perceptions of mental disorder of Yaqui Indians in Arizona: An initial investigation. *White Cloud Journal, 3*(4), 19-26.

Srole, L, Langer, T. S., Michael, S. T., Kirkpatrick, P., Opler, M. K., & Rennie, T. A. C. (1962). *Mental health in the metropolis: The midtown Manhattan study.* New York: McGraw-Hill Book Company.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32*, 616-624.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Trimble, J. E., Manson, S. M., Dinges, N. G., & Medicine, B. (1984). American Indian concepts of mental health: Reflections and directions. In P. Pedersen, N. Sartorious, & A. Marsella (Eds.), *Mental health services: The cross-cultural context* (pp. 119-220). Beverly Hills, CA: Sage.

U.S. Senate Select Committee on Indian Affairs. (1985). *Indian juvenile alcoholism and eligibility for BIA schools* (Senate Hearing 99-286). Washington, DC: U.S. Government Printing Office.

Authors Note

The author is grateful to Margarita Kay, Ph.D., RN for her comments and suggestions.

Footnote

[1]Traditional Indian Alliance wishes to acknowledge the support and assistance with this study, of the University of Arizona's Native American Research and Training Center. There was an organizational name change in 1993 from *Traditional Indian Alliance* to **Inter-Tribal Health Care Center, Inc.**

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.