MENTAL HEALTH, HEALTH, AND SUBSTANCE ABUSE SERVICE NEEDS FOR THE NATIVE AMERICAN REHABILITATION ASSOCIATION NORTHWEST (NARA NW) IN THE PORTLAND, OREGON METROPOLITAN AREA

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Abstract: Consistent with results of previous needs assessments for urban American Indian and Alaska Native populations, a needs assessment in the Portland, Oregon metropolitan area for the Native American Rehabilitation Association Northwest revealed high levels of co-occurring conditions for American Indian and Alaska Native clients, often combining chronic health problems, substance abuse histories, and mental health diagnoses. Focus group results suggest the need for crisis care as well as specific needs of children and families, veterans, elders, and adults.

Introduction

Like other urban health programs, the Native American Rehabilitation Association Northwest (NARA NW) in Portland, Oregon provides comprehensive services (health, mental health, substance abuse, and cultural and spiritual support) to the American Indian/Alaska Native (AI/AN) population of the metropolitan Portland area. Clients also come to NARA NW from throughout the Pacific Northwest for residential substance abuse treatment. During the summer of 2003, NARA NW's services were redefined and redeveloped (e.g., the health

clinic was relocated to a new, larger location; outpatient substance abuse treatment was upgraded; and programs for children and youth were added). At this time, agency staff also decided to conduct a needs assessment to ascertain the service needs, especially mental health needs, of AI/ANs. (Throughout this report, it is important to keep in mind that the goals were to determine the unmet needs of the AI/AN population in the Portland metropolitan area and to learn who in the AI/AN community, especially among those already receiving services from NARA NW, needed additional services. This is a needs assessment, not an epidemiological report or an assessment of the relative strengths or assets of the community.)

The AI/AN population in the Portland metropolitan area (which includes Multnomah County, Washington County, and Clackamas County in Oregon along with Clark County in Washington) is very diverse. Approximately 15,000 people in the 2000 U.S. census self-identified as AI or AN. When people who identified with more than one race are included, the number increases to almost 32,200 (31,979; see Table 1). To understand these census figures, two background issues need to be explained—definitions related to AI/AN people and the relocation of AI/ANs to urban areas.

Table 1
Portland Metropolitan Area American Indian/Alaskan Native Population

County	One Race	AI/AN White	AI/AN Black	AI/AN White Black	AI/AN Other	AI/AN Asian	AI/AN White Other	AI/AN Hawaiian/ PI	AI/AN Multi	Total
Multnomah	6,785	5,320	793	651	294	179	167	44	264	14,497
Washington	2,913	2,376	118	188	193	81	87	26	88	6,070
Clackamas	2,416	2,338	59	111	80	46	40	19	77	5,186
Clark, WA	2,910	2,771	119	154	94	48	42	18	70	6,226
Total	15,024	12,805	1,089	1,104	661	354	336	107	499	31,979

Source: Social Science Data Analysis Network (n.d.)

While *American Indian* is a census category identifying people by race and including Alaska Native peoples (Ogunwole, 2002), *American Indian and Alaska Native* also refers to a citizenship status identifying peoples who have a definite legal status as members of sovereign nations (Goodluck & Willeto, 2000). The U.S. government has entered into a series of treaties with surviving AI tribes or nations, which retain all powers of self-government not taken over by the Federal government (Nichols, 1998). While the U.S. Federal government offers no single definition of who is AI or AN, the Indian Health Service (IHS) definition of who qualifies for services probably best applies here: "A person of Indian descent

designated by a tribe as being Indian, residing in the Continental U.S.; and Indians, Aleuts, and Eskimos in Alaska" (Indian Health Service, 1994 p. 11 2.6.3a[c]). Therefore, a NARA NW client may be a citizen or enrolled member of an AI tribe who has a primary racial identification as Black or African American, or may be a Pacific Islander who has AI heritage.

Most AI people live in urban areas (Nebelkopf & King, 2003). Beginning in the 1950s and continuing into the 1960s, the Bureau of Indian Affairs (BIA) created relocation programs designed to decrease pressure on reservation resources by helping young adult AIs to resettle in urban areas (Waddell & Watson, 1984). Many of the employment opportunities provided by these programs were temporary, and AIs who moved to urban areas were often left with short-term and insufficient support (Nichols, 1998; Waddell & Watson, 1984). Having a generation of AI/ANs relocated to urban areas without sufficient support has contributed to the cultural alienation, alcoholism, unemployment, and housing problems seen today (Nebelkopf & King, 2003).

The Portland metropolitan area has the advantage of being a traditional gathering and trading location for AI/ANs. In addition to NARA NW, the Portland metropolitan area benefits from other organizations dedicated to serving AI/ANs' needs, including the Native American Youth Association, as well as urban offices for the Confederated Tribes of Siletz Indians and the Confederated Tribes of Grand Ronde. Portland is home to area offices of the IHS and the BIA. The National Indian Child Welfare Association—which provides public policy, research, and advocacy information and training on AI child welfare to a national audience including tribal governments, state child welfare agencies, and other organizations—is headquartered in Portland. The Northwest Portland Area Indian Health Board, also headquartered in Portland, represents the 43 Federally recognized tribes of Washington, Oregon, and Idaho on health-related matters and provides health-related technical assistance to Northwest tribes. Cultural organizations that often take on social service needs and provide volunteers to serve the community include the Northwest Indian Veterans Association, the Portland State University student organization United Indian Students in Higher Education, the local chapter of The American Indian Science and Engineering Society, and the Bow and Arrow culture club.

Together, these urban AI/AN organizations and agencies strive to provide a circle of support for community members. In many ways, NARA NW plays a central role in providing basic needs to community members and in assisting other agencies and community groups. One community member described NARA NW as the hub for the Portland urban AI/AN

community. This is because NARA NW is a leader in developing county, state, and Federal contracts. NARA NW has also been the first employer of many agency health and social service leaders, providing training and development that allowed them to go on to leadership positions in other Native and non-Native agencies. NARA NW also supports other agencies (e.g., by providing health care and social services for those agencies' staff members). Nevertheless, many other hubs exist in the community. For example, the Native American Youth Association may be more central to youth and families needing recreational and educational support, and the Northwest Indian Veterans Association may be more central for AI/AN veterans.

When reviewing the methods and results of this needs assessment, it is important to keep in mind the central nature of NARA NW in the community, while understanding that other urban AI/AN agencies have their own clienteles, services, and roles in the community. One challenge was to try to assess community members' needs, accounting for assistance from other agencies and cultural groups while focusing on the specific needs of current NARA NW clients. It can be difficult to gain an understanding of the needs of AI/AN populations due to their diverse nature, unique challenges, and concerns about research (Weaver, 1997). Prior needs assessments of urban AI/AN communities helped to guide this needs assessment and provided a context for the results.

Needs Assessments for Urban AI/AN Communities

Needs assessments describing urban community mental health issues for AI/ANs include reports from Seattle (King County, Washington), Tucson, Denver, Phoenix, Flagstaff (Northern Arizona), and the San Francisco Bay Area. These six sites were selected because they offered published information at the time of the research, were located in the West, and included mental health issues in the community research. Appendix 1 summarizes the results of these prior needs assessments.

Because the goal of the current research was to find unmet needs in the Portland, Oregon urban area, in order to direct social, health and mental health services to meet those needs, literature review focused on studies that examined needs of AI/AN urban communities and highlighted information about problems in these urban areas. Readers should assume that these communities all have strengths that support thriving and healthy members as well.

In the Seattle area, Public Health—Seattle and King County and the Seattle Indian Health Board (2001) used locally available health data, statewide surveys, and findings from the 1999 Seattle Public Schools

Teen Health Survey. The urban AI/AN population of the Seattle and King County area was reported to be 33,000 (including people self-identifying in the 2000 census as AI or AN, both one race and mixed heritage). The King County urban AI/AN population is also ethnically diverse, with AI/AN people from 238 Federally recognized tribes. While AI/ANs in King County had decreasing mortality rates, improved maternal and prenatal care, and reductions in sexually transmitted diseases, the report emphasized continuing serious disparities in health indicators, as well as increased risk for lung cancer, unintentional injury, diabetes, and substance abuse. Up to 41% of the AI/ANs in King County had incomes below 200% of the Federal poverty level and 23% of adults reported having no health insurance (Public Health, 2001). Suicide and depression rates for the AI/AN population were similar to overall rates for Seattle urban area. AI/AN youth reported increased risk for substance abuse. American Indian and Alaska Native middle and high school students reported many more problems than other youth in the Seattle area, and fewer AI/AN high school students felt their futures would be good.

The mental health needs assessment of Tucson's urban Native population (Evaneshko, 1999) used home and office interviews of 174 people in a purposeful sample of representatives from the major tribal groups (Yaqui, Tohono O'Odham, Navajo, Apache, Cherokee, and other) of the Tucson area. Almost one-third of the respondents in this survey (29.3%) had less than 12 years of education, and more than half (54.6%) had total yearly incomes less than $10,000. A majority of the respondents (60%) said they would travel to their reservation or tribal area for health care services instead of using services in the Tucson area. The services these respondents wanted to receive from their community provider, the Traditional Indian Alliance, were expanded and improved health care, social services, health education, and transportation. They felt the AI community in Tucson should work on solving alcohol and drug problems, as well as on increasing employment. For adolescents, the Tucson community was concerned about gangs and delinquency, pregnancy, school dropouts, and suicide (Evaneshko, 1999).

King (1999) conducted a survey of Denver AIs' mental health needs. King developed three mental health questionnaires for AI adults, AI adolescents, and service providers. The Denver survey used a convenience sample of 374 adults and focused on past and present personal problems, problems experienced by household members, and perceptions of problems existing in the community. The estimated AI/AN population for Denver in this report (prior to the 2000 census) was 20,000. Most of the Denver participants were tribally enrolled,

with 47% from South Dakota and 11% from Oklahoma. While over half had at least a high school education, 26.6% did not finish high school. The majority of the Denver respondents were unemployed (58%), with 20% reporting part-time jobs and 18%, full-time employment. Almost 70% reported incomes less than $10,000. The most common problems occurring weekly or more often were financial difficulties (65%), family problems (35%), and feeling overwhelmed (29%; King, 1999).

In the Denver needs assessment, 61.2% of those surveyed self-reported a history of alcohol or drug problems. Depression had been experienced at least once by 50% of those surveyed; almost 20% reported experiencing suicidal thoughts or making a suicide attempt. Other reported psychological problems included marital problems and anxiety. Experiences of personal trauma included spousal abuse (37.2%), child abuse or neglect (12%), and rape or sexual abuse (10%). Most respondents reported turning to church or traditional healing methods to resolve psychological problems (King, 1999).

Clifford-Stoltenberg and Earle (2002) examined the mental health needs of two communities: the Oglala Sioux Tribe and AIs receiving care from the Phoenix Indian Medical Center. The goal was to survey both rural tribes (Oglala Sioux) and urban communities (Phoenix). Researchers conducted team site visits with informational sessions including opportunities for community responses and questions, and a cultural competence presentation. They also conducted interviews with executive directors, school officials, and people involved with services. The Phoenix site review is most relevant to the NARA NW needs assessment.

At the time of the report, the Phoenix Indian Medical Center (PIMC) served about 14,000 patients per year, with psychiatric providers seeing about 130 patients per month (Clifford-Stoltenberg & Earle, 2002). PIMC provides 24-hour on-call crisis services, as well as a Guiding Star substance abuse program for pregnant women and women with children under age 12. Clients in the Guiding Star program can participate in traditional healing practices. Suicide was a major issue for PIMC, as Arizona ranked sixth in the nation for suicide at the time of the report. Preventive health care was an issue in this urban setting, as patients with preventive needs had to wait behind those with urgent needs. Often patients reported traveling to rural reservation clinics where the wait time was shorter. Additionally, the director of PIMC wanted to improve comprehensive services (i.e., psychosocial, medical, and developmental services provided in one place) because clients could not find needed services in one site (Clifford-Stoltenberg & Earle 2002).

A mental health needs assessment of off-reservation AIs in Northern Arizona sponsored by the Native Americans for Community Action (NACA) covered both Flagstaff and other Northern Arizona communities, including Page and Grand Canyon Village (Chester, Mahalish, & Davies, 1999). The estimated total off-reservation AI population in this area at the time of the report was almost 7,200 people. This needs assessment included interviews with 235 people—some selected from the NACA clinic population and some recruited from NACA's non-clinical programs. The interviews were targeted to include children, adolescents, and adults. The Northern Arizona needs assessment also included a medical record review of 10% (144) of the adult intake files selected at random from the Family Health Center (Chester, Mahalish, & Davies, 1999).

For the Flagstaff area, estimates indicated that 55% of AI adults were unemployed and 35% were underemployed (Chester, Mahalish, & Davies, 1999). Three-quarters of the adults (75%) were estimated to have not completed high school or achieved a GED. None of the non-AI/AN community agencies in the area provided culturally specific or bilingual services, and none employed AI clinicians. For adults, mental health issues included family deaths (39%), anxiety (37%), and depression (16%), with suicidal thoughts as a problem for 9%. Over one-quarter of the adults (27%) reported that suicide attempts or completed suicides occurred in their families. For youths, problems included nightmares (58%), truancy (42%), and alcohol or drug abuse (27%). The medical record review indicated that 14% of patients reported problems with alcohol abuse either for themselves or their spouses (Chester, Mahalish, & Davies, 1999).

For the San Francisco Bay Area, Nebelkopf and King (2003) drew on previous research reports and key informant interviews to describe the development of a holistic system of care for the Native American Health Center and other urban AI/AN programs nearby. The AI/AN population in the San Francisco Bay Area is diverse, with nearly 80,000 people from over 100 American Indian and Alaska Native nations (including those identifying with one or more races in the census). Previously documented health concerns for AIs in the San Francisco Bay Area include homelessness, drug and alcohol diagnoses, domestic violence, and sexual assault. San Francisco has been reported to have the highest percentage of AIs with AIDS of all metropolitan areas (Satter, 1999 as cited in Nebelkopf & King, 2003). Problems related to HIV/AIDS are made worse by mental health issues, breakdown of traditional family life, and substance abuse. According to the needs assessment, American

Indian and Alaska Native youth in the San Francisco Bay Area were at high risk for alcoholism, substance abuse, mental illness, HIV/AIDS, and juvenile delinquency (Nebelkopf & King, 2003). Using a strategic plan and 16 grants over a four-year period, the Native American Health Center was able to make considerable progress towards a holistic community-based system of care for AI/ANs in the San Francisco Bay Area (Nebelkopf & King, 2003).

Methods

Prior urban AI/AN mental health needs assessments provided direction for this needs assessment. Given the available resources and the guidance of the NARA NW mental health advisory committee, the researchers decided to base the needs assessment for NARA NW on focus groups and a review of medical records of NARA NW clients. At the beginning of this project, researchers were cautioned by NARA NW administration to avoid the words *research* and *mental health* because of the adverse impression the local AI/AN community had about both subjects. While the researchers were unable to follow this caution, they did invest time and resources to discuss with community members the meaning of mental health and to reassure community members that this effort was undertaken to provide NARA NW with information that would help the agency to develop services. The use of a mental health advisory group was a vital part of the process. The advisory group varied in membership between five and twelve people and included community leaders and elders, NARA NW clients, and NARA NW staff members. The advisory committee evaluated the chart review format, and advised on focus group topics and questions.

Focus Groups

In the summer of 2003, focus groups were conducted on five topics: children and families, adults, veterans, elders, and historical trauma. One focus group was conducted for each topic. These topics were selected in consultation with a community-based mental health advisory panel and reflected current issues of concern in the AI/AN community.

The advisory group recommended the children and families focus group because of their concerns about the availability of services to children; also, they wanted children to be regarded as members of extended family or clan systems. They recommended an adult group

to balance the focus on children and families. Based on testimony from veterans during community ceremonies, the advisory group was concerned about the effect of the Iraq war on veterans, and they recommended the veterans focus group. The advisory group had experienced the recent loss of several key elders and wanted to see if other elders in the community were reacting to that loss, so they recommended the elders focus group.

The historical trauma focus group reflected a concern the advisory group saw in the community about lasting scars left by policies of annihilation and assimilation that AI/AN peoples have had to endure and survive. The process of colonization (Duran & Duran, 1995) was to destroy and demean the traditional ways of indigenous people. This also meant destruction of methods of economic survival and of family systems, as well as overt and covert genocide (Tafoya & Del Vecchio, 1996). Between 1500 and 1900, the death rate for indigenous peoples in North American was considerably higher than the birth rate. American Indians died by the millions from disease, wars of extermination, and reservation and boarding school conditions comparable to those in concentration camps. Historical trauma for AI/ANs is similar to trauma for other historically oppressed groups with important common features: "difficulty in mourning a mass grave, the dynamics of collective grief, and the importance of community memorialization" (Brave Heart & DeBruyn, 1998, p. 61). While the advisory committee recognized that this history is painful to recall, they also believed that this history becomes more painful when it seems to be forgotten, trivialized, or denied.

Recruitment

To recruit members for focus groups on these topics, the researchers advertised widely in the AI/AN community using flyers and word of mouth. For the focus groups, the researchers recruited people 18 years or age or older who were associated with the AI/AN community in Multnomah County. For each focus group, a maximum of 18 participants were recruited; for most groups, about 12 community members were actually present. The Native American Youth Association helped to recruit members for the children and families group, and also hosted the focus group. The Northwest Indian Veterans Association helped to recruit members for the focus group on veterans. The focus group on children and families had more people attend than were recruited (slightly more than 18 participants). Each focus group participant signed a consent form approved by the IHS Institutional Review Board and agreed to keep confidential what was shared in the focus group, although the

researchers stressed that they could not guarantee that focus group members would keep other group members' statements confidential. To protect confidentiality no identifying information about focus group members was recorded.

Methodology

The focus group methodology followed the recommendations of Strickland (1999), with modifications for the urban AI/AN environment (e.g., shorter sessions and more attention to the time invested by participants). While tribal community members in Strickland's studies were willing to invest four hours in a focus group meeting, most urban community members would find that too demanding. Still, the sessions lasted two hours with some participants arriving 30 minutes early and some staying 30 minutes after the group ended.

Focus groups were conducted in AI/AN agency facilities: NARA NW and the Native American Youth Association. These sites were large enough to accommodate the groups, and had facilities to prepare and serve food. The groups were moderated by a researcher with an AI heritage, with AI/AN research assistants distributing consent forms and collecting the data. Focus groups were conducted around a table. Sessions were not audio taped. A recorder took observational notes on a flip chart that all participants could see. At the end of the session, participants were invited to review the flip chart notes and make corrections or additions. Sessions took an average of two hours, including time to get acquainted, time for an opening including a blessing, time for participants to obtain food and drink, and time for a "give-away" at the end of the session. The more traditional people and elders in these focus groups (as in Strickland's [1999] tribal community groups) often did not talk until the end of the meeting, if at all, and some came to more than one meeting to make their contribution. Although participants needed review and clarification of the nature of the focus group and the goals of the study, and expressed concerns about research in general, once they were assured that the research was intended to aid NARA NW and AI/AN people they were quite willing to engage in a dialogue. The fact that the groups were not audio taped may also have helped to increase participation.

Incentives

Similar to focus groups with any population, participants here were provided with $20 gift certificates to a local multipurpose store. While participants came from a variety of AI/AN cultures, they had a

general expectation that food would be provided and that there would be gift giving. Participants were provided with light food, juice, and soft drinks. At the end of each focus group, participants (starting with the elders) could choose a gift from a table; gifts included NARA NW T-shirts, cups, flashlights, and other small items.

Chart Review

This report is based on reviews of 106 charts from the NARA NW health clinic. Thirty-three of the charts were chosen from a random selection process between August and October 2003. The random sample was based on a client database query that included all adults 18 years of age and older with any type of mental health diagnosis. This query indicated that there were 633 adult female clients and 456 adult male clients (1,089 total) who made a clinic visit to NARA NW between November 1, 2001 and July 15, 2003. (November 1, 2001 represented the best date for current data as data were entered into the client database; thus, it was selected as the sample start date.) Researchers attempted to oversample adult clients with a listed mental health diagnosis. Out of the 1,089 clients listed, a random sample of 250 clients (approximately 25%) and a group of 100 clients without mental health diagnoses were drawn. The random sample also attempted to include more women than men, because more women had mental health diagnoses.

Researchers planned to contact clients in the random sample by telephone, to ask them to come into the clinic and sign an IHS Institutional Review Board-approved consent form allowing their chart to be used in the review. However, they found that they could not reach the vast majority. Clients who had moved, had disconnected numbers, or otherwise could not be reached by telephone composed approximately 84% of the random sample. Approximately 2% were contacted and refused to consent for the chart review, and approximately 14% were contacted and agreed to give consent.

This finding suggests that NARA NW has a high percentage of homeless clients, and that the client population is consistently in flux. In this case *homeless* does not mean that clients were living on the street; rather, they did not have a regular or consistent place to stay. They moved from relative to relative and friend to friend and from the urban area to reservations and back. While NARA NW serves 1,000 or more people per year, specific clients seem to vary considerably from month to month and year to year.

The chart review process clearly demonstrated that the vast majority of participating clients were those coming to the NARA NW clinic for health concerns. In actuality, therefore, the random sample process was not going to yield a different result than a convenience sample. Given this reality, the research shifted to a convenience sample, with researchers asking clients coming into the clinic to voluntarily give their consent to have their chart reviewed. All clients who agreed to review the consent form received a $10 gift certificate.

The final sample for the chart review is a convenience sample that combines (1) people who were selected in the random sample and who were then located when they came into the clinic (rather than by telephone) and (2) a convenience sample of volunteers drawn from people who came into the clinic for health care. Thus, the chart review sample and the chart review results cannot be considered representative of NARA NW clientele in general or of the AI/AN community in the Portland metropolitan area.

Because the initial random sample attempt oversampled for women, clients who gave consent for the initial random sample differed from clients in the convenience sample by gender. More women were in the random sample group (78%) than in the convenience sample (56%, $\chi^2 = 4.5$, $df = 1$, $p = .03$), and they reported more gynecological problems (24% random, 10% convenience, $\chi^2 = 4.0$, $df = 1$, $p = .04$). The only other statistically significant difference between the initial random sample group and the subsequent convenience sample was treatment for pain. More of the random sample clients (30%) than convenience sample clients (12%) were in treatment for pain ($\chi^2 = 5.0$, $df = 1$, $p = .02$).

Demographics

The majority of the clients in the chart review were between 31 and 60 years of age (see Table 2). Most were women (61.3%, n = 65), with 28 men (35.8%), and 3% where gender could not be determined from the chart review. Most of the clients were linked to Pacific Northwest (37.7%) or Midwest Plains tribes (34.9%; see Table 3).

Table 2
Age Ranges for Clients in Chart Review

Age	Frequency	%
18 – 30	22	20.7
31 – 40	25	23.6
41 – 50	27	25.5
51 – 60	23	21.7
61 – 80	9	8.5

Table 3
Tribal Affiliations for Clients in Chart Review

Region	Frequency	%
Alaska/Alaskan Native	11	10.4
Pacific Northwest	40	37.7
Midwest Plains	37	34.9
Southwest	10	9.4
Northeast or Southeast	5	4.7

Results

Focus Groups

Five themes emerged as common responses across focus groups. First, AI/ANs coming to Portland, especially from reservation areas, look to NARA NW for care because they are familiar with and seek out IHS service providers. Second, although the AI/AN community is diverse, representing many tribes and traditions, AI/ANs are attracted to NARA NW because of the Native culture that is familiar, and because of the cultural awareness of the NARA NW providers. One respondent, with the agreement of others in the focus group, described NARA NW as "the hub of the Native community" because it provides cultural and community supports and connections as well as treatment.

Third, American Indians and Alaska Natives in the focus groups reported being treated better at NARA NW than at non-AI/AN agencies in the Portland metropolitan area, because at NARA NW they do not have to deal with assumptions and prejudice. Fourth, respondents praised NARA NW for providing personal care, providing a safe and comfortable environment, giving clients individual attention, and treating clients like people able to understand how to care for themselves. Focus group respondents also reported that other agencies sent them to NARA NW or "back to your people" for care. In part, this is because NARA NW provides coverage (including providing medications) for AI/ANs who have no other insurance or funding available.

Finally, focus group participants indicated that they wanted NARA NW to add a psychiatric after-hours response system to provide direct interventions or care for AI/ANs experiencing mental health crises (or health crises that may be misinterpreted as substance abuse or

mental health issues). Focus group participants expressed concern that emergency response systems do not understand AI/AN cultures. They were concerned that mainstream providers' crisis responses were made less supportive by assumptions that interfere with care (e.g., holding stereotypes about urban AI/ANs, assuming that any urban AI/AN crisis would be related to alcoholism).

Unique Issues for Each Focus Group

In addition to the common themes that emerged across focus groups, each topic had themes unique to that conversation.

Children and Families

Focus group participants appreciated that NARA NW accepted grandparents, aunts, and uncles as guardians for children. This meant extended family members were able to bring children into care, whereas their status as guardians was challenged by other agencies that only considered birth parents as guardians for children. Focus group participants believed that NARA NW could improve services to children and families by adding counseling to address the needs of extended families. Also, this focus group called attention to the need for parenting skill supports and early childhood prevention programs.

Adults

The focus group on the needs of adults called attention to chronic illness and the number of NARA NW clients who needed combined medical and mental health support to deal with such illness. Members of this focus group also identified the need for NARA NW to have connections and referral arrangements with agencies that are open to alternative lifestyles (e.g., gay and lesbian support and HIV programs). This focus group was concerned about the number of urban AI/ANs who ended up in jail or in the justice system because of a lack of other resources or services. The focus group urged NARA NW to connect with jails and the justice system to provide support to adult AI/ANs.

Elders

The focus group on elders (mostly comprised of elders) noted the loss of several important elders in the community during the summer of 2003, and asked for grief and loss groups. This focus group also stressed the importance of services to help elders cope with anxiety related to aging and losing health and physical capabilities.

Historical Trauma

Participants in the historical trauma focus group reported needing assistance to address abuse they experienced in Indian boarding schools. They reported that other providers did not understand and might even discount those experiences: "They tell us that the people who ran the schools meant well." Focus group participants believed NARA NW staff could assist people to realize when they are experiencing historical trauma, and could provide traditional healing ceremonies for historical trauma. Participants also wanted NARA NW to be able to send people home to their reservations or homelands for ceremonies.

Veterans

Participants in the focus group on veterans (who were mostly veterans) reported a need for assistance to cope with post-traumatic stress disorder, especially from Vietnam. They discussed how veterans from different wars need different types of assistance. For example, Middle East veterans might need medical and emotional support to cope with the effects of chemical or biological weapons. NARA NW could best assist veterans by coordinating services between the Veterans Administration and other agencies.

Results from Chart Reviews

Results from the focus groups are supplemented by results from the review of NARA NW charts. While the chart review results cannot be considered representative of NARA NW clientele or the entire AI/AN community in the Portland metropolitan area, they do illustrate client needs.

Co-occurring Disorders

The number and severity of co-occurring disorders documented in these NARA NW charts is important. Nearly 37% (n = 39) of the clients had co-occurring mental health diagnoses, histories of substance abuse, and one or more serious health problems. Only 12% of the clients (n = 12) were "well patients" with no serious diagnoses. Few clients were diagnosed only with distinct mental health or substance abuse disorders. About 13% (n = 14) had mental health and serious health problems, and approximately 25% (n = 27) only had documented health problems.

Substance Abuse

Close to half of the charts (45.3%, n = 48) included histories of substance abuse; 24.5% (n = 27) indicated no substance abuse. In 29.2% of the charts there was no clear indication whether substance abuse was or was not a treatment issue.

Mental Health

Diagnoses of mental health problems indicated in these charts included depression and dysthymia, anxiety disorders such as panic attacks, adjustment disorders, pervasive developmental disabilities, bipolar disorder, and schizophrenia.

Just over half of the charts indicated no prescriptions for psychiatric medications (52.8%, n = 56). One psychiatric medication was prescribed in 27.4% of the charts (n = 29), two in 13.2% of the charts (n = 14) and three to four in 6.6% of the charts (n = 7). Global assessment of function (GAF) scores were recorded for 34.9% of the charts (n = 36) with scores ranging from 40 to 70, with serious symptoms indicated by low scores and mild symptoms indicated by high scores (see Table 4).

Table 4
Global Assessment of Functioning (GAF) Scores for Clients in Chart Review

GAF Score Range	Frequency	%
40-50 (Serious Symptoms)	6	5.6
51-60 (Moderate Symptoms)	16	15.1
61-70 (Some Mild Symptoms)	15	14.1

Health Problems

The health problems recorded from the charts were cardiac problems, diabetes, hepatitis, gastrointestinal disorders, hypertension, pain management, respiratory problems, back problems, and other diagnoses (see Table 5). For clients with health problems, about 5% had five or more health diagnoses. In 28.3% of charts, (n = 30), clients had three or four major health diagnoses. In 20.8% of charts (n = 22) there were two diagnoses; in 27.4% of charts (n = 29), one diagnosis; and in 18.9% (n = 20), no diagnoses. The most commonly noted health problems were hepatitis, diabetes, and back problems. Hepatitis (either A, B, or C) was diagnosed in 20.8% of the charts reviewed (n = 22). Diabetes was also diagnosed in 20.8% of the charts reviewed (n = 22). Back problems were noted in 22.6% of the charts (n = 24).

Table 5
Health Problems for Clients in Chart Review

Disorder	Frequency	%
Gynecological	15	14.2
Hepatitis	22	20.8
Back	24	22.6
Cardiac	Few	Few
Diabetes	22	20.8
Gastrointestinal	15	14.2
Hypertension	13	12.3
Pain	19	17.9
Respiratory	14	13.2
Other	69	65.1

Discussion

Limitations

This study is a needs assessment primarily for use by NARA NW and Multnomah County to plan for improvements in mental health care for AI/ANs in the Portland metropolitan area. This is not a prevalence study, and should not be interpreted as providing an indication of the incidence or prevalence of mental health or health conditions for NARA NW or the Portland metropolitan area. While the researchers and the mental health advisory committee believe the focus group participants represent the local AI/AN community, there is no confirmation that the small numbers of people in the focus groups actually do so. Also, focus group participants were asked to limit their comments on NARA NW services and development to services within the Portland metropolitan area.

The chart review results are mostly limited to clients coming into the NARA NW health clinic and willing to consent to chart review during the time of the study. The researchers were not able to provide a random sample of the NARA NW clientele. Participants in the chart review were likely to be those with greater need; those in most pain; and those with more than one health, mental heath, or substance abuse condition. Beals et al. (2005) reported that AIs from a Southwest reservation and a Northern Plains reservation were more likely to seek help if they had co-occurring conditions.

Clinical and Policy Implications

The results of this needs assessment are consistent with other needs assessments for urban AI/AN populations. NARA NW and other AI/AN service providers in the Portland metropolitan area are challenged to

provide basic services to a population with serious needs for housing and basic support; health care; mental health care; substance abuse treatment; and cultural connections, healing ceremonies, and affirmations. Writing about Denver AI community, King (1999) reported dire needs for all levels of mental health care—family, marital, adult, adolescent and child, school-related, court-related, and social services-related. In a report on children's mental health, Cross, Earle, Echo-Hawk Solie, and Manness (2000) noted that all participating sites identified post-traumatic stress resulting from historical oppression and multigenerational trauma as a major contributor to current mental health problems.

Understanding the depth of the need of AI/AN peoples; the diversity of cultures, languages, and traditions; the unique legal status of AI/ANs as citizens of sovereign nations; and the impact of historical trauma is a challenge for urban AI mental health agencies. This task is even more daunting for mainstream mental health providers. Participants across focus groups—children, adults, veterans, and elders—emphasized the need for NARA NW to provide mental health services so they could receive care that was culturally appropriate and that took into account their legal rights, obligations, and history. A consistent theme was the need for psychiatric crisis services for substance abuse and mental health emergencies.

From the focus groups and the chart reviews, the need for a holistic system of care became clear. As researchers attempted to contact recent NARA NW clients to participate in the chart process, the extent of homelessness became evident. While issues of homelessness or social service needs were not usually included in client charts at the time of the review, these areas need to be included in future client assessments. Indeed, given the concern of focus group members about the impact of chronic health conditions on mental health—and the high percentage of chart reviews where clients had documented chronic health, mental health, and substance abuse issues—each client should receive a comprehensive assessment for all conditions regardless of the problem that brings them to NARA NW.

On a policy level, the unmet service needs of AI/ANs in the Portland metropolitan area (and in other urban AI/AN communities where mental health needs assessments have been conducted) reflect a lack of available services and supports across Indian country. Tribes have not been eligible for Federal mental health block grants (U.S. Department of Health and Human Services, 2001). Therefore, they must use Federal funds from various sources to piece together what services they can for families (Cross, 1997). The IHS is one Federal funding source for tribes and

urban AI/AN programs, but it is limited; for example, only 1.3% of the 1988 IHS budget went to direct tribal mental health services (Cross, 1997). In terms of real dollars, IHS funds have been declining. Federal reductions in IHS funding, along with reductions in Medicaid and Medicare reimbursements, have reduced local ability to provide services (U.S. Department of Health and Human Services, 2001). Fewer mental health personnel are available to serve AI/ANs than other populations: One estimate is 101 mental health providers per 100,000 people for AI/ANs compared to 173 per 100,000 for Whites (Manderscheid, & Henderson, 1998 as cited in U.S. Department of Health and Human Services, 2001). The result is immediate and urgent need for AI/ANs with severe mental health, health, and substance abuse needs, and a considerable unmet need for prevention and treatment for people who have not been able to receive appropriate services for generations.

NARA NW Service Enhancements

Following the needs assessment, NARA NW worked to enhance services. Core services in 2003 were the Indian Health Clinic, the Residential Treatment Center for family substance abuse treatment, and outpatient substance abuse treatment. Additional services added after 2003 include Star Shield Family Wellness (a culture-based program designed to give support to parents and extended family members serving as caregivers for children), a grief and loss group for elders, and an urgent response system and community support program for community members experiencing mental health crises. Like the Native American Health Center in the San Francisco Bay Area (Nebelkopf & King, 2003), NARA NW is following a strategic plan to provide a holistic system of care.

Conclusion

This is the beginning of an ongoing effort to define the needs of the local AI/AN community and to find the means to meet the needs of the people. While many of the results from this needs assessment were either discouraging or challenging, one encouraging result was an understanding of the community's investment in providing care for the most vulnerable, and the desire to strengthen the AI/AN community to provide opportunities for individual, family, community, cultural, and spiritual health.

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Appendix A
Summary of Previous Needs Assessment for Western Urban AI/AN Populations

Location	Demographics	Social/Mental Health Needs	Health Needs
Seattle Public Health Seattle & King County & the Seattle Indian Health Board (2001) Data Collected 1999	33,000 Urban AI/AN from 238 Federally recognized tribes Up to 41% had incomes below 200% of the Federal poverty level and 23% of adults reported no health insurance	Suicide and depression similar to overall rates for urban area. Increased risk for substance abuse. Middle and high school students report many problems-fewer high school students felt future would be good	Decreasing mortality rates, improved maternal and prenatal care, reductions in sexually transmitted diseases. Continuing serious disparities in health indicators including increased risk for lung cancer, unintentional injury, diabetes, and illnesses related to substance abuse. Smoking and being overweight were risk factors for adults and children
Tucson Evaneshko, (1999) Data Collected 1992	174 people representative of major tribal groups (Yaqui, Tohono O'Odham, Navajo, Apache, Cherokee, and other) 29.3% less than 12 years of education, 54.6% total yearly incomes less than $10,000	Concerns about suicide, alcohol & drug problems, gangs & delinquency	Respondents wanted expanded and improved health care, social services, health education, and transportation. Worried about teen pregnancy

Appendix A, continued

Location	Demographics	Social/Mental Health Needs	Health Needs
Denver (King, 1999) Data Collected 1992	Convenience sample 374 adults-47% from South Dakota and 11% from Oklahoma, Over ½ High School Education, 70% incomes less than $10,000 Denver AI/AN population 20,000	65% financial difficulties, 35% family problems, 29% feeling overwhelmed, 61% history of drug or alcohol problems, 50% depression, 20% suicidal thoughts	
Phoenix Clifford-Stoltenberg & Earle (2002) Data Collected 2002	Phoenix Indian Medical Center (PIMC) approx14,000 patients per year 130 per month psychiatric	Substance abuse for pregnant women & women with children, suicide	Preventative health care, combining psychosocial, medical and developmental services
Flagstaff & Northern Arizona Chester, Mahalish, & Davies, (1999) Data Collected 1992	Flagstaff & Northern AZ including Page & Grand Canyon Village, population 7,200 people-235 convenience sample, & 144 clinic files	55% adults unemployed, 35% underemployed, 75% not completed high school, Adult Mental Health: family deaths (39%), anxiety (37%), depression (16%) with suicidal thoughts as problems for 9%. Youth Mental Health: 58%, nightmares, 42%, truancy 27% alcohol/drug	None of the non-Indian community agencies provided culturally specific services or bilingual services, and none employed American Indian clinicians Medical record review indicated 14% of the patients reported problems with alcohol abuse either for themselves or their spouses
San Francisco Bay Area Nebelkopf & King (2003) Key Informants 2001	80,000 people, from over 100 tribes	Homelessness, drug & alcohol diagnoses, domestic violence and sexual assault, Youth at high risk for alcoholism, substance abuse, mental illness, and delinquency	HIV/AIDS