

A COMMUNITY NEEDS ASSESSMENT ON MENTAL HEALTH SERVICES  
AMONG NATIVE AMERICAN INDIANS IN SANTA CLARA, CALIFORNIA

A Project Report

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Master of Arts

by

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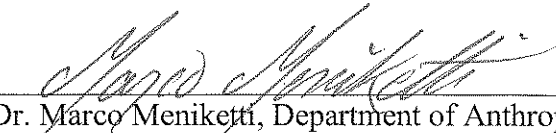
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By

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## **ABSTRACT**

The purpose of this project was to conduct a community needs assessment on mental health services within the Native American Indian community of Santa Clara County. The results are to be used by Native Family Outreach and Engagement (NFOE), a mental health advocate group, to support the production of services necessary in establishing an effective mental health service program. This way, NFOE can continually meet the needs of the Native American Indian Community in Santa Clara County.

Arthur Kleinman's view of *Culture as a Concept* illustrates the importance of culture as a tool of treatment within the community, as is the case with this Native American Indian community in Santa Clara County. This community-needs assessment established a baseline reflecting the participants' experiences in regards to mental health issues. It documented the community's perception of what mental health and illness meant to them. This data was analyzed using Arthur Kleinman's approach on how individuals construct or frame health, illness, treatment, and prevention in relation to their culture and family. The goal of this project was to examine what factors assisted or hindered access to mental health services by the participants.

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## INTRODUCTION

I thought that our mental health program was, to a great extent, when I say mental health, I mean the dominant culture, that their mental health program was pretty much to control people and to make it so that the straight people in the world are comfortable, and you don't have somebody making you be afraid, not knowing what to expect from the person talking to themselves or acting out, or something of that sort. So, treatment was a matter of control. I really felt that approach did more harm than it did good. So one of the natural implications of that is that if you had a chance to build your own program to me one of the primary things will be to do as much harm reduction as possible and that's what a good program, a good community based program, will do, would be to contribute greatly to harm reduction. ("Ramon J," Lakota Indian).

The purpose of this project was to conduct a community-needs assessment on mental health services within the Native American Indian community of Santa Clara County. The results are to be used by Native Family Outreach and Engagement (NFOE), a mental health advocate group, to support the production of services necessary in establishing an effective mental health service program. This way, NFOE can continually meet the needs of urban Native American Indians in Santa Clara County.

For this project, a qualitative research approach was used for data recording. It included open-ended semi-structured interviews on mental health services, conducted by the researcher with the Native American Indian community members in Santa Clara County, who agreed to participate in this applied project. This project provided data from the testimonies of the Native American Indian participants on culturally relevant mental health services, which provides important context for comments such as made by Lena P., Navajo, a Santa Clara resident, in her interview:

I think my criticisms toward them (existing mental health services) would be maybe some of them might be too professional so they are not so intimate you know like it's their job versus them like actually caring and that for me, that's really important you know, like if I am going go somewhere talking to somebody

that cares makes a huge difference then going in and talking to someone because it's their job. ("Lena P," Navajo, Santa Clara resident.)

These narratives can be used to improve existing mental health services or design new services that the Native American Indian mental health consumer truly needs and wants, both currently and for future use. From the testimonies of Native American Indian consumers we can offer solutions to the challenges mental health consumers and their families face in their everyday lives when they access mental health services within Santa Clara County. By using consumer testimonies, we can link the people who access mental health services to the actual situations that cause them to need these services.

This community-needs assessment established a baseline reflecting the participants' experiences in regards to mental health issues. It documented the community's perception of what mental health and illness meant to them. After conducting the community-needs assessment, I analyzed the types of culturally relevant mental health services from the testimonies provided by the Native American Indian community participants in this Applied Anthropology project. I examined what factors assisted or hindered access to current local mental health services by the Native American Indian participants in this project. Those forces are laid out in the theme section.

## **BACKGROUND**

On November 4, 2004, Californians went to the polls and voted for the passage of Proposition 63 (Prop 63), now known as the Mental Health Service Act (MHSA). This Act imposes a one percent (1%) income tax on personal income in excess of one million dollars aimed to reduce the long-term adverse impact of untreated mental illness

(California Department of Mental Health 2008). It is the first opportunity for the California Department of Mental Health (DMH) to provide increased funding, personnel and other resources to support county mental health programs. MHSA is a community driven approach to providing community based mental health services and support for California residents.

The Santa Clara County Mental Health Department (SCCMHD) invited directors and counseling directors from local mental health agencies, to strategize ways of implementing mental health services to various ethnic communities. During these strategic meetings, SCCMHD discussed the idea of formulating “advisory committees” for each of the ethnic groups in Santa Clara County. These committees would include individuals from various ethnic agencies so that the local ethnic communities were not left out of the planning process. The Family Outreach and Engagement Team of the Native American Community (FOENAC), for example, was one of the newly formed advisory committee. It was comprised of Native American Indian professionals, community members, and mental health consumers concerned with matters around mental health within their families and their community. FOENAC explored “ways to foster a therapeutic culture of support and love for our families and our community” (FOENAC 2008:1). Discussions were centered on what the issues were in regards to mental health and how best to address those issues.

The various ethnic “advisory committees” met and compiled the outcomes of their discussions into a five-page report. The barriers, the strengths, and the resources were three major themes that emerged from these discussions. According to Daniel D.,

SCCMHD “wanted to keep the advisory committees intact” and created the Ethnic and Cultural Community Advisory Committee (ECCAC), bringing all the different ethnic advisory committees under one group. He goes on to say that SCCMHD submitted a proposal to the State of California for Prop 63 funds to provide mental health services to the underrepresented ethnic communities through the “Family Outreach and Engagement Program. The Family Outreach and Engagement program is implemented by the ECCAC. The focus of ECCAC is to (1) provide ethnic perspective and create the cultural setting most conducive to mental health healing, (2) build community awareness and action to address stigma and discrimination, and (3) assist underserved populations by functioning as a bridge to appropriate health care (Santa Clara County Mental Health Services 2011b).

FOENAC of Santa Clara County developed a plan called “The Traditional Plan to Wellness” (FOENAC 2008:1), which incorporated a more holistic approach to healing by “healing the mind and spirit” (FOENAC 2008:1). The plan states that Native American Indians “culturally, do not separate mental health from physical health, mind from body or spirit, or consumer from family or community” (FOENAC 2008:1). The intended program aids both the consumer and the family in need of mental health services and ultimately, it would serve to strengthen the community as a whole, as illustrated by Daniel D., Apache Indian:

What we were talking about was sort of changing the paradigm in a sense, and for us it's not changing the paradigm, for other peoples it is. What I mean by that is they call us a non-traditional program, where we call ourselves a traditional program. It's about bringing traditional people in, to be able to, as an example, if people in the clinical world, if you tell somebody that you're hearing voices or that you're seeing things they start thinking that you're psychotic or that you're

schizophrenic or that you're delusional or those are terms that come up, right? In the Indian world, it can be a spiritual thing, but somebody has to determine that – whether that's what's really going on or not. And so, we bring in traditional people to be able to do that, so we kind of bring spiritual assessments, if that's what the client wants, if that's what the person wants. To kind of rule those things out first, to rule out if somebody is psychotic or somebody is delusional or again, if it's a spiritual thing going on and not everybody understands that. (“Daniel D,” Apache Indian)

Daniel D. statement illustrates how the Native American Indian perspective differs from that of others. He points out that traditional people are called in as part of the mental health assessments to rule out spiritual causes first. This concept of spiritual assessments and traditional people to perform them are part of FOENAC argument, in their grant proposal, to SCCMHD that culturally Native American Indians do not separate “mind from body or spirit,” which is hard for many to understand but not to Native American Indians.

FOENAC applied for a grant from SCCMHD that would aid their “Traditional Plan to Wellness” (FOENAC 2008:2). The team’s purpose was to: (a) develop a mental health program within the Native American Indian community to educate and support families dealing with mental illness, (b) implement and support plans which result in harm reduction, (c) integrate and optimize the efforts of the therapeutic milieu including consumers’ families, professional agencies, county health, and MHSA services, and (d) practice a culturally competent acknowledgment of the spiritual significance within this community (FOENAC 2008:2). FOENAC intention was to: (1) identify societal problems, such as social stigma, familial shame, and consumer isolation, (2) develop specific plans of action, (3) create harm reduction strategies, (4) assess the effectiveness of the plans, adjusting the programs as needed with thought and flexibility, (5) create a

therapeutic network that reduces stigma associated with mental health, affirming Native American traditions which value responsibility and the interdependence for Native people, and (6) establish partnerships within the Indian service community to aid in the program's success (FOENAC 2008:2).

FOENAC's vision of a family advocacy/liaison program for the Native American Indian community was intended to "provide individual support and guidance to families coping with mental illness or familial crises" (FOENAC 2008:2). FOENAC envisioned the community advocacy group as being an additional support group, as a valuable resource for the Native American Indian community in Santa Clara County and to better understand their mental health issues, as is reflected in this statement.

What we were envisioning was that these community committees would be an advocate for that – to be able to give them resources, to provide support. What happens often times when a family member has what they call their first episode, the families themselves don't know how to deal with that. It's a crisis. So, let's say that a child, or not a child, a young adult is like most adults, their first episode of schizophrenic as an example, is when they're around in the early twenties, around twenty three or twenty five, somewhere around there. But, let's say that happens and the family members don't know how to deal with that. You know the parents are worried about their child, the parents are worried about all this stuff, the siblings don't know how to deal with this stuff, and so, somebody needs to be that support. Somebody needs to teach people how to do that, how to get services for this person, how to, whatever it is, resources – just somebody to console them. Somebody that'll drive the mom to go see the kid or that'll drive the mom to go and get groceries or something like that, or go and take food to somebody during that process. ("Daniel D," Apache Indian).

Many of the individuals that were recruited for the Native American Indian family advocacy/liaison program complemented the goal and intentions FOENAC envisioned for its community advocacy group. In regards to how the advocates assisted the consumer, many of the participants in this project reported that the community advocates exceeded

the expectations conceptualized in Daniel D.'s statement. What is interesting to note, from the participants responses, is that many of the community advocates felt that the role of a community advocate to the Native American Indian health consumer was that of a family member helping out another family member. Many of the NFOE advocates commented that they had become a community advocate because of their own personal experiences, one of their family members who were either a past or current mental health consumer. The NFOE advocates reported that they wanted to help other individuals learn how to access mental health services and give them the support they need during a time of crisis.

### **The Project**

This project breaks new ground as the first collaborative research project between Native Family Outreach and Engagement (NFOE), and myself, a research graduate student in the Master's program in Applied Anthropology at San José State University. The project included urban Native American Indians diagnosed with a mental illness, Native American Indians who have used local mental health services and who currently utilize existing mental health services, family members affected by mental illness, NFOE advocates, and Native American Indian community members and leaders who previously met to discuss mental health issues and challenges in their community.

### **Organizational Expectations**

NFOE is a community based advocacy group comprised of Native American Indian individuals who live in the Santa Clara County area. Their mission is centralized around the premise that they are a circle of American Indians who "collectively strive to



achieve mental wellness through community interdependence and Native traditions” (NFOE 2009:1). NFOE’s objective for this project was to document and validate what they already knew about the issues surrounding mental health in the Native American Indian community. The community-needs assessment in this Applied Anthropology Master’s project serves to validate and document NFOE’s objective.

Arthur Kleinman is a psychiatrist trained in anthropology. He has worked in the Chinese culture on problems concerning medicine and psychiatry. He has taught cross-cultural psychiatry and medical anthropology. He takes a clinical approach to his research and cross-cultural teaching (Kleinman 1980:ix). Kleinman’s approach on how an individual constructs health and illness, treatment, and prevention served as a framework for this project. I conceptualized the relationship of the Native American Indian participants and their culture in regards to: (1) mental health and illness; (2) utilization of current local mental health services; and (3) what factors assisted or hindered access to mental health services by the Native American Indian project participants.

### **The Importance of Evaluation Anthropology**

NFOE has had to function in two very distinctive capacities. They must act as a community based advocacy group – providing support and resources to its consumers and function in a professional capacity representing the SCMHD – as part of the ECCAC vision of a Family Outreach and Engagement Program. The former is essential to achieving mental wellness. The latter binds the group to state requirements and restrictions.

Survey research, or quantitative methods, is a major industry in the United States (Bernard 1995:226). It is most often employed when a sizeable amount of data needs to be collected quickly and cost effectively. Quantitative evaluation methods are successful when you want to capture different aspects of an issue and when you want to count things. One of the advantages of utilizing quantitative methods is that it generates quantitative analysis that can be generalized over entire populations but does not provide meaningful insight on the issues or the underlying causes.

Qualitative methods “seek to explain what quantitative observations actually mean to actual individuals” (Pereceman and Curran 1990:4). When needs are identified, as in the case of this project, it should be assessed in its fullest context (Ervin 2000:66-67). A qualitative approach can contribute to revealing the needs of a community as well as provide an explanation on “what is happening from multiple frames of reference” (Camino 1007:50). This approach provides meaningful insight to the issues that Native American Indian consumers face, as made by Lena P., Navajo, Santa Clara resident:

It’s also really, I think it might be hard sometimes. I know it’s been hard for me in my experience to reach out to organized services like different facilities just because it’s like, again like that stigma oh you don’t want to be associated with that kind of label. (“Lena P.,” Navajo, Santa Clara resident.)

The ability to bring those multiple frames of references to the forefront is a valuable asset to any qualitative approach. This community-needs assessment provided both a voice and a venue for Native American Indian participants to express their needs and concerns with mental health issues and services. The narratives illustrates the complexity of the issues they face when accessing mental health services and insight to

what the Native American Indian mental health consumer truly needs and wants in terms of mental health services.

## **METHODOLOGY**

### *Native Families Outreach & Engagement (NFOE)*

The NFOE team was formed to carry out the goals and expectations of FOENAC's vision through a family advocacy/liaison program specifically targeting Native American Indian families affected by mental health issues. The NFOE team is a circle of people in Santa Clara Valley comprised of Native American Indian consumers of mental health services, professionals in community agencies and professionals in county mental health services, who collectively strive to achieve mental wellness through community interdependence and the use of Native traditions (NFOE 2010:1). In effect, NFOE sought (1) to enact the advocacy/liaison program to provide individual support and guidance to families coping with mental illness or familial crises; (2) to host a three day Gathering of Native Americans (GONA) workshop that focuses on families dealing with mental health issues and related familial problems, such as domestic violence and child abuse; (3) to host discussions that draw connections between mental health and Native heritage; (4) to host seasonal healing ceremonies that are relevant to the Native American Indian community's cultural and spiritual needs; and (5) to facilitate bi-weekly talking circles and family support meetings (NFOE 2010:1).

### *Native American Indian Community of Santa Clara County*

There are 362,801 people listed as American Indian and Alaskan Native in Santa Clara County, California (US Census Bureau 2010b). According to California's

Department of Mental Health (DHM), the prevalence of persons with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) in Santa Clara County is 7.75% (California Department of Mental Health 2007). The 2000 Census lists over thirty nine federally or state-recognized tribes, bands and clans. The ten largest in the United States are: Apache, Blackfeet, Cherokee, Chippewa, Choctaw, Iroquois, Latin American Indian, Navajo, Pueblo, and Sioux (U.S. Census Bureau 2010a)

In the U.S. Census 2000, respondents were able to report one or more races to reflect their self-identification. As a result of these changes, the U.S. Census data on race is not comparable with the data from the 1990 or earlier censuses. For this project, a survey was distributed to participants to collect demographic data to find out how the participants self identified and to obtain a sample of the racial or ethnic categories prevalent among the participants that reside in Santa Clara County, California.

### *Project Design*

This project used a qualitative approach to investigate what perceptions are held by Native American Indian participants in regards to mental health, illness, and wellness. It assessed the perceptions of cultural fit between mental health services and those who accessed them. This project was exploratory and inductive in nature because little is known on the subject matter of a mental health advocacy program for Native American Indians. Participant responses generated new information on how culture ties into the decision process of utilizing mental health services. Additionally, it was important to evaluate the mental health program activities of local mental health agencies in Santa Clara County, as the results will be used to modify and improve existing NFOE services

to ensure NFOE program quality and responsiveness to the needs of the targeted population on mental health services.

### *Research Goals*

The main research goals for this project were: (1) to conduct a community-needs assessment with urban Native American Indian participants in Santa Clara, California, in regards to mental health, illness, and wellness; (2) to engage in open-ended, semi-structured interviews with FOENAC and NFOE members about their experience with mental health services, wellness promotion, and the formation of the NFOE advocacy program; and (3) to report on what factors, if any, assisted or hindered participants from accessing local mental health programs.

NFOE objective for the researcher in this projects were: (1) to document the opportunity for mental wellness promotion to at-risk urban Native American Indian population in Santa Clara, California; (2) to survey demographic information and general perceptions toward mental health from a non-random sample of the participants in the Native American community in Santa Clara, California; (3) to analyze the data according to factors that influence the perception of mental health, illness, wellness and accessing mental health services by NFOE participants, and provide these results in a report; and (4) to assess what kinds of culturally competent mental health services NFOE participants want and need, and provide these results in a report and presentation form.

### *Selection of Participants*

The selection of participants in this community-needs assessment was a collaborative effort between me, the researcher and NFOE. Fourteen out of seventeen

participants that were initially contacted actually participated in this project. The ages of the participants ranged from twenty to seventy years of age. The sample pool of participants was narrowly focused to Native American Indians, residing in and using services in Santa Clara County. Participants were drawn from a pool of clients who have participated or who were currently accessing NFOE services, NFOE advocates who have a family member with a mental illness, and Native American Indian participants who have previously accessed mental health services in Santa Clara, California. The community participants who have received services from NFOE were contacted by them and made aware that a community-needs assessment was being conducted. The participants were asked if they would like to participate in an open-ended informal semi-structured interviewing and to contact the researcher if they were interested in being interviewed. Participants were informed that they would be asked questions regarding their perceptions of what mental health and illness meant to them, their past or current personal experiences with mental health services, and to assess what kinds of mental health services are currently needed.

As this project required interviewing human subjects, an application was submitted to the San Jose State University Institutional Review Board for approval to interview human subjects. In addition, since the NFOE advocacy program receives funding from SCMHD and the State of California, a second application was submitted to the Santa Clara County Mental Health Department Institutional Review Board for approval to interview human subjects within the Santa Clara County area. Participants

were asked to sign a consent form prior to the actual interviewing. Participation in this project was voluntarily and was stated verbally and written in the consent form.

#### *Demographics and Site Locations*

Santa Clara County is made up of people from diverse cultural, national, and racial groups. According to the U.S. Census Bureau 2009 People Quick Facts data, 61.6% of the population is white, 31.7% are Asian, 2.9% are black, 0.4% are Native Hawaiian or Pacific Islander, 26.3 % are Hispanic or Latino, 34.1% are Foreign born, and .8% are American Indian and Alaskan Native reside in San Jose, Santa Clara County. Of this population, 45.4% speak a language other than English at home. The median household income was \$88,525, per capita, money income was \$32,795, and 7.6% of the population was below the poverty range (U.S. Census 2010c).

The interviews were conducted at the following locations: (1) at NFOE's office site, (2) at the School of Social Work conference room at San Jose State University, and (3) at a mutually agreed upon location. The interview sites were selected because they were easily accessible or convenient to the participant.

#### *Demographic Survey and Community-needs Assessment Qualitative Surveys*

A demographic survey was distributed prior to the interviews to the participants in order to collect demographic data. The demographic questionnaire included twelve (12) open-ended questions concerning the following categories: gender, age, marital status, racial/ethnicity, tribal affiliation, religious/spiritual/tribal beliefs, resident location, education level, occupation, annual income level, children and household members. A

table of the demographics information collected illustrates the variety of participants surveyed by Race and Ethnicity.

**Table 1 – Demographic Survey**

# of	Race	Ethnicity
2	Native American	Native American
1	Apache	Chicano
1	Lakota	Native American
2	American Indian	American Indian
1	Hawaiian/Japanese/Chinese/Pilipino	Hawaiian/Japanese/Chinese/Pilipino
1	Native American/Guamanian/Filipino	Native American/Guamanian/Filipino
1	Cherokee	Black /White
1	Oglala Lakota/Mexican	Oglala Lakota/Mexican
1	Native American	Hispanic
1	Native American	Navajo
1	European	Lakota
1	Native	Indigenous
1	Indian	Purépecha

In collaboration with NFOE advocate members and the researcher, a total of three “Community Needs Assessment Qualitative Instruments” were developed. The first was designed for FOENAC members, for the purpose of collecting background information and to assess the issues that were prevalent prior to the project. The second was designed for NFOE advocates who had a family member or a loved one with a mental illness in order to assess the participants’ experience in regards to mental health issues and services. The third was designed for Native American Indian participants who currently or previously accessed mental health services within Santa Clara County to assess the participants’ perception of what mental health and illness meant to them.

The first research instrument, directed at FOENAC, included nine (9) open-ended questions that target participant’s perceptions of mental illness, health and wellness and



the participant's experiences as a FOENAC member. Although the research interview instrument is similar to the second and third, both in its design and methodology, the data results from the open-ended semi-structured interviews were used for the background on FOENAC and to report on the mental health issues that existed prior to this project.

The second research instrument, directed at NFOE, included eight (8) open-ended questions that target participant's perceptions of mental illness, health and wellness and the participant's knowledge of NFOE. This research interview instrument is similar to the first and third project, both in its design and methodology; the data results from the open-ended semi-structured interviews were used for the background information on NFOE, to assess the participant's knowledge of NFOE, and the participant's experience in regards to mental health issues.

The third research instrument, directed at the Native American Indian community, included eight (8) open-ended questions that target participant's perceptions of mental illness, health and wellness. Although the research interview instrument is similar to the one directed to FOENAC and NFOE participants, both in its design and methodology, the data results from the open-ended semi-structured interviews with the project participants were used to assess the participant's perception of what mental health and illness meant to them.

To minimize any discomfort or nervousness to the participants during the interview, the "Community Needs Assessment Instrument" was distributed prior to the actual interview so they had a chance to familiarize themselves with the questions. The surveys were used to discover participant's attitudes towards mental health, illness,

wellness and mental health services. Some questions targeted participant's personal experience with mental illness, when and where they have come in contact with mental health services or professionals. A few questions targeted participant's perceptions of coping with mental illness, their experiences with current mental health services, and the ideal mental health service program that would fit their needs.

The data from the interviews established a baseline point, reflecting the participant experience in regards to mental health issues documenting this community's perceptions of what mental illness is. The interview instrument takes a more qualitative approach to data collection. The data results of the NFOE interviews were analyzed and compared with the analyzed data from the open-ended semi-structured interviews with project participants. The program construction of NFOE advocacy program was designed with community input at several 'community' based group meetings and explains why the results of other non-Native American Indian mental health wellness promotion programs and prevention services will not be used as a cross-comparison.

### *Data Collection*

I conducted a total of fifteen (15) interviews. Thirteen (13) of the interviews were completed in person and in real time, each one open-ended and semi-structured. Two (2) interviews were conducted via email per the participant request. One of the participants was a new mother and was unable to sit down for the time it took to be interviewed. The other participant had school, family and work commitments that made it impossible for her to schedule a time that was convenient for her. I performed content analysis of web

materials, publications, and proposals to familiarize myself with key perspectives important to the both FOENAC and NFOE.

The following data sources were utilized in this project: (1) research journal articles on mental health, stigma, and mental health services for Native American Indians in order to get a better understanding of the issues facing Native Americans when accessing mental health services, (2) content analysis of web materials, publications and reports on the Mental Health Service Act to grasp the State of California purpose and intent in enacting the MHSA act, (3) content analysis of publications on FOENAC and NFOE to comprehend the key issues and perspectives important to the organization, (4) qualitative data from the one-on-one, open-ended semi-structured interviews with participants in regards to mental health service needs, and (5) research and evaluation of local mental health services currently offered to this community for cultural relevance and sufficiency in meeting the needs of today's Native American Indian consumer.

In any research project, a practitioner needs to consider the ethical issues that arise when working with project participants. At many colleges, universities, and research institutions that perform research involving human subjects, there are review boards put in place to evaluate the ethical implications of that research. Institutional review boards (IRB) are there to "protect research subjects from unacceptable risks, but also protect researchers in the event of complaints or legal suits" (Gwynne 2003:94). In the case of this project, submitting forms for approval to San Jose State University IRB not only alerted me to the ethical concerns in my project, but also to the challenges of working within a university environment. For example, interviewing a protected class, such as

minors, requires special considerations. For this reason, I chose to exclude them from the interview process because of the extra precautions that were required to protect the interest of the minors and my time constraints. Working with NFOE alerted me to the fact that additional precautions had to be met. NFOE program funds come from the Santa Clara County Mental Health Department via a grant submitted to the State of California, and as a result, a second IRB application had to be submitted to the Santa Clara County Mental Health Department as well. As a Graduate student in the Applied Anthropology program this added additional time to the IRB process.

To conduct this project, a high degree of trust was necessary between me, the researchers and the community and NFOE advocates themselves. Being a part of the Native American Indian community for twenty years was not a guarantee that trust was established between me, NFOE advocates, and the community participants. Being visible at the meetings and getting to know community members at the events was what I felt established that trust that was needed in this project. What compromised that trust was not being in attendance at NFOE meetings when they conflicted with my classes at San Jose State University.

Respect was integral to the project and instrumental in how the interviews were conducted. For many Native American Indians, the giving of tobacco is a form of respect. The gifting of tobacco varies among Natives and will vary on how they were taught. For one participant, tobacco is offered to someone for ceremonial purposes or to aid you in a humble task. Being a Sundancer, I was taught by my Sundance teachers that one can offer tobacco as a form of respect when knowledge is exchanged or if one is making a

request. I offered tobacco to NFOE members at the meetings out of respect to all the members present, to make my request to conduct this project with them, and to thank them for the knowledge I would gain. For each participant in this project, I offered tobacco out of respect with no expectation from them and to thank them for sharing their time and knowledge with me.

Confidentiality was an issue that needed to be addressed in my project. San Jose State University IRB felt it was harder to mask the identity of public figures because of the nature of their position. I was required to submit a separate signed release form that informed our public figures that their identity would not be kept confidential. In any project, a researcher strives to maintain the confidentiality of each participant by conducting interviews in private in order to maintain the anonymity of that person. In my project, I found that confidentiality and anonymity could not always be met. Not all participants could meet at a private location. In a few of the cases, at the request of the participant, interviews were conducted in a cubicle or other public space.

A researcher cannot always anticipate the ways in which confidentiality and anonymity can be breached. In my project, I found I was unable to use some responses because they would reveal the identity of the person interviewed. The Native American Indian community is a small population in comparison to other ethnic communities. In these cases, I could not use their response in my report because it would reveal the person's identity and be a violation of ethical conduct.

Real-world situations require flexibility from the researcher. Flexibility is a key requirement of any researcher who undertakes a study. The methods themselves are not

perfect, and a good researcher takes on these challenges when formulating their approach. In this project, I collaborated with NFOE advocate members to develop a total of three “Community Needs Assessment Qualitative Instruments” that were used to address three different groups: 1) FOENAC members, to assess the issues that were prevalent prior to the project and for the purpose of collecting background information; 2) NFOE advocates, who had a family member or a loved one with a mental illness in order to assess the participants’ experience in regards to mental health issues and services; and 3) Native American Indian participants, who currently or previously accessed mental health services within Santa Clara County, to assess the participants’ perception of what mental health and illness meant to them. This enabled us to use our varied knowledge and perspectives to come up with novel ways of addressing these issues when designing the questions in the instrument survey. In a way, this strengthened this research because it reduced personal bias in my project.

In this project, I mitigated these methodological challenges and unexpected issues through adapting to the situation and at the convenience of the participant being interviewed. For example, many of the participants had time constraints. In most cases, I had to reschedule the interviews multiple times. For the participants who did not have the time to meet or the one who recently had a child and was unable to sit down for even a brief amount of time, the interview survey was emailed to them. In this way, participants could complete the survey at their leisure and the responses were emailed back to be included in the report. In addition, being interviewed can be overwhelming experience and discussing personal experiences with mental health issues can be rather emotional. In

this project, the survey instrument was emailed prior to the interview to allow the participants to familiarize themselves with the questions and to better prepare for the interview.

### *Theoretical Approaches*

“Determining the origins of a theory involves examining the purpose and reason for the development as well as existing evidence for its support of its claims” (Phillips 2005:18). Theoretical approaches are effective in guiding the research and “theorizing helps to explain or predict the events in people’s lives” (Beebe & Masterson 2003:32). Although there is substantial research available on mental health and a large body of work on mental illness, there were only a few studies focused on the Native American Indian community. The studies available on Native American Indians lack a strong theoretical approach. In the case of this project, Kleinman’s theoretical approaches inform the individual’s construct toward health and illness, mental illness treatment and prevention, and illustrate how mental health is framed by Native American Indians in an urban setting.

### *Explanatory Models*

“Explanatory models are beliefs and knowledge that individuals use in response to a specific experience of illness. Explanatory models of an illness...are constructed by the individual through interaction with the sociocultural environment and past experience and include both conscious and tacit knowledge” (Skelly et al. 2006:10). Anne H. Skelly believes that the individual constructs its beliefs and knowledge of health and illness in response to a specific experience of illness through the interaction with the sociocultural

environment. She supports Kamaldeep Bhui & Dinesh Bhugra's (2002) views on Kleinman's original approach:

...which involved asking questions through an exploratory process of qualitative enquiry. This leads to complex and multi-layered responses which carry with them information about social rituals, symbols in communication, forms of knowledge and illness narratives. The patients' rich view of the world and of their illness within that world gives rise to a better understanding of their illness, including its meaning to them and their expected recovery process. (Bhui & Bhugra 2002:6)

Based on the participant responses in this project the role of community became a factor on how the individual view their illness and their possible treatment. For those individuals who rely on traditional people to conduct Yuwipi's as a treatment method for mental illness the role of community is vital. A Yuwipi is a Lakota healing ceremony where a traditional person or healer prays for the healing of a person. People who are invited to the ceremony will also prayer for the person who is ill. For the participants in this project community is part of their framework of how the they view their mental health and illness and the treatment methods, without community presence at the Yuwipi ceremonies to help them pray for healing then the individual does not get well.

When explanatory models are used in explaining the patient's view of his or her illness, then the "socio-anthropological framework of participant observation and open-ended conversation embraces the authentic view of the patient's world" (Bhui and Bhugra 2002:6) reflecting how the patient construct or frame health, illness, treatment, and prevention . Bhui and Bhugra (2006) stress that the patient's view "is lost if the questions focus on making a diagnosis and introducing a treatment" (Bhui and Bhugra 2002:6). Bhui and Bhugra go on to say that when making a diagnosis or introducing a



treatment are given higher priority than this leads “to the neglect of the patient’s total experience of the illness” (Bhui and Bhugra 2002:6). Bhui and Bhugra’s study was helpful in showing the importance of considering an explanatory model to illustrate the participant’s view of illness.

Kleinman states the focus of diagnosis and treatment in participant observation and interviews would interfere with the “anthropologist who works in medical settings... to interpret how illness and clinical reality are organized in a particular local cultural systems of meanings, norms and power” (Kleinman 1985:69). While explanatory models from the medical field give a better understanding of an individual construct on health and illness, disease treatment and disease prevention on mental illness, the bulk of the studies reviewed for this project on Native American Indians did not inform the research as to whether or not cultural, social or economic factors assisted or acted as barriers.

### *Health and Illness*

According to the 2010 United States Census Bureau there are 362,801 people in Santa Clara County, California who are listed as American Indian and/or Alaskan Native (US Census Bureau 2010b). (The 2000 Census lists over thirty-nine federally or state-recognized tribes, as well as bands and clans (U.S. Census Bureau 2010a). Establishing a definition for what is healthy and what is illness in a non-Western culture such as that of the Native American Indians becomes problematic in an urban setting, especially when its community members come from an array of tribal affiliations.

Singer points out that this notion of wellness is a utopian one and that “it is unlikely that many people in this world would be found healthy in terms of these kinds of

definition” (Singer 2007:63). When defining healthy and illness or mental health and mental illness, the participants in this project varied in their responses based on their personal perspective of what health, illness, mental health, and mental illness meant to them. Singer (2007) explains that “health” and “illness” are words commonly used most often and that “upon closer examination the definition of these terms are much more complex and loaded with cultural ideas than they first seem to appear” (Singer 2007:63). Many of the participants introduce the concept of *balance* to explain their perspective of wellness. There is a shared understanding among the participants that incorporates a holistic view of the individual “being in” or “being out” of balance that embodies the physical, mental and spiritual aspect of the person’s well being. As Merrill Singer notes (WHO 1978) the World Health Organization (WHO) defines health as “not merely the absence of disease and infirmity but complete physical, mental and social wellbeing” (Singer 2007:63), which is reflected in the comment made by a Native/Indigenous Santa Clara resident:

I would say healthy would be someone with good health physically, mentally, and or spiritually. Illness would mean to me a sickness that occurs when someone is not healthy, physically, mentally and spiritually. (“Shirley M,” Native/Indigenous, Santa Clara resident.)

For this project the concept of *balance* serves as the main definition for what health, illness, mental health and mental ill meant to the respondents and provides important context for the remark made by the following participant:

I kind of relate all of that to just like being in balance and when you’re ill, it’s like your body or your mind or you know some form of you is out of balance. In my own perspective, being out of balance is kind of again letting something to take over you, not being able to process, whether it’s like a chemical process or an emotional process or a spiritual process, physical process like not having that

ability I think I would define that as being out of balance. (“Lena P,” Dine, Santa Clara resident.)

What is interesting to note, is that the concept of *balance* is used interchangeably to define both health and illness simultaneously with mental health and mental illness, a shared idea among the participants that incorporates an understanding of the individual being in or being out of balance. For this project, the definition of health, illness, mental health and mental illness were framed around the participant’s concept of *balance*. Participants defined healthy and mental health as being “*in balance*”. In contrast, illness and mental illness was defined as being “*out of balance*”. These two definitions are illustrated in the following comments:

Healthy, well, its balance...It’s this concept of healthy balance. Healthy is understanding that it’s ok to feel sadness and it’s great to feel joy. It’s really having appropriate responses to your situation and its knowing how to handle or to respond to these situations. (“Ramona L,” Native American, Santa Clara resident.)

I think mental health or I kind of relate it to just being in balance, mental, physical, spiritual, and emotional, all those things being in balance. Mental health is being in balance, not letting one thing take over your whole emotion and your whole life. It’s finding the good in things, maintaining that in yourself and your outlook in life. (“Lena P,” Dine, Santa Clara resident.)

Although there is a shared notion among the respondents on the concept of *balance* the two statements above reflect how the respondents differ in their individual view of what health, illness, mental health and mental illness meant to them. For Ramona L. “the concept of healthy balance” is perceived in terms of understanding the emotions that affect the individual and being able to respond appropriately to situations.

Whereas, for Lean P. mental health is being in balance, mental, physical, spiritual, and emotional, and not letting one thing take over your life.

In terms of how individuals frame health, illness, mentally healthy and mental illness only a few respondents defined health and illness or mental health and mental illness in context of their cultural and tribal beliefs, as depicted in the following comments:

Healthy, like my brother says, somebody who has a well-being about themselves, is able to go out and is able to deal with what's ever going on in the world. Being healthy in your body, your mind, your spirit, being able to just go out and do whatever you want to do and not be negative, be positive, to love yourself, just being able to deal with day-to-day life and the situations around you. Illness, within the American Indian community. You can't cope. You can't deal with the situations around you. You have to drink, you have to take drugs, you have to...or something's as you were growing up, the way you grew up, there's dysfunctional families, and I myself had a dysfunctional family and it's sort of still is, but I'm at the point where I'm older and I don't think about that anymore, but I can see it in my younger sister. ("Cathy R," Nez Perce, Santa Clara resident.)

Out of balance, that we're out of balance that people who have those kinds of mental issues that we're out of balance and that we need to find our balance again we need to go back to that center to find the creator, to find everything that that entails. To make sure the creator is in the center. That we understand that something got haywire, it wasn't wired correctly. When you're in balance, it'll eventually make sense. ("Susie F," Oglala Lakota, Santa Clara resident.)

For Cathy R., "the concept of mental health" is perceived in terms of well being and being positive. In contrast, illness is being unable to cope and associated with drug addiction and alcoholism. For Susie F., mental issues are a result of being in out of balance and to find one's balance means finding your center where the creator is. Susie F., responses illustrates how important the role of Creator has on how their cultural and tribal beliefs frame health, illness, mentally healthy and mental illness. There are numerous studies that underscore the varied definitions for health, illness, mental health and mental

illness, not one sufficiently embodies the Native American Indian approach to mental wellness, one that incorporates a spiritual significance and maintains balance. It is important to understand how Native American Indians construct and frame health, illness, mental health, and mental illness in relation to their culture and spiritual practices in order to contextualize what role they have on treatment and prevention.

The participants who framed health, illness, mental health and mental illness in terms of the biomedical perspective were involved in the medical field, as a social worker, counseling services, a professor in psychology or in college to become a substance abuse counselor, as is explained below:

Health is being healthy, recognizing if I got a cough or a cold. I know that if I'm healthy, I know I feel good, I know I can function. I get up in the morning, because I've known a time where I was deathly ill. That was unhealthy. Illness was when I knew that I see it, like my auntie right now, she has a problem with her liver and she never touched a drop of alcohol in her life. So I know that she's ill and that's how I define that and she will never get better. ("Manuel H," Oglala Lakota, Santa Clara resident.)

I see mental illness has to do with brain chemistry, and so I see at one level mental illness as being a physical condition a biomedical condition and to some extent an unbalance in the brain but I don't use the phrase simplistically like some people say take Zoloft or Prozac cause you got a chemical imbalance and all that does is increase the imbalance and I understand the bio chemistry of that. When I talk about its being some kind of imbalance, it's just that there's either a structural or a bio-chemical condition which is due to probably some structural or genetic factor which in essence results in a person behaving in a way that make it harder for them to get along in society. ("Ramon J," Lakota Indian)

### *Mental Health, Mental Illness and Wellness*

When considering the concept of mental health and mental illness it is vital that "health care professionals become culturally competent about the traditional belief

systems that are embraced by the particular American Indian or Alaskan Native (AIAN) groups, and the principles that they embrace in general” (Grandbois 2005:1005).

If you look at it from a medical model, mental health is a diagnosable issue, whether it be depression or schizophrenic or bipolar or whatever it is that you have to do this whole assessment on to be able to give that diagnosis. The way we were defining it is that a person is unbalanced. The way we were looking at is that everything that happens is a form of mental health. Or everything that doesn't happen in that concept because one thing leads to another. (“Daniel D,” Apache Indian.)

For example, in the Family Outreach and Engagement Team of the Native American Community (FOENAC) of Santa Clara County proposal for Proposition 63 funds, the role tradition has on mental wellness is acknowledged as the most appropriate remedy to mental illness. The team emphasizes culturally they “do not separate mental health from physical health, mind from body or spirit, or consumer from family or community” (FOENAC 2008:1). Daniel D. statement illustrates that Native American Indians views mind, body and spirit is interconnected. Culturally there is no separation between health and mental health, illness and mental illness, or even consumer from family or community, everything is connected.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), provides standard criteria for classifying mental disorders and is used by clinicians when diagnosing mental disorders. The DSM-IV-TR is a categorical classification system and a patient with a close similarity to the symptoms is said to have that disorder. The DSM design is primary concerned with the signs and symptoms of mental disorder rather than the causes. The criticism with this type of criteria system is that a diagnosis is a label that encompasses the mind and body

only. When individuals are diagnosis with a mental disorder the problem that can arise is that the individual identity can becomes entangled with the label, as illustrated in this comment by one of the participants.

I think people could have severe physical challenge or mental challenges, and they are working with it and have knowledge of it and they feel hope and they can have very fulfilling lives and have these differences. It's one of the things why I have a problem with diagnosis...one thing is to have a diagnosis, but another thing is to tell a person you are schizophrenic, you are manic, you are bi-polar, you are an alcoholic, that people, their identity becomes entwined with this. Illness exists where a person feels unable, they are chained, in a sense, of personal vision. They may not speak of that to the world, like a front. I have no problems. If you feel you're not able to live the way you want to live, then there is illness. ("Yolanda A," Purepecha Indian, Santa Clara community resident.)

The diagnostic criteria used to explain the perspective of mental health and employed by FOENAC committee members in their proposal is derived from the DSM-IV-TR. FOENAC goes one step further than a simple diagnosis but rather as an "ever-evolving process toward greater mental health and congruence for consumers and non-consumers alike" (FOENAC 2008:1). FOENAC's "Traditional Plan to Wellness" does not rely solely on the DSM it incorporates traditional Medicine men and women in the assessment of mental disorders.

One important finding in Kleinman's 1985 seminal article, "Interpreting Illness Experience and Clinical Meanings: How I See Clinically Applied Anthropology," is that we can grasp the significance of illness to the sick person and how the meaning is managed by both the individual and its family members. These meanings, relationships and other factors, such as work, medical and community, affect how the sick person and its family member will seek care and treatment (Kleinman 1985:69), which is expressed in the following statement:

I think my mental illness started from just the abuse that I had as a child. So growing up, it was very hard for me to communicate with my mother, there was no relationship there. So as I became a teenager, it got worse. When I was 13, I got into therapy, she got me into therapy because she thought it would help the relationship, but it didn't help that relationship, it just got kind of worse. I always wanted to have good relationships with my kids, because I didn't want the same history happening when I had kids, but it just kind of seemed like it was the same, not the abuse, me not being able to communicate. I could never communicate with my mother. It's very hard for me to communicate with my kids. ("Marie W," Native American, Santa Clara resident.)

Kleinman's point was important to investigate in this project in assessing how Native American Indian participants perceive their mental illness and how family members will discern it. Mental illness affects the relationships between the individual and the family members as was expressed by Marie W. in her statement. Learning how Native American Indian consumer access mental health services and discovering whether social factors, such as family support or community, assist or act as barriers will aid in the construction of services the individual wants and needs.

## **THEMES**

All of us access services in one form or another. Few of us voluntarily choose to seek aid or services offered by an organization, unless we have a need to do so. Many consumers in the United States who are eligible for assistance programs choose not to utilize them due to a variety of factors such as personal pride, inaccessibility, or challenges involved in navigating the unfamiliar world of service providers for the first time. How people utilize mental health services varies according to the situation that led them to seek out treatment. An important point to consider is how to link people who access mental health services to the situations that cause them to need these services in the first place. One of the goals was to examine what factors assisted or hindered the



project participants from accessing mental health services in Santa Clara County and report on them. Five themes emerged from the interview responses.

### *Mental Health Services*

The Native American Indian population is small in relation to everybody else, but there's still, I think the last census there were 26,500 and some odd people, there. Those are the ones that are identifying with it (census count). There are a whole lot of other people that don't identify with it (census count) or that we aren't even aware of. ("Daniel D," Apache Indian)

The amount of funds allocated for each ethnic community is dependent on the numbers that are reported in the US census. The allocation of dollars for services in each county is based on population size. The Native American Indian population in Santa Clara County may be small in regards to the rest of the ethnic communities, as Daniel D. pointed out, and as such entitled to the same type of services that are available to the rest of the communities. What he liked most about mental health services that are available is "that they exist".

I get kind of surprised when people talk about not having access to services or not enough services being available. When you look at the county itself, there's an abundance of services here. But part of it I think is that people just don't know about them. People don't know about the services. ("Daniel D," Apache Indian)

Daniel D. brings up a valid point in his interview. Do Native American Indians know about the mental health services that are available in Santa Clara County? More importantly, do they know who to contact or where to go during a time of crisis? The following statement illustrates how one participant did not know who to contact and the impact it had on her:

He's threatened me. He's disrupted my house. Put my house at jeopardy where I almost lost it because the police were coming to the house and raiding it and he does not feel sorry about it. I just needed somebody to talk to at the time and

didn't really have anybody around. I didn't have nobody there for months as I was fighting this by myself and I got really depressed and I was locking myself away and I didn't want nothing to do with nobody and finally my one my older son got through to me and brought us closer and he's actually seen firsthand some of the stuff that's going on. ("Cynthia G.," Native American Indian, Santa Clara community resident.)

In trying to cope with her son's threatening behavior during a crisis period, Cynthia G. had no one to which she could turn. As a result she fell into a depression and isolated herself from her community and her family. When asked the question, "*Were there any services that helped you?*" Cynthia replied, "No, because the doctor, she just she asked me and said she was going to refer me and never did." In Cynthia G. case she did seek out mental health service in dealing with her son, but as she pointed out the doctor did not follow up with her with the referral she needed. In her case the services were available and she did access them, but the follow through by the doctor whom she contacted did not occur.

In dealing with a crisis, as in the case of Cynthia G., being overwhelmed and not knowing who or where to turn can make people feel alone, and as a result, they can isolate themselves from family members and friends. It is in these situations that NFOE becomes an important support system for the Native American Indian consumer. Their one-on-one service approach makes the individual feel less alone and less isolated. Their caring and compassionate approach makes the individual feel like a human being rather than another statistic.

Funding for mental health services in relation to existing service became a point that many interviewees addressed in their interviews. Many of the respondents were concerned how budget cuts are affecting the way services are being delivered and even if

those services would continue to exist. In his interview, Daniel D. points out that with today's budget cuts, mental health services delivery has now become dependent on income level, geographical area, and other factors. Based on these criteria, many individuals who seek mental health service may become ineligible if they do not meet them.

When asked the question, "*What services or help are currently available for people with mental illness that you know of?*" the response of the mental health provider interviewed for this project varied from that of the Native American Indian mental health consumer, as is highlighted by the two statements below:

If you look at the community as a whole, anybody can go to a county service. So that's a resource. There are boarding care places, there's emergency housing, there's soup kitchens, there's a lot of resources in Santa Clara County. Santa Clara County spends the most on their community than other counties do. Los Angeles County as an example, whatever grant they get, that's all they spend on their mental health, on the mental health community. Whereas Santa Clara county puts in a lot of their general fund dollars, so even though, even if they got, let's say like \$25 million to provide mental health services they would match that with another \$25 million so now you have \$50 million instead of just 25. So, Santa Clara County has really done a really good job on trying to help their community as a whole. ("Daniel D," Apache Indian )

Well, I know there are some services out there, the County, I know they try to support, but I don't think they understand how to support those different ethnic groups. I see where some of the county employees are pretty good. They try to provide events or activities for those individuals with mental health issues. I know they try to reach out, they have been trying to reach out to the different ethnic groups and find out what they can do better as far as counseling and mental health issues, but I think there needs to be a lot more. I know they are trying to be more supportive, but there is that cultural issue where they don't know culturally how to deal with American Indians. ("Cathy R," Nez Perce, Santa Clara resident.)

Daniel D. response differs from Cathy R. because each is looking at mental health services with different lenses. As a health provider, Daniel D. has access to information

on mental health services and what type of funding is available, which may not be so readily available to the Native American Indian consumer. As a consumer, Cathy R response is based on the issues a consumer faces in the delivery of services rather than the availability.

When asked the question, *“What services or help are currently available for people with mental illness that you know of?”* Many of the participants responded with specific agencies or in general categories. The list includes: (1) Indian Health Center; (2) NFOE; (3) Emergency Psychiatric Services; (4) AAKI Asian Americans; (5) Ujima; (6) Bill Wilson Center; (7) Valley Medical Hospital; (8) New Creations Ministries; (9) Gardner Mental Health; (10) GONA; (11) American Indian Alliance Health Conferences; (12) Ceremonies; (13) Counseling services; (14) Social workers.

When reviewing local and county services there were a few mental health services that participants did not mention in their interviews and those are (1) Urgent Psychiatric Care Unit; (2) Serious Mental Health Help and Counseling; (3) 2-1-1 Santa Clara County; (4) EMQ Child/Adolescent Mobile Crisis program; (5) Mental Health Advocacy Project (MHAP); (6) Peer Pals; and (7) NAMI. With the many search engines, such as Google, Yahoo, AltaVista, on the Internet and more organizations listing services on their webpage, today’s Native American Indian mental health consumer can access the Internet and seek out mental health services on their own.

### *Standardization*

Kleinman states that “the legacy of institutional racism is not absent from health care and biomedicine. It is for these reasons that culture matters in the clinic” (Kleinman 2006:835), as portrayed in this comment made by Lena P.

Again that caring factor is really important and I think that sticks out the most. For me and seeing NFOE and the way that they work with each other and with the community is just caring, you know treating each other like a human being because sometimes that’s all that’s really needed is just one human being, a human to another human instead of this hierarchy or here I’m doctor I’m treating you it’s just like hey let’s have a conversation so I think you know that’s really important, there’s no pre-judgment there’s no, I guess, profiling you know and discrimination everybody is really just they just really get to established that kind of true relationship with the community and help them in that way and sometimes that’s all like somebody needs to get back in balance is actually just have like a friend or companion to talk to, you know type of thing and I think that NFOE does a really good job of doing that and being there for that person and supporting them and like the needs of that situation and their family. (“Lena P,” Dine, Santa Clara resident.)

For many of the respondents, the stigma that is associated with mental illness and the labels that are attached to them make them hesitant to seek out mental health services. How they are treated in the clinical setting is the deciding factor if they will continue with those services. More importantly how they are treated by community members in their community determines whether or not they will disclose if they have a mental illness or not. For many Native American Indians, racism and stereotyping is an issue that they face in society as well as in a clinical setting, as is depicted in this comment:

There is a lot of stereotyping when you walk into the clinical facility, I mean what they are taught, what they got fused that are instilled in them already, but I don’t think the playing field is fair sometimes and it’s hard to get your answers to your questions or your understandings when they got a template that is just so plain Jane. Standardization! Institutionalization! And when seeing it now it’s like wow, you are tapping into my culture, you are tapping into my heart and my mind and my being, how the way I do live life, its commends them because you’re taking that extra step you know at NFOE or even Indian Health, you are understanding it in a different point of view than a clinical aspect of it. I have been to a couple of

facilities where this is this, this is this and this is that, this is how it goes, there is no options for you, it's just this is the playing field and this is how we are going to play it. ("Nancy B," Lakota Indian, Santa Clara community resident.)

The standardization of services for a lot of agencies can be cost effective and save programs thousands of dollars but what is the cost to the individual seeking services? As Nancy B., Lakota Indian, points out in her interview, the stereotyping that goes on in a clinical facility and the standardization of services does have an effect on whether or not a Native American Indian mental health consumer will access those services at a clinical facility versus accessing them at Indian Health. Many of the respondents commented that NFOE delivery of services by advocates that are of Native American Indian descent fosters a sense of understanding and trust.

I think mental health services in the county really tries to pigeonhole us into one of those other categories that they've done to other minorities. Trying to fit us into those little categories it's like having a pegboard and this one's square, and this one's a triangle, this one's a rectangle, and guess what, we didn't fit in any of those and so that's why they weren't able to. Once they try to give the services and they didn't hit upon the essence of what's going on, guess what, those people walked away. A lot of times with us, as natives, as American Indians, you reach out and you try to get the help, but guess what, you might be offended by something that's being said or done or not done. You'll never see us again, you'll never know why, but we'll walk away. It didn't work there, I don't need you, I don't need to talk to you anymore...we'll disappear you won't see us again. ("Susie F," Oglala Lakota, Santa Clara resident.)

Generalizing mental health services to fit all groups becomes problematic to the Native American Indian mental health consumer whose tribal practices, beliefs, religion, and spirituality is different from their neighbor, their co-worker, their friend. For Cathy R., mental health services are trying to be more supportive, but for her there is a cultural issue. As she puts it, local county services try to reach out to ethnic groups but the county really does not "know culturally how to deal with American Indians."

I think there's been so much given out, about who Hispanic is, who a black person is, who a white person is, and most of the people who are delivering the services, and I would say the majority of them are white people, and I don't mean to put them down in that sense, but they have their own perspective and perceptions about who we are as native people, or we're people of the earth and we have this spiritual thing and whatever, sort like the mystic warrior, and all of that kind of stuff, but we're real people. Now we cry and we hurt just like anybody else, but we do things in a little bit different way. We keep going to that whole thing of being in a circle. And we understand...we have probably more of a global understanding of our world. ("Susie F," Oglala Lakota, Santa Clara resident.)

For Susie F., local county services try to understand the Native American Indian community when it reaches out but fails to see the perspective of this community. As she puts it, "We are a unique group, we're a unique community. I don't think there's anything, anybody else like us." There is a benefit in having a health organization such as Indian Health Center and a Mental Health Advocacy program as NFOE that is made of staff and members who are of Native American Indian descent that specifically targets Native American Indians. Those consumers who find it tough to access mental health services because of stigma issues find it easier to access when programs like NFOE exist.

*Cultural Competency – "The Native American Indian Perspective"*

Maybe just dealing with your own race as one being culturally sensitive just entering a door and not being stereotyped, going back to the talking circle, going back to offering foods and tobaccos and smudging and just as in respect all across the board of how to present yourself within the need of Community, dealing with it in that way. ("Nancy B," Lakota Indian, Santa Clara community resident.)

Kleinman's interpretation of culture is "culture is not seen as homogenous or static by anthropologists, who emphasize that culture is a process through which ordinary activities and conditions take on emotional tone and moral meaning for participants. The development of interpersonal attachments, the serious performance of religious practices,

the cultivation of an identity and the embodiment of meaning in physiological reactions—these are all cultural process” (Kleinman 2006:864) as depicted in this comment:

I don't think they understood. I don't think they really. I think they try to. One of the reasons that came out of the grant is that we are unique, we are a unique group, we're a unique community. I don't think there's anything, anybody else like us, in the way we view the world on global level. I think we're more spiritual, and what the spirituality of who we are, no matter whether it's the Native American church, whether it's sweats, whether it's ceremonies, or whatever each individual native group has, it's there. As long as that's put in the center and you're looking at issues for health, just physical health, mental health, emotional health, spiritual health, it's there, people there who can help can be brought in or it's already here. (“Susie F,” Oglala Lakota, Santa Clara resident.)

For both Nancy B. and Susie F. the Native American Indian perspective on issues of health, whether it is physical, mental, emotional, and spiritual, has meaning in context of their culture and religious practices. For both of the participants, culture sensitivity is not just about recognizing what matters most to the Native American Indian mental health consumer. It is about acknowledging those items, for example sage and tobacco that is part of the healing process. It is about having sage available in counseling sessions for smudging or tobacco for offering to the Creator. Culture sensitivity is seeing the Native American Indian mental health consumer in context of their culture and belief system. It's about local mental health services understanding the Native American Indian mental health consumer by their perspective and incorporating their religious practices as part of the delivery of mental health services. It is for these reasons many of the respondents choose the Indian Health Center over local county services because the services at Indian Health Center meet the distinctiveness of the Native American Indian consumer as illustrated by the comment made by this participant:



At the health center, here in the counseling department we have you know, individual and case management, we have psychiatrists, we have alcohol and drugs, we have prevention services, we do drum and dance class, we have sweats, we bring in traditional people to do ceremonies, there's groups going on, we have dual-diagnose groups, we take them on outings, there's a variety of things for people to do. ("Daniel D," Apache Indian)

The drum and dance workshops are cultural enrichment activities that foster self-esteem, positive self-image and cultural pride. Sweats are healing and cleansing ceremonies that many Native American Indians participate in for the spiritual balance that is an important aspect of their life. Traditional people are brought in to perform the ceremonies that Native Americans Indians feel are an integral part of their healing process. The services that are offered at the Indian Health Center fit the uniqueness of the Native American Indian consumer.

Local county services offer services that meet the needs of the general population rather than individual ethnic communities. Services such as dance and drum workshops that improve self-esteem, self-image and cultural pride of the Native American Indian consumer would not apply overall to the general population. When consumers seek counseling services at the Indian Health Center, they know they will find sage there for cleansing and will find comfort in that. From the interview responses in this project many felt that cultural sensitivity and cultural understanding is a need of theirs that needs to be met.

*Advocacy - "Being the voice for the Community"*

What I was concerned about is giving our community a voice. Sitting there and listening and making sure that if these services were going to be delivered through us as a community that we had qualified people that understood our community, know our community, and were able to

function within our community. (“Susie F,” Oglala Lakota, Santa Clara resident.)

Sometimes what happens when new services or programs are introduced to a community, they are not as successful as the agency would have liked. In many cases, focus groups with the community and community meetings become effective venues to discuss the services and to address the issues that arise. For many Native American Indians, it is not enough to have a discussion with the community; it is being able to understand the perspective of the Native American Indian community and being able to navigate and function within the community itself that has an important impact with how those services will be received.

FOENAC vision for the community advocacy group is to be a support group to aid both the consumer and the family in need of mental health services. They envisioned that NFOE would become a valuable resource and ultimately strengthen the Native American Indian community. NFOE’s mission for its community advocacy program is clearly stated in their program brochure. As a group they “collectively strive to achieve mental wellness through community interdependence and Native traditions” (NFOE 2009). NFOE has become much more than a support group to the Native American Indian consumers they assist. NFOE has brought hope and strength to the families that have come to them seeking services, as is highlighted in this comment made by one of its advocates:

The most effective that I can see offhand are those in advocacy. Part is going out to the families that are having mental health issues with the family member. Them just going, “I don’t know what I’m going to do, I don’t know what is going on, I don’t know what is up, his or her options are, I’m kind of lost, I’m getting stressed out, I’m getting all this anxiety, I’m getting depressed” to us saying what

do you need help with? I don't know how to get in touch with them. They locked up in EPS, and the fact that we can just tell them, please calm down, we are going to try to do everything we can for you and them putting a lot of their hope into us and we can pull through cause the county's backing us and you kind of have that strength and being able to give them those resources right away instead of having to call around and find out what's going and those types of things, and you see it in their face when you show up at their homes and they're just like "oh, thank you so much," and they're happy and they're glowing and they're "oh, hi!" A few families we helped we've seen at Pow Wows or GONAs and they'll just be "How are you?" I'll say "How's your mental health situation?" You know they're good, you know their family members are doing well, doing those things they need to do to be mentally well. That probably sticks out the most because that just makes my heart warm, but I know just because we are in the community and we know how powerful those Pow Wows and ceremonies are. ("Lisa S.", Santa Clara resident.)

What makes NFOE successful as a community advocacy group is not just the delivery of services they provide but also the advocates themselves that aid in the program's success. Many of the respondents commented it is the human factor that makes the difference. The one-on-one service is a valuable asset, but it is the compassionate and caring nature of the advocate that make the difference to the consumer. As one participant mentioned in her interview it matters to her whether or not she will go to talk to someone who cares versus someone because it is his or her job. In this regard, NFOE has successfully met the needs of today's Native American Health consumer.

From the interview responses, the caring nature of a NFOE advocate was not the only consensus of what made the program successful but also that the advocates truly understood what the Native American Indian consumer experiences when they are dealing with mental health crisis in their family. The NFOE advocates I interviewed in this project understood the consumers because they themselves have gone through similar experiences with a family member as the consumer has. Their personal stories of having

to deal with a family member in crisis, accessing and having to navigate mental health services for the first time, how hard it has been on them dealing with the emotions and feelings, and not having the support there at times mirror that of the consumer. The caring and compassionate nature of the NFOE advocate toward the Native American Indian consumer is what makes the difference for the consumer that seeks them out.

*Community - "What is Community"*

Community is a very important aspect for many of the participants interviewed for this project. For many of them community is as intimate as family, as is expressed in the narrative below:

You may still have the issues, some of the issues, but you are going to have the respect, you're have the acknowledgement of getting the help and having the respect that you are a person and you have these needs that they're being met, but they are being met by our own people. And they're going to do it with love and they're going to do it with care and confidentiality and you don't have to run away, you don't have to go hiding from our own community. That's what I would like to see with the mental health, what Native Families is doing and that you can have these issues, but you're not an outcast, you're not a leper. Being in balance, that's the difference that I see is that it's ok, you're ok, and you're loved, and you're respected, but you don't have give in to the whole thing because for me, I think family, and being part of the community that is healing, that is family, as long as you're not on the periphery and you're accepted, it's ok. You're part of a family and you're loved and you're cared about and you're prayed for. ("Susie F," Oglala Lakota, Santa Clara resident.)

It is the community that will show up at a Yuwipi, a healing ceremony, to help you pray for that loved one who has a mental illness. Many of the participants responded that the Native American Indian community of Santa Clara County will be there to support you when you need help, when you need prayers, when you need that care, and for many Native American Indians that is vital when dealing with a family member with a mental illness, as shown in this comment:

What we also had, like evening barbeques or picnics just to get the community together to know that there is no shame here, it's okay to come out with your family members. Some people, they really isolate and I think that can be a little harmful sometimes and its better if you get out there and show there is an existence, you have so much support in your community and then they realize that we are all on this journey and we are all trying to help each other as a community, not only as one on one. But it does start with that one person. You got to instill that trust with that one person in that family and it's just word of mouth from there. ("Nancy B," Lakota Indian, Santa Clara community resident.)

The Indian Health Center was created by the community. In its infancy, it was not a professional organization in the sense of other organizations you see today. The Indian Health Center started because the relocated Indians that came here to this county saw the need for their own clinic, the need for their own place to get health services. Daniel D. commented in his interview that the Indian Health center first started with a volunteer desk, with a community of volunteers and people putting the program together, and over the years it has grown into the organization it is today.

NFOE is a community-based advocacy group and began on the same premise as the Indian Health Center: the need for a program to aid both the consumer and the family in need of mental health services. For many of the participants, going to NFOE for mental health services is a more viable option over local ones. NFOE is viewed as part of the community, as family, whereas county services are not. Other organizations have not quite grasped the view of community that the Native American Indian has, as illustrated in this comment:

I'm not sure if they totally understood that an organization can be a part of the community, in the sense of it being, most of our, or at least our Indian staff, get involved in the agency because they want to help their community not because they're looking for a job. I mean, obviously they're looking for a job, but it's because they want to give back to their community. They don't look at it as a profession, right, I went to school to be a doctor and now, that type of thing.

They're doing it because they want to give back. Or they want to strengthen the American Indian community, but not everybody's like that in terms of organizations, they get involved in it because, I mean obviously they want to help but at the same time that's their profession – that's how they identify themselves. They identify themselves as being a doctor or a lawyer or a psychologist or something like that. They don't identify themselves by their ethnicity. Whereas most American Indians do that, you know, you'll ask them who they are and they'll say "I'm Apache." or "I'm Lakota," and this is what I do. Whereas in most other cultures they'll, you'll ask them "hey, well what do you do?" and they'll say "I'm a doctor," you know what I mean? And there's a difference in that. ("Daniel D," Apache Indian)

For many of the participants interviewed, NFOE is not viewed as just another program. It is viewed as a community mental health program of community members helping other community members with mental health issues. The advocates are not just viewed as community members but in some cases as family members. For project participants, it is family to whom you go for help during a family crisis and for them NFOE is made up of family members.

#### *The Needs - "What Do We Want"*

They need good doctors, they need counselors they need options, they need that follow through, they need understanding of Mental Health is not just one issue, its many issues. We need to advocate that liaison who is going to be able to, you know we have individuals in our community who advocate, who is going to help us follow through with that on a long run, who is going to make this existing facility, who is going to expand it, who is going to make Native American Mental Health Clinic, I mean you could dream as big as it could get because this is not going away so to have any kind of foundation to just to develop that would be great. Our needs immediately to have anything that associates in our community that there is a Mental Health issue, there is a need there that needs assessment, that's a good start if you ask me. ("Nancy B," Lakota Indian, Santa Clara community resident.)

At the request of NFOE, the purpose of this project was to assess and identify the issues, as experienced by providers and users of mental health programs used by urban

Native Americans. Nancy B. statement illustrates that an important area of focus for this project was the framing of mental health needs from the aspect of the Native American Indian participants and that of NFOE. As Nancy B. comments mental health is not one issue but many issues that need to be understood. The beliefs on mental health needs varied accordingly with the participants. Five areas emerged from the interview responses.

### *Stigma*

Societal mental health stigma is expressed to and about mental health consumers in different ways. It deeply affects consumers, their family members and friends in many ways, including outright experiences of discrimination and devaluing. Stigma can be defined as negative attitudes, assumptions and behaviors that people may express, directly or indirectly, to others that help continue stigma, discrimination and bias. This stigmatization appears to be more directed toward mental health consumers and other marginalized groups in our society (Hodson 2008:1). For many of the respondents the fear of societal stigma is all too real concern for them. More importantly, the fear of community mental health stigma makes a difference on whether or not they will disclose their mental condition to other community members. The participants in this project reported that stigma is an area that still needs to be addressed, as is noted in these comments:

There's, I mean, so much stigma around it. People just don't want... you ignore it, you want to act like it's not there and if it's in your family, you keep it inside. That really, that does nothing for the problem, right? They were really on to something when they said ok, no, communities are going to design their own programs for families dealing with mental illness and we're going to design support programs. Given the autonomy, we're going to give them what they need to develop a successful program. ("Ramona L," Native American, Santa Clara resident.)

I think...okay, I am going back to my culture and understanding that and not being stereotyped. Not being looked at as a typical statistic or something that is maybe a minority of minorities you know, that were looked upon as just, you have a mental health issue, let's get educated, let's get on this and see what we could do. No promises, just what can we do to help, you know. Help the awareness; help the rising to getting things better, on a level where it is livable. ("Nancy B," Lakota Indian, Santa Clara community resident.)

### *Support Groups*

Many of the respondents found it overwhelming dealing with a family member with a mental illness in a time of crisis. Having a support system is crucial in those times of crisis. Having to deal with a loved one with a mental illness every day can be difficult for both the individual and each of the family members. The stress of having to cope with episodes and mental health services can be challenging. It is important to have a good support group to go to where the person can feel comfortable and not feel stigmatized or labeled. Being able to go to a talking circle or support group to discuss those mental issues with others, who are going through the same experiences, aids the individual to cope with the stress and challenges they face. For participants in this project they would like NFOE to continue being a support system they can rely on. The comments from these participants reflect this view:

I'm really big on support system and sometimes I feel that maybe they should have more support groups out there, where people can join in and communities for support. ("Maria W," Native American, Santa Clara resident.)

Probably a good support system, feeling comfortable to like reach out like to people or services or community. It's also really I think it might be hard sometimes. I know it's been hard for me in my experience to reach out to organized services like different facilities just because it's like again like that stigma oh you don't want to be associated with that kind of label. ("Lena P," Dine, Santa Clara resident.)



### *Affordability*

For many of the respondents, the cost of services has been an increasing concern for them, especially for those who are not insured. The cost of medications can become rather expensive for the average mental health consumer. For those who have no health insurance, the cost of medications becomes a primary concern when one cannot afford them. Project participants report that they self medicate, missing a dose here and there, in order to stretch the medication as far as they can, as illustrated by this participant.

Medications are getting to the point where people can't afford them, so they just stop taking them. I think that's where a lot of the mental illness now is coming from, because people are not taking their meds because it's just too costly. ("Maria W," Native American, Santa Clara resident.)

As Maria W. points out that for the mental consumer who can't afford their medication will stop taking them or skip doses and where she believes is where their mental illness is now coming from. Based on the participants' responses, one way that NFOE can help them in regards to medication is to act as a resource in finding pharmacies or programs that would reduce or offset the rising cost of medications. For those who have no health insurance the cost of office visits can become costly over time. One respondent stressed that the ideal mental service program should be free and have no limitation. The service would be available not just to the mental health consumer but to the family members and community as well, as illustrated in Lena P. statement below.

If I were to create the ideal mental service program it would be free. Yeah, it would be free and it would, they wouldn't be very many limitations because again I think that everything is all you know connected it's related you know the mental, the spiritual, the emotional, the physical all those things and I think that like a mental health program would include everything and not just like to certain individuals but also to the family, to the community because it's usually deeper than one person so. ("Lena P," Dine, Santa Clara resident.)

### *Intervention*

Kleinman states, “The belief held by persons in a society play a significant part in both disease causation and in remedy. In different societies, such categorizations, beliefs, and expectations are culturally organized to various degrees...the significance of those beliefs in disease causation and cure is the same as that of microorganisms and medicinals; given certain conditions of host and environments, pathology or healing consistently follows belief” (Kleinman 1983:3). The importance of this type of framing stems from the belief that perception of preventive behavior among each of the groups will vary depending on the belief of each group and, therefore, have bearing on the expectations of the services and program components from said groups. After analyzing the participants’ interviews there were some differences in preventive behavior, such as the role of fitness to improve mood or activities to combat stigma but there were many similarities as well. For example, the role of community on preventive behavior and the use of traditional ceremonies was a commonality shared by the participants.

An important area of focus for this project was the framing of preventive behavior from the aspect of the Native American Indian participants and that of NFOE and FOENAC. In this project, the beliefs on preventive behavior did not vary accordingly with Native American Indian participants and that of NFOE and of FOENAC. For the respondents, intervention and resources were areas of preventive behavior that can assist the Native American Indian consumer, as is reflected in these comments:

Some kind of intervention type...but I mean...to be it’s...I’m told it has to be the person’s choice, which I understand that, that person has to make the first step. But there’s got to be a way for people out there in the mental health area or

services to help people who need to get a family member help (“Maria W,” Native American, Santa Clara resident.)

Furthermore, help prevent...early intervention and prevention. PNI’s are a new thing that we look for, prevention and early intervention, if we can spot it before it goes to crises, we’ve averted costly, costly expenses and save tax dollars in the process. (“Manuel H,” Oglala Lakota, Santa Clara resident.)

Kleinman says, “Culture factors are crucial to diagnosis, treatment and care. They shape health-related beliefs, behaviors, and value” (Kleinman 2006:834). In short, Native American Indians know what works for them. They have been using traditional ways of healing to keep them in balance and traditional ceremonies for hundreds of years. They are unique, and local standard mental health services that are offered need to incorporate those traditional ways in intervention and preventive care, as illustrated by this participant in her commentary:

We learned that healing comes from our own traditions and ways of healing and they work; prayer, ceremony, the talking circle, keeping communication open. There would be certainly those things, but we also need to keep things light and easy, not everything needs to be so heavy-hearted, fun activities to keep people engaged, and to keep people connected. Social events, art classes, mother’s circles, father’s circles, sweats, all these things keep communities like our community healthy and strong, that’s what we know works. (“Ramona L,” Native American, Santa Clara resident.)

Ramona brings up an interesting point in her response, keeping things light and having fun activities to keep people engaged. A good perspective to have when a family member is coping with the stress and challenges of a loved one who has a mental issue. Many of the participants reported that keeping people connected through social events, art classes or sweats is a good approach in trying to address stigma. Once again the role of community is vital in keeping not only the individual health and strong but the community as well.

## *Fitness*

One need that was expressed by a few of the respondents illustrate the role fitness has on improving the mental health of an individual. Energy driven activities and Yoga were reported as ways of maintaining mental stability, as noted in these comments.

An exercise and fitness center where there's classes such as Yoga, which helps mental health and where there's personal trainers that if you want one-on-one time with them they can accommodate your needs and what you need to help stay mentally stable or if you're not mentally stable it will help reduce that...that's really all I got. (Anna R., Cherokee, Santa Clara resident.)

For the Native Community itself, I guess more support groups and more energy directive programs. Meaning activities that people can take part in where exercise and meditation is involved. Now the American Indian Health Center may have this set up already. To be honest I haven't been an active member of the Santa Clara native scene for a while. If these programs are in place, then I would like the word to get out so that all natives in the area can start using the programs. ("Jackie W," Navajo, Santa Clara resident.)

Since many of these activities are in place and a fitness program available for all Native American Indians in Santa Clara County, NFOE can bring this resource to the consumers. They can bring the consumer to the fitness center and help them get started in the fitness programs. Then can organize and sponsor more energy directed activities as well. They can promote and educate individuals of the benefits that fitness, yoga and other energy driven activities has on improving the mood and mental health of the Native American Indian mental health consumer and there family members.

## **CONCLUSION**

What stood out in this project is the perspective of the mental health provider on in establishing an effective mental health service program did vary with that of the Native American Indian mental health consumer. Daniel D., one of the mental health providers,

states that there is an abundance of mental health services available for the Native American Indian mental health consumer in Santa Clara County to access and utilize. The participants in this project argue that the availability of mental health services is not the issue. In Cynthia G. case she did not know where to go to first when first experiencing a crisis and when she did there was no follow up on providing her with the mental health services that she needed. For some respondents the concern is how budget cuts and criteria systems are affecting the way services are being delivered and the longevity of those services.

One of the points that was brought up by one of the mental health providers is that when Santa Clara County receives funding for its mental health services it will match that amount from their general fund, more than any other county will do. Native American Indian mental health consumers argue that the funding of services is not a main concern. For them it is being culturally sensitive to the needs of Native American Indian mental health consumers. The standardization of mental health services to fit the general population ignores the tribal practices, beliefs, religion and distinctive needs the Native American Indian find important, such as the use of sage for smudging. It's acknowledging the beliefs systems of the Native American Indian and incorporating traditional healing practices in the treatment process, such as sweats, or bringing a traditional person to do a spiritual assessment.

When a local mental health organization comes into the Native American Indian community to introduce new services or conduct focus groups about mental health issues the Native American Indian community and mental health consumer argues it is not

enough to just come in and have a discussion with the community. Local mental health organizations and providers need to come into the community and understand the Native American perspective, first learn how to function within the Native American Indian community before introducing new services and when you do provide those services don't forget the human factor. The participants want someone who doesn't just treat this as a job, they want someone who will treat them as human beings and take the time to develop human relationships and they want consistency. The revolving social worker or case worker that comes and goes cannot foster trust with the mental health consumer if they are there for a brief time.

The participants in this project want to see more progress in addressing the issue of stigma. Some have suggested that more education or workshops be offered to the community. Others suggest more social and community activities with mental health consumer so people can begin to feel more comfortable with each other. Others suggest more fun activities are needed, such as art and craft classes. Participants in this project are asking for early intervention before a crisis becomes problematic. Participants want to see support groups and talking circles that incorporate their tribal practices, such as the use of sage for smudging or offering tobacco to the Creator. They want to see fitness and yoga as part of the treatment and to improve the mood of the Native American Indian mental health consumer and their families. Lastly, participants want help in finding ways to deal with the rising costs of medication and mental health services.

A researcher cannot always anticipate the outcome of a project or what response from the interviewees prior to designing the instrument survey. For this project, the

design of the instrument survey was a collaborative venture between NFOE and myself, in an effort to reduce bias and provide multiple frames of references. Based on the participant responses, the role of community on the Native American Indian mental health consumer, family members, and the treatment process was vital and an area that was not captured in the interview instrument. For future projects, the role of community should be incorporated into the design of the interview instrument, questionnaire or survey that is used.

One of the lessons I learned when doing this project is that being part of the Native American Indian community is not a guarantee that I automatically understand the Native American perspective or the significance of what community means. It wasn't till I interviewed the participants that I came to understand how this community functions and how they view their own wellbeing. It was a very humbling experience and one that awakens me as well to the personal biases a researcher can have on a project. From the responses I began to see how important community is to a person overall wellbeing and how crucial it is when treatment plans include traditional ceremonies. Having your community come out and help you pray for the health of a loved one is a powerful thing.

As noted by Scott D. Grosse, "A business case for a health care improvement intervention exists, if the entity that invests in the intervention realizes a financial return on its investment in a reasonable time frame" (Grosse et al. 2006:S-93). Funders need to see successful results for their return. The continual success of NFOE is dependent on the funding available to them. A successful program demands the continual support of its funders. The reverse is true as well. Success is also dependent on the support and

resources available from the funders to the groups they fund. This community-needs assessment provided both a voice and a venue for Native American Indian participants to express their needs and concerns with mental health issues and services. The results can be used by NFOE to support the production of services necessary in establishing an effective mental health service program and continually meet the needs of the Native American Indian Community in Santa Clara County.



## REFERENCES

- Beebe, Steven A. and Masterson, John T.  
2003 *Communicating in Small Groups: Principles and Practices*. Boston: Allyn and Bacon.
- Bernard, Russell H.  
1995 *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Walnut Creek: AltaMira Press.
- Bhui, Kamaldeep and Bhugra, Dinesh  
2002 Explanatory Models for Mental Distress: Implications for Clinical Practice and Research. *The British Journal of Psychiatry* 181:6-7.
- California Department of Mental Health  
2008 Mental Health Service Act (Proposition 63). Electronic Document.  
[http://www.dmh.ca.gov/Prop\\_63/MHSA/default.asp](http://www.dmh.ca.gov/Prop_63/MHSA/default.asp), accessed September 29. 2008.
- California Department of Mental Health  
2007 Statistics and Data Analysis: Prevalence Rates of Mental Disorders. Electronic Document. [http://www.dmh.ca.gov/Statistics\\_and\\_Data\\_Analysis/Prevalence\\_Rates\\_Mental\\_Disorders.asp](http://www.dmh.ca.gov/Statistics_and_Data_Analysis/Prevalence_Rates_Mental_Disorders.asp), accessed May 12. 2008.
- Ervin, Alexander M.  
2000 *Applied Anthropology: Tool and Perspectives for Contemporary Practice*. Needham Heights: Allyn & Bacon.
- Family Outreach and Engagement Team of the Native American Community  
2008 Request for MHSA Funds for Mental Health Services for Native American Indians In Santa Clara County. Proposal.
- Grandbois, Donna  
2005 Stigma of Mental Illness Among American Indian and Alaska Native Nations: Historical and Contemporary Perspectives. *Issues in Mental Health Nursing* 26:1001-1024.
- Grosse, Scott D., Sergey Sotnikov, Sheila Leatherman, and Michele Curtis  
2006 The Business Case for Preconception Care: Methods and Issues. *Maternal and Child Health* 10:93-99.
- Gwynne, Margaret A.  
2003 *Applied Anthropology: A Career Oriented Approach*. Boston: Pearson Education, Inc.

Hahn, Robert A. & Kleinman, Arthur

1983 Belief as Pathogen, Belief as Medicine: "Voodoo Death" and the "Placebo Phenomenon" in Anthropological Perspective. *Medical Anthropology Quarterly* 14(4):3-19.

Hodson, Charley

2008 MHIP Mental Health Anti-Stigma Newsletter, November 1:1.

Kleinman, Arthur

1980 Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine and Psychiatry. Berkeley: University of California Press.

1985 Interpreting Illness Experience and Clinical Meanings: How I See Clinically Applied Anthropology. *Medical Anthropology Quarterly* 16(3):69-71.

Kleinman, Arthur and Benson, Peter

2006 Culture, Moral Experience and Medicine. *The Mount Sinai Journal of Medicine* 73(6):834-839.

NAMI

2011 Community Resource & Support Center Newsletter. Electronic Document.

<http://www.sccvote.org/portal/site/mhd/agencychp?path=%2Fv7%2FMental%20Health%20Services%20%28DEP%29%2FMental%20Health%20Services>, accessed April 11, 2011.

Phillips, Lorraine,

2005 Analysis of the Model of Health Promotion and Quality of Life in Chronic Disabling Conditions. *Rehabilitation Nursing* 30: 18-24.

Pereceman, Ellen, and Sara R. Curran

1970 *Anthropological Research: The Structure of Inquiry*. Cambridge: Cambridge University Press.

Santa Clara County Mental Health Department

2011a Family Outreach and Engagement Program Job Announcement. Electronic Document. <http://www.sccgov.org/SCC/docs%2FMental%20Health%20Services%20%28DEP%29%2Fattachments%2FOffice%20of%20Consumer%20Affairs%2FECCAC%20Job%20announcement%20FPC%2012%2029%2010.pdf>, accessed March 9, 2011.

Santa Clara County Mental Health Department

2011b Mental Health Services. Electronic Document. [http://www.dmh.ca.gov/Prop\\_63/MHSA/default.asp](http://www.dmh.ca.gov/Prop_63/MHSA/default.asp), accessed September 29, 2008.

Singer, Merrill & Baer, Hans

2007 *Introducing Medical Anthropology*. Lanham: AltaMira Press.

Skelly, Anne H., et al.

2006 African American Beliefs About Diabetes. *Western Journal of Nursing* 28(1):9-29.

State of California

2011 California Welfare and Institutions Code Section 5150-5157. Electronic document, <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001-06000&file=5150-5157>, accessed April 03, 2011.

US Census Bureau

2010a American Indian and Alaska Native Alone or in Combination Population by Tribe: 2000. Electronic document, <http://www.census.gov/population/www/cen2000/briefs/phc-t18/tables/tab019.pdf>, accessed May 12, 2011.

US Census Bureau

2010b American Indian and Alaska Native Tribes in California: 2010. Electronic document, [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC\\_10\\_PL\\_P1&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_PL_P1&prodType=table), accessed May 12, 2011.

US Census Bureau

2010c State and County Quick Facts. Electronic document, <http://quickfacts.census.gov/qfd/states/06/06085.html>, accessed May 12, 2011.

## APPENDIX A

### *Demographic Questionnaire*

The following questions will provide the information needed to describe the participants demographic and background information. Your name will not be included in any part of the report. If you choose not to answer any of these questions please indicate this to the researcher. Thank you.

- 1) Gender: \_\_\_\_\_
- 2) What is your age? \_\_\_\_\_
- 3) What is your racial and ethnic background? \_\_\_\_\_
- 4) What county do you reside in? \_\_\_\_\_
- 5) How long have you lived in the area? \_\_\_\_\_
- 6) What is the highest grade or year of school completed? \_\_\_\_\_
- 7) What is your employment status? \_\_\_\_\_
- 8) What is your current marital status? \_\_\_\_\_
- 9) What is your religious or spiritual affiliation? \_\_\_\_\_
- 10) How many children do you have? \_\_\_\_\_
- 11) Including yourself, what is the total number of people of people currently living in your household? \_\_\_\_\_
- 12) What language do you speak at home? \_\_\_\_\_

## APPENDIX B

### ***Research Interview Questions for Native American Community Members***

The following questions will aid the researcher in this project. Your name will not be included in any part of the report. If you choose not to answer any of these questions please indicate this to the researcher. Thank you.

- 1) Who is in your family?
- 2) What do you think about mental health/mental illness?  
*(Probe: In your own words, how would you define healthy or illness?)*
- 3) Has there been mental illness in your family?
- 4) Tell me about that experience.  
*(Probe: How did this experience/event affect the other family members?)*  
*(Probe: How was that person referred to mental health services?)*  
*(Probe: What services did they seek?)*  
*(Probe: What services were available?)*  
*(Probe: What services were provided?)*
- 5) What do you think mental health and illness means now that you have this experience? *(Probe: What words would you use to describe mental health and mental illness now?)*
- 6) From your experiences what services could have helped you cope with the crisis of the person with mental illness?  
*(Probe: What services help?)*  
*(Probe: What services did not help?)*  
*(Probe: What services were missing?)*
- 7) What do you like about existing mental health service programs?
- 8) What services would the ideal mental health program provide?  
*(Probe: What services would you like?)*

## APPENDIX C

### ***Research Interview Questions for NFOE members***

The following questions will aid the researcher in this project. Your name will not be included in any part of the report. If you choose not to answer any of these questions please indicate this to the researcher. Thank you

- 1) How did you come to know about NFOE? (*Probe: When did you come in contact with NFOE? What are the reasons you are a member with NFOE?*)
- 2) What did you think about mental health/mental illness prior to joining NFOE? (*Probe: In your own words, how would you define healthy or illness?*)
- 3) Do you know of any person with mental illness?
- 4) In what way is that person mental illness impacting your life?
- 5) What services or help are currently available for people with mental illness that you know of? (Please describe.)
- 6) From your experiences what services could help people cope with a mental health crisis or persons with mental illness?
- 7) What do you like about existing mental health service programs? (*Probe: What do you dislike about them?*)
- 8) What do you think mental health and illness means now that you are an advocate of NFOE? (*Probe: What words would you use to describe mental health and mental illness now?*)
- 9) In your own words, please describe what kind of services do you think NFOE can offer to the community? (*Probe: Please describe what those would be.*)

## APPENDIX D

### *Research Interview Questions for FOENAC members*

The following questions will aid the researcher in this project. Your name will not be included in any part of the report. If you choose not to answer any of these questions please indicate this to the researcher. Thank you

- 1) How did FOENAC begin? (*Probe: Who were the major organizers? Why did the FOENAC group form? How did you go about getting funding for NFOE?*)
- 2) What services did FOENAC envision NFOE would provide?
- 3) What did you think about mental health/mental illness before FOENAC? (*Probe: In your own words, how would you define healthy or illness?*)
- 4) Do you know of any person with mental illness?
- 5) In what way is that person mental illness impacting your life?
- 6) What services or help are currently available for people with mental illness that you know of? (Please describe.)
- 7) From your experiences what services could help people cope with a mental health crisis or persons with mental illness?
- 8) What do you like about existing mental health service programs? (*Probe: What do you dislike about them?*)
- 9) What do you think mental health and illness means now that you participated in FOENAC? (*Probe: What words would you use to describe mental health and mental illness now?*)
- 10) In your own words, please describe what kind of services do you think NFOE can offer to the community? (*Probe: Please describe what those would be.*)