A Pilot Study to Assess the Health Needs and Statuses among a Segment of the Adult American Indian Population of Los Angeles

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According to the 1990 census, the United States has a population of 1,878,285 American Indians and Alaska Natives, with 554 federally funded tribes ranging in size from 20 to 250,000 people. It is a common misconception that the majority of these individuals live in rural reservation communities, far removed from modern American society. (Except, of course, for those reservations with casino facilities that host thousands of non-Indians annually.) The truth is, however, that approximately two-thirds of all American Indians live outside of reservation contexts, with 56% now residing in metropolitan areas.

There is also a misperception that American Indians are a diminishing ethnic population, on the brink of extinction. This, too, is wrong. Like other ethnic minorities in the United States, American Indian populations are increasing steadily. The Census Bureau estimates that since July 1, 1990, the American Indian and Alaska Native population has increased by 10.4%. That number is expected to rise to 2.4 million by the end of 2000, to 3.1 million in 2020, and to 4.4 million by 2050.[1]

Los Angeles County is interesting from an American Indian research standpoint. Los Angeles County is home to the largest urban American Indian concentration in the United States. The 45,689 (U.S. Census 1990) American Indians who live there represent more than 100 different tribal groups. Within each of these tribal affiliations, there

are also distinct subcultures containing individuals with many different socioeconomic, educational, and political backgrounds.[2] This diversity is the result of three historical processes: aboriginal location, self-relocation, and federal relocation.

Aboriginal location. The indigenous tribes of Los Angeles County are the Chumash, Gabrielino/Tongva, and Juaneno-Acjachemen.

Self-relocation. Over the years, other native groups joined the indigenous tribes as they migrated to Southern California. During the nineteenth and up to the mid–twentieth century, a small but steady stream of Indian people moved from Western reservations to Los Angeles. Many more came to Southern California to work in defense-related industries during World War II. The migration was often provoked by reservation poverty, family strife in home communities, and hopes for economic, educational, and urban lifestyle opportunities. These motivations, coupled with the Federal Relocation Program, brought many other American Indians to the Los Angeles area during the latter half of the twentieth century.

Federal relocation. The 1952 Federal Relocation Program, sponsored by the Bureau of Indian Affairs, lured thousands of Indians to Los Angeles and other metropolitan areas in the West. Government officials promised high-paying jobs, job-training programs, and housing assistance. The federal goal was assimilation. It is well documented, however, that the program failed to assimilate American Indians and resulted in devastating social consequences. After federal funding for the relocation programs dried up, for example, large Indian ghettos formed, where unemployment and poverty created a socioeconomic pattern of abuse and despair. Disconnected from cultural roots and ill-equipped for modern city life, many urban Indian families in the 1970s and 1980s broke under the stresses of urban existence. Today, urban Indian centers across Southern California report high rates of poverty and alcoholism, low educational attainment, domestic abuse, and support system deficits (particularly for elders and children).

To validate these observations scientifically, however, has proved a difficult task. To begin with, there is a paucity of statistically significant data relevant to the health care statuses and needs of American Indians, even less pertaining to urban Indians. Indeed, most of the available information comes from studies of rural and reservation-based Indians. As a result, researchers and program planners tend to rely almost exclusively on data taken from a few specific regions and tribes. The situation is made worse by the lack of adequate representation of the Indian population in national surveys and databases. However, what data there are seem consistent with the observations of the urban Indian Centers. Available data indicate that American Indians have a disproportionate pattern of social problems, chronic illness, accident, homi-

cide, suicide, and other conditions, unparalleled among other racial and ethnic minorities in the United States.

Because of substantial limitations to medical care, we can surmise (but not fairly conclude) that these problems are exacerbated in urban settings. Unlike their reservation-based counterparts, Los Angeles's urban Indians do not have appropriate access to an Indian Health Service facility. (Indian Health Service is the major federal health care program for American Indians.) In many ways, urban Indians are the orphans of Indian Health Service, left to depend on minimal and fragmented resources available from the state government.

Because American Indians have a legal relationship with the federal government, not the state, it is difficult for them to obtain their legal entitlements. Like their reservation-based brothers and sisters, urban Indians come from federally recognized tribes and are therefore guaranteed health, education, and welfare.[3] However, the majority of federal health care service dollars is currently spent in reservation-based contexts, where less than half of the American Indian population resides. Because American Indian health is not a major priority for the state, health care services for American Indians in Los Angeles County are recognized (by community leaders, university researchers, and program planners) as limited and fragmented following the defunding of the single existing Indian-operated primary care clinic in 1995.[4]

It is unlikely that this situation will change. American Indian health needs will not become a priority for policy makers until meaningful data are collected that document the health needs and statuses of this population. Otherwise, from the state's perspective, funding for better and increased services cannot be justified.

Data deficits have two fundamental causes. First, state agencies and private foundations, though well intentioned, are often ignorant of the cultural and historical difficulties unique to American Indians. They know little of the public health crises resulting from misguided federal programs and are not prepared to spend precious research dollars on an otherwise "invisible" population. Because American Indians are the smallest ethnic population in the United States, their research problems are not perceived as urgent and therefore tend to be overlooked and/or underprioritized.

American Indian public health researchers thus find themselves in an extraordinary position. They are primarily scholars who do what they are trained to do—tailor complex research programs that are statistically meaningful, culturally relevant, and community based. At the same time, they spend enormous amounts of energy traveling to visit government officials, one-on-one, educating those few who may be friendly to Indian issues. In effect, researchers are acting as lobbyists, educators, and advocates (activists) in order to provide the cultural and historical foundations for their proposals. When the friendly officials are

replaced, the educational process begins again from scratch. In short, to be successful, researchers must be good scholars, advocates/activists, and politicians all at once, a situation that is not only unethical but easily leads to burnout. In Los Angeles, many research programs have begun over the years, often with great and noble intentions, only to fizzle out because researchers were forced to wear so many different hats.

Despite these difficulties, over the years attempts have been made to improve the database in Los Angeles. Small-scale, demographically specific health surveys and ethnographies, as well as various demonstration projects, have been helpful in casting the urban Indian public health outline. Unfortunately, however, these studies have tended to be narrowly focused on either elders, youth, and/or specific disease categories, with analyses of problems and their potential solutions.[5] While this research is no doubt quite valuable, the downside is that the published research record in Los Angeles is as fragmented and limited as the service provisions themselves.

In addition, the problems have a common root. The focus restrictions are due primarily to lack of adequate resources—to funding limitations and the strictly defined scope of work requirements. Funding limitations also lead to an overreliance on convenience-based samples. These studies are usually not based, for example, on the randomization of census tracts, telephone books, or township maps. Of course, convenience-based samples provide important guideposts to indicate problems and potential solutions. However, as mentioned previously, the data are too weak to substantiate policy change. Related methodological problems include a pattern of residence migration, misclassification of ethnic status on federal survey forms, and a pervasive unwillingness on the part of American Indians to participate in such surveys (due to a long-standing distrust of governmental authorities and a feeling of having been "surveyed to death"). All of these problems have thus far prevented the use of a statistically significant sampling strategy to determine the health needs and statuses of American Indians in Los Angeles County.

A large-scale, statistically significant, community-based research project is the only hope to ameliorate data deficits and to provide good, well-reasoned urban Indian public health planning. Such a project would be very expensive.

The following discussion presents the results of a pilot study, intended as a preliminary step toward a much larger health needs assessment. The concept for this study evolved through meetings of the Southern California American Indian Health Working Group (AIHWG), a consortium that recognizes very well the plight of urban Indians. The AIHWG consists of community members, community service specialists, and research scientists (including physicians, policy and public health experts, and social scientists). All have a professional

stake in improving health care in the Los Angeles American Indian community. From the members' combined experience, the group determined the necessity of a reliable health needs assessment. The first step was a pilot study. It was anticipated that a larger baseline study would follow.

An important step in correcting the data deficit problem occurred in 1998 when the AIHWG obtained funding from the State Office of Indian Health, via the Southern California Indian Center, for a pilot needs assessment in Los Angeles (contract #97-15483). Though it was to be a small, convenience-based survey, and therefore methodologically flawed, it succeeds in adding texture to the American Indian database. It is, to the best of our knowledge, the only broad-based, professional needs assessment survey ever conducted in Los Angeles County. The validity of our data is reinforced by our numbers, which tend to be congruent with or higher than national statistics. These include disproportionately high rates of diabetes, cardiovascular disease, and substance abuse.

In January 1998, the State of California/Department of Health Services/Office of Indian Health funded a mobile health and wellness van, operated by the Southern California Indian Center (SCIC) and the University of California, Irvine, to conduct health screenings, distribute resource information, and collect data at a variety of locations frequented by urban Indians. In February, the SCIC subcontracted with the UCLA/American Indian Studies Center (AISC) to conduct the health needs and access to service assessment component of this contract. It was intended to complement the *California Behavioral Risk Factor Survey* (CBRF), completed March 21, 1997.[6] Diane Weiner, a UCLA medical anthropologist, served as coprincipal investigator, and the project was supervised by the members of the AIHWG. Data collection was undertaken March 1 through July 31, 1998.

METHODOLOGY

The investigators and American Indian graduate student specialists conducted individual and group interviews to assess the health statuses of urban Indian individuals and their access to health care. To qualify for participation, individuals had to be over the age of 18 and reside in one of 29 chosen cities in eastern sections of the county (census tracts with a relatively large proportion of American Indians). The researchers administered a survey tool, designed by the investigators and the AIHWG. Student data gatherers interviewed 96 participants at community sites, such as powwows, athletic events, and area churches. The survey instrument represented 24 pages of questions relevant to health conditions and service needs; it was administered on an individual basis. For elaboration and cross-check purposes, focus groups were organized at three additional community sites. The

coinvestigators facilitated these meetings, using questions that were structured by the AIHWG.

SURVEY METHODOLOGY (QUANTITATIVE)

Dr. Rita Ledesma (California State University), Candace Caufman (University of California, Irvine), Dr. Josea Kramer, and Dr. Nancy Reifle (University of California, Los Angeles) volunteered their expertise on the tool subcommittee, defining the survey and focus group questionnaires. In a culturally appropriate way, the tool assessed sociodemographics, perceptions of general health, health and health-screening histories, health-seeking behavior, access to care, and risk behaviors. The majority of questions were posed in a closed-end format: yes/no/maybe, never/always/frequently, or excellent/good/fair/poor. However, several inquiries concerning perceptions of personal health and health-seeking behavior were left open-ended, to be recorded verbatim.

The instrument was administered as an oral interview, thereby avoiding refusals due to low literacy levels or impaired eyesight. Interviews lasted anywhere from 20 to 90 minutes, depending on the style of the interviewee. All were conducted individually in private areas around the survey site. Quantitative data analysis was performed using SPSS software. The student data gatherers were trained in research techniques over the course of two days; their training combined lecture materials with role-playing exercises. Health advocates from the UCLA/Health Working Group attended these sessions and assisted with cultural competence issues.[7]

Survey sites were chosen with the help of health advocates and community leaders on the advisory board. These sites included the SCIC, two powwows, two senior groups, a women's shelter, two mobile van sites, and the American Indian Health Center.[8]

STUDY LIMITATIONS

1. Our interviewees tended to be in established social networks.
2. The state's stipulation that our interview sources live in one of 29 cities in East Los Angeles eliminated many volunteers who were ineligible due to the residential criteria. Overall, this requirement cut our sample by 50%. It was most frustrating to the Gabrielino (Tongva) and Chumash volunteers, the indigenous descendants of the Los Angeles area.[9]
3. The state's stipulation that we interview adults only, over the age of 18, prevented us from collecting data on the

health needs and access to service levels for American Indian children.[10]

FOCUS GROUP METHODOLOGY (QUALITATIVE)

The research team used focus groups as an additional tool for providing elaboration and cross-check on key issues generated from survey results. By discussing these questions in an open-ended manner with community members who possessed special experiential knowledge, we generated in-depth awarenesses about significant health issues.

Focus group sites were chosen strategically to provide a window into the experiences of subpopulations in the American Indian community. These included a local alcohol and drug rehabilitation center, a church group whose purpose was to explore and create healthier lifestyles, and an elders support group at a community center. Each group interview lasted approximately two hours.

Three focus groups took place during the summer of 1998. In June, 10 men and women from the American Indian (Methodist) Church participated in the first interview. They represented a well-established group of American Indians who met regularly throughout the year to discuss ways and means for incorporating a healthier lifestyle into a Native/Christian belief system. The majority of participants were women ages 35 to 60.

The second group was composed of clients and counselors from a local alcohol recovery program. Their ages ranged from 19 to 50.

An elders support group meeting was the setting for the third focus group. It was held at a local community center in July 1998. Thirty men and women, ages 60 to 80, participated in these discussions. About half had lived on a reservation at some time in their lives.

At each of these gatherings, similar questions were posed. For example, the coinvestigators were interested in determining the cultural definitions of health and wellness that might be useful for service planners. Because the survey instrument could provide us with only limited information about what it subjectively means to be healthy, the focus groups qualified our understanding on this issue by providing additional in-depth information through anecdote and personal example.

Qualitative data analysis was based on cultural domains theory, by which emergent themes are categorized and described.[11]

SURVEY FINDINGS (QUANTITATIVE): SOCIODEMOGRAPHICS

Our sample contained 96 individuals, 62% female and 37% male. The average age was 43 years. They resided in 17 cities with the majority

living in El Monte, followed by Bell Gardens and Bellflower.[12] The average household contained four individuals.

Consistent with the 1990 census report, tribal affiliation was an eclectic ethnic mix; our sample contained 29 American Indian groups. The Navajo, Sioux, and Apache were the most frequently named in our study.[13] The majority of people surveyed, 79%, claimed to be enrolled in a tribe or nation and are therefore eligible for health care on their home reservation or other Native community. It is important to emphasize, however, that due to the survey residency criteria, most potential volunteers of Tongva/Gabrieleno descent were not eligible to participate. These people do not have access to Indian Health Service care.

SURVEY FINDINGS (QUANTITATIVE): HEALTH BELIEFS AND CONDITIONS

The 1997 CBRF survey found that the majority of respondents rated their general health as "excellent" or "very good," but the majority of our interviewees believed their health was a notch down from these results. On a scale ranging from "excellent" to "poor," 45% rated their general health as "good." Another large percentage (30%) rated it as "fair." Those who thought their health was excellent represented 19%, and only 5% said their health was "poor."[14]

The following chronic health conditions were captured on our survey (see Figure 1): allergies (24%), asthma (14%), arthritis (33%), diabetes (21%), hypertension (36%), coronary heart disease (22%), gallbladder disease (23%), and vision problems (51%).[15]

Chronic diseases have surpassed infectious diseases as the most prevalent illness category of American Indian adults. Previously, tuberculosis, influenza, and pneumonia represented the greatest health threats.[16]

Today, hypertension, heart and gallbladder disease, diabetes, and some cancers are linked to poor nutrition, sedentary lifestyles, (acculturative) stress, and the lack of informational resources. With higher rates of poverty (32% vs. 13% all races), lower rates of educational attainment (65% high school graduates vs. 75% all races), and limited access to health care, urban Indians succumb to these afflictions more than the general population.[17] Then, too, the combination of the above factors can result in obesity, which is a predisposition for the illnesses noted. In our study, 44% (n = 36) of participants self-reported being overweight. Hypertension, high cholesterol, heart and gallbladder disease are linked to additional risk factors, such as tobacco/alcohol use and to high-fat diets, both disproportionately represented in the American Indian population.

The American Heart Association (AHA) defines an obese person

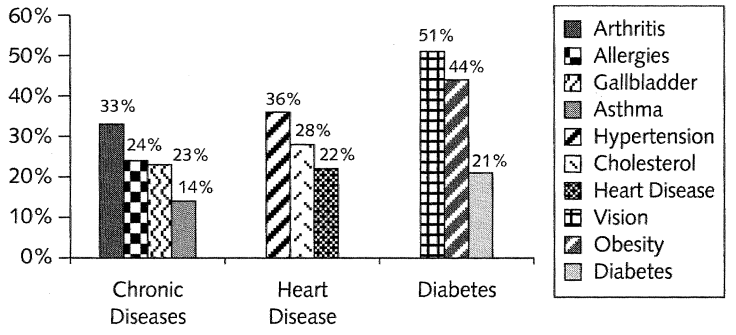

Figure 1. Chronic disease summary

as someone whose body weight exceeds "desirable" weight for height and gender by 20% or more, according to 1983 (revised) insurance industry tables.[18] Obesity is a major risk factor for coronary heart disease because it tends to raise blood cholesterol and blood pressure levels. At the same time, obesity can induce diabetes. It is also recognized as a significant cause of gallstones and can worsen degenerative joint disease.

Diabetes. Diabetes mellitus is the inability of the body to produce or respond to insulin properly. Type II diabetes is well established in the American Indian population, with incidence rates 230% greater than national ones.[19] It represents a major cause of morbidity and mortality, as well as being a risk factor for other afflictions such as blindness, infection, kidney problems, stroke/heart disease, and nerve damage. There is no cure for diabetes, but it can be controlled through diet, exercise, and the maintenance of appropriate blood glucose levels.

Approximately 21% of our respondents reported being diabetic or borderline diabetic and 74.5% claimed to have a relative who has been diagnosed with the disease. Almost 58% of participants remember being screened for diabetes at some time in their life. Testing was most commonly done by HMOs, the Indian Health Service, private physicians, or medical centers.[20] Of those tested, 1997 was the median year for the most recent screening.

Respondents who had diabetes tended to see a health care provider about four times per year. Approximately 15% used pills to treat their condition and 8% injected insulin.[21] Neuropathic, cardiovascular, and vision problems were listed as the most common complications.

High cholesterol. Cholesterol is a waxy substance found among lipids in the bloodstream. The body uses it to build cell membranes. Too much cholesterol is harmful, however, because it cannot be dissolved in the blood. High cholesterol levels are linked to high-fat diets and sedentary lifestyles. Arteriosclerosis results when excess amounts build up inside blood vessels. This accumulation causes hypertension and heart and gallbladder disease. The American Heart Association

defines high cholesterol values as those that are 200 mg/dl and higher, and estimates that 51% of American adults have this condition.[22]

In our sample, over a quarter of those polled (27.8%) knew they had high cholesterol, and 53% had been screened for it. Testing was most commonly done at an HMO, an Indian Health Service or urban Indian health facility, or a private physician's office.[23]

Hypertension. Hypertension can be defined as blood pressure readings greater than or equal to 140 mm Hg systolic and 90 mm Hg diastolic. Those who are overweight are more likely to be hypertensive. Of those who are hypertensive, approximately 35% are not aware of their condition.[24] In our sample, 36% (n = 29) of respondents reported being hypertensive.

The overall age-adjusted prevalence rate of hypertension in the American Indian community is 23%, according to the Strong Heart Study, which analyzed Indian Health Service records across the country. This report demonstrated varying degrees of hypertension incidence by tribe. It would be premature to generalize these statistics to our results, because prevalence rates had a wide distribution. However, it is worth noting that our sample had a 13% higher rate than this average.

About 71% of the participants had been screened for hypertension at some time in their life. The most frequently cited places for testings were at an HMO, a private physician/SCIC mobile van, or an urban Indian health clinic.[25] For those who had been tested, the median year for the most recent screening was 1997.

Coronary heart disease. The arteriosclerotic narrowing of the coronary arteries causes heart disease. American Indians and other ethnic subgroups are particularly vulnerable because studies show that the risk of death is greatest among the least educated. Moreover, diabetes seriously increases the risk of developing this affliction, with approximately 80% of diabetics likely to die from some form of heart or blood vessel disease.[26]

In our sample, 22% (n = 16) of participants reported having coronary heart disease. The major risk factors are diabetes, high blood pressure, physical inactivity, obesity, tobacco use, alcohol abuse, and individual responses to stress. As mentioned before, most of these factors are disproportionately represented in the American Indian population.

Vision problems. Diabetes mellitus causes changes in the arteries and veins that carry blood around the body. Diabetes can thus affect the patient's vision by causing damage to blood vessels in the eye. Diabetic retinopathy is often referred to as a complication of diabetes. Such damage may cause blood vessels to leak and to develop scar tissue inside the eye. This can create blurred or distorted vision. Macular degeneration, glaucoma, cataracts, hyperopia (farsightedness), astigmatism, and myopia (nearsightedness) are other common eye disorders.

Over half our respondents reported vision problems, though our survey neglected to ask them to specify the type of dysfunction. Fifty-six percent had been tested for glaucoma. The most common places for testing were at the office of an eye doctor, an HMO, an Indian Health Service facility, or a private physician's office.[27] For those tested, 1996 was the median year for the most recent screening.

Oral health. The American Dental Association and the Indian Health Service have publicly recognized that there is a large parity gap between the oral conditions of American Indians and the rest of the nation, and that there are inadequate resources to address the oral health problems of the eligible population satisfactorily.[28] In addition to inadequate preventive care, smoking and poor diet make American Indians more vulnerable to periodontal disease.

On a scale ranging from "excellent" to "poor," only 7% of those interviewed rated their dental health as "excellent." Thirty-five percent rated their oral health as "good." Another large percentage, 26%, rated it as "fair" or "OK."[29] Those who thought their health was "poor" represented 18%, with 4% describing it as "very poor."

Just under half of those interviewed in our survey, 46% (n = 44), said they had some kind of dental insurance; 16 of these were men and 27 were women.

Another means for evaluating oral health is to consider the number of teeth lost to dental disease per individual. Approximately 39% of respondents have *never* lost teeth due to dental disease. However, even though oral health is good for a segment of our sample, a substantial number of respondents reported missing teeth and therefore may be in need of complex dental treatment. Thirty-nine percent have lost at least one and no more than five teeth, and 17.9% have lost six or more teeth due to decay or periodontal disease.[30]

Participants tended to visit the dentist for a specific problem, rather than for preventive exams. Altogether, 53% of those surveyed went to the dentist because something was wrong, 33% went because they thought it was time for an exam, 13.6% did so because they were sent reminders, and another 18% went as part of a series of treatments. (The cumulative percentage equals more than 100% because people were able to answer in more than one category.)[31]

Significantly, of the 79 respondents who answered the dental section, over half (52.6%) had been to the dentist within the past year, and 12.8% had not been in more than five years. Only 3.8% of those interviewed claim never to have visited the dentist's office.[32]

AIDS. Acquired immunodeficiency syndrome (AIDS) is an epidemic retroviral disease caused by infection with the human immunodeficiency virus (HIV1). It is transmissible through blood or semen and characterized by an ineffective immune response. Those at risk include homosexual or bisexual males, intravenous drug abusers, hemophiliacs,

blood transfusion recipients, all sexual contacts of males in at-risk groups, and newborn infants of mothers with AIDS.

The National American Indian AIDS Prevention Center tracks the prevalence of this disease in the American Indian population.[33] According to their statistics, the annual AIDS incidence rate per 100,000 in 1996 was 10.4 for American Indians, third behind Blacks (83.7) and Hispanics (37.7) and equal to that of whites. In 1996, there were approximately 1,569 confirmed cases of American Indian AIDS in the United States, and 100 deaths from the disease in the same year. Since 1991, 720 American Indians have died from the disease nationwide. The growth in American Indian AIDS cases during the years 1996–1997 was down to 12%, from 83% in 1992–1993.

The incidence data at the state level differ from national figures. According to the California Department of Health Services/Office of AIDS, American Indians in California have a lower incidence rate of HIV compared to whites and all other minority populations.[34] Our study supports these data; however, it is important to emphasize that no baseline epidemiological figures exist for AIDS in the Los Angeles American Indian population.[35]

Approximately 44% of our sample reported having been tested for HIV; the most common places for screenings were at Indian Health Service facilities, military hospitals, and offices of private physicians.

Tuberculosis. According to the Centers for Disease Control and Prevention (CDC), the national tuberculosis case rate has declined steadily since 1992, when the numbers of cases peaked during the resurgence of tuberculosis in the United States.[36] However, the incidence rate remains much higher than average for American Indians, especially for those who are under age 5 or over age 65. In 1997, for example, CDC reported that the national incidence rate for these age groups in Native America was four times greater than for whites.

To make progress toward the goal of tuberculosis reduction in the Native community, efforts must continue to strengthen surveillance and testing at the local level. In our study, the majority of respondents reported having been screened for tuberculosis. Sixty-two percent had been tested at HMOs, at community and urban Indian clinics, by private physicians, at Indian Health Service facilities, or at medical centers.[37]

Cancer. Only about 5% of our respondents claimed to have a current diagnosis of cancer, either skin, colon, nasal/pharyngeal, or uterine. A much larger number (59%, $n = 52$) reported having a relative diagnosed with cancer.

Breast cancer is the leading type of noncutaneous cancer in women, with 178,000 new cases projected to occur in the United States in 1998.[38] On average, a woman's chances of developing the disease are 1 in 8. Breast cancer incidences among American Indian women

are generally lower than that of the general population, but because the cancers are more advanced at detection, the survival rates are not as high.[39]

In our study, 60% of respondents reported having had a mammogram through an HMO, an Indian Health Service facility, a community clinic, or an urban Indian health clinic.[40] The vast majority of female participants had also received a Pap smear, with 1996 the median year for the most recent screening. Pap smears were obtained through HMOs, Indian Health Service facilities, the SCIC mobile van, medical centers and/or community clinics.[41]

Prostate cancer screenings occurred less often. Only 28.1% of male respondents had been screened. Colon cancer screening results were fewer yet. Only 3.8% (n = 3) of respondents remembered having been screened.

FINDING AND CONCLUSIONS: STRESS/SUBSTANCE ABUSE/ RISK BEHAVIORS

Stress. Stress is a category of experience resulting from a combination of economic and social factors that multiply to create emotional/familial/mental tension. These circumstances are exacerbated in the American Indian community by disproportionately higher poverty rates, lower educational attainment levels and acculturative difficulties. Twenty-six percent of our respondents claimed to have stress, and 10% have suffered more serious mental health problems.[42]

Our results indicated that crime in general and gang activities in particular, including drugs, gun violence, and kidnapping, represent the most threatening elements in Los Angeles's American Indian communities. Almost half of our respondents believed there were dangerous situations in their neighborhoods. Only 33.7% of our sample felt safe walking in their community, and 11.6% "rarely" felt safe.[43]

Alcohol/illicit drug use. The *National Household Survey on Drug Abuse,* conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services, compiles data on the prevalence of substance use among racial/ethnic subgroups in the United States.[44] The 1991–1993 surveys found that American Indians exhibit higher prevalences of illicit drug use, heavy cigarette use, alcohol dependence, and the need for illicit drug abuse treatment.[45]

For those age 12 and above, American Indians had the highest percentage of illicit drug use in the prior year, compared to other ethnic minorities. Twenty percent of American Indians reported having used such a drug, compared to 13.3% of Puerto Ricans and 13.1% of African Americans.[46] American Indians were also the highest represented

minority group for marijuana use. Fifteen percent of American Indians had smoked marijuana in the last year, compared to 10.8% of Puerto Ricans and 10.6% of African Americans.[47] American Indians were also the highest represented minority group for those needing drug abuse treatment. Eight percent of American Indians, twice that of other minorities, were in need of drug treatment compared to 3.9% of African Americans and 3.7% of Puerto Ricans.[48] The report also found that, regardless of ethnic subgroup, individuals residing in the West or in metropolitan areas with populations over one million have relatively high prevalences of illicit drug use. These users also tended to be unemployed and unmarried, to lack health insurance, and to have no more than 9 to 11 years of school. Our numbers were consistent with national figures. In our study, 11.5% (n = 9) of respondents reported that a health care provider had told them they had a problem with substance abuse.

In the SAMHSA survey, all ethnic groups reported high incidences of heavy alcohol use. Alcohol can raise the levels of fats in the blood stream, increasing blood pressure and causing heart failure when used in excess. Binge drinking can lead to stroke. Significantly, 27% of our respondents reported that a health care provider had informed them they had a problem with alcohol abuse. Forty percent of our participants claimed to drink beer, wine, or liquor, with beer being overwhelmingly the drink of choice. Eleven percent of those who drank alcohol reported consuming more than three drinks at a time, and 8.1% tended to have more than six drinks in a single period.[49] Seven percent reported consuming just one drink.

Tobacco. Tobacco is considered a sacred part of many American Indian religious ceremonies, and there is a great deal of cultural and geographic diversity with regard to its use. For some American Indians, it is difficult to separate tobacco's sacredness from the harmful health effects associated with chronic smoking. Moreover, many are exposed to tobacco at a much earlier age than their non-Indian counterparts are because tribes are not subject to state laws prohibiting the sale and promotion of tobacco to minors. The problem is made worse by the tobacco industry, which sometimes targets American Indians and Alaska Natives by funding cultural events, powwows, and rodeos to build its image and credibility in the community.[50]

In the SAMHSA household survey, American Indians were also in first place for cigarette use, compared to other ethnic subgroups. Fifty-two percent of American Indians over age 12 reported themselves as smokers. This figure is 33% higher than the next most prevalent ethnic subgroups, Puerto Ricans (32.7%) and Caucasians (31.5%).[51] In 1994 and 1995, a national survey for the Office of the Surgeon General reported slightly lower percentages; smoking rates among American Indians were estimated at 40%.[52]

Cigarette smoking combines with other previously mentioned risk factors to greatly increase the risk for coronary heart disease and several types of cancer, according to the American Heart Association. Our sample found that 58% of respondents had smoked at some point during their lifetime, with 29.5% doing so currently.[53] This is about 10% lower than national estimates, and lower than the 1997 CBRF survey. However, it is important to remember that our sample was a convenience one, not a random one.

The Surgeon General Report found that 8% of American Indian/Alaska Native men used spit tobacco. This is slightly higher than the prevalence rate for white men (7%) and more than double that for African American men (3.1%). Our study found lower rates of chew tobacco use compared to national averages. Eleven percent of respondents claim to have chewed tobacco at some point in their life; however, only 2.5% do so currently.[54]

Several studies have found links between second-hand smoke and heart and blood vessel disease in nonsmokers. The American Heart Association estimates that 37,000 to 40,000 people in the United States die annually from heart and blood vessel disease caused by other people's smoke.[55] Second-hand smoke may also provoke allergies, asthma, and other respiratory problems. Our study found that second-hand smoke impacts about a quarter of those interviewed every day, 17% have contact with it less than once per week, and 8.4% are exposed all the time. Twenty percent report having had no contact whatsoever.[56]

Exercise. Physical inactivity has long been established as a major risk factor for the development of coronary heart disease. Indeed, exercise acts to prevent diseases of the heart by controlling blood lipid abnormalities, diabetes, and obesity. According to the American Heart Association, even modest levels of physical activity can be beneficial.

Physical activity is also important for those suffering from arthritis. Exercise is usually part of a larger treatment program that includes relaxation, proper diet, medication, and pain relief methods. The three types of exercise best for arthritis sufferers are aerobic, range of motion, and strengthening.

With 33% of our sample affected by arthritis, and with so many risk factors for heart disease and diabetes disproportionately represented, the investigators hoped to find evidence of regular exercise by the majority. It turns out that physical activity rates were very inadequate. Almost a quarter, 22.8%, reported never exercising. Only 30% of respondents say they exercise 30 minutes or more once or twice per week, and 17.4% exercise four times per week.[57]

Seatbelts. In terms of other risk behaviors, the overwhelming majority of participants reported wearing seatbelts. Almost 75% said they used them "always," and another 13.7% used them "almost all the time."[58]

Access to care. In September 1997, the Census Bureau issued a national health insurance benefits report. According to the study, about 15.6% of the American population did not have health insurance benefits in 1996. Poorer people, younger people, those with lower educational attainment, and ethnic minorities tended to be those who lacked benefits. Despite government programs, such as Medicaid and Medicare, 30.8% of the poor had no health insurance of any kind in 1996.[59]

The question of insurance is less important for reservation Indians who are guaranteed health, education, and welfare in exchange for historical land cessions. These individuals usually have immediate access to an Indian Health Service facility. For urban Indians in Los Angeles, however, who are also guaranteed health, education, and welfare, Indian Health Service clinics are not immediately available. Urbans must commute long distances to obtain care at an Indian Health Service facility or a community clinic. If they do not have private insurance through an employer, they must obtain it through a government program such as Medi-Cal, Medicaid, Medicare, and/or military health care, or they go without. The uninsured usually forgo preventive and pharmaceutical care.

Unlike those who participated in the 1997 CBRF survey, the majority of persons interviewed in our study did not have health insurance. Indeed, 46% of our sample, disproportionate to the national averages above, reported having none. About 13% ($n = 6$) said they made use of Indian Health Service benefits.

Of the 54% who said they had some kind of health insurance, public or private, 16 were men and 35 were women. Of the 51 individuals who had insurance, 48 could describe the type. Ten people had more than one kind. The vast majority (73%) were HMO members, and Medi-Cal/Medicare members represented 23%.[60] The others used a variety of alternative services.

FOCUS GROUP FINDINGS (QUALITATIVE)

Several themes emerged from focus group discussions. The investigators heard a wide variety of commentaries on what it means to be healthy, on specific health problems, barriers to care, and special problems affecting elders.

What it means to be healthy. A common denominator among focus group participants was the notion that being healthy involves balancing the mental, emotional, social, and physical aspects of life. In addition to exercising, eating right, and avoiding drugs and/or alcohol (captured on the survey tool), focus groups identified the importance of engaging in spiritual activities and of being accountable to one's personal and social responsibilities as prerequisites for being healthy and

well. The need to purify is important in balancing the various dimensions of life. Purification connects one with a spiritual foundation rooted in indigenous and/or Christian concepts of health and wellness. Spiritual outlets for purification include the American Indian Church, sweat bath ceremonies, Kateri circles, work with traditional healers/shamans/priests/singers, and Indian (Christian) Churches.

Healthy individuals were described as those who are "balanced spiritually, mentally, and physically." Health is also something that is "reflected in someone's face; they have an inner radiance." On the other hand, an individual "may be hurting and you will never know it, especially [if] an elder," unless extra effort is taken to speak with and learn from him or her.

Health problems. Focus group participants reported health problems comparable to the survey results: dental and vision ailments, allergies, high cholesterol, heart disease, diabetes, obesity, aging, and back problems. There was an overwhelming consensus that alcoholism, drug abuse, teenage pregnancy, dysfunctional families, domestic violence, and homelessness, characteristic of many American Indian communities, are symptoms of disease as per the social and spiritual imbalances outlined above. Said one respondent, "all deal with poverty and shame; people can't get a job and they're ashamed of themselves." As a result, they lose "confidence and self-esteem" sinking into "despair."

Elders' problems. The health care problems of elders revolve around a perceived urgency for better access to services. Elders complained that Los Angeles's HMOs are primarily concerned with saving money even if it means skimping on care.[61] Most agreed that care was better at IHS clinics, on their home reservation or in California, because these provided all of the important services in one location: vision, dental, and medical. Many took advantage of Greyhound bus arrangements for seniors and disabled persons, which allow a companion to ride free when traveling to these clinics.[62] The majority thought reservation Indians were better off in terms of health care. They pointed out, however, that traditional people continue to view hospitals as places "where you go to die."

The needs of this population are complex. They require services that take into account the special physical and social conditions of elderhood. Elders are the least mobile of all of the American Indian subpopulations, so participants agreed that social workers, physicians, and public health nurses should come to the homes of seniors who are often poor, alone, and/or lack transportation. They expressed a need for better mental health services as well, pointing out that people live longer these days and that loneliness and depression are exacerbated by a lack of interpersonal contact. It is important to provide a social context for elders conducive to the definition of health outlined above. Concern was expressed about elder abuse as part of family violence,

and the drug/alcohol/poverty issues that are at the root of it. Finally, respondents indicated that complementary therapies, such as chiropractic and acupuncture, are services they would like to see targeted for them.

Barriers to care. Problems with HMOs were reiterated in all focus groups. Participants reported distrusting them for a number of reasons including inflexibility in being able to choose a physician, incompetent and/or culturally insensitive physicians,[63] and the lack of American Indian physicians/healers. These deficiencies force people to travel "home" to obtain care by Indian doctors and traditional practitioners.[64]

For those who must rely on public clinics for health care, there were reports of discrimination.[65] Elders complained that some of the free clinics in the Los Angeles area showed favoritism to Mexican-Americans. Several seniors shared stories in which they were either moved back in line or spoken to exclusively in Spanish.

Respondents agreed that reservation clinics made rural Indians better off in terms of care. However, the sedentary lifestyle there put them at a disadvantage compared to their more physically active urban counterparts. Finally, issues of blood quantum and eligibility make access to care inconsistent.

FOCUS GROUP CONCLUSIONS

Future studies should investigate whether free clinics and other public providers could better serve the urban Indian population by tailoring their programs to meet the cultural needs of American Indians.

Future feasibility studies should evaluate whether social workers, physicians, and public health nurses could be made available to the homes of seniors and those who are alone and/or lack transportation.

Future studies should evaluate whether existing mental health services should be expanded for Native seniors, who are living longer but are lonely and depressed due to the lack of interpersonal contact.

RECOMMENDATIONS FOR FURTHER RESEARCH

Though Los Angeles is home to the largest population of urban Indians in the nation, it is important to emphasize that no baseline epidemiological data exist for the afflictions that disproportionately affect them. The problem is exacerbated by the misclassification of Indians in clinical settings. It is hoped that this report sheds light on some of the problems regarding the health status and access to service needs of Los Angeles's American Indians. Nevertheless, it is important to caution policy makers not to overgeneralize from the results of this study.

Indeed, the most important finding of our research is that a *statis-*

tically significant determination of health statuses and access levels will be required in the future if the state is to meaningfully assess the health needs of a population as dispersed and complex as that of Southern California's urban Indian population. This study should collect data holistically, using both quantitative and qualitative methodologies, purposive sampling at community events, as well as the randomized sampling of census tracts as prospective survey sites.

As the database becomes more complete, future feasibility studies will be required. These should suggest demonstration projects that will test the cost/benefit of tailoring existing programs to meet the yet-to-be-determined unmet urban Indian health care needs.

NOTES

1 U.S. Census Bureau, Department of Commerce.

2 The exact number of people who identify themselves as American Indians and/or Alaska Natives in Los Angeles County may be much greater. Some experts suggest that population figures may be double that estimated by the Census Bureau. An ethnographic study conducted by Dr. Joan Weibel-Orlando, for example, estimated the 1990 Los Angeles County Indian population to be 75,000 individuals. See Weibel-Orlando, *Indian Country, L.A.: Maintaining Ethnic Community in a Complex Society* (Urbana: University of Illinois Press, 1991). Dr. Josea Kramer, an expert on Los Angeles American Indian populations and aging, reports there are probably more than 100,000 in Los Angeles County, 11,000 of whom are elderly. See Kramer, "Serving American Indian Elderly in Cities: An Invisible Minority" (Washington D.C.: U.S. Department of Health and Human Services, 1992); and Kramer, "Health and Aging of Urban American Indians: Cross Cultural Medicine: A Decade Later," *Western Journal of Medicine* (1992).

3 This is in exchange for huge land cessions made to the U.S. government in the seventeenth, eighteenth, and nineteenth centuries.

4 The small-scale outreach, referral, and treatment services currently funded by the Indian Health Service, the Veteran's Administration Medical Center, Long Beach, and the State Indian Health Program fail to provide the comprehensive services needed by this population.

5 Kramer; Weibel-Orlando (see note 2).

6 *California Behavioral Risk Factor Survey*, Indian Health Service Report (Sacramento, Calif.: CBRF and the Centers for Disease Control, 1997).

7 The investigators wish to acknowledge the hard work and commitment of the student assistants: Angie Brown, Rebecca Hernandez, and Shawna Red Cloud.

8 The investigators wish to acknowledge community health advocates Maxine Judkins and Richard Coulson for introducing UCLA's team and the project to leaders at these sites. Their volunteer efforts paved the way for a successful survey.

9 The 1990 census shows that American Indians in Los Angeles live in widely dispersed communities and tend to be transient, with fluid household constituencies.

10 Future studies should incorporate a maternal and child health component along with a family needs section (see "Recommendations for Further Research" section, at the end of this paper).

11 J. P. Spradley, *Participant Observation* (New York: Harcourt, Brace Jovanovich, 1980).

12 One gender was unrecorded. The average age for females was 45 years; it was 43 years for males. El Monte: $n = 17$, 18.3%. Bell Gardens: $n = 10$, 10.8%. Bellflower: $n = 9$, 9.7%.

13 Navajo: $n = 18$, 18.9%; Sioux: $n = 11$, 11.6%; Apache: $n = 8$, 8.4%.

14 We did not have a category for "very good," so "good" should be considered its equivalent. Good: $n = 44$; fair: $n = 29$; excellent: $n = 18$; poor: $n = 5$.

15 Allergies: $n = 20$; asthma: $n = 11$; arthritis: $n = 26$; hypertension: $n = 29$; coronary heart disease: $n = 16$; gallbladder disease: $n = 18$; vision problems: $n = 45$.

16 However, American Indian incidence rates of tuberculosis in California are eight points higher than the total incidence rate (23.1 versus 15.5 total). See *Analysis of Health Indicators for California's Minority Population*, prepared for Governor Pete Wilson, Sandra Smoley, secretary of Health and Welfare Agency, and Kim Belshe, director of the Department of Health Services, February 1994, p. 54.

17 U.S. Bureau of the Census, Department of Commerce.

18 Report of the American Heart Association, 1996.

19 Indian Health Service Reports.

20 Diabetic or borderline diabetic: $n = 19$; relative with the disease: $n = 70$; screened for diabetes: $n = 50$; HMOs: 19.8%, $n = 17$; Indian Health Service: 7%, $n = 6$; private physicians: 5.8%, $n = 5$; medical centers: 4.7%, $n = 4$.

21 Pills: $n = 11$; insulin: $n = 6$.

22 Official definition of the American Heart Association, 1996.

23 High cholesterol: $n = 22$; screened for high cholesterol: $n = 47$; HMOs: 16.5%, $n = 14$; Indian Health Service or urban Indian health facility: 7.1%, $n = 6$; private physician: 4.7%, $n = 5$.

24 American Heart Association Report.

25 Screened for hypertension: $n = 64$; HMOs: 19.1%, $n = 17$; private physician/SCIC mobile van: 5.6%, $n = 5$; urban Indian health clinic: 4.5%, $n = 4$.

26 American Heart Association Report, 1996.

27 Tested for glaucoma: $n = 47$; office of eye doctor: 15.9%, $n = 13$; HMOs: 12.2%, $n = 10$; Indian Health Service facilities: 4.9%, $n = 43$; private physicians: 7%, $n = 3$.

28 American Dental Association, *News Daily*, March 10, 1997.

29 Excellent: $n = 7$; good: $n = 33$; fair or OK: $n = 24$.

30 Never lost teeth: $n = 37$; lost one to five teeth: $n = 37$; lost six or more teeth: $n = 17$.

31 Something was wrong: $n = 35$; for an exam: $n = 22$; reminded: $n = 9$; for series of treatments: $n = 12$.

32 Within past year: $n = 41$; more than five years: $n = 10$; never: $n = 3$.

33 See R. Roswell, *Community Profiles: The American Indian/Alaska Native Community: The Challenge of HIV/AIDS in Communities of Color* (Washington, D.C.: National Commission on AIDS, 1993), 55–62.

34 However, there are suspected problems with these data. Several leading American Indian physicians and other researchers have observed that American Indian ethnic categories are often misclassified in clinical settings (see Marshall G. Hurlich, "Racial Ascertainment of AI/AN Persons with AIDS, Seattle/King County, WA, 1980–89," *Provider* [May 1992], 73–74).

35 Only 9% of our respondents claimed to have been diagnosed with any kind of STD.

36 See M. F. Cantwell, D. E. Snider, G. M. Cauthen, and I. Onorato, "Epidemiology of Tuberculosis in the United States, 1985 through 1992," *Journal of the American Medical Association*, 272 (1994): 535–39; and Centers for Disease Control and Prevention, "Tuberculosis Morbidity—United States 1997," *Morbidity and Mortality Weekly Report* 47 (1998): 253–57.

37 HMOs: 12.2%, $n = 11$; community and urban Indian clinics: 7.8%, $n = 7$; private physicians and Indian Health Service facilities: 5.6%, $n = 5$; medical centers: 4.4%, $n = 4$.

38 National Cancer Institute.

39 F. A. Hubbell, L. R. Chavez, S. I. Mishra, J. R. Magana, and R. B. Valdez, "From Ethnography to Intervention: Developing a Breast Cancer Control Program for Latinas," *Journal of the National Cancer Institute*, 18 (1995): 109–15.

40 HMOs: 14.8%, $n = 12$; Indian Health Service facilities: 4.9%, $n = 4$; community clinics: 2.5%, $n = 2$; urban Indian health clinics: 4.5%, $n = 4$.

41 HMOs: 19.1%, $n = 17$; Indian Health Service facilities: 5.6%, $n = 5$; SCIC mobile van, medical centers and/or community clinics: 4.5%, $n = 4$.

42 Stress: $n = 21$; more serious mental health problems: $n = 8$.

43 Dangerous neighborhoods: $n = 43$; rarely felt safe: $n = 11$.

44 National Clearinghouse for Alcohol and Drug Information.

45 Along with Mexican-Americans, Puerto Ricans, and African Americans.

46 Rates for the total U.S. population were estimated at 11.9%.

47 Prevalence of marijuana use in the total U.S. population was estimated at 9%.

48 Prevalence rates of needing drug abuse treatment in the total U.S. population were estimated at 2.7%.

49 Problem with alcohol abuse: $n = 22$; drink beer, wine, or liquor: $n = 36$; more than three drinks: $n = 10$; more than six drinks: $n = 7$.

50 SAMHSA Survey, National Clearinghouse for Alcohol and Drug Information.

51 Prevalence of cigarette use in the total U.S. population was estimated at 30.9%.

52 U.S. Department of Health and Human Services, *Tobacco Use among U.S. Racial/Ethnic Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*, Centers for Disease Control and Prevention, 1998.

53 Smoker at some time: $n = 53$; current smoker: $n = 26$.

54 Chewed tobacco at some time: $n = 9$; currently chew tobacco: $n = 2$.

55 Report by the American Heart Association.

56 Every day: 25.3%, $n = 24$; less than once per week: $n = 16$; all the time: $n = 8$; no contact: $n = 16$.

57 Never: $n = 21$; once or twice per week: $n = 28$; four times per week: $n = 16$.

58 Always: $n = 71$; almost all the time: $n = 13$.

59 U.S. Census Bureau, *Health Insurance Coverage*, 1996.

60 Some kind of health insurance: $n = 51$; HMOs: $n = 35$; Medi-Cal/Medicare: $n = 11$.

61 Some expressed concern about getting to a specialist. When their doctor made it difficult, they went without, obtained a loan, or spent their personal savings to go on their own.

62 Elders who were otherwise not participants in an established support group would most likely not be aware of this program.

63 One woman reported that her cancer was not diagnosed. Fortunately, she was able to obtain care at the City of Hope. She wound up in a legal quagmire with her HMO.

64 Those who can afford it.

65 There were several anecdotes about relatives who did not have health insurance, though they had growing families. The children of these families were not getting their immunizations on time.