

**Behavioral Health Services and Staff Perceptions in Urban Indian Health Organizations**

by

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A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
(Psychology)  
in The University of Michigan  
2020

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## **Acknowledgements**

I would like to acknowledge a number of people who have been instrumental in my completion of this degree program. This dissertation would not have been possible without the love and support of my partner, Casey Yates. Casey helped me to bear this burden more than any other single person and I could not have completed this task without him.

At several points in this difficult journey I received the helpful support and advice of a great therapist, Naomi Bartakke, to whom I owe a debt of gratitude.

My co-chairs, Dr. Joseph Gone and Dr. Cheryl King, have played important roles in shepherding this project to completion, providing moral support and scholarly guidance at crucial junctures. Dr. Gone's work and ideas also provided much of the inspiration for this project. Dr. King has worked diligently to support me and provided useful insights into this work that helped me to better frame it for my readers. I also wish to thank Dr. Donna Nagata and Dr. Sandra Momper, the other members of my committee, for their support and their flexibility throughout this process. My undergraduate mentor, Dr. Heidi Levitt, has been a cheerleader and source of wise counsel at many times when I needed one. I would further like to extend my thanks to Dr. Patricia Deldin, who offered her support at several difficult moments.

Several current and former University of Michigan graduate students have also been vital supports in the past six years. Thank you in particular to Rachel Burrage, Janelle Blazek, Amy Dawson-Andoh, Petal Grower, Will Hartmann, Ka Ip, Chelle Jones, Sunny Lin, Jaime Munoz-Velazquez, Sara Stein, Cecilia Votta, Dennis Wendt, and Elizabeth Yu.

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## Abstract

Three studies were conducted to determine how urban American Indian health organizations deliver behavioral health services. The first study, *Behavioral Health Services in Urban Indian Health Organizations: Results of Survey and Observational Research*, presents a survey of the offered services at fourteen UIHOs, and summaries drawn from in-person visits to six UIHOs. The aim of this study was to document the extent to which typical behavioral health services are being offered at UIHOs and to observe how the services these sites offer may differ from other settings. The results of the first study indicated that UIHOs report offering services similar to national outpatient clinics, but that their offering of American Indian cultural education and traditional healing is a crucial difference in terms of what services they offer. The second study, *Behavioral Health Services Offered at Urban Indian Health Organizations: A Thematic Analysis*, presents a thematic analysis drawn from interviews with ten directors of behavioral health at UIHOs. The aim of this study was to further document through interviews what services are offered in behavioral health and what resources are used to offer them. The results of the second study indicated that behavioral health services at these UIHOs goes beyond psychotherapeutic treatment of psychological disorders and includes significant amounts of case management to address clients' basic living needs, as well as the coordination of cultural and traditional healing programming. While funding was identified by participants as a primary barrier to offering adequate services, they also noted additional challenges due to the lack of psychiatrists, and a lack of American Indian therapists. The third study, *American Indian Behavioral Health Treatment Preferences as Perceived by Staff at Urban Indian Health*



*Organizations*, presents a thematic analysis drawn from interviews with twenty-eight behavioral health staff at six UIHOs along with focus groups with twenty-three staff from five UIHOs. The aim was to better understand how therapists at UIHOs manage demands for evidence-based practice and culturally relevant behavioral health care for American Indian clients. The results of the third study suggested that these therapists attempt to blend and tailor empirically-supported treatments with American Indian cultural values and practices (where possible and appropriate), while trying simultaneously to honor the client's specific preferences and needs and to encourage clients to seek cultural practices and connection outside the therapy room. These three studies together suggest that UIHOs offer a wide array of behavioral health services, but variation from UIHO to UIHO is noteworthy. A lack of resources, both financially and in terms of the availability of particular types of clinicians, were reported to limit the amount and type of behavioral health services offered. Cultural education and traditional ceremonial practice are commonly employed in both theorization and implementation of behavioral health treatment in service to wellbeing and healing for American Indian clients. Staff at all UIHO sites in these studies utilized some form of cultural education, traditional practice, or both in their approach to offering behavioral health services. Participants described how these practices may be incorporated in treatment, provided to clients outside of treatment, or referred out for client active engagement. These findings suggest UIHO staff blend theories of empirically-supported treatments with cultural programming to promote American Indian wellbeing, while consciously aware of the limitations of the evidence base and the lack of research with American Indian clients.

## CHAPTER I

### **Behavioral Health Services in Urban Indian Health Organizations: Results of Survey and Observational Research**

Although the majority of American Indians (AIs) today live away from reservation lands, most funding for services through the Indian Health Service (IHS) are provided to reservation clinics and hospitals or directly to tribal groups in reservation settings (IHS, 2020). Urban Indian Health Organizations (UIHOs) are a vital part of the IHS system; this network of 41 UIHOs represents the only funding in the IHS budget specifically set aside for treatment of urban AIs, making up just one percent of the budget (IHS, 2019; IHS, 2020). These 41 sites vary widely in terms of the scope of their operation; six sites are exclusively inpatient behavioral health treatment centers, five are designated outreach and referral sites, seven are designated limited ambulatory, and the remaining 23 are designated full ambulatory (IHS, 2018). Although 41 is the official number of UIHOs according to IHS, only 34 were officially listed on the IHS website at the beginning of this project, and only 33 are listed today; one site lost its UIHO grant during the span of the project (IHS, 2019). This public list of 34 UIHOs formed the population of this study. The sites that are not listed among the 34 national UIHO programs but counted in the 41 total programs are primarily inpatient treatment programs, which also do not report statistics about service usage to IHS and are not included in numerical reports regarding UIHO service usage (IHS, 2018).

In addition to the discrepancy between where the majority of AI people live and where the majority of IHS funding is dedicated to, the IHS system has been criticized for a number of shortcomings more generally. One, the system is inherently patchy; some service regions do not have a hospital, many services are operated at a tribal level (thus creating significant intertribal disparities in terms of the availability of services among the over 500 federally-recognized tribes), and services are often located far from AI population centers (Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004). Two, the actual level of funding provided to IHS was estimated to be less than 40% of the total cost of funding health care for the approximately two million federally-recognized tribal members in the United States in 2012 (Gone & Trimble, 2012). Three, several gaps have been noted in the availability of certain forms of care: Zuckerman et al. (2004) found that few AI women were receiving mammograms or other preventive care, possibly as a result of the lack of available preventive care at IHS facilities; Gone (2004) noted that at the time only 7% of the IHS budget went to mental health and that the majority of this was earmarked for substance use treatment specifically, resulting in a rate of two psychiatrists to treat every 100,000 individuals in the IHS population. Thus, IHS is perceived as a patchwork system, primarily used by those who are unable to afford better healthcare from private insurers (Zuckerman et al., 2004), seen as a kind of “broken promise” among many in the AI community (Gone, 2004). Some limited earlier investigations have suggested high dropout rates among AI clients and high rates of employee turnover in mental health at IHS facilities (Sue, Allen, & Conaway, 1978; Gone, 2004); however, these earlier works did not survey a large number of IHS sites and even if accurate at the time may not reflect the contemporary situation with regards to AI behavioral health at IHS sites and elsewhere.

One important way in which AI behavioral healthcare differs from behavioral healthcare aimed at other populations is the population's demand for culturally relevant care specifically emphasizing connection or engagement with traditional AI cultural values, teachings, and practices. Urban AI communities have made multiple calls for culturally relevant behavioral health treatment, including the incorporation of traditional healing into models of treatment (e.g. Gone, 2009; Goodkind et al., 2011; Moghaddam, Momper, & Fong, 2013). Traditional healing is a term for the use of Indigenous cultural practices in mental health services, typically finding their basis in historical Indigenous healing practices, community activities, and worldviews (Duran, 2006). These practices are often viewed as at odds with the evidence-based practice model outlined by the APA Task Force (2006), but efforts have been made to demonstrate the scientific validity and medical value of these treatment forms. Dickerson et al. (2014) utilized a traditional drumming circle as part of substance abuse treatment in an urban center, with preliminary results indicating its potential for success in improving engagement among this population. Another study utilizing traditional teachings in an urban setting documented qualitative reports of increased engagement with one UIHO as a result of this approach (Gone et al., 2017). However, these studies have been limited to a single site each to date, and the published data have been only correlational or qualitative; no clinical trials have been published utilizing these approaches to treatment.

Existing reviews of UIHO services and surveys of community needs have generally focused on individual sites rather than looking across multiple UIHOs or cities. A recent needs assessment at one UIHO found that greater cultural competence, more specialized services, and improved transportation services to healthcare appointments were desired by current service users (Dennis & Momper, 2016). A needs assessment at another UIHO, primarily concerned

with youth participants, found that community members identified improved funding, more cultural and educational programming, and specific programs targeting youth mental health as unmet needs (West, Williams, Suzukovich, Strangeman, & Novins, 2012). A third example of a single site needs assessment found that both clients and providers reported a need for increases in available services and capacity for existing services (Kropp, Lilleskov, Richards, & Somoza, 2014). Further recommendations in this report included increased case management, assistance with transportation, improved outreach and education, incorporation of AI traditions into existing services, and improvements in care coordination between state, tribal, and IHS agencies. Other research on UIHOs has focused on the inherent challenges of balancing multiple, sometimes conflicting identities. In a brief ethnography conducted at one UIHO, Hartmann, Gone, & Saint Arnault (2020) noted that while behavioral health clinicians attempted to frame their work in an AI context, the majority of clients seen at the site were not AI, and the clinicians' own knowledge of cultural practices was too limited to provide clients with traditional healing practices or teachings. Despite this, the UIHO still attempted to provide some limited traditional teachings and added AI symbolism in the course of therapy, due to the demand from clients who were AI as well as in order to match with the clinic's identity as an AI-specific treatment site. As such the culturally-relevant care at this site supposedly devoted to such a purpose was ultimately limited.

Two notable peer-reviewed studies have conducted multi-site UIHO inquiry; Beitel et al. (2018) and Pomerville & Gone (2018). Beitel et al. (2018) examined therapy sessions at three UIHOs and found that therapists were in general less likely to employ cognitive-behavioral approaches to therapy at these UIHOs compared to national averages, even among therapists at UIHOs who identified as having cognitive-behavioral orientations. In a survey of 11 UIHOs,

Pomerville & Gone (2018) found that behavioral health directors reported offering a wide selection of behavioral health services, close to the averages of other outpatient clinics surveyed by the Substance Abuse and Mental Health Services Administration (SAMHSA) nationwide. However, it was also found that all 11 of the surveyed UIHOs utilized native-specific treatments labeled “traditional healing,” in stark contrast with typical behavioral health practice.

In addition to these two examples from the peer-reviewed literature, a 2012 report from the Urban Indian Health Institute surveyed 24 UIHOs regarding behavioral health services and also conducted interviews with four sites; however, this report was not published in a peer-reviewed source. The results of this survey indicated that individual and group therapy, comprehensive behavioral health care, substance abuse treatment, and medication management were fully available at 50% or more of sites surveyed, and some limited availability of these services was present at 75% or more of the 24 sites surveyed (UIHI, 2012). Further, it was indicated that nearly all sites incorporated some form of traditional healing or cultural teaching into behavioral health services (UIHI, 2012). However, the report did not indicate any specific treatments available at any of these sites, whether any of the treatments were based in any form of evidence, and what cultural elements were being utilized in behavioral health. The purpose of this study is to conduct an initial survey of UIHOs to better understand the types of behavioral health treatment treatment available at these sites, and to investigate what the current needs for behavioral health services are at these sites, from the perspectives of current UIHO clinicians and staff.

## **Method**

### **Data Collection**

Data collection began October 17th, 2014, and was concluded May 25th, 2018. All

UIHOs were contacted by phone and, if possible, email in order to get in contact with Behavioral Health Directors at each site. UIHOs were defined as the 34 health programs for urban AIs listed by the IHS on their website (IHS, 2019) at the beginning of this project.

A total of 14 out of 34 sites chose to participate in at least some portion of the study. An additional 10 sites responded and directly declined to participate for the following reasons: four sites indicated they did not have a behavioral health director and/or did not offer behavioral health at that time; five sites declined to participate because of the time commitment or concerns about client privacy; one site closed during the period that data collection was ongoing. Some response was received from the majority of the remaining 10 sites, which neither participated nor formally declined but stopped responding to follow-up contacts. All 14 sites that participated in the surveys were also contacted regarding their interest in potential participation in further research. Ultimately, six of the participant sites also participated in site visits, which allowed for further data collection as described below under “site profiles”.

### ***Director Surveys***

Behavioral health directors at all UIHOs were contacted by phone or email to complete a survey. This survey used questions from the National Mental Health Services Survey or N-MHSS (HHS, 2010) and the Evidence Based Practice Attitudes Scale or EBPAS (Aarons, 2004). The survey also included questions concerning clinician training, client retention, and the use of traditional healing practices. A detailed description of each measure follows.

**The 2010 National Mental Health Services Survey (N-MHSS).** A subset of questions from the 2010 N-MHSS was used. These questions are used by SAMHSA as part of their regular survey of treatments offered at health clinics nationwide, which collects these data via self-report from clinic staff. A total of nine measures from the N-MHSS were included, asking yes/no

questions regarding treatments and services available and the quality assurance practices that clinics use (e.g. “which of these mental health treatment approaches are offered at this facility, at this location” followed by a list including “cognitive behavioral therapy,” “activity therapy,” etc.) as well as asking for utilization and demographic data. These measures were asked exactly as they appeared on the 2010 N-MHSS survey, and Program Directors were given the official definitions from the original survey if they asked for clarification. As some UIHOs oversee multiple clinical sites and the N-MHSS is specifically intended for surveying a single site, Program Directors were asked to only consider services at the primary site if their UIHO was responsible for more than one location offering behavioral health services. The complete survey data from the 2010 N-MHSS survey was released in 2014, and the full list of N-MHSS questions is publicly available (HHS, 2010).

**Clinician profiles.** Program Directors were asked to state the number of clinicians working at their primary UIHO location, and for details of these clinicians’ educational backgrounds, including their relevant educational degrees if any and whether any clinicians were currently trainees in degree programs.

**Client profiles.** Program Directors were asked to estimate the percent of clients who return after an initial session. They were then asked to estimate the average number of sessions that clients who return after the initial visit receive.

**The Evidence-Based Practice Attitude Scale (EBPAS).** The EBPAS consists of 15 items regarding manualized treatment and research-based psychotherapeutic interventions, using a Likert-like scale ranging from zero to four for all questions (Aarons, 2004). Each item is attached to only one subscale, with four subscales in all. The combined scores for items on a single subscale are averaged to calculate the total score for that subscale. The subscales are



*appeal* (scored 0 - 4, how likely is a clinician to use novel treatments and treatments developed by researchers if they appeal to the clinician?), *requirement* (scored 0 - 4, how likely is a clinician to use a treatment if they are required to by supervisors or government?), *openness* (scored 0 - 4, how open is a clinician to new evidence-based treatments?), and *divergence* (scored 0 - 4, to what degree is a clinician resistant to research-based treatments that are divergent from current practice or experience?). Scores closer to 4 on *appeal*, *requirement*, and *openness* represent greater interest in using manualized and research-based interventions. Scores closer to 4 on *divergence* represent greater resistance to these treatment approaches. Scores on the four subscales are combined and then averaged for a total EBPAS score of 0 to 4, with items from the *divergence* subscale reverse scored. A large-scale study (Aarons et al., 2010) established national norms on these measures and “moderate to excellent” reliability of the measure (p. 360).

**Traditional healing profiles.** Two open-ended questions and two closed-ended questions on traditional healing were developed specifically for this study. Respondents were asked to list specific traditional healing practices offered at their sites in open-ended fashion. Similarly, respondents were asked to define traditional healing in open-ended fashion. Then, respondents were asked to indicate in closed-ended fashion whether traditional healing was offered in each (or all) of three ways: as part of therapy; available on-site but separate from therapy; and available by referral to traditional healers in the community. Finally, respondents were asked to approximate the percentage of clients at their site making use of traditional healing that was offered.

### ***Site Profiles***

All participants who completed the Director Interview were invited to participate in site visits. These visits involved two or three day in-person visits, where interviews were conducted with members of the behavioral health staff and others who had a stake in behavioral health at UIHOs. Wherever possible, all clinicians working in behavioral health at each site were interviewed, and Behavioral Health Directors at each UIHO identified any additional staff outside the behavioral health clinicians who might have insight into the research questions. In addition to these interviews, focus groups were conducted with behavioral health staff at five out of the six site visits. Further, Behavioral Health Directors at each site provided materials concerning different available treatments as well as other internal documentation of behavioral health service operations at their UIHO, with this material varying from site to site depending on what printed material was available and what each Director was willing to share. Ethnographic field notes were taken during these visits, following the model for ethnographic note-taking described in Emerson, Fretz, & Shaw (2011). These notes, as well as supplemental information from interviews and the materials provided by the Behavioral Health Directors, were used to generate site profiles addressing the research questions, which were written following each site visit. These descriptive profiles were completed between two and five days after the conclusion of the site visit. The profiles documented the nature of the sites and a broad overview of all services available including outside of behavioral health, the specific available behavioral health treatments and any concerns from staff or clinicians about being able to adequately provide these treatments, the utilization of traditional healing and cultural education or other traditional AI practices as part of the treatment process, and the current needs and inadequacies of the sites as reported by clinicians and other staff members. Analysis of these profiles aggregated the answers to these questions to produce general statements about what was observed about the sites.

## **Analysis of Director Survey Results**

Findings in response to the Director Survey were previously published based on the responses of 11 participants in Pomerville & Gone (2018). Data from three additional participants has since been collected and thus this portion of this report presents an expanded picture of those data. Further, unlike Pomerville & Gone (2018) and expanding on the results of that previous work, tests of statistical inference were conducted to determine whether participants' reports in these surveys differ from nationally established norms from Aarons et al. (2010). The EBPAS subscales were constructed in accordance with Aarons (2004) and those scores were tabulated and compared with the national norm results presented in Aarons et al. (2010). Two-sample t-tests were conducted to compare the scores of Behavioral Health Directors at UIHOs attained in this study to those national norms. Based on previous literature concerning providers working in AI mental health suggesting a general resistance to evidence-based practices, it was hypothesized that the Directors surveyed for this study, compared to national norms, will score lower on the overall EBPAS; that they will score lower on the subscales of requirements, appeal, and openness; and that they will score higher on the subscale of divergence.

The responses to the N-MHSS questions on treatment and support services were tabulated in order to offer a concise picture of current treatment available at these sites as compared to national averages based on the same survey. The remaining descriptive data is presented in tabular and narrative form. Responses to the two open-ended questions on traditional healing were compared and grouped based on relatively self-evident similarities in wording and meaning of responses.

## **Analysis of Site Profiles**

Site profiles were developed and analyzed utilizing the methodologies for developing and interpreting field notes laid out in Emerson, Fretz, & Shaw (2010). Using what Emerson et al. (2010) refer to as “focused coding,” the field notes and observations from the site visits were developed into written summaries of each site focused on answering key questions of interest to this research. This analysis was particularly concerned with the treatments available in a behavioral health context at these sites, the populations seen at these sites with an emphasis both on racial/ethnic considerations and presenting concerns of clients seen, and the current unmet financial and staffing needs of the sites as perceived by staff members. These summaries were then subjected to what Emerson et al. (2010) refer to as “integrative memoing”, in which the summaries of the different sites were compared to understand the similarities and differences in the sites’ available behavioral health treatments, client populations, and unmet needs. The researcher conducting this analysis is a white non-Hispanic gay man who was a doctoral candidate in clinical psychology at the time the work was conducted. These identities, his past work in the field of psychotherapy research, and his experiences personally conducting these site visits all likely contributed to his specific interpretation of these site profiles. The conclusions from this analytic process are presented under “Observational Site Profile Results” below with each subsection representing a different area of comparison that was intentionally highlighted in the focused coding and integrative memoing in order to be able to compare staff perceptions across sites.

## **Results**

### **Survey Results**

#### ***Results to Questions from the N-MHSS 2010***

Behavioral Health Directors at 14 of the 34 contacted sites completed the survey. Results regarding the reported availability of different treatment types across these 14 sites can be seen in Tables 1 through 3. Ten out of 14 behavioral health directors indicated their site treats clients under age 18, and all sites indicated they see adults (clients aged 18 to 64) and seniors (clients aged 65 and older). Table 4 indicates the reported use of quality assurance practices compared to national averages. On average, Behavioral Health Directors reported their site serving an estimated 151.2 clients in the past month (SD = 155.0), with one Director not reporting an answer. On average, the 14 Directors estimated 53.4% of these clients seen in the past month were male and 46.6% were female. Out of 13 Directors who reported an estimate of the ethnicity of those participants in the past month, the average estimate was that American Indian or Alaska Native clients made up 72.0% percent of clients seen. Three Directors provided estimates indicating less than half of the clients seen in the past month were American Indian or Alaska Native. One Director did not provide an answer to this question.

### ***EBPAS Results***

A summary of the Behavioral Health Directors' scores on the four EPBAS subscales and the overall scale, as well as the national norms from Aarons et al. (2010) can be seen in Table 5; note that a correction to Aarons (2010) was made regarding the EPBAS mean score. Behavioral Health Directors scored significantly higher than national norms on the subscale of Requirements (M = 3.2857, SD = 0.7829),  $t(13) = 4.185$ ,  $p = 0.001$ . This result is the opposite of the stated hypothesis that Directors would be more likely to score lower on this subscale than average. In all other cases, the null hypothesis was retained. Behavioral Health Directors did not differ from national norms on the subscales of Appeal (M = 2.9464, SD = 0.96166)  $t(13) = 0.142$ ,  $p = 0.889$ , Openness (M = 2.750, SD = 1.0143)  $t(13) = -0.037$ ,  $p = 0.971$ , or Divergence (M = 1.5179, SD

0.6684)  $t(13) = 1.499$ ,  $p = 0.158$ . Directors did not differ from national norms on the overall EBPAS ( $M = 2.8381$ ,  $SD = 0.5116$ )  $t(13) = 0.791$ ,  $p = 0.443$ .

### ***Clinician Profiles***

Directors reported employing an average of 6.1 clinicians ( $SD = 3.88$ ) including themselves. Nine out of 14 Directors reported that at least one clinician currently on staff was a trainee (e.g. practicum student, doctoral intern). Nine out of 14 Directors reported at least one doctoral-level clinician on site. Thirteen out of 14 Directors reported at least one masters-level clinician on site. Nine out of 14 Directors reported at least one bachelor's level clinician on-site. Three directors reported at least one clinician on-site with a different level of training such as a certificate or associate's degree.

### ***Client Profiles***

Directors at 13 sites estimated on average that 77.5% of clients return after the first session; one Director did not answer. Of those clients who return after the first session, Directors at these 13 sites estimated these clients receive an average of 10.85 therapy sessions ( $SD = 6.32$ ).

### ***Traditional Healing Profiles***

Directors at 12 out of 14 sites indicated that traditional healing is sometimes incorporated into therapy. Directors at 9 out of 14 sites indicated that traditional healing was available on-site separate from therapy. Directors at 10 out of 14 sites indicated that traditional healing may be referred out to healers in the community. All sites indicated that traditional healing was available in at least one of these three formats. Directors across the 14 sites estimated that on average 36.4% of clients made use of the traditional healing practices that were available. Asked to list what forms of traditional healing were available at their site, Directors at two or more sites independently listed the following forms of traditional healing as something conducted or

available to clients: Sweat lodge (n = 7), Cultural Education/Teachings (n = 6), Smudging (n = 5), On-site consultation (n = 4), Drum ceremony (n = 3), Talking circle (n = 3).

### **Site Profile Results**

The following information is taken from the ethnographic field notes as described above and compiled into specific categories based on the goals of this project and the topics that were regularly raised across multiple site visits.

#### ***Availability of Treatment***

A major determinant of available treatment at UIHOs is, unsurprisingly, which services can be billed for. Across the six site visits, it became clear that the patchwork state of funding and the different statuses that different UIHOs had created a highly varied scenario. At one site, due to their status with IHS, it was not possible to bill for individual therapy; the only services that this UIHO could bill for were group-based approaches to substance abuse treatment. It is important to note that some therapists at this site chose to see individual clients on a case-by-case basis despite this, however, serving as one example among many in which funding alone is not entirely determinant of available treatment. Another site found itself in the opposite situation, able to bill only for individual sessions and not group approaches to treatment.

Other factors influencing availability of treatment include the availability of practitioners and physical space limitations. Availability of practitioners varied widely between sites. While some sites indicated provider shortages either due to funding or a lack of competent providers in the area (or both), other sites indicated that they currently have enough clinicians with the appropriate training to meet demand. At sites with reported provider shortages, some were unable to offer the particular forms of therapy that they wanted to as no one on staff was trained in these areas; other sites had clinicians trained in the relevant skills to offer all the therapies they

desired to offer, but could only serve a fraction of the client population due to the high demand for treatment compared to the number of providers. As an example of the limitations caused by physical space, some UIHO sites lacked large private available space to conduct group therapy sessions, limiting them to providing only one-on-one, family, or couples therapy.

Specific forms of treatment were also informed by director and clinician preferences. Modalities of treatment indicated as available across multiple sites included cognitive behavioral therapy, narrative therapy, client centered therapy, psychodynamic therapy, and mindfulness-based therapy. Clinicians differed in their applications of these approaches depending both on their own preferences and the expectations set by the site's director. At some sites and with some clinicians, evidence-based applications of these treatments in manualized fashion was utilized to provide treatment. Other sites and clinicians consciously deviated from this model of evidence-based treatment, instead relying on a more eclectic application of principles from different therapies as necessary and relevant for specific clinical cases. Clinicians who took the latter approach generally justified their deviation from manualized approaches to treatment in the differences between their client base and the groups that such approaches are intended for; for example, one clinician indicated that clients seen at the site were facing extensive and co-occurring behavioral health disorders as well as homelessness and other economic challenges and were thus in ongoing treatment for years, a mismatch with the time-limited therapeutic format that many well-known evidence-based practice models utilize.

### *Clients*

Among the six sites visited, two served exclusively members of federally recognized tribes or their family members. Two sites were FQHCs and thus were required to see all clients regardless of their racial or ethnic identity. The remaining two sites were not specifically



FQHCs, but did see clients who were not AI. Among the four sites that did see clients of all races and ethnicities, the rates of self-identified AI people being seen in behavioral health ranged from estimates as low as 15% to estimates as high as 75%.

Basic economic insecurity was a major issue reported by clients in one way or another across every site. Although these difficulties were not part of the original research questions for the project, they were spontaneously raised by participants. At four sites, homelessness was mentioned as a major problem facing many of the clients seen in behavioral health. Participants at five sites noted that clients were generally extremely low income and that this disincentivized more financially well-off clients from seeking treatment at the site, even among AI people. According to employees at these sites, meeting basic needs came before addressing their behavioral health concerns for many clients, with multiple employees mentioning that this was fundamentally a question of Maslow's hierarchy of needs (Maslow, 1943). At three sites, these concerns were handled in part or in whole by social services coordinators and/or case managers with jobs devoted entirely to these functions. Participants at one site indicated they had enough of these services when asked; participants at four sites indicated that they would like more or any such services; at one site without dedicated case managers, some clinicians indicated that because of a low overall number of clients who qualify to receive treatment, they do not feel they need additional assistance in this area because they have time to do this work themselves.

Two sites identified substance abuse as the primary problem facing clients seen on-site, with one indicating opioids were the primary substance that was abused among clients and another indicating that alcohol was the primary substance abused. Alcohol was also mentioned as a primary substance of abuse at the four sites that did not consider substance abuse the primary problem facing their client base. Notably, the only site that did not identify alcohol as a serious

problem was the site that identified opioid use as the primary problem facing its client base; staff at this site indicated that alcohol was comparatively protective in that it seemed to be associated with better outcomes than those of other clients seen at that site. Methamphetamines and marijuana were also mentioned by two sites as problems for clients; clinicians shared examples of clients who failed drug tests for marijuana by their employers and lost their jobs. No other drugs aside from opioids, alcohol, methamphetamines, and marijuana were mentioned at any of the six sites as a regular problem.

Multiple sites indicated that the relative substance abuse profile of their client base was driven in part by the services that were provided at that site. For example, one site indicated that the medical director eschewed opioid treatment and thus few clients were seen for opioid addiction. Another site indicated that it saw high levels of substance abuse clientele because this is the primary area of its billable services. Thus, although some of these distinctions were likely driven by the regional differences in the populations served, others are more likely explained by idiosyncrasies of the clinic itself and the billing process in mental health.

Considering the mental health concerns beyond substance abuse, the most common issues clients presented with at three out of six sites were depression and anxiety. Two out of six sites indicated that trauma was the primary presenting problem among their clients. One site indicated that they had few clients coming in for mental health problems outside of substance abuse given both the high rates of substance abuse in the local community and the lack of available therapists to see them, but that it did see clients on a case-by-case basis for depression, anxiety, bipolar disorder, and schizophrenia.

### ***Traditional Healing and Cultural Programming***

All six sites indicated offering at least some form of traditional healing, but the availability of these services was inconsistent across the different sites. Two sites that offered only very limited practices are described below, followed by a more general description of services at the other four sites.

At one site, traditional healing and cultural programming consisted exclusively of youth programming, which included growing sacred medicines and education on AI culture. Discussion of AI cultural values and traditions and their relevance to clients was addressed on a case-by-case basis, but some of this information had come from internet searches and there was an acknowledged lack of good information on the topics at this UIHO. They identified three reasons for the scarcity of traditional healing services on site: a lack of interest among clients, a lack of personal knowledge in these areas among staff, and a lack of traditional healers in the local region. The site did not have local trusted traditional healers, sweat lodges, or other resources to refer clients to, and it was expressed that this was due to the local area lacking trustworthy traditional healers; this was not seen as an especially great concern due to the lack of interest among the client base in traditional AI approaches to healing.

Another site offered smudging (a spiritual cleansing practice typically involving the burning of sage) in the therapy room for clients who were interested, and also held Red Road meetings (a program sometimes referred to as “Native American AA” that incorporates references to following Native ways of life), but otherwise offered no direct traditional healing or cultural education. Physical space constraints at the site as well as a lack of local traditional healers were cited as reasons for not utilizing these approaches. Cultural education classes were available at other sites in the city, but clients who wish to see a traditional healer or participate in a sweat lodge reportedly had to travel out of state for such services.

The remaining four sites had considerably more robust programs of traditional healing and cultural education. Two sites had on-site sweat lodges, and two sites indicated that there were sweat lodges available in the local area that were separate from the center and that would require clients to provide their own transportation. Two sites had developed a Native-specific form of treatment planning independent of one another. Smudging was regularly used across these four sites.

### ***Challenges in Traditional Healing***

Employees at two sites noted that there was generally a lack of interest in traditional healing among AI clients seen at the site. Five sites noted that they faced specific challenges related to offering traditional practices due to tribal differences. Examples include: differences over whether sweat lodges should be limited to a single sex; rejection of certain ceremonial approaches by clients who feel there is mismatch between local AI traditions and the practices at the clinic that may be Pan-Indian or taking from tribal groups in other regions; challenges incorporating traditional practices into group therapy when clients' traditions do not share basic qualities with the traditional practices that the group therapy curriculum was based upon; and a local tribal group being primarily Christian today and some clients therefore rejecting traditional spiritual practices at the site as "witchcraft."

Two sites noted an additional challenge in identifying competent local traditional healers to work with their clients at all, and other sites identified challenges in finding enough traditional healers or finding funding to allow for them to provide services for clients. In addition, four sites specifically noted that there are no publicly usable and reputable local sweat lodges available for clients within less than an hour's drive from the site itself. The only two sites for which the lack of sweat lodge was not identified as a problem had their own sweat lodges on site.

## Discussion

This study serves to answer two questions relevant to current and future researchers engaging with UIHOs. The first is whether UIHOs may be suitable for research partnerships aiming to test psychotherapeutic interventions. Based on the survey data presented here, it appears that UIHOs may be open to research partnerships and have a large enough regular client base for partnership to be fruitful, at least at the UIHOs surveyed. The survey data indicate the existence of robust therapy programs across UIHOs with significant numbers of licensed therapists, and clients regularly receiving an average of 10 sessions, which would be amenable to most contemporary mental health intervention research. Second, and considerably broader, is the question of what kind of mental healthcare a typical UIHO offers. As the site profiles demonstrate, there is no singular picture that can be drawn, but there are similarities that may be useful to remark upon from an observer's perspective, both for other researchers and for UIHOs themselves.

The six UIHOs that participated in this study operate in vital community roles, providing therapy to populations with high need and few alternative options. Although the size and scope of the operations vary considerably, a strong clinic AI identity and a set of resulting practices appear universal despite some disagreements among staff who may wish for more incorporation of this identity dependent on the specific site. Despite this, these practices and concepts are particular to each site; that is to say, even among sites that see their mission and identity as fundamentally "pan-indigenous", there is a particular set of meanings and practices attached to the AI identity of each site. Naturally, there is a wide diversity of traditional and contemporary practices among the hundreds of federally recognized AI tribes and other groups identifying with AI heritage. Further, there is a great deal of value and meaning in a shared identity for users and

staff of individual sites, especially at sites that are operating in an additional role as community centers, as some UIHOs do. Having said this, there are some specific observations concerning problems with this diversity of site conceptualizations of AI identity that may be worth considering.

A specific example of this problem was witnessed where two different sites had separately produced their own AI-specific treatment plans. One site indicated that they did not use this for patients billed with insurance, because they did not believe the insurance companies would accept their AI-specific treatment plan. The other site had submitted and gained special approval for use of their treatment plans with at least some insurance companies. It seemed clear that this was both an unnecessary doubling of work effort and a potential space for communication on an important topic affecting these sites. Another example, mentioned in the results, is a UIHO with limited access to traditional knowledge and teachers, that is relying on Google searches for some materials. While not all materials will be appropriate for all AI populations (or age groups or diagnoses, etc.), many UIHO sites have robust programs of cultural teachings that may have some potential to be shared and utilized by other UIHOs as appropriate and culturally acceptable. Of course, it is possible that this material is already being shared online and is found via these internet searches, or that the material found online is from other valid sources of knowledge of Indigenous practice.

The implications of this study are limited by several factors. The sample sizes for the survey and site visits are small, though this is naturally limited by the number of total UIHOs in operation. It is possible that the UIHO sites that participated in this research differ in some systematic way when compared to those UIHOs that chose not to participate. That being said, UIHOs in this study were located across 12 different states, including all four different US

regions defined by the United States Census Bureau (n.d.). Furthermore, this study included UIHOs of each different type defined by IHS – outreach and referral, limited ambulatory, and full ambulatory (IHS, 2018). The numerical data on services offered are dependent on subjective answers from UIHO behavioral health directors and cannot be said to be necessarily representative of the services and practices at the sites surveyed; however, this is also the methodology used in the nationally available data from the N-MHSS (2010) to which these results were compared. The qualitative data analysis was intentionally designed to draw upon the observations of the first author during his time at each site. Qualitative analysis is generally not intended to be generalizable to a broader population, and although the analysis presented here provides one perspective on what is occurring across multiple UIHOs, it should not be taken to generalize to all UIHOs. Instead, this analysis is intended to provide a richer picture of what occurs at some UIHOs in order to paint a more complete picture of behavioral health care at some UIHO sites. It is hoped that despite these limitations, this deeper analysis can help researchers and funding agencies working with UIHOs in the future to consider a bigger picture of services, service providers, and needs at these sites.

Based on this research, it appears that UIHOs may be suitable partners for researchers interested in validating and adapting therapeutic approaches with AI clients. Because there is so little behavioral health research conducted with AI populations (Pomerville, Burrage, & Gone, 2016), it would be a valuable contribution for researchers to consider this as one avenue to adapt and validate interventions for an underserved population. However, it must be cautioned that this should be done with respect for and knowledge of the unique history of these populations' interface with healthcare as well as the importance of culture in contemporary AI therapeutic approaches. Furthermore, as documented in the qualitative analysis presented here, some sites

may be providing primarily substance use treatment or social services rather than therapeutic interventions for non-substance-abuse behavioral health disorders; researchers should consider how they can match the existing needs of these sites to best work in partnership with them. This is especially important given the history of university researchers studying (in ways that have sometimes felt exploitative to) AI peoples to produce academic knowledge (and to advance their careers) while providing little of value to the communities they study.



## **CHAPTER II**

### **Behavioral Health Services Offered at Urban Indian Health Organizations: A Thematic Analysis**

UIHOs, although representing just one percent of the IHS budget (IHS, 2020), are one of the primary sources of IHS care for the millions of AI people living in urban areas (Norris, Vines, & Hoffel, 2012). With an operating budget of 4.7 billion dollars, IHS is intended to provide care to federally-recognized AI tribal members (IHS, 2020). Approximately half of this budget, 2.4 billion dollars, goes to the direct provision of health, dental, and behavioral health services at mostly non-urban IHS facilities including IHS-run hospitals and health clinics located primarily on reservation lands; 82 million of this amount is for mental health specifically and 200 million is for substance abuse treatment (IHS, 2020). Another 900 million dollars goes to the purchase of care performed at non-IHS sites. The remainder of the budget covers preventive health, grants to tribes, scholarships for AI people seeking to enter the healthcare professions, building and maintenance costs, and approximately 45 million dollars designated explicitly for urban health care services.

According to IHS, the funds designated for urban health care services support 34 UIHOs that are designed to serve the medical needs of AI people with “culturally acceptable, accessible, affordable, accountable, and available health services to an underserved urban off-reservation

population” (IHS, 2019). However, 15 of these sites are Federally Qualified Health Centers (FQHCs), which also see non-AI clients as mandated by federal law (IHS, 2019). UIHO sites vary greatly in terms of care offered, with the plurality offering comprehensive health services, and an additional 40% offering limited health services; the remaining sites are “outreach and referral” sites which primarily serve to connect community members with other health services (IHS, 2009; Urban Indian Health Institute [UIHI], 2012).

Although a 2009 IHS report indicated that there was an increasing need for these services in more diverse locations and provided a list of 17 especially underserved regions, including four which the report claims had interested and capable parties to establish new sites at that time, no new IHS sites have been established in these regions and at least two sites have closed or lost their UIHO status in recent years. Yet, as identified by the 2009 IHS needs report (which is the last such IHS needs report documenting UIHO needs in this way), the existing UIHOs provide a vital support net for many who would otherwise be unable to receive services, with an emphasis on behavioral health services such as suicide prevention and substance abuse treatment. Even this report, however, provides little detail regarding the services that are offered, whether these services are based in any particular scientific evidence or established treatment model, or how treatment is or is not modified to be more relevant for AI people. This study was conducted to document the available behavioral health services at these sites in order to more clearly establish what services are and are not available in these seemingly underfunded yet vital health care centers.

When considering behavioral health treatment at a site treating a significant number of AI clients, it is important to understand the role of AI cultural practices and teachings in many contemporary therapies designed for this population. Cultural practices and teachings derived

from AI cultural heritage often figure in behavioral health treatments that have been tailored for AI populations. Adapted AI cultural practices, symbols, or values are often employed as a form of appropriate cultural tailoring, incorporated within more common psychotherapeutic practices like trauma-focused cognitive behavioral therapy (e.g. Bigfoot & Schmidt, 2011), but in some cases cultural practices may themselves be the primary form of treatment being employed (Gone & Calf Looking, 2015; Rowan et al., 2014). Practices that emphasize AI culture as treatment in itself and incorporate AI ceremony or traditional AI healers may be described using the term “traditional healing”. Many common AI traditional cultural practices used in behavioral health settings, such as the sweat lodge and the medicine wheel, are pan-Indigenous and draw from multiple AI traditions rather than referencing a specific tribal practice (Coggins, 1990; Dapice, 2006; Garrett et al., 2011). Pan-indigenous practices may be especially relevant for traditional healing in UIHO settings, as the urban setting inevitably leads to these sites serving AIs from multiple traditions and differing backgrounds.

Current research into behavioral health treatment at UIHOs has been limited, but some previous work exists to ground the inquiries of this study. For example, multiple investigations have documented the use of traditional AI healing methods at UIHO sites and client interest in these practices. For just one example, Moghaddam, Momper, & Fong (2015) noted in an examination of one UIHO site that traditional AI healing played a central role in how behavioral health services were conceptualized at this site, and that clients had a significant interest in these practices as part of their behavioral health treatment and wanted the existing programs expanded. Other researchers have noted a gulf between genuine traditional AI practices and those commonly incorporated into therapy in an investigation of at least one site (Hartmann, Gone, & Saint Arnault, 2020). This work suggested that although clinicians at that UIHO site expressed

interest and ideological commitment to broader ideas of AI culture as a form of healing, the observed services that were offered were typical psychotherapeutic services; in the researcher's words, these were "high quality clinical practices and processes with added, pliable symbols of Indigeneity (Hartmann et al., 2020, p. 178). The therapists were non-AI community members with only limited training in AI culture, and utilized primarily traditional psychotherapeutic practices to which traditional AI terms and worldviews had been applied as a form of culturally appropriate tailoring. Considering these studies together, it is clear that any attempt to survey the types of treatments available at UIHOs is incomplete without also investigating in depth any traditional healing practices utilized as part of or incorporated within behavioral health treatment. This desire for a deeper understanding of how traditional healing is being utilized is one reason for using semi-structured interviews in this study rather than faster survey methods.

Other research in the area of behavioral health at UIHOs specifically has suggested a wide range in terms of what different UIHO sites are able to offer. Pomerville & Gone (2018) documented that in many areas, UIHOs appear to operate similarly to national outpatient clinics (as defined by SAMHSA), at least on measures designed to assess available behavioral health treatments. Beyond this, the study documented traditional healing practices being employed in some manner across all surveyed UIHO sites. Although Pomerville & Gone (2018) documented some basic statistics regarding availability of different treatments at 11 UIHOs, this report did not indicate how widely these treatment methodologies are used, and the surveys used in this study did not ask about many common therapeutic modalities such as psychodynamic psychotherapy or motivational interviewing. Another study looking at three UIHO sites found that therapists at these sites were less likely than national averages to use cognitive behavioral therapy, even among those who identified themselves as having a cognitive behavioral

orientation (Beitel et al., 2018). This may reflect a cultural preference for other approaches to therapy among AI clients, as has been suggested in some research with other AI populations (e.g. Fiferman, 1990; Jackson, Schmutzer, Wenzel, & Tyler, 2006; Villanueva, Tonigan, & Miller, 2007). However, the authors in Beitel et al. (2018) were unable to rule out that there may be other explanations for their results besides the client population served, such as the therapists' own training. One goal of the present study is to answer some of these questions regarding how commonly different therapeutic approaches are employed, as well as the reasons for utilizing particular therapeutic approaches at these sites.

### **This Study**

The goal of this study was to better understand what services are available at UIHOs and how funding or other resources are being used to support these services. Because the research that has been done in this area is so limited, the initial response to this question is largely descriptive. However, answering this may also shed light on why specific approaches are adopted by clinicians at these sites, providing insight into both theoretical and practical explanations for the services UIHO offer. This research question is in part driven by previous research in Pomerville & Gone (2018), which established that many UIHOs claim to offer an array of behavioral health services. Given what is known about funding challenges in these areas and the lack of research on both UIHOs and also AI people as therapy clients, this study is an attempt to more clearly establish the degree to which behavioral health services are offered, what kinds of services are offered, and how they are paid for. Thematic analysis was employed to analyze interviews conducted with Behavioral Health Directors at ten UIHOs. Using what Braun & Clarke (2006) call a theory-driven approach, this analysis focused on only the portion of this

data which can answer the research question: what services are currently available at UIHOs, and what resources are used to be able to offer these services?

## **Method**

### **Participants**

Data collection for this study involved soliciting all 34 UIHO sites to participate in interviews regarding their sites.

Ten directors agreed to participate in interviews for this study. Eight directors were men, two directors were women. Four directors identified as AI, Six directors identified as non-AI. Five directors had a doctorate in a field related to behavioral health (PhD or PsyD), with the other five having master's or other postbaccalaureate licensure in behavioral health. The UIHO sites that these ten directors worked for were spread across nine states and included all four regions of the United States defined by the US Census Bureau (n.d.).

### **Measure**

A semi-structured interview was the only measure in this study. Semi-structured interviews are a commonly used form of data collection in which researchers design a predetermined set of questions, or interview schedule, and follow up on responses to these initial questions with unscripted follow-up questions designed to clarify answers and gain a better understanding of participant perspectives (Kallio, Pietilä, Johnson, & Kangasniemi, 2016). The interview schedule for this study can be seen in the Appendix.

### **Procedure**

Data collection began October 17th, 2014, and ended May 25th, 2018. All UIHOs were contacted by phone to solicit the participation of each site's Behavioral Health Director in a semi-structured interview. The protocol for this project was approved as exempt from

Institutional Review Board (IRB) oversight by the University of Michigan IRB Health Sciences and Behavioral Sciences Office.

After receiving affirmative consent for their participation in this research and the recording of their voices for use in later transcription, all directors were interviewed following the interview schedule that had been developed, along with follow-up questions as described above. Eight of these interviews were conducted via Bluejeans, a software for video calling. Two interviews were conducted in person. All interviews were recorded. Interviews ranged from 36 to 58 minutes. All recordings were transcribed via a transcription service, and all transcripts were then checked for fidelity to the recordings by the researcher and corrected as necessary.

### **Thematic Analysis**

Transcriptions of the ten interviews were subject to a thematic analysis, using a methodology laid out in Braun & Clarke (2006). Braun & Clarke (2006) also includes a 15-point checklist of criteria for good thematic analysis; the researcher's effort to meet these standards is described below alongside the different parts of the procedure where these were carried out. Each criterion can be read in Table 6; the descriptions of criteria in this table are taken directly from Braun & Clarke (2006).

This analysis was "theory driven" (Braun & Clarke, 2006, p. 88), informed by preconceived notions of the researcher regarding this topic. Only relevant data were coded and included in this analysis; any portion of the transcripts that did not bear on the research question was disregarded and not coded. Research is inherently a constructive process, and this and other decisions were informed by a constructivist perspective on the part of the researcher. Further, the researcher is a white non-Hispanic gay man. At the time of this work, the researcher was a psychology doctoral candidate in a clinical science oriented training program, with previous

published work in the areas of general psychotherapy research and also American Indian behavioral health treatment. This statement of positionality grounds readers in an understanding of the researcher's perspective and also to fulfill Braun & Clarke (2006)'s Criterion 12 for good thematic analysis. This approach to analysis is also in keeping with Braun & Clarke (2006)'s emphasis on the researcher as an active participant in research in their Criterion 15 for good thematic analysis. A detailed description of the analytical process used in this study as well as commentary on theory follows, in keeping with Braun & Clarke (2006)'s checklist Criterion 13 for good thematic analysis. The six-phase methodology proceeded as follows (the names of all phases are taken directly from Braun & Clarke [2006]):

***Phase One: Familiarizing Yourself with the Data***

Interviews were conducted by the researcher, and then transcribed by a second party. These transcripts were then read through by the researcher. All original audio files were listened to by the researcher while simultaneously conducting a complete and careful reading of the existing transcripts. During this phase, notes were taken by the researcher on initial impressions of the material. This step, in addition to providing an opportunity to take initial notes on impressions as recommended by Braun & Clarke (2006), served as an additional check on the fidelity of the transcripts to the original data. This also fulfills Criterion 1 of Braun & Clarke (2006)'s checklist for good thematic analysis.

***Phase Two: Generating Initial Codes***

For the second phase and onward, the qualitative analysis software program NVivo was employed to assist with analysis. The transcripts refined in Phase Two were loaded into NVivo, and each transcript was individually read through to extract short sentences or sentence fragments that summarize and thus reduce the larger set of data. These short sentences or



sentence fragments are called codes (sometimes called meaning units in other forms of analysis). The codes served as the basic unit of analysis for the following steps of analysis, and were based in part in the initial impressions formed in Phase 1 of the analysis. Because this is a “theory-driven” analysis focused on a specific research question as described above, material in the interviews that was not directly relevant to this research question was not coded. All data were given equal attention in the process (Criterion 2 for good thematic analysis); interviews had between 28 and 53 codes generated for each, and the differences in this range largely reflected the extent to which directors discussed the specific topic at hand. This stage condensed the direct words of participants into a set of more discrete and manageable data points while staying true to the original meanings expressed by participants.

### ***Phase Three: Searching for Themes***

After a complete set of codes across the entire data set was created, the codes generated from different participants were compared to one another in order to locate similarities in responses. During this stage of analysis, potential thematic maps, driven by the grouping of the codes into themes and sub-themes, were created to understand how the data comes together to a coherent whole, and to test different conceptualizations against the data itself to determine how well each conceptualization fit. Themes were generated by slowly reviewing the whole of the data and seeking matches between multiple participants, avoiding the use of vivid anecdotal narratives to create themes, in keeping with Braun & Clarke (2006)’s Criterion 3 for good thematic analysis. Themes are intended to go beyond merely restating the data in the codes, but to analyze what they may be construed to say about the larger research question; this analytical process that goes beyond restating the codes aligns with Criterion 7 of Braun & Clarke (2006)’s checklist for good thematic analysis. At this stage, potential themes were checked to determine

that they created meaningful answers to the research question in this study; themes that answered the question too broadly to be useful were pared down to be more specific, while themes that were too idiosyncratic to specific situations or sites were either incorporated within larger themes or abandoned, with the codes making up these themes being matched to more appropriate and coherent themes within the dataset. All codes were checked against themes to ensure that all relevant codes were included in each theme, in keeping with Braun & Clarke (2006)'s Criterion 4 for good thematic analysis.

#### ***Phase Four: Reviewing Themes***

At this point in the analysis, both the codes and the candidate themes were reviewed. Reviewing the codes involved reading the original text extracts from the transcripts that comprise the codes under each theme, in order to ascertain that they were in fact similar even in the original data. Once this process confirmed that the themes were internally consistent in this manner, a further reading of the entire data set was undertaken. The purpose of this was to check that the existing themes are an accurate reflection of the data set and that the coding and theme creation process had not so abstracted the data as to make the conclusions from the data not clearly reflected within the original transcripts themselves. This in keeping with Braun & Clarke's Criterion 5 for good thematic analysis.

At this stage, the themes were also analyzed for internal homogeneity and external heterogeneity (Patton, 1990, as cited in Braun & Clarke, 2006). In other words, the candidate themes generated in Phase Three were examined in terms of the codes which comprise them; the codes making up a theme should be similar to one another (internally homogenous) and the different themes should be comprised of different sets of codes rather than overlapping

(externally heterogeneous). This process is in keeping with Braun & Clarke (2006)'s Criterion 6 for good thematic analysis.

#### ***Phase Five: Defining and Naming Themes***

In order to accurately reflect the essence of each theme, each theme was clarified and named as accurately as possible, creating a title for each that appears in the results reported below. Beyond naming the themes, a detailed analysis of each theme was written to help further clarify what is interesting or noteworthy about it.

#### ***Phase Six: Producing the Report***

The final report includes detailed descriptions of the themes as well as data extracts (i.e. quotes), which help demonstrate and contextualize each of the themes, as part of fulfilling Criterion 8 of Braun & Clarke (2006)'s checklist for good thematic analysis. These quotes omit the self-identified ethnicity of participants intentionally to protect their anonymity, given that the total number of behavioral health directors at UIHOs could make them too easily identifiable if additional information were provided. The work was intended to mix both an analytical narrative and extracts in balance (Criterion 10) while telling a well-organized story about the data (Criterion 9). This analysis was carried out over a five month period and each phase engaged in fully as described here, reflecting Braun & Clarke's Criterion 11 that enough time should be allotted to such an analysis and steps should not be rushed through or done lightly. In keeping with Criterion 14 of Braun & Clarke (2006)'s checklist for good thematic analysis, this report should reflect the explicitly constructivist epistemological position of the researcher. The language is intended to reflect that these conclusions are based in this particular researcher's perspective on the data, and that the directors' expressed views in the interviews reflect an

outward telling of a personal narrative as opposed to an objective truth. The product of this sixth phase is seen below as the results section.

## **Results**

The final thematic map included two top-level themes in the responses, each with four subthemes. Although it was not the intention to discretely answer the two portions of the research question, the two major themes that were created did roughly correspond to two halves of the research question (i.e. “what services are UIHOs able to offer” and “what resources are used to be able to offer those resources”). Figure 1 provides a visualization of the final thematic map. The themes and subthemes are described below with examples.

### **UIHO Behavioral Health Departments Provide an Umbrella of Services to meet Goals**

This theme includes response from all directors, who expressed that their behavioral health departments offered a wide array of services, many going beyond those typically thought of as behavioral health treatments. This umbrella of services and care reflected the broad missions of UIHOs generally and of behavioral health departments within them. Although discrete mental health treatment for specific conditions was a significant portion of this profile of services, such treatment was only a portion of the total picture. Other services offered under the behavioral health umbrella included traditional healing practices, AI cultural education, direct social services and case management, and preventive behavioral healthcare.

### ***Mental Health Therapeutic Services Are Available but Staffing Places Limits on Capacity and Available Treatment Types***

All directors described mental health therapeutic services as being available in some form. Only one director mentioned not generally offering individual psychotherapeutic treatment, instead offering primarily group therapies, but even at this site individual

psychotherapy was made available on a case-by-case basis. A wide range of psychotherapeutic modalities were described across and within sites; cognitive-behavioral (7), client-centered (5), narrative (2), and psychodynamic (2) approaches were all mentioned by directors as treatments actively employed. Other specific approaches mentioned included dialectical behavioral therapy (DBT) (3), eye movement desensitization and reprogramming (EMDR) (2), art therapy (2), and hypnosis (1). Directors generally described offering these specific therapeutic services not as part of an intentional plan for serving the community but rather as a reflection of the training and experience of clinicians on-site. At five sites, interns, volunteers, and/or paraprofessionals filled psychotherapeutic roles, rather than fully licensed clinicians. One director described these workers as “filling in the gaps” due to a lack of funding for hiring licensed clinicians, while two others framed the use of these workers as an intentional part of their UIHO’s mission and described their site as in part a training clinic.

Two sites indicated that their profile of services includes individual teletherapy to provide services to those unable to travel to the physical location of the UIHO, and also to connect clients with therapists in other locations who may be a better fit for their needs than those available on-site. This was particularly important for sites located in regions with few or no other providers offering tailored therapy for AI clients; as described by directors, many clients were not themselves from the urban area but from the surrounding region and sought care at UIHOs as these were the closest option for culturally tailored healthcare.

### ***Cultural Education and Traditional Healing are Offered on a Limited Basis in and outside of Therapy***

Every director indicated that cultural education and traditional healing practices are employed as part of the site’s behavioral health goals, but there is considerable variation from

site-to-site. Sites varied in their usage of cultural practices. Cultural education and practices were described as being incorporated into therapeutic practices by seven directors, such as through the use of a medicine wheel treatment plan or smudging as a part of individual treatment. Six directors also mentioned cultural programming that is designed as a direct form of intervention, but occurs in a group setting; the most common example of this is red road/white bison, a program that incorporates traditional AI teaching and practices with twelve-step facilitation for prevention of and recovery from substance abuse. Six directors also described cultural education or activity programs that are not necessarily regarded as a form of behavioral health intervention, but that clients may be encouraged to attend for its benefits to their holistic wellbeing. Two directors said they emphasize to clients that they themselves are not spiritual teachers or traditional healers, and that they try to maintain a clear boundary in this regard.

Within individual psychotherapy, directors described a limited utilization of basic traditional healing or education practices; such as encouraging clinicians to smudge with clients, or provide education on traditional AI culture to clients as part of therapy. One director described clients connecting with AI culture as a primary goal of therapy: “with the clients that we have, we appreciate and it’s very gratifying when clients are able to find value in their culture (Participant 1).” This director indicated that he regarded it as one of the two things he looks for in client improvement, second to meeting their therapy goals and completing their treatment plan.

Traditional healing and education within the therapy room are limited in scope as described by these directors, who acknowledged that neither themselves nor their therapists are qualified to provide most forms of traditional healing. Instead, directors indicated traditional healing and education programs are largely separate from therapy. Five directors described the

selection of traditional healers or teachers and organization of these activities as a portion of their duties as directors of behavioral health. Seven directors mentioned cultural practices being directly sponsored by these UIHOs and regarded as internal. Seven directors indicated they refer clients to external sources for some or all traditional healing and cultural education needs. All directors fell into one of these two categories; in other words, all directors claimed to either have traditional practices available on-site at their UIHO, or to refer clients for such services elsewhere.

### ***Client Population and Department Mission Require Services Beyond Psychotherapy***

Seven directors mentioned ways in which practices beyond individual or group psychotherapy were a part of their work in behavioral health, outside of the specific area of traditional healing. The interview schedule was specifically designed around traditional psychotherapeutic services; it is possible these services would have also been mentioned at the other sites if directors had been asked more directly about this topic. These services include exercise programs (not physical therapy or movement-based therapy that might be cast as medical or psychotherapeutic), case management, numerous support groups, social engagement programs, and assistance connecting to community in ways that occur outside the therapy room. These programs were described as reflecting behavioral health department missions to treat client mental health in a holistic manner. They also reflect the difficult realities facing clients at many of these sites. As one director described: “I think maybe 20% of our population are homeless. They are usually underinsured. They don’t have a lot of formal education or just struggling to make ends meet (Participant 3).” Thus, client populations at these sites may have more urgent needs than mental health treatment, and these services may be prioritized. These

services may also reflect a desire to assist clients in remaining well after direct treatment for any psychological disorder has ended.

### ***Substance Abuse Treatment May Cut Across Behavioral Healthcare***

This subtheme includes responses from seven directors who directly mentioned how substance abuse treatment impacts their offered services. Directors mentioned utilizing co-occurring disorders models, harm reduction models, and the matrix model as examples of care that is offered in the area of substance abuse.. Three directors within this subtheme described substance abuse as a pervasive issue in the client population, indicating that it was present in nearly all clients seen. For these directors, substance abuse was seen as a pervasive issue that cut across all areas of treatment and served as the primary function of behavioral health at their UIHO. An example of the seriousness and extent to which this is the case was summarized by one director as follows: “You know I think if you were to look at our case files you would- I think you’d probably realistically be able to say that you know it’s 75 to 90% are co-occurring based to both mental health and substance use disorder (Participant 7).” Two directors saw recovery and wellbeing for clients primarily in terms of sobriety and recovery from substance abuse, emphasizing these measures over measures that might focus more on recovery from other psychological disorders. Other directors, however, made only passing mention of substance abuse treatments on-site, appearing to indicate a wide variation among these sites in terms of the amount of clients seen for substance abuse related issues.

### **Available Resources Bound UIHO Services and Can Risk Goal Displacement**

This theme is made up of four subthemes and includes responses from all directors. All directors described ways in which the resources that they had available to them bound the possible range of services that they were able to offer. Sites sought money and other resources



from all available funding sources including IHS and grants from other parts of the federal government, local government sources, and private sources. Because most of these grants are designed with specific purposes in mind, this shapes the available services. UIHOs may not be able to choose their own priorities directly but only be able to serve a particular portion of their community's needs. Given the general difficulties with funding for mental health and provider shortages nationally, these results may not be specific to UIHOs but reflect the general functioning of urban clinics. Respondents generally indicated that available resources were inadequate to provide the ideal range of services, although there was some variation among directors regarding the severity of this gap, and differences as well in what resources were necessary at the present time. Although financial concerns limited the ability at many sites to provide desired services, others faced resource scarcity problems that were not fundamentally financial. An example of this includes a lack of providers who were themselves AI; the majority of sites in this study had zero reported AI behavioral health clinicians, and even sites that had AI providers indicated a desire for more of them, as they could not meet current demand in this area. Respondents also indicated a similar shortage in the availability of prescribing providers.

The subthemes below that make up this major theme include more specifics on how funding defines services, and how some of these factors are idiosyncratic to UIHOs as AI-focused clinics while others may be more general to urban behavioral health care or behavioral health care in general.

### ***Behavioral Health at UIHOs depends on IHS Funding and Grants***

This category includes responses from all ten directors regarding sources of funding for their site. UIHOs are, by definition, funded in part via IHS, but this was not the sole funding source mentioned at any site. Grants were mentioned as sources of funding for services that are

peripheral to behavioral health but still under its purview, such as allowing sites to offer traditional healing or cultural education programs. In other cases, grants directly fund the hiring of clinicians or other staff to see clients and run therapeutic programming.

Additional sources of funding mentioned include gaining access to see clients on government assistance by becoming what is known as a Federally Qualified Health Center, or FQHC. Three directors interviewed indicated that their site either currently had this status or was seeking this status. While this can be a source of financial stability, federal law prohibits FQHCs from turning clients away based on race; as a result of this, these UIHOs serve significant percentages of non-AI clients. Speaking of the shift to being an FQHC, one director described it as follows: “But broadly, you know, we think of the community still more in terms of Native Americans or self-identified people who are living in an area who may need extra support because of, you know, historical injustices and disenfranchisements or people who have been relocated through forced programs or, you know, just people who may be in need of more support, but haven’t quite reached our doorstep yet, so we do a lot of outreach and think about that (community) as well (Participant 3).” Thus, according to this director, the site’s identity as an AI-oriented facility remains largely intact, with a through-line between the experiences of AI people and other non-AI historically and currently disadvantaged populations who currently use the site alongside AI clients.

### ***Availability of Providers Defines Client Population and Available Services***

Provider availability was mentioned a limiting factor for what types of services can be offered by all ten directors. In seven cases the issue was described as partially or entirely financial; either the site did not have any funding for a particular position, or the funding was too limited to hire someone with specific desired skilled or attributes. In five cases, a major reported

difficulty was filling funded positions due to shortages in providers. Five directors said they could not find adequate psychiatric service providers. Three directors also said they were not able to find enough providers who self-identified as AI to meet client demand: “Our clinicians, all of them have experience working with Native populations, however only one of them is Native themselves. And we've been trying to recruit, you know, doctoral level, either psychologists or clinicians, masters level, LPC’s, whatever, from Native populations. And it's just really challenging ... just because there are not that many people in the field. So sometimes we get- we'll get a request from someone who really wants to work with a Native person and we don't have a schedule available (Participant 5).”

In some cases an intentional decision is made to limit what types of clients will be seen, such as a site with a prescribing provider who chose not to see clients with substance abuse disorders as part of his practice, thus shaping what that UIHO was able to offer. In addition, the culture and attitude of a site may cause potential clients to not attend therapy or to seek alternative sources of healing. For example, one director (Participant 6) noted that their clinic is fundamentally grounded in “western” perspectives of healing and does not have staff who can offer traditional ceremony, and that AI clients who reject such approaches in favor of their own culture “just don’t show up at our door”. The director expanded further: “Yeah, I mean they have an understanding that they have some understanding of mental health issues and realize that there are evidence-based treatments for those issues ... I mean just like western medicine, I mean indigenous cultures use western medicine every day, you know. They realize that a ceremony might not cure cancer. And some believe that it will. And those are the people that aren’t gonna show up at our door and that’s fine (Participant 6).”

***Local and Site Specific Factors Limit the Availability of Traditional Healing Practices***

Six directors reported some way that the availability of traditional healing was limited due to local factors. These factors included a lack of physical space to hold ceremonies requiring it, such as sweat lodge; a lack of trustworthy or reliable local traditional healers; and difficulty with providing traditional healing relevant to the large and diverse population of native traditions that UIHOs serve. Three directors in this subtheme described programming based in traditional values and practices of specific AI groups or regions had been developed and was utilized. This programming was not necessarily aligned with the beliefs or cultural heritage of the AI clients on the site, however; for example, one director noted that their programming was developed based in ideas from tribal groups from a different part of the country. Other sites noted that it can be difficult to find legitimate traditional healers, as this director described: “So a lot of the people we try to make sure that they’re not, you know selling ceremony- and it’s a very hard line to walk because we would like to provide them with a gift for their service which is usually what we try to do. But the other big problem has been is making sure that what they’re teaching is legitimate ... And really that’s one of the reasons why we haven’t done any sweats lately, because we haven’t been able to find someone who seems like they can really do it legitimately in a good way (Participant 10).”

***Space and Expectations Create Additional Limitations on Services Offered.***

Six directors mentioned ways in which either physical space or expectations from clients, therapists, and administrators may limit what therapeutic approaches can be offered. Physical space limitations included lacking rooms for group treatments, other limitations on office space, and lacking outdoor spaces to offer sweat lodge and other therapeutic or traditional practices that require some form of outdoor environment. Some examples of limitations based on expectations included expressed beliefs that younger clients at the site lack the necessary underlying skills to

engage in many interventions, and expectations from administrators that therapists should be separate from the local AI community for boundary reasons. One director at a site with no outdoor space or space for group treatments described these as limitations in meeting what clients would like to see for the site: “So yeah, we’ve heard from patients that they would like group space, they would like a garden, they would like a sweat lodge. So there’s a lot more I think we can offer with appropriate space and appropriate connection to traditional healers (Participant 9).” Another director described the lack of physical space and clinicians as barriers to providing support groups: “Support groups, I’d love to be able to offer, but I just don’t have the resources. I don’t have the space and I don’t have the staff. That’s the problem, but that I would definitely do that. We get people; they’re kind of ready to discharge from one-to-one treatment ... but if we had support groups we could ease them into the support groups with a nice clean sort of coordination of care, but we don’t offer it, so we have to refer it out while they’re not getting ... people that are familiar with traditional healing practices or maybe they’re not getting the quality of therapist at another place; they use a lot of interns to do these by the way, so it creates problems. So that’s a continuity-of-treatment kind of problem (Participant 2).” One director indicated that their UIHO were the only site in the local area dedicated to treatment of AI clients, despite thousands of AI people living in the region, creating challenges in which there were more potential clients interested in treatment at the site than the site could ever meet.

## **Discussion**

The results here have emphasized the available services UIHOs offered at the time of these interviews. Based on these findings it appears that UIHO behavioral health services were broad, encompassing numerous missions that exist at the periphery of behavioral health, outside of purely psychotherapeutic interactions and interventions as this study was originally intended

to document. An accurate accounting of behavioral health services at UIHOs must take into account not only the ways that their service is shaped by the sites' AI identities in the offering of cultural education and traditional healing, but also consider the full range of social services, case management, and community building offered under the umbrella of behavioral health.

Psychotherapy was, in general and according to these directors, offered by these UIHOs. In some cases, long wait lists and limited numbers of clinicians may create challenges for clients accessing these services. Teletherapy programs and purchase-of-care appears to be used at some sites to ameliorate these difficulties. Other sites do not have these limitations, but in these cases it may be that there is less demand for psychotherapy because they do not currently offer services for some major psychological disorders and the types of clients seen is limited.

Directors indicated that traditional healing practices and AI cultural education are offered in some form at every UIHO site contacted for this study, but the variation from place-to-place makes any further generalization difficult. If these reports are accurate, some UIHOs are partnered with numerous traditional healers, host on-site educational workshops, and have physical spaces for ceremonies such as sweat lodges to take place while others are limited to doing little more than smudging with individual clients and refer out to a limited set of local partners for any cultural needs their AI clients may have. Future investigations should bear in mind the significant reported variations between these sites.

At least according to these research findings, resource shortages are a serious barrier to the goals expressed by UIHO behavioral health directors. These shortages are not only financial, but include limitations of physical space, a lack of clinicians of specific types available for hire, and a lack traditional healers able to meet UIHO needs. Despite these shortcomings, each of these sites tries to offer an abundance of named psychotherapeutic practices and other

programming intended to improve the overall wellbeing of their clients. Many of these services are dependent on competitive, temporary grants that sites have been awarded. These grant programs allow new hires, new trainings, and new interventions or community programs to be offered to clients and are of course a boon to any site that receives them. They are, however, unreliable for long term service and staff planning. They also make it difficult to be definitive about the types of services offered in behavioral health at UIHOs for these same reasons.

These conclusions may provide the basis for future research into the topic of UIHO Behavioral Health Services, by providing a broad roadmap for the types of services currently offered and allowing for more direct questions in these areas to be asked. In particular, case management and social services provision were described as a significant portion of the caseload at these sites. This may reflect their status as urban clinics, or their location in low-income areas, or be due to UIHOs serving a generally lower income AI clientele who is reliant on IHS services in the absence of other health insurance.

Certain limitations constrain the interpretation of these findings. The nature of semi-structured interviews means that not all participants are asked precisely the same questions, and participant responses are also more variable than in closed-ended research (though this also has advantages, as it allowed for greater contextualization of the quantitative analysis above). For this reason, it is impossible to determine certain questions that might naturally spring out of this topic, such as how many sites use each treatment approach. Caution is urged in interpreting the counts of any therapeutic practices reported in these results; they reflect the number of directors who reported offering those treatments, but it cannot be said that the directors that did not mention them necessarily do not employ them. These responses are from directors of behavioral health at these ten UIHOs; their viewpoints may not reflect the experiences of clinicians or

clients at these sites regarding how services are offered. Furthermore, these results entirely dependent on the self report of said directors. Just as there may be discordance between a clinician's statements about what they do in therapy and what an observer of their sessions might report, it is reasonable to speculate that directors' narratives of behavioral health services might also diverge somewhat from a more direct observation or auditing of these services.

Assuming that these directors' reports accurately reflect the situation at UIHOs currently, there are several potential policy recommendations. Funding for UIHOs specifically earmarked for behavioral health could help to address many of the concerns expressed by directors here regarding the inability to find adequate numbers of providers. Support for existing and new programs like "Indians into Psychology" (IHS, 2014) could help address the lack of AI providers. Indians into Psychology is a funding program providing grants for undergraduate and graduate education to AI people pursuing degrees that will lead to a Ph.D. in clinical psychology; the program also requires recipients to complete a period of service following completion of their degree. Grants and funding packages that make it possible to pay traditional healers and others working to provide culturally relevant programming for AI clients as treatment and prevention for behavioral health concerns are another possible avenue to improve care, based on the responses of these directors.

This study provides a simple roadmap for future research with UIHOs. Future open-ended and qualitative analytical work might investigate in greater depth the specific uses of traditional healing, the role of UIHOs as social service providers and case managers, and analysis of sessions directly observed. There is also potential for future research to quantify much of the additional adjunctive services that occur at UIHOs, measure the extent to which these conclusions might accurately run across UIHOs, and consider how such data compares to other



urban health clinics in order to determine how much of this is specific to UIHO settings. Many important research questions remain to be answered. What do the cultural and educational programming components look like at different UIHO sites, and might there be some way of testing their impact? What additional services might best help this underserved population? How do the clients at UIHOs perceive these currently available services? More direct research partnerships with UIHOs may help develop other research questions that stakeholders feel bear more directly on their needs and concerns at this time.

## **CHAPTER III**

### **American Indian Behavioral Health Treatment Preferences as Perceived by Staff at Urban Indian Health Organizations**

AI identity in the United States is heavily associated with geographical ties to rural areas and reservation lands (Peroff & Wildcat, 2002). This concept of AI identity as a partial function of rural space is at odds with the reality that the majority of AI people live in urban areas today; in the last census, 78% of AIs indicated that they lived away from reservations or other rural areas (United States Census Bureau, 2010). Despite this population makeup, the only specific portion of the IH) budget set aside for urban or suburban AI people is the one percent of the IHS budget dedicated to UIHOs (IHS, 2020). This study is intended to document important details regarding the available behavioral health services in these organizations, as well as the experiences and perspectives of those who work at UIHOs in behavioral health.

The contemporary distribution of the AI population away from reservation lands and other rural areas is in part a result of post-World-War-II American federal policy; beginning in the late 1940's and continuing through the 1950's and 1960's, the Bureau of Indian Affairs (BIA) and other government agencies concerned with AI peoples created and maintained programs to relocate AIs to urban areas (Fixico, 1991). In understanding the contemporary situation of urban AIs, it is important to consider the outsized effects of this policy; in 1955, approximately 95% of the AI population lived on or near reservation lands; fifty years later, over 60% of AI people lived away from these lands (Duran, 2005). AI people and the federal

government today maintain a complex relationship in which the federal government shares partial responsibility for providing healthcare for members of federally-recognized tribes as a result of treaties and acts of Congress (Lillie-Blanton & Roubideaux, 2005). After the shift in the AI population from rural to urban environments, however, no shift in funding for AI federal services materialized. Although rural healthcare inequities could explain why IHS funding has not shifted with the population, research has demonstrated that urban AI people fare no better on numerous health measures than those living in reservation areas (Castor et al., 2006).

Despite the apparent imbalance in funding, IHS remains a vital lifeline for a vulnerable population. For example, Sequist, Cullen, & Acton (2011) credited the efforts of IHS for reducing rates of diabetes in the AI population and also reducing the inequity in the average age of death for AI people from eight years to five. Given the socioeconomic causes of many of these inequities, however, health services alone are unlikely to ever address the whole problem. Further, more recent research has suggested a reversal in some of these positive trends (Sequist, 2017; Stanley et al., 2017). Calls to address health inequities by designing interventions to target socioeconomic causes have been issued by the National Institutes of Health (NIH), but the extent to which the IHS (a separate part of the HHS from NIH) has room to utilize its budget to test such interventions is likely limited, requiring partnerships with researchers. This can present additional difficulties as researchers are sometimes viewed with skepticism among IHS practitioners and patients due to historical exploitation of AI people in psychological and other social science research (Yuan, Bartgis, & Demers, 2014).

Demands for standards of care based in the best scientific evidence have been growing across behavioral health treatment disciplines for the past two decades. Contemporary ideas of Evidence-Based Practice (EBP) are built on a “three-legged stool” model, emphasizing the best

available research matching disorders to empirically-supported treatments (ESTs), taking into account the client's characteristics and personal preferences (APA Task Force, 2006; Spring, 2007). Numerous critiques of this system have been made both in general and specifically in relation to AI clients, however. For one, clinicians generally do not employ evidence as intended even when they believe they are using ESTs (Stewart, Chambless, & Wiltsey Stirman, 2018). Another criticism is that a lack of research exists to employ empirically-supported treatments (ESTs) with populations around whom they were not designed, especially for AI clients with whom little research exists (see Pomerville, Burrage, & Gone, 2016, in particular for a review of the status of research into psychotherapy with AI people).

A further question raised in the settings of UIHOs is that client needs may not in themselves be a match for ESTs as often discussed in the context of psychotherapy research. ESTs are typically designed to match specific disorders with therapies that have proven effective for those disorders in clinical research. Behavioral healthcare in urban settings may require handling more basic needs (e.g. stable housing, employment, or medical care) or life challenges that are not diagnosable behavioral health disorders. Finally, both clinicians and clients are often resistant to ESTs for personal and cultural reasons, which has been specifically documented in the existing literature on therapy with AI people. Reasons for this include the lack of inclusion of AI people in treatment outcome research, and the exclusion of traditional healing and cultural practices from this research (Goodkind et al., 2011).

The use of ESTs in AI communities when they have not been tested with AI people has even been referred to as “another form of institutional racism” (Goodkind et al., 2011, p. 462). Many AI people prefer their own cultural traditions over what they view as “Western” approaches to mental health care and healing, thus creating challenges to designing intervention

research in which AI clients and the people who treat them are interested in participating (Yuan et al., 2014; Goodkind et al., 2011). Although there is of course a great deal of variation in client preferences among the millions of AI people, research to date has found interest in the incorporation of traditional healing among some portion of urban AI populations receiving care at UIHOs (Gone, Tuomi, & Fox, 2020; Hartmann & Gone, 2012; Hartmann, Gone, & St. Arnault, 2020), including among AI youth (Goodkind et al., 2011).

AI cultural practices and education are often discussed as a part of healing or treatment for behavioral health problems in the literature on AI clients (Gone, 2013). Traditional healing is a term for the incorporation of AI cultural practice in behavioral health treatment, including the use of ceremony and individual meetings with traditional healers who may provide individualized advice on cultural, spiritual, and personal matters (Duran 2006; Gone, 2009; Hartmann, Gone, & St. Arnault, 2020; Moghaddam, Momper, & Fong, 2013, 2015). These approaches are in part both a response and an attempt to heal the effects of colonization (Duran, 2006; Gone, *in press*). The term traditional healing may also be applied to simple practices such as smudging, a form of traditional cleansing that typically involves the burning of sage. Previous research has established that clients at UIHOs specifically are interested in and receiving these types of treatments to some extent (Gone, Tuomi, & Fox, 2020; Hartmann & Gone, 2012; Moghaddam, Momper, & Fong, 2015; Pomerville & Gone, 2018). Traditional healing can also be part of culture-as-treatment, the idea that engaging in AI culture can be a form of healing in itself for AI people (Gone & Calf Looking, 2011, 2015). Such approaches apply traditional knowledge, such as the use of the medicine wheel or programs of cultural education, to attempt to engage clients in their culture as a form of addressing historical traumas and providing holistic healing (Pomerville & Gone, 2019). Historical trauma is a term regularly employed in

therapeutic settings focused on AI clients, and refers to the intergenerational effects of colonization and maltreatment of AI peoples, often but not always with reference specifically to the negative impact of Indian boarding schools (Gone et al., 2019).

Previous searches of the literature have found few controlled outcome studies of therapeutic interventions for AI people regardless of urban or rural status. Gone & Alcántara (2007) found only two controlled outcome studies for AI people in a review of the literature, both of which were preventive in nature rather than being intended to treat current mental health concerns. More recently, in a systematic review, Pomerville, Burrage, & Gone (2016) found only four intervention outcome studies with adult AI clients that used inferential statistics to measure the effectiveness of a given treatment, none of which included a waitlist or control group. A 2020 systematic review on trauma interventions for AI clients found no new intervention research since 2016 (Gameon & Skewes, 2020).

Given what is known regarding the lack of available funding for UIHOs, the push for EBP in behavioral health, and the resistance to ESTs in some AI-specific behavioral healthcare, UIHO behavioral health may provide a window into the management of limited resources and research evidence in applied behavioral health care. This study attempts to answer the following research question: How do UIHOs manage any existing tensions between AI treatment preferences and contemporary demands for evidence-based approaches to behavioral health care, especially given the lack of evidence-based research with these populations?

## **Method**

### **Participants**

Participants for this study were UIHO staff at six UIHOs. Individual interviews of 28 UIHO staff across these six UIHOs were conducted in person during research site visits; focus

groups of staff members were also conducted during five of the six visits. The six UIHOs were located in five different states, none of which share a land border. The 28 interviewees were made up of: 20 behavioral health providers, three behavioral health administrators, three UIHO administrators, and two cultural advisors. Although these categories are listed separately, these only indicate the interviewee's self-identified primary role on site, and there is some overlap in roles; for example, all behavioral health directors interviewed were also licensed therapists of some type. Interviewees included 20 women and eight men. In terms of race or ethnicity, 14 participants identified as AI, 13 identified as non-AI, and 1 participant declined to state.

Focus groups included a total of 23 participants split across the five focus group interviews. Participants in the focus groups included 17 men and 6 women. By self-identified ethnicity, 8 identified as AI and 15 identified as non-AI. An accounting of the different participants by type and number of participants at each site for both interviews and focus groups can be seen in Table 7.

## **Measure**

A semi-structured interview procedure was used for all interviews in this study, including the focus groups. An interview schedule was used to guide all interviews (see Appendix). In a semi-structured interview, the interview schedule provides a guide for the interviewer to follow, while the interviewer is also allowed to ask other, follow-up questions not included in the interview schedule. This process allows the researcher flexibility to get expanded and in-depth responses on topics of interests while assuring some similarity across interviews via the interview schedule.

Although the same material was covered in focus group and individual interviews, focus groups were conducted and included here for their potential to provide other insights into the

topic at hand via group dynamics. Group dynamics permit participants to consider and discuss questions between themselves, often leading to different insights than they might have when questioned one-on-one (Luke & Goodrich, 2019). In the context of this study specifically, as subjectively observed by this researcher, the process of focus groups allowed staff to have discussions that at times covered a greater breadth of what treatment looked like in practice at a given UIHO as different participants reminded others of specific clients, events, or services that they then wanted to comment on. At the same time, individual interviews allowed participants to share negative or discordant comments from the rest of the staff that they may not have shared in focus groups for fear of social consequences . These two sources of information are considered together here in order to provide a more rounded picture of UIHO services.

### **Procedure**

As part of a larger research project, all 34 UIHO sites were contacted in order to solicit participation in a series of studies. Fifteen of these sites participated in previous research studies conducted online and over the phone, and were asked if they were interested in engaging in future research. Those sites that expressed interest were provided with information about a potential site visit by a researcher for in-person data collection. Six UIHO sites ultimately chose to participate in these site visits, and the data in this study was collected during these site visits. Data collection began in February of 2017, and ended in May of 2018.

To the extent possible, the researcher interviewed all available clinical staff members who provide behavioral health interventions to clients. Other relevant members of staff for interviewing were identified and made available by the director of behavioral health at each site. All participants received a written statement of consent to review, and were asked to affirm their consent if they wished to participate in the study. Following this consent process, all interviews



were conducted and voice recorded. This study was deemed exempt from Institutional Review Board (IRB) oversight by the University of Michigan IRB Health Sciences and Behavioral Sciences Office. Following the interviews, the recordings were transcribed by a transcription service. For this analysis, the transcripts from 28 interviews and five focus groups were analyzed.

### **Thematic Analysis**

Transcripts of the 28 interviews and five focus groups were subject to thematic analysis following the model of Braun & Clarke (2006). This qualitative analysis took place in six phases, as defined in Braun & Clarke (2006) and described below:

#### ***Phase One: Familiarizing Yourself with the Data***

All interviews and focus groups were conducted by the researcher, giving an initial familiarity with the data. These interviews were audio recorded, and an outside party was contracted to produce transcripts of all 33 files. After this, the first author listened to all files while simultaneously reading each transcript in order to correct any errors as well as to gain greater in-depth familiarity with the data.

#### ***Phase Two: Generating Initial Codes***

Code generation in this thematic analysis involved a careful reading of the transcripts to identify any statements by interviewees that touched upon the pre-defined research question. Data not relevant to the research question was not coded for this analysis, consistent with Braun & Clarke (2006)'s approach to theory-driven analysis. When these statements were identified, they were turned into "codes" by the first author; codes are brief summaries, generally one sentence or less, that elucidate the intended meaning of the interviewee. An example code from this study is: "We have a holistic approach to wellbeing to help address AI clients with doubts

about therapy”. Each of these codes were tagged with participant numbers to track different respondents across the dataset, and several hundred codes were produced for the analysis.

Braun & Clarke (2006) note that theory-driven approaches to thematic analysis are a best fit with constructivist approaches to scientific inquiry, which this researcher endorses. Decisions on what received attention during interviews and their coding reflects the narratives of both the participants and the researcher. This analysis and the results that follow should be understood as perspectives that reflect particular worldviews, as opposed to objectively observed truths about how services in UIHOs play out for real clients. Furthermore, the researcher’s own experiences may well inform the interpretation of this data. Specifically, the researcher is a white non-Hispanic gay man, who at the time of this research was a psychology doctoral candidate in a clinical science oriented training program.

### ***Phase Three: Searching for Themes***

After the entire data set had been subject to initial code generation, comparisons were made between the codes, particularly across different interviewees, to identify potential candidate themes that appeared to answer the research question and match to multiple interviewees’ reported experiences. Potential thematic maps were then created in order to group these different candidate themes together, and to consider how the data might broadly answer the research question for this study.

### ***Phase Four: Reviewing Themes***

Existing themes were analyzed for internal homogeneity and external heterogeneity in order to see how a potential thematic map might best fit the data in a clear way consistent with this form of data analysis (Patton, 1990, as cited in Braun & Clarke, 2006). Checking the codes at this stage also included reading the original transcripts they had been based in, in order to

verify that they matched accurately to the themes that had been created, and that they could accurately be said to reflect the broader themes they were a part of. Some initial categories were removed from the data, and others were subsumed into larger themes. For example, initial impressions included a theme for rejection of AI cultural practice, and another for rejection of ESTs. These ideas were combined into a single theme reflecting this idea of rejection of either ESTs or AI culture.

#### ***Phase Five: Defining and Naming Themes***

Once a final check on themes was conducted against the original data in phase four and the thematic map had been finalized, an additional stage of considering the accuracy of the names was conducted, and final names for each were generated, as presented in the final report here. For example, the previously mentioned category of rejection was changed to “Clashes May Reflect Rejections or Perceived Flaws of Either the Culture of Behavioral Health or AI Culture”, as this appeared to more accurately reflect the codes under this theme, which included challenges to some prevailing ideas about one of these two cultures that could not be termed outright rejection.

#### ***Phase Six: Producing the Report***

This final stage reflects the writing of a final report of the data, as presented here. As was done during other phases, the descriptions in the final report were checked against the original data to be sure that this report accurately reflects statements expressed by the interviewees in this study. Furthermore, representative quotes from the original transcripts were selected for each theme and are presented in the results along with the themes that they helped to inform and define. Except when necessary to illustrate a point within the quote, participant identities with

respect to their more specific roles at their UIHO as well as their self-identified ethnicity have been intentionally omitted in order to protect the anonymity of these participants.

Throughout this analytical process, the researcher drew from and attempted to faithfully utilize thematic analysis as described by Braun & Clarke (2006). Based on their 15-point checklist of criteria for good thematic analysis, this work aligns with those standards on all points but one. Criterion 2 of their checklist is “each data item has been given equal attention in the coding process” (Braun & Clarke, 2006, p. 96). Some participants in this study were administrators and cultural advisors with either limited or no experience providing psychotherapy to clients. All transcripts were read through in their entirety during coding and coded for any material relevant to the research, and all 33 transcripts contributed to the final thematic map; however, analytic emphasis was placed on participant commentary regarding providing or overseeing behavioral healthcare for AI people.

## **Results**

The final thematic map is presented in Figure 1, including counts of how many interviews and focus groups each theme contains. The final thematic map includes one overarching theme: *Client-Centered Understandings of Individual Preferences Ground Therapeutic Treatment Decisions*. Psychotherapists and other staff members emphasized across these interviews that the clients’ lead must be taken, and this ran across all understandings of how AI treatment preferences interacted with contemporary psychotherapeutic practices. Two themes comprise this overarching theme. The first theme was that *The Intersection of Client Preference with the Evidence Base is Managed through Clinician’s Conceptions of Compatibility*. The second theme was that *AI Cultural Practices Are Incorporated as Part of a Broader Understanding of Behavioral Health and Healing*. These two themes are described

below in detail, along with the six subthemes within them. Quotes from the interviews are included to illustrate ideas presented in these subthemes; these include a site number and the role of the speaker.

The overarching theme of these results, *Client-Centered Understandings of Individual Preferences Ground Therapeutic Treatment Decisions*, includes all 28 respondents and all five focus groups. Across every theme and subtheme, and in every interview, participants emphasized the importance of client preferences, perspectives, and goals. Participants warned against reducing AI clients or any other client populations to a single monolithic group or stereotype. At one UIHO with a large number of available treatment approaches tailored for AI people, one participant summarized how an initial session might proceed after describing these options to a new client: “Usually then I would ask them, what modalities are you interested? This is all I have, some have groups, individual, blah, blah, blah. You know, what are you interested and where do you want to go? ... We’ll meet for the next time and we can you know, think about it. Or my homework is to give them that list. They can go home read the information, see what they’re interested ... maybe if you don’t know right now, maybe in-between, just go attend one, see how it goes. Because sometimes I could describe things here, but when you go you’re like wow, I really like this. Or wow, I don’t like it at all (Site 5, Substance Abuse Counselor).” The importance of the client’s preferences runs through the responses that make up the themes and subthemes below.

**First Theme: The Intersection of Client Preference with the Evidence Base is Managed through Clinician’s Conceptions of Compatibility**

This theme includes respondents from all six sites. Responses from 27 respondents and all five focus groups are included in this theme. According to these respondents, clinicians make

individual decisions regarding whether a tension exists between a particular client's preference for any AI-tailored treatments and the treatment that the evidence base might suggest is most effective for a client's condition. Although some participants described personal ideological commitments with regards to evidence-based practices and/or AI culture-as-treatment, even these participants acknowledged the role of the client in decision making about their own care and the importance of personal preference in determining what treatments to provide. Within each subtheme below, participants described the importance of considering the individual client in making any treatment decision, and the risks of reducing clients to cultural stereotypes if this was not done. The subthemes below summarize different approaches, experiences, and orientations that participants expressed as reflecting any perceived tensions between evidence-based behavioral health approaches and AI client treatment preferences.

***Subtheme 1: Conscious Tailoring of Behavioral Health Practices Blends them with AI Cultural Elements to Reflect Treatment Preferences or Perceived Needs***

This subtheme includes respondents from all six sites. Responses from 21 respondents and all five focus groups are included in this subtheme. Respondents across sites described ways in which evidence-based approaches to behavioral health were consciously blended or tailored as part of the approach to meeting a client's or population's needs. Participants described utilizing tailored approaches to evidence-based standards of practice, sometimes relying on models of tailoring that previously existed and have been published on (e.g. Bigfoot & Schmidt, 2010). Another example is treatment plans that had been specifically designed to incorporate AI teachings; two sites had developed their own such treatment plans, incorporating the medicine wheel or other models of pan-indigenous AI cultural values. Published academic literature was cited by nine participants as a source of information on how to culturally tailor or adjust

programming to meet perceived AI client preferences. Other sources of information included other UIHO staff members, personal experience, trainings held by traditional healers, trainings by mental health professionals, and web searches. Respondents indicated it was important to assess the degree to which it is appropriate or desired to blend these approaches in each client's case, depending on an assessment of their acculturation and expressed interest in their culture.

Participants noted several reasons for choosing to apply tailored or blended approaches to providing psychotherapy. The perceived importance of addressing cultural loss and historical trauma in these populations, the value of improving cultural connections in improving overall wellbeing, and the perceived positive impact of having an AI identity, were all commonly cited as to why these services are offered. One participant described doing bead work as a way of replicating traditional culture while engaging in a safe healing process in discussing trauma: "And what I love about that, I love when our people participate in making whether it's a quilt or moccasins, is that we do that in the context of like behavioral health groups. So when it might be difficult for me to like look at you face-to-face and tell you what my experience was being raped. If I'm working on a bead work project and I can look at the project, then I can still talk about what I'm doing, but I can be engaged in something else and I don't have to make direct eye contact with you and I can communicate with my sisters. And it's also a way of replicating, you know, traditional ways that women would work and women would share information (Site 1, Administrator)."

Participants also noted that cultural tailoring can help keep clients interested in coming for therapy, and that it can help clients feel comfortable discussing sensitive personal topics. Two respondents noted that this comfort allowed clients to share experiences of having visual hallucinations common to their culture, which are often interpreted as psychosis by clinicians

unfamiliar with AI cultures: “I had worked with a client like for about a year before like she shared some, like, I guess what would be seen as like some sort of hallucination. But which she shared where it’s like very commonplace in her like, in her tribe and her culture. And so, but even like in her talking about like her hesitancy to share that, and in ways that had been like misunderstood in the past ... people are hesitant to share those things” (Site 2, Social Worker). Demonstrations of comfort and knowledge with AI culture via cultural tailoring can make the sharing of this kind of material between client and therapist more likely, according to these respondents.

***Subtheme 2: Clashes May Reflect Rejections or Perceived Flaws of Either the Culture of Behavioral Health or AI Culture***

This subtheme includes responses from all six sites. Responses from 21 respondents and four focus groups are included in this subtheme. This subtheme consists of responses that indicated there was some difficulty in bridging any existing gap between client preferences and contemporary behavioral health treatment. These difficulties as reported were a result of someone involved rejecting or seeing flaws with ways of thinking either in behavioral health culture and practice or in elements of AI culture. Some responses indicated direct rejection of other perspectives. Eight participants described some AI community members and clients as directly challenging evidence-based practices and saying it is not relevant to them, because those therapies were not specifically tested on AI people or on their specific tribal group. For another example, participants at two sites said they had difficulty running two-spirit groups for AI clients who identify as Lesbian, Gay, Bisexual, or Transgender (LGBT). The specific difficulty in both cases was that some clients at these sites rejected the inclusivity of such groups because these clients did not believe that LGBT people have a role in AI culture. Past researchers have also



noted the specific role of colonization on this dynamic in AI culture more broadly: prior to European influence, many AI cultures viewed gender and sexuality in more fluid and socially constructed terms, and more rigid understandings of these topics in many AI communities today reflect the effects of European Christian cultural norms on AI culture as it exists today (Nebelkopf & Penagos, 2005). Respondents at one UIHO reported some Christian AI clients rejecting AI spiritual practices as non-Christian and therefore unacceptable to them and even sacrilegious.

Staff members themselves in some cases also expressed views that rejected either some current evidence-based approaches to behavioral health treatment, or parts of AI culture or particular approaches to AI-tailored behavioral health treatment. Three participants suggested that emphasis on historical trauma can be used to paper over a client's personal struggle to address their behavioral issues, as is expressed by an administrator at one UIHO here: "That is to say, working with American Indians we want to, we, a bunch of us, want to go straight back to, 'It was the white man who caused all of this.' To say that's what we see as historical trauma, but as well the workers are looking for that to be addressed. Not that I have a problem that I drink too much and I get put in jail too much or too often, therefore I've got some problems. So we justify that behavior by saying, oh yeah you learned that from 1870. No, no, no, come on, certainly people who lived in 1870 had that problem ... goodness, I'm a modern person. I live in [a city]" (Site 2, Administrator).

Seven participants noted that certain evidence-based approaches such as CBT and DBT are too rigid and demand too much from low-income clients in particular who may not be familiar with setting goals and measuring them. Further, one of these seven participants noted that what was called cultural tailoring to evidence-based practices did not actually incorporate

anything meaningful from AI culture: “Well so we don't always stick with the, (short laugh) the curriculum because it doesn't, it's not always useful or specifically tailored for native clients. ... there is a version that has been tailored, well says it's been tailored. Typically which is something that I've seen is that just the graphics and the pictures are different but the actual material is exactly the same (Site 6, Health Worker).” Six Participants at four different UIHOs mentioned that the lack of legitimate traditional healers in their local area, as well as the lack of a budget for their UIHO to pay these healers, created a barrier to providing the treatment or care that they wished to be able to provide to their clients.

***Subtheme 3: Cultural Treatment Preferences May be Met Outside of Therapy in Alternative Settings***

This subtheme includes respondents from all six sites. Responses from 21 respondents and two focus groups are included in this subtheme. Participants at four sites described relatively robust networks of cultural practice and education that clients could utilize outside of therapy, and were often directly encouraged to use as part of their treatment. These services were generally cast as therapeutic and may happen on-site at the UIHO, but did not involve the same clinician providing direct services to the client. Participants described numerous cultural groups offered on-site as supplements to therapy for those clients interested in having culture be part of their therapy. One participant mentioned referring clients to traditional healers to discuss traditional medicines, specifically for clients that are not interested in receiving medication for their behavioral health conditions. Behavioral health treatment in these areas diverges from evidence-based models of care that emphasize specific interventions. Instead, clients receive cultural education and practices from traditional healers and other community members, and chances to engage in cultural events.

These practices are described as healing as part of a philosophy that engagement with AI culture can in itself be a healing process (through physical, psychological, social, and spiritual means). Numerous examples were given by participants, including the making of tobacco ties, the holding of AI gatherings, the construction of miniature longhouses, pipe ceremonies, water ceremonies, sweat lodges, and instruction in traditional dance. The incorporation of these practices into behavioral health treatment models reflects a belief that re-engagement with AI culture can be healing for AI people, but was also cast by participants as a way to keep clients engaged in therapy and returning to the UIHO for services. One participant indicated these practices were the primary reason some AI clients come to their UIHO: “I mean, it's, you know, I would say 90% of the time people are looking to connect with ceremony. That's why we have a big turnout for a water walk or the [Gathering of Native Americans] that we do or any community events, especially when there's going to be some kind of cultural teaching or a cultural - someone that comes in that's got a lot of cultural teachings. We have staff that have a lot of cultural knowledge, but you know there's something about when somebody new comes in and somebody that speaks their language, it's really important to people that have been disconnected. So, it's empowering (Site 4, Social Worker).”

#### ***Subtheme 4: Cultural Treatment Preferences are Overlapping with Contemporary***

##### ***Psychotherapeutic Practice***

This subtheme includes respondents from all six sites. Responses from 13 respondents and four focus groups are included in this subtheme. Participants described significant overlap between the scientific evidence base for behavioral health treatments and the treatment preferences of AI clients. Participants indicated that treatment preferences do not necessarily follow lines of race and ethnicity. Instead, client preference was perceived as having a basis in

personal experience and, according to two respondents, age (with older clients being more likely to be interested in including AI cultural practice in their treatment). The urban environment and the resulting level of acculturation among AI clients seen at UIHOs were mentioned as factors that may cause clients at UIHOs to be less interested in culturally-tailored therapeutic approaches.

Participants included in this subtheme also generally indicated that there was an overlap between elements of AI cultural practices or values and more typical approaches in behavioral health, allowing these to be merged seamlessly. Trauma-informed care, holistic approaches, family systems therapy, liberation psychology, motivational interviewing, and client-centered therapy were all mentioned by different participants as examples of behavioral health theories or practices that mapped onto AI values or cultural practice. For example, one respondent described the discipline of social work's values as meshing with ideas of AI culture that she had learned in cultural trainings held at that UIHO: "Also, you know I feel that being a social worker you're kind of trained to like see people as very holistic beings incorporating their spirituality and their culture or their history along with all the other things. So I think that kind of more relational worldview really meshes well with the social work philosophy in general (Site 3, Social Worker)." Thus, according to this sample of participants, work with many AI clients at UIHOs does not involve any significant tailoring. This can either be because clients are not interested in culturally-tailored interventions, or because the clinician does not feel tailoring is necessary to make a practice fit with a client's worldview or cultural values that the client wishes to incorporate as part of their treatment preference. In the latter case, however, it may be that certain psychotherapeutic approaches were being chosen over others because of this perceived pre-existing fit.

## **Second Theme: AI Cultural Practices are Incorporated as Part of a Broader Understanding of Behavioral Health and Healing**

This theme includes respondents from all six sites. Responses from 20 respondents and 4 focus groups are included in this theme. Participants generally described their views of client improvement in holistic terms, taking into account a range of client needs beyond treatment for substance abuse or psychological disorders. In particular, AI client desires for community connection and cultural engagement were said to be common and the need to meet them was described by participants as an important part of healing. Efforts to meet this need in psychotherapy were described primarily in terms of psychoeducation. Participants described regularly referring clients to cultural activities held both at their UIHO and elsewhere in the community as a primary way of assisting clients to meet this need.

### ***Subtheme 1: Clients are Referred to AI Cultural Connections to Meet Life Goals***

This subtheme includes respondents from all six sites. Responses from 16 respondents and four focus groups are included in this subtheme. Participants described referring clients to community members, events, and ceremonies on a regular basis, as relevant to the client based on their level of interest in such activities. Four UIHOs in this study had on-site cultural centers and acted as community centers in their own right; in these cases it was common for participants to mention referring clients to these resources, but participants at all sites still described referring clients to outside sources to meet any expressed cultural need or interest. Educational programming, traditional forms of crafting such as beading, sweat lodges, talking circles, and pow wows were all mentioned as events clients have been referred to, in addition to referring clients to individual meetings with traditional healers.

Nine participants expressed difficulty with finding appropriate references to meet their clients' desires for cultural connections. Reasons for not being able to find references included a lack of respected traditional healers in a given area, the existing traditional healers being too busy or unavailable at certain times to meet with clients individually, a lack of finances (some traditional healers charge for their services and many clinicians described their client population as very poor), a lack of outdoor space for certain ceremonies such as a sweat lodge to be performed, and a lack of local community events for AI people more generally.

Efforts to connect clients with cultural and community events was, in part, a way of meeting client needs and serving their broader wellbeing, even if not attempting to specifically address a mental health problem. The impact of connections with community and culture on wellbeing was expressed by participants across sites. One AI clinician described her own experience as an urban AI person and the negative effects of disconnection from culture. "So- because I was raised in the city my entire life ... that's always been the struggle for me is having access to that and just being raised in like that community, right, we're all a sense of community and we all want that belonging. And when people don't have that they feel isolated you know and that can turn to depression. I think several factors you know can contribute to that, but- so it's some of the things that we deal with I think." (Site 3, Health Worker) Even when not framed in terms that are so strictly mental health related as they are here, participants described having clients engage with community as a part of encouraging their holistic wellbeing.

### ***Subtheme 2: AI Cultural Education is Employed as Part of Therapeutic Intervention***

This subtheme included respondents from all six sites. Responses from 12 respondents and four focus groups are included in this subtheme. Emphasizing that they themselves were not traditional healers, participants saw referrals to community members and encouraging

engagement with cultural practices and events as more appropriate than directly attempting to engage in anything like traditional cultural practice or healing in the therapy room themselves. However, two practices appeared generally acceptable to clinicians to engage in on their own. One was the practice of smudging, with clinicians who mentioned doing this practice with clients also saying that they typically only did it on request of their clients. The other practice commonly employed in therapy was cultural education. This education can take multiple forms depending on the clinician and UIHO, but generally included educating clients on the history of AI people with an emphasis on local tribal groups, as well as providing information regarding historical trauma and its legacy of negative impacts in the AI community.

Participants described education on historical trauma as generally healing because it put clients' lives into a broader historical perspective that could explain negative patterns they had observed: "So someone might like come in and say that, all these horrible things have happened in their life and like don't connect it to like, oh these horrible things happened in my parent's life and my grandparent's life and my great grandparent's life. So I think sometimes you can help people connect the dots and that can be really healing" (Site 2, Psychologist). This participant followed this comment by remarking that some clients are already largely aware of this history, in which case they might more directly discuss how the client's own life patterns might relate to historical trauma. This kind of education was another space where clinicians indicated they must follow the client's lead, and some AI clients were not interested in any greater historical or cultural understanding as part of their services.

Beyond this basic education on history, six participants described also providing additional knowledge about AI culture to clients. This knowledge came from trainings at their current UIHO or other AI service organizations where they had worked previously, their own

meetings with traditional healers,, or through their own AI family and community. The types of knowledge imparted in therapy among these participants included the use of sacred and traditional medicines, teachings of cultural values and applying them to a client's life, and telling of traditional stories. One participant described incorporating traditional stories in her cognitive behavioral therapy with clients, for example: "Well probably some, um, using cognitive behavioral techniques. Sudden confrontation, I'll confront people if they're strong enough to be confronted. Sometimes I'll, as I chart it, sometimes it's gentle confrontation which may not sound like a confrontational question, but it is a confrontational question. Sometimes I'll use a metaphor. I'll use traditional story. If particularly if it's people that are Native." (Site 4. Social Worker). As this participant described it, using a traditional story and applying it to a client's situation in order to point out contradictions or negative behavior patterns was a way of blending cognitive behavioral therapy with traditional cultural knowledge.

### **Discussion**

The primary theme reflects the underlying value expressed across participants' responses to study interviews. They perceived that a client-centered approach comes first and informs how to approach therapy. Numerous interviewees stressed that client perspectives differ, many clients are not interested in or actively reject the culture of their family of origin, and treatment preferences should emphasize the individual client's preferences rather than imposing a one-size-fits-all idea of the value of AI culture (or any other cultural perspective). Nonetheless, participants also described their own perspectives on the importance of AI cultural participation for AI clients, in some cases using cultural engagement as an informal measure of client improvement.



Overall, cultural tailoring appears to be commonly employed to address AI client treatment preferences where possible and necessary, while maintaining a core of behavioral health treatment described in similar terms to typical behavioral health practice. Much of the tailoring appears to be done informally, with clinician to clinician variation based on their experience and trainings, as well as consultation with AI staff members on subjects related to AI culture, healing practice, and history. However, therapists also reported using tailored approaches that, although not empirically tested for effectiveness themselves, are published in the scientific literature and draw upon previously tested empirically-based practices (e.g., Bigfoot & Schmidt, 2010). Further, many sites have developed their own models integrating some form of evidence-based care and AI cultural practice or education; these are thus manualized approaches to therapy even if the adapted components are untested.

Despite these outwards declarations of tailoring or combining of worldviews and methods, participants were vague on application in therapy. Little was said in concrete terms with regards to how these broad ideas could be applied in a therapeutic practice. This may confirm results of another recent study into one UIHO which found that while clinicians' dialogue on the topic of therapy emphasized cultural and historical issues and the potential to bring holistic wellbeing to clients, the reality of treatment in practice largely resembled typical approaches to behavioral health treatment with little applied adjustment to treatment beyond AI cultural symbolism (Hartmann, Gone, & Saint Arnault, 2020).

In considering the tension between AI client treatment preferences and ESTs, participants in this study by-and-large embraced client treatment preferences, with ESTs receiving more limited attention. Participants described using ESTs especially when those approaches appeared to map onto their own conceptions of AI cultural worldviews, and of blending or weaving the

two together when they did not map on so neatly. Stewart et al. (2018), in a paper asking if the three-legged stool is balanced, found that clinicians generally weighed their own judgment of client treatment preferences and client characteristics strongly over ESTs. This was described in their paper as a form of imbalance in the model of the three-legged stool, and they recommended that clinicians be educated more about specific ESTs (namely cognitive-behavioral therapy) to better serve their clients across a multitude of dimensions. However, perhaps there is nothing inherently wrong with a stool that weights treatment preferences and client characteristics more heavily than specific treatment approaches. Stewart et al. (2018) and others (e.g. Lilienfeld and Herbert, 2011) equate the first leg of the stool, called “research evidence” in many models cited by these scholars (e.g. Spring, 2007) with ESTs and interventions, emphasizing the importance of ESTs almost exclusively. In the case of Stewart et al. (2018), cognitive and behavioral therapies are referred to as if another term for ESTs, which compounds these errors by equating them despite the existence of many other ESTs outside the cognitive-behavioral framework. The absence of ESTs tested with AI clients, and the repeated expression from many in the AI psychotherapy community that AI culture can heal, suggests it may be appropriate in such settings to weight client preferences more heavily. In many ways this may be a correction of the imbalance in the three-legged stool as perceived by many researchers, overweighting ESTs compared to other evidence, client preferences, and clinical judgment. If EBP is actually a three-legged stool, client preferences and clinical judgment should at least be taken in equal measure with ESTs, and ESTs themselves are only one part of the research evidence. Greater attention to these other parts of the EBP model should be incorporated in conceptualization of how evidence informs what works, particularly for populations where research evidence is limited.

Stewart et al. (2018) also caution, correctly, that the use of treatment preferences and client characteristics may not be based in bodies of evidence. Clinicians should rely on scientific evidence for what works in therapy, and clinicians working with AI clients with treatment preferences outside of typical EBP should still be guided by some empirical work. As described in these results, many clinicians at UIHOs declare that they are doing so already; that the empirical body of work with AI clients, limited as it is, provides guidance in how to adapt therapy to match their clients' treatment preferences.

A great deal of what is described by participants in this study takes place outside of the boundaries of formal or designated therapy sessions. To the extent that AI cultural treatment needs are reflected in the many cultural programs and community events mentioned, UIHOs are going to great lengths to meet these needs whether by providing them directly or referring clients to community contacts. Treatment preferences that go beyond basic tailoring, when considered, are being met in these largely extra-therapeutic environments where ceremony, community connection, and cultural education can take place. This attendance to the holistic needs of behavioral health clients may reflect ideas that go beyond treatment to become a form of holistic healing and encouragement of all-around wellbeing. Such models have been suggested as especially relevant to AI clients in past research (see e.g. Gone, 2009), and it is possible these values are being demonstrated in practice today at some level at these UIHOs.

As an answer to the research question proposed for this study, clinicians at UIHOs describe themselves as using client-centered approaches to understandings of client preference. The lack of significant empirical literature causes some clinicians to be more cautious in choosing approaches and more open to practices that may fall outside of typical behavioral health treatment or the current evidence base. A familiarity with basics of AI culture and history

allows clinicians to connect with AI clients, but such practices were sometimes framed in familiar terms of client retention and engagement. Most clinicians are not able to provide any kind of traditional healing or cultural practice and recognize this, and thus clients who come to UIHOs seeking to make use of traditional healing or culture-as-treatment largely get referrals to events and programming external to the therapist. Based on these descriptions, it appears that behavioral health treatment itself at UIHOs is largely similar to treatment elsewhere, and what makes them unique is instead what is external to direct treatment. Given that the vast majority of clinicians at UIHOs could never be expected to offer these cultural services that are provided external to therapy, interesting questions are raised regarding the application of AI preferences for traditional healing and culture-as-treatment to models of behavioral health. Behavioral health research focused on treatment for AI clients must broaden beyond typical understandings of what treatment looks like to capture a complete picture of what practices are being done in the name of healing (Gone, 2009, 2010, 2011; Waldram, 2013).

The findings in this study have a number of limitations. Although participant counts are included in the results, these numbers reflect only the number of participants who actively commented on these specific matters; as it is entirely likely that some topics did not get covered in their entirety over the course of these interviews, these counts do not necessarily represent all participants who might agree with a given viewpoint. This research was self-report by clinicians and other UIHO staff, and bias is inherent in any self-report measure. This work may not provide an accurate portrait of what behavioral health treatment is like at these UIHOs, but instead represent a portrait of what these staff believe they are doing or aspire to do in broad terms. Because respondents came from only six UIHOs, and because the analysis was qualitative in nature, the results may not generalize to other UIHO sites.

Future research into the topic should investigate behavioral health via observation, rather than relying on self-report by clinicians. Future research should also include creative methods of understanding and measuring practices that go beyond the scope of behavioral health interventions as typically conceived, as these are what a significant portion of AI clients at UIHOs appear to be seeking as part of their treatment, according to the participants here. There may be particular potential for new work that seeks to validate or test the models of behavioral healthcare operating at these sites. If holistic healing is really happening as described here, and if client outcomes are generally positive, this may suggest exciting new possibilities for clinicians and clinics that work with large AI client populations.

## Appendix: Semi-Structured Interview Schedule

1. Could you give me an overview of the clinic's treatment philosophy?
2. What do you think counts as evidence for the types of treatments that are offered?
3. What treatments do you believe are most effective for common conditions that you treat?
4. What outcomes do you most value in client care?
5. How do you measure client outcomes?
6. What obstacles do you face to offering the kind of therapy or follow-up that you would like?
7. What does your training and supervision model look like, and what evidence do you draw upon for it?
8. What is the most common form of traditional healing offered?
9. What other forms of traditional healing are offered?
10. What would you change about the treatment that you offer if resource constraints were not an issue?
11. How are the traditional healing services you offer conceptualized as part of therapy?
12. How do you ensure the traditional healers who work with you are best able to treat clientele?
13. Some people feel there are tensions between Indigenous perspectives and clinical research that are difficult to resolve. What thoughts do you have about these challenges?
14. What types of research do you think could most benefit clinicians working with Indigenous clients now?
15. What is your training background?
16. What experience do you have with practicing psychotherapy?
17. How do you identify in terms of ethnicity or race?
18. Can you discuss how you became involved in American Indian behavioral health?

Figure 1: Thematic Map of Director Interviews

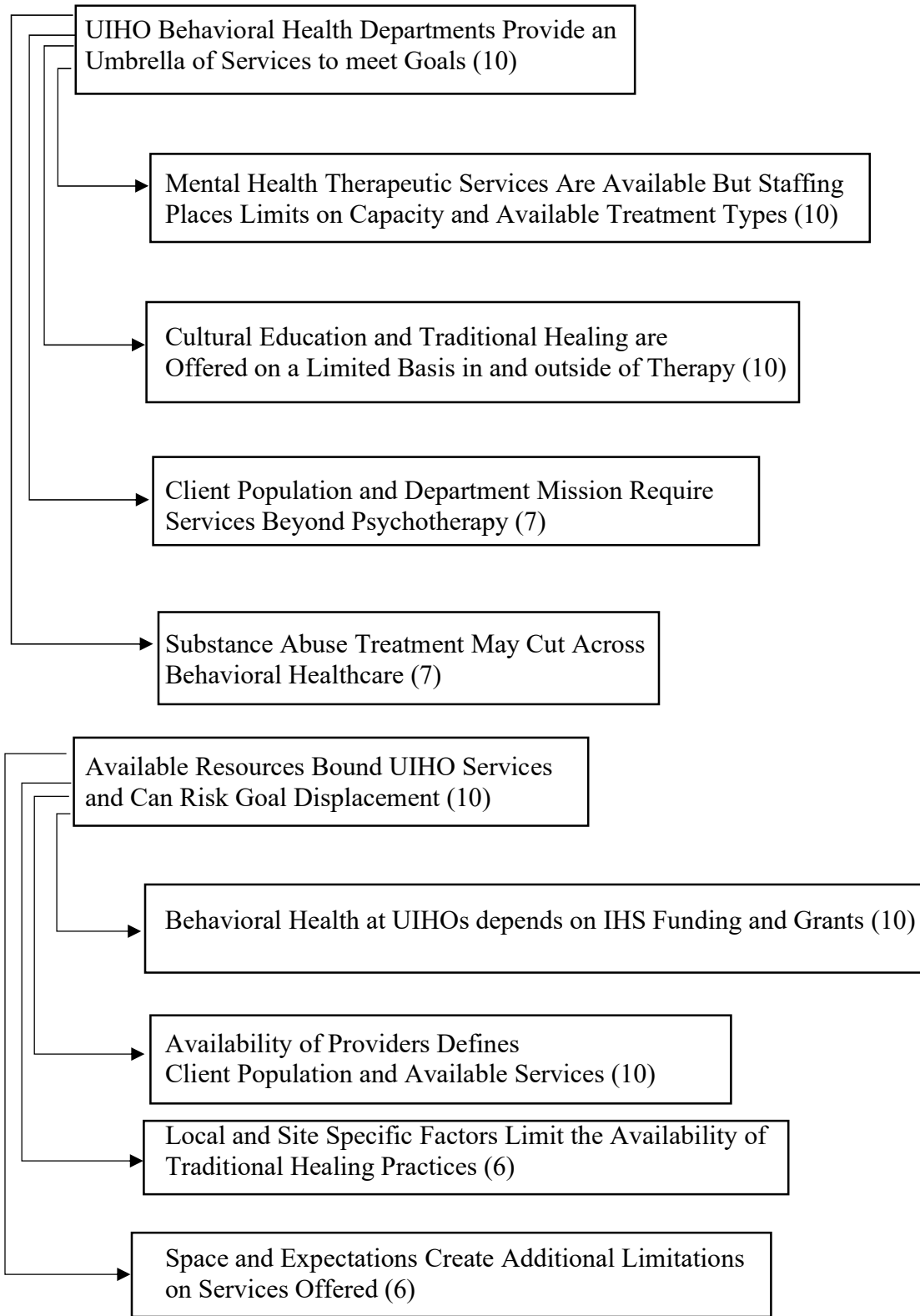
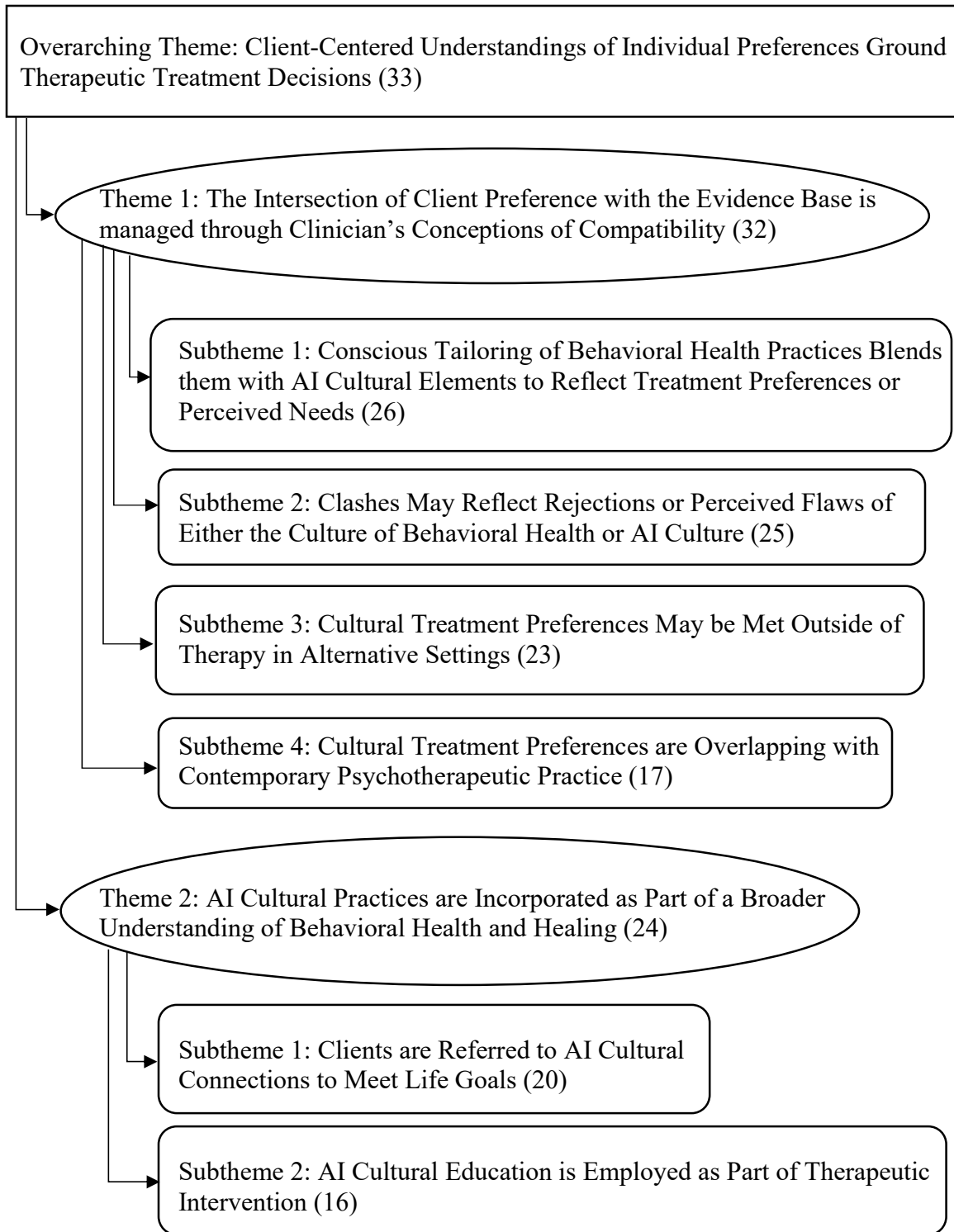


Figure 2: Thematic Map of UIHO Staff Interviews and Focus Groups





*Table 1: Treatment Approaches at Surveyed UIHO Sites Compared to National Averages for Outpatient Clinics*

Treatment Approaches	UIHO <sup>a</sup> Sites	National Averages <sup>b</sup>
Activity Therapy	50%	35.0%
Behavior Modification	78.6%	65.7%
Cognitive/Behavioral Therapy	92.9%	92.0%
Couples/Family Therapy	85.7%	74.7%
Electroconvulsive Therapy	0%	0.7%
Group Psychotherapy	85.7%	82.9%
Individual Psychotherapy	100%	89.9%
Integrated Dual Disorders Treatment	64.3%	55.1%
Psychotropic Medication Therapy	64.3%	79.8%
Telemedicine Therapy	14.3%	17.4%
<sup>a</sup> : Urban Indian Health Organizations; <sup>b</sup> : National Averages From Substance Abuse & Mental Health Services (2014).		

*Table 2: Supportive Practices and Services at UIHOs Compared to National Averages for Outpatient Clinics*

	UIHO <sup>a</sup> sites	National Averages <sup>b</sup>
Assertive community treatment	0%	18.7%
Case management	100%	77.1%
Chronic disease/illness management (CDM)	71.4%	16.8%
Consumer-run services	21.4%	20.5%
Education services	64.3%	38.3%
Family psychoeducation	71.4%	61.6%
Housing services	21.4%	22.0%
Illness management and recovery (IMR)	57.1%	32.4%
Legal advocacy	21.4%	5.5%
Psychiatric emergency walk-in services	0%	37.5%
Psychosocial rehabilitation services	35.7%	47.8%
Smoking cessation services	57.1%	15.6%
Suicide prevention services	92.3%	55.6%
Supported employment	21.4%	23.6%
Supported housing	7.1%	19.7%
Therapeutic foster care	0%	7.1%
Vocational rehabilitation services	7.1%	15.8%
<sup>a</sup> : Urban Indian Health Organizations; <sup>b</sup> : National Averages From Substance Abuse & Mental Health Services (2014).		

*Table 3: Programs for Specific Populations at surveyed UIHOs Compared to National Averages for Outpatient Clinics*

	UIHO sites	National Averages <sup>b</sup>
Youths with serious emotional disturbances (SED)	35.7%	49.5%
Transition-aged youths 18-25	28.6%	33.9%
Adults with severe mental illness (SMI)	28.6%	64.2%
Individuals with Alzheimer’s or dementia	7.1%	7.8%
Individuals with co-occurring mental health and substance abuse disorders	85.7%	59.1%
Individuals with co-occurring mental health and non-substance abuse disorders	42.9%	44.1%
Individuals with post-traumatic stress disorder (PTSD)	78.6%	50.7%
Veterans	28.6%	23.3%
Individuals with traumatic brain injury (TBI)	14.3%	10.5%
Gay, lesbian, bisexual, or transgendered clients	35.7%	27.8%
Forensic clients	50%	35.8%
<sup>a</sup> : Urban Indian Health Organizations; <sup>b</sup> : National Averages From Substance Abuse & Mental Health Services (2014).		

*Table 4: Use of Quality Assurance Practices at Surveyed UIHOS Compared to National Averages for Outpatient Clinics*

	UIHOs	National Averages
Monitoring Continuing Education Requirements for Staff	92.9%	87.8%
Regularly Scheduled Case Review with a Supervisor	85.7%	94.4%
Regularly Scheduled Case Review by an Appointed Quality Review Committee	71.4%	72.1%
Client/Patient Follow-Up After Discharge	57.1%	49.8%
Period Utilization Review	71.4%	89.7%
Periodic Client/Patient Satisfaction Surveys	100%	94.5%
<sup>a</sup> : Urban Indian Health Organizations; <sup>b</sup> : National Averages From Substance Abuse & Mental Health Services (2014).		

Table 5: EBPAS Subscale and Total Score for Directors Compared to National Norms

	EBPAS <sup>a</sup> Overall	Requirement	Appeal	Openness	Divergence
UIHO <sup>b</sup> Director Scores	M = 2.8381 (SD = 0.5116) $\alpha = 0.799$	M = 3.2857 (SD = 0.7829) $\alpha = 0.840$	M = 2.9464 (SD = 0.9617) $\alpha = 0.941$	M = 2.7500 (SD = 1.0143) $\alpha = 0.916$	M = 1.5179 (SD = 0.6684) $\alpha = 0.771$
National Averages <sup>c</sup>	M = 2.73 (SD =0.49) $\alpha = 0.76$	M = 2.41 (SD = 0.99) $\alpha = 0.91$	M = 2.91 (SD = 0.68) $\alpha = 0.80$	M = 2.76 (SD = 0.75) $\alpha = 0.84$	M = 1.25 (SD = 0.70) $\alpha = 0.66$
<sup>a</sup> : Evidence-Based Practice Attitudes Scale; <sup>b</sup> : Urban Indian Health Organization <sup>c</sup> : National Averages from Aarons et al. (2010)					

Table 6: Fifteen Point Good Thematic Analysis Checklist from Braun & Clarke (2006)

Criterion Number	Criteria
1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
2	Each data item has been given equal attention in the coding process.
3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive
4	All relevant extracts for all each theme have been collated.
5	Themes have been checked against each other and back to the original data set.
6	Themes are internally coherent, consistent, and distinctive.
7	Data have been analysed - interpreted, made sense of - rather than just paraphrased or described.
8	Analysis and data match each other - the extracts illustrate the analytic claims.
9	Analysis tells a convincing and well-organized story about the data and topic.
10	A good balance between analytic narrative and illustrative extracts is provided.
11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
13	There is a good fit between what you claim you do, and what you show you have done - ie, described method and reported analysis are consistent.
14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
15	The researcher is positioned as <i>active</i> in the research process; themes do not just 'emerge'.

*Table 7: Participant Types by Interview Type and Site*

Sites	Participant Type	Interview Participants	Focus Group Participants
Site 1	Provider	1	1
	Administrator	2	3
	Cultural Advisor	0	0
Site 2	Provider	2	2
	Administrator	2	1
	Cultural Advisor	0	0
Site 3	Provider	2	3
	Administrator	0	2
	Cultural Advisor	0	0
Site 4	Provider	6	Not Applicable
	Administrator	0	Not Applicable
	Cultural Advisor	0	Not Applicable
Site 5	Provider	6	5
	Administrator	1	2
	Cultural Advisor	1	1
Site 6	Provider	3	2
	Administrator	1	1
	Cultural Advisor	1	0

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