ASSESSING NEED ACROSS PROVIDER AND COMMUNITY MEMBER DIMENSIONS IN AN URBAN AMERICAN INDIAN CENTER

by

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DEDICATION

To my family, my friends here, there (Dartmouth), and everywhere (Jamelia and Eric), as well as my advisor, Sandy Momper, with tremendous appreciation of each.

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Glossary

AI/ AN: Refers to Indigenous peoples in North America; used interchangeably with American Indian.

Acculturation: The degree to which members of a group adopt the traditions, language, and customs of the majority culture.

Integration: The incorporation of Western Medicine and Ritual Healing activities as a means to culturally appropriate treatment.

Mainstream Religion: An organized recognized approach to human spirituality which includes prescribed beliefs, practices, symbols, and narratives.

Native American: Refers to Indigenous peoples in North America; used interchangeably with American Indian.

Ritual Healing: Native American-based ceremonies and processes that promote mental and physical well being including smudging, sweat lodges, and talking circles.

Smudging: Purification ceremony that involves the burning of sage and/or other herbs in order to create a cleansing smoke.

Spirituality: The beliefs and philosophies concerned with matters of the spirit; may include ideas about religion and faith.

Sweat Lodge: Ceremonial sauna which involves prayers, drumming, and offerings to the spirit world.

Talking Circle: A talking circle is a traditional form of Native American group communication where topics are discussed in a non-confrontational manner. Members are sensitive to cultural and symbolic traditions like the burning of sage (smudging) before the talking circles, or the passing of an eagle feather or a shell to symbolize a person's turn to talk. In talking circles news is shared, help is offered, problems are solved and stories are shared with the younger members of the group as a form of teaching.

Urban Native: Refers to Native people who reside in metropolitan areas, as opposed to reservations.

Western Medicine: Conventional, mainstream approaches to wellness. In the context of substance abuse recovery, this would include Alcoholics Anonymous and Narcotics Anonymous meetings, detoxification, and process groups.

ABSTRACT

Assessing Need across Provider and Community Member Dimensions in an Urban American Indian Center

by

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Chair: Sandra L. Momper

A needs assessment of American Indian and Alaska Native (AI/AN) community members and providers of an American Indian Health and Family Services Center in Southeast Michigan was conducted to identify health needs with an emphasis on traditional Native healing. The first study in this three-paper project includes qualitative material from interviews of community members (N = 27; age 12-82) and service providers (N = 11; age 26-70). Three overarching themes resulted from manual and NVivo coding. Theme one indicated a need to include services that relate to the mind, body, and spirit. Respondents emphasized that the path to wellness includes physical, spiritual and mental health and that traditional healing can restore the imbalance that occurs from addiction, physical illness, and stress. Theme two emphasized traditional healing as a complement to Western medicine. Theme three highlighted the uses of traditional healing on a continuum in which health issues for which *Western medicines* are appropriate, health issues for which *traditional medicines* are better (e.g. treating addictions), and those situations for which a *combination* of both is ideal. In the second study talking

circles (N = 9 groups; N = 73 participants; age 12-77), a traditional method of group communication in Native communities were conducted. Resulting themes were: 1) barriers to treatment: a) need for specialty services, b) lack of knowledge of services, and c) limited transportation; and 2) a request for culturally relevant youth services. The third study is a secondary analysis of data collected regionally from AIs/ANs (N =389; age 18-65+) by the Bemidji Area Office of Indian Health Service to identify health needs. Logistic regression indicated that participation in traditional services was associated significantly with ages 45-54; having received healthcare services in the past 12 months; wanting to see more traditional healing, health, and wellness; discrimination in healthcare settings; and knowing somebody with an addiction. This dissertation emphasizes the role that traditional healing occupies in the lives of AI/AN consumers and service providers of an urban Indian health center and serves to highlight the need to utilize both traditional Native healing and Western oriented treatment when providing services to urban AIs/ANs.

CHAPTER I

Introduction

The first two papers in this three-paper dissertation include qualitative material, interviews and talking circles, garnered from service providers and community members of American Indian Health and Family Services, a social service agency that serves the American Indian and Alaska Native community of the greater Detroit, Southeast Michigan area. The ability to analyze the needs of the local community from both a provider and consumer perspective is important in crystallizing not only the needs of the area, but identifying the mechanisms in which they are differentiated by several purveyors of the community. Of specific interest in the data will be the inclusion of traditional Native American spirituality and traditional ceremony as a complement to Western modes of healing. Excerpts from both service providers and community members that focus on the need for such traditional services will be highlighted, as will recommendations for increasing access to traditional healing.

Paper three in this series proposes the quantitative results of a large-scale needs assessment project of urban American Indians/Alaska Natives living in the greater Detroit, Southeast Michigan area. The project focused on six areas of investigation including (1) healthcare, (2) health program funding, (3) systems and regulations, (4) healthcare access, (5) healthcare quality, and (6) social issues that impact health. Of particular interest in the study was how demographic characteristics (age, marital status, household size) as well as veteran status and insurance coverage impacted one's

participation in traditional and ritual healing. Using logistic regression, the relationship between the aforementioned variables (in addition to others) and participation in traditional and ritual healing were investigated in order to determine the nature of such variables and the ways that they impact treatment seeking behaviors. In summary, this dissertation focuses on the health needs of the urban American Indian and Alaska Native community of the greater Detroit area by way of the service provider and community member impressions of an urban Indian health center. These findings are reinforced by the quantitative processes of a larger-scale and comprehensive needs assessment.

Specific Aims:

Chapter II

(1) To identify the mental and physical health needs of the community served by the AIHFS center from semi-structured interviews of service providers and community members to identify the strengths and weaknesses of the current programming, and evaluate the recommendations for modifications to current programming.

Chapter III

(II) To understand the ways in which the community members of AIHFS, who participated in talking circles, conceptualize their own treatment needs, identify the barriers to their treatment needs, and identify culturally appropriate programming as feedback to the center's advisory board, board of directors, and other administrators.

Chapter IV

(III) To define the treatment needs of the greater Detroit Indian community on a large scale extracted from a comprehensive survey of need. Furthermore, to identify the

demographic factors that impact participation in traditional services as part of an overall wellness program.

CHAPTER II

Assessing Need at AIHFS: Semi Structured Interviews From Provider and Community Member Perspectives

Introduction and Background

The advent of American Indian and Alaska Native (AI/AN)[1] centered health and wellness treatment centers has been largely based on the premise that there are significant inconsistencies in the respective philosophies of the dominant culture and those of the Indigenous self concept that raise serious implications for health care treatment (Saylors, 2003; Marbella, Harris, Diehr, Ignace, & Igance, 2010). While the push toward a more AI/AN culturally sensitive approach to medicine and overall wellness has been well documented in the last 20 years (McCabe, 2007), it is important to first illustrate the historical backdrop against which the movement has developed. The journey that contemporary AI/AN people face today is one that is colored and marred by colonization, displacement, disease, and near eradication. U.S. policies included prejudicial practices such as the removal of Native children from their homes and placement in residential boarding schools, where they were forbidden to speak their Native languages and partake in traditional practices "are at the core of the subsequent failure of Native people to thrive" (Mulcahy & Lunham-Armstrong, 1998 p. 242). Furthermore, in 1887 the Dawes Act was passed and forced thousands of AI/AN people to operate under the prospect of social and economic systems that were inconsistent with their own approach to

[1] American Indians, Alaska Natives, AI/AN, Native Americans, Indigenous peoples, and Native peoples are terms that are used interchangeably throughout this dissertation to refer to the Native peoples of the continental United States and Alaska.

'communal landholding' (Garrett & Pichette, 2000). The Dawes Act encouraged the assimilation of AI/AN people into the dominant society by allotting plots of land to individual AI/AN people, thus disrupting and eventually weakening the tribal societies. In turn many Native peoples sold their individual plots as they needed the monies for survival. By 1934, the forced sale of large areas of AI/AN owned tracts of land resulted in the loss of nearly 90 million acres of property and widespread poverty under the guise of self-serving federal policies (Garrett & Pichette, 2000). Federal policies once again marginalized Native people in the 1950's and 60's when they implemented relocation campaigns targeted at young AIs/ANs, encouraging them to leave their home reservations to move to urban areas, including Los Angeles, Chicago, and Detroit, with promises of jobs and financial success (Weibel-Orlando, 1999). However, many of the employment opportunities associated with these federal efforts were temporary and the fallout of the government's proposals has given rise to several generations of AIs/ANs who have been left with insufficient financial, family, cultural, and vocational support in many of the country's urban centers (Crofoot, et al., 2008; Nebelkopf & Penagos, 2005). While these historical constraints have in effect created economic strife and suffering in AI/AN communities, they have also allowed for unique experiences in urban AI/AN communities, with many continuing to celebrate and maintain their tribal traditions and values that permeate the health offerings of today. However, the historical deficits continue to reflect themselves in the patterns of substance abuse, mental health problems, and other abuses that continue to plague AI/AN society today. In order to understand the context of the study presented here a brief review of the literature surrounding these deficits follows.

Review of the Literature

Substance Abuse among American Indians and Alaska Natives

Substance abuse, depression, suicide, and domestic abuse all occur at rates far higher in AI/AN groups than for the general population (Saylors, 2003; Nielsen, 2003). In general AIs/ANs aged 12 and older are more likely to report an alcohol use disorder in the past year when compared to other racial and ethnic groups (National Survey on Drug Use and Health (NSDUH), 2007). Furthermore, death rates due to alcohol dependence in AIs/ANs have been reported to be 7 times greater than that of all U.S. races, even when adjusted for age (Indian Health Services (IHS) 2001). Among AI/AN adults between the ages of 25-44 death rates stemming from liver disease are 6 times greater than for European Americans (Torres Stone, 2005). While the consequences of alcohol consumption have been especially devastating for Native men, women have not been immune from its toll. Alcohol related death rates for AI/AN women are 3 to 10 times higher (depending on age) than for women in the general population (Ehlers, 2007). AI/AN youth have also been impacted by the burdens of addiction. Using longitudinal data via the NSDUH collected from 1975-1994, 62% of AI/AN youth aged 12-17 indicated that they had been intoxicated at least once by age 15; 71% had used alcohol during their lifetime (Hawkins, Cummins, & Marlatt, 2009). In another study of AI/AN boarding school students, lifetime prevalence rates of alcohol consumption were an astounding 93% (Hawkins, Cummins, & Marlatt, 2009). In the general population, a comparable longitudinal study conducted by the Center for Disease Control found that only 24.2% of 9-12th graders from private and public schools across the U.S. indicated that they had consumed five or more drinks in a row (thus likely meeting criteria for

intoxication) (Center for Disease Control, 2009). While differences in illicit drug usage as a function of gender have been noted in some studies of AI/AN youth, problem drinking rates between female and male AI/AN youth have remained relatively equal (Hawkins, Cummins, & Marlatt, 2009). Nonetheless, consequences of substance abuse for AI/AN youth continue to be grave. Early onset of substance abuse is associated with drunken driving, delinquency and other behavioral problems, and unprotected sexual activity (Hawkins, Cummins, & Marlatt, 2009). Early onset of substance abuse has also been linked with increased psychopathology, including depression, suicide, conduct disorder, as well as the development of substance use disorders later in life (Hawkins, Cummins, & Marlatt, 2009).

Addiction has been described by Indigenous scholars as a 'crisis of the spirit', a corollary of years of "colonization, discrimination, internalized racism, and prejudice" (Torres Stone, 2005).

> Quintero (2001) argued that colonialism is the most dangerous in its effect on the American Indians' self-concept when they internalize the negative attributions and prejudices of the majority culture. Duran and Duran (1995) reconceptualize alcohol use from the point of view of traditional culture as a spirit that must be encountered and fought in traditional ways to store harmony in human lives. This approach takes the problem out of the colonial contexts of Western psychology and places it within the realm of traditional belief systems and traditional healing processes (Torres Stone, 2005, p. 238).

Protective factors. However, certain facets of AI/AN culture may serve as protective factors against substance abuse problems (Yu & Stiffman, 2007). When 401 AI/AN youth (205 from a reservation and 196 from an urban area) were interviewed, researchers concluded that having family members with substance abuse problems and associating with misbehaving peers were all positively associated with alcohol symptoms. Conversely, higher levels of cultural pride/spirituality were negatively

associated with alcohol symptoms (Yu & Stiffman, 2007). It is of note that focus groups were included in the study, in which AI/AN college students indicated that cultural events such as powwows, although they were alcohol free, could be followed by a "49er," identified as an informal social gathering of powwow attendees during which alcohol is present. The same study concluded that pride in one's AI/AN heritage was associated with fewer alcohol symptoms (Yu & Stiffman, 2007). Methods of promoting cultural pride and spirituality, particularly in the presence of problematic peers and family situations, may reduce alcohol involvement and consequently, prevent problems across several domains of functioning with AI/AN adolescents. However, the presence of alcohol at culturally salient events, including powwows and "49ers," must also be considered for analysis purposes.

Participation in traditional healing and spirituality is one of the primary components of *enculturation*, or the degree to which one embraces their cultural traditions by way of language, spirituality, and cultural identity (Torres Stone et al., 2005). In a study of 980 AI/AN adults, enculturation was found to be the only significant predictor of alcohol cessation (Torres Stone et al., 2005). Also emerging from the substance abuse literature has been the study of natural remission from alcohol, which has opened up a dialogue into the possible cultural factors inherent in the AI/AN way of life that may serve to augment the spontaneous remission process. In a longitudinal study comparing Navajo American Indians and Europeans, the Navajos in the study quit drinking in their 40's and 50's, while the Europeans in the studies did not do so until their 60's (Torres Stone et al., 2005). Researchers concluded that the most significant findings of the study were the effects of religion and spirituality on

maintaining sobriety post natural remission (Torres Stone et al., 2005).

Suicide among American Indians and Alaska Natives

American Indians and Alaska Natives are 3 times more likely to commit or attempt suicide and it is the 2nd leading cause of death for American Indians aged 15-24 years. For all age groups of AIs/ANs, suicide is the 8th leading cause of death, whereas it is the 11th leading cause of death across all racial/ethnic groups in the United States (Pettingell, Bearinger, Skay, Resnick, Potthoff, & Eichhorn, 2008). The suicide rate for American Indians is approximately 190% of the rate for the general population (US Commission on Civil Rights, 2004). In some tribal populations in the Great Plains region of the United States, the rate of suicide is 10 times the national average (McLeigh, 2010). Studies have identified the risk factors associated with suicide in AI/AN communities, some of which include sociodemographic markers specific to AI/AN individuals, such as perceived discrimination, intergenerational trauma, and varying levels of enculturation (Langhinrichsen-Rohling & Powell, 2009; Muehlenkamp, Marrone, Gray, & Brown, 2009).

Protective factors. Enculturation is defined as the process of learning and embracing one's own culture by way of language, cultural celebrations, and other relevant practices (Barnard, 2007; Garett & Pichette, 2000). For AIs/ANs it includes participation in ritual or spiritual healing. Acculturation on the other hand is understood to be the loss of one's own cultural characteristics in order to gain the cultural values from another group. However, contemporary abstractions "take a multidimensional approach that place both cultures on different continua indicating an individual's ability to maintain their culture of origin while adopting characteristics from other groups

deemed appropriate for cultural adaptation" (Verney & Kipp, 2007, p. 51). The few studies that report on enculturation and acculturation patterns in AIs/ANs related to overall functioning in both Native and dominant cultures present a dichotomous view. On the one hand, participation in American Indian spiritual events lends itself to a type of resiliency that proves to be helpful in the face of depression and other life stressors. In fact, in a study of over 1400 Northern Plains AI/AN adults, a commitment to traditional spirituality was associated with fewer suicide attempts, even after controlling for gender, age, substance abuse status, and psychological distress (Muehlenkamp et al., 2007; Garoutte, Goldberg, Beals, Herrell, Manson, & the AI-SUPERPFP Team, 2003). Furthermore, suicide rates were positively associated with acculturation stress and negatively associated with traditional integration using epidemiologic data from 18 tribes (Lester, 1999). However, the opposing theory postulates that subscribing to traditional AI/AN values and those of the dominant culture simultaneously can be tense. It can contribute to acculturative stress that may cause an individual to undergo inner conflict as they navigate and balance their traditional values while living within the constraints of the dominant culture (Verney & Kipp, 2007; Garoutte, et al., 2003). Despite this philosophical debate, recent epidemiological data make a significant distinction in favor of bicultural individuals.

> American Indians with a low orientation towards traditional culture were more than 4.4 times as likely to be heavy drinkers, compared with more culturally oriented adults. Bicultural individuals were almost three times as likely to drink heavily and 2.3 times as likely to have an alcohol use disorder, compared with individuals with a high American Indian (or traditional) cultural orientation. Furthermore, there is evidence that enculturation is negatively associated with alcohol misuse among American Indian adults (Torres Stone et al., 2005, p. 237).

While these figures demonstrate high levels of drinking across groups of Native people

regardless of cultural status, it is important to clarify that these levels exist on a continuum, in which bicultural AIs/ANs drink more heavily and are more likely to develop an alcohol use disorder when compared to their more traditional or culturally oriented AI/AN counterparts.

Gender Roles, Domestic Violence, and Intergenerational Trauma among American Indians and Alaska Natives

Scholars have cited the incidence of male violence within Native society to be the manifestation of the deterioration of traditional gender roles that were disrupted by Western colonization (Weaver, 2009). Pre-contact, many tribes operated as matrilineal societies, with women owning most or all of a family's property; elderly women were prized for their roles in socialization and the transmission of cultural values (Weaver, 2009). The radical change in gender roles was a deliberate function of ethnic cleansing and colonization. By weakening the underpinnings of the social systems that united Indian people, government officials could more readily proceed with the steps necessary to achieve manifest destiny. Furthermore, the occurrence of male violence in the AI/AN community has been conceptualized as yet another consequence from the abuse that occurred in residential boarding schools both in the United States as well as in Canada. While residential boarding schools were initiated to help assimilate Native children into the dominant society, they served a dual purpose by preventing them from speaking their Native language, practicing their traditions, and observing other cultural customs (Witko, 2006). Furthermore, the children in the schools were subjected to physical, sexual, and emotional abuse, the fallout from which continues to be documented even today (Witko, 2006). Needs assessments of First Nations people (Aboriginal peoples of Canada) in

Southwestern Ontario continue to reflect the negative impact that historical constraints have had on this contemporary Indigenous society. A recent study indicated that an astounding 90% of the women surveyed revealed that they were the victims of physical, mental, emotional, or spiritual abuse by their current or previous partners (Mulcahy & Lunham-Armstrong, 1998). Furthermore, 63% of the women surveyed were currently involved in an abusive relationship (Mulcahy & Lunham-Armstrong, 1998). These patterns of abuse are also related to the deterioration of parenting skills and the breakdown of the Native family unit, both of which have become the tragic hallmarks of contemporary Native society. The advent of residential boarding schools inaugurated a generation of AI/AN children who were not exposed to traditional parenting styles, but rather, were witnesses to harsh punishments and models of abuse. In turn, this generation passed on these inadequate and inappropriate parenting models to their children, only to be faced with dire circumstances of their own poverty, addiction, and domestic abuse.

Former Needs Assessments in American Indian and Alaska Native Communities

It has been asserted that within AI/AN societies, "experiences of loss and rapid cultural changes have contributed to deep feelings of having no meaning or purpose in life among Native people" (Mulcahy & Lunham-Armstrong, 1998, p. 242). The legacy of mistreatment and abuse highlights the struggles of daily life for many Native people and gaps continue to exist in access to health care and rates of service utilization. AIs/ANs they are more likely than non-Hispanic Whites to be uninsured especially if they are low income (Zuckerman, Haley, Roubideaux, & Lillie-Blanton (2004). Furthermore, half of those AI/AN consumers who utilize health services will *not* return for a second visit (Mulcahy & Lunham-Armstrong, 1998). AI/AN patients exhibit dropout rates higher

than other ethnic minorities and are less likely to respond to treatment offers by health care professionals (Mulcahy & Lunham-Armstrong, 1998). Clearly, data concerning the degree to which services for alcohol, drug, and mental health services for AIs/ANs are utilized are limited at best. In what has been identified as the singular study involving the receipt of mental health services in AI/AN youth, it was reported that among those who had been formally diagnosed with a psychiatric disorder (109 youth), only 14% had received mental health services from a mental health worker in the past three months (Novins, Beals, Sack, & Novins, 2000). Comprehensive needs assessments in AI/AN communities pose great difficulties "because of significant epidemiologic, cultural, and service system differences among the 556 federally recognized American Indian tribes" (Novins, et al., 2000, p. 1045).

Traditional Medicine and Spirituality Today

Research that is concerned with the lives of the urban, contemporary American Indian family underscores the harsh nature of everyday living, often highlighted by anecdotes of addiction, abuse, and poverty. Although these phenomena are reinforced by statistics, the treatment centers that serve modern Indigenous people and their families have developed unique programming that reflects the cultural nuances of AIs/ANs. Previous studies have concluded that despite urbanization and acculturation members of urban American Indian centers continue to retain their cultural customs. Underlying these traditions is the maintenance of time honored ceremonies, medicines, and Native language. What has been the most striking aspect of studies concerned with American Indian acculturation is the degree to which urban AIs/ANs maintained formal ties with their home reservations or tribal areas while residing in urban areas. Researchers

conceptualize this phenomenon as viewing the urban residence in which one lives as a merely an extension of one's home reservation or tribal area (Evaneshko, 1999; Wyrostok & Paulson, 2000). The traditional healing practices of AIs/ANs are an important part of the everyday lives of Indian people across geographical areas, tribal affiliation, age, and gender (Marbella, Harris, Diehr, Ignace, & Igance, 2010). For many AI/AN people participation in traditional healing serves a dual purpose. It promotes cultural salience in the face of urbanization and acculturation and at the same time addresses the health concerns of AI/AN people that are often overlooked by the health practices of the dominant culture.

Ritual or *traditional healing* is an umbrella term that refers to American Indian/Alaska Native ceremonies that promote mental and physical well-being. Specific examples include talking circles, sweat lodges, and smudging. Ceremonies including the sweat lodge do not have a parallel in Western culture. Rather, the Western philosophy usually views physical health, mental health, and the spiritual earth as distinct domains of functioning, "each with its own set of beliefs, practices, and practitioners" (Morse, Young, & Swartz, 1991, p. 1365). "In addition to lacking a cultural perspective that has meaning for Native people, Western health care is expensive and frequently ineffective" (Morse, Young, & Swartz, 1991, p. 1365).

> A sweat lodge ceremony is one in which patients sit around a pit full of hot rocks in a tent-like structure designed to keep in the heat and keep out the light. The darkness and the rhythmic singing of the healer (assisted by rattles) are intended to bring patients into closer contact with the spirit world. The intense heat forces patients to 'center' or 'focus' and also opens the pores of the skin, thus allowing herbally-medicated water (which is occasionally sprinkled upon the hot rocks to create a medicated steam) to penetrate the lesions. From time to time, the healer stops singing to talk to the patients and to convey messages from the spirit world (Morse, Young, & Swartz, 1991, p. 1363).

Traditional healing addresses the afflictions resulting from a loss of harmony brought about by "general etiologies" such as spiritual violations, including stress, addiction and disease. Diseases are traditionally identified with reference to their causes rather than their symptoms, and are thought to follow a personal, rather than a natural history (Van Sickle, Morgan, & Wright, 2003). Traditional treatment usually begins with a visit to the diagnostician to determine the cause of the illness (Wyrosok & Paulson, 2000). With the guidance of a medicine man, the individual and his or her family work backwards to identify the contaminating event or behavior causing the illness, and attempt to restore harmony through ceremonies (Van Sickle, Morgan, & Wright, 2003). By removing obstacles to healing, traditional ceremonies allow the body to recover on its own, returning to its natural state of harmony and health. There is no doubt then, that the increase in the number of treatment centers that offer traditional medicine and healing services has been accompanied by a resurgence of participation in such practices by Native peoples. In a cross sectional study of 300 Navajo adults presenting to an Indian Health Services facility approximately two thirds had consulted a traditional healer at least once in their lifetimes, and 39% had used a Native healer during the last year alone (Van Sickle, Morgan, & Wright, 2003). In a study of nearly 100 First Nations students over 80% reported at least some previous experiences with traditional healing (Wyrosok & Paulson, 2000). Aside from the cultural incongruence that exists within Western and Native paradigms of treatment, many prefer the treatment options of traditional healing (Nielsen, 2003; Schiff & Moore, 2006; Marbella, et al., 2010). There is no doubt then that there is a significant need for treatment services in the AI/AN community that are not only culturally sensitive and appropriate, but effective as well. The degree to which

former studies have explicitly explored the health needs of urban American Indians as pertains to such services, including traditional services, is rare. Using qualitative data gathered from the providers of care and other staff members in an American Indian health agency in Detroit, Michigan, this study attempts to reduce the deficit in the literature.

Research Design and Methods

Setting

American Indian Health and Family Services (AIHFS) is a public, non-profit health center that serves the American Indian community of greater Southeastern Michigan. The stated mission of the center is to empower local American Indian individuals and families with comprehensive health care, education, wellness, and other related services. The center's mission is to take a culturally accommodating approach to the resources that it provides, meaning that the medical, dental, mental health and addiction services that it offers utilize approaches from both traditional American Indian elements and Western methods of wellness (AIHFS, 2010). While the greater Detroit AI/AN area is tribally diverse, the combined reservation population of AIs/ANs in Michigan is comprised of 12 distinct, federally recognized tribes (National Indian Child Welfare Association, 2005). AIHFS is open to local community members regardless of insurance status. While the majority of the center's funding come from federal agencies such as Indian Health Services, the Administration for Native Americans (ANA), the U.S. Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration (SAMHSA), AIHFS also receives financial resources from private donations and state and foundation grants. AIHFS employs 40 staff, including administrative, licensed mental health care professionals, substance abuse

counselors, nurse-midwives, physicians, consultants, and a traditional healer. The center is regulated by a board of directors comprised of faculty from surrounding universities, administrators, youth coordinators, financial consultants, and community members. AIHFS regularly hosts a variety of workshops, educational opportunities, wellness fairs, powwows, and other cultural events in order to promote community cohesion. While the majority of staff members and board members at the center are Native, the center is open to hiring multicultural staff members who are interested in pursuing and learning about traditional Native practices within the context of healing and wellness (AIHFS, 2010). Although AIHFS can be recognized strictly as a medium for medical services, local community members often regard it as a cultural pillar in the community. As of 2009, the U.S. Census estimates that there are nearly 10,000 individuals who self-identify as American Indian and Alaska Native (race alone or in combination with one or more other races) living in Detroit proper (U.S. Census, 2009). Furthermore, Southeastern Michigan holds the largest American Indian population in the state and the 10th largest American Indian population in the country (U.S. Census, 2009). AIHFS's catchment area includes a seven county area in southeast Michigan where according to 2010 census reports, over 47,900 Native people reside, representing 1.4% of the population (See Table 1.1).

Table 1.1

2010 Census AI/AN Population for Seven County Service Area of AIHFS

	Livingston	**Macomb**	**Monroe**	**Oakland**	**St. Clair**	**Washtenaw**	**Wayne**	**Seven County Total**	**State Total**	**Totals in %**
Total Pop	180,967	840,978	152,021	1,202,362	163,040	344,791	1,820,584	4,704,743	9,883,640	59.5%
Native Only	707	2,646	467	3376	729	1174	6991	16,090	62,007	0.63%

Alone or 2+ Races	1,756	7,944	1,548	10,491	2,032	3,939	20,245	47,955	139,095	1.41%
% of Total Native	1.26%	5.71%	1.11%	7.54%	1.46%	2.83%	14.55%	34.48%		

Based on AIHFS's Uniform Data System (UDS) report 473 patients were seen in 2010 between ages 1 to 85+; 181 males and 292 females; and of those 119 males and 218 AI/AN only. However, while other local ethnic enclaves are often easily identified by monikers including "Mexican town" or "Greek town," the American Indian community of Detroit has largely existed in the absence of a clearly centralized geographical area. This situation is not unique to the American Indian community of greater Detroit either, as many Indigenous communities often struggle to maintain unity amidst the fallout of the urban relocation projects of the 1950's and early 1960's, and the years that were to follow (Nebelkopf & Penagos, 2005)

Recruitment of Participants

We utilized Community Based Participatory Research (CBPR) so that community members could be full participants in the research project. CBPR has been shown to improve the quality of data collected as well as lead to community ownership of the research (Farquhar, Parker, Schultz, & Israel, 2006; Gittelsohn et al., 2006). First, staff and community members assisted in recruiting Advisory Board members to include elders, adults, youth and service providers. The Advisory Board provided input on the design and implementation of the project, and presentation of results to the community. We provided food, child care, and raffled gift cards at each meeting to encourage attendance. Second, community members and service providers were recruited via flyers posted at the center, AIHFS' email listervs, the AIHFS newsletter, word of mouth, and other community member referrals (see Appendix A). Additionally, the Project Manager and Community

Outreach Worker (both Native) called, e-mailed and talked in person to providers and community members about the project. The research team openly discussed the purpose of the needs assessment which was to gather information about health to be able to improve the physical, emotional and spiritual health services available to the community in order to design a health program that included their input regarding health needs and services. Interviews were conducted on site at AIHFS and at two other central locations in the metro Detroit area between May and August of 2009. A total of 38 interviews were conducted with 27 community members and 11 service providers. Transportation, food, and child care were provided.

Sampling Method

Qualitative research typically uses non-probability sampling techniques (Murphy et al., 1998) and findings are not intended to be generalizable but to provide information rich data (Grbich, 1999). At this point in the study we utilized a purposive sampling technique which is defined as the conscious selection of certain subjects to include in the study (Crookes & Davies, 1998) and is an appropriate non-probability sampling technique in conducting qualitative research (Patton, 1990).

Community member interviews. In choosing our non-probability sample we had specific criteria that only AIHFS community members be purposefully sampled (N =27) and that we included a wide range of ages (12 to 85). In doing so we were able to interview 7 youth under 18, 7 adults between 18 and 35, 7 adults between 36 and 50 and 6 adults between 51 and 82. All interviewees signed consent forms and filled out a short demographic survey (see Appendix B and D). The interviews were audio taped and lasted between 45 and 75 minutes. Interviewees were paid $20 for their time and willingness to

share information. The minimum age of participation for community members was 12. If community members were between the ages of 12 and 17 parental consent and child assent were obtained (see Appendix B). A protocol of questions was used and adapted for the youth interviewees (see Appendix C). Of the 27 community members (ages 12-82) who were recruited to participate in the study 100% participated. Community member socio-demographic information collected included tribal affiliation (if applicable), gender, age, marital status, educational status, total household members, employment status, and total monthly household income (see Appendix D). Select relevant demographic information is included in Table 1.2.

Table 1.2.

Sample Characteristics of Community Member Interviewees (N =27)

Variable	n	%
Tribal Affiliation		
Yes	25	(92.6)
No	2	(7.4)
Gender		
Female	18	(66.7)
Male	9	(33.3)
Marital Status[+]		
Single/Never Married	7	(26.0)
Married	8	(29.6)
Co-Habitating	2	(7.4)
Div/Sep/Not Co-Habitating	3	(11.1)
Widowed	1	(3.7)
Living with Parents	5	(18.5)
Education Status[+]		
Completed Grade School	5	(18.5)
Some High School	5	(18.6)
Completed High School	3	(11.1)
Some College	13	(48.1)
Employment Status[+]		

Unemployed	3 (22.2)
Employed Part-Time	2 (7.4)
Employed Full-Time	10 (37.0)
Retired	1 (3.7)
Student	7 (26.0)

Note. [+]The remaining 3.7% = missing data.

Service provider interviews. In choosing our non-probability sample we had a specific criteria that only AIHFS service providers be purposefully sampled (N =11). Additionally, amongst this sample we made sure that we included a variable range of providers in both the behavioral, physical health as well as administrative departments of AIHFS. All service providers who were asked to participate agreed to do so. The purpose of the study was described, questions answered and informed consent received. Service provider information collected included tribal affiliation (if applicable), gender, age, type of service provided to AIHFS, how long the respondent had been providing this service, respondent role as a provider of this service, and how long they had been in this role (see Appendix D). Of the 11 service providers 5 were tribally affiliated, 6 were not; 5 were male and 6 were female; the age range was 26 to 70; type of services provided were clinical, medical and administrative; 1.75 months to 20 years of service were reported.

Research Procedures

Semi structured interviews. Once the research team obtained a letter of support from the director of AIHFS, Institutional Review Board approval was obtained via the University of Michigan per the directive of Indian Health Service's IRB. Participation was voluntary and did not impact one's ability to receive services at AIHFS or employment status at AIHFS if one was a service provider. The interviews were conducted in private rooms at the center, in community members' homes, and providers'

places of employment and lasted approximately one hour. The interviews were audio taped for later transcription. Thirty-six of the 27 community member and 11 service provider interviews were conducted by a Native member of the research team. While the moderator used a protocol to guide the interviews, the direction and content of the interviews was heavily influenced by participants. Sample interview questions included "What do you think about health services in general at AIHFS?"; "What do you think about Native American/Indigenous traditional medicine/healing?"; "Are the services culturally appropriate for the community?" (see Appendix C).

Data Analysis

The audiotapes of the interviews were transcribed verbatim. The first coding method was an 'open coding' method, meaning that the PI identified major themes that were present throughout the interview transcripts. The open coding method is often employed in grounded theory, during which the researcher analyzes the text (including transcripts, field notes, or other documents) for emerging themes (Creswell, 2007). Then, using a 'constant comparison' approach, the PI aims to 'saturate' these categories by selecting new cases that further illustrate the previously selected code or theme that in turn provides new perspectives about the codes themselves (Creswell, 2007). The term 'constant comparison' refers to the idea that the coder constantly adds qualitative materials to the pre-existing codes, ensuring that the code corresponds with the newly added qualitative data (Creswell, 2007).

"In qualitative research 'reliability' often refers to the stability of responses to multiple coders of data sets" (Creswell, 2007, p.210). In order to ensure reliability in this study, manual coding of transcript data was completed by two additional readers who

followed a parallel grounded theory coding process. Not until the 'open coding' was complete did the independent readers share the results of the open coding in order to preserve the validity of the cross-comparison of the themes across readers. After comparing the final codebooks from the independent coders and the PI, respectively, the list of codes was refined in phases. Eventually, a final codebook was generated which would later be used in conjunction with the analyses from a qualitative analysis software program (NVivo).

Using the qualitative analysis software program, NVivo, the transcripts from the interviews were further analyzed for content in order to extract themes. NVivo is helpful in qualitative data management, storage, as well as analysis; it is distinctive from other software programs in that codes can be displayed graphically as well as categorically (Creswell, 2007). In qualitative analysis, researchers can utilize a preset list of codes that correspond with the data analysis procedure (Creswell, 2007). In this case, the refined, final copy of the codebook from the manual coding was used to initiate NVivo analysis. "Then, as data are reviewed during computer analysis, the researcher can identify information that fits into the codes or write memos that become codes" (Creswell, 2007, p. 169). The use of both manual coding and the software program allowed for a comprehensive qualitative analysis approach that reflected the richness of the data set. The themes presented hereafter are not necessarily exhaustive, but rather are used to demonstrate agreement among the majority of interview responses. Therefore if a theme is presented here, it was discussed amongst the majority of interviewees.

Results

Following the systematic analysis of interviews, themes relevant to the treatment experience at AIHFS were generated. The list of themes is a representative sample of the themes recovered from the data because they received support from the majority of providers and community members. However, the list is not exhaustive. Although additional themes were generated from the data, those included in this dissertation are the most relevant to the objectives of the present study. Narrative passages from interviews are used to demonstrate reasonable support, not necessarily absoluteness, for a given theme. Note that the terms "KI" in the excerpts refers to a de-identified key informant from the interviews and "I" refer to a de-identified interviewer. The overarching themes are: (1) Inclusion of services as relates to mind, body, and spirit; (2) Role of traditional healing as a complement to Western medicine; and (3) Appropriate uses of traditional healing.

Themes

(1) Inclusion of services as relates to mind, body, and spirit. Respondents emphasized the belief that the path to true wellness and health implies matters of not only physical well being, but functions of spiritual and mental health as well. Inherent in this idea of holistic balance is that traditional medicine is one of the primary pathways to restoring the imbalance that occurs as a result of a variety of holistic upsets, including but not limited to addiction, physical illness, and stress. The Western paradigm of health places a significant singular emphasis on the physical body, and narrowly defines wellness as the absence of symptom expression. Respondents considered the connection between the mind and the body, a relationship that is often ignored in mainstream Western medicine. The Native orientation of health on the other hand sponsors a view of

the self as having multiple natures-including the spiritual, mental, and physical. Good health involves a balance of all of these areas; healing becomes possible only when individuals begin to lead balanced lifestyles. For many participants the healthcare services that they receive through the dominant culture has likely not addressed the multi-faceted nature that is implied by the traditional Native self-concept. While these passages address the circular nature of the physical and mental health needs of AIHFS clients, there is an emphasis on the interrelationship between mental and physical wellness. The participants remark that the care at AIHFS is reflective of this principle, meaning that there is an offering of comprehensive services that meet the multidimensional needs of the clients on a number of levels.

> **Interviewer (I):** What about different types of care that you have, the physical care, and then the kind of things that you do. How do you feel that those work together, or don't?
> **Key Informant (KI):** They're intertwined, our physical health and our mental health, they're kind of one. They're like the circle, you know. Our physical feeling can be caused by feeling bad, being in a bad mental situation and it could be chemical or it could be environmental, you know, so I think they're not separate. That's why I'm so excited about their organization here. It's providing care, and integrated care, with health and behavioral health, and physical health **(Interview 3).**

> **I:** And what do you think about American Indian traditional medicine and healing?
> **KI:** I think it's better because the spirituality…they deal with the mind and the mind has a lot of control over the body… with the Western medicine they don't consider the mind, and it's just the physical, but it's not all it is **(Interview 2).**

> **KI:** Well, if you go to the doctor in Western medicine…say I have a stomachache and it hurts here. Well they're like 'here's five prescriptions and call me if it's not better in a month'. And you don't even know what could be going on, and in Native medicine, they seem to probe more, and see what's going on in your life. If its stress that's causing it, they will order tests if they feel that's necessary, but they cover the whole body and mind **(Interview 2).**

(2) Role of traditional healing as a complement to Western medicine.

Initially, respondents spoke to the fact that Western providers traditionally do not probe beyond physical symptom expression, as this is common in the Western paradigm of wellness. However, many conceptualized their thoughts regarding traditional medicine strictly within the context of Western medicine. Considering the urbanization and acculturation status of many AIHFS patients, one might consider if the benefits of spiritual healing and traditional medicine may be maximized were they continued to be offered as a complement to Western healing. For many participants Western medicine served as the backdrop against which the explicit need for traditional medicine developed, especially for those with low levels of acculturation. Therefore, to minimize or eliminate the role that Western medicine plays in the healing process may not be feasible, or even in the best interest of patient health. The idea that traditional healing is seen as a complement to Western medicine becomes increasingly significant when one considers the tribal diversity of an urban center such as Detroit. In fact in previous studies of the AI/AN population in the Detroit area over 100 different tribal groups were identified. Spiritual activities might take a 'Pan-Indian' approach and depend heavily upon the tribal background of the individual leading the specific ceremony. For example, if an Ojibwe spiritual healer were to lead a sweat ceremony at the center, the ceremony would be heavily influenced by the Ojibwe teachings of the individual leading the ceremony. The service providers and administrators must be sensitive to the nuances inherent in the community. In light of these distinctions and differences there still appears to be unanimous support for traditional healing and spirituality as a means to greater well being and overall health. In fact, one respondent stated that although the center does

need to make progress in specific areas, the ways in which health services are being delivered is generally good.

> **I:** And what do you think about American Indian traditional medicine and healing?
> **KI:** I think it's crucial to somebody's whole well-being…talking about those different components of the self, like traditional medicine really speaks to those differences…that we're not just a physical person, we're more than that. And then each tribe and each tradition has their own practices and cultural traditions that helps shape a person...I think, you know, pairing Western medicine with traditional medicine is a good, a good balance **(Interview 4).**

> **KI:** And I think we really need to be able to work with the whole family and the whole person- mental, spiritual, physical…we need to do a better job of being able to serve that whole person. But what we do have is good **(Interview 4).**

> **KI:** I am what, a believer of the Native medicine, because when you go to a medicine person, they not only treat you for whatever your illness may be, they believe in treating the whole body. Because there's also…the psychological…there's the exercise. It all is included in Native medicine. It includes the whole body, not just the area of illness. And they believe the whole body is affected so they cure the whole body if you do go to a medicine person. This is how they believe and this is what they teach. Whereas if you go to the modern doctor he only treats you for what ails you and that's it, and he makes you go on certain diet foods, which may be negative. But other than that, he doesn't look at the psychological effects...or how it's affecting the person and say, "Well, look, I think you need to have some kind of further tests or go to someone who will also clear you mind" because the mind is a crazy thing. It can affect how well you'll recover or extend your illness. And this is where the Native, like I said, treats the whole body including not only the body, but the mind as well, which is a healing process. So that's what I feel about Native medicine…if it were here, I would prefer to have it **(Interview 13).**

(3) Appropriate uses of traditional healing. Both community members and service providers indicated that there were several benefits to offering traditional healing in addition to Western medicine health services. Interview respondents commented on the fact that there were more appropriate venues for traditional healing services than others. In fact, the inclusion of traditional healing within Western medicine may be best understood as a continuum. There are health issues for which modern, *Western medicine* is seen to be the most appropriate means to wellness, health issues for which *traditional*

medicine is seen to be an ideal route for achieving health, and those situations for which a *combination* of both traditional and Western medicine is understood to be ideal. Service providers indicated that the field of addictions was one that has responded well to this amalgamation of movements. They emphasized that the field has evolved in light of the patient population, meaning that because of a demand for more spiritually and traditionally-orientated healthcare procedures, addictions as an area of practice has had to adapt accordingly. This also speaks to the fact that many urban providers will often tailor an individual's treatment plan depending on their own acculturation status or tribal background, as these will have significant implications for their propensity and ability to participate in traditional healing activities. While there are areas in wellness and health in which traditional healing has flourished, some respondents spoke about the possible limitations of traditional healing, once again against the greater backdrop of Western medicine. However beneficial in practice, such as in treatment for addictions, purification ceremonies, or chronic illness, practitioners in fields including emergency medicine and surgery continue to rely on Western medicine philosophies. This concept is demonstrated in the last excerpt, in which a community member advocates for ritual healing in general because although it has been successful for others around them, it has not necessarily been a useful tool for them personally.

> **KI:** My formal clinical training is basically from the Western approach. But in addictions the Western approach has, for the last 50 years at least, included by necessity a spiritual integration, and a physical integration. So therefore, I have to integrate things too…from a Western point of view…I also happen to have studied some…holistic and Eastern kinds of approaches, also some non-traditional approaches to the Western side **(Interview 8).**

> **KI:** I was a certified life coach. My training was through a company…you've got a philosophy of language but it also includes both spiritual things like Shamanic medicine, for instance, and energetic medicine, and there's Ayurvedic medicine,

> and all sorts of things like that. And I picked up quite a bit of that along the way, and so I have a big respect for that. I'm also training and I'm utilizing some distinctions out of the martial art of Ki-Aikido to teach people about body-mind integration, which I do whenever I get a chance. I have also studied the spiritual approaches of many different societies, including the Native American spiritual approach, which I have a huge regard for. Matter of fact, I sought out this place because of the Native American crossover, because I learned in the sense that it should go really well with my views on addiction **(Interview 5).**
>
> **I:** Then you could have this question, what do you think about the traditional medicine healing within the Native community?
> **KI:** I'm totally supportive of it…I've heard about people that have healed…but I don't know that that's happened for me **(Interview 7).**

Discussion

Service providers and community members recounted their experiences with traditional healing and spiritual activities, many of them recounting their personal narratives, which provided rich data. The intention of this study was to capture the ways in which both community members and service providers conceptualize the medical and mental health services that are both offered and received at the center. Respondents spoke to the fact that from a traditional AI/AN perspective one needs to restore spiritual balance before well being can truly be achieved. In fact, all respondents who did comment on the matter discussed traditional healing against the backdrop of Western medicine. It is clear then that although AI/AN ritual healing and Western medicine may share similar objectives (to improve one's health); they are indeed guided by unparallel processes. While Western medicine is primarily concerned with providing acute symptom relief, traditional medicine and ritual healing are "expected to heal the underlying spiritual imbalance, to restore or fortify mental well-being, and even to minimize the perceived negative effects of biomedical regimens" (Van Sickle, et al., 2003, p. 13). Indigenous scholars have postulated that there may be a place in the Native self-concept for both

practices, particularly for bicultural or acculturated individuals. According to this model, there is not a conflict between both healing customs. Rather, ritual healing and Western medicine are seen as complementary to one another, with each addressing different aspects of the person's illness (Van Sickle, et al., 2003). Therefore, in framing the health needs of the greater Detroit Indian community, there is a significant need for ritual healing practices at AIHFS in addition to the Western oriented options that are readily offered already.

Initially, it may appear that respondents who discussed traditional healing did so by highlighting the shortcomings of the Western medicine offerings of the center. However, a closer examination of these passages implies significant matters of acculturation levels, tribal values, and individual preferences for ritual healing. While it may seem intuitive to frame the entire Western medicine service as a general weakness, it is also important to consider the implications that this designation may have on differing levels of acculturation in the community. One respondent indicated that although they were supportive of traditional healing, they were not sure that it had necessarily been successful for them; they were nonetheless supportive of traditional practices in general. Therefore, efforts to continue to offer both Western medicine alongside ritual healing may be the best practice in an AI/AN health center frequented by AI/AN patients who represent a wide range of acculturation statuses. Furthermore, interview passages that speak to the power of traditional healing (only when compared to practices of Western medicine as a default health model) may not necessarily be indicative of explicit weaknesses of Western medicine per se.

While staff interviewees were proponents of traditional healing and its propensity for healing, especially against a backdrop of Western medicine and its relative shortcomings, a health center that chooses to focus exclusively on ritual healing may eventually exclude a large proportion of its clientele. Further, several of the respondents spoke about the practicality of some fields of practice being better suited for the introduction of ritual healing than others, with addiction being the most widely recognized. This acknowledgment is not the first of its kind. Several texts, video series, and lectures have been produced for both Native clients and providers that include some type of traditional, ritual component in addition to their core addiction curriculum. While many of these learning tools also borrow facets from the Western addiction model, including Alcoholics/Narcotics Anonymous and motivational interviewing, it is the offering of traditional alongside Western genres that are likely to appeal to an urban, bicultural audience (Spicer, 2001).

Upon review of the qualitative results from the study, the following limitations should be noted. The results of the study garnered from one urban health center that caters to American Indians/Alaska Natives cannot be generalized beyond this specific sample, treatment setting, or population. While the sample in the study represents both service provider and community member perspectives, the sample size was small and purposive. The participants in the study were self-selecting and self-reporting, meaning that the qualitative results acquired from the interviews are limited in the extent to which they accurately represent behaviors.

While this project has demonstrated the importance of ritual and traditional healing for urban American Indians/Alaska Natives in a urban Indian Health Center that

relies on Indian Health Service funds that are generally aimed at Western-oriented treatment, future research and policy should focus on the implementation and funding of AI/AN traditional healing as a complement to Western-oriented treatment to reduce health disparities among American Indian and Alaska Native urban communities.

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CHAPTER III

Assessing Need at AIHFS: Focus Groups Conducted as Talking Circles with Community Members

Introduction and Background

American Indians and Alaska Natives (AIs/ANs) as a clinical population have elevated rates of psychopathology, including addiction, mental illness, and suicidality, but low rates of service utilization (Walls, Johnson, Whitbeck, & Hoyt, 2006; Chester, Beals, et al., 2005). In a study of AI/AN reservation youth, researchers found that only 39 percent of the adolescents who had been formally diagnosed with a psychiatric disorder had received mental health or substance abuse treatment services in their lifetime when compared to 83% in the general population (Novins, Beals, Sack, & Novins, 2000; Flischer et al., 1997). Studies of cultural epidemiology have suggested that the stress stemming from "forced acculturation, urbanization, and cultural disruption have increased the vulnerability of American Indian youth for developing psychological problems" (Hawkins, Cummins, & Marlatt, p. 309). When patterns of alcohol misuse and abuse are examined specifically, these behaviors tend to be associated with young age, having less than a high school education, and unemployment status (Torres Stone, Whitbeck, Chen, Johnson, & Olson, 2005). Reports indicate that suicidal behavior is as high as 72% more common in AI/AN communities than in the general population (Garroutte, Goldberg, Beals, Herrell, & Manson, 2003). Furthermore, rates of preventable death among American Indian adults are 133% higher than their

Euro-American counterparts (Torres Stone, et al., 2005). These findings suggest significant levels of not only psychological suffering, but undoubtedly of inadequate access to treatment services. However, the issue of healthcare access for the AI/AN community is complex because it implies not only issues of access, but also matters of cultural competence and appropriateness (Olson, 2003). Founded upon the idea that Western modes of wellness and health are incongruent with those embraced by Native tradition, there has been a rise in the number of community centers whose aim is to provide culturally appropriate and comprehensive mental and physical healthcare for American Indians and their families (Moran & Bussey, 2007; Schiff & Moore, 2006). Many of these centers offer what is known as Native American traditional healing, including sweat ceremonies, blessings, smudging ceremonies, cleansing, and prayers (Nielsen, 2003). In many instances, aspects of traditional healing are offered alongside Western healing modalities. In a growing response to this kind of need in both urban, and to a degree, rural areas, modern health treatment centers with AI/AN clientele have tailored their interventions with cultural competence and cultural sensitivity in mind. In some instances, this translates to an amalgamation of both Western and traditional Native practices to reflect the acculturative diversity inherent in many of the urban centers in contemporary society. There is no doubt then that there is significant need for treatment services in the AI/AN community that are not only culturally sensitive and appropriate, but effective, and draw from methods that are empirically validated as well.

Historical Context for Urban American Indians & Alaska Natives

Western means of wellness can pose treatment barriers for bi-cultural American Indians who must strike a balance between living in the dominant Western society but

still maintain significant ties to their Native heritage. Despite pervasive beliefs concerning residential patterns, most AIs/ANs today live in urban areas as a result of government relocation programs in the 1950's and 1960's that aimed to alleviate limited reservation resources (Crofoot, et al., 2008; Nebelkopf & Penagos, 2005). Young AIs/ANs were urged to relocate from reservations to urban areas with promises of jobs and financial success (Weibel-Orlando, 1999). However, many of the employment opportunities associated with these federal efforts were temporary and the fallout of the government's proposals has given rise to several generations of AIs/ANs who have been left with insufficient financial, family, cultural, and vocational support in many of the country's urban centers (Crofoot, et al., 2008; Nebelkopf & Penagos, 2005). While these historical constraints have in effect created economic strife and suffering in this community, they have also allowed for unique experiences in the urban AI/AN communities, with many continuing to celebrate and maintain their tribal traditions and values that permeate into the health offerings of today.

Review of the Literature

Former Needs Assessments in American Indian and Alaska Native Communities

It is important to first illustrate the significant role that the formal assessment of need in urban AI/AN populations can play in the infrastructure of Indigenous communities. The findings of such studies can serve as an impetus at multiple levels that empower AI/AN groups, as they become informed of the social and health issues that their fellow community members face in the hope that they develop self-sufficiency in the process. In 1993, seven AI/AN agencies in the San Francisco Bay area agreed to participate in what would become the Community Mobilization project with the goal of

facilitating "the efforts of urban American Indians to create the structure and means necessary to reach their social, economic, and political goals as they perceive and define them" (Nebelkopf & Phillips, 2004, p. 47). The occasion was marked not only by a formal assessment of community needs, but a declaration of priorities, and the development of fiscal and social growth. Five years following the initiation of the project, the hallmark foundation of the project, the Native American Health Center, received a federal three year planning grant from the federal Center for Mental Health Services. The goal of the center was to implement a culturally competent approach to working with urban AI/AN children with serious emotional and mental disturbances and their families, as well as their evolving needs, from a services, evaluation, planning, and implementation perspective (Nebelkopf & Phillips, 2004). Similar national grant funding programs, most notably the Healthy Nations Initiative, have been funded in order to combat substance abuse by implementing community-based strategies (Noe, Fleming, & Manson, 2003). In addition to these efforts the Substance Abuse and Mental Health Services Administration (SAMHSA) has created Circles of Care grants to build infrastructure for Children's Mental Health Systems in American Indian/Alaska Native Communities. Furthermore, tribal organizations are encouraged to develop their own models to address substance abuse in their communities, including incorporating tribal and spiritual traditions into their respective substance abuse curricula (Noe, Fleming, & Manson, 2003).

The occasional needs assessments that have been conducted with urban AI/AN groups have demonstrated a request for services across multiple domains. In a survey conducted using census data in the Seattle area researchers found that members of the

AI/AN community were at increased risk for substance abuse, lung cancer, unintentional injury, and diabetes (Crofoot et al., 2008). Furthermore, more than 40% of the 33,000 person sample reported incomes 200% below the federal poverty level (Crofoot et al., 2008). In a mental health needs assessment of the Denver AI/AN community, more than half of the 374 survey respondents reported a history of drug and/or alcohol abuse; nearly half had experienced a depressive episode once during their lifetime, and nearly 20% reported a past suicide attempt or suicidal ideation (Crofoot et al., 2008).

In work conducted with AI/AN women at a coed residential substance abuse treatment facility in San Francisco 59% or 171 women who were interviewed indicated that they were in need of services related to HIV education, mental health, substance abuse, birth control, medical care, trustworthy child care, parenting skill training, and spiritual healing support (Saylors, 2003). Moreover, nearly half of the women in the study were the sole providers in the households and nearly half relied on public assistance; over half of the women reported personal problems due to their drinking (Saylors, 2003). Assessing need in an AI/AN community in a way that is comprehensive enough to serve the communities it intends to aid must also explore the ways in which people conceptualize treatment and the behaviors that characterize their treatment seeking. The aforementioned coed residential substance abuse treatment facility in San Francisco, called the Women's Circle, described their clinical approach as one with "Western psychotherapeutic practice with cultural ceremony and ritual" (Saylors, 2003, p. 61). When asked at intake how important culture was to them, 73% of participants responded that it was "very important" to them (Saylors, 2003).

Another component in the current literature has been the identification of issues that impact the health seeking experience for AIs/ANs. The outcomes of such studies have reported on the social, cultural, and economic circumstances that both urban and reservation AIs/ANs face every day as they navigate their respective healthcare systems. Evaneshko (1999) found that of the 174 AIs/ANs currently living in Tucson, Arizona, close to 60 percent would prefer to travel home to their home reservation to receive medical services even though local services were available. When asked what would make visits to the local community service center more feasible, as opposed to the reservation clinic, the most popular responses included better transportation, followed by better hours, efficient appointment systems, and reduced waiting times (Evaneshko, 1999). A possible moderator of such conditions at urban clinics is attributed to funding. Many clinics who serve AI/AN clientele rely on funding from federal sources, including the Indian Health Service (IHS). Despite the fact that the majority of Native people today live in urban centers, a relatively small percentage of funding from sources such as IHS is earmarked for urban clinics (Nebelkopf & Phillips, 2004). In fact, it has been estimated that this figure is as low as 1.7% for urban clinics (Castor, Smyser, Taualii, Park, Lawson, & Forquera, 2006).

In another needs assessment that evaluated the medical, mental health, and substance abuse service needs at a rehabilitation center in Portland, Oregon, focus group content was analyzed in order to evaluate the current programming as conceptualized by the AI/AN clientele. Although the center is home to a number of tribes and their respective traditions, AIs/ANs were attracted to the center because of its cultural familiarity and sensitivity of its service providers. However, community members

strongly indicated that a psychiatric after-hours response system was strongly desired in order to help provide "direct intervention" for clients involved with crisis situations, mental health concerns, substance abuse issues, or for those who needed ambulatory services because standard emergency room services were not culturally equipped to understand cultural issues of AIs/ANs (Crofoot, et al., 2008).

Barriers to Treatment

However valuable and necessary the need for culturally salient treatment in the AI/AN communities is, researchers have identified specific barriers to treatment that prevent AIs/ANs and their families from receiving services in the first place. Several of these obstacles have achieved nearly unanimous status regardless of the specific sub-population or tribe being surveyed, and continue to contribute to low rates of service utilization in AI/AN groups. Obstacles identified in the literature include cultural disconnect with the respective service provider, lack of transportation, and the limited availability of specific services (McCabe, 2007). Furthermore, cultural beliefs about one's own reference group may serve as a barrier to treatment in which aversive behavior reinforces negative stereotypes and beliefs about certain groups. Moran and Bussey (2007) found that in the context of an alcohol prevention program with urban AI/AN youth, engaging in alcohol misuse as a youth was regarded as 'normative' Indian behavior. AI/AN youth from the study who engaged in underage drinking were also more likely to perform poorly in school, did not identify strongly with AI/AN culture, and came from families with a history of substance abuse (Moran & Bussey, 2007). In an examination of need of urban AIs/ANs living in Baltimore, MD, focus group data indicated that health issues including HIV, substance abuse, and hepatitis were

unanimously considered to be an overwhelming problem in the community (Johnson, Gryczynsky, & Wiechelt, 2007). Yet, at the same time, study participants noted a number of variables that prevented them from receiving proper treatment, even when resources were available; many of these conditions were rooted in cultural tradition. These included pride, shame, and stigma because they were associated with activities including gang activity, intravenous needle sharing, and promiscuous and unprotected sexual activity (Johnson, Gryczynsky, & Wiechelt, 2007; Speier, 2005). Such factors could inhibit one from undergoing necessary medical testing for diseases such as HIV or hepatitis. Additional barriers to treatment included a skeptical view of mainstream health services, which was related to insensitivity to one's status as Native American (being incorrectly identified as another race), experiencing prejudice, or a lack of connection with their assigned provider (Johnson, Gryczynsky, & Wiechelt, 2007). Socioeconomic disadvantage was also identified as a barrier to treatment, which was related to uninsured status, living in a single parent household, and lack of education (Johnson, Gryczynsky, & Wiechelt, 2007). Several participants indicated that lack of education as a method of succeeding and advancing in the dominant society were all burdens in terms of healthcare access (Johnson, Gryczynsky, & Wiechelt, 2007). Few studies have explored the health needs of urban AIs/ANs pertaining to service needs, treatment barriers, and traditional healing. The need for such research is great, with implications for clinical practice as well as on a policy level. Using qualitative data gathered from the clientele of an AI/AN health agency in Detroit, Michigan, this study attempts to reduce the deficit in the literature.

Research Design and Methods

Setting

American Indian Health and Family Services (AIHFS) is a public, non-profit health center that serves the American Indian community of greater Southeastern Michigan. The stated mission of the center is to empower local American Indian individuals and families with comprehensive health care, education, wellness, and other related services. The center's mission is to take a culturally accommodating approach to the resources that it provides, meaning that the medical, dental, mental health and addiction services that it offers utilize approaches from both traditional American Indian elements and Western methods of wellness (AIHFS, 2010). While the greater Detroit AI/AN area is tribally diverse, the combined reservation population of AIs/ANs in Michigan is comprised of 12 distinct, federally recognized tribes (National Indian Child Welfare Association, 2005). AIHFS is open to local community members regardless of insurance status. While the majority of the center's funding come from federal agencies such as Indian Health Services, the Administration for Native Americans (ANA), the U.S. Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration (SAMHSA), AIHFS also receives financial resources from private donations and state and foundation grants. AIHFS employs 40 staff, including administrative, licensed mental health care professionals, substance abuse counselors, nurse-midwives, physicians, consultants, and a traditional healer. The center is regulated by a board of directors comprised of faculty from surrounding universities, administrators, youth coordinators, financial consultants, and community members. AIHFS regularly hosts a variety of workshops, educational opportunities, wellness fairs,

powwows, and other cultural events in order to promote community cohesion. While the majority of staff members and board members at the center are Native, the center is open to hiring multicultural staff members who are interested in pursuing and learning about traditional Native practices within the context of healing and wellness (AIHFS, 2010). Although AIHFS can be recognized strictly as a medium for medical services, local community members often regard it as a cultural pillar in the community. As of 2009, the U.S. Census estimates that there are nearly 10,000 individuals who self-identify as American Indian and Alaska Native (race alone or in combination with one or more other races) living in Detroit proper (U.S. Census, 2009). Furthermore, Southeastern Michigan holds the largest American Indian population in the state and the 10th largest American Indian population in the country (U.S. Census, 2009). AIHFS's catchment area includes a seven county area in southeast Michigan where according to 2010 census reports, over 47,900 Native people reside, representing 1.4% of the population (See Table 2.1).

Table 2.1.

2010 Census AI/AN Population for Seven County Service Area of AIHFS

	Livingston	**Macomb**	**Monroe**	**Oakland**	**St. Clair**	**Washtenaw**	**Wayne**	**Seven County Total**	**State Total**	**Totals in %**
Total Pop	180,967	840,978	152,021	1,202,362	163,040	344,791	1,820,584	4,704,743	9,883,640	59.5%
Native Only	707	2,646	467	3376	729	1174	6991	16,090	62,007	0.63%
Alone or 2+ Races	1,756	7,944	1,548	10,491	2,032	3,939	20,245	47,955	139,095	1.41%
% of Total Native	1.26%	5.71%	1.11%	7.54%	1.46%	2.83%	14.55%	34.48%		

Based on AIHFS's Uniform Data System (UDS) report 473 patients were seen in 2010 between ages 1 to 85+; 181 males and 292 females; and of those 119 males and 218 AI/AN only). However, while other local ethnic enclaves are often easily identified by monikers including "Mexican town" or "Greek town," the American Indian community of Detroit has largely existed in the absence of a clearly centralized geographical area. This situation is not unique to the American Indian community of greater Detroit either, as many Indigenous communities often struggle to maintain unity amidst the fallout of the urban relocation projects of the 1950's and early 1960's, and the years that were to follow (Nebelkopf & Penagos, 2005)

Sampling Method

Participants for focus groups/ talking circles were selected using purposive sampling (Morgan, 1997; Vaughn, Shay Schumm, & Sinagub, 1996) in which we selected participants based on the knowledge and expertise of the subject under investigation (Talbot, 1995; Poklit & Tatano Beck, 2006). In the case of this study we were interested in community member views of health and behavioral health needs and services presently provided. We formed the community member groups based on select categories of individuals so that the groups were homogeneous in makeup, but not necessarily in views on the subject. This is defined as 'segmentation' (Morgan, 1997). We used a combination of mixed age and gender groups: elders (male and female) only, women only, men only and youth (male and female) only groups.

Recruitment of Participants

We utilized Community Based Participatory Research (CBPR) so that community members could be full participants in the research project. CBPR has been shown to improve the quality of data collected as well as lead to community ownership of the

research (Farquhar, Parker, Schultz, & Israel, 2006; Gittelsohn et al., 2006). First, staff and community members assisted in recruiting Advisory Board members to include elders, adults, youth and service providers. The Advisory Board provided input on the design and implementation of the project, and presentation of results to the community. We provided food, child care, and raffled gift cards at each meeting to encourage attendance. Second, semi-structured interviews of service providers and community members (N = 38) were conducted and results of these interviews informed the protocols for the talking circles. Goals were established for the focus group/talking circles with input from the Advisory Board, the community, staff and community and service provider interviewee participants. The project team had a desire to expand upon the information shared by the community members and service providers by further identifying strengths and weaknesses of current agency programming as viewed by community members from all ages, genders and AIHFS service area. Third, talking circle participants were recruited via flyers posted at the center, AIHFS' email listervs, the AIHFS newsletter, word of mouth, and other community member referrals (see Appendix A). Additionally, the Project Manager and Community Outreach Worker (both Native) called, e-mailed and talked in person to community members about the project. The research team openly discussed the purpose of the needs assessment which was to gather information about health to be able to improve the physical, emotional and spiritual health services available to the community in order to design a health program that included their input regarding health needs and services. The Project Manager and other team members were all trained in the conduct of focus groups as talking circles. The talking circles were conducted by the Project Manager and other team members at AIHFS and other local community

centers between July and September of 2009. Nine community member groups were completed for a total of 73 participants. Transportation, food, and child care were provided.

Community member talking circles. All participants signed consent forms and filled out a short demographic survey (see Appendix D and E). The groups were audio taped and lasted one to two hours. Participants received $20 gift cards for their time and willingness to share information. The minimum age of participation for community members was 12. If community members were between the ages of 12 and 17 parental consent and child assent were obtained (see Appendix E). A protocol of questions was used (see Appendix F). Of the 73 community members (ages 12-77) who were recruited to participate in the study 100% participated. In order to insure that participants of different ages and genders would be willing to talk openly in the group we used a combination of mixed age and gender groups: elders (male and female) only, women only, men only and youth (male and female) only groups. Community members participated in 9 talking circles comprised from anywhere from 4 to 15 people (see Table 2. 2). Community member socio-demographic information collected included tribal affiliation (if applicable), gender, age, marital status, educational status, total household members, employment status, and total monthly household income (see Appendix D). Select relevant demographic information is included in Table 2.2.

Table 2.2.

Sample Characteristics of Community Members: Talking Circles (N = 73)

Variable	n	%
Tribal Affiliation[a]		
Yes	88	(83.6)
No	9	(12.3)
Gender		
Female	37	(50.7)
Male	36	(49.3)
Marital Status[b]		
Single/Never Married	24	(32.9)
Married	14	(19.2)
Div/Sep/Not Co-Habitating	8	(11.0)
Widowed	3	(4.1)
Living with Parents	16	(21.9)
Other	1	(1.4)
Educational Status[c]		
Completed Grade School	18	(24.7)
Some High School	19	(26.0)
High School Diploma	16	(22.0)
GED	6	(8.2)
Some College	12	(16.4)
Employment Status[d]		
Unemployed	33	(45.2)
Employed Part-Time	13	(17.8)
Employed Full-Time	11	(15.1)
Retired	3	(4.1)
Other[e]	9	(12.3)

Note. [a] 4.1% is missing data. [b] 9.5% is missing data. [c] 2.7% is missing data. [d]5.5% is missing data. [e]Other, disabled, homemakers

Table 2.3.

Talking Circle Characteristics (N = 9 groups; N = 73 participants)

Variable	n	Male	Female	Age Range
Elder Group	4	2	2	56-76
Mixed Community Group	7	3	4	23-73
Women's Group One	6		6	20-60
Women's Group Two	12		12	19-77
Men's Group One and Two[a]	17	17		16-54
Youth Group One	6	3	3	12-16
Youth Group Two	15	7	8	12-18
Youth Group Three	6	4	2	12-17

Note. [a] Raw data was combined for the men's groups.

Research Procedures

Focus groups conducted as talking circles. Once the research team obtained a letter of support from the director of AIHFS, Institutional Review Board approval was obtained via the University of Michigan. Participation was voluntary and did not impact one's ability to receive services at AIHFS. This study utilized focus groups in a talking circle format. In the AI/AN tradition, a talking circle is a communal gathering where stories are exchanged in a respectful manner; talking circles emphasize the interrelationship that individuals hold with one another as well as with their world (Lowe, 2008; Wilbur, Garrett, & Yuhas, 2001). They were conducted in a private room at the center, and were audio taped for later transcription. There were 73 community member participants and 9 groups. All interviews were conducted by a member of the research team who is Native. While the moderator used a protocol to guide the groups, the direction and content of the interviews was heavily influenced by participants (see Appendix F). Participants smudged (Native purification ceremony that involves the burning of sage and/or other herbs in order to create a cleansing smoke), said a prayer

prior to each talking circle, and passed an abalone shell to designate who was speaking so that they would not be interrupted. The groups lasted approximately 2 hours. Participants received a $20 gift card, a feast, child care (if needed) as well as reimbursement for transportation. Questions used to guide the groups were developed from the emergent themes from the 38 community member and service provider interviews and agreed upon by the Advisory Board. Sample talking circle questions included "What would be culturally and spiritually appropriate services for you and your family?"; "From your perspective, what services are available in the community?; "What services would you like to have available?"; "What 'community strengths' would help heal the emotional and behavioral stress in our youth and families?" (see Appendix F).

Data Analysis

The audiotapes of the talking circles were transcribed verbatim. The first coding method was an 'open coding' method, meaning that the PI identified major themes that were present throughout the talking circle transcripts. The open coding method is often employed in grounded theory, during which the researcher analyzes the text (including transcripts, field notes, or other documents) for emerging themes (Creswell, 2007). Then, using a 'constant comparison' approach, the PI aims to 'saturate' these categories by selecting new cases that further illustrate the previously selected code or theme that in turn provides new perspectives about the codes themselves (Creswell, 2007). The term 'constant comparison' refers to the idea that the coder constantly adds qualitative materials to the pre-existing codes, ensuring that the code corresponds with the newly added qualitative data (Creswell, 2007).

"In qualitative research, 'reliability' often refers to the stability of responses to multiple coders of data sets" (Creswell, 2007, p. 210). In order to ensure reliability in this study, manual coding of transcript data was completed by two additional readers who followed a parallel grounded theory coding process. Not until the 'open coding' was complete did the independent readers share the results of the open coding in order to preserve the validity of the cross-comparison of the themes across readers. After comparing the final codebooks from the independent coders and the PI, respectively, the list of codes was refined in phases. Eventually, a final codebook was generated which would later be used in conjunction with the analyses from a qualitative analysis software program.

Using the qualitative analysis software program, NVivo, the transcripts from the interviews were further analyzed for content in order to extract themes. NVivo is helpful in qualitative data management, storage, as well as analysis; it is distinctive from other software programs in that codes can be displayed graphically as well as categorically (Creswell, 2007). In qualitative analysis, researchers can utilize a preset list of codes that correspond with the data analysis procedure (Creswell, 2007). In this case, the refined, final copy of the codebook from the manual coding was used to initiate NVivo analysis. "Then, as data are reviewed during computer analysis, the researcher can identify information that fits into the codes or write memos that become codes" (Creswell, 2007, p. 169). The use of both manual coding and the software program allowed for a comprehensive qualitative analysis approach that reflected the richness of the data set. The themes presented hereafter are not necessarily exhaustive, but rather are used to demonstrate agreement among talking circle responses. Agreement in this context implies

that if a theme is presented here, it was discussed amongst the majority of talking circle respondents.

Results

Following the systematic analysis of interviews, themes relevant to the treatment experience at AIHFS were generated. The list of themes is a representative sample of the themes recovered from the data because they received support from the majority of community members. Although additional themes were generated from the data, those included in this dissertation are the most relevant to the objectives of the present study. Narrative passages from talking circles are used to demonstrate reasonable support, not necessarily absoluteness, for a given theme. Note that the terms "M" in the excerpts refer to a moderator from the talking circles and "KI" refer to a de-identified key informant participant of the talking circles. There were 2 major overarching themes, one of which had 3 corresponding sub-themes. The themes are: (1) Barriers to treatment (1a) Need for specialty services; (1b) Lack of knowledge of available services; and (1c) Transportation; (2) Request for culturally relevant services for youth.

Themes

(1) Barriers to treatment. All community members discussed their treatment experiences at AIHFS. Several of the prompts that were posed during the talking circles were concerned with the potential obstacles that might prevent one from receiving ideal physical or mental health care, i.e. "What prevents Native parents from developing a strong family unit?"; "Do you feel it is easy for you or your family to get treatment as needed (as you define it)?"

(1a) Need for specialty services. Talking circle participants routinely made reference to a need for specialty services that were not currently being offered at the center, or were at one point offered at the center and had since been discontinued. Youth from the community stated that in the event of an emergency they would most likely not seek services at AIHFS. Instead, they preferred the emergency medical services of a hospital due to better staffing, access to better equipment, and shorter waiting times. The other dimension to this sub theme of specialty services was concerned with the request for culturally competent mental health services, including parenting classes and activities for elders. Respondents remarked that there was a lack of resources in the community for raising children, especially for single parents. Instructional classes directed at teaching parenting skills, with a focus on specific, tangible coping skills were ideas that were consistently generated by several participants in several of the women's talking circles. One participant in the women's talking circle suggested that the center hire a mental health provider, only with a stipulation that they either be AI/AN or be willing to learn about Native culture. This discussion also included practical concerns as well; respondents wanted to ensure that the mental health providers, were they to be hired by the center, accept the insurance of the community members. It is important to point out that while AIHFS makes significant efforts to make its healthcare services accessible and affordable to its patients, AIHFS cannot accept all types of insurance at this time. Based on the qualitative results garnered in this study, this limitation also impacts the treatment-seeking behavior of AIHFS patients.

Participants discussed the role that elders played in the community. However, the capacity in which community members conceptualized the needs of AI/AN elders

differed by a function of the talking circle demographics. In the women's focus group, participants discussed the need for an elder component at the center in order to address pervasive issues such as hunger and elder abuse. In the men's focus group, on the other hand, community members spoke at length regarding the teaching role that elders can play to younger generations of AIs/ANs in the face of assimilation and loss of AI/AN culture. In this capacity elders would be able to tell their stories, share their experiences, and bond over a common history. For those elders who may have a limited understanding of their history, male focus group members suggested that this kind of cultural sharing could serve as a learning experience for the acculturated elders as much as for younger generations at the center.

Perhaps what was the most striking in the analysis of the qualitative responses was the degree to which the youth respondents expressed a need for culturally and spiritually salient activities, including language courses, cooking classes, and traditional ceremonies for the community at large. Conversely, participants in the women's groups, men's groups, and elders' groups all consistently cited the need for culturally oriented activities specifically for youth in the community. (These responses will be discussed accordingly in theme 2; request for culturally relevant services for youth). Participants in all youth talking circles repeatedly acknowledged that the center currently maintains a diverse offering of culturally meaningful projects. However, these responses suggest that most of these activities are marketed towards Native youth; the degree to which families or older adults participate in such cultural events is limited. Participants in the youth talking circles agreed that groups concerned with cultural content should be marketed towards parents and elders in that they may be used as effective learning tools in

preserving Native traditions as well as bridging different generations of AIs/ANs in the community.

> **Moderator:** What if you had an emergency?
> **Key Informant (1):** I probably wouldn't come here.
> **M:** No. Ok. Why wouldn't you come here then?
> **KI (1):** Well, if it's an emergency, I'd rather go to a hospital, because they're faster and they have more doctors.
> **M:** Right, and probably more equipment too.
> **KI (1):** Yeah **(Youth Focus Group 3).**
>
> **KI (27):** I think we need a lot of help with advocacy for parents. For when you have problems with kids in schools, or things like that. I think there should be more things available for us as parents, you know, that could help us out in those kinds of ways…because I think it's hard raising kids [laughs] by yourself.
> **KI (2):** We could even do parenting skills. That's really good, to learn how to cope with different things **(Women's Focus Group 2).**
>
> **M:** What would be culturally and spiritually appropriate services for you and your family?
> **KI (3):** I would like to see some services for Native single parents that can help give support on, you know, where their children are without the other parent being there, or be able to talk about whatever issue is going on in their home.
> **KI (4):** I think what I would like to see more of our programs focused on teaching parenting…whether they're young, middle aged, or whatever…making parents aware of what to look out for when it pertains to mental health and to get appropriate treatment in time, it's important to know what to look out for **(Women's Focus Group 1).**
>
> **M:** What would be culturally and spiritually appropriate services for you and your family?
> **KI (5):** The first one that comes to mind for me would be a mental health provider who takes our insurance and either is Native or knows something about it…if they're accepting…or if they're willing to learn.
> **KI (6):** I think that we do need a senior kind of component, or an elder's component in our organization that does address different issues about the aging process. So I would like to see that as far…a service that we would provide. I don't often hear about senior services. I don't think it's ever really been addressed or brought up and maybe I'm just not aware of it. But I think there is a lot of abuse, and seniors do go hungry and seniors do go without a lot **(Women's Focus Group 1).**
>
> **M:** What services would you like to see made available?
> **KI (7):** The process has been used against the communities to make their culture disappear so that they'd be assimilated to fit in with the mainstream. To have those elders who have elements of their culture that they've maintained…to share

their stories with the children…and even let the older ones sit there who were not part of any cultural experiences growing up where they were connected with any tribal group and bring them back to the state to know that their history is and also to more or less contrast of how the Native culture was different and how it affected people different than the culture that is…that has come into this **(Men's Focus Group).**

M: What would be culturally and spiritually appropriate services for you and your family?
KI (8): Cooking classes and tutoring…and pottery classes.
KI(9): I've come to AIHFS for a long time and it actually does a good job of teaching children about, you know, Native culture and traditions.
KI (10): But not just the children need to know, I think they should…more Native parents should be more involved in learning as well, and not just the children.
KI (11): I agree…I think there should be classes for older people too, because a lot of these are geared towards younger ones.
KI (9): I'd like to see more parents involved, and their children involved. Then they can learn a lot more **(Youth Focus Group 2).**

M: What would be culturally and spiritually appropriate services for you and your family?
KI (12): I'm going to say sweat lodge…those are my favorite things to do.
KI (1): I would think smudging…I like cleanses. It cleanses you all…
KI (13): I'm going to say going to a powwow.
KI (1): The shell dancing **(Youth Focus Group 3).**

(1b) Lack of knowledge of available services. Initially, respondents recounted their personal treatment experiences via AIHFS. While they themselves had been able to access any number of the services available, they also acknowledged that a barrier to treatment for fellow community members was a pervasive lack of knowledge of the specific resources available at the center, treatment or otherwise. Participants in the women's talking circles elaborated upon past experiences with local school systems in which their children had encountered emotional and behavioral problems, only to emerge from the experience feeling unsupported and overwhelmed. In the face of abandonment by the school themselves, these women were seeking advocacy services on the part of their children because they themselves did not have the resources, financial or otherwise,

to do so. A member of the same talking circle suggested that currently available services at the center be readily advertised and posted in order to increase access and visibility to the AI/AN community at large. In the men's talking circle participants discussed the idea that a lack of sufficient facilities compounded by an absence of an awareness of available services prevented Native families from developing a strong family unit. While AIHFS does offer a diverse array of programming, including that for families, the degree to which such programming is instrumental in bringing Native families together rests upon the actual usage of such services by community members. These sentiments were echoed by members of the youth talking circles, who stated that accessing particular treatment services had not been difficult for their family specifically. However, many had been witnessed the difficulty that other community members constantly face via anecdotes from friends, family members, and other community members. Many of those who were struggling with health difficulties were unaware of AIHFS' existence; for those who were familiar with the center, many had lingering questions that still hindered treatment seeking, including associated cost, treatment services offered, and to what degree the services offered at the center were culturally sensitive. While the youth in the study were currently utilizing the resources of the center, they spoke to the fact that community-wide knowledge of the center itself is still limited, and inhibits treatment-seeking behavior. Therefore, not only is a lack of knowledge of AIHFS a barrier to treatment itself, but the associated details of the center are as well, including specific services offered, associated costs, and cultural components to the treatment services, all factors that impact treatment seeking in Native populations.

> **KI (2):** These schools, they don't take any time out to help you. They really don't. They talk down on you, they talk down on your child, and how dare they

talk down on you or your child because your child has a problem? They should be saying "What can we do to help you, you know, what can we offer you?" So we, as parents, I guess we've got to get out there and find out what we have to do. So maybe if you had those things in our community of Native Americans, we would know where to go get help.
KI (14): I agree with 1 and 12
KI (15): I agree with number 1 too, and also, whenever programs are available, it would be nice if they were advertised more so we would know more about them. And they would put flyers and…because I don't know where any of the stuff is at **(Women's Focus Group 2).**

M: Question number three is what prevents Native parents from developing a strong family unit? What prevents them from doing that?
KI (16): Not having enough facilities and then trying to get stuff like that, you know?
M: So basically a lack of knowledge of the services?
KI (16): Yeah **(Men's Focus Group).**

M: Do you feel it is easy for you or your family to get treatment as needed?
KI (11): I would say yes, but like other families…they don't know where to turn to.
M: Don't know where to turn to. Okay.
KI (9): Yeah, I find it easy to find treatment…but a lot of them, people don't know who to turn to.
KI (17): Yeah **(Youth Focus Group 2).**

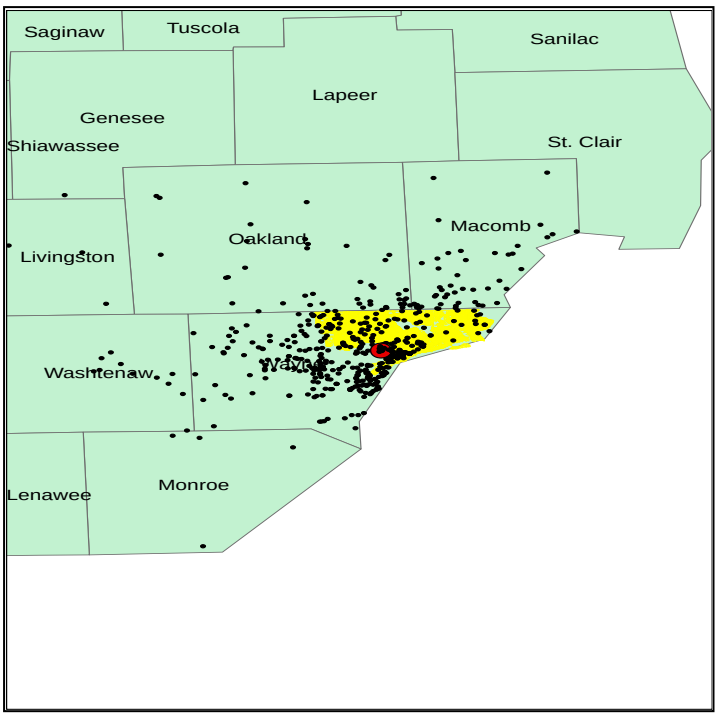
M: Anyone else have any ideas or things they'd like to share?
KI (11): We have one…But if we have them other places, we need to make sure people know about them where they don't know that we have…like we build them. They still don't know about them **(Youth Focus Group 2).**

(1c) Transportation. Participants in the focus groups discussed the unique role that AIHFS plays in the local AI/AN community. Because the center is the only Indian Health Service facility of its kind that serves Native people in the seven county area including Wayne County, the situation poses practical issues for those community members who must commute to and from the center. Community members articulated that transportation is a factor that routinely impacts their therapeutic experiences. This is especially true in Detroit where public transportation is often lacking and has limited geographic coverage. The very lack of density is a huge barrier to awareness and access

for providers, youth and families. Figure 1 shows the distance travelled by AIHFS users in 2009. The seven county area covers 4500 square miles.

Figure 1.

AIHFS Seven County Service Area



Many participants in discussing this theme were working parents who stated that despite the fact that they preferred that their children attend the afterschool activities provided by AIHFS, the lack of transportation between their children's respective schools and the center made this impossible to do at times. Group members suggested that the center provide transportation from local schools to AIHFS in order to alleviate such limitations. Several participants in the men's focus group spoke frankly about their limited financial resources and the impact it had on their ability to seek needed medical attention. Although these community members were certainly aware of the services at the center,

and were actively pursuing them, transportation and the financial burdens associated with them were significant barriers that hindered treatment seeking despite an overt, stated need for services. One participant in the men's group went so far as to state that the difference between a 30 minute commute and an hour commute to the center were still so problematic that they were negatively impacting his ability to receive services in the way that he would like. Another member, who receives treatment for alcohol addiction, stated that he has often debated whether to pursue treatment services on a given day depending on if he can finance transportation to the center. Although the addiction services that he receives are important to him, these services are not the singular factor in the actual pursuit of treatment. Practical factors, including transportation, also impact his treatment experience and significantly influence the decisions that he will eventually make regarding his status. In order to alleviate this financial strain, some community members suggested making access to desired services closer, perhaps in a satellite or community-based outpatient clinic capacity. The theme of transportation as a barrier to treatment was apparent only in the adult talking circles, most likely because youth participants are provided transportation by their adult parents and guardians, as well as staff at AIHFS

> **KI (29):** Yeah, we have a pretty good, I would say a pretty good clientele across…Wayne County that come in here. This really is one of a kind, this facility, in the Detroit area, anyway.
> **KI (16):** I've never seen one like this.
> **M:** I mean except for this, this is in our area; this is the first and only one of a kind. So I think having a central location may be a benefit that people can come to this.
> **KI (29):** Yeah.
> **KI (16):** So if that's help, having some place for that, then yeah, then the agency itself could be what helps parents…so transportation would be a great help **(Men's Focus Group).**

> **KI (18):** I think for parents who work…sometimes the child is out like 3 or 3:15…well I work and after school, it's hard, you know. It would be nice to have something like daycare or to pick them up from school, wait for the parents to get off of work and then go pick up their child, so you know the locations. So that would be helpful [laughs] **(Women's Focus Group 2).**
>
> **M:** Do you feel you or your family get treatment as needed?
> **KI (19):** Services are out of reach or far away. So it is difficult to make it to those places to get the services that you need. If you had to drive two hours to get to a place, pretty much gas prices are high. So you're spending a lot of money making it to the services no matter what. So if they make them closer to where we can establish and use those resources that they are giving us that would be awesome.
> **KI (20):** Well, at least to help us out there you can go out there and just give us the help that we needed. It is no better if you have to drive a half hour or an hour. I mean, it becomes a big deal.
> **KI(21):** Let's say I'm having an problem…well maybe I should go, maybe I shouldn't…I have to think about what kind of money that has got to come out of my pocket but I do not think it is easy. Because it's not easy to just go there if you even if need to get some kind of help with alcohol and so on **(Wayne County Men's Focus Group).**

(2) Request for culturally relevant services for youth. Community member participants consistently discussed the need for culturally salient activities provided for youth in the local AI/AN community. When prompted concerning what Native families and the community can do to address emotional and mental stress in their youth, talking circle participants referenced the existing "youth only" groups at the center, while others referenced traditional healing activities. Participants described youth groups as a way to maintain Native cultural values, ensure mental health, and promote group cohesion. They discussed the tendency of AI/AN youth to turn away from their parents and guardians during their teen years, and so the role of youth groups during this period takes on an increasingly significant role. Talking circle members discussed the importance of youth groups particularly in the context of social issues that are significant for AI/AN teens, including peer pressure and substance abuse. Participants in the women's and men's

groups specifically were concerned about providing services for teen parents in the community, namely for the provision of parenting skills. They stated that many of the teens in the community who were becoming parents at increasingly early ages were themselves exposed to maladaptive parenting models. By implementing a parenting intervention at AIHFS, a more ideal and sound parenting model could be provided to a new generation of AI/AN parents that could counteract the negative effects of abuse and poverty that had affected earlier generations. Other cultural opportunities, including dance classes, education on Indian culture, and the opportunity to partake in powwows were suggestions that were put forth. The women stated that while their children recognized that they had AI/AN heritage, it was through the participation in culturally salient practices that this cultural identity could be more shaped, particularly in the face of urbanization and acculturation.

When asked about culturally and spiritually appropriate services for them and their families, the women's and men's groups also discussed the role that afterschool activities play in the lives of AI/AN youth. A participant suggested hiring a mental health practitioner who specialized in working with young people. While some parents did acknowledge that their children were struggling with mental health issues, they were not sure where to refer them in order to receive proper psychological treatment, or even aware that such resources existed at the center. While group members recognized that the propensity of the center to hire a youth therapist heavily depended on financial resources, group members suggested writing a grant to obtain additional funding. In addition to extended mental health services, other suggestions by the men's and women's groups included mentoring programs, especially for young Native men who could be paired up

with an adult Native male. Participants likened such programs to those seen in the African American community.

When the qualitative responses of the youth were examined, there was a general preference for culturally significant events and classes, including spiritual ceremonies, powwows, and cooking classes. The youth in the study were concerned with the preservation of AI/AN traditions through mechanisms that were culturally meaningful, yet enjoyable and fun for their age cohort. They were interested in being taught the formal procedures of sweat ceremonies, the art of storytelling, and learning recipes for cultural foods such as fry bread.

> **M:** How can Native families and the community address emotional and mental stress in Native youth?
> **KI (1):** Counseling in school, or like, youth groups.
> **M:** Youth groups, like we have here?
> **KI (1):** Yes
> **M:** Do they help?
> **KI (1):** Yeah
> **KI (22):** I'm going to agree with her **(Youth Focus Group 3).**

> **M:** Do you have any idea what kind of services you would like? Or what kind of class you would like to attend?
> **KI (23):** I think there should be more…sweat lodges for the kids. They were fun. And I like health classes; like you teach people CPR and first aid…they can help other people.
> **KI (24):** Powwow are fun too…I like cooking class too because you get to make fry bread. Yeah, ceremonies and sweat lodges…long houses…for the boys and girls groups that would get to be part of the learning. They have their own talks about what the men are supposed to do and what the women are supposed to do, for their ceremonies and sweat lodges and like storytelling **(Youth Focus Group 1).**

> **KI (5):** Services for children having children…some kind of service program to help these young kids having kids becoming good parents because of lot of them don't come from good, healthy background homes. A lot of them grew up in the abuse world with the drugs and alcohol surrounding them, and that what they learned, so that's what they have a tendency to pass on **(Women's Focus Group 1).**

M: What would be culturally and spiritually appropriate services for you and your family?
KI (2): For me, I think if they had some place where my kids could dance in powwows…my children know they're Indian, but they don't know what it's all about.
KI (27): Well last year we had way more classes offered here for Native American language, Ojibwa, and me and my daughter attended, and it was really wonderful. We had a great time. We learned a lot. I think more of that would be really good. They have different dancing; grass dancing…it's a wonderful thing for her to learn things like that, because she takes it to heart.
KI (25): I agree. I think there should be more education on the Indian culture.
KI (26): I agree too, and maybe a group for our teenagers **(Women's Focus Group 2).**

M: What would be culturally and spiritually appropriate services for you and your family?
KI (4): I'd like to see more sports with the youth.
KI (6): What about having a mental health person who…has the credibility in youth type therapy? I mean, what's the possibility of having someone who has training…educated in that particular area on board? I mean, we get adults. Why not a special youth therapist? So why not find someone who actually has the credentials and that's their area of expertise, and write a grant, okay? And I know money's tight, but I know that would be my thought on what to do as far addressing…mental health stress in youth because if their parents can't direct them somewhere, if they don't know where to go, what happens to these kids?
KI (27): They need a place to go where they…how to deal with it. Just like the adults do. They need somewhere, okay, how do I deal with this problem? You know, not make it go away. But help me deal with it, because tomorrow…probably something else…so they need a place to tell them how to deal with it, for them and the adults.
KI(6): What about a program…a mentoring program, at the agency, where they set up…can you get enough Native men to take on that role of a mentor with a young man, like you find the lots of times you hear in the Afro-American community. Well, what about finding enough strong Native American men to mentor these young men? Even if they might have a father, it's nice to have a buddy **(Women's Focus Group 1).**

M: From your point of view, what services are available to families, parents, and the youth? What services would you like to have made available?
KI (18): Having youth groups and outlets for them because they really need someone to talk to. Sometimes they don't want to go to their parents; they don't want to say anything to their parents. So they'd rather say something to somebody else. They need more for teenagers, because teenagers are the ones going through a lot…most teenagers go through that stress, peer pressure, they're pressuring them for drugs.

KI(2): When a child is involved in a lot of sports, it does keep them out of trouble, I mean, they're just more focused, they've just got so much to do with that sport, they don't have time to be hanging out **(Women's Focus Group 2).**

M: What would be culturally and spiritually appropriate service for you and your family?
KI (19): Maybe we should get some more youth groups…to give us more history and know what is there for us and who is there for us…some of our youth groups to help out…to get the youth involved in. So if we start with the youth groups now, maybe the generation would get to know the history and what is there for us.
KI (16): Have something different where tribes learn their language. Start something up new and to teach the younger children because language is going to be lost. Once you lose their language, you know, pretty much, or you know. Keep the language.
KI (21): I say more stuff for the kids and youths to do…like field trips, you know, stuff like that **(Wayne County Men's Focus Group).**

M: Anyone else? What would help alleviate stress in our youth and family?
KI (28): Outreach groups because in outreach you find out what really helps Native families to get strong…more recreation. People come and cut the grass….keep the kids off the streets. If you can do that, there are more kids out there. Well you can pick them up and drop them off every day…an after school program **(Wayne County Men's Focus Group)**

Discussion

Community members detailed their experiences receiving a number of treatment services at AIHFS in a talking circle format. The intention of this study was to conceptualize the ways that community members view their own treatment needs, identify the barriers to treatment, and to generate culturally appropriate programming feedback for AIHFS. Participants in the study identified three barriers to treatment that prevented them from effectively receiving needed health services. These barriers included the absence of specialty services at the center, lack of knowledge of available services at AIHFS, and limited use of transportation to health appointments.

Study participants routinely cited the need for specific physical and mental health services, including emergency services, cultural activities, family counseling, youth

groups, parenting courses, and activities for elders. It is important to highlight that in nearly every appeal for such services, community members also requested that when applicable such services be provided in a manner that was culturally competent. For some community member participants this translated into services being provided by a member of the Native community; for others, it implied the hiring of staff that was simply willing to learn about AI/AN culture and ways. Furthermore, discussions regarding the need for specific services at the center were also concerned with matters of urban living, including the need for services to be accepting of participants' insurance. It is therefore not surprising, given the findings of comparable needs assessments of urban AIs/ANs, that issues regarding both insurance status and cultural sensitivity in the context of counseling and mental health were salient during the analysis of this study. In fact, former studies of treatment seeking in communities of color have demonstrated that preference for providers from one's own ethnic group is not limited to Native people.

Research has demonstrated that many ethnic minorities prefer to receive mental health services from providers from their respective backgrounds (Diala, et al., 1999; Takeuchi, Sue, & Yeh, 1995). However, given the relatively low number of trained ethnic minority mental health professionals many health systems are unable to accommodate such preferences on a large scale (Diala, et al., 1999, Takeuchi, et al., 1995). Furthermore, the few ethnicity-matching mental health service programs that have emerged in the last 15 years have done so in the context of "communities with relatively large ethnic populations and serve a predominantly ethnic clientele" (Takeuchi et al., 1995, p. 638).

The second factor discussed as a barrier to treatment by community members was the lack of knowledge of current services. While the youth participants in the sample appeared to have less difficulty with a lack of knowledge of services impacting their ability to receive healthcare at AIHFS, the issue was more salient for adult talking circle participants. Adult participants suggested that the services that the center offers, including the mental health, medical, dental, social advocacy, etc., be advertised in public places so that they are readily available. AIHFS is a technologically sound organization, meaning that much of its advertising is done via email notifications, list-servs, etc. Considering that the youth in the sample remarked that they did have a good sense of the services offered at the center, efforts to publicize both the services offered at AIHFS and their respective physical locations through methods offline may better serve the center's clientele, especially the elderly and those living in poverty without funds to purchase computers.

The last component to treatment barriers as identified by talking circle participants was transportation. Adult participants routinely discussed the limitation that transportation to and from the center plays in their ability to receive services, not only because of financial restrictions, but because of time constraints as well. Providing transportation and the associated logistics was especially problematic for the parents in the sample, who articulated that locating childcare services between the end of public school hours and the beginning of youth groups at the center was often difficult and expensive, or both. Furthermore, participants who sought services at the center themselves stated that necessary appointments at AIHFS had to be sacrificed in order to reserve the would-be transportation funds to use for other family expenses. While the

alternative of utilizing public transportation in the Detroit and seven county area should be considered, it is important to note, as previously mentioned, that these areas do not have reliable public transportation. During the course of the talking circles community members suggested that they would be more willing to seek services were they provided closer to their home, and hence, costing less in transportation fees and possibly more feasible in terms of arranging childcare. The possibility of another community based outpatient clinic, on a smaller scale, or even the inclusion of satellite services, is one that may be considered. However, feasibility of this proposal is limited by current funding at AIHFS.

The last finding of the study was concerned with the participants' enthusiasm and investment in the community's youth services, particularly those activities with a cultural component. There was unanimous agreement amongst all talking circles, including men, women, and youth groups that cultural and traditional healing activities played an important role in the preservation of Native culture, promoted mental hygiene, and reinforced Native values in the face of acculturation and assimilation. They cited former language and dance classes as positive and safe recreational outlets for Native youths during a time when teens face increased amounts of peer pressure and are at increased risk for truancy. These risks are well documented in the literature as a critical period for the acquisition of substance dependence patterns. Research has demonstrated that an earlier age of tobacco initiation specifically in AI/AN youth is associated with a number of factors, including peer influences and acceptance of cigarette and cigar smoking during community gatherings (Henderson, et al., 2009). Furthermore, the teenage years have been demonstrated to be a high-risk period for polysubstance abuse for AI/AN

youth. Compared to non-American Indian/Alaska Native youth, AI/AN youth initiate substance use at a younger age, are more likely to continue use after initial use, and have higher rates of polysubstance use (Beauvais, 1992a; U.S. Congress, Office of Technology Assessment [OTA], 1990). While polysubstance use has contributed to negative self-ratings of health in AI/AN youth, especially alcohol and tobacco, studies have indicated a highly significant relationship between social competence and self-ratings of health. Therefore, activities focused on engaging AI/AN youth in what are considered to be "social-competence enhancing" culturally significant activities is significant not only for cultural preservation but for intervention purposes as well (Parker, 2004).

Upon review of the qualitative results from the study, the following limitations should be noted. The results of the study garnered from one urban Indian Health Center that serves American Indians/ Alaska Natives cannot be generalized beyond this specific sample, treatment setting, or population. While the sample in the study represents community member perspectives, the sample size was small and purposive. The participants in the study were self-selecting and self-reporting, meaning that the qualitative results acquired from the interviews are limited in the extent to which they accurately represent behaviors. While this project has demonstrated the importance of ritual and traditional healing for urban American Indians/Alaska Natives in a urban Indian Health Center that relies on Indian Health Service funds that are generally aimed at Western-oriented treatment, future research and policy should focus on the implementation and funding of AI/AN traditional healing as a complement to Western-oriented treatment to reduce health disparities among American Indian and Alaska Native urban communities.

Conclusion

While this dissertation has highlighted the behavioral and physical health needs of clients served by AIHFS, it is important to illustrate that the center, as part of the community based participatory research component of the heretofore mentioned studies, has been privy to the qualitative and quantitative results from the initial studies. They have responded to the needs of the community in a number of ways. Recently, AIHFS hired a youth mental health counselor to address the concerns of AI/AN youth, including suicide, peer pressure, and substance misuse. The center purchased a van in order to provide transportation to individuals and families who formerly cited transportation difficulties as a barrier to treatment. AIHFS is currently working towards having State Medicaid reimburse AI/AN community members to receive 'double billing' for multiple services performed on the same date. Currently, for example, if a Medicaid eligible individual were to attend the center for a dental check-up and see a mental health counselor, Medicaid would only reimburse for one of these services, meaning that they would have to pay a large out-of-pocket fee for the alternative service. The only way for AIHFS clients to avoid paying such a fee for the alternative service would be to return to the center at a different time for a separate appointment. This is a hardship for many members as they live on the outskirts of the seven county service area. Should the new policy be ratified, both services could be billed to insurance, thus impacting transportation as well as out-of-pocket insurance concerns for AI/AN clients. Additionally, AIHFS is negotiating for reimbursement for transportation for clients as part of a State Medicaid benefit. AIHFS has also hired a part-time employee to update the center's website so that its services, location, and mission statement can be more

readily accessible via the internet. Lastly, AIHFS recently obtained an Administration for Native Americans grant, a program which provides funding for parenting programs. In their grant application, AIHFS proposed programming that included a traditional component within the greater framework of parenting curricula with the local AI/AN community that it serves.

While the modifications that AIHFS has made to its policies, resources, and programming can be seen as a provisional means to circumstances that require more elaborate and intricate solutions, AIHFS continues to be informed of the needs of its community by needs assessments such as the one described in this dissertation. Made aware of the social, cultural, and treatment requirements by the very people that it aims to serve, AIHFS continues to evolve and develop its own philosophies of health and wellness. Recently, the center wrote two federal grants that if funded will initiate an equestrian therapy program and a canoe-building project in order to address mental health and substance abuse issues with AI/AN youth and adults. There is no doubt then that AIHFS will continue to be informed not only by local research, but by the voices of actual Native people.

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CHAPTER IV

Identifying Trends in the Bemidji Area AIHFS Needs Assessment Project

Background on Urban American Indians and Alaska Natives

Traditional healing in the context of the American Indian and Alaska Native (AI/AN) community is regarded as the use of spiritually and culturally salient ceremonies, including smudging, talking circles, and sweat ceremonies in order to provide "cleansing, insight, and personal growth" (Witko, 2006, p. 183). For over 50 years Indigenous people have increased their use of traditional healing as a means to assert their social and cultural belonging (McCabe, 2007). At the same time, many AIs/ANs have experienced treatment limitations put forth by Western medical systems. In fact, due to the conflict that exists between Western and Indigenous philosophies of health, particularly mental health, imposing Western norms on Indigenous people can be regarded as another form of colonization (McCabe, 2007). Therefore, the role that traditional healing plays in the lives of AIs/ANs is an important one, for both urban and reservation AIs/ANs.

Despite the perceptions reinforced by popular media, the majority of American Indians live in urban settings and are "the descendants of those who first came to urban areas during the federal government's relocation program in the 1950's and early 1960's" (Nebelkopf & King, 2003, p. 44). Additionally, "the Bureau of Indian Affairs (BIA) did not deliver on its promise of transitional assistance, and relocation created a chronically

disenfranchised urban Indian population" (Nebelkopf & King, 2003, p. 44). American Indians today are plagued by elevated rates of poverty, incarceration, and type 2 diabetes (Nielsen, 2003; Thompson, Allen, Cunningham-Sabo, Yazzie, Curtis, & Davis, 2002). Furthermore, the rates of preventable death among AIs/ANs are 133% higher when compared to European-Americans, with most occurrences being alcohol related (Torres Stone et al., 2005). Research has indicated that for AIs/ANs high levels of drinking are associated with being male, being young, being unemployed, and having less than a high school degree (Torres Stone, Whitbeck, Chen, Hoyt, & Adams, 2004). Furthermore, the historical losses associated with residential boarding schools and the abuses which AIs/ANs experienced have given rise to a term known as "intergenerational trauma", a term which was first applied to the victims of the World War II Holocaust survivors (Torres Stone, et al., 2004).

The Power of Traditional Healing

These statistics illustrate the plight of contemporary Native people as being hindered by social and cultural oppression. However, health providers in Native communities have responded by re-introducing traditional healing as effective treatment programs that empower Native people and acknowledge their heritage. In a study of over 1500 AIs/ANs aged 15-54, those participants with strong levels of cultural/ spiritual orientations were found to have lower rates of suicide attempts, even when controlling for the effect of socio-demographic variables, substance abuse, and emotional distress (Garouette, Goldberg, Beals, Herrell & Manson 2003). These findings suggest that "cultural spirituality may provide a particularly accessible and powerful source of the meanings and symbols that give order to life and ward off the perceptions of anomie"

(Garouette, et al., 2003, p. 1577). In a study of AI/AN youths (205 reservation; 196 urban), cultural pride and spirituality were associated negatively with alcohol symptoms, after controlling for other demographics in the model (age and location) (Yu & Stiffman, 2007). In other words, the youths who reported higher levels of cultural pride and spirituality had fewer alcohol symptoms. The use of traditional healing has been documented in applied health contexts as well. Researchers documented the experience of 24 families with one or more family members with asthma (N =35) in regards to participation in Navajo traditional healing practices for general health and for asthma related symptoms (Van Sickle, Morgan, & Wright, 2003). Almost one-half (47.8%) of the under age-16 participants had used a traditional healer and 26.1% had used a traditional healer for asthma (Van Sickle et al, 2003). Of the adults 54.3% had used a traditional healer and 28.6% had used a healer for asthma (Van Sickle et al., 2003). Of the asthma sufferers who had used traditional healing 7 reported participation in ceremonies that resulted in a decline in asthma attacks and 2 asthma sufferers had used traditional herbs to treat asthma (Van Sickle et al., 2003). Participants indicated that medicinal herbs could be used to successfully treat asthma symptoms, but "emphasized the importance of enlisting a traditional healer to lead and supervise herbal treatment" (Van Sickle et al., 2003, p. 5). In response to the well-documented destruction that alcohol misuse has played in AI/AN communities, traditional healing has been cited as having a positive effect on alcohol use. In a sample of 980 American Indian adults, both participation in traditional activities and traditional spirituality were shown to have significantly positive effects on alcohol cessation (Torres Stone, et al., 2004). Therefore, not only has the role of traditional healing been proven to be an important cultural factor

in the lives of AI/AN people, but it continues to impact the pervasive health behaviors that affect the community from a public health perspective as well.

Need for Traditional Healing in AI/AN Communities

In addition to epidemiologic data that speaks to the need for healthcare in AI/AN groups, members of these communities have articulated that the pathway to addressing concerns of psychopathology, substance abuse, suicide, and other society-wide problems often include culturally specific practices, such as traditional healing. In the few studies that have explored the explicit need for traditional services, as made clear by Native people themselves, this requirement has been great. In a study of 150 AI/AN patients aged 18-83 years old recruited from a Milwaukee clinic, 86% of those who were not seeing a traditional healer reported that they would consider seeing a traditional healer in the future; more than a third of the participants were currently seeing a healer in additional to receiving care from a physician (Marbella, Harris, Diehr, Ignace, & Ignace, 1998). In one of the rare mental health needs assessments performed with urban AIs/ANs, Tucson, Arizona survey data from 174 adult AIs/ANs revealed interesting findings about cultural and family resources in the community (Evaneshko, 1999). Despite the fact that survey respondents considered themselves to be "long time urban residents", an overwhelming eighty-three percent continued to hold on to at least one part of traditional Native ways (Evaneshko, 1999). Nearly one-fourth of respondents (22%) stated that they were likely to use a sweat lodge if needed, and 20% percent cited the use of Native medicine (Evaneshko, 1999).

Traditional Healing and Demographics

In perhaps the only identifiable study of its kind, a Milwaukee-based sample of 150 adult AI/AN female patients were found to be more likely to pursue traditional healing when compared to male patients; older patients were more likely to seek care from traditional healing when compared to younger patients (Marbella, et al., 1998). Differences for both age and gender were statistically significant. Only rarely have former studies explored the demographic variables that impact participation in traditional healing. This study attempts to address this deficit in the literature by exploring the demographic, clinical, and treatment variables that impact one's propensity to participate in traditional healing.

Background on the Bemidji Needs Assessment Study

The Urban Indian Health Institute (UIHI) is a sub-division of the Seattle Indian Health Board. The stated mission of the UIHI is to assist with the health of the nation's urban American Indian/ Alaska Native (AI/AN) community via scientific research and information (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009). The Bemidji Area Office of Indian Health Service (IHS) comprises a region of the United States that includes Minnesota, Wisconsin, Michigan, Illinois and Indiana, and is known to be the home of over 200,000 individuals who identify as AI/AN alone, and over 400,000 people who identify as AI/AN alone or in combination with another race (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009). Within the Bemidji area, there are five urban Indian health organizations (UIHO) located in Chicago IL, Detroit MI, Green Bay WI, Milwaukee, WI and Minneapolis, MN. Following a request by the urban Indian community and the Bemidji

Area Office Indian Health Service (IHS), a needs assessment and subsequent data analysis was conducted in 2008. The needs assessment was conducted in six urban centers within the Bemidji area: the five cities with an urban Indian health organization (Chicago IL, Detroit MI, Green Bay WI, Milwaukee WI and Minneapolis MN), as well as Grand Rapids MI. The UIHI has provided technical assistance for the project since 2005 (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009). The overarching goal of the project was to identify the health needs of urban American Indians currently living in the Bemidji area. The needs assessment aimed to capture the barriers to treatment, identify gaps in the health services provided, and understand the challenges associated with obtaining health services in the Bemidji area. At the same time, the project also sought to learn the ways in which the current health programming was successful, and to identify additional methods in which the health of urban AIs/ANs could be ensured. The quantitative data collected from the Detroit, Michigan American Indian Health and Family Services (AIHFS) center will be considered in the context of this dissertation chapter to provide a more global addendum to the results of the smaller-scale qualitative needs assessment reported in the earlier chapters of this dissertation.

Demographics of the Bemidji Needs Assessment

In addition to an urging by the urban American Indian community itself, the necessity for this needs assessment was also premised on demographic information compiled from the 2000 census and the National Center for Health Statistics that indicate that AIs/ANs, both in the Bemidji area and in the general population were facing a number of damaging socio-economic factors. Those factors included higher rates of

disability, more single parent homes, elevated rates of poverty, and lower rates of formal education (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment, 2009). In an examination of the data collected from the Detroit area (N= 389), 62% of AIs/ANs lived in households with income below the poverty level and nearly 12% reported no income (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009). Teen births, single parent homes, lack of prenatal care, and substance use during pregnancy were all significantly higher for AIs/ANs compared to the general population. Furthermore, 30 % had no health insurance; more than double the rate for all races (14.5%) (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009).

Methods

Procedures

Data collection for the seven county area served by AIHFS occurred from March - October of 2008. Interviews were conducted during times that were convenient for community members, including daytime, weekdays, and weekends. In order to minimize/eliminate the use of paper surveys, the data were collected via a Microsoft Access data entry system (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009). The survey responses were kept in a separate database from contact information so that only a randomly assigned ID number was present in the survey database.

The interviews were conducted by AIHFS staff as well as temporary community member staff. Interviewers were of AI/AN heritage. All interviewers attended a one-day training on the use of the survey conducted by the Great Lakes Inter-Tribal Epidemiology

Center (GLITEC) and UIHI staff (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009). All of the interviews were conducted in person. Once consent was obtained, each interview required approximately 45 minutes to administer and participants were compensated for their time with a $25 gift certificate. Each participant was given the opportunity to ask any questions at the time of the interview, and was provided the name and contact information of the Project Coordinator at GLITEC to answer any questions (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009).

Sampling Method

A non-probability convenience sampling methodology was utilized for this study. The criteria for participation were that participants be 18 or older, and residents in the seven county area which comprises the Bemidji area of Indian Health Service. Venues for recruiting participants were varied and many in order to ensure that the convenience sample represented a broader array of American Indian and Alaska Native community members.

Recruitment. Participants in the Detroit area were self-identified American Indian and Alaska Natives age 18 and older living in the seven-county area served by AIHFS which includes Detroit. Participants were recruited from the Detroit area using the client list. Additional AIs/ANs living in the seven county area were recruited by advertising the needs assessment in newspapers, the newsletter, word of mouth, flyers at the center, flyers at events, and community member referrals. Other AI/AN organizations dedicated to promoting Indian heritage and culture, and organizations providing health and social services to AIs/ANs were contacted to recruit additional participants. Finally,

recruitment also took place at local AI/AN events, such as powwows and community celebrations. The recruitment was designed to capture not only those already utilizing the urban Indian Health Services, Tribal and urban Indian healthcare systems, but a broad spectrum of the urban AI/AN population (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009).

Measures

Survey development and design. Funding for survey development, pretesting and database development was provided by the Indian Health Service Division of Epidemiology and Disease Prevention, Tribal Epidemiology Center grant. Questions were developed based on the feasibility study results, which identified six major themes, including (1) Health education and health promotion; (2) Healthcare and health program funding; (3) Systems and regulations; (4) Healthcare access-general; (5) Healthcare quality and (6) Social issues that impact health. The Bemidji Advisory Committee reviewed the survey draft during a two-day in-person meeting, removing some of the questions and adding others (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009). The Bemidji Advisory Committee was comprised of administrative representatives from each of the Bemidji Area offices, including Minneapolis, Detroit, Green Bay, Grand Rapids, Milwaukee, and Chicago. Further revision and refinement of the survey instrument occurred on two subsequent conference calls with the Bemidji Advisory Committee. The final draft resulting from the Advisory Committee review was used for pretesting. During pretesting ten interviews were conducted in each of the five locations using standard probing techniques for a total of 50 interviews. Upon completion of the interviewing, a final recommended survey instrument

was produced. This draft of the needs assessment instrument was reviewed by the Advisory Committee, UIHI, the Great Lakes Inter-Tribal Epidemiology Center (GLITEC), and Bemidji Area Office IHS staff to produce the further revised survey instrument (Bemidji Area Urban American Indian/ Alaska Native Needs Assessment: Detroit, 2009).

Bemidji area urban American Indian and Alaska Native needs assessment. The final survey administered to participants consisted of 79 required questions (in addition to 7 optional questions), divided into 12 sections (See Appendix H). The majority of survey questions were categorical in nature; meaning that participants were prompted to select the most appropriate response from the choices provided pertaining to the respective question. Participants were occasionally given the opportunity to address survey questions in an open-ended format. For the purposes of this project seven sections included relevant variables and are the following: (1) *Section 1, Background Information:* gender, age, marital status, veteran status, household size, and zipcode of primary residence. A sample question is, "Are you a veteran?" [Response options were (1) = No; (2) = Yes]. (2) *Section 2, Finances and Healthcare:* current health coverage status, current health coverage status of their dependents (if applicable), employment status, and income. A sample question is, "What does the health care plan for your children or dependents not cover (please specify)?" (3) *Section 3, Enrollment:* tribal enrollment. A sample question is "Are you enrolled in a federally recognized tribe, State recognized tribe, First Nations Band (Canada) or Alaska Native shareholder or descendent?" [Response options were (0) = No; (1) = Yes]. (4) *Section 4, Patient's Choice and Utilization of Health Care:* where healthcare received, how often healthcare

services received and if applicable, why no pursuit of healthcare services if needed. A sample question is "What is most important when choosing where you receive healthcare for yourself?" [Response options were (1) = Convenience; (2) = Quality; (3) = Transportation; (4) = Cost; (5) = Specialist; (6) = Culturally sensitive care; (7) = Other reason]. (5) *Section 5, Traditional Services:* past and future use of traditional services, preferred uses for traditional medicine. A sample question is "Would you like to use traditional services?" [Response options were (1) = Would use; (2) = Might like to use; (3) = I don't want to use; (4) Don't know/ not sure]. (6) *Section 9, Health Education and Health Promotion:* the local Indian community and the resources available. A sample question is "There is health education that includes domestic violence in my community." [Response options were (1) = Strongly agree; (2) = Agree; (3) = Neutral; (4) = Disagree; (5) = Strongly disagree, (7) = Don't know. (7) *Section 12, Social Issues:* how do socio-demographic factors, such as affordable housing or gang activity, impact health behaviors. A sample question is "I believe that my neighborhood is dangerous." [Response options were (0) = No; (1) = Yes; (2) = Does not apply].

Secondary Data Analysis Procedures

Thirty-eight items from the survey were included in the study as possible predictors of participation in traditional healing (See Appendix G). The single item selected as the outcome variable, *participation in traditional healing,* is listed below as the dependent variable. Those items which were selected for inclusion in the final model are listed below as independent variables.

Dependent Variable (1)

Participation in traditional healing was assessed by asking the respondent the following: “Have you used traditional services for yourself?” [Response options were (0) = No; (1) = Yes; (7) = Don’t know/ not sure].

Independent Variables Included in the Final Model (9)

Gender was recorded by asking “What is your gender?” [Response options were (1) = Female; (2) = Male; (3) = Two Spirit/ Other. The term ‘two spirit’ refers to individuals who embody both masculine and feminine spirits simultaneously. Age was recorded by asking “What is your age?” [Categorical response options were (1) = 18-19; (2) = 20-34; (3) = 35-44; (4) = 45-54; (5) = 55-64; (6) = 65-74; (7) = Over 74]. In the course of analysis the categorical variable “age” was recoded in order to minimize the standard error of one of the age categories (18-19). [Recoded categorical response options were (1) = 18-34; (2) = 35-44; (3) = 45-54; (4) = 55-64; (5) = 65+]. Marital status was recorded by asking “What is your current marital status? [Categorical response options were (1) = Married; (2) = Divorced; (3) = Widowed; (4) = Separated; (5) = Never Married; (6) = Long-Term Partner]. Tribal enrollment status was recorded by asking “Are you enrolled in a federally recognized tribe, State recognized tribe, First Nations Band (Canada), or Alaska Native shareholder or descendent?” [Categorical response options were (0) = No; 1 = Yes]. Receipt of health services in the past 12 months was assessed by asking, “Have you received any health services in the past 12 months?” [Categorical response options were (0) = No; (1) = Yes)]. Want more traditional services was assessed by asking “I would like to see more traditional healing, health, and wellness.” [Likert scale options were (1) = Strongly agree; (2) = Agree; (3) = Neutral; (4) = Disagree; (5) = Strongly disagree; (7) = Don’t know; (9) = Refused].

Discrimination in healthcare settings was assessed by asking "I believe I have experienced discrimination while seeking/ receiving healthcare." [Categorical response options were (0) = No; (1) = Yes; (2) = Does not apply)]. Knowing someone with an addiction was assessed by asking "I know someone with an addiction." [Categorical response options were (0) = No; (1) = Yes; (2) = Does not apply)].

Exploratory Analysis

Data from the 38 independent variables identified as initial predictors of participation of traditional healing were managed in SPSS 8.0. Descriptive and frequency calculations were performed as part of the exploratory data analysis process. Responses that were coded as "missing," "refused," "does not apply," or "don't know/not sure" were excluded from their respective variable indexes to ensure a robust model.

Logistic Regression Analysis

Variables which were missing more than 25 cases (out of the total 389 cases) were excluded from the regression analyses as to ensure a more robust model. Variables excluded were from the following questions: Do you feel domestic violence in the Indian Community is a problem?; There are health and wellness fairs directed towards Urban Indians; There is support for people to deal with life stress; Support programs for men are available in my community; and I have a hard time finding affordable housing.

Prior to conducting the regression analyses, the relationships between the potential independent variables and the dependent variable were assessed by conducting Pearson Chi-Square analyses. Independent variables that resulted in Pearson Chi-Square values at a level of $p < .05$ were added to the model for consideration. Then, a bivariate logistic regression model was created using the step-wise backward elimination method

in order to identify variables from the survey that were possible predictors of traditional services use. All variables that were significant (p <.05) or demonstrated a trend towards significance (p <.10) in exploratory analyses were included in the regression analyses. An exhaustive list of the variables initially included is presented in Appendix F. All variables were examined, and the most parsimonious models were chosen. In addition, predictors that were demographically significant (including sex, age, marital status, and tribal enrollment status) were included regardless of statistical significance because they have been previously found to be associated with use of traditional healing (Gurley, et al., 2001; Marbella, et al., 1998).

Results

Demographic Characteristics of the Respondents

Of the original 389 survey participants 100% completed the survey. Nearly half of the Detroit sample (48%, n = 185) had used traditional services; 50% (n = 196) had not used traditional services; the remaining 2% (n = 8) were missing data on the item, i.e. had refused to answer, indicated that they did not know/were not sure. The main demographic variables of the two sub-groups of the sample, users of traditional services (TSU) and non-users of traditional services (NU), are summarized in Table 3.1. The two subgroups were not significantly different for age, (p = .85); gender (p = .98); marital status (p = .39); enrollment in a federally recognized tribe (p = .78); household size (p = .61); having dependent children (p = .54); and veteran status (p = .94).

Description of the traditional services users (TSU). Of the 185 TSU's females comprised 63% of the group (n = 112), and men comprised the remaining 37% (n = 67). Age-wise, a little more than a quarter of the TSU's were in the 35-44 range (27%, n =

50), followed by 18-34 range (24%, n = 40), then 45-54 (21%, n = 38), and ages 55-64 (16%, n = 30). The remaining 12% (n = 22) were in the 65+ age category. Most of the TSU's were either currently married (36%, n= 67) or had never been married (27%, n = 51). The remaining were divorced (18%, n = 33), had a long-term partner (9%, n = 16), were widowed (7%, n = 13), or separated (3%, n = 5). Ten percent (n = 17) of the TSU's were veterans. Over half of the TSU's (51%, n=94) had a household size of 1-2 persons (including the participant). Forty-two percent of the TSU's reported a household size of 3-5 (42%, n = 77), followed by 6-51 persons (7%, n = 12), and then 0 persons (0.5%, n = 1). Approximately one third of the TSU's reported dependent children (37%, n = 68). Seventy-eight percent (n = 144) were enrolled members of a federally recognized tribe.

Description of the traditional services non- users (NU). Of the 196 NU's, females comprised 63% of the group (n = 62), men comprised 37% of the group (n = 37), and two-spirit/other comprised 1% of the group (n = 3). Age-wise, one-quarter of the NU's were in the 18-34 age range (n=49), followed by those in the 35-44 age range (22%, n = 43), then 45-54 (22%, n = 42), and 55-64 (18%, n = 35). The remaining 13% were in the 65+ age category (n = 25). Thirty-four percent of the NU's were currently married (n = 66) or had never been married (31%, n = 61). The remaining NU's were widowed (8%, n = 16), had a long-term partner (4%, n = 7), or were separated (3%, n = 6). Nine percent (n = 18) of the NU's were veterans. Nearly half of the NU's had a household size (including the participant) of 1-2 (49%, n = 86), followed by 3-5 (41%, n = 72), and then 6-51 persons (9%, n = 16). Approximately one third (34%, n = 67) of the NU's reported dependent children. Seventy-seven (n = 151) percent of NU's reported

enrollment in a federally recognized tribe, First Nations Band, or Alaska Native shareholder.

Table 3.1

Demographic Characteristics: Users and Non-Users of Traditional Services

	TS Users	TS Non-Users
	n (%)	n (%)
Sex		
Female	112 (63)	121 (62)
Male	67 (37)	72 (37)
Two-Spirit/ Other	0 (0)	3 (1)
Age		
18-34	43 (24)	49 (25)
35-44	50 (27)	43 (22)
45-54†	38 (21)	42 (22)
55-64	30 (16)	35 (18)
65+	22 (12)	25 (13)
Marital status		
Married	67 (36)	66 (34)
Divorced	33 (18)	40 (20)
Widowed	13 (7)	16 (8)
Separated	5 (3)	6 (3)
Never married	51 (27)	61 (31)
Long term partner	16 (9)	7 (4)
Veteran status		
Yes	17 (10)	18 (9)
No	161 (90)	175 (91)
# in hsehld including self		
0	1 (0.5)	0 (0)
1-2	94 (51)	86 (49)
3-5	77 (42)	72 (41)
6-51	12 (7)	16 (9)
Have dependent children		
Yes	68 (37)	67 (34)
No	114 (63)	128 (66)
Know someone in a gang		
Yes	59 (32)	41 (21)
No	125 (68)	153 (79)
Enrolled in a federally recognized tribe		
Yes	144 (78)	151 (77)
No	40 (22)	45 (23)

†$p < 0.10$ *$p < .05$ **$p < .01$ ***$p < .001$

Significant Predictors of Participation in Traditional Healing

Logistic regression analyses indicated that participation in traditional services was associated significantly with the following variables: age range of 45-54; receiving healthcare services in the past 12 months; wanting to see more traditional healing, health, and wellness; discrimination in healthcare settings; and knowing somebody with an addiction (Table 3.2).

Table 3.2

Health Characteristics: Users of Traditional Services (TU) and Non-Users (NU)

	TS Users	TS Non-Users
	n (%)	n (%)
Received healthcare services in past 12 month***		
Yes	159 (86)	145 (74)
No	26 (14)	51 (26)
Would like more traditional healing, health, wellness***		
Strongly Agree	88 (48)	44 (23)
Agree	92 (50)	125 (65)
Neutral	4 (2)	20 (10)
Disagree	0 (0)	1 (0.5)
Strongly Disagree	0 (0)	1 (0.5)
Know someone with an addiction***		
Yes	174 (95)	160 (82)
No	9 (5)	34 (18)
Have exp. discrimination while receiving healthcare***		
Yes	58 (33)	27 (14)
No	120 (67)	155 (85)
Know someone who does not get prenatal care		
Yes	48 (28)	27 (14)
No	124 (72)	164 (86)
Know someone who died by suicide		
Yes	132 (72)	104 (53)
No	52 (28)	91 (47)

$^{\dagger}p < 0.10$ $*p < .05$ $**p < .01$ $***p < .001$

Participation in traditional healing and age. There were significant differences in the distribution of the traditional healing variable between the age categories of 45-54 and the reference group of 65+. For those in the 45-54 age group, the odds of participating in traditional healing decrease by 61% when compared to those 65+ when controlling for all other independent variables in the model (OR = 0.39; $p = .06$) (see Table 3.3).

Participation in traditional healing and receipt of services in the last 12 months. For individuals who have received health services in the past 12 months, the odds of participating in traditional healing increase by 236% when compared to those who have not received health services in the past 12 months when controlling for all other independent variables in the model (OR = 3.36; $p \leq .001$) (see Table 3.3).

Participation in traditional healing and want more traditional healing. For individuals who want to see more traditional healing, health, and wellness, the smaller the numerical value on the Likert scale (1 = Strongly Agree; 5 = Strongly Disagree), the more likely one is to participate in traditional healing. A one unit increase in the Likert scale decreases the odds of participation in traditional healing by 70% when controlling for the other independent variables included in the model (OR = 0.30; $p \leq .001$) (see Table 3.3).

Participation in traditional healing and discrimination while seeking healthcare. For individuals who have experienced discrimination while seeking healthcare, the odds of participating in traditional healing increase by 195% when compared to those who have *not* experienced discrimination while seeking healthcare

when controlling for all other independent variables in the model (OR = 2.95; $p \leq .001$) (see Table 3.3).

Participation in traditional healing and knowing someone with an addiction. For individuals who know somebody with an addiction, the odds of participating in traditional healing increase by 376% when compared to those who do *not* know somebody with an addiction when controlling for all other independent variables in the model (OR = 4.76; $p = .001$) (see Table 3.3).

Table 3.3

Regression Model for Participation in Traditional Services

Predictor	*B*	*SE B*	Wald's x^2	*df*	*OR*	*p*	*Lower CI (OR)*	*Upper CI (OR)*
Gender (Ref = Male)								
Female	0.14	0.26	0.30	1	1.15	0.58	0.69	1.93
Age category (Ref = 65+)								
18-34	-0.76	0.53	2.07	1	0.47	0.15	0.17	1.32
35-44	-0.47	0.49	0.91	1	0.63	0.34	0.24	1.63
45-54	-0.95	0.50	3.7	1	0.39	0.06†	0.15	1.02
55-64	-0.62	0.49	1.6	1	0.54	0.20	0.21	1.40
Marital status (Ref = married)								
Divorced	-0.069	0.34	0.041	1	0.93	0.84	0.48	1.82
Widowed	0.50	0.58	0.73	1	1.65	0.39	0.53	5.16
Separated	1.05	0.82	1.64	1	2.87	0.20	0.57	14.37
Never married	-.004	0.35	.000	1	1.00	0.99	0.50	1.99
Long term partner	0.49	0.56	0.77	1	1.63	0.37	0.55	4.87
Enrolled in fed. recognized tribe	-0.56	0.31	0.032	1		0.86	0.52	1.74
Received health services in past 12 mos.	1.21	0.33	14.0	1	3.36	.000***	1.78	6.36
Want more trad. healing (lower scores = want more healing)	-1.20	0.23	26.2	1	0.30	.000***	0.19	0.48
Experienced discrimination while seeking healthcare	1.08	0.31	12.3	1	2.95	.000***	1.61	5.39
Know somebody with an addiction	1.56	0.49	10.2	1	4.76	.001***	1.83	12.4
Constant	1.73	0.90	3.70	1	5.66	0.05	-	-

†$p < 0.10$ *$p < .05$ **$p < .01$ ***$p < .001$

Discussion

Descriptive analyses indicate that roughly half (48%) of the study sample had participated in some form of traditional healing. The majority of those who used traditional services were women (63%) (See Table 3.1). The largest proportion of those who used traditional services were participants ages 35-44 (27%). The largest proportion of those who used traditional services were married (36%). Thirty-seven percent of traditional service users had dependent children. Tribal enrollment status did not impact one's propensity to participate in traditional healing, as users and non-users of traditional services were not statistically different for enrollment status (p = .78). While little has been published in the way of enrollment status on the role of receipt of traditional services, the results as related to actual usage rates and the overrepresentation of females as recipients of such services are consistent with findings of earlier research (Marbella et al., 1998; Schiff & Moore, 2006).

Regression analyses reveal that study participants age 45-54 were significantly less likely to participate in traditional healing when compared to their counterparts aged 65 and above. While the literature that exists on the demographic variables associated with traditional healing is rare, results from this study are consistent with comparable studies. In an interview study of 174 urban AIs/ANs, Marbella et al., (1998) concluded that traditional healing was more likely to be pursued by older patients in the 150-person sample than younger patients in general. These results may be related to the ways in which traditional healing ceremonies are applied in AI/AN health care settings. American Indian/Alaska Native healing traditions have been recognized for their role in maintaining spiritual, physical, and mental wellness in a traditional way (Portman &

Garrett, 2006). However, traditional healing has for centuries been utilized for its healing properties, including treating chronic illnesses such as arthritis (Van Sickle, Morgan, & Wright, 2003). It is likely then that the need for traditional healing would most likely not become salient until after the development of such illnesses, many of which are seen in elevated rates amongst older patients. Therefore, not only are older patients at increased risks for developing the health conditions for which traditional healing has been known to be used, but older adults may also have had more negative experiences with Western health care settings, and hence be more willing to engage in traditional modes of healing.

Demographic analyses also indicate that AI/AN women are over-represented as users of traditional services (63%). These findings are consistent with those established by comparable, yet rare research studies. In Marbella et al.'s (1998) Milwaukee-based study of 150 AI/AN outpatients (ages 18-83), more women patients (41.7%), compared to men (29.8%), sought care from traditional healers (Marbella, et al., 1998). In Schiff and Moore's (2006) portrait of the sweat lodge ceremony, the sample size was considerably smaller, 39 participants. However, women who participated in traditional healing were overrepresented by a large margin when compared to men who did so (72% and 28%, respectively (Schiff & Moore, 2006). It is of note that in this study, differences in gender distribution were partially attributed to the time of day that the sweat lodges were held.

Analyses from this study indicate that those who have received any type of health services (as defined by the participant) in the past year are significantly more likely to participate in traditional healing. American Indian/Alaska Native consumers of traditional medicine in this sample are also users of other health services which may include Western medicine. It is possible then that the treatments that patients receive for their

health issues are either not being effective on their own, or must be used in conjunction with traditional services in order for patients to receive relief from their symptoms. The finding that many Native people prefer traditional practices to Western medicine has been confirmed by research and in some cases, traditional healing may be pursued after Western treatments in order to offset the counterintuitive and ineffective conventional medical and psychological practices one may have experienced (McCabe, 1997). In a qualitative examination of adult 39 AIs/ANs living in Baltimore, skepticism of mainstream healthcare services, including fear of being classified as another racial category, was a major theme highlighted by researchers (Johnson, Gryczynsky, & Wuechelt, 2007). Studies have also concluded that minority consumers of mental health services who held more negative views of services were less likely to use them again (Diala, et al., 2000). It is possible then that after internalizing negative healthcare experiences in mainstream healthcare settings, participants in our study then pursued traditional services; however, the sequence of actions is not necessarily causal and must be interpreted with caution. The connection between the receipt of health services in the past year and participation in traditional healing may also be related to treatment seeking and stigma. Shame, stigma, and pride have been identified as factors that prevent AIs/ANs from seeking healthcare (Johnson, Gryczynsky, & Wuechelt, 2007). Furthermore, research demonstrates that the cultural nuances inherent in distinct AI/AN tribes pose difficulties in securing accurate medical diagnoses, particularly in the field of psychiatry (Beals, et al., 2005). Therefore, the high number of individuals who participate in both traditional healing and have received health services in the past 12 months may be controlling for the fact that these are patients who are more likely to have

a) been formally diagnosed (accurately or otherwise) and b) have to some degree confronted, or even overcome the stigma associated with their respective presenting health issue(s).

Analyses indicate that those who desire more traditional healing are significantly more likely to participate in such services. This finding that traditional service users are satisfied with the care that they are currently receiving may mean that traditional healing services are in some aspect responsive to the presenting health issues for which traditional healing has initially been pursued. Literature regarding satisfaction with and/or the effectiveness of traditional healing is limited. Walls, Johnson, Whitbeck, & Hoyt (2006) conducted qualitative analyses with over 800 tribally enrolled AI/AN youth. They found nearly 40% of those surveyed found visiting a traditional healer to be effective; 37.7% thought participating in a traditional ceremony was effective; 33.6% felt a healing circle was effective; and 33.2 % found that participating in a sweat lodge was effective (Walls, et al., 2006).

The results of the logistical regression indicate that those who have experienced discrimination while seeking healthcare are significantly more likely to participate in traditional healing. It is of note that a related measure was included in the survey ("I have been refused medical care from a tribal healthcare or an IHS-funded urban program"). However, preliminary analyses deemed the measure insignificant and so the measure was not used in subsequent analyses. Nonetheless, the inclusion of the measure is poignant, as it implies settings at which the cited discrimination is likely to have taken place, i.e. non-Native health centers and non-tribal health facilities. Survey respondents were asked about their health behaviors at IHS and other tribal health programs in a separate part of

the survey. It is therefore likely that the discrimination referenced in the measure has taken place within the context of dominant culture healthcare settings. Barriers to treatment for AIs/ANs as identified in previous research include discrimination in dominant culture healthcare settings (Johnson, Gryczynsky, & Wuechelt, 2007). Discrimination is a part of the daily lives of AIs/ANs, and has been associated with delinquent behaviors, and early substance abuse in AI/AN youth (Whitbeck, et al., 2001). While traditional healing may be seen as an alternative to the inherent shortcomings in the health modalities offered by the dominant culture, this finding is telling that urban AIs/ANs may be discovering traditional healing by way of marginalization and discrimination.

Our final finding indicates that those participants who know somebody with an addiction are significantly more likely to participate in traditional healing. Alcohol use and misuse in the AI/AN community has been well documented. In some tribal populations, alcohol use is estimated to be as high as 84% (Spicer, 2001). In this study 97% of those surveyed stated that they knew somebody with an addiction. There is no doubt then that there is a need for recovery services for urban AIs/ANs. Research in this domain has indicated that money from federal agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) is often earmarked for prevention programs with AI/AN youth, not necessarily addiction treatment programs for adults (Moran & Bussey, 2007; Hawkins, Cummins, & Marlatt, 2004). While such prevention programming has been advantageous in that it allows for the use of culturally salient practices, including traditional medicine, its implementation has been somewhat limited to rural, reservation-based areas. Nebelkopf and Phillips (2004) have cited the lack of

resources for urban AIs/ANs, stating that "the mainstream system of care has been designed around the needs of funding agencies instead of the needs of clients. Managed care does not recognize that effective services must acknowledge individual differences and cultural identities" (Nebelkopf and Phillips, 2004, p. 47) At AIHFS, for example, the nearest inpatient substance abuse facility is over nine hours away. Nonetheless, the relationship between traditional healing and substance abuse is a telling one for urban AIs/ANs. Research has identified traditional healing to be a culturally appropriate means for substance abuse treatment for AIs/ANs. For many, components from traditional healing, such as sweat ceremonies and talking circles are used in conjunction with Western practices including AA meetings (Nebelkopf & Penagos, 2005; Nebelkopf, & King, 2003). The finding that those who knew somebody who has an alcohol or tobacco addiction (96% and 95%, respectively) are more likely to participate in traditional healing captures not only the high incidence of addiction in Indian communities, but the growing use of traditional healing in addiction treatment. In this sense, treatment for addiction is the avenue by which urban AIs/ANs are being introduced to traditional healing, and considering the epidemiological data on alcohol use, we would only expect to see increasing levels of traditional healing run parallel to rates of addiction. An alternative interpretation of these findings suggests that there is simply a high incidence of addiction amongst the sample of urban American Indians used in the study, and the relationship between traditional healing and addictions cannot be considered causal.

Upon review of the logistic regression results from the study, the following limitations should be noted. The study was a cross-sectional design, and the survey results cannot be generalized beyond this specific sample, treatment setting, or population

as it was a convenience sample. The participants in the study were self-selecting and self-reporting, meaning that the quantitative results acquired from the survey measure are limited in the extent to which they accurately represent behaviors and opinions of all American Indians/Alaska Natives. However the overall study goals were to learn about the care that was received and additional recruitment methods described previously were used to recruit participants from a broader area. Little has been captured surrounding the demographic factors that impact participation in ritual and traditional healing for urban American Indians/Alaska Natives in predominantly Western-oriented health centers. This project aimed to address this deficit in the literature as well as to provide future directions for research in the areas presented in this study. Participants were recruited through convenience sampling. In addition, many were clinic patients, adding a bias towards persons who seek care. Clinic patients may differ from the general population in several ways: poorer health resulting in more medical care, or better health outcomes due to more medical attention. It is possible that those with the greatest need, such as persons who are homeless or those who do not seek care, were missed. The results may not be generalizable or representative of the general population of AIs/ANs living in these six urban areas or the greater urban AI/AN population.

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CHAPTER V

Conclusion

Contemporary American Indian and Alaska Natives who live in urban areas today face the daunting task of navigating an urban landscape while maintaining the facets of their respective Native cultures. While AIs/ANs continue to grapple with the intergenerational trauma associated with forced assimilation, relocation movements, and boarding schools, these traumas have manifested themselves in elevated rates of psychopathology. AIs/ANs have been shown to have elevated rates of domestic abuse, poverty, suicide, and substance misuse. For centuries, Native people have followed the tenets of ritual and traditional healing to address imbalances in the body, mind, and spirit. In the last 50 years, there has been a resurgence in traditional healing, particularly in part due to the utilization of traditional and ritual healing by health clinics that serve urban AIs/ANs today. For the purposes of this dissertation, the services provided by a singular urban AI/AN health center were considered.

The first two papers in this three-paper project included qualitative material via talking circles aimed at capturing the needs of both the service providers and community members of the Detroit health center. The ability to identify both the current strengths and weakness of the current programming of the center are significant in providing a forum in which the community can influence the very center from which it receives treatment. Furthermore, as evidenced by its recent grant submissions, staff hirings, and

attempts to modify health policies, AIHFS, its policies and health offerings continues to be informed by the needs of its own patients. The third paper in this project has implications concerning the degree to which a number of demographic and health variables impact urban AIs'/ANs' propensity to engage in traditional and ritual healing. While such findings are informative in terms of who is participating in traditional healing, they may also provide future directions as to how to increase engagement in ritual healing in AI/AN subgroups where participation has traditionally been low.

The role of traditional healing for AI/AN people has been shown to be an important one, whether it serves as a protective factor, or as a means to connect with one's Native heritage in a world in which one must simultaneously process the values of the dominant culture. The findings presented in this three-study dissertation are findings related not only to the health needs of Detroit's urban AI/AN community, but offer recommendations for making health services accessible, culturally salient, and influenced by those who are or may become consumers of such services. Further research in these areas may continue to be guided by the findings demonstrated in the preceding dissertation, with the hope that future studies will only expand our knowledge in the areas presented here.

APPENDIX A

Recruitment Material

Gda'shkitoomí
(We are Able!)

Circles of Care Community Research Project

- ***Advisory Board***
- ***Interviews***
- ***Talking Circle Focus Groups***

American Indian Health and Family Services Needs Your Input!

You can help build a healthy community

Participate in an <u>hour long</u> Interview about the health of our community and you will receive $20.

OR

Participate in an <u>hour long</u> Talking Circle Focus Group about the health of our community and you will receive $20.

You must be 12 years or older to participate in an interview or talking circle focus group.

For more information please contact:
Cecelia (313) 846-3718 ext 1119

Jerilyn Church, Site Coordinator
Minobinmaadziwin
American Indian Health and Family Services
Ann Arbor

Cecelia LaPointe, Project Specialist
Minobinmaadziwin
American Indian Health and Family Services

Sandy Momper, PI
School of Social Work
University of Michigan,

APPENDIX B

Interview Consent Forms

Provider Consent to Participate in a Research Study
Gda'shkitoomi (We are able!) Circles of Care Research

Investigator: Sandra Momper, PhD, School of Social Work, University of Michigan
Jerilyn Church, MSW, American Indian Health and Family Services

The purpose of this research study is to gather information about health to be able to improve the physical, emotional and spiritual health services available to our American Indian community. This information will help us design a health program that will include your input regarding health needs and services. For that reason we are conducting one hour interviews with providers of service to members of the American Indian community.

If you agree to be part of this study you will be asked general questions about physical, emotional and spiritual health needs and services in the community. The interview will be in a private room so that you can talk freely. We will record what you say. If you do not want to be recorded you will not be able to be interviewed. You may not receive a direct benefit from being in the interview, but we hope that this study will result in better health services for Indians. Answering questions may be uncomfortable. You can choose not to answer a question or stop the interview at any time. Just tell the interviewer you want to leave.

We plan to publish the results of this study, but will not include any information that would identify you. To keep your information safe the tape of the interview and the written copy of the discussion will be placed in a locked file cabinet. To protect confidentiality your real name will not be used in the written copy of the discussion. The researchers will enter data on a computer that is password-protected. There are some reasons why people other than the researchers may need to see information you provided as part of the study. This includes organizations responsible for making sure the research is done safely and properly, including the University of Michigan, government agencies, or the study sponsor, SAMHSA. Also, if you tell us something in the interview that makes us concerned that you or others may have been harmed, we have an ethical obligation to report suspected child or elder abuse to the Michigan Department of Human Services.

Your help in this project is voluntary-entirely up to you. Even after you agree to participate and receive payment you may decide to leave at any time.

If you have questions about any of this contact Sandy Momper at (734)-998-6323, smomper@umich.edu or Cecelia LaPointe at CLaPointe@aihfs.org.
If you have questions about your rights as a research study participant contact the Institutional Review Board at the University of Michigan at (734) 936-0933, or irbhsbs@umich.edu.
Consent
Are you willing to be interviewed?

IRB: Health Sciences IRB Number: HUM00027801 Document Approved On: 3/20/2009

Community Member Consent to Participate in a Research Study
Gda'shkitoomi (We are able!) Circles of Care Research

Investigators: Sandra Momper, PhD, School of Social Work, University of Michigan
Jerilyn Church, MSW, American Indian Health and Family Services

The purpose of this research study is to gather information about health to be able to improve the physical, emotional and spiritual health services available to our American Indian community. This information will help us design a health program that will include your input regarding health needs and services. For that reason we are conducting one hour interviews with members of the American Indian community.

If you agree to be part of this study you will be asked general questions about physical, emotional and spiritual health needs and services in the community. The interview will be in a private room so that you can talk freely. We will record what you say. If you do not want to be recorded you will not be able to be interviewed. You may not receive a direct benefit from being in the interview, but we hope that this study will result in better health services for Indians. Answering questions may be uncomfortable. You can choose not to answer a question or stop the interview at any time. Just tell the interviewer you want to leave.

You will be paid a $20 Meijer Gift Card for being interviewed and if you decide to quit before the interview is over, you will still be paid.

We plan to publish the results of this study, but will not include any information that would identify you. To keep your information safe the tape of the interview and the written copy of the discussion will be placed in a locked file cabinet. To protect confidentiality your real name will not be used in the written copy of the discussion. The researchers will enter data on a computer that is password-protected. There are some reasons why people other than the researchers may need to see information you provided as part of the study. This includes organizations responsible for making sure the research is done safely and properly, including the University of Michigan, government agencies, or the study sponsor, SAMHSA. Also, if you tell us something in the interview that makes us concerned that you or others may have been harmed, we have an ethical obligation to report suspected child or elder abuse to the Michigan Department of Human Services.

Your help in this project is voluntary-entirely up to you. Even after you agree to be interviewed and receive payment you may decide to leave at any time. If you have questions about any of this contact Sandy Momper at (734)-998-6323, smomper@umich.edu, or Cecelia LaPointe at CLaPointe@aihfs.org.
If you have questions about your rights as a research study participant contact the Institutional Review Board at the University of Michigan at (734) 936-0933, or irbhsbs@umich.edu.

Consent

Are you willing to be interviewed?

IRB: Health Sciences IRB Number: HUM00027801 Document Approved On: 3/20/2009

Parental Consent for Your Child to Participate in a Research Study
Gda'shkitoomi (We are able!) Circles of Care Research

Investigator: Sandra Momper, PhD, School of Social Work, University of Michigan

The purpose of this research study is to find ways to provide better health services to Indian community members. For that reason we are conducting one hour interviews with American Indian community members. We are asking for your permission for your child to participate in a study. Even if you give your child permission to participate, I will ask her/him if s/he wants to participate and if s/he declines to participate then s/he does not have to be in the study.

If you agree that your child can be part of this study s/he will be asked questions about health. We will be in a private room so that s/he can talk freely. We will record what s/he says. If s/he does not want to be recorded s/he will not be able to be interviewed.

S/he may not receive a direct benefit from being interviewed, but we hope that this study will result in better health services for Indians. Answering questions may be uncomfortable for her/him so s/he can choose not to answer a question or stop the interview at any time. S/he can just tell the interviewer s/he wants to leave. I will ensure that the discussions that occur in the interviews are respectful, kind and courteous ones. If as a result of the discussion s/he experiences some distress and would like to talk to someone the interviewer will contact you to ask if s/he can discuss counseling options, with her/him, or people you or s/he may want to talk to. A list of potential places with phone numbers will be available from me.

S/he will be paid $20 for being interviewed and if s/he decides to quit before the interview is over, s/he will still be paid $20.

We plan to publish the results of this study, but will not include any information that would identify her/him. To keep the information safe the tape of the interview and the written copy of the discussion will be placed in a locked file cabinet. To protect confidentiality her/his real name will not be used in the written copy of the discussion. The researchers will enter data on a computer that is password-protected. There are some reasons why people other than the researchers may need to see information you provided as part of the study. This includes organizations responsible for making sure the research is done safely and properly, including the University of Michigan, government agencies, or the study sponsor, SAMHSA. Also, if s/he tells us something in the interview that makes us concerned that s/he or others may have been harmed, we have an ethical obligation to report suspected child or elder abuse to the Michigan Department of Human Services.

Her/his help in this project is voluntary-entirely up to you and her/him. Even after you agree that s/he can be in this study s/he may decide to leave the study at any time.

If you have questions about any of this contact Sandy Momper at (734)-998-6323, or smomper@umich.edu.
If you have questions about your rights as a research study participant contact the Institutional Review Board at the University of Michigan at (734) 936-0933, or irbhsbs@umich.edu.

Consent
Do your give permission for your child to be interviewed?

Assent to Participate in a Research Study (under 18)
Gda'shkitoomi (We are able!) Circles of Care Research

Investigator: Sandra Momper, PhD, School of Social Work, University of Michigan

The purpose of this research study is to find ways to provide better health services to Indian community members. For that reason we are conducting one hour interviews with American Indian community members. We already talked to your parent(s) about this and they said it was okay if you want to do it, but if you don't want to do it that's okay too.

If you agree to be part of this study you will be asked questions about health. We will be in a private room so that you can talk freely. We will record what you say. If you do not want to be recorded you will not be able to be interviewed.

You may not receive a direct benefit from being in the interview, but we hope that this study will result in better health services for Indians. Answering questions may be uncomfortable. You can choose not to answer a question or stop the interview at any time. Just tell the interviewer you want to leave.

You will be paid $20 for being interviewed and if you decide to quit before the interview is over, you will still be paid $20.

We plan to publish the results of this study, but will not include any information that would identify you. To keep your information safe the tape of the interview and the written copy of the discussion will be placed in a locked file cabinet. To protect confidentiality your real name will not be used in the written copy of the discussion. The researchers will enter data on a computer that is password-protected. There are some reasons why people other than the researchers may need to see information you provided as part of the study. This includes organizations responsible for making sure the research is done safely and properly, including the University of Michigan, government agencies, or the study sponsor, SAMHSA. Also, if you tell us something in the interview that makes us concerned that you or others may have been harmed, we have an ethical obligation to report suspected child or elder abuse to the Michigan Department of Human Services.

Being in this study is completely up to you. Even if your parents say you can talk to us, you do not have to do so. Even if you say yes, you may change your mind and stop at any time. You may choose to not answer a question for any reason.

If you have questions about any of this contact Sandy Momper at (734)-998-6323, or smomper@umich.edu. If you have questions about your rights as a research study participant contact the Institutional Review Board at the University of Michigan at (734) 936-0933, or irbhsbs@umich.edu.

Assent: Are you willing to be interviewed?

APPENDIX C
Interview Protocols

Protocol of Questions for the Adult Key Informant Interviews (Providers and Community Members)

Guide for Interviewer: First: Introduce yourself and say how you are connected to the community (this establishes your credibility and helps to build trust). Second: Then say we (AIHFS and the U of M) are conducting interviews of key community members and want your input regarding existing health services (physical, emotional and spiritual) and want your view of those services. Note: Explain who else is involved in interviews (maintain confidentiality, but say in general). Third: Explain why what they have to say is important to AIHFS and the U of M so that they and the community in general can benefit from changes that may be able to come about as a result of these information gathering interviews. Remind them that the interview will be recorded so that none of their important insights and discussions is missed.

For the providers first ask what they do for AIHFS. Also, this is your guide you do not have to read verbatim.

Introduction: We are interested in learning about your impressions of health services and health needs in our community, please tell me what you think about health services and health needs, start wherever you want, talk as long as you want, but tell me everything you think we need to know to better understand health services and health needs in our community.

Questions:

1) What do you think about the provision of health care for Native Americans in general?
2) What do you think about health services in general at AIHFS?
   Probes: What do you think about Western medicine?
   What do you think about Native American traditional medicine/healing?
3) What do you think about physical health services at AIHFS?
4) What do you think about mental health services at AIHFS?
5) What do you think about substance use and abuse (alcohol, drugs (legal and illegal), smoking, etc.) services at AIHFS?
6) What do you think about the availability of health services for Native Americans in our community?
7) What do you think about the accessibility of health services for Native Americans in our community?
8) What do you think about the appropriateness of services for Native Americans in our community?
   Probes: Are the services culturally appropriate for the community?
   Are the services spiritually appropriate for the community?
9) If you would design a survey of health services and needs for the community of AIHFS what kinds of questions would you ask?
   Probes: Who would you ask these questions?
   What kinds of existing measures might you use?
   Would you design your own?
10) What would you recommend to AIHFS about integrating behavioral and physical health services for the Indian community?

Wrap-up: If time permits, quickly summarize the major comments heard throughout the interview and ask if you covered all the major points. Ask them if there is anything else they would like to tell you that you have not asked them. Finally, thank them for their time.

"Is there anything else you'd like to tell me?"

Take notes as soon as possible after words so you do not forget anything. Check the recording equipment before, in the first few minutes, and after the interview.

Protocol of Questions for the Youth (under 18) Key Informant Interview

Guide for Interviewer: First: *Introduce yourself and say how you are connected to the community (this establishes your credibility and helps to build trust).* ***Second:*** *Then say we (AIHFS and the U of M) are conducting interviews of community members and want to know how they feel about health care for Natives in our community.* ***Note:*** *Explain who else is involved in interviews (maintain confidentiality, but say in general).* ***Third****: Explain why what they have to say is important to AIHFS and the U of M so that we can provide better health services for Natives. Remind them that the interview will be recorded so that nothing they say is forgotten.*

Also, this is your guide you do not have to read verbatim and please simplify for younger children.

Introduction: We are interested in learning about your impressions of health in our Native community for the youth, please tell me what you think about health, start wherever you want, talk as long as you want, but tell me everything you think we need to know to better understand health care for the Native youth in our community.

Questions:

1) How long have you been coming to AIHFS?
   Probes: What do you think about how health care at AIHFS that is provided to you and other Native children/youth?
   What has been your experience like at the doctors?
2) What do you think about health services provided at AIHFS for the youth?
   Probes: What do you think about Western (modern) medicine?
   What do you think about Native American/Indigenous traditional medicine/healing?
2) What do you think about physical (of the body) health services provided at AIHFS for the youth?
   Probes: What does a healthy lifestyle mean to you?
   ` What is important for you to have a healthy lifestyle?
   Are there any services or programs that we don't provide that you would like to see?
3) What do you think about mental (of the mind) health services provided at AIHFS for the youth?
   Probes: Are there any services or programs that we don't provide that you would like to see?
4) What do you think about our youth programs for alcohol, drugs, and smoking?
   Probes: Do you participate in any of these programs? Any programs for ATOD that you would be interested in seeing? If you could develop some programs of your own around ATOD what would you develop? What do you like or dislike about these programs?
5) Are there enough available health services for Native youth?
   Probes: What health services would you like to see?
   What health services would you like to see in your community provided for Native youth?
7) Are the health services that are available easy to get to for you?
   Probes: Do you or your parents drive you to AIHFS, take mass transit or walk to get here?
8) Are the health services the right kind of services for Native youth?
   Probes: Are they cultural enough?
   Are they spiritual enough?
   Any programs that you would like to see for youth that we don't provide?
   Workshops, etc?
9) If you could make up a questionnaire about health services and health needs for Native youth, what kinds of questions would you put in the questionnaire?
   Probes: Who would you ask these questions?
   What kinds of things would you be interested in finding out or learning?
   Would you design your own questionnaire? Would you work with others in the community to design the questionnaire?

10) What would you want to tell us about how to bring these health services - the physical (of the body) and mental (of the mind) health services for the Native youth of our community?

Wrap-up: *If time permits, quickly summarize the major comments heard throughout the interview and ask if you covered all the major points. Ask them if there is anything else they would like to tell you that you have not asked them. Finally, thank them for their time.*

FINAL QUESTION - "Is there anything else you'd like to tell me?"

Take notes as soon as possible after words so you do not forget anything. Check the recording equipment before, in the first few minutes, and after the interview.

APPENDIX D

Demographic Forms

Gda'shkitoomi (We are Able!) Research
About You
(Service Providers: Complete for Interview and/or Talking Circle Focus Group)

1. Today's date: _____ _____ _____
   MONTH DAY YEAR

2. What is your Tribal Affiliation (if applicable):
   _____

3. What is your gender?

   1 Male

   2 Female

4. What is your age? _____

5. What type of service do you provide for American Indian Health and Family Services?

   _____

6. How long have you/the agency been providing this service?

   _____

7. What is your role as a provider of this service?

   _____

8. How long have you been in this role?

   _____

Gda'shkitoomi (We are Able!) Research
About Your Background
(Community Members: Complete for Interview and/or Talking Circle Focus Group)

1. Today's date: _____ _____ _____
   MONTH DAY YEAR

2. What is your Tribal Affiliation?
_____

3. What is your gender? (circle one)

   1 Male

   2 Female

4. What is your age? _____

.
5. Which of these categories best describes your situation? (circle one)

   1 Single/Never Married

   2 Married (Legally/Spiritually)

   3 Co-Habitating

   4 Divorced/Separated/Not Co-Habitating

   5 Widowed

   6 Living with Parents

   7 Other (specify)
_____

6. Are you going to school? (circle one)

   1 Full Time

   2 Part Time

   3 Not in School

7. What is the highest grade of school you have completed? (circle one)

1 Grade School What grade have you completed? _____

2 Some High School What grade have you completed? _____

3 High School Diploma

4 GED

5 Some Education Beyond High School

AA Degree _____
BA/BS Degree _____
Other Degree (specify):_____

8. How many other people, besides you, live in your home? (Please list a number next to each category, example: 1 Spouse/Partner)

____Spouse/Partner ____Children ____Grandchildren ____Your Brothers or Sisters

____Parents ____Grandparents ____Other Relatives ____Non-Relatives or Friends

9. What is your employment status? (Please check only one)

___Unemployed ___Employed Part-Time ___Employed Full-Time ___Retired ____Student

10. Which is the closest to your **total monthly household income** (everyone in the household)? Include money from jobs, social security, retirement income, unemployment payments, or any other source of income. Give your best guess if you are not sure**.** (Circle one)

1 $800 or less

2 $800 to $1,000

3 $1,000 to $1,500

4 $1,500 to $2,000

5 $2,000 to $2,500

6 $2,500 to $3,000

7 $3,000 or more

98 don’t want to answer

99 don’t know

MIIGWETCH

APPENDIX E

Talking Circle Consent Forms

Adult Consent to Participate in a Research Study
Gda'shkitoomi (We are able!) Circles of Care Research

Investigators: Sandra Momper, PhD, School of Social Work, University of Michigan
Jerilyn Church, MSW, American Indian Health and Family Services

The purpose of this research study is to gather information about health to be able to improve the physical, emotional and spiritual health services available to our American Indian community. This information will help us design a health program that will include your input regarding health needs and services. For that reason we are getting together members of the American Indian community in talking circles focus groups that will last about one hour.

If you agree to be part of this study you will be a member of a talking circle focus group with 7 other community members. Y**ou will be asked general questions about physical, emotional and spiritual health needs and services in the community.** We will record what you and other people say. If you do not want to be recorded you will not be able to be in the group. If you also feel you cannot keep what other people say in the group confidential you will be asked not to participate.

You may not receive a direct benefit from being in the group, but we hope that this study will result in better health services for Indians. Answering questions may be uncomfortable. You can choose not to answer a question or leave the group at any time. Just tell the moderator you want to leave.

You will be paid a Meijer $20 Gift Card for being in the group and if you decide to quit before the group is over, you will still be paid.

We plan to publish the results of this study, but will not include any information that would identify you. To keep your information safe the tape of the group and the written copy of the discussion will be placed in a locked file cabinet. To protect confidentiality your real name will not be used in the written copy of the discussion. The researchers will enter data on a computer that is password-protected. There are some reasons why people other than the researchers may need to see information you provided as part of the study. This includes organizations responsible for making sure the research is done safely and properly, including the University of Michigan, government agencies, or the study sponsor, SAMHSA. Also, if you tell us something in the interview that makes us concerned that you or others may have been harmed, we have an ethical obligation to report suspected child or elder abuse to the Michigan Department of Human Services.

Your help in this project is voluntary-entirely up to you. Even after you agree to participate and receive payment you may decide to leave the study at any time. If you have questions about any of this contact Sandy Momper at (734)-998-6323, smomper@umich.edu, or Cecelia LaPointe at CLaPointe@aihfs.org If you have questions about your rights as a research study participant contact the Institutional Review Board at the University of Michigan at (734) 936-0933, or irbhsbs@umich.edu.

Consent

Are you willing to be a part of this talking circle focus group?

Parental Consent for Your Child to Participate in a Research Study
Gda'shkitoomi (We are able!) Circles of Care Research

Investigator: Sandra Momper, PhD, School of Social Work, University of Michigan

The purpose of this research study is to find ways to provide better health services to Indian community members. For that reason we are getting together members of the American Indian community in talking circles focus groups that will last about one hour. We are asking for your permission for your child to participate in this study. Even if you give your child permission to participate, I will ask her/him if s/he wants to participate and if s/he declines to participate then s/he does not have to be in the study.

If you agree that your child can be part of this study s/he will be a member of a talking circle focus group with 7 other community members. S/he will be asked questions about health. We will record what s/he and other people say. If s/he does not want to be recorded s/he will not be able to be in the group.

S/he may not receive a direct benefit from being in the group, but we hope that this study will result in better health services for Indians. Answering questions may be uncomfortable for her/him so s/he can choose not to answer a question or leave the group at any time. S/he can just tell the moderator s/he wants to leave. We will ensure that the discussions that occur in the groups are respectful, kind and courteous ones. If as a result of the group discussion s/he experiences some distress and would like to talk to someone the moderator will contact you to ask if s/he can discuss counseling options, with her/him, or people you or s/he may want to talk to. A list of potential places with phone numbers will be available from me.

S/he will be paid $20 for being in the group and if s/he decides to quit before the group is over, s/he will still be paid $20.

We plan to publish the results of this study, but will not include any information that would identify her/him. To keep the information safe the tape of the group and the written copy of the discussion will be placed in a locked file cabinet. To protect confidentiality her/his real name will not be used in the written copy of the discussion. The researchers will enter data on a computer that is password-protected. There are some reasons why people other than the researchers may need to see information you provided as part of the study. This includes organizations responsible for making sure the research is done safely and properly, including the University of Michigan, government agencies, or the study sponsor, SAMHSA. Also, if s/he tells us something in the interview that makes us concerned that s/he or others may have been harmed, we have an ethical obligation to report suspected child or elder abuse to the Michigan Department of Human Services.

Her/his help in this project is voluntary-entirely up to you and her/him. Even after you agree that s/he can be in this study s/he may decide to leave the study at any time.

If you have questions about any of this contact Sandy Momper at (734)-998-6323, or smomper@umich.edu. If you have questions about your rights as a research study participant contact the Institutional Review Board at the University of Michigan at (734) 936-0933, or irbhsbs@umich.edu.

Consent: Do you give permission for your child to participate in the talking circle focus group?

Assent to Participate in a Research Study (under 18)
Gda'shkitoomi (We are able!) Circles of Care Research

Investigator: Sandra Momper, PhD, School of Social Work, University of Michigan

The purpose of this research study is to find ways to provide better health services to Indian community members. For that reason we are getting together members of the American Indian community in talking circles focus groups that will last about one hour. We already talked to your parent(s) about this and they said it was okay if you want to do it, but if you don't want to do it that's okay too.

If you agree to be part of this study you will be a member of a talking circle focus group with 7 other community members. You will be asked questions about health. We will record what you and other people say. If you do not want to be recorded you will not be able to be in the group. If you feel you cannot keep private what other people say in the group you will be asked not to participate.

You may not receive a direct benefit from being in the group, but we hope that this study will result in better health services for Indians. Answering questions may be uncomfortable. You can choose not to answer a question or leave the group at any time. Just tell the moderator you want to leave.

You will be paid $20 for being in the group and if you decide to quit before the group is over, you will still be paid $20.

We plan to publish the results of this study, but will not include any information that would identify you. To keep your information safe the tape of the group and the written copy of the discussion will be placed in a locked file cabinet. To protect confidentiality your real name will not be used in the written copy of the discussion. The researchers will enter data on a computer that is password-protected. There are some reasons why people other than the researchers may need to see information you provided as part of the study. This includes organizations responsible for making sure the research is done safely and properly, including the University of Michigan, government agencies, or the study sponsor, SAMHSA. Also, if you tell us something in the interview that makes us concerned that you or others may have been harmed, we have an ethical obligation to report suspected child or elder abuse to the Michigan Department of Human Services.

Being in this study is completely up to you. Even if your parents say you can talk to us, you do not have to do so. Even if you say yes, you may change your mind and stop at any time. You may choose to not answer a question for any reason.

If you have questions about any of this contact Sandy Momper at (734)-998-6323, smomper@umich.edu, or Cecelia LaPointe at (313) 846-3718 x1119, CLaPointe@aihfs.org.
If you have questions about your rights as a research study participant contact the Institutional Review Board at the University of Michigan at (734) 936-0933, or irbhsbs@umich.edu.

Assent
Are you willing to be a part of this talking circle focus group?

APPENDIX F

Talking Circle Protocol

CIRCLES OF CARE– TALKING CIRCLE FOCUS GROUP QUESTIONS

1. How can Native families and the community address emotional and mental stress in Native youth?

2. What are the consequences of this stress both short term and long term?

3. Do you feel it is easy for you or your family to get treatment as needed (as you define it)?

4. What would be culturally and spiritually appropriate services for you and your family?

5. From your perspective, what services are available to families, parents and youth? What services would you like to see be made available?

6. Please give your thoughts on what HELPS Native parents develop a strong family unit.

7. What PREVENTS Native parents from developing a strong family unit?

8. In your opinion, what is special or different about raising children in a Native family in the Detroit area in comparison to families in the majority culture?

9. What 'community strengths' would help heal the emotional and behavioral stress in our youth and families?

APPENDIX G

Exhaustive List of Independent Variables Used in Initial Model of Binary Logistic Model

Section 1: Background Information			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
1. What is your gender?	gender	1=female 2=male 3=2spirit/other .=missing	Sex
2. What is your age?	agecat	1=18-19 2=20-34 3=35-44 4=45-54 5=55-64 6=65-74 7=75+ 9=refused .=missing	Age
	agecatcom	1=18-34 2=35-44 3=45-54 4=55-64 5=65+ 6=missing	Age Recode
3. Are you currently …..?	marital	1=Married 2=Divorced 3=Widowed 4=Separated 5=Never Married 6=Long-term partner 9=Refused	Marital status
4. Are you a veteran?	Isvet	0=No 1=Yes	Veteran
5. How many people live in your house, including yourself?	househol	Open-ended, 15 unique values, ranging from 0-51	# in household
	rhousehol	1=0-2 2=3-5 3=6-51 9=Missing	# in household recode
5.5 How many children <18 currently in your hsehld?	household0	Open-ended, 7 unique values ranging from 0-6	# children in household
6. Zip code of primary residence?	zip	125 unique values, zipcodes ranging from 48001-49910	Zipcode
Section 2: Finances & Healthcare			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
7. Do you have health care coverage for yourself?	insured	0=No 1=Yes	Insured?

7a. If yes, what type of health care coverage do you have:		0=No, 1=Yes, .=Missing	
	privins	Private Insurance	Private Insurance
	medicaid	Medicaid	Medicaid
	medicare	Medicare A (Hosp)	Medicare A
	medicar0	Medicare B (Medical)	Medicare B
	medicar1	Medicare D (Prescrip)	Medicare D
	va	va	Veteran's Insur.
	statedis	State Disability	State Disability
	ssi	SSI/SSDI	ssi/ssdi
	tribal	Tribal Insurance	Tribal Insur.
	workcomp	Worker's Comp	Worker's Comp
	otherins	Other	Other Insur.
	insothertext	Other – open-ended	XXXX
9. Do you have children that you claim as dependents? Dependents can be either birth children or foster children.	isdepend	0=no 1=yes	Has dependents
14. Are you currently ….?	employca	1=full-time wages 2=part-time wages 3=self-employed 4=out of work >1yr 5=out of work <1yr 6=retired 7=disabled 8=student 9=unable to work 10=seasonal/shift work 11=refused	Employment
15. What is your annual income from all sources? Include only your income and not your household's.	incomeca	1=none 2=<$5,000 3=<$10,000 4=<$15,000 5=<$20,000 6=<$25,000 7=<$35,000 8=<$50,000 9=<$75,000 10=$75,000 or more 11=don't know/not sure 12=refused	Income
	rincomeca	1=none 2=<$10,000 3=$10,000-$24,999 4=$25,000-$34,999 5=$35,000-$49,999 6=$50,000+ 7=don't know/not sure	Income recode
	reincomeca	1=none 2=<$10,000 3=$10,000-$24,999 4=$25,000-$34,999 5=$35,000-$49,999	Income recode

	recincomeca	6=$50,000+ 1=none-<$10,000 2=$10,000-$34,999 3=$35,000+	Income recode

Section 3. Enrollment			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
16. Are you enrolled in a Federal recognized tribe, State recognized Tribe, First Nations Band (Canada), or Alaska Native shareholder or descendent?	isenroll	0=no 1=yes 9=refused	Fed. Recog. Tribe

Section 4: Patient's Choice and Utilization of Health Care			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
18. Where do you go to receive most of your healthcare?	mosthc	1=Urban Indian Hlth Org(UIHO) 2=Indian Hlth Serv facility 3=Tribal Hlth facility 4=Community Hlth Cntr 5=Hospital 6=Private Hlth Clinic 7=Other, please specify 8=None	Primary healthcare facility
	mosthcothertext	Open-ended "other, please specify"	XXXX
	rmosthc	1=IHO user (UIHO+IHO Service facility) 2=Non-IHO user (tribal+comm. hlth cntr., hosp., private, other, none)	Primary healthcare facility
	ihsuser	1=IHO user (UIHO+IHO Service facility) 2=Non-IHO user (comm. hlth cntr., hosp., private, other, none)	Primary healthcare facility recode
19. What is most important when choosing where you receive healthcare for yourself?	hcfactor	1=Convenience-hrs, location 2=quality 3=transportation, ease to get to 4=cost 5=specialist 6=culturally sensitive care 7=other _____ 9=refused	1st reason choose healthcare
19b. What is the second reason most important factor in how you choose where to receive healthcare?	hcfacto0	1=Convenience-hrs, location 2=quality 3=transportation, ease to get to 4=cost 5=specialist 6=culturally sensitive care 7=other _____	2nd reason choose healthcare

20. Have you received any health services in the past 12 months?	ishc12mo	0=no 1=yes	Healthcare in past 12 mo
22. Please indicate which services you have used from any facility in the past 12 months?	 drvisit eye dental meds ear fp drug mental er hosp shospitaltext special tradheal prevent othserv sothertext	0=No, 1=Yes Dr.'s visit Eye Care Dental Care Prescriptions Hearing testing Family Planning Alcohol/Drug Treatment Mental/Emotional Health Emergency Care Hospitalization, indicate where Open-ended "where hospitalized" Special needs such as handicapped needs Traditional Healing Prevention/education services Other, specify Open-ended "other type of healthcare services"	 Dr. Visit Eye exam Dental exam Prescriptions Hearing test Family planning Alcohol/drug treatment Mental/Emotional health Emergency Care Hospitalization XXXX Specialneeds/handicapped Traditional healingPrevention/education Other service XXXX
25. Do most native people in your community have access to these resources?	nativeac	0=no 1=yes 2=to some, but not all 3=don't know about services 9=refused	Native access to resources

Section 5. Traditional Services			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
28. Have you used Traditional services for yourself?	trad	0=no 1=yes(skip to 30) 7=don't know/not sure	Used traditional services
29. Would you like to use Traditional services?	liketotr	1=would use 2=might like to use 3=I don't want to use 4=don't know/not sure 9=refused	Want to use traditional services
30. Which traditional services did you or would you use?	 tgen temo2 till2 tspirit2 tsweat2 theal2	0=no, 1=yes general physical health problems emotional or mental health problems specific disease or illness spiritual assistance or purification sweats traditional healing alcohol or drug problem as a learning experience	 Trad.-physical health Trad.-emotional health Trad.-specific illness Trad.-spirit. assist/purif. Trad.-sweats Trad.-healing Trad.-alc/drug Trad.-learning exper.

	tdrug2 tlearn2 tmidwife	traditional midwife or doula	Trad.-midwife/doula

Section 6: Physical and Emotional Well-being			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
33. Have you ever needed services for emotional well-being?	neededem	0=no 1=yes 9=refused	Need emotional services
33b. Why didn't you use services for emotional well-being? Was it because you ….	whynotus	1=felt uncomfortable about seeking help 2=didn't trust anyone to help me 3=didn't want anyone to know 4=didn't think it would help 5=didn't know where to go 6=didn't have money 7=please list any other reasons_____ 9=refused	Why no emotional services
39. I have been refused medical care at a non-Indian clinic	refusedn	0=no 1=yes 2=not applicable 7=don't know/not sure 9=refused	Nontribal care refused

Section 8: Preference and Suggestions for Service Delivery			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
40. How important is it to you to receive health care from a facility specifically for Native peoples?	iindianc	1=not important 2=somewhat important 3=undecided 4=important 5=very important 9=refuse	Importance of Indian care

Section 9: Health Education and Health Promotion			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
45. I would like to see more traditional healing, health and wellness.	ctrad	1=strongly agree 2=agree 3=neutral 4=disagree 5=strongly disagree 7=don't know 9=refused	More traditional healing
49. There is support for people to deal with life stress.	cstress	1=strongly agree 2=agree 3=neutral 4=disagree 5=strongly disagree 7=don't know 9=refused	Stress support
51. Support programs for men are available in my community.	cmen	1=strongly agree 2=agree 3=neutral	Men's support

		4=disagree 5=strongly disagree 7=don't know 9=refused	

Section 10: Healthcare and Health Program Funding			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
52. It is easy for me to travel to a reservation to receive IHS healthcare.	ftraveli	1=strongly agree 2=agree 3=neutral 4=disagree 5=strongly disagree 7=don't know 9=refused	Travel to IHS

Section 12: Social Issues			
Question	**Variable Name**	**Variable Values**	**Variable Labels**
65. I believe I have experienced discrimination while seeking/receiving healthcare.	sidiscri	0=no 1=yes 2=does not apply 9=refused	Healthcare discrimination
66. I know someone with an addiction	siaddict	0=no 1=yes 2=does not apply	Addiction
65a. If yes, check all that apply and indicate whether you know many or only few people with this addiction:	siaddic0 siaddic5 siaddic6	Alcohol: 1=many; 2=few Prescriptions: 1=many; 2=few Gambling: 1=many; 2=few	Alcohol addiction Prescription addiction Gambling addiction
68. I have a hard time finding affordable housing.	sihousin	0=no 1=yes 2=does not apply	Affordable housing
70. I know someone in a gang.	sigang	0=no 1=yes 2=does not apply	Gang
72. I know someone who does not get prenatal care	siprenat	0=no 1=yes 2=does not apply	No prenatal
74. I know someone who had committed suicide.	sisuicid	0=no 1=yes 2=does not apply	Suicide
77. Do you feel child abuse/neglect in the Indian Community is a problem?	icchilda	0=no 1=yes 7=don't know/not sure 9=refused	Child abuse
78. Do you feel domestic violence/violence in the Indian Community is a problem	icdv	0=no 1=yes 7=don't know/not sure 9=refused	Domestic violence

APPENDIX H

Bemidji Area Urban American Indian/Alaskan Native Needs Assessment Survey

Section 1: Background Information

1. What is your gender?

☐ 1 Female

☐ 2 Male

☐ 3 Two Spirit / Other

(READ IF NECESSARY :) *"Two Spirit" definition:* A term used by some Native Gay, Lesbian, Bisexual, and Transgender people to refer to either their gender and /or sexuality.

2. What is your age? _____
(READ IF NECESSARY :)

☐ 1 18-19

☐ 2 20-34

☐ 3 35-44

☐ 4 45-54

☐ 5 55-64

☐ 6 65-74

☐ 7 Over 74

☐ 9 **(DO NOT READ :)** Refused

3. Are you currently…?

☐ 1 Married

☐ 2 Divorced

☐ 3 Widowed

☐ 4 Separated

☐ 5 Never Married

☐ 6 Long-Term Partner

☐ 9 **(DO NOT READ :)** Refused

3.5 Are you a veteran?

☐ 1 Yes ☐ 0 No

4. How many people live in your house, including yourself? ____
(**READ IF NECESSARY :) You may include people who may not live in the house**

all of the time, but who do live there regularly. For example, a child who may go between parents who are divorced.
5. How many children under age 18 currently live with you in your household?_____

5.5 What is the zip code of your primary residence? _____

Section 2: Finances and Healthcare

6. Do you have health care coverage for yourself?

☐ 0 No Health Coverage (**SKIP TO QUESTION 8)**

☐ 1 Yes

6a. If yes, what type of health care coverage do you have:
(MARK ALL THAT APPLY :)

☐ 1 Private Insurance (for example, provided by your employer, an HMO, etc.)

☐ 2 Medicaid

☐ 3 Medicare A (**READ IF NECESSARY :)** Hospital Insurance

☐ 4 Medicare B (**READ IF NECESSARY :)** Medical Insurance

☐ 5 Medicare D **(READ IF NECESSARY :)** Prescription Insurance

☐ 6 VA (Veteran's Affairs)

☐ 7 State Disability

☐ 8 SSI/SSDI **(READ IF NECESSARY :)** Supplemental Security Income, Social Security Disability Insurance

☐ 9 Tribal Insurance

☐ 10 Worker's Comp

☐ 11 Other (please specify):_____

7. Does your health care plan meet your needs?

☐ 0 No

☐ 1 Yes **(SKIP TO QUESTION 9)**

☐ 7 Don't know/not sure

8. What does your health care plan not cover (please specify)?
_____

9. Do you have children that you claim as dependents? Dependents can be either birth children or foster children.

☐ 0 No **(SKIP TO QUESTION 14)**

☐ 1 Yes

10. Do you have healthcare for your children or dependents?

☐ 0 No Health Coverage **(SKIP TO QUESTION 13)**

☐ 1 Yes

11. If yes, what type of healthcare coverage do you have for your children or dependents? **(MARK ALL THAT APPLY :)**

☐ 1 Private Insurance (for example, provided by your employer, an HMO, etc.)

☐ 2 Medicaid

☐ 3 Medicare A (**READ IF NECESSARY :)** Hospital Insurance

☐ 4 Medicare B (**READ IF NECESSARY :)** Medical Insurance

☐ 5 Medicare D **(READ IF NECESSARY :)** Prescription Insurance

☐ 6 VA (Veteran's Affair)

☐ 7 State Disability

☐ 8 SSI/SSDI **(READ IF NECESSARY :)** Supplemental Security Income, Social Security Disability Insurance

☐ 9 Tribal Insurance

☐ 10 Worker's Comp

☐ 11 Other (please specify):_____

12. Is your health care coverage for your children or dependents adequate?

☐ 0 No

☐ 1 Yes **(SKIP TO QUESTION 14)**

☐ 7 Don't know/not sure

13. What does the health care plan for your children or dependents not cover (please specify)?_____

14. Are you currently…?

☐ 1 Employed for wages – Full time

☐ 2 Employed for wages – Part time

☐ 3 Self-employed

☐ 4 Out of work for more than 1 year

☐ 5 Out of work for less than 1 year

☐ 6 Retired

☐ 7 Disabled

☐ 8 Student

☐ 9 Unable to work

☐ 10 Seasonal / Shift Work (**READ IF NECESSARY :)** If throughout the year you alternate between full time and either part time or unemployed.

☐ 11 **(DO NOT READ:)** Refused

15. What is your annual income from all sources? Include only **your** income and not your household's.**(READ IF NECESSARY:)**

☐ 1 None

☐ 2 Below $5,000

☐ 3 Below $10,000

☐ 4 Below $15,000

☐ 5 Below $20,000

☐ 6 Below $25,000

☐ 7 Below $35,000

☐ 8 Below $50,000

☐ 9 Below $75,000

☐ 10 $75,000 or more

☐ 11 Don't know / Not sure

☐ 12 **(DO NOT READ:)** Refused

APPENDIX F

Section 3. Enrollment

16. Are you enrolled in a Federal recognized tribe, State recognized Tribe, First Nations Band
(Canada), or Alaska Native shareholder or descendent?

☐ 0 No ☐**Skip to question 17**

☐ 1 Yes

☐ 9 **(DO NOT READ:)** Refused

16a. What is your enrolled Federal recognized tribe, State recognized Tribe, First Nations Band (Canada), or Alaska Native shareholder or descendent?

_____

17. If you are not enrolled in a Tribe, but are a descendent of a Tribe(s), please enter the tribe
name here:_____

(IF PERSON REFUSES TO ANSWER, WRITE IN "REFUSED")

Section 4: Patient's Choice and Utilization of Health Care

This section asks about how you make health care choices for you and your family.

18. Where do you go to receive most of your healthcare?
CHOOSE ONLY ONE:

☐ 1 Urban Indian Health Organization, such as (**SAY NAME OF YOUR**

ORGANIZATION)

☐ 2 Indian Health Service facility (could be hospital) (**SKIP TO QUESTION 19)**

☐ 3 Tribal health facility (clinic on reservation) **(SKIP TO QUESTION 19)**

☐ 4 Community Health Center (**READ IF NECESSARY:)** free clinic, public clinic (**SKIP TO QUESTION 19)**

☐ 5 Hospital (non-IHS) **(SKIP TO QUESTION 19)**

☐ 6 Private health clinic (**READ IF NECESSARY:)** Doctor in private practice, HMO **(SKIP TO QUESTION 19)**

☐ 7 Other (please specify):_____ **(SKIP TO QUESTION 19)**

☐ 8 Do not go anywhere (**SKIP TO QUESTION 19)**

18a. How did you hear about the urban Indian health organization?
_____

19. What is most important when choosing where you receive healthcare for yourself?

☐ 1 Convenience (**READ IF NECESSARY:)** hours, location

☐ 2 Quality

☐ 3 Transportation (**READ IF NECESSARY:)** how easy is it to get to

☐ 4 Cost

☐ 5 Specialist

☐ 6 Culturally sensitive care (**READ IF NECESSARY:)** they are open to traditional medicine or practices, they will let me include my family in healthcare decisions

☐ 7 Other Reason:_____

19a. (IF "OTHER" TO QUESTION 19, PLEASE ASK TO SPECIFY AND WRITE IT BELOW:)
_____

19b. What is the second most important factor in how you choose where to receive healthcare? **(WRITE IN ITEM FROM QUESTION 19 LIST:) _____**

19c. What is the third most important factor in how you choose where to receive healthcare? **(WRITE IN ITEM FROM QUESTION 19 LIST :) _____**

20. Have you received any health services in the past 12 months?

☐ 0 No **(SKIP TO QUESTION 23)**

☐ 1 Yes

21. On average, how many times per month did you receive any health services in the past? year? _____

22. Please indicate which services you have used from any facility in the past 12 months. **(MARK ALL THAT APPLY :)**

For Yourself:
a) Dr. visit (e.g. for physical examination, pains and aches)
b) Eye Care
c) Dental Care
d) Prescriptions
e) Hearing testing
f) Family Planning
g) Alcohol/Drug Treatment
h) Mental/Emotional Health
i) Emergency Care
j) Hospitalization (**please indicate where you go:**
_____)
k) Special needs such as handicapped needs
l) Traditional healing
m) Prevention/education services
n) Other (**please specify:**
_____)

23. **(IF "NO" TO QUESTION 20 :)** Why have you not received health services in the past 12 months?
(MARK ALL THAT APPLY :)

☐ 1 Didn't need services

☐ 2 No insurance

☐ 3 Cost

☐ 4 Transportation

☐ 5 Safety

☐ 6 Didn't have time

☐ 7 Other reason:_____

☐ 8 Not applicable

☐ 9 (**DO NOT READ:)** Refused

24. **(IF "YES" TO QUESTION 9, ABOUT WHETHER THEY HAVE DEPENDENTS:)** Have you used the following services for your dependents from any facility in the past 12 months?
(READ IF NECESSARY:) Dependents can be either birth children or foster children.
(MARK ALL THAT APPLY:)
For Dependents:
a) Dr./provider visit (e.g. for physical examination, pains and aches)
b) Eye Care
c) Dental Care
d) Prescriptions
e) Hearing testing
f) Alcohol/Drug Treatment
g) Help with a personal problem
h) Emergency Care
Hospitalization (**please indicate where you would go:_____)**

i) Special needs such as handicapped needs
j) Traditional healing
k) Prevention/education services
m) Other (**please specify:**
_____)

25. Do most native people in your community have access to these resources?

☐ 0 No

☐ 1 Yes

☐ 3 To some but not all - please explain (**WRITE IN BELOW**)

☐ 4 They don't know about these services

☐ 7 Don't know/not sure

25a. **(IF "TO SOME BUT NOT ALL" TO QUESTION 25, ASK TO PLEASE EXPLAIN, AND WRITE THEIR ANSWER BELOW:)**

_____

26. Now I would like to ask you about dental care. Have you been to the dentist in the past 12
months?

☐ 0 No

☐ 1 Yes **(SKIP TO QUESTION 28)**

27. Why have you not been to the dentist in the past 12 months?
(MARK ALL THAT APPLY:)

☐ 1 Didn't need services

☐ 2 No insurance

☐ 3 Cost

☐ 4 Transportation

☐ 5 Didn't have time

☐ 6 Other reason:_____

☐ 9 **(DO NOT READ:)** Refused

Section 5. Traditional Services

Many people have different cultural views on Traditional Native/Indian Medicine. If you
do not feel comfortable answering these questions or talking about Traditional Medicine
please feel free to skip this section. There are many names for traditional healers and
healing so for example we could use any of the following: Indian Doctor, Country Medicine, Indian Medicine, Medicine Man/Woman, roadman, Clan Mother, or even

your grandmother or grandfather…

28. Have you used Traditional services for yourself?

☐ 0 No

☐ 1 Yes → **(SKIP TO QUESTION 30)**

☐ 7 Don't know/not sure

☐ 9 **(DO NOT READ:)** Refused

29. Would you like to use Traditional services?

☐ 1 *I would* use Traditional services

☐ 2 *I might* like to use Traditional services

☐ 3 *I do not want* to use Traditional services → **(SKIP TO QUESTION 31)**

☐ 7 Don't know/not sure → **(SKIP TO QUESTION 31)**

☐ 9 **(DO NOT READ:)** Refused → **(SKIP TO QUESTION 31)**

30. Which traditional services did you or would you use?
(MARK ALL THAT APPLY:)
Please check: Refused:
a) General Physical Health Problems
b) Emotional or Mental Health Problems
c) Specific disease or illness
d) Spiritual Assistance or Purification
e) Sweats
f) Traditional healing
g) Alcohol or Drug Problem
h) As a learning experience
i) Traditional midwife or doula (**READ IF NECESSARY:)** A doula is someone who helps the mother in delivery, for example with breathing exercises, and is not a nurse or midwife

Section 6: Physical and Emotional Well-being

This section asks you about your current physical, body, and emotional, spirit, well being. If you feel the questions are too personal or too revealing you do not have to answer them.

31. How would you rate your current physical well-being:

☐ 1 Excellent

☐ 2 Good

☐ 3 Fair

☐ 4 Poor

Do not read:

☐ 7 Don't know/Not sure

☐ 9 Refused

32. How would you rate your current emotional well-being:

☐ 1 Excellent

☐ 2 Good

☐ 3 Fair

☐ 4 Poor

Do not read:

☐ 7 Don't know/Not sure

☐ 9 Refused

33. Have you ever needed services for emotional well-being?

☐ 1 Yes

☐ 0 No **(SKIP TO QUESTION 34)**

☐ 9 **(DO NOT READ:)** Refused

33a. If you felt you needed services, did you use them?

☐ 1 Yes**(SKIP TO QUESTION 34)**

☐ 0 No

☐ 9 **(DO NOT READ:)** Refused

33b. Why didn't you use services for emotional well-being? Was it because you…

☐ 1 Felt uncomfortable about seeking help

☐ 2 Didn't trust anyone to help me

☐ 3 Didn't want anyone to know

☐ 4 Didn't think it would help

☐ 5 Didn't know where to go

☐ 6 Didn't have money

☐ 7 Please list any other reasons:_____

☐ 9 **(DO NOT READ:)** Refused

34. The next question asks about household members. Have you or anyone in your household
had any of the following problems in the past 12 months? **(MARK ALL THAT APPLY:)**

☐ 1 Not enough money

☐ 2 Unemployment

☐ 3 Running out of food before the end of the month

☐ 4 Depression

☐ 5 Anxiety or Stress

☐ 6 Problems with paperwork to get assistance (for example food stamps, welfare)

☐ 7 Getting along with your family

☐ 8 Legal Problems

☐ 9 Substandard/undesirable/poor housing conditions (pests, getting things fixed)

☐ 10 Problems with a landlord

☐ 11 Caring for a sick or elderly family member

☐ 12 Getting childcare

☐ 13 Getting enough shifts

☐ 14 Other (pleae specify):_____

Section 7: Systems and Regulations

Please rate the degree to which these statements apply to you.

Strongly Strongly Don't
Agree Agree Neutral Disagree Disagree know Refused

35. I have healthcare for myself that I can afford

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 7 ☐ 9

36. I have healthcare for my family that I can afford

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 7 ☐ 9

37. Medications I need are available to me

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 7 ☐ 9

38. I have been refused medical care from a tribal healthcare or an IHS-funded urban program

☐ 0 No

☐ 1 Yes → Indicate reason given:_____

☐ 2 Not applicable

☐ 7 Don't know/not sure

☐ 9 **(DO NOT READ:)** Refused

39. I have been refused medical care at a non-Indian clinic

☐ 0 No

☐ 1 Yes → Indicate reason given:_____

☐ 2 Not applicable

☐ 7 Don't know/not sure

☐ 9 **(DO NOT READ:)** Refused

Section 8: Preferences and Suggestions for Service Delivery

40. How important is it to you to receive health care from a facility specifically for Native peoples?
(READ IF NECESSARY:) Native could refer to American Indian, Alaska Native, or First Nations people

☐1 Not Important

☐2 Somewhat Important

☐3 Undecided

☐4 Important

☐5 Very Important

☐9 **(DO NOT READ:)** Refused

Section 9: Health Education and Health Promotion

The next series of questions ask about the Indian community in the city where you live. Please
rate the degree to which these statements apply to you.

Strongly Strongly Don't
agree Agree Neutral Disagree disagree know Refused

41. The healthcare provider that I go to helps me be healthy
☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

42. There is health education that includes domestic violence in my community
☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

43. The health education I get is relevant to me and my community
☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

44. Breast milk is best for nursing babies ☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

45. I would like to see more traditional healing, health and wellness
☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

46. I know how to maintain a healthy weight ☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

47. There are health and wellness fairs directed towards Urban Indians
☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

48. I think Indian families make healthy food choices

□1 □2 □3 □4 □5 □7 □9

49. There is support for people to deal with life stress

□1 □2 □3 □4 □5 □7 □9

50. There is weight management support for people

□1 □2 □3 □4 □5 □7 □9

51. Support programs for men are available in my community

□1 □2 □3 □4 □5 □7 □

Section 10: Healthcare and Health Program Funding

Please rate the degree to which these statements apply to you.

Strongly agree | Strongly Agree | Neutral | Disagree | Strongly disagree | Don't know | Refused

52. It is easy for me to travel to a reservation to receive IHS healthcare

□1 □2 □3 □4 □5 □7 □9

53. I can travel to all of my healthcare appointments

□1 □2 □3 □4 □5 □7 □9

54. The office hours at the place I usually go to for healthcare are acceptable for my schedule

□1 □2 □3 □4 □5 □7 □9

Section 11: Healthcare Access - General

The next series of questions ask about the **Indian community** in the city where you live. Please rate the degree to which these statements apply to you.

Strongly agree | Strongly Agree | Neutral | Disagree | Strongly disagree | Don't know | Refused

55. HIV/AIDS and Hepatitis C testing and services are available

□1 □2 □3 □4 □5 □7 □9

56. Mental health services are available □1 □2 □3 □4 □5 □7 □9

57. Diabetic screening, support and treatment are available

□1 □2 □3 □4 □5 □7 □9

58. Substance abuse treatment services are available

☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

59. The people in my community can afford the health aids they need (glasses, hearing aids, wheelchairs, canes, walkers)

☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

60. Screenings for cancer and heart conditions are

☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

61. I can get emergency care ☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

62. I can get dental care ☐1 ☐2 ☐3 ☐4 ☐5 ☐7 ☐9

Section 12: Social Issues

The following is a list of experiences; please indicate your agreement with the following statements.

NO YES Does not apply

63. When I go off state/public assistance, I can still afford health care for my dependents

☐0 ☐1 ☐2

64. I have or know somebody that has experienced police brutality that led to healthcare needs

☐0 ☐1 ☐2

65. I believe I have experienced discrimination while seeking/receiving healthcare

64a. If yes, please elaborate:

_____

☐0

Skip to Question 66

☐1 ☐2

66. I know someone with an addiction. **Read if necessary: an addiction is a behavior that can't be controlled even when it causes harm to the individual and others around them.**

65a. If yes, check all that apply and indicate whether you know many or only a few people with this addiction:

Circle one:

☐ Alcohol many few

☐ Tobacco many few

☐ Drugs many few

☐ Food many few

☐ Sex many few

☐ Prescriptions many few

☐ Gambling many few

☐ Other (please specify:____) many few

☐0

Skip to Question 67

☐1 ☐2

67. I believe that my neighborhood is dangerous ☐0 ☐1 ☐2

68. I have a hard time finding affordable housing ☐0 ☐1 ☐2

69. My job provides health insurance ☐0 ☐1 ☐2

70. I know someone in a gang ☐0 ☐1 ☐2

71. I know someone who is a parent under the age of 16 ☐0 ☐1 ☐2

72. I know someone who does not get prenatal care ☐0 ☐1 ☐2

73. I know someone who cannot afford food _0 ☐1 ☐2

74. I know someone who has committed suicide ☐0 ☐1 ☐2

75. I know someone who has been in an accident ☐0 ☐1 ☐2

76. What do you think are the causes of violence in the Indian Community:
(MARK ALL THAT APPLY:)

☐1 Alcohol/drugs

☐2 Poverty

☐3 Unemployment

☐4 Low self-esteem

☐5 Historical Trauma (**READ IF NECESSARY:)** Historical trauma refers to the effects of discrimination and persecution being passed to the next generation.

☐6 Other (please specify:_____)

☐7 Don't know

☐9 **(DO NOT READ:)** Refused

77. Do you feel child abuse/neglect in the Indian Community is a problem?

☐0 No

☐1 Yes

☐ 7 Don't Know/not sure

☐ 9 **(DO NOT READ:)** Refused

78. Do you feel domestic violence/violence in the Indian Community is a problem?

☐ 0 No

☐ 1 Yes

☐ 7 Don't Know/not sure

☐ 9 **(DO NOT READ:)** Refused

79. Please share any final comments with us:

_____

(PROCEED TO OPTIONAL QUESTIONS ON NEXT PAGE IF DESIRED. IF FINISHED:)
Thank you for your participation in this needs assessment!
(REFER TO RESOURCE ADVOCATE IF NEEDED)

Optional Questions

Healthcare Quality/Client Satisfaction:

1. How satisfied are you with healthcare services you receive?

☐ 1 Very Satisfied

☐ 2 Satisfied

☐ 3 Don't Know

☐ 4 Dissatisfied

☐ 5 Very Dissatisfied

2. How would you rate the ability of your health care provider to meet the needs of Indian people in your community?

☐ 1 Excellent

☐ 2 Good

☐ 3 Fair

☐ 4 Poor

☐ 9 **(DO NOT READ:)** Refused

2a. What healthcare needs are not being addressed?

_____

3. How do you get to the clinic where you receive care?

☐ 1 Your car

☐ 2 Other car

☐ 3 Bus

☐4 Taxi

☐5 Walk

☐6 Other (please specify:_____)

4. How far would you travel to get care? _____ miles

5. If you receive services at an urban Indian health clinic, please rate your satisfaction with the
following:

	Good	**Fair**	**Poor**	**Does Not Apply**
Instructions from Pharmacy	☐1	☐2	☐3	☐4
How Providers treat you.	☐1	☐2	☐3	☐4
How other staff (besides providers) treat you.	☐1	☐2	☐3	☐4
Instructions from Providers.	☐1	☐2	☐3	☐4
Confidentiality of Records.	☐1	☐2	☐3	☐4
Providers Knowledge and Skill.	☐1	☐2	☐3	☐4
How easy it is to talk to Provider when needed.	☐1	☐2	☐3	☐
Cleanliness of facility.	☐1	☐2	☐3	☐4
How easy it is to get through to healthcare provider by phone.	☐1	☐2	☐3	☐4
Amount of time with providers.	☐1	☐2	☐3	☐4
Comfort of waiting room.	☐1	☐2	☐3	☐4
Courtesy of front desk staff.	☐1	☐2	☐3	☐4
How long it takes to get an appointment.	☐1	☐2	☐3	☐4
Waiting time to be seen after you check in for an appointment.	☐1	☐2	☐3	☐4
Waiting time to be seen if you walk in to get care.	☐1	☐2	☐3	☐4
Parking	☐1	☐2	☐3	☐4
Other (please specify):_____	☐1	☐2	☐3	☐4

5a. If you marked **poor** for any choice on the list above please explain why:
_____

6. What do you like best about your healthcare provider?
_____

7. What could be better about your healthcare provider?