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Behavioral Health Services in Urban American Indian Health Organizations: A Descriptive Portrait

Andrew Pomerville and Joseph P. Gone
University of Michigan

The federal Indian Health Service (IHS) is the primary funding source for health services designated for American Indians (AIs; Gone & Trimble, 2012). Urban Indian health organizations (UIHOs), funded in part by IHS, are typically the only sites in large metropolitan settings offering treatments tailored to AI health needs. This is a first look at how mental health treatment is structured at UIHOs. UIHO staff at 17 of 34 UIHOs responded to our request to participate (50%), 14 employed behavioral health program directors who could complete the survey on behalf of their programs, and 11 of these submitted complete data regarding their current treatment practices and personal attitudes toward empirically supported treatments. Reported treatment profiles differed less than expected from available data on national outpatient clinics from the National Mental Health Services Survey (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), and program director attitudes toward empirically supported treatments were similar to national norms reported by Aarons et al. (2010). One way in which treatment differed was in the reported use of traditional AI healing services. All program directors indicated that traditional AI healing services were available within their behavioral health programs in some form. These findings seem promising for the development of new empirically supported treatments for AI clients, but also raise concerns, given what is known about AI treatment preferences and mental health disparities. For example, traditional healing services are often considered "alternative medicine," outside the purview of evidence-based practice as typically construed by mental health services researchers. This potential conflict is a subject for future research.

Keywords: urban American Indians, mental health services, evidence-based practice, indigenous populations, traditional healing

The IHS serves as the primary funder of mental health services that are explicitly designated for AIs in the United States, but gaps in funding limit the availability of care through IHS, with behavioral health in IHS facing particularly severe funding challenges (Gone, 2004; Gone & Trimble, 2012). Federal funding for tribal members via IHS in the past has been provided at a rate that is roughly half of the amount assumed by the federal government to be necessary to cover federal employees, and IHS has traditionally allocated more than double the amount of funding to substance abuse treatment than mental health treatment receives (Gone, 2003). In addition, according to the most recent United States census, 78% of AIs and Alaska Natives reside outside of Indian lands such as reservations, typically living in urban areas (United States Census Bureau, 2010; IHS, n.d.).

To serve this population, there are 34 UIHOs in the United States that form an important but understudied part of the IHS system (IHS, n.d.). Despite the size of the population they serve, these sites have limited funding, receiving approximately one percent of the IHS budget (IHS, n.d.). UIHOs are charged with providing "culturally acceptable, accessible, affordable, accountable, and available health services to an underserved urban off-reservation population" (IHS, n.d., para. 4). It is not clear, however, to what degree these organizations are fulfilling this mission with regard to mental health services, particularly given the funding challenges described above. Little is known about the actual therapeutic practices at UIHOs, with suspicion of research in response to past exploitation creating a barrier for collecting information regarding urban AI populations and organizations (Yuan, Bartgis, & Demers, 2014). We seek in this study to break new ground by being the first to survey and report on UIHO mental health services.

Past surveys of mental health services, including the 2010 National Mental Health Services Survey (N-MHSS), have not included IHS and tribally operated health services in their survey efforts (United States Department of Health and Human Services [HHS], 2010). The 2010 N-MHSS was part of a yearly surveying procedure of clinical services in the United States conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), and is the most recent of these surveys for which data

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Andrew Pomerville and Joseph P. Gone, Department of Psychology, University of Michigan.

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Correspondence concerning this article should be addressed to Andrew Pomerville, Department of Psychology, University of Michigan, 2250 East Hall, 530 Church Street, Ann Arbor, MI 48109-1043. E-mail: pomervil@umich.edu

have been released (HHS, 2010; SAMHSA, 2014). These data are used to provide a rough national picture of available services at over 10,000 sites of various types ranging from individual outpatient clinics to psychiatric hospitals. Considering specifically the 5,519 outpatient clinics surveyed in 2010, it was reported that cognitive-behavioral therapy, individual psychotherapy, and group psychotherapy were widely available, with each of these types of services being utilized at over 80% of clinics (SAMHSA, 2014). In addition, over half of all these facilities reported offering suicide prevention services, integrated dual disorders treatment, and activity therapy (SAMHSA, 2014). It is not currently known how the services at UIHOs compare with these nationally reported trends.

It is also currently unknown what level of training mental health providers at UIHOs have achieved. Past research with a reservation IHS clinic noted that turnover was exceptionally high in mental health services and that appropriate clinicians were frequently unavailable, but this anecdotal description represented only a single reservation site (Gone, 2004). At the national level, SAMHSA (2013a) has estimated that 6.7% of the behavioral health workforce is comprised of psychiatrists, 16.0% are psychologists, 32.3% are clinical social workers, 34.6% are counselors or marriage and family therapists, 8.1% are substance abuse counselors, and 2.3% are psychiatric nurses. Moreover, according to SAMHSA (2013b), standards for behavioral health providers vary significantly by state, and while a master's-level education is typically required for licensure in mental health counseling, requirements for alcohol and drug counseling often include a bachelor's degree or less. In fact, SAMHSA (2013b) reported that only about half of alcohol and drug counselors have master's-level educations, with approximately one-quarter lacking a bachelor's degree as well. Given the emphasis on substance abuse counseling in IHS as previously mentioned, it is possible that education rates for UIHO staff are quite low.

What is known is that UIHOs serve a population that faces serious health disparities compared with the average person in their service areas, with urban AI populations facing health rates similar to AIs living on reservation lands (Castor et al., 2006). The majority of AIs live in urban areas, as previously noted, yet little attention is given to their health needs in contrast with the relatively wide availability of reservation IHS-funded sites (Gone & Trimble, 2012). West, Williams, Suzukovich, Strangeman, and Novins (2012) reported that urban AI communities desire behavioral health treatments that are more relevant to their needs and culture; these researchers did not, however, report on the current practices at UIHOs beyond the impressions of community members participating in focus groups.

Psychotherapy dropout rates for AIs have been found to be higher than for any other group: almost double the rate for White Americans in one early study (Sue, Allen, & Conaway, 1978). Cultural tailoring may assist in improving this disparity, and the importance of UIHO mental health clinics is, in large part, that they are typically the only programs that are in a position to tailor mental health services to AIs in urban areas (Gone & Trimble, 2012). However, even IHS sites face severe challenges in terms of treatment retention. Again, casual inquiry at one reservation IHS service unit found that behavioral health clients were likely to attend for only limited, crisis-focused interventions of two or three sessions, if they attended at all; many never showed up after initial consultations (Gone, 2004). Questions remain about how much psychotherapy is being provided at UIHOs, the level of training for clinicians who are delivering these services, and the rates at which urban AI clients are participating in psychotherapy.

It is currently unknown whether UIHOs employ empirically supported treatments, owing to the deficiencies in empirical research with AI therapists and clients specifically. Empirically supported treatments, established via randomized clinical trials, are one of the three central components of evidence-based practice. The other two are client preferences/characteristics, such as race and culture, and clinical expertise (APA Presidential Task Force on Evidence-Based Practice, 2006). However, AI clients have rarely been included in psychotherapy research studies, let alone had specific trials devoted to them (Miranda et al., 2005; Watkins, 2012), and a recent systematic review of the literature on psychotherapy with Indigenous clients identified only two controlled outcome studies (Pomerville, Burrage, & Gone, 2016). Among those studies that have been conducted, AIs have differed from other racial groups in terms of preferences for treatment (Fiferman, 1990; Jackson, Schmutzer, Wenzel, & Tyler, 2006) and treatment outcomes (Villanueva, Tonigan, & Miller, 2007). In general, models of psychotherapy developed specifically for AIs diverge from empirically supported treatments for other populations (e.g., Duran, 2006), and these models remain untested.

One specific difference in mental health services that are tailored for AI clients is the interface with traditional healing (Gone, 2010). Traditional healing is a term employed in clinical settings to describe the use of Indigenous cultural practices in mental health services, theoretically finding their basis in historical Indigenous healing traditions, community activities, and worldviews (Duran, 2006) as opposed to clinical evidence. Resistance to the idea of adhering to empirically supported treatment protocols and research paradigms among experienced AI clinicians has been noted multiple times (Duran, 2006; Gone, 2009; Goodkind et al., 2011). This is a cause for some concern for the adaptation and dissemination of empirically supported treatments that have been established with other client populations to AIs. If authority for traditional healing practices is not drawn in part from scientific literature demonstrating its efficacy, such practices may also seem to be at odds with the evidence-based practice model outlined by the APA Presidential Task Force (2006). In addition to our other goals, this study is a first attempt to establish whether the conditions at UIHOs are conducive for conducting research on empirically supported treatments tailored specifically for AI clients.

The existing gaps in the literature with regard to available treatments at UIHOs make it impossible to provide realistic guidance for improving mental health for urban AI clients. Five research questions were developed for this study in the effort to fill these gaps. First, according to behavioral health program directors, what are the typical mental health services offered by UIHOs? Second, what is the training background of those providing mental health services at these sites? Third, how often do clients return after the first therapy session and how many sessions do those clients who return receive? Fourth, how do those in charge of making decisions at these sites perceive empirically supported treatments? Fifth, how and to what degree is traditional healing being used in UIHOs? We expect, based on the information just summarized, that UIHOs will be severely hampered in terms of the services they are able to provide when compared with national profiles. In addition, based on existing evidence about AI popula-

tions and their mental health treatment, we expect to find limitations in terms of the number of sessions for which clients return, as well as in openness to empirically supported treatments. To answer these questions, behavioral health program directors at UIHOs (or persons in equivalent positions, such as directors for UIHOs in charge of both health and behavioral health) were surveyed concerning the services provided at their sites and their attitudes toward empirically supported treatments. Where possible and appropriate, these results are compared with extant national data.

Method

Settings

UIHOs are the 34 general health programs aimed at urban AIs that range from small, single-location sites offering limited health treatment and relying heavily on referral, to comprehensive programs offering full ambulatory health care services at multiple locations (IHS, n.d.). Although all of these sites are funded in part through IHS, this does not mean that they are necessarily funded in full. As of 2008, just over half of funding for UIHOs came from IHS on average, with another 14.5% coming from federal grants (National Council for Urban Indian Health [NCUIH], 2008). An additional 9.0% came from Medicaid, on average, and 8.9% came from third-party insurance, with no other single source accounting for more than 5% of funding at UIHOs (NCUIH, 2008). Fifteen of the UIHOs are also federally qualified health centers that are obligated to serve non-AI clients as well (IHS, n.d.). The 34 UIHOs are distributed across 21 states with over half of them concentrated in the region designated by the United States Census Bureau (n.d.) as the West.

Participants

In all, 17 of the 34 UIHOs responded to email and phone inquiries (50%). Three of these were unable to complete the survey due to lacking a behavioral health program director: one indicated that they do not offer behavioral health services at this time and two indicated that they were currently hiring someone to fill the position of director of behavioral health. An additional three of the 17 UIHOs that responded completed fewer than half of the items on the survey, and did not fill out payment information. The partial results from these three sites were excluded. Data from the remaining 11 respondents were analyzed for the study. Participants were program directors or equivalent staff members at UIHOs. No demographic data was collected from program directors. The 11 UIHOs in this study represented nine different states. Using United States Census Bureau (n.d.) definitions again, five of 11 participant sites were located in the West.

To check for potential differences between the sites that responded and those that did not, we utilized the Urban Indian Health Institute's (2011) Community Health Profiles. These profiles provide statistical data for AIs in the service regions of each UIHO. We tested for differences in the AI populations of these regions on six variables related to behavioral health using independent-sample *t* tests: alcohol-induced death, smoking rate, poverty rate, social support, suicide rate, and mental distress. These six items were selected from among all statistics presented in the Community Health Profiles, as they were expected to be the most relevant for available behavioral health services. There were no other direct measures of mental health in this data set. In some communities, data were missing for some variables; missing data were simply omitted rather than imputed. Specifically, seven communities lacked alcohol-induced death rates, one community lacked social support data, and eight were missing suicide data. The other three variables had no missing data. No statistically significant differences were found on any of these measures between the sites that responded to our survey and those that did not, indicating that at least for these items, the sites we surveyed did not differ systematically from those that did not respond.

Measures

In order to examine the current state of mental health treatment at these centers, one existing measure of mental health services was used. In addition, questions designed for this study regarding the training and educational backgrounds of clinicians were asked. Program directors were also asked to estimate the percent of clients who return after one session, and the average number of sessions that these clients receive. An existing measure of attitudes toward new, research-based or manualized therapies was used to assess program director perspectives about empirically supported treatments. Finally, program directors were asked about the traditional healing practices offered at their sites.

The 2010 N-MHSS. A partial set of questions from the N-MHSS were selected for inclusion to investigate what treatment types are being used at these sites. The N-MHSS adopted here is the 2010 version of a regular survey of clinical practices conducted by SAMHSA. For this study, we used four multiple-item measures from the N-MHSS concerned with the types of treatments and services available and the quality assurance practices that clinics use. These measures consist of a single overarching question with only yes or no responses to whether each item on a list of specific treatments or services are offered (e.g., "which of these mental health treatment approaches are offered at this facility, at this location" followed by a list including "cognitive behavioral therapy," "activity therapy," etc.). These measures were asked exactly as they appeared on the 2010 N-MHSS survey, and program directors were given the official definitions from the original survey if uncertain about whether they utilized a specific treatment service or quality assurance practice. As some UIHOs oversee multiple clinical sites and the N-MHSS is specifically intended for surveying a single site, program directors were asked to only consider services at the primary site if their UIHO was responsible for more than one location offering behavioral health services. The complete survey data from the original N-MHSS survey, released in 2014, and the full list of N-MHSS questions, is publicly available (HHS, 2010).

Clinician profiles. Program directors were asked to identify the number of clinicians working at the site and for details of these clinicians' educational backgrounds, including their last degree completed and whether they were currently trainees in degree programs.

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

also asked to indicate the ethnoracial makeup of clients seen in the past month.

The Evidence-Based Practice Attitude Scale (EBPAS). The EBPAS consists of 15 items regarding manualized treatment and research-based interventions, using a Likert-like scale ranging from zero to four for all questions (Aarons, 2004). Each item is attached to only one subscale, with four subscales in all. The combined scores for items on a single subscale are averaged to calculate the total score for that subscale. The subscales are Appeal (scored 0–4; how likely is a clinician to use novel treatments and treatments developed by researchers if they appeal to the clinician?), Requirement (scored 0–4; how likely is a clinician to use a treatment if they are required to by supervisors or government?), Openness (scored 0–4; how open is a clinician to new treatments?), and Divergence (scored 0–4; to what degree is a clinician resistant to research-based treatments that are divergent from current practice or experience?). Scores closer to 4 on Appeal, Requirement, and Openness represent greater interest in using manualized and research-based interventions. Scores closer to 4 on Divergence represent greater resistance to these treatment approaches. Scores on the four subscales are combined and then averaged for a total EBPAS score of 0 to 4, with items from the Divergence subscale reverse scored. A large-scale study (Aarons et al., 2010) established national norms on these measures and "moderate to excellent" reliability of the measure (p. 360). For this study, Cronbach's alphas for the four subscales ranged from .80 to .95, indicating high reliability for these measures, with adequate reliability ($\alpha = .73$) for the total EBPAS score.

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

Procedure

Efforts were made to contact the program directors (or persons in equivalent positions) for the behavioral health programs at all 34 UIHOs via phone and email to make them aware of the study and to invite them to participate. Email messages included a link to a Qualtrics online survey that also asked program directors to provide a phone number for a brief follow-up call to confirm and clarify their answers. Solicitations by telephone also invited program directors to complete the survey live over the phone. Two program directors responded to emails and completed the survey via the Qualtrics website and follow-up phone call. Nine program directors participated in the survey live over the phone, going through the survey with the first author item by item instead of using the Qualtrics website. Together, these program directors represented 32% of the total number of UIHOs (including at least three sites that did not employ a behavioral health program director at the time of the survey). Some program directors sought assistance from other behavioral health staff at their sites to answer specific questions about the services offered by the clinic, but all answers to questions from the EBPAS were from program directors and therefore represent their attitudes toward evidence-based practice. All program directors received a $30 gift card for their participation.

The answers to the N-MHSS questions on treatment and support services were tabulated in order to offer a concise picture of current treatment available at these sites as compared with national averages based on the same survey. The EBPAS subscales were constructed in accordance with Aarons (2004) and those scores were tabulated and compared with the national norm results presented in Aarons et al. (2010). The remaining descriptive data are presented in tabular and narrative form. Responses to the two open-ended questions on traditional healing were compared and grouped based on relatively self-evident similarities in wording and meaning of responses.

Results

An interesting portrait of the UIHO behavioral health service ecology emerged from our inquiry, with program directors reporting greater prevalence of many treatments and services than are offered nationally at outpatient clinics. More than 70% of clinicians were reported to have graduate training in mental/behavioral health across the 11 sites. Over the past month, 76.8% of clients seen at these sites were reported to be AI or Alaska Native, with considerable variation between sites on these percentages. Program directors' EBPAS scores were largely in line with national norms. While traditional healing was offered in some manner at all sites, the ways in which such treatments were offered appeared to vary in important ways.

Treatments and Support Services

Table 1 presents the treatment and support services data from the UIHO N-MHSS survey questions as well as the national reported rates for outpatient clinics offering these services. In seven of the 10 categories of treatment types, program directors were more likely to report offering a given treatment compared with the national average. The greater availability of individual therapy, group therapy, couples and family therapy, and behavior modification at these sites may speak to a relatively robust program of mental health services at these 11 UIHOs. The greater rate of dual disorders treatment may reflect IHS's financial commitment to substance abuse treatment. Still, behavioral modification was the only category that differed by more than 15 percentage points from the national average. Seven program directors indicated that they used other specific treatments. Other specific treatments mentioned by at least two program directors were AI-specific treatments ($n = 4$) and dialectical behavioral therapy ($n = 2$).

Also apparent in Table 1: larger differences exist between typical support services reportedly offered at the surveyed UIHOs compared with those offered at outpatient clinics nationally. The program directors surveyed for this study were more likely to report offering 10 of 17 potential support services listed, with a difference of more than 30 percentage points regarding four of those services: suicide prevention, smoking cessation, illness man-

Table 1
Availability of Behavioral Health Treatments and Services as Reported by Program Directors at 11 UIHOs in Comparison to National Averages

Treatments			Services		
Treatment type	UIHOs offering (%)	National (%)[a]	Supportive service	UIHOs offering (%)	National (%)[a]
Individual therapy	100	89.9	Case management	100	77.1
CBT	90.9	92.0	Suicide prevention services	90.9	55.6
Group therapy	90.9	82.9	Chronic illness management	81.8	16.8
Couples/family therapy	81.8	74.7	Smoking cessation	63.6	15.6
Behavior modification	81.8	65.7	Family psychoeducation	63.6	61.6
Psychotropic medication	72.7	79.8	Education services	63.6	38.3
Dual disorders treatment	72.7	55.1	Illness management and recovery	63.6	32.4
Activity therapy	36.3	35.0	Psychosocial rehabilitation	36.3	47.8
Telemedicine therapy	19.1	17.4	Housing services	27.2	22.0
Electroconvulsive therapy	0	.7	Consumer-run services	27.2	20.5
			Supported employment	18.1	23.6
			Legal advocacy	18.1	5.5
			Vocational rehabilitation	9.0	15.8
			Psychiatric emergency walk-in services	0	37.5
			Supported housing	0	19.7
			Assertive community treatment	0	18.7
			Therapeutic foster care	0	7.1

Note. UIHOs = urban Indian health organizations; CBT = cognitive behavioral therapy.
[a] National percentage for outpatient clinics in 2010, from SAMHSA (2014).

agement and recovery, and chronic illness management. Similarly, the comparatively higher rates at which UIHO sites reported offering case management, education services, and illness management and recovery were noteworthy. At the same time, four services from the survey were not offered at any of the sites surveyed. Finally, seven program directors indicated that they offered support services other than those listed. The only two other specific support services mentioned by more than one program director were exercise programs ($n = 2$) and domestic violence support ($n = 3$).

Table 2 provides a list of specific populations for which behavioral health clinics might designate tailored treatment programs. Although within 15 percentage points on most items, dramatic differences are noticeable in UIHOs being more likely to offer specific treatments or groups for individuals with co-occurring mental health and substance abuse disorders, as well as for individuals with posttraumatic stress disorder. Program directors were also less likely than the national average to report offering specific treatments or services for those with serious mental illness.

Reported use of quality assurance practices at UIHOs, as depicted in Table 3, were largely in line with national averages. Only periodic utilization review, less common at UIHOs than outpatient clinics nationally, differed by more than 15 percentage points.

Clinician Profiles

According to the program directors surveyed, sites included a mean of 6.45 clinicians ($SD = 4.08$). Only three sites did not have at least one doctoral-level clinician, and only one site did not have any doctoral or master's-level clinicians. Of the 71 providers

Table 2
Availability of Specific Behavioral Health Treatments for Specific Client Populations as Reported by Program Directors at 11 UIHOs in Comparison With National Averages

Specific client population	UIHOs offering (%)	National (%)[a]
Individuals with co-occurring mental health and substance abuse disorders	90.9	59.1
Individuals with posttraumatic stress disorder	72.7	50.7
Individuals with co-occurring mental health and nonsubstance abuse disorders	45.4	44.1
Forensic clients (referred by the court/judicial system)	45.4	35.8
Youths with serious emotional disturbances	36.3	49.5
Transition-aged youths 18–25	36.3	33.9
Veterans	36.3	23.3
Adults with serious mental illness	27.2	64.2
Gay, lesbian, bisexual, or transgendered clients	27.2	27.8
Individuals with traumatic brain injury	18.1	10.5
Individuals with Alzheimer's or dementia	9.0	7.8

Note. UIHOs = urban Indian health organizations.
[a] National percentage for outpatient clinics in 2010, from SAMHSA (2014).

Table 3
Use of Quality Assurance Practices as Reported by Program Directors at 11 UIHOs in Comparison to National Averages

Assurance practice	UIHOs offering (%)	National (%)[a]
Periodic client/patient satisfaction surveys	100	94.5
Monitoring continuing education requirements for staff	100	87.8
Regularly scheduled case review with a supervisor	81.8	94.4
Periodic utilization review	72.7	89.7
Regularly scheduled case review by an appointed quality review committee	72.7	72.1
Client/patient outcome follow-up after discharge	54.5	49.8

Note. UIHOs = urban Indian health organizations.
[a] National percentage for outpatient clinics in 2010, from SAMHSA (2014).

enumerated for the 11 sites, master's-level clinicians made up over half of all providers ($n = 37$), followed by doctoral clinicians ($n = 15$), and a limited number of bachelor's-level clinicians ($n = 7$). Level of education was either not indicated or something other than doctorate/master's degree/bachelor's degree, such as an associate's degree, for 12 clinicians. These proportions approximate national percentages of the behavioral health workforce at the doctoral level (as reviewed earlier), but otherwise appear to skew toward lesser educational attainment, with fewer master's-level clinicians and a small percentage of associate's-level providers. Moreover, eight sites indicated that at least one of their current clinicians was a trainee in a degree or certificate program of some type.

Client Profiles

As estimated by program directors, a mean of 76.18% of clients at these sites returned after an initial visit ($SD = 11.36$). Among those that return, program directors estimated that these clients receive a mean of 11.3 treatment sessions ($SD = 6.77$). When asked about clients seen in the past month, three program directors reported serving exclusively AI or Alaska Native clients in that time period. Two program directors indicated that fewer than half of clients seen in the past month were AI or Alaska Native, though both indicated a number above 30%. One program director declined to provide data on the ethnoracial makeup of clients seen in the past month. The mean percent of clients who were identified as AI or Alaska Native seen in a monthly period at the 10 UIHO sites reporting data was 76.8% ($SD = 24.29$). In comparison, the national average of AI or Alaska Native clients who were seen over a 1-month period for all sites that SAMHSA surveyed, as well as for separate assessment of outpatient clinics specifically, was just 0.6% (SAMHSA, 2014).

Program Director Attitudes Toward Evidence-Based Practice

Table 4 presents results from the four EBPAS subscales and total EBPAS score. The program directors at these 11 UIHOs reported an average total EBPAS score of 2.69. As shown in Table 4, this average was nearly identical to the national average reported in Aarons et al. (2010). Scores from the program directors were not as close to the national norms on specific subscales as they were on the total EBPAS score, but these scores deviated less than half a point from national norms on three out of the four EBPAS subscales. The only subscale that differed by more was Requirements, with program directors' scores indicating they were more likely than the national norms to use a new intervention if it was required by supervisors or government entities.

Traditional Healing

When asked to define traditional healing, program directors relied on definitions that described traditional healing in terms of sources of authority and primary stakeholders. This came out in fours ways, with overlap between many respondents. First, six of 11 program directors made reference to tribal authority in their definition, defining traditional healing as cultural activities with

Table 4
Program Director Scores on the Evidence-Based Practice Attitudes Scale from 11 UIHOs in Comparison to National Averages

Subscale	UIHO program director means	UIHO program director Cronbach's α	National norm[a] means	National norm[a] Cronbach's α
Appeal	$M = 2.818$ ($SD = 1.04$)	.95	$M = 2.91$ ($SD = .68$)	.80
Divergence	$M = 1.659$ ($SD = .68$)	.79	$M = 1.25$ ($SD = .70$)	.66
Openness	$M = 2.546$ ($SD = 1.03$)	.90	$M = 2.76$ ($SD = .75$)	.84
Requirements	$M = 3.212$ ($SD = .85$)	.84	$M = 2.41$ ($SD = .99$)	.91
Total EBPAS score	$M = 2.729$ ($SD = .48$)	.72	$M = 2.73$ ($SD = .49$)	.76

Note. UIHO = urban Indian health organization; EBPAS = Evidence-Based Practice Attitudes Scale.
[a] From Aarons et al. (2010).

tribal endorsement and historical precedent. Second, seven of 11 program directors made reference to the individual client as a stakeholder, referencing the importance of an individual's cultural and personal background. This included the specific client's needs, their personal level of interest in traditional healing, and their identity as multitribal versus a member of a specific tribal group.

Third, five of 11 program directors made reference to the importance of the clinic as a stakeholder in traditional healing, with traditional healing practices, in part, defined by the needs of the clinic in terms of the form it takes (e.g., that pan-Native approaches are required because of the multitribal urban environment of UIHOs, or that traditional healing operates as part of a larger psychotherapeutic intervention). Finally, four of 11 program directors referenced authority in their definition of traditional healing as coming from the specific individual traditional healers with whom they interact, either with or without tribal endorsement. All 10 of the program directors' responses are represented within at least one of the four categorizations above.

Cultural education in itself was reported as among the most common traditional healing practices ($n = 5$). Specific practices of traditional healing used by at least two of these sites included sweat lodge ceremonies ($n = 6$), talking circles ($n = 3$), smudging rites ($n = 3$), pipe ceremonies ($n = 2$), and drumming ($n = 2$). Five sites indicated at least one other specific, named ceremonial or therapeutic practice that was utilized under the label of traditional healing. Four sites indicated in response to this question that they directly offer or refer clients for traditional healing that is individualized in some manner, either on the basis of the needs of the client or on the basis of the practice of the traditional healer.

Nine of the 11 sites indicated that traditional healing is incorporated into therapy. Eight of the 11 sites also indicated that traditional healing is available at the facility separate from therapy, but the overlap with the first response was imperfect. Eight sites indicated that they refer clients to traditional healers in the community. All 11 sites indicated they participated in at least one of these three approaches. When asked approximately how many clients make use of or are referred for traditional healing, participants indicated a mean of 35.64% of their clienteles ($SD = 25.30$).

Discussion

These results run counter to our initial expectation and suggest that, despite chronic underfunding for UIHOs and the larger IHS system (Castor et al., 2006; Gone, 2003; Yuan et al., 2014), the UIHOs that participated in this study manage to offer a greater range of services than is typical of outpatient clinics nationwide. Funding allocations for IHS are approximately half of what is typically thought to be necessary to pay for health care for the number of people IHS is responsible for, and little of this money goes to mental health (Gone, 2003). With funding that is so out of proportion to need, how could UIHOs offer a wider spectrum of services than most clinics?

One possibility is that there are errors in reporting that account for our data. It could be that program directors reported more services than would have resulted from some other form of measurement. However, given that the national comparators come from self-reported measures as well, it is unlikely that this alone explains the differences. At least some program directors in this study made note that the answers they were providing came from actual records, even though retrospective self-report was allowed. Similarly, it is possible that the participants misunderstood what some of the terms for various services actually meant, but official SAMHSA definitions were given to participants for any items that they indicated were unclear. There is also no obvious reason why UIHO program directors would differ from others in misunderstanding these terms. It is also possible that response bias played a factor in our results, and that the 11 sites that chose to participate are those with more robust services available. On the contrary, participants who oversee multiple UIHO sites were asked to consider a single site, which may mean that these results may actually underestimate the kinds of available services.

Another possibility is that these services are not offered concurrently or consistently over time, but may instead represent various temporary services that are available depending on current funding climates. Although the majority of UIHO funding comes from IHS, federal grants make up the second largest funding source for these sites (NCUIH, 2008). It may be that many of these programs and services are offered in time-limited formats based on temporary funding from grants. This would allow UIHOs to offer a broader range of services overall, while services remain limited in that only a small number of clients can participate in any given program, and the program can only run as long as there is some temporary form of grant funding.

Other Differences

In considering some of the other obvious differences that were visible in these results, it is possible that the need to devote a greater number of resources at these UIHOs to managing chronic illness, smoking, and addressing high suicide rates among urban AIs (Pettingell et al., 2008) may explain, in part, why some services common at non-UIHO sites, such as psychiatric emergency services or services for adults with serious mental illness, appear to be less common at UIHOs. Another explanation may be that the funding priorities of IHS partially drive which services are offered, which in the past has put significant emphasis on substance abuse treatment over funding for other behavioral health problems (Gone, 2003). As such, these sites may have more money to spend on certain services, such as smoking cessation and dual disorders treatment.

These results may also reflect funding pressures that surround evidence-based practice. Support for evidence-based practice among program directors was higher than prior research might have suggested, nearly matching the national average despite a lack of specific evidence demonstrating beneficial treatment outcomes for various psychotherapies delivered to AI clients (Gone & Alcántara, 2007; Pomerville, Burrage, & Gone, 2016). In addition, sites report offering many more services associated with evidence-based practice than might be expected in light of the available funding. Given that evidence-based psychotherapies have not been studied for AIs specifically (Gone & Alcántara, 2007), it may be that the program directors surveyed here frame their efforts as evidence-based independent of actual therapist activity in the context of institutional (and especially funding) pressures to adopt and promote evidence-based practice.

Although not necessarily incompatible with evidence-based psychotherapies, UIHOs are known to employ divergent practices such as traditional healing and spiritual ceremonies as part of their

effort to tailor mental health treatment to AI clients (Moghaddam, Momper, & Fong, 2015). All program directors in this study endorsed offering these services in one form or another, with sweat lodges and cultural education programs reportedly being used as forms of treatment at approximately half of the sites surveyed. If these results are accurate, there are at least four different ways in which program directors may be reconciling these positions with their reported support for evidence-based therapies.

First, considering the results seen in this study, it is possible that program directors regard the endorsement of tribal leaders and individual healers as a form of evidence. Second, given the lack of empirically supported approaches to behavioral health treatment for AIs specifically, program directors may feel there is little need to point to a specific evidence base for these types of treatment practices. Third, program directors may understand traditional healing as a complementary practice which is directed at general well-being or cultural engagement rather than as a form of mental health treatment per se. Fourth, reported support for evidence-based approaches in this study may reflect a response to the above mentioned pressures surrounding evidence-based practice as opposed to a genuine commitment. Future open-ended interviews with program directors might help to gain some insight into which of these explanations, if any, explains the reason for this apparent contradiction.

Of 71 clinicians, 52 were reported to have graduate-level education in some form (73.2%), which suggests a somewhat lower educational attainment among these providers in comparison with national estimates of the training level of the behavioral health workforce (SAMHSA, 2013a). Despite this finding, if these results reflect similar situations at other UIHOs, this could still reflect an advantage among the urban sites in this study in comparison with the environment of high turnover and low clinician availability described at one rural IHS site (Gone, 2004). In contrast with this anecdotal report that clients in an IHS clinic rarely received more than three sessions of "crisis management" psychotherapy, UIHO clients were estimated to receive an average of 11 sessions by the program directors in this study. On the one hand, it is possible that the report by Gone was idiosyncratic and our results represent a better estimate of typical services that AI clients are receiving at IHS-funded sites, but on the other hand, it should also be noted that Gone's observations about treatment dropout accord with other anecdotal reports by clinicians. As most program directors provided estimates rather than systematic data, our findings may also reflect overly optimistic perspectives of the program directors surveyed. Further research with both urban and rural IHS-funded behavioral health services could help clarify the accuracy of these intriguing results.

A promising finding here is the potential for new mental health treatment approaches developed by researchers to serve these communities. The similarity of program directors' scores on the EBPAS to national norms is not the only reason to suggest this potential. Over 70% of clinicians were reported to have a graduate-level education in mental health. While this may not be necessarily predictive of a strong commitment to evidence-based practice or openness to new clinical research, it does indicate a level of training and commitment to mental health services that goes beyond what previous research might have suggested. Future research that asks all clinicians at these sites to complete the EBPAS may better clarify the degree to which providers at UIHOs are open to new research-based treatments. The similarly high percentage of UIHOs surveyed here that serve as training sites could be another indicator of openness to training in new approaches. Future research to better investigate this topic may include site visits to UIHOs to determine the real state of current practice via more direct observation. In addition to verifying the types of practices actually happening at UIHOs, site visits would help researchers better understand program directors' perceived needs regarding new therapeutic approaches, and may make it possible to forge the types of partnerships necessary to build a body of empirical support for such approaches with AI clients.

Limitations

Several limitations should be acknowledged in interpreting the results of this study. Although we have no reason to believe that these data are anomalous, all results must be understood to reflect the 11 sites that responded to this survey, and cannot be assumed to be representative of or generalizable to all UIHOs. Moreover, the responses are based on self-report by program directors; despite the fact that the N-MHSS comparison data were similarly obtained, program director reports should not be assumed to transparently reflect the complex clinical realities that characterize behavioral health services at their sites. Additionally, the small size of our sample undermined our ability to conduct meaningful inferential statistics, effectively limiting the possibility of identifying subtle but true differences in our comparisons. Fortunately, many of these comparisons remained illuminating on a descriptive basis alone, including several surprising similarities between the behavioral health services profiles at these UIHOs and extant national services profiles.

Future Directions

This initial inquiry suggests that UIHOs offer numerous services and may be open to collaboration in tailoring empirically supported treatments for use with AI clients. However, future work is necessary to assess the validity of these findings. Open-ended interviews with program directors and in-person visits where multiple measures might be delivered to other staff members could assist in clarifying some of the tensions between these results and past research. Open-ended interviews would be especially useful for better understanding program directors' attitudes toward evidence-based practice, and their perspectives on how this fits with traditional healing practices. Interviews might also illuminate the degree to which funding sources are having an impact on services offered at UIHOs, as well as an explanation for how program directors are able to offer the number of behavioral health services that they reportedly do. Site visits would be useful for determining the degree of correspondence between program directors' reports and actual services. Assessment of treatment fidelity at these sites (e.g., Moyers, Martin, Manuel, Hendrickson, & Miller, 2005) could be used to gain a better sense of the match between what is being offered and what is being reported. Even without access to recordings of sessions, clinician-report measures could be used to assess how often various components of specific therapies are being used at these sites (Hogue & Dauber, 2013). An in-depth understanding of what is on offer at these sites is a crucial future step in considering how subsequent treatment research might be useful to UIHOs and other sites serving AI clients.

This beginning foray provides an initial portrait of urban AI behavioral health treatment that should serve to direct future work on the topic. Underfunded and facing a population in distress, program directors at these UIHOs report offering strong programs of mental health treatment similar to what is available at outpatient mental health clinics nationally, with average overall rates of support for using evidence-based approaches. They also report having a staff of graduate level clinicians as well as client retention rates that should be favorable to treatment. In addition, program directors report offering a variety of traditional healing practices. While certain inconsistencies and tensions need to be addressed through other research, these reports paint a picture of surprisingly robust service offerings in behavioral health at UIHOs. If accurate, the results of this study bode well for future research and funding efforts to further improve mental health treatment at UIHOs, and perhaps to "Indian Country" more broadly.

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