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Behavioral Health Services for Urban American Indians and Alaska Natives: A Thematic Analysis of Interviews With 10 Program Directors

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Urban Indian Health Programs (UIHPs) are one of the primary sources of government-funded health care for the millions of American Indian and Alaskan Native (AI/AN) people living in urban areas. The goal of this study is to better understand what services are available at UIHPs and how resources are being used to support these services. Semistructured interviews with behavioral health directors at 10 UIHPs were reported, transcribed, and thematically analyzed to address this knowledge gap. Our analysis indicates that UIHP behavioral health services were broad, encompassing numerous commitments that extend far beyond purely psychotherapeutic interactions and interventions to the periphery of behavioral health. An accurate accounting of behavioral health services at UIHPs must consider not only the ways that these services are shaped by distinctive visions to provide Indigenous cultural education and traditional healing, but also by expansive commitments to offering a full range of social services, case management, and community building under the broad umbrella of behavioral health. Implications of these findings include the need for additional funding for UIHPs, greater sponsorship of pathway training programs for AI/ANs in the mental health professions to increase the availability of AI/AN providers, future expansion of traditional healing practices, and direct empirical observation of behavioral health service delivery.

Impact Statement

Urban Indian Health Programs (UIHPs) are one of the primary sources of government-funded health care for millions of American Indian and Alaskan Native people living in urban areas. Based on interviews with behavioral health directors at 10 UIHPs, we found that behavioral health services were broadly conceived yet underresourced, encompassing distinctive visions to provide Indigenous cultural education and traditional healing as well as a full range of social services that were ill-supported by existing resources.

Keywords: American Indians and Alaska Natives, behavioral health, Urban Indian Health Programs, traditional healing, qualitative interviews

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Urban Indian Health Programs (UIHPs), although representing just 1% of the Indian Health Service (IHS) budget (IHS, 2021), are one of the primary sources of IHS care for the millions of American Indian and Alaskan Native (AI/AN) people living in urban areas (Norris et al., 2012). With an operating budget of 4.7 billion dollars, IHS is intended to provide care to federally recognized AI/AN tribal members (IHS, 2021). Approximately half of this budget, 2.4 billion dollars, goes to the direct provision of health, dental, and behavioral health services at mostly nonurban IHS facilities. This includes IHS-run hospitals and health clinics located primarily on reservation lands with $82 million allocated for mental health specifically and $200 million for substance use disorder (SUD) treatment (IHS, 2021). Another $900 million is allocated to purchase care performed at non-IHS sites. The remainder of the budget covers preventive

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health, grants to tribes, scholarships for AI/AN people seeking to enter the health care professions, and building and maintenance costs. Only $45 million is designated explicitly for urban health care services. Current funding for UIHPs is at 22% of the projected need for primary care services. This indicates that UIHP services are critically undersupported (IHS, 2020).

According to IHS, the funds designated for urban health care services currently support 41 UIHPs that are designed to serve the medical needs of AI/AN people with "culturally acceptable, accessible, affordable, accountable, and available health services to an underserved urban off-reservation population" (IHS, 2020). UIHP sites vary greatly in terms of care offered, with the plurality ($N = 23$) offering full ambulatory services, which are defined as direct medical care for 40 or more hours per week. Additionally, seven programs offer limited ambulatory care of less than 40 hr a week, seven offer outreach and referral but not direct medical care services, and four are classified as Residential Treatment Centers (IHS, 2020). However, 15 of these sites are Federally Qualified Health Centers (FQHCs), which also treat non-AI/AN clients as mandated by federal law (IHS, 2019). This means that only 40% of the total patients seen are AI/ANs (IHS, 2020).

In addition, 18 cities have an urban population large enough to support an UIHP, though they currently do not have one. In response to the critical needs of UIHPs documented in an IHS (2009) report, the IHS office of UIHPs now manages the 4-in-1 Grant Program. This program requires participation in national evaluation while providing funding to UIHPs. Their aim is to provide "comprehensive, culturally appropriate health care services" (IHS, 2020, p. 5) in 3-year funding cycles while addressing four service areas: health promotion and disease prevention, immunization, alcohol and SUD services, and mental health. In 2019, this program funded 33 UIHPs. A recent report highlighted nine themes from these grantees concerning unmet needs: social determinants of health, funding, capacity needs, cultural practices, data needs, target population, programming and services, external challenges, and major service area gaps (IHS, 2020). The most prevalent medical service area gap identified by grantees was behavioral health services. Concerns reported by grantees included shortages in the number of psychiatrists, specific training in behavioral health treatment for staff, and resources for SUD treatment.

The existing UIHPs provide a vital support net for many who would otherwise be unable to receive services, with an emphasis on behavioral health services such as suicide prevention and SUD treatment. This study complements existing evaluation efforts by focusing specifically on behavioral health directors' perceptions of available services provided at UIHPs.

Indigenous Cultural Practices

When considering behavioral health treatment at a site that serves a significant number of AI/AN clients, it is important to understand the role of AI/AN cultural practices and teachings in the many contemporary therapies designed for this population (Gone, 2010). AI/AN cultural practices and teachings are often included in behavioral health treatments that have been tailored for these populations (Gone, 2009, 2011; Rowan et al., 2014). These adapted AI/AN cultural practices, symbols, or values are often employed as a form of appropriate cultural tailoring, incorporated within more common psychotherapeutic practices like trauma-focused cognitive behavioral therapy (e.g., BigFoot & Schmidt, 2010). Increasingly, cultural practices may themselves be the primary form of treatment being employed (see Redvers & Blondin, 2020, for a review).

Practices that emphasize AI/AN "culture as treatment" (Gone, 2013; Gone & Calf Looking, 2011, 2015) and incorporate AI/AN ceremony or traditional AI/AN healers (Hartmann & Gone, 2012; Moorehead et al., 2015) may be described using the term *traditional healing*. Many common AI/AN traditional cultural practices used in behavioral health settings, such as the sweat lodge ceremony and the medicine wheel, are widely accepted and draw from multiple AI/AN traditions rather than referencing a specific tribal practice (Coggins, 1990; Dapice, 2006; Garrett et al., 2011; Pomerville & Gone, 2019). Such widely circulating Indigenous practices may be especially relevant for traditional healing in UIHP settings, as the urban setting inevitably leads to these sites serving AI/AN people from multiple traditions and differing backgrounds (Gone et al., 2017, 2020).

Prior Research

Prior research on behavioral health treatment at UIHPs has been limited, but a few studies exist to ground this study. Multiple investigations have documented the use of traditional AI/AN healing methods at UIHP sites and client interest in these practices. For example, Moghaddam et al. (2015) noted in an examination of one UIHP site that traditional AI/AN healing played a central role in how behavioral health services were conceptualized at this site, and that clients had a significant interest in these practices as part of their behavioral health treatment and wanted the existing programs expanded. Other researchers have noted a gulf between traditional AI/AN practices and those commonly incorporated into therapy in an investigation of at least one site (Hartmann et al., 2020, 2022).

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

Other research in behavioral health at UIHPs specifically has suggested a wide range in types of services that different UIHP sites are able to offer. One study investigating three UIHP sites found that therapists at these sites were less likely than national averages to use cognitive behavioral therapy, even among those who identified themselves as having a cognitive behavioral orientation (Beitel et al., 2018). This may reflect a cultural preference for other approaches to therapy among AI/AN clients, as has been suggested

in research with other AI/AN populations (e.g., Fiferman, 1990; Jackson et al., 2006; Villanueva et al., 2007). However, Beitel et al. (2018) were unable to rule out that there may be other explanations for their results besides the client population served, such as the therapists' own training.

In a prelude to this study, Pomerville and Gone (2018) conducted survey research and reported that in many areas, UIHPs appear to operate similar to National Outpatient Clinics (as defined by the Federal Substance Abuse and Mental Health Services Administration), at least on measures designed to assess available behavioral health treatments. Additionally, documented traditional healing practices were employed in some manner across all UIHP sites. Although Pomerville and Gone reported the availability of different treatments and support services at 11 UIHPs, they did not indicate how widely these treatment methodologies are used. Moreover, their survey did not ask about many common therapeutic modalities, such as psychodynamic psychotherapy or motivational interviewing. Consequently, there is a need to deepen understanding of therapeutic approaches and behavioral health services utilized at UIHPs and evaluate providers' perceptions of these services. This study expands the initial study by going beyond survey results to qualitative analysis of interview data.

The Present Study

The goal of this study is to better understand available services and resources at UIHPs. The research in this area is limited, thus, the initial response to this question is largely descriptive. We hope to shed light on why specific approaches are adopted by clinicians at these sites, providing insight into both theoretical and practical explanations for the behavioral health services that UIHPs offer, including the extent to which traditional healing is integrated and services are otherwise culturally responsive. Given the lack of research on UIHPs and AI/AN people as therapy clients, this study endeavors to understand current behavioral health services and further explore associated funding challenges. Semistructured interviews were conducted with Behavioral Health Directors at 10 UIHPs. Thematic analysis was used to answer the following research questions: what behavioral health services are currently available at UIHPs, and how are resources being used to support these services?

Method

Participants

Data collection for this study involved soliciting all 34 UIHP sites in existence at the time of data collection to participate in interviews. Pomerville and Gone (2018) provided additional details regarding the recruitment procedure and characteristics of UIHP respondent sites. Of note, no statistical differences were found between sites that participated and nonparticipant UIHPs on measures of social support, suicide rate, mental distress, poverty, smoking rate, and alcohol-induced deaths (Pomerville & Gone, 2018). Ten directors agreed to participate, of which eight were men and two were women. Four directors were identified as AI with the remaining identifying as non-AI. Five directors had a doctorate in a field related to behavioral health (PhD or PsyD), while the other five held master's or other postbaccalaureate licensure in behavioral health. The UIHP sites represented all four regions of the United States (as defined by the U.S. Census Bureau, n.d.) and were spread across nine states.

Measure

This study used a semistructured interview to address the research questions. Follow-up questions were unscripted to allow the interviewer to clarify answers and gain a better understanding of participant perspectives (Kallio et al., 2016). The 18-question interview schedule for this study is found in the Supplemental Material.

Procedure

Data collection began on October 17, 2014, and ended on May 25, 2018. All UIHPs were contacted by phone to solicit the participation of each site's Behavioral Health Director in a semistructured interview. The protocol for this project was submitted to and declared as exempt from review by the University of Michigan institutional review board Health Sciences and Behavioral Sciences Office. After receiving affirmative consent for their participation in this research and voice recording for use in later transcription, all directors were interviewed by the first author, following the interview schedule. Eight of these interviews were conducted via Bluejeans, a software for video calling. Two interviews were conducted in person. All interviews were recorded. Interviews ranged from 36 to 58 min. All recordings were transcribed via a transcription service, and all transcripts were then checked for fidelity to the recordings by the first author and corrected as necessary.

Thematic Analysis

Transcriptions of the 10 interviews were subjected to thematic analysis. This study adopted the methodology set forth by Braun and Clarke (2006), attending to their six phases and 15-point checklist for undertaking sound thematic analysis. We adhered to all 15 of these criteria, as described below alongside a brief description of the analytic process.

Research is inherently a constructive process, and this and other decisions were informed by a constructivist perspective on the part of the researchers. The first author, who collected and served as primary analyst of these data, is a White non-Hispanic gay man. At the time of this work, the first author was a psychology doctoral candidate in a clinical science-oriented training program, with previously published work in the areas of general psychotherapy research and AI/AN behavioral health treatment. The coauthors are an AI research psychologist, who mentored and supervised this inquiry, and two AI doctoral students who joined the project team during the final write-up of this study.

This statement of positionality grounds readers in an understanding of the researchers' perspectives and to fulfill Braun and Clarke's (2006) Criterion 12 for good thematic analysis. This approach to analysis is also in keeping with Braun and Clarke's (2006) emphasis on the researcher as an active participant in research as outlined in Criterion 15.

A description of the analytical process used in this study as well as commentary on theory follows, in keeping with Braun and Clarke's (2006) checklist Criterion 13 for good thematic analysis.

The six-phase methodology proceeded as follows (the names of all phases are taken directly from Braun & Clarke, 2006).

Six Phases

Interviews were conducted by the first author and then transcribed by a research transcription service. In Phase 1 of the analysis, all original audio files were listened to by the first author while he simultaneously conducted a complete and careful reading of the existing transcripts. During this phase, the first author took notes on initial impressions of the material. This step, in addition to providing an opportunity to take initial notes on impressions as recommended by Braun and Clarke (2006), served as an additional check on the fidelity of the transcripts to the original data.

In Phase 2 and onward, the qualitative analysis software program NVivo was employed to assist with analysis. NVivo assists researchers in organizing and analyzing qualitative data such as interviews and can accommodate a wide range of analytic approaches, including thematic analysis (QSR International, 2022). The transcripts refined in Phase 2 were read to generate initial codes. The codes served as the basic unit of analysis for the following steps and were based in part on the initial impressions formed in Phase 1 of the analysis.

As the analysis focused on the two research questions described above, interview material not relevant to these questions was disregarded and not coded. This includes questions that were outside of the scope of this study (see Pomerville & Gone, 2018; Pomerville et al., 2022). Interviews had between 28 and 53 codes generated for each, and this range largely reflects the extent to which directors discussed the specific topic at hand.

In Phase 3 of this analysis, after a complete set of codes across the data set was created, the codes generated from different participants were compared to one another to locate similarities in responses known as *themes*. The first author then created potential thematic maps driven by the grouping of the codes into themes and subthemes. These thematic maps allowed the research team to understand how the data come together into a coherent whole as well as to test different conceptualizations against the data to determine how well each conceptualization fits. Potential themes were then checked to determine that they created meaningful answers to the research question. The themes that answered the question too broadly to be useful were pared down to be more specific, while themes that were too idiosyncratic to specific situations or sites were either incorporated within larger themes or abandoned. Codes making up these discarded themes were then matched to more appropriate and coherent themes within the data set.

In Phase 4, both the codes and the candidate themes were reviewed. This involved reexamining the original text extracts from the transcripts to ascertain whether codes and themes were internally consistent. At this point, a further reading of the entire data set was undertaken to check that the existing themes were an accurate reflection of the overall data set. In other words, the data set was reread to ensure that the coding and theme creation process had not so abstracted the data as to make the conclusions not clearly reflected within the original transcripts themselves. Then, the themes were also analyzed for internal homogeneity and external heterogeneity (Patton, 1990, as cited in Braun & Clarke, 2006).

In Phase 5 of the analysis, each theme was clarified and named as accurately as possible. A unique title for these themes appears in the results reported below. Beyond assigning a name, a detailed analysis of each theme was written to clarify what was interesting or noteworthy about it.

In Phase 6 of this analysis, the final report was created. The final report includes detailed descriptions of the themes as well as data extracts (i.e., quotes) to demonstrate and contextualize each theme. Given that the number of sampled Behavioral Health Directors at UIHPs increases concerns of identifiability, these quotes omit the self-identified ethnicity of participants intentionally to protect their anonymity.

Results

The final thematic map included two top-level themes in the responses, each with four subthemes. The two major themes that were created corresponded to the two research questions (i.e., "what services are UIHPs able to offer" and "what resources are used to be able to offer those services"). Figure 1 provides a visualization of the final thematic map. The themes and subthemes are described below with examples.

First Theme: UIHP Behavioral Health Departments Provide an Umbrella of Services to Meet Goals

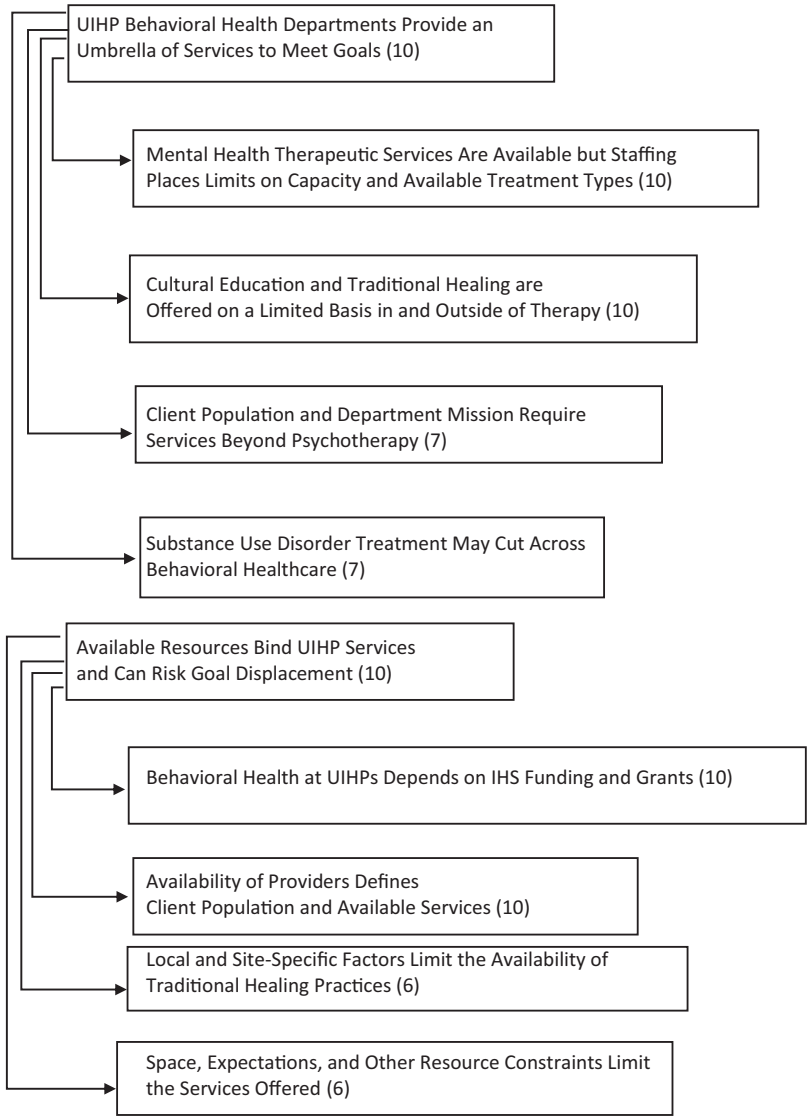
This theme includes responses from all directors, who expressed that their behavioral health departments offered a wide array of services, many going beyond those typically thought of as behavioral health treatments. This umbrella of services and care reflected the broad missions of UIHPs generally and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

Subtheme 1: Mental Health Therapeutic Services Are Available but Staffing Places Limits on Capacity and Available Treatment Types

All directors described mental health therapeutic services as being available in some form. Only one director mentioned not generally offering individual psychotherapeutic treatment, instead offering primarily group therapies. However, even at this site, individual psychotherapy was made available on a case-by-case basis. A wide range of psychotherapeutic modalities was described across and within sites: cognitive behavioral (seven participants), client-centered (five participants), dialectical behavioral therapy (three), narrative (two participants), psychodynamic (two participants), eye movement desensitization and reprocessing (two), art therapy (two), and hypnosis (one).

Approaches were all mentioned by directors as treatments actively employed. Directors generally described that the types of treatment modalities and approaches offered were not as part of an intentional plan to respond to community needs but rather as a reflection of the training and experience of those clinicians who were

Figure 1
Thematic Map of Director Interviews



Note. Number in parentheses is the frequency of endorsement of the theme across interviews. UIHP = Urban Indian Health Programs; IHS = Indian Health Service.

on-site. At five sites, interns, volunteers, and/or paraprofessionals filled psychotherapeutic roles rather than fully licensed clinicians. One director described these workers as "filling in the gaps" due to a lack of funding for hiring licensed clinicians, while two others framed the use of these workers as an intentional part of their UIHP's mission as a training clinic.

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

Subtheme 2: Cultural Education and Traditional Healing Are Offered on a Limited Basis in and Outside of Therapy

Every director indicated that cultural education and traditional healing practices were employed as part of the site's behavioral health goals, with considerable variation from site to site. Sites varied in their usage of cultural practices. Seven directors described cultural education and practices as being incorporated into therapeutic practices, such as using a medicine wheel treatment plan or smudging as a part of individual treatment. Six directors mentioned

offering cultural programming that is designed as a direct form of intervention and occurred in a group setting. The most common example of this is Red Road/White Bison, a program that incorporates traditional AI/AN teaching and practices with 12-step facilitation for the prevention of and recovery from SUDs (White Bison, 2022). Six directors also described cultural education or activity programs that are not necessarily regarded as a form of behavioral health intervention but that clients may be encouraged to attend for benefits to their holistic well-being. Two directors said they emphasize to their clients that they themselves are not spiritual teachers or traditional healers and that they try to maintain a clear boundary in this regard.

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

Traditional healing and education within the therapy room are limited in scope, as described by these directors, who acknowledged that neither they nor their therapists are qualified to provide most forms of traditional healing. Instead, directors indicated that traditional healing and education programs are largely separate from therapy. Five directors understood the selection of traditional healers or teachers and the organization of these activities as part of their duties as directors of behavioral health. Seven directors mentioned that cultural services were being provided by their sites. Seven directors indicated they refer clients to external sources for some or all traditional healing and cultural education needs. All directors fell into one of these two categories; in other words, all directors claimed to either have traditional practices available on-site at their UIHP or to refer clients elsewhere for such services.

Subtheme 3: Client Population and Department Mission Require Services Beyond Psychotherapy

Seven directors mentioned ways in which other services beyond individual or group psychotherapy were a part of their work in behavioral health outside of the specific area of traditional healing. Of note, the interview questions were specifically designed to inquire about traditional psychotherapeutic services; it is possible that these services (described later) would have also been mentioned at the other sites if directors had been asked more directly about this topic. These services include exercise programs (not physical therapy or movement-based therapy that might be cast as medical or psychotherapeutic), case management, numerous support groups, social engagement programs, and assistance connecting to community in ways that occur outside the therapy room.

These programs were described as reflecting behavioral health department missions to treat client mental health in a holistic manner. They also reflect the difficult realities facing clients at many of these sites. As one director described: "I think maybe 20% of our population are homeless. They are usually underinsured. They don't have a lot of formal education or [are] just struggling to make ends meet" (Participant 3). Thus, client populations at these sites may have more urgent or primary needs than mental health treatment. These services may also reflect a desire to assist clients in maintaining health after direct treatment for a psychological disorder has ended.

Subtheme 4: SUD Treatment May Cut Across Behavioral Health Care

This subtheme includes responses from seven directors who discussed how SUD treatment impacts their offered services. Directors described utilizing co-occurring disorder models, harm reduction models, and the matrix model as examples of care that are offered in SUD treatment. Three directors within this subtheme described SUDs as a pervasive issue in the client population, indicating that it was a concern for the majority of clients. For these directors, SUDs were seen as a pervasive issue that cut across all areas of treatment and served as the primary function of behavioral health at their UIHP.

An example of the seriousness and extent to which this is the case was summarized by one director as follows:

> You know I think if you were to look at our case files you would- I think you'd probably realistically be able to say that you know it's 75 to 90% are co-occurring based to both mental health and substance use disorder. (Participant 7)

Two directors defined recovery and well-being for clients primarily in terms of sobriety and recovery from SUDs. They emphasized these measures over those that might focus more on recovery from other psychological disorders. Other directors, however, made only passing mention of SUD treatments on-site. This indicates a wide variation among these sites in terms of the number of clients seen for substance use-related issues.

Second Theme: Available Resources Bind UIHP Services and Can Risk Goal Displacement

This theme is made up of four subthemes and includes responses from all directors who described how available resources constrained the possible range of services offered. Directors reported that their sites sought financial support and other resources from all available funding sources including IHS, other federal grants, local government, and private sources. Because most of these grants are designed with specific purposes in mind, this shaped the services that are offered at sites. UIHPs may not be able to choose their own priorities directly in response to community needs and rather offer services to serve a particular portion of their community's needs.

Respondents generally indicated that available resources were inadequate to provide the ideal range and extent of services. There was variation among directors regarding the severity of this gap, as well as differences in perceived needs at the time of the interview. Although financial concerns limited the ability of many sites to provide desired services, others faced resource scarcity problems that were not fundamentally financial. An example of this includes a lack of providers who were themselves AI/AN. The majority of sites in this study had zero reported AI/AN behavioral health clinicians. Sites that did have AI/AN providers indicated a desire

for more of them, as they could not meet the current client demand for AI/AN clinicians. Respondents also indicated a similar shortage in the availability of prescribing providers. The subthemes below that comprise this theme include additional details about how resource availability shaped service provision at these sites.

Subtheme 1: Behavioral Health at UIHPs Depends on IHS Funding and Grants

This category includes responses from all 10 directors regarding sources of funding for their site. UIHPs are, by definition, funded in part via IHS, though this was not the sole funding source mentioned at any site. Grants were mentioned as sources of funding for services that were seen as peripheral to behavioral health but still under its broader umbrella. Grant funding allowed sites to offer traditional healing or cultural education programs. In other cases, grants directly funded the hiring of clinicians and other staff who administer therapeutic programming.

Three directors indicated that their site either currently had status or was seeking to establish their site as a FQHC. As a FQHC, sites would receive additional funding and expand care to clients with low socioeconomic status. While this can be a source of financial stability, federal law prohibits FQHCs from turning clients away based on race. Therefore, those UIHP sites that hold FQHC status serve significant percentages of non-AI/AN clients.

Speaking of the shift to becoming a FQHC, one director described it as follows:

> But broadly, you know, we think of the community still more in terms of Native Americans or self-identified people who are living in an area who may need extra support because of, you know, historical injustices and disenfranchisements. Or people who have been relocated through forced programs or, you know, just people who may be in need of more support, but haven't quite reached our doorstep yet. So we do a lot of outreach and think about that (community) as well. (Participant 3)

According to this director, the site's identity as an AI/AN-oriented facility remains largely intact, with the director drawing a link between the experiences of AI people and other non-AI/AN historically and currently disadvantaged populations who use the site alongside AI/AN clients.

Subtheme 2: Availability of Providers Defines Client Population and Available Services

All respondents discussed provider availability as a limiting factor for the types of services offered. In seven cases, the issue was described as partially or entirely financial; either the site did not have any funding for a particular position or the funding was too limited to hire someone with specific desired skills or attributes. In five cases, a major reported difficulty was filling funded positions due to shortages in available providers. Five directors said they could not find adequate psychiatric service providers.

Three directors also said they were not able to find enough providers who self-identified as AI/AN to meet client demand:

> Our clinicians, all of them have experience working with Native populations, however only one of them is Native themselves. And we've been trying to recruit, you know, doctoral level, either psychologists or clinicians, master's level, LPCs, whatever, from Native populations. And it's just really challenging … just because there are not that many people in the field. So sometimes we get- we'll get a request from someone who really wants to work with a Native person, and we don't have a schedule available. (Participant 5)

In some cases, an intentional decision by individual providers may limit what types of clients will be seen. For example, one site's prescribing provider chose not to see clients with SUDs as part of his practice, thus shaping what that UIHP was able to offer clients.

In addition, the culture and attitude of a site may cause potential clients to not attend therapy and/or instead seek alternative sources of healing. For example, one director noted that their clinic is fundamentally grounded in "western" perspectives of healing and does not have staff who can offer traditional ceremony, and that AI/AN clients who reject such approaches in favor of their own culture "just don't show up at our door." The director expanded further:

> Yeah, I mean they have an understanding that they have some understanding of mental health issues and realize that there are evidence-based treatments for those issues … I mean just like western medicine, I mean indigenous cultures use western medicine every day, you know. They realize that a ceremony might not cure cancer. And some believe that it will. And those are the people that aren't gonna show up at our door and that's fine. (Participant 6)

Subtheme 3: Local and Site-Specific Factors Limit the Availability of Traditional Healing Practices

Six directors reported the availability of traditional healing as being limited due to local factors. These factors included a lack of physical space to hold ceremonies such as a sweat lodge ceremony, a lack of trustworthy or reliable local traditional healers, and difficulty with providing traditional healing relevant to the large and diverse population that UIHPs serve. Three directors in this subtheme described programming based on traditional values and practices of specific AI/AN groups or regions that had been developed and utilized at their sites. This programming was not necessarily aligned with the particular beliefs or cultural heritage of the AI/AN clients on the site, however. For example, one director noted that their programming was developed based on the beliefs of tribal groups from a different part of the country.

Other sites noted that it can be difficult to find legitimate traditional healers, as this director described:

> So a lot of the people we try to make sure that they're not, you know selling ceremony. And it's a very hard line to walk because we would like to provide them with a gift for their service which is usually what we try to do. But the other big problem has been is making sure that what they're teaching is legitimate … And really that's one of the reasons why we haven't done any sweats lately, because we haven't been able to find someone who seems like they can really do it legitimately in a good way. (Participant 10)

Subtheme 4: Space, Expectations, and Other Resource Constraints Limit the Services Offered

Six directors mentioned ways in which either physical space or expectations from clients, therapists, and administrators may limit what therapeutic approaches can be offered. Physical space limitations included a lack of rooms for group treatments, other limitations on office space, and lacking outdoor spaces to offer sweat lodge ceremonies and other therapeutic or traditional practices that require

some form of outdoor environment. Examples of limiting expectations included beliefs that established therapeutic interventions may incorrectly presume underlying or foundational coping skills for younger clients and perceived attitudes from administrators that therapists should be separated from the local AI/AN community to maintain appropriate boundaries.

One director at a site with no outdoor space and no designated area for group treatments described these as limitations in meeting what clients desired for the site:

> So yeah, we've heard from patients that they would like group space, they would like a garden, they would like a sweat lodge. So, there's a lot more I think we can offer with appropriate space and appropriate connection to traditional healers. (Participant 9)

Another director described the lack of physical space and training level of clinicians as barriers to providing support groups:

> Support groups, I'd love to be able to offer, but I just don't have the resources. I don't have the space and I don't have the staff. That's the problem, but that I would definitely do that. We get people; they're kind of ready to discharge from one-to-one treatment … but if we had support groups we could ease them into the support groups with a nice clean sort of coordination of care, but we don't offer it, so we have to refer it out while they're not getting … people that are familiar with traditional healing practices or maybe they're not getting the quality of therapist at another place. They use a lot of interns to do these by the way, so it creates problems. So that's a continuity-of-treatment kind of problem. (Participant 2)

A third director indicated that their UIHP was the only site in the local area dedicated to treatment of AI/AN clients, despite thousands of AI/AN people living in the region, creating a critical gap in which there were more potential clients interested in treatment at the site than the site could ever meet with their current resources.

Discussion

These results have emphasized the available services UIHPs offered at the time of these interviews. Based on these findings, it appears that UIHP behavioral health services were broad, encompassing numerous missions that exist at the periphery of behavioral health, outside of purely psychotherapeutic interactions and interventions. An accurate accounting of behavioral health services at UIHPs must consider not only the ways that their services are shaped by the sites' mission to serve AI/AN communities in the offering of cultural education and traditional healing, but also consider the full range of social services, case management, and community building offered under the umbrella of behavioral health. In particular, case management and social services provision were described as a significant portion of the caseload at these sites.

All but one UIHP in this study offered individual psychotherapy. In some cases, long wait lists and limited numbers of clinicians may create challenges for clients accessing these services. Teletherapy programs and purchase-of-care appear to be used at some sites to ameliorate these difficulties. Other sites do not have these limitations. In these cases, there may be less demand for psychotherapy because the sites' scope of care may limit the types of clients seen.

Directors indicated that traditional healing practices and AI/AN cultural education are offered in some form at every UIHP site contacted for this study, but the variation from place-to-place makes any further generalization difficult. As reported by directors, some UIHPs are partnered with numerous traditional healers, host on-site educational workshops, and have physical spaces available for ceremonies. Other UIHPs are limited in scope to only offer smudging with individual clients while referring out to a limited set of local partners for their AI/AN clients' cultural needs. Future investigations should bear in mind the significant reported variations between these sites.

According to these research findings, resource shortages are a serious barrier to the goals expressed by UIHP Behavioral Health Directors. These shortages are not only strictly financial but also include material and human resources. These include limitations of physical space, a lack of AI/AN clinicians, a lack of clinicians with specific training backgrounds (e.g., training in specific treatment modalities, prescription providers) available for hire, and a lack of traditional healers able to meet the diverse needs of tribal communities served by an UIHP.

Given the general difficulties with overall funding for mental health and shortages in available providers nationally, some of these challenges, such as shortages in providers with prescription authority, may not be specific to UIHPs but reflect the general functioning of urban clinics, or even more broadly, troubling disparities and gaps in behavioral health services nationally (U.S. Department of Health & Human Services, 2022). Similarly, some directors expressed concern about the challenge of maintaining professional boundaries owing to the duality of relationships between community members and providers in small and rural communities (Schank et al., 2010).

Of note, consternation about chronic underfunding of IHS is not new (Dixon & Roubideaux, 2001). The results provided in this study further support concerns regarding the shortage of trained AI/AN providers (IHS, 2020). Moreover, directors described the challenges of developing and providing diverse yet culturally specific treatment for an intertribal constituency, echoing prior work about culturally adapted and relevant treatments as well as spiritual practices in urban AI/AN settings (Hartmann et al., 2020).

This is complicated by a lack of trustworthy and appropriate culture keepers and traditional practitioners available in urban settings, where community participants may not have the correct knowledge to vet potential practitioners (Hartmann & Gone, 2012). And yet, there may be significant value in adapting or supplementing existing behavioral health treatments with indigenous spiritual practices in these settings (Gone, 2022). In line with prior work, these directors noted the community's enthusiasm and interest in traditional healing and cultural practices. These results suggest that UIHP directors may benefit from additional support in providing culturally responsive and adaptive therapy or treatment in response to diverse community needs.

Despite these challenges, each of these sites tries to offer an abundance of named psychotherapeutic practices and other programming intended to improve the overall well-being of their clients. Many of these services as described by the directors are dependent on competitive, temporary grants that sites have been awarded. These grant programs allow new hires, new trainings, and new interventions or community programs to be offered to clients and are of course a boon to any site that receives them. They are, however, unreliable for long-term service and staff planning. They also may constrain or inform services offered at UIHPs in ways that are consistent with funding availability instead of community needs.

Site-specific grants make it difficult to be definitive about the types of behavioral health services that are offered at UIHPs. Moreover, the directors' reports reflect the intersecting and cumulative nature of resources. As an example, one site's ability to offer support groups was not limited solely by available physical space, but also by the lack of available staff to facilitate the intervention. This director also expressed concerns with their ability to provide desired and appropriate behavioral health services. Piecemeal solutions may prove ineffective if the ultimate goal is to equip UIHPs to serve their communities based on needs rather than on available resources.

Limitations

Certain limitations constrain the interpretation of these findings. The nature of semistructured interviews means that not all participants are asked precisely the same questions, and participant responses are also more variable than in confirmatory research. For this reason, it is impossible to determine certain questions that might naturally spring out of this topic, such as how many sites use each treatment approach. Therefore, caution is urged in interpreting the counts of any therapeutic practices reported in these results; they reflect the number of directors who reported offering those treatments, but it cannot be said that the directors that did not mention them do not employ them.

Relatedly, the viewpoints of this smaller number of UIHP directors may not reflect the experiences of all directors, let alone the clinicians or clients at these sites regarding how services are offered (for a complementary analysis of interviews and focus groups with UIHP service providers at six sites, see Pomerville et al., 2022). Furthermore, these results are entirely dependent on the self-report of said directors. Just as there may be discordance between a clinician's statements about what they do in therapy and what an observer of their sessions might report, it is reasonable to speculate that directors' narratives of behavioral health services and resources might also diverge somewhat from a more direct observation or auditing of these sites.

Implications and Future Directions

These conclusions may provide the basis for future research into the topic of UIHP behavioral health services by providing a broad roadmap for the types of services currently offered and allowing for more direct questions in these areas to be asked. Future exploratory and qualitative work might investigate in greater depth the specific uses of traditional healing, the role of UIHPs as social service providers and case managers, and the analytic benefits of directly observing therapy sessions. There is also potential for future research to quantify much of the additional adjunctive services that occur at UIHPs, measure the extent to which these conclusions might accurately run across UIHPs, and consider how such data compare to other urban health clinics to determine how much of this is specific to UIHP settings. In addition, attention should be paid to UIHP models of care and how those might be limited by resource allocation.

For example, the American Indian Telemental Health Clinics developed a model of care in partnership with the U.S. Department of Veterans Affairs and the Centers for American Indian and Alaska Native Health at the University of Colorado Anschutz Medical Campus. This model of mental health service delivery emphasized cultural facilitation, increased access through technology, and improved coordination of care (Goss et al., 2017). Developers of this model noted that extensive resources are necessary to provide culturally sensitive, patient-centered services in this manner (Goss et al., 2017). Important future research questions to consider are: How are models of care enacted at UIHP sites? What do the cultural and educational programming components look like at different UIHP sites, and how can we test their impact? What additional services may benefit this underserved population? How do the clients at UIHPs perceive the services currently offered? More direct research partnerships with UIHPs may help develop other research questions that stakeholders feel bear more directly on their needs and concerns at this time.

Importantly, results of this study align with the gaps identified by UIHPs that were 4-in-1 Grant Program Grantees (IHS, 2020). Therefore, we make the following recommendations. First, increased funding for UIHPs earmarked for behavioral health could address the expressed concerns surrounding inadequate numbers and types of providers. In addition, we recommend greater financial support for existing and new educational pathway programs like the American Indians into Psychology (INPSYC) Program (IHS, 2014). INPSYC provides grants to universities to support undergraduate and graduate AI/AN students that are pursuing degrees that will lead to a PhD in clinical psychology. The program requires student recipients to complete a period of service following their degree. As of 2019–2023, only three universities have an INPSYC program. Increasing support for pathway programs could help address the lack of AI/AN providers by increasing the representation of AI/AN psychologists and mental health care providers.

Moreover, universities should consider establishing their own pathway programs aimed toward AI/AN students in addition to these federally funded programs such as INPSYC. Beyond this, grants and funding packages that compensate traditional healers and others working to provide culturally relevant programming are another possible avenue that may be utilized to improve the range of services offered for AI/AN clients. Importantly, more long-term funding is recommended at the federal level to prevent disruptions in program development and sustainability.

Conclusion

Given the import of UIHPs as a primary source of government-funded health care for the millions of urban AI/AN people, this study strove to understand what services are available at UIHPs and how resources are being used to support these services. To address the knowledge gap regarding UIHPs, semistructured interviews with behavioral health directors at 10 UIHPs were reported, transcribed, and thematically analyzed. Results indicated that directors' saw UIHP behavioral health services as broad, encompassing numerous commitments that extend far beyond purely psychotherapeutic interactions and interventions. These commitments included a full range of social services, case management, and community building under the broad umbrella of behavioral health. In addition, directors saw these services as informed not just by community needs but rather by restrictions on human and financial resources. Implications include the critical and ongoing need for additional funding for UIHPs, greater support for AI/AN pathway training programs in the mental health professions, future expansion of

available traditional healing practices, and direct empirical observation of behavioral health service delivery.

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