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Behavioral health services in Urban American Indian Health Programs: Results from six site visits

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Abstract

This study explores behavioral health services for American Indians and Alaska Natives (AIANs) at six Urban Indian Health Programs (UIHPs). Interviews and focus groups with clinicians and staff inquired about behavioral health treatment available, service needs, client population, and financial and staffing challenges. Resulting site profiles were created based on focused coding and integrative memoing of site visit field notes and respondent transcripts. These six UIHPs evidenced diversity across multiple facets of service delivery even as they were united in their missions to provide accessible and effective behavioral health treatment to urban AIAN clients. Primary challenges to service provision included heterogenous client populations, low insurance coverage, limited provider knowledge, lack of resources, and incorporation of traditional healing. Collaborative research with UIHPs harbors the potential to recognize challenges, identify solutions, and share best practices across this crucial network of health care sites for improving urban AIAN well-being.

KEYWORDS

American Indian health, barriers to care, behavioral health services, Indian Health Service, traditional healing, Urban American Indians

1 | INTRODUCTION

American Indians and Alaska Natives (AIANs) are the First Peoples of the land currently known as the United States (US). The term encompasses 574 federally recognized and hundreds of state-recognized tribes, each with their own unique history, culture, language, geography, and health care needs. While each AIAN Nation is unique, they share a collective history of traumatic settler colonialism, which has profoundly shaped both the health experiences of past and contemporary peoples, as well as the health care resources available. Today, AIANs experience some of the greatest disparities in health of any population in the United States. Inequities in behavioral health—the preferred terminology of the federal Indian Health Service (IHS) that encompasses mental health and addiction—are particularly stark, with evidence that AIANs experience higher rates of substance use disorder, post traumatic stress disorder, and attachment disorders (American Psychological Association [APA], 2017) than the general population. In 2019, suicide was recorded as the second leading cause of death for AIAN young people (aged 10–34 years) (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2019), and AIAN adults were 2.5 times more likely than non-Hispanic Whites to experience severe psychological distress over the previous 30 days (Center for Disease Control and Prevention, National Center for Health Statistics, 2018). Health inequities rooted in histories of trauma are compounded by structural limitations in health care availability.

Historical trauma theory is frequently employed as an explanatory model for understanding how experiences of trauma by past generations, including decimation by disease and warfare, forced relocation, and cultural eradication, may continue to impact the well-being of AIAN people today (Ehlers et al., 2013; Gone, 2009; Paradies, 2016; Whitbeck et al., 2004). While there is an extensive literature base supporting the deleterious impact of traumas in past generations on contemporary health (Brave Heart & DeBruyn, 1998; Duran et al., 1998; Evans-Campbell, 2008; Running-Bear et al., 2019; Walters et al., 2011), there is also a growing body of scholarship, much of it driven by Indigenous researchers, which indicates that the inclusion of culturally appropriate health interventions may improve efficacy in AIAN settings (Beltran et al., 2018; Geana et al., 2012; Gone, 2009; Lavalle & Poole, 2010). Indeed, the continued presence and vitality of AIAN peoples in the face of hundreds of years of intentional structural violence and traumatization is indicative of the tenacity and value of AIAN communities.

AIAN approaches to wellness and healing focus on relationships: between individuals, communities, and the natural and spiritual world (Martin, 2012). Contemporary approaches to health care in the US largely center around biomedical reductionism, which prioritizes biological disease etiologies and treatments while neglecting social and spiritual causes (Fijal & Beagan 2019). It is, therefore, unsurprising that AIAN-focused behavioral health care differs from mainstream approaches due to population demand for culturally relevant care, specifically emphasizing connection or engagement with traditional AIAN cultural values, teachings, and practices. This pattern is seen across both reservation and urban-based populations, but is particularly notable in urban AIAN communities. These communities have repeatedly called for culturally relevant behavioral health care, including the incorporation of traditional healing into existing models of treatment (e.g., Gone, 2009; Goodkind et al., 2011; Moghaddam et al., 2013).

Traditional healing is a term for the use of Indigenous cultural practices as treatment for general well-being that are rooted in historical Indigenous healing practices, community activities, and worldviews (Duran, 2006). For example, Dickerson et al. (2014, 2021) utilized a traditional drumming circle as part of substance use disorder treatment in an urban center, with preliminary results indicating potential for success at improving engagement within this population. Another study utilizing traditional teachings in an urban setting qualitatively documented increased engagement with an Urban Indian Health Program (UIHP) (Gone et al., 2017, 2020; Pham et al., 2022). These studies, however, have been limited to one or two sites each, and the findings have been correlational or qualitative; no full-scale clinical trials have been published utilizing these approaches to treatment. Additional considerations must be made in urban Indigenous settings, in which significant cultural heterogeneity is likely present. The current study seeks to understand how professional behavioral health treatment is balanced with a diversity of traditional healing services within urban AIAN-centered health care to identify best-practices and

challenges to the provision of treatment within these unique settings. Traditional healing in this study refers to cultural practices undertaken within a general therapeutic context.

The continued demand for cultural programs and traditional approaches to healing as a form of intervention among AIAN populations presents an added dimension of diagnostic and treatment complexity, especially in the context of historical trauma (Brave Heart & DeBruyn, 1998; Hartmann et al., 2019). For example, AIAN individuals may seek cultural connection and traditional healers for issues not typically described in conventional biomedical terms or diagnoses (e.g., depression, anxiety). These cultural practices are often perceived to be at odds with the evidence-based practice model outlined by the APA Task Force (2006). Efforts are being made, however, to demonstrate the scientific validity and medical value of these treatment forms (Alcántara & Gone, 2022; Bernal et al., 2009; Pomerville & Gone, 2019). Despite the challenges of balancing professional evidence-based interventions with Indigenous knowledge systems and beliefs, it is essential to recognize that unique histories of trauma demand unique approaches to treatment. Put simply, it remains an open question whether treatment modalities developed within systems of oppression can be expected to ameliorate harms for those who have been historically and systematically oppressed by such systems.

2 | THE IHS

The US has treaty-based obligations to improve AIAN health to the highest possible level through the provision of health services (IHS, 2017a, 2017b). The provision of health services for AIANs has largely fallen under the purview of the IHS, a federal agency within the Department of Health and Human Services, which provides primary care, behavioral health, laboratory support, preventative care, dental, hospital care, and optometry with limited funding available for specialty care. The IHS system is funded annually through appropriations by the US Congress as well as through Medicare and Medicaid reimbursement, a funding stream protected with the passing of the Affordable Care Act in 2010 through permanent authorization of the Indian Health Care Improvement Act (IHCIA) (Kruse et al., 2022). The five types of facilities operated by the IHS include hospitals, youth regional treatment centers that offer inpatient behavioral health treatment to youth, health centers that provide outpatient services in addition to primary and preventative care, health stations that tend to be smaller and have limited hours, and Alaska village clinics (Clinical Reporting System Report, 2016). The IHS designates approximately 1% of its annual budget to Urban Indian Organizations with the rest supporting facilities located on or near reservations, despite the fact that more than 70% of AIANs currently reside in urban settings (Department of Health and Human Services Office of Minority Health, 2018).

While the discrepancy between geographic funding allocation and population location contributes to barriers to care for many AIANs, there exist other service delivery gaps which result in suboptimal utilization and care. First, the system is inherently scattered; some service areas lack a hospital and many services are operated at a tribal level, creating significant intertribal discrepancies in service availability among tribes, services may be geographically remote from tribal communities (Zuckerman et al., 2004), and primary care providers face difficulty in accessing expert behavioral health care specialists (Sequist et al., 2011). Additionally, funding, estimated in 2012 to be less than 40% of the total cost of meeting the health care needs for the approximately two million federally recognized tribal members in the Unied States, remains vastly insufficient (Gone & Trimble, 2012; Kruse et al., 2022). This is due in part to the complicated and contradictory nature of health policy, federal Indian law, and intergovernmental ties (Warne & Frizzell, 2014). Service intent, therefore, is seldom achieved. Finally, several gaps have been noted in the availability of certain forms of care. For example, Zuckerman et al. (2004) found that few AIAN women received mammograms or other preventive care and theorized that the lack of available services at IHS facilities contributed to behavioral health problems. Moreover, the majority of behavioral health funding is earmarked for substance use disorder treatment specifically, yielding disparities such as a rate of just two psychiatrists to treat every 100,000 individuals in the IHS population.

Collectively, these gaps contribute to the perception of the IHS as a patchwork system, primarily used by those who are unable to afford better health care underwritten by private insurers (Zuckerman et al., 2004). The system is seen as a kind of "broken promise" among many in AIAN communities (Gone, 2004). Today, despite theoretical access to IHS resources, more than 20% of AIANs lack private or employee-provided insurance, more than twice as many as in the general population (APA, 2017). In consequence, some limited earlier investigations have observed high dropout rates among AIAN clients and high rates of employee turnover in behavioral health at IHS facilities (Gone, 2004; Sue et al., 1978).

3 | UIHPS

While the majority of IHS funding is allocated to reservation-based communities (IHS, 2020), AIANs living in urban areas do have opportunities to access behavioral health treatment at UIHPs (IHS, 2019, 2020). UIHPs are nonprofit entities funded through a combination of grants and IHS contracts. They are also eligible to receive Medicaid funding through reimbursements and fees for service as well as reimbursement from private insurance; however, the specific funding combination for each differs according to grant availability and insurance or Medicaid status of the population it serves (IHS, 2022). Comprising 41 sites nationally, UIHPs vary widely in terms of the scope of their operation and available facilities. Generally, UIHPs provide behavioral health treatment in the form of counseling and/or medication management. Existing reviews of UIHP services, alongside surveys of urban community needs, have generally focused on individual sites rather than looking across multiple UIHPs (Dennis & Momper, 2016; Kropp et al., 2014; West et al., 2012).

A recent needs assessment at one UIHP found that greater cultural competence, more specialized services, and improved transportation services to health care appointments were desired by current service users (Dennis & Momper, 2016). A needs assessment at another UIHP, primarily concerned with youth participants, found that community members identified improved funding, more cultural and educational programming, and specific programs targeting youth behavioral health as unmet needs (West et al., 2012). A third single-site needs-assessment found that both clients and providers reported a need for increases in available services and capacity for existing services (Kropp et al., 2014). Further recommendations included increased case management, assistance with transportation, improved outreach and education, incorporation of AIAN traditions into existing services, and improvements in care coordination between state, tribal, and IHS agencies.

Other research on UIHPs has focused on the inherent challenges of balancing diverse clientele. In a clinical ethnography conducted at one UIHP, Hartmann et al. (2020) noted that while behavioral health clinicians attempted to frame their work in an AIAN context, most clients served at the site were not AIAN, and the clinicians' own knowledge of cultural practices was too limited to provide clients with tailored traditional healing practices or teachings. Despite this, the UIHPs still attempted to provide some limited traditional teachings and added AIAN symbolism during therapy, due to demand from clients who were AIAN and to match with the clinic's intended purpose as an AIAN-specific treatment site.

Two notable peer-reviewed studies have conducted multisite UIHP inquiry. Beitel et al. (2018) examined therapy sessions at three UIHPs and found that therapists were generally less likely to employ cognitive-behavioral approaches to therapy at these UIHPs compared to national averages, even among therapists at UIHPs who identified as having cognitive-behavioral orientations. In a survey of 11 UIHPs, Pomerville and Gone (2018) found that Behavioral Health Directors reported offering a wide selection of behavioral health services, close to the averages of other outpatient clinics surveyed by the Substance Abuse and Mental Health Services Administration (SAMHSA) nationwide. However, it was also found that all 11 of the surveyed UIHPs utilized native-specific treatments broadly labeled "traditional healing," in stark contrast with typical behavioral health practice.

Finally, a 2012 report from the Urban Indian Health Institute surveyed 24 UIHPs on behavioral health services offered and conducted interviews with four sites. The results of this survey indicated that individual and group

therapy, comprehensive behavioral health care, substance use disorder treatment, and medication management were fully available at 50% or more of sites surveyed, and some limited availability of these services was present at 75% or more of the 24 sites surveyed (Urban Indian Health Institute, Seattle Indian Health Board, 2012). Further, it indicated that nearly all sites incorporated some form of traditional healing or cultural teaching into behavioral health services (Urban Indian Health Institute, Seattle Indian Health Board, 2012). However, the report did not indicate any specific treatments available at any of these sites, whether any of the treatments were based in any form of evidence, and what cultural elements were being utilized in behavioral health.

As a subfield, community psychology exited the behavioral health clinic decades ago in pursuit of participatory partnerships with citizens that could mobilize action and prevent dysfunction through systems-oriented change in community contexts. More recently, Hartmann et al. (2018) invited community psychologists back into the clinic, observing that these settings remain "a powerful, foundational institution within fields of behavioral health that shapes the lives of diverse people made vulnerable by experiences of distress in overt and subtle ways" (p. 63). Specifically, in the absence of engagement by community psychologists, these sites "have increasingly embraced reductionist biomedical narratives of human hardship that pathologize and de-politicize human suffering" (p. 69).

This is particularly harmful for AIAN people seeking behavioral health care, as approaches to behavioral health treatment that pathologize the individual absolve the systems that substantively contribute to the current state of dis-ease. Instead, re-engagement with the clinic can afford new possibilities for dialogue and assessment that might "instigate transformative change in community mental health" (Hartmann et al., 2018, p. 69). UIHPs that serve AIANs (as just reviewed) seek to accommodate AIAN needs beyond the narrow confines of biomedical treatment. In consequence, discovery-oriented investigations of such settings may reveal innovative approaches to treatments and services that reflect deeper institutional responsiveness to community considerations and concerns that could set important precedents in health care.

4 | THE PRESENT STUDY

Based on research engagement with additional UIHP settings, this article extends the findings of Pomerville and Gone (2018) by reporting results from six site visits to UIHPs to conduct program interviews and on-site observations with Behavioral Health Directors (hereafter "Directors"), clinicians, and staff. With this work, we aim to understand how professional behavioral health treatment is balanced with traditional healing services provided in AIAN-centered spaces by asking: (1) What are the types of behavioral health treatment available at these sites?; (2) What are the current needs and perceived concerns surrounding behavioral health services at these sites?; (3) Who is the client population for these sites?; and (4) What are financial and staffing challenges at each site as perceived by clinicians and staff members?

This study is the result of the collective efforts of five scholars. At the time of this research, the first author was a White, non-Hispanic gay man, and doctoral candidate in clinical psychology who was not a member of the study community. These identities and his past work in the field of psychotherapy research combined with the experience of conducting the study site visits to contribute to interpretation of the site profiles. The first author led research design, data collection, analysis, and manuscript preparation for this study. The senior author—a clinically trained, AI research psychologist—directed and supervised the research, while the fourth author—a clinically trained White research psychologist—provided constructive feedback on the design, analysis, interpretation, and reporting of the study. The second author—an early career, mixed-race AI/White human biologist—and the third author—an early career Vietnamese American psychiatrist—contributed to the writing and revising of this article.

5 | MATERIALS AND METHODS

5.1 | Data collection

An initial report from this study based on UIHP survey and telephone interview data was published in 2018 (Pomerville & Gone, 2018). Site visits for a subset of these UIHPs were conducted between April of 2017 and May of 2018 (the extended phase of data collection is not unusual for research conducted in under-resourced AIAN health care settings). All UIHPs were contacted by phone and email (when available from the target UIHP) to reach Directors at each site. UIHPs were defined as the 34 programs for urban AIANs listed by the IHS on their website (IHS, 2019) when the project was initiated. Verbal and written consent was obtained for all participants. As this study was a quality improvement project, it was determined to be exempt from review by the University of Michigan Institutional Review Board. At the time of the research, no participating UIHPs required or requested additional formal research review. This study focuses on previously unreported analyses of data gathered during six site visits, described below as "site profiles."

5.2 | Site profiles

In the initial study (Pomerville & Gone, 2018), all 34 health programs for urban AIANs listed on the IHS website were approached and 14 (41%) agreed to participate. Reasons for not participating included lack of a behavioral health director or lack of behavioral health services ($n = 4$), time constraints or concerns around client privacy ($n = 5$), and in one case the site closed during the study period. Of the 34 sites originally contacted, 10 were lost to follow-up. From the 14 sites ultimately included in the initial study, 6 chose to further participate in site visits, and comprise the sample for this analysis. These six UIHPs were located in five different states, which did not share a land border (no further detail is provided to protect site, staff, and client anonymity).

Each site visit was conducted in-person over 2–3 days. During this time, semistructured interviews were conducted with members of the behavioral health staff and others who had a stake in behavioral health at each UIHP. Questions included an overview of the clinic's treatment philosophy, personal beliefs about what constituted an "evidence-base," obstacles to treatment, details about traditional healing offerings, and personal experience or training in different types of behavioral therapies (see Supporting Information Material for complete interview guide). Interview priority was given to clinicians working in behavioral health at each site as well as any additional staff identified by the Director who might have insight into the research questions.

Data collection efforts focused on UIHP clinicians and staff rather than clientele to limit undue risk to participants and because clinicians and staff can offer insight into overarching patterns observed across clients. Overall, 28 individual interviews were conducted with personnel across the 6 UIHPs, including 20 behavioral health providers, 3 behavioral health administrators, 3 UIHP administrators, and 2 cultural advisors (see Table 1 for details of the roles of interviewees at each site). Although these categories are listed separately, each represents the interviewee's self-identified primary role on site; however, overlap in roles did occur. For example, all behavioral health directors interviewed were also licensed therapists (for further interviewee demographics, see Table 2).

In addition to interviews, focus groups and smaller group interviews were conducted with behavioral health staff at five of the six sites visited. Focus groups and small group interviews were semistructured and minimally adapted from the interview-guide. Collectively, focus groups and small group interviews included a total of 23 participants, split across the five different sites (for further focus/small group demographics, see Table 2). The Director at each site provided materials concerning different available treatments as well as other internal documentation of behavioral health service operations at their UIHP. This material varied between sites depending on availability and Director comfort with dissemination. Site visit field notes were taken during these visits in accordance with Emerson et al. (2011) model of ethnographic notetaking.

TABLE 1 Interviewee role by site.

Site	Participant type	Interview participant	Focus group participant
Site 1	Provider	1	1
	Administrator	2	3
	Cultural advisor	0	0
Site 2	Provider	2	2
	Administrator	2	1
	Cultural advisor	0	0
Site 3	Provider	2	3
	Administrator	0	2
	Cultural advisor	0	0
Site 4	Provider	6	--
	Administrator	0	--
	Cultural advisor	0	--
Site 5	Provider	6	5
	Administrator	1	2
	Cultural advisor	1	1
Site 6	Provider	3	2
	Administrator	1	1
	Cultural advisor	1	0

TABLE 2 Demographics of interviewees and focus group participants.

Population	Interviews, *n* (%)	Focus groups, *n* (%)
Men	8 (40)	17 (74)
Women	20 (71)	6 (26)
AIAN	14 (50)	8 (35)
Non-AIAN	13 (46)	15 (65)
Declined to state identity	1 (3)	0 (0)

Abbreviation: AIAN, American Indians and Alaska Native.

The first author collectively used the field notes, focus group and interview responses, and materials provided by each Director to generate a site profile for each UIHP. Site profiles were completed between 2 and 5 days after the conclusion of each site visit and documented the nature of the sites and provided a broad overview of services available, including those outside of behavioral health. They also detailed available behavioral health treatments and any concerns from staff or clinicians about being able to adequately provide these treatments, the utilization of forms of traditional healing and cultural education or other traditional AIAN practices used in treatment, and the current needs and inadequacies of the sites as reported by clinicians and other staff members.

5.3 | Site profile analysis

The first author conducted all analysis utilizing the methodologies for developing and interpreting field notes described by Emerson and colleagues (2011). Using what they referred to as "focused coding," the first author integrated the field notes and observations into written summaries of each site focused on topics related to the research questions. A thematic map of the findings from staff interviews, focus groups, and small group interviews was developed following focused coding (for details, see Pomerville et al., 2016). Site summaries were then subjected to what Emerson and colleagues referred to as "integrative memoing," in which the summaries of the different sites were compared to understand the similarities and differences in the sites' available behavioral health treatments, client populations, and unmet needs. The conclusions of this analytic process are presented below with each subsection representing a different area of comparison that was intentionally highlighted in the focused coding and integrative memoing as a means for comparing staff perceptions across sites.

6 | RESULTS

Findings are reported below for four domains associated with each of our research questions.

6.1 | Client populations at sites

Among the six sites visited, two exclusively served members of federally recognized tribes or their family members. Two sites saw all clients regardless of their AIAN identity as part of a federal mandate. These sites were Federally Qualified Health Centers (FQHC) and by extension had to accept all Medicare/Medicaid beneficiaries for care and treatment. The remaining two sites also saw clients who were non-AIAN individuals but not as an FQHC mandate. Among the four sites that did see clients of all identities, it was estimated that the rate of self-identified AIAN people being seen in behavioral health was anywhere between 15% and 75%.

6.2 | Types of available behavioral health treatment

The forms of treatment available at each site were informed by Director and clinician preference and capacity. Available treatment modalities at the UIHP sites visited included cognitive behavioral therapy, narrative therapy, client centered therapy, psychodynamic therapy, mindfulness-based therapy, and various forms of traditional healing. Clinicians differed in their applications of these approaches depending both on their own preferences and the expectations set by the site's Director. Some sites and clinicians provided evidence-based, manualized applications of these treatments. Other sites and clinicians consciously deviated from this model of evidence-based treatment, instead integrating principles from different therapies depending on the clinical scenario. Clinicians who took the latter approach generally did so, per their justification, because of cultural incompatibility between manualized therapies and their targeted client base. One clinician, for example, noted a mismatch between time-limited, evidence-based practice models and clients who required year-long treatment to adequately address multiple co-occurring behavioral health disorders as well as being unhoused and other economic challenges. Concern regarding therapeutic mismatch for AIANs, particularly those pursuing treatment in urban settings, is not uncommon as extensive histories of political disempowerment and cultural neglect on the part of practitioners can serve as significant barriers to the delivery of culturally informed care (Pham et al., 2022).

The majority of the different treatment modalities (cognitive behavioral therapy, narrative therapy, client centered therapy, psychodynamic therapy, and mindfulness-based therapy) offered by the six behavioral health

sites surveyed is in keeping with what could be expected at general urban behavioral health centers. Given evidence of the benefits of integrating traditional means of healing into mainstream health care for AIANs (Gone, 2009; Goodkind et al., 2011; Moghaddam et al., 2013), there is increasing pressure across the system to expand the services of programs which serve AIAN clientele. In keeping with this pattern, all six sites indicated offering at least some form of traditional healing, but the availability of these services was inconsistent across the different sites.

Five sites noted that they faced specific challenges related to offering traditional practices due to tribal differences. This is not surprising given the vibrant diversity of AIAN people residing in urban settings. Examples include differences over whether sweat lodges should be limited to a single sex; rejection of certain ceremonial approaches by clients who feel there is mismatch between local AIAN traditions and the practices at the clinic that may be Pan-Indian or taken from tribal groups in other regions; challenges incorporating traditional practices into group therapy when clients' traditions do not share basic qualities with the traditional practices that the group therapy curriculum was based upon; and a local tribal group being primarily Christian today and some clients therefore rejecting traditional spiritual practices at the site as "witchcraft."

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

Two sites that offered only very limited practices are described below, followed by a more general description of services at the other four sites.

6.2.1 | Site 1

Traditional healing and cultural programming at this UIHP site consisted exclusively of youth programming, which included growing sacred medicines and education on AIAN culture. Discussion of AIAN cultural values and traditions and their relevance to clients was addressed on a case-by-case basis. Some of this information, however, came from internet searches and there was understood to be a lack of knowledge regarding forms of traditional healing and associated cultural practices at this UIHP. Three reasons for the scarcity of traditional healing services on site were identified by interviewees: a lack of interest among clients, a lack of personal knowledge in these areas among staff, and a lack of traditional healers in the local region. The site was not aware of locally trusted traditional healers, sweat lodges, or other resources to refer clients to, and it was expressed that this was due to the local area lacking trustworthy traditional healers. This was not a significant concern of interviewed clinicians and staff due to the perceived lack of interest among the client base in traditional AIAN approaches to healing.

6.2.2 | Site 2

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

6.2.3 | Sites 3–6

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

6.3 | Current needs and perceived concerns

Of the six participating sites, two identified substance use disorder as the primary problem facing clients, with one indicating opioids were the primary substance that was abused among clients and another indicating that alcohol was the primary substance abused. Alcohol was also mentioned as a primary substance of abuse at the four sites that did not consider substance use disorder the primary problem facing their client base. Notably, the only site that did not identify alcohol dependence or abuse as a serious problem being faced by their clients was the site that identified opioid use as the primary issue seen; staff at this site indicated that problems with alcohol use were comparatively more manageable in that they seemed to be associated with better outcomes than clients with other substance-use concerns seen at that site. Methamphetamines and marijuana were also mentioned by two sites as problems for clients; clinicians shared examples of clients who failed drug tests for marijuana by their employers and lost their jobs. No other drugs aside from opioids, alcohol, methamphetamines, and marijuana were mentioned at any of the six sites as a regular problem.

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

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

Client economic insecurity was perceived to be a recurring concern across sites. At four sites, being unhoused was identified by staff as a significant barrier affecting clients seeking behavioral health services. Participants at five sites noted that clients were generally very low income and that this disincentivized more financially well-off clients from seeking treatment at the site, even among AIAN people. According to employees at these sites, meeting basic needs came before addressing behavioral health concerns for many clients, with multiple employees mentioning that this was fundamentally a question of Maslow's hierarchy of needs (Maslow, 1943). At three sites, these concerns were handled in part or in whole by social services coordinators and/or case managers with jobs devoted entirely to these functions. Participants at one site indicated they had enough of these services when asked; participants at four sites indicated that they would like more or any such services; at one site without dedicated case managers, some clinicians indicated that because of a low overall number of clients who met site-specific eligibility requirements for treatment, they did not feel they needed additional assistance in this area because they had time to do this work themselves.

6.4 | Financial and staffing challenges

Financial concerns emerged as a barrier to care for treatment centers as well as clients. A major determinant of available treatment at UIHPs is, unsurprisingly, the kind of services for which they can be bill. Across the six study sites, it became clear that the patchwork state of funding and the different statuses that individual UIHPs occupied created a highly varied scenario. At one site, it was not possible to bill for individual therapy, as the only services that this UIHP could bill for were group-based approaches to substance use disorder treatment. Notably, some therapists at this site chose to see individual clients on a case-by-case basis. This served as one example among many in which funding alone did not entirely determine available treatment. Another site found itself in the opposite situation, able to bill only for individual sessions and not group approaches to treatment. Financial concerns also impacted the availability of AIAN-specific treatment plans, with one site indicating that they did not use these for patients with insurance because they did not believe the insurance companies would pay for AIAN-specific treatment. A different site had submitted and gained special approval for use of their treatment plans with at least some insurance companies.

Other factors influencing availability of treatment included the availability of practitioners and physical space limitations. Availability of practitioners varied widely between sites. While some sites indicated provider shortages either due to funding or a lack of competent providers in the area (or both), other sites indicated that they had enough clinicians with the appropriate training to meet demand. Some sites with reported provider and specialist shortages were unable to offer their desired forms of therapy; other sites had clinicians with relevant skillsets, but their limited number meant they could only serve a fraction of client demands. Due to limited physical space, some UIHP sites had to provide one-on-one, family, or couples therapy in lieu of group therapy sessions. Therefore, while financial limitations informed the availability and type of treatment provided, the specific contours of these impacts differed across settings.

7 | DISCUSSION

To better appreciate the counterbalancing of biomedical reductionism in behavioral health services with novel institutional accommodations that are deeply responsive to AIAN communities (Hartmann et al., 2018), this study endeavored to provide rich descriptions of behavioral health treatments and services across six UIHPs. We addressed research questions pertaining to the following behavioral health domains: the types of available treatments, the service needs and concerns, the background of presenting client populations, and the unmet financial and staffing needs. As the diverse practices across site profiles demonstrate in this analysis, no singular picture of a typical UIHP's behavioral health care can be drawn, but there are similarities that may be useful to remark upon from an observer's perspective.

The six UIHPs that participated in this study operated in vital community roles, providing therapy to populations with high need and few alternative options. Available services were generally dictated by available space and practitioners, funding, director/clinician preferences, and perceived compatibility with client preferences. For instance, services could deviate from evidence-based, manualized psychological interventions to better meet the needs of presenting clients. Most of these clients were AIANs and contended with multiple stressors including basic economic insecurity, substance use disorder, depression, and anxiety. To target these issues, especially in the context of intergenerational trauma due to forced cultural assimilation, dispossession, and oppression, UIHPs at times stepped outside of the confines of conventional biomedicine to include less-rigid therapies, more expansive cultural programs, and traditional healing, albeit inconsistently across different sites. Nevertheless, as the background data indicate, robust therapy programs exist across UIHPs with significant numbers of treatment-seeking clients and licensed therapists.

7.1 | Finding commonalities across distinctive UIHP efforts

The size and scope of the operations varied considerably. With the exception of Site 1, all other sites practiced some degree of AIAN cultural education or engagement, and each site included some traditional healing elements, although disagreements occurred among staff regarding the desired degree of incorporation of these activities. Despite these shared commitments, such practices and concepts are particular to each site; that is to say, even among sites that see their mission and identity as fundamentally "Pan-Indigenous," there is a particular set of meanings and practices attached to the AIAN identity of each site due to the make-up of both clients and staff.

This may reflect regional differences and the great diversity of traditional and contemporary practices among tribes, or of the background, cultural, or educational experiences of individual UIHP Directors, clinicians, and staff. Indeed, as leaders in their settings, Directors exhibited considerable discretion in determining service availability at individual sites. Thus, owing to well-documented benefits of the integration of traditional approaches to healing, there may be value in targeted system-wide education on the value of culturally relevant behavioral health practices. Further, there is a great deal of value and meaning in a shared identity for users and personnel of individual sites, especially at sites that are operating in an additional role as community centers, as some UIHPs do. That said, there are some specific observations concerning challenges with this diversity of site conceptualizations of AIAN identity that may be worth considering.

We noted earlier the independent production of AIAN-specific treatment plans at different sites. It seemed clear that this was both an unnecessary doubling of work effort and a potential space for communication on an important topic affecting these sites. Another example mentioned earlier was a UIHP with limited access to traditional knowledge and teachers which relied on the internet for AIAN-specific content. While not all materials will be appropriate for all AIAN populations (or age groups or diagnoses, etc.), many UIHPs have robust programs of cultural teachings that may have some potential to be shared and utilized by other UIHPs, as culturally acceptable and appropriate.

Harmonizing UIHP interventions may result in positive trickle-down effects for AIAN individuals in urban communities. This is especially critical in the context of ongoing demand for cultural programs and traditional healing services at UIHPs. Variability in the availability of culturally based and traditional approaches to behavioral health care underscores the historically embedded connection between culture and rural reservations on one hand and the potential for psychosocial anomie and behavioral health problems within urban areas on the other hand. It is important to note that five sites did not participate in the study because they lacked behavioral health services. This may hint at severely unmet- or undermet behavioral health and substance use disorder treatment needs among AIAN individuals within urban settings. Unfortunately, the path toward bolstering this community of professional sharing and reducing the behavioral health treatment gap remains hampered by the multiple structural limitations previously noted (e.g., limited funding, restrictive billing guidelines).

7.2 | Enhancing benefit through collaborative UIHP research

The findings presented here are important because urban AIAN behavioral health care has not been well-studied. Given the current dearth of behavioral health research conducted with urban AIAN populations (Pomerville & Gone, 2018), further research will be essential for elucidating strategies for improving behavioral health treatment and outcomes for AIAN people. The successful completion of the current study indicates that at least some UIHPs are open to research partnerships and have the capacity to participate. Community psychology offers promising avenues through which to pursue these collaborations, given its longstanding focus on dismantling structural harms experienced at the community level that help to context person-centered problem attributions or individualized narratives of pathology (Caplan & Nelson, 1973).

Findings from our study have underscored the need for targeted approaches to research in the future, given the diverse focus of behavioral health treatment offered at different UIHPs. For example, some sites may provide primarily substance use disorder treatment or social services rather than therapeutic interventions for

nonsubstance-abuse behavioral health disorders; researchers should consider how they can match the existing needs of these sites to best work in partnership with them, perhaps to adapt and validate promising interventions for the AIAN population. This should all be done with respect for and knowledge of the unique history of these populations and how they resultingly have chosen to interface with mainstream health care.

Findings from this work also indicate that future interventions should balance the potential epistemological and practical contradictions between evidence-based professional practices and culture-based healing practices (Gone, 2010, 2015; Hartmann & Gone, 2012). Study designs which equally consider the knowledge and contributions of professional and Indigenous therapeutic approaches, and researchers well-versed in both, may prove most effective at elucidating the nuanced benefits of each approach, with benefits for AIAN patients (Gone, 2021, 2022). Finally, scaling-up interventions based on culture and traditional healing in urban AIAN settings must consider significant intertribal variation that can make defining and generalizing such treatments challenging. Efforts should be made at the systems-level to develop a UIHP behavioral health program which can be easily, and consistently, personalized by individual sites to suit the unique needs of each population.

7.3 | Limitations

This study has several limitations. The sample sizes for the survey and site visit results were small. In particular, 20 sites declined to participate in this study, with five explicitly citing an inability to offer meaningful data because of they lacked behavioral health services. Thus, extrapolating beyond these six sites raises interesting questions. It is possible that the UIHP sites that participated in this research differ in systematic ways when compared to those UIHPs that chose not to participate. For example, sites may have elected to participate and/or delivered responses based on their perception of the study's desired expectations (e.g., the six participating sites elected to join the study because of their relative abundance of behavioral health services). That said, UIHPs in this study were geographically diverse and included sites in all four regions of the United States as defined by the Census Bureau (n.d.). Additionally, this study included UIHPs with a diversity of focus, including outreach and referral, limited ambulatory, and full ambulatory (IHS, 2018). The numerical data on services offered were dependent on subjective answers from UIHP Director estimates and may not fully represent the services and practices at the sites surveyed; note, however, that this methodology was employed to produce comparable data characterizing behavioral health services in the United States Department of Health and Human Services (2010).

The open-ended, discovery-oriented approach to data analysis was intentionally designed to draw upon the observations of the first author during his time at each site. Qualitative analysis is generally not intended to be generalizable to a broader population, and although the analysis presented here provides one perspective on what is occurring across multiple UIHPs, it should not be taken to generalize to all UIHPs. Instead, this analysis is intended to provide a more nuanced idea of what occurs at some UIHPs to paint a more complete picture of behavioral health care at some UIHP sites. It is hoped that despite these limitations, this analysis can help researchers and funding agencies working with UIHPs in the future to gain a better understanding of services, service providers, and needs at these sites. Finally, while the participating UIHPs did not require or request formal research review, the history of research abuses by researchers with respect to Indigenous populations (Gone, in press) suggests that additional protective actions should be adopted for research undertaken with urban AIAN populations (Haozous et al., 2021).

8 | CONCLUSION

This study reported findings from discovery-oriented site visits to six UIHPs for purposes of gaining a deeper understanding of prior survey and telephone interview findings concerning behavioral health services for urban AIAN populations. Summary site visit profiles were used to characterize availability of treatment, site and client

characteristics, cultural programming and traditional healing, and challenges associated with traditional healing. These six UIHPs evidenced diversity across multiple facets of service delivery even as they were united in their missions to provide accessible and effective behavioral health treatment to their clients. Collaborative research with UIHPs harbors the potential to recognize challenges, identify solutions, and share best practices across this crucial network of health care sites that are charged with meeting the obligations of the United States to care for the health needs of AIAN peoples.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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