AN URBAN AMERICAN INDIAN HEALTH CLINIC'S RESPONSE TO A COMMUNITY NEEDS ASSESSMENT

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Abstract: Utilizing community-based methods, we assessed the behavioral and physical health needs of a Detroit metropolitan Indian health clinic. The project goal was to identify health service needs for urban American Indians/Alaska Natives and develop the infrastructure for culturally competent and integrative behavioral and physical health care. We conducted 38 semi-structured interviews and 12 focus groups with service providers and community members. Interview and focus group data indicated a need for 1) more culturally competent services and providers, 2) more specialized health services, and 3) more transportation options. We then report on the Indian health clinic's and community's accomplishments in response to the needs assessment.

Major difficulties exist when attempting to identify the health service needs of urban American Indians and Alaska Natives (AI/ANs) and develop the appropriate infrastructure for care delivery. Of the 2.9 million people who identify solely as AI and/or AN, 67% live outside of reservation or tribal lands (U.S. Census Bureau, 2012). Providing for the health service needs of urban AI/ANs is imperative, as, compared to the general population they struggle with disproportionate rates of obesity and chronic diseases and are more likely to smoke, less likely to visit a dentist, more likely to report their health as poor or fair, and less likely to use primary care services (Glasnapp, Butrick, Jamerson, & Spinoza, 2009; U.S. Commission on Civil Rights, 2004). Urban AI/ANs experience worse health outcomes than the general population as a result of racial and social inequities; high unemployment rates; cultural and historical trauma; and limited social, health, and cultural resources (Moy, Smith, Johansson, & Andrews, 2006; Weaver, 2012).

Urban programs also have the difficult task of providing culturally appropriate behavioral and physical health care for AI/ANs who represent multiple tribal backgrounds and have varying levels of knowledge regarding health care that utilizes traditional Native methods of healing (Urban Indian Health Institute [UIHI], Seattle Indian Health Board [SIHB], 2012b). Furthermore, urban AI/ANs have limited access to health care and fewer available health professionals. A U.S. Commission on Civil Rights report (2004) notes that there were 101 mental health professionals available per 100,000 AIs, compared to 173 per 100,000 Whites. The Detroit metropolitan area, where the clinic in this study is located, is a designated Health Provider Shortage Area with a score of 17 out of 20 (higher scores indicate more shortages), revealing the lack of providers throughout the health system (U.S. Department of Health and Human Services [USDHHS], 2014). Another common barrier to providing the highest quality of care lies in the significant gaps in behavioral health data for the AI/AN population. An analysis of the 2006 National Health Disparities report indicated that only 50% of the data for AI/ANs were available, data were unreliable, samples were too small to be statistically significant, and only two-thirds of the utilization data were usable.

DETROIT METROPOLITAN INDIAN HEALTH CLINIC

Services Provided by the Indian Health Clinic

American Indian Health and Family Services of Southeast Michigan, Inc. (AIHFS or "the center") is funded by Indian Health Service (IHS). Like many urban Indian health clinics, it receives little funding. For example, tribally run health services and IHS facilities received approximately 53% and 43% of the 2010 IHS budget respectively, while urban programs received only 1%, although the majority of AI/ANs reside in urban areas (USDHHS Fiscal Year 2010 Budget in Brief: IHS, as cited in UIHI, SIHB, 2012b.) AIHFS' service area is composed of seven counties in southeast Michigan where over 47,900 AI/AN people reside (U.S. Census Bureau, 2010). AIHFS' mission is to "empower and enhance the physical, spiritual, emotional, and mental wellbeing of American Indian families and other underserved populations in SE MI through culturally grounded health and family services" (AIHFS, 2014). AIHFS provides medical care, women's health care, maternal and child health care, diabetes management, dental referrals, behavioral health care, substance abuse counseling and prevention, tobacco cessation

programs, youth programming, parent support programming, fitness programs, and traditional healing ceremonies (e.g., sobriety lodge). AIHFS aspires to integrate traditional AI healing and spiritual practices with contemporary Western medicine in both treatment and prevention (AIHFS, 2014). AIHFS also hosts annual health fairs, celebrations, and other cultural events.

Indian Health Clinic Service Needs and Response

At the time of this study, AIHFS served 2,304 clients, approximately 10% of whom were receiving behavioral health services. Identifying and recruiting specialized providers (e.g., in behavioral health) who are AI/AN is challenging. The behavioral health program was not able to provide services to all of the clients in need of those services.

In response, AIHFS recognized that a needs assessment was necessary to increase organizational capacity and build an infrastructure that could better provide for the health care needs of the AI/AN population in its service area. A Substance Abuse and Mental Health Services Administration Circles of Care Infrastructure Development grant funded AIHFS to plan and perform an in-depth needs assessment of the systems of care impacting the physical and mental health and wellness of AI/AN children, youth, and their families. The specific purpose was to assess, plan, and design a culturally appropriate integrative system of behavioral and physical health care that incorporated traditional healing.

In this paper, we present needs assessment data from AIHFS' 2008-2011 community project entitled *Gda'shkitoomi* ("We are Able"). The data reported here were collected between April of 2008 and October of 2009. Additionally, we report on the AIHFS' and the community's response to the needs assessment data. This community-based project posed the following questions: 1) Are health services in general available, accessible, and appropriate? and 2) What are the culturally appropriate health services needed in the Detroit metropolitan area?

METHODS

Study Purpose

Between April of 2008 and October of 2009, the team conducted 38 semi-structured interviews with 27 community members and 11 service providers, and also conducted 12 focus groups, 10 with just community members and 2 with just service providers. We chose these

qualitative data methods as we felt they would elicit richer data. Data saturation, community and staff composition, and cost were considered when choosing the number of interviews and focus groups. The purpose was to collect information from a diverse group of people who could provide insight into the nature of the health issues (e.g., availability, accessibility, and appropriateness of treatment; cultural and spiritual relevance of services), recommend solutions, and provide guidance about integrating behavioral and physical health services. We determined that it was important to get the views of community members, as they receive the services and are aware of service improvement needs and preferences, and the views of service providers, as they were more knowledgeable about currently provided services.

Research Design

Study Team and Advisory Council

The study team was composed of the second author/evaluator, a research assistant, the project manager, and AIHFS staff members. The team collaboratively designed, developed, and conducted this community-based study. An advisory council was formed by recruiting community members via telephone calls, flyers posted at the center, notices in the center newsletter, and word of mouth. The advisory council met once a month (in the evening, to accommodate participants' work and school schedules). Attendance varied from 15 to 22 members. The council was composed of tribal elders and leaders, parents, youth, AIHFS staff members from various departments, and representatives from local organizations interested in developing programs to support the community. This group reviewed the study processes and offered oversight on cultural appropriateness and viability of the project. This study was approved by AIHFS and the University of Michigan Institutional Review Board.

Recruitment and Consent

Interview and focus group participants were recruited via face-to-face discussions, flyers posted at the center and at local community events, and at AIHFS. The interviews and talking circles occurred at AIHFS, at other Indian centers in the Detroit metropolitan area, and at community venues. All participants signed consent forms, and parental consent was obtained for youth under the age of 18 years.

Data Collection

We conducted both individual interviews and focus groups in order to tailor the venues toward the comfort of the participants, as we thought some might be more apt to share in a private setting and others might need group interactions to elicit detailed perspectives. The interviews were conducted in private areas of the venues and/or in interviewee homes. The focus groups took place in a private area of the center. Interviews and focus groups were digitally recorded and lasted between 45 and 75 minutes. Community member participants filled out a demographic survey and were provided transportation, child care, a meal, and a $20 gift card. Service provider participants filled out a different demographic survey (asking for less identifying information) that included questions on individual service provision, role, and length of time in this role at AIHFS and elsewhere.

Talking Circles

The focus groups were conducted as talking circles, a traditional method of group communication in Indian country (Becker, Affonso, & Blue Horse Beard, 2006; Montejo, 1994). In typical focus groups, the moderator plays an active role in eliciting information; in talking circles, the moderator defers to elders. If an elder is speaking, it is inappropriate for anyone to interrupt. The team began the talking circle by sharing a meal, and an elder (or other participant, if no elder was present) offered a brief prayer. Everyone sat in a circle and the moderator passed around a shell which a participant held while only he/she was talking. When the speaker was finished, he/she then passed it to another person; then, only that person could speak. Everyone was given the opportunity to talk, and no one was interrupted. If a person did not want to talk he/she passed the shell to the next participant. The shell was passed multiple times for each question to ensure that everyone was able to share his/her views.

Interview and Focus Group Questions

Three major topics were addressed: 1) availability of, access to, and appropriateness of treatment; 2) culturally and spiritually appropriate services; and 3) gaps or limitations in current services. The questions posed in both the interviews and the talking circles were: 1) What do you think about the way health care is provided for American Indians in general? 2) What do you think about the appropriateness (cultural and spiritual) of services for American Indians in our community? and 3) What do you think about the availability and accessibility of health services for American Indians in our community?

Analyses

The interview and talking circle data were transcribed verbatim and reviewed by the study team for accuracy. Then, the team utilized a content analysis approach whereby three project staff members became familiar with the data by reading through the transcripts (Tutty, Rothery, & Grinnell, 1996). We used this approach so we could analyze the text to define common themes in participants' views of community needs (Berg, 1989; 2004). During the first stage of coding, the staff members re-read the transcripts to define categories from repeating ideas. The team met to review the independently coded data, and then organized it into broad categories that highlighted the specific themes reported in this paper. Themes identified by participants were very consistent throughout the interviews, and were repeated in the talking circles. Therefore, themes from the interviews and talking circles were combined and subsequently catalogued using taxonomic method and arranged into a matrix format (Berg, 2004). All results were reported to the AIHFS advisory council at their meetings and to the AIHFS community at large community events. Dissemination methods included PowerPoint presentations, posters, and discussions.

RESULTS

Select Characteristics of the Participants

Interview Participants

Of the 27 community member interviewees, 18 were women; the age range was 12 to 82 years, and 25 were tribally affiliated (many urban AI/ANs identify as affiliated, but are not enrolled in a tribe). Of the 11 service provider interviewees, 6 were women; the age range was 26 to 70 years, and 5 were tribally affiliated. The services they provided were mental health ($n = 5$), physical health ($n = 2$), administrative ($n = 1$), and support ($n = 3$).

Talking Circle Participants

Twelve talking circles were conducted, 10 with community member participants and 2 with service provider participants. The groups were organized by gender or age. Some groups were composed solely of women or men, some of only youth, and some of elders of both genders. Of the 73 community members, 37 were women; the age range was 12 to 77 years, and

62 were tribally affiliated. Of the 10 service providers, 8 were women; the age range was 21 to 70 years, and 1 was tribally affiliated. The services they provided were behavioral health ($n = 6$), physical health ($n = 3$), and support ($n = 1$).

Participants shared feedback regarding the services that currently are provided in the Detroit metropolitan area. The themes that emerged were needs for 1) more culturally competent services and providers, 2) more specialized health services, and 3) more transportation options.

Need for More Culturally Competent Services and Providers

Community member participants requested more services tailored to their cultural needs: more traditional healing; more cultural programming; more marketing of provided services (especially traditional services); AI/AN and/or culturally competent providers, both at AIHFS and offsite; service integration so the whole body and mind could be served; and collaboration between providers and community members.

A community member interviewee (#26) stated, "I have more faith in Indigenous healing now than I have in any other." Another community member interviewee (#2) stated:

I think [traditional healing] is better than [Western medicine] because they deal with the spirituality, they deal with the mind and the mind has a lot of control over the body, where the Western medicine they don't consider the mind, and it's just the physical but that's not what it is.

Talking circles where people can gather to share wisdom and knowledge, support one another, and experience the cultural components of prayer were important for participants. When a community member interviewee (#39) was asked what kind of mental health services she would like to see the center provide, the response was, "Talking circles...like bringing in more like Native teachers, like elders, community members that could like lead a talking circle or share a teaching." Another participant, in the male community member talking circle (#2), shared:

You know, myself, sometimes I wish I had somebody to talk to. You know what I mean? I am 49 years old and sometimes I wish I just had somebody to open up to. A lot of people hold stress inside of them…A lot of people just do not know where to turn, you know. Or a lot of people do not trust people to talk to. You know. You have got to be around somebody that you can trust, somebody you can open up to.

Overwhelmingly, participants wanted AIHFS to provide both Western medicine and cultural and social programming that includes education and activities that teach language, culture, spirituality, and traditional ways of life. AIHFS does incorporate cultural activities into its programming, but this study highlighted the gap between what is offered and what the participants expressed as their cultural needs. Participants also noted that there are many AI/AN community members who want more traditional healing and cultural knowledge, but do not know what these might look like. Many times, the ceremonies and spiritual beliefs that the participants wanted were not passed down as a result of cultural trauma, family dysfunction, intermarriage, or shame. Many AI/AN children are being raised by non-AI/AN family members/caregivers who may need assistance to learn about AI/AN cultures and teach them to their children. Youth who receive cultural programming via AIHFS' after-school program, are aware of the need for their caregivers (both AI/AN and non-AI/AN) to be involved in cultural programming tailored to their needs. One youth talking circle participant (#2) observed: "But not just the children need to know, I think they should, you know? ... More Native parents should be involved in learning as well, not just the children." Youth revealed that they are struggling at home, struggling as adolescents, and struggling over school pressures. One youth (#1) remarked in a talking circle that, "For me, it's kind of hard to keep seeing my family like one unit… my dad is going through depression and he's using it through alcohol, and getting drunk, coming home at two o'clock in the morning." Many shared stories of challenging home environments and the benefit of connecting and sharing with others to alleviate their stress at events at the center (e.g., the Dreamseekers traditional youth after-school program).

Community awareness of services—or the lack of marketing of services—was a dominant theme throughout, appearing in all the interviews and talking circles. A community member interviewee (# 27) stated:

> Um, I wasn't aware there was a clinic here. You know, I have been without insurance for a long time, struggling, and, um, I didn't know that you guys offered any service, because I was not aware that the clinic was here. So it should be like more advertisement around our city.

The service providers also acknowledged their responsibility to the community and their shortcomings in providing information about available services. For example, a service provider interviewee (#6) stated, "…Just getting the word out is what we really need, as well as more

transparency where people [service providers] are open, honest, accountable, and communicate well." One service provider shared that AIHFS has AI staff, including behavioral and physical health specialists, paraprofessionals, and programming staff members; however, many of the participants were unaware of their existence (e.g., that AIHFS has an AI physician in the health clinic).

Community member and service provider participants discussed culturally competent service and practice as it relates to interactions with health care providers. Participants wanted both AI/AN physicians and service providers at the clinic, as well as service providers at non-IHS clinics who are not AI/AN affiliated, to be more culturally competent (AIHFS' employees, as well as its service population, are diverse in terms of tribal affiliation, and level of cultural competence). The desire for AI/AN service providers and for cultural competence reflects participants' need to be comfortable working with providers who understand that AI/ANs have had historical, cultural, geographical, and social experiences that may differ from those of the general population. An AI service provider (#8) shared in an interview: "I'm hoping that people will get comfortable with being a community and see me as a resource when they need me." Participants often found themselves educating the service providers in non-IHS clinics about their cultures. Participants stressed the need for building trust with their service providers, noting that providers can help by considering their patients' cultural needs. One service provider interviewee (#4) said that "building a network of traditional people who can be consultants or provide traditional services would increase the appropriateness of the services we offer."

Participants advocated for the integration of services as an effective way to meet community needs. One community member interviewee (#2) shared:

A lot of times with Native people they're not going to tell you they have needs, and by addressing both a counselor and a physical doctor at the same visit you might be able to find out more of what they need.

AIHFS attempts to provide services that treat the whole person, and includes spiritual and cultural aspects in services. Despite the existence of these services, the participants wanted more integration of Western medicine and traditional medicine. A male community member in a talking circle (#1) talked about what is important to him: "Reconnecting with tribal heritage… going back to tribal practices and healing along with Western medicine." The theme of culturally

competent services and providers also included collaboration between staff and community members. Collaboration is an AI/AN value and traditional way of interacting. A service provider interviewee (#7) noted the importance of collaboration:

> Having like really good communication about the changes, like with all the staff, and…involving the staff in like creating the...programs so that everybody knows how it's going to work….asking the community's opinion and feedback on it.

Need for More Specialized Health Services

Participants wanted more specialized services at AIHFS, as external providers were not receptive to, or knowledgeable about, AI/AN cultures. They suggested that offering specialized services in both the behavioral and medical health programs would help to build trust in AIHFS. A service provider interviewee (#26) stated:

> We provide here just a basic medical health…if they need any specialized services, we have to refer them out for those services…if they need an internist, a pulmonary specialist...any sort of specialist, we have to refer them out.

AIHFS provides a range of services, but some clients felt there were limitations that forced them to go to more than one clinic, some non-IHS, for their health needs, as shared by this service provider interviewee (#11):

> I had one patient yesterday that told me that she goes to the other county . . . for her women's health screening, but she came to us for family medicine and I was able to at least give her that information, that we are working on it . . . So I think that is going to have more of a central, kind of continuity of care, rather than breaking up women's health in their county and them coming here for family members.

There is a greater demand for services than AIHFS currently is able to meet financially, which leads to waiting lists and patients left with unmet health needs. Lack of onsite services results in referrals, often leaving the uninsured to maneuver through a great deal of paperwork and a 25- to 30-day wait for an appointment. Participants desired more mental health services (e.g., case management; support groups for loss, grief, and stress management), a psychologist or psychiatrist on staff, drug and alcohol treatment targeted at AI/AN populations, and more youth-tailored services. A community member talking circle participant (#1), who is a mother, shared

her experiences with the general mental health system and her wish that AIHFS could provide advocacy and guidance in helping families work with multiple providers and systems in the greater Detroit metropolitan area.

Need for More Transportation Options

Participants wanted more transportation options to be able to attend events. Given that services are provided to a seven-county metropolitan area, many of the participants, including one community member interviewee (#27), stated, "Transportation is one of the biggest challenges." Participants cited lack of public transportation and not having a vehicle as transportation barriers that prevented them from accessing services. AIHFS is located on the fringe of the Detroit metropolitan area, and there was a desire for it to be more centrally located or to have more locations, as some patients have to drive more than 60 miles for services. A community member interviewee (#30) shared:

I think that if they're able to get here, it's a wonderful thing, because [patients]

may not be located near it, some people decide not to come this far. I think that a

lot of people don't know they can use these services.

Transportation in the Detroit metropolitan area is automotive-centric, so public transportation is underfunded, is nonexistent or sporadic in many areas, and does not connect the greater metropolitan area to the city. As a service provider interviewee (#1) stated, "With our programs they [clients] would get so much out of it, if we could just get them here…"

To offset the challenges posed by limited transportation, participants requested extended or evening hours of operation at AIHFS. In particular, participants who held traditional workday jobs asked AIHFS to provide health services on weekends and later in the evening to better accommodate travel time. One community member interviewee (#15) suggested, "Being able to come in an evening, seeing a therapist, for instance, that the kids go to school all day and the parent works, um, maybe even on the weekends." Another community member interviewee (#29) added, "You know, available times… in the evening hours after you work."

AIHFS' and the Community's Response to the Results of the Needs Assessment

AIHFS reviews service delivery and programming at the advisory council's monthly meetings. At these meetings, elder members receive updates, provide input, and also teach younger members traditional ways of praying, dancing, and singing. To facilitate youth input on programming and service needs, a monthly youth advisory council has also been formed. More creative, low-cost, and potentially high-impact solutions to the unmet mental, emotional, physical, and cultural needs of the local AI/AN community are being generated by management, providers, and staff and community members. Oral reports from the advisory council and community members, as well as increased community participation in events (measured by sign-in sheets) have been positive.

Overall, participants were satisfied with the quality of services provided at AIHFS, but wanted even more culturally appropriate services to be available both offsite site with other providers, and onsite at AIHFS.

Need for More Culturally Competent Services and Providers' Response

In response to the needs assessment, AIHFS has provided more traditional healing, culturally competent programming, marketing, AI/AN or ally providers; and service integration. AIHFS has a made a concerted effort to increase the use of traditional healers and elders practiced in traditional healing methods (e.g., use of medicinal plants and herbs) to conduct teaching and ceremonies. AIHFS has launched a weekly Native-specific women's Wellbriety group and more regularly scheduled peer-led men's and women's talking circles that include traditional activities. It has also initiated a nutrition program where members learn how to cook healthy Native foods, more regular sweat lodges, and naming ceremonies. These activities require only space and minimal funds.

To increase its marketing efforts and reach more community members, especially youth, AIHFS updated its website with available programs and links to social media accounts, made its newsletter accessible on the website, and developed a listserv for weekly emails. Finally, a marketing committee was formed to increase visibility and membership with videos, brochures, flyers, and signs posted on the website and distributed at community venues around the Detroit metropolitan area.

The participants asked for AI/AN health providers and staff members, of which there are now several at AIHFS, working in the health, youth, parenting, suicide prevention, and substance abuse programs, as well as in the facilities and administrative departments. AIHFS' increased marketing efforts and infrastructure development enabled it to recruit and support these AI/AN staff members, as well as local university interns, many of whom are AI/AN. AIHFS continues to have an AI physician as well.

AIHFS services are being integrated. For example, a behavioral health provider was relocated to the physical health clinic for quick onsite assessments and referrals for behavioral health. More services that involve a holistic, traditional healing approach are being introduced and also are being integrated with Western medicine. For example, the newly hired AI/AN staff members are professionally trained in the Western model, but have backgrounds in AI/AN cultures.

Need for More Specialized Health Services Response

Due to funding restrictions, more specialized services are difficult to access at AIHFS. However, AIHFS' response has been to increase collaboration with providers and community members, internally and externally, particularly in the behavioral health program. Via a grant-funded project, Detroit metropolitan service providers are working to integrate AIHFS into Detroit Wayne Mental Health Authority's system of care management team, and the agencies involved are participating in training that infuses more cultural programming with an emphasis on AI/AN cultures. At AIHFS, more substance abuse and mental health programming is being developed. The center has received funding for a suicide prevention project that provides gatekeeper trainings, which teach those who are positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers) about the warning signs of a suicide crisis and appropriate responses (Suicide Prevention Resource Center, n.d.). Suicide screenings and referrals for ongoing mental health services also are provided. To increase behavioral and physical health staffing numbers in specialized areas (addictions, children and youth mental health, innovative behavioral interventions) AIHFS has formed internship programs with local universities and has accessed grant funding for suicide

prevention and addictions programming. Finally, the center is applying for accreditation, which can lead to an increase in reimbursements from regulators, thus generating more income for specialized services.

To develop more cultural activities and programs, AIHFS, tribal organizations, tribal communities in Michigan, and First Nations people in nearby Canada are doing more networking. As part of this effort, AIHFS and two local Native agencies formed a coalition to collaborate in services, funding, and events. Each site is working to decrease redundancy in services and maximize participation in funded programs. AIHFS and one of the agencies have jointly sponsored a powwow. Together, the three coalition partners are conducting more cross-agency behavioral and physical health trainings and events to share funding and increase collaboration and participation among staff and community members.

Additionally, AIHFS staff and community members are involved in accessing funds for capital improvements, capacity building, mental health, substance abuse, and medical services. The advisory councils and staff members collaborate on grant applications, and, when funds are awarded, they collaborate on the implementation of programs. Community input is frequently obtained for projects, especially those involving youth.

Need for More Transportation Response

Understanding these challenges related to transportation has allowed AIHFS to brainstorm solutions and apply for funding to alleviate this burden for its community members. AIHFS has acquired two additional vehicles (for a total of 4) since these data were collected, and additional staff members have been trained as qualified drivers. Furthermore, in order to accommodate patient work schedules and travel time to the center, AIHFS has added evening hours and walk-in days.

DISCUSSION

This study identified the following needs: more culturally competent services and providers, more specialized services, and improved transportation options. The participants' desire for culturally competent services is not unique to AIHFS. For example, in a study in the

Chicago metropolitan area, AI/AN participants indicated a need for culturally relevant services that utilize traditional medicine or spiritual healing (West, Williams, Suzukovich, Strangeman, & Novins, 2012).

Many AI/AN elders and adults experienced assimilation strategies imposed by the federal government, including forced attendance at boarding schools and the Indian Relocation Act of 1956. In particular, relocation created a chronically disenfranchised and traumatized urban Indian population (Nebelkopf & King, 2003). These assimilation practices estranged AI/AN adults from their traditions and increased their need for programming to reclaim culture for themselves and their children.

There are challenges to providing culturally competent programming, including the diversity of tribes and cultural practices within an urban setting, which prevents a one-size-fits-all approach. Further, few providers know about AI/AN cultures; most need to be educated about the cultural and historical contexts that influence the diagnoses and treatments providers can offer. Traditional healers can help to bridge this gap, but they are few in number and often must travel far to provide services. In order to tackle these obstacles, funding is needed to improve the quantity and quality of culturally competent services at urban Indian health clinics and positively impact health outcomes in the community.

Another interesting result of the needs assessment is the desire for more onsite specialized services, especially mental health services. A 2012 Urban Indian Health Institute report shows that, among AI/AN adults residing in urban areas, 15.1% reported at least 14 poor mental health days within the last month, compared with 9.9% of the all races population (UIHI, SIHB, 2012a). The mental and physical health of AI/AN people are affected by the traumas associated with historical events. These traumas often are not understood, recognized, or discussed in the current U.S. health care system (UIHI, SIHB, 2012a).

Even with an increase in funds for more comprehensive culturally competent services and providers, and the provision of more onsite specialized services, many AI/ANs in the Detroit metropolitan area are unable to get to the center. The effects of insufficient transportation on AI/ANs' ability to access health care in Michigan is noted in the 2009 Bemidji area urban Indian needs assessment. Among 389 respondents, a lack of insurance (23.3%), and then a lack of

transportation (13.9%) were the major reasons for not being able to access health care (UIHI, 2009). These findings reaffirm that urban Indian health clinics need more funds to be able to provide transportation as well as cultural and specialized services.

For this study, the following limitations should be noted. The results of the study from one urban AI/AN health center cannot be generalized beyond this specific sample. While the sample in the study represents community member and service provider perspectives, the sample size was small and purposive, and the results may not reflect the needs of AI/ANs in the entire Detroit metropolitan area. Additional research would be needed to develop a more comprehensive understanding of the health needs of urban AI/AN populations.

CONCLUSION

As a result of this study, AIHFS' staff and community members, service providers, and external service providers have enhanced and expanded physical and mental health programs, as well as integrated more culturally competent programming into their present services. Community members, staff members, service providers, regional AI/AN centers, and Detroit metropolitan area social service agencies need to continue to collaborate in order to provide services effectively and reduce health disparities for this urban Indian population.

"We need to stand together as a whole Nation…We need to lift each other up, you know, to keep us strong. We need to be strong" (Community member interviewee #28).

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ACKNOWLEDGEMENTS

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