

ASSESSING THE NEEDS OF URBAN AMERICAN INDIANS IN NORTH TEXAS: A COMMUNITY-BASED PARTICIPATORY RESEARCH PROJECT

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Abstract: This article discusses a community-based participatory research project with university researchers, an urban inter-tribal center, and other community partners to develop, administer, and deliver a community needs assessment of an urban American Indian (AI) community. In the development process, community focus groups identified major domains of inquiry for a needs assessment survey: mental health and substance abuse, medical care, and social services, including cultural programming. Results are presented and discussed in each domain. Overall, this community needs assessment contributes to a better understanding of American Indian and Alaska Native (AI/AN) urban challenges by providing information about the AI/AN population in a large southwest metropolitan area. Specifically, it highlights the relevance of local and state contexts for understanding issues facing AI/AN populations.

A growing body of research indicates that AI/AN populations demonstrate some similar challenges in terms of health, social service needs, and mental health and substance abuse needs due to shared histories of colonization and misguided or underfunded government programs, among other factors. It remains true that AI/AN communities nonetheless are each distinctive and face unique challenges and opportunities within the local, state, and regional contexts in which they reside. The process described in this paper will inform policy, practice, and research communities interested in understanding the unique realities of an urban community representing many different AI tribes.

INTRODUCTION

While the majority of American Indians (AI) and Alaska Natives (AN) live in urban areas, their social, emotional, and medical needs have received less study than communities on reservations

or tribal lands. High poverty, unemployment, and physical and mental health disparities are well documented for the AI/AN population at large and urban AI/AN communities more specifically (Trombino, 2005). Home to more than 75,000 AI/ANs, the urban southwest metropolitan area described in this paper shares similarities with other large metro areas with significant AI/AN populations (Norris et al., 2012; UITCT, 2017). While census data combines AI/AN populations, the community in North Texas primarily identifies as AI and as members of specific AI tribal nations. Urban AI/ANs in this area—as in other places—are impacted by the long-term consequences of historical trauma due to loss of tribal lands and identity, suppression of cultural and spiritual beliefs, boarding schools, and relocation programs in the 1950s and 1960s (Fixico, 1986). These consequences include loss of cultural connectedness and a subsequent impact on overall health, education, employment, child welfare, and engagement with the criminal justice system. This is evidenced by high rates of violence, substance abuse, unresolved grief and loss, depression, and suicide (Brave Heart & DeBruyn, 1998; Evans-Campbell, 2008).

While the U.S. government provides health care to members of federally recognized tribes through the Indian Health Service (IHS), resources continue to be focused mostly on reservation-based tribal nations. Moreover, the IHS reports that current congressional appropriations only meet 60% of the health needs of the AI/AN population (IHS, n.d.a). In addition, only 1% of the IHS budget is allocated for Urban Indian Health programs, with the IHS estimating that urban programs are funded at only 22% of need (Office of Urban Indian Health Programs, n.d.a). The problem of limited care providers and underfunding is exacerbated in a state like Texas, which has one of the largest uninsured populations more generally, in part due to state policies such as not participating in Medicaid expansion (Buettgens et al., 2018). A key purpose of this study was to gauge the needs of AI/ANs in North Texas based on community members' perceptions as well as the observations of people familiar with the community, such as care providers. Awareness of such needs can inform policy, practice, and research communities about the unique issues facing urban AI/AN communities.

Community Organization

Historically, urban AI/ANs have worked to address the needs of their communities by forming urban intertribal centers, churches, Powwows, and student organizations (Britten, 2017). The roots of the Urban Inter-Tribal Center of Texas (UITCT), the key partner for researchers in this study, reflect this broader history. While the Dallas-Fort Worth area was originally the territory

of multiple Indigenous groups, including Comanche, Wichita, and Caddoan peoples, by the late-nineteenth century, few remained after years of war and displacement to tribal lands in Indian territory, later Oklahoma (Smith, 2006). It was not until the U.S. government implemented a new relocation program in the 1950s and 1960s that the AI population of North Texas grew significantly; by 1970, more than 20,000 AIs from more than 90 different tribes moved off tribal lands and into the Dallas area (UITCT, 2017). Officially, this program sought to lure AI people off tribal lands to cities with promises of employment and opportunity. In practice, people often reported arriving in cities like Dallas to face isolation and discrimination (Fixico, 1986; Britten, 2017).

The UITCT opened in 1971 to meet the needs of the growing AI/AN population (UITCT, 2017). In the present day, the UITCT is a key community organization that provides health care services to clients representing 174 federally recognized tribes. However, the UITCT has limited resources to provide health and social services to the community. Data limitations have impeded it from obtaining funding to expand services or to fully assess the social and cultural needs and interests that may exist. In fact, staff were not aware of any other needs assessments having ever been conducted.

Currently, the UITCT primary care clinic has an active user population of 4,956 who had a total of 26,297 visits in 2018. Most clients live in the Dallas/Fort Worth Metroplex: Dallas (53.2%), Fort Worth (16.4%), and surrounding suburban counties (10.5%). Three and a half percent of the patients are veterans. While clients are members of many different tribes, the following table (Table 1) represents the top ten tribes whose members make up 77.3% of the clients utilizing UITCT services.

Table 1
Tribes Represented

Tribe	%
Choctaw Nation, OK	29%
Cherokee Nation, OK	14.5%
Muscogee (Creek) Nation, OK	6.7%
Chickasaw Nation, OK	6.5%
Navajo Tribe, AZ, NM, and UT	5.6%
Comanche Indian Tribe, OK	4.3%
Mississippi Band Choctaw Indians	3.3%
Seminole Nation, OK	2.2%
Kiowa Indian Tribe, OK	1.9%
Citizen Potawatomi Nation, OK	1.7%

Compared to some metropolitan areas with significant AI/AN populations, this North Texas metropolitan area is further characterized by limited access to health and social services, such as government-funded Indian health facilities. Because UITCT is the only Urban Indian Health Program (UIHP) clinic in the entire state, people travel long-distances from across the state to receive care. Moreover, because the services of this clinic are limited, many people also travel back to tribal communities in Oklahoma and elsewhere to see specialists or to avoid long wait times (Office of Urban Indian Health Programs, n.d.b).

RESEARCH METHODS

The researchers received University of Texas at Arlington institutional review board and human subject review approval for all stages of the project. Researchers employed a community-based participatory research design. The key principles of participatory evaluation include the direct, strategic, and inclusive involvement of stakeholder groups and the ongoing communication and use of evaluation results to guide decision making and change. With an eye towards capacity building and solution focused principles, community members were actively sought to fill data collection, analysis, and interpretation roles. This empowers the individuals and communities being studied and provides a catalyst for community-defined change.

The participatory evaluation involved a partnership between the University of Texas at Arlington evaluation team and AI community partners. Initially, key community stakeholders were engaged to discuss possibilities for projects examining the issue of AI/AN health and medicine broadly conceived. The idea for a needs assessment project came from these groups' discussions as it was not believed that an assessment had ever been conducted, and UITCT believed that the resulting data could be useful to their work. At that stage, additional university researchers with relevant expertise were brought into the project.

The participatory evaluation approach continued to be utilized going forward, including: 1) engaging stakeholders in instrument development; 2) obtaining perspectives from all relevant stakeholders; 3) providing translation and interpretation as necessary; 4) using and refining methods that consider cultural sensitivities or preferences; and 5) ensuring communication and research materials are appropriate and accessible to the range of ages represented. Participatory evaluation is also a critical approach recommended for use with AI communities (Yuan et al., 2014).

During the first phase of the design (October and November 2016), we conducted focus groups, teamed with a community member, to understand the domains of concern the community wanted to explore. Three focus groups were conducted at various times and days to accommodate participants' availability. Participants were recruited via flyers at UITCT and through snowball sampling. Each participant had to be a client of the Center or affiliated with it as an employee or community member. All the focus groups were held at UITCT and included a discussion of the purpose, and each participant signed an informed consent. Participants received a \$10 stipend for their participation.

Focus group sessions ranged in participant size from 11 to 17 and lasted between 60 and 90 minutes. In total, 31 women and 10 men participated. Each session began with an open-ended question about the perceived needs of AIs living in North Texas: What general areas of needs are there for American Indians living in North Texas? Follow-up questions probed topics of concern raised by participants. At each session, similar concerns were voiced. Substance abuse treatment and mental health services were discussed in all the focus groups. The need for AI-specific programming for children and youth was another common area, including cultural education within public schools and more awareness among school counselors of scholarships for AI students. Notably, diabetes care did not emerge as a specific topic of concern in the focus groups, perhaps owing to this being an existing focus of care at UITCT. Many social service needs were discussed, such as housing, employment, and financial assistance of all kinds. The relatively limited services offered at UITCT and the need to travel to tribal nations in Oklahoma to receive specialized care also emerged as a concern.

Phase two involved the development of the needs assessment measurement tool (December 2016 and January 2017). The evaluation team, which included tribal members and UITCT staff, evaluated the focus group findings. In particular, we analyzed themes across each of the three focus group sessions to determine the domains of needs expressed by participants. The needs assessment was informed in this process. Key areas of need were mental health and substance abuse, cultural programming and education, access to specialized health care and health insurance, and social service needs such as food, clothing, and childcare. A search of the literature for other needs assessments done in urban AI communities also informed the development of the measurement items by confirming that no major categories of need identified in previous studies had been overlooked. Twenty-three areas of need were identified through the focus groups and ranged from mental health/substance abuse treatment to affordable housing and employment (see

Appendix). A few examples are Mental Health Services for Youth, Sober Living Alternative Housing for Youth, AI/AN-Specific Domestic Violence Counseling, and Availability to AI/AN Cultural Events. Additionally, there were 14 items asking about the respondents themselves (e.g., age, education, income), such as: *Are you enrolled in a federally recognized tribe?*, *What is your tribal affiliation?*, and *Do you have health insurance?*

During this second phase, we also conducted a pilot administration of the measurement to ensure validity of the needs assessment survey tool. The survey was found to be sound, and we did not have to make any adjustments.

The third phase of the research (February-May 2017) involved administering the survey, which included an informed consent. Participants were asked to rate identified areas of needs on a scale from 1 to 4 (4 = *critical need*, 3 = *moderate need*, 2 = *low need*, 1 = *not a need*). The survey was administered through multiple means to ensure the community was well represented. Recruitment occurred via social media, flyers at the UITCT, at community events, and through snowball sampling. Survey administration included web-based survey, paper surveys, and, when necessary, face-to-face administration if there were language or reading limitations. Surveys were collected at the UITCT clinic, and the evaluation team also participated in several community outreach events in order to reach the community, such as Powwows, American Indian Heritage Day, and Agency events. The original sample ($N = 382$) included non-AI/AN respondents ($n = 110$) who were self-identified spouses or care providers knowledgeable of AI/AN needs. AI/AN respondents ($n = 272$) consisted of clients of UITCT (who must be enrolled members of federally recognized tribes) and self-identified members of the urban AI community. Phase four (June 2017-December 2018) included analysis of the needs assessment and dissemination of the results to the organization and the community through sponsored face-to-face presentations of the findings. Based on reviewer feedback, we subsequently removed the non-AI/AN respondents from the sample. While our community partner, UITCT, had found it useful to understand non-AI/AN perceptions of AI/AN needs, the primary contribution of this study is in terms of the perceived needs of the AI/AN community itself.

NEEDS ASSESSMENT RESULTS

The majority of AI/AN respondents identified as female (66.8%). The mean age of respondents was 47 years of age. Most participants had some college or had completed college (71%). The majority of the sample had an income under \$35,000 (56.8%), with a significant

percent under \$15,000 (23.6%). Most of the respondents had part-time or full-time employment (64.7%).

Table 2
Demographic Information

	<i>N</i>	<i>f (n)</i>	<i>%</i>	<i>M</i>	<i>SD</i>	<i>Min/Max</i>
Age	268			47.39	14.24	19 / 92
Gender	270					
Male		85	31.50%			
Female		185	68.50%			
Education	266					
Neither high school diploma, nor GED (1)		16	6.00%			
GED (2)		19	7.10%			
High school diploma (3)		42	15.80%			
Some college/Associate degree (4)		120	45.10%			
College degree or higher (5)		69	25.90%			
Income	259					
\$ 0 - 14,999		61	23.60%			
\$15,000 - 34,999		86	33.20%			
\$35,000 and above		112	43.20%			
Employment Status	261					
Employed FT 35+ hrs/wk (1)		135	51.70%			
Employed PT (2)		34	13.00%			
Unemployed (FT student) (3)		10	3.80%			
Other ** (4)		82	31.40%			

Self-reported health was a part of the assessment survey. The majority of the respondents rated their health as excellent or very good (59%).

Table 3
Self-Reported Health

	<i>N</i>	<i>f (n)</i>	<i>%</i>
Self-Reported Health Rating	266		
Excellent (1)		56	15.10%
Very Good (2)		174	46.80%
Fair (3)		126	33.90%
Poor (4)		16	4.30%

In the area of mental health and substance abuse, adult substance abuse treatment was the greatest need ($M = 3.45$), followed by adult mental health treatment ($M = 3.44$). Youth substance abuse treatment ($M = 3.39$) and youth mental health services ($M = 3.36$) were also seen as important needs.

Table 4
Mental Health/Substance Abuse

Mental Health/Substance Abuse	No need: %	Low need: %	Moderate need: %	Critical need: %	M	SD
YOUTH Mental Health Services	6.5%	7.2%	30.0%	56.3%	3.36	0.88
ADULT Mental Health Services	4.5%	5.3%	32.3%	57.9%	3.44	0.79
YOUTH SA Treatment	8.3%	6.8%	22.3%	62.5%	3.39	0.94
ADULT SA Treatment	6.4%	5.7%	24.9%	63.0%	3.45	0.86
YOUTH Sober Living Alt. Housing	6.8%	12.9%	33.8%	46.4%	3.20	0.91
ADULT Sober Living Alt. Housing	6.1%	10.2%	31.1%	52.7%	3.30	0.88

The social service areas were divided into social service 1, representing AI/AN-specific type services, and social service 2, representing tangible needs. In the social service 1 grouping, after-school programs for AI/AN children and youth was found to be the greatest need ($M = 3.39$), followed by AI/AN-specific childcare ($M = 3.32$). Domestic violence shelters specific to AI/AN women was also seen as a critical need ($M = 3.31$).

In the social service 2 category, employment was ranked as highest need ($M = 3.55$), followed by affordable housing ($M = 3.5$). Financial assistance was also a stated need for both rental assistance ($M = 3.43$) and food assistance ($M = 3.45$).

In addition to social services, there were two questions on cultural activities. Availability of cultural activities ($M=3.36$) was rated most highly.

Table 5
Social Services and Cultural Activities

	No need: %	Low need: %	Moderate need: %	Critical need: %	M	SD
Social Service 1						
Domestic violence Shelter	6.1%	11.8%	27.0%	55.1%	3.31	0.90
Child Care	6.4%	8.3%	31.7%	53.6%	3.32	0.88
After School Prog. for Child/Youth	4.1%	9.4%	29.7%	56.8%	3.39	0.82
Parenting Classes	5.6%	13.5%	30.8%	50.0%	3.25	0.89

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Table 5 Continued
Social Services and Cultural Activities

	No need: %	Low need: %	Moderate need: %	Critical need: %	<i>M</i>	<i>SD</i>
Social Service 2						
Employment	3.4%	6.3%	22.0%	68.3%	3.55	0.76
Transportation	4.5%	8.3%	35.0%	52.3%	3.35	0.82
Affordable Housing	3.8%	6.8%	25.6%	63.9%	3.50	0.78
Rent Assistance	3.7%	6.7%	32.6%	56.9%	3.43	0.78
Food Assistance	3.0%	6.4%	33.3%	57.3%	3.45	0.75
Cultural Activities						
Availability to rec. activities	3.0%	16.3%	38.3%	42.4%	3.20	0.82
Availability to cultural events	3.4%	12.8%	27.9%	55.8%	3.36	0.83

The needs assessment also included some access to health and medical care questions. Access to health insurance ($M = 3.63$), medications ($M = 3.58$), and eye care ($M = 3.58$) were ranked as critical need areas. Specialized medical care was also ranked high ($M = 3.54$), as was access to eye glasses ($M = 3.54$).

Table 6
Health Care

Health Care	No need: %	Low need: %	Moderate need: %	Critical need: %	<i>M</i>	<i>SD</i>
Access Specialist – Medical reasons	2.3%	7.1%	24.8%	65.8%	3.54	0.73
Access to Eye Care	1.5%	5.2%	26.6%	66.7%	3.58	0.66
Access to Eye Glasses	1.9%	6.4%	25.5%	66.3%	3.56	0.70
Access to Medications	1.9%	5.2%	25.9%	67.0%	3.58	0.68
Access to Birth Control	6.3%	8.2%	23.9%	61.6%	3.41	0.89
Access to Health Insurance	2.6%	5.6%	18.4%	73.4%	3.63	0.71

DISCUSSION

Our study responded to a lack of prior needs assessments conducted in the urban AI community in North Texas. However, a review of the literature reveals that this lack of data is indicative of a broader paucity of urban AI/AN needs assessments. Recent studies conducted in Chicago, IL and Tulsa, OK provide a basis for comparison based on demographics, proximity to tribal communities, and state and regional context, but more work is needed (Johnson et al., 2010; West et al., 2012). The broader scholarship on AI/AN health and social services also

provides a context in which to situate the perceived needs of urban AI/AN communities like the one in the Dallas-Fort Worth area. Key themes emerging in the current literature include: Health Needs (especially substance abuse and diabetes), Cultural Competency, Social Service Needs and Community Awareness, and Cultural Programming. These themes in the scholarly literature were reflected in focus groups conducted to develop the needs assessment survey tool and provide context for considering the implications of the results of our study.

Overall, the results suggest that the urban AI community in the Dallas-Fort Worth area has similarities to other urban AI/AN populations. For example, the study found that there was a critical need for mental health and substance abuse treatment programs, childcare, domestic violence shelters, and employment assistance. These findings fit with studies of urban AI/AN communities elsewhere discussed in the literature. Yet, the needs assessment also suggested certain needs shaped by the local and state context that warrant further discussion and point to the need to further research the unique circumstances of urban AI/AN communities around the country. The broader implications of our findings for key themes in the scholarly literature are discussed below.

Health Needs

The physical and psychological needs of AI/AN community members and how these relate to their overall health is a key theme in the existing literature. Substance abuse treatment and prevention has been identified as a major need especially among AI/AN youth (Dickerson & Johnson, 2011; Johnson et al., 2010; Lowe et al., 2016). Cultural interventions that utilize traditional healing practices combined with evidence-based treatments have been found to be effective treatment approaches to help treat substance abuse and address this need in AI/AN communities (Dickerson & Johnson, 2011; Lowe et al., 2016). Diabetes prevention and treatment have also been found to be a major need in these communities (Johnson et al., 2010; Parker et al., 2011). Community members believe diabetes prevention can be addressed by allowing elders, tribal leaders, and everyday people to educate the youth and the community about diabetes and diabetes treatment (Parker et al., 2011). However, community members might encounter barriers that prevent them from attaining behavioral change, such as conflicting priorities (e.g., difficulty in scheduling appointments because of school, work, and home demands), lack of support (e.g., lack of childcare to attend educational programs), or the cost and availability of healthy foods that might prevent them from improving their diets (Parker et al., 2011). When addressing health needs

in AI/AN communities, health professionals must be aware of the challenges created by a lack of cultural awareness because these may influence community members from bringing about the desired change.

The fact that only 59% of AI/AN respondents in our study rated their health as good or excellent suggests that health disparities evident in other AI/AN populations are also reflected in North Texas. Yet other reported health care needs may reflect the unique concerns of urban AI/AN communities, and more specifically, the urban AI population in the Dallas-Fort Worth area. While more data on other urban AI/AN communities is needed to make direct comparisons, it is striking that the health care area rated as the most critical need by our respondents was access to health insurance. This was not the case, for example, in a recent study in Tulsa, OK (Johnson et al., 2010). This issue is likely exacerbated by two characteristics of the location of this urban AI population. First, as of 2016, Texas had both the highest total number and highest percentage of residents who are uninsured, in part because Texas elected not to expand its population eligible for Medicaid after the implementation of the Affordable Care Act in 2010. States that did elect to expand coverage have seen the largest drop in their uninsured population according to census data (Buettgens et al, 2018). Secondly, while members of federally recognized tribes may obtain health care without private insurance at Indian Health Service, Tribal, or Urban Indian Health Program facilities, such facilities are underfunded and limited in the services they offer, and there is only one such facility in the Dallas-Fort Worth area, the UITCT (IHS, n.d.b). Three other tribal health facilities in Texas serving members of federally recognized tribes are significantly distant from Dallas: Alabama-Coushatta Health Center (approximately 3.5-hour drive), Eagle Pass Kickapoo Health Center (approximately 7 hours), and Ysleta Del Sur Pueblo Health Station (approximately 9 hours).

The combination of limited access to health insurance and limited AI/AN-specific health care services in Texas may help to explain other health care access issues rated as especially critical areas of need: Access to Medications, Access to Specialists, and Access to Eye Care. In focus groups sessions, community members noted that they often travel to tribal facilities in Oklahoma to receive such care. A recent arrangement made between UITCT and Choctaw Nation facilities in Durant, OK may facilitate access to specialized care, yet this still requires travel of three hours or more roundtrip (UITCT, 2018).

Social Service Needs/Community Awareness

Our findings support existing research that shows that while AI/AN communities vary significantly from each other, as a whole unemployment, substance abuse, mental health concerns, and violence against women, including domestic violence, remain significant concerns across the larger AI/AN population. At times, it is not a lack of services to address these needs that is a challenge for the AI/AN community, but rather a lack of awareness about the services that are offered (Dennis & Momper, 2016). Suggestions have been made about how this can come about; some suggest that health information be disseminated through the stories and teachings of elders and tribal leaders who are considered the most respected and honored members of AI/AN communities (Parker et al., 2011). Others have proposed the use of printed material, television, and culturally appropriate media (e.g., *Chickasaw Times*) to reach the community and make them aware of these services (Parker et al., 2011). Other important factors to consider in the marketing of services is the location and hours of operation of service providers. Conflicting schedules and lack of transportation have been listed as some of the challenges associated with seeking out services (Dennis & Momper, 2016; Parker et al., 2011). Communities have identified a need for weekend/evening hours, family programs, and/or easily accessible locations (Dennis & Momper, 2016; Parker et al., 2011). Optimal locations could be “community places, Chickasaw Nation program sites, and programs in schools for children” (Parker et al., p.59). These findings from prior studies show that it is not enough to offer needed services; the community must be made aware that these services exist and must make efforts to improve access to them.

While our results largely support findings in the literature, characteristics of the Dallas-Fort Worth metropolitan area nonetheless are evident. For example, while employment opportunities were rated the most critical social service need for the AI/AN community, affordable housing ranked second. This is unsurprising given the significant rise in rent and home sales prices in North Texas in recent years. A 2017 study found Dallas-Fort Worth to be ranked #5 (tied with two California metro areas) on a list of Metropolitan areas with the lowest availability of affordable rental homes (Aurand et al., 2017). Home sale prices suggest that home ownership is similarly out of reach for many, as sales prices between 2014 and 2017 rose by 33% (Dickson, 2018).

Similarly, the fact that culturally specific after school programming for children and youth was identified as an area of moderate or critical need by respondents may be influenced by the nature of this metro area. While two school districts in Dallas and Fort Worth have programs for AI students, the dispersal of the AI/AN population across these major cities and suburbs may limit

access to AI/AN-specific school programming and counseling (Dallas Independent School District, 2019; Fort Worth Independent School District, 2019). At focus groups, several community members were particularly concerned about the lack of guidance counseling for AI students about resources specific to these students for funding college education.

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Cultural Programming

Compared to many of the social service and health needs assessed, availability of AI/AN cultural activities was ranked as a less critical need in our study. This is somewhat surprising, given that past studies have indicated significant community concerns about AI/AN youth's diminishing interest in engaging in traditional activities and cultural practices (Johnson et al., 2011). Members of the AI/AN community experience great pride from their tribal identity, and they want to make sure this is reinforced with AI/AN youth (Basto et al., 2012). AI/AN youth are sometimes raised by adoptive or foster parents who are not from the same culture and cannot appropriately teach and explain AI traditions and cultural values (Dennis & Momper, 2016). Therefore, the literature demonstrates a need for "cultural programming," where youth can engage in cultural activities and learn about their tribal culture and traditions (Dickerson & Johnson, 2011; Johnson et al., 2011). AI/AN people's fears that their youth may be losing their cultural pride are an important need that must be addressed, so that their cultures can be preserved and do not disappear as a result of historical oppression and discrimination. In sum, there is a protective factor for youth in cultural programming revealed in the current literature.

Our results suggest that AI/AN cultural activities are perceived as a less critical need in North Texas. This may in part be related to the existing vibrancy of events organized by community leaders, including American Indian Heritage Day, two major Powwows, a crafts fair, radio programming, active American Indian Students Associations at area universities including

Texas Christian University and UT-Arlington, and religious organizations (Native American Student Association, n.d.; Schrader, 2015). The availability of such cultural offerings in part reflects the distance of the Dallas area from reservation communities. Because there was not existing readily accessible cultural programming within the metropolitan area, urban AI leaders established their own events and organizations to provide access locally.

Transportation Challenges

A final theme identified in the scholarly literature and evaluated in our needs assessment survey is the issue of transportation. Transportation has been identified as a major need in AI/AN communities (Dennis & Momper, 2016; Johnson et al., 2010; Parker et al., 2011). Lack of public or reliable transportation has made it difficult for individuals to attend appointments and seek services (Dennis & Momper, 2016), especially because a large percentage of AI/ANs experience poverty, unemployment, and earn less than \$20,000 a year, which limits their ability to pay for things like gas and car repairs (Johnson et al., 2010). A more central location for agencies providing AI/AN-specific services or multiple locations may be one way to help address this need (Dennis & Momper, 2016). If improved transportation is not possible, extended or evening hours might help reduce some of the challenges associated with transportation, mainly challenges associated with travel time (Dennis & Momper, 2016; Parker et al., 2011). Interventions aimed at addressing the transportation need in AI communities must explore the possibilities of implementing better public transportation or selecting locations where travel (if any) will be minimal.

Somewhat surprisingly, transportation was not rated as highly as some other areas as a critical need facing the AI/AN community in North Texas. Some communities in the Dallas-Fort Worth metropolitan area lack public transportation entirely, which raises questions about why respondents would not have rated this as a more critical area of need (Limón, 2019). This may in part reflect certain limitations of our study, as community leaders and more affluent community members may have been overrepresented in the sample of respondents. Yet it may also reflect the efforts of the Urban Intertribal Center and tribal partners, such as the Choctaw Nation of Oklahoma, to ensure that community members have transportation options to access specialized health care in particular (UITCT, 2018).

CONCLUSION

A major change effort requires strong and trusting relationships—within the organization and with external partners. When there has been a challenging history between people or organizations, only time and demonstrating a different behavior will rebuild the trust. This cannot be rushed. This project demonstrated a process enabling the building of a trusting relationship among a university, urban inter-tribal center, and community.

The community-based participatory research design proved to be successful in the development and implementation of a culturally appropriate needs assessment. Involvement of multiple stakeholders led to a robust discussion of the AI/AN mental health, health, substance abuse, and other needs in an urban environment. Participants were engaged at every stage of the research process, which directed community engagement resulting in a successful project. It will be important for other urban communities to replicate this process to build on culturally relevant knowledge gained.

Overall, this research points to the need for further study of the needs of urban AI/AN communities in other metropolitan contexts. A growing body of research indicates that AI/AN populations demonstrate some similar challenges related to health and social services needs due to shared histories of colonization and misguided or underfunded government programs, among other factors. Yet, it remains true that AI/AN communities nonetheless are each distinctive and face unique challenges and opportunities within the local, state, and regional contexts in which they reside. The reported needs of the AI community in North Texas are illustrative, as the areas of most critical need reflect challenges facing the Dallas-Fort Worth metro area and the state of Texas at large.

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CONFLICT OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

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