Qualitative Needs Assessments

of Urban Indian Health Programs and Behavioral Health Providers Serving AI/AN Populations Pre- & Mid-COVID-19

National American Indian and Alaska Native
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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Preliminary Report

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SAMHSA
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Preface

This project started before the world changed due to the outbreak of COVID-19. The mission of our National American Indian and Alaska Native Mental Health Technology Transfer Center (National AI/AN MHTTC) is to meet the needs for training and technical assistance expressed by Native mental health providers. In order for us to meet those needs, we regularly conduct formal needs assessments and key stakeholder interviews. The development of our formal needs assessments always start with provider input and collaboration to make sure we ask questions behavioral health providers serving Native clients deem important to address. Our overriding model for working with the urban and tribal Native communities is community-based participatory research and programming (CBPRP). Using this framework, we can focus both on the strengths and resources as well as the challenges expressed by the Native workforce serving clients with mental and behavioral health disorders and their communities.

Native communities are very diverse both culturally and in the kind of services being provided. Accordingly, we decided to study the needs for workforce development in urban and tribal communities separately. This report focuses on the needs of the behavioral health workforce serving Native Americans in urban setting. We chose to do extensive key stakeholder interviews in order to initiate specific projects based on the needs expressed. We collaborated with the Indian Health Service (IHS) and received support from the Office of Tribal Affairs and Policy (OTAP) within the Substance Abuse and Mental Health Services Administration (SAMHSA) in our efforts.

When the COVID-19 pandemic struck, we decided to complete the first round of data collection earlier than planned, and begin to analyze the results. Due to the change in circumstances, we had to redirect our attention from the study and focus on the immediate need of our Native providers and communities. Staff in our center spent a lot of time discussing how to approach the situation internally, and we reached out to our advisory council members for advice and suggestions. After a lot of deliberation, staff and I decided that the only way we would know how to support tribal and urban Native communities in this extreme situation was to listen to their needs. We initiated eight different weekly listening sessions, covering the communities represented by each of our programs, in addition to multiple formal needs assessment like the one described in this report. Our collaborators all over the country, members of our advisory council, and staff in our center were all actively involved in these sessions. We deemed this situation to be a “war-time effort,” to do whatever we could to support our colleagues and friends from tribes across the country. It took a lot of daily planning from our homes, and many of us had to get out of our comfort-zones to accomplish this. I am eternally grateful for all the efforts and support we received during this very stressful time both for us all personally and also for our Native colleagues.

Our listening sessions taught us a great deal about the needs in the tribal behavioral health workforce, and we actively worked to provide resources and suggestions. However, we also determined that this was the time to go back to our Native colleagues in urban areas and do a second needs assessment through key stakeholder interviews. The goal for this second round of interviews was to make sure we understood how the workforce development needs might have changed from the year before due to the pandemic. Our second goal was also to change our training and technical assistance plans to meet the needs of the behavioral health workforce during and after COVID-19.

This preliminary report includes two data-points. The first was conducted prior to the start COVID-19 with key stakeholders providing behavioral health services to Native populations in a variety of contexts *(Part 1)*. The second round of interviews was conducted in the midst of COVID-19 with a subset of the participants from *Part 1*, specifically, key stakeholders from Urban Indian Health Programs *(Part 2)*. You will be able to read about changes we have observed regarding the needs of these programs as a result of COVID-19, and better understand the mental and behavioral health workforce and the services available for Native individuals.

Finally, I want to prepare you for a second and third report based on our listening sessions that will be coming sometime in 2021. The COVID-19 pandemic has really revealed the strength and resourcefulness of the Native behavioral health workforce. These reports will also show us where and how we need to increase the support for the Native behavioral health workforce for the future.

Anne Helene Skinstad, PhD

Clinical Professor, Department of Community & Behavioral Health, College of Public Health, University of Iowa; Program Director, National American Indian & Alaska Native Mental Health Technology Transfer Center

Acknowledgments

Many colleagues have contributed to the development of this report, and we are very grateful for their direction, support, and encouragement. I would first and foremost like to thank Noah Segal, MPH, for taking the lead in writing this report and for Megan Dotson, BA, Manager of the National American Indian and Alaska Native Mental Health TTC, for keeping us all on track and organizing this study; Sean A. Bear, 1st, BA, Meskwaki Nation, Co-Director; and Ray Daw, MA, Navajo Nation, for providing culturally based suggestions to the development of the interview guide; and Kate F. Thrams for formatting and designing this report. We could also never complete a report like this without students, and I would like to acknowledge Julia Bollwitt, MA student for providing literature reviews in preparation for this report, and Christian Cota, MHA student for his significant contributions to this document.

Our outside evaluation team consisting of Professor Clyde McCoy, Ph.D. Eastern Band of the Cherokee nation and Director of the Comprehensive Drug Research Center and Health Services Research, Department of Epidemiology and Public Health. University Of Miami School Of Medicine, has provided valuable directions to the development and implementation of the study, as well as Shikha Puri, MD, who provided clerical support. I would also like to thank Korrine C. Rodrigue, for conducting most of the interviews of UIH providers across the country, and Jeanene Bengoa for her qualitative analysis of the interviews.

In preparation of this study we worked in collaboration with Indian Health Service Headquarters and I would like to especially acknowledge the important support we received from Rose Weahkee, Ph.D. Director of Urban Indian Health, Navajo Nation, on our data collection efforts, Capt. Andrew Hunt, MSW, LICSW Lumbee, Associate Director of Division of Behavioral Health IHS Headquarters for his valuable advice and feedback on the interview guide and finally Acting Director Division of Behavioral Health IHS, Tamara James, PhD, for important suggestions to the sampling plan.

I also would like to thank our Program Officer Humberto Carvalho, MPH, Substance Abuse and Mental Health Services Administration (SAMHSA), for his unwavering support of our initiatives; and Alec Thundercloud, MD, Member of the Menominee Nation, Director of the Office of Tribal Affairs and Policies (OTAP) for encouragements and suggestions for collaborations.

Anne Helene Skinstad, PhD

We would like to take this time to acknowledge the land and pay respect to the Indigenous Nations whose homelands were forcibly taken and inhabited.

Past and present, we want to honor the land itself and the people who have stewarded it throughout generations.

This calls us to commit to forever learn how to be better stewards of these lands that we now inhabit.

We acknowledge the painful history of genocide and forced occupation of their territories, and we respect the many diverse Indigenous people connected to this land on which we gather from time immemorial.

While injustices are still being committed against Indigenous people on Turtle Island, today we say thank you to those that stand with Indigenous peoples and acknowledge that land reparations must be made to allow healing for our Indigenous peoples and to mother earth, herself.

Dekibaota, Elleh Driscoll, Meskwaki and Winnebago Nations

Ttaki-mawekwe, Keely Driscoll, Meskwaki and Winnebago Nations

Ke-o-Kuk, Sean A. Bear, 1st. Meskwaki Nation

Introduction

Over the last few decades, there has been major progress in improving the physical and mental health outcomes of American Indian and Alaska Native (AI/AN) populations. Mortality data collected by the National Center for Health Statistics (NCHS) show that AI/AN populations have seen reductions in death from heart disease, respiratory illness, diabetes, and unintentional injuries between 2000 and 2018 (2021). Findings from the same report also show that there has been more than a 50% reduction in rates of teen pregnancy among AI/AN populations from 2008 to 2018 (NCHS, 2021). These changes can be at least partially attributed to national improvements in public health and medical services as well as efforts from AI/AN-specific health organizations like the Indian Health Service, in addition to community and tribal health initiatives (Sequist, Cullen, & Acton, 2011).

Though AI/AN individuals have seen some improvements related to physical health, other outcomes - particularly mental and behavioral health – remain lacking for Native populations. According to the 2016 National Survey on Drug Use and Health (NSDUH), the proportion of AI/AN aged 18 and older reporting using alcohol in the last month (61.2%) and last year (37.2%) was lower than that of the national average, 69.2% and 55% respectively (SAMHSA, 2018). Despite this, the number of AI/AN individuals aged 18 and older reporting having an alcohol use disorder in the past year (9.8%) was higher as compared to 6% in the national average (SAMHSA, 2018). Similar disparities exist for other behavioral and mental health disorders.

Additionally, rates of serious psychological distress and suicide have worsened in recent years. In this population, reported rates of serious psychological distress in the past 30 days have increased from 7.8% in 1997-98 to 9.2% in 2015-16, and age-adjusted rates of suicide have also increased from 10.4 per 100,000 in 2000 to 14.2 per 100,000; these rates are higher than any other racial or ethnic group and are historic highs for the AI/AN population (NCHS, 2018; NCHS, 2021). Though there have been noticeable health improvements among Native populations, these advances often lag behind those of other racial groups leading to widening disparities. These concerning trends will likely worsen as a result of the COVID-19 pandemic, in which Native populations are exhibiting higher rates of mortality and likelihood of contracting the virus compared to the general population (Hatcher, Agnew-Brune, Anderson, Zambrano, & et al., 2020).

American Indian and Alaska Native (AI/AN) populations have historically exhibited greater rates of mental, physical, and socioeconomic factors that are detrimental to their health (Sarche & Spicer, 2008). However, as a result of several treaties and legislation over the past century, AI/AN populations are one of the only groups in the United States guaranteed a right to healthcare (Warne & Frizzell, 2014). As such, the Indian Health Services (IHS), and subsequently the Office of Urban Indian Health Programs (UIHPs), was created to ensure Native populations had access to quality and culturally appropriate mental, behavioral, and physical healthcare.

1920 to 2020: Impact of Pandemics on Native Communities

The 1918 influenza pandemic – also known as the Spanish Flu – killed millions of individuals (including thousands of Americans) and remains the worst pandemic the world has seen in recent history. According to government reports from 1919 and 1920, the impacts of the Spanish Flu on American Indian/Alaska Native (AI/AN) populations were far more severe than larger U.S. cities. Specifically, AI/AN communities exhibited mortality rates 4 times higher than the general population (Groom et al., 2009). The higher mortality can likely be attributed to the intensified exposure to the flu virus in isolated tribal communities, often which had crowded housing and inadequate access to medical care.

Over 100 years later, the COVID-19 pandemic is disproportionately impacting AI/AN communities in strikingly similar ways: limited access to healthcare services (including mental health), overcrowded and multigenerational housing, high rates of poverty, and higher susceptibility to chronic disease (Sarche, 2008). Addressing trauma and inequities experienced by AI/AN communities is imperative to ensure the safety of AI/AN populations. The pre-existing social determinants of health have manifested within AI/AN families and have historically exhibited characteristics of generational trauma (Sarche, 2008). Furthermore, these disadvantages are exacerbated by the COVID-19 pandemic and continue to widen the gap for AI/AN populations– particularly the accessibility of mental and behavioral health services.

According to data collected through the Office of Personnel Management, over 90% of IHS staff (all positions) are American Indian or Alaska Native (2020). This is in comparison to the behavioral health workforce more broadly, in which AI/ANs are underrepresented. Even though AI/ANs make up roughly 1.7% of the total population, in 2015 only 0.8% of counselors and social workers, and 0.2% of psychologists identified as Native (National Center for Workforce Analysis, 2017). Compounding the fact that AI/ANs are severely underrepresented in the behavioral health field, behavioral health staff have an extremely high turnover rate, around 30% annually, compared to other professions with already established high annual turnover rates such as physicians (7%) and teachers (8%) (Brabson, Harris, Lindhiem, & Herschell, 2020). These rates were likely increased because of COVID-19 due to job/funding loss, illness, and other psychosocial impacts of the pandemic. The presence of on-going mental and behavioral health disparities within AI/AN populations, as well as the challenges faced by the behavioral health staff serving the population, reinforce the importance of culturally appropriate behavioral health programs and assessments of said programs.

There is currently a paucity of research related to the needs of the behavioral health workforce serving Native communities. This research is critical to understanding how behavioral health professionals are addressing the unique needs of AI/AN populations. Furthermore, assessments, such as the ones conducted for this study, are important for the targeted and strategic allocation of resources, funding, training, and technical assistance. Justification for this study came out of the identified lack of research about the behavioral health workforce serving Native populations, and feedback from professionals who have participated in Listening Sessions and activities hosted by the AI/AN Mental Health Technology Transfer Center (MHTTC).

Study Aims and Design

Over a multi-phase qualitative study consisting of confidential interviews and focus groups with behavioral health providers serving Native populations and Urban Indian Health Program (UIHP) staff, information was gathered on staff perceptions of behavioral health service delivery and access. The study includes 7 stages: (1) qualitative analysis and evaluation of the results of the initial Needs Assessment *(Part 1)* data; (2) present the findings to interviewees for additional feedback; (3) develop a new Needs Assessment given the disruptions from COVID-19; (4) establish a sampling methodology to effectively compare pre-and mid-COVID conditions; (5) conduct a new set of Needs Assessment interviews tailored to COVID-19 *(Part 2)*; (6) analyze the new interview data, and (7) compare pre-and mid-COVID interviewee responses for UIHP respondents (Part 3). Stages 1-6 have been completed and are described in this report, while stage 7 is still in progress.

The goals of this report are to describe the needs of behavioral health providers serving AI/AN populations identified before the start of the COVID-19 pandemic and detail the impacts of COVID-19 on the UIHP workforce and services. These findings can be used to direct resources, guide decision-making, and provide support for UIHPs to effectively meet the needs of those they serve - during and following the COVID-19 pandemic. This publication includes the findings from two separate Needs Assessments conducted with behavioral health providers and UIHPs supporting Native individuals to identify needs and existing assets related to behavioral health treatment and resources. This will be the first published work that analyzes the needs of behavioral health-specific needs of providers and UIHPs serving Native communities immediately before and during the COVID-19 pandemic.

About Urban Indian Health Programs

Urban Indian Health Programs (UIHPs) are private, non-profit organizations that provide Urban AI/AN communities and their service areas with a variety of health and social services ranging from outreach and referral to outpatient and/or ambulatory care. They are partially funded under Subtitle IV of the Indian Health Care Improvement Act and receive limited grants/contracts from the Indian Health Service (UIHI, 2020). UIHPs provide traditional Native and Western healthcare services in culturally competent healthcare facilities. These programs are imperative to the Urban Indian population, as they often lack family and traditional cultural environments, intensifying pre-existing mental and physical austerities. There are currently 41 UIHP programs across nineteen states. These programs serve an estimated 150,000 Native individuals living in approximately 100 urban counties, in which over 1 million AI/ANs reside (UIHI, 2020). Eighteen additional cities have been identified with Urban Indian populations large enough to support a UIHP (Indian Health Service, n.d.). Approximately 25% of the roughly 3 million AI/AN individuals in the nation live in areas served by UIHPs (Indian Health Service, n.d.).

About the National American Indian & Alaska Native Mental Health Technology Transfer Center

The National American Indian and Alaska Native Mental Health Technology Transfer Center (AI/AN MHTTC) has partnered with the University of Miami's Comprehensive Drug Research Center (CDRC) on conducting a comprehensive, national Needs Assessment on behavioral health providers serving urban AI/AN populations. The National American Indian and Alaska Native Mental Health Technology Transfer Center is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the Technology Tranfer Centers (TTCs) is to develop and strengthen the specialized behavioral and primary healthcare workforce that provides prevention, treatment, and recovery support services for substance use disorder (SUD) and mental illness.

Methods

Researchers from the National American Indian & Alaska Native Mental Health Technology Transfer Center (AI/AN MHTTC) and the Comprehensive Drug Research Center conducted a qualitative Needs Assessment of Urban Indian Health Programs (UIHPs). The goal of this study was to listen to the needs of behavioral health workers and leaders who are providing a wide variety of services to Native populations. The Needs Assessment was originally planned to take place from February 2019- July 2020, however, due to the onset of the COVID-19 pandemic, in February 2020, a second research plan was developed to capture the changes in circumstances and needs of UIHPs. This resulted in the creation and administration of two Needs Assessment interview protocols: one before the onset of the COVID-19 pandemic (Feb 2019-Feb 2020), and one during the pandemic (Aug 2020-Sep 2020). Both interview scripts were vetted over three months by a diverse team including Native staff, behavioral health professionals, staff from the Indian Health Service (IHS), and the evaluation team. Following the data collection, researchers conducted a conventional content analysis to identify themes, patterns, and topic frequencies mentioned in the interviews.

Pre-COVID (Part 1)

Before the development of the research questions and interview script, the research team conducted a comprehensive review of existing research related to the behavioral health disparities faced by Native populations. The team used this research, as well as existing project goals, objectives, and outcomes, to create a framework for the research questions. As such, an eleven-question interview script was developed to cover the following domains: educational challenges/opportunities for staff, internal workforce development, technical assistance, evidence/experience/Tribal based knowledge-based practices, agency characteristics, and outreach and prevention initiatives. More specifically, these confidential interviews focused on 1) staff perceptions of delivery and barriers to service, 2) specific clinical training needs, 3) availability of tribal mental health programs and 4) views on leadership and mentoring.

Potential participant contacts were gathered from an established MHTTC distribution listserv and via recommendations from national partners. The evaluation team was also provided a list of 41 UIHPs located throughout the United States. Researchers emailed the possible contributors to request participation in the Needs Assessment via in-person interviews, telephone, and conferences . Most individuals were emailed two to three times to request participation. Follow-up phone calls were conducted to those individuals where a telephone number was provided. Additionally, attendees of national AI/AN MHTTC meetings were recruited for participation during the event. The resulting sample included a total of 70 participants contacted through the MHTTC listserv, the UIHPs, and meeting attendees. Inclusion criteria were volunteers over 18 years of age serving Native clients with behavioral health disorders.

Each interview was conducted over an approximately 60-minute period. Most participants were interviewed over the phone (N=35) while some were interviewed in person (N=9) using a pen and paper format with no tape recording. Researchers also used the same interview script for four focus groups (N=26) of 5, 10, 6 & 5 respectively. All participants were assured of confidentiality and that no names or identifying information would be tied to the interview report. All participants were explained the purpose of the interview/focus group and assured that they would be provided with a copy of the final report from the study.

In line with Community-Based Participatory Research methodology, participants were invited to a presentation of results after all the interview/focus group transcripts had been analyzed. Participants were recontacted via email and given information about the presentation. Researchers used a virtual poster through Zoom to present the findings and welcomed any feedback from participants. This presentation took place on July 1st, 2020.

Mid-COVID (Part 2)

In response to the onset of the COVID-19 pandemic, researchers concluded data collection of the pre-COVID *(Part 1)* component and adapted the study design to reflect the new situation. A new nine-question survey was developed based on; research related to the impact of COVID-19 in health care settings serving Native populations, findings from the pre-COVID Needs Assessment, and information gathered from prior assessments and listening sessions with behavioral health professionals serving Native populations. The survey questions were vetted over four months between Native staff, UIHB, IHS, MHTTC staff, and the evaluation team. Researchers randomly selected half of the participants from a list of UIHPs that had previously participated in "pre-COVID." Twenty, approximately 60-minute one-on-one telephone interviews were conducted (August –September 2020). Inclusion criteria were the same as pre-COVID; volunteers over 18 years of age serving Native clients with behavioral health or substance use disorders. These confidential interviews focused on 1) staff perceptions of delivery and barriers to service, 2) how the COVID-19 pandemic has affected services, 3) availability of tribal mental health programs during the pandemic, and 4) what are the biggest needs and challenges during the pandemic.

A preliminary report of findings was shared with key stakeholders and interview participants from the Indian Health Service (IHS) in Feb – Mar of 2021. No corrections were mentioned.

Data Analysis

Handwritten notes were taken by the interviewer in real-time for both *Part 1* and *Part 2* of the study. These notes were dictated by the interviewer to create a verisimilitude transcript of the response. A member of the research team read through all transcripts and used an inductive approach to develop codes for the responses. The researcher separated each of the responses per question by coding the entirety of each response to a specific question. This created a complete running transcript of each question individually. During this process of coding by questions, themes, categories, and concepts that seemed to be recurring were all noted by the researcher on paper. The result of this notation resulted in an interconnected and somewhat hierarchical diagram, resembling mind map exercises. Categories tended to be grouped by the question but on many occasions, ideas were recurring or connected to more than one question/prompt.

As the transcripts were worked through, there were minimal attempts to combine codes. However, it was decided to create a logical hierarchy of codes, especially where some respondents gave specific responses, and others used more general terms. In these cases, the actual words of the respondent were coded individually and then aggregated to gather all the material in the individual-specific child nodes that then rolled it up to the more general parent node. By the end of the full read-through of an individual question, an organization scheme for most of the parent nodes was determined.

These "transcripts" were then used for a qualitative analysis using NVivo software. During the coding process, if there was a particularly illustrative wording for the prompt, it was coded as "Quote". These were then pulled later for report inclusion. For each code/node, a count was recorded if the participant mentioned that category at least once in response to that question. A total number of participants that mentioned the specific category code was then generated by using both NVivo and Excel.

For the one-on-one interviews, all questions were asked, but in the various focus groups, some questions were skipped in the interest of time. Therefore, the number of respondents asked the question was used as the denominator for each question's percentage. Using this method, the organizational counts were then converted into percentages. Also, Word Frequency queries were run on all responses per question in NVivo. The search was done on the top 100 words of three or more letters, combining the words of the same stem.

Participants

Individuals were invited to participate in the Pre-COVID Needs Assessment *(Part 1)* if they were over 18 years of age and were serving Native clients with behavioral health disorders. The resulting sample for *Part 1* included a total of 70 participants contacted through the MHTTC listserv, the UIHPs, and meeting attendees. Participation for *Part 2* of the study was limited to UIHPs key stakeholders who participated in interviews or focus groups for *Part 1*. Participant characteristics are listed on the following pages.

Part 1 (Pre-COVID) Demographics

Gender Identification

	Female	Male	Total
Count	43	18	60
Percent	70.49%	29.51%	100%

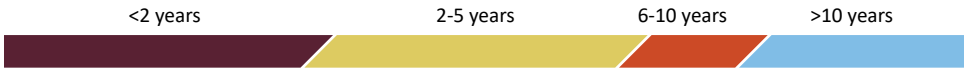
Table 1

Ethnic Heritage

	American Indian/Alaska Native	Asian/Pacific Islander	Black/African American	Caucasian	Hispanic or Latino American	Other	Total
Count	36	2	2	18	2	1	61
Percent	59.02%	3.28%	3.28%	29.51%	3.28%	1.64%	100%

Table 2

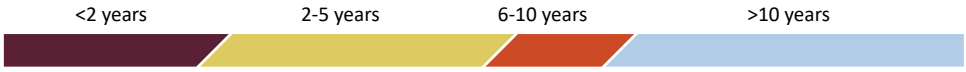
Time in Current Role



	<2 years	2-5 years	6-10 years	>10 years	Total
Count	18	18	7	13	56
Percent	32.14%	32.14%	12.50%	23.21%	100%

Table 3

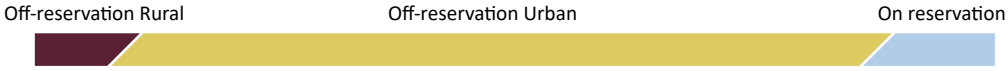
Time with Agency



	<2 years	2-5 years	6-10 years	>10 years	Total
Count	13	15	7	21	56
Percent	23.21%	26.79%	12.50%	37.50%	100%

Table 4

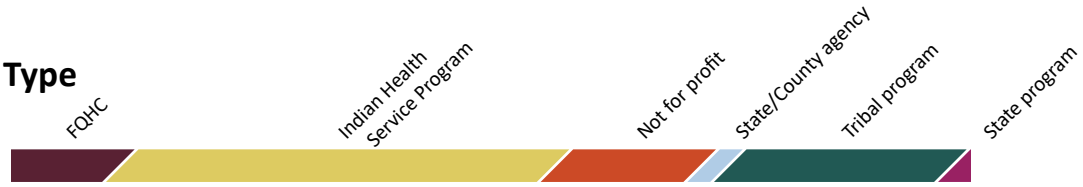
Program Location



	Off-reservation Rural	Off-reservation Urban	On reservation	Total
Count	5	44	7	56
Percent	8.93%	78.57%	12.50%	100%

Table 5

Program Type



	FQHC	Indian Health Service Program	Not for profit	State/County agency	Tribal program	State program	Total
Count	6	26	9	1	13	1	56
Percent	59.02%	3.28%	3.28%	29.51%	3.28%	1.64%	100%

Table 6

** Complete participant demographic data was not collected during all focus groups resulting in demographic totals less than Part 1 total participation (N=70).*

Part 2 (Mid-COVID) UIHP Demographics

Individual Characteristics (N=21)

All information below was combined to ensure each category had a minimum of 4 to prevent the identification of individuals. All designations in this first section below are attributed to individuals. There are twenty-one (N=21), as two individuals answered jointly for one UIHP.

Gender Identity	Count (N=21)	Percent of sample
Female	13	62%
Male	8	38%
Birth Year		
<1960	4	19%
1961-1970	10	48%
1971-1980	7	33%
Tribal Affiliation		
Enrolled with a tribe	13	62%
Time with Agency		
>6 years	13	62%
<=5 years	8	38%
Current Role/Job Title		
CEO	10	48%
Executive Director	5	24%
Other	6	29%
Time in Current Role		
<2 years	5	24%
>10 years	7	33%
2-10 years	9	43%

Table 7

Agency Characteristics (N=20)

Age/Gender Population Served	Count	% of participants
18+/Adults only	2	10%
All populations	18	90%
Ethnic Populations Served		
All Ethnic Populations	15	75%
Only persons of NA/AN heritage enrolled in a federally recognized tribe/nation	5	25%

Table 8

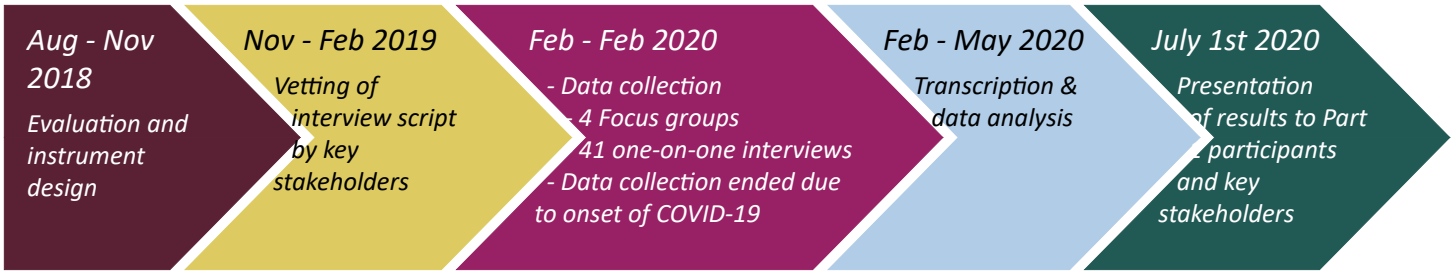
Part 1 and Part 2 Agency Location by IHS Region

IHS Region	*Part 1* count	% of participants	*Part 2* count	% of participants
Alaska	11	16%	0	0%
Albuquerque	3	4%	1	5%
Bemidji	13	19%	3	15%
Billings	4	6%	2	10%
California	11	16%	4	20%
Great Plains	9	13%	1	5%
Nashville	5	7%	2	10%
Navajo	1	1%	0	0%
Oklahoma	5	7%	2	10%
Phoenix	2	3%	2	10%
Portland	6	9%	1	5%
Tuscon	0	0%	1	5%
Grand Total	70	100%	20	100%

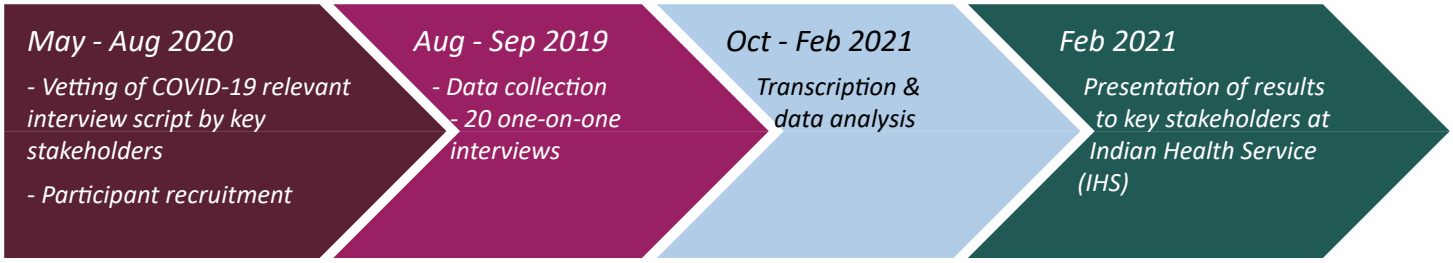
Table 9

Timeline

Part 1: **Pre-COVID**



Part 2: **Mid-COVID**



Results

Though the interviews conducted pre- and mid-COVID involved mainly open-ended questions, some of the questions implied Yes/No responses. Summary of the Yes/No responses collected during the pre-COVID interviews (Part 1) are shown below.

Question (N-67)	Yes	No	No Response
Has your staff been able to obtain proper licenses and/or certifications?	81%	19%	0%
Does your staff have access to educational webinars during working hours and continuing education?	84%	16%	0%
Would your staff benefit from leadership training or mentoring?	82%	9%	9%
Does your staff have specific training needs?	91%	9%	0%
a. Motivational Interviewing?	37%	25%	37%
b. Screening, Brief Intervention, and Referral to Treatment?	19%	43%	37%
c. Cognitive Behavioral Treatment?	39%	22%	39%
d. Motivational Incentives?	40%	16%	43%
e. Medication-Assisted Treatment?	51%	15%	34%
f. Specific Treatment approaches for mental health disorders (depression, PTSD, etc.)?	67%	9%	24%
Has your staff been provided cultural competency training and mental health issues among Natives?	76%	22%	1%
Do you currently utilize any culturally informed tribal mental health programs?	43%	49%	7%
Does your agency have access to Tribal TA and Training Needs?	70%	28%	1%
Are EBPs used for trauma, suicide, or other behavioral health needs?	88%	4%	7%
Are mental health services accessible to your clients?	84%	9%	7%
Are you involved in any outreach activities?	87%	1%	1%
a. Are you involved in any community education initiatives?	49%	0%	51%
b. Are you involved in any prevention activities?	57%	0%	43%

Table 10

Qualitative analysis was conducted on questions that elicited responses beyond "Yes" or "No". Certain topics/themes were mentioned when prompted by the different interview questions; however, just because an individual did not mention a topic/theme does not strictly imply the absence of the area in their organization. Furthermore, responses to questions described in the result section are NOT mutually exclusive as respondents may have touched on several topics/themes in response to the interview questions. Acknowledging this, an analysis of the mentioned items for pre- and mid-COVID interviews are still valuable for understanding the state of UIHPs and behavioral health providers serving Native populations. A comparison of the interview responses collected pre- and mid- still provide implications regarding changes resulting from COVID-19. Interview responses support key themes of this Needs Assessment as shown below in the form of five sections: Staff Development and Support (Pre-COVID), Staff Development and Support (Mid-COVID), Delivery of Behavioral Health Programs (Pre-COVID), Delivery of Mental Health Programs (Mid-COVID), and Use of Cultural Practices (Pre- and Mid-COVID). Results in this section highlight participant responses from interviews conducted pre-COVID with behavioral health providers serving Native populations and mid- COVID interviews with a subset of participants who were key stakeholders at UIHPs.

Staff Development and Support (Pre-COVID)

Pre-COVID questions primarily concentrated on career readiness. Response counts of the themes and topics related to continuing education access, training, and leadership development are highlighted in Table 11.

Pre-COVID, 84% (N=56) of respondents indicated that staff had access to continuing education material(s) and/or educational webinars during work hours, while 16% (N=11) indicated that they did not have access to this content during working hours. Respondents mentioned the various sources of continuing education available to the behavioral health professionals. As seen in the table below, there was significant variation and variety of the source of continuing education resources. IHS and SAMHSA were commonly noted as the source of these materials, with many also dependent on grants for this type of material:

Access to Educational Webinars & Continuing Education

N=46	Count	%
Indian Health Service (IHS)	31	67%
Substance Abuse and Mental Health Services Administration (SAMHSA)	22	48%
Webinars	22	48%
National	14	30%
Many Available	13	28%
Organizations	11	24%
Grants	10	22%
County	9	20%
University	9	20%
Local	8	17%
Conferences	6	13%

N=46	Count	%
Consultants	6	13%
Internal/In-House	6	13%
State	6	13%
Listserv	4	9%
ATTC	4	9%
Urban Indian Health	4	9%
Other	4	9%
Native Tribes	4	9%
Online	3	7%
Indian Health Boards	3	7%
City	2	4%
Suicide	2	4%

Table 11

82% (N=55) of respondents also indicated that their staff could benefit from leadership or mentoring opportunities, with 9% (N=6) indicating no need. Some interview respondents (N=23) also mentioned specific areas where they felt they needed the most professional support:

Areas for Improvement/Benefit: Leadership Training & Mentoring

N=23	Count	%
Program Management	14	61%
Staff Management	12	52%
Leadership	9	39%
Clinical Supervision	7	30%
Supervision	7	30%
Financial	6	26%
Grants	10	26%
Teamwork	6	26%
Grant Writing	5	22%
Mentoring	5	22%
Staff Roles & Responsibilities	5	22%

N=23	Count	%
Cultural Competency	4	17%
Grants Management	4	17%
Staff Development	4	17%
Internal	3	13%
Promotional Criteria	3	13%
Data Collection	2	9%
Native-Specific	2	9%
Quality Improvement	2	9%
Transition from Coworker to Supervisor	2	9%
Use of Technology	2	9%

Table 12

It is important to note the varying responses given in the table shown above. One common theme that is worth mentioning is the widely reported need for fundamental business and/or management skill-building opportunities, such as staff and program management, leadership skills, and finance fundamentals.

Staff Development and Support (Mid-COVID)

Whereas interview questions used in the pre-COVID Needs Assessment *(Part 1)*, focused on career readiness, interviews conducted with UIHPs mid-COVID *(Part 2)* had a focus on supporting staff during the pandemic. Mention frequencies of topics related to staff burnout, supporting staff, and staff reactions are described below. Responses highlight the prevalence of effective communication and other practices.

Addressing Burnout in the Workplace

N=20	Count	%
Mutual Staff Support	7	35%
Self-Care	3	15%
Traditional Practices	2	10%
Wellness Activities	2	10%
Cooking Classes	1	5%

Table 13

How Supervisors are Supporting Staff

N=20	Count	%
Effective Communication	6	30%
Days Off	5	25%
Working from Home	4	20%
Changing Processes	3	15%
Controlling/Minimizing Case Load	2	10%
Flexible Schedules	2	10%

N=20	Count	%
Keeping Staff Safe	2	10%
Lunches	2	10%
Motivational Speakers	2	10%
Team building	2	10%
Trainings	2	10%

Table 14

Respondents were originally asked questions specifically about staff burnout and how supervisors are supporting their staff. However, UIHP key stakeholders also described various reactions staff had in response to the situation caused by COVID-19. Notably, childcare challenges were most frequently mentioned with 30% (N=6) of individuals mentioning the issue during interviews. Overall, staff reactions mentioned were a mix of positive and negative outcomes. Counts of the mentioned reactions are listed below.

Staff Reactions to COVID-19

N=20	%
Childcare Challenges	30%
Commitment to Cause	25%
Flexible	20%
Good Morale	20%
Grief (due to COVID loss)	15%
Lost Staff	15%
Overwhelmed/Burnout	10%

N=20	%
Stable	10%
Staff Stress is Manageable	10%
Stressed	10%
Supportive	10%
Work from Home: Negative	10%
Work from Home: Positive	10%

Table 15

Delivery of Behavioral Health Programs (Pre-COVID)

Interview respondents were actively delivering many types of behavioral health programs pre- and mid-COVID. However, pre-COVID interviews *(Part 1)* focused on what was being offered and used in the day-to-day for their clients. Responses included discussion of the sources, and types of mental and behavioral health services, in addition to key stakeholders.

Agency Characteristics

Pre-COVID, 84% of respondents (N=56) indicated adequate accessibility of mental health services to their clients, with 9% (N=6) indicating that they were not easily accessible. Responses were broken down into three categories: type(s) of centers available to clients (Table 16) , available mental health services (Table 17), and mental/behavioral health partners and stakeholders in the community (Table 19).

Center Type

N=14	Count	%
Mental Health	5	36%
Detox	4	29%
Clinic	3	21%
Local	3	21%
State	3	21%
Domestic Violence	2	14%
Out of State	2	14%
Native/Tribal	2	14%

Table 16

Furthermore, the types of service delivery varied among respondents:

Services

N=37	Count	%
Inpatient	24	65%
Counseling	17	46%
Outpatient	17	46%
Treatment Group (Tx)	12	32%
Challenging	7	19%
Severe Mental Health	7	19%
Not Many	6	16%
Many Services	5	14%
Crisis	4	11%

N=37	Count	%
None Available	4	11%
Youth	4	11%
Dental	3	8%
Detox	3	8%
In-House	3	8%
Medical	3	8%
Adult	2	5%
Evaluations	2	5%
Psychiatry	2	5%

Table 17

Evidence-Based Practices

88% (N=59) of respondents interviewed pre-COVID *(Part 1)* indicated that evidence-based practice (EBP) programs, both Native and Western, were utilized for trauma, suicide, and other behavioral health services. Though only 4% (N=3) of respondents indicated no use of EBPs, 9% (N=4) indicated that they were unaware of such practices, with 24% of respondents emphasizing the importance of incorporating traditional AI/AN approaches in conjunction with EBPs. Currently, the most common forms of EBPs are used for trauma and suicide-related treatment approaches. Cognitive Behavioral Therapy (CBT) was the most commonly mentioned EBP with 37% (N=17) of participants indicating its use.

Evidence-Based Practice Utilization

N=46	Count	%
Cognitive Behavioral Therapy (CBT)	17	37%
Eye-Movement Desensitization and Reprocessing Therapy (EMDR)	12	26%
Question. Persuade. Refer. (QPR).	12	26%
Incorporate Tribal/Native Approaches	11	24%
Seeking Safety	11	24%
Suicide	9	20%
Motivational Interviewing (MI)	7	15%
Dialectical Behavioral Therapy (DBT)	6	13%
Gathering of Native Americans (GONA)	6	13%
Mental Health First Aid	6	13%
Zero Suicide	5	11%
Trauma	5	11%

N=46	Count	%
Unaware	4	9%
Safe Talk	3	7%
Screening, Brief Intervention and Referral to Treatment (SBIRT)	3	7%
Trauma-Informed Care	3	7%
Many Available	2	4%
12-Step	2	4%
Anger Management	2	4%
Dimethyltryptamine Therapy (DMT)	2	4%
Medication-Assisted Treatment (MAT)	2	4%
Matrix Model	2	4%
Medicine Wheel	2	4%
Protecting You, Protecting Me	2	4%

Table 18

Respondents were also asked what partners and other external stakeholders they collaborate with providing comprehensive behavioral health services to their patients. Most respondents (33% or N=9) listed hospitals as their primary service delivery partner(s):

Evidence-Based Practice Utilization

N=27	Count	%
Hospitals	9	33%
Many Services	6	22%
Local	5	19%
State	5	19%
Native/Tribal	5	19%
County	4	15%
Crisis	4	15%

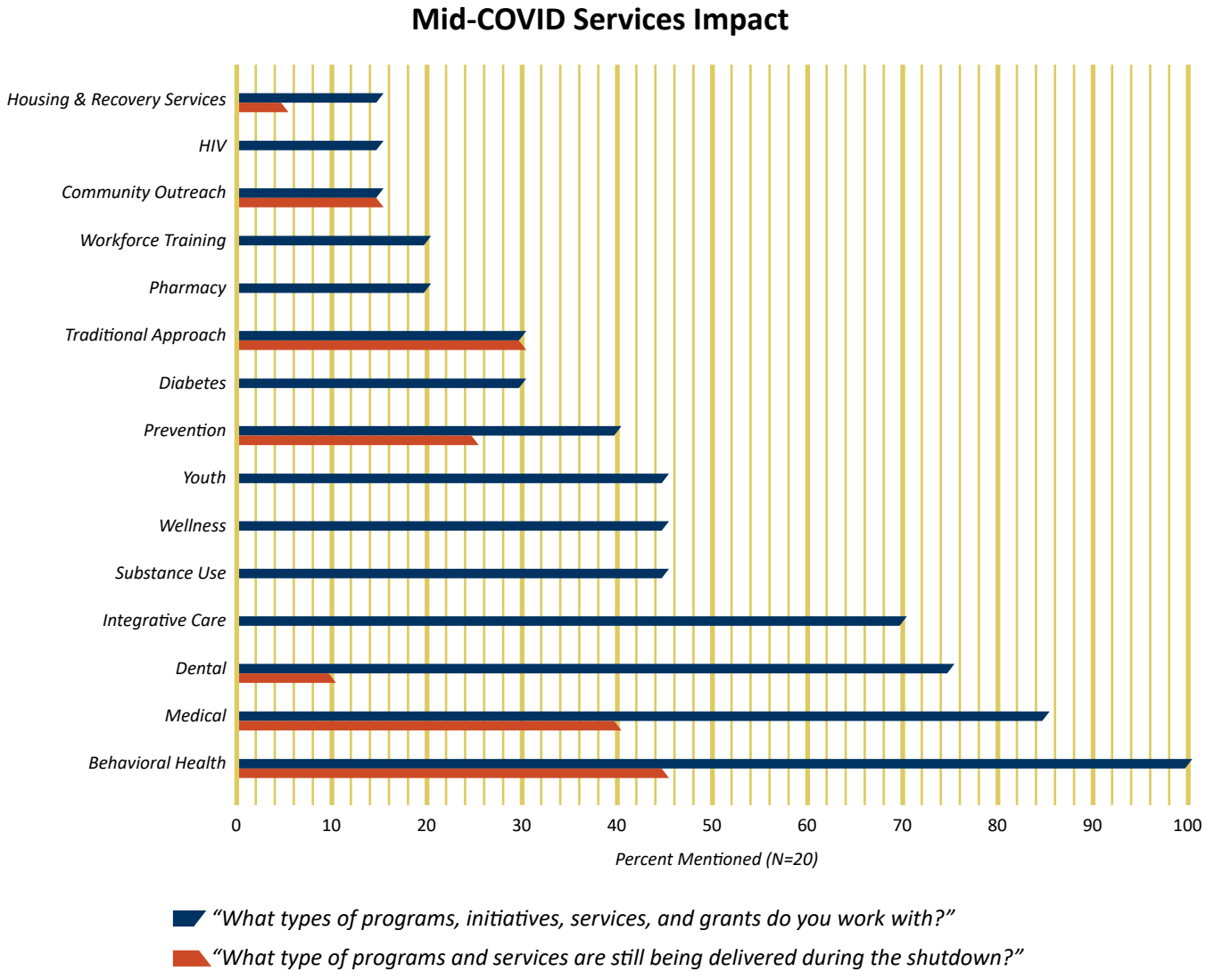
N=46	Count	%
Mental Health	4	15%
Clinics	3	11%
Other	3	11%
Challenging	2	7%
City	2	7%
Indian Health Service (IHS)	2	7%
Out of State	2	7%

Table 19

Delivery of Behavioral Health Programs (Mid-COVID)

Service Impacts

Several things had to change in service delivery with the onset of the pandemic. UIHP key stakeholders (N=20) interviewed mid-COVID *(Part 2)* were asked to describe the programs/services the organization normally works with, as well as the programs/services still being offered during the pandemic "shutdown". Behavioral health, medical, and dental services were mentioned most frequently as services normally offered but had a steep reduction in responses for being offered during the "shutdown". Additionally, 45% (N=9) of respondents mentioned other services related to substance use, wellness, and youth with moderate frequency as service normally provided, but these same services were not mentioned at all for services still being provided at the time of the interviews. The figure below illustrates the percent of respondents who mentioned different types of programs and/or services normally offered (blue) compared to those still being offered during the COVID-19 shutdown (orange).



Participants also described how undergoing lockdown(s) impacted the delivery of services mid-COVID. Due to varying responses and the open-ended nature of this question, a list of common themes was created using a "Pros and Cons" format regarding changes brought upon by the pandemic:

Pros
Behavioral Health (BH) participation increased, with no-show rates decreasing after virtual/hybrid transitions
Telehealth transitions have gone relatively smoothly
Technology upgrades/advancements to "meet those where they are"
Many social services (such as WIC and food delivery) have expanded

Cons
Dental services faced the largest impact; many offered under emergent needs
Vulnerable individuals relying on community services were heavily impacted (homelessness, drug use, food pantries, community mental health)
Many organizations had to undergo technology upgrades to make the virtual/hybrid transition (unexpected expenditures)

Table 20

Community Mental Health Services: Successes and Shortcomings

As displayed in the table below, interviewees were asked about successes and shortcomings with mental and/or behavioral health services in their communities during the COVID-19 pandemic. Among the main findings were the reports of effective utilization of telehealth and teamwork:

Community Mental Health Services: Successes

N=20	Count	%
Telehealth	9	45%
Working Together	6	30%
Traditional Practices	5	25%
Funding	2	10%
Community Awareness of Addiction	2	10%

N=20	Count	%
Client Service Flexibility	2	10%
Providing Essential Services	2	10%
Prevention and Health Promotion	2	10%
Outpatient Service(s) Access	2	10%
Knowledgeable Staff	2	10%

Table 21

However, respondents identified many shortcomings associated with community mental/behavioral health services, partially attributable to the allocation of already scarce resources and multifaceted strain from the pandemic:

Community Mental Health Services: Successes

N=20	Count	%
Under staffing	5	25%
Substance Use	4	20%
Groups	3	15%
Homelessness	3	15%
Services Not Sought Out	3	15%
Telehealth	3	15%
Underfunding	3	15%

N=20	Count	%
Lack of Case Management	2	10%
Cultural Competency	2	10%
Inpatient Service(s) Access	2	10%
Medical Screenings	2	10%
Population Not Reachable via Technology	2	10%
Traditional Practices	2	10%
Transportation	2	10%

Table 22

Current Community Challenges

The respondents were asked also asked mid-COVID, what they thought the greatest needs and/or challenges for people are currently. When asked this question, responses varied greatly by organizational structure with twenty-one topics mentioned in total:

Community Challenges

N=20	Count	%
Increased Mental Health Challenges	6	30%
Increased Drug Use	5	25%
Food Insecurities	4	20%
Isolation	4	20%

N=20	Count	%
Homelessness	2	10%
Domestic Violence	2	10%
Transportation	2	10%
No Childcare/School	2	10%

Table 23

Items mentioned by one respondent: increased crime, elders in social isolation, lower face-to-face service delivery, civil unrest, technology for clients, and more.

Use of Cultural Practices (Pre- & Mid-COVID)

Pre-COVID, 76% (N=51) of respondents reported that their staff has undergone culturally competent workforce training specific to mental health issues among Native Americans, and 43% (N=29) reported that they were currently utilizing tribally focused mental health programs in their facilities. Table 24 and Table 25 depict the mentioned providers and types of cultural competency training available to their staff. The most frequently mentioned providers include IHS (N=23), consultants (N=21), and Native tribes. 15% (N=7) of participants indicated that they were unaware of any specific cultural competency training specifically focused on working with native health issues in Native Americans.

Sources of Cultural Competency Training

N=47	Count	%
Indian Health Service (IHS)	23	49%
Consultants	21	45%
Native Tribes	17	36%
Internal/In-House	11	23%
Elders	8	17%
Many Available	7	15%
National	7	15%
Unaware	7	15%

N=47	Count	%
University	7	15%
Members	5	11%
County	4	9%
State	3	6%
Medicine Men	3	6%
Traditional Healers/Spiritual Leaders	3	6%
Conferences	2	4%

Table 23

In the interviews conducted pre-COVID, 72% of participants (N=33) mentioned the incorporation of tribal/Native approaches into their mental health programs. However, a majority of respondents (61%, N=28) also indicated that they were not aware of tribal specific mental health programming. There was also great deal of variability in the cultural programs mentioned and no program was mentioned overwhelmingly. The most common forms of tribal behavioral health programs mentioned in pre-COVID interviews *(Part 1)* were White Bison (N=12) and Gathering of Native Americans (N=7).

Tribal Mental & Behavioral Health Programs

N=46	Count	%
Incorporate tribal/Native approaches into mental health programs	33	72%
Unaware of tribal specific mental health programs	28	61%
Cultural Programs		
White Bison	12	26%
Gathering of Native Americans (GONA)	7	15%
Medicine Wheel	5	11%
Assist	3	7%
Counseling	3	7%
Question. Persuade. Refer. (QPR)	3	7%
Red Roads	3	7%
American Indian Life Skills	2	4%
Family Spirit	2	4%
Mending the Broken Hearts	2	4%
Mental Health First Aid	2	4%
Additional Themes		
Internal/In-House	6	13%
Suicide	4	9%
Indian Health Service (IHS)	3	7%
Other	3	7%
University	3	7%
Youth	3	7%
Prevention	2	4%
Substance Abuse and Mental Health Services Administration (SAMHSA)	2	4%

Table 24

Interviews conducted mid-COVID *(Part 2)* intended to collect information about the use of cultural and Native approaches by UIHPs. The same respondents were also asked if culturally focused AI/AN treatment approaches were still being used amid the countrywide shutdown(s). Though responses varied among location and tribes, 55% of respondents (N=11) mentioned that they were still able to incorporate these approaches in some capacity. Similarly, many individuals also mentioned that cultural activities were being delivered completely virtually. Additionally, activities mentioned may not be a comprehensive list of cultural/Native activities offered. Below is a table of responses to this question.

Cultural/Native Approaches During Lockdown

N=20	Count	%
Native Approaches Still Possible	11	55%
Completely Virtual	11	55%
Talking Circles	5	25%
Drumming	4	20%
Beading	3	15%
Herbal Natural Way	3	15%
Art	2	10%

N=20	Count	%
Crafts	2	10%
Dancing	2	10%
Rituals	2	10%
Sewing/Quilting	2	10%
Sweat Lodges	2	10%
Youth Programs	2	10%

Table 25

Discussion

Summary of Results

These findings suggest that COVID-19 has had a major impact on the operation of Urban Indian Health Programs (UIHP) across the country. An analysis of the key informant interviews and focus groups conducted with leaders of UIHPs describes the unique challenges caused by the presence of COVID-19 and measures aimed at reducing the spread.

First, many UIHPs had to undergo technology upgrades to make the virtual/hybrid transition, resulting in unexpected expenditures and organizational changes in workflow. Regarding community mental health services, many respondents indicated that they are struggling with inadequate staffing levels, funding, and case management issues, though respondents cited vastly different challenges as their greatest. Many individuals also noted that the most vulnerable Urban Indian populations were impacted the greatest as they often rely on community services (homeless shelters, food pantries, substance abuse treatment, etc.) which were heavily limited by the pandemic.

Many respondents offered medical and dental services within their organization, typically through the means of integrated care networks. After COVID-19 spread to the United States, several of these services were limited, only being accessible on an emergency basis. However, many organizations had to remain open in some capacity, as vulnerable, high-risk populations rely upon the services they provide. Respondents also mentioned the severe impact the pandemic has had on their staff, citing issues with grief, stress, and burnout. Lack of childcare was also mentioned as a major concern for staff, illustrating the interconnectedness of the needs of the community beyond those specifically related to the UIHPs.

"There is a lot of staff burnout for different issues. Some people are scared to come into the office, and when they need to come back full-time, they may resign…" – UIHP Interview Respondent, Mid-COVID *(Part 2)*

Although the respondents described many negatives impacts of COVID-19 on behavioral health service delivery, there were some positive outcomes mentioned as well. Many respondents noted the smooth transition to telehealth delivery format for a variety of services such as behavioral health. Telehealth was mentioned frequently as an important tool for service delivery during the pandemic. Individuals also mentioned that technology upgrades, though an unexpected expense, were important for reaching those they serve.

Interestingly, some respondents mentioned that behavioral health participant increased as a result of the pandemic, with no-show rates decreasing following the virtual transition. This is likely due to the reduction in barriers often associated with in-person services and an increase in the need for behavioral health services. Participants also noted that they were able to adapt some cultural activities for virtual settings, though overall, it was difficult to incorporate cultural and/or traditional Native approaches during the lockdown.

Additionally, though many health services were limited due to the pandemic, respondents noted the expansion of important social services like the Supplemental Nutrition Program for Women, Infants, and Children (WIC) and food delivery. Though these programs were expanded to meet the increased need during the pandemic, decision-makers may decide to maintain the expansion of these services to continue to meet the needs of individuals going forward.

Lastly, findings from these Needs Assessments indicate that additional staff and funding are vital to support these behavioral health programs. However, many respondents also mentioned that technical assistance on how to use funding, cultural competency training, and partner strengthening are also needed to help meet the behavioral health needs of American Indians and Alaska Native populations in urban settings and more broadly. This emphasizes the importance of supporting staff and resources with adequate and culturally tailored training and technical assistance. Through these actions, decision-makers can ensure they are providing Native individuals with the physical, mental, and behavioral health services they are entitled to receive.

"All of [the UIHPs] are always underfunded…. They handle so much and there are so many problems seen with clients; a lot of needs and not enough staff or money." – UIHP Interview Respondent, Mid-COVID *(Part 2)*

Justification of Time Shift

At the onset of the MHTTC Needs Assessment, it was determined that approximately 100 interviews would be a good goal for proper representation of the nationwide workforce being evaluated. Researchers sought to have as much geographic distribution of interviewees as possible since the location was identified as a likely variable in responses. The initial period to conduct the Needs Assessment interviews was set at 18 months (Feb 2019 - Aug 2020). However, approximately one year into the interviews, two converging challenges occurred; 1) the list of contacts for potential participants had been exhausted and was failing to yield further interviews, and 2) COVID-19 was emerging as a concern and public venues to recruit further participants were being canceled. The team discussed possible next steps and decided there was value in capturing the impacts of COVID-19 on these same organizations to best serve their changing needs resulting from the pandemic. At this time it was decided that 1) it was unlikely to schedule further interviews; 2) even if they were conducted, they would yield results specific to the pandemic's conditions and no longer represent "business as normal" which was the original intent of the Needs Assessment; and 3) a study on the impacts of COVID-19 and how those changed the needs of the workforce would be more valuable to both the organizations and the researchers so that more timely pieces of training and resources could be developed to help the workforce as they adjusted to the pandemic's conditions. Therefore, the previous MHTTC Needs Assessment interviews ceased and were analyzed based on the data gathered by that time (Feb 2020). The goal then became to 1) analyze the results of the MHTTC Needs Assessment data, 2) present it to the interviewees for feedback, 3) create a new Needs Assessment based on the changes due to the pandemic, 4) create a sampling plan to ensure rapid responses and the ability to compare pre-pandemic and ongoing pandemic conditions, 5) conduct COVID-19 Needs Assessment interviews, 6) analyze COVID-19 Needs Assessment data, and 7) Compare pre-pandemic and on-going pandemic responses where possible. Currently steps 1-6 have been completed, and step 7 is in process.

Implication to Research

This research provides insight into the needs and assets of health systems in addressing behavioral health among American Indian and Alaska Native populations (AI/AN). To the researchers' knowledge, there has not been any national behavioral health Needs Assessment for Urban Indian Health Programs (UIHP) conducted previously. Moreover, due to the timing of the original study and the addition of a COVID-19 specific element, this research provides a unique perspective on how the COVID-19 pandemic has impacted UIHPs. Since the researchers had already been in contact with UIHPs for a behavioral health Needs Assessment, they were able to respond to the change in circumstances and collect information promptly.

Additionally, this study involved key stakeholder interviews. This methodology is valuable in understanding the perceptions of those in positions of power within UIHPs that might not be captured in staff surveys or performance measures. These individuals are likely the most qualified to describe the needs, resources, and activities of the UIHPs.

These findings might also be used to identify key priority areas for other federally funded healthcare programs such as Federally Qualified Health Centers (FQHC) or Veterans Health Administration (VA) programs. Though this study largely focused on UIHPs , who serve a unique population, these results might provide insight into how health systems across the country, both public and private, have responded to COVID-19.

Future suggestions

Due to the time-sensitive nature of these Needs Assessments, researchers were unable to conduct as robust of a study as had originally been planned. Future needs assessments could build on the findings of this report by expanding the number and representation of respondents. Now that a broader understanding of possible responses has been gleaned from these open-ended questions, it could be possible to create more quantitative survey instruments. These instruments could be more widely distributed and used to generate comparisons amongst groups and over time which could be subject to statistical analyses. Additionally, other sources of information such as outcome measures, staff and client perspectives, and survey data could also be used as tools to ensure findings are inclusive of the experiences of all stakeholders in the field of behavioral health who work with Native Americans and Alaska Natives. However, researchers must prioritize the cultural sensitivity of any evaluation of UIHPs and Native communities more broadly.

Though this report highlights preliminary findings of the implementation of telehealth and tele-behavioral health services, it does not fully capture the current status of such initiatives. To do so, researchers much look at the expansive infrastructure, knowledge, and other such capabilities that must be in place for the successful delivery and telehealth services. A widescale study with more representation and data sources from the various stakeholders who use telehealth would be necessary to understand the needs and resources associated with using telehealth to deliver mental and behavioral health services to Native individuals.

Furthermore, participants under both the *Part 1* and *Part 2* study components are likely not completely representative of the behavioral health workforce serving Native communities. For example, 50% (N=28) and 62% (N=13) of respondents for *Part 1* and *Part 2* respectively, had worked in their current organization for six or more years. However, the behavioral health workforce has an average annual turnover rate of 30% (Brabson, Harris, Lindhiem, & Herschell, 2020). This discrepancy suggests that interview participants are, on average, well established in their organizations and may not have the same experience or perceptions of other behavioral health professionals who are caught up in the cycle of turn-over. Additionally, most of those responding to these surveys were in supervisory roles as they were the ones most qualified to speak to all the policies and programs of the organization; it is likely that the experiences of other behavioral health workers might be different than those collected for these assessments. More research is needed to understand the scale of, and factors contributing to, the turn-over of behavioral health staff serving AI/AN populations.

There is also a large amount of evidence that mental and behavioral health providers can suffer from emotional exhaustion, secondary trauma, and other negative outcomes as a result of continued exposure to the needs and trauma of those they serve (Dreison, et al., 2018). This is compounded by the fact that many Native behavioral health providers experience the same factors leading to higher rates of mental and behavioral health problems in AI/AN populations as compared to the general populations. These impacts were likely worsened as a result of the COVID-19 pandemic as Native communities were hit especially hard by the virus. Additional research should be conducted to understand how to best support the well-being of providers serving Native populations.

Currently, the research team is working on a more in-depth comparison of the responses collected pre-and during the COVID-19 pandemic. These additional findings will be provided to key stakeholders and interview participants once they are completed. However, an additional UIHP behavioral health needs assessment after the conclusion of the pandemic could provide important insight into how/if the pandemic has led to systematic changes to UIHPs. This post-COVID study would help decision-makers and researchers understand the true impact of the pandemic on the healthcare system, and what priority areas still need to be addressed going forward.

Conclusion

Native American and Alaska Native (AI/AN) populations experience a disproportionate burden of mental, behavioral, and physical health issues. These disparities have been caused by several historical and systemic factors including - but not limited to - historical trauma, under-resourcing, structural racism, and the subsequent issues caused by these factors (Bailey, et al., 2017). Urban Indian Health Programs (UIHPs) are responsible for providing comprehensive mental, physical, and behavioral health services to roughly 25% of the AI/AN population in the United States (Indian Health Service, n.d.).

This report outlines the findings from two different, yet related, behavioral health Needs Assessments conducted with key stakeholders from UIHPs and other organizations that work to address the behavioral health needs of Native individuals. The first Needs Assessment *(Part 1)* was developed and conducted before the start of the COVID-19 pandemic (Aug 2018 – Feb 2020) while the second assessment *(Part 2)* occurred during the pandemic (Mar 2020 – Feb 2021).

Findings from a qualitative analysis of four focus groups and forty-four one-on-one interview conducted before the start of the COVID-19 pandemic as well as twenty additional interviews conducted during the pandemic, provide insight into the current situation and the needs of UIHPs in providing behavioral health services to Native populations in their service areas. These findings suggest that while most services remained open during the pandemic, the availability of certain services varied greatly between different UIHPs. Services such as dental health, substance abuse treatment, community mental health, and integrative care, faced the greatest reduction. Also, respondents indicated that those who were most vulnerable suffered the greatest impact from the changes caused by COVID-19. Telehealth was mentioned as a critical tool for the delivery of behavioral health services, and transitions to the new format have been relatively successful. Lastly, UIHPs and behavioral health professionals need support through more staff (specifically Native staff), funding increases, technical assistance tailored to funding use, cultural competency training, and partnership strengthening. These strategies can help ensure that American Indian and Alaska Native individuals can access the adequate behavioral health care they are entitled to receive.

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Native Center for Behavioral Health

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