URBAN INDIAN VOICES:
A COMMUNITY-BASED PARTICIPATORY RESEARCH HEALTH AND NEEDS ASSESSMENT

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Abstract: This community-based participatory research (CBPR) project utilized a mixed-methods survey design to identify urban (Tulsa, OK) American Indian (AI) strengths and needs. Six hundred fifty AIs (550 adults and 100 youth) were surveyed regarding their attitudes and beliefs about their community. These results were used in conjunction with other community research efforts to inform program development, support proposals for external funding, and develop a comprehensive service system model to be implemented in the community.

INTRODUCTION

As a result of social inequalities, high poverty and unemployment rates, disparities in healthcare access and utilization, and cultural/historical trauma, urban American Indians (AIs), who make up 45% to 67% of the total AI population (Grant & Brown, 2003; Urban Indian Health Institute, 2007), face a host of physical and mental health concerns (Urban Indian Health Institute, 2004). More AIs experience serious mental illness, commit suicide, and report mental distress than do members of any other racial group, and they do so at twice the rate of the general population (Harvard Project on American Indian Economic Development, 2004; Grant & Brown). A multitude of challenges threaten AI youth in particular. According to the Harvard Project on American Indian Economic Development, Native youth are 60% more likely than their non-Native peers to get into fights at school. They also are more likely to drink heavily, abuse drugs, and attempt suicide. They have disproportionate arrest rates, as well as a teen birth rate 50% higher than that of non-Native youth (Harvard Project on American Indian Economic Development).

AI communities frequently use needs assessments to evaluate current health, mental health, and community needs and to gain empirical data for program development and external funding support to address these needs. A special issue of *American Indian and Alaska Native Mental Health Research* presented several examples of needs assessments from Native communities around the country (Manson, 1999). The community needs assessment discussed here, which represents findings from one site funded through the Circles of Care Initiative (Manson, 2004), complements this earlier work. We hope that this project might serve as a model for other AI community needs assessments and research partnerships, particularly in urban settings.

ORGANIZATIONAL OVERVIEW

Active for over 30 years, Indian Health Care Resource Center of Tulsa, Inc. (IHCRC) is a 501(c)(3) nonprofit, comprehensive health care facility, governed by a local volunteer Board of Trustees, the majority of whom are AI. IHCRC strives to promote quality health care by providing comprehensive culturally appropriate access to comprehensive medical and mental health care. Medical, health education, dental, optometry, behavioral health, chemical dependency, HIV/AIDS prevention, and pharmacy services are provided directly to the Tulsa AI community. Members of any federally recognized tribe and their children under age 18 are eligible to receive care.

IHCRC's service area consists of Tulsa County and contiguous regions—a blend of urban areas and rural communities, substantial portions of which are impoverished as well as medically and socially underserved. According to the 2000 U.S. Census, the AI population within IHCRC's service area numbers 55,722, 41.9% of whom are under age 22 (U.S. Census Bureau, 2002). Most reside within 30 miles of Tulsa. Overall, Tulsa is home to one of the largest urban AI populations in the U.S., with 86,118 AIs living in the metro area, comprising 10.7% of the total population (U.S. Census Bureau). Many AIs in this area live close to affluent communities, but remain functionally isolated from mainstream society because of cultural, economic, social, and educational barriers. They make up a community within a community, a culture within a culture.

The clinic's history highlights its importance as the necessary cultural foundation that would organize and mobilize the Tulsa AI community for decades to come. Prior to the 1950s, most AIs and Alaska Native peoples lived on reservations, in rural towns, or in tribal jurisdictional areas (Fixico, 2000). In the 1950s and 1960s, Congress passed legislation focused on assimilating Indian people into mainstream society. This legislation resulted in the Bureau of Indian Affairs (BIA) Relocation/Employment Assistance Programs, which promised incentives to Native people for leaving impoverished rural areas and moving to cities for jobs and education. Urban Indian leaders soon began to emerge in relocation cities throughout the United States, including Tulsa. These

leaders began organizing to address the issues facing relocated Native people, many of whom found themselves culturally disconnected from their homes, isolated, lonely, and suffering from the effects of city poverty.

The advocacy of these urban Indian leaders resulted in Congressional appropriation of funds for a 1966 pilot project in Rapid City; by the 1970s, Congress had passed the Indian Health Care Improvement Act, leading to the establishment of Urban Indian Health Centers in relocation cities all over the country. IHCRC was founded to address the real need for culturally based health and wellness services for the Tulsa AI community. The clinic has served as more than just a house of physical healing: IHCRC has provided the infrastructure necessary for inter-tribal community connections, community education about health and wellness, and 30 years of advocacy that has built up the spirits, hearts, and minds of the community.

AI Mental Health in Oklahoma

There is a severe lack of culturally sensitive mental health services for AIs in Oklahoma, particularly for youth. IHCRC strives to achieve organizational cultural competence; it is an ongoing developmental process that requires reflection, evaluation, and the ability to change. Cultural competence is particularly challenging because more than 150 different tribes are represented in the Tulsa area, each with different customs, beliefs, languages, and traditional healing practices. However, there are some common factors that tie AI people together, including belief in the Creator and the use of holistic healing processes. The culturally based services at IHCRC reflect this common thread of holistic care for AI people. In addition to comprehensive health and behavioral health services, IHCRC provides community-based cultural programs and services, including Indian youth leadership development; after-school programs about traditional foods, music, dance, and arts; connections to spiritual healing resources for adults suffering from substance addiction; and incorporation of cultural elements into treatment plans for young people suffering from mental illness.

Unfortunately, the state's Department of Mental Health and Substance Abuse has suffered severe funding cuts over the past several years. As a result, mental health and substance abuse services across Oklahoma have been greatly reduced, and service provision is often fragmented and ad hoc. Families, legal authorities, providers, educators, public officials, and community leaders often lack knowledge regarding the problems facing AIs, as well as appropriate treatments, which further limits behavioral health services. Additionally, the social stigma associated with mental health and substance abuse treatment in AI communities negatively affects both referrals

for care and intervention. Other variables known to limit AIs' access to care include cost, lack of transportation, and lack of trust in an often transient and marginally qualified cadre of service providers (Cunningham & Cornelius, 1995).

Circles of Care Program

In September 2005, the Substance Abuse & Mental Health Services Administration (SAMHSA), Center for Mental Health Services Circles of Care program funded the *Strengthening Our Children* project at IHCRC in September 2005; the needs assessment discussed here was a component of this project. The purpose of the *Strengthening Our Children* project was to develop a culturally appropriate service system model for treating children, youth, and their families who are struggling with serious emotional difficulties. In other words, the goal was to expand the provision of mental health services and to create a comprehensive mental health treatment delivery system to fully accommodate the complex, multiple, and ever-changing needs of AI youth and their families. The Circles of Care program supports the overall SAMHSA agenda for transformation of mental health systems through a focus on infrastructure development and service capacity expansion.

IHCRC staff forged a number of partnerships with community agencies and stakeholders to accomplish this goal. To assess the strengths and needs of the Tulsa AI community, IHCRC staff joined with the University of Oklahoma-Tulsa to survey a community sample of adults and youth. This paper presents the results of this community health and needs assessment.

PURPOSE

This paper consists of two parts. First, we describe the results of the community health and needs assessment of AI youth and adults in the greater Tulsa area. The aims of this project were to provide the leadership at IHCRC with important health and community data to inform the development of a comprehensive service system model, enhance the quality of services provided, and support applications for external funding. To achieve these aims, the following community-developed research questions guided the project: (1) What do community members perceive as the greatest social/health problems facing AIs in Tulsa? (2) What wellness and social programs are desired? (3) How connected and safe do AIs feel in the Tulsa community? (4) What strengths does the Tulsa AI community possess? and (5) How do adults and youth differ in their perceptions of problems and needs?

Second, this paper briefly evaluates the process of conducting community-based participatory research (CBPR), including the relationship between the university research partners and the Tulsa AI community. CBPR is a culturally sensitive, collaborative, multi-method research approach

that seeks to include the target community as an equal partner in every phase of the research and to directly translate the findings into interventions and policies (Israel, Schulz, Parker, & Becker, 1998; Viswanathan et al., 2004). This commitment covers the spectrum including research design, implementation, data collection, analysis, and dissemination of results. CBPR was chosen as the research framework for a variety of reasons. For example, all involved felt that it was important to conduct a collaborative, strengths-focused assessment. We aimed to improve the ability of IHCRC and the Tulsa AI community to conduct independent research and evaluation, and to implement interventions based on this research.

METHOD

CBPR

Consistent with the principles of CBPR, IHCRC staff assembled a community advisory board to review and provide input on the research purpose, design, methodology, instrument development, and results. This community advisory board consisted of tribal elders and leaders, parents, youth, IHCRC staff and board members, and other people and local organizations interested in developing programs to support the Tulsa AI community (e.g., police, teachers, social/youth services workers, religious leaders). The community advisory board met monthly and was open to the public. Meetings usually consisted of 15-35 attendees. Public announcements were sent through IHCRC e-mail lists, newsletters, and other AI publications. The meeting were coordinated and facilitated by a community coordinator (funded through the Circles of Care grant) and the IHCRC project director/staff psychologist.

The research for this project followed APA ethical standards (APA, 2002) and was approved by the University of Oklahoma's IRB.

Measures

The community advisory board, IHCRC staff, and the university research partners worked together to develop a telephone script and two surveys—one for adults and one for youth ages 14-19. (Fearing that a long survey would decrease youth participation rates, the community advisory board chose not to ask youth all of the questions that were asked of adult participants.) The team reviewed existing surveys and needs assessments and constructed original items as proposed by community members (e.g., items related to community problems, youth concerns, participation in cultural activities, and feelings of community connection, as well as most of the open-ended items). The surveys went through a number of revisions until all partners agreed on the content.

After data were collected early in the interview process, the community advisory board suggested further revisions to improve the survey, and other questions and response options were added (e.g., "gambling" was added to the section on community problems list, and questions concerning parental involvement were added to the youth survey). Because they were added later, these items were not asked of all respondents and, thus, sample sizes for them were smaller; however, the overall analyses were not significantly affected.

The surveys included information about physical health, behavioral health, wellness, demographics, and community services and supports. Because the youth survey was intentionally kept shorter and several items asked of adults were not asked of youth, we could not compare the two groups on these items. The surveys contained both Likert and open-ended questions, resulting in both quantitative and qualitative data.

Procedure

Participants were recruited in a variety of ways, including letters mailed out to parents through Tulsa Indian Education (a community program providing academic support, resources, and cultural programming for AI public school students and their families), ads placed in AI and tribal newspapers, flyers passed out at area churches and community events, in-person requests at area pow-wows, and in-person requests in the IHCRC waiting room and at the reception desk. We attempted to obtain a representative sample from different regions (by zip code) in the Tulsa area. (In one instance, recruitment letters were inadvertently sent to the incorrect school districts, which probably resulted in low representation from those areas.) As an incentive, participants were offered a $20 gift card to Wal-Mart. Surveys were conducted in an interview format, either via telephone or in person, and took approximately 25 minutes each. A total of 550 adult interviews were conducted: 200 at IHCRC, 78 at area pow-wows, and 272 via telephone. We conducted a total of 100 youth interviews: 15 at area pow-wows and 85 via telephone.

Research from the U.S. Department of Commerce (1999a, b) has shown that AI households fall far below national averages in telephone service and computer/internet access. Thus, although we utilized telephone interviews, we initially recruited participants using the various in-person strategies mentioned above. It has also been noted that, given issues with trust and privacy, AIs tend to prefer in-person contact to the impersonal nature of telephone interviews (Christopher, 2005; Sobeck, 2003). Many participants who completed the survey via telephone were recruited in person at community and cultural events.

RESULTS

Results were presented and discussed at several community advisory board meetings. Comments from these meetings are included in the following discussion.

Demographics and Personal Information

The community advisory board selected several demographic variables to investigate, including age, gender, family indicators (e.g., number of children in home, marital status), income, tribal affiliation, volunteerism, religious indicators (e.g., type of church attended and how frequently), transportation, and telephone access. These variables were chosen because the board believed that this information would provide the most meaningful categories for comparison and for evaluating the representativeness of the sample. The median age of the adult participants was 38.0 years (mean = 40.2; range = 18-83 years), and most had lived in the Tulsa area for quite some time (average = 25.05 years). The mean age of the youth participants was 15.9 years (range = 14-19 years). Of the 100 youth that participated in the survey, 43% were male and 57% were female. A disproportionate number of women were represented in the adult sample (74.2% women vs. 25.8% men). According to the U.S. Census Bureau (2002), the AI population in Tulsa County is composed of 52.1% women and 47.9% men. Community members hypothesized that women are more likely to (a) go to IHCRC, (b) bring their children for medical appointments, and (c) participate in surveys. They also indicated that men may not be able to take time off from work as easily as women because of gender role expectations. (However, members did note a growing impression that AI men are more frequently becoming primary caretakers for their children.)

Of the 350 adult participants not interviewed at IHCRC, 58.5% indicated that they had received care at IHCRC. Overall, 72% of the adults surveyed were familiar with and/or had received services at IHCRC.

Family

Marriage and family status were similar to general 2000 U.S. Census data for Tulsa County (U.S. Census Bureau, 2000). Approximately 53.8% of the sample reported being in a marriage or cohabitating relationship, compared with 52% overall in Tulsa County. A large majority of the participants (85.3%) reported having at least one child, with an average of 2.43 children under age 19. Tulsa County census data (U.S. Census Bureau, 2000) showed that 49.5% of families had children less than 18 years old. (Although the 2000 U.S. Census considered children to be less than 18 years old, the community advisory board selected 19 years of age as the cutoff for youth because its members felt there were a significant number of youth this age still living at home and dependent on their parents or families.) The sample averaged 3.63 total children per family, compared with

3.03 children per family in the general Tulsa County population. This information suggests that the AI households in this sample contained more children (and total people), on average, than Tulsa County households in general. Household members may be extended family such as nephews, nieces, or other community children living in the home.

Tribes

We asked respondents to select a primary tribal affiliation and also to indicate whether they identified with other tribes. In terms of primary tribal affiliation, more than 40 tribes were represented in the adult sample. The majority of the respondents were Creek (30.5%), Cherokee (28.7%), Choctaw (6.9%), and Osage (5.3%)—consistent with the general AI population in Tulsa. Of those responding, 46.4% stated that their ancestry included other tribes. Ninety-two percent of youth respondents were members of a federally recognized tribe; 16 tribes were represented, with Cherokee (33%) and Creek (23%) named by the most respondents. Regarding AI blood, the majority (62.7%) of participants were one half to full-blooded AI, and 44.9% were three quarters to full-blooded AI. This finding suggests that most respondents had a high degree of AI lineage.

Income

Concerning household income, 45.7% of respondents indicated that they earned less than $20,000 per year; 32.5%, between $20,000 and $35,000; and the remaining 21.8%, more than $35,000. U.S. Census (2000) data revealed that the median household income for AIs in Tulsa County was $32,367, and that 703 out of 8,987 total families with children under 18, both Native and non-Native, were below the poverty line in the city of Tulsa.

Telephone and Transportation

When questioned about having a telephone and transportation, 94.9% of the adult respondents reported having a telephone and 87.4%, access to dependable transportation. The number of respondents having a telephone was higher than expected for AI households, and there was no difference in telephone access among those interviewed in person and those interviewed by telephone. Regarding transportation, 13% of the respondents reported they did not have access to dependable transportation. Furthermore, on open-ended questions, many respondents indicated that lack of transportation was a primary obstacle to obtaining health care.

Church attendance

Regarding church attendance, 30.9% responded that they attended frequently; 35.9%, sometimes; and 23.2%, rarely. Only 9.9% responded that they never attended church. Almost half (46.3%) of church attendees stated that they attended an Indian church.

Volunteerism

Among adult respondents, 36.8% stated that they recently performed volunteer work. They mentioned a wide range of volunteer activities, including work with community service agencies, AI activities (e.g., pow-wows, stomp dances), church activities, school programs, providing assistance to elders, and providing general assistance to others. Survey respondents appear to have a relatively high rate of volunteerism, as national surveys indicate that, in general, an average of 26.2% adults volunteer (Corporation for National and Community Service, 2008).

Health, Interest in Wellness Programs, and Youth Issues

This section of the survey inquired about self-reported health status, types of wellness and health programming community members might participate in, and youth perspectives on common activities and parental involvement.

Health

Regarding general health, 61.1% of adults reported being in good to excellent health, while 38.9% indicated poor to fair health (to keep the youth survey short, youth were not asked about health). The community advisory board found this to be a high number of adults reporting poor to fair health, and believe that these results are consistent with the high levels of health problems found among AIs. As is often reported, AIs have higher levels of diabetes, obesity, and cardiovascular disease than the general population (Urban Indian Health Institute, 2004). Fewer than half of survey respondents indicated having medical insurance coverage for themselves (43.6%) or their children (35.3%, although 50.1% reported having Medicaid or Sooner Care for their children).

Wellness programs

Table 1 summarizes the adult respondents' interest in participating in (or making available) a variety of health and wellness programs (to keep the youth survey short, youth were not surveyed about this topic). Respondents were most interested in the following wellness programs: traditional Indian games and activities, Indian youth and family clubs, youth sports teams, and weight management classes.

Table 1
Interest in Wellness Programs[1]

Type of Program	Mean	SD
1. Traditional Indian Games & Activities	3.69	0.62
2. Indian Youth & Family Clubs	3.58	0.72
3. Youth Sports Teams	3.55	0.76
4. Weight Managemnt Classes	3.46	0.84
5. Walking Club	3.35	0.87
6. Healthy Cooking Classes	3.34	0.88
7. Aerobic Exercise Classes	3.31	0.87
8. Nutrition Classes	3.20	0.91
9. Stretching Classes	3.14	0.92

[1]A rating scale of 1-4 was used, with 1 = *Don't know*, 2 = *No*, 3 = *Maybe*, and 4= *Yes*

Youth issues

Almost half (49%) of youth respondents indicated that they played in school or youth sports leagues. Activities included softball, basketball, volleyball, baseball, track, soccer, football, cheerleading, tennis, boxing, and golf. A majority of youth (55%) indicated that they would like to participate in youth sports leagues outside of school. Many youth (61%) indicated that they would be interested in participating in an Indian youth club or council. Participants also identified Indian dancing, language classes, bead working, ribbon working, and learning more about Indian heritage as activities they wished were available.

Youth were also surveyed about perceived parental involvement; 56.9% reported being satisfied with their parents' level of involvement in their lives, while 10.3% were at least somewhat dissatisfied. Similarly, 57.8% reported wished their parents were at least somewhat more involved with their lives, contrasted with 42.2% who wished their parents were at least somewhat less involved.

AI Strengths

The community advisory board and university research partners desired to assess strengths as well as needs and limitations in the community; therefore, adult and youth participants were asked the following open-ended question: "What are the greatest strengths of American Indians?" Overwhelmingly, community members emphasized Indigenous AI culture, including "Native

rituals," "heritage," "ceremonies," and "tribal ways" as primary strengths. In addition, participants recognized family—"strong family values" and the importance of "closeness among family members." Participants viewed spirituality and religion as important strengths—traditional tribal practices and beliefs as well as Christian ones. Community members noted unity among AIs as a source of pride and resilience. They expressed a sense of "unity," "togetherness," and "solidarity." Finally, the ability to persevere in the face of adversity (e.g., "stubborn," "determined," "willpower") and the pride shown in Native traditions and culture were seen as vital strengths.

Statistical Analyses

The community advisory board wanted to examine the differing views of adults and youth. Therefore, both surveys included the same questions regarding several topics, allowing comparison of responses using a one-way Analysis of Variance (ANOVA). These topics included: attending traditional events, importance of learning culture, likelihood of attending cultural events, life satisfaction, stigma of mental health, safety of neighborhood, connection to Tulsa AI community, and connection to tribal community. Results are provided in Table 2. We also compared adults and youth on their ratings of several social and health issues: poverty, unemployment, public transportation, racism, teen pregnancy, gangs, youth suicide, adult suicide, depression, anxiety, stress, obesity, alcohol abuse, drug abuse, youth tobacco use, diabetes, child abuse or neglect, domestic violence, school dropout rate, bullying at school, learning difficulties, availability of health care, and religious or spiritual problems. Results are provided in Table 3. We computed effect sizes for the adult vs. youth comparisons. The partial eta-squared (η^2) is an effect size index that reflects the proportion of effect and error variance that is attributable to the effect. Another type of effect size is Cohen's d-statistic (Cohen, 1992), which is, essentially, a difference between standardized means.

AI Heritage

We surveyed participants regarding their identification with and participation in traditional or cultural American Indian activities and events; 69.8% of adults and 56.5% of youth indicated that they attended such events at least sometimes. Only about 11.1% of adults and 14.1% of youth reported never attending these events. Seventy-two percent of adults reported that it was very important for their children to learn about traditional AI culture; in contrast, only 52% of youth stated it was very important to them. In another discrepancy between adults and youth, 52% of adults—but merely 28.6% of youth—reported that they would frequently attend intertribal community social activities if they were offered on a regular basis (only 0.9% of adults and 3.1% of youth said they would never attend). Results (see Table 2 for complete statistics) indicated that adults were more likely to support and participate in traditional events, $F(1, 646) = 8.38$, $p = .004$; partial $\eta^2 = .013$. Likewise, adults

responded more positively than youth to questions about the importance of learning traditions, F $(1, 632) = 16.53$, $p = .0001$; partial $\eta^2 = .025$. Adults also reported higher likelihood of supporting and attending intertribal events than youth, F $(1, 638) = 17.18$, $p = .00004$; partial $\eta^2 = .026$.

Table 2
Descriptive Statistics: Means, Standard Deviations, Skewness, and Kurtosis

	Overall					Youth			Adult				
	n	Mean	SD	Skewness	Kurtosis	n	Mean	SD	n	Mean	SD	F	d
Attend traditional events	648	2.92	1.01	-0.51	-0.87	99	2.65	0.98	549	2.96	1.01	8.38	0.31
Important to learn traditions	634	3.60	0.66	-1.62	1.99	100	3.36	0.75	534	3.65	0.64	16.53	0.44
Intertribal events	640	3.38	0.69	-0.89	0.42	98	3.11	0.72	542	3.42	0.69	17.18	0.45
Satisfied with life	647	3.26	0.75	-0.78	0.13	100	3.50	0.64	547	3.22	0.77	11.91	0.39
Stigma to mental health	646	1.93	0.87	0.58	-0.52	100	2.18	0.69	546	1.88	0.89	10.21	0.35
Safety of neighborhood	643	2.75	0.91	-0.33	-0.67	100	2.97	0.78	543	2.71	0.93	7.18	0.31
Connected to community	637	2.58	0.89	-0.41	-0.62	98	2.55	0.79	539	2.59	0.91	0.16	ns
Connected to tribe	641	2.74	0.98	-0.52	-0.71	98	2.74	0.78	543	2.74	1.02	0.0001	ns

Table 3
Identified Community Problems[1]

Adult Sample	Mean	SD	Youth Sample	Mean	SD
1. Alcohol Abuse	4.42	0.86	1. Alcohol Abuse	3.79	1.18
2. Diabetes	4.35	0.95	2. Drug Abuse	3.62	1.25
3. Obesity/Overweight	4.24	0.97	3. Youth Tobacco Use	3.61	1.21
4. Drug Abuse	4.22	1.04	4. Obesity	3.51	1.09
5. Youth Tobacco Abuse	4.12	1.02	5. Stress	3.46	1.16
6. Stress	4.04	1.06	6. Gangs	3.34	1.30
7. Depression	3.95	1.07	7. Diabetes	3.31	1.34
8. Gambling	3.86	1.10	8. Depression	3.30	1.12
9. Teen Pregnancy	3.84	1.07	9. Teen Pregnancy	3.28	1.30
10. Unemployment	3.80	1.03	10. School Dropout Rate	3.20	1.31

[1]A rating scale of 1-5 was used, with 1 = *Not a problem* and 5 = *A severe problem*

Connection to Community

When asked about their feeling of community connection, 62.2% of adults and 61.2% of youth reported feeling at least somewhat connected to the Tulsa AI community, while 37.8% and 38.7% indicated feeling at least somewhat not connected, respectively. Thirteen percent of adults and 6.1% of youth felt very connected; in contrast, 16.3% of adults and 12.2% of youth felt that they were not connected at all. Moreover, 67.8% of adults and 74.5% of youth felt at least somewhat connected to their specific tribes, while 32.2% and 25.5% reported feeling at least somewhat not connected, respectively. A noteworthy percentage of adults (17.7%) felt that they were not connected at all to their tribe, compared to 10.2% of youth. For each comparison, the more rigorous $\alpha = .025$ criterion for level of statistical significance resulted in the same set of conclusions as the conventional .05 criterion. However, none of these comparisons were statistically different; i.e., adults and youth did not differ statistically in their reported feelings of connection with the greater AI community or their specific tribe.

Adult participants listed a number of important qualities when asked the open-ended question (youth were not asked): "What do you think a caring community should look like?" First, respondents said a caring community should be "cohesive and collaborative." Members should "work and play well together" and "support one another." Second, a caring community should "take great care of its environment including parks, streets, and neighborhoods," which should be "clean and attractive to residents and guests alike." Third, this community should be "welcoming, warm, respectful, and promote happiness among its members." Fourth, a caring community should have plentiful programs and services for children, families, and those in need. These include outreach programs, recreational facilities, counseling, after-school programs, adequate and accessible health care, elder care, and money for things like funerals. Fifth, a caring community would reflect a high level of AI cultural awareness, respect differences, and provide equal opportunities for everyone. Finally, respondents stated that a caring community should be safe and relatively free from violence, drugs, and violations of property and person.

Safety and Well-being

We surveyed participants as to their perceptions of community safety and their levels of life satisfaction. Participants were asked to rate the perceived safety of their neighborhoods. Most adults (62.2%) rated their neighborhood safety as good to excellent, while 12.2% perceived it as poor. In contrast, 74.4% of youth perceived their neighborhood as safe, and only 3% thought the level of safety was poor. Scores on questions about neighborhood safety were higher among youth than among adults, $F (1, 641) = 7.18$, $p = .008$; partial $\eta^2 = .011$. In other words, youth perceived greater levels of safety and security in their neighborhoods than adults did.

In terms of life satisfaction, 40.2% of adults and 57% of youth reported being very satisfied with their lives right now. Conversely, 2.4% and 1% reported being very dissatisfied with their lives, respectively. Higher scores were recorded from youth than from adults on questions pertaining to life satisfaction, F (1, 645) = 11.91, p = .001; partial η^2 = .018.

Perspectives on Mental Health

Regarding mental health, 41.8% of adults indicated that there is stigma attached to seeking mental health care (33.5% said there was no such stigma, and 24.7% were unsure). In contrast, only 12% of youth reported perceiving such a stigma (62% did not, and 26% were unsure). Overall, youth reported less stigma regarding mental health than adults, F (1, 644) = 10.21, p = .001; partial η^2 = .016. When asked why the stigma exists, adults reported concerns about being labeled or stigmatized, being thought crazy or weak, and being ashamed of their problems; they also mentioned cultural reasons (e.g., taboo, belief that AIs are private people). Youth thought that the stigma exists because of the "shame" involved and "people's pride." Perceived causes of mental health problems included, for adults, "substance abuse," "stress/coping issues, "family background," poverty/unemployment, and health issues (e.g., "awareness of shorter life span," "problems with weight and diabetes"), and, for youth, "substance abuse," "parents," and "health issues."

Identified Community Problems and Needs

Interviewers queried AI adult and youth participants regarding their ratings of 24 possible problems. Table 3 lists the top ten problems identified by the participants in rank order by the mean rating (1 = *not a problem* to 5 = *a severe problem*). Statistically significant differences between youth and adult responses were noted on all social issues except racism, gangs, and religious or spiritual problems. Adults reported higher scores on all issues; that is, adults were more likely than youth to view each of the issues as a problem.

Participants were also asked, in open-ended question format, "What do you think are the biggest problems faced by AIs who live in the Tulsa area?" The results were similar to the ranked list above. Adults and youth reported the following categories, ranked in order of descending frequency: Substance Use/Abuse (e.g., "Alcohol is still our biggest problem"), Lack of Tribal Services/Resources (e.g., "There is no regional office for my tribe in Tulsa," "We need more activities for kids and food for families"), Unemployment/Poverty (e.g., "It is very difficult to find a job, especially if you are Native"), Health Issues (e.g., "We need more clinics and better clinics," "Diabetes and obesity are major problems"), Lack of Education (e.g., "Poor education for Indian folks"), Lack of Indian Culture/Education (e.g., "Lack of Native language," "Kids don't have enough educational places to learn about their heritage"), Lack of Community Involvement and Leadership (e.g., "Indians

don't communicate," "Lack of connectedness among tribes"), and Racism/Prejudice/Discrimination (e.g., "People think we're drunks and we steal," "They think that we're savages," "I've been called a squaw").

DISCUSSION

One of the primary purposes of the study was to identify community health and well-being needs that could then be addressed through program and community development. The following sections highlight the most pertinent areas for program development and intervention according to the participants surveyed.

Substance Abuse

Participants consistently listed drug and alcohol abuse as the most serious problem (see Table 3). Some community members noted that this perception may be the result of a perpetual stereotype, as AIs and non-AIs alike continue to perpetuate the myth that AIs have a higher prevalence of drinking than the general population (May, 1994). According to May, however, the evidence shows a different picture: Prevalence of drinking varies widely among tribes and communities. The research evidence suggests there are higher rates of binge drinking among AIs who drink, but not a higher prevalence of drinking overall (May). The fact remains, however, that participants viewed substance abuse as a major threat to community and individual health. Participants reported that substance abuse treatment and counseling was one of the most needed community services.

Health issues

Diabetes and obesity were reported as the most problematic health issues for AIs (see Table 3), and it appears that programs targeting prevention and treatment of these issues are warranted. Of course, access to health care must also be addressed. A number of respondents noted that there was a lack of health care services and insurance in the Tulsa area, and that increased health services and improved health care were the highest priorities for the community.

Mental health issues

Although the adult community sample was divided on whether there is stigma attached to seeking mental health care, participants agreed that stress and depression were serious problems in the community (see Table 3). Programs designed to address these issues, especially preventive measures, appear to be needed. Indeed, prevention, education, and treatment were noted as highly needed health services in Tulsa. It is unclear why youth and adults had different views on the stigma

attached to mental health care. It may be that youth have not yet developed such a stigma, or their views may represent a change in attitude toward mental health services. This finding could also be an example of "rose-colored glasses" among youth—who, although aware of problems among their peers, may maintain hope that things are not that bad and will improve.

Similarly, we do not know why adults and youth differed on ratings of safety and well-being. It might be that youth have experienced less discrimination and frustration with life than adults have, or youth may differ in their perception of the world, influenced by the so-called "optimism of youth" and the feeling of invulnerability that is common to youth. Perhaps their lives appear improved compared with those of the adults around them, although current rates of poverty, unemployment, and mental health issues cast this idea in doubt.

Socioeconomic issues

Given the high incidence of poverty in the sample and community (almost half earned less than $20,000 per year), and the large number of households with children, it is clear that socioeconomic issues are of paramount importance. Poverty and unemployment were reported as major problems, and many other issues noted by respondents have strong connections with poverty (e.g., depression, lack of transportation, gangs, stress– see Results section and Table 3). For example, many respondents reported that they lacked transportation. Although some community members felt that the severity of this issue might be exaggerated, it is nonetheless a cause for concern. Even those with dependable transportation may not necessarily have had *convenient* transportation (e.g., many had access to a car, but did not have money for travel expenses such as gas, repairs, and inspections). Programs aimed at eliminating poverty and providing assistance for those in poverty are greatly needed.

Cultural issues

The respondents appeared to highly value AI culture and activities focused on promoting it. However, youth demonstrated significantly less participation and interest in traditional Native activities than adults. Community members were concerned about this finding, and believed that programs focused on developing this interest and nurturing the ethnic identity of AI youth were needed. It is encouraging that almost 30% of youth indicated interest in frequently attending intertribal community events, as such activities are the reality of urban Indian communities. Involving youth in planning community activities and integrating traditional events into the framework of youth culture are recommended.

Youth Issues

Community members stressed that they were concerned about several youth issues, including tobacco use, teen pregnancy, and educating youth about Native traditions and culture (see Results section and Table 3). Youth themselves were primarily concerned about drug and alcohol problems among their peers and community.

LIMITATIONS

There are a few notable limitations to this project. First, although we had hoped to achieve a representative sample of AIs from the Tulsa area, there were far more female than male participants. Thus, the findings may not represent the views of AI men. As with most social science and applied research, we were not able to obtain a statistically random sample of participants. We utilized purposive, snowball sampling to recruit participants and offered an incentive for participation. Therefore, our confidence in generalizing the results from this study to all AIs, even in the Tulsa area, is limited. Recruiting this sample took considerable effort on the parts of both the community and university research partners, and we believe it provides meaningful data about community needs and issues. Finally, administration of the survey items was not counterbalanced; thus, the possibility exists that prior items influenced responses to later items. For example, respondents ranked a series of problems first; they then responded to open-ended questions about perceived problems. It is impossible to know whether their rankings influenced their answers to the open-ended questions.

An important component of CBPR is increasing the research capacity of the community. In this vein, project staff adapted a research-training curriculum developed by the Los Angeles urban AI community (directed by Carrie Johnson, PhD) to train AI community members as researchers for the Circles of Care project. The training curriculum included the following modules: History of Research in Indian Country, Institutional Review Boards (Protection of Human Participants Rights), CBPR, Conducting Key Informant Interviews, and Conducting Focus Groups. These community researchers, who were involved in collecting data with project staff, received a total of 8 hours of training: 4 hours in the fall of 2006 and 4 in the spring of 2007. A total of 20 community members (including 7 students from the university and 1 teenager) were trained to conduct research activities. A full-time community coordinator and administrative assistant were also funded through the SAMSHA grant. The community coordinator co-facilitated community advisory board meetings, developed and facilitated community/research events, and served as primary liaison between IHCRC and the Tulsa AI community. The administrative assistant recruited community participants, managed administrative duties, and kept and disseminated records and project information.

THE UNIVERSITY AND TULSA AI COMMUNITY PARTNERSHIP

Both IHCRC staff and the university research partners were eager to work together on the project for several reasons. First, both saw the benefit of combining resources to address health, economic, social, and mental health needs of AIs in Oklahoma. Second, IHCRC staff recognized the benefit of expanding research and evaluation capacity through collaborating with and receiving training from the university research partners. Third, the university research partners realized that developing a collaborative working relationship with IHCRC might increase scholarly understanding of AI issues, build a trusting relationship that could lead to ongoing research and community service projects, and improve recruitment and retention of AI faculty and students.

However, issues soon arose that exposed the challenges of CBPR. First, IHCRC staff asked a non-Native university researcher to assist in conducting the needs assessment. Although the researcher had received training in multicultural theory and social justice, he had only a passing familiarity with CBPR, and first assumed that he should independently develop a survey instrument and utilize university resources (e.g., graduate assistants, students) to collect the data with minimal collaboration with the community—bringing Eurocentric and imperialistic assumptions and practices to the research endeavor. When he learned that IHCRC staff wanted the research to be co-designed and approved by community members, these assumptions caused him some initial frustration, mostly due to his lack of familiarity with CBPR, the increased amount of time needed for completion of the project, and perceived lack of control. However, after the initial misunderstanding, he recognized the automatic, culturally encapsulated assumptions guiding his reactions, actively sought training and education in CBPR and research among AIs, and fully embraced its underlying principles and goals. This change of perspective became helpful when the university legal counsel had some concern regarding intellectual property rights.

As is standard practice, when the university research partners entered into a contractual agreement with IHCRC, the university legal counsel drafted a memorandum of understanding. This initial document awarded all intellectual property rights to the university and its principal investigator (a non-Native researcher). Although universities often use this practice to protect data and publication rights, it directly contradicts the core principles of CBPR (Israel, Schulz, Parker, & Becker, 1998; Viswanathan et al., 2004), which state that the research and its data belong to the community and its members. The university research partners and IHCRC staff agreed that the community and its representatives should have full intellectual property rights and discussed the situation with legal representatives for both parties for 2-3 months, educating the university about CBPR and research with Indigenous populations. It helped that they presented a consolidated

front; in the end, the university legal counsel made provisions in the contract so that the researcher could publish material from the project, in partnership (and with the approval of) IHCRC and the community.

Community-based participatory research projects represent a valuable opportunity for both communities and universities. This project demonstrated a successful partnership that benefitted IHCRC, the university research partners, and the Tulsa AI community in a variety of ways:

University faculty and staff learned about CBPR and community members learned about the research process. Many community members received research training and collaborated in the implementation of the research project. They—and the community advisory board—gained a greater appreciation for research and its usefulness for improving community conditions. They also experienced empowerment (e.g., they negotiated intellectual property rights with the university and claimed ownership of the data), and increased their capacity for evaluating, designing, and implementing research projects for themselves—an important principle of CBPR.

The project provided meaningful information that was disseminated to the community, and increased capacity for an Urban Indian Health Center. In accordance with CBPR principles, the results from this study have been disseminated to the community and beyond. For example, the university research partners and IHCRC project director have presented the results of the project and the CBPR process at national conferences. Also, the university research partners and the community advisory board provided technical reports to community members, posted the results on the IHCRC Web site, and presented the results at community meetings. One community leader expressed the importance of "looking at our data" to improve conditions for the Tulsa AI community. The study results also helped IHCRC prioritize its goals and allocate resources to those areas most needed (e.g., development of substance abuse treatment and prevention and health promotion programs). In addition, important strengths and needs were identified and included as part of a larger research project to develop a comprehensive service system model. This model has been refined and presented to IHCRC and the community, and is currently being implemented and evaluated.

The project served to assist IHCRC with developing an improved system of care and additional programs. For example, IHCRC has successfully obtained three youth/family grants for the next 3-5 years to address cultural traditions, food, physical activity, community gardening, community building, and family/community empowerment (from the Centers for Disease Control, the U.S. Department of Agriculture, and the new Oklahoma Tobacco Settlement Endowment Trust). These programs are designed to teach healthy nutrition and sustainable food production, and involve community members in gardening and communing together. They also include cultural components and activities to emphasize Native beliefs and values.

Additionally, the partnership forged through this study has led to other collaborative research and service projects. For example, IHCRC and university research partners have submitted a proposal to the National Institute of Mental Health to develop a community-based prevention program focused on strengthening cultural identity to prevent substance abuse and mental illness and to promote school functioning and youth assets. Moreover, work is underway to submit a grant proposal the National Institutes of Health to address organ/tissue donation among AIs and to develop a social marketing campaign.

We hope this project will serve other Urban Indian Health Centers in developing and implementing community health research with university partners.

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