COMMUNITY HEALTH FORUM

2019-2023

URBAN INDIGENOUS COLLECTIVE

COMMUNITY HEALTH FORUM: END OF YEAR REPORTING

CONTENTS

INTRODUCTION

Lenapehoking and surrounding areas, also known as the New York City tri-state area (New York, New Jersey, Connecticut) is the traditional, unceded land of the Lenape, the Manahatin, the Canarsie, the Shinnecock, the Reckgawanc, Munsee and Haudenosaunee Nation. Our Indigenous communities have long held intimate knowledge about our people, the land, and our non-human relations (plants and animals); indigenous plant medicines; as well as health and cultural practices and traditions. With the settler-colonial project, however, came systematic policies and practices (e.x. Forced removal, Indian Removal Act Treaties, boarding schools, Indian Reorganization Act of 1934, Dawes Act of 1886, Indian Relocation Act of 1956, and many many more) that targeted our way of life, with the intent of eliminating our existence. Today, because of the enduring legacy of settler colonialism, Indigenous people experience a disproportionate burden of health disparities including: alcohol and other substance misuse; depression, anxiety, and suicidality; child abuse and neglect and domestic violence; posttraumatic stress disorder; unclean water, and proximity to hazardous waste sites. Further, because of extractive research practices and a lack of data sovereignty, these stories about Indigenous health disparities are often presented as individual deficits, instead of a response to the larger, centuries-long project of settler colonialism. Despite being systematically targeted, Indigenous people are still here. We are taking back control of our data which is more than just numbers, but represent our past, present, and future.

WE ARE CONTINUING OUR TRADITIONS AS KNOWLEDGE KEEPERS AND SCIENTISTS. WE ARE WORKING WITH OUR COMMUNITIES TO DEVELOP AND IMPLEMENT CULTURALLY-TAILORED SERVICES TO BEST SERVE OUR RELATIVES.

PISCOPO (2017). AMERICAN INDIAN OR ALASKA NATIVE (AIAN) 2016 NSDUH SUMMARY SHEET.
RETRIEVED FROM: HTTPS://WWW.SAMHSA.GOV/DATA/SITES/DEFAULT/FILES/AIAN%202016%20SHEET_FINAL_2018.DOCX
PARK-LEE, E., LIPARI, R. N., BOSE, J., HUGHES, A., GLASHEEN, C., HERMAN-STAHL, M., PENNE, M., PEMBERTON, M., & CAJKA, J. (2018). SUBSTANCE USE AND MENTAL HEALTH ISSUES AMONG U.S.-BORN AMERICAN INDIANS OR ALASKA NATIVES RESIDING ON AND OFF TRIBAL LANDS. 48.
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URBAN INDIGENOUS PEOPLE & HEALTHCARE PROVISION

The US federal government fulfills its treaty responsibility to provide healthcare to Indigenous people, through the Indian Health Services (IHS). Currently, members of the urban Indigenous community only qualify for services provided by IHS if they are a member of a federally recognized tribe of American Indian or Alaska Natives in the United States. Because the Indian Relocation Act of 1956 lured Indigenous people into metropolitan areas with the largely unfulfilled promise of support and services, we now see approximately 70% (approximately 1 million) Indigenous people living in or near urban areas. Still there remains a heavy reservation-focus when it comes to research and service provision.

For example, only 25% of the urban Indigenous population lives within an IHS service area with only about one percent of IHS budget allocated to urban programs and no uniform policy regarding Urban Indian Health Programs, so the need for culturally-specific services remains high.

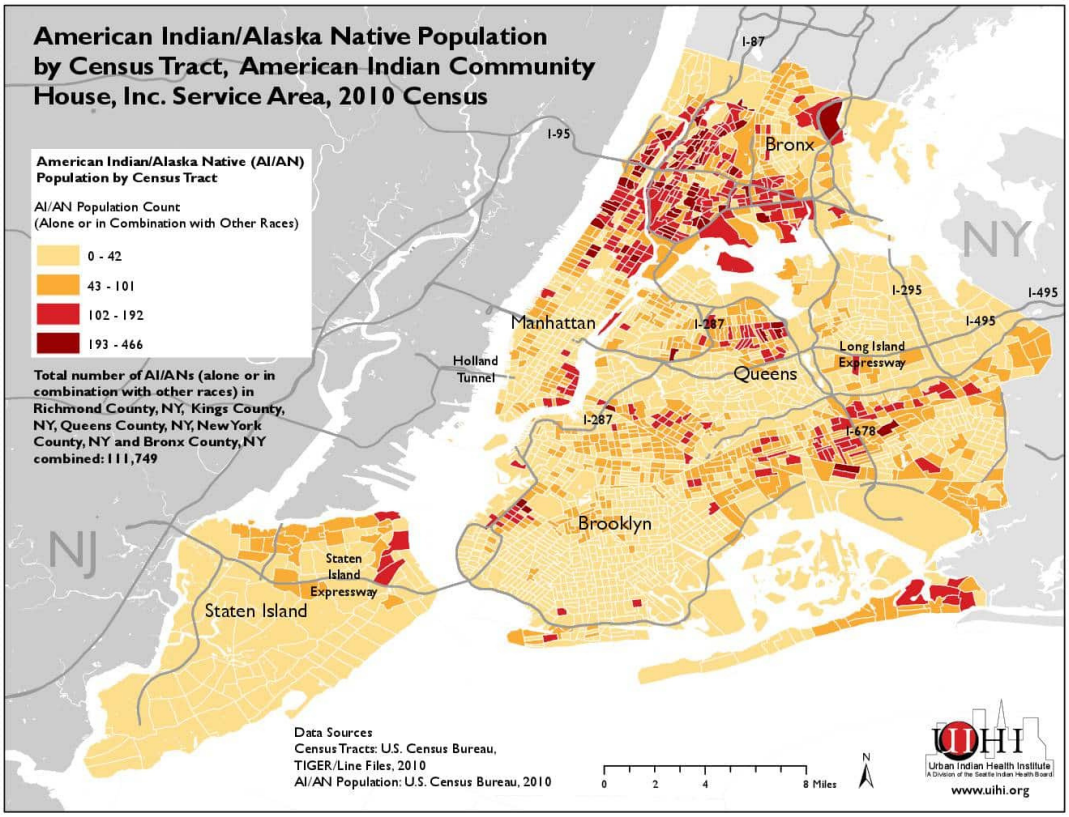
This is especially evident in New York City which is home to the largest number of AI/AN people (111,749; alone or in combination with another race) out of any other city in the US. Urban Indigenous people living in New York City account for just over half of the 221,058 New Yorkers who identified as AI/AN in the 2010 Census (Norris, Vines, &; Hoefel, 2012). Even with this substantial urban Indigenous population, there is only one Urban Indian Health program in NYC, which has a scope of outreach and referral, compared to the full ambulatory, physical and mental health, and broader service offered at Urban Indian Health Programs in other services areas.

Thus, this multi-part Community Health Forum lays the groundwork for better understanding the health priorities and services needs of Urban-living Indigenous people.

"ELIGIBILITY," ABOUT IHS, N.D., HTTPS://WWW.IHS.GOV/ABOUTIHS/ELIGIBILITY/.
YUAN, N. P., BARTGIS, J., & DEMERS, D. (2014). PROMOTING ETHICAL RESEARCH WITH AMERICAN INDIAN AND ALASKA NATIVE PEOPLE LIVING IN URBAN AREAS. AMERICAN JOURNAL OF PUBLIC HEALTH, 104(11), 2085-2091. HTTPS://DOI.ORG/10.2105/AJPH.2014.302027
"INVISIBLE TRIBES: URBAN INDIANS AND THEIR HEALTH IN A CHANGING WORLD" (URBAN INDIAN HEALTH COMMISSION , 2007), HTTPS://WWW2.CENSUS.GOV/CAC/NAC/MEETINGS/2015-10-13/INVISIBLE-TRIBES.PDF.
NORRIS, T., VINES, P.L. & HOEFEL, E. (2012). THE AMERICAN INDIAN AND ALASKA NATIVE POPULATION: 2010. U.S. CENSUS BUREAU. RETRIEVED FROM HTTPS://WWW.CENSUS.GOV/PROD/CEN2010/BRIEFS/C2010BR-10.PDF)

COMMUNITY HEALTH FORUM

The Community Health Forum (CHF) was born in 2019, out of UIC's mission to support access to culturally-tailored health and wellness services for self-identified Indigenous peoples in Lenapehoking and the tristate area through advocacy, research, community programming, and direct services. The CHF is rooted in the development of community-informed programming that supports traditional healing practices while working holistically with western medicine. Through an emphasis on Community Based Participatory Research (CBPR), UIC cultivates Indigenous-informed decolonial data collection. Our decolonial research methodologies are underscored by consultation, continuous consent, co-creation, and data sovereignty.



All research is done with proactive consultation with our community members, who give affirmative consent every step of the research process from data collection through dissemination. Participants are affirmed sovereignty over their data in that they may withdraw their participation and/or any data related to it from study at any time with no consequence. This community-based research, in turn, informs the health programming that UIC seeks to offer at our community center.

METHODOLOGY

Our data collection methodology consisted primarily of a survey administered both online and in-person, as well as two focus group discussions.

Who was included?
We included self-identified Indigenous adults, 18 and older, living in the NYC tri state area (New Jersey, Connecticut, New York).

How did we recruit?
We recruited participants online through emails list servs, newsletters, social media posts, and asking our community partners to share the recruitment materials. We also shared about the CHF surveys and upcoming focus groups at community events, such as the Indigenous Peoples Day Pow Wow 2022 and the Columbia University Pow Wow 2023. Potential participants were invited to fill out the survey via a QR code and could also sign up to participate in the focus group. UIC staff were also available to answer questions about the CHF. Data were collected between September 2019 and May 2023.

How were surveys and focus groups conducted?
The CHF Survey was administered through Google Forms, which assessed non-identifiable demographic information, as well as questions about physical and mental health needs, access to services, and spiritual/cultural practices. Meanwhile, the focus groups were conducted on an encrypted Zoom account, and covered issues related to health, mental health, cultural connection, as well as barriers and facilitators to accessing health services.

How were participants compensated?
Each participant for our online focus groups was compensated $40 for their time via Paypal or electronic gift card. People who completed the survey could choose to be entered into a raffle for a chance to win a gift card up to $30 at an Indigenous-owned business.

DATA ANALYSIS

After both focus group sessions, the conversation was transcribed, paired with notes written during the focus group, and coded thematically. In the following section of this report, these results are summary and descriptive statistics from our survey responses.

Throughout the planning, data collection, analysis, and dissemination processes, the Community Health Forum was advised by our Community Advisory Board (CAB), a group of Indigenous Elders, leaders, and community members who meet quarterly to inform the guidance of the development of UIC's projects and initiatives.

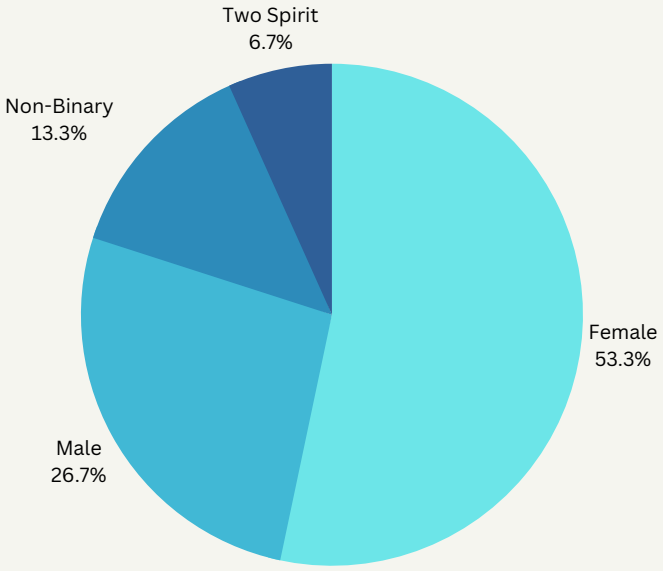
Examples of CAB feedback included: development of focus group questions, development of outreach materials and strategies, deciding data points were to be presented and how graphic representations of data were displayed, and future dissemination of the information beyond this report. The research protocol was approved by the Columbia University Institutional Review Board.

SURVEY RESULTS

DEMOGRAPHIC INFORMATION

GENDER IDENTITY

N=140

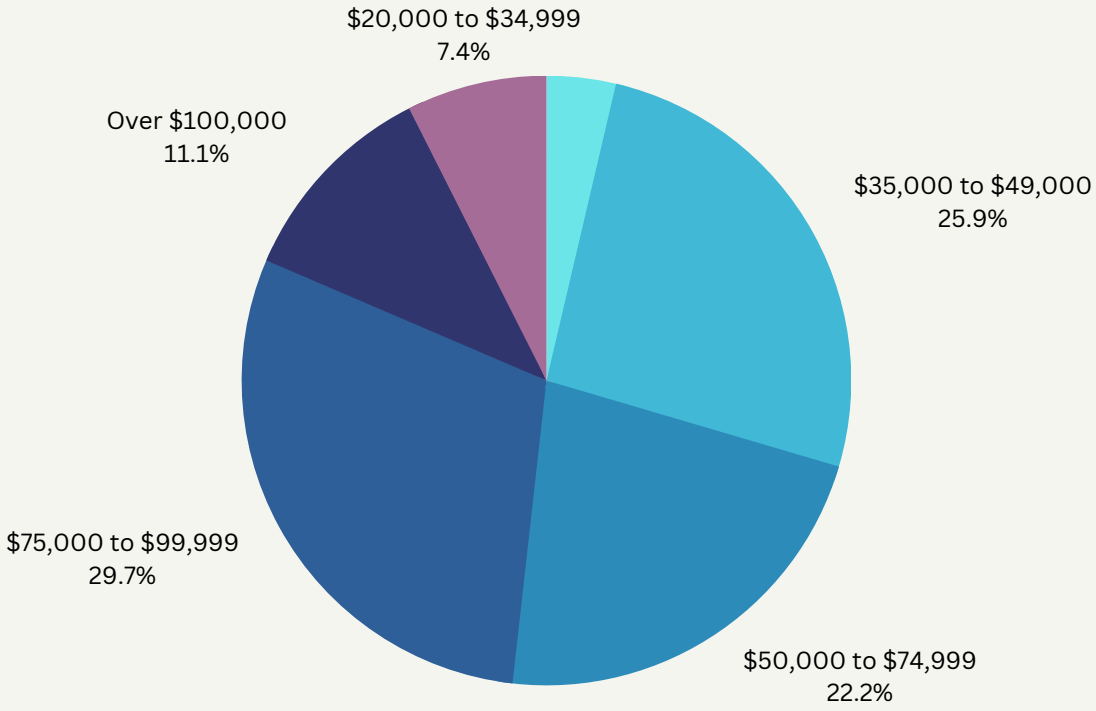


RESPONDENTS IDENTIFIED WITH A MULTITUDE OF TRIBAL NATION AFFILIATIONS INCLUDING:

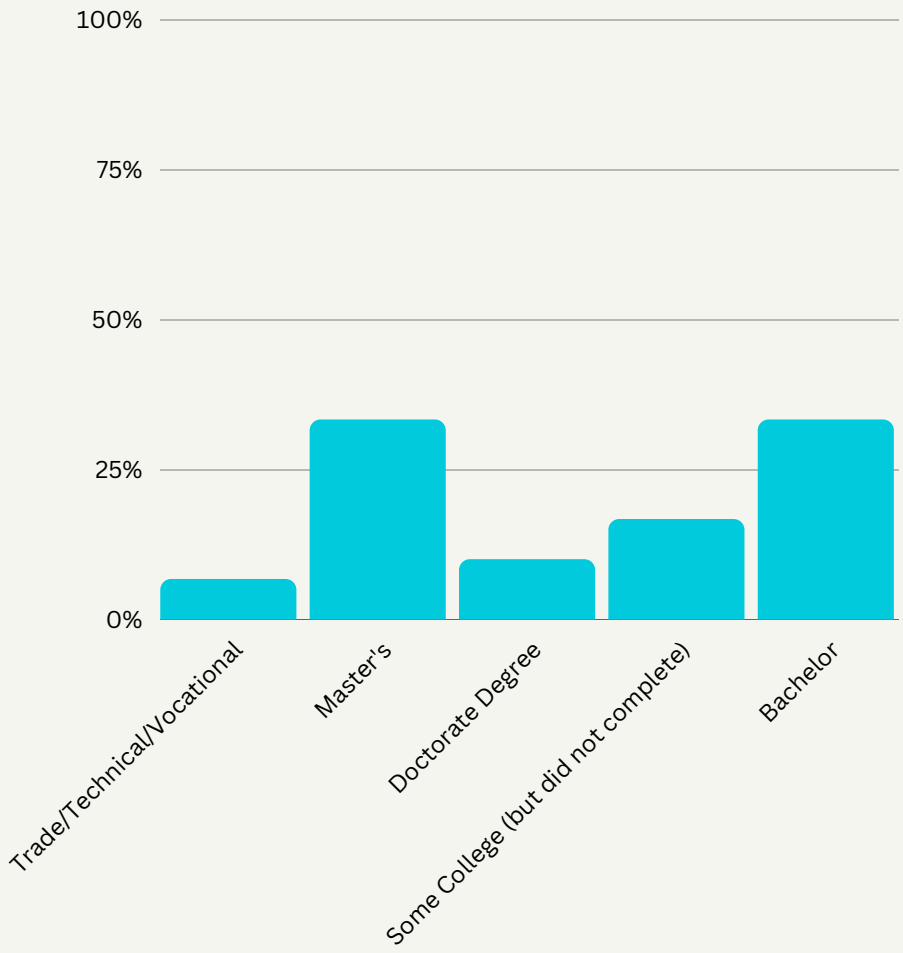
YAKAMA NATION, CHINOOK INDIAN NATION, TOHONO O'ODHAM NATION, TONAWANDA SENECA NATION, SIKSIKA NATION (UNDER THE BLACKFOOT CONFEDERACY)

FINANCIAL BACKGROUND

N=116

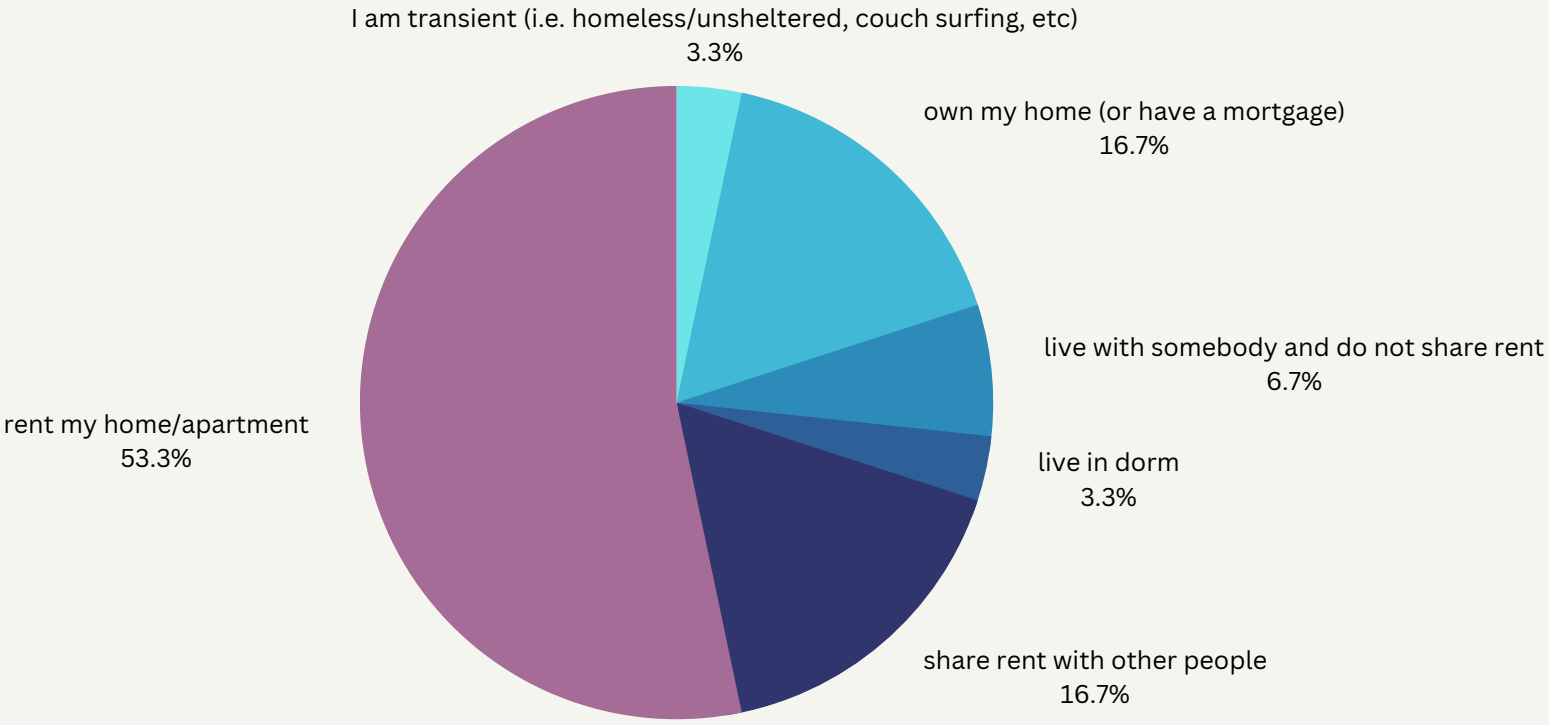


EDUCATIONAL BACKGROUND N=133



WHEN ASKED ABOUT THE HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT, THE MAJORITY OF OUR RESPONDENTS (33%) REPORTED HAVING OBTAINED A BACHELOR'S DEGREE.

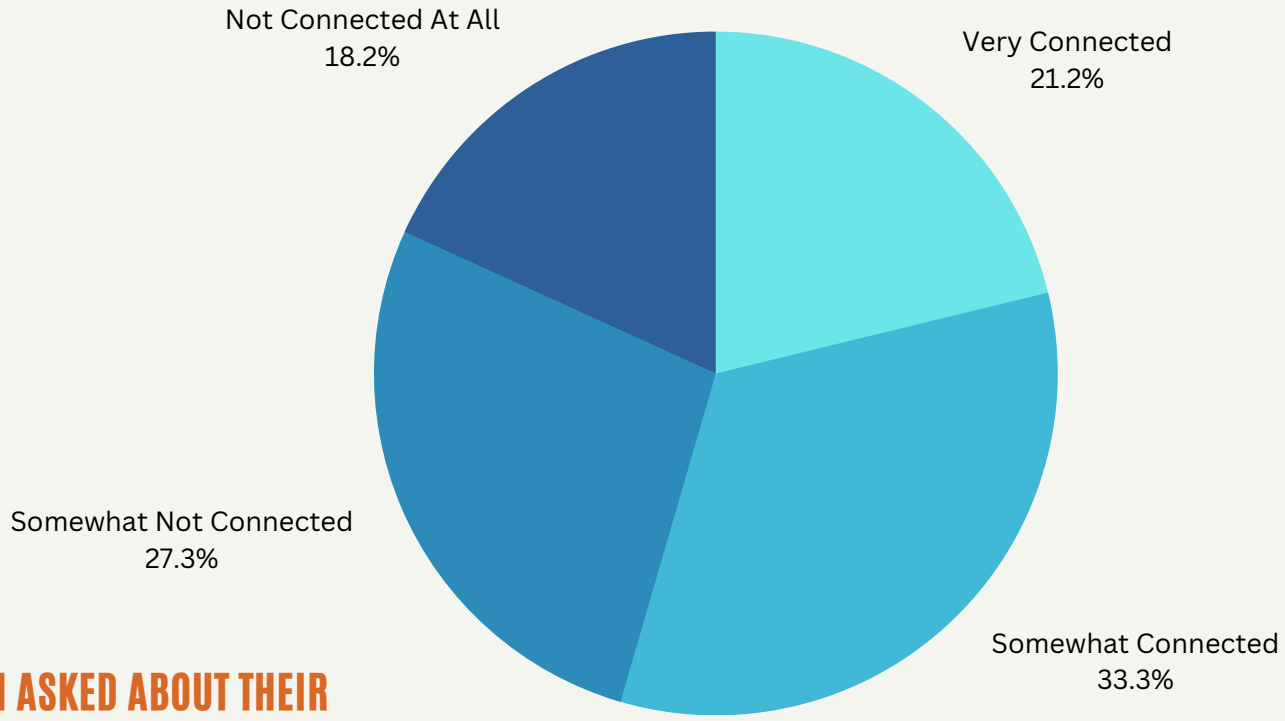
HOUSING SITUATION
N=136



WHEN ASKED ABOUT THEIR HOUSING SITUATION, THE MAJORITY OF RESPONDENTS (53%) RENTED THEIR HOME OR APARTMENT.

COMMUNITY CONNECTION

HOW CONNECTED DO YOU FEEL TO THE LOCAL NATIVE AMERICAN/ INDIGENOUS COMMUNITY?
N=145



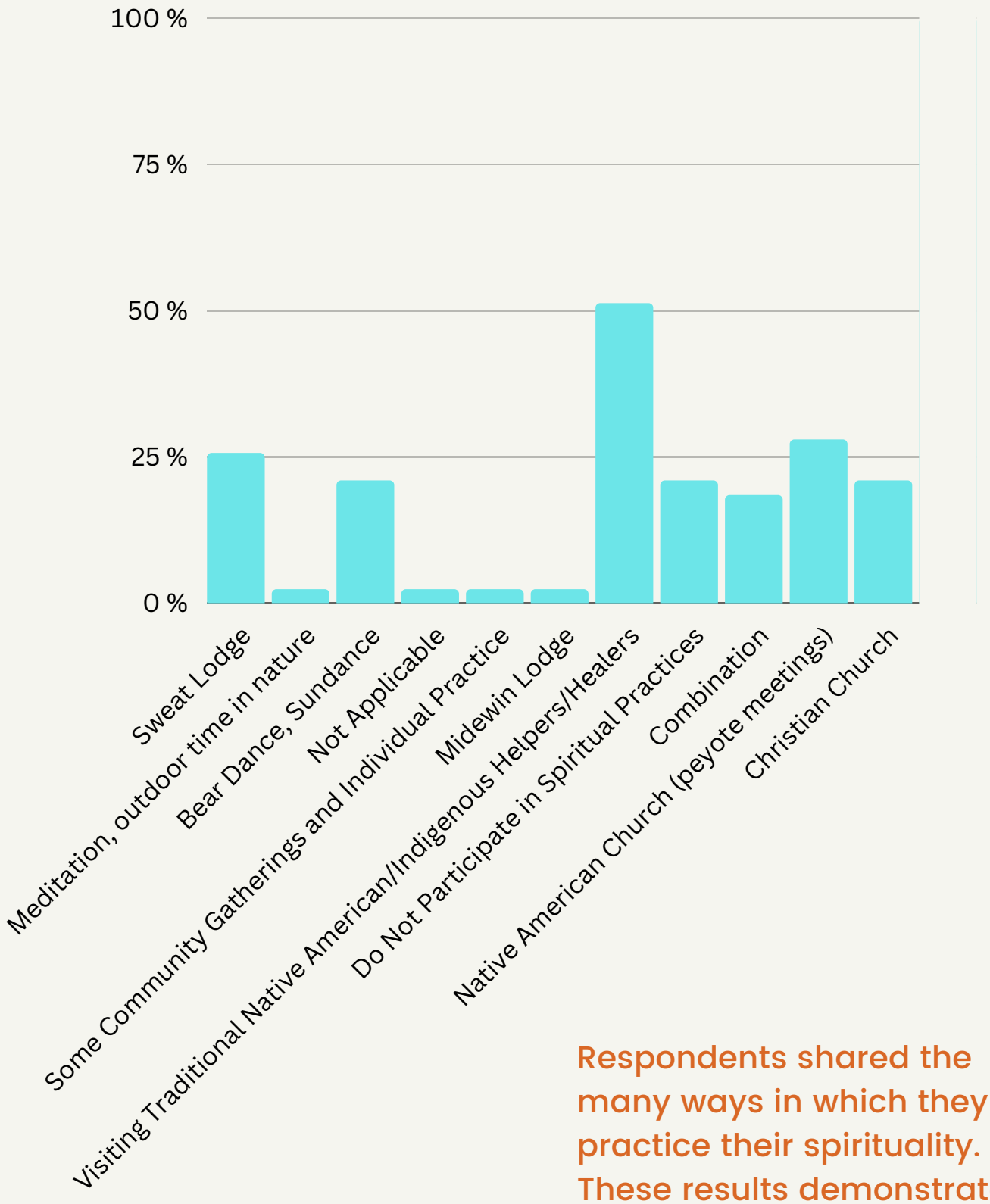
WHEN ASKED ABOUT THEIR CONNECTEDNESS TO INDIGENOUS COMMUNITY, OVER 54% FELT SOMEWHAT OR VERY CONNECTED TO THE LOCAL INDIGENOUS COMMUNITY

WHAT ARE THE GREATEST STRENGTHS OF NATIVE AMERICAN/INDIGENOUS PEOPLE IN THE TRI-STATE AREA?

When asked about the greatest strengths of Native American/Indigenous people in the Tri-state area, common themes included:

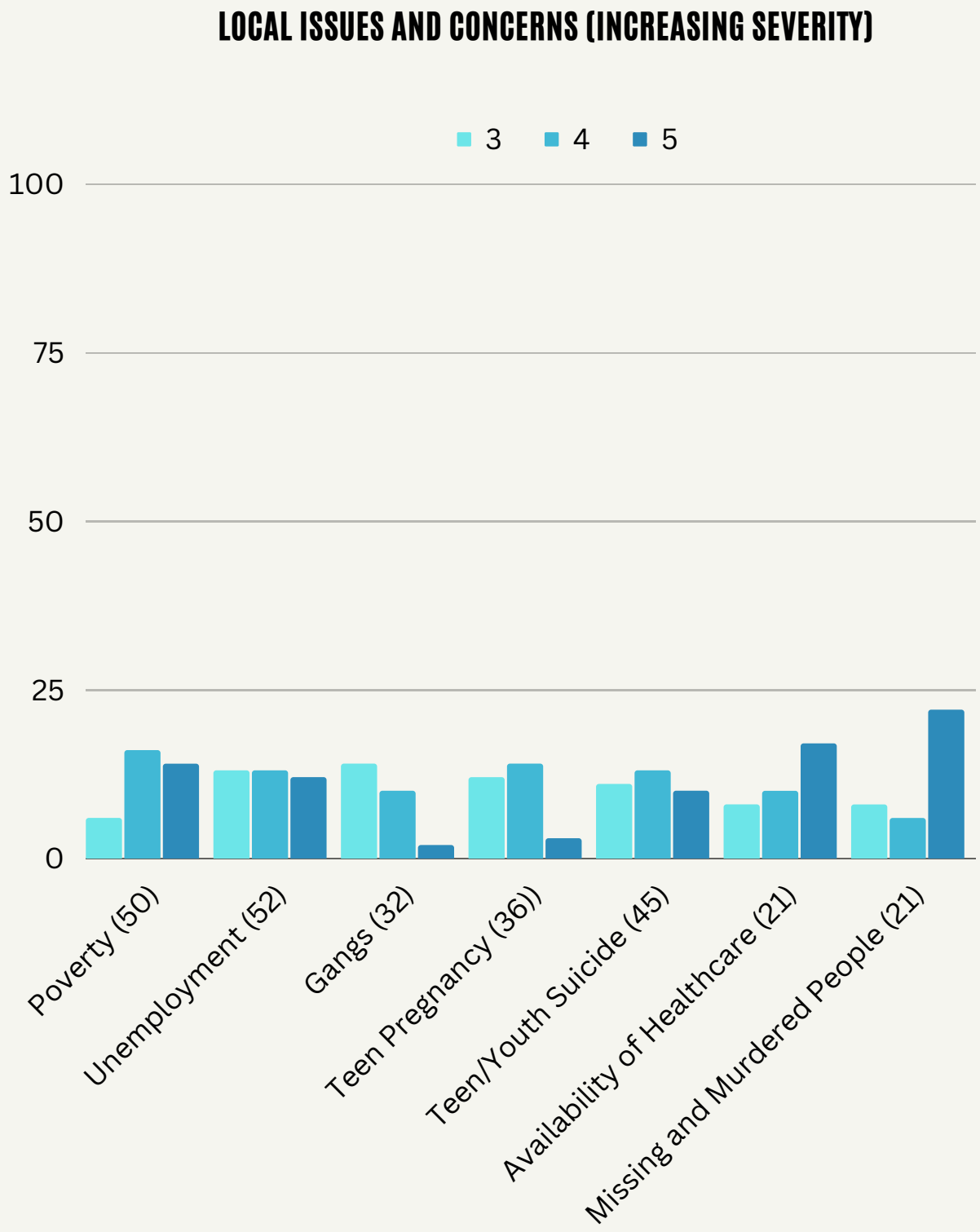
- Strength of Indigenous community
- Diversity of Indigenous populations
- Ability to connect over shared cultural and spiritual traditions that honor ones identity

WHAT ARE YOUR PREFERRED SPIRITUAL PRACTICES?
N=138



Respondents shared the many ways in which they practice their spirituality. These results demonstrate a breadth of ways in which they connect.

TRI-STATE NATIVE INDIGENOUS ISSUES AND CONCERNS



We asked respondents to rank issues and concerns affecting indigenous communities across the tri-state area on a scale of 1-5, with 5 being the most urgent. Standouts amongst these issues were housing, availability of healthcare, stress, anxiety, depression, food sovereignty, alcohol abuse, domestic violence, and the crisis of murdered and missing women, which were ranked of the highest urgency (5) by the majority of respondents.

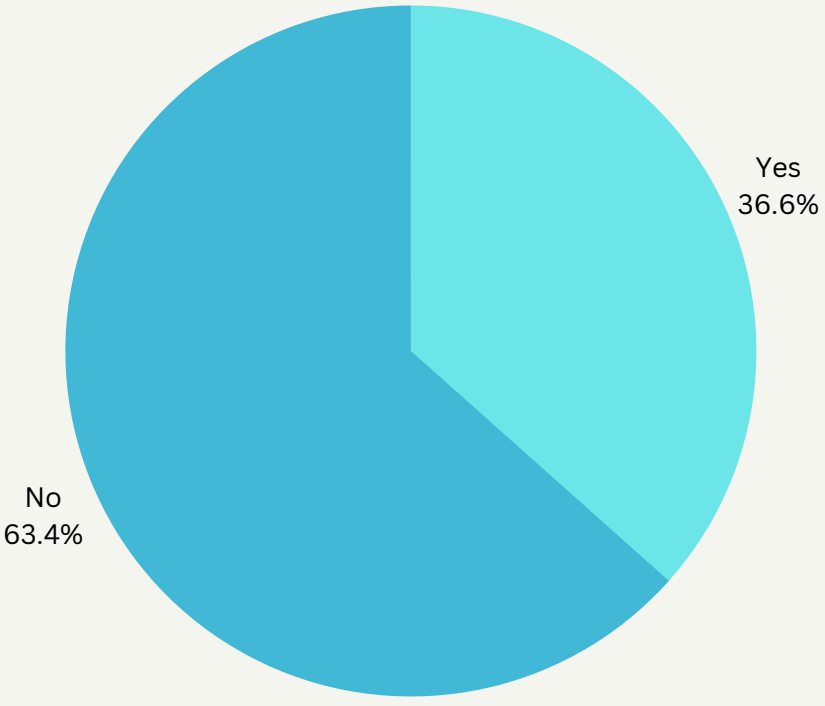
MENTAL HEALTH

WHAT DOES "GOOD MENTAL HEALTH" MEAN TO YOU?

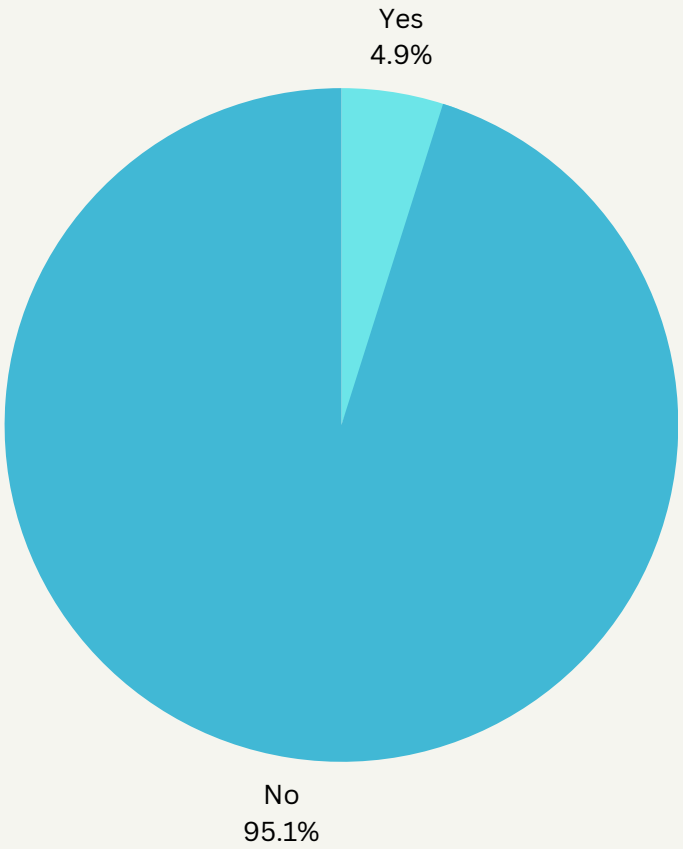
WHEN ASKED WHAT “GOOD MENTAL HEALTH” MEANT TO THEM, THE RESPONSES WERE UNDERSCORED BY THEMES OF MENTAL RESILIENCE AND THE ABILITY TO FUNCTION AND RESPOND TO THE TRIALS OF EVERYDAY LIFE ROOTED IN PERSONAL AND COMMUNITY HEALTH, SPIRITUAL BALANCE, AND ACCESS TO QUALITY HEALTHCARE AND FOOD.

DID YOU EVER NEED, BUT NOT RECEIVE SERVICES FOR...

MENTAL HEALTH/BEHAVIORAL HEALTH SERVICES
N=141



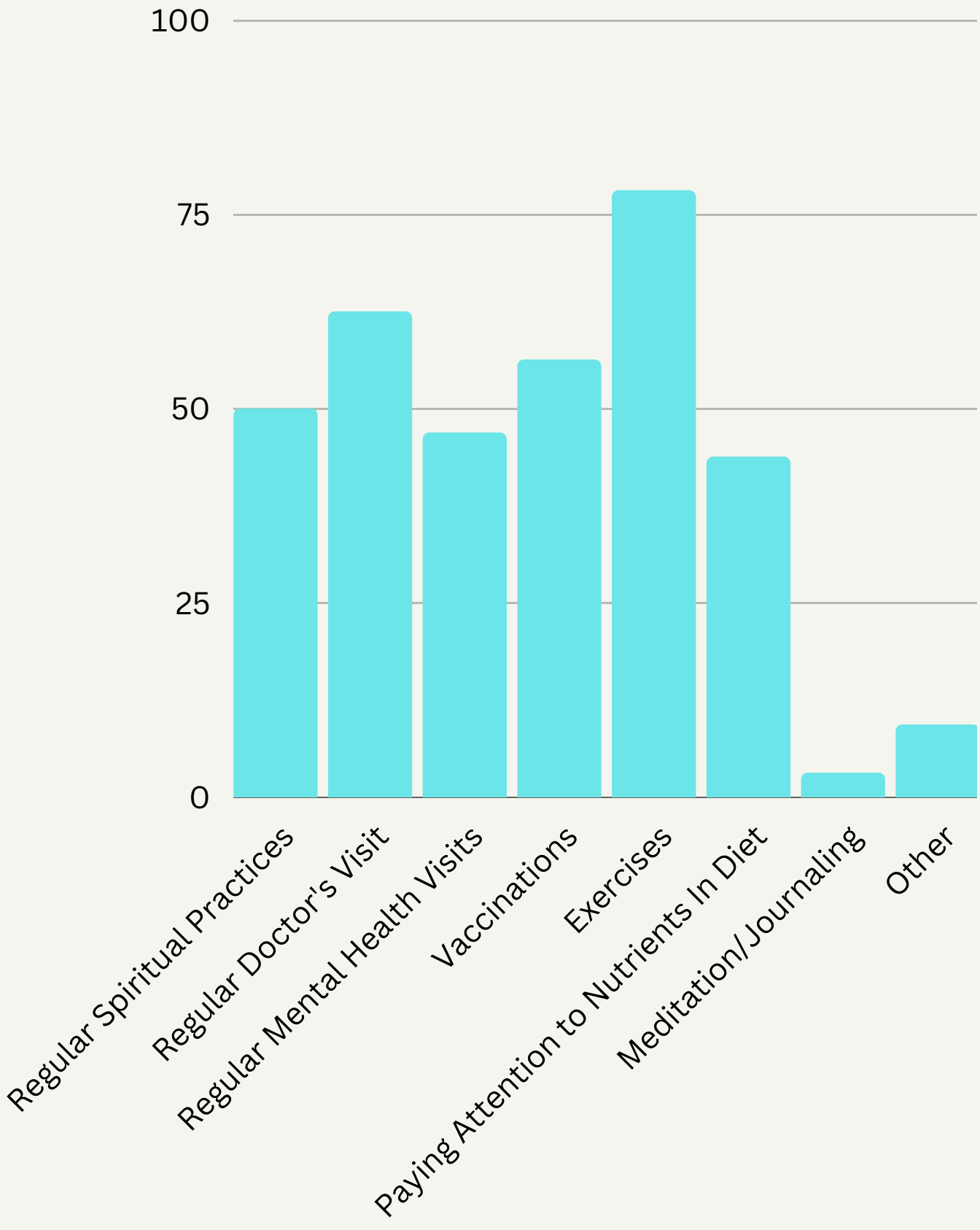
Substance Use/Abuse Services
N=140



SEEKING SERVICES

WHAT DO YOU DO TO MAINTAIN YOUR HEALTH?

N=22



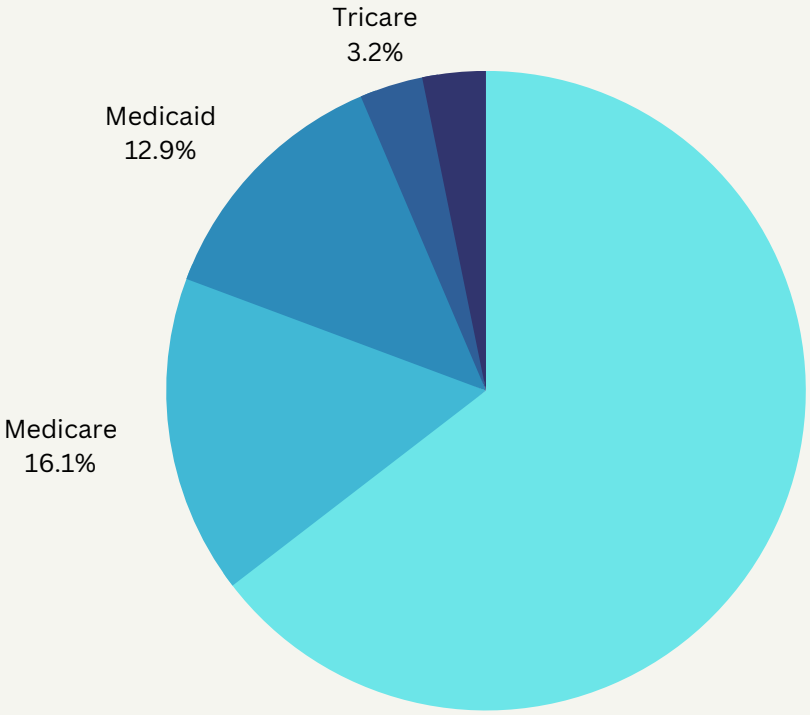
WHAT DO YOU THINK CAN BE DONE TO REDUCE EMBARRASSMENT OR SHAME ABOUT SEEKING OUT/RECEIVING MENTAL HEALTH SERVICES OR SUBSTANCE USE SERVICES?

Amongst the most common reasons attributed for the shame or embarrassment across the Native community in seeking healthcare is fear of people seeing mental illness as weakness, the minimization of everyday experiences of intergenerational trauma, stigma coming from family, and challenges with vulnerability.

In an effort to improve the shame and embarrassment Indigenous people experience when seeking mental healthcare, respondents suggested encouraging open discussion of mental health challenges and healthcare within community, using more culturally and spiritually informed practices to address mental health challenges, enhancing accessibility of safe spaces, and bonding with other members of Indigenous community over shared mental health challenges.

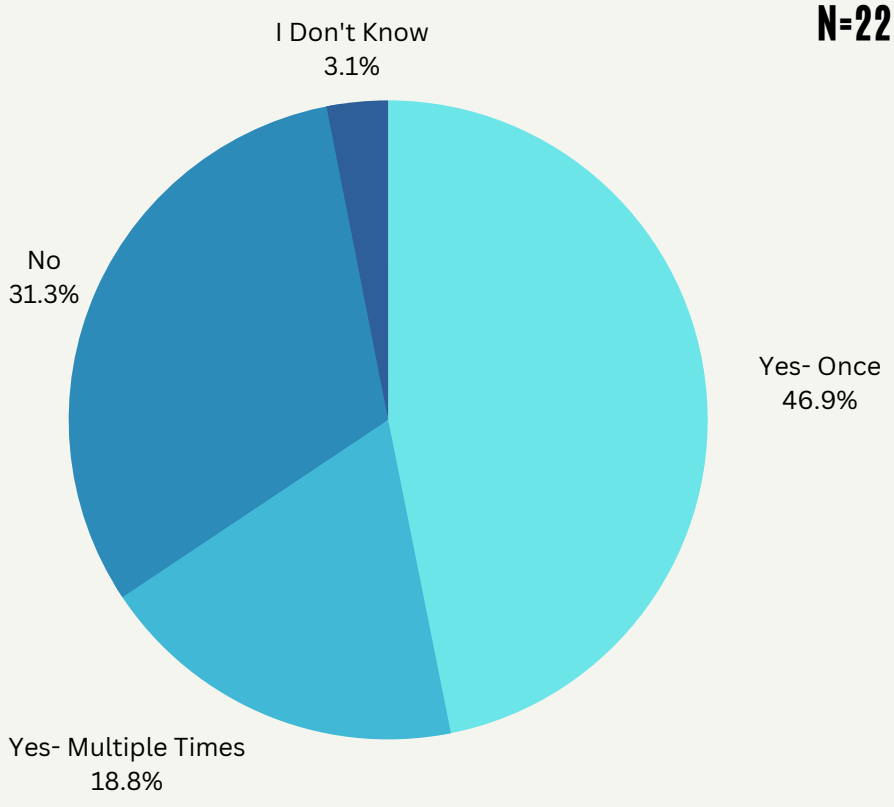
COVID-19 EXPERIENCES

WHAT TYPE OF HEALTH INSURANCE DO YOU HAVE?
N=21



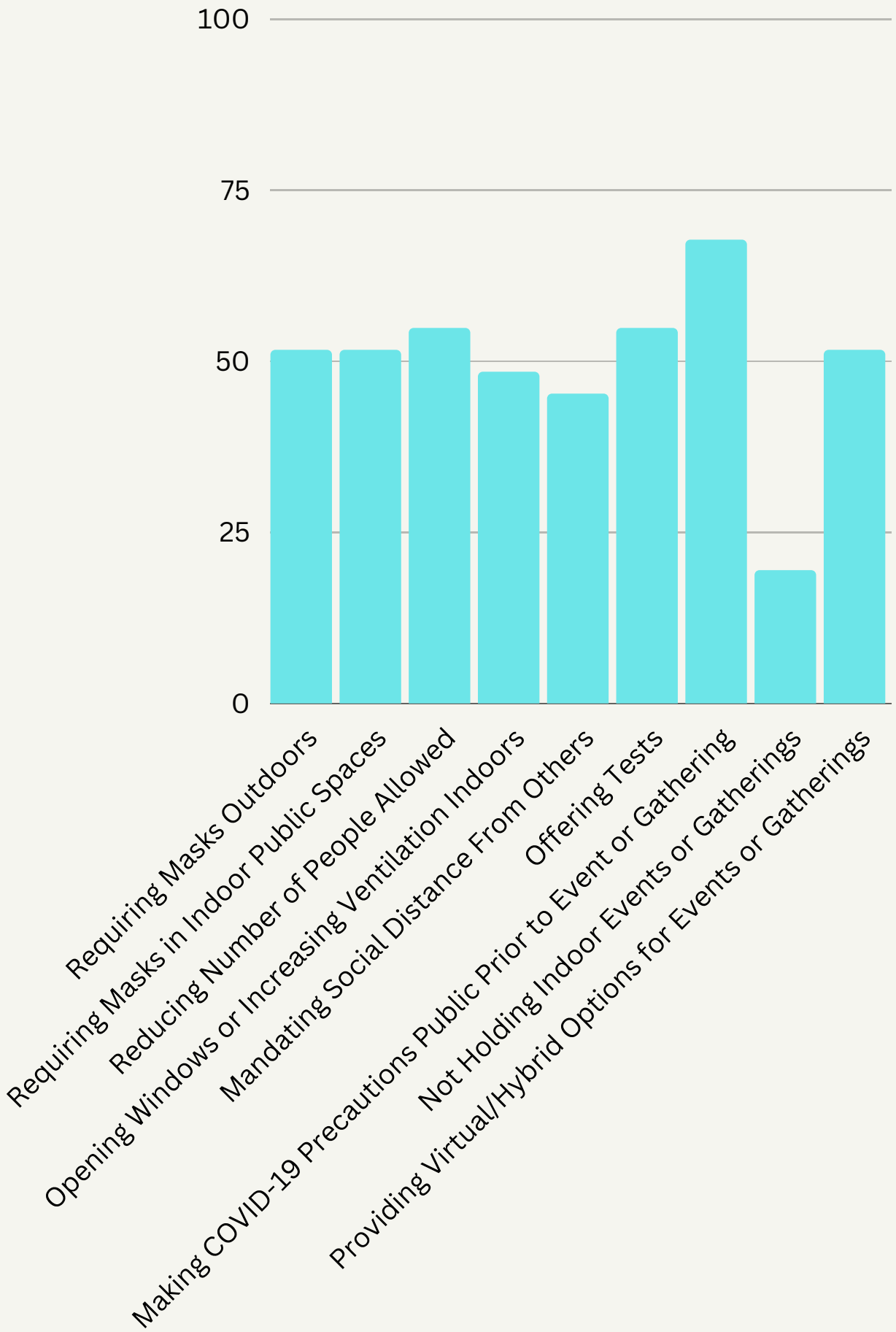
INDIGENOUS PEOPLE ARE OFTEN DISPROPORTIONATELY NEGATIVELY IMPACTED BY DISEASES AND THE NOVELTY OF THE COVID-19 PANDEMIC. AS SUCH, UIC WAS ESPECIALLY INTERESTED IN UNDERSTANDING OUR INDIGENOUS COMMUNITIES' EXPERIENCES WITH COVID-19

HAVE YOU CONTRACTED COVID-19?
N=22



WHAT PRECAUTIONS DO YOU PREFER AN INSTITUTION (EX. GOVERNMENT, GROCERY STORE, RESTAURANT) PUT IN PLACE TO KEEP YOU AND YOUR COMMUNITY SAFE AGAINST COVID-19?

N=20



FOCUS GROUPS THEMES

DISPLACEMENT/ EAST COAST INDIGENOUS LONELINESS

Many of the participants within our focus groups emphasized feelings of displacement, whether generationally or short-term. When feelings of loneliness were vocalized, many spoke of the distance they felt from their original Indigenous communities or systems of support. One of our focus group participants describes the process of readjusting after he was displaced by the 2018 California wildfires and came to New Jersey. The pandemic happened during this adjustment period for him while he was both reconnecting with old friends and trying to meet new people at the same time. Because of this, the pandemic posed significant challenges for him as he was trying to date, socialize and build a community of his own on the East Coast. For another one of our participants, she felt the loss of community and the strong friendships she developed with Indigenous females, as well as Two Spirit folks, back home when across the country for graduate school. Leaving her community behind for graduate school has been very difficult in terms of stress but she still tries to reach out to those friends and look to them for wisdom. The support group this participant had at home was older and very engaged in work for their communities. As a part of her way of relieving stress, she calls her community back at home and asks them what activities they are up to. These connections help to ground her within both her personal tribal community and the Indigenous community in general. The sense of longing she feels for her community back at home has motivated her to look for Indigenous people within her current school to connect with regarding shared Indigenous identity and values.

LAND LOSS AND SPIRITUAL HARM

Deeply connected to feelings of displacement and isolation from Indigenous communities was the accompanying sense of loss of physical connections to community as embodied by land. Our participants often underscored that the loss of land that often accompanied displacement harmed them spiritually. Our participant who was displaced from his home due to the California wildfires found that exercise was harder to do because he was no longer as motivated within his life as he was on the West Coast. He described his land as a natural motivator for exercise and being active, which he missed a lot. Another participant who struggled with stress, anxiety, and depression said she thought it had a large part to do with disconnection from soil, land, and water.

PLANT MEDICINE

The usage of plant medicine was underscored by nearly all of the participants within our focus groups. One of our community members described being able to stop medicating with food when he tried cannabis for the first time. He realized that it abated his symptoms of anxiety, ADHD, etc. and this is what led him into exploring his diet and eventually breaking the first initial addiction and connection to bad food in his life. He credits cannabis with opening up his world and his connection directly to Spirit using medicinal herbs. He has also connected to Indigenous medicine stories in other Native traditions, specifically tobacco and how the great Spirit gave his people tobacco to offer with their prayers. Another participant explains that when she is stressed or anxious she goes to cedar or another local medicine, and burns it to pray with it. She feels as if tobacco has been helpful because smoking tobacco calms people down, and calls forth the truth.

CULTURALLY RELEVANT MENTAL HEALTHCARE

Nearly all of our participants faced challenges in obtaining culturally relevant mental healthcare. One of our participants described a long search for Indigenous mental healthcare practitioners and another described difficulty in connecting with non-Indigenous therapists offered by her graduate school. She described one of the most successful mental health services she's ever had was in undergrad where they had something called “wellbeing” coaches. These coaches were Indigenous women who used to be students who now offer support to other students. Another participant has never experienced Western therapy, but has received ample mental healthcare from sweat lodge sessions. This participant even went as far as saying that sometimes the lodge might have saved her life, as the lodge was a place where she learned how to be really honest with herself. Especially when she was beginning to transition from the use of alcohol, sessions in the sweat lodge were critical for detoxing her body. She feels as if this is the way that Native people should heal and reconnect with themselves, as she has seen Native people in even worse situations than her have their lives saved multiple times by the sweat lodge. Finally, one of our participants was institutionalized by a state foster care system, and because her other relatives had been subjected to this process, she was advised from a young age not to talk to counselors about her mental state and family life. As a result, it remains difficult for her to work with mental health professionals because a lot of mental health workers are carceral and work closely with police departments and child services.

OBTAINING AND MAINTAINING HEALTHCARE

Along with difficulties obtaining culturally relevant mental healthcare, many of our participants experienced challenges finding and maintaining healthcare in general. One of our participants describes using Indian Health Services when she is back home because there is one near her tribe. Her life with the Indian Health Services was much easier because she didn't have to think about shifting or navigating a new service. She stresses how convenient it would be to have an Indian Health Service on the East coast, as she wouldn't have to re-explain her chronic health history and learn the functioning of an entirely new system of healthcare. Another participant describes the challenges of being on and off healthcare since his twenties. At 27 he applied for state assistance and got food stamps and healthcare which allowed him to put back on weight he had lost and gain self esteem. After 2018 came and he had to resettle in New Jersey, he lost his insurance again and remains without healthcare in his late thirties. He describes his ability to take advantage of pandemic unemployment as a transformational event because it was the first time in many years that he was able to have some money in the bank. He met a member of his tribe around this time that taught him that federally enrolled Native citizens have access to free healthcare, especially in the absence of the Indian Health Centers. Here on the East coast there aren't many, so he was taught how to invoke his right to this and fight for the healthcare to which he was entitled. Finally, another participant mentioned how healthcare practitioners at a clinic helped her register for Medicaid by sitting down with her and going through the forms. Now she is not covered by the youth care section of healthcare and it has been a challenging health journey. She has since tried to establish care with another clinic, but there have been incredibly long waits. This participant caught COVID during Summer 2020, but was uninsured and had to take Tylenol to manage symptoms and try and sleep the sickness off. She believes she wouldn't have had COVID for as long as she did (1-2 months) if she had healthcare.

SPIRITUALITY, HEALING, AND FOOD

Many of our participants stressed the spiritual nature of the relationship to food as medicine. One of our participants described cutting out carbs and sugar, and for the first time noticing a spike in his mental and physical health. This began his journey of incorporating his grandmother's teachings regarding how his diet had a direct effect on him physically and mentally. He's been vegetarian for about 12 years now and uses herbal medicines from all around the world. This participant was able to stop self medicating with food and this is what led him into exploring his diet and eventually breaking the first initial addiction and connection to bad food in his life. Because of this he stresses that food sovereignty, and that realizing what we eat affects everything physically and mentally, is one of his passions and life missions. Another of our participants believes there is a large disconnection with where people obtain their food, and what they are putting in their bodies in NYC, and she feels the full negative effects of this on our health will only be realized in the future. She believes that there is a lot of healing and health that comes with not just planting and harvesting food but the ceremonies that come with doing this. So she believes that one of our major challenges is our relationship with how we consume and obtain food, because the biggest changes in our physical, mental, and emotional dispositions come from food. She also feels as though it is connected to her fertility and hormones as a woman.

WATER AND SPIRITUALITY

A big aspect of spirituality for our participants was related to the water. One of our participants described attending a kayak tour with a representative from Shinnecock Nation on Long Island. She credits this tour with bringing her back to the relationship she has with water as a resource in her life. She will now often go to a park in New York City that has a little pond and connects with the water there, as well as the water running from the faucet where she lives, understanding that not everyone has access to clean water on the American continent. She describes a process of no longer just looking at water but talking to it. Another participant recalls going to the New York City beaches all the time, especially during the Standing Rock protests. She feels as if the beach is really powerful for her, and she has felt strong vibration and energies there, underscoring how special this place is. This participant also has a special relationship with the East River because as she used to cross the bridge, even with the feeling of being lost, it underscored her process of discovering herself. Without knowing at the time she felt as if the East River was healing for her. She also knows someone who is Kishore (Ecuadorian) practicing traditional fishing in the East Hudson River, and she emphasizes the importance of talking about the waterways and rivers that connect New York City. She believes if one understands the beach on a deeper level they will understand why its so special, with all the things that it has witnessed, and this is part of why she loves being by the water in New York.

MOVING FORWARD

Through the work of UIC's Community Health Program, the Urban Indigenous Collective is helping to meet the explicit need expressed by the NYC Department of Health for "increased qualitative data collection efforts through focus groups and other methods would provide a more nuanced understanding of the strengths and challenges of the communities of Indigenous peoples of the Americas living in NYC." Based on our data collection and results, we can observe many, overlapping unaddressed needs with respect to health for our urban Indigenous community. Although the data collected is not statistically representative of the urban Indigenous community across the tri-state area, it allows us to better understand areas through which UIC can be of service to our community. Amongst some of our largest areas of concern are programming to enhance the sense of pan-Indigenous community, cultural preservation, and ensuring access to healthcare for our urban Indigenous community. Within the next year, UIC looks forward to hosting winter storytelling circles, talking circles, beading classes, and further dedicating spaces to Afro-Indigenous members of our community, open mic nights, and potluck events through our community center. In the longer term we hope to incorporate suggestions for pan-Indigenous reading groups and book clubs, as well as pan-Indigenous food and cultural festivals.

This culturally tailored programming will be implemented in tandem with UIC's efforts to scale capacity to the point at which we can begin providing sustainable health services to our urban Indigenous community. Through the research undertaken by the Community Health Program, as well as the programming and policy built via our community based participatory methods, UIC can ensure that the health of our urban Indigenous community is supported and sustained for generations to come.

CONTACT

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