FACTORS THAT CONTRIBUTE TO RURAL PROVIDER RETENTION, SERVICE UTILIZATION, AND ENGAGEMENT IN MENTORSHIP BY CULTURAL EXPERTS

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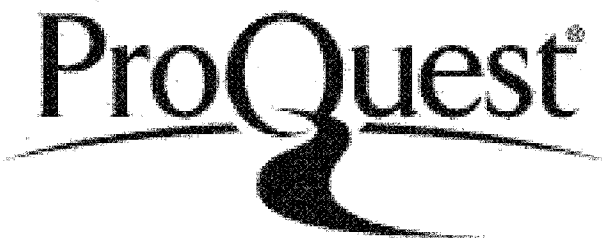

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ABSTRACT

A substantial amount of time, money, and other resources are expended on recruiting behavioral health providers to fill vacant positions in rural Alaska. This exhaustive drain on resources is perpetual due to the high turnover rates of providers. This exploratory qualitative study utilized grounded theory methodology to investigate personal qualities of providers and other factors contributing to long-term retention of providers relocating to Alaska's Bering Strait Region from elsewhere, community members utilizing the provider's services, and the provider's engagement in cultural mentorship to facilitate the integration of culture into their practice. Furthermore, factors contributing to local provider retention were examined. Key informant interviews were conducted with 21 healthcare providers living and working in the region long-term. A theory emerged that connected provider retention to community member service utilization and cultural mentorship. Results indicated that providers who are open, willing to learn, good listeners, calm, friendly, respectful, flexible, compassionate, genuine and possess a sense of humor, humility, and ability to refrain from imposing personal values, beliefs and worldviews upon others are a good fit for living and work in rural Alaska. Such qualities facilitate a provider achieving professional and personal satisfaction through building relationships and creating opportunities for cultural mentorship, professional support, and social support. These opportunities enhance the delivery of quality services that are culturally appropriate and well-utilized by community members, which, in turn, increase provider satisfaction and retention. Recommendations are made to healthcare organizations regarding recruitment and retention strategies. Recruitment strategies

include careful screening of potential applications for specific qualities and enlisting local community members and students into the healthcare field. Retention strategies include professional support by way of a comprehensive orientation program, clinical supervision, cultural mentorship, and continuing education training opportunities that focus on cultural competency. Recommendations for retention of local providers include professional development incentives and opportunities that qualify local providers for positions typically held by outside providers.

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Chapter One: Introduction

Brief Overview of the Study

Organizations across the state of Alaska spend a significant amount of time, money, and other resources recruiting behavioral health providers to fill vacant positions in rural areas. Although these efforts are warranted and necessary, this exhaustive drain on resources is perpetual due to the high turnover rates of providers. More importantly, the quality of service delivery is diminished every time a new provider moves to rural Alaska only to leave within a short period of time. Different providers constantly moving through rural communities one after another negatively affect community members. Trust diminishes, continuity of care is compromised, problems fester, and behavioral health issues are not addressed, detected, or prevented. To provide effective services, it seems vital for organizations to recruit and retain providers who remain within the organization for a substantial amount of time. Consequently, a provider screening process could be beneficial for organizations to predict a provider's potential longevity in rural Alaska and determine the provider's training, support, networking, and supervisory needs that if met, could enhance provider retention and service delivery. In particular, a new provider's longevity and service utilization by community members may be positively influenced by completing a thorough cultural orientation to the region along with ongoing cultural supervision and mentorship facilitating the provider's ability to integrate the local culture into her or his practice.

This exploratory study utilized qualitative methodology to investigate three specific domains from the perspective of professional and paraprofessional healthcare

providers, who have lived and worked in rural Alaska long-term. Furthermore, the study endeavored to gain the perspective of local Alaska Native healthcare providers while also recruiting other long-term providers. First, the study sought to identify factors contributing to long-term retention of practitioners relocating to rural Alaska. Second, the study investigated the qualities of newly hired behavioral healthcare providers that would facilitate community members' accessing and utilizing the services offered by the provider. Finally, the study explored the qualities of newly hired behavioral healthcare providers, who relocate to the region, that allow them to engage in cultural mentorship facilitating the integration of culture into their practice. The important local perspectives on the issues of provider retention, service utilization, and cultural mentorship were drawn from qualitative data and provided a foundation for drawing meaningful conclusions from the study. In turn, the conclusions guided future continuing education training efforts for new providers relocating to the Bering Strait Region focusing on the development of provider qualities facilitating longevity, service utilization by community members, and cultural mentorship. Finally, the results, along with other possible uses, may guide future recruitment and retention activities of behavioral health organizations operating in the Bering Strait Region.

Significance of the Study

Considering the resources expended by the State of Alaska and Alaska Native health organizations to recruit and hire qualified providers to live and work in rural Alaska, retention of those providers is paramount. Over the years, Alaska Native community members have witnessed individuals, affiliated with a variety of

organizations, filter in and out of their communities. In some cases, individuals from outside of the community remained in the area for a substantial length of time, provided quality services that are utilized by community members, and interacted with community members in a culturally appropriate manner. Local long-term healthcare providers have witnessed a variety of qualities within individuals, who relocate to rural Alaska, that facilitate these individuals' successful service delivery in rural Alaska.

Currently, a paucity of literature exists that may explain why some providers choose to remain living and working in rural Alaska as compared to the majority who leave after a brief period of service. Furthermore, the literature lacks information regarding cultural supervision and mentorship of professional behavioral healthcare providers from local Alaska Native professional and paraprofessional staff. Given the limited literature to guide research, a qualitative study examining these issues was the logical first step (Sofaer, 1999). The study sought to fill this gap in the literature. Results from this study will be utilized to develop continuing education and training targeting recently hired behavioral healthcare providers to improve their ability to live and work in rural Alaska, approach service provision in a manner that increases utilization by community members, and modify practice to ensure cultural attunement.

Problem Statement of the Study

Many factors impede service provision in rural Alaska. Provider attrition is a crucial impediment to service provision in rural Alaska. Cultural considerations also affect service delivery in rural Alaska. Many new providers relocate to rural Alaska from other locations and are unfamiliar with the diverse cultures and languages in Alaska. In

addition to cultural considerations, issues of rurality also affect service delivery. For many new providers, rural Alaska can seem isolated, disconnected, and remote. Extreme weather, changes in the daylight, and the perceived lack of amenities and services can result in new providers leaving their positions. Premature provider turnover negatively influences the array of services that rural behavioral health organizations extend to community members, and it continues to exacerbate the ever-growing workforce shortage in the area of behavioral health.

Provider turnover affects Alaska Native people residing in rural communities. Rural community members have experienced the effects of people from outside of the region infiltrating their communities for hundreds of years. More recently, Alaska Native community members frequently experience new teachers, healthcare providers, law enforcement, and other professional workers relocating to their communities only to leave within a short period of time. However, exceptions exist and long-term healthcare providers, including local Alaska Native paraprofessionals and professionals, are uniquely situated to lend a very useful perspective regarding the important qualities of these exceptional professional providers who choose to remain in rural Alaska long-term, deliver services that are well-utilized by community members, and engage in cultural mentorship.

This study identified provider qualities, and other factors, deemed important by professional and paraprofessional healthcare providers who have lived and worked in rural Alaska long-term. More specifically, the study explored those provider qualities,

and other factors, believed to be important by long-term healthcare providers in the following three categories:

1) qualities, and other factors, contributing to provider longevity;
2) qualities, and other factors, facilitating the willingness of community members to access and routinely utilize the services offered by the providers;
3) qualities, and other factors, facilitating a provider's engagement in cultural mentorship.

The ultimate goals of this study was 1) to develop recommendations to guide future continuing education and training for recently hired behavioral healthcare providers relocating to the Bering Strait Region 2) to guide future recruitment and retention activities of behavioral health organizations located in the Bering Strait Region. Table 1 outlines the research questions that were explored through this study.

Table 1

Research Questions

Research Category	Research Questions
Category One: Longevity	What factors or qualities do long-term healthcare providers view as being important in terms of provider longevity?
Category Two: Service Utilization	How have providers approached service delivery in rural Alaska to facilitate community member utilization?
Category Three: Cultural Mentorship	What qualities have providers possessed allowing them to engage in a relationship with a local Alaska Native cultural advisor in order to access cultural supervision and/or mentorship?

Chapter Two: Review of the Literature

Introduction

Behavioral health service delivery in rural and remote areas presents organizations and individual providers with a unique set of considerations. This literature review begins with information that will define and conceptualize the term "rural." Furthermore, it offers information regarding the distinctive features associated with rural communities. Next, barriers to rural behavioral health service delivery are presented in terms of service availability, accessibility, and acceptability. After summarizing rural behavioral health service delivery on a national level, considerations specific to the Alaskan environment are provided along with information about current efforts to resolve the behavioral health workforce shortage in Alaska. Finally, the aims and goals of this study are presented in light of the issues, along with the gaps identified in the literature.

Conceptualizing Rural

Population density varies across the different regions of the United States. Depending on the number of people per square mile, the U.S. Census Bureau categorizes a given area as being metropolitan or urban versus nonmetropolitan or rural. On the surface, this categorization appears to be merely a label; however, it greatly influences an individual, family, and community's access to services including healthcare, mental healthcare, and education.

The Census Bureau defines an urbanized area as having 50,000 or more people. The Bureau classifies an area populated with 2,500 to 50,000 people as an *urbanized cluster*. They define as *rural* an area populated with fewer than 2,500 people (Health

Resources and Services Administration [HRSA], 2005). As further explained by Harowski, Turner, LeVine, Schank, and Leichter (2006), the U.S. Census Bureau classified an urban area as having a population density of 1,000 people per square mile at their core and surrounding blocks with an overall population density of 500 people per square mile. The U.S. Census Bureau classifies a rural community as any community existing outside of urban centers and clusters (Harowski et al., 2006). For areas with six or less people per square mile, the U.S. Census Bureau created the category of *frontier* (Harowski et al., 2006).

One of the biggest challenges in defining rurality is the lack of homogeneity existing from one rural area to another. Rural communities are comprised of people from diverse multicultural backgrounds with varying ages, needs, and worldviews. Although each rural community is unique, some unifying characteristics exist to include: poverty, low population density, geographical distance from urban centers, isolation, geographical barriers, strong community connectedness, self-sufficiency, traditional values, patriarchal social structures, limited transportation options, and diminished access to technology (Barbopoulos & Clark, 2003; Judd et al., 2002; Mulder et al., 2000; Strasser, 2003).

The residents of rural areas tend to experience marginalization in terms of access to resources and mental health services. As noted by Harowski and colleagues (2006), psychology tends to be an urban-based profession and rarely acknowledges the needs of rural residents although the majority of the United States surface area is rural. According to the U.S. Health and Human Services Rural Task Force (as cited in President's New Freedom Commission on Mental Health, 2003), 90% of the United State's land exists in

rural areas and 25% of the nation's people reside within these rural areas. This relatively small population is spread out over a large area of land requiring innovative methods of service delivery. Consequently, service providers in rural areas must consider the unique differences existing between urban and rural residents in terms of access to care, infrastructure available for service provision, and cultural issues of residents (Barbopoulos & Clark, 2003; Brems, Johnson, Warner & Roberts, 2006; Chipp, Johnson, Brems, Warner, & Roberts, 2008; Judd et al., 2002; Strasser, 2003).

Barriers to Rural Behavioral Health Service Delivery

Rural residents experience a variety of barriers that influence their ability to utilization healthcare services. In fact, barriers to utilization and availability of services may hinder researchers from accurately capturing the prevalence and incidence of various behavioral health issues existing in rural areas. For example, a discrepancy exists in the literature regarding the prevalence of substance abuse in rural areas as compared to urban areas (Brems & Johnson, 2007). According to the President's Commission on Mental Health (2003), the prevalence of substance abuse and mental health issues in rural America are comparable to those existing in urban America. However, fewer services and service providers are available for rural residents as compared to those available for urban residents (Ciarlo, Wackwitz, Wagenfeld, Mohatt, & Zelarney, 1996; Johnson, Brems, Warner, & Roberts, 2006b; Mohatt, 1997; Nelson, Pomerantz, Howard, & Bushy, 2007; Williams & Cutchin, 2002), and rural residents tend to utilize available services less than their urban counterparts (Brems & Johnson, 2007) possibly due to the rural culture of independence (Edgerton, 1983) and concern over stigmatization (Sears, Evans,

& Perry, 1998). The President's New Freedom Commission on Mental Health Subcommittee on Rural Issues (2003) noted three significant barriers to rural residents accessing behavioral healthcare to include accessibility, availability, and acceptability (Human & Wasem, 1991).

Accessibility. Knowledge, transportation, and financing define accessibility to care. Lambert and Agger (as cited in President's New Freedom Commission on Mental Health, 2003) determined that rural residents tend to access treatment later than their urban counterparts due to a lower perception of need as well as a lack of service providers. For many rural communities, limited prevention programs and sparse public education efforts result in community members lacking knowledge about mental health issues, treatment options, and local resources (Fox, Blank, Rovnyak, & Barnett, 2001; Stamm, Lambert, Piland, & Speck, 2007).

Limited transportation and lack of resources further compound the problem of accessibility to behavioral health services in rural communities. Because specialized healthcare is frequently unavailable in a rural resident's home community, they must seek out and travel to services in neighboring regional or urban centers (Barbopoulos & Clark, 2003; Buchanan et al., 2006). Inexpensive rural public transportation is limited leaving rural residents with few options to secure adequate care and traverse the large geographical distances between their home communities and service providers (Barbopoulos & Clark, 2003; Ciarlo et al., 1996). A study completed by Campbell and colleagues illustrated this disparity with rural residents, living in Oregon, who travel greater distances (at least four times the distance) to access in-patient psychiatric care as

compared to urban residents (Campbell, Kearns, & Patchin, 2006). Consequently, rural behavioral health service agencies incur increased costs, as compared to their urban counterparts, because of transporting rural residents to and from care. Unfortunately, rural residents absorb the increased cost of services. The lack of local service providers and transportation options directly affects access to care for all rural residents (Nelson et al., 2007) but especially children, elderly, and people with disabilities (Human & Wasem, 1991; President's New Freedom Commission on Mental Health, 2003).

The socioeconomic status of rural residents is less than that of urban residents (Campbell, Gordon, & Chandler, 2002; Carlton-LaNey, Murty, & Morris, 2005; Gammon, 2000; Strasser, 2003). Employment opportunities available in rural areas tend to consist of service sector positions providing low wages. According to the U.S. Congress (as cited in President's Commission on Mental Health, 2003), 23 % of rural counties meet the income requirements categorizing them as persistent poverty counties. Poverty is prevalent in rural areas with residents experiencing less opportunity for upward mobility as compared to urban residents (Gammon, 2000; President's New Freedom Commission on Mental Health, 2003). Literature suggests that community members residing in impoverished regional areas experience a high level of unmet healthcare needs (Peterson & Litaker, 2010), and people living rurally have less access to health insurance with limited behavioral healthcare benefits further impeding their access to care (Fox et al., 2001; Mohatt, 1997; Ziller, Anderson, & Coburn, 2010).

Availability. In addition to the accessibility of care, education and training opportunities, recruitment and retention activities, and continuing education and support

for both future and current behavioral healthcare providers directly affect the service disparities between rural and urban areas (Human & Wasem, 1991; Stamm et al., 2007). Currently, the majority of providers are not educated or trained for competent rural practice. Providers practicing in rural areas receive very little support in terms of implementing evidenced based practices, and the programs specifically targeting training and continuing education needs of rural providers have diminished (Campbell, Gordon, & Chandler, 2002; Campbell et al., 2006; President's New Freedom Commission on Mental Health, 2003). The lack of available specialized training opportunities for rural service provision is particularly noteworthy given that rural behavioral healthcare providers working in small rural communities (fewer than 3,500 residents) report utilizing alternative treatment approaches and adjust their treatment style with clients more often than providers working in larger communities and urban centers (Chipp et al., 2008). As noted by Chipp and colleagues, better preparation and ongoing training may increase provider retention leading to "more stable and consistent rural health care services" (2008, p. 8).

The lack of training opportunities and diminished support of rural providers are not the only issues contributing to the spurious availability of services. As noted by the President's New Freedom Commission on Mental Health (2003), many rural hospitals have closed over the years or they have transitioned into providing critical care only. As a result, the infrastructure for behavioral health services has dwindled. According to Bird, Dempsey, and Hartley (2001), 85% of the mental health provider shortages occur in rural areas. Furthermore, the National Advisory Committee on Mental Health (as cited in

HRSA, 2005) found that 55% of the 3,075 rural counties in the United States lack a practicing psychologist, psychiatrist or social worker.

Recruitment and retention of professional service providers to rural areas also influence availability (Williams & Cutchin, 2002). As noted by HRSA (2005), loan repayment programs have only minimally alleviated the shortages of mental healthcare providers in rural America (McCabe & Macnee, 2002). The rural workforce shortages persist due to lower salaries for rural providers as compared to urban providers (McCabe & Macnee, 2002), reduced job opportunities for the spouses of mental healthcare providers (HRSA, 2005; Mayo & Mathews, 2006; Perlman & Hartman, 1985; State of Alaska Department of Health and Social Services Primary Care and Rural Health Unit, 2004), and difficulties of providers transitioning to a rural lifestyle (HRSA, 2005; Perlman & Hartman, 1985).

Acceptability. The stigma associated with seeking behavioral health services can be more prominent in rural areas (HRSA, 2005; Human & Wasem, 1991; Isaacs, Pyett, Oakley-Browne, Gruis, & Waples-Crowe, 2010). The close interconnectedness of many rural communities prevents the anonymity innate to urban centers (Carlton-LaNey et al., 2005). Not only is this true for those seeking services, but it is also a vital consideration for providers living and working in rural communities (Barbopoulos & Clark, 2003; Brems & Johnson, 2007; Judd et al., 2002). Although the interconnectedness of community members inhibits privacy and anonymity at times, it also may serve as an essential resource for rural residents and providers (Brems & Johnson, 2007; Carlton-LaNey et al., 2005).

Since many rural communities lack the resources available to contend with various behavioral health issues, the natural support network existing within the community provides a safety net for residents of rural areas. For many providers, the lack of resources available to the community requires them to become knowledgeable of and able to treat a wide variety of issues (Stamm et al., 2007). At times, the provider will need to practice outside of his or her area of expertise (Brems & Johnson, 2007; Judd et al., 2002; Roberts, Battaglia, & Epstein, 1999). Consequently, many providers often struggle to balance their commitment to practicing within their area of competency with being responsive to the needs of the community. This is only one example of the unique ethical dilemmas innate to rural practice, which influences a multitude of professionals working in rural Alaska (Chipp et al., 2008; Johnson, Brems, Warner, & Roberts, 2006a; Warner et al., 2005).

Conceptualizing Rural Alaska

Extending services across the state of Alaska is a formidable task for a number of reasons. First, Alaska is a very large state. If it were a country, it would be the 18th largest country in the world geographically. Alaska is the largest state in the union consisting of 586,412 square miles (University of Alaska Anchorage, n.d.). Alaska is 1/5 of the size of the lower 48 contiguous states (State of Alaska Office of Economic Development, n.d.). Secondly, Alaska is the home to many different Alaska Native cultural groups, each with its own unique culture and distinctive language. The Native groups within Alaska encountered settlers from other countries at different times and each group endured a certain amount of trauma because of the contact (Napoleon, 1996).

Presently, many Alaska Native people continue to be affected by historical trauma (Easley & Kanaqlak, 2005) and forced acculturation (Birman, 1994) as evidenced by changes in their cultural practices and Native languages.

As a result of the U.S. governmental policies regarding assimilation of the Alaska Native groups, concepts linked to manifest destiny are considered insensitive and culturally inappropriate to many residents of Alaska. According to a class lecturer, during Spring Semester 2007, some people deem the term "frontier" as inappropriate terminology for use when referring to rural Alaska. The term "remote" is considered more acceptable to some people when describing areas with less than six people per square mile.

Similar to rural areas in the contiguous lower 48 states, rural Alaska is far from homogeneous. In Alaska, one road system exists and connects Southcentral Alaska to the interior region of Alaska and to Prudhoe Bay on the North Slope of Alaska. The road system links a small number of rural communities to one another and to the two urban centers in the state, Anchorage and Fairbanks. Diverse groups of people to include both nonnative and Alaska Native people inhabit most of these communities (University of Alaska Anchorage Institute of Social and Economic Research, 2004). A greater number of small rural communities exist away from the road system and are only accessible by plane, boat, or snow machine. Alaska Native people tend to inhabit these communities; however, some of the communities are home to a mixture of indigenous and other people, while non-Native people predominantly inhabit some villages (Alaska Department of Labor and Workforce Development, 2002). Therefore, the cultural considerations of

behavioral health service provision are varied and unique to each community within Alaska.

Larger communities, referred to as "regional hubs," provide most behavioral health services for rural Alaska (Sherry, 2004). The regional hubs are responsible for the healthcare needs of the outlying villages (Bristol Bay Area Health Corporation, 2006; Council of Athabascan Tribal Governments, 2009; Norton Sound Health Corporation, 2007; Yukon Kuskokwim Health Corporation, 2011). Service providers tend to live in the regional hubs with some providers itinerating out to the villages on a rotating basis. Regional health corporations provide healthcare and behavioral health services to Alaska Native people throughout the state. Under the Alaska Native Claims Settlement Act (ANSCA), 12 Native Corporations were established and currently operate within the state and administer regional health corporation services to Alaska Native shareholders and their families (University of Alaska Anchorage Justice Center, 2004). A Thirteenth Native Corporation was also created last and represents individuals of Alaska Native heritage residing outside of Alaska (The 13th Native Corporation, 2006). Although regional hub communities administer the majority of the Native Corporation's regional health services, local village health clinics provide various services in outlying areas (Bristol Bay Area Health Corporation, 2006; Council of Athabascan Tribal Governments, 2009; Norton Sound Health Corporation, 2007; Yukon Kuskokwim Health Corporation, 2011).

The regional hubs tend to be staffed with healthcare professionals to include physicians, nurses, psychologists, social workers and other healthcare staff (Bristol Bay

Area Health Corporation, 2006; Council of Athabascan Tribal Governments, 2009; Norton Sound Health Corporation, 2007; Yukon Kuskokwim Health Corporation, 2011). These professional positions frequently turnover (Cunningham, Madigan, Mann, & Ward, 2003; Fischer, Pearce, Statz, & Wood, 2003) and may remain vacant for extended periods of time (University of Alaska Anchorage Alaska Center for Rural Health, 2007). In fact, Fischer and colleagues studied the length of employment of 996 doctors, nurses, and community health aides, who were employed by Yukon Kuskokwim Health Corporation; Norton Sound Health Corporation; Maniilaq Health Corporation; and Bristol Bay Area Health Corporation Alaska, and found that community health aides were retained significantly longer, with a median length of retention of 1,186 days, than doctors (Median=596) and nurses (Median=408) (Fischer, 2003). Since community health aides are paraprofessionals who tend to be from the local community and the healthcare professionals tend to relocate to the area from outside of Alaska, these results may support other findings in the literature suggesting that providers originating from rural areas are more likely to practice rurally than providers originating from urban areas (Woloschuk & Tarrant, 2004).

Workforce recruitment and retention issues are particularly important in Alaska's healthcare system due to the industry's continued growth (Fried, 2008) and high costs associated with recruiting new providers (Fischer et al., 2003). In many Alaskan communities, healthcare organizations serve as one of the largest employers in the area (Fried, 2008). Since 2000, Alaska's healthcare industry has grown three times as fast as any other industry in the state and projections suggests that it will only continue to grow

(Fried, 2008). The Center for Rural Health conducted a study of 76 small hospitals, rural health clinics and community health centers, and rural mental health centers in Alaska and determined that in one year these organizations spent over $12 million dollars on recruitment activities for physicians, pharmacists, midlevel practitioners, nurses, dentists, hygienists, psychiatrists, clinical psychologists, masters-level therapists, and licensed clinical social workers (State of Alaska Department of Health and Social Services Primary Care and Rural Health Unit, 2004). The rural Alaskan healthcare organizations in this study expended approximately $38,000 for each new provider recruited and hired (State of Alaska Department of Health and Social Services Primary Care and Rural Health Unit, 2004).

For many healthcare professionals, working in an underserved rural area provides educational loan repayment. Currently, Alaska relies solely on federal loan repayment programs, while other states have developed state sponsor support-for-service programs (Health Planning & Systems Development, 2007). As a result, Alaska is recruiting healthcare professionals who are also being sought after by other states with more scholarship and loan repayment options as compared to Alaska. As indicated by Williams and Cutchin (2002), recruiting professionals to rural and underserved areas is only one step in the process of resolving workforce shortages. Retention of those professionals also deserves adequate attention (Williams & Cutchin, 2002). However, Pathman and colleagues examined the outcomes of 69 state sponsored physician support-for-service programs and determined that not only did the programs successfully recruit physicians to underserved and impoverished communities, but over half of the physicians

were retained for over eight years (Pathman, Konrad, King, Taylor, & Kroch, 2004). Another study compared the length of physician job retention employed in health professional shortage areas, such as rural, as compared to those employed in non-health professional shortage areas and determined very similar lengths of service between the two groups (Pathman, Konrad, Dann, & Koch, 2004). Therefore, the authors concluded that the physician shortages in rural areas are likely due to recruitment issues as opposed to retention issues (Pathman, Konrad, Dann et al., 2004). This study did not include Alaskan physicians. Consequently, the affects of provider retention on the behavioral health workforce system in Alaska may very well differ from other rural areas in that the providers must work under extreme conditions in very remote locations. According to key informants from rural Alaska, professionals tend to move from rural Alaska to practice in other areas of the country or state, once their student loans are repaid, only to further exacerbate existing workforce shortages (Gifford, 2007; Gifford, Koverola, & Rivkin, 2010). To address service provider shortages, specialists from urban areas within Alaska and from outside Alaska often provide itinerant services for a short period of time in the regional hubs (Gifford, 2007), and some Alaskan healthcare organizations are exploring and utilizing telemedicine as a treatment modality for physical and mental healthcare service delivery (Alaska Native Tribal Health Consortium, 2011; Fischer, 2003; Gifford, 2007; Hudson, 2005; Sherry, 2004).

The availability of specialized healthcare services in the regional hub tends to vary across the state. Some hubs offer substance abuse treatment services, training opportunities for people experiencing mental illness and/or disabilities, and safe houses

for victims of domestic violence (Council of Athabascan Tribal Governments, 2009; Bristol Bay Area Health Corporation, 2006; Norton Sound Health Corporation, 2007; Yukon Kuskokwim Health Corporation, 2011). For example, I completed a clinical practicum at one regional health corporation that offered a wide range of healthcare services to include behavioral health. The behavioral healthcare staff consists of two licensed psychologists, a licensed clinical social worker, master's level clinicians, and village-based counselors. Furthermore, a psychiatrist from the lower 48 contiguous states itinerates to the regional hub every other month to provide care to patients. Similar to other regions in Alaska, the master's level clinicians travel to and from the regional hub in order to provide itinerant counseling services to the surrounding villages (Brems et al., 2006). In this particular regional hub, the behavioral health clinic is located near the hospital and works in conjunction with State of Alaska's Public Health Services. Other regional health corporations provide a similar level of care to residents of their respective regions (Council of Athabascan Tribal Governments, 2009; Bristol Bay Area Health Corporation, 2006; Norton Sound Health Corporation, 2007; Sherry, 2004; Yukon Kuskokwim Health Corporation, 2011). Alaska's healthcare organizations, to include hospitals, community health clinics, and behavioral health clinics, are forced to rely on itinerant service providers coming from the lower 48 contiguous states at a cost of approximately $12 million in fiscal year 2006 in an attempt to remedy the provider vacancies existing across the state (University of Alaska Anchorage Alaska Center for Rural Health, 2007)

Other attempts to increase the behavioral health service availability, accessibility, and acceptability for rural Alaskan residents included training local residents as paraprofessional behavioral healthcare providers in outlying villages (Alaska Native Tribal Health Consortium, n.d.). They are referred to as behavioral health aides, community wellness counselors, or village-based counselors depending on the regional health corporation's job title (Council of Athabascan Tribal Governments, 2009; Bristol Bay Area Health Corporation, 2006; Norton Sound Health Corporation, 2007; Robert Wood Johnson Foundation, 2003; Sherry, 2004; Yukon Kuskokwim Health Corporation, 2011). Regardless of their title, they are tasked with providing behavioral health services within their local villages (Robert Wood Johnson Foundation, 2003). Often times, the behavioral health aides deliver services in one of the exam rooms located in the health clinic. Smaller villages often train one provider to serve as both health aide, local community member trained to provide paraprofessional level of care for physical health issues (Alaska Community Health Aide Program, 2011; Fischer et al., 2003), and behavioral health aide. Local clinics are able to attend to a patient's primary care needs; however as typical of many rural areas, if more specialized care is required, the patient will have to travel great distances to the regional hub and possibly to the nearest urban center—Anchorage, Fairbanks, Juneau, or Seattle (Barbopoulos & Clark, 2003; Brems & Johnson, 2007; Buchanan et al., 2006; Gifford, 2007).

Barriers to Behavioral Health Service in Rural Alaska

Many factors impede behavioral health service provision in rural Alaska (Brems & Johnson, 2007). First, high rates of turnover for behavioral health professionals affect

service delivery (Astor et al., 2005; Cunningham et al., 2003; Fischer et al., 2003; HRSA, 2004; University of Alaska Anchorage Alaska Center for Rural Health, 2007). Second, the inability of providers, who relocate to rural Alaska from other areas, to adapt to and integrate local cultural knowledge and practices into services negatively affects service provision (Gifford, Koverola, & Rivkin, 2010). Third, many new providers are ill-suited for living and working in rural conditions (Perlman & Hartman, 1985). Moreover, a number of providers struggle to manage their personal and professional lives with the demands of living and working in close-knit and remote communities (Roberts et al., 1999; Warner et al., 2005). Finally, providers face professional considerations and may often struggle to access clinical supervision, mentorship, and professional development opportunities in rural areas (Perlman & Hartman, 1985).

Provider retention. In addition to affecting behavioral health service delivery, rural workforce shortages plague many professions. For instance, results of a study indicated physicians migrate from developing countries to developed countries due to desires for more income, access to technology, stability/security in the environment, and opportunities for their children (Astor et al., 2005). As highlighted by Fischer and colleagues (2003), provider turnover hinders Alaska from providing an adequate healthcare workforce in rural areas. Interestingly, this study concluded that Alaskan healthcare organizations retained community health aides significantly longer than physicians or nurses in rural areas (Fischer et al., 2003). Another study examined factors influencing retention and attrition of community health aides in Alaska. The study

determined co-worker support, access to training, fully staffed clinic, community support, and supportive families as keys to retention (HRSA, 2004).

Burnout of professional staff routinely emerges in the literature as a plausible cause of premature provider attrition (Lambie, 2006) and diminished quality of service delivery (Jenaro, Flores, & Arias, 2007; Wilcoxon, 1989). As noted by Perlman and Hartman (1985), many administrators working in rural mental health settings are trained clinicians who have little training in administration and may experience role overload caused by having to fulfill numerous duties and multiple roles within the organization. To alleviate the affect of role overload, which may contribute to burnout and eventual provider turnover, Perlman and Hartman (1985) suggest that rural mental health organizations become proactive in building a provider's competence as an administrator. This recommendation is particularly salient given that only 9% of the 314 rural mental health administrators participating in National Institute of Mental Health study actually had received any formal administrative training (Perlman & Hartman, 1985). Moreover, Wilcoxon (1989) found a connection between the style of administration and therapist burnout in rural agency settings. Therapists reported less burnout when working for administrators who exhibited structure by clearly defining roles, expectations, and lines of communication and consideration by fostering mutual trust, respect, warmth and friendship (Wilcoxon, 1989). Therefore, it appears that organizations, administrators, clinicians, and clients could benefit by rural mental health administrators receiving adequate administrative training opportunities.

In addition to rural organizations hiring well-trained administrators, other factors affecting burnout and retention must be considered. Rottier, Kelly, and Tomhave (2001) examined teacher burnout in rural schools and determined that many schoolteachers choosing to work in rural schools for long periods did so because of feeling as though they and their families were part of the community. Furthermore, the University of Alaska Anchorage Center for Human Development (2006) researchers determined that teachers originally from Alaska and teachers educated in Alaska tend to remain in rural Alaska longer. The study determined job satisfaction to be related to retention, specifically noting school climate, salaries, collegial interaction, positive working conditions, mentoring, professional development, paperwork, and caseload issues (University of Alaska Center for Human Development, 2006). These findings warrant further investigation of the result of burnout, quality of life and job satisfaction on retention of behavioral healthcare providers in rural Alaska.

Because provider retention is a critical impediment to service provision in rural Alaska, exploring provider longevity is the primary aim of this proposed study. Forty-two percent of behavioral health provider positions turnover every year in Southcentral Alaska (Cunningham et al., 2003). Agencies residing in Anchorage, Chugiak, Copper Center, Homer, Kenai, Kodiak, Palmer, Seward, Valdez, Wasilla, Soldotna, and Cordova reported this data. All of these communities are accessible via the road system or jet services. Regions lying outside of Southcentral Alaska experience less accessibility, greater rates of provider turnover, and higher vacancy rates (University of Alaska Anchorage Alaska Center for Rural Health, 2007). Although provider turnover is an

important construct to measure, provider longevity is equally important. A preliminary study sought to understand the factors that contribute to the longevity of providers working in rural Alaska (Gifford et al., 2010). Key informant interviews were conducted with professional behavioral healthcare providers who had relocated to rural Alaska from other areas of the United States. Participants of this study had been working in rural Alaska for at least five years. According to the professionals participating in the interviews, a provider must work in rural Alaska anywhere from three to six or more years to be considered a long-term service provider (Gifford et al., 2010). This finding suggests that rural community members have become accustomed to new providers leaving, after such short periods of time, that a mere three to six years of services appears to be a substantial length of time. In fact, it is long enough to be considered long-term.

Cultural considerations. Cultural considerations also affect service delivery in rural Alaska. Many providers moving to rural Alaska from the lower 48 contiguous states are not aware of local culture and erroneously assume that local people understand and operate under a worldview similar to their own (Oleska, 2005). In some cases, language impedes service delivery. Although some Alaska Native people no longer speak their Native language, many people remain fluent in their Native language and have English as a second language (Allen et al., 2006). For example, there are an estimated 10,500 fluent Central Yup'ik speakers out of a total population of approximately 25,000 people, 1,000 fluent Siberian Yupik speakers out of a total population of approximately 1,400 people, and 2,144 fluent Inupiaq (Inuit) speakers out of a total population of approximately 15,700 (Krauss, 2007). Krauss warns readers to

consider these statistics with caution due to the innate difficulties with accurately indentifying fluent speakers and recognizing members of various cultural groups (Krauss, 2007).

In addition to language barriers, service delivery is affected by many professionals coming to rural areas ill prepared in terms of cultural knowledge and lacking training to deliver behavioral health interventions in a culturally accessible and appropriate manner (Human & Wasem, 1991). When queried about the effect of culturally competency on a provider's longevity, participants involved in a preliminary study noted cultural interest and openness of a provider as an important factor influencing longevity (Gifford et al., 2010). Specifically, participants linked a provider's willingness to learn about the culture, embrace new ways of understanding mental health, and refrain from imposing personal values and beliefs on local people to the provider's likelihood of remaining in rural Alaska long-term (Gifford et al., 2010). These findings support recommendations proposed by Sue (2003) to develop cultural competency guidelines in order to enhance the "rigor, nature, and substance of [psychotherapy] treatment outcomes" (p. 4). Specifically, Sue (2003) speculates that the development and utilization of cultural competency guidelines may assist with narrowing the service disparities that exit for ethnic minorities.

Because cultural factors influence an individual or family's help-seeking process (Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005), a provider's cultural interest and openness is paramount in culturally competent service delivery (Fowers & Davidov, 2006) and may be linked to rural resident's ability to trust them and access behavioral

health services. Furthermore, results of a study conducted by Fuertes and Brobst (2002) indicated that ethnic minority client satisfaction with their mental health service provider was directly linked to their perception of the provider's cultural competency. Consequently, the second aim of this study seeks to understand the specific factors and qualities of providers that may enhance community members' satisfaction with services and service utilization.

Living and working rurally. The ability to provide culturally grounded and appropriate services is not the only consideration for providers moving from the lower 48 to rural Alaska. Issues of rurality also affect service delivery. Many providers are ill suited for the isolation associated with life in rural Alaska, and they must adapt to geographic isolation (Campbell et al., 2002; Ciarlo et al., 1996), a pervasive quality of remote areas. In fact, provider isolation is cited as a major cause of turnover in rural areas, which is substantially higher than urban areas (Stamm et al., 2007).

Similar to other rural areas (Barbopoulos & Clark, 2003; Ciarlo et al., 1996), environmental factors, such as cold weather and changes in daylight, can greatly affect providers who are new to Alaska. Results of a preliminary study conducted with long-term providers noted that many people relocating to rural Alaska are often unprepared for the lack of services such as shopping centers, garbage removal, and running water (Gifford et al., 2010). Furthermore, participants indicated that providers may struggle with personal issues such as accessing necessary medical care for their own health needs, managing stressors associated with aging family members residing in the lower 48 contiguous states, and the effect of the quality of schools in rural Alaska on their

children's education (Gifford et al., 2010). Other providers may struggle with the high cost of living in rural Alaska resulting from expensive housing options, heating bills, fuel expenses, and food prices (Gifford et al., 2010). While some providers are able to rise to the occasion, others struggle and prematurely leave their positions. A long-term provider in rural Alaska stated that "providers who tend to fare well in rural Alaska enjoy a slower pace of life and have the ability to appreciate living in a remote community" (Gifford et al., 2010).

The weather is a factor affecting the personal lives of novice providers; however, it is also a factor that greatly influences their day-to-day professional lives by interrupting service delivery. Since master level providers itinerate from the regional hub community to outlying villages to see clients, their ability to provide service depends upon arriving to the client's community. Many providers travel by small plane to and from rural villages (Brems et al., 2006) and are frequently weathered in or out of their home community (Gifford, 2007). Throughout the year, the weather frequently interrupts service delivery (Gifford, 2007). As indicated in the literature, telehealth models of service delivery are emerging as a tool for lessening the service disparities in rural areas (Brems et al., 2006; Fischer et al., 2003; Johnson et al., 2006b; Schopp, Demiris, & Glueckauf, 2006; Stamm et al., 2007). A number of regional health corporations in Alaska have instituted the delivery of telehealth service, via two way videoconference equipment, from regional hubs to rural villages (Fischer et al., 2003; Gifford, 2007; Norton Sound Regional Health Corporation, 2007; Sherry, 2004). Although telebehavioral health services increase the providers contact with rural clients, weather and technical problems can negatively affect

telehealth service delivery in Alaska (Gifford, 2007). As reported by a provider from a remote region of Alaska, many clients welcome telebehavioral health services but tend to prefer face-to-face interventions (Gifford, 2007).

Professional considerations. Telehealth not only serves as a valuable resource that connects a behavioral health provider to clients, but it also offers a means for connecting providers to clinical supervisors and other networks of professionals (Greenwood & Williams, 2008; Wood, Miller, & Hargrove, 2005). For many providers, working in remote or rural areas can lead to feelings of professional isolation as they typically lack access to clinical supervision, continuing education, and professional development opportunities (Barbopoulos & Clark, 2003; Stamm et al., 2007; Wood et al., 2005). According to the results of a preliminary study of long-term providers in rural Alaska, the ability of a rural provider to remain connected with their profession and other professionals appeared as an important factor in provider longevity (Gifford et al., 2010). Additionally, telehealth supervision and consultations presents as a valuable tool that allows rural providers to access the expertise of specialists when they are expected to provide services that exist outside of their ordinary scope of practice (Stamm et al., 2007).

A behavioral health provider's access to ongoing supervision and consultation is important for many other reasons. For example, the nature of living and working in rural settings may complicate a provider's application of ethical standards to practice (Halverson & Brownlee, 2010; Warner et al., 2005). A study conducted by Chipp and colleagues (2008) determined that rural health care providers employed a variety of

adaptations to overcome many of the barriers innate to ethical service delivery in rural areas. In another study (Johnson et al., 2006a), doctoral and master's level providers indicated interest in completing continuing professional educational opportunities that focus on ethical issues related to colleague misconduct and management of ethical issues with clients from special populations (substance abuse coexisting with another serious illness, addictions, ethnic minorities, etc.).

In a recent study, participants noted the direct result of appropriately setting boundaries in rural work on a provider's longevity. Results revealed the importance of providers setting boundaries with community members, clients, colleagues, and employers in manner that honors the code of ethics as well as the local culture (Gifford et al., 2010). Setting appropriate boundaries may be complicated for rural providers who are new to the profession, working in remote locations without adequate professional support, and attempting to facilitate cross-cultural understanding between themselves and community members. One study, examining the roles of nursing professionals in rural Australia, supported the interconnectedness and multiple roles that rural providers consistently encounter by stating that rural nurses manage "a complex web of relationships and interactions using multiple perspectives of self that included their roles as community members, nurses, and healthcare consumers" (Mills, Francis, & Bonner, 2007, p. 586). The interconnectedness and multiple roles of many rural community members only exacerbate the boundary issues faced by novice providers. In fact, the interconnectedness of people in rural communities often results in many individuals, including providers, personally experiencing the residual effects of trauma known as

vicarious or secondary trauma (Barbopoulos & Clark, 2003; Harrison & Westwood, 2009). However, another study determined that psychologists may experience vicarious resiliency by way of their clients overcoming trauma (Hernandez, Gangsei, & Engstrom, 2007). Although providers tend to be more affected by trauma in rural areas, vicarious resiliency may serve as a protective factor for them and potentially influence retention. On-going clinical supervision, consultation, and continuing education opportunities serve as an important provider resource in managing the unique stressors associated with rural work.

Cultural Mentorship

In many rural areas, providers work cross-culturally requiring them to develop new skill sets and adapt or modify their existing skills to the local communities. Multicultural training models typically focus on building a provider's self-knowledge in terms of their own cultural background and biases, knowledge about different cultural groups, skills for making culturally grounded and appropriate interventions, and experiences working with culturally diverse clientele (Kiselica, 1998). Once again, clinical supervision and consultation can serve as an invaluable resource guiding this process; however, the role of mentorship in a novice provider's development as a rural practitioner must also be explored.

Mentoring is defined as "the alliance of two people with varying degrees of experience in order to provide support and learning opportunities" (Mills, Lennon, & Francis, 2007, p. 393). For neophyte nurses practicing in rural Australia, mentorship offered by experienced rural nurses served an important strategy for retention of novice

nurses, "demystification of local culture and clinical mores," increasing professional confidence, and developing strategies for managing multiple roles within an interconnected rural community (Mills, Lennon et al., 2007, p. 588). A cross-cultural mentorship project paired five Euro-American and one Chinese American graduate counseling students, mentors, with Native American public school students enrolled in special education programs, mentees (Salzman, 2000). Mentors and mentees attended local powwows, engaged in talking circles, and committed to a bi-directional learning opportunity. Results indicated that the mentors gained an awareness of cultural differences, increased their overall cultural competency, and became interested in exploring their own cultural influences (Salzman, 2000). This study emphasized the importance of dominant cultural mentors "not adopting a missionary attitude of trying to 'save' or 'fix' Native Americans" (Salzman, 2000, p. 4). Participants of another study support the dangers associated with imposing outside agendas and values on local community members and view such actions as culturally inappropriate and harmful (Gifford et al., 2010).

The majority of the literature focuses on the role of experienced professionals mentoring those with less experience as well as members of the dominant culture mentoring those from minority cultural groups. However, many novice professionals in rural Alaska greatly benefit from the cultural guidance and expertise of local Alaska Native community members. In fact, according to experienced providers, new providers, who seek out opportunities to engage in local cultural activities in the community, tend to fare better living and working in rural Alaska than those providers who remain isolated

and disengaged (Gifford et al., 2010). The third aim of this study seeks to explore Alaska Native community members serving as cultural mentors for novice professionals relocating to rural Alaska. In addition to ongoing clinical supervision and consultation, cultural mentorship may be an important factor facilitating provider longevity and culturally appropriate service delivery.

Workforce Development and Training Solutions

By 2010, researchers expect that Alaska will face an increase of 47.3% in the need of behavioral health service providers (Madison, 2004). The sixth fastest growing occupation in Alaska is in mental health and substance abuse counseling and the current enrollment and graduation trends of students in the University of Alaska system will not fulfill these needs (Madison, 2004).

The University of Alaska, Alaska Mental Health Trust Authority, and the State of Alaska, Department of Health and Social Services, Division of Behavioral Health formed an alliance called Alaska Behavioral Health Workforce Initiative in order to address workforce needs (Madison, 2004). During a two-day summit held in May 2004, the alliance developed a strategic plan consisting of four goals to include:

- "increase the supply of workers from certificate to doctoral level,
- improve course and program articulation across university campuses and programs
- increase cultural competence skills of the existing and new workforce, and
- ensure curriculum reflects new practice trends, especially integration of substance abuse and mental health practices" (Madison, 2004).

These goals translated into the development and enhancement of academic programs that focus on training helping professionals for Alaska. The University of Alaska Southeast developed a Behavioral Health Aide Certificate to train entry-level providers to deliver residential services to children. The University of Alaska Fairbanks (UAF) Human Services program will continue training cohorts of 20 students who are tribal employees. Currently, this program has a completion rate of 85% and 50% of the students articulate to the bachelors of social work or psychology program. The UAF social work program continues expanding its horizons by offering the degree program to rural students mostly employed by regional health corporations. This program utilizes a cohort model and plans to increase its student enrollment by 15 annually (Madison, 2004).

The University of Alaska Anchorage (UAA) Human Services program continues to expand its enrollment by recruiting certificate students having completed the Rural Human Service program. This effort increases the program's graduates by approximately 15% annually. Furthermore, UAA expanded it Masters in Social Work (MSW) program to offer courses via distance delivery. This program admits students who have completed a Bachelors degree in Social Work. These efforts will double the number of MSW graduates. The collaborative efforts continued as UAF and UAA joined to develop and implement a Ph.D. program in clinical and community psychology with a rural and indigenous emphasis (Madison, 2004). Through these efforts, the University of Alaska can offer students, who are interested in the helping profession, programs spanning from a certificate to a doctoral program. The alliance also addressed the continuing education

needs of licensed providers currently working in Alaska by developing and funding the Alaska Rural Behavioral Health Training Academy (Madison, 2004).

Continuing education for behavioral health workforce. The mission of the Alaska Rural Behavioral Health Training Academy (ARHBTA) is working to ensure an effective behavioral health workforce for rural Alaska. ARBHTA's goal is to meet ongoing continuing education and professional development needs of individuals who provide behavioral health services to individuals, families, and communities in rural Alaska (Koverola, Gifford, & Landen, 2007). Based upon the diverse needs of Alaska, ARBHTA developed training institutes tailored to meet the continuing education needs of behavioral healthcare providers (Landen, Gifford, & Koverola, 2007). Each institute is delivered by instructors inclusive of Native Alaskan Elders. The content of the training institute is based upon evidence based practices that are Alaskanized and culturally adapted to meet the various needs in different regions of the state. Furthermore, the institutes address cultural competency, ethics in rural practice, and vicarious trauma (Landen et al., 2007).

The instructor teams are composed of content experts on evidence-based practices, local clinical experts, and Alaska Native Elders. The Elders are integral members of the instructor team, and they provide advice on adaptations of evidenced based intervention (Gifford, Koverola, & Landen, 2007). They offer participants a cultural perspective on behavioral health service provision and they introduce participants to various cultural perspectives, worldviews, values, and belief systems. Furthermore, the training institutes facilitate participants learning how to interact with Elders during

both formal educational times and informal times for socializing (Gifford et al., 2007). The training institutes model the use of Elders as a community resource and cultural mentor. Finally, Elders as instructors offer participants a safe place to ask culturally related questions in an open and supportive environment (Gifford et al., 2007).

Over the years, behavioral healthcare providers have become increasingly aware that straight importation of Lower 48 practices fail in Alaska (Koverola et al., 2007). Although evidenced based practices are important and continue to be utilized in Alaska, adaptations are necessary. The adaptations are possible by building the practitioner's multicultural knowledge, skills, attitude and behaviors that facilitate the adaptations of mainstream interventions into culturally appropriate interventions (Gifford et al., 2007). During the training institute, the cultural adaptations evolve as the instructor team and participants examine the evidenced based approach. Through dialogue, the adaptation is created and brainstormed as experts, Elders, new clinicians, and seasoned clinicians consider the suitability of the approach to the Alaskan environment. Once created, the adaptation is practiced and examined in various role-plays with the experts and Elders providing feedback and guidance. It is important to mention the wealth of knowledge offered by seasoned clinicians who have worked in rural Alaska for extensive periods of time. Their expertise is irreplaceable and often guides the evidence-based approach in practical and adaptable ways while remaining true to the spirit of the approach (Gifford et al., 2007).

Conclusion

A variety of complex factors affect the provision of behavioral health service in rural areas. The distinctive remoteness of many areas of Alaska compounds the innate challenges of rural service delivery. Although efforts to provide professional certificates and degree opportunities for Alaskan students and continuing education opportunities for existing providers are essential for developing an effective workforce for rural Alaska, providers from outside Alaska will continue to be recruited and hired to fill many positions in rural Alaska.

Alaska Native people residing in rural Alaska have experienced the effect of people from outside of the region infiltrating their communities for hundreds of years. More recently, many Alaska Native community members frequently experience new teachers, healthcare providers, law enforcement, and other professional workers relocating to their communities only to leave within a short period of time. However, exceptions exist and local experts are uniquely situated to lend a very useful perspective regarding the important qualities of these exceptional professional providers who choose to remain in rural Alaska long-term. Consequently, it would also be useful to understand factors that contribute to providers living and working in rural Alaska for long periods of time, offering services that are well-utilized by community members, and engaging in cultural mentorship in order to provide culturally grounded and appropriate services. This study sought to fill the existing gaps in literature. It explored those factors as well as provider qualities believed to be important, by local professionals and paraprofessionals affiliated with behavioral health service delivery, in the following three categories:

1) provider qualities, and other factors, contributing to provider longevity;
2) provider qualities, and other factors, facilitating the willingness of community members to access and routinely utilize the services offered by the providers;
3) provider qualities, and other factors, facilitating a provider's engagement in cultural mentorship.

The ultimate goals of this study were 1) to develop recommendations to guide future continuing education and training for recently hired behavioral healthcare providers relocating to the Bering Strait Region 2) to guide future recruitment and retention activities of behavioral health organizations located in the Bering Strait Region.

Chapter Three: Research Design and Methods

Overview of the Rationale for a Qualitative Approach

Qualitative research provides a framework that facilitates understanding complex subject matter that has yet to be quantified or fully explained (Berg, 2009). Although qualitative research is broad in scope and meaning, it primarily serves as a type of research producing results arrived at in ways other than statistical analysis (Strauss & Corbin, 1998). Moreover, researchers utilize a qualitative approach to understand people's lives, experiences, behaviors, emotions, feelings, organizational functioning, and cultural phenomena (Strauss & Corbin, 1998). Most importantly, researchers utilize qualitative approaches to explore problems or issues facing specific groups or populations, identify variables that can measured in later studies, and hear marginalized or silenced voices (Creswell, 2007). Qualitative researchers typically utilize multi-method approaches such as conducting key informant interviews along with focus groups or analysis of written documents to enhance their understanding of a phenomenon and conduct their research in naturalistic settings (Denzin & Lincoln, 1994)

Given the paucity of literature regarding factors that might enhance provider retention in rural and indigenous areas, behavioral healthcare service utilization by indigenous community members and indigenous cultural mentorship of non-indigenous providers, this study utilized a qualitative approach to refine research questions, begin developing hypotheses, and explore these substantive areas. This study capitalized on the strength of a qualitative research approach to understand these issues from the perspectives of long-term healthcare providers. A particular effort was made to capture

the perspectives of local Alaska Native paraprofessionals and professionals working in the behavioral health field. To develop a clear understanding of the region and communities inhabited by the long-term healthcare providers, I made every attempt to conduct the interviews in the naturalistic settings of the regional health corporation, community clinics, or social services agencies.

Social Constructivist Paradigm

Since the overall purpose of this study was exploratory in nature, a social constructivist paradigm underpinned its design. Rather than testing an existing hypothesis or theory, the study inductively developed a theory or pattern of meanings (Creswell, 2007) attempting to explain the three domains of the study: factors and qualities of providers affecting longevity, service utilization, and engagement in cultural mentorship. As true of social constructivism, this study relied on the views, understandings, and interpretations of long-term health care providers with specific emphasis on the perspectives held by local Alaska Native behavioral healthcare providers (Creswell, 2007). Research participants were diverse in many ways to include their cultural and ethnic background, professional and paraprofessional training experiences, and length of time living and working in the region. Therefore, the study was designed to honor the constructivist paradigm assuming the existence of multiple realities and provides a rich description that presents the various perspectives offered by diverse research participants (Denzin & Lincoln, 1994).

The study utilized the constructivist approach of interpreting the research findings. Consequently, the interviews consisted of general open ended questions

facilitating the interaction between the participants and me. This interaction aided in co-constructing meaning in participants' own words about observations of and experiences with behavioral healthcare providers relocating to their communities from other places (Mills, Bonner, & Francis, 2006). Through this interview process, I sought to elicit responses from participants about their observations, perceptions and experiences. I later analyzed and interpreted their responses to better understand the three domains of the study and develop future studies with targeted research questions, theories, and/or hypotheses.

Grounded Theory

This study took a different approach, which sought to understand the factors and provider qualities leading to successful retention and service provision, as compared to previous and less applicable studies, which focus on factors resulting in unsuccessful service provision and provider turnover. Furthermore, the environment of the research participants is unique in its extreme remoteness and predominantly Alaska Native influence. Therefore, theories explaining the success of behavioral healthcare providers working in this particular type of setting can best be generated by developing a theory that directly emerges from the expertise of research participants, who live and work in the region, offering key informant interviews.

Grounded theory is a hypothesis generating method within the field of qualitative research that naturally fits with the social constructivist paradigm (Auerbach & Silverstein, 2003). This study's research design was based upon the two principles inherent to grounded theory. First, this study sought to question individuals in a manner

that elicits local community member expertise. Knowledge was derived from local community members providing key informant interviews where they answered open-ended questions. As a result, the second principle of ground theory was employed involving the development of plausible theories that emerged directly from the expertise of key informants explaining the three domains of the study. To develop plausible theories, both substantive and theoretical coding were utilized to generate hypotheses, with memoing occurring throughout the entire coding process (Auerbach & Silverstein, 2003; Strauss & Corbin, 1998). As a result, a substantive-level theory evolved that can be tested later for its empirical verification and generalizability. In sum, grounded theory facilitated an inductive approach to theory development from the data produced by key informant interviews (Strauss & Corbin, 1994). To fully understand the perspective of the region's long-term healthcare providers sufficiently to generate future hypotheses, an adequate number of interviews were conducted to ensure saturation (Creswell, 2007).

Methods of Data Collection and Analysis

Participants. The research participants were individuals who live and work in the Bering Strait Region of Alaska. This region extends to the Russian border in the Bering Sea and encompasses 44,000 square miles (Norton Sound Health Corporation, 2007). It is home to approximately 9,200 people with 81% of the population being Alaska Native (Norton Sound Health Corporation, 2007; Norton Sound Health Corporation, 2011). The Alaska Native population includes Inupiat, Siberian Yupik, and Central Yup'ik individuals. Nome, Alaska, serves as the region's hub and is home to approximately 3,500 residents (Norton Sound Health Corporation, 2007) with

approximately half of the residents being Alaska Native (Norton Sound Health Corporation, 2011). In addition to the regional hub community of Nome, 19 smaller communities, known as villages, comprise the Bering Strait Region (Norton Sound Health Corporation, 2011). Research participants from the communities in this region provided the key informant interviews.

The long-term healthcare providers from this region are in a unique position to help identify factors and provider qualities that affect longevity, successful service provision, and engagement in cultural mentorship. Therefore, the goal of this study was to capture their perspectives. Consequently, to be eligible to participate in the study, key informants must have identified as a long-term provider residing in the Bering Strait Region. Furthermore, participants must have lived in Alaska for most of their lives, been born and raised in the Bering Strait region, or must have lived and worked in the region for at least five years to participate in the study. Not only did this eligibility requirement capture the perspective of Alaska Native healthcare providers, but it also elicited information from other long-term healthcare providers who, similar to the Alaska Native providers, have witnessed providers deciding to remain in the region long-term or leave after a short period of time.

Two categories of key informants were sought out and included healthcare paraprofessional and professional providers who are employed by Norton Sound Health Corporation, the State of Alaska, and other social service organizations serving the region. Examples of paraprofessional staff positions included village-based counselors, caseworkers, and community health aides. Professional staff positions included

healthcare administrators, clinicians/counselors, social workers, and various medical providers (physicians, physician assistants, and nurses).

To understand the multiple perspectives existing within the region, every attempt was made to secure key informant interviews from diverse individuals representing a variety of perspectives. In particular, interviews were acquired from participants living and working in two types of communities, the regional hub (Nome) and outlying rural communities. Efforts were made to secure a sufficient number of key informant interviews from both types of communities in order to reach saturation. In addition to location, diversity in age, gender, and ethnicity was sought out. Finally, due to the remoteness of the region and its limited number of healthcare providers, it was expected that many of the key informants would not only provide the perspective of healthcare providers but also that of community stakeholders who were consumers of the region's healthcare and behavioral healthcare system.

Creswell (2007) recommends conducting between 20 to 30 interviews for grounded theory studies. However, as noted by Berg (2004), a number of factors influence the proper sample size of a study to include heterogeneity of the population, the number of subgroups the researcher wishes to simultaneously consider in the analysis, desired accuracy of the sample, size of the phenomenon to be detected, and financial and time constraints of the study. In the case of this study, financial constraints certainly limited the sample size. I conducted 20 interviews with 21 participants endeavoring to reach saturation. During one of the interviews, two participants were interviewed simultaneously per request of the participants. Eleven key informant interviews were

conducted with participants identifying as Alaska Native and 10 interviews occurred with participants identifying as non-Native. Ten participants lived and worked in villages and 11 participants resided in the regional hub. Eleven participants were employed as paraprofessionals and 10 were employed as professionals.

Participant recruitment. Two methods of sampling were utilized in this study. First, purposeful sampling was utilized in order to select key informants who could "purposefully inform an understanding of the study or research problem" (Creswell, 2007, p. 125). Because of my familiarity with the Bering Strait Region and prior connections with community members residing in the region, I employed purposeful sampling to contact these key informants with expertise in areas of exploration. However, the number of key informants reached through this purposeful sampling method was insufficient to reach saturation of the subject matter.

Relying on key informants from the purposeful sampling, I asked them to refer other highly regarded people that met the eligibility requirements to participate in the study. This method is known as snowball sampling (Auerbach & Silverstein, 2003) and it is considered a viable option for connecting with difficult-to-reach populations (Berg, 2004).

Because of the sampling methodologies that support the exploratory purpose of this study in a specific region from a rural long-term healthcare provider perspective, the sample was non-representative of all healthcare staff providers across Alaska. Consequently, the findings may not be generalizable outside of the Bering Strait Region, as generalizability was not the goal of this study. Instead, I intended to target the

expertise of key individuals in order to develop an understanding of the formerly specified three phenomena. This information was elicited through interviewing key informants.

Instrument. A semi-structured interview was conducted with each key informant to query them about the areas of interest in the study. Due to the exploratory nature of this study, a semi-structured interview format allowed me to utilize an ordered and predetermined set of open ended questions; however, it also provided me with the freedom to utilize probes in order to further query the key informants and elicit additional information (Berg, 2009). This semi-structured interview guide, as shown in Appendix A, allowed for the comparison of responses between healthcare providers from various cultural and ethnic backgrounds, paraprofessionals and professionals, and key informants from the regional hub and outlying villages while permitting the exploration of unforeseen topics or issues (Denzin & Lincoln, 1994).

To obtain rich and in-depth data, the interview schedule was developed based upon Berg's suggestions of beginning with nonthreatening questions, such as demographics. In the proposed study, the interview commenced with questions regarding the key informant's ethnicity/cultural background, age, number of years residing in the Bering Strait Region, years of service as a behavioral health provider, educational background, and training. In accordance with Berg's advice, demographic questions were followed by more important questions that were not querying about the most sensitive material but were directly asking about one domain of the study (2009). The next question attempted to draw out the most sensitive information from the key informant

regarding the domain. It was followed by a query that was re-worded, but probed about the same domain, to establish validity of the prior information provided by the key informant (Berg, 2009). This method of structuring the interview schedule continued until all three domains of the study were addressed.

The purpose of the qualitative semi-structured interview schedule was to explore three domains: provider qualities, and other factors, affecting retention and longevity; provider qualities, and other factors, facilitating community members accessing and routinely utilizing the services offered by the provider; and provider qualities, and other factors, facilitating their engagement in cultural mentorship. Based upon results from a preliminary study that examined factors contributing to long-term retention of behavioral healthcare providers who relocated to rural Alaska for work (Gifford et al., 2010), additional domains were thought likely to emerge in this study around the area of new provider training and ongoing provider professional support. Other findings from this pilot study that were thought likely to emerge in the study included the effect of the environment on the provider's hobbies and interests, the provider's ability to successfully engage with the local community and work cross-culturally, the effects of living far from family members who may be ailing, and the provider's ability to establish a social network to include locating a mate and establishing a family. To allow for the exploration of unanticipated domains that emerged in this study, the content of the interview questions in Table 2 was tentative and served as a guide.

Table 2

Key Informant Interview Questions

Domains	Tentative Questions
Qualities affecting longevity	1. I would like to understand how many years a provider, coming from outside, must work in the community to be considered a long-term provider. What are your thoughts on this idea of long-term? 1a. How long must a provider live and work in your community before you would consider them a long-term provider? 2. What factors influence whether or not a provider stays to work in the region for a long time? 2a. What role does the community play in whether or not a provider stays for a long time? 2b. What are your thoughts about community support or lack of community support on a provider's decision to stay? 3. Some providers stay and work longer than others. What qualities have you noticed about providers that help them stay longer than others? 4. For those providers who leave after only a short time, what qualities about them have you noticed? 5. What about community members who have left to pursue training or education as behavioral healthcare providers and then returned to the region to live and work? 5a. What helps them stay? 5b. How does the community respond to them? 5c. How does this affect their work?
Qualities affecting Service Utilization	6. For some people, it can be difficult to talk about their problems with clinicians who are from outside. What are your thoughts about this? 7. What factors influence whether or not a community member feels comfortable seeking help from an outside provider? 8. What qualities do clinicians have that help community members feel comfortable seeking their help? 9. What qualities do clinicians have that seem to make it difficult for community members to use their services? 10. What do clinicians do to make people more comfortable?
Qualities affecting Cultural Mentorship	11. Some providers who are from outside are not familiar with the local culture. How do they learn about the local culture? 11a. What are your thoughts about new providers working with local Alaska Native community members to learn about the culture? 12. What factors influence whether or not a provider works with a local community member or provider in order to learn about the culture? 13. What qualities do you think would important for a provider to have in order to learn from a local community member? 14. What challenges come to mind when you think about a provider from the outside learning from local community members? 14a. What provider qualities might make it difficult to learn from a community member?

Prior to conducting key informant interviews, questions on the interview guide and protocol were reviewed by three individuals. First, an Alaska Native doctoral candidate with extensive experience in qualitative research, including key informant interviews with Alaska Native community members using a semi-structure interview guide, examined each question and prompt on the interview guide. Next, I conducted a mock interview with a resident from western Alaska, who is a fluent speaker in Central Yup'ik and English, to refine the interview protocol and guide. Finally, a doctoral student in the clinical and community doctoral psychology program reviewed my interview questions and interview protocol. All three individuals evaluated the clarity and understandability of the interview protocol and each question and prompt on the interview guide. Each individual provided feedback so the problematic language, statements, questions and prompts could be reworked in order to avoid interviewee misinterpretation and confusion.

Method. Through purposeful sampling, I contacted potential key informants by telephone, email, or in person. For those individuals interested in participating in the study, an informed consent was distributed via mail, fax, email, or in person. The consent form described the details of the study including full disclosure of potential risks and harm, non-coercion, confidentiality assurances and limitations. Furthermore, the informed consent described the study's purpose, procedures, eligibility criteria, time requirements, and a gift for participation. If still interested, I contacted key informants via telephone to arrange a convenient time for a face-to-face or telephone interview. Every effort was made to conduct face-to-face interviews where the participant

physically signed an informed consent form which I collected. A copy of the informed consent form was provided to the participant (see Appendix C for a copy of the participant consent form).

Telephone interviews were conducted only in extenuating circumstances when an in-person interview was not possible. Interviews with three participants were conducted by telephone; interviews with 18 participants were completed in-person. Similar informed consent procedures were followed for a telephone interview as for an in-person interview except that rather than signing an informed consent form, the participant's verbal consent to participate was recorded and I noted their willingness to participate on a consent form.

Regardless of interview format (face-to-face or telephone), all interviews were recorded for transcription purposes. I was responsible for conducting the interviews, reviewing the informed consent with the participant, answering any questions related to the informed consent and/or study, and obtaining a signed copy of the informed consent at the face-to-face interview. At the conclusion of the interview, key informants from the purposeful sampling effort were asked to identify other potential key informants for this study allowing for snowball sampling. The same procedure was followed for those key informants involved in the snowball sampling methodology.

I explained the interview protocol to each participant prior to commencement of the interview. Each interview lasted approximately 60 to 90 minutes. This process was initiated by my contacting the potential participant via telephone or email in order to determine their interest in participation and providing them with an informed consent

form describing the study. The key informant and I discussed a convenient time and location for completing the interview. At the time of the face-to-face interview, the following occurred:

- I provided the participant with another copy of the informed consent form. The informed consent was explained to the participant verbally. The participant was given an opportunity to ask any questions related to the informed consent and/or study. If the participant agreed to participate, they were asked to sign the form. A copy of the signed form was provided to the participant and I retained a copy.
- Following the completion of the interview, the participants, was thanked and provided with a $50.00 visa gift card. Participants were reminded of the process for obtaining results of the study once it is completed.

In the event of a telephone interview, the following occurred:

- I verbally confirmed that the participant received a copy of the informed consent form. The informed consent was explained to the participant verbally. The participant was given an opportunity to ask any questions related to the informed consent and/or study. If the participant agreed to participate, they were asked to provide their verbal assent stating that they wish to participate in the study. This assent was captured on the recording and noted on an informed consent form. If the participant needed another copy of the informed consent form, I emailed, faxed, or mailed them a copy of the form.

- Following the completion of the interview, the participant was thanked and a $50.00 visa gift card was mailed to them. Participants were reminded of the process for obtaining results of the study once it is completed.

Data analysis. All recorded interviews were transcribed verbatim into MS Word files and uploaded into Atlas.ti qualitative data analysis software. A fellow doctoral candidate (DC) in the clinical-community psychology doctoral program with substantial qualitative analysis and research experience and I conducted a two-fold coding process, substantive and theoretical coding (Glasser & Strauss, 1967). We analyzed the interviews for concepts and themes that increased our understanding of long-term healthcare providers' perspectives on the three specified domains. These domains included those qualities possessed by outside providers enabling them to remain living and working in rural Alaska long-term, offer services that are well-utilized by community members, engage effectively in cultural mentorship, and other factors affecting retention, service utilization, and mentorship that emerged in the data. Analyses were descriptive and conceptual in nature and ultimately articulated substantive theoretical propositions, based upon the understood relationships between categories, specific to behavioral healthcare providers living and working within Bering Strait Region. Procedures for conducting qualitative analysis—based upon grounded theory involving open, axial, and selective coding—followed well established guidelines for assessing themes or categories, properties, dimensions, and concepts (Berg, 2009; Kelle, 2007; Charmaz, 2006; Creswell, 2007; Strauss & Corbin, 1998).

To reduce travel costs, I attempted to schedule as many key informant interviews as possible within short blocks of time. I scheduled two fieldtrips to rural Alaska in order to collect the data. Therefore, transcription of interviews began immediately following the first block of interviews and qualitative data analysis including open coding and memoing commenced following transcription. During the interviews, I noted spontaneous impressions, thoughts, and observations that emerged. Following each interview, I completed notes that documented impressions, thoughts, and observations. The practice of conducting data analysis prior to the collection of all data is a well-supported strategy enabling researchers to identify emerging themes and conceptualize relationships between categories early on in the research process (Berg, 2009). During the early stages of data analysis, my notes from each interview served as a tool enabling me to begin identifying the emergence of themes and the relationships between categories. Both transcription and data analysis continued until the next block of interviews were conducted. This process resumed until all interviews were conducted, transcribed, and analyzed.

Open coding. Substantive coding allows researchers to identify "in vivo codes," which provides rich empirical substance for the various emerging categories of the study, in the language of the key informants (Kelle, 2007). Using open coding, the DC and I identified emerging themes and categories (Strauss & Corbin, 1998). The open coding process incorporated the methods of microanalysis, a line-by-line analysis used to generate initial categories (Strauss & Corbin, 1998), to facilitate a comprehensive and systematic approach to analyzing the transcribed data.

A sub-set of four interviews were randomly selected for microanalysis and open coding by the DC and me. The sub-set was comprised of two selected interviews from each group of key informants (professional and paraprofessional healthcare providers) obtained on the first data collection visit. Furthermore, the sub-set was diverse and representative of key informants who live and work in the regional hub and outlying villages. The DC and I coded this sub-set of interviews together allowing for the consensus regarding the emergence of themes. To further solidify this process, the DC and I decided to select one more interview to further develop consensus on emerging themes. Based upon this process, a codebook was developed that included the identified themes or categories, definition of the categories, and excerpts from the transcribed interviews exemplifying the categories.

Following the development of the initial codebook, the DC and I randomly selected two professional interviews and two paraprofessional interviews from the remaining transcribed interviews and coded them independently using microanalysis. After independently coding each additional interview, the DC and I met to discuss emerging themes or categories in order to establish inter-rater reliability. As we identified additional themes emerging from the transcriptions, additional categories were defined and added to the codebook. As necessary, existing categorical definitions were revised to accommodate developing themes.

Disagreements in coding were identified by comparing coded interviews prior to the meeting. During the meeting, the DC and I reviewed whether a code was applied appropriately or inappropriately. Based upon the decision, the code was applied to the

project or removed from the project. New categories were created when an emerging theme could be incorporated into an existing categorical definition. The coding process was iterative; therefore; any codebook modifications were applied to previously coded interviews. The DC and I employed the use of memo writing as we open coded interviews allowing us to record impressions, thoughts, and future directions (Strauss & Corbin, 1998). Memo writing enabled the DC and me to recall pertinent information to guide us during the coding discussions. Utilizing the revised codebook, I coded all remaining transcribed interviews and the DC coded every fourth interview to control for drift. Double coded interviews were compared to ensure that codes were consistently and accurately applied. Inter-rater reliability was calculated from the four randomly selected interviews plus every fourth interview coded by both the DC and me. Inter-rater reliability averaged 79% agreement. A total of six interviews were double coded with inter-rater reliability for each consecutive interview yielding agreements of 73%, 78%, 81%, 91%, 78%, and 82%.

Axial coding. Next, theoretical coding occurred explaining the relationship between the substantive codes, which emerged during open coding, in order to develop a hypothesized causal model (Kelle, 2007). I utilized axial and selective coding to guide the process of theoretical coding. The purpose of axial coding is to identify the relationships existing between codes and subcategories repeatedly verified in the data (Charmaz, 2006; Strauss & Corbin, 1998). As suggested by Strauss and Corbin, I attempted to enhance the explanatory power of the concepts by developing subcategories that answer questions such as Who?, What?, Where?, When?, How?, and With what

consequences (1998). To aid in this process, demographic data about the participants was entered into Atlas.ti for use in analyzing coded data by key informant demographic characteristics. Demographic categories that were utilized in data analysis included: ethnicity, healthcare providers classified as a professional versus a paraprofessional, and key informants living and working in a hub community versus an outlying village.

I worked, in consultation with the faculty advisor and DC as needed, to reassemble the data into major categories. Throughout the axial coding process, I engaged in memo writing. Memos contained information attempting to answer questions related to axial coding and explain the plausible relationships existing between categories (Strauss & Corbin, 1998). This information was used to guide the decision making process and theoretical discussion occurring during consultation meetings with the faculty advisor and/or DC.

Selective coding. Finally, I utilized selective coding, a process of integrating categories into a grounded theory (Strauss & Corbin, 1998). The categories were incorporated into three central phenomena of interest in this study: provider qualities affecting long-term retention, service utilization by community members, and use of cultural mentorship. The central theme of each phenomenon was identified and explanatory statements were developed that link major categories to the central theme (Strauss & Corbin, 1998). I developed diagrams and reviewed memos to aid with integrating major categories into central themes and grounded theories. The proposed theories were validated by comparing them to raw data (Strauss & Corbin, 1998).

Implications of the Results

Upon completion of this study and committee review, Norton Sound Health Corporation will be provided with a summary report describing the study's purpose, methods, and results. Furthermore, the summary report would include specific recommendations for Norton Sound Health Corporation to consider based upon the findings of the study. It is expected that the study's results will be utilized to inform future recruitment and retention activities of Norton Sound Health Corporation.

Based upon key informant interviews, I will provide Norton Sound Health Corporation with recommendations regarding specific qualities indicative of a provider who is well-suited for working in the region. Recommendations may include potential interview questions and scenarios used to identify whether an applicant possesses identified qualities leading to long-term retention and community member service utilization. In addition to recruitment and screening activities, the study may be utilized to inform retention activities of Norton Sound Health Corporation. Recommendations may be made to enhance new provider orientation programs, develop continuing education opportunities, and facilitate on-going cultural mentorship. Other recommendations based upon the study's findings have been generated and will be discussed in the conclusion section and will be included in the summary provided to Norton Sound Health Corporation.

Human subject protection issues. This study was submitted to the University of Alaska Fairbanks Institutional Review Board (IRB) and the Norton Sound Health Corporation Research Ethics Review Board (RERB) for approval prior to

commencement. The approved protocol submitted to both review boards included procedures regarding face-to-face and telephone key informant interviews. Although Alaska Native people are considered a vulnerable population, the IRB did not require a full review because of the unobtrusive nature of the study and its interview questions (see Appendix B for the IRB documentation). Following IRB approval, the study was submitted to the RERB for approval.

I am mindful of the vulnerabilities of individuals participating in research and upheld the principles of respect for persons, beneficence, and justice throughout this study. I have completed the Collaborative Institutional Training Initiative (CITI) web-based training program for the protection of human research subjects. Recruitment processes, consent processes, confidentiality protections, data collection and storage were conducted in an ethical and confidential manner with faculty advisor, IRB, and Norton Sound Health Corporation oversight.

I discussed the details of the study as well as potential risks and benefits with participants. Furthermore, a written informed consent document, as shown in Appendix C, was provided to each participant detailing all of the information provided during the discussion. All willing participants reviewed and signed the informed consent form, which I collected. Participants were provided with a copy of the informed consent form. In circumstances that required telephone interviews, willing participants provided their recorded verbal assent to participate in the study, which I noted on an informed consent form, once the details of the informed consent had been reviewed verbally. A copy of the informed consent was mailed, emailed, or faxed to participants completing telephone

interviews prior to conducting the interview. This informed consent form delineated information regarding the voluntary nature of the study, the rights of participants-- to include discontinuing participation at any time without repercussions-- the risks and benefits associated with the study, and plans to protect participants from any risks. Due to the nature of this study, no adverse effects were anticipated and none occurred.

I ensured that procedures were in place to address the safety, confidentiality, and comfort of each participant. The DC was apprised of all procedures, completed CITI training, and agreed to safeguard the confidentiality of each participant. I worked with key informants to schedule interviews at times and in locations that were conducive to privacy in order to safeguard confidentiality. Signed informed consents were stored in a locked file cabinet separate from that of the recording devices, transcribed interview material, and codebooks. Only the DC, faculty advisor and I have access to the study's data. However, because people are easily identifiable by small community and employer in rural Alaska, all names of communities and employers have been removed from the transcribed data in addition to the removal of participant names. Participants were assigned a participant number that was entered into the data analysis software as opposed to participant names. Communities were identified as being either a village or regional hub. Any information that would cause a participant's identity to be revealed was eliminated from the summary report for the Norton Sound Health Corporation. Such information was also removed from the results, discussion, and conclusion sections of the study.

Chapter Four: Results

Overview

Themes emerging for each of the research questions are reported in this section. First, those themes that emerged when exploring factors and provider qualities contributing to the retention of outside providers are defined and exemplified followed by those that emerged when discussing the retention of local providers. Next, factors and provider qualities that influence community member utilization of an outside provider's services are summarized. Lastly, themes associated with factors and provider qualities that contribute to an outside provider acquiring cultural mentorship are reported. In each section, themes are described in order of decreasing frequency.

Factors or Provider Qualities Viewed as Important for Long-Term Retention of Outside Providers

The first research question addressed in the study examined the factors or qualities participants deemed as being important for the retention of healthcare providers who relocate to the region from outside. Participants identified themes of engagement, being open, and imposing values, beliefs, and worldviews with the most frequency in this section. Themes of social support, job stress, personal qualities, professional support, and community acceptance also emerged with some frequency followed by love of rural, self care, adaptable approach to service delivery, weather/darkness, personal adjustment, boundaries, commitment, and job satisfaction.

Engagement. The ability of a provider to engage in the local community appeared to be viewed by participants as an essential quality that aids in retention of

providers. The theme of engagement was defined as providers actively participating and willingly investing in the local community, environment, and culture. Engagement was also described as providers openly approaching and interacting with others to experience opportunities existing in the area; appreciating what is offered within the community, culture, and environment; and thriving within the community, culture, and environment. This concept encompassed a provider making efforts to develop relationships with community members, and it captured a provider's willingness to give back to the community. The following quotation was provided by a participant who identified as a professional who relocated to the region from elsewhere:

> . . . it's how a person conducts themselves. You know; if they immerse themselves in the culture, as long as they're respectful in that process, they're gonna stay. They're gonna do well. They're gonna be great. And if they don't immerse themselves in a culture and remain on the outside of the culture, not participating in the activities, not hanging out with the locals, not visiting elders, not doing as the locals do, not taking risks and experiencing new foods, new things, they're not gonna last.

The following quotation, provided by a paraprofessional participant originally from rural Alaska, concurs with the previous quotations by furthering illustrating the negative consequences of providers not engaging with the community:

> . . . if the outsiders come in and don't interact with the community, if they don't go to the community and be one of them and let them know that they're interested in them, and they don't get involved with their events-- like potlatches, you know,

those special things that mean so much to us-- and they just isolate themselves and have their own little community, they're not benefiting themselves or the community.

Participants noted the theme of engagement 53 times. Eighty-one percent of participants noted engagement as an important theme influencing retention. A greater percentage of participants from villages, Alaska Native participants, and paraprofessional participants identified engagement as an important theme when compared to participants from the regional hub, non-Native participants, and professional participants. However, engagement was referenced by the majority of participants in each demographic category as shown in Table 3.

Table 3

Percent of Participants Identifying Theme as Important for Provider Retention

Theme	% of Partici-pants n=21	% From Regional Hub n=11	% From Villages n=10	% Non-Native n=10	% Alaska Native n=11	% Profes-sionals n=10	% Para-profes-sionals n=11
Engagement	81	73	90	70	91	70	91
Being Open	71	64	80	70	73	60	82
Imposing Values, Beliefs, and World Views	67	64	70	70	64	60	73
Social Support	52	82	20	80	27	80	27
Personal Qualities	52	55	50	50	55	60	45
Job Stress	43	55	30	60	27	60	27
Professional Support	33	45	20	50	18	50	18
Community Acceptance	52	36	70	40	64	40	64
Love of Rural	52	91	10	90	18	100	9
Self-care	33	45	20	50	18	50	18
Adaptable Approach to Service Delivery	38	36	40	40	36	40	36
Weather and Darkness	57	64	50	70	45	70	45
Personal Adjustments	43	55	30	60	27	50	36
Boundaries	29	45	10	50	9	50	9
Commitment	43	55	30	50	36	50	36
Job Satisfaction	48	55	40	60	36	60	36

Being open. Participants identified the theme of being open as a main factor that positively contributes to the longevity of providers. It was defined as a quality that allows providers to learn about culture, embrace new ways of understanding mental health, and refrain from imposing personal values and beliefs on local people. Furthermore, it related to the provider's cultural interest in various worldviews, beliefs, values, and practices that are different from their own. It involved the provider being unassuming which then gives way for acceptance, compromise, suspension of judgment, and understanding of culture. The next quotation illustrates the importance of provider openness. It was provided by a paraprofessional who described ways in which local providers and providers from the outside can work together:

> I would like them to learn to try to understand us too and work with us too. You know. There's nothing wrong with blending both worlds. Their way and our way. We can always compromise and make it work, you know? A little bit of your way and a little bit of my way, you know you don't have to totally give up your way, and we don't have to totally give up our way. I'm sure if we discuss it we can meet and make it work.

A professional participant commented on qualities necessary for living and working in the region long-term by stating, "You just have to have an open mind to work up here. And you have to be very, very, very flexible. And non-judgmental."

Being open emerged a total of 48 times, and it appeared in interviews with 71% of the participants. It was more likely to occur in interviews with paraprofessional

participants and participants from villages than professional participants and participants from the regional hub (see Table 3).

Imposing values, beliefs, and worldviews. Participants discussed that providers who impose their values, beliefs, and worldviews on local community members are unlikely to remain in the region long-term. Imposing values, beliefs, and worldviews was defined as the inability of outsiders to understand, think, and interact with people from different cultural backgrounds in a way that honors diverse worldviews, values, and beliefs. Instead, these outside providers appeared to hold onto their own worldviews, values, and beliefs and expected others to adhere to them. They tended to view and judge other cultures through their own cultural lens, and they perceived their worldviews, beliefs, and values as superior. This concept included historical trauma that led to the loss of culture for Alaska Native people in the region as a result of outsiders putting their values and beliefs on them. It also involved providers assuming expertise by seizing power and decision making authority. This concept included the providers believing that they were "right" and assuming that their ideas and methods were superior to those of others. A sense of arrogance and superiority on the part of the provider was implied, and a sense of rigidity existed in the provider's beliefs, practices, and interactions. This theme is the opposite of the previously described theme of being open. One participant summed up the essence of this theme:

> I think those that come with this attitude it's going to be my way or no way at all, only trying to influence only their own western way of doing things and not accepting the Native ways of doing things, and...They run into problems.

Another participant further explained the danger of outsiders trying to impose lower 48 methods in the region:

> . . . we have had some who can't let go of, 'Well, back in [Name of Lower 48 State City] we did it this way.' Well, this isn't [Name of Lower 48 State City]. This is an entirely different type of medical service. You can't operate up here the way you operate down there. It would fall apart. You, it's physically impossible. They just can't seem to let go of that and grasp what works here, in Bush, Alaska. So. . . And if you can't let go of it, you're leaving.

Imposing values, beliefs, worldviews surfaced 33 times. This theme emerged in interviews with 67% of the participants. Paraprofessionals were somewhat more likely to discuss this theme than professionals (see Table 3).

Social support. Participants considered the providers' social support to be an important factor in their decisions to remain in the region long-term. Social support was described as the ability of the provider to establish long-term personal relationships within the community. It was defined as the provider's connection to familial support and networks. This theme also described the challenges faced by some providers in establishing a social support network. A participant from the region explained, "Mainly the provider stays because they make connections here. They make real long-term type connections, whether that is by purchasing a home or getting into a relationship that's going to be long-term." One professional who relocated to the region from the lower 48 explained the hardship experienced by some providers caused by the physical distance that exists between them and their families:

> The fact that many people still have strong family ties still, in spite of the fact we are a rapid transit country and families being spread all over the country. They still have like having family close by. People that are here have family close by. We develop strong relationships here but if you are a person that has to go see your mother every three months this may not be the place. In the lower 48 they can be 500 miles away and that is not necessarily too much of a problem. Here there is only three aircraft a day to go somewhere and that is Anchorage. Most people are not from Anchorage that come up here, they are from everywhere else.

Social support emerged a total of 28 times with 52% of participants discussing it in their interviews. Participants from the regional hub, non-Native participants, and professionals were much more likely to discuss the role of social support when compared to participants from villages, Alaska Native participants, and paraprofessionals (see Table 3).

Personal qualities. The theme of personal qualities included traits or characteristics that were viewed by participants as positive influences or hindrances to provider retention. Personal qualities were defined as providers' traits or characteristics that influence their success with living and working in rural Alaska. The characteristics or traits may be related to providers' personalities, attitudes, appearances, temperaments, and interpersonal styles. Examples may include gender, minority status, sense of humor, work ethic, flexibility, adaptability, calmness, respectfulness, adventure-seeking, talkativeness, ability to connect with others, being a team player, self-awareness, listening skills, introversion, and ability to admit they are scared or intimidated. A

participant who grew up in the region noted personal qualities that appear linked to providers leaving after a short period of time by stating, "Introvert. They're not really social creatures. They remain alone, and their home is elsewhere. They don't make this region, or [Name of hub], their home." A participant who relocated to the region from another part of Alaska explained the importance of providers being independent self-starters:

> I think a person has to be very independent, in terms of their personal interests and activities. So they need to be an independent starter, they need to be able to go to the swimming pool and figure out how to get there, if that's what they want to do. If they want to ski, they need to be able to go out and do it, whether or not there are a lot of people who want to do it with them. They have to be able to seek out the things that are going to be supportive for the activities that they like to do. And not get discouraged if things are not always available. There are lots of different ways of going out and finding things to do, and I think that somebody who really is needy isn't going to be able to have their needs met.

The theme of personal qualities as related to the retention of providers who relocate to the region emerged a total of 26 times during interviews with 52% of the participants. A somewhat greater percentage of professional participants identified this theme as compared to paraprofessional participants (see Table 3).

Job stress. Job stress emerged as a crucial factor contributing to provider retention. It was defined as a provider struggling with work-related stressors that may or may not be coupled with personal issues such as loss of family members. It related to a

sense of being over-extended. This concept included the provider's experience of burnout and vicarious trauma stemming from employment. In addition, this code captured challenges related to the travel requirements of the position including small plane travel. One participant described the intensity of the workload and its relationship to burnout.

> I think the burnout rate is extremely high, and that is that you don't deal with seven clients a day and go home and close your door. You're dealing with um, mainly the unknown every time you walk through a door. There's crisis, there's suicides, there's um, traumatic experiences, deaths, people falling through the ice or four wheeler wrecks and things like that, and it seems like it never stops, if that makes sense. So, plus you have um, a lot more on-call, a lot more responsibility. If you're assigned to one village then everything that happens in that village . . . the trauma that you deal with on such a personal basis day after day or week after week, becomes your total responsibility. Certain viewpoints that are very hard to deal with, the number of hours and the number of unknowns. . . It's your responsibility to take care of everything, you know, it's hard. It's very hard.

A participant who was born and raised in the region summarized the unique stressors faced by providers working in the region, "[There are always] questions like are you coming to pick me up at the airport, do I have a place to stay, is there water, little things do add up that can be stressful."

This theme emerged a total of 24 times during interviews with 43% of the participants. Non-Native participants, professionals and participants from the regional

hub were more likely to discuss job stress compared to Alaska Native participants, paraprofessionals and participants from the villages (see Table 3).

Professional support. Professional support emerged as an important theme in the longevity of providers. It was defined as providers being able to routinely connect with other professionals and paraprofessionals both locally and distally for support. This may occur in the form of being able to connect with providers who have ample experience living and working in the area. Professional support may offer new clinicians support, guidance, and advice about working as a provider in the region. This concept also involved systems, communities, and organizations having realistic expectations of providers and supporting them in a workload that is healthy and reasonable. Furthermore, professional support was defined as feeling valued by a system or organization that viewed someone's contribution as being important and comparable to that of another person's contribution. It lent itself to people feeling respected and appreciated. This concept also described historical factors such as oppression influencing the way present-day organizations have been structured and interface with employees. A participant explained the importance of the clinical supervisor offering support and oversight in order to protect a new provider that may appear extremely motivated from burning out:

> . . . those types of clinical supervisors or administrators saying, 'Let's look at schedules, let's make sure it's evenly distributed and not one person or two people doing all the travel and all the on-call.' And that kind of thing. Cuz it tends to sometimes, and it's like that anywhere, you know, the new people get the most.

> And they're gung ho to do it, so, therefore they get more, you know. 'Oh they can handle it. They're young, or they're new.' And that kind of thing, but that's, I don't that's the case here. I think the new person needs; it needs to be more gradual.

A participant with many years of living and working in the region explained the role of professional support:

> I've been very fortunate. I've known some really good people who've been good teachers, good help, very fortunate. Good role models. And I think that's kept me on track here. I can even trace it back to the year and the person. And the other thing that keeps me here is I feel that experience is useful to other people. Because I've stood on the shoulders of some folks, so it's okay if they stand on my shoulders, too. So I get a lot of bang out of being able to help other people. Staff, in particular. Clients are always great. Staff is more challenging, because they're under a lot of pressure, and some folks are just not sure of themselves, especially beginners, and you really need to put together something that will make life better for these folks. Help them to experience where they're going to feel that they're doing something important, you know? So you've got to be able to get a bang out of it. You know, inner convictions, a belief that somehow is compatible with what people need.

Profession support emerged 21 times during interviews with 33% of the participants. Non-Native participants, professionals, and participants from the regional hub were more likely to speak about the importance of professional support when

compared to Alaska Native participants, paraprofessionals, and participants from villages (see Table 3).

Community acceptance. Participants considered community acceptance a factor that influences provider retention. Community acceptance was defined as the community welcoming and willingly interacting with provider. It involved the provider no longer feeling like a newcomer or a complete outsider. They were able to assume a certain type of role in the community that allowed them to feel a sense of belonging as a provider as opposed to feeling like a stranger. This concept required mutual respect between the provider and the community. It involved a sense of having built relationships. A local participant identified respect as a key element allowing providers to be accepted by the community by stating, "They'll [community members] feel they're being respected and listened to, then you're [provider] gonna get their respect, and you're going to be accepted." Another local participant explained the idea of being "adopted" by the community as an example of community acceptance by saying, "When that [acceptance] happens, it is almost like you get adopted. You get a Yupik name and become part of the community and it can be nice, I think."

Community acceptance emerged a total of 21 times during interviews with 52% of the participants. A greater percentage of participants from villages, Alaska Native participants, and paraprofessionals identified community acceptance compared to participants from the regional hub, non-Native participants, and professionals (see Table 3).

Love of rural. Love of rural emerged as a strong factor contributing to retention of providers. Love of rural was defined as genuinely enjoying aspects unique to living and working in remote areas. It required one to be creative or adventurous in their work and play. Love of rural was further defined as liking rural/isolation and enjoying a slower pace of life. It was described as a provider enjoying the interconnectedness of community members and surrounding villages. One participant explained the effect of a provider enjoying the outdoors on a goodness of fit for working in the region.

> . . . well the fact they look at their experience a little deeper than the superficialities of what is available, what a person can buy and the challenges of the environment. Many people here are outdoorsy, maybe not hunters and fishermen, but hikers and cross country skiers and that sort of thing. They enjoy that part of it. Outdoorsy people, urbanites and metrosexuals are generally no.

This theme surfaced a total 18 times during interviews with 52% of the participants. Professionals, participants from the regional hub and non-Native participants were much more likely to note love of rural as a vital factor in the retention of provide when compared to paraprofessionals, participants from villages, and Alaska Native participants (see Table 3).

Self-care. Participants considered self care a significant factor in the longevity of providers. Self care was defined as attending to one's needs, honoring personal limitations, and adhering to appropriate boundaries. It involved nurturing one's self outside of work in personal relationships, spiritual practices, physical activities,

emotional well-being, recreational activities, and intellectual needs. One participant explained the importance of self-care in following quotation:

> 'Hey we need to slow down here. We need to make sure you take care of yourself.' So it's, it's the young that, whether it's young at heart or young in age, or young in the profession that has not learned to say, 'I can't do anymore. I need a break. I need a mental health day. I need to pull myself together, or I need to debrief.'

Self care emerged 18 times during interviews with 33% of participants. This theme was more likely to surfaces during interviews with non-Native participants and professionals than with Alaska Native participants and paraprofessionals (see Table 3).

Adaptable approach to service delivery. Adaptable approach to service delivery was discussed as a factor contributing to the provider's ability to remain in the region long-term. This theme was defined as the ability to creatively approach interventions as well as develop and utilize available resources. Furthermore, it was defined as providers willingly accepting challenges of providing a wide range of services to clients and creatively acquiring the necessary expertise to do so. It also referred to the concept of blending western ways of helping and providing services with the ways of the local community. It involved an appreciation of teamwork and an ability to work with others. A professional participant explained the importance of providers expanding their areas of expertise in order to meet the needs of the region:

> Other factors, many of the people here, the doctors and nurses specifically, are generalists. If a physician comes in and his primary experience has been very

> singular, just working in one department, he will find that he is very uncomfortable. Nurses as well. We had a cardiac nurse who was very proficient, knew everything about blood gases and arterial pressures, and here we do not know anything about even how to spell A-line. A nurse here has to learn more how to be a generalist and feel comfortable doing a number of things such working labor and delivery etc . . . and so many of our long-term nurses here have many more certifications than you can find anyplace else. They have to be adaptable and willing to expand their horizons, their professional horizons.

Adaptable approach to service delivery emerged a total of 20 times during interviews with 38% of participants. A similar percentage (between 36%-40%) of participants from all demographic categories identified this theme as a factor contributing to the retention of providers who relocate to the region from elsewhere (see Table 3).

Weather and darkness. The theme of weather and darkness appeared as a key component influencing retention. This theme was defined as the provider's ability to live in an environment with extended periods of time of subzero temperatures, snow, and darkness. It was further described by the various methods providers use to cope with the harshness of the environment. It included discussion of the positive aspects of other seasons that helped providers contend with the cold and darkness. One participant described the negative influence of the weather and darkness on retention by stating, "Some people just cannot stand either the weather or the dark winters. That SAD [Seasonal Affective Disorder]." One local participant explained the harshness of the environment and the need to be prepared for it:

> One provider went to [Name of village] and he ended up being stormed out in the village. He ended up outside for a couple of hours not knowing where he was at, and he was in the middle of town. It was storming and windy, but he was smart. He just stayed where he was and waited for it to clear up a little, till he could see a building and he walked to it. It can be dangerous traveling to villages if you do not know what you are doing or what to expect and if no one has prepared you for it.

This theme surfaced a total of 18 times during interviews with 57% of participants. Non-Native participants, participants from the regional hub, and professionals were more likely to discuss weather/darkness as a factor influencing retention than Alaska Native participants, participants from the village, and paraprofessionals (see Table 3).

Personal adjustment. Participants noted the importance of providers who originate from outside of the region being able to make the necessary adjustments to live and work in the region. This theme was defined as the ability of providers to adapt to cultural and environmental differences. It also referred to overcoming shock related to the differences that exist between living in mainstream America and rural Alaska. This concept involved individuals choosing to adapt their lifestyle to fit the requirements of the job, training center, and environment. It was further defined as the need for new providers to alter their preconceived notions, expectations, and fantasies and embrace the reality of what it means to live and work in their new environment. It involved new providers experiencing stress associated with navigating their new surroundings amongst

unfamiliar people. Individuals may feel overwhelmed or agitated by differences of pace and experience a sense of being disconnected from their cultural roots. Some people may struggle with adapting to the unavailability of shopping centers, entertainment options, medical services, educational opportunities, and other services typically offered in urban centers. This code was further defined by the important resources found only in rural Alaska that tie individuals to their culture and way of life.

A local participant from the region described the struggle faced by providers from outside to adjust to a different environment and a new culture: "There are a lot of reasons [why adjusting is difficult], but most of the time I think it's because they . . . for one thing uh . . . . it's new. It's...culture is so different from what they're used to. Sure they have running water and everything just like where they came from, but it's so different from what they thought it was gonna be. I think that." Another participant who relocated to the region a number of years ago described new providers' reactions to what they perceive as a lack of services and amenities: "I have seen people shocked when we don't have a shopping mall. I really don't understand that, so much retailing is done online now. But uh, there is that satisfaction of holding something up to see it and have it, which you don't necessarily get online."

Personal adjustments surfaced as a theme 16 times during interviews with 43% of participants. Non-Native participants, participants from the regional hub and professionals were more likely to discuss this theme than Alaska Native participants, participants from villages, and paraprofessionals.

Boundaries. Participants considered boundaries an important factor contributing to the retention of providers. This theme was defined as the provider's ability to manage, in a culturally appropriate way, the inevitable multiple relationships that occur in a rural setting. Furthermore, boundaries were defined by providers possessing self-awareness allowing them to manage their own issues and refrain from internalizing the actions and decisions of clients. Boundaries also referred to the ability of providers to set limits within the organization to allow them to attend to their own physical, spiritual, mental, and emotional needs (self-care). This concept attested to their ability to set limits even when community, organizations', and professionals' expectations conflict. Finally, this concept also captured the ability of the provider to attend to safety concerns by setting appropriate limits. A participant who relocated to the region described the challenges associated with providers setting boundaries when the need for service is great and the expectations are high:

> Before they [provider] can say,' uuuuh, I need a break.' But that, I think that's the key. They have to learn to say, 'No.' And they have to learn to set their own boundaries professionally. And I think that sometimes the expectations, and I'm not just talking about [Name of organization], I'm talking about all the agencies here you know. 'You come in here, you're going to help our people and this is what you've got to do,' and there's just kind of a double standard there, you know. It's hard to say no when those expectations are so high.

Another provider who relocated to the area shed even more light on the challenges associated with setting boundaries in rural communities:

> You also have to very carefully know your boundaries. I think boundary issues here, in any kind of a rural area, are probably the singular most difficult thing, as a challenge, to be able to both maintain and still be able to participate and become a part of the community.

Boundaries emerged a total of 16 times in this section of the interview with 29% of the participants. This theme was more likely to occur during interviews with participants from the regional hub, non-Native participants, and professionals than with participants from villages, Alaska Native participants, and paraprofessionals.

Commitment. Participants considered commitment an important factor contributing to provider retention. This theme was defined as the providers' persistent beliefs in and desires to continue engaging in their work within the community. It involved not giving up easily and a willingness to make sacrifices while completing work and providing services. It implied a sense of caring about one's work and about the community. A participant from the region provided insight into her views about the importance of a provider committing to the region:

> Willing to stick it out, willing to endure, willing to, you know. When you say that, it's kind of weird, because we have long-term providers that I really enjoy working with, and then we have long-term providers that I really don't enjoy working with that are from outside that have come in. But I think, yeah. I don't know, that's willing to stick it out . . .

Another local participant further added to this concept by discussing the role of passion, commitment, and patience, "You have to be passionate about your work. Have that

commitment to bring positive change within a community. Long-term goals, I guess, to bring about a change."

Commitment emerged 15 times during interviews with 43% of the participants interviewed. Approximately half of the participants from the regional hub, non-Native participants, and professionals spoke about the role of commitment during their interviews compared to approximately one third of participants from villages, Alaska Native participants, and paraprofessionals (see Table 3).

Job satisfaction. Participants identified job satisfaction as an important factor contributing to provider retention. Job satisfaction was defined as a sense of fulfillment and enjoyment emerging from providers' positions of employment. A participant explained the importance of job satisfaction on a provider's decision to remain in the region, "You have to like what you are doing and like where you are at." Another participant echoed those sentiments:

> I came up for the job, and I'm enjoying the job that I have. And I personally get a lot of personal satisfaction out of my job, which I think is really important, that somebody coming up like what they're doing.

Another participant commented on his enjoyment of his work in region:

> There have been years where I couldn't believe I was getting paid to do the work I was doing. It was so much fun. [Everything] just flowed, as if I was running dogs, or taking a moose down or something. Same thing with working.

Job satisfaction surfaced 14 times during interviews with 48% of the participants. This theme was more likely to emerge with non-Native participants, professionals, and

participants from the regional hub than with Alaska Native participants, paraprofessionals, and participants from villages.

Factors or Provider Qualities Viewed as Important for Retaining Local Providers

In addition to exploring the factor and qualities contributing to the retention of providers who relocate to the region from outside, the first research question also explored the factors or qualities participants deemed as being important for the retention of local providers from the region. Themes of community support for local providers, social support, and professional support emerged most frequently. Fitting back in, job stress, and personal adjustments also emerged with some frequency followed by professional development, role model, and boundaries.

Community support for local providers. Participants viewed community support of local providers as an essential quality that aided in the retention of local providers. Community support for local providers was defined as the community's positive response to local people or Native people pursuing training and education to work in the local community or region. This concept included the community's receptiveness and desire to be treated by Native people either from the region or from other regions. It involved the local community supporting its members in pursuing training/education and returning to live and work amongst their own people. This concept was further defined by community members respecting the local providers and accessing care from them. This code also captured fear experienced by community members that individuals would not return to the area following completion of their training. A participant from the region expressed her support for Alaska Native

healthcare professionals, "I believe that we should have more of our own Native clinicians, psychiatrists, you name it. Our own Native doctors, our own Native teachers. But you know, a few of us are able to make it because we're persistent." A local participant reported experiencing a newfound level of respect after completing training:

> It seems they [community members] just respond and respect them [local providers] more, that is my opinion. We [local providers] get a lot of respect if they went to training and went through what they went through to become what they are now, like a health aid. It took me, I went to training . . . and some people did not really like me and they thought I did not know anything until I went to training. I got training and certified and they noticed a big change when I got certified. Makes a big difference with the people. They respect you more and they see what you know. . .

A participant from the region offered another perspective demonstrating the complexity of community support:

> Sometimes they [community members] are envious and thankful and jealous. Those are the three I can think of. More thankful, sometimes people look for the other side of what they are doing, they are providing a service and when you help, those that are being helped are thankful, sometimes there are others that are watching how that person changed. They target the person and whoever is helping and look for faults.

Community Support for Local Providers emerged a total of 27 times during interviews with 80% of the participants. The theme was most likely to emerge during

interviews with Alaska Native participants and participants from villages; however, the majority of participants in each category spoke about this theme and its influence on local provider retention as shown in Table 4.

Table 4

Percent of Participants Identifying Theme as Important for Local Provider Retention

Theme	% of Partici-pants n=21	% From Regional Hub n=11	% From Villages n=10	% Non-Native n=10	% Alaska Native n=11	% Profes-sionals n=10	% Para-profes-sionals n=11
Community Support for Local Providers	80	73	90	70	91	80	82
Social Support	43	45	40	50	36	40	45
Professional Support	29	18	40	20	36	20	36
Fitting Back in	29	45	10	40	18	40	18
Job Stress	33	09	60	10	55	10	55
Personal Adjustment	38	55	20	60	18	60	18
Professional Development	24	18	30	20	27	20	27
Role Model	24	18	30	20	27	20	27
Boundaries	14	0	30	0	27	0	27

Social support. Similar to the results that emerged for retaining providers from outside of the region; social support emerged as an important theme for retaining local providers. A participant who relocated to the region from elsewhere stated, "Well of course, they [local providers] have the support system and other things here. They have an identity with the community." A local provider commented on her experience of leaving for training and later returning to the village: "I was real happy to get back, I missed everyone. I missed home and my family and friends. It was good for me to go back home."

This theme emerged a total of 17 times during interviews with 43% of participants. Non-Native participants were somewhat more likely to discuss the importance of social support on local provider retention than Alaska Native participants.

Professional support. Professional support appeared as an important theme in the retention of local providers. A paraprofessional participant summed up the importance of professional support for coping with the village politics, jealousy, gossip, distrust or interpersonal conflicts experienced by local providers as they provide services to community members residing in their own communities. She stated "I talk to my boss and people I can trust, and they listen to me and people believe only what they want to believe. It hurts them and it hurts me inside. I talk about it and let my boss or supervisor know about what is going on. I feel a lot better."

Professional support emerged a total of 15 times during interviews with 29% of the participants. This theme emerged with less than half of the participants in each

demographic category. It was more likely to surface during interviews with participants from villages, Alaska Native participants, and paraprofessionals.

Fitting back in. Participants discussed the importance of the local provider being able to fit back in to the community following a training experience as a vital element in retaining them. Fitting back in was defined as local providers adjustments to returning to their community after having lived, worked, or studied elsewhere. It involved a sense of distance between themselves and the rest of the community as a result of having been absent for an extended period of time. This concept captured the local provider's struggle to be accepted back into the community and feeling a sense of belonging with family, friends, and community members. The following quotation exemplifies a local provider's experience of leaving her community for training and later returning:

> . . . it is not so much the conveniences [offered in an urban area], it is just relationships. They are different in the village sometimes. It is hard to fit in sometimes, and once you have been away, it is hard to fit back in. I think it might take awhile, I guess, I was lucky to move back home.

A participant who relocated to the region from elsewhere echoed the challenges that local community members experience when they return to their community after completing a training: "You, at times, are no longer accepted, as being part of the village, because you have now gone out and done something and gotten an education, and you're different." Another participant from the region explained how many of his relationships changed upon returning to the community:

> Myself as the example coming back to [this community]. To come back with a degree, and then work with a group of people who are . . . and have this higher level of education. It's difficult to really socialize with all of my old friends who finished high school and had vocational training, because our thinking patterns and interests have changed. We've gone in different directions. I don't banter with my old friends as they banter together, and that's their method of communication.

Fitting back in surfaced a total of 12 times during interviews with 29% of participants. It was more likely to occur during interviews with participants from the regional hub, non-Native participants, and professionals than with participants from villages, Alaska Native participants, and paraprofessionals.

Job stress. The theme of job stress appeared to be viewed by participants as having negative influences on local provider retention which is similar to how it was viewed for providers relocating to the region from elsewhere. A local provider explained the emotional consequences of the need for confidentiality:

> To my husband, I can't tell him anything. It's confidential stuff. But he knows why I'm crying. I can't go to a community member and speak of how I'm feeling. Confidentiality, you know? So that's the situation us [local providers] are in.

This theme emerged a total of 12 times during interviews with 33% of participants. Over half of the participants from villages, Alaska Native participants, and paraprofessionals identified job stress as a factor influencing the retention of local

providers. Very few participants from the regional hub, non-Native participants, and professions identified it as a contributing factor (see Table 4).

Personal adjustments. Participants noted the importance of local providers being able to make the necessary adjustments between rural Alaska and other areas. A participant who relocated to the region from outside explained the stressors experienced by individuals from the region attending training elsewhere in following statement:

> I have known many youngsters, many young people who have graduated and went to college in the western states and even in Anchorage and never get a degree because the stressors of the metropolitan environment are too difficult and the choices are very difficult as well. You go into a major university setting and live in a dormitory that has more people in it than you have in your entire village and none of them are personally known to you. That is a very extreme environment to cast yourself into.

A participant from the region commented on the challenges associated with people from the region leaving to get training and having to readjust upon their return to the village:

> In a way I guess it is a different life [in an urban setting]. There is running water, and it is hard to deal with village politics, to come back and deal with it again. They got used to having some of the conveniences.

During the local provider retention portion of the interviews, personal adjustments appeared in a total of 12 interviews with 38% of participants. Non-Native participants, professionals, and participants from the regional hub were more likely to identify

personal adjustment as having an influence on local provider retention than Alaska Native participants, paraprofessionals, participants from the villages (see Table 4).

Professional development. Participants agreed that professional development positively influences local provider retention. Professional development was defined as a provider's access to continuing education training, lectures, guest speakers, and other professional development activities. This concept allowed for providers to remain connected to their field and continue growth, mastery, and expertise. It facilitated the ability of providers to feel competent in their areas of practice. A participant captured the spirit of this theme:

> And several of the [paraprofessionals] have been trained in it [suicide intervention training], too. And what it is, it's just an intervention. If somebody in the village is saying, 'I wanna hurt myself,' it teaches you what to do right then. And it's not, I mean it has a prevention component, but mainly it's an intervention. So I just, you know, just watching them learn those skills and say, 'Oh my God if I'd only known this, you know, a year ago.' So those types of trainings really make them feel good about their jobs. It's not, you know, what's gonna help down the road, it's what's gonna help right here, the here and now.

Professional development emerged as a theme a total of 10 times during interviews with 24% of participants. Participants from villages were more likely to discuss this theme than participants from the regional hub.

Role model. Participants spoke to the importance of the local providers serving as role models for the community. For some individuals this may serve as a factor that

positively influences retention, while for others, it may be viewed as a stressor caused by having to live up to the high expectations associated with the position. The theme of role model was defined as a local provider serving as an example to other community members. It involved inspiring others to pursue training, education, helping professions, or healthy lifestyles. The following quotation offering an explanation of this theme:

> You have to be a good role model for your community. If you go out and be drunk and go out and drink with people who like to drink, do pot or cigarettes and you are a provider, and you do all that, you are not going to be respected by your own people. You cannot, in my field; I do not drink or smoke. I want to be a good role model for my people and also for my kids. Both me and my husband do not do that. It is really important how you present that and yourself in the community. If you do all that stuff nobody in the community will want to come in and see you. They will not want to see you in the clinic if you are going to be out there drinking and smoking. You have to be drug and alcohol free if you want to be in this field or the health aide field.

The concept of local providers serving as role models surfaced a total of 8 times during interviews with 24% of participants. Participants from villages, Alaska Native participants, and paraprofessionals were more likely to identify this theme as a factor contributing to long-term retention of local providers than participants from the regional hub, non-Native participants, and professionals.

Boundaries. Boundaries emerged as an important theme contributing to the retention of local providers. A participant from the region explained how she maintains boundaries while living in a small village:

> . . . the only places I'll go are the events in the community where there are lots of people, and there's no time to talk about sad stuff. You know, there are too many things going on, so you talk about other stuff, you know. And I just, basketball events, there's no time to talk about sad things. Our potluck dinners. There's no time to talk about that. Everybody's just enjoying their meal and just talking about nonsense stuff, you know. But to socialize other than the events I stay away from it. I just don't want to hear any more, I'm tired. You know?

During interviews with 14% of the participants, the theme of boundaries emerged a total of 7 times. Approximately one third of participants from villages, Alaska Native participants, and paraprofessionals identified boundaries as a contributing factor to local provider retention, while none of the participants from the regional hub, non-Native participants, and professionals identified it (see Table 4).

Provider's Approach to Service Delivery that Facilitates Community Member Service Utilization

The second research question examined the factors that influence community member utilization of services offered by providers as well as the qualities that are important for providers to possess that facilitate service utilization by community members. Participants identified themes of being open, gaining trust, adaptable approach to service delivery, and personal qualities with the most frequency in this section.

Themes of engagement, imposing values, beliefs, and worldviews, willingness to confide in an outside provider, and investing time also emerged with some frequency followed by boundaries, genuineness, and job stress

Being open. Participants identified the theme of being open as a main quality of a provider that positively contributes to community members using the provider's services. A provider who relocated to the region explained the importance of her willingness to learn about her clients: "So I try, you have to be creative and you have to be able to really want to learn about their [lives]...about them. I mean, I've learned so much about whaling, and these kids who are on crews." A participant who was born and raised in the region expressed strong feelings about providers being open to Elders, their role within the village, and expertise that exists within the community:

> You got to listen to the elders on their advice. Our elders are the college graduates, not you. Just because you went to school, UAF, UAA or Dartmouth, does not mean you are more educated than we are. We live here in this village. You have to understand that we live in this village and you have to understand where we come from too. These are our people, and you have to listen to what we have to say. That is what I always let them know. I let them know about my experiences with clinicians and I let them know why I did not get along with them. The experience that I had, I let them know. This is where I am coming from.

A participant from outside of region stated that a provider must approach service delivery by conveying a sense of openness to encourage clients to use their services. He said the

provider must be "Welcoming and inviting. Not judgmental, not fearful, I don't know. Embracing of the culture, and curious. Wanting to learn in a respectful manner."

Being open appeared 33 times in this portion of the interview with 57% of participants. Participants from the villages, Alaska Native participants, and paraprofessionals were more likely to discuss this theme than participants from the regional hub, non-Native participants, and professionals as shown in Table 5.

Table 5

Percent of Participants Identifying Theme as Important for Community Member Service Utilization

Theme	% of Partici-pants n=21	% From Regional Hub n=11	% From Villages n=10	% Non-Native n=10	% Alaska Native n=11	% Profes-sionals n=10	% Para-profes-sionals n=11
Being Open.	57	45	70	50	64	40	73
Gaining Trust	71	64	80	70	73	70	73
Adaptable Approach to Service Delivery	52	45	60	40	64	50	55
Personal Qualities	52	45	60	50	55	40	64
Engagement	67	64	70	60	73	60	73
Imposing Values, Beliefs, and Worldviews	48	55	40	60	36	50	45
Willingness to Confide in an Outside Provider	48	55	40	50	45	50	45
Investing Time	43	27	60	30	55	30	55
Boundaries	29	27	30	30	27	30	27
Genuine	24	45	0	50	0	50	0
Job Stress	19	27	10	30	9	30	9

Graining trust. Participants discussed the significance of a provider gaining the trust of community members for their decision to utilize the provider's services. As a result of this recurring discussion, gaining trust was defined as an essential factor that enables a community member to connect with an outside provider. It involved the provider being able to offer a safe environment where the community members feel secure enough to engage in the helping relationship. Gaining trust also addressed the negative results of provider turnover on the ability of community members to trust providers. A participant from the region explained the relationship that exists between trust and time:

> They [clients] become willing to trust you [provider] and open up. . . But it is hard if you are there for a year or two and disappear. Then another one comes in and it starts all over. So, I don't know what would help. Retention!

Another participant from the region further explained the damage turnover causes to gaining the trust of community members:

> Well, we've been getting new clinicians, changing, and some [community members] don't trust them, you know? We've been getting different clinicians that come and go, and they don't know who to call or contact, and they'll ask where the other clinicians are that used to come here, and we'll say they left . . . A big hole . . . they come and see the patient, and they provide everything with pamphlets and brochures and talk to them, make visits, come every other month, and then the clinician leaves. So what do we do? The patient really trusted the clinician and now he's gone . . .

A participant who relocated to the region a number of years ago describes his experience with providers leaving the region and its effect on the community's level of trust:

> You know, you build trust . . . I think the biggest obstacle I noticed when I came here [number] years ago was that people are very irritated, especially the local people, or the Native people, are very irritated by how they trust somebody and then they leave. That has a devastating impact upon people. And I didn't appreciate that problem until I was here a bunch of years, and then people left. I realized what people here go through. It takes a while to form relationships. You depend on those relationships, and then the next thing you know, somebody picks up and leaves. And I think people who are Native, or who grew up here, feel even more sensitive to that.

Gaining trust emerged a total of 28 times during interviews with 71% of the participants. Eighty percent of participants from villages spoke about the importance of gaining trust and were the demographic category most likely to discuss it. Over half of the participants in every other category also discussed gaining trust as a significant theme during the service utilizations section of the interview (see Table 5).

Adaptable approach to service delivery. Adaptable approach to service delivery was seen as a contributing factor to community members utilizing a provider's services. One participant who was not originally from the region described creative ways she approached her work with adolescents:

> I think you have to be open to very creative techniques. It's not sitting behind a desk and counseling these kids. Some of my best work has, or some of the best

> sessions that I've had with kids have been in the green house or at a dog lot or on the beach talking or taking a walk. Because they're very, the Alaska Natives are very um hands on people. When we're filling dirt or soil in the green house in boxes, these kids are talking about everything, you know, but if you get 'em behind a desk, it's very difficult. So I try, you have to be creative and you have to be able to really want to learn about their ways and about them.

Another participant who relocated to the region from outside offered the following example that illustrates the importance of adapting to the pace of the environment:

> They have to be relaxed. They can't be on, like, a New York City pace. They have to adapt to the pace. I used to always say, it's kind of like dance music. If they're playing slow music, but a person's gyrating like they're doing intense rock and roll, it's basically crappy dancing. You're supposed to dance with the music. And a good dancer makes the music look better, you know? So they're supposed to enhance each other, the music and the dancer. Dancing is an expression to the music. It's just adding more to the art. And people who are out of sync with the environment don't do well. So again, the hurried, New York, got-to-get-the-task-done doesn't do well up here.

A participant from the region echoed the above sentiments:

> They [clients] say they [providers] are going too fast sometimes. They [providers] need to start off slower and not get to the nitty gritty right away. They [clients] need to have time to relax. They [providers] need to slow down because they [clients] can't give everything all at once. It means more sessions which is

> harder because the clinician only travels once a month, and it takes them a long time to get started, and the clinicians have billing requirements. In so many days, they have to see the treatment plan and assessment from the intake. It makes it hard I think because this needs to go slower sometimes. Some people, it takes a while to build a relationship and get to know you and get to where they trust you. That is one complaint I have heard, it was a little too rushed.

Adaptable approach to service delivery emerged 25 times during interviews with 52% of the participants. Alaska Native participants and participants from villages spoke about this theme more than non-Native participants and participants from the regional hub (see Table 5).

Personal qualities. The personal qualities of providers emerged as an important theme that participants believed influences community member utilization of services offered by providers. A participant from the regional hub pointed out the importance of providers being good listeners. She stated, ". . . talking too much. Some clinicians are talking more than they are listening." This sentiment was echoed by another participant from the region who pointed out that being too talkative may be a quality that negatively affects services utilization: "They [providers] talk too much, some people say that." Another local participant noted the importance of providers respecting the local agencies and systems that are in place:

> Respect, is one of them [important quality] too, just going through proper channels. When the first clinicians come in, we take them around to the clinics

> and introduce to them to the local agencies, the IRA and the city, and take them to the school and introduce them to the school staff.

A participant who relocated to the region a number of years ago seconded this idea of the importance of respect:

> As long as they [community members] feel respected, I think it is the same basic common human quality of decency. If you treat people with respect you get respect back. If you treat people with dignity you get dignity back. If you treat people with fear you get fear back.

Two participants who were born and raised in the region cited a provider's sense of calmness as an important quality that influences service utilization. One participant stated:

> I know this one [medical provider] that when everything is all messed up and going wrong, he is like the most calm person in the room. I am thinking 'to do this and to do that and gotta get this done,' and he is just the most calm person in the room. You are trying to rush, and then see him. He is not being slow, just calm and he knows what he is doing. You calm down and do what you got to do too. It gives me more confidence and I am glad he is here.

Personal qualities emerged a total of 25 times with 52% of participants interviewed. Alaska Native participants and participants from villages were more likely to discuss this theme when compared to non-Native participants and participants from the regional hub (see Table 5).

Engagement. Engagement appeared as an important theme influencing community members' use of the services offered by providers. A participant from the region explained that in order for services to be utilized, the community members expect to see the provider involved in the community. She stated, "Getting involved. Being visible in the community helps, you know, getting out and not just being in the office and having sessions, but getting out and about and involved in the community is going to help." A participant who relocated to the region described qualities of providers that impede community member service utilization, and further supported the need for providers to interact with community members outside of their offices:

> Being very rigid, being a clinician who only goes to the clinic and never walks around, never goes to the bingo hall, or the school, or [doesn't] make relationships with other people like a pastor in the village. You need to get to know the community members and community leaders, the ICWA worker, the preschool teachers, the school teachers, and just make that a part of your village travel, or your village trip. And, that's also true in [Name of regional hub], because those people are where the referrals are gonna come from, and it takes a team to help. . .

Engagement surfaced 22 times during interviews with 67% of the participants. This theme emerged with more Alaska Native participants and paraprofessionals than non-Native participants and professionals (see Table 5).

Imposing values, beliefs, and worldviews. Participants noted that community members are unlikely to utilize services from providers who impose their values, beliefs, and worldviews on local community members. One participant who relocated to region

warned against providers assuming expertise and imposing themselves upon the community:

> There have been clinicians that have been thrown out of [Name of village], because they go in, and they, you know, you're not the one to tell them [community members] what to do. . . Those who go in and say, 'You're not raising your kid right. You need to change this, you need to do this.' They're not gonna last.

Another participant from the region explained her response to outside providers coming in attempting to assume control:

> If you are working with me, then you have to work on my level. Not just because you have a Social Work degree, you cannot control everything. You have to work on my level, or else you can go to another village. I do not need you in my village. You are not going to work in my world, you have to move on.

One participant who originated from outside the region commented on the importance of providers being aware of their reactions to differing lifestyles:

> It's very hard if you're a very finicky person with anything that has to do with your lifestyle, because you're going to be forced into new situations that you may never have been in before. You may have to use a honey bucket that you've never used before. If you stick your nose up at it, it's going to be offensive.

Imposing values, beliefs, and worldviews emerged 21 times during interviews with 48%

of participants. More non-Native participants and participants from the regional hub identified this theme than Alaska Native participants and participants from villages (see Table 5).

Willingness to confide in an outside provider. Participants considered a community member's willingness to confide in an outside provider as an important factor influencing service utilization. Willingness to confide in an outside provider was defined as a sense of safety when speaking in confidence with someone who is not part of one's community, circle of friends, or family. It acknowledged the importance of one trusting confidentiality/anonymity that an outsider offers because pre-existing relationships do not threaten objectivity or privacy. It operated on the premise that because an outsider has a different personal investment in the community member's life compared to that of a local person, the community member may trust the outsider's ability to remain objective and hold information in confidence. One participant who relocated to the region from elsewhere explained the nuances when community members decide who to talk to about certain topics:

> There are some things that may never get discussed with somebody on the outside. The same is true for discussing several things with a relative. And sometimes, it's easier to talk to a stranger than it is to a relative, so you've got both areas to weigh in here.

This participant went on to explain the therapeutic challenges associated with an outside provider who is unfamiliar with the local culture:

> It's very difficult to talk to a stranger who has absolutely no concept of how you live, your culture, who you are or [who] your people [are]. [Someone] who you feel you have to educate on everything to the point where the frustration of teaching, let's say, the provider, just to get them up to speed on what your basic lifestyle is, let alone what the problems are that you're facing.

A participant from the region expressed her beliefs that community members appreciate the opportunity to talk with an outsider:

> I think they feel a lot better sometimes because they are not related to them. It makes a big difference for a lot of guys I noticed, and even some women. They don't really want to talk about stuff or talk to anybody else that they know.

Another participant from the region disagreed:

> I think a lot of that depends on the client, because each client is different. But I would say, for especially most Native clients, that yes, it would be difficult for them to talk to somebody who is from the outside. For some of them, it's like, oh, it's somebody new. They don't know my problems, they don't know my family.

Willingness to confide in an outside provider emerged as a theme 19 times during interviews with 48% of the participants. Participants from the regional hub were somewhat more likely to discuss this theme during their interviews when compared to participants from villages (see Table 5).

Investing time. Participants explained the importance of providers investing time in the region on service utilization. Investing time was defined as providers staying in the region long enough for community members to recognize them and know their work.

The providers investing time in the community was viewed as a factor that led to community members accepting and feeling comfortable with them. A participant from the region emphasized the importance of time on the community member's ability to trust and engage in a helping relationship:

> New clinicians come into the village it is really hard for people to open up. You do not open up people. Native people do not open up to the new clinician because they do not trust them yet. They do not trust, which is very important. It is this way in any village. A new person comes in and you do not trust them automatically. It is takes a long time to really trust your own counselor or clinician when they come to your village. It takes a long time.

A participant who relocated to the region from outside supported the importance of time on the helping relationship:

> So you [providers] will get them [clients] talking about it [problems] sometimes, but I think, again, to talk about that kind of stuff, you have to be working with that person for a long, long time.

Investing time appeared 17 times during interviews with 43% of participants. This theme emerged with over half of participants from villages, Alaska Native participants, and paraprofessionals. It emerged with approximately one third of the participants from the regional hub, non-Native participants, and professionals (see Table 5).

Boundaries. Boundaries surfaced as an important theme affecting service utilization. One provider who relocated to the region from outside described the nuances of establishing boundaries in a small rural community where anonymity does not exist:

> To get to the root of what psychotherapy is. The relationship, your office, is supposed to be 100% for the other person. But you're not going to be anonymous to the person. A person may know that your wife was at a meeting last night that you didn't even know about, or may ask you, 'hey, so I heard you got married.' Well, when I worked in [Name of City in Lower 48], I may not have told my patients I was getting married, and here patients were congratulating me all the time, you know? Things like that. So you have to know the roots of psychotherapy . . . If 20 galaxies from here, I was a therapist and I got dropped off by a Star Trek spaceship. . . if it's universal, the same rules apply. They're not ethnocentric rules, and a lot of people assume psychotherapy from the lower 48 ethnic assumptions, and they have to think those things through. So a universal rule is that a therapeutic relationship is for the patient, not yourself. You may end up talking about things about yourself, because the patient knows those things about you, but you always know that everything you do with the patient is for their benefit, not your own. And things like that. You have to know the basic principles of what the profession's about, and you've really got to study up on them, because you're going to be put in situations where it's greyer. It's not as black-and-white up here. And people make that mistake.

Boundaries emerged at total of 10 times during interviews with 29% of the participants. In fact, approximately one third of the participants in each demographic category spoke about the importance of boundaries.

Genuineness. A provider's genuineness emerged as a theme shaping community members' utilization of services. Genuineness was defined as community members sensing that they are being listened to and that the provider truly cares for them and their situation. It also involved a provider authentically engaging with the community and culture as opposed to superficial engagement. This concept related to community members believing that the provider is authentically motivated to help rather than be motivated by other forces such as financial gain. One participant who relocated to the region from elsewhere provided the following example illustrating the importance of providers interacting with community members in a sincere and genuine manner:

> . . . if he [a provider] is not sincere in his embracing of the culture it is immediately transferred. Insincerity would be my answer. Sometimes providers come here and they embrace only the costume, they will wear Kuspuks and that sort of thing, and I think the people look through that pretty quickly as superficial.

A participant from the region emphasized the importance of a provider being perceived as caring:

> You know, you come in to see different people, you may be using all of the same strategies that you used in the other job, and you may be very successful in both places, but the reason you're going to be successful is going to be because you were perceived as caring.

Genuineness appeared a total of 10 times during interviews with 24% of the participants. Results indicate that approximately half of the participants from the regional hub, non-Native participants, and professionals cited genuineness as an important quality; however, none of the participants from the villages, Alaska Native participants, or paraprofessionals cited it (see Table 5).

Job stress. Job stress also emerged as a factor influencing service utilization. A participant from the region reflected on the unrealistic expectations that new providers face. She stated, "I think we put a lot of pressure on people when they are brand new, we expect them to know a lot instead of giving them time to adjust." A participant who relocated to the region spoke about the job stress associated with appropriately managing unavoidable multiple relationships that exist in rural communities in a way that is acceptable to the client and the provider:

> And it's different here. Cuz, you're gonna see your clients in the store. Your clients are gonna be the ones giving you services outside. The guy who delivers your oil could be your client. The guy who works on your car could be your client. The guy who works on your teeth could be your client. It does happen and it has happened to me.

Another participant who relocated to the region from outside spoke about the need for providers to understand and respond to the serious nature of the client's presenting problems with respect and efficiency:

> By the time somebody comes to us, they're basically in crisis, you know? We don't have people walking in the door who just thought that maybe they'd like to

> do a little work. Depression this week. You know. They're coming in the door because they're feeling like killing themselves and they don't want to, or they're making attempts that aren't real attempts because they're screaming for help. And we need to have people seen quickly, we need to respect that need, and I think that that's an area that we aren't always able to do, sometimes because of the lack of personnel we have.

Job stress surfaced a total of 10 times during interviews with 19% of participants. This theme was most likely to emerge with participants who identified as being from the regional hub, non-Native participants, and professionals. Participants from the other demographic categories were less likely to discuss it (see Table 5).

Qualities Allowing Providers to Engage in Cultural Mentorship

The third research question addressed in the study examined the factors or qualities that participants identified as being important for providers to possess for accessing cultural mentorship. The themes that emerged most frequently included being open, increasing cultural competency, and personal qualities. Adaptable approach to providing services, engagement, and imposing values, beliefs, and worldviews also appeared with frequency. In addition, VBC liaison, professional support, job stress, and boundaries emerged with some frequency.

Increasing cultural competency. Participants agreed that possessing an interest in increasing cultural competency positively influences a provider's ability to engage in cultural mentorship. Increasing cultural competency was defined as the actions a provider takes or needs to take in order to obtain cultural information about a particular

region. It involved seeking out written, factual, and/or historical information about a culture typically found in books, libraries, museums, and on the Internet. It also involved seeking out information by taking courses or seeking knowledge from cultural experts. Cultural experts may include village council members, Elders, village-based counselors, and cultural educators in local schools. This concept was further defined by a provider respectfully seeking out these opportunities by asking questions, observing, visiting, and interacting with cultural experts.

A participant from the region explained the importance of providers grounding ideas within the cultural context in order for the community to accept and utilize them. She offered the following advice:

> Introduce your ideas in a way that the village would be receptive to them. You know, maybe, slowly or involving the Native values or Native culture. Cuz if it is foreign to them, there might be some resistance.

Another participant from the region further explained the importance of cultural education on a provider's ability to be accepted by the community. She stated, "You need to educate him [provider] in order for him to be accepted." A participant who relocated to the region from elsewhere explained how she learned about the culture:

> I was real lucky because [Name of a seasoned provider] kind of was my mentor. I went to him with a lot of the questions. That was helpful, but I think that anyone coming into this region, or [Names of other regions in Alaska], I think they should have to go through a culture 101 class, because I think for the most part, it's left

for you to understand yourself. I don't think there's a lot of mentorship with the culture.

Increasing cultural competency emerged a total of 64 times during interviews with 86% of the participants interviewed. At least 80% of the participants in each demographic category identified this theme as important for cultural mentorship with the most participants being from the villages, Alaska Native participants, and paraprofessionals as shown in Table 6.

Table 6

Percent of Participants Identifying Theme as Important for Providers to Engage in Cultural Mentorship

Theme	% of Partici-pants n=21	% From Regional Hub n=11	% From Villages n=10	% Non-Native n=10	% Alaska Native n=11	% Profes-sionals n=10	% Para-profes-sionals n=11
Increasing Cultural Competency	86	82	90	80	91	80	91
Being Open.	76	82	70	80	73	80	73
Personal Qualities	43	45	40	50	36	40	45
Engagement	52	55	50	50	55	50	55
Imposing Values, Beliefs, and Worldviews	62	64	60	60	64	60	64
Adaptable approach to Service Delivery	33	36	30	40	27	40	27
VBC Liaison	24	27	20	30	18	20	27
Professional Support	29	36	20	40	18	40	9
Job Stress	24	36	10	40	9	40	9
Boundaries	29	36	20	40	18	30	27

Being open. Participants viewed being open as a vital quality for providers to possess when seeking out and receiving cultural mentorship. One participant who relocated to region shared his opinion about the importance of openness, humor, and acceptance when working cross-culturally:

> I think being open, making fun of yourself, having a good time, not taking yourself too seriously. You cannot take yourself too seriously. I think all of those qualities make you open to accepting things. Accepting change, accepting things that are going to happen, I think that is where I see it. If you can do that, you can survive and succeed anywhere.

A participant from the region commented on the importance of providers from outside being open enough for community members to find ways to connect with them:

> Ask and share. You might find out that they may know someone you know. I might know someone from Montana. A lot of what I want is to relate to the teachers [or providers] that come in. They make a big impact on students first and then the community. When we get to know them, and we hear about them later, [and discover] I know someone who came from there.

Another participant from the region further explained:

> I think they [new providers] just gradually learn if they're open-minded and willing to learn . . . Just getting themselves familiar, or getting in touch with the Native staff here just to see their point of view. I think a lot of Native [people], if you're willing to; they're willing to show you their traditions or their skills.

Being open emerged a total of 55 times during interviews with 76% of the participants. A somewhat larger percentage of participants from region discussed this theme than participants from villages (see Table 6).

Personal qualities. Participants agreed that certain personal qualities of providers also influence their ability to engage in cultural mentorship. A local participant pointed out the importance of a provider having a sense of humor:

> That sense of humor really helps too, that is a really big piece. You gotta have a sense of humor here. If you are real serious, I do not know. It is not something you can learn, you have to nourish it and use it. A sense of humor is very helpful. It does get tough.

A participant who relocated to region echoed the importance of a sense of humor:

> I come to find out humor is a culturally held value, and figuring out what the local values are. The local, the native values here are also love of children. I mean, if you, if you didn't know that and you're kind of scolding and dismissing the children, they're not gonna, they're gonna look at you different. So really, trying to take your time and be cautious of how you act before you learn [the values]. . .

Another participant who relocated to the region discussed the importance of approaching cross-cultural work with curiosity, humility, and an understanding of the similarities and difference that exist between people:

> Humility, interest in culture, having confidence. I mean, putting two very important opposites together, one which is that all people universally are the same, then putting the dialectic opposite that all people have completely

> individual, everybody has different cultures, and everybody is therefore very different, putting that, that everybody is the same, and that everybody is very different, and synthesizing that, and being fascinated with it, and being respectful of it, and also accepting that there's no such thing as a cultural hierarchy.

Personal qualities emerged 35 times in this section with 43% of the participants. It was somewhat more likely to emerge with participants identifying as non-Native than with participants indentifying as Alaska Native (see Table 6).

Engagement. Participants considered a provider's engagement with the community as important for cultural mentorship to occur. A participant who relocated to region explained:

> I think that it would depend on how much they are willing to invest in the community. If I am only here for a couple of years, I don't really care to get that involved in it or if I am out here to pay off my debt. It depends on how willing they are to invest and what their goals are.

A participant from the region further explained the importance of getting involved:

> Just basically getting involved. I think, when you talk about Native culture, I think most of them are receptive and willing to tell you their culture if you're willing to listen, or if you're genuinely interested. If they just see you as, oh, you're just another tourist and you just want to analyze us, then no, they're not going to open up.

Another local participant pointed out the importance of a provider learning to participate in the culture by giving and receiving:

> First thing you'd have to do is be able to give and help, and you'll begin the process of receiving, and learning about the foods and feeling, when it gets cold, how the different foods, the foods up here can warm you up. So cultural mentorship, I would really suggest [it].

Engagement emerged in this section a total of 23 times during interviews with 52% of participants. In fact, at least 50% of participants in each demographic category spoke about the importance of engagement for cultural mentorship (see Table 6).

Imposing values, beliefs, and worldviews. Participants noted the damage that could be caused to cultural mentorship by providers imposing values, beliefs, and worldviews on local communities. When queried about qualities that might prevent a provider from engaging in cultural mentorship, a local participant stated, "Not being flexible. If you are set or fixed in path, you know. Being rigid, I guess." Another local participant further explained:

> They [new providers] do not want to learn or accept it. They are not motivated to learn about our culture, values, or traditions. They don't care, that is how I look at it. They are not motivated to learn. They think they know everything and we don't. That is how I look at it. It is true in a lot of them.

A participant who relocated to the region described another quality impeding cultural mentorship. He stated, "Well, they're [providers] too self-centered. That's the easiest way to put it. They're too self-centered, as opposed to, universally centered. They're not centered on others, they're centered on themselves."

This theme emerged a total of 18 times during interviews with 62% of participants. At least 60% of participants in each demographic category identified imposing values, beliefs, and worldviews as an important theme affecting cultural mentorship of providers (see Table 6).

Adaptable approach to providing services. Participants identified adaptable approach to providing services as being important for providers to engage in cultural mentorship. For example, a participant who relocated to the region described the importance of providers reconsidering the cultural appropriateness of some ethical guidelines:

> Someone who comes up here and is not open to change, or to flexibility, or the thing about accepting gifts. If I'm in a village and somebody makes me a hat, I'm gonna accept it, but ethically that might not be right, according to the counseling ethics. But, I think if I didn't accept that [hat], then I'm not going to be accepted in that village.

Adaptable approach to providing services appeared a total of 16 times during interviews with 16% of the participants. This theme was most likely to emerge during interviews with non-Native participants and professionals than in interviews with Alaska Native participants and paraprofessionals (see Table 6).

Village-based counselor (VBC) liaison. Participants discussed the role of the village-based counselor on the cultural mentorship of providers. A participant who relocated to the region expressed her gratitude for the mentorship she received from a village-based counselor:

> I was very lucky; I had [Name of a village-based counselor]. She would whip me into shape if I was saying or doing the wrong thing, but I asked her to. That was how I was able to learn. But I think that there's so many wonderful leaders in [Name of regional hub] that would probably love to [mentor] I was fortunate to have a village-based counselor like [Name of a village-based counselor] who helped me a lot. . .

This theme emerged a total of 10 times with 24% of the participants. It was more likely to emerge with non-Native participants than with Alaska Native participants (see Table 6).

Professional support. Some participants explained the role of professional support in cultural mentorship. A local participant described how she supports new providers:

> . . . usually, what I tell anybody new who's willing to listen or willing to, you know, come [ask]. It's not like I present it or anything. But if they were coming in to talk to me and they told me they thought they might have done something wrong, or asked me to tell them what they shouldn't do, I'll be open minded and tell them.

A participant who relocated to the region expressed her support for the role of mentorship for new providers: "I think it goes back to mentorship, but when a new person comes up here, you know, I think there, there needs to be a seasoned clinician that is their mentor."

Professional support emerged a total of 10 times with 29% of participants. More non-Native participants discussed this theme than Alaska Native participants (see Table 6).

Job stress. For some participants, job stress emerged as a theme influencing cultural mentorship. A participant who relocated to the region explained how being a team player affected co-workers' willingness to provide support and mentorship:

> Part of the reason I like this job and part of the reason I don't like this job is you don't know what you're gonna get every day. You just don't know what you're gonna get. I go up to the waiting room just now and I get thrown at me the phone call, you know, [a co-worker says] "Sit here," [to staff the front desk] I fill in for them. But, I'm kinda a team player. You gotta be a team player. If you're not a team player that's one major thing. You gotta be a team player [for others to help you out].

This theme emerged a total of 10 times during interviews with 24% of the participants. It was more likely to emerge with participants who identified at non-Native participants and professionals than with Alaska Native participants and paraprofessionals (see Table 6).

Boundaries. Participants also considered the influence of boundaries on cultural mentorship. One participant who relocated to region explained, "And that's the other thing. Good judgment. People need to know that boundaries are not what westerners always think. Boundaries here are different. They're fluid. They ebb and flow. They're not walls." A participant from the region explained the struggles that can emerge around

cultural mentorship when a young therapist is attempting to find the balance between engaging with the community and observing important boundaries:

> For example, I think a lot of mistakes that providers will sometimes make here is that, like I say, 'get involved with the culture, but don't get involved with the bad culture. Don't go out to [Name of Local Bar] and get wasted. Because everybody's going to see you there, and every potential client, whether court-ordered or not, is going to come through [Name of Behavioral Health Organization].' And they're going to say, 'Oh yeah, there's that therapist.' Maybe the therapist doesn't have a drinking problem, but I know, with clients here, the mentality is, if they're coming here for substance abuse services, and you're a substance abuse therapist, you'd better not be drinking. Anyway, I think that's kind of the sad thing, especially for young therapists that come here. They have to learn that and realize that . . .

Boundaries emerged 10 times with 29% of participants. It was more likely to appear with non-Native participants and participants from the regional hub than with Alaska Native participants and participants from the village (see Table 6).

Chapter Five: Discussion

This study explored three research questions that focused on identifying factors and provider qualities influencing provider retention, community member utilization of services offered by providers originating from outside of the region, and cultural mentorship of outside providers. For each research question, specific themes emerged with a greater importance for people of some demographic groups than for others. These differences illustrate the unique perspectives of participants from assorted demographic roots.

Retention of Providers Originating from Outside of the Region

During the portion of the interview that explored factors and qualities that influence the retention of providers who relocate to the region from elsewhere, a total of 16 themes emerged with strong frequency and high percentages of participants identifying them as important considerations. Engagement; being open; imposing values, beliefs, and worldviews; personal qualities; and adaptable approach to service delivery emerged somewhat equally as important considerations for participants from all demographic categories. Consequently, it seems that participants tend to view retention of outside providers as being influenced by their ability to positively engage in the community and culture and adapt service delivery to fit the local needs. Such findings are consistent with literature citing the importance of providers utilizing community resources grounded in the local culture and value system when working in rural areas (Brown & Herrick, 2002; Campbell et al., 2002; Geller, Beeson & Rodenhiser, 2000; Gibb, Livesey, & Zyla, 2003). These important qualities appear to be influenced by

providers being open to new ideas, beliefs, and practices and refraining from imposing their own values, beliefs, and worldviews on the community, paraprofessionals, and healthcare organization. These findings further support similar results that emerged in the preliminary study conducted by Gifford and colleagues (2010). The following quotation illustrates the interrelatedness of these themes:

> What's important in the Native culture is your accepting 'em for who they are, their values, their beliefs, and not imposing yourself. . . even if you may not agree with them, you know, just listen to them.

Another participant explained damage caused by providers assuming expertise: "[A new provider] trying to come in here and say 'Well, I am the right person and I do it this way' and not be willing to listen to anyone on professional tasks, purposes, procedures or anything else."

Eleven themes emerged with different percentages of participants across the demographic categories noting them as important considerations for retention. Ten of those themes emerged with a higher percentage of non-Native participants, participants from the regional hub, and professionals as compared to Alaska Native participants, participants from the villages, and paraprofessionals. Those 10 themes included social support, job stress, professional support, love of rural, self-care, weather and darkness, personal adjustments, boundaries, commitment, and job satisfaction. The participants identifying as non-Native, living in the regional hub, and professionals tended to be providers who relocated to the regional from elsewhere. In this portion of the interview, they were responding to prompts querying them about their own experience and offered

an inside view into the experience of an outsider relocating to the region. Therefore, they may have more awareness about the personal adjustments necessary to be successful such as adapting to the weather and darkness, developing an enjoyment of the outdoors and activities available in a rural area, rural living, and adjusting to a new way of life. One participant explained, "They [providers] have to be adventurous, you have to be able to invent your own fun, I guess. Because there's not, you know, a concert to go to here, or that kind of thing." A provider's adjustment to and suitability for living and working in a rural area have been identified as crucial factors influencing provider retention in previous literature (Barbopoulos & Clark, 2003; Gifford et al., 2010; Perlman & Hartman, 1985).

Non-Native participants, participants living in the regional hub, and participants identifying as professionals also appeared to be drawing upon their own experience of professional support, self-care, and boundaries aiding them in managing job stress associated with delivering healthcare services in remote locations. A participant reflected on her experience of managing stress through self-care: "I've definitely learned more self-care for myself as time progressed, but when I first came up here I thought that the expectation was to work all those hours and to do all that travel." One participant recalled the professional support and mentorship offered to a new provider:

> Like (name of Provider) a couple of times she left the [Name of regional hub] office and then someone traveled with her, one of the case managers one time, then the file clerk another. It was her first time in those places and it helped since

she didn't know. It made it easier for her, so that after a couple of trips she was able to go alone without a lot of stress.

Previous literature has cited a rural provider's access to clinical supervision and mentorship as being critical to preventing burnout and supporting retention (Barbopoulos & Clark, 2003; Perlman & Hartman, 1985). Concerns about boundary issues, complex ethical dilemmas, and self-care challenges experienced by rural providers have been well-noted (Chipp et al., 2008; Johnson et al., 2006a; Halverson & Brownlee, 2010; Morgan, 2006; Roberts, Battaglia et al., 1999; Warner et al., 2005). In addition, the literature has identified that rural providers contend with high service demands (Barbopoulos & Clark, 2003) including on-call duties (Iversen, Farmer, & Hannaford, 2002), put in long work weeks and many hours (Larimore & Rehm, 2001), serve patients with an acute level of need (Gibb et al., 2003), and manage unlimited caseloads (Gibb et al., 2003; McCabe & Macnee, 2002).

In addition to having first-hand experience with the personal adjustments necessary for living and working in rural Alaska and developing ways to manage job stress, participants from these three demographic categories experienced the importance of establishing a social support network in the region. Developing social supports allowed many of them to establish a sense of belonging with the community and workplace contributing to their overall commitment to the region and job satisfaction. This study's finding of the importance of social support is consistent with other literature noting it as significant for rural providers (AbuAlRub, Omari, & Al-Zaru, 2009; Buykx,

Humphreys, Wakerman, & Pashen, 2010; Gardiner, Sexton, Kearns, & Marshall, 2006). One participant explained:

> If you need help with anything you can pick up the phone and call the police station. I have called them to come pick me up and take me to work in the middle of a blizzard. So, everybody helps everybody here. We're all so far away from our family so we're like one big extended family here.

Only one theme, community acceptance of outside providers, emerged with a higher percentage of Alaska Native participants, participants from the villages, and paraprofessionals when compared to non-Native participants, participants from the regional hub, and professionals. Participants identifying as Alaska Native, living in the village, and paraprofessionals tended to be local providers originating from rural Alaska. As a result, this set of participants offers an important vantage point as not only are they providers, but they are community members. Their perspective yields an understanding of the importance of local community members accepting an outside provider, which ultimately leads to the provider's retention within the community. The significance of community acceptance for provider retention is further supported by previous literature noting its importance in rural service provision (Baldwin et al., 1998; Murray, 1984). It appears to be tied to provider qualities as illustrated by this quote from participant from the region:

> . . . if you find this clinician as a very caring person that understands you and where you are coming from, and understands your traditions and values, they [community members] accept you to the community right away. We had a

clinician that did and he was accepted right away. Everybody loved him in my village. He did not try to go above them, he worked at their level. He did not try to think that he was better educated; he worked at our same level, in our office in my village with our people.

In sum, retention of outside providers is connected to their engagement with the community and their ability to adapt service delivery to fit local needs. Openness to new ideas, beliefs, and practices and the ability to refrain from imposing values, beliefs, and worldviews on others contributes to providers' engagement with the community and their success with adapting services. Retention is affected by a new provider's adjustment to the region including the weather, darkness, rural living, and cultural differences. Professional support, self-care, and ability to set boundaries emerged as important themes aiding outside providers with managing job stress. Furthermore, participants noted social support and community acceptance as being essential for outside providers to establish a sense of belonging, commitment, and job satisfaction, which ultimately leads to their retention.

Local Provider Retention

During the portion of the interview that explored factors and qualities that influence the retention of local providers from the region, a total of nine themes emerged with strong frequency and high percentages of participants identifying them as important considerations. Community support for local providers, professional support, fitting back in, job stress, personal adjustment, professional development, role model, and boundaries

emerged with higher percentages of participants in some demographic categories than others.

Participants identifying as Alaska Native, being from villages, and paraprofessionals tended to be local providers from the region. Therefore, in this portion of the interview, they offered an insider perspective about their own experience of living and working in the region where they were born and raised. Professional support, boundaries, and job stress were themes that emerged with the highest percentage of these participants. Interestingly, these were the same themes that emerged with the highest percentage of participants identifying as non-Native, living in the regional hub, and professionals when responding to queries about their experience as an outside provider relocating to the region. The strength of this parallel finding from insider perspectives suggests that professional support, boundaries, and job stress are key factors that contribute to provider retention, regardless of whether they are locals or outsiders.

Professional support for local providers brings with it important considerations given the unique nature of their work. Many Alaska Native paraprofessionals living in the villages work in very remote locations. For behavioral healthcare paraprofessionals, they are likely the only local person hired to provide behavioral healthcare services for that community. Consequently, they have even less access to collegial support compared to other types of behavioral healthcare providers residing in the regional hub. Consistent with the current study, previous literature noting rural providers' lack of access to clinical supervision and mentorship negatively influences their retention (Barbopoulos & Clark, 2003; Perlman & Hartman, 1985).

Boundaries also emerged as an influential theme with unique considerations for participants identifying as local providers. Because these participants tend to live in small villages with close acquaintances and relatives, boundary issues are likely to be even more complicated for them than for participants who live in the larger regional hub and typically originate from outside of the region. Alaska Native paraprofessional participants from the local villages are likely better suited to understand the stressors associated with boundary issues when delivering healthcare services to family and friends as their client base is comprised of those individuals. Similar findings with rural providers having to contend with boundary issues and complicated ethical dilemmas have been documented in the existing literature (Chipp et al., 2008; Johnson et al., 2006a; Halverson & Brownlee, 2010; Warner et al., 2005). A significant stressor for local providers appears to be that maintaining boundaries and attending to self-care in a small community can often lead to some degree of social isolation. This finding is consistent with the literature regarding rural providers experiencing limited social opportunities (Barbopoulos & Clark, 2003). A participant from a village explained:

> I just make the best of it. I pretty much am more, well, when you work, you're always tired anyway. So I go from my work to my home to the post office and store and that is about all I do. Once in a while I go to a friend that invites me to take a sauna. And, most of the time I think the reason why I'm doing that is because I work with everybody in the village. And I don't want to hear anymore problems. I don't want to hear anymore other than in my own office. I hear it all day long in my office; I don't want to hear it anymore.

Job stress for local providers also emerged with some distinctive features. It appears to be tied to community members not utilizing services offered by the local provider due to jealousy, distrust, or village politics. Other stressors included community members gossiping about local providers, being on-call frequently, responding to crises and receiving little or no debriefing, feeling isolated, struggling with paperwork, and approaching retirement age without having a prospective replacement for their position. A participant from the region explained:

> It's real hard to find our people to work in this field. In fact, I am retired, but I continue to work. But I choose to, you know. I find it's real hard to try to get the young people to work in this field. Because people that are in counseling, they're getting older. You've got to find ways to attract more of our people into this field. It's real hard to find even a counselor. If you don't know how to do your paperwork, like, for me, I can work on paperwork. If you don't learn how to keep up, know your paperwork, a lot of times, I've seen people who have tried to work as a village-based counselor and they come here and they end up quitting, because they can't handle the paperwork. They can't take it. Because you can't keep up with the paperwork. And it's stressful. The work is stressful work. You have to learn how to take care of you, I find. Know when to take a break.

Alaska Native participants and participants from villages were most likely to identify community support for local providers as an important factor influencing local provider retention. However, the majority of participants from each demographic category noted this theme as important. This finding suggests that both local providers

and providers from outside are aware of the value community members place upon receiving healthcare services from their own people. A participant from the region discussed his experience of being accepted by the community after seeking out training and education:

> They're glad to see me. A lot of my friends are really proud of the higher level of education I reached. They appreciate someone who can understand the way this community has evolved from past. A need for subsistence to subsidize their financial ability, or lack of, to now, many subsist because of interests, and because they enjoy the foods.

Another participant from a village commented, "The community, to my knowledge and awareness, wants the children, or the school children, to go on to school, get their education, and then return to, back to [Name of village]. They would like to see that." This finding is consistent with the literature noting the preference of rural community members to seek out assistance from local providers or informal supports (Barry, Doherty, Hope, Sixsmith, & Kelleher, 2000; Fox, Blank, Rovnyak, & Barnett, 2001; Harris, Zhou, Liao, Barclay, Zeng, & Gao, 2010; Molla, 2008).

Professional development and role model emerged the most with participants from the village. Professional development activities are critical for providers residing in the villages as they typically serve as first responders helping community members to access healthcare services and respond to crises. Once community members are receiving care, village providers typically offer maintenance and follow-up care. Similar findings in the literature note that rural providers are required to be knowledgeable about

and treat a variety of issues (Stamm et al., 2007). Consequently, theses providers are called upon to provide an array of services that requires a broad range of skills.

Many rural providers are required to practice outside of their area of expertise (Brems & Johnson, 2007; Judd et al., 2002; Roberts et al., 1999); therefore, professional development activities likely build that capacity within the local provider by offering them the necessary tools to confidently carry out their duties with competence. Professional development offers continuing employment opportunities and provides local providers with a sense of purpose and pride. A participant from the region stated, "They realize and I surprise them since I am taking college courses, that people my age need education and I am very proud of that." This finding is consistent with the literature suggesting that ongoing training may support the retention of providers and improve healthcare in rural areas (Baernholdt & Mark, 2009; Chipp et al., 2008).

Due to the nature of village providers living within close proximity of their clients who also their friends and family members, village providers tend to be cognizant of clients noticing their actions. This lack of anonymity as a reality of rural service delivery is similar to those finding already noted in the literature (Carlton-LaNey et al., 2005; Nelson et al., 2007) and is an important consideration for providers living and working in rural communities (Barbopoulos & Clark, 2003; Brems & Johnson, 2007; Judd et al., 2002). Serving as a role model for living a healthy lifestyle is not only an expectation the community holds for the provider, but it also directly influences whether or not community members will seek out services from the local provider. This theme of

serving as a role model is an important aspect of the village provider's function. A participant from the region noted:

> You have to be a good role model if you are going to be in this field. That is the key, being a good role model. If I were out there being a drunk every weekend, nobody will be in my office. Not even one person. Not even the kids in this village would come and see me.

Two themes, fitting back in and personal adjustments emerged the most with non-Native participants, participants from the regional hub, and professional participants when discussing local provider retention. This is a particularly interesting finding as the participants most likely to discuss these themes were participants originating from outside of the region, and they were commenting on factors influencing retention of local providers originating from the region. Most of the quotations focused on the challenges faced by local providers when they are forced to make personal adjustments during times that they leave the region to pursue training and education, followed by challenges associated with having to readjust and fit back into the community upon their return. One possible explanation for outside participants being more likely than local participants to discuss personal adjustments as a local provider issue could be the outsiders' assumptions that local community members return to the region without completing a university degree or training opportunity due to difficulties with adjustment. In all likelihood, local community members may return to the region without degree or training completion based on many factors including changes in goals, priorities, or life circumstances which may be similar to reasons that outside providers return to their homes outside of the

region. However, it is important to consider the role of social support in a local provider's ability to adjust when leaving the region for training. This finding is consistent with the literature that identifies the positive influence of Native American students' social support networks on their success in higher education (Johnson, Okun, Benallie & Pennak, 2010). Additionally, social support appears to play a strong role in local providers readjusting and fitting back in upon returning to their communities.

It appears that both participants from the region and from outside of the region acknowledge the challenges local providers face when returning to the region and fitting back into the community. A local participant explained that having some of the conveniences in the rural communities that exist in urban center can help local providers readjust to returning home: "Having running water does not hurt, Internet, cell phones. Whatever gets you going, I guess." A participant from outside the region echoed similar sentiments: "I understand, from what people have told me that it can be extremely difficult to go back to your village, because your life experiences have changed."

A similar number of participants from each demographic category noted social support as an important factor influencing local provider retention. Participants generally agreed that local provider retention is generally influenced by local providers having familial and cultural ties to the region. A participant who relocated to the region stated, "Well of course, they have the support system and other things here. They have an identity with the community." A local participant echoed, "So in that sense, I have my group of friends, and they're very, I don't know if the word is supportive, but maybe that's it."

Participants from outside of the region were more likely to speak about social support stressors associated with local providers navigating the familial expectations, roles, and responsibilities. A participant who originated from outside of the region discussed a dilemma faced by a local provider navigating a familial dilemma:

> And you [a local provider] have to watch members of your family, who have not made the decisions that you have, possibly deteriorate, possibly get sick. Make choices that aren't the ones that you want your children around. And if you're living in a village, and even sometimes in [Name of Regional Hub], you feel obligated to help when people are really in crisis. And you may be really challenged as to whether that's the best thing for your family. There are just a lot of stresses on the young people, and the choices they have to make. . .

This topic was not discussed by local participants possibly because the decision to help one's family is not viewed as a dilemma or it may not be culturally acceptable to discuss such matters openly within this context.

In sum, participants identifying as local providers offered insider perspectives about factors influencing local provider retention. Although these findings were similar to those insider perspectives offered by participants identifying as outside providers when commenting on factors influencing retention of outsiders, unique issues also emerged regarding local provider retention. Both groups yielded findings with professional support, boundaries, and job stress emerging as important factors. For local providers, professional support and professional development emerged as positive influences that may counteract job stress, a factor viewed as negatively affecting retention. Because

paraprofessionals work in remote locations and typically do not have frequent face-to-face contact with others working in similar positions, professional support is paramount for helping them cope with crises and boundary considerations when providing care to family and friends. Furthermore, professional development activities may also serve as a protective factor against job stress by offering paraprofessionals tools that enhance their effectiveness and confidence, as these providers often serve as first-responders in crisis situations and offer on-going follow-up care. Community support for local providers may also help with counteracting job stress. Participants noted that community members place a high value on receiving healthcare services from their own people, and local providers are frequently viewed as important role models for living a healthy lifestyle. In fact, local providers' sense of community support for their efforts and their desire to serve as a role model may lead to a heightened sense of job satisfaction. In turn, job satisfaction may help them contend with the challenges they face when pursuing training and education in urban settings and readjusting to village life after completing the training. Although paraprofessionals face unique challenges associated with providing care to members of their support system, participants generally agreed that local provider retention is positively influenced by local providers having familial and cultural ties to the region.

Service Utilization

During the segment of the interview that explored factors and qualities influencing community member utilization of services offered by outside providers, a total of 11 themes emerged with strong frequency and high percentages of participants

identifying them as important considerations. Engagement and gaining trust were the strongest themes that emerged with participants from all demographic categories. However, a slightly larger percentage of Alaska Native participants, participants from villages, and paraprofessionals spoke about these two themes as compared to non-Native participants, participants from the regional hub, and professionals. An outside provider's engagement in the local community contributes to community members accessing service. In fact, engagement appears to be linked to the provider's ability to gain the trust of local community members. The following quotation illustrates the connection between engagement and gaining trust:

> Some of it comes with familiarity. . . If a certain person sees you enough then well 'Oh, OK, I know who you are so I can talk to you.' I found that to be true when I first moved here. I would talk to a patient and then the physician would come in and talk to the patient. The litany of complaints was completely different. I would look at the doc and say, 'I thought you said he had this.' Truth changes, and sometimes it is because 'I remembered I had this' and sometimes it is because it is based on the fact there is a different rapport [with a known provider] than with a there is with a stranger, safety. It matters.

This finding begins to explain potential solutions such as building trust, establishing relationships, and developing rapport to counteract rural community members' reluctance to use services and fully disclose symptoms (Holzer & Ciarlo, 2000; Morgan, Semchuk, Stewart, & D'Arey, 2002; Starr, Campbell, & Herrick, 2002) and failure to fully disclose symptoms (Van Hook, 1996) as noted in the literature.

Willingness to confide in an outside provider and boundaries emerged with a similar percentage of participants from each demographic category. These two themes also appear to be closely connected with a community member's level of trust with an outside provider. One participant explained that community members are often willing to engage with outside providers because they are not close relatives or friends. He described the value of being an outsider: "Villagers like outsiders. Somebody that they can trust." Other participants explained the gravity of appropriately managing boundary issues in a way that is culturally appropriate in a rural setting so that community members would feel comfortable seeking out services.

A larger percentage of participants identifying as Alaska Native, residing in a village, and paraprofessionals spoke about the importance of four themes (being open, personal qualities, adaptable approach to service delivery, and investing time) for service utilization than participants identifying as non-Native, residing in the hub, and professionals. These participants offer a unique perspective on understanding the process involved in community member utilization of outside providers' services because they live and work in the community delivering services to fellow community members, friends, and family members. Furthermore, these participants frequently help connect fellow community members to the services offered by outside providers and are privy to important feedback from community members. Often times, these participants serve as liaisons facilitating the services that occur between the outside provider and client. A similar model is described in the literature with aboriginal healthcare workers bridging cultural and communication barriers that exist between non-indigenous healthcare

providers and aboriginal patients (Abbott, Gordon, & Davison, 2008). These participants noted that the ability of outsider providers to adapt how they approach their work depends upon their openness, flexibility, and cultural sensitivity:

> You don't have to be culturally competent, but at least be sensitive of the cultural differences. Sometimes, the rhythm of a person from outside culture [differs] from this village culture and all of the cultures that are within [Name of Regional Hub]. Slow down when they come to [Name of Regional Hub]. So there's a different rhythm that people work with, and some people come from outside cultures, their rhythm may be out of sync, and it will put people ill-at-ease. So you can imagine somebody from New York going "boom, boom, boom, boom", and somebody from a village, feeling as though they don't have the opportunity to communicate.

Alaska Native participants, participants from villages, and paraprofessionals also discussed the importance of outside providers investing time in the community in order to gain trust and facilitate community member utilization of their services. This finding offers a potential suggestion for remedying community member distrust of outsiders which is discussed in the literature (Balamurugan, Rivera, Sutphin, & Campbell, 2007; Brown & Herrick, 2002; Coward, DeWeaver, Schmidt, & Jackson, 1983; Isaacs et al., 2010; Nordal, Copans & Stamm, 2003; Owens, Richerson, Murphy, Jageleweski, & Rossi, 2007). Local participants working in the villages as paraprofessionals frequently coordinate meetings between outside providers and community members. As a result of this job function, they may experience a heightened awareness of the importance of

outside providers spending time in the community before community members feel comfortable accessing their services. Furthermore, these participants expressed some frustration with outside providers inconsistently traveling to the villages causing community members to view services as unreliable. A local participant living and working in a village explained:

> A new provider should come more often to [Name of village], and be known to the community that he's a healthcare provider, and not just stay in [Name of Regional Hub] and make calls to us. We need providers that come to our community and are open and are known to help others in need. Not just talk over the phone.

A larger percentage of participants identifying as non-Native, residing in the hub, and professionals spoke about three themes including being genuine, imposing values, beliefs, worldviews, and job stress as influencing community member service utilization when compared to participants identifying as Alaska Native, residing in a village, and paraprofessionals. Participants from outside noted that community members' decisions to utilize an outsider's services are influenced by their perception of the provider as genuinely caring about them. A participant explained, ". . . some of the other characteristics, if someone is genuine, and has a genuine interest and genuine caring, is not self absorbed, or narcissistic. . ." Consistent with the current study, the literature notes that provider qualities of genuineness and congruence positively influence the therapeutic alliance (Kolden, Klein, Wang, & Austin, 2011); whereas, provider qualities

of being disconnected, cold, and distant negatively influence the alliance (Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009).

These participants also viewed outside providers' impositions of their own values, beliefs, and worldviews as critical impediments to community member service utilization. A participant who relocated to the region warned, "Some people want them [local community members] to match the lower 48 standards, their [outside providers'] own cultural standards and their own upbringing. They can't do that." Another participant who relocated to the region explained frequent responses he has heard when new providers impose their values, beliefs, and views:

> You know, I've seen people [outsiders] ask questions about culture and then say, 'Oh my God,' you know, about their [local community members] responses. You don't do that, you know. 'I can't believe you guys do it that way.' 'You should try it this way.' 'Well, where I'm from they do it this way.'

This finding supports recommendations existing in the literature calling for culturally appropriate interventions to address the healthcare needs of rural and ethnic minority populations (Isaacs et al., 2010; Mier, Ory, & Medina, 2010; Owens et al., 2007).

Participants from outside of the region discussed how job stress affects a provider's ability to refrain from passing judgment and imposing values, beliefs, and worldview on community members. For instance, a participant explained how local community members view behavioral health services differently compared to people in the lower 48 states, as they tend to wait until they are experiencing a crisis. When behavioral health is understaffed, it can be stressful and challenge providers to accept the

way that local community members approach accessing behavioral healthcare. These findings are consistent with the literature stating that rural community members are reluctant to seek out preventative healthcare, utilize healthcare screening services, and obtain healthcare treatment early (Guralnick, Kemele, Stamm, & Greving, 2003; Walker, 2002; Ziller et al., 2010). Preventative healthcare is even further limited by a lack of providers serving in rural areas (Brown & Herrick, 2002; Johnson et al., 2006b; Mohatt, 1997; Nelson, Pomerantz, Howard, & Bushy, 2007; Strasser, 2003). These provider shortages likely influence the job stress experienced by providers choosing to live and work rurally.

In sum, it appears that engagement and investment of time in the community by providers allows them to gain the trust of local community members, thus positively influencing community member service utilization. Participants noted that some community members trust outside providers and are willing to confide in them because they are not close relatives or friends. Furthermore, participants identified outside providers' ability to adapt how they approach service delivery as important; this ability appears to be based upon their openness, flexibility, and cultural sensitivity. In addition, it likely influences providers' success with managing boundary issues in a culturally appropriate manner, which participants noted as a factor affecting community members' comfort and willingness to seek out their services. An outside provider being perceived as someone who genuinely cares about the community and does not impose values, beliefs, and worldviews further aids the provider in gaining trust and encourages service utilization.

Cultural Mentorship

During the segment of the interview that explored factors and provider qualities influencing an outside provider's ability to access cultural mentorship, a total of 10 themes emerged with strong frequency and high percentages of participants identifying them as important considerations. Increasing competency; being open; and imposing values, beliefs, and worldviews were the strongest themes for participants from all demographic categories. Engagement emerged as an important theme with at least half of the participants in all demographic categories. Personal qualities emerged as an influential theme with slightly less than half of the participants in each of the demographic categories.

These findings suggest that most participants viewed providers' interests in increasing cultural competency as influencing their efforts to seek out cultural mentorship. Previous literature further supports the importance of rural providers developing cultural competency in order to reduce barriers that hinder rural residents from seeking out and utilizing healthcare services (Barbopoulos & Clark, 2003; Duckworth, 2005; Nelson et al., 2007; Strasser, 2003; Willging, Waitzkin, & Nicdao, 2008; Williams & Cutchin, 2002; Wolff, Dewar, & Tudiver, 2001). A participant from the region described the importance of new providers being open to increasing their cultural competency: "And just try to understand, be curious, you know, want to learn." Another participant who relocated to the region pointed out that developing cultural competency is an on-going process requiring providers to remain open to continuous development: "I mean, it's an on-going process. You know, just because you know one

village, doesn't mean you know the next." A strong connection also appears to exist between increasing cultural competency, being open to new experiences, and engagement. A local participant explained this connection and how an opportunity for new providers to immerse themselves in the culture could add to their overall competence:

> I think it would be good for them, to let them learn what we go through in our culture. Or at least let them work for a year [in our village] and see what we go through. I think it gives them more respect. Just being here for the community and getting along with them is the best thing. That would be good, just to have somebody come in and learn. See if they stay longer than six months or a year. Just to stay in the village and work with them. They would understand more of what we go through in the village.

Participants also noted the influence of additional personal qualities on their ability to benefit from cultural mentorship. Non-Native participants were somewhat more likely to discuss this theme compared to Alaska Native participants. However, the theme emerged during interviews with both groups. A participant, who relocated to region, identified the importance of being observant and advised new providers to proceed with some caution initially until they have a chance to observe and become familiar with local cultural values:

> I come to find out humor is a culturally held value, and figuring out what the local values are. The local, the Native values here are love of children, I mean, if you didn't know that and you're kind of scolding and dismissing the children, they're

> gonna look at you differently. So really, trying to take your time and be cautious of how you act before you learn.

Patience, listening skills, openness, and avoidance of making assumptions were discussed as important personal qualities that facilitate the ability of providers to increase their cultural competency. Furthermore, participants noted that providers increase their cultural competency by approaching their work with a sense of curiosity and interest that propels them into asking questions in a respectful and humble manner. It appears that an array of personal qualities coupled with openness, engagement, and the ability to refrain from imposing oneself upon the community facilitates providers benefiting from cultural mentorship.

Non-Native participants, participants from the regional hub, and professionals were most likely to discuss the role of the village-based counselor facilitating a new provider's access to cultural mentorship. A participant described past difficulties with providers clearly understanding the role of the village-based counselor:

> Unfortunately, some [village-based counselors] were told that I was the important person, because I had the degree from the lower 48. Somebody told [village-based counselors] that worked with me that I was the important person, because I had the degree. But they were important, because they were going to teach me the culture. Well, I thought that was a real putdown to them. It was almost like their value was to teach me the culture, and that was it. It was implied as kind of a putdown. You're only valuable as a 'Native guide' and I think that's kind of insulting.

Similar to findings in another study, Native providers may serve as a cultural mentor for non-Native providers (Abbott et al., 2008); however, Native providers must be respected for the array of skills and experience they possess. Furthermore, it appears important that new providers develop a clear understanding of their role along with the role of the village-based counselor and approach their work with the VBC in a respectful and collegial manner. A participant from the region advised, "I think they [new providers] need to sit down with the village-based counselors and to learn some of the things they can't do, how to act in their [village-based counselor's] community, and what to do." The VBC appears to be an important connection that facilitates a new provider accessing cultural mentorship which may ultimately result in increased cultural competency for a new provider.

Participants identifying as non-Native, residing in the regional hub, and professionals were most likely to discuss themes of adaptable approach to service delivery, professional support, job stress, and boundaries in relationship to cultural mentorship. Understanding the culture allows providers to make necessary adaptations in the way they approach their work. A participant explained:

> Every individual has their own culture, and every good social worker or good family therapist knows that. I think that's how good clinicians should adapt up here. Fling themselves into looking at things from another perspective, getting to know another way of seeing things. Native culture is different than western culture.

Once providers understand the local culture and feel comfortable in their cross-cultural knowledge and competency, it is likely that they will be able to adapt service delivery effectively to meet the needs of community members. A participant described the importance of being able to jump in and do what needs to be done in culturally competent manner:

> Figure out what needs to be done, figure out how, who needs it, when, where, what. Do it. And it doesn't matter if it was part of how you were trained, you know. We're the problem solvers in the [type of facility where participant is employed], and people can't figure out how to get something done. And it's kind of a neat role, because it's always changing, and it's always great.

Professional support also emerged as an important factor aiding in cultural mentorship along with helping providers manage job stress and adapt to the culture. One participant commented on the importance of mentorship, "I think it goes back to mentorship, but when a new person comes up here, you know, I think there needs to be a seasoned clinician that is their mentor." A participant described a stressful situation occurring after only two weeks in her position and the support she was offered by a local village-based counselor:

> When I came, I was here for two weeks before I was sent to [Name of village] for a suicide by myself. And I was scared to death. But, I walked in, you know, and thankfully had [Name of local village-based counselor] there who I had met the week before.

Mentorship and professional support appear to be important factors facilitating the ability of new providers to learn about the culture, understand their job duties, and manage stressful or new situations. Literature supports the positive effect of cultural mentorship and training on providers understanding cultural differences, exploring their own cultural influences, and considering the dynamics of cross-cultural interactions (Morgan, 2006; Salzman, 2000). Furthermore, mentorship and professional support may assist new providers with understanding how to set and maintain culturally appropriate boundaries.

In sum, participants noted that interest in increasing cultural competency influences whether providers seek out cultural mentorship and opportunities to learn about the culture. The ability of providers to receive cultural mentorship appears linked to their openness to new experiences and efforts to engage in the community. Providers who approach cross-cultural work with a sense of curiosity and interest coupled with respect and humility are well-equipped to receive cultural mentorship. Furthermore, participants noted the importance of new providers being able to patiently listen without making assumptions or imposing outside values, beliefs, and worldviews on others in order to understand the culture. Professional support and mentorship were viewed as important facilitators of new providers learning about the culture, understanding their job duties, managing stressful or new situations, maintaining culturally appropriate boundaries, and making necessary adaptations in service delivery.

Summary of Factors and Provider Qualities Influencing Retention, Service Utilization, and Cultural Mentorship

Many factors and provider qualities appear to influence retention, service utilization, and cultural mentorship. Participants viewed the ability of outside providers to engage with the community and adapt service delivery to fit the local community as being influential factors in their retention. Openness to new ideas, beliefs, and practices and the ability to refrain from imposing outside values, beliefs, and worldviews on others contributes to outside providers engaging with the community and appropriately adapting their model of service delivery.

Retention is also affected by a new provider's adjustment to the lifestyle, environment, and culture of the region. Professional support, boundaries, and job stress emerged as having substantial influence over both outside provider and local provider retention. In fact, it appears that professional support and setting appropriate boundaries facilitates the ability of both provider groups to manage job stress. Self-care surfaced as being essential for outside providers to counteract job stress; whereas, local providers counteract job stress through professional development and community support. For both outside and local providers, social support emerged as important. However, community acceptance coupled with social support lead to the ability of outsider providers establishing a sense of belonging, commitment, and job satisfaction. In contrast, community support coupled with social support and functioning as a role model lead to local providers overcoming challenges with completing training , readjusting to village life after training completion, and contending with village politics. Finally, familial and cultural ties to the region appear to positively influence local provider retention; whereas, the lack of those ties seems to negatively affect outside provider retention.

Community member utilization of an outside provider's services appears to be linked with the outside provider engaging with and investing time in the community, both of which also result in local community members trusting them. Community members' trust and service utilization are both linked to outside providers being perceived as genuinely caring about the local community members and refraining from imposing outside values, beliefs, and worldviews upon them. The ability of outside providers to adapt their approach to service delivery also affects utilization of services and appears to be connected to provider openness, flexibility, and cultural sensitivity.

Participants viewed cultural mentorship and professional support as important factors aiding new providers in learning about the culture and making necessary adaptations in service delivery. Openness, engagement, interest in increasing cultural competency, and willingness to seek out learning opportunities facilitate providers engaging in cultural mentorship. Participants identified personal qualities that are important for new providers to possess in order to benefit from cultural mentorship including curiosity and interest in cross-cultural work, respectfulness, humility, patience, good listening skills, and the ability to refrain from making assumptions or imposing outside values, beliefs, or worldviews.

Theoretical Underpinnings of Provider Retention, Service Utilization, and Cultural Mentorship

The interview process of this study explored each research question as a separate topic; however, the three questions appear to be interrelated for outside providers. The long-term retention of providers relocating to the Bering Strait Region from other

geographic areas appears to be influenced by community members utilizing the services they offer. Furthermore, the data suggest that cultural mentorship of outside providers is viewed as a factor that may influence provider retention and community member service utilization. Through the interrelatedness of these concepts, a theory develops detailing how specific factors and provider qualities connect to one another and affect the long-term retention of outside providers who relocate to the region from other geographical areas as shown in Figure 1. Consequently, the model only applies to the retention of outside providers who are known to experience a higher rate of turnover as compared to local providers (Fischer et al., 2003).

In this model, I have illustrated the personal qualities indicating that a candidate is likely to be a good fit for living and working in rural Alaska. Providers possessing such qualities are likely to achieve professional and personal satisfaction, both of which contribute to their decision to remain living and working in the region. As relationships are built, providers develop professional and social supports creating opportunities for guidance and cultural mentorship. These opportunities only enhance their ability to provide quality services that are utilized by community members, which, in turn, increases provider satisfaction and retention. Providers who are open and able to refrain from imposing their ways upon others are better able to develop satisfaction while living and working in the region.

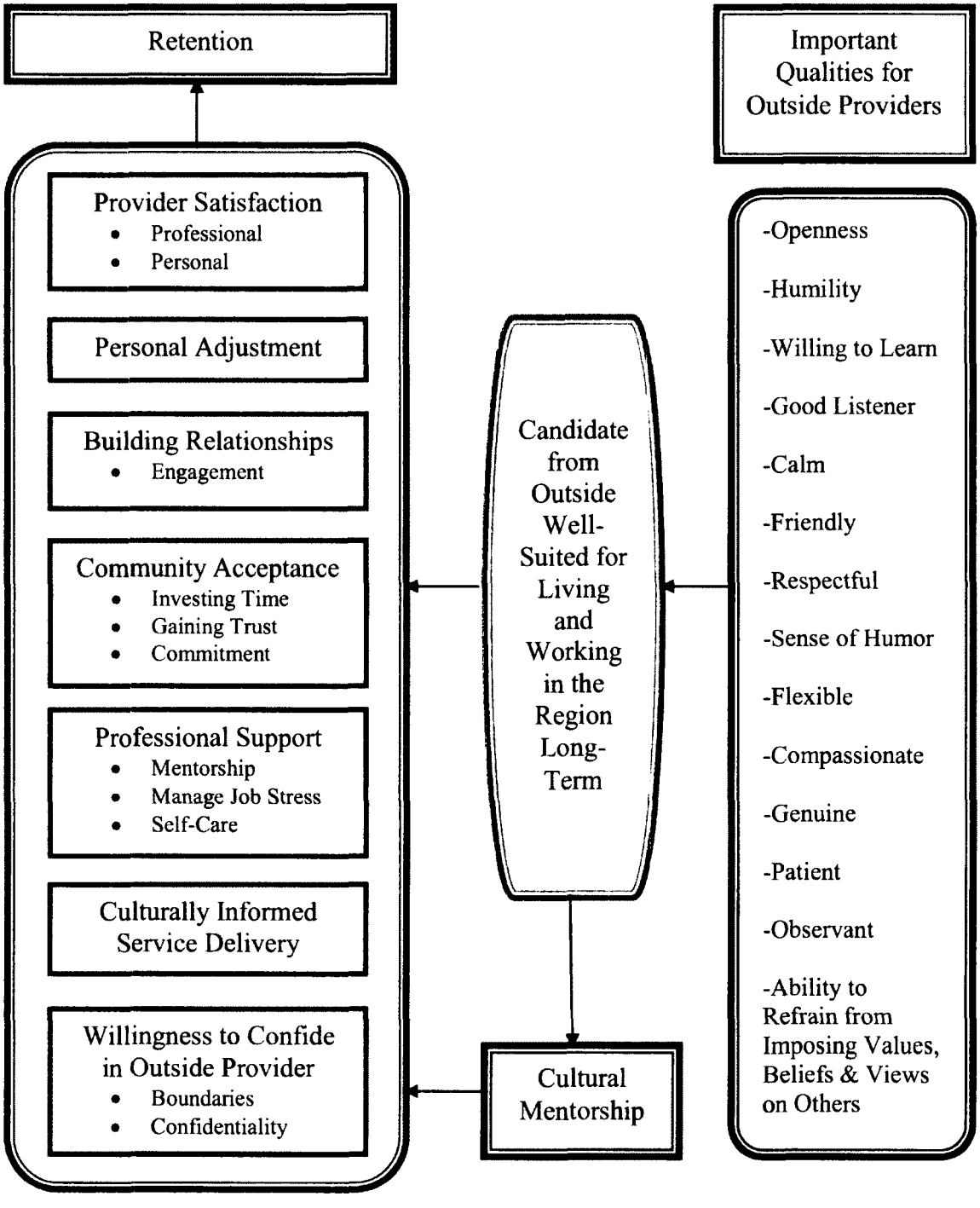

Figure 1

Factors and Provider Qualities Influencing Retention, Service Utilization, and Cultural Mentorship

Sense of professional and personal satisfaction. Providers' satisfaction with their professional and personal life contributes to their retention. According to almost half of participants, satisfaction of providers with their job influences their willingness to continue living and working in the region. Many participants spoke about the importance of providers enjoying their work, work environment, co-workers, and clients. A participant described her colleagues as a "close knit family" while another participant described her work environment as "a wonderful hospital to work in." The following quotation ties the influence of community members' utilization of a provider's services to the provider's job satisfaction and decision to remain working in the region:

> . . . if we have a provider that comes in, and thinks of the Natives as just unintelligent or drunks, just having a bad attitude about it, they're [providers] not going to last. People don't want to see them [providers]. . . Clients won't see them [providers] so they [providers] have nothing to do to the point where the provider gets so sick of themselves that they leave. . . Clients won't want to see them, so therefore they won't have any work to do, and they'll get so sick of themselves for not doing any work that they'll leave.

In addition to professional satisfaction, providers finding fulfillment in their personal life is essential for them to remain living and working in the region. This finding is consistent with the literature noting the importance of rural providers' satisfaction with their community of residence on their overall job satisfaction and retention (AbuAlRub et al., 2009; Baernholdt & Mark, 2009; Buykx et al., 2010; Kulig et al., 2009; Penz, Stewart, D'Arcy & Morgan, 2008; Stenger, Cashman, & Savageau,

2008). Many participants noted outside provider stressors stemming from relocating to an unfamiliar place and living in a new culture without established friendships or familial ties. Participants spoke about outside providers experiencing social isolation, culture shock, and a steep learning curve when initially arriving to the region. In order to derive personal satisfaction from such intense and new experiences, providers must undergo many adjustments and develop a support network.

Personal adjustments. For both professional and personal satisfaction to occur, outside providers must make adjustments that allow them to adapt. Participants noted the adaptation of providers to the culture, environment, weather, and job as being essential for them to derive a sense of satisfaction. One participant stated:

> As long as they have good communication with people and they get along with everybody, if they love their job and what they are doing, I would say those things [are important] and if they get used to the cold climate and the winter.

Moreover, many participants explained the importance of providers developing an appreciation of the environment by learning to hunt or fish. Other participants spoke about the importance of developing outdoor hobbies such as skiing, snowmachining, or dog mushing. In fact, some participants who originated from outside of the region expressed the importance of providers developing a strong love of living a rural lifestyle. The following quotation illustrates one participant's love of rural:

> You got to be up here to get that. And it's gorgeous. There's no other way to describe it. Even in the winter. Walk out at 3:00 in the morning and watch the

> northern lights. It's all part of it. And it's the Native culture and everything. It's a wonderful place to be sitting in the middle of if you open your eyes.

In order for personal adjustment to occur, it is essential for providers to possess the qualities of openness, humility, and willingness to learn from others. Providers with such qualities are typically individuals who are able to avoid imposing outside values, beliefs, and worldviews on others which allows them opportunities to learn from others and receive mentorship. The following quotation demonstrates the links that exist between these concepts:

> How well they adapt, if they are willing to learn and work with people, and willing to understand. Maybe put some things aside, like put aside their degree once in awhile, and just ask questions and not be scared to learn or not know everything. It can be scary moving to a new place. I can understand that, say if you are scared and ask for help. It makes a difference.

The need for providers to make personal adjustments in order to live and work in a rural area is an important finding because previous literature notes geographical isolation (Campbell et al., 2002; Mohatt, 1997), weather and seasons (Barbopoulos & Clark, 2003; Ciarlo et al., 1996), inadequate housing (Campbell et al., 2002), sparse services for continued care (Kowalenko, Bartik, Whitefield, & Wignall, 2003), and limited social opportunities (Barbopoulos & Clark, 2003) as factors with which rural residents and providers contend.

Building relationships. A provider's ability to establish relationships with community members, local providers, and other outside providers influences service

utilization, cultural mentorship, and social support, which, in turn, influences provider satisfaction. Engagement emerged as a key theme associated with an outside provider's ability to build relationships. This theme involves a provider actively participating in the community by being visible, meeting people, and attending important functions such as feasts or potlucks. This finding aligns with previous literature noting the importance of rural providers engaging with natural helpers that exist within local supports to build upon local strengths and values (Campbell et al., 2002; Gibb et al., 2003).

Participants noted many personal qualities that are important for an outside provider to possess for engaging with community members, building relationships, and accessing cultural mentorship. As with personal adjustments, building relationships requires a provider maintain a sense of openness. Some other important qualities include being a good listener, possessing a sense of calmness, being friendly and respectful, having a sense of humor, possessing flexibility, and being compassionate and genuine. Providers with such qualities are viewed as better equipped for establishing relationships within the community. One provider explained the importance of genuinely caring on building relationships with the community:

> We have some good people [providers who relocated to the region] here. They really care about people. It makes a difference, genuinely caring and wanting to make a difference. It does not matter where you work; I think that would be true wherever you are if you are the type of person who cares.

Community acceptance. By building relationships outside providers increase the chances that community members utilize their services, offer them cultural

mentorship, and provide support. Most importantly, outsider providers build relationships by investing time in the community and gaining community member trust. In turn, community acceptance of outside providers ensues. Gaining trust and investing time are two themes that frequently co-occurred suggesting a strong link between them. One participant explained this link by stating, "Time is a big factor. Just because you are the new clinician, do not expect to see people just like that. People have to trust you." Another participant from the region explained the challenges that outside providers face due to the itinerant nature of their position influencing their ability to form trusting relationships:

> And then, umm, building relationships within the community, I think too. Be part of the community, once you introduce yourself. Being involved, you know. It is hard if you are just coming in just once a month as an outside clinician into a village. It would really make a huge difference if you were there full-time. That way the people can get to know you and you can get to know the community better instead of once a week or once a month for a few days. It is hard to build any kind of relationships.... but it is possible.

The literature notes the importance of a rural provider building community acceptance (Baldwin et al., 1998; Murray, 1984), a factor that may counteract community members' distrust of outsiders (Balamurugan et al., 2007; Brown & Herrick, 2002; Coward et al., 1983; Isaacs et al., 2010; Nordal et al., 2003; Owens et al., 2007).

In addition to gaining trust and investing time, continued positive engagement with the community appears to influence community members' acceptance of outside

providers. A participant explained the challenges associated with living and working in small communities and the importance of engaging with others in a way that does not damage relationships as those relationships may be vital for continued success:

> They [long-term providers] are the ones that don't isolate themselves and get involved in the community. They seem to find something to do that they enjoy. They like to visit with people, and people who do not try to go out, the ones who do not last, it seems they pick the wrong fights and they wear themselves out. It is a small place and everyone knows each other and if you do not try to get along, it comes back to get you later. It is hard to be accepted, you have to it is not like a big place where you only see certain people, everything gets back. Things get around eventually. They [long-term providers] just try to get along. If you do have a problem with someone, instead trying to fight them, you need to find a way to work with them.

Providers' commitments to the region and their work also seem to be important factors that inform community acceptance of the providers. Commitment is influenced by the amount of time invested in the region by the provider. The following quotation illustrates the relationship between time, commitment, and community member acceptance:

> The third and fourth years are kind of nice, and you know your job by your fourth year. You're beginning to be accepted by the people you're working with. Sometimes more so or less so, but in that third or fourth year, people are

> beginning to realize that you've made a commitment to the area. So by the fifth year, I'd say people have either accepted you or not.

Participants also viewed the commitment of providers to their work as a factor directly influencing provider retention. A local provider explained her view of the role of commitment in the long-term retention of providers:

> I think their commitment. I mean how much are they willing to, I guess, sacrifice in providing their services. For me, it has to do with how committed they are. If there is a passion within them. If it is their passion to help.

Professional support. As providers build relationships and begin to establish community acceptance, their access to professional support increases. Professional support is an important theme likely influencing a provider's professional and personal satisfaction. Rural providers tend to experience a lack of access to clinical supervision and mentorship (Barbopoulos & Clark, 2003; Perlman & Hartman, 1985), deal with complicated ethical dilemmas (Chipp et al., 2008; Halverson & Brownlee, 2010; Johnson et al., 2006a; Warner et al., 2005), and are asked to practice outside of their areas of expertise (Barbopoulos & Clark, 2003; Gibb et al., 2003), all factors that make professional support a vital component for improving the success and longevity of rural providers. Participants noted the value in having experienced senior staff looking out for the welfare of new staff members by helping them set boundaries, manage workload, and understand the culture and environment of the region. In addition, professional support may be a key to assisting providers with managing job stress and finding ways to engage

in self-care activities. One participant explained the importance of providers receiving mentorship around self-care to reduce job stress:

> . . . mentorship, administration learning self-care themselves and to be able to say, 'Whoa, man, haven't you been working in the village all week? Maybe we need see if someone will switch on-call for you this weekend so you can take some time.' Cuz you don't sleep in a village, I mean, especially in the summers. . .

Furthermore, professional support also influences an outside provider's personal satisfaction. During multiple interviews, participants discussed the role of colleagues offering support and guidance professionally; however, due to the interconnectedness of individuals residing in rural areas, these same individuals also serve as the provider's "extended family" and may compose part of the provider's social circle.

Culturally informed service delivery. As previously noted, providers' professional and personal satisfaction contributes to their long-term retention; however, the way they approach delivering services is likely to influence their ability to derive a sense of satisfaction from their work. Providers who are able to adapt services to fit the local culture increase the likelihood of community members utilizing their services. A provider's openness to embracing new ways of approaching service delivery without imposing upon others gives way to the development of new skills that can be acquired through cultural mentorship.

Cultural mentorship and cross-cultural training are supported in the literature as strategies that increase providers' knowledge of the role culture plays in the provision of services (Abbott et al., 2008; Morgan, 2006; Salzman, 2000). Furthermore, mentorship,

training and support assist a provider with developing strategies for overcoming service utilization barriers that emerge as a result of cultural differences between the provider and community members (Barbopoulos & Clark, 2003; Duckworth, 2005; Nelson et al., 2007; Strasser, 2003; Willging et al., 2008; Williams & Cutchin, 2002; Wolff et al., 2001).

Willingness to confide in an outside provider. Once outside providers are accepted by the community and begin to adapt service delivery in culturally appropriate way, community members are more likely to begin confiding in them. However, some community members may only feel comfortable talking to someone from the local community while others may only talk to an outside provider. A participant explained:

> So you've got people who can talk about certain types of things with strangers a lot easier than they can with local people, and there are other things that they can talk about more easily with local people than with strangers.

Willingness to confide in an outside provider and community acceptance may be indicators of providers successfully dispelling the distrust of outsiders which tends to occur in rural communities (Balamurugan et al., 2007; Brown & Herrick, 2002; Coward et al., 1983; Isaacs et al., 2010; Nordal et al., 2003; Owens et al., 2007).

The way outside providers approach maintaining boundaries influences community members' willingness to confide in them. The literature supports the complexity of boundary issues in rural service provision (Chipp et al., 2008; Halverson & Brownlee, 2010; Johnson et al., 2006a; Morgan, 2006; Nelson et al., 2007; Roberts et al., 1999; Warner et al., 2005). Therefore, the ability to properly manage multiple roles and

engage appropriately in the community influences whether providers are viewed by community members as respected and trusted resources. One participant explained:

> We had a clinician that joined the crowd and was a drunk on weekends. [The provider] was booted out of here pretty fast. You can't be going out there and being drunk in the village. Nobody will come see you.

Along with boundaries, confidentiality emerged as a theme informing a community member's willingness to confide in an outside provider. The complicated nature of maintaining client confidentiality in rural service delivery is discussed in the literature (Nelson et al., 2007; Roberts et al., 1999; Schank, 1998; Sobel, 1992). Outside providers appear to be perceived as individuals who offer the benefit of not having familial ties to community members. As result, some community members may view them as "safe" persons in whom they can confide. A local provider stated, "People do not want to talk to me cause they know me and see me every day, so they want to talk to with a clinician." In this case, the clinician is viewed as someone safe to confide in because she or he is not from the community; however, this does not hold true for all community members. One participant from region stated, "I think they'd rather talk to us [local provider]. You know, if the clinician comes, they hardly come here, only as needed."

Summary

The ability of providers to establish a sense of satisfaction in their professional life as well as in their personal life affects their retention. Making the necessary personal adjustments to thrive in the environment requires providers to adapt to a rural lifestyle

and cultural groups, thus enabling them to develop satisfaction. Essential provider qualities facilitating their adjustment include openness, humility, and willingness to learn from others.

Building relationships is an important key to provider satisfaction. A provider's ability to establish relationships directly influences community members' willingness to utilize services, offer cultural mentorship, and give social support. In order to build relationships, a provider must be open to new experiences and ideas and engage with the community. Through these efforts to build relationships, community acceptance of the outsider provider begins to emerge. As a provider invests time in the community and gains the trust of community members, the community members begin to perceive a sense of commitment to the region on the part of the provider and community acceptance increases.

Providers access professional support through building relationships that positively influence their professional and personal satisfaction. Professionally, this mentorship allows providers to engage in self-care, learn about the complicated nature of maintaining boundaries in rural areas, manage a workload that requires frequent crisis intervention, and offer services in a culturally appropriate manner. Providers' personal lives are influenced by these professional supports as they also serve as important members of outside providers' social support systems.

Community member service utilization is increased by providers being culturally sensitive in their approach to service delivery and refraining from imposing their ways upon others. Professional support and cultural mentorship contribute to a provider's

ability to deliver such services. Individuals possessing openness, interest in developing cultural competency, and an eagerness to learn are well-suited for implementing culturally appropriate services with the guidance and support of others. In order for community members to utilize an outsider's services, they must be willing to confide in the outsider. This willingness emerges through community acceptance of the provider who is offering culturally sensitive services. Investing time, gaining trust, and appropriately managing boundary issues and client confidentiality also increase community acceptance and willingness to confide in an outside provider.

Chapter Six: Conclusions

Healthcare provider retention, community member service utilization, and cultural mentorship are interrelated concepts that influence the consistency and quality of rural healthcare service delivery. Rural healthcare organizations are challenged with providing services to meet the needs of culturally diverse populations across large geographic areas (Barbopoulos & Clark, 2003; Judd et al., 2002; Mulder et al., 2000; Strasser, 2003). Furthermore, rural healthcare organizations experience provider shortages and frequent provider turnover (Astor et al., 2005; Cunningham et al., 2003; Fischer et al., 2003; HRSA, 2004; University of Alaska Anchorage Alaska Center for Rural Health, 2007). Findings from this exploratory study combined with those from previous literature inform the following recommendations that attempt to guide future provider recruitment and retention strategies of Norton Sound Health Corporation.

Recruitment and Screening

Retention of healthcare providers begins with selecting individuals possessing the personal qualities and skills making them a good match for the position, organization, and region (Buykx et al., 2010; Felix, Wootten, & Stewart, 2005). Furthermore, specific recruitment efforts targeting healthcare professionals to work in rural underserved areas are necessary for remedying provider shortages (Pathman, Konrad, Dann et al., 2004). Organizations must consider the benefits of recruiting providers from various geographical areas.

For instance, recruiting providers from urban areas may increase the possibility of hiring a provider with experience providing care to diverse populations and possessing

skills and knowledge associated with culturally competency (Molinari & Monserud, 2009). However, recruiting from northern rural geographical areas increases the chances of hiring providers who are accustomed to rural lifestyles and cold climates, and these individuals may experience more job satisfaction compared to those from an urban background (Molinari & Monserud, 2009). Therefore, it appears that recruitment efforts in various geographical areas could yield providers who are well-suited for some of the aspects of living and working in the Bering Strait Region; however, it seems very unlikely that any provider hired from outside of the region would be adequately prepared and experienced in all aspects necessary for living and working in the Bering Strait Region. Consequently, it is vital to focus recruitment efforts on identifying personal qualities that emerged in this study such as being open, flexible, adaptable, and willing to learn, traits that will increase the likelihood of a prospective applicant adjusting and thriving while living and working in the region with the proper training and support.

Carefully reviewing applications, resumes, and cover letters for indicators of an applicant's interest and openness to living and working in a remote setting with culturally diverse clientele is the first step. In fact, applicants who do not highlight their experience or interest in working with culturally diverse populations are likely individuals who have not adequately researched the position or the region. Application materials should be evaluated on multi-cultural or cross-cultural work experiences, volunteer positions, and training opportunities. When reviewing materials, the applicant's exposure to diversity should be evaluated in its broadest context and could include the knowledge and experience of diversity in ethnicity, religion, socio-economics, sexual orientation, gender

identity, geographic locality, age, ability as well as other types of human diversity. An applicant with experience, knowledge, or interest in diversity is likely a better suited candidate for a position in the region than a candidate whose application materials do not highlight such important areas.

The interview process is another opportunity to evaluate applicants on their openness, cultural interest, flexibility, adaptability, sense of humor, and general interpersonal style. Forming an interview panel that consists of a diverse group of people may facilitate acquiring multiple perspectives on applicants' personal qualities and interpersonal styles. The interview panel should take care to include a village-based counselor, seasoned clinical provider, and Elder who may offer important insight into applicants' suitability for the position. The interview process should allow for informal time when members of the interview panel can interact with the applicant on a personal level. This will enable members of the panel to see how the applicant interfaces with diverse members of the panel from which additional impression may be gleaned.

The interview panel may consider using a series of scenarios to evaluate applicants' personal qualities as well as their cultural competency and knowledge of rural work. Table 7 summarizes important areas to evaluate during the interview, suggested scenarios or questions to utilize for the evaluation, and possible elements of a response indicative of potential goodness of fit between an applicant and the position.

Table 7

Potential Interview Questions or Scenarios Evaluating Important Provider Qualities

Quality	Question or Scenario	Key elements
Openness	You are working in an outlying village for a week. The weather is cold with subzero temperatures and a slight wind. The village health aide invites you to go out on a snow machine to ice fish after work. How would you respond?	Respect; Willingness to try something new; Openness to a subsistence lifestyle
Engagement	Being accepted in the community is vital to community members utilizing your services. How would go about entering the community, getting to know people, and becoming part of the community?	Introduce self to village leaders; Participate in community activities; Become involved with the village/tribal council efforts; Visit school and offer outreach services
Flexibility	It is Thanksgiving weekend. You are weathered in a village. How would you respond? How would you spend your weekend?	Ability to manage frustration/disappointment; Interest in reaching out to local community members to build supports and relationships
Adaptability; Cultural competency; Willingness to learn from others	A man in his late 50's has been court ordered to see you for substance abuse services. He is a fluent Native language speaker with limited English proficiency. He recently attempted suicide and is currently expressing suicidal ideation. How would you approach providing care to him? What elements would be contained in your treatment plan for this client?	Suicide risk assessment; Use of local resources for safety planning; Attending to cultural values; Incorporation of cultural supports and resources into the treatment plan; Consultation with client, his family, VBC, cultural mentor and/or clinical supervisor to develop the treatment plan
Adaptability to living and working rurally	Living and working in remote areas can be very challenging and some people can experience burnout. How do your recharge and take care of yourself to avoid burnout?	Feasible self-care plan that can be carried out realistically in the region; Recreational interests that are available in the region; Intact support system

In addition to screening applicant materials and the interview process, the interview panel may also gain useful information by having applicants complete cultural competency inventories. The California Brief Multicultural Competency Scale (CBMCS) is 21-item instrument used to measure self-reported multicultural competencies of mental health practitioners (Gamst et al., 2004). Another cultural competency inventory that could be utilized is the Multicultural Knowledge Awareness and Skills Survey-Counselor Edition-Revised (MKASS-CE-R) (Kim, Cartwright, Asay, D'Andrea, 2003). This inventory is a self-report inventory comprised of 33 items measuring cultural competency. Either or both inventories may be used and could offer additional information about an applicant's suitability for a position. It must be noted these inventories are mere tools that should not be solely utilized to decide whether an applicant would be well-suited for living and working in the Bering Strait Region.

Recruitment of local providers. Recruitment of local providers from the region is an important consideration for resolving provider shortages. Many educational opportunities are available for students statewide with some of the opportunities allowing students to remain in their home region. For example, students from the Bering Strait Region could pursue a human services associate's degree, bachelor's of social work degree, and master's of social work degree through distance-delivered programs allowing them to complete their education from their community. Norton Sound Health corporation's recruitment efforts may be strengthened by bolstering partnerships with secondary schools and the University of Alaska Fairbanks branch campus to deliver career education information about the professional healthcare training opportunities

available within the region and state of Alaska. Furthermore, job shadowing and summer job opportunities in human services fields for high school juniors and seniors may also increase interest in behavioral health fields within the region.

Retention

Once a suitable candidate is successfully recruited, factors that influence her or his decision to remain living and working in the region must be addressed. The literature points to the importance of the following factors on provider retention: appropriate staffing; infrastructure; remuneration; workplace organization; professional environment; social, family and community support (Buykx et al., 2010); and comprehensive orientation and cultural training for working in remote locations with indigenous populations (Morgan, 2006). This study yielded similar findings in that a provider's retention is influenced by professional and personal satisfaction, both of which are dependent upon the ability to adapt to the culture, work environment, and rural lifestyle. Professional support and cultural mentorship emerged as key themes throughout this study.

Professional support is vital for providers working in remote areas as they are required to develop extensive knowledge of a broad range of issues along with competency when working with diverse populations. In fact, their ability to be successful is dependent on their ability to adapt service delivery to fit the local culture. Therefore, it is recommended that providers participate in a bundle of support activities that includes a comprehensive orientation program, clinical supervision by a licensed and seasoned provider, cultural mentorship provided by a cultural expert such as the village-based

counselor or Alaska Native Elder, and continuing education opportunities with a primary focus on working with indigenous populations.

The orientation program could be designed to offer training and support to new providers periodically over an extended period of time. This model would allow providers the opportunity to obtain and retain important cultural knowledge over time as it becomes pertinent in their service delivery. The orientation program could utilize a developmental model for addressing cultural competency of these providers and challenge them to continue grappling with and exploring the complex nature of multicultural and cross-cultural service delivery. As providers acquire experience in the region, a variety of questions are likely to emerge. The orientation program could offer them a venue for exploring their questions within a context or framework that helps them understand the historical nature of the challenges experienced by the region's residents. Both supervision and mentorship should also focus on helping providers to understand these issues, develop cultural competency, and adapt evidenced based practices to meet the local needs of community members. The organization could support providers in pursuing continuing education opportunities that address training in evidence-based practices adapted to meet the needs of culturally diverse populations. The Alaska Rural Behavioral Health Academy is one example of an organization offering this type of continuing education.

In addition to a comprehensive orientation program, clinical supervision, cultural mentorship, and continuing education, it is advised that providers develop consultation groups and multidisciplinary teams with other local healthcare and social service

agencies in villages as well as the regional hub. Members of the consultation groups and multidisciplinary teams could include clinicians, social workers, case managers, physicians, physician assistants, nurses, probation officers, Office of Children's Services workers, Indian Child Welfare Act workers, village-based police officers, tribal social service workers, school counselors and village-based healthcare providers in order to address the needs of community members. By routinely meeting for clinical supervision, cultural mentorship, consultation groups, and multidisciplinary teams, providers are likely to develop a professional support network that allows them to decrease feelings of professional isolation and provide a comprehensive array of services to their clients. Furthermore, it allows them an opportunity to consider ethical matters that arise in rural and cross-cultural practice as well as monitor boundary issues and self-care.

Beyond offering providers opportunities to connect with other professionals and develop their clinical skills, professional support addresses organizational factors that cause burnout and turnover. The organization may reduce provider turnover by monitoring provider caseloads and ensuring that providers serve an array of clientele with varying clinical issues. In fact, the literature suggests that diversifying a provider's caseload is a preventative measure that guards against provider turnover and the development of vicarious trauma (Harrison & Westwood, 2009). Furthermore, retention may be positively influenced by organizational schedules that help providers balance village-based travel with on-call and after hours duty. For example, it may be advisable to refrain from scheduling a provider with on-call duty prior to or following village travel. In fact, providers who primarily offer village-based services may benefit from

being taken off of on-call duty when returning to the regional hub. Organizational and professional support of new providers to the region is vital for retention. Oversight of a new provider's schedule and caseload by seasoned providers may avoid early burnout and turnover of new providers.

Retention of local providers. Efforts to retain local providers are similar to those for retaining outside providers. Professional support in the form of clinical supervision and professional mentorship allow local providers to address the complicated nature of providing behavioral healthcare services to family, friends, and close acquaintances. In fact, receiving clinical supervision from a seasoned village-based counselor, participating in case staffing with other clinicians, and taking part in consultation and multidisciplinary teams are likely to decrease professional isolation. Furthermore, these activities help develop and hone local providers' clinical skills allowing them to develop confidence as a counselor. The development of a reciprocal relationship between the itinerant clinician and the village-based counselor facilitates the development of clinical expertise for both parties, as each person brings an important set of skills to the relationship from which the other person can learn.

Organizational support of providers' professional development is a vital component in retaining them. Moreover, rural healthcare organizations benefit when local providers are interested in completing degrees, especially at the master's level, as it reduces the need for the organization to recruit master level clinicians from outside of the region. Consequently, local providers may benefit from the regional healthcare organization supporting their education efforts through scholarships, paid release time

from work to complete studies, and tutoring. Furthermore, providers may benefit from the development of professional mentorship and a support group for local providers working on advanced degrees. This effort could be supported by the organization hosting regularly scheduled meetings between these individuals allowing education mentorship and support to occur. Meetings could be held in person as well as by teleconference or videoconference. Increased remuneration could occur per course completed toward a degree in human services.

Lastly, the existing behavioral health service model between the licensed clinician and village-based counselors could be modified. Taking into consideration billing requirements from various funding sources, it is likely that licensed clinicians will continue to be required to sign off on assessments and treatment plans. With that said, the service delivery model could be explicitly modified in a way that utilizes itinerant clinicians as a support mechanism for village-based counselors. This philosophy sets forth the expectation of the local provider being the expert in offering care to local community members. Since this model would have the outside clinicians serving in a supportive role, local providers, community members, and healthcare organizations would not expect outside providers to be utilized for on-going long-term care. Instead, given the frequency of turnover, their utility could be in lending a specific type of expertise until local providers are available to replace them. By creating a service model that explicitly outlines the short-term work of outside providers and the ongoing long-term work of local providers, community members' expectations of outside providers can be altered and disappointment may be lessened when outside providers depart.

Therefore, a concerted effort to change the way local community members view the role of the outside provider could ensue along with organizational support for the continued training efforts of local providers allowing them to eventually fill positions held by outside providers.

Summary of Conclusions and Recommendations

Healthcare provider shortages in rural underserved areas challenge healthcare organizations routinely to review recruitment and retention practices. Appealing to and selecting applicants who are well-suited to live and work in remote areas has the potential to decrease provider turnover. Once applicants are successfully recruited and hired, the organization must address the factors that influence retention. By building in opportunities and supports for providers to experience professional and personal satisfaction from their work, the probability of retention is likely enhanced. Retention issues for rural healthcare organizations relying on outside providers relocating to their area to offer services are likely to persist. Therefore, it is important for organizations to offer adequate support to reduce outside provider turnover while also developing opportunities for local community members to acquire skills, training, and education to eventually fill the bulk of these positions.

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Appendix A

Interview Guide

Demographic Questions

1. Name
2. Date of birth
3. Place of birth
4. Place of birth urban, rural, or remote
5. Cultural background/Ethnicity
6. Current community of residence
7. Educational Background
8. Behavioral Health or Healthcare Training
9. Number of years working in the healthcare field
10. Locations of past employment and employers (only those affiliated with healthcare)
11. Length of time living in the Bering Strait Region
12. Length of time living in current community
13. Current place of employment
14. Length of time in with this above mentioned employer
15. Current position
16. Length of time in the above mentioned position

Longevity

1. I would like to understand how many years a provider, coming from outside, must work in the community to be considered a long-term provider. What are your thoughts on this idea of long-term?

2. What factors influence whether or not a provider stays to work in the region for a long time?

3. Some providers stay and work longer than others. What qualities have you noticed about providers that help them stay longer than others?

4. For those providers who leave after only a short time, what qualities about them have you
noticed?

5. What about community members who have left to pursue training or education as behavioral healthcare providers and then returned to the region to live and work?

5a. What helps them stay?

5b. How does the community respond to them?

5c. How does this affect their work?

Service Utilization

6. For some people, it can be difficult to talk about their problems with clinicians who are from outside. What are your thoughts about this?

7. What factors influence whether or not a community member feels comfortable seeking help from an outside provider?

8. What qualities do clinicians have that help community members feel comfortable seeking their help?

9. What qualities do clinicians have that seem to make it difficult for community members to use their services?

10. What do clinicians do to make people more comfortable?

Mentorship

11. Some providers who are from outside are not familiar with the local culture. How do they learn about the local culture?

10a. What are your thoughts about a new provider working with a local Alaska Native
community member to learn about the culture?

12. What factors influence whether or not a provider works with a local community member or provider in order to learn about the culture?

13. What qualities do you think would be important for a provider to have in order to learn from a local community member?

14. What challenges come to mind when you think about a provider from the outside learning from local community members?

14a. What provider qualities might make it difficult to learn from a community member?

Appendix B

University of Alaska Fairbanks Institutional Review Board Approval

(907) 474-7800
(907) 474-5444 fax
fyirb@uaf.edu
www.uaf.edu/irb

UAF UNIVERSITY OF ALASKA FAIRBANKS

Institutional Review Board

909 N Koyukuk Dr. Suite 212, P.O. Box 757270, Fairbanks, Alaska 99775-7270

June 12, 2009

To: Inna Rivkin, PhD
Principal Investigator

From: Bridget Stockdale, Research Integrity Administrator
Office of Research Integrity

Re: IRB Protocol Application

Thank you for submitting the IRB protocol application identified below. This protocol has been administratively reviewed and determined to meet the requirements specified in the federal regulations regarding human subjects' protections for exempt research under 45 CFR 46.101(b)(2) for research involving the use of educational test, survey procedures, interview procedures or observation of public behavior, unless: (i) information is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects, and (ii) any disclosure of the human subjects' responses outside of the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing employability, or reputation.

Protocol #:	09-26
Title:	*Qualities of Clinicians Relocating to Rural Alaska that Predict Longevity, Successful Service Provision, and Engagement in Mentorship by Cultural Experts*
Level:	Exempt
Received:	June 1, 2009
Exemption Date:	June 12, 2009

If there are major changes to the scope of research or personnel involved on the project, please contact the Office of Research Integrity. Email us at fyirb@uaf.edu of call 474-7800. Contact the Office of Research Integrity if you have any questions regarding IRB policies or procedures.

University of Alaska Fairbanks Institutional Review Board Approval

(907) 474-7800
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FAIRBANKS

Institutional Review Board

909 N Koyukuk Dr. Suite 212 P.O. Box 757270 Fairbanks, Alaska 99775-7270

October 26, 2009

To: Inna Rivkin, PhD
Principal Investigator

From: Bridget Watson
Research Integrity Administrator
Office of Research Integrity

Re: IRB Modification Request

Thank you for submitting the modification request for the protocol identified below. It has been reviewed and approved by members of the IRB. On behalf of the IRB, I am pleased to inform you that your request has been granted.

Protocol #:	09-26
Title:	*Qualities of Clinicians Relocating to Rural Alaska that Predict Longevity, Successful Service Provision, and Engagement in Mentorship by Cultural Experts*
Modification:	Minor wording changes per the request of Norton Sound Health Corporation's Research Ethics Review Board (RERB).
Level:	Exempt
Received:	October 26, 2009
Approved:	October 26, 2009

Any modification or change to this protocol must be approved by the IRB prior to implementation. Modification Request Forms are available on the IRB website (http://www.uaf.edu/irb/Forms.htm). Please contact the Office of Research Integrity if you have any questions regarding IRB policies or procedures.

Appendix C

Participant Consent Form

The purpose of this research study is to understand what makes a behavioral health professional, who relocates to rural Alaska from another place, remain working and living in rural Alaska long-term. I am interested in learning about this subject from local professionals and paraprofessionals who work in the healthcare system. I would like know what you think effects:

1) how long a provider will stay working and living in rural Alaska
2) community members feeling comfortable using the services offered by providers;
3) providers learning about the culture and learning from local community members who are knowledgeable about the local culture.

Description of Study:
I am asking you to help me by taking part in an interview. If you want to participate in this research study, you will be asked to complete an interview that will last about 60 minutes. During the interview, you will be asked to provide your opinion by answering some questions. The interview will be recorded for transcription and purposes of analysis. Your answers will remain private, and your name will not be revealed in the findings or results of the study.

Benefits and Risks of Participating:
You will be provided with a $50.00 gift card for completing an interview. I expect this information will help me, and others working in behavioral health organizations, understand how provider retention and service provision could be improved. While you may not benefit directly from this study, I hope that the knowledge gained will improve the behavioral health services offered to people living in rural Alaska. Norton Sound Health Corporation will receive the results of this study. The results will be used to help hire and train future behavioral health providers. Results may be shared with other organizations serving rural Alaska and the larger field of rural healthcare through journal articles. Finally, the results will be included in my dissertation and will be shared during my dissertation defense.

I do not expect you to experience any risks from participating in the interview or this research study. However, some people might experience discomfort with some questions. You may choose not to answer any question that bothers you. You can also take breaks as you need. Should you feel uncomfortable, you may choose to stop and end your participation at any time.

Confidentiality:
I will safeguard your confidentiality. Your name will not be revealed in any report or presentation associated with this research study. The audio recorded information will be destroyed after transcription is completed. Your name will not appear on the transcribed

interviews. Furthermore, your name on the consent form will be kept separate from the interview data and stored in a different locked file cabinet.

Voluntary Nature of the Study:
Your decision to take part in the research study is voluntary. You are free to choose not to take part in the study or to stop taking part at any time without any penalty to you.

Contacts and Questions:
This research study has been reviewed and approved by the University of Alaska Fairbanks' Institutional Review Board (IRB) and Norton Sound Health Corporation's Research Ethics Review Board (RERB). If you have questions now, feel free to ask us. If you have questions later, you may contact me, Valerie Gifford. Or you can contact the principal investigator, Dr. Inna Rivkin.

You can contact Valerie Gifford at:

University of Alaska Fairbanks
Psychology Department, P.O. Box 756480
Fairbanks, AK 99775-6480
Telephone: (907)455-5784
Email: fsvmg@uaf.edu

You can contact Dr. Inna Rivkin at:

University of Alaska Fairbanks
Psychology Department, P. O. Box 756480
Fairbanks, AK 99775-6480
Telephone: 907-474-6178
Email: inna.rivkin@uaf.edu.

If you have questions about your rights or what to do if you are upset or hurt, you may contact the Research Coordinator in the Office of Research Integrity. The phone is (907) 474-7800 (Fairbanks area), or 1-866-876-7800 (outside the Fairbanks area). You can contact them by e-mail at fyirb@uaf.edu.

Signing this means that the research study has been told to you out loud or you have read it yourself and that you of your own free will agree to take part. Thank you for your help with this project.

I have read the above statement (or have had it read to me) and I understand my rights with regard to participating in this research study.

_____I agree to participate in this research study.

Participant Signature	Date
Participant Printed Name	Date